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Pensions, health and long-term care

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1 Executive Summary

Pension reforms implemented or approved in the past 2-3 years improve the financial situation in the pension system and contribute also to the long-term sustainability of public finances. Important changes in the public pay-as-you-go pension pillar include an automatic adjustment of retirement age to life expectancy as from 2017 and modified indexation of pensions, which shall be indexed to pensioner inflation as from 2018. The private funded pension pillar has been weakened in favour of public pensions, as the contribution rate to the second pillar was lowered from 9% to 4% until 2016 (shall increase to 6% during 2017-2024) and the default enrolment of young people was changed to voluntary. In addition, the scheme was reopened for 5 months, resulting in 90 thousand persons opting out and 15 thousand joining. The reform of the private pension scheme temporarily improves the balance in the public scheme, but in the long term will lead to increased pressure in the pay-as-you-go pillar.

Reasonable changes have been approved in supplementary pensions and special pension schemes for policemen and soldiers. The supplementary pension pillar receives stricter rules for payment of supplementary retirement pensions and reintroduced tax incentives. Revision of special schemes aims to restrict privileged and financially unsustainable pension provisions by way of increasing contributory periods and reducing replacement rates. The pension reform debate now turns to the drafting of legislation for the payout of benefits from the funded pension scheme. First pensions from the private pillar will be paid out in 2015.

The health care sector struggles to translate increased spending into efficiency gains. A crucial problem is the high debt in the system, generated mainly by state-owned health facilities. Another dilemma is that the system promises comprehensive coverage for which adequate resources are not available. Recent reforms have strengthened state intervention in hospital care and health insurance. The government did not abandon the idea of changing the competitive health insurance model to a unitary system with a single state-controlled insurance company. Nevertheless, the mounting public debt tentatively postpones the implementation of this controversial reform plan, which would include the buy-out or expropriation of two private health insurers.

Significant cost-saving has been achieved with reference-based pricing of pharmaceuticals. The implementation of a Pharmaceutical Cost Group model of policyholder classification improves the redistribution of finances from public health insurance. The launch of a Diagnoses-Related Group payment system in hospital care has been postponed to 2016.

Policy measures in long-term care have concentrated above all on resolving the critical situation in financing of social services. However, even after several funding injections from the State budget and slightly modified financing rules, the existing arrangements do not ensure sufficient and sustainable financing of care provision for a growing number of clients. A comprehensive amendment to the law on social services is currently under preparation. It proposes changes in the funding mechanism, increased income protection of clients, and reorganisation of some types of social services in line with the deinstitutionalisation strategy. Nevertheless, there are caveats as to the negative fiscal impact of the changes and the decreased financial participation of clients.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The current pension system is in operation since 1 January 2005, when the introduction of a private funded pension scheme concluded a comprehensive pension reform. One of the main goals of the reform was to mitigate the unfavourable effects of demographic ageing on the long-term sustainability of the pension system by way of dividing the resources for future pensions between the labour market (pension insurance) and capital markets (pension saving). The reform involved also systemic and parametric changes in the existing pay-as-you-go pension system (revision of pension insurance, increase of retirement age, and revised pension calculation and indexation) as well as the voluntary supplementary pension tier.

As a result of the reforms, the Slovak pension system is now based on three pillars: a mandatory defined-benefit pay-as-you-go scheme, a mandatory defined-contribution funded scheme, and a voluntary supplementary defined-contribution funded scheme.

2.1.2 System characteristics

The mandatory defined-benefit pension scheme (1st pillar) is administered by the state-controlled Social Insurance Agency. It is financed primarily by pension insurance contributions paid by economically active citizens in the amount of 18% and/or 14% of the assessment base (gross wage), depending on whether they are enrolled only in the first pillar or concurrently in the first and second pillars. Employees contribute with 4% and employers with 14%; in a mixed pension plan, 4% of contributions are redirected to the employee's personal pension account.

The scheme is compulsory for all persons in employment or similar types of gainful activity. However, the minimum assessment base applicable to self-employed persons and voluntary contributors equals to 50% of the economy-wide average wage, meaning that pension insurance is not compulsory for self-employed with an annual income below this level. There is an upper cap on the assessment base which is set at five times of the average wage. The minimum contribution period for pension entitlements is 15 years. The State pays contributions on behalf of specific groups, such as persons on maternity leave, persons taking care of children up to age 6 and carers of persons with severe disabilities. Contributions as well as pensions in payment are exempt from taxation.

Statutory retirement age is set at 62 years for men and women. Due to an ongoing transitional period, however, women retired at age 57.5 to 61.5 years in 2013, depending on the number of children raised. As from 2017, the retirement age shall be linked automatically to the development of life expectancy. The automatic adjustment shall take into account changes in 5-year averages of life expectancy at the applicable retirement age. In line with expected longevity gains, the retirement age could increase by approximately 50 days per year. The obvious goal is to improve the long-term sustainability of the pension system.

The formula for the calculation of a retirement pension is "Pension = APWP x Y x APV"

APWP stands for Average Personal Wage Point and represents the ratio of individual earnings to average earnings in the economy. It is determined as an average of ratios respective to each year since 1984 till the retirement year. APWP equal to 1 would mean that the worker has earned the average wage in the economy. The maximum value of APWP is 3. The initial aim

of the 2004 pension reform was to gradually decrease, with the help of a correction coefficient, the solidarity component in the pay-as-you-go scheme so to have fully earnings-related pensions as from 2015. In 2011, the APWP adjustments had been frozen, and since 1 January 2013 values of APWP below 1 are added 17% of the difference between APWP and 1 (the percentage shall increase to a final 22% in 2018) and values between 1.25 and 3 are reduced to 80% of APWP (and shall gradually decrease to 60% by 2018). The aim of the revision is to increase solidarity in the calculation of new retirement pensions.

Y stands for the number of years of pensions insurance.

APV stands for Actual Pension Value, which is a number determined by law in 2004 at SKK 183.58 (EUR 6.0937), aimed at providing a 50% replacement rate to a retiring worker who has contributed for 40 years. APV is indexed annually by the average wage growth in the economy (in 2013 the value is EUR 10.0098).

Until 2013, retirement pensions have been indexed every year by the arithmetic average of wage growth and inflation. In the period 2013-2017, pensions are to be indexed annually by a fixed sum determined as a certain percentage of the average monthly retirement benefit. This percentage is calculated taking into account year-on-year changes in wages and consumer prices, with a growing weight of inflation (by 10% every year). Starting from 2018, pensions shall be indexed again by a percentage, but reflecting only the year-on-year growth of consumer prices in pensioner households.

Early retirement is possible under certain conditions. The claimant must have at least 15 years of pension insurance, apply not earlier than 2 years prior to legal retirement age, and the awarded early retirement pension must be higher than 1.2 times of the minimum subsistence level (EUR 237.71). In addition, the retired person may not perform a gainful activity liable to compulsory pension insurance (i.e. s/he may not be in paid employment or self-employment, but may perform work agreed outside an employment relationship such as so-called work performance agreements or work activity agreements). The amount of an early pension is calculated the same way as the retirement pension, but reduced by 0.5% for each 30 days of early retirement.

The mandatory defined-contribution funded pension scheme (2nd pillar) is in operation since 2005. During an initial 18-months period (1 January 2005 – 30 June 2006), persons registered for pension insurance (1st pillar) had to decide whether to join or not the new scheme. More than 1.5 million citizens (i.e. around 60% of the economically active population) joined and redirect part of their pension contributions (9% of the gross wage at that time) to their newly created personal pension accounts. As of 1 September 2012, the contribution rate has been lowered to 4%. Savers may contribute with additional 2% and deduct the sum from their income tax base. Between 2017 and 2024, the 4% contribution rate to the second pillar shall be increased by 0.25% each year to reach 6%.

Participation is compulsory for persons who have already joined the scheme. New entrants to the social security system are by default enrolled only in the first pillar, but may apply for membership in the second pillar up to age 35. This change follows a short period of 'mandatory' participation for new labour market entrants (1 April – 31 December 2012), when the default option was a two-tier pension plan with the possibility to opt out of the second pillar in the first two years of saving. Mandatory membership for new entrants has been changed to optional for the first time in 2008. The scheme had been temporarily opened three times to enable participants to opt out, the last time from 1 September 2012 to 31 January 2013.

Pension management companies (currently six) are obliged to administer two types of funds, a guaranteed bond fund and an unguaranteed equity fund. They can also run other types of guaranteed or unguaranteed funds (e.g. mixed). Until 31 December 2012, pension management companies administered four types of statutory funds (bond, mixed, equity, and index funds), while before 1 April 2012 there had been three funds (conservative, balanced, growth). Only bond and cash investments may now be included in bond funds. There is a 10-year running interval for balancing pension unit value in bond funds and savers have to be compensated for possible decreases. There is an upper limit of 80% on shares and also on bond and cash investments in unguaranteed equity funds. After reaching the age of 47 years, savers may not be included in an equity fund, and after age 55 in no unguaranteed fund.

The minimum contribution period for pension entitlements in the second pillar is 10 years (until 1 April 2012 it was 15 years). Pension benefits can have the form of life annuity or programmed withdrawal with life annuity. A programmed withdrawal is paid as a disposable surplus, i.e. the difference between the actual balance of the saver's personal pension account and the amount required for the purchase of a retirement pension. First retirement pensions from the scheme will be paid out in 2015. A so-called annuity law shall be prepared in the first half of 2014, which will govern the calculation and payment of pensions from the second pillar. Contributions and pensions in payment are not subject to taxation.

The voluntary supplementary defined-contribution funded scheme (3rd pillar) was launched in 1996. The private scheme is open to employees, self-employed and voluntary savers, who sign contracts with one of the currently four supplementary pension companies. The amount of contributions, payment method and period are specified in individual contracts. Until 2011, participants could deduct up to EUR 398.33 of paid contributions per year from the income tax base. Tax allowances shall be reinstalled as from 1 January 2014 in the maximum amount of EUR 180 from paid contributions per year. Employers may contribute to their employees' savings accounts, usually under terms specified in collective agreements. They can deduct paid contributions in the sum of up to 6% of the employee's gross wage from the tax base. For specified categories of employees (hazardous professions such as miners or workers exposed to radioactive materials), participation in the scheme is mandatory and respective employers are obliged to contribute with at least 2% of the employee's gross wage. A recently approved reform entails important changes to the scheme (see section 2.1.3).

