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Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

Slovakia

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1 Executive Summary

The Annual National Report outlines the current status in the pension system, health care and long-term care, analyses important reforms implemented in the previous year and the political and scientific discourse. The report includes an overview of new publications and a list of key institutions.

The parliament approved a revision of stringent investment rules and guarantees in the fully funded pension tier. To improve the viability of the private scheme, mandatory participation of new labour market entrants has been reinstalled as a default option.

A promising reform of the public pay-as-you-go pension system has been withdrawn from parliamentary negotiations after the fall of the government in October 2011. Plans included a linking of retirement age increase and pension calculation to demographic indicators. Earlier in 2011, a tightening of the early retirement scheme has been passed which disallows concurrence of early pensions and employment.

Given the political situation, the likelihood that the new regular government will adopt necessary parametric and systemic changes in the public scheme is relatively low. In contrast, the risk that fiscal consolidation may result in a weakening of the funded tier is not negligible.

Reform of drug policy and austerity measures in inpatient care including a reduction of hospital beds are perceived as the most beneficial health care reforms of 2011. On the other hand, a number of crucial reforms such as reduction of the basic benefit package or the introduction of a Diagnoses Related Groups payment system have been stopped due to the early elections.

The health sector witnessed an unprecedented protest action of doctors for higher remuneration and better working conditions. Mass filing of notices forced the government to proclaim a state of emergency in 15 hospitals in the beginning of December 2011. The government eventually acceded to all claims of the medical unionists. This will have a negative fiscal impact on the already highly indebted sector.

The parliament overrode the veto of the Slovak president and approved changes in the financing of social services. The provisional system envisages direct subsidies from the State budget to public providers and non-public providers of selected care services, and also higher co-payments by clients. Protective elements for low-income pensioners are included, but there is no impact assessment available.

The coalition wasted the opportunity to progress in the integration of health services and social services into a functioning long-term care system. Plans of a comprehensive long-term care law have not been materialised.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

Two factors have decisively impacted on the implementation of social protection reforms in the 2nd half of 2011: the fall of the Iveta Radicova government (resulting in early elections to be held on 10 March 2012) and the worsening economic outlook. Both issues entail negative implications for consolidation efforts and the structural reform agenda.

The economy continued to grow at decent pace in 2011 (GDP growth expected to exceed 3% in 2011 after 4.0% in 2010) and reached already the pre-crisis level. Economic growth benefited from a recovery in foreign demand, but domestic demand remains in the doldrums on the back of weak labour market performance. Unemployment remains on elevated levels (13.4% in 1-3Q2011) and the deteriorating external outlook and uncertainty about developments in the Eurozone add to the risk of further stagnation. Indicators of poverty and social exclusion have slightly worsened since 2008, but elderly people seem to be less affected than the remaining population owing to relatively unaffected pension provision.

The Slovak government pushed through changes in the fully-funded pension scheme to improve its viability. Promising reform plans in the pay-as-you-go scheme and the tax-contribution system had to be dropped after the fall of the government. Reforms in health care were overshadowed by a protest action of doctors and nurses for higher salaries. A partial reform of funding of social services was approved to mitigate the critical situation in long-term care financing.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The Slovak pension system comprises three tiers: a mandatory defined-benefit pay-as-you-go scheme, a mandatory defined-contribution funded scheme, and a voluntary supplementary defined-contribution funded scheme.

(1) Mandatory defined-benefit pay-as-you-go scheme *(pension insurance)*. The public scheme is administered by the state-controlled Social Insurance Agency (SIA). It is financed primarily by pension insurance contributions paid by economically active citizens in the amount of 18% of the assessment base (gross earnings) in case they are enrolled only in the first tier, and/or 9% of the assessment base if they are in the first and second tiers. Employees contribute with 4% and employers with 14% (in a mixed pension plan, 9% are redirected to the employee's pension account).

The maximum assessment base for contributions to the first (and also second) pension tier is set at four times of the average economy-wide gross wage established by the Statistical Office two years ago. The minimum assessment base applicable to self-employed persons and voluntary contributors equals to 44.2% of the equivalent average wage, for persons in paid employment a minimum base is not defined but remuneration must comply with minimum wage regulation.

The minimum insurance period for pension entitlements from the public scheme is 15 years. The State pays contributions on behalf of persons on maternity leave, persons taking care of children aged up to 6 years, caregivers and assistants to persons with severe disabilities. Social

insurance contributions paid to SIA as well as awarded pensions are exempt from the income tax. Pension insurance covers next to old-age also disability risks (contribution rate additional 6% of gross earnings), and as part of both subsystems, also survivors risks. According to preliminary data, SIA disbursed EUR 5.41 billion on disability, old-age and survivor pensions in 2011 (7.83% of GDP).

The 2004 reform of social insurance stipulated a gradual increase of the statutory retirement age from 60 years (men) and 53-57 years (women) to 62 years. Men retire at age 62 since 2008. Women will reach the same level by 2024. In 2011, women retired at age 56.75 to 60.75 years depending on the number of children raised.

The formula for retirement pensions from the PAYG pillar is the following:

Pension = POMB * R * ADH

"POMB" stands for Average Personal Wage Point and represents the ratio of individual earnings to average earnings in the economy. It is computed as an average of ratios respective to each year since 1984 till the retirement year. Maximum POMB is 3.00. POMB equal to 1.00 would mean that the worker has earned the average wage in the economy. The 2004 pension reform specified a transition period until 2014, during which values of POMB had to be adjusted (values below 1.00 increased and values between 1.25 and 3.00 reduced) with decreasing intensity so that as from 2015 benefits would be fully linked to earnings. A "freezing" of the POMB adjustments as of 1 January 2011 (values of POMB below 1.00 are added 16% of the difference between 1.00 and POMB, values between 1.25 and 3.00 are reduced to 84% of POMB) aims to maintain a certain degree of solidarity in the calculation of new pensions.

"R" stands for the number of years of pensions insurance (working period). The minimum insurance period is 15 years.

"ADH" stands for Actual Pension Value, which is a number determined by law in 2004 at SKK 183.58 (EUR 6.0937), aimed at providing a 50% replacement rate to a retiring worker who has contributed for 40 years. ADH is indexed annually by the average wage growth in the economy; in 2012 the value is EUR 10.0059.

Old-age pensions in the first tier are indexed every year as of 1 January taking into account year-on-year changes in wages and prices for the first half of the preceding year (so-called Swiss indexation by the arithmetic average of wage growth and inflation). In 2011, pensions were indexed by 1.8% and in 2012 by 3.3%.

The amount of an early retirement pension is calculated using the old-age pension formula, while the malus for each 30 days of early retirement is 0.5% of the calculated pension (equivalent to 6% per year). Entitled to receive an early retirement pension is a person meeting four conditions:

(i) at least 15 years of pension insurance;

(ii) less than 2 years till statutory retirement age;

(iii) his/her retirement pension is higher than 1.2 times of the minimum subsistence level (i.e. EUR 227.9 monthly since 1 July 2011).

(iv) effective since 1 January 2011, an early retired pensioner may not perform a gainful activity liable to compulsory pension insurance (i.e. he/she may not be in paid employment or self-employment, but may perform contractual work agreed outside an employment relationship such as so-called work performance agreements or work activity agreements). Early retirement pensioners were granted a two-month period (until 28 February 2011) during

which they had to decide between work and early pension. The number of disbursed early pensions decreased indeed from 49,151 as at end of February to 38,598 as at end of March and down to 32,130 as at end of December 2011. Reduced early pension payouts had a positive effect on SIA's old-age insurance fund, which closed the year 2011 with expenditures lower by EUR 91.53 million (-2%) against the plan.

There is no guarantee of a minimum retirement pension. Persons with low pensions or without pension entitlement whose income is below the minimum subsistence level (EUR 189.93 for a single person since 1 July 2011) may apply for a means-tested social assistance benefit and additional allowances to the benefit.

A draft amendment to the Act on social insurance, putting forward a number of parametric and systemic changes in the first tier, was in the pipeline in the second half of 2011. The proposal, however, did not find enough political support after the fall of the government on 11 October (see also section 2.2.2).

(2) Mandatory defined-contribution funded scheme (old-age pension saving). The funded system is in operation since 2005 and is administered by six private pension management companies. Citizens registered for pension insurance with SIA were granted an 18-months period from 1 January 2005 to 30 June 2006 to decide whether to join or not the second pillar and redirect part of contributions (9% of the gross wage) to personal accounts. More than 1.5 million citizens, i.e. 60% of the economically active population, joined the second pillar. During 2008 and 2009 the scheme had been temporarily opened two times for a total of 13.5 months to enable citizens to reassess their participation, which consequently led to the departure of approximately 135 thousand savers to a single pay-as-you-go (PAYG) pension plan. Since 1 January 2008, young people born after 31 December 1986 have a six months period after commencement of pension insurance to decide whether they will pay full 18% contributions to the PAYG scheme or save 9% in a personal pension account. Prior to the change, entering the second tier was mandatory for new policyholders. Experience shows that after optionality has been introduced, merely 13% of young people decide to join. As of 1 April 2012, mandatory participation of new labour market entrants will be reinstalled as a default option with the possibility to opt out of the funded scheme in the first two years (730 days) of saving. As at end of 2011, the funded scheme counted 1.44 million savers and assets totalled EUR 4.6 billion (6.7% of GDP). Old-age pension saving is also freed from the income tax.

Participants in the second pillar can choose between one of three funds administered by pension management companies – growth, balanced and conservative funds. These funds differ in terms of risk allocation; growth pension funds may include as much as 80% shares on total assets, balanced funds less than 50%, and conservative pension funds may not include shares. The highest portion of shares on total assets of pension funds was achieved in the beginning of 2008, when shares made up 15 to 20 % in growth funds and 10 to 15 % in balanced funds. By end of 2009 shares practically disappeared from pension fund portfolios (down to 0.1% of total assets) as a result of the financial crisis and new regulation obliging pension management companies to compensate possible negative returns in half-yearly intervals.

Out of the total number of 1.44 million savers, about two thirds are in growth funds, almost 30% in balanced funds and 5% in conservative funds. The allocation of assets is almost identical (Table 1).

Table 1: Assets in the DC scheme (as of 5 January 2012)

Growth funds	Balanced funds	Conservative funds	Total
EUR 2.96 billion (64%)	EUR 1.41 billion (31%)	EUR 0.23 billion (5%)	EUR 4.59 billion (100%)

Source: Association of Pension Funds Management Companies.

The saver may only be enrolled in one fund at the same time; changing the pension fund is conditioned by a saver's application. The life-cycle approach envisages that higher investment risk is taken in the earlier stages of working life. After reaching age 47 (i.e. in most case 15 years before retirement) the saver may not be enrolled in a growth pension fund. At age 55+ (in most cases 7 years before retirement age) the saver may not be enrolled in a growth or balanced pension fund.

