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EUROPEAN SOCIAL POLICY NETWORK (ESPN)

Financing social protection

Slovakia

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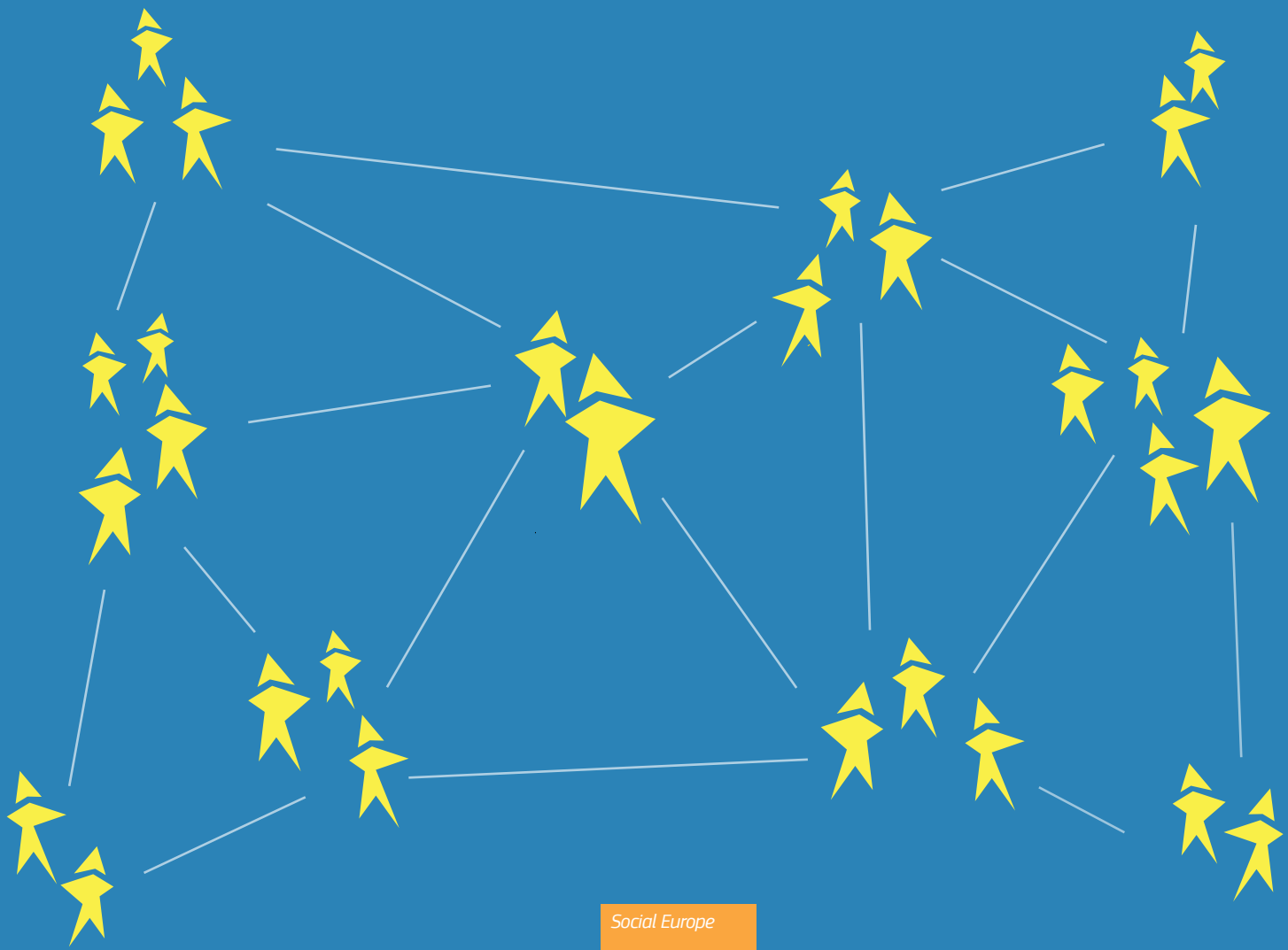

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European Social Policy Network (ESPN)

ESPN Thematic Report on Financing social protection

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary

In 2016, gross expenditure on social protection in Slovakia amounted to 18.4% of GDP, which was far below the EU average (28.2%). However, it increased by 2.3 percentage points overall between 2005 and 2016 (the period examined), and also increased in constant price terms in almost every year.