Special social security systems cover so-called force departments, including soldiers, policemen, customs officers, firemen and rescuers. The schemes are administered by the Ministry of Defence and the Ministry of Interior. Financing comes from contributions paid by active members and direct State budget subsidies. Average awarded pensions are 1.5-2 times higher than pensions paid from the public pay-as-you-go scheme.[1]

Since 2006 the government provides old-age pensioners, early retirement pensioners and disability pensioners with a **Christmas pension bonus** financed from the State budget. This benefit is not a component of the social insurance scheme, but a recurrent income support paid every year around Christmas to pensioners with pensions below 60% of the average wage in the economy (in 2012, up to a pension of EUR 471.6). In 2012, the sum ranged from EUR 38.69 to EUR 66.39 based on the amount of the recipient's pension (the higher the pension, the lower the bonus).

There are no occupational pension schemes in Slovakia.

[1] Above average retirement pensions are drawn also by judges and prosecutors, who receive special bonuses on top of their old-age pension.

2.1.3 Details on recent reforms

The pension system has undergone substantial reforms over the past two years. The following table provides an overview of the most important changes.

Table 1: Recent reforms of the pension system

1st pillar (DB)	**2nd pillar (DC)**	**3rd pillar (DC)**	**Special schemes**
1 January 2011 • Restriction of early retirement by way of discontinuing concurrence of an early retirement pension and employment • Freezing of an adjustment coefficient in the pension calculation formula to preserve some solidarity in the 1st pillar	*1 April 2012* • Minimum required contribution period decreased from 15 to 10 years • Change from voluntary participation to mandatory for new entrants to pension insurance • Change in the portfolio of funds (growth, balanced and conservative funds replaced by equity, mixed and bond funds, introduction of index funds), 80% limit on shares in equity funds • Removal of guarantees from mixed and equity funds, balancing period increased from 6 months to 5 years • Changes in administrative fees charged by pension management companies	*1 January 2011* • Discontinuing of tax deductions of up to EUR 398 per year from paid contributions	*1 May 2013* • Minimum service period for the entitlement to a service pension increased from 15 to 25 years for those who had as at 1 May 2013 less than 15 years of service • Change in the assessment base for the calculation of service pensions, service benefits and discharge benefits (from the best paid year of the last 10 career years gradually to the 10 last career years) • Restrictions in the calculation of service pensions (persons starting service after 1 May 2013 will be entitled to a pension for 25 years of service in the amount of 37.5% of the assessment base, this percentage will grow to 65% for 40+ years of service; pensions awarded to persons already in service range from 30% of the base for 15 years to 60% for 40+ years of service) • Restricted indexation of service pensions, which shall as from 2018 be indexed the same way as pensions in the 1st pillar (pensioner inflation), until then restricted indexation formula taking into account years of service • Tightening of entitlements for service benefits and discharge benefits • Increase of the
1 September 2012 • Increase of the contribution rate from 9% to 14% of the gross wage	*1 September 2012* • Lowering of contributions from 9% to 4% of gross wage, in plan is an increase of the contribution rate to 6% between 2017 and 2024 • Opening of the scheme until 1 January 2013, enabling opt out or joining		
1 January 2013 • Linking of retirement age to the development of life expectancy as from 2017 • Restriction of pension indexation from an arithmetic average of wage and price growth to price growth in pensioner households as from 2018, until then indexation by a fixed sum • Revision of adjustment coefficient in the pension formula to strengthen solidarity gradually between 2013-2018 • Increase of maximum assessment base for pension insurance from 4 to 5 times of the national average wage established 2 years ago, increase not reflected in benefit	*1 January 2013* • Change in statutory pension funds (portfolio must include one guaranteed bond fund and one unguaranteed equity fund, mixed and index funds are optional), savers by default transferred to bond funds • Abolition of mandatory participation for new entrants, who are by default included only in the 1st pillar, entry to 2nd pillar possible until age 35 • Savers may until end of 2016 deduct 2% of voluntary contributions	*1 January 2014 (enacted)* • Reintroduction of tax deductible contributions (up to EUR 180 per year) • Introduction of stricter rules for payment of supplementary retirement pensions (minimum age for payout raised from 55 to 62 years and/or date of award of retirement pension or early pension, abolition of a minimum contribution period) • Stricter rules shall apply also to supplementary	

entitlements, increase and unification of assessment base at 5 times of AW also for sickness insurance, guarantee insurance, unemployment insurance and sickness insurance • Increase of minimum assessment base for self-employed, voluntarily insured and state insured persons from 44.2% to 50% of the national average wage established 2 years ago • Self-employed may no longer deduct paid social and health insurance contributions from the tax base, a coefficient used for lowering the assessment base for social security and health insurance contributions paid by self-employed will be gradually decreased by 2015 • Agreements on work performed outside an employment relationship (non-standard types of employment) are now liable to social security contributions the same way as standard employment contracts, preferential regimes for students and pensioners	from the tax base • Period for balancing returns increased from 5 years to 10 years in bond funds and up to 15 years in other guaranteed funds • Increase of administrative fees charged by pension management companies	service pensions paid out to persons in risky occupations (minimum contribution period raised from 5 to 10 years, minimum age from 40 to 55 years) • Replacement of a termination settlement by an early withdrawal, which enables participants who have not fulfilled the conditions for payment of a supplementary retirement pension to receive a payment corresponding to contributions paid by the participant to date • Substantial decrease of administrative fees charged by supplementary pension companies for the administration of funds and appreciation of savings	contribution rate from 22% (employees 5%, employers 17%) to 27% of gross wage (employees 7%, employers 20%)

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Participation in the public pay-as-you-go pension scheme (1st pillar) is compulsory for all persons in employment or similar types of gainful activity (e.g. self-employment, agreements on work perfumed outside an employment relationship). Unemployed and/or inactive persons may take out pension insurance voluntarily. The minimum assessment base applicable to voluntary contributors as well as to self-employed persons equals to 50% of the economy-wide average wage. It means that pension insurance is not compulsory for self-employed with an annual income below this level. In fact, more than 80% of self-employed pay minimum contributions which will impact on the amount of their future pensions.

There is no guarantee of a minimum retirement pension in the existing system. Persons with low pensions or without pension entitlement, whose income is below the minimum subsistence level (EUR 198.09 for a single person since 1 July 2013), may apply for a means-tested material need benefit and additional allowances to the benefit which are part of the social assistance scheme.

The pension reform of 2004-2005 stipulated a gradual weakening of solidarity in the calculation of new pensions. The result was that the net pension replacement rate[2] has grown along with increasing earnings. Recent changes pursuing strengthened solidarity in pension calculation (modification of personal wage point adjustment) have asymmetrically weakened the link between career earnings and retirement pensions since 2011. Table 2 shows

[2] Defined as the individual net pension entitlement divided by net pre-retirement earnings, taking account of personal income taxes and social security contributions paid by workers and pensioners.

prospective net replacement rates of newly awarded retirement pensions, reflecting the scheduled solidarity adjustments of the personal wage point.

Table 2: Net pension replacement rate (% of individual net wage)

Nominal wage as % of average wage	2012	2013	2014	2015	2016	2017	2018	Change 2018-2012 (percentage points)
0.25	77.0	78.6	80.2	81.7	83.3	84.8	86.4	9.4
0.50	62.9	63.4	64.0	64.5	65.1	65.6	66.1	3.3
1.00	59.4	59.4	59.4	59.4	59.4	59.4	59.4	0.0
1.50	59.6	59.2	58.8	58.4	58.0	57.6	57.2	-2.4
2.00	58.3	57.6	56.7	55.8	54.8	53.9	53.0	-5.4
3.00	57.7	56.7	55.2	53.7	52.2	50.7	49.2	-8.5
5.00	34.0	34.6	33.7	32.8	31.9	31.0	30.1	-3.9

Note: The relatively lower decrease of the net replacement rate for highest income earners is caused by new income tax legislation, which since 2013 stipulates an increased tax rate (25% instead of 19%) on income exceeding 176.8 multiple of the applicable subsistence minimum (income above EUR 2,867 monthly in 2013 and above EUR 2,919 in 2014).

Source: Council for Budget Responsibility (2012)

When measured as a ratio of the retirement pension to the average gross wage in the economy, the highest pensions are logically drawn by high earners (earnings at 3 times the average wage and above) at around 110% of the average wage, while persons who earned a minimum wage will receive a pension at around 30% of the average wage. However, when pensions are compared with individual gross earnings, high-income groups will receive the relatively lowest pension (around 20%) and low earners the highest (at around 56% of previous gross wage).[3] Replacement rates are effectively increased by the Christmas pension bonus paid to pensioners with pensions below 60% of the average wage.

The rate at which retirement pensions will substitute previous income from work will be influenced also by the modified indexation mechanism. The linking of pension indexation to the growth of prices in pensioner households should maintain real purchasing power of pension benefits during the entire period of provision, however, the unlinking from nominal wage growth will result in a relative decrease of pensions in relation to the living standards of the working-age population. According to the estimates by the Council for Budget Responsibility[4], the amount of a retirement pension drawn in the last year (notionally after 19 years of receipt) may decrease by 11-12% compared to the previous indexation rules.

Table 2 shows that high earners may expect a decreasing replacement of their career earnings in the following years. In absolute terms, however, their pension provisions should suffice to provide for a decent standard of living in old age. Available data and comparisons suggest that current pension provisions substantially reduce old-age income poverty and tend to be reasonably sufficient to preserve income and living conditions when moving from work to retirement. However, for groups such as low earners and persons with short or fragmented contributory periods (e.g. long-term unemployed), the system generates low pensions and/or social assistance benefits, associated with a higher risk of poverty.

