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

Annual National Report 2011

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 pension system in Slovakia generates a fiscal deficit exceeding 2.0% of GDP annually. An unsustainable public pay-as-you-go scheme and transitional costs incurred by the introduction of a private funded scheme are behind the unfavourable situation. Demographic projections suggest that Slovakia will be facing one of the most intensive ageing processes in the EU in the next decades.
- A comprehensive pension reform is in preparation, which aims to stabilise the system. Plans include restrictions in the pension formula and reduced indexation of public pensions. Early retirement entitlements have been tightened as of 1 January 2011. Entry to the funded scheme shall become mandatory again for young people, with the possibility to opt out. Strict investment rules and guarantees in the second pillar shall be complemented by unguaranteed schemes to enable savers to invest in riskier securities. A reform of the tax and social security contributions scheme is also getting under way. The government admits the need to link pension age with longevity, but for now postpones an increase in the retirement age.
- Spending on health is growing and is expected to rise substantially in the next decades due to population ageing. Research indicates that the Slovak health care system is inefficient in translating high expenditure growth into better health outcomes. According to estimations by the OECD, life expectancy at birth could be raised by as much as four years in Slovakia, at equal spending, if the country would exploit its potential for improving efficiency of the system.
- A package of reforms strives to make health spending more effective and improve access and quality of health care. Stabilisation measures include the transformation of state hospitals to joint-stock companies and the reduction of redundant hospital beds and ineffective hospital departments. Sustainable financing requires an explicit definition of the scope of the basic benefit package and the introduction of regulated cost-sharing. An upper limit on co-payments for drugs for low-income pensioners and severely disabled persons has been approved. There are also plans to introduce a lucid system of quality assessment and provider accreditation and revise rules applying to waiting lists.
- People aged 65+ account for 12.5% of the total population and their share is expected to rise to more than 30% by 2050. There is little doubt that the need for long-term care services will increase. Estimations suggest that public spending for long-term care in Slovakia may triple by 2050.
- The government legislated changes which equalise the position of public and non-public care providers. The current reform priority is the introduction of a transparent and equitable funding mechanism. Preliminary plans envisage that the existing funding of care services via providers will be redirected to the eligible care recipient who may then freely chose a provider.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

Social protection policies have witnessed lively developments in the past year. Firstly, this has much to do with the political cycle and the entering into office of a new right-wing coalition in July 2010, which announced a number of reforms in the social protection area. Secondly, the economic crisis induced a sizeable shortfall in public finances and the consequent fiscal consolidation efforts highlighted the necesity of social protection reforms.

The major impact of the financial and economic crisis in Slovakia was on the labour market. Unemployment has risen from levels below 9% at the end of 2008 to above 15% in just one year and affected all age cohorts, including elderly workers. Employment recovery is progressing, but slowly and a return to pre-crisis levels is expected to take several years. The slump in tax and social security revenues has negatively impacted on the financing of social protection policies and has stirred up discusions about the sustainability of existing funding arrangements in view of the projected demographic developments.

The new political representation subscribed to a reform of all pension tiers in order to stabilise the system and lay the foundations for its longer-lasting sustainability. This, in short, involves reductions in some parameters of the public pension scheme (pension formula, indexation, early pensions) and revision of the voluntary entry to the funded scheme and the strict guarantees and investment regulation. Austerity and rationalisation are keywords of reform plans in health care and long-term care. The government intends to streamline health care spending and introduce a new multi-source financing scheme for long-term care.

2.2 Pensions

2.2.1 The system's characteristics and reforms

A wide-ranging pension reform implemented in 2004-2005 reorganised the structure of the pension system in Slovakia, which since then comprises three pillars.

(1) Mandatory public pension insurance scheme *(defined benefits)*. The pay-as-you-go (PAYG) system 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 wage) in case they are enrolled only in the first pillar, and/or 9% of the assessment base if they are in the first and second pillars.

The maximum assessment base for contributions to the first (and also second) pillar is set at four times of the average gross wage in the economy. The minimum insurance period needed to claim a retirement benefit is 15 years. The State pays contributions on behalf of persons taking care of children aged up to 6 years. Social insurance contributions paid to SIA as well as awarded pensions are exempt from the income tax. SIA runs also the disability pension fund where economically active contribute with 6% of their gross wage. In 2010, SIA disbursed EUR 5.24 billion on disability, old-age and survivor pensions (7.95% of GDP).

The **formula for old-age pensions** from the PAYG pillar is the following:

Pension = POMB * R * ADH

"POMB" stands for Average Personal Wage Point and represents the ratio of the individual gross wage to the average gross wage 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. Values of POMB between 1.25 and 3.00 are adjusted by a coefficient of 0.84, i.e. only 84% of the value is figured in. Values below 1.00 are added 16% of the difference between 1.00 and POMB. This "freezing" of POMB in December 2010 aims to provide for a certain degree of solidarity, against the previous regulation which stipulated a gradual change of the coefficients toward fully merit-based pensions by 2014.

"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 50% replacement rate in the first year after the reform for a pensioner who has been insured for 40 years. ADH is indexed annually by the average wage growth in the economy; in 2011 the value is EUR 9.5756.

Old-age pensions in the first pillar 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 (Swiss method, weight of both parameters is 1:1). In 2010, pensions were indexed by 3.05% and in 2011 by 1.80%.

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. The longer transitional period for women means that in 2010 women retired at age 56.75 to 60.75 years depending on the number of children raised and their retirement age will continue to gradually increase until 2024, when all women will retire at age 62.

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 222.50 monthly since 1 July 2010).

(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).

The amount of an early retirement pension is calculated using the old-age pension formula, while every 30 days of early retirement are penalised with 0.5% of the calculated pension.

(2) Mandatory private old-age pension saving scheme *(defined contributions)*. 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 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 system or save 9% in a personal pension account. Prior to the change, entering the second pillar was mandatory for new policyholders. Experience shows that after optionality has been introduced, merely 13% of young people decide to join. The government announced plans to restore mandatory entry for young people (see also chapter 2.1.2). As at end of 2010, the funded scheme counted 1.439 million savers and assets totalled EUR 3.7 billion, i.e. 5.6% 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. In fact, pension management companies have never come close to the stipulated limits on stocks. 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 the government's unsupportive approach to private pension saving (repeated opening of the scheme, new regulation obliging pension management companies to balance returns in 6-monthly running intervals, restrictions on investments).

Out of the total number of 1.439 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 second pillar (as of 21 April 2011)

Growth funds	Balanced funds	Conservative funds	Total
EUR 2.60 billion (65%)	EUR 1.19 billion (30%)	EUR 0.18 billion (5%)	EUR 3.97 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 lifecycling 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.

(3) Voluntary private supplementary pension scheme ***(defined contributions)***. The funded system is in operation since 1996 and is at present governed by five private supplementary pension companies. The number of savers dropped from 860,000 in December 2008 (32.0% of economically active) to 720,000 in December 2010 (26.6% of economically active). Until the end of 2010, contributions up to EUR 398.33 per year could be deducted 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. Assets in the third pillar amounted EUR 1.145 billion as at end of 2010 (1.7% 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; for example, average retirement pensions of soldiers and police officers are approximately 2 times and 1.5 times of an average retirement

pension paid by SIA, respectively. Substantially above average are also retirement pensions paid to retired judges and prosecutors who are entitled to special pension bonuses.

Since 2006 the government provides old-age pensioners, early retirement pensioners and disability pensioners with a **Christmas pension benefit**. This bonus is not a component of the social insurance scheme, but a one-off income support paid every year around Christmas to pensioners with pensions below 60% of the average wage in the economy. In 2010, the sum ranged from EUR 40.64 to EUR 66.39 based on the sum of the recipient's pension (the higher the pension, the lower the benefit). In April 2011, the government approved new rules for the calculation of the Christmas benefit, which shall be applied already 2011.[1] Pensioners with pension benefits below the minimum subsistence level shall be granted the maximum Christmas benefit of EUR 66.39. The sum of the bonus for other pensioners will be 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 average wage in the economy. The amended calculation should provide for a smoother correlation between the pension amount and the Christmas bonus and replace the existing intervals.

2.2.2 Debates and political discourse

A debate about the setting of the pension system takes place at least since 2003, when the then acting coalition decided to reform the social insurance system and introduce a private saving scheme. The outcomes of this reform are shaping the political discourse to date. The main concern is the unsustainable condition of the public PAYG system in view of the demographic trends, which was even intensified by the redirection of part of the pension contributions to private accounts in the second pillar. The 2004-2005 pension reform found many opponents particularly in the ranks of Trade Unions and opposition parties, which after entering the office in the following term (2006-2010), took repeated action to weaken the second pillar.