A revision of the Act on old-age saving, coming into effect on 1 April 2012, changes a number of parameters in the second tier. The minimum contribution period for pension entitlements in the second tier will be decreased from 15 to 10 years. The scheme regains its mandatory character as new labour market entrants will be enrolled by default with the possibility to leave to a single PAYG pension plan in the first two years of saving. New savers have 180 days to choose a pension management company, otherwise SIA will assign a company and place the saver in a mixed fund. Modified investment rules, guarantees and fees should motivate pension companies to invest in riskier securities and thus potentially attain higher returns. To this end, existing funds will be renamed to equity funds (until now growth funds), mixed funds (balanced funds) and bond funds (conservative funds). The sum of bond and cash investments in the equity fund will be limited to 80% of the fund's net property value (i.e. at least 20% will have to be invested in high-risk securities such as shares). A new so-called index fund will be introduced that will allow unlimited investments into high-risk securities tied to global equity indexes or derivatives tied to interest rates, exchange rates and currencies. Mixed and growth funds will be also enabled to invest in precious metals up to 20% of the fund's value of property. Guarantees (i.e. obligation of funds to compensate decreases in the value of pension units) will be abolished in growth and balanced funds and preserved only in conservative funds. The half-yearly running interval for balancing pension unit value will be gradually extended to 5 years in bond funds and abolished in other funds.

Savers will gain the possibility to divide their savings into two funds of which one has to be the guaranteed bond fund. The existing life-cycle approach will be amended as follows: a saver reaching age 50 must have as a minimum 10% of assets in a bond fund and the percentage shall increase by at least 10% each year so that after 10 years the entire property will be saved in the guaranteed fund.

Changes concern also fees. The fee charged by pension funds on appreciation of assets (5.6% of attained returns) will be abolished in the bond fund. The 1% (of monthly contribution) fee, which is taken by pension management companies for keeping the personal pension accounts, will be modified to maximum 1%. Fees charged by pension management companies for the administration of pension funds will remain at the current level (up to 0.3% of a pension fund's property, yearly). Administration fees in an index fund will amount to 0.2% of property yearly at most, while the fee will be halved when attained returns will not reach a pre-defined reference value. At the same time, the array of costs that may be charged beyond this fee will be widened (by account service charges, fees for financial transactions, fees to securities dealers and depository, etc.).

(3) Voluntary supplementary defined-contribution funded scheme *(supplementary pension saving)*. The funded scheme is in operation since 1996 and is at present governed by four private supplementary pension companies.[1] It counted almost 0.8 million participants as at end of 2011 (30% of the economically active population), indicating an increase compared to 2010 (0.72 million savers). Until 2011, contributions up to EUR 398.33 per year could be deducted

[1] In June 2011 company AEGON left the supplementary pension saving market. With less than 5 thousand clients the smallest supplementary pension fund substantiated its departure by the stagnating supplementary pension market and the reduction of stimuli.

from the income tax base. This tax allowance has been discontinued since 1 January 2011 as a part of the fiscal consolidation package. The possibility for employers to count in contributions paid on behalf of employees up to the amount of 6% of their gross wage has been preserved. In 2010, employers contributed to around 85% of contracts. Assets in the third pillar amounted EUR 1.12 billion as at end of 2011 (1.6% of GDP).

Certain public services, so-called force departments (mainly army and police), fall under special social security systems, administered by competent ministries (Ministries of Interior and Defence). Financing comes from contributions paid by active participants, but a substantial part is covered by State budget subsidies. Average awarded pensions are significantly higher than pensions paid by SIA.

The social security system of force departments is regulated by the *Act on social security of policemen and soldiers*. Pension entitlements arise after a minimum of 15 years of service. The pension benefit for a 15-year career amounts to 30% of average earnings in the best salaried calendar year, received in the last 10 years of pre-retirement service. For each additional 5 years at work, the retirement pension is raised by 2% of earnings, and beginning with the 26th year in service the pension is increased by 1% per year up to a maximum of 60% of earnings. Payout is not conditioned by a fixed retirement age. A ministerial analysis of the long-term sustainability of pensions (Ministry of Labour, Ministry of Finance, 2011) concludes a.o. that soldiers and policemen contribute at substantially lower rates than would be actuarially fair rates (a contribution rate at which paid premium is in accord with pension entitlements of an individual throughout life). The preferential system is clearly unsustainable and providing it remains unreformed, the negative fiscal impact will further increase (see also section 2.2.2).

Since 2006 the government provides old-age pensioners, early retirement pensioners and disability pensioners with a Christmas pension benefit financed from the State budget. This bonus is not a component of the social insurance scheme, but a recurrent income support paid every year around Christmas to pensioners with pensions below 60% of the average wage in the economy (in 2011, up to a pension of EUR 461.4). In 2011, the sum ranged from EUR 39.24 to EUR 66.39 based on the sum of the recipient's pension (the higher the pension, the lower the benefit). Effective from 1 August 2011, new rules apply for the calculation of the Christmas benefit. The maximum benefit of EUR 66.39 is granted to pensioners with pension benefits below the minimum subsistence level (EUR 189.83 since 1 July 2011). The sum of the bonus for other pensioners is calculated using the formula 66.39 – 0.1*(P – SM), where P stands for pension and SM for subsistence minimum. The upper eligibility limit remains unchanged at 60% of the economy-wide average wage. The amended calculation is intended to provide for a smoother correlation between the pension amount and the Christmas bonus, in comparison to the previously applied intervals.

2.2.2 Debates and political discourse

Reforms of 2004-2005 set the framework for current pension provision by revising the public pay-as-you-go scheme and launching a private funded tier. The intention was to improve the sustainability of the pension system and ensure that pension provision starts to adapt to unfavourable demographic trends in advance. The new design, however, proved to be deficient to stabilise the system. A higher than expected number of persons redirected half of their contributions to the new funded scheme, and the insufficiently adapted public scheme, until 2015 responsible for entire pension provision, generated a growing deficit.

A number of revisions tried to address the shortcomings after 2005[2], many of them reversing previously adopted changes (e.g. mandatory or voluntary participation in the second tier). The high number of legislative amendments implies that in almost ten years stakeholders have not arrived at a consensus about the basic tenets of pension provision in the country. Frequent ad hoc changes, often politically motivated, have negatively impacted on the stability of the legal framework and added to uncertainty and distrust among citizens.

The Iveta Radicova government (in office between July 2010 and March 2012) pledged to reform all three pension tiers to improve current and future pension provision. To that end, the right-wing coalition decided to revise the stringent guarantees and investment rules and re-introduce compulsory participation in the funded scheme. Coalition MPs gave green light to the changes in October 2011 and pushed through also a shortening of the minimum saving period for entitlements from 15 to 10 years. The main subject of political debates was the legitimacy of removing guarantees from existing funds, which political opponents regarded as unconstitutional. Alternatively, they proposed to merge the three existing funds into one guaranteed conservative fund and to create a new equity fund (and possibly also a bond fund) with no guarantees. Given that conservative attitudes and low activity prevail among savers, although majority of them are enrolled in growth and balanced funds (ca. 65% and 30%, respectively), such a change would presumably not lead to a great movement between funds. In contrast, the approved version will leave most savers in an unguaranteed scheme and require individual action by savers if they prefer guarantees to riskier investments. Nevertheless, it may be assumed that even under these rules no mass movements will take place. Pension management companies were obliged to inform savers about the changes by 15 January 2012. The Ministry of Labour, Social Affairs and Family (MOLSAF) announced in September that another amendment to the old-age saving law is scheduled for 2012. This should primarily enact rules on the payout of pensions from the DC scheme.

Opposition party Smer, the main opponent of the changes, declared that if elected to constitute the new government they will reinstall guarantees in the balanced and growth funds and introduce an unguaranteed fund. At the same time, Smer intends to change participation in the funded scheme once again to voluntary for new entrants. The probability that a Smer-led government would proceed to a substantial reduction of the second tier because of the critical situation in public finances is not negligible (e.g. by changing the 9% : 9% contribution ratio to 15% : 3% in favour of the PAYG scheme).

In August 2011 the government approved an amendment to the *Act on social insurance* (submitted as a part of a package of legislative changes under the heading of the draft act on adjustment of income from dependent activity). The aim was to reform the public tier so as to make it financially sustainable. Unfortunately, the amendment was withdrawn from parliamentary negotiations after the break-up of the government on 11 October. Proposals included several potentially useful changes:

- An automatic adjustment mechanism would link statutory retirement age as from 2016 to the development of life expectancy at 62 (jointly for men and women).
- As from 2016, the annual indexation of actual pension value by average wage growth would be added an automatic correction coefficient reflecting the changing ratio of recipients and contributors.
- Calculation of the average personal wage point (POMB) would be amended to strengthen solidarity in the public scheme (i.e. to decrease higher pensions and increase

[2] The Act on old age saving (2nd tier) was subject to 21 legislative amendments since 2005. The Act on social insurance (1st tier) was changed no fewer than 60 times since 2004.

lower pensions). As from 2016, values of POMB between 1.00 and 3.00 would be decreased to 86% of the value and then gradually lowered by 2 ppt per year down to 52%. Similarly, POMB values below 1.00 would be added 20% of the difference between 1.00 and POMB and each following year another 2 ppt up to 40%.

- As from 2013, retirement pensions from the first tier would be indexed only for so-called pensioner inflation (inflation computed from the consumer basket typical for pensioner households).

In the review process, coalition MPs put forward a modified version of pension indexation that would remain partly attached also to wage growth (pensions would be raised by 50% of real wage growth if real wages increased by more than 3% year-on-year). A substantial comment voiced by the Institute for Labour and Family Research (public institution subordinated to MOLSAF) pointed to the fact that such important parametric changes as an increase in retirement age require a broad consensus in the society and should be debated more carefully in the expert community. Representatives of the research institution suggested that a major revision deserves to be addressed in a stand-alone legislative amendment. In spite of these reasonable arguments, there is little doubt that proposed changes would substantially improve the sustainability outlook in the PAYG scheme and perhaps help to improve the country's 'high risk' position in the assessment of long-term fiscal sustainability.

MOLSAF proposed as part of the consolidation measures to cancel the payment of the Christmas pension bonus and to use the EUR 65 million instead to top up the deficit financing of long-term care. The proposal, however, did not find enough support in the coalition.

The disrupted coalition stopped also a long-prepared tax and social contribution reform. The reform aimed to simplify the entire system and to reduce the gap in the contribution burden of employees and self-employed persons and contractual workers (burden is disproportionally high for dependent employment). Proposed were a unification of social contributions into a single contribution and the discontinuation of the 'fund' management of SIA.[3] In a next phase, the reform foresees unified administration and collection of taxes, social contributions and custom duties by a single financial office (project UNITAS).