The share of pensioners (65+) threatened by poverty decreased from 10.8% in 2009 to 7.7% in 2010 and 6.3% in 2011, but returned to 7.7% in 2012 (EU SILC). There are no details

[3] Council for Budget Responsibility (2012)

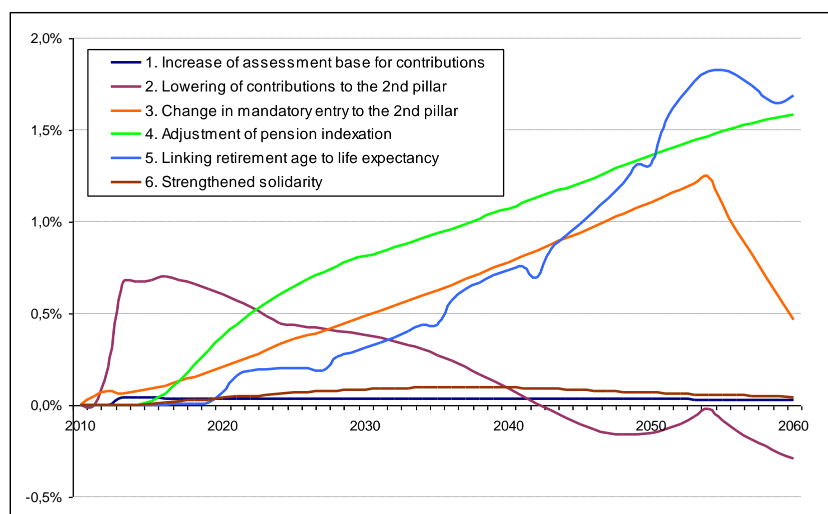
[4] The Council for Budget Responsibility is an independent body set up in 2012 to monitor and evaluate Slovakia's fiscal performance.

available for the 2012 survey thus far. Slovak pensioners face in general a comparatively lower poverty risk than the working-age population (at-risk-of-poverty rate at 6.3% against 12.7% in the 16-64 population in 2011). Female pensioners encounter a poverty risk 2 to 3 times higher (8.2%) than elderly men (3.4% in 2011).

2.2.2 Sustainability

Recent pension reforms improve the sustainability outlook in the system. New projections carried out by the Council for Budget Responsibility show an improvement in the balance of the pay-as-you-go pillar by 3.5% of GDP by year 2062 (decrease of the deficit from 7.9% to 4.3% of GDP). As stated in the Council's *Report on the Long-term Sustainability of Public Finances* from April 2013, the improvement is attributable to the linking of the retirement age to life expectancy (1.7% of GDP contribution), revised pension indexation mechanism (1.6% of GDP), and higher social insurance contributions. The pension age increase improves the balance by extending the contribution period and shortening the benefit period, but should enhance also labour market participation of elderly people and GDP growth (Council for Budget Responsibility, 2013). Projections confirm that the reduction of contributions to the private funded scheme temporarily improves the balance, but in the long run (after 2040) will lead to increased claims and expenditures in the public pay-as-you-go pillar. A similar effect is expected from the abolition of the default inclusion of young people in the second pillar (see Graph 1). It should be noted that the projections do not consider labour market effects of increased social contributions.

Graph 1: Contribution of pension reforms to the change in the PAYG balance (as % of GDP)



Source: Council for Budget Responsibility (2013)

A positive contribution to overall fiscal sustainability is expected also from the reform of special social security systems for armed forces and police corps. According to the official fiscal impact assessment, public spending to cover the deficit in the special scheme should decrease by EUR 193 million (0.26% of GDP) between 2013 and 2015.

The redirection of part of pension contributions from the first to the second pension pillar created a shortfall in the pay-as-you-go scheme of around 1.2% of GDP annually. After lowering the contributions paid to the second pillar from 9% to 4% since 1 September 2012 the deficit shall decrease to around 0.5% of GDP. These transitional costs should start to decrease as from 2015 when the first pension benefits in the funded scheme will be paid. For participants in the second pillar, retirement income from the pay-as-you-go scheme will be proportionally reduced for the period of membership in both pillars.

Taking into account Eurostat's demographic projections, the automatic adjustment of retirement age to life expectancy should translate into an increase of pensionable age by approximately 40 to 50 days per year. This could result in an increase of the average retirement age for men and women to approximately 68 years by 2060 and stabilise the average number of years spent in retirement at around 19-20 years (Council for Budget Responsibility, 2012).

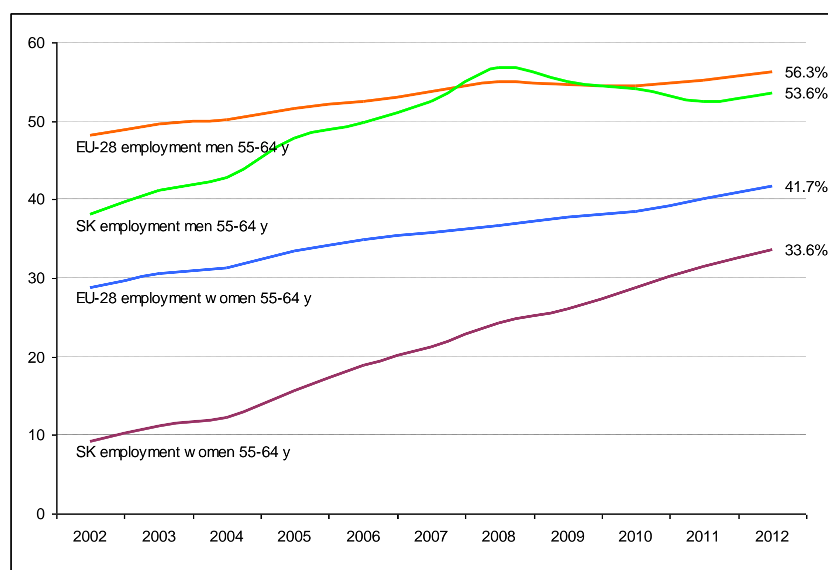
Table 3: Retirement age projections (years)

	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2030**	**2040**	**2050**	**2060**
Men	62.00	62.00	62.00	62.00	62.00	62.00	62.00	62.14	62.28	62.42	62.56	63.94	65.26	66.49	67.68
Women	59.00	59.43	59.86	60.29	60.71	61.14	61.57	62.14	62.28	62.42	62.56	63.94	65.26	66.49	67.68

Source: Council for Budget Responsibility (2012)

Prolonged working lives should translate into higher employment rates in the pre-retirement age population. This is suggested by a significant increase of employment in the 55-64 age group following the 2004 pension reform, which stipulated a gradual increase of retirement age to 62 years for men and women (from 60 and/or 53-57 years, respectively). Graph 2 shows that particularly women in this age cohort recorded a remarkable employment catch up over the last decade. For men, unlike women, the effect of pension age increase ceased in 2008 when the transitional period was completed. In addition, the male part of the workforce became substantially more affected by redundancies in the early stages of the economic crisis than female workers.

Graph 2: Employment rate (55-64 years, in %)



Source: Eurostat

The number of early retirement pensions is continually decreasing since March 2011 when the combination of early pensions and work has been restricted. As of 30 September 2013, the number of disbursed early pensions was less than half of the early pensions paid out in February 2011 (24,116 vs. 49,151 pensions).

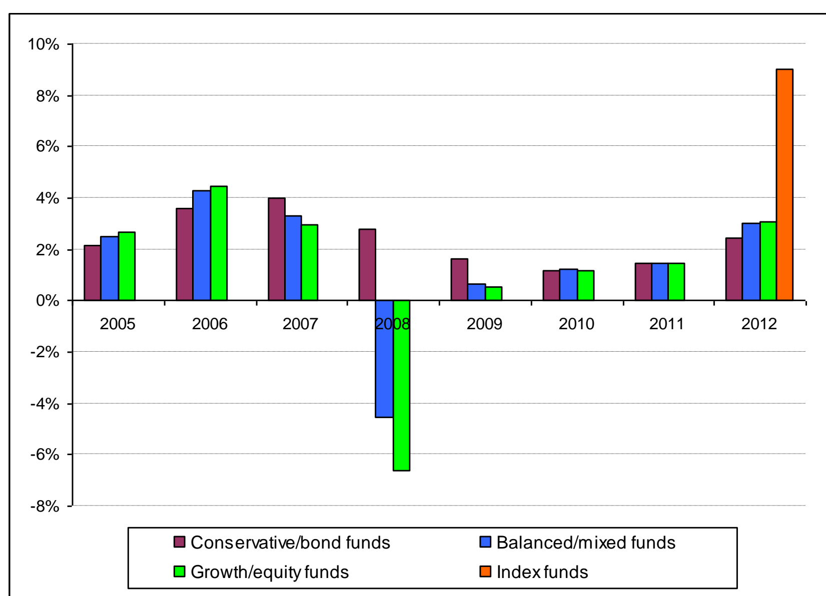
2.2.3 Private pensions

The third opening of the funded pension pillar from 1 September 2012 to 1 January 2013 resulted in the departure of 90 thousand members and the entry of almost 15 thousand new savers. The scheme covers now approximately 1.45 million persons, i.e. about 53% of the

economically active population. The number of participants is set to further decrease owing to the reintroduction of voluntary entry for young people. In fact, this change puts a bigger question mark over the future viability of the private scheme than the lowering of the contribution rate. The weakening of the second pillar shifts the load of future pension provision on the local economy (and unpredictable decision makers) and limits the diversification of resources in old age.

The proclaimed reason for the most recent interventions in the second pillar was the continuing unsatisfactory performance of pension funds. Returns in the second pillar have been significantly affected by the financial crisis but also by legislative restrictions on investments adopted in 2009, in particular the obligation of pension funds to balance returns in half-yearly intervals. The situation has prompted pension management companies to edge away from riskier assets, which led to the levelling of returns in the different funds. The abolition of guarantees in other than bond funds as of 1 April 2012 and the prolongation of the balancing period from 6 months to 5 years and later on to 10-15 years (as of 1 January 2013) should result in a gradual increase of higher-risk/higher-return investments and the differentiation of funds by investment portfolio. This assumption is partly reflected already in the 2012 results (see graph 3).

Graph 3: Gross nominal returns in the funded pension pillar (weighted averages)



Note: Index funds were introduced in April 2012.

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

The Institute for Financial Policy of the Ministry of Finance publishes since June 2013 monthly reports on pension fund performance in the second pillar. As suggested in the September release, returns in one- and three-year horizons fell behind the selected benchmarks in all bond, mixed and equity funds.[5]

Pension management companies were tasked to provide all savers in other than guaranteed bond funds with a printed form enclosing the request for the retention in an unguaranteed fund. If a saver did not fill out and mail the form to the pension management company until 31 March 2013, s/he was automatically transferred to a guaranteed bond fund. The aim of the reform was to leave in the unguaranteed funds only persons who actively request it, i.e. those

[5] https://www.finance.gov.sk/Default.aspx?CatID=9254

who are presumably aware of the risk associated with the enrolment in an unguaranteed fund. As shown in Table 4, the measure had significant impact on the structure of assets in pension funds. Majority of savers in equity and mixed funds did not respond and were hence moved to bond funds. Assets in the funded scheme totalled almost EUR 5.6 billion in September 2013 (approximately 7.7% of GDP).