In its **Programme Manifesto** of July 2010[2], the new right-wing coalition committed itself to protect the private pension pillar by way of a constitutional law, which should among others stipulate that any privatisation revenues may be used only to cover transitional costs caused by the redirection of contributions from SIA to the funded scheme. The Manifesto subscribed also to a revision of the stringent regulation of pension funds, particularly the half-yearly balancing of returns, constraints on risk allocation, etc. As for the public pension pillar, the new government agreed on the necessity to revise pension indexation and to introduce a minimum pension as a "*means of increasing solidarity in the pension system in order to ensure that no insured persons who have been insured for the defined period of time would find themselves in material need*". Another declared priority of the Manifesto is the reform of the revenue side of social insurance, i.e. a revision of the tax and social contribution set-up and payments.

In the meantime, the policy debate about a pension reform moved on and some plans have been made public. The 2011-2014 **National Reform Programme** (NRP)[3], approved on 20 April 2011, contains thus far the most coherent information about the government's reform plans in the pension system. The cabinet announced in the NRP changes which should strengthen solidarity and sustainability in the public pension scheme. One of the most important proposals concerns the indexation of public pensions. The plan envisages a

1 http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=19571.
2 http://www.vlada.gov.sk/22864/programove-vyhlasenie-vlady-sr.php.
3 http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=19533.

restriction of the indexation formula so that starting in 2012 public pensions would be indexed only for inflation (presumably, inflation computed from the consumer basket typical for pensioner households, i.e. pensioner inflation). In plan is also the introduction of an upper limit on disbursed pensions at the level of the average wage in the economy and a revision of the pension formula in order to factor in the changing ratio between contributors and recipients. The changes would be an important contribution to the sustainability of the pension system. The Ministry of Labour, Social Affairs and Family is currently drafting an amendment to the *Act on social insurance*, which should materialise aforementioned plans.

The NRP outlines also plans in the second pillar. The funded scheme shall become mandatory again for new entrants to social security as a default option with the possibility to opt out in after a certain period. The NRP reaffirms the government's intention to revise the strict investment and guarantee rules in the second pillar to enable pension funds to regain the possibility to invest in more risky securities and thus potentially attain higher returns.

The debate on the second pillar reform took on a more concrete form when the Ministry of Labour, Social Affairs and Family presented in May 2011 a **draft amendment to the Old-age savings act**.[4] The Ministry proposes the abolition of guarantees in the growth and balanced funds (these would be renamed to equity and mixed funds, respectively), preservation of guarantees in the conservative fund (renamed to bond fund), and the introduction of an index fund which would replicate movements of global stock indices and have no limit on the proportion of shares. Savers should have the possibility to divide their savings into two funds of which one would have to be the guaranteed bond fund. Lifecycling should take place gradually and start at age 50. The draft law envisages mandatory entry for young people with the option to leave the scheme in the first two years of saving. Liberalisation of investment regulation and new fees are also part of the proposal.

The ministerial draft struggles to find political support. The main point of concern is the legitimacy of changing guarantees. Coalition partners, political opposition and some pension management companies argue that an abolition of existing guarantees – basically a return to regulation valid before 1 July 2009 – could be questioned as unconstitutional. Another argument is that a high number of savers enrolled in growth funds are in fact persons with conservative attitudes to investment risk.[5] Instead, opponents put forward a merging of the three existing funds (conservative, balanced, and growth) into one guaranteed conservative fund and the creation of a new equity fund and/or possibly also a bond fund, with no guarantees but merely lifecycling rules. All stakeholders agree that a revision of the half-yearly running intervals for balancing pension funds returns is inevitable.[6]

The policy debate on **increasing the retirement age** is rather marginal. It is mainly independent research organisations which pursue an unbiased discussion about this politically unpopular measure. Unlike the former government, which adopted a refusing approach as a matter of principle, representatives of the current administration admit that a linkage between the retirement age and demographic developments must be created. However, the official

[4] https://lt.justice.gov.sk/Material/MaterialHome.aspx?instEID=-1&matEID=3938&langEID=1.

[5] This is evidenced by a public opinion survey conducted in November 2010 by the Focus agency, which showed that 68% of respondents have a low risk propensity. An e-mail survey conducted by pension management company Allianz on a sample of 10,050 respondents found that 81% of savers in the growth fund consider guarantee, i.e. saving money on personal accounts without expectations of higher returns, the most important value of old-age saving.

[6] See, for instance, the results of the official review process at: http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=19787.

position is that changes in the pensionable age will not be applied before 2016.[7] The government argues that there is not an immediate need to increase the legal retirement because (i) a prolongation of the pension age (of women) is still going on and mitigates the fiscal imbalance, (ii) pension indexation is relatively low due to decelerated wages, and (iii) the period of old-age pension benefit drawing is comparable with the average of OECD countries. However, anecdotal evidence suggests that the Ministry of Labour is considering the inclusion of a legal framework establishing the link between statutory retirement age and life expectancy into the forthcoming amendment to the *Act on social insurance*, meaning that such a change could possibly enter into effect already in 2013.

There is also an intense discussion going on about a **reform of the tax and social contribution system**. The scheme is characterised by undue administrative and financial burdens and low efficiency of collection. The payment burden is disproportionally high for dependent employment, while other employment statuses take advantage of legally avoiding contribution liabilities. A *Green paper on the reform of the tax and contributions system* was approved by the government on 18 May 2011.[8] The reform is part of a broader policy project called UNITAS which should result in unified administration and collection of taxes, insurance contributions and custom duties. The proposed tax-contribution reform envisages the introduction of a super-gross wage (gross wage plus insurance contributions paid by the employer) which will serve as the assessment base for the income tax (flat 19% rate preserved) and insurance contributions (a single social contribution at 19% for employees and 13% for self-employed, and a single health contribution at 9% for employees and self-employed). Lower social contribution rates for self-employed and also for persons in non-standard types of contracts on work performed outside an employment relationship reflect the fact that these persons are not entitled to certain benefits (e.g., self-employed may not claim unemployment and accident insurance benefits). The contribution rate to the funded pension scheme, which will be part of the single social payment, is tentatively set at 6.7% of the super-gross wage (equivalent to the existing 9% contribution). Social security contributions shall no longer be deductible from the tax base.

The breaking point of the reform debate is the proposed lowering of tax deductible lump-sum expenditures for self-employed (deductible expenses at 40% of income remain unchanged, but only up to the level of the subsistence minimum per month), which would increase the effective burden mainly for tradesmen with higher incomes who deduct lump sum expenditures but in fact have minimum expenses. All stakeholders agree on the necessity to reform the system, but differ in their opinions as to whether and how the different regimes for particular forms of work should be harmonised. The Ministry of Finance argues that changes are not achievable without removing the deformations which disadvantage employees and lead to a shift of dependent jobs to speculative or forced self-employment. The business community, supported also by representatives from coalition and opposition parties and Trade Unions, point to the particularities of the self-employment status and to its vital role in the economy and employment.[9] The reform envisages a number of legislative amendments to be

[7] In 2015, the transitional period for childless women will cease, during which their retirement age is being increased to 62 years.

[8] http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=19683.

[9] http://ekonomika.sme.sk/c/5802595/zivnostnici-nie-sme-prisati-na-statny-rozpocet.html#ixzz1Gli9Drwt. http://ekonomika.sme.sk/c/5802742/zamestnavatelia-nesuhlasia-so-zvysenim-odvodov-pre-zivnostnikov.html#ixzz1GlhsKZca. http://ekonomika.sme.sk/c/5843394/zivnostnici-su-za-reformu-no-nechcu-zvysovanie-nakladov.html#ixzz1JyshJUse.

approved by the cabinet and the parliament, thus a continuation of the debate and further changes are to be expected.

The Ministry of Interior published in March 2011 an analysis of the **social security system of armed forces**.[10] The document proposes restrictions in the retirement scheme for policemen and soldiers, among others:

- entitlement for a discharge benefit would require at least 10 years of service instead of the currently applied 5 years;
- the minimum years of service needed for a retirement pension would increase from 15 to 20 years;
- policemen/soldiers who served 15 to 19 years would be provided a retirement pension for a period of four years instead of a lifetime provision.

The changes pursue a reduction of the high cost of the special system, while preserving reasonable incentives reflecting the risks associated with the performance of these professions. Restrictions should apply only to policemen and soldiers admitted after the changes enter into effect, tentatively scheduled for 1 July 2012.

2.2.3 Impact of EU social policies on the national level

Despite some progress initiated by the EU2020 Strategy and the launch of the first European Semester, EU social policies and initiatives remain more or less on the margins of the national policy debate. This statement is based on a summarised assessment of the country's response to the EU social protection agenda.