2.2.3 Impact of EU social policies on the national level

Although the national policy debate is referring to the EU social agenda and the country's ensuing commitments evidently more often than it was two or three years ago, not much has changed on the perception of the roles of national policies and EU-level initiatives. The joint approach to ensuring adequate and sustainable pensions is acknowledged in the national reform agenda, but there seems to be no demand for greater EU coordination of social protection policies beyond the current open method of coordination.

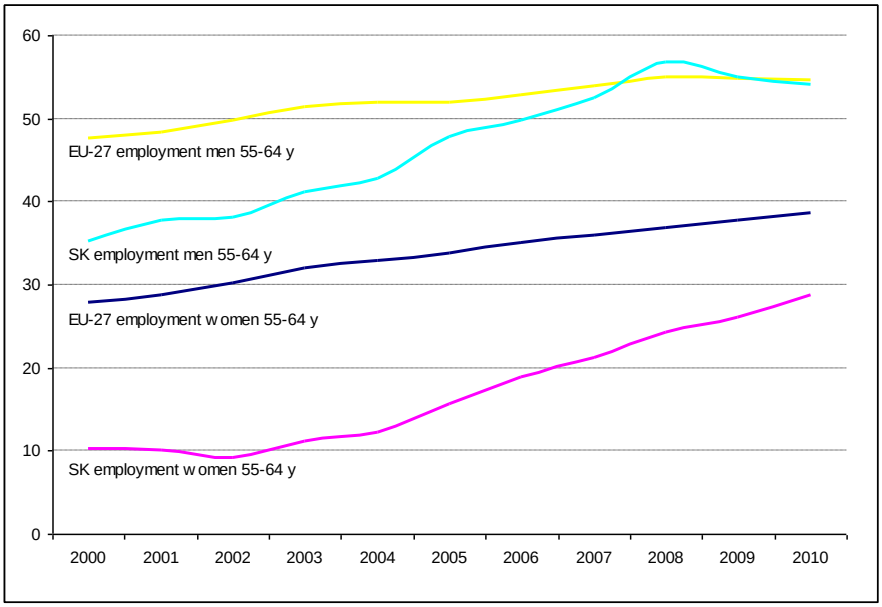
The pension reforms implemented and prepared in 2011 are in line with the Annual Growth Survey priorities, the Country Specific Recommendations and the Euro Plus Pact commitments in the area of sustainable public finances. The early retirement scheme has been tightened as of 1 January 2011. Participation in the fully-funded pension scheme has become mandatory again and investment rules have been relaxed to enable potentially higher returns. Even though the crucial reform of the public PAYG pillar eventually did not make it to the vote, the proposal showed the direction to be followed by the next cabinet.

[3] SIA administers seven different funds – the sickness insurance fund, old-age pension insurance fund, disability pension insurance fund, accident insurance fund, guarantee insurance fund, unemployment insurance fund, and reserve fund. Old-age insurance and disability insurance together form pension insurance.

2.2.4 Impact assessment

Economic activity of older citizens recorded a noteworthy increase in the past years owing mainly to the increase in the pensionable age (see section 2.2.1). Without the effect of prolonging years of service no substantial changes in pre-retirement employment would presumably occur. Figure 1 shows that employment of Slovak senior workers is catching up significantly with the EU average. This catch up process will likely continue in the female elderly workforce as a result of the ongoing retirement age increase. This very factor was behind employment growth of older female workers during the crisis when employment of the remaining workforce clearly decreased.

Figure 1: Employment rate in the age group 55-64 y (%)



Source: Eurostat Database.

Employment of older workers is negatively affected by several factors, including early exit pathways[4], low participation in adult learning activities[5], skills shortages (notably language and IT skills), but also stringency of labour regulations[6] and age discrimination[7].

MOLSAF's 2010 edition of the *Global report on the state of gender equality in Slovakia* (Ministry of Labour, 2011a) draws attention to the increasing gender gap in retirement

[4] According to Eurostat data, expenditures on early pensions in Slovakia are the highest in the EU relative to total labour market policy expenses. The abolition of work and early retirement concurrence resulted in a sizeable decrease of early pensions in 2011 (see section 2.2.1).

[5] Eurostat data suggest that the overall very low participation rate of adults in any form of lifelong learning in Slovakia displays particularly low in the older age groups (less than 1% of population aged 50 and above, compared to 4.5% in the EU-27).

[6] Recent literature on labour market impacts of employment protection has found that overly strict protection worsens employment chances of disadvantaged groups, especially youth, but also unskilled workers and to some extent elderly workers. See, for example Venn, D. (2009), Legislation, collective bargaining and enforcement: Updating the OECD employment protection indicators. OECD, Paris, retrieved at http://www.oecd.org/dataoecd/36/9/43116624.pdf.

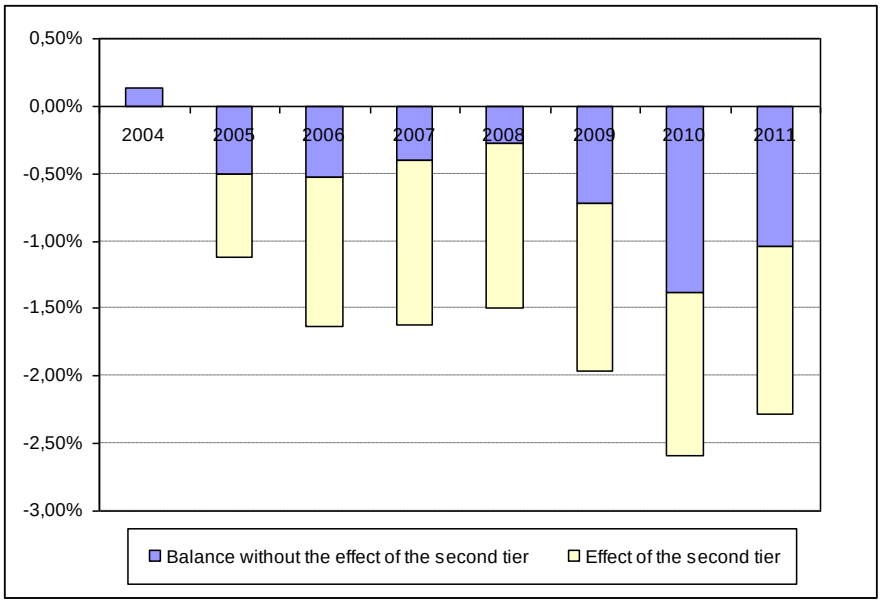
[7] Information provided by control departments of labour offices indicates that age is the most frequent cause of discrimination in the workplace, particularly in hiring and firing procedures. It is often exercised latently and thus difficult to prove. Source: Report on the Observance of Human Rights Including the Observance of The Principle of Equal Treatment in the Slovak Republic for the Year 2008, Slovak National Centre for Human Rights, 2009, retrieved at http://www.snslp.sk/files/SNCHR_Report_Observance_of_Human_Rights_2008.pdf.

pensions. While in 2005 the difference between an average male and a female old-age pension was 16.8%, in 2010 the gap increased to 21.3% (EUR 400 and 315, respectively). Slower increase of average female pensions reflects the strengthening link in the pension system between contributions paid and benefits received (introduced by the 2004 reform). Lower pension benefits and longer periods of pension drawing explain why women face a significantly higher risk of poverty in old age than men (10.1% and 3.9% in 2010, respectively).

In contrast to the working-age population, the income situation of pensioners has relatively improved during the crisis, suggesting that current provisions in old age have not suffered from the negative effects of the crisis to the extent as have earnings from work. Other than that, the impact of the crisis is clearly negative in all pension tiers, as it deepened the deficit in public pensions and decreased accumulation of assets in the funded schemes, and will thus affect future retirement provisions.

The calculation and indexation of pensions in the first tier does not take into account changes in SIA's real revenues, which are influenced by economic and demographic factors. The setting of the public scheme does not enable a flexible adjustment to the economic cycle and population ageing, resulting in deepening financial imbalance in public pensions. This has become an urgent problem in 2009 and 2010, when unemployment as a consequence of the economic crisis elevated significantly and wage growth slowed down, which subsequently turned into a deepening shortfall in SIA's old-age pension fund (Figure 2).

Figure 2: Pension fund balance (as % of GDP, including the reserve fund surplus)



Note: 2011 - estimate
Source: INEKO calculations based on data from the Ministry of Finance and the Social Insurance Agency.

The impact of the fully-funded tier on the pension fund shortfall (i.e. transitional costs) is around 1.2% of GDP annually. Abstracting from this effect, the deficit in the pension fund decreased to 0.3% in GDP terms in years of strong economic growth in 2006-2008, while after the break out of the crisis it exceeded 0.7% of GDP in 2009 and mounted to 1.4% of GDP in 2010. Counting in the effect of the second pillar the shortfall arrived at 2.6% of GDP in 2010.

SIA finances the deficit in the pension fund primarily from the surplus attained in other administered funds (mainly the reserve fund, sickness fund, and unemployment fund). Besides that, state financial assets from privatisation revenues serve to cover transitional costs associated with the introduction of the funded pillar in 2005. All these sources, however, had

been spent by end of 2009 and since 2010 the deficit in the pension fund is fully covered from the State Budget. As shown in Table 2, according to preliminary estimates the subsidy amounted to EUR 1.5 billion in 2011, of which 0.86 billion were transitional costs.

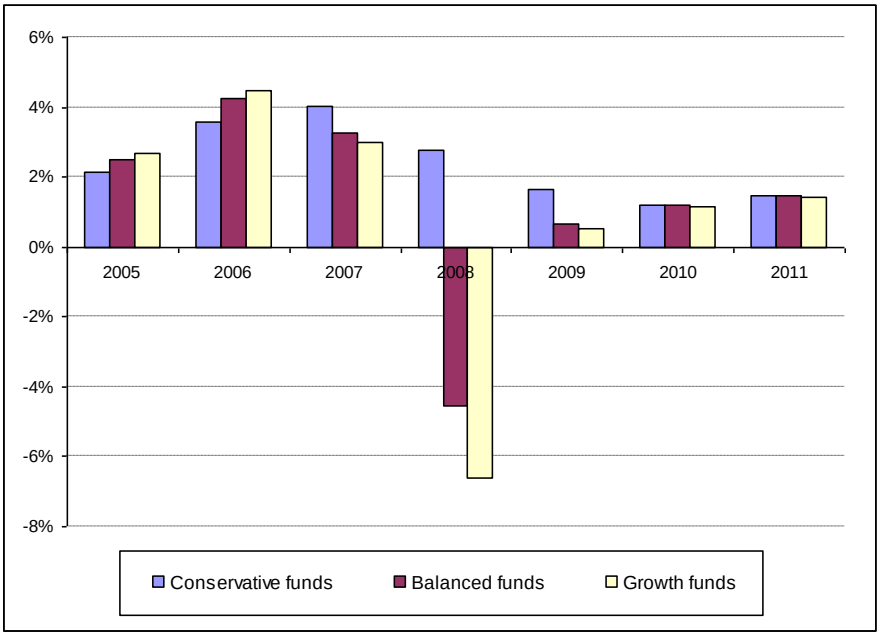
Table 2: Transfers to cover the deficit in the Social Insurance Agency (in EUR million)

	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Transfer from SIA to PMC	305	606	750	815	780	781	857
Transfer from SFA to SIA	0	637	671	568	875	76	0
Transfer from SB to SIA	0	0	0	0	0	1,492	1,509

Note: 2011 – estimate. SIA – Social Insurance Agency, PMC – pension management companies, SFA – state financial assets, SB – State Budget
Source: Social Insurance Agency.