Table 4: Assets in the second pension pillar (in EUR million)

Funds	Equity funds	Mixed funds	Bond funds	Index funds	Total
As at 28 Dec 2012	3,277 (59.9%)	1,436 (26.2%)	752 (13.7%)	6 (0.1%)	**5,471 (100%)**
As at 20 Sept 2013	457 (8.2%)	61 (1.1%)	5,036 (90.3%)	26 (0.5%)	**5,580 (100%)**

Source: Association of pension funds management companies

The third (voluntary) pension pillar reached an average number of 447 thousand contributing members in 2012, which corresponds to one sixth of the economically active population.[6] The coverage of the supplementary private scheme is decreasing since 2008 when it included 527 thousand participants. Assets in the third pillar amounted to EUR 1.3 billion in 2013 (i.e. 1.8% of GDP).

The Institute for Financial Policy released its first monthly report on the performance of pension funds in the third pillar in September 2013. It states that since 2010 the average rate of return in supplementary pension funds was lower than the rate of return on time deposits in banking institutions (cumulatively by 2.4 percentage points). Returns in the third pillar were also insufficient to compensate for inflation. The growth of prices in the economy exceeded the rate of return in the third pillar by 3.1 percentage points. The report concludes that the very low performance of funds is given (among other reasons) by the relatively high commission charged by the supplementary pension companies for the administration and appreciation of assets. In 2010-2012, pension companies collected fees equalling to 54% of returns in administrated funds.[7] The recently approved reform of the third pillar is addressing most of the shortcomings in the system.

2.2.4 Summary

Reforms implemented and/or approved in the past 2-3 years have helped to improve the financial situation in the pension system. Perhaps with the exception of the controversial weakening of the private funded pillar, the reforms contribute also to the long-term fiscal sustainability. There are, however, some caveats which should be taken into consideration. Bearing in mind the assumed effects of recent reforms, the main strengths and weaknesses of the pension system may be characterised as follows:

Strengths (and opportunities)

- *Broad coverage.* The first and second pension tiers cover the vast majority of the population. Persons without pension entitlements are provided income support from the social assistance scheme.
- *Reasonable replacement rates.* Available data imply that current adequacy of pension provision is at reasonable levels. However, future replacement of income will tend to decrease as sustainable arrangements will have to be pushed forward in a rapidly ageing society.

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6 The total number of participants in the scheme (i.e. active contributors and benefit recipients) was 732 thousand persons in 2012.

7 http://www.finance.gov.sk/Default.aspx?CatID=9103

- *Improved financial sustainability.* Recently approved reforms in the pay-as-you-go scheme (mainly the automatic-adjustment mechanism of retirement age and restricted pension indexation), but also in supplementary pensions and special pension schemes for police and army, reduce the implicit debt and contribute to improved sustainability of public finances. Nevertheless, additional adjustments will be needed to bring the system on a fully sustainable track for the future.

Weaknesses (and threats)

- *Poor labour market performance.* Persisting high levels of unemployment and inactivity reduce resources for current pension provision, and at individual level affect prospective retirement income. Nevertheless, what appears as a weakness may be seen as an opportunity. Reforms promoting employment and tax-contribution discipline would benefit also pension provision.
- *Demographic change.* Although not appearing as an instant problem, demographic trends are going to put increased pressure on the pension system as Slovakia's population is expected to age at highest pace in the EU in the next 50 years. Demographic change creates challenges, which will have to be tackled with further adjustments in the pension system (e.g. linking of pension calculation formula to demography, default enrolment of young people in the funded scheme, promotion of alternative resources for future retirement provision, etc.).
- *Insufficient diversification of resources.* The current pension system, more than ever after adoption of recent reductions in the second pillar, tends to be overly reliant on the statutory pay-as-you-go system. This poses a risk to sustainability and adequacy of future pensions.
- *Lacking stability and transparency of rules.* Pension legislation is subject to frequent changes, which are often politically-driven and not clearly substantiated and communicated to the public. An unbiased policy debate on the tenets of pension provision is clearly missing.

2.3 Reform debates

After the adoption of comprehensive reforms in 2012 and the first half of 2013, debates on pension reforms somewhat quieten down in Slovakia. Perhaps the main theme of expert debates is the setting of rules for the payment of pension benefits from the second pillar. First benefits from the funded scheme shall be paid out in January 2015. The Ministry of Labour, Social Affairs and Family started with the preparation of a so-called annuity amendment to the law on old-age pension saving (2nd pillar). The amendment shall address the following questions:

- Terms of payment of retirement pensions, early retirement pensions and survivor pensions from the second pillar. This includes questions concerning the minimum contribution period (currently 10 years), entitlements to an early pension and the links to early pensions in the first pillar, or individualised retirement by the individual replacement rate.
- Forms of pension benefit payout, i.e. if existing regulation of life annuity and/or life annuity with programmed withdrawal is suitable.
- Regulation of pension inheritance and survivor's pensions.
- Indexation of pensions paid from the second pillar.

- Arrangements for members with low sums of savings, i.e. savers who will not be able to purchase a life annuity in a commercial insurance company and/or the amount will be insufficient. The Ministry of Labour contemplates a number of options, including the transfer of participants to the Social Insurance Company (1st pillar), one-off payment of the saved sum, payment of a programmed withdrawal or annuity in a given amount and for a given period, and possibly also the payment of a life annuity.
- Administration of an individual's savings during the payout phase. In discussion is the transfer of savings to the Social Insurance Agency.

In 2012, negotiations have taken place at the level of political parties represented in the parliament about a stabilisation of the second pension pillar through a constitutional law. Negotiations were initiated by ruling party SMER, but political parties failed to come to an agreement. The reasons for disagreement are of political nature. In 2010, the incoming government formed by centre-right parties (now in opposition) committed itself in the Programme Manifesto to protect the private pension pillar by way of a constitutional act. This intention was to a large degree a reaction to the interventions taken in the second pillar by the preceding SMER-led government. The new coalition, however, failed to accomplish its plan in the early interrupted election term. Early election winner SMER made the proposal of a constitutional backup of the second pillar actually after pushing through reforms that weaken the scheme (voluntary enrolment of young people, lowering of contributions).

The 2011 and 2012 Council's country specific recommendations (CSR) called on Slovakia to "further adjust the pay-as-you-go pension pillar, mainly by changing the indexation mechanism, introducing a direct link between the statutory retirement age and life expectancy and introducing a sustainability factor in the pension calculation formula reflecting demographic change" and to "ensure the stability and viability of the fully funded pillar". Policy response to the recommendations in the pay-as-you-go pillar was almost surprisingly practical, as government representatives have long rejected discussions about an increase of the pension age. Media signalled speculations that the government proceeded to the changes under pressure from the European Commission, which allegedly conditioned its consent to the reduction of contributions to the funded pension pillar by the reforms in the pay-as-you-go scheme. Unfortunately, the implemented reforms did not involve a revision of the pension calculation formula.

More generally, the setting up of the European Semester has strengthened the influence of European policy coordination on the national reform agenda. The National Reform Programme has gained significantly on political importance over the past 2-3 years and is now considered the country's key policy reform strategy. The Commission's feedback on national reform priorities and policies in the form of CSRs has become an important driver of national reforms.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The current shape of the health care system is the outcome of reforms that were implemented by a centre-right coalition in 2002-2006 and revised thereafter by successive governments. The initial reforms introduced a new approach based on individual responsibility, market

principles and regulated competition. Health insurance companies were transformed into joint stock companies, hard budget constraints were introduced and a new regulatory and institutional framework created. User fees were introduced to encourage cost consciousness among patients and managed competition became a central concept. The government elected in 2006 made a shift in the paradigm and supported more direct state involvement. Although the institutional and regulatory framework remained largely intact, health insurance companies were no longer allowed to make a profit, selective contracting was restricted and user fees reduced or abolished. The shortened term of a new government (2010-2012) brought a resumption of hospital transformation, re-allowed profits for health insurance companies, increased independence of the Health Care Surveillance Authority (HCSA), and a proposal on a diagnoses-related group (DRG) payment system. The new left-leaning government, which took office in April 2012, returned in many aspects to previous arrangements. The transformation of hospitals to joint stock companies has been discontinued, the so-called terminal (or minimum) network of hospitals was reinstalled and the independence of HCSA restricted. Besides these minor changes, the current government strives for a transformation from a competitive insurance model (existing since 1995) to a unitary system with a single state health insurance company.[8]

3.1.2 System characteristics

The Slovak Constitution guarantees all citizens a universal and free-of-charge access to a comprehensive basic package of health services. All citizens are insured and obliged to pay social health insurance contributions[9], except for specified inactive groups[10] for whom insurance is paid by the State. Every citizen and registered long-term resident has guaranteed access to equal treatment for an equal need regardless of one's social status or income. Patients have the right to choose a health insurance company, general practitioner (GP), specialist as well as hospital.

There is a plural system of health insurance. After several fusions and market departures, public health insurance is since 2010 performed by one state-owned and two private health insurance companies. The state-owned Vseobecna zdravotna poistovna (VsZP) has a dominant market position (64.4% share on the number of policyholders in 2012). Health insurance companies are obliged to contract all providers of general outpatient care, pharmacies, providers of emergency service and providers included the minimum network of health care providers. Since pricing is flexible, insurance companies use selective contracting and own quality assessment criteria. The Health Care Surveillance Authority (HCSA) is responsible for monitoring health insurance, health care provision and the health care purchasing markets. HCSA supervises the redistribution of financial resources between health insurance companies. There is a risk-adjustment/equalisation system among insurers.

Hospital (inpatient) care is primarily financed through payments from health insurance companies and direct state subsidies. Majority of hospitals are run by the public sector. Almost all GPs, pharmacies and diagnostic laboratories and a considerable majority of specialists are private. Primary care physicians act as gatekeepers. Since 1 April 2013, the GP referral system is in operation again, after it was abolished in 2010.