The public debate on the Commission's Green Paper on pensions took place in a lukewarm atmosphere. Statements and opinions published by think tanks, civil society institutions or individuals caught perhaps more public attention than a somewhat hidden joint statement by the Ministries of Finance and Labour, Social Affairs and Family and the National Bank of Slovakia.[11] The general impression from the response is that although aware of the similarity of future challenges faced in pensions across the EU, the national debate emphasises the responsibility of national policies and takes a rejecting stance towards any closer coordination efforts at EU level.[12] The goals of adequate and sustainable pensions are generally acknowledged but there is not a uniform position on how these goals should be pursued. In addition to parametric and structural reforms of the pension system, the national response underlines the crucial role of employment and family policies, health and long-term care. As far as specific inquiries are concerned about the character and role of a regulatory framework at EU level, opinions are rather unwavering in that EU coordination and harmonisation initiatives should not be extended beyond the scope of the current OMC. As for the relevance of pension solvency regimes, national stakeholders are of the opinion that such arrangements are hardly applicable in defined contributions and/or mixed systems.

This year's NRP makes a visible step forward in terms of political importance and presence. The government and its representatives refer to the NRP as a strategic reform document. The linkage to the EU2020 strategy and the common targets plays presumably an important role in this respect. The NRP took on board the conclusions of the Annual Growth Survey and the

[10] https://lt.justice.gov.sk/Material/MaterialHome.aspx?instEID=-1&matEID=3714&langEID=1.
[11] ttp://ec.europa.eu/employment_social/empl_portal/pensions/written_responses.zip.
[12] See also, for example:
http://ekonomika.sme.sk/c/5806776/radicova-nemozu-nas-z-bruselu-nutit-zvysit-penzijny-vek.html.
http://www.iness.sk/modules.php?name=News&file=article&sid=3524.

Pact for the Euro calling for social protection reforms. The already implemented response includes a tightening of the early retirement scheme as of 1 January 2011. In plan are a number of reforms in the PAYG pillar and the funded scheme, which respond to the EU policy documents particularly in pursuing sustainability of pensions (reduction of public pension indexation, mandatory participation in the funded scheme, etc.).

2.2.4 Impact assessment

Positively, the political discourse is complemented more actively by research and analytical work carried out by ministries and independent research institutes. The main topic discussed is the sustainability of the pension system in view of the demographic changes.

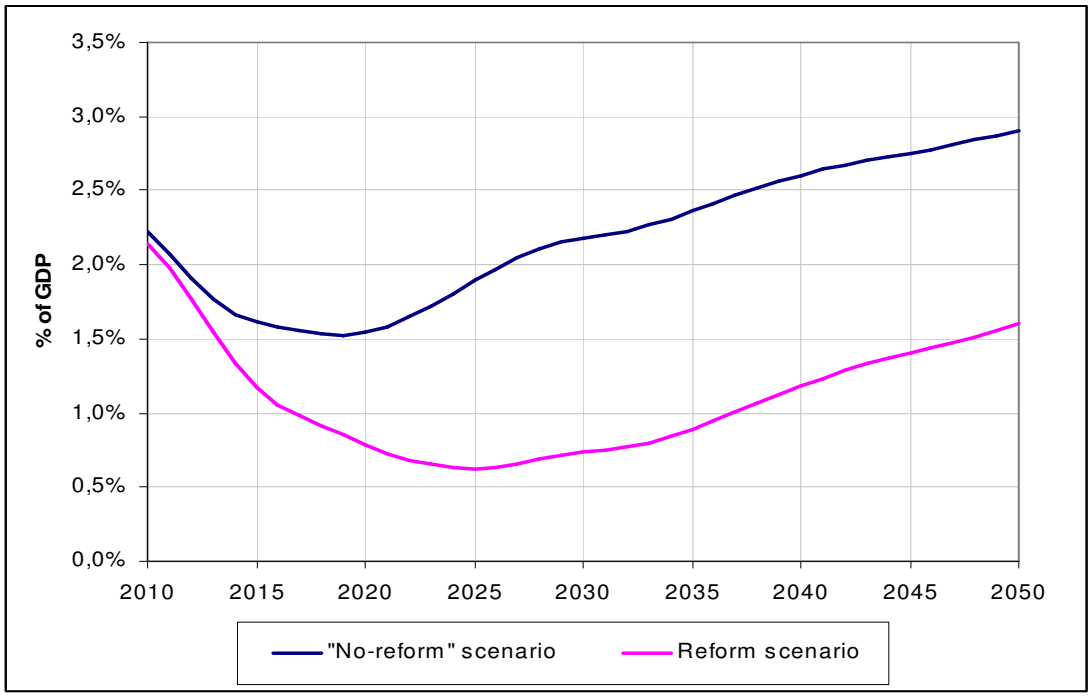
For the time being, **population ageing** may not appear as an urgent problem in Slovakia. However, the demographic outlook is clearly unfavourable. According to population forecasts, the current old-age dependency ratio of 5.4 productive-age persons (18-64) per one pensioner (65+) will decrease to 1.8 by 2050. The ageing index (ratio of population aged 65+ to population aged 0-14) is projected to grow from the current value 70 to 190 in 2050.[13] Total fertility rate was at 1.41 in 2009 among the lowest in the EU and is projected to increase only moderately in the next decades (to 1.70 in 2050).[14] Eurostat projections suggest that Slovakia is going to experience one of the most intensive ageing processes in the EU.[15] Provided the current dependency ratio would be chosen as a benchmark, the retirement age would have to be increased to 70 years by year 2030 and/or to 74 years by year 2050.

In May and June 2010, INEKO institute and the Business Alliance of Slovakia published long-term forecasts of the financial stability of the pension system in Slovakia, using the World Bank's PROST model.[16] The main conclusions are:

- The pension system generates a deficit exceeding 2% of GDP annually. Owing to the increasing pensionable age of women and the anticipated economic performance growth, the shortfall may decrease to 1.5% in GDP terms in 2020. However, if future governments avoid any reforms, the fiscal impact of the pension system is estimated to grow to 2.6% by 2040. The debt produced by the pension system would thus mount to 200% of GDP by year 2100, excluding interest expenses.
- The impact of the second pillar on the pension system balance will be negative until around 2040; thereafter, the effect becomes significantly positive. This effect has been partially weakened by the introduction of voluntary participation in the funded scheme for new entrants to social security.
- To support long-term stability, pension indexation should be reduced to inflation-based only and the statutory retirement age should be increased from 62 years to at least 65 years. These changes are needed to ensure sustainability of the pension system until 2040.

[13] Projections by the Demographic Research Centre of INFOSTAT Bratislava: http://www.infostat.sk/vdc/sk/index.php?option=com_content&task=view&id=17&Itemid=18.
[14] Dito.
[15] Source: Eurostat population projections.
[16] For more information, visit: http://www.ineko.sk/clanky/kalkulacka-financnej-stability-penzijneho-systemu http://www.ineko.sk/clanky/dochodkovy-vek-treba-predlzit-aspon-na-65-rokov.

Figure 1 Deficit generated by the pension system (as % of GDP, projection)



Source: INEKO, Business Alliance of Slovakia.

The Ministry of Labour, Social Affairs and Family released in February 2011 a comprehensive analysis of the long-term sustainability of the pension system.[17] The analysis concludes that:

- Contribution rates to the pension fund are above OECD average. However, the real rate is even higher in Slovakia as the deficit in the pension fund is subsidised from other surplus insurance funds, notably the reserve fund. The actual contribution rate is in fact higher than a modelled "fair" rate, implying that the setting itself should not lead in the short term to financial imbalance. The main reason for the deficit in the system is the significantly higher number of actually retired persons than should be in a situation when retirement age is set at 62 years.
- In the long-term, expenditures on public pensions are expected to increase due to demographic changes by 3.4% of GDP by year 2060 (from 6.8% in 2007 to 10.2% of GDP in 2060); the fiscal impact of this 50% increase against current spending is clearly negative. Counting in private pensions, expenses should grow by 5.6%.
- Pensionable age is low in international terms, notably for women, which in terms of average effective retirement age is the lowest in the OECD (OECD, 2011b). Data on the average period of pension benefit drawing (calculated using the legal retirement age) show that for men the period is comparable with the OECD average (16.3 and 17.5 years, respectively). On the other hand, Slovak women draw a retirement pension for 25.1 years on average, which is 3 years more than the OECD average (21.9 years) and almost 9 years more than Slovak men. The gradual increase of the female retirement age to 62 is expected to decrease the gap. The study finds that with regard to longevity and the period of benefit drawing the current retirement age is adequate and in compliance with standard practice applied in the OECD. Nevertheless, in the longer-term, parametric changes such

[17] http://www.rokovania.sk/Rokovanie.aspx/NezaradenyMaterialDetail?idMaterial=19196.

as increase of the retirement age and reduction of replacement rates will likely be unavoidable.

The **net pension replacement rate** (retirement pension relative to pre-retirement earnings, taking account of income tax and social security contributions paid by workers and pensioners) in Slovakia was at 72.9% roughly at the average of OECD countries (71.9%) in 2010. Slovakia belongs to a small group of countries where the net replacement rate increases along with growing income. The freezing of the average personal wage point in 2011 (see section 2.1.1) resulted in the net replacement rate moderately decreasing along with increasing earnings.