Assets in pension funds have clearly suffered from the downturn on financial markets and legislative restrictions on investment rules adopted in 2009. The obligation of pension management companies to compensate negative returns created incentives to reduce proportion of riskier assets just in the time when financial markets started to revive. As a result, the structure of assets and attained returns in the different funds have practically harmonised.

Figure 3: Gross nominal returns in the second tier (weighted averages)



Source: INEKO calculations based on data of the Association of pension funds management companies.

An *Analysis of the long-term sustainability of the pension system and proposals for changes* (Ministry of Finance, 2011)[8] concludes that:

- The pay-as-you-go pension system will experience serious problems of financial sustainability on the back of unfavourable demographic developments. It is therefore necessary to respond already today with the integration of mechanisms that would adapt the system automatically and continuously to demographic factors.
- The real rate of contributions to balance the pay-as-you-go system in old-age insurance is around 27%, i.e. approximately 4.15 ppt above the current rate (the reserve solidarity fund

[8] The analysis connects on a homonymous document, prepared in January 2011. The new version is supplemented by policy recommendations, most of which have been incorporated in the halted draft amendment to the Act on Social Insurance (see section 2.2.2).

with 4.75% is considered a component of old-age insurance as it is entirely used to co-finance retirement pensions). The deficit in the old-age pension insurance fund is cross-financed not only from the disability pension insurance fund but subsidised also from other surplus insurance schemes, in particular sickness, unemployment, and accident insurance.

- Today's economically productive population consisting of demographically strong age-groups of 1960-1985 will gradually reach pensionable age. The demographic crisis will culminate around year 2055 when the old-age dependency ratio (population aged 65 and over as a percentage of the population aged 15-64) is expected to peak. To put it simply, while today six productive persons "finance" one retired person, in 2060 there will be only 1.5 working-age persons per one pensioner.
- Expenditures on pensions (in GDP terms) are expected to grow rapidly after 2020 and will continue to grow until the end of the projected period (2060). After 2020, however, first pensioners from the mixed system (first and second tiers) will start to retire.[9] Payment of part of the pension benefits from old-age pension saving will significantly relieve spending in the pay-as-you-go scheme.
- Calculations show that policemen and soldiers contribute at rates which are substantially below fair rates. In that case policemen would have to pay contributions at 59% of wages and soldiers even 72% considering their earlier retirement and longer remaining life expectancy. Even a 30-year service and a retirement age of 50 would not suffice for the system to be financially sustainable. The main reasons are very high effective replacement rates and long periods of pension benefit drawing.

Available national data and international comparisons suggest that current pension provisions are relatively sufficient to preserve income and living conditions when moving from work to retirement. The system generates low pensions for low earners and those with short contributory periods, but these cohorts are supported with social assistance benefits. However, given the adverse demographic trends, the replacement rates are expected to decrease over the long term. According to a recent exercise by the Indicators' Sub-Group of the Social Protection Committee on current and prospective theoretical replacement rates, the percentage of an average worker's net pre-retirement income to be paid out upon retirement will decrease by 9.2 ppt from 74.6% in 2010 to 65.4% in 2050. Similarly, replacement rates are expected to drop for most of the workers represented by the 'variant cases', but mostly for low-income earners (-13.6%) and older pensioners (-16.2%). Lowest prospective replacement rates are found for workers with careers breaks, but these start from rather low current levels and are expected to change just moderately (except for a 10 year career break, where the negative effect would increase from 24.9% to 27.2% of the net replacement rate of an average earner).

2.2.5 Critical assessment of reforms, discussions and research carried out

The key challenge for the Slovak pension system is to ensure financially sustainable and socially adequate retirement income provision. The year 2011 was a year of important reforms and reform plans in this respect.

The main objectives of amendments to the second tier were to stabilise the private scheme and to improve incentives for pension funds to adopt a more dynamic investment policy. The reintroduction of mandatory participation for new labour market entrants may be considered as a relevant measure with regard to the long-term sustainability of the system. The shortening of the contribution period needed for a pension was not included in the government's draft law but

[9] Due to a shortening of the minimum contribution period required for entitlements from the second tier from 15 to 10 years (approved in October 2011), first beneficiaries from the mixed system will 'arrive' already after 2015.

pushed through by MPs. The change means that the scheme will start to pay first pensions in 2015 and thus shorten the transitory period to a mixed system. On the other hand, shorter minimum saving period may translate also into lower pensions in payment.

It is regrettable that the coalition has not found a consensus on the public pension reform. Proposed changes, above all the linking of retirement age and pension formula to demographic indicators, would create preconditions for a more sustainable PAYG system. In their election programmes, political parties avoid the discussion about retirement age increase. The chances are fairly low that the new government, which will enter the office after early elections on 10 March 2012, will reopen the debate about parametric and systemic changes in the first tier. Nevertheless, the new political representation will be forced to deal with the shortfall in the pension fund.

The new government should open a society wide debate about the tenets of the pension system and the necessary changes. After years of countless revisions the pension system calls for stable legislation and clear rules. Reforms of the individual tiers should be prepared and implemented in conjunction. Ideally, reforms would include the introduction of automatic adjustment mechanisms of retirement age and pension calculation to demographic trends. Early retirement and disability pensions should be further examined for undue incentives to leave the labour market prematurely. Mandatory participation of new labour market entrants in the funded scheme as a default option should be definitely preserved. A return to voluntary participation would most likely weaken the scheme's future positive contribution to sustainable pensions. The second tier requires the enactment of clear rules on payment of future pensions. The government could also reconsider the introduction of reasonable incentives in the supplementary pension scheme. Another policy priority is a thorough reassessment of the financially unsustainable special pension schemes of soldiers, policemen and other relevant occupations.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The Slovak health care system is characterised by universal health care provision to which all citizens are entitled on the basis of mandatory public health insurance. The contribution rate is 14% of the assessment base (gross earnings), of which employees contribute with 4% and employers with 10%.[10] The universal claim covers basically the entire health care with the exception of a small number of performed services (e.g. in stomatology and cosmetic surgery) and also a part of costs for drugs and medical aids, covered by patients in cash.

Minor changes in co-payments for drugs arrive with almost every quarterly classification of pharmaceuticals. Co-payments tend to rise even though drug prices in general decrease. As from 1 April 2012, this trend may even intensify as drug prices will be referenced at the level of the second lowest price in the EU (at present, prices may not exceed the average of six lowest prices in the EU). Increase of co-payments is in line with health experts' recommendations, who state that Slovakia has one of the lowest shares of private spending on total drug expenditures in the OECD.

On the other hand, Slovakia ranks above the OECD average in out-of-pocket payments. Direct payments have risen sharply in Slovakia in the past years, owing not only to fees introduced within the 2003-2004 reform. Payments for visiting the doctor and staying in hospital have been abolished and fees for drug prescription lowered in 2006, but a high level of out-of-pocket

[10] The same 14% contribution rate applies also to self-employed persons. If the policyholder is a disabled person, his/he contribution rate is 7% (2% employee, 5% employer).

payments remained thereafter. The reasons can be found in the uncontrolled rise of diverse semi-official payments, which are insufficiently regulated.

According to a ministerial report (Ministry of Health, 2011) there are no analyses available of this phenomenon. In practice, payments are taken for instance for club cards, annual fees for dispensarization in private centres, charges for differently defined above-standard care and services, fees for choosing a doctor, operating surgeon or obstetrician, and health care offered by non-contractual providers. Last but not least, there remains lack of information about the size of the grey economy particularly in hospital care, where doctors are offered various payments for preferential treatment or choice of a doctor. According to the Ministry of Health, provided that the scope and level of public financing in health care will not be raised, the financial burden on patients is to increase and the access to quality health care for socially vulnerable groups will decline. A substantial increase of spending from public sources, however, is unrealistic given the current strain in public finances. Instead, it is necessary to bring order into the regulation of fees to prevent their uncontrolled expansion. To prevent that growing out-of pocket spending unbearably burdens disadvantaged groups, an upper limit for direct payments needs to be installed.

The Ministry of Health submitted in mid-2011 a draft law stipulating rules on fees for preferential treatment, above-standard hospital rooms, choice of surgeon and co-paid and/or fully paid drugs. The proposal de facto legalised common practice applied in Slovak hospitals. The fee for hospital stay was eventually taken out, although it would be reasonable to charge inpatients for accommodation and boarding which they would have to pay when staying at home. Ultimately the draft law even did not make it to the government's session.

The government approved the introduction of a protective upper limit on co-payments for drugs for low-income pensioners (up to EUR 372.25 monthly) and severely disabled persons. The limit applies only to the cheapest alternative of particular drug. Pensioners and disabled persons are since 1 January 2011 entitled to a reimbursement of expenses exceeding EUR 45 and EUR 30 per month, respectively. Data for the 3rd quarter of 2011 show that health insurance companies reimbursed 6 thousand pensioners and disabled persons on average with EUR 15 for drug co-payments. An amendment widens since 1 December 2011 the number of medications counted in the protective limit. This will now include all drugs co-paid from health insurance (until now it applied to drugs co-paid by health insurance companies at least at 75% of the price). Patients will first benefit from the change in June 2012 when co-payments for the 1st quarter will be refunded.

Mandatory public health insurance is performed by one state-owned and two private joint stock companies. As far as the market position is concerned, state-owned Vseobecna zdravotna poistovna (VsZP) has a dominant position with a 64.7% share on the number of policyholders. The respective shares of private insurance companies Dovera and Union are 27.5% and 7.8%, respectively (Table 3).

Table 3: The Slovak health insurance market

Company	Number of policyholders as of 30 Sept 2011	Incoming	Outgoing	Balance	Number of policyholders as of 1 Jan 2012 (est.)	% of insurance stock
Dovera	1,401,058	88,182	47,208	+ 40,974	1,442,032	27.54%
VsZP	3,448,558	14,152	75,693	- 61,541	3,387,017	64.68%
Union	387,025	54,997	34,430	+ 20,567	407,592	7.78%
Total	5,236,641	157,331	157,331	—	5,236,641	100.00%

Source: Health Care Surveillance Authority.