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[8] Szalay et al (2011), WHO (2012), Zachar (2012)

[9] The contribution rate is 14% of the assessment base (gross wage), of which employees contribute with 4% and employers with 10%. The same 14% contribution rate applies to self-employed persons. If the policyholder is a disabled person, his/her contribution rate is 7% (2% employee, 5% employer).

[10] Dependent children, students, persons on parental leave, registered unemployed, persons on long-term sickness benefits, pensioners, carers and personal assistants to severely disabled citizens.

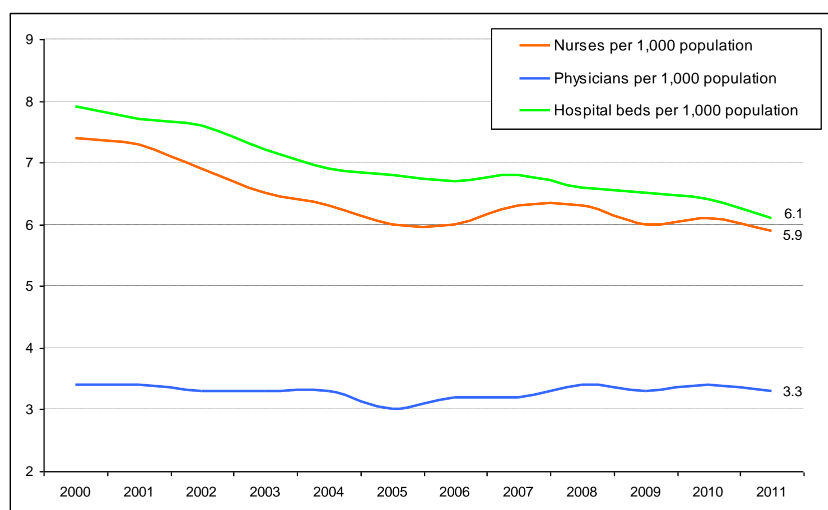
Total health spending accounted for 7.9% of GDP in 2011, lower than the average of 9.3% in OECD countries. In Slovakia, 71% of health expenditures were funded by public sources in 2011, close to the OECD average of 72% (OECD, 2013). Out-of-pocket payments have risen sharply in the past decade, from 11.7% in 2003 to 26.0% in 2010 (OECD average at 19-20%), although the latest figure for 2011 shows a decrease to 22.6%, attributable presumably to an upper limit on co-payments for low-income pensioners and severely disabled persons and to positive changes in drug policy.

There were 3.3 physicians per 1,000 population in 2011 (3.2 in OECD). Slovakia has one the highest numbers of doctor consultations per person per year in Europe (11.3 consultations, EU average at 6.3 consultations), in spite of the fact that Slovak patients reduced contacts with physicians the most during 2000-2010 (OECD, 2012).

The number of nurses per 1,000 population (5.9) is lower than the OECD average of 8.7. Since 2000, the number of nurses per capita has increased in all European countries, except in Lithuania and Slovakia (more than 20% decrease in Slovakia; OECD, 2012). According to national statistics, there were 32,043 nurses in 2011, compared to 40,077 in 2000 (National Health Information Centre, 2012).

The total number of hospital beds in the Slovak Republic was 6.1 per 1,000 population in 2011, above the OECD average of 4.8 beds. In particular, the number of acute beds is high. On the other hand, there is a significant deficit of beds for chronic and long-term ill patients, and so-called social beds. As in most OECD countries, the number of hospital beds per capita has fallen over time in Slovakia. During 2010-2011, the state-owned VsZP carried out a reduction of approximately 3 thousand (mostly acute) beds and ineffective hospital departments. Rationalisation of beds and departments is going on at present, yet at slower pace. Data of the National Health Information Centre show that the hospital bed occupancy rate at end of 2011 was 67.7%[11], which is clearly below the average occupancy rate in Western Europe (83%[12]). There is apparently room for further cost-saving and increased efficiency in this area.

Graph 4: Numbers of physicians, nurses and hospital beds per 1,000 population



Source: OECD, http://ekonomika.sme.sk/c/6855496/sestriciek-je-v-nemocniciach-malo-lozok-zasa-vela.html

[11] http://www.nczisk.sk/Aktuality/Pages/Pocet-posteli-v-nemocniciach-nadalej-klesa.aspx

[12] Boston Consultancy Group, http://ekonomika.sme.sk/c/6980252/najvacsia-nemocnica-mina-desiatky-milionov-zbytocne.html

3.1.3 Details on recent reforms

The years 2012 and 2013 have been marked by many reforms that strengthen statism and political interventions in the Slovak health care sector. Examples of such measures include the reinstallment of a minimum network of (state) providers who have guaranteed contracts with all health insurance companies, and the weakening independence of the regulatory authority HCSA (both in 2012). There is a question mark over a number of other measures with potentially unhelpful effects on efficiency and financial stability, referring above all to the halted transformation of state hospitals to joint stock companies (2012), softening of solvency rules for health insurance companies (2012), or another increase of minimum wage claims for doctors for which there are no earmarked funds (2013). Among positive reform steps is the implementation of a Pharmaceutical Cost Group (PCG) model of policyholder classification (2012) that brings a more equitable redistribution of finances from public health insurance. It is also acknowledged that the government is pursuing rationalisation measures in personnel policy, organisational and procedural matters and procurement policy. In contrast, the launch of a DRG payment system in inpatient care has been postponed by two years to 2016.

A specific policy issue is the announced introduction of a unitary public health insurance system. The reform was presented by the government in 2012 as a key measure to streamline use of funds in health care. The initial deadline for the implementation (1 January 2014) was postponed until 2015, and according to most recent news, tentatively until there is full financial coverage of the project. The Ministry of Finance considers public debt reduction a top policy priority at the moment. The buy-out or expropriation of the two private insurance companies would cost hundreds of millions of euro. Moreover, there is no convincing evidence that a change to state-run insurance monopoly would be beneficial for the health system.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The Constitution guarantees universal coverage and free-of-charge access to a comprehensive basic package of health care services for all citizens. In Slovakia, there is a compulsory health insurance system. Health insurance companies are obliged to ensure accessible health care to their insured according to provisions laid down by law. There is a free choice of health insurance companies, general practitioners, specialists as well as hospitals. Their services are provided without cost-sharing from patients, with some exceptions involving direct payments (notably in dental care and above-standard services). There are some lump sum payments as well: EURO 1.99 for emergency services, EURO 0.17 for each drug prescription, EURO 0.07 per km for transportation in an ambulance (except for emergency use or for transport of disabled patients), EURO 1.66-7.30 per day for curative stays in spas.

Slovakia has a high score for the scope and depth of coverage defined by legislation, but one of the lowest scores for the actual level of coverage; i.e. the size of the population insured and entitlements are wide, but in reality, out-of-pocket payments are high (Devaux and de Looper, 2012).

Almost 40% of Slovaks can access a general hospital near their place of residence. Inpatient care is accessible in all medical specialties within 45 minutes by car. Combined with 15 minutes distance to emergency medical services, this makes urgent hospital care accessible within 60 minutes. Outpatient care is easily accessible in the place of residence for 77% of the population. Between 40% and 50% of inhabitants have direct access to most of the ambulatory care specialists within their municipality. Ambulatory care is generally available

by car within 30 minutes. Health care is least accessible in the mountainous and sparsely populated regions of northern and eastern Slovakia.[13]

According to the WHO (2012), geographical distribution of general practitioner practices seems to be even, although some evidence suggests imbalances at district level. More than two thirds of Slovaks live within 20 minutes travel from a GP practice. One general practitioner for children and adolescents (GPC) was available for every 1,008 people of 18 years or younger in 2011 and one general practitioner for adults (GPA) for every 2,141 aged 19 and older. The number of face-to-face patient contacts is 47 per day for GPAs and 39 for GPCs. Home visits are few at 4 to 5 per week and GP, with a large majority of patients reporting GPs' reluctance to make home visits. Most patients (59% based on WHO survey) have to pay for medicines or injections prescribed by their GP. About 8.5% of patients report that having to pay for medicines had caused them to delay or cancel a visit to their GP. Slovak GPs' official referral rates are extremely high at around 245 referrals per 1,000 contacts per year. Two thirds of patient contacts result in a drug prescription.

The network of pharmacies is relatively well developed, although there are some regional disparities. The number of pharmacies per 100,000 population is at 27.8 close to the OECD average of 28.4.[14]

3.2.2 Quality and performance indicators

One of the conditions for an effective competition in the health care sector is reliable and comprehensible information provided to patients and other stakeholders, including information on quality and efficiency of insurers and health care providers. Slovakia belongs to OECD countries that publish information on many aspects of quality and efficiency of hospital services and services provided by physicians (clinical outcomes, appropriate processes and use of resources, patient satisfaction, and patient experience).[15]

National legislation presupposes that health insurance companies will carry out annual evaluations of official indicators of quality, submit results to the HCSA and take them into account when signing contracts with providers. In practice, insurance companies often use also their own criteria and indicators.

Existing official information on quality and efficiency of health care providers is associated with several problems:

- Official government criteria (a.k.a. quality indicators) do not provide sufficient information value due to their relatively poor structure and the fact that they enable only a minimal differentiation of providers in terms of quality and efficiency. Regularly, 97-98% of providers are ranked in the category "standard quality" which is one of three categories.
- Evaluation of official criteria is sporadic and not very transparent to the public (every health insurance company uses a different method of evaluation and presentation of outputs, year-on-year comparisons are complicated, compilation of rankings is insufficient, etc.).
- There is no website which would provide aggregate data on quality and efficiency of health care providers gathered by all health insurance companies. Policyholders do not

[13] Szalay et al (2011), http://www.hpi.sk/hpi/sk/view/3056/moderny-koncept-minimalnej-siete.html
[14] Minister of Health, http://www.nrsr.sk/web/Default.aspx?sid=schodze/ho_detail&MasterID=13255
[15] Paris-Devaux-Wei (2010)

have the option to find out, in a central access point, how providers perform, if they meet particular criteria, or to compare annual changes.

The Ministry of Health identified in the *Draft Strategic Framework for Health Care for the years 2013-2030*[16] key indicators of health care, corresponding to areas in which Slovakia is falling behind OECD countries, and specified targets to be achieved by 2030.