Spending on the old-age 'function' was the largest component of gross social expenditure in Slovakia in 2016, accounting for 40.1%. Its share fluctuated between 2005 and 2016, but showed an overall increase of 1 percentage point. The second largest component was expenditure on sickness/health. The share of that in social spending fell during the crisis, but later it stabilised before rising to 32.5% in 2016. Among other spending components, family/children and disability amounted to the largest shares.

Financing of social protection in Slovakia relied heavily on social contributions, which represented 68.2% of total financing in 2016. The largest proportion of receipts came from employer social contributions (46.6%).

Means-tested benefits played a minor role, amounting to 4% of total spending on social benefits in 2016. Social protection benefits are provided as net benefits, without taxation. In 2016, net social protection benefits accounted for 99.7% of gross social benefits. On the other hand, Slovakia belonged to those countries in which the budgetary costs of tax breaks for social purposes were significant.

The current design of the social insurance system in Slovakia was established in 2004. Contributions to old-age, invalidity, and survivor insurance, which had previously formed one package, were divided, with separate contributions redirected to separate funds.

In 2005, a two-tier pension system was established, consisting of a defined-benefit pay-as-you-go scheme and a funded defined-contribution scheme. Pension contributions were partly redirected to personal accounts managed by private companies. The deficit in the pension fund of the Social Insurance Agency is covered by surpluses out of other funds. After exhausting these resources (and transfers from privatisation), the deficit is covered by transfers from the state budget.

From 2012, the pensionable age was linked to average life expectancy (men and women taken together), with automatic adjustments based on changes in 5-year averages of life expectancy at the applicable pensionable age.

Pension contribution rates have been changed repeatedly. After 2012, the contribution rate for the second pillar fell from 9% to 4% of gross wages, but since 2017, it has been increased automatically each year by 0.25 percentage points. The aim is for the process to continue until it reaches 6% (with a rate for the first pillar of 12%).

During the period examined pensions were indexed to wages and/or prices in various ways, and since 2018 they have been indexed to pensioners' cost of living. But additionally in 2017, an ad hoc annual minimum increase of 2% was approved for the period 2018-2021.

Healthcare reform in the period 2002-2005 brought budgetary constraints aimed at a more effective utilisation of resources, as well as a newly designed system of health service provision which transferred responsibility from the state to patients, health insurance companies, and providers. In the period 2004-2010, economic growth (and hence higher revenues from contributions) helped to finance a growth in healthcare expenditure, which increased both in absolute terms and relative to GDP. After 2010 expenditure fell, and then remained more or less stable as result of cost-containment measures, as well as of declining private spending.

One of the measures with a strong potential to affect the level and structure of social protection financing is Act 493/2011 on fiscal responsibility. This Act created a regulatory framework to enhance the long-term sustainability of public finances in Slovakia,

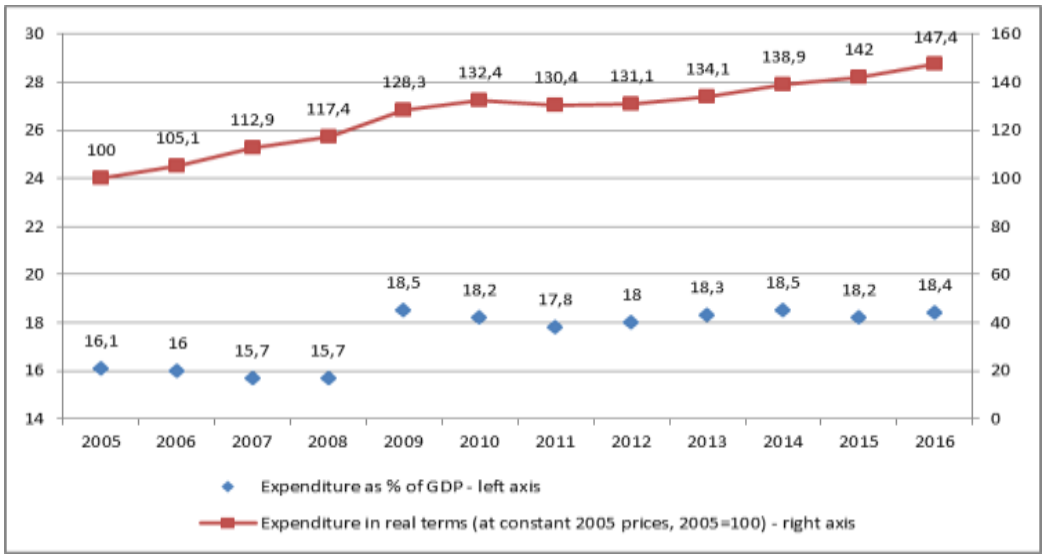
including a rule which sets the gross debt limit at 50% of GDP (after 60% during a transitional period).