VsZP reported a preliminary loss at EUR 70 million as at end of 2010, yet an inspection uncovered that the previous management did not create sufficient adjusting entries on receivables and hence the actual loss amounted to EUR 120 million (see Table 4). The Health Care Surveillance Authority (HCSA) alerted the company in October 2010 to take urgent stabilisation measures. VSZP adopted a recovery package, including cuts in health care purchase and redundancies. The critical financial situation of VsZP was behind the government's decision to postpone the coming into effect of an amendment to the *Act on health insurance companies* from April 2011 to January 2013. The revised law stipulates stricter conditions of reporting on financial solvency. HCSA stated that VsZP demonstrated in 2011 solvency pursuant to the health care law, meaning that the insurance company did not report financial liabilities towards providers more than 30 days after maturity date. The goal for 2011 and 2012 is a balanced financial statement. As of 31 October 2011, VsZP attained profits at EUR 5.3 million. Private company Dovera expected in 2011 profit at 1% of the company's returns and in 2012 a balanced budget. Private company Union assumed a profit at EUR 9 million in 2011 and a moderate surplus in 2012.

Table 4: Balance of health insurance companies (as at 31 December 2010, final data, in EUR)

VsZP	- 120,230,292
Dovera	16,200,000
Union	- 2,264,534

Source: Health Care Surveillance Authority, eTrend.

No substantial changes occurred in the public-private mix of health care provision in the monitored period. The former cabinet (in office until mid-2010) pushed through preferable conditions for state providers (minimum network of providers with guaranteed contracts, repayable financial aid, restrictions on profit in health insurance, etc.). The state maintains decisive influence in the provision of institutional care through major teaching hospitals as well as in health insurance through the dominant VsZP.

An ambitious plan aimed at the transformation of state hospitals into joint-stock companies by end of 2011. In the framework of this goal, the cabinet and the parliament gave green light to the Ministry's proposal to remit hospitals a EUR 130 million loan and approve additional EUR 350 million for further debt consolidation. After the fall of the government in October 2011, the Slovak president stopped the transformation of hospitals under the pressure of protesting doctors. Since the non-repayable state aid was conditioned by the transformation of hospitals, the Minister of Health had to re-classify the aid to repayable loan, as it could otherwise be considered by EU authorities as unjustified state aid.

In the analysed period, a number of reforms have been implemented:

- New definition of the minimum network of providers, which health insurance companies are obliged to contract. The revision removed the preferential position of 34 state-owned hospitals.
- Revision of the decree on waiting lists with the aim to enhance transparency of inserting policyholders in waiting lists for planned medical services, improve comparability and shorten waiting periods for diagnoses, outpatient and oncological care (maximum 12 months after insertion).
- As from 1 April, emergency care services will be available only until 10:00 PM. The Ministry of Health agreed to a request from doctors, arguing that emergency services in late night hours are inefficient.
- The administratively burdensome annual health insurance clearance will be carried out as from 2012 by health insurance companies instead of policyholders and/or their employers.
- Health insurance companies regain the possibility to keep profits. Two preconditions apply: part of the profit must be used to finance a reserve fund up to the sum of 20% of the paid-in capital, and technical reserves must be created for the reimbursement of planned health care for policyholders on waiting lists. The Constitutional Court of the Slovak Republic ruled that restrictions on utilisation of profit enacted by the former government were unconstitutional.
- Reform of drug policy introduces a more flexible and transparent drug classification. New drugs will be classified temporarily for 2 years and then their effectiveness must be proved. New rules forbid for instance that representatives of pharmaceutical companies visit physicians during office hours or grant them any financial or in-kind gifts or benefits.

On the other hand, several reform plans have not been passed or have been stopped due to the political turmoil. Besides the halted transformation of state hospitals, uncompleted reforms include also the introduction of a lucid system of quality assessment and provider accreditation, deregulated sale of over-the-counter drugs, or the redefined scope of supplementary private health insurance. The shortened election term slowed down also the introduction of a Diagnosis Related Groups payment system (DRG-system). Nevertheless, progress has been achieved and HCSA signed in December 2011 a contract on cooperation with the German Institute for the Hospital Remuneration System. Slovakia will hence implement the German DRG-system.

2.3.2 Debates and political discourse

Inspired by a successful protest of doctors in neighbouring Czech Republic, the Slovak Medical Trade Unions (MTUs) initiated in early 2011 a campaign for reforms in the health care system. Their claims included an increase of salaries to 150-300% of the economy-wide average wage, stop of state hospital transformation, compliance with Labour Code provisions, and reformed financing of health care facilities. MTUs gave an ultimatum to the Ministry of Health for the fulfilment of the requests. Being dissatisfied with the progress, doctors started a protest action under the threat of mass filing of notices. As at 1 October 2011, more than 2,400 doctors filed a notice (37% of all doctors employed in hospitals). The coercive action continued after the fall of the government. The Slovak president who overtook some of the government's key powers, suspended and later on completely cancelled the transformation of hospitals. Negotiations between MTUs and the caretaker government intensified with the expiring notice periods and focused already merely on wage increases. Unyielding MTUs refused a proposal to raise the basic salaries of doctors by EUR 300 (to compare, an average retirement pension was EUR 362 in December 2011). The public sentiment turned against the protesting doctors; according to a

public opinion poll, 60% of citizens expressed non-support to the protest action. The government offered MTUs a Memorandum addressing all requests. On 29 November the government proclaimed a state of emergency in 15 hospitals where health care provision was supposed to be mostly threatened by notices. Approximately 1,200 doctors have not withdrawn notice. Protesting doctors have been eventually given guarantees for the fulfilment of all claims and the state of emergency was ended on 8 December. In December the parliament approved legal amendments guaranteeing a stepwise raising of minimum wage claims for commencing and experienced doctors up to 120% and 190% of the average wage, respectively, by 30 June 2012. The government committed also to guarantee that doctors will not have to work more hours than specified in the Labour Code and that so-called personal norms will be observed (defining for example the maximum number of patients per one practitioner).

Wages of Slovak doctors grew cumulatively by 47% between 2005 and 2008, while the average wage in the economy grew by 26% in the same period.[11] According to the OECD, average salaries of general practitioners reached EUR 1,537 monthly, equal to 220% of the economy-wide average, which is a level comparable with the majority of advanced economies. A lower estimate by institute INEKO sees Slovak doctors earning on average between EUR 1,050 and 3,200 monthly in 2010, based on specialisation.

The Czech case inspired also Slovak nurses who considered a mass filing of notices to achieve higher salaries, better working conditions and earlier retirement. They decided, however, to pursue their claims through intensive negotiations with the Ministry of Health, which eventually paid off. They succeeded to push through all their claims except for the last one (earlier retirement) and in February 2012 a new law stipulated minimal wage claims of nurses and birth assistants according to the length of practice and achieved education level (EUR 640-994).

The approved pay increases for doctors and nurses, however, are not backed by sufficient funds in the sector. Several hospitals report incapacity to pay higher salaries and the Social Insurance Agency expects growing evasion of social security payments. Organisations providing long-term care intend to re-classify nurses to "cheaper" caregivers (see also chapter on long-term care).

A thorough quality assessment system is still absent. Measuring quality of health care and disseminating information to the public is essential for reducing information asymmetry which is a typical feature of the system. The commitment from the 2011-2014 National Reform Programme to introduce a meaningful system of quality assessment and provider accreditation has not been accomplished and the development of a new enlarged list of indicators of quality is waiting for the next government. The new list is expected to address critical gaps such as the occurrence of decubitus ulcers which are an urgent problem in Slovak hospitals owing also to the shortage of staff. The Ministry of Health critically acknowledges the shortcomings in the existing system of quality assessment and its linkage to accreditation of providers.

2.3.3 Impact of EU social policies on the national level

The national debate about the role of OMC in the field of health care remains non-existent. The perhaps only important reference to the OMC and Europe 2020 strategy can be found in the 2011-2014 National Reform Programme of April 2011, which set a national health target to improve health care services to facilitate an increase of healthy life expectancy without disability or a severe handicap at birth to 60 years by 2020. The NRP presents plans to make health spending more effective and improve access and quality of health care services.

[11] Source: HPI (2011).

The links between health and ageing and poverty are materialised in the protective upper limit on co-payments for drugs for low-income pensioners and severely disabled persons. The limit has been widened in 2011 to cover all drugs from the classification list. According to a ministerial Report on the state of health care (Ministry of Health, 2011) a substantial part of the Roma population in Slovakia (estimated 350-380 thousand) is dependent on social assistance. The multidimensional nature of poverty includes increasing health risks, which are accelerated also by worsened geographical and financial accessibility of health care. The National action plan of the Slovak Republic for the Decade of Roma Inclusion 2005-2015 sets policy priorities within the area of health, including the creation of a reliable database on the health status and inequalities, steps to improve access of Roma (mainly those from segregated communities) to health care and improved awareness thereof, and improvements in vaccination and sexual health of Roma.

2.3.4 Impact assessment

As stated in the previous Annual National Report, the economic crisis accelerated a recovery process in the Slovak health system that would have been necessary anyway in view of unsustainable arrangements. The unfavourable short-term effects of rationalisation measures on access to health care are experienced with different intensity among particular population groups. The Ministry of Health points to a worsening financial accessibility in socially disadvantaged groups mainly in specialised outpatient care and stomatology.

The *Report on the state of health care in Slovakia* (Ministry of Health, 2011) states that physical accessibility of health care is at a very good level. Almost 80% of citizens have a general practitioner office in the place of their residence. Basic outpatient specialists are accessible in the place of residence for 50% of the population, and for 99% of the population within a 30 minute car drive. Similarly, hospitals are easy reached by 98% of inhabitants. Territorial division of emergency services ensures that an ambulance arrives within 15 minutes to the residence of 95% of the population (Filko, 2010). According to the Ministry, suboptimal is the access to highly specialised health care, while the access to nursing services for chronically ill is perceived as low. A major problem is the generally poor access (not only physical) to long-term care services for elderly people (see also chapter 2.4)

As far as the gender dimension is concerned, there are no observable differences in the access and quality of health care between men and women. A different picture is suggested by health outcomes. Although mortality of men from most causes significantly improved[12] over the last decade while at the same time it stagnated for women, there remain substantial gender differences. Mortality from cardiovascular diseases is 1.5 times higher for men than women. The death rate for cancers is 1.9 times higher in men and the biggest gap concerns external causes of death, which are 4.5 times more prevalent in men than women. Nevertheless, the gender gap in death rates somewhat decreased in the last ten years and this has also translated into higher gains in life expectancy for men (from 69.2 years in 2000 to 71.7 years in 2009) than women (from 77.5 years in 2000 to 79.3 years in 2010).