3.2.3 Sustainability

The Slovak health system promises comprehensive coverage for which resources are inadequate. The gap between revenues and spending has been widening over the years, giving rise to growing debt.[17]

Total debt measured as financial liabilities after maturity date amounted to EUR 213.29 million (0.3% of GDP) as at 31 December 2012. The largest portion of debt (EUR 141.75 million) is generated by health care facilities administered by the Ministry of Health, followed by facilities transferred to self-government authorities and transformed to nonprofit organisations (EUR 71.4 million). The loss-making operation of hospitals negatively impacts on current public finances (Ministry of Health, 2013) and entails fiscal risks also in the medium term. Approved wage increases for doctors for 2014 and 2015 add further to the negative outlook. Unresolved indebtedness of hospitals has, next to relatively significant fiscal effects, also implications for the quality and accessibility of health care; it can result, for example, in longer waiting lists, obsolete technologies and medical procedures, departure of top-ranking doctors and nurses to the private sector or abroad, worsened hygiene, and so on.

State hospitals fail to repay their liabilities because they lack the right motivation. Politically nominated and 'short-lived' management, absence of hard budget rules, inefficient purchasing, legislation obliging to provide care without financial back-up, immense state intervention – all of these factors contribute to the loss-making operation of state hospitals. The Ministry of Health sees room for improvement in focusing on the following measures: eHealth project implementation, introduction of effective control mechanisms, implementation of a DRG payment system, centralisation of certain health procedures, or streamlined purchasing and procurement (Ministry of Health, 2013).

The total number of employees in health care facilities was 105,743 natural persons as at 31 December 2011, of which 78,842 were health care workers (2.2% decrease compared with 2010). Almost 80% of the health care workforce are women. About 39% of all health care workers work in health care facilities founded by the Ministry of Health, 2% founded by other state resorts, 15% founded by regional self-governments, and up to 44% under the competence of other founders (including private). Out of the total number of health workforce, 26% comprised physicians and dentists, 43% nurses and midwives, 4.3% pharmacists and 26.7% other health care workers.

According to a WHO (2012) survey on primary care, Slovakia has a nationwide shortage of dentists, but no such shortages exist for other health professionals in the primary care. Some regions lack GPs, gynaecologists and obstetricians and homecare nurses, but no shortage was reported for primary care nurses, pharmacists and physiotherapists.

An ageing workforce, restructuring of health care facilities and professional migration are likely to result in a shortage of health care workers in Slovakia in the long-term. Although exact data on migration are lacking, it is considered common practice.

[16] http://www.health.gov.sk/Zdroje?/Sources/Sekcie/IZP/navrh-strategickeho-ramca-v-zdravotnictve-pre-roky-2013-2030.pdf

[17] Colombo and Tapay (2004)

One of the assumed reasons for the undersized number of nurses (see chapter 3.1.2) is relatively low average pay. However, the solution is not a flat increase of wages or minimum wage claims, as currently considered, but a differentiation of salaries enabling hospital directors to remunerate based on quality of work and financial conditions of a given provider.

Szalay et al. (2011) and WHO (2012) state that the health care workforce in Slovakia is ageing. According to the latest available data from 2011, the largest group of physicians belonged to the 55-59 age group.

Table 5: Number of physicians distributed by age (2011)

<table>
<tr><th>Physicians Total</th><th colspan="10">Age</th></tr>
<tr><td></td><td>20-24</td><td>25-29</td><td>30-34</td><td>35-39</td><td>40-44</td><td>45-49</td><td>50-54</td><td>55-59</td><td>60-64</td><td>65+</td></tr>
<tr><td>17 849</td><td>75</td><td>2016</td><td>1438</td><td>2156</td><td>2288</td><td>1680</td><td>2020</td><td>3036</td><td>1842</td><td>1298</td></tr>
<tr><td rowspan="3">100%</td><td>0.4%</td><td>11.3%</td><td>8.1%</td><td>12.1%</td><td>12.8%</td><td>9.4%</td><td>11.3%</td><td>17.0%</td><td>10.3%</td><td>7.3%</td></tr>
<tr><td colspan="2">11.7%</td><td colspan="2">20.1%</td><td colspan="2">22.2%</td><td colspan="2">28.3%</td><td colspan="2">17.6%</td></tr>
<tr><td colspan="6">54.1%</td><td colspan="4">45.9%</td></tr>
</table>

Source: National Health Information Centre (2012); calculations: INEKO

3.2.4 Summary

The fact that the Slovak health system offers universal coverage, but does not secure adequate resources, gives some indication of its strengths and weaknesses. On the positive side, citizens benefit from decent access to basic and also specialist care. They can freely choose the insurer, doctor, specialist or hospital. An important part of the system is the independent regulatory body (Health Care Surveillance Authority), although being subject to some political interference.

Out of the recent reforms, the perhaps biggest 'success story' is reference-based pricing of pharmaceuticals. Slovakia has traditionally one of the highest expenses on drugs in the OECD, both as a percentage of total expenditures and in GDP terms. With the implementation of international referencing of drug prices since 2009 (Slovakia was one of the first European countries to introduce such a system), nominal growth of pharmaceutical costs has almost halted[18] and Slovakia now effectively has the second cheapest drugs in the EU (Institute for Financial Policy, 2012). The initial model was based on the referencing of prices against the average of six lowest prices in the EU. In 2011, referencing was tightened, so that drug prices could not exceed the level of the second lowest price in the EU. As of 2013, prices are referenced at the level of the average of three lowest prices for a given drug in the EU.

The Slovak health care system is struggling with several problems, which were outlined in the previous sections (high indebtedness, unsustainable basic package, undue state interventions, etc.). The major weakness, however, seems to be a low efficiency of the system, as observed in studies by the OECD (2010, 2012), IMF[19] and the Institute for Financial Policy[20]. The health system in Slovakia is one of the less efficient systems in EU and OECD countries, and its outcomes are one of the worst. According to the OECD and the IMF, Slovakia could save 2.7% and/or 3.5% of GDP per year, respectively, if the country would fully exploit its potential for improving efficiency of the system. In other words, Slovak citizens could receive better health care and enjoy better health for the money they pay. The Institute for Financial Policy concludes that due to the system's inefficiency, life expectancy of Slovaks is by 2 years

[18] For illustration, pharmaceutical costs increased in Slovakia by 1.1% in 2009. In the same time, costs increased by 10.3% in the Czech Republic and 10.2% in Poland (Zachar, 2012).

[19] Grigoli (2012)

[20] Filko et al (2012)

shorter than the average of advanced countries. The problem of Slovakia's health system is not necessarily a lack of funds, but their inefficient use (Zachar, 2012). A forthcoming study by the institute INEKO points out that the efficiency of the national health system tends to appear in better light when models of efficiency take into consideration existing poverty rates, referring mainly to the poor living conditions of a significant part of the Roma population.

3.3 Reform debates

The government seems to be aware of the weaknesses and threats the health sector is facing. The 2013 National Reform Programme pinpoints the crucial problems and names a number of reasonable plans for improvement.

The imminent priority for policy makers is to tackle the high debt in the system. At the same time, the government will be confronted with dissatisfaction of patients with accessibility and quality of health care financed from statutory health insurance. To improve efficiency and minimise negative effects on quality and availability, it will be important:

- to introduce hard budget constraints on the operation of health care providers and health insurance companies;
- to redefine and possibly also to narrow the basic package of services to be covered from statutory health insurance; this should also improve conditions for voluntary co-insurance;
- to provide transparent information to patients, providers and insurance companies regarding costs, volume and quality of health care services, publish rankings of quality and efficiency of providers/insurance companies – better informed public can more effectively press for improved quality of health care provision;
- to clean-up the system of out-of-pocket payments and enable regulated lump-sum payments for hospital stays or doctor visits;
- to introduce and adhere to diagnostic and medical treatment guidelines;
- to put into effect a catalogue of medical procedures and a DRG system of payments in hospital care;
- to resume the halted transformation of state hospitals to joint stock companies and enable the entry of private capital – strategic investors could bring more sustainable financial management, corporate culture and know-how;
- to abolish minimum wage claims stipulated by law for doctors, and disapprove the adoption of minimum wage claims for nurses;
- to abolish the terminal network of hospitals, which are by law automatically entitled to contracts with all health insurance companies;
- to proceed with more vigour with the rationalisation/optimalisation of inpatient care;
- strengthen the independent position of the regulatory body, by way of making impossible to recall the director de facto for any reason.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The current system of long-term care (LTC) is the product of institutional and legislative reforms implemented over the past decade. The public administration reform of 2002-2004 concluded the transfer of competences in the area of social services from state administration to local and regional self-government authorities. Provision of social services has been regulated by an universal law on social assistance until 2008, when a new *Act on social services* was adopted. The law set the existing legal framework for the provision of social care services, which is supplemented by special legislation on cash benefits for compensation of severe disability. Important systemic changes in health-related LTC have been launched in 2004, when new legislation on health care provision, health insurance and health care providers created conditions for the provision of health and nursing care outside health facilities (e.g. at home or in social care facilities) and the possibility to finance such care from public health insurance.

4.1.2 System characteristics

Long-term care in Slovakia does not comprise a uniform system of social and health care. The legal framework is formed by special legislation pertaining to different conditions and risks, including disability, ill health, old-age, social need and dependence.

LTC in the area of health is provided in the form of geriatric care in outpatient departments, specialised hospital departments, day care centres, home nursing agencies, hospices and other facilities. Most of the medical services are covered by statutory health insurance, but co-payments from clients are required for certain types of care.

Social long-term care is provided in the form of benefits in kind and cash benefits. *Benefits in kind* are referred to as social services and typically include institutional care provided by public and non-public providers[21] in homes for seniors, homes of social services for persons with disabilities, facilities of supported living, care service facilities, rehabilitation and day centres and other specialised facilities. Besides residential care, attendance services may be provided also at home to help persons in need with activities of daily living. Selected facilities (senior homes, homes of social services, care service facilities and specialised facilities) may provide medical nursing care specified by the Ministry of Health. Social services are financed by local and regional self-governments, State subsidies, and payments by care recipients.[22] *Cash benefits* include compensatory payments provided to severely disabled persons and their carers to support financing of home care. Typical recurring cash benefits are the personal assistance allowance (granted to a disabled care recipient for hiring a non-relative carer) and the care allowance (provided to an informal carer, usually relative of a disabled person). Other compensatory payments are intended to support transportation, dietary meals, purchase or operation of medical aids and motor vehicles, adaptation of dwellings, etc. Cash benefits are financed by the State and provided through a network of local offices of labour, social affairs and family.