Table 2 Net pension replacement rates by earnings

	Individual earnings (as multiple of mean for men)			
	Median earner	**0.5**	**1**	**1.5**
Slovakia	72.9	68.3	74.5	76.7
Slovakia (after POMB freezing)	73.8	77.1	72.6	72.9
OECD34	71.9	82.8	68.8	63.4

Source: OECD, Pensions at a Glance 2011; Ministry of Labour, Social Affairs and Family of the SR, Analysis of the long-term sustainability of the pension system.

Labour market participation of older citizens recorded a noteworthy increase in the last five years, triggered mainly by the increase in the legal retirement age. Employment in the 55-64 age cohort benefited also from the generally favourable economic and labour market developments until the economic crisis set in. The crisis affected the entire labour force, elderly workers including. Unemployment almost doubled in the age group 55-64 during 2008-2010, but the low base effect and the parallel gradual increase of the effective retirement age resulted in a moderate increase in the employment rate of older workers during the crisis years 2009 and 2010 when overall employment clearly decreased. In view of the facts that men were hit harder by the crisis and the pension age increase concerns now only women, the gender gap in employment of elderly people continued to shrink in 2010.

Table 3 Employment and unemployment of older workers (55-64)

Indicator	**2007**		**2008**		**2009**		**2010**	
	SK	**EU27**	**SK**	**EU27**	**SK**	**EU27**	**SK**	**EU27**
Employment rate	35.6	44.6	39.2	45.6	39.5	46.0	40.5	46.3
Men	52.5	53.9	56.7	55.0	54.9	54.8	54.0	54.6
Women	21.2	35.9	24.2	36.8	26.1	37.8	28.7	38.6
Unemployment rate	8.2	5.5	6.4	5.1	7.7	6.3	10.1	6.9
Men	7.8	5.5	5.4	5.1	6.4	6.5	9.6	7.3
Women	9.0	5.5	8.5	5.1	9.9	5.9	11.0	6.2

Source: Eurostat Database.

Data show that employment of Slovak senior workers is catching up significantly with the EU average. This catch up process will likely continue as a result of the female retirement age increase taking place and the recent restrictions in the early retirement scheme. A more distinct progress could arrive with a full labour market recovery from the crisis and a prospective legal retirement age increase to at least 65 years.

Pension funds in the second pillar have been seriously affected by the **financial and economic crisis** and legislative restrictions on investment policy and risk allocation. For the entire period since the launch of the second pillar until 15 April 2011, growth funds attained returns at 6.35%, balanced funds at 8.64% and conservative funds at 17.54%. However, since 1 January 2008 and the evident fall on equity markets, growth funds are losing 4.73%, balanced funds 2.48%, and only conservative funds recorded positive returns at 6.05%.

Table 4 Gross nominal returns in the second pillar (weighted averages)

	23 March 2005 – 15 April 2011	**1 January 2008 – 15 April 2011**	**1 January 2009 – 15 April 2011**	**1 January 2010 – 15 April 2011**
Growth funds	6.35%	-4.73%	2.01%	1.46%
Balanced funds	8.64%	-2.48%	2.16%	1.51%
Conservative funds	17.54%	6.05%	3.17%	1.50%

Source: Association of pension funds management companies.

The crisis took its toll also on returns in the third pillar. After a slump in most funds in 2008 by -1.8% on average (nominal returns adjusted for fees ranged from -20.9% to +2.9%), an average growth by 3.4% (from -1.0% to +15.8%) and 1.9% (from +0.22% to +5.37%) followed in 2009 and 2010, respectively.

2.2.5 Critical assessment of reforms, discussions and research carried out

The pension system in Slovakia is ready for far-reaching reforms. The government decided to revise the public PAYG scheme and the private funded scheme to increase financial stability of the system. Some changes have already been implemented in the framework of a fiscal consolidation package (reduction of early retirement), but the decisive pension reforms are currently in the pipeline. Preliminary reform plans include for the most part useful measures.

The PAYG pillar is financially unsustainable, thus a restriction of the pension formula to reflect the contributors-recipients ratio, and a reduced indexation of pensions to take account only of inflation, as proposed by the government, are reasonable ideas. Independent calculations suggest that to ensure long-term sustainability with respect to demographic trends, an increase in the legal retirement age should be considered as well. Whether or not an increase in the retirement age is needed at the moment is subject of considerable controversy. Taking into consideration all available arguments, it may be assumed that a gradual increase in the pensionable age to 65 years phased in at an earlier point in time than proposed by the government (year 2016) would not only help to stabilise public finances but also enable to spread out the increase over a longer period of time. Certainly, raising the retirement age must coincide with measures promoting job creation and employment of elderly and minimising negative effects on job prospects of other groups, notably youths. Experience from past reforms suggests that age-specific groups benefit more from "general" reforms than specially targeted programmes.

Positively, the coalition agreed on the return to compulsory entry (with the option to leave) of new policyholders to the funded scheme. Although optionality provided some relief to the fiscal strain in public pensions, from a long-term point of view the effects on sustainability and adequacy of pensions would be clearly negative. It is also widely accepted that alongside reasonably strong guarantees savers should have the possibility to take more risk when investing their assets.

The government should reassess the inclusion of incentives in supplementary pensions and possibly also in other occupational pension schemes. In discussion with competent departments, the government should explore possibilities of reducing the high cost of a parallel social security system for armed forces. The provision of the Christmas pension benefit should be discontinued and funds used to finance regular pensions.

Policy makers have to make all efforts to furnish people with clear and concise information on policy reforms, plans and developments, so that individuals can make informed decisions and have realistic expectations regarding future benefits.

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 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. This tendency 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 payments remained thereafter. The reasons can be found in the uncontrolled rise of diverse semi-official payments, which are insufficiently regulated. Anecdotal evidence suggests that these expenditures at least partly reflect informal payments.[18] To prevent that growing out-of pocket spending unbearably burdens socially disadvantaged groups, an upper limit for direct payments needs to be installed. The government approved the introduction of a protective upper limit on co-payments for drugs for low-income pensioners 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.

Mandatory public health insurance is performed by one state-owned and two private joint stock companies. As of 1 January 2010, state-owned Vseobecna zdravotna poistovna merged with the smaller state-owned Spolocna zdravotna poistovna. At the same time, a fusion of two private health insurance companies Dovera and Apollo came into effect. The mergers resulted in a significant concentration on the health insurance market. As far as the market position is concerned, state-owned Vseobecna zdravotna poistovna (VsZP) has a dominant position with a 66% share on the number of policyholders and a 67% share on revenues. The respective shares of private insurance company Dovera are 27% and 24%, and Union 7% and 9%. Several analysts criticised the concentration for impairing competition on the insurance market. Some critics propose a demonopolisation of VsZP through its division into smaller companies and their subsequent privatisation. VsZP reported a loss at EUR 70 million as at end of 2010 (Table 5). The Health Care Surveillance Authority alerted the company in

[18] OECD (2010a).

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 the recently approved 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.

Table 5 Balance of health insurance companies (as at 31 December 2010, preliminary data, in EUR)

VsZP	- 69,666,794
Dovera	9,171,178
Union	- 2,264,534
Total	*- 62,760,150*

Source: Health Care Surveillance Authority.

One of the most pressing long-term problems of the Slovak health care system is its high indebtedness which thus far no administration succeeded to bring in a sustainable way under control. There are several reasons for this condition, notably soft budget constraints in the health sector, uncovered increases of salaries of health professionals, legal claim for an almost unlimited scope of health services financed from public health insurance, provision of care without sufficient funds, inefficiency, non-transparency and corruption. The debt increased by EUR 91.98 million in 2010, year-on-year. Information on financial liabilities after maturity date show that the highest debt increase occurred in non-transformed health care facilities administered by the Ministry of Health.

Table 6 Development of financial liabilities after maturity date (principal) in the health sector (cumulative data since 1 January 2005, in EUR million)

Facilities	**as at 31 Dec 2005**	**as at 31 Dec 2006**	**as at 31 Dec 2007**	**as at 31 Dec 2008**	**as at 31 Dec 2009**	**as at 31 Dec 2010**
under the competence of the Ministry of Health	67.48	147.22	193.92	195.55	115.45	209.36
transformed to joint-stock companies	-	0.05	0.02	0.05	0.04	0.05
transferred to municipalities and SGR and transformed to nonprofit organisations	79.13	75.52	71.50	76.71	77.51	75.76
health insurance companies	40.40	3.22	2.39	0.40	0.19	0.00
Total	*187.01*	*226.01*	*267.83*	*272.71*	*193.19*	*285.17*

Note: SGR – Self-governing regions.

Source: Report on development of debts in the health care sector as of 31 December 2010, Ministry of Health of the SR, April 2011.