1 Current levels and past changes in financing social protection

In 2016, gross expenditure on social protection in Slovakia amounted to 18.4% of GDP, which was far below the EU average (28.2%): however, it increased by 2.3 percentage points overall between 2005 and 2016. Although in the pre-crisis period (between 2005 and 2008) the share of GDP spent on social protection fell slightly, by 0.4 percentage points, during the crisis years (2008-2010) it rose by 2.5 percentage points. From 2010 to 2016 it increased by 0.2 percentage points.

When expressed in constant price terms (2005=100), expenditure on social protection grew almost every year between 2005 and 2016.[1] Expenditure in real terms grew even when expenditure relative to GDP fell or stagnated. This was notably the case for the pre-recession period, as Figure 1 shows. GDP growth may explain a part of the story. The pre-recession period in Slovakia was characterised by strong economic and employment growth. Real (annual) GDP growth reached 8.3% in 2006, 10.8% 2007, and 5.6% in 2008.[2] Such economically favourable conditions allowed the relative share of social protection expenditure to fall, despite the fact that expenditure in real terms grew.

Figure 1: Gross expenditure on social protection in Slovakia, 2005-2016, as % of GDP and in real terms (2005=100)



Source: Eurostat, ESSPROS (European System of integrated Social PROtection Statistics) data.

Spending on the old-age 'function' represented the largest part of gross social expenditure in Slovakia during the period. In 2016, it accounted for 40.1%, which was the same as the EU average. The share fluctuated between 2005 and 2016, but showed an overall increase of 1 percentage point. The lowest levels were reached in the crisis years – 2008 (37.1%), 2009 (37.2%), and 2010 (37.5%).[3] At the same time, as we will show in the next paragraphs, the share of expenditure on unemployment rose sharply. Notwithstanding these changes, old-age related spending remained the biggest item of social protection expenditure.

Old-age expenditure includes spending on several different measures, but pensions represented the most important part, accounting for 87.4% in 2016 (Statistical Office of the Slovak Republic, 2019: 13). An increasing number of old-age pension recipients was the main factor behind the growth in old-age expenditure during the period. Further, the

[1] The only exception was 2011.

[2] Eurostat (tec00115).

[3] At the onset of the crisis (between 2007 and 2008) the share of old-age expenditure fell by approximately 1 percentage point.

introduction of a funded defined-contribution scheme (the second pillar) contributed to a deficit in the Social Insurance Agency (a statutory public body), which was covered by transfers from other insurance funds administered by the Agency and from the state budget. The overall deficit on old-age insurance is expected to fall slightly by 2035 (to 1.5% of GDP); but then it is expected to increase due to population ageing, reaching 2.3% of GDP by 2060 (Ministry of Finance, 2017:63).

Spending on sickness/health represents the second largest part of gross social protection expenditure. In absolute terms, sickness/health expenditure grew continuously over the period. Relative to GDP it increased by 1.1 percentage points between 2005 and 2016, reaching 5.6% in 2016. Expressed as a share of gross social protection expenditure, spending on sickness/health developed in three stages. While in the pre-crisis period its share grew (from 29.9% in 2005 to 32.6% in 2008), the crisis years brought a decline (by 2.4 percentage points between 2008 and 2011). After that it rose again, and reached 32.5% in 2016.

In-kind benefits prevail in sickness/health expenditure. They include resources allocated to outpatient care, institutional care, medicaments, and other benefits mostly financed by healthcare insurance companies. In 2016, in-kind benefits amounted to 81% of total sickness/health expenditure, compared with 9% on financial transfers (e.g. sickness benefits or benefits for the care for sick relatives) (Statistical Office of the Slovak Republic, 2019:10).