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[21] Public providers are local and regional self-governments (municipalities, towns, regional units) and/or legal entities founded by these authorities. Non-public providers include legal entities, physical persons, church and charity organisations and other civil sector institutions.

[22] Non-public not-for-profit providers receive financial contributions for the operation and provision of services through self-governments and/or directly from the State budget.

Legislation defines the required duration of a functional disease as well as the minimum degree of dependence (on assistance from other persons) for the provision of the various benefits. The entitlement to cash benefits is subject to a means test. The level of recipients' income and assets also determine the amount of the benefits. Recipients of benefits in kind have to co-pay for services in the sum specified by the service provider, but usually only up to the level of economically justified costs. Charges are determined also based on the recipient's income and assets, but the person has to be left with a certain minimum income (from 20% of the subsistence minimum per month when in all-year residential care, to 130% when receiving a home care service). For the entitlement to compensatory cash benefits and social services, income of family members living in the same household with the recipient is regarded. Co-financing of social services may be imposed on closest relatives not living in the same household only when their income exceeds 130% of the subsistence minimum; however, enforcement of this obligation tends to be problematic.

As at 31 December 2012, there were 811 institutional social service facilities for adults, of which 518 (63.7%) were founded by public authorities and 293 (36.3%) by non-public organisations. The number and proportion of private providers has been steadily increasing over the past decade.

4.1.3 Details on recent reforms in the past 2-3 years

Practically all reforms adopted in the past 2-3 years were taken in reaction to the worsening financial situation in social services. In 2010 and 2011, the government repeatedly approved one-off subsidies for public and private providers to compensate the shortfall in financing of social services caused by the economic crisis. Following a ruling by the Constitutional Court, the government was required to amend the *Act on social services* so that municipalities and self-governing regions are obliged to provide for a social service at a public or non-public provider according to the client's choice (non-public providers had been discriminated before). The modified rules came into effect on 1 April 2011, however, as experience suggests, problems with ensuring equal conditions for private providers persist (see also chapter 4.3).

The critical situation in financing of social services compelled the outgoing centre-right government to revise anew the financing mechanism. As from 1 March 2012, public providers founded by municipalities and non-public providers of specified types of services receive special-purpose subsidies from the State budget to finance provision of social services (equal sum for a given service granted to all providers). The amendment stipulated a minimum limit on co-payments for clients of public facilities at 50% of economically justified costs of a given social service (no lower limit before), to be implemented since 1 July 2012. In addition, the means-test for entitlements to social services has been tightened. The new left-leaning government abolished the minimum 50% co-payments in June 2012 because of criticism from affected population and civil society organisations. In December 2012, the parliament postponed the obligation for self-governments to provide clients with a social service within 60 days from the application date (postponed from 1 January 2013 to 1 January 2016). A new amendment to the social services law is currently in the pipeline, aiming to improve quality of services and revise financing from public funds (see chapter 4.3).

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The diversity of care services and the non-existence of a unified database[23] make it difficult to quote coverage rates and other relevant statistics on LTC in Slovakia. Annual data on the numbers of social services providers, beds and clients generally show an moderate upward trend, but there is little contextual information available on how supply of services corresponds to the growing need. Data on waiting lists signify that access to social services is restricted by insufficient capacity. As at end of 2011, there were 9,280 wait-listed applicants for residential care (after 11,508 in 2010; Ministry of Labour, 2012). There is also evidence of unsatisfied demand for field care services. The existing capacity and financing problems were behind the postponement of a 'social service guarantee' until 2016 and/or its proposed exclusion (see chapter 4.1.3).

The share of old-age pensioners and long-term disabled persons on the total number of clients of social care institutions for adults is steadily increasing (from 68.7% and 74.7% in 2008 to 71.9% and 83.2% in 2012, respectively). The figures are an indication of population ageing, but presumably also of a disappointing trend of increasing ill-health in old-age, as suggested by Eurostat data.

Statistics on the social situation of LTC recipients are not readily available. Co-payments for benefits in-kind are specified by the care provider up to the level of economically justified costs (except for services rendered by private for-profit providers), but actual payments are usually much lower. Protection from undue financial burden and risk of poverty shall be safeguarded by the specification of a certain level of income (differentiated by type of service) which has to be left to the care recipient every month. Data on how many LTC clients live below the poverty line are unknown. Earlier surveys have pointed to the negative implications of the low sum of a care allowance on the income situation of informal carers who take care of a relative with the highest degrees of dependence and are thus practically excluded from employment. Another aspect brought to attention concerns the indexation of retirement pensions, which leads effectively to a reduction of means tested benefits and to benefit trap effects (Repkova, 2010).

4.2.2 Quality and performance indicators

The law on social services stipulates a system of quality assessment, focused on procedural, personnel and operational aspects of provided social care services. The assessment grid includes 24 performance indicators, including elaboration and assessment of individual plans for recipients, system of further education of carers and other employees, or material equipment and barrier-free design. The system of quality assessment shall become fully effective in 2016 under supervision of the Ministry of Labour, Social Affairs and Family. Individual providers and/or founders (e.g. self-governing regions) set up their own quality assessment schemes. Providers are obliged to establish procedures and rules to identify satisfaction of recipients with provided social services. Aggregate evaluation outcomes are not available, but there is a general belief that quality of LTC is deficient especially in those types of (public) institutional care which are short of supply. A critical factor is lack of

[23] There exists a Central registry of social services providers, which however does not cover health-related and other care services provided outside the social sector. Moreover, as long-term care is not embodied in legislation and statistics, the decision on what should be regarded as LTC or not, is not always straightforward.

financial resources in the system, which has aggravated since the onset of the economic crisis, affecting not only the material aspects of care provision but also human resources.

Surveillance over provision of health care (including quality assessment) and public health insurance is carried out by the Health Care Surveillance Authority. According to official assessments, health care for the long-term ill, immobile and geriatric patients in Slovakia is characterised by low physical accessibility and poor quality in practically all forms of residential and home nursing care (Ministry of Health, 2011).

4.2.3 Sustainability

The setting up of a sustainable financing system is perhaps the main challenge in the national context. Existing regulations 'guarantee' entitlements of citizens to care services, but do not ensure sufficient and sustainable financing. Demographic changes signal a growing demand for LTC in the future. According to EC projections, expenditures for LTC are expected to more than double in the next 50 years (from 0.3% in 2010 to 0.7% of GDP in 2060). The Council for Budget Responsibility points out that by 2062, the expenditures sensitive to population ageing should increase by 3.7% of GDP compared to 2012, of which health care and long-term care represent 2.2% of GDP. After promising reforms in the pension system, significant sustainability risks are concentrated mainly in these two sectors (Council for Budget Responsibility, 2013).

Growing demand for LTC is directly linked with the challenge of having sufficient LTC workers. Informal care provided by family members or close non-relatives plays a decisive role in Slovakia. It is often of hidden nature, i.e. performed based on the principle of family and generation solidarity and beyond the reach of social statistics (Bednarik et al, 2009). A number of policy issues weaken the position of informal carers, notably a low and undifferentiated amount of the means-tested care allowance and poor employment- and former job protection. It may be therefore assumed that the role of formal care provided at home will increase in the future. However, low remuneration, unappealing working conditions and poor career prospects discourage young people from the profession of a carer and induce existing LTC workers to migrate to other professions and/or to work abroad. The resulting shortage of qualified carers and nurses will require increased policy attention.

4.2.4 Summary

The major strength of the Slovak LTC system appears to be a decent coverage of target groups, through an array of cash benefits and a large network of care providers, at a reasonable price and acceptable quality. Certainly, this statement must be taken with some reserve, as there are waiting lists and clients dissatisfied with quality and prices. Nevertheless, the list of weaknesses is considerably longer. The major weak point is an unsustainable and partly unfair (towards private not-for-profit providers) financing system. Another systemic weakness is a deficient coordination between health care and social long-term care. As a result of poorly coordinated competences, there remain practical obstacles to provide and finance health/nursing care in social service facilities, and vice versa. There are no clear pathways of a smooth transition and succession of care interventions for different situations of dependence. From a subject matter point of view, one can observe poor coordination of policies for disabled persons and the elderly, even though there is substantial overlapping between the two target groups. The system offers a variety of in-kind and cash benefits but these are not clearly arranged into a transparent scheme, what makes it difficult for clients and even for professionals to orientate themselves. The worsening social status of the LTC workforce will result in further outflow of workers from the sector.

4.3 Reform debates

As noted in the previous sections, the setting up of a sustainable financing mechanism is the core theme of recent reform debates in the LTC area. The economic crisis and subsequent consolidation plans resulted in a cutdown of funds transferred to local and regional self-governments whose budgets finance most of the benefits in-kind. The shortfall has been first tackled with one-off subsidies from the State budget. What followed was the approval of a provisional financial arrangement involving special-purpose subsidies to prevent the immediate collapse of care provision. Part of the endeavour was an increase of co-payments and stricter means-testing to motivate persons to remain in the home environment as long as possible and/or to make use of outpatient care.

Another revision of rules is currently under preparation. A draft amendment to the *Act on social services* was approved by the government on 26 September and shall be negotiated by the parliament in November, with a tentative entering into effect on 1 January 2014. The government's draft puts forward a number of changes, which concern also long-term care for the elderly and disabled persons:

- Revision of financial subsidies for the operation and provision of social services granted to non-public providers. The main objective of modified rules is to equalise financial support for public and non-public providers. It is proposed that non-public providers will receive subsidies directly from the Ministry of Labour, Social Affairs and Family (now channelled through municipalities which for various reasons may defer or decrease payments). The negative fiscal impact of the change is estimated at EUR 21.3 million in 2014.
- Redefinition of items which may be included in the calculation of economically justified costs of a given service, with the aim to prevent inclusion of undue expenses and increase income protection of clients.
- Increase of sums which have to be left to the clients after payment for a service (by 5%-30%, depending on type of accommodation – year-round, weekly, daily – and use of boarding service). The aim of higher protective thresholds is to increase the income protection of care recipients. The estimated negative fiscal impact is EUR 2.6 million in 2014.
- Introduction of upper limits on the numbers of clients in newly founded facilities for seniors, homes of social services and specialised facilities. The limit shall not apply to existing facilities, which however may not henceforth increase existing capacity. The aim is to support the creation of a home environment in these facilities in line with the deinstitutionalisation strategy.
- The obligation for self-governments to provide clients with a social service within 60 days from the application date shall be withdrawn from the law. This change was requested by municipalities due to practical unfeasibility of such a guarantee.
- Introduction of an upper age limit for year-round accommodation in homes of social services, which shall equal to the statutory retirement age. The goal of this change is to distinguish this type of facility as an institution for the productive-age population.
- Introduction of a new social service called support of independent living. The idea is to provide persons in an unfavourable situation with assistance in the form of different social services in the home environment to increase their independence (e.g. severely disabled persons after moving from residential to home care).