A serious problem of the Slovak health care system is the worsening situation in human resources, perceptible most of all in hospital care (Ministry of Health, 2011). The main reasons are an ongoing outflow of qualified workers to the private outpatient sphere and migration abroad. There are no precise data on migration of medical staff, however, available estimates on doctors suggest that between 2004 and 2009 approximately 2,800 Slovak doctors left for work abroad, of which about 1,000 headed to the Czech Republic and 1,800 to other EU

[12] Respiratory diseases are an exception (Ministry of Health, 2011).

countries.[13] It means that out of the total number of 18,000 doctors around 15% left the country. Inward migration of foreign medical workers is negligible and is limited to individual incoming of mainly Ukrainian workers and foreign graduates of Slovak universities. The number of foreign born doctors in Slovakia does not exceed 0.4% of the total staff according to data of the Ministry of Health. Data on backward migration are completely missing, but it is estimated that up to 15% of those who left eventually return. Migration has a serious impact on the age structure of medical staff, as on the leave are mainly graduates and young certified doctors. Ageing of medical workers continues – while in 2002 workers aged 55+ accounted for 8.6% of total staff, in 2009 the percentage climbed to 20.4%. The Ministry envisages a serious shortage of doctors in certain specialisations as soon as in 5-10 years. A similar trend concerns nurses. According to the Slovak Chamber of Nurses and Birth Assistants, each year 1,200-1,600 nurses retire and only 500 graduates leave schools, of which at least 200 emigrate for work abroad.

2.3.5 Critical assessment of reforms, discussions and research carried out

According to a Special Eurobarometer survey, 53% of the Slovak population rate the overall quality of health care in their country as good (70% in the EU-27), but nearly the same percentage (51%) think that the quality of health care is worse than in other Member States. More than two thirds (68%) of Slovaks are afraid they might be harmed through incorrect, missed or delayed diagnoses (European Commission, 2010). Research suggests that life expectancy at birth could be raised by as much as 4 years in Slovakia just by way of improving efficiency of the health care system (OECD, 2010).

The Ministry of Health initiated a number of policy reforms in 2011 but several plans have been stopped after the fall of the government in October 2011. Among the most beneficial projects is the reform of drug policy and the rationalisation of hospital beds and departments and other austerity measures implemented in cooperation with the state-owned health insurance company VsZP (such as prioritisation of one day care). Changes in drug policy have the potential to bring in more transparency and efficiency in the system and thereby also attain some savings in public finances. An important qualitative change is the mandatory prescription of drugs at the level of their active ingredients (generic drug prescription). A positive step was also the redefinition of the minimum network of providers, ensuring equal position of public and non-public providers of hospital care. Several important changes are at different stages of preparation (DRG-System, Pharmacy-based Cost Group model) and should be put into practice by the next government.

The perhaps biggest failure was the underestimation and late response of policy makers to the unprecedented protest action of medical trade unions. The fact that the government has bowed to the pressure and accepted all claims of the protesting doctors is a very unhelpful outcome. It will put additional pressure on the already high debt in the sector, threaten health facilities and consequently the quality of care rendered to patients. Not to mention, public sector employees were given an example that coercive action is an effective tool for achieving higher wages.

Unfortunately, the Ministry of Health and the government missed the opportunity to proceed to the much needed reduction of the unlimited and unsustainable scope of health care financed from public insurance. Outstanding reforms further include the introduction of quality assessment on all levels, deconcentration of the insurance market and the (partial) privatisation of health care facilities. The new regular government will be forced to deal with the high debt in the sector, which is going to further increase owing to the approved wage increases for doctors and nurses.

[13] Source: Estimates by the Slovak Medical Chamber and the Ministry of Health of the SR.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care (LTC) provided as a combination of social services and health care services on a long-term basis is not defined in the Slovak legislation. Both social and health care services are subject to different legal frameworks which fall under two different sectors. The lack of integrated social and medical care is a crucial problem of the Slovak LTC system.

Social services aim to prevent, mitigate or overcome an unfavourable social situation, which is defined as a threat of social exclusion or limited ability of a person to socially integrate and independently solve his or her problems. With respect to long-term care, the most common reasons for an unfavourable situation include severe disability or a generally unfavourable health condition, reaching of retirement age, and care of a physical person with disability.

Social services are funded mainly from the budget of self-governing regions and municipalities (through shared taxes), but additional transfers from the State budget have become a necessity in recent years to compensate the shortfall in regional and local budgets caused by lower revenues and increasing demand for services. Care recipients are obliged to co-pay for services in the sum specified by the provider, but usually only up to the level of economically justified costs. Exceptions are services provided by non-public providers with the aim to attain profit. Charges are determined also based on a recipient's income, thus they may vary. Health care services provided within long-term care are mostly covered by statutory health insurance.

Social and medical LTC services in Slovakia can be divided into formal and informal care. Formal care is provided through the public network of social and health care facilities and through private providers and usually takes the form of institutional care (e.g., facilities for seniors, homes of social services, facilities of supported living, nursing care facilities, rehabilitation centres, specialised hospital departments, agencies for nursing care services, hospices, sanatoria), outpatient care (usually referring to primary and specialised health care) and home nursing care. Home care and outpatient care have to be preferred to institutional care as long as they adequately address the unfavourable situation. The most common home-care service is the so-called care service, provided to a person dependent on assistance in activities of daily living by another physical person. Informal home care is provided usually by a family member or a close contact of the dependent person and is not covered by any legal agreement (Radvansky – Palenik, 2010). LTC includes also supportive services such as boarding, guidance and read-out service, lending of aids, etc.

LTC is provided also in the form of direct payments granted to severely disabled persons and/or their carers (financed from the State budget). The Act on cash allowances for compensation of severe disability stipulates different compensation instruments for severely disabled persons. Allowances are for the most part income-tested. One of these payments is the allowance for personal assistance, which is granted to the care recipient for hiring a personal assistant (not a family member). Another frequently used financial tool is the care allowance. This cash benefit is paid to the caregiver, usually a relative of a disabled person (informal care). Other recurring compensation payments are intended to support transportation, dietary meals, clothes or the operation of a motor vehicle. One-off payments are mostly used for the purchase of medical aids and cars and the adaptation of dwellings. Part of the sickness insurance scheme is a nursing allowance, to which entitled are insured persons taking personal all-day nursing care of an ill relative; this allowance is provided as compensation of income for a maximum of ten days.

One of the basic principles of the health system is the freedom to choose the care provider. In the LTC system, this principle is also applied with respect to social services (Radvansky –

Palenik, 2010), but until recently (31 March 2011) with important limitations. Previous regulation stipulated that an applicant for a social service had to be satisfied in first place by means of services falling under the competence of the municipality or self-governing region. Only when the capacities of public providers were occupied, the municipality or region was obliged to arrange the service by contracting a non-public provider. The regulation restricted the clients' freedom of choice and discriminated private providers. In May 2010, a Constitutional Court ruling decided that municipalities and self-governing regions shall be obliged to provide for a social service at a public or non-public provider according to the client's choice. The revised legislation came into effect on 1 April 2011.

The positive change, however, would not be feasible without a revision of the funding mechanism due to the critical situation in financing of social services. A new amendment to the *Act on social services* enters into force on 1 March 2012, which modifies financing of public providers founded by municipalities and non-public providers of selected types of services (facilities for seniors, nursing care facilities, day care stationeries, reception centres). Providers will receive a special-purpose subsidy from the State budget to finance the provision of services (equal sum for a given service granted to all providers, different sum for individual services). The amendment stipulates co-payments for clients of public facilities in the amount of at least 50% of economically justified costs of a given social service. The measure should improve the revenue side of regional/local budgets. Tested for social dependence and the actual amount of co-payments will be not only current incomes and property of the care beneficiary, but henceforth also income from immovable property sales earned in the past five years (this condition applies only to new applicants).

2.4.2 Debates and political discourse

Access to LTC services for elderly people developed into a serious problem in Slovakia. Demand for these services is exceeding supply for a long time already. There are long waiting lists, and new facilities are not entering the market because of an unsuitable system of financing. MPs overrode the president's veto and ratified the amended social services law in a repeated vote in January 2012. Increased financial participation of clients and retrospectivity of some provisions were the reasons for the president's refusal to sign the law. According to the opponents the measure will result in decreased accessibility for many persons in need. Self-governments and the Ministry of Labour, Social Affairs and Family (MOLSAF) argued that low prices have threatened the access to social services, since many facilities would be forced to close their operation without increased funds. Another argument of the Ministry is that clients with low incomes and/or property will continue to pay minimal or no cost-sharing fees. Clients of facilities offering all-year accommodation must be left at least 20% of the monthly subsistence minimum (EUR 38). There is no impact assessment available of the changes on the social situation of pensioner households.

Stricter means-testing should achieve that clients remain in the natural home environment as long as possible, or make use of one-day care or other types of outpatient care, and thereby relieve the packed capacities of facilities for seniors. MOLSAF argues that the measure is in line with EU initiatives.

The reform also partly addresses the shortage of LTC workers. Care services may be from now on provided also by workers without certified qualification in the subject field. The precondition is an age of at least 55 years and a minimum practice of 3 years.

The coalition announced in September the readiness to prepare a comprehensive law on long-term care under joint responsibility of the ministries of health and labour. It is hoped that the new government will follow up on this plan.

The social services sector was directly affected by the protest action of nurses (see chapter 2.3.2). There are more than 2,600 nurses working in facilities of social services. According to the Ministry of Labour, existing regulation in the competence of the Ministry of Health prevents that facilities of social services are considered providers of health care, although the *Act on social services* enables them to render such care. This means that work performed by nurses in the framework of social services cannot be remunerated from health insurance. As a consequence, nurses working in facilities providing social care shall not be entitled to the wage increases approved for "medical" nurses as from 1 April. The result of the legal confusion was that several social care facilities have reportedly re-classified nurses to caregivers as they lack sources for higher salaries.

2.4.3 Impact of EU social policies on the national level

The shortage of places in social care facilities and the unsustainable funding scheme have livened up the policy debate about long-term care in Slovakia. Surprisingly, though, there have not been any noticeable attempts to examine the situation in other countries facing similar challenges for best practices or know how. The national debate makes practically no reference to the OMC or other EU-level initiatives in the field of LTC, perhaps with the exception of activities organised within the Year of Active Ageing and Solidarity between Generations.

The 2011-2014 NRP of April 2011 outlined the plans of a new financing mechanism for social services. The government's commitment is "to ensure access to available, sustainable and high-quality social services by providing equal terms of funding for all social service providers and establishing conditions for the funding of service purchase at the level of the beneficiary rather than the individual service providers. The financial contribution shall be directed to the social service beneficiary, who may thus freely choose a provider." MOLSAF's plan was to materialise the aforementioned idea of a new financing mechanism in another revision of the social services law. The plan however had to be dropped due to the early elections.