According to the Ministry of Health, several factors are responsible for the considerable debt increase in 2010. The main reason, in the opinion of the Ministry, is the flat decrease of payments by health insurance companies to health care providers. In addition, debt is accumulated also by outstanding payments from health insurance companies for services performed beyond the contracted volume. The Ministry concludes that the situation was induced by the economic crisis and the consequent labour market deterioration, which resulted in decreased revenues, decelerated wage growth and a worsened payment discipline.

No substantial changes occurred in the public-private mix of health care provision in the monitored period, although 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 Vseobecna zdravotna poistovna. The current government is stepwise revising the discriminatory framework for non-state providers, which could in the future translate into a stronger position of the private sector. The government's ambitious plan counts with the transformation of state hospitals into joint-stock companies by end of 2011, but not with privatisation. The cabinet adopted a similar rejecting stance towards the proposal to divide and privatise state-owned VsZP.

Reforms implemented during the last year include also:

- a reinstallment of the degressive business surcharge on drugs destined for hospitals;
- widening of the assessment base for health insurance payments by additional types of income (e.g., severance pay, discharge benefit, work stand-by and overtime work compensation, dividends);
- tightening of criteria assessing liquidity of health insurance companies;
- strengthening of the independence of the Health Care Surveillance Authority by way of weakening the powers of the government.

Fiscal consolidation affected the health sector on several fronts. Instead of a planned increase of payments by the state on behalf of 3.1 million state policyholders[19], the contribution rate was lowered from 4.78% to 4.32% of the average wage in the economy reported two years ago. This measure was met with strong disagreement in the sector. The Ministry of Finance assumes that lower payments will be compensated by higher collection of insurance contributions resulting from the widened assessment base, and retrenchment within the health sector. A further decrease of state payments to 4.0% is projected for 2012 and 2013. Consolidation gave a red light to an increase of wages in public health care.

Table 7 Payments by the state on behalf of state policyholders

	2006	**2007**	**2008**	**2009**	**2010**	**2011**
Percentage of average wage	4.00%	4.33%	4.50%	4.90%	4.78%	4.32%
Total sum in EUR million	773	893	979	1,162	1,283	1,198 (P)
as% of GDP	1.4%	1.5%	1.5%	1.8%	1.9%	n.a.

Note: P- prognosis; n.a.-not available.

Source: Ministry of Finance of the SR.

Implemented and planned consolidation measures in health insurance and provision of care (fewer contracts between insurance companies and providers, reduction of hospital beds, etc.) may entail unfavourable short-term effects on the accessibility of health care, especially for priority groups.

[19] Comprising dependent children, students, pensioners, registered unemployed, persons taking care of children up to age 3.

2.3.2 Debates and political discourse

A debate about the shortage of medical staff livened up after the emergence of protests in neighbouring Czech Republic. The 'Czech' protest had a double impact on the Slovak health sector. Firstly, it was assumed that the impending mass dismissals of Czech practitioners and the following acute demand would be partly satisfied by doctors from Slovakia (which would then lead to a shortage in Slovakia). Secondly, after the Czech doctors succeeded in getting their requests fulfilled, a similar protest action was started by Slovak practitioners. Medical Trade Unions demand an increase of salaries to 150-300 % of the average wage in the economy depending on qualification and years of professional practice. Among the requested changes is a suspension of the transformation of hospitals to joint-stock companies.

The Czech case inspired also Slovak nurses who consider a mass filing of notices to achieve higher salaries, better working conditions and earlier retirement.

Other important debates and plans in health care, partly referenced also in the National Reform Programme, include:

- Removal of restrictions on utilisation of profits attained from public health insurance. Health insurance companies should regain the possibility to keep profits providing that they (i) use part of the profits to finance a reserve fund up to the sum of 20% of the paid-in capital, and (ii) create technical reserves for the reimbursement of planned health care for policyholders on waiting lists. The former government enacted restrictions on utilisation of profit which stipulate that profit attained from public insurance may be spent only on payments for health care provision. In reaction to the intervention, owners of private insurance funds Dovera and Union filed arbitration procedures against the State to claim compensation for investment damage. Restrictions on profit use have been disputed also by the European Commission, which started an infringement proceeding against Slovakia in November 2009 because of suspects of infringing rules on the free movement of capital.
- Transformation of state hospitals into joint-stock companies with the aim to raise efficiency and transparency of hospital management. Trade Unions and the political opposition criticise the process and voice concerns about a possible privatisation. The government rejects any speculations about privatisation. Debated are the tight deadline (end of 2011) and the availability of funds for debt reduction prior to their transformation.
- Revision of the minimum network of providers, which health insurance companies are obliged to contract, hence restricting their contractual freedoms.
- Introduction of a lucid system of quality assessment and provider accreditation. A new enlarged list of indicators shall be adopted by end of 2011 in order to provide for a meaningful assessment and differentiation of health care providers. Rankings of providers and indicators shall be published at least once per year in a user-friendly format to improve awareness of patients.
- Revision of regulation on waiting lists with the aim to enhance transparency of inserting policyholders in waiting lists for planned medical services and to shorten waiting periods for diagnoses, outpatient and oncological care.
- Introduction of supplementary private health insurance beyond the scope of the basic package of health care. However, prior to such change a determination of an adequate (reduced) basic benefit package financed from public health insurance is needed.

Individual voluntary insurance is formally allowed already today but owing to the broadly defined basic package it is practically non-existent.

- Introduction of a Diagnosis-related group payment system to pursue a more efficient, transparent and fair system of financing hospital care.
- Inclusion of health status indicators (pharmaceutical cost group) into redistribution of insurance companies' revenues with the aim to more equitably compensate the differences in the structure of insurance stocks. Redistribution criteria include sex and age and since 2010 also economic activity of policyholders.
- As from 2012, the annual clearance of health insurance contributions shall be completed by health insurance companies instead of policyholders and/or employers.
- Determination of a cost efficiency rate of treatment by way of stipulating an acceptable price of one quality-adjusted life year in the sum of 24-times to 35-times of the average wage.
- Introduction of generic drug prescription to reduce public expenditures on pharmaceuticals, out-of-pocket spending, and improve patients' awareness.
- Stricter rules for the benchmarking of drug prices, so that the price of a given drug in Slovakia must not exceed the second lowest price in EU Member States (now below the average of prices in six EU Member States with lowest prices of the given drug).
- More flexible and transparent drug classification, sale of selected over-the-counter drugs should not restricted to pharmacies.

2.3.3 Impact of EU social policies on the national level

A debate about the role of OMC and other European initiatives in the field of health care is practically non-existent in Slovakia. Particular policy issues such as cross-border care or portability of health insurance receive some attention because of practical implications, but usually remain isolated and hardly noticeable in the national policy debate.

The 2011-2014 NRP contains a set of policy reforms considered vital for economic growth, employment and quality of life in general. Health is identified as one of the five priority areas. The Slovak government set a national health target with respect to the Europe 2020 strategy which seeks to improve health care services in order to increase healthy life expectancy without disability or a severe handicap at birth to 60 years by 2020.[20] The NRP points out that spending on health is growing and is expected to rise substantially over the next decades due to rapid population ageing. At the same time, international comparisons suggest that the Slovak health care system is relatively inefficient in translating high expenditure growth into better health outcomes. The NRP presents plans to make health spending more effective and improve access and quality of health care services. Particular attention should be paid to improved access of disadvantaged groups where the government intends to follow up on already adopted limits on co-payments for drugs for old-age pensioners and individuals with severe disabilities and thus promote the social aspect in health care.

The Ministry of Health plans a reduction of redundant hospital beds. It is assumed that part of the saved funds will be redirected to the care for chronically and long-term ill patients (that is,

[20] In 2008 the indicator for Slovakia was 52.3 healthy life years, after 55.9 years in 2007. The EU average was at 62.3 healthy life years in 2007. Source: 2011-2014 National Reform Programme for the Slovak Republic, Eurostat.

in most cases elderly people). There is shortage of so-called social beds. Thus, the proposed transfer of chronic health care from university and teaching hospitals to smaller medical institutions and general hospitals seems to be reasonable as these facilities could specialise on provision of such care and attain higher quality of services.