The reform proposal includes some reasonable ideas. The revised financing scheme could be a step towards equalising access of public and private providers to public funds. However, it is in question whether the proposed mechanism is a move towards financial sustainability. The LTC sector will be in need of a continuing increase of funding, which will obviously put growing pressure on public finances. The proposal takes a step back from higher financial involvement of clients. This will be in the long-run inevitable, be it in the form of higher co-payments or some form of insurance. A broad societal consensus should be achieved on this crucial issue. In the official review procedure, social service providers and civil society organisations criticised the undue cumulating of competences in the hands of municipalities which assess dependency of applicants, provide services, register and finance non-public providers, and perform also supervision.

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Annex – Key publications

[Pensions]

COUNCIL FOR FISCAL RESPONSIBILITY (2012), Stanovisko k novele zakona o socialnom poisteni, Bratislava, 12 December 2012, Bratislava, retrieved on 4 October 2013 at http://www.rozpoctovarada.sk/vo_download/Zakon_252-2012_socialne_poistenie_01_03.pdf

"Assessment of the amendment to the Act on social insurance"

The report examines the revision of the law on social insurance and its effects on the pension system, social situation of households, employment, and public finances.

COUNCIL FOR FISCAL RESPONSIBILITY (2013), Sprava o dlhodobej udrzatelnosti verejnych financii, April 2013, Bratislava, retrieved on 3 October 2013 at http://www.rozpoctovarada.sk/download2/sustainability_report_2013_final.pdf

"Report on the long-term sustainability of public finances"

The report, published annually in April, provides a detailed assessment of long-term sustainability indicators, taking into account implemented reforms on the revenue – and expenditure side. The report points to positive effects of the 2012 reform of the pay-as-you-go pension pillar.

MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY OF THE SR, Sprava o socialnej situacii obyvatelstva SR v roku 2012, June 2013, Bratislava, retrieved from: http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=22529

"Report on the social situation of the population of the Slovak Republic in 2012"

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

PORUBSKY, MAREK – PRIEVALSKY, MICHAL (2013), Starnutie zvysi vydavky, dochodkova reforma pomohla. Dlhodobe dochodkove projekcie po reforme z roku 2012, commentary, Institute for Financial Policy, Ministry of Finance of the SR, 29 April 2013, Bratislava, retrieved on 30 September 2013 at http://www.finance.gov.sk/Components/CategoryDocuments/s_LoadDocument.aspx?categoryId=8886&documentId=9796

"Long-term projections of pensions after the reform of 2012"

The study concludes that the 2012 pension reform will result in a lowering of the deficit in the system by from previously expected 9% of GDP to 5% of GDP by 2060.

PORUBSKY, MAREK (2013), Indexacia dochodkov pevnou sumou? Nie, dakujem., commentary, Institute for Financial Policy, Ministry of Finance of the SR, 2 April 2013, Bratislava, retrieved on 30 September 2013 at http://www.finance.gov.sk/Components/CategoryDocuments/s_LoadDocument.aspx?categoryId=8191&documentId=7193

"Indexation of pensions by a fixed sum? No, thank you."

The short report argues that indexation by a fixed sum is a non-systemic approach, resulting in artificial solidarity.

NOVYSEDLAK, VIKTOR – PORUBSKY, MAREK – GABIK, RASTISLAV (2012), Analyza dlhodobej udrzatelnosti a navrhy na zmeny dochodkoveho systemu, Economic analysis No.26, Institute for Financial Policy, Ministry of Finance of the SR, April 2012, Bratislava, retrieved on 15 September at
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"Analysis of the long-term sustainability and proposals for changes in the pension system"

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

[Health care]

FILKO, MARTIN – MACH, JURAJ – ZAJICEK, MICHAL (2012), Malo zdravia za vela penazi: Analyza efektivnosti slovenskeho zdravotnictva, December 2012, Financial Policy Institute of the Ministry of Finance of the SR, Bratislava, retrieved on 5 October 2013 at http
http://www.finance.gov.sk/Components/CategoryDocuments/s_LoadDocument.aspx?categoryId=8789&documentId=9367

"Little health for a lot of money: Analysis of efficiency of the Slovak health care"

The study carries out a thorough assessment of the efficiency of health care and health insurance.

GRIGOLO, FRANCESCO (2012), Public Expenditure in the Slovak Republic: Composition and Technical Efficiency; IMF Working Paper No. 173, International Monetary Fund, July 2012, retrieved on 5 October 2013 at
http://www.imf.org/external/pubs/ft/wp/2012/wp12173.pdf

The paper analyses the composition of public expenditure and the relative efficiency of spending in education and health. While Slovakia manages to translate the low expenditures into outcomes in an efficient manner in the education sector, this is not true for health. Moreover, the recent increases in expenditure levels have not improved outcomes, suggesting that significant budgetary savings could be achieved through increases in efficiency.

KAHANCOVA, MARTA (2013), Governing the Healthcare Sector in Slovakia, CELSI Research Report No.5, Central European Labour Studies Institute (CELSI), May 2013
http://www.celsi.sk/en/publication/report-details/22/governing-the-healthcare-sector-in-slovakia/

The report discusses recent developments in the governance of the health care sector in Slovakia. The focus is on the main challenges that public health care has been facing since 2001.

MORVAY, KAROL (ed.) (2013?), Zdravotnictvo – trhy, regulacia, politika, Health Policy Institute, Bratislava, forthcoming, retrieved on 2 October 2013 at
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"Health care – markets, regulation, policies"

The forthcoming study pays attention to the economy of health care, concretely to the functioning of markets and regulatory policies.

MUZIK, ROMAN – SZALAYOVA, ANGELIKA (2013), Analyza cakacich dob, Health Policy Institute, Bratislava, September 2013, retrieved on 10 October 2013 at http://hpi.sk/hpi/sk/view/10299/analyza-cakacich-dob-2013.html

"Analysis of waiting periods"

The analysis examines waiting periods for selected medical procedures in 2013 and their evolution over time.

NATIONAL HEALTH INFORMATION CENTRE (2012), Zdravotnicka rocenka Slovenskej republiky 2011, Bratislava, 2012, retrieved on 10 October 2013 at http://www.nczisk.sk/Documents/rocenky/rocenka_2011.pdf

"Health Statistics Yearbook of the Slovak Republic 2011"

The statistical yearbook offers a comprehensive overview of data and trends on demographic indicators, health status of the population, health care establishments, and international comparisons.

OECD (2012), Economic Surveys: Slovak Republic 2012, OECD Publishing, December 2012, retrieved on 15 September 2013 at http://www.oecd.org/eco/surveys/slovakia2012.htm

A special chapter of the economic survey focuses on Improving cost-efficiency in the healthcare sector. Authors state that efficiency in the healthcare sector is low by international standards. As a result, the adoption of best practices may yield large productivity increases. According to OECD estimates, Slovakia could achieve the same health outcomes with cost savings of around 2% of GDP in 2060.

WHO (2012), Evaluation of the structure and provision of primary care in Slovakia. A survey-based project, April 2012, retrieved on 9 October 2013 at http://www.euro.who.int/__data/assets/pdf_file/0003/175242/Evaluation-of-the-structure-and-provision-of-primary-care-in-Slovakia.pdf

The report assesses whether primary care service delivery in Slovakia is supported by an adequate legal and normative framework, financing mechanisms, human resource strategies, supply of appropriate facilities, equipment and medicines, etc.

ZACHAR, DUSAN – DANCIKOVA, ZUZANA (2012), Analyza verejneho obstaravania nemocnic v rokoch 2009-2012, INEKO, Transparency International Slovakia, August 2012, retrieved on 5 October 2013 at http://www.ineko.sk/file_download/693

"Analysis of public procurement in hospitals in the years 2009-2012"

Public procurement in Slovak hospitals is characterised by a low number of submitted proposals. More than two thirds of procured funds has been realised in tenders with only one bidder.

[Long term care]

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"State of social protection in Slovakia: Situation as at 1 January 2013"

The half-yearly report provides background information and updates for the MISSOC comparative tables database.

BEDNARIK, RASTISLAV (2013), Stav socialnej ochrany na Slovensku: Situacia k 1. julu 2013, Institute for Labour and Family Research, Bratislava, retrieved on 15 September 2013 at
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"State of social protection in Slovakia: Situation as at 1 July 2013"

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REPKOVA, KVETOSLAVA (ed.) (2012), Policy brief 4 – Terminologia sluzieb dlhodobej starostlivosti – vybrane problemy, Institute for Labour and Family Research, Association of providers of social services, Bratislava, June 2012, retrieved on 10 October 2013 at
http://www.ivpr.gov.sk/IVPR/images/IVPR/Interlinks/policy_brief_4.pdf

"Policy brief 4 – Terminology of long-term care services – selected problems"

The report discussed LTC terminology in the national and international context, which causes some problems in the policy application.

STATISTICAL OFFICE OF THE SR (2013), Zariadenia socialnych sluzieb v Slovenskej republike 2012, July 2013, Bratislava, retrieved on 20 September 2013 at

http://portal.statistics.sk/showdoc.do?docid=70353

"Social service facilities in the Slovak Republic 2012"

The publication provides a detailed overview of social service facilities, their numbers, occupancy, numbers of users, expenditures and employees, all data arranged also by founder.

Ratio of average retirement pension to average wage

	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**
Average pension (EUR)	273	295	313	337	352	362	376
Average wage (EUR)	623	669	723	744	769	786	805
Ratio of pension to wage	43.8%	44.1%	43.3%	45.3%	45.8%	46.1%	46.7%

Source: Social Insurance Agency, Statistical Office of the SR

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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