In the period 2004-2010, economic growth (and hence higher revenues from contributions) helped to finance a growth in healthcare expenditure, which increased both in absolute terms and relative to GDP. After 2010 expenditure fell, and then remained more or less stable as result of cost-containment measures, as well as declining private spending[4] (Smatana et al., 2016: 65). Cost-containment measures (such as price referencing) were important for reducing expenditure on pharmaceuticals, one of the most significant parts of overall healthcare expenditure in Slovakia. Whereas pharmaceutical expenditure represented 28% of total expenditure by health insurance companies in 2009 and 26% in 2010, in 2012 its share started to decrease and in 2013 represented only 21%.

Population ageing has a strong impact on healthcare expenditure and it will play an even more important role in the future by increasing demand for healthcare. According to the European Commission's 2018 Ageing Report, healthcare expenditure in Slovakia is expected to grow by 1.1 percentage point of GDP, to 6.8%, by 2070, (compared with 0.2 percentage points in the EU as a whole), representing the sixth-fastest growth in healthcare expenditure among EU member states (quoted in Ministry of Finance, 2018: 36).

Among other areas of social protection spending, family/children and disability contribute the biggest shares. In 2016, the share of spending on families and children amounted to 9% and the share of disability expenditure reached 8.8%. Although at similar levels, their developments differed: while the share of family/children-related spending declined between 2005 and 2016 (by 1.5 percentage points), that of disability expenditure increased (by 0.6 percentage points).

Both categories of expenditure consist mainly of financial transfers. In the family/children category, universal benefits funded from the state budget[5] accounted for approximately 70% of total expenditure in 2016. In spending on disability, invalidity pensions represented the highest share – almost 64% of the total in 2016.[6] Among in-kind benefits, expenditure on facilities for long-term disabled persons represented the largest

[4] Mainly because of changes in the method of reporting.

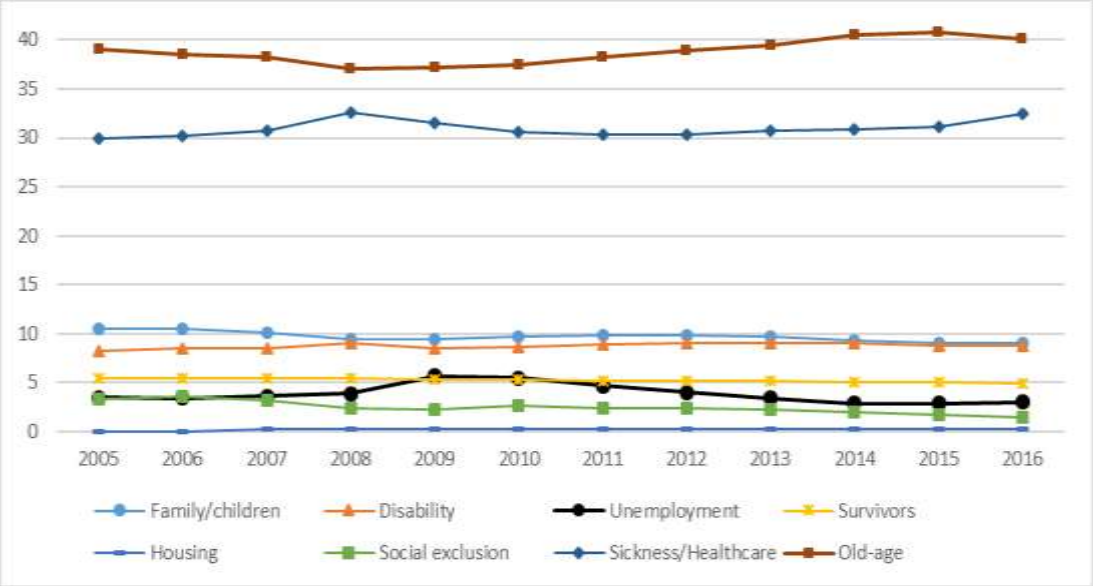
[5] Parental benefit, child benefit, child tax credit, birth grant, and adoption grant.

[6] The costs of attendance service benefit, paid to the informal carers of long-term disabled people, amounted to 3.6%.

item of expenditure on disability – 17.4% in 2016 (Statistical Office of the Slovak Republic, 2019: 18).

The volume of financial resources spent on unemployment also deserves attention because it showed a specific, although expected, trajectory. As Figure 2 shows, during the crisis years its share jumped above 5% of gross social protection expenditure. The post-crisis period brought a decline, and by 2016 it had fallen to 3%, which was below pre-crisis levels.