2.3.4 Impact assessment

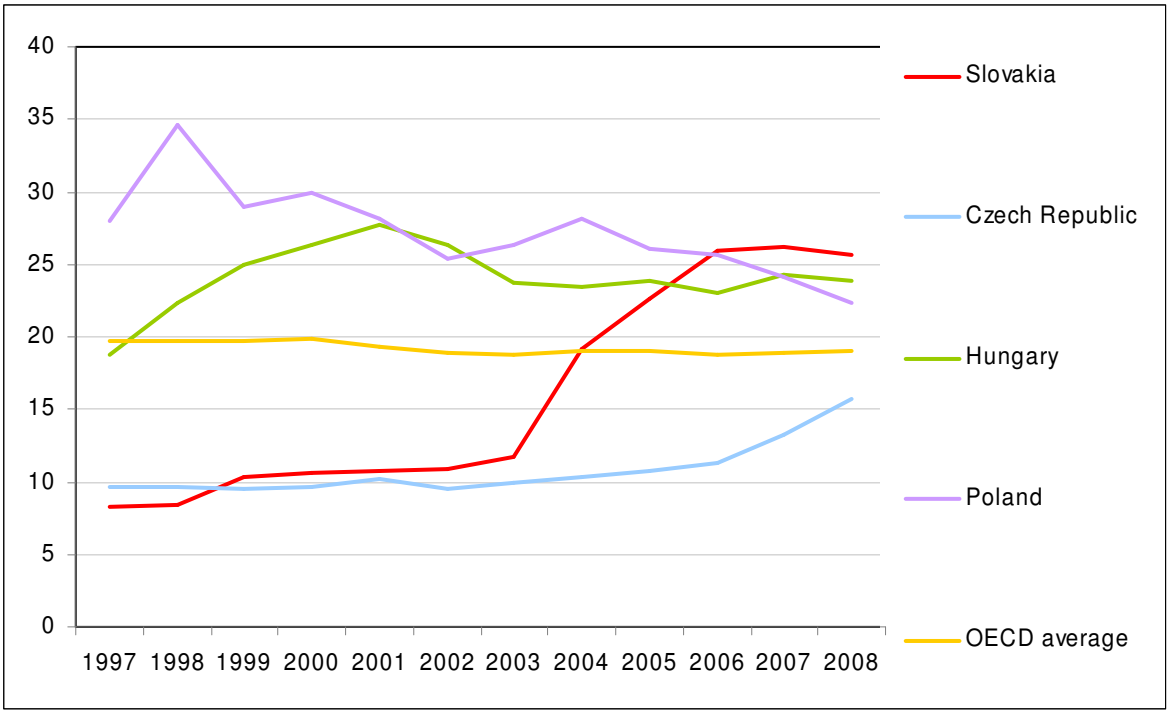
The economic crisis impacted on the availability of funds in health care. On the other hand, the crisis accelerated a recovery process in the Slovak health system that would have been necessary anyway in view of unsustainable arrangements. The main problem, as it seems, lies in the mismatch between the broadly defined free-of-charge basic package and the scarce resources available in the system.

On the basis of public health insurance patients are entitled to free of charge care. They pay neither for visiting the practitioner nor for staying in the hospital; applied are only user fees for prescription of drugs and medical aids (EUR 0.17), for emergency care (EUR 1.99), for ambulance (EUR 0.07 per km) and spa treatment (EUR 1.66 – 7.30 per day according to diagnoses). Currently debated is the introduction of similar fees for "room service" in hospitals (food and accommodation), which hospitals intend to charge even without legislation. This is a typical outcome of an absent unambiguous definition of a basic benefit package, enabling thus providers to arbitrarily interpret what is regarded as an above-standard service and what is not. Under the present legislation providers may charge direct fees for preferential appointments, issuing of certificates for administrative purposes, and medical examination upon patient's request. In addition, providers may charge fees for above-standard services (such as choosing a doctor for performing an operation, superior accommodation and food, etc.), but not for the provision of health care. In reality, however, providers often include services to which the patient is entitled from public health insurance. This is a seedbed for semi-official direct payments.

Out-of-pocket payments are among the highest in OECD countries considering their share on total health expenditures. Spending on health out of pocket has steeply increased over the last decade (from 10.6% in 2000 to 25.2% in 2008, as a share of total health spending). Health analysts agree that the reasons for the increase are not only rising co-payments on drugs or higher spending on over-the-counter drugs, but also an increase of different administrative fees and informal payments.[21] The non-transparent environment tends to benefit insiders and not the entire health care system. Consequently, access to health care deteriorates mainly in socially vulnerable populations. Experts in health policy have thus advised the Ministry of Health to introduce regulated cost sharing, which would legalise the already levied charges, abolish unreasonable payments and/or introduce new if necessary, and stipulate a protective upper limit for dependent individuals.

[21] See, for example Slovakia-Health system review (2011).

Figure 2 Out-of-pocket expenditure on health (as % of total expenditure on health)



Source: OECD Health Data 2010.

Legislation establishes conditions for the creation of **waiting lists** for the provision of deferrable health care. In the opinion of health analysts, the applicable rules lack transparency and enforceability and create room for informal payments, corruption and unequal access of patients to timely care. The Ministry of Health is drafting new rules which should introduce waiting lists for all diagnostic and therapeutic services that are provided more than 1 month after indication. Health insurance companies shall be obliged to publish waiting periods by individual providers. As of mid 2010, state-owned VsZP had 6,145 persons on waiting lists, private Dovera about 7,000 and Union 50 patients. The average waiting period in VsZP was three to six months; the longest waiting time concerns replacements of hip joints (in some hospitals more than one year).

According to Filko (2010), a certain degree of regional disparities in health care infrastructure is reasonably explainable by the concentration of medical capacities in regional or national centres, different sickness rates and migration flows. However, **regional differences** in Slovakia are significant to that extent that they may cause problems of physical accessibility in some regions. There are 1.97 doctors in teaching hospitals per 1,000 inhabitants in the Bratislava region, while the corresponding number in the Trencin region is 0.33. Similar (multiple) differences are observed in general hospitals and outpatient care, and notably in regional availability of medical technology (e.g. imaging technologies). Differences in infrastructure display also in differences in accessing health care services. Data from VsZP point to significant differences in the number of visits in specialised ambulatory care and hospitals; the numbers are falling behind mainly in the southern and eastern parts of the country where incidence of poverty is higher.

Spending on health is growing and is expected to rise substantially over the next decades due to rapid population ageing. At the same time, cross-country analyses suggest that the Slovak health care system is relatively inefficient in translating high expenditure growth into better

health outcomes (e.g. longevity). There are many reserves in the efficiency of using available resources. Pazitny et al (2010) concludes that life expectancy at birth in Slovakia is shorter by five to seven years in comparison to the EU15, and the gap is not decreasing. While in Slovakia life expectancy increased by three years for men and two years for women in the period 1990-2006, in EU15 countries it was 4.5 and 3.7 years, respectively. In neighbouring Czech Republic both indicators increased by five years in the given period. Slovakia belongs to countries with the highest number of years lost due to deaths that are potentially preventable with timely and effective health care (so-called amenable mortality).

2.3.5 Critical assessment of reforms, discussions and research carried out

One of the crucial dilemmas of the Slovak health care system is – in a simplified way – that everyone is entitled to everything, but there is no funding for everything. The situation results in a growing debt, long waiting lists, insufficient quality and access to health care, semi-official payments and corruption. However, the core of the problem is not a lack of funds, but their inefficient use. Research done by OECD suggests that life expectancy at birth could be raised by as much as four years in Slovakia, while holding health care spending steady, if the country would fully exploit its potential for improving efficiency of the system (OECD, 2010).

Bringing the system on track to financial sustainability and efficiency envisages a number of reforms to be launched and/or continued. To address the enduring debt in the health sector, consolidation and streamlining must be pursued on all fronts. It is acknowledged that the Ministry of Health, in cooperation with the state-owned health insurance company, proceeded to tighter contracting of providers. Reasonable plans include also a reduction of redundant beds (mainly in acute care) and ineffective hospital departments, improved coordination of related subdivisions, and enlarged scope of outpatient care and one day care. Additional cost reduction could be achieved through concentration of specialised cost and medically demanding inpatient care in specialised hospitals and institutions. Frequent relocation of patients and unneeded hospitalisation are among the main aspects of inefficiency. The insufficiency of long-term care for chronically ill patients could benefit from the transfer of long-term care from teaching and university hospitals to smaller general hospitals. Changes in drug pricing lead already to significant retrenchment and there are further measures announced which could attain savings.

Sustainable financing requires an explicit definition of the scope of a reduced basic benefit package and the introduction of regulated cost-sharing. Competition on the health insurance market should be promoted. The transformation of state-controlled indebted hospitals to joint-stock companies would enable the entry of strategic private sector partners either through privatisation or long-term rental.

Increasing the quality of health care is another goal to be pursued. Key in this respect are reforms which promote the introduction of quality standards and their assessment, and bring as much information as possible to the patient.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care (LTC) in Slovakia is provided within the framework of (i) social services and (ii) financial assistance provided to compensate severe disability.

Responsibility for the provision of **social services** has been transformed from central administration to municipalities and self-governing regions in 2002-2004. The *Act on social services* of 2009 replaced the blurred regulation of social services within the social assistance scheme and adjusted competences and responsibilities of providers and users anew. The main objective of social services is to prevent, solve or mitigate 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 addressing the above situations differ in type and form. Institutional care is provided mainly in pensioners' homes, nursing homes, facilities of supported living, rehabilitation centres, and homes of social services. 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. Long-term care includes also supportive services such as canteens, guidance and read-out service, lending of aids, etc. Pursuant to the social services law, care is provided in different forms – outpatient, residential (institutional), field (usually at home) or other forms adjusted to the situation of the user. Home care and outpatient care have to be preferred to institutional care as long as they adequately address the unfavourable situation.