The government approved on 30 November 2011 the *Strategy on Deinstitutionalisation of the System of Social Services and Substitute Care*. Slovakia subscribes to global trends of a systemic removal of the historically outdated model of institutional isolation and segregation of people requiring long-term care and assistance and its replacement with an alternative model of services and measures attached as much as possible to the routine of everyday life. Such changes are, according to MOLSAF, prioritised by the EU Social Protection & Social Inclusion policy framework. The strategy proposes the elaboration of a National Action Plan on the transition from institutional care to community care in the field of social services and the development of a national project on deinstitutionalisation of care services.

2.4.4 Impact assessment

According to the 2010 edition of the *Report on the social situation of the population of the SR* (Ministry of Labour, 2011a) formal institutional long-term social care was provided to 32,547 clients in 685 facilities in 2009 (0.6% of the total population and/or 92.7% of all recipients of social care). The number of old-age pensioners (62.8%) and long-term disabled persons (73.5%) on the total number of clients has increased year-on-year by 2.7 ppt and 2.4 ppt, respectively. Care services at home were rendered to 17,050 dependent citizens. The decreasing number of home care recipients (-10.6% in 2008 and -14.5% in 2007) are an indication of the worsening fiscal situation of self-governments. The provider structure has not undergone noteworthy changes.

Recurring financial allowances were provided to almost 220 thousand recipients in 2010 (+6.5% year-on-year), of which 55,933 were granted a care allowance (+7.2% yoy) and 6,945

the allowance for personal assistance (+5.2% yoy). The relatively high increase of cash benefit recipients suggests that the worsened financing of social services by municipalities and regions has been partially compensated by financial allowances provided by the State.

According to a study by Radvansky and Palenik (2010), about 183,000 persons were in need of LTC in 2007 and nearly half of them were older than 65. More than 38,000 received formal institutional care, more than 70,000 received some kind of formal home-based care and around 60,000 received some form of informal care. By rough estimations, about 20% of persons in need did not receive any kind of LTC.

Slovakia's population is projected to age at highest pace in the EU by year 2060 (Ageing Report, 2009). Consequently, the need for care in such a rapidly ageing society will increase. Human resources in LTC are clearly undersized and while an ever growing demand for LTC is expected, there is no sign of a response on the supply side. On contrary, according to a recent research by the Slovak Academy of Sciences, migration of Slovak caregivers to Austria has almost tripled since 2009 (est. from 6,000 to 16,000 care givers). The research points to two main assumed causes of the steep increase: legalisation of caregiver work in Austria since 2009 and unemployment growth in Slovakia resulting from the economic crisis.[14]

2.4.5 Critical assessment of reforms, discussions and research carried out

The coalition carried out its promise to reform the financing system of social services with a temporary reform. The approved mechanism of special-purpose subsidies is a provisional arrangement which should prevent the immediate financial collapse of existing LTC provision. The new regular government will be obliged to prepare a systemic multi-source funding scheme for social services. There is unfortunately no alternative to a higher financial participation of clients. The initiative to tighten criteria of assessing social dependency at admission to public LTC facilities is therefore a reasonable measure.

One of the main challenges for the new political representation is the integration of health-related care and social care into a functioning transparent system. Although there is a possibility to provide LTC services in integrated facilities already today, the complex legal and financial framework clearly hinders a smooth application in practice. The legal chaos concerning the status of nurses active in social services is proof enough that long-term care is in need of integrated legislation.

Another area requiring attention is the shortage of qualified LTC workers, particularly in the area of services for senior citizens. In a situation of growing demand for long-term care, more needs to be done to attract workers to the sector. The loosening of qualification criteria, as approved recently, is one of the potential tools. Another would be a regulated opening of the market for migrant workers following the example of Austria and other western European countries. A reassessment of the position of informal carers in the social security scheme could shed more light on the (dis)incentives to carry out these activities.

Surveys show that elderly people prefer home care to inpatient care.[15] There are also economic reasons why home care should be referred to institutional care. The new LTC framework must take this into consideration when setting priorities.

[14] Press Release by the Sociological Institute of the Slovak Academy of Sciences, held on 31 January 2012.

[15] Lezovic et al. (2007) concludes based on surveys that as many as 90 % of Slovak citizens prefer health and social care delivery in home settings.

2.5 The role of social protection in promoting active ageing

2.5.1 Employment

Pension reforms of 2004-2005 have sought to improve sustainability and adequacy in pension provision in consideration of the demographic challenges. Important elements of the reforms, notably an increase of the statutory retirement age, stronger links between earnings and retirement pensions, and the coverage of the entire contributory period in the pension formula have provided stimuli for employment and longer working lives. Revisions of the pension laws implemented since 2005 have primarily attempted to resolve the deficit in public pension, although with mixed results. Many of the adjustments increased (intentionally or not) incentives to work for workers approaching retirement age. Hereby we refer mainly to the reforms that tightened access to early retirement and increased the minimum contributory periods for pension entitlements.

There are no restrictions for workers above statutory retirement age to stay in employment. In case a worker continues to work and does not exert his/her retirement pension claims, he/she gets entitled to a bonus of 0.5% for each 30 days of deferred retirement. A mandatory retirement age is not stipulated in pension legislation and as such may not be agreed in collective agreements. Social security schemes covering specific occupations (military, police) stipulate a lower retirement age, yet this does not imply mandatory retirement at lower age. Certain occupations such as mineworkers had been retiring at lower age in the past, but since covered by the universal social insurance scheme, unfavourable working conditions and health effects are compensated merely by higher pension benefits.

2.5.2 Participation in society

Unpaid work is not considered as a contributory period, unless clearly specified in legislation. Such cases include:
persons taking care of a child up to age 6 years (and/or age 18 in case of a child with long-term unfavourable health condition);
persons who are provided with a care allowance, for a period up to 12 years;
persons who are based on a contract performing personal assistance to a person with severe disability for a minimum of 140 hours monthly, for a period up to 12 years.

Additional conditions require that these persons (caregivers) are permanent residents in the Slovak Republic, they do not have pension insurance from other reasons, they were not granted an early retirement or disability pension, and they have not reached statutory retirement age.

Voluntary work is not covered by social security.

2.5.3 Healthy and autonomous living

The *Act on social services* stipulates that home care and outpatient care have to be preferred to residential care. If home care and outpatient care are not adequately addressing the unfavourable situation of the recipient, residential care should be provided, while weekly residential care should be preferred to all-year residential care.

This provision of the law should be applied in accord with the person's right to choose a concrete type of social service. The law also obliges social care providers to cooperate with the family, municipality and community in creating conditions for a return of the residential care recipient to the natural family environment or community environment with a preferred provision of home care or outpatient care and/or weekly residential care. There is, however, not sufficient evidence on the application of these rules in practice.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R] MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, MINISTRY OF FINANCE OF THE SR Analyza dlhodobej udrzatelnosti a navrhy na zmeny dochodkoveho systemu, August 2011, Bratislava, retrieved from:
http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=20117

"*Analysis of the long-term sustainability and proposals for changes in the pension system*"

The analysis examines the three-tier pension system in Slovakia, compares performance indicators with EU/OECD countries and puts forward proposals for reforms in all pension tiers.

[R] MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, Sprava o socialnej situacii obyvatelstva SR v roku 2010, June 2011, Bratislava, retrieved from: http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=18272

"*Report on the social situation of the population of the Slovak Republic in 2010*"

The report focuses on the state of art and trends in socio-economic indicators. It includes an overview of demographic trends, labour market developments, wages, active labour market measures, and social protection policies.

[H] Health

[H5] GOLIAS, Peter, Ako odmenovat lekarov, June 2011, INEKO, retrieved from:

http://www.i-health.sk/sk/zdravotnictvo/ako-odmenovat-lekarov/

"*How to remunerate doctors*"

The research paper proposes to supplement the existing remuneration system based on capitation by a pay-for-performance component.

[H5] GOLIAS, Peter, Kolko zarabaju slovenski lekari?, August 2011, INEKO, retrieved from:

http://www.i-health.sk/sk/zdravotnictvo/kolko-zarabaju-lekari

"*How much do Slovak doctors earn?*"

The research paper critically reviews the non-transparent financing of doctors' salaries and proposes a lucid monitoring system.

[H5] GOLIAS, Peter, Vyhody a rizika riadenej starostlivosti, December 2011, INEKO, Bratislava, retrieved from:
http://www.i-health.sk/sk/zdravotnictvo/managed-care/

"*Advantages and risks of managed care*"

[H] HLAVATY, Tibor et al., Sprava o stave zdravotnictva na Slovensku, June 2011, Ministry of Health of the SR, retrieved from:

http://www2.health.gov.sk/redsys/rsi.nsf/0/24C299636CC7A088C125705F0036CDF3/$FILE/Sprava-o-stave-zdravotnictva-na-Slovensku.pdf

"*Report on the State of Health Care in Slovakia*"

The publication offers a complex audit of the state of play in the Slovak health care system and serves as groundwork for strategic policy documents and reforms.

[H1] Morvay, Karol – SIVAK, Tomas – PAZITNY, Peter, Zakladne ramce zdravotnej politiky pre roky 2011-2012: Ake budu dopady reformy na zdravotnictvo? June 2011, HPI, retrieved from:

http://www.hpi.sk/cdata/Publications/hpi_zakladne_ramce_2012.pdf

"*Basic health policy framework for 2011-2012: What will be the impact of reforms in health care?*"

The study presents a prognosis of revenues and expenditures in the health care sector until 2012.

[H3] POUROVA, Maria – PAZITNY, Peter, Nominalne poistne: Priklady fungovania v Holandsku, Svajciarsku a Nemecku, November 2011, HPI, retrieved from:

http://www.hpi.sk/cdata/Publications/nominalne_poistne.pdf

"*Nominal premium: Examples from the Netherlands, Switzerland and Germany*"

The study analyses the insurance systems of three European countries and opens a discussion about the introduction of nominal premium in Slovakia.

[H] SZALAY, Tomas – PAZITNY, Peter – SZALAYOVA, Angelika – FRISOVA, Simona – PETROVIC, Marek – VAN GINNEKEN, Ewout, Slovakia: Health system review. Health Systems in Transition, Vol. 13, No. 2, 2011, Copenhagen, retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0004/140593/e94972.pdf

The comprehensive publication gives a detailed overview of the Slovak health system, major reforms and health outcomes. Authors conclude that although large improvements have been made since the 1990s, health outcomes are generally still substantially worse than the average for the EU15. Key challenges include: improving the health status of the population and the quality of care while securing the future financial sustainability of the system.