Figure 2: Social protection expenditure in Slovakia by function, 2005-2016 (% of gross social protection expenditure)



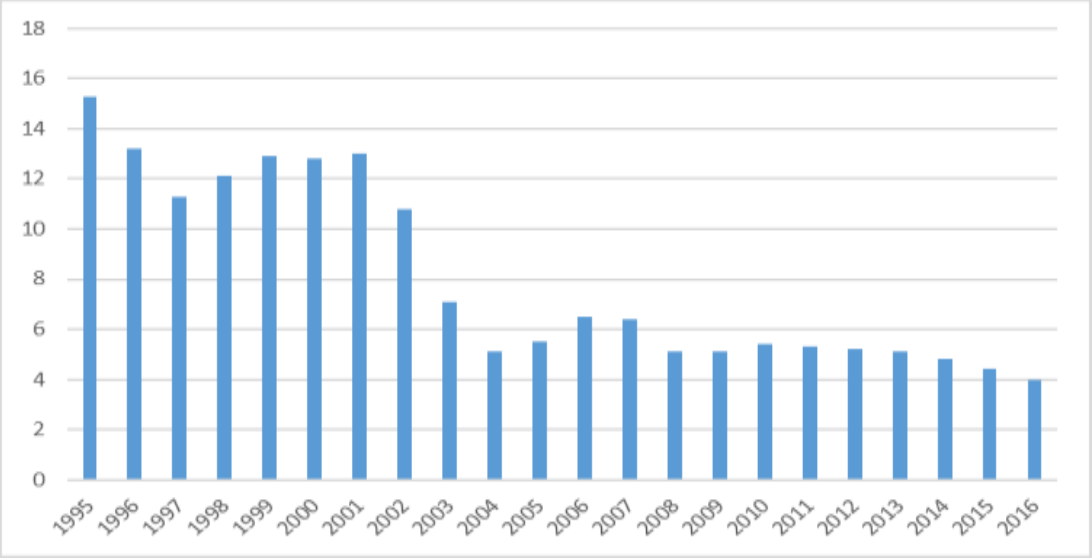
Source: Eurostat, ESSPROS data.

Means-tested benefits played a minor and declining role. Their highest share of total spending on social benefits in the period examined was in 2006 (6.5%) and 2007 (6.4%). But by 2010 it amounted to 5.4%, and by 2016 only 4% (EU average 12.1%). Means-tested benefits were far less important during the whole period 2005-2016 than in the 1990s and at the beginning of the 2000s, as Figure 3 shows. Their share of total spending on social benefits was higher than 11% in those years and reached almost 13% in 1999-2001.[7] This was mainly because in those years several social benefits were income-tested. Later, the situation changed and more emphasis was placed on universal financial transfers. This holds true, for example, for child benefit, which became a universal social benefit in 2004.

The share of means-tested benefits in total benefits spending varies between areas. In 2016 it represented 83.4% of total spending on social benefits related to social exclusion, and even 100% in the case of housing. On the other hand, 12.5% of expenditure related to disability benefits went to means-tested social transfers (Statistical Office of the Slovak Republic, 2019: 6). Means-testing is even less important for old-age benefits (3%), family and children benefits (2%), and benefits for survivors (0.7%).

[7] Based on data from the Statistical Office of the Slovak Republic.

Figure 3: Expenditure on means-tested benefits in Slovakia 1995-2016 (% of total expenditure on social benefits)



Source: Statistical Office of the Slovak Republic (2019: 6).

Social protection in Slovakia relies on public financial resources to a great extent (Social Protection Committee, 2015: 12). Social protection benefits are provided as net benefits, without taxation. In 2016, net social protection benefits accounted for 99.7% of gross social benefits. This share remained more or less stable during the period examined. On the other hand, tax allowances for social purposes played an important role. According to a report from the Social Protection Committee (2015: 13), Slovakia belonged to the countries in which the budgetary costs of tax breaks for social purposes were significant. Child tax credit (child tax bonus) represented one of the main tools in this respect.

2 Current mix and past changes in the sources of financing for social protection

2.1 Design of social contributions

The current design of social contributions consists of contributions by employers, employees, and self-employed persons. Some specific groups are covered by contributions paid by the state. The total contribution for employees is 13.4% of the assessment base, which is represented by taxable income (i.e. gross wages). Employees pay 4% of taxable income to health insurance and 9.4% to social insurance (which includes sickness, pension, disability, and unemployment). There is a maximum threshold for employee contributions (except for health insurance) of seven times the average wage reported two years previously.