Social services are funded mainly from shared taxes (centrally collected taxes transferred to municipalities, towns and regions). Recipients of a service are obliged to pay for the service 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.

Until 31 March 2011, regulation stipulated that an applicant for a social service had to be satisfied in first place by means of services (facilities) 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. Criticism from non-public providers and civil society organisations found support in the then political opposition, which filed a complaint to the Constitutional Court. In May 2010, the Constitutional Court ruled that preferential treatment of public providers is not in compliance with the Constitution given that the field of activity and the conditions laid down by the law on performance of this activity are the same irrespective of the legal status of the provider. In other words, municipalities and self-governing regions shall be obliged to provide for a social service at a registered public or non-public provider according to the client's choice.

The new government declared in its Programme Manifesto of July 2010 to amend the social services law accordingly. The revised legislation came into effect on 1 April 2011. Apart from the main change the amended law creates conditions for streamlined medical and social assessment of a client's dependence on subsidised care services. In addition, the law explicitly specifies the types of social services which have to be reimbursed by municipalities and regions in the sum of economically justified costs. The change does not significantly affect provision of long-term care; excluded from the mandatory subsidy are shelters and reception centres due to recipients' permanent residence issues. With respect to the unfavourable financial situation of municipalities resulting from the economic crisis, municipalities shall

not be obliged to finance social services provided in institutions founded by self-governing regions, since regions have these costs covered by shared taxes.

Latest available detailed data from the end of 2008 show that 34,904 recipients (0.65% of total population) were provided a social service within a network of 720 facilities. In addition, a total of 19,067 citizens were receiving care services, usually at home. Persons with disabilities accounted for 71% of the total number of institutional recipients, while 60% were old-age pensioners. Retired people are mostly represented among recipients of services provided in pensioners' homes and nursing homes (92%), but they account also for a relatively high number among recipients of services intended for disabled persons (44%). Waiting lists for social services counted 17,591 persons, of which 12,244 (70%) were applicants for services provided in pensioners' homes. Public providers comprised 65% of all providers (municipalities: 168 entities, self-governing regions: 301 entities), while non-public providers operated 35% of facilities (legal entities: 167 entities, physical persons: 19 entities, church: 65 entities). Specific reporting on non-public providers of social services and their recipients shows that as of 31 December 2009, 383 subjects provided services for 54,845 persons (Report on the social situation of the population of the SR in 2009).

Long-term care is provided also in the form of **direct payments granted to severely disabled persons** and/or their carers. The *Act on cash allowances for compensation of severe disability* of 2009 stipulates different compensation instruments for severely disabled persons with the aim to alleviate or overcome social consequences of severe disability. Severe disability is defined as a level of functional impairment of at least 50%. The degree of functional impairment and social dependence of a disabled person is assessed by a committee comprised of doctors and social workers. Allowances are for the most part income-tested and the sum of all recurring benefits is set as a percentage of the minimum subsistence level, which is indexed annually. 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 form of LTC is the provision of a care allowance. This cash benefit is paid to the caregiver, usually a relative of a disabled person. Allowances may be combined with an invalidity pension. 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. In 2009, LTC in the form of cash benefits was provided to more than 200 thousand recipients, of which 52 thousand were granted a care allowance and almost 7 thousand and allowance for personal assistance (Report on the social situation 2009).

Formal long-term care in Slovakia is provided by professional LTC workers, however, care for dependent elderly or disabled people is still mainly performed by informal carers (OECD, 2011a).

2.4.2 Debates and political discourse

Two issues dominated the policy discourse in the area of social services and long-term care – the ruling of the Constitutional Court on the equal position of public and non-public providers and the funding of care which was negatively affected by the economic crisis and amplified by the aforementioned verdict.

Pursuant to the social services law, municipalities and self-governing regions are obliged to co-finance social services. They have pushed through in the original law that services have to be provided preferentially by a public provider. In fact, municipalities and regions have been reluctant to contract non-public providers even when public facilities had filled capacities.

The reasons are obvious – private provision stands for unwanted competition and ultimately also higher costs. The ruling of the Constitutional Court is a positive message for the LTC sector, however, bringing the regulation in accord with the verdict without a revision of the funding mechanism worsens the already unfavourable financial situation of self-governments. The economic crisis led to a significant fall in tax revenues, which finance delegated competences of self-governments. Funding of several policies in charge was thus threatened, including provision of social services. A monitoring system has been launched to examine the implementation of the new social services law and the financial implications of the new competences of municipalities and regions in the provision of social services. The monitoring is set within a framework of activities agreed in a memorandum between the government and the Association of towns and municipalities. This arrangement should also monitor the impact of the economic crisis and since the 2nd half of 2010 also the ruling of the Constitutional Court.

The shortfall in funding, determined on the basis of the monitoring, has been thus far compensated by extra subsidies from the State budget. In 2010, the former government approved a one-off subsidy amounting EUR 13.7 million to public and private providers of social services for the compensation of costs, of which EUR 6.4 million were allocated to regions to finance non-public providers, and EUR 7.26 million to municipalities and towns to finance facilities established under their governance after 2002. The new cabinet decided in December 2010 about a transfer of EUR 2.74 million to municipalities and EUR 3.03 million to regional units in order to refund their costs from the second half of 2010. In view of the unimproving fiscal situation, the government intends to carry on with the monitoring and refunding mechanism in the first half of 2011.

The creation of a sustainable and fair financing mechanism in social services is currently the greatest challenge. The Ministry of Labour launched a consultation process in order to sort out attitudes of key stakeholders and prepare a comprehensive revision of legislation. Preliminary plans envisage that funding of care via covering part of the costs of providers will be replaced and co-financing provided directly to the eligible recipient.

2.4.3 Impact of EU social policies on the national level

Long-term care has always been somewhat on the periphery of the national policy discourse and it is only recently that there has been some movement. It is therefore not surprising that the national debate is reflecting but insignificantly on the EU Open Method of Coordination in the field of long-term care. Sharing best practice and information is more or less limited to the official reporting process (national strategy reports on social protection and social inclusion since 2006, National Reform Programme since 2011).

The 2011-2014 NRP made a brief statement on reform plans in the area of social services, notably the introduction of a new financing scheme. 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. A financial normative shall be introduced for all service types and forms. The NRP subscribes also to further unspecified plans to improve supervision and quality assessment of care, and streamline multi-resource funding of social services.

Available data from the EU SILC suggest that elderly people do not belong to groups facing above average risks of poverty and social exclusion. However, monetary poverty among

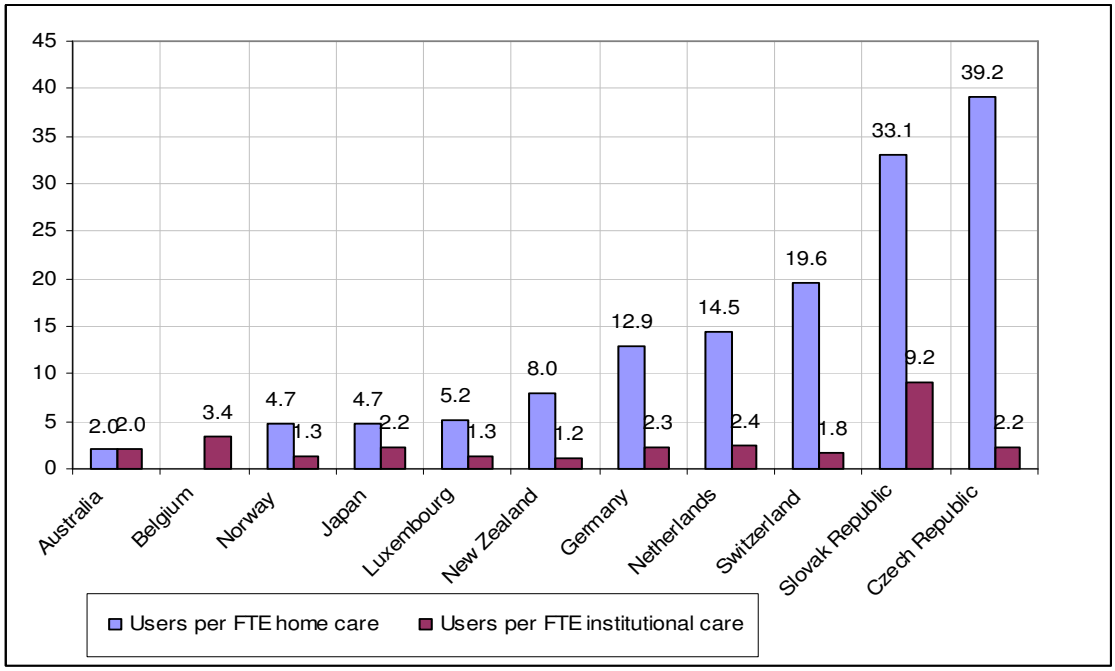
pensioners increased over the past five years as opposed to a moderate decrease in the total population. Most of the social protection reforms ahead will presumably tend to tighten levels and sources of retirement income, particularly in the public pension scheme. Thus, it is likely that along with an ageing population and a growing demand for LTC services the group of pensioners with lower incomes will increase, who will require higher public support to long-term care.