[H6] SZALAYOVA, Angelika, Genericka preskripcia, April 2011, Health Policy Institute, Bratislava, retrieved from:
http://www.hpi.sk/cdata/Publications/hpi_genericka_preskripcia_online.pdf

"*Generic prescription*"

The study defines the advantages and risks of generic prescription and attempts to rebut myths associated with generic prescription. It draws from international experience suggesting that countries, which implemented generic prescription, achieved sizeable decreases of drug prices.

[H6] ZACHAR, Dusan, Problemy v liekovej politike, February 2011, INEKO, Bratislava, retrieved from: http://www.i-health.sk/sk/zdravotnictvo/problemy-liekovej-politiky/

"*Problems in drug policy of the SR*"

High drug expenditures and consumption are among the crucial problems of the Slovak health care system. One of the reasons are high reimbursement levels meaning that patient co-payments are much lower than the OECD average. Consumption of pharmaceuticals remains higher than the OECD average in six out of nine main therapeutic groups. Poor health of the Slovak population and the preference for a quick fix rather than following a healthy lifestyle are among the main reasons.

[L] Long-term care

[L] MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, Sprava o socialnej situacii obyvatelstva SR v roku 2010, June 2011, Bratislava, retrieved from: http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=18272

"*Report on the social situation of the population of the Slovak Republic in 2010*"

The report focuses on the state of art and trends in socio-economic indicators. It includes an overview of demographic trends, labour market developments, wages, active labour market measures, and social protection policies.

[L] RADVANSKY, Marek – PALENIK, Viliam, The Long-Term Care System for the Elderly in Slovakia, ENEPRI Research Report No. 86, ENEPRI-ANCIEN, June 2010, retrieved from http://www.ceps.eu/ceps/download/3590

The study gives a concise overview of the long-term care system in Slovakia and presents basic data on types of services, providers, clients, and financing of long-term care

[L] REPKOVA, Kvetoslava, Spolufinancovanie socialnych sluzieb z privatnych zdrojov, Institute for Labour and Family Research, November 2011, Bratislava, retrieved from:

http://www.ivpr.gov.sk/IVPR/images/IVPR/vyskum/2011/Repkova/Repkova.pdf

"*Private co-financing of social services*"

The research study examines the question how the general public perceives the need for a more consistent property assessment of social service recipients to co-finance costs of residential social care.

4 List of Important Institutions

Zdruzenie zdravotnych poistovni Slovenskej republiky – Association of Health Insurance Companies of the Slovak Republic

Contact person: Eduard Kovac, President
Address: Kominarska 2-4, 831 04 Bratislava, Slovakia
Webpage: http://www.zzp-sr.sk/

The Association is an independent agency with the membership of all health insurance companies. The main objective is to advocate interests of health insurance companies in the framework of the Slovak health care sector and health policy. The Association promotes a continuous improvement of quality of health insurance.

Asociacia dochodkovych spravcovskych spolocnosti – Association of Pension Funds Management Companies

Address: Bajkalska 30, P.O.Box 86, 820 05 Bratislava, Slovakia
Webpage: http://www.adss.sk/

The association is an interest group established by pension management companies to protect and enforce common interests of pension management companies mainly in the sphere of legislation.

Asociacia poskytovatelov socialnych sluzieb – Association of Providers of Social Services

Contact: Milada Dobrotkova, Chairman
Address: Cachticka 17, 831 06 Bratislava, Slovakia
Webpage: http://www.apssvsr.org/

The Association of Providers of Social Services is an independent professional association of legal and physical entities providing social services. The objective of the association is to assist members in the provision of quality services for the client.

Asociacia doplnkovych dochodcovskych spolocnosti – Association of Supplementary Pension Companies

Contact person: Marcel Forisek, Secretary
Address: Bajkalska 30, P.O.Box 86, 820 05 Bratislava, Slovakia
Webpage: http://www.adds.sk/

The association is a voluntary association of legal entities (currently four supplementary pension companies), which pursues common interests of members and beneficiaries of supplementary pension saving.

Ustredie prace, socialnych veci a rodiny – Central Office of Labour, Social Affairs and Family (subordinated to the Ministry of Labour, Social Affairs and Family of the Slovak Republic)

Address: Spitalska ulica 8, 812 67 Bratislava, Slovakia
Webpage: http://www.upsvar.sk/

The central office of labour, social affairs and family is a public institution responsible for the administration of employment services (registry of job seekers, job vacancies, provision of employment services) and social affairs (state social allowances, social assistance, consultancy services, social and legal protection of children and custody). Policies are implemented by a network of 46 territorial offices.

Dokumentacne a informacne stredisko socialnej ochrany – Documentation and Information Centre for Social Protection (operated by the Institute for Labour and Family Research
Address: Zupne namestie 5-6, 812 41 Bratislava, Slovakia
Webpage: http://disso.sspr.gov.sk/
The centre was established under the auspices of the EU Consensus Programme and is administered by the Institute for Labour and Family Research as an independent, non-political centre. The main objective of the centre is to collect and disseminate information on social security and social protection at the local, European and international levels and to create a contact point for a wide network of organisations and institutions active in the social sphere.

Forum pre pomoc starsim – Forum to Help the Aged
Contact person: Lubica Galisova, President
Address: Zahradnicka 24, 971 01 Prievidza, Slovakia
Webpage: http://www.forumseniorov.sk/
The Forum is a civic association of physical and legal entities providing care, assistance and services to elderly people with the aim to protect their rights, pursue their interests and assist in the satisfaction of their needs.

Vlada Slovenskej republiky – Government of the Slovak Republic
Address: Urad vlady SR, Namestie slobody 1, 813 70 Bratislava, Slovakia
Webpage: http://www.government.gov.sk/, http://www.rokovania.sk/
The Government is the top executive body in the country.

HPI – Health Policy Institute
Contact person: Peter Pazitny, Director
Address: Prokopova 15, 851 01 Bratislava, Slovakia
Webpage: http://www.hpi.sk/
HPI is a non-governmental organisation specialised in health care policy. In accordance with its mission, HPI advocates such operation of health care systems which promote the responsibility of the patient, responsibility of the provider and responsibility of the health care purchaser.

INEKO – Institut pre ekonomicke a socialne reformy – INEKO – Institute for Economic and Social Reforms
Contact person: Peter Golias, Director
Address: Bajkalska 25, 827 18 Bratislava, Slovakia
Webpage: http://www.ineko.sk/
INEKO Institute is a non-governmental non-profit organisation established in support of economic and social reforms which aim to remove barriers to the long-term positive development of the Slovak economy and society. Besides general economic and social issues, INEKO activities cover also reforms in the health care and education sectors.

INESS – Institut ekonomickych a spolocenskych analyz – INESS – Institute of Economic and Social Studies
Contact person: Richard Durana, Director
Address: Na Vrsku 8, 811 01 Bratislava, Slovakia
Webpage: http://www.iness.sk/
INESS is a non-governmental non-profit organisation focused on monitoring the functioning and financing of the public sector, effects of legislative changes on the economy and society and comments on current economic and social issues. Priority areas include taxation and

contributions to the state budget, the public health care system, monetary policy, EU membership issues, government regulation and property rights.

Infostat - Institut informatiky a statistiky – Infostat - Institute of Informatics and Statistics
Address: Dubravska cesta 3, 845 24 Bratislava, Slovakia
Webpage: http://www.infostat.sk/
Infostat is a research and development organisation established and partially subsidised by the Statistical Office of the Slovak Republic. In accordance with its foundation charter, the main mission of Infostat is to support the development of the national statistical system and its integration into the European Statistical System by solving relevant research, methodological and development tasks. Part of the activities is carried out on commercial basis.

Institut pre vyskum prace a rodiny – Institute for Labour and Family Research
Contact person: Kvetoslava Repkova, Director
Address: Zupne namestie 5-6, 812 41 Bratislava, Slovakia
Webpage: http://www.sspr.gov.sk/
The public contributory organisation is subordinated to the Ministry of Labour, Social Affairs and Family. It focuses mainly on sociological studies in the field of social and family policy, labour market and employment policy, industrial relations and working conditions, and occupational safety and health. The newest research agenda covers also social protection. Outputs are used primarily by the founder (Ministry of labour) in creation of laws, concepts, strategies, etc.

Ministerstvo zdravotnictva Slovenskej republiky – Ministry of Health of the Slovak Republic
Address: Limbova 2, P.O.BOX 52, 837 52 Bratislava, Slovakia
Webpage: http://www.health.gov.sk/
The Ministry of Health is the central body of state administration in the field of health care, health protection, health education, and natural curative sources.

Ministerstvo prace, socialnych veci a rodiny Slovenskej republiky – Ministry of Labour, Social Affairs and Family of the Slovak Republic
Address: Spitalska 4-6, 816 43 Bratislava, Slovakia
Webpage: http://www.employment.gov.sk/
The Ministry is the main executive body competent in the fields of employment and labour market policy, collective bargaining, wage and remuneration, social security, social and legal protection of children and youth, and family policy.

Narodna banka Slovenska – National Bank of Slovakia
Address: Imricha Karvasa 1, 813 25 Bratislava, Slovakia
Webpage: http://www.nbs.sk/
The National Bank of Slovakia is the central bank of Slovakia and a member of the Eurosystem. The NBS together with other central banks and the European Central Bank participates in activities covering monetary development and economic growth in the Euro area. The other important function of the NBS is supervision of the financial market, including the operation of pension management companies.

Narodna rada Slovenskej republiky – National Council of the Slovak Republic
Address: Namestie Alexandra Dubceka 1, 812 80 Bratislava, Slovakia
Webpage: http://www.nrsr.sk/

The National Council of the Slovak Republic (i.e. parliament) is the sole constitutional and legislative body of the Slovak Republic.

Socia – nadacia na podporu socialnych zmien – Socia Foundation (non-governmental organisation)

Contact person: Vladislav Matej, Executive Director
Address: Legionarska 13, 831 04 Bratislava, Slovakia
Webpage: http://www.socia.sk/

The Socia Foundation is a non-profit organisation administering grant programmes and funds aimed at the development of social services and the support of disadvantaged groups of citizens. Socia Foundation carries out also own projects on national and international level. The main areas of interest include social services and prevention and counselling for disadvantaged people.

Socialna poistovna – Social Insurance Agency

Address: Ul. 29. augusta 8–10, 813 63 Bratislava, Slovakia
Webpage: http://www.socpoist.sk/

The Social Insurance Agency is a public institution administering social insurance (sickness insurance, pension insurance – old-age and disability insurance, accident insurance, guarantee insurance and unemployment insurance), with competences also in the field of old-age pension saving (collection of contributions, transfer of contributions to pension management companies, registration of pension saving contracts).

Statisticky urad Slovenskej republiky – Statistical Office of the Slovak Republic

Address: Mileticova 3, 824 67 Bratislava, Slovakia
Webpage: http://www.statistics.sk/

The central state administration body responsible for the state statistical system.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en