2.4.4 Impact assessment

People aged 65 and more account presently for 12.5% of the total population and their share is expected to rise to 17% by 2020 and more than 30% by 2050. The trend will be even more distinct in the group of very old. The share of population aged 80 and over is expected to increase from less than 3% in 2010 to almost 9% in 2050.[22] Consequently, the need for care in such a rapidly ageing society will increase. According to OECD projections, public spending for LTC services in Slovakia is expected to rise significantly from around 0.2% of GDP in 2007 to 0.5-0.6%[23] of GDP in 2050 (OECD, 2011).

International comparisons show that the ratio of care recipients to the long-term care workforce is very high in Slovakia, indicating large workloads (Figure 3). At the same time, while in most OECD countries the number of LTC workers is growing in line with the share of the very old population, in Slovakia the worker density (number of workers per 100 people aged 80 or over) decreased from 1.6 in 2004 to 0.7 in 2008 (OECD, 2011). A likely explanation is the outflow of workers from long-term care to other sectors (e.g. health care) due to unappealing working conditions, and migration to other countries, especially neighbouring Austria.

Figure 3 LTC users per full-time equivalent worker in home care than in institutions



Source: OECD Health Data 2010 (in OECD, 2011).

[22] Projections by the Demographic Research Centre of INFOSTAT Bratislava: http://www.infostat.sk/vdc/sk/index.php?option=com_content&task=view&id=17&Itemid=18.

[23] Depending on different scenarios of prevalence of dependency, cost of delivering care, and the availability of family care. See OECD (2011) for more details.

Demand for LTC workers is expected to triple in Slovakia by 2050, while at the same time the society will face a decline of potential supply of carers due to a sizeable shrinking of the working-age population and also a reduction of the potential pool of family carers (OECD, 2011).

2.4.5 Critical assessment of reforms, discussions and research carried out

Looking ahead, the key challenges in long-term care resemble those faced in other social protection policies, namely population ageing, quality of care, shortage of LTC workers, and not least, sustainable funding.

The government's current priority is the introduction of a new financing arrangement in social services. It is acknowledged that the government is aiming for a more transparent and equitable funding mechanism. Providing targeted support to an eligible care recipient instead of subsidising the provider is definitely a step forward. Some questions regarding the setting of the new scheme remain open. Notably, (i) whether funding is going to be further channelled through regional and local authorities and/or financed centrally, and (ii) to what extent will the new scheme keep features of universal coverage and/or apply means testing. Another important aspect, perhaps crucial for the long-term stability of the system, is the level of cost-sharing, or more generally, the public-private coverage mechanism. It may be assumed that the announced introduction of a financial normative, which shall be determined for individual LTC services, will take account of the fiscal margins. Public finance limitations and the anticipated developments on the demand and supply sides of LTC, coupled with uncertainty about future needs from an individual user's point of view, call for some form of insurance-based financing.

More attention in the policy debate should be paid to the coordination between social care and health care in the framework of LTC provision. The current system where health care and social services are regulated within different legal and financial frameworks, is unaccommodating to users requiring health care services alongside social care.

In a situation of persisting shortage in supply of the most demanded LTC services, quality of services is not in the foreground of debates. The government's reform plans include the commitment to enhance quality of social services. However, this is a long distance run considering the scarcity of resources, the human resource situation, and the technical condition of care facilities. The government should further encourage home care, particularly integrated forms of home-care services.

There is no discussion about the emerging shortage of LTC workers. The situation where demand for care workers is growing and the supply of qualified carers is shrinking due to low pay and poor working conditions should alert policy makers and other stakeholders to explore possibilities how to enhance attractivity of LTC jobs and possibly open the market for migrant workers. This call for action will gain urgency as the aforesaid mismatch will be intensified by future demographic developments.

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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, Analyza dlhodobej udrzatelnosti dochodkoveho systemu, 2011, Bratislava, retrieved from: http://www.rokovania.sk/Rokovanie.aspx/NezaradenyMaterialDetail?idMaterial=19196

"Analysis of the long-term sustainability of the pension system"

The analysis gives a concise overview of the Slovak pension system. It attempts to establish whether the parameters of the Slovak system are in compliance with the standards of EU and OECD countries. The central part of the analysis is discussing the reasons of problems faced in the public pay-as-you-go scheme.

[R] MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, Sprava o socialnej situacii obyvatelstva SR v roku 2009, July 2010, 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 2009"

The report focuses on the state of art and trends in socio-economic indicators. It includes an overview of labour market developments, wages, active labour market measures and specific attention is given to policy changes and performance in social protection policies.

[H] Health

[H1] INEKO, Analyza roznych moznosti financovania zdravotnictva s dorazom na zmeny vo vybere odvodov, September 2010, Bratislava, retrieved from: http://www.i-health.sk/sk/zdravotnictvo/reforma-financovania/

"Analysis of different possibilities of financing health care with emphasis on changes in the collection of contributions"

The paper gives an overview of the main pros and cons of different funding options. Particular attention is paid to solidary and merit-based financing of health care. The analysis discusses possible implications of social security reforms on health care financing.

[H6] INEKO, Problemy v liekovej politike SR, February 2011, 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.

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

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[H] FILKO, Martin – PAZITNY, Peter – SZALAY, Tomas – SZALAYOVA, Angelika, 2 cesty k lepsiemu zdravotnictvu, April 2010, Slovak Governance Institute, Bratislava, retrieved from: http://www.noveidey.sk/downloads/cesty-k-lepsiemu-zdravotnictvu.pdf

"2 ways to better health care"

The paper offers two different, but in many ways overlapping views on a health care reform in Slovakia. One view builds on a strong regulatory framework and the role of public health in providing for accessibility of health care for all population groups. The other view calls for an explicit definition of the scope of the basic benefit package, financial protection of poor, responsible and independent regulation, and privatisation of state hospitals and of the dominant health insurance company.

[H6] SZALAYOVA, Angelika, Genericka preskripcia, 2011, Health Policy Institute, Bratislava, retrieved from: http://hpi.sk/cdata/Publications/hpi-genericka_preskripcia.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.

[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 but close to the other Visegrad Four countries. Key challenges include:

improving the health status of the population and the quality of care while securing the future financial sustainability of the system.

[L] Long-term care

[L] MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, Sprava o socialnej situacii obyvatelstva SR v roku 2009, July 2010, 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 2009"

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[L] REPKOVA, Kvetoslava, Analyza vyvoja v zabezpecovani novych kompetencii na useku socialnych sluzieb na Slovensku v rokoch 2009-2010, May 2010, Institute for Labour and Family Research, Bratislava, retrieved from: http://www.sspr.gov.sk/texty/File/vyskum/2011/Repkova/Kompetencie_Repkova_2011.pdf

"Analysis of the provision of new competences in the field of social services in Slovakia in the years 2009-2010"

The report summarises information on the development of new competencies in the area of social services performed by regional and local self-governments. The main aim of the document is analyse data gathered during four monitoring cycles in order to examine dynamics and/or stagnation in the monitored indicators.

[L] REPKOVA, Kvetoslava, Podpora neformalne opatrujucich osob - odporucania pre socialno-politicku prax, October 2010, Institute for Labour and Family Research, Bratislava, retrieved from: http://www.sspr.gov.sk/texty/File/vyskum/2010/Repkova/VU%202406.pdf

"Support of informal carers – Recommendations for social policy practice"

The report summarises the key findings of a 3-years research project called *Informal carers in the long-term care sector*. The document comprises four relatively independent studies dealing with (i) a general overview, (ii) financing of long-term care, (iii) social and employment protection of informal carers, and (iv) pro-employment behaviour of informal carers and benefit traps. Each study includes policy recommendations.

4 List of Important Institutions

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.

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.

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.

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).

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 doplnkovych dochodcovskych spolocnosti – Association of Supplementary Pension Companies
Contact person: Marcel Forisek, Secretary
Address: Trnavska cesta 50/B, 821 02 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.

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.

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.

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.

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.

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.

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.

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 are carried out on commercial basis.

HPI – Health Policy Institute
Contact person: Peter Pazitny, Director
Address: Hviezdoslavovo namestie 14, 811 02 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.

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 an international level. The main areas of interest include social services and prevention and counselling for disadvantaged people.

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: Hviezdoslavovo namestie 17, 811 02 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.

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.

Forum pre pomoc starsim – Forum to Help the Aged

Contact person: Lubica Galisova, President
Address: Kukucinova 5, 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.

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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