Employers pay 35.2% of the assessment base (employees' taxable income), with the highest rates for pension and health insurance. In addition to health and social insurance, employers contribute to accident insurance and to two funds administered by the Social Insurance Agency. The same maximum threshold applies as in the case of employees.

The list of social contributions paid by self-employed people slightly differs from that for employers and employees. The assessment base is defined as 67.3% of the average taxable income reported two years previously. There is a minimum assessment base, which amounts to 50% of the average taxable income reported two years previously.

Reduced rates apply to persons with disabilities (see note in Table 1).

Table 1: Design of social contributions in Slovakia (% of assessment base, February 2019)

Branch of social protection	Type of contributor			
	Employers	Employees	Self-employed	Voluntary contributors
Health insurance	10.5	4.0	14.0	n.a.
Sickness insurance	1.4	1.4	4.4	4.4
Pension insurance	14.0	4.0	18.0	18.0
Disability	3.0	3.0	6.0	6.0
Unemployment insurance	1.0	1.0	n.a.	2.0
Accident insurance	0.8	n.a.	n.a.	n.a.
Contributions to Reserve Fund	4.75	n.a	4.75	4.75
Contributions to Guarantee Fund	0.25	n.a.	n.a.	n.a.
Total amount	35.2	13.4	47.15	35.15

Note: Reduced rates of health insurance apply to persons with a disability (5% for employers, 2% for employees, and 7% for self-employed people); n.a.=not applicable.
Source: Author, based on the Slovak legislation.

In addition to the contribution rates described above, there are other financial resources that must be taken into account. The state pays health insurance contributions on behalf of several categories, including children, pensioners, parental benefit recipients, persons caring for children under 6, persons caring for relatives aged more than 80, jobseekers, and asylum-seekers. The contribution rate is defined by government decree on a yearly basis. In 2019, it equals 3.2% of the average wage reported two years ago. The state

also contributes to old-age and invalidity insurance on behalf of persons who care for children or disabled persons.[8] More concretely, the state covers contributions on behalf of insured employees and self-employed persons who receive maternity benefit, as well as on behalf of persons who care for children under 6 or for disabled children aged less than 18, for informal carers receiving attendance service benefit, and personal assistants of disabled persons. Furthermore, the state also pays contributions to the Reserve Fund.

Financing of social protection in Slovakia relies heavily on social contributions, which represented 68.2% of total financing in 2016. The largest proportion of receipts came from employer contributions (46.6%), employee contributions amounted to 17.3%, and contributions by self-employed persons amounted to 3.8%.[9] General government contributions added 28.9% to social protection receipts.[10] This division of financial resources differed from the picture in the EU as a whole, where general government contributions in 2016 had greater weight (40.4%) than contributions from employers (34.9%).

The relative weight of employer contributions in total social protection receipts was influenced by the crisis. Whereas in 2005 their share amounted to 46.4%, in 2009 it was 42.4% and in 2010 39.9%, which was the lowest value in the 2005-2016 period. In absolute terms, the volume of financial resources from employers stagnated during the crisis years. Its declining relative weight in total receipts was mirrored by the growing role of government. The share of general government contributions increased by 1 percentage point between 2008 and 2009, by 1.5 percentage points between 2009 and 2010, and by more than 8 percentage points between 2010 and 2011.[11]

In terms of sector of origin, financial resources come mainly from corporations (35.5% of total receipts in 2016) and central government (33.9%). While the role of regional and local government was rather minor (general state and local government contributions represented 5.8%), it increased significantly at the beginning of the 2000s as a result of the decentralisation process under which several key competences were transferred to regional and municipal level. In 2001, general state and local government contributions amounted to 1.3% of total social protection receipts. In 2002, they increased to 3% and they then jumped to 6.5% in 2003.

The mix of social protection financing varied across social protection functions (see Table 2). The old-age function relied on social contributions. In 2015,[12] these represented 50.6% of old-age funding. The largest share came from employer contributions (35.3%), followed by contributions from protected persons (12.6% from employees and 2.7% from self-employed people). Although the role of government revenues in old-age funding was limited (15.4%, compared with 19.8% in the EU as a whole), its relative weight increased during the period by 3.6 percentage points.

What made the financing of old-age measures in Slovakia really special was the importance of 'other receipts' which accounted for 34% of the total in 2015, far above the EU average (15.4%). This category includes in particular 'transfers from other schemes', which became significant after the reforms of the pension system in 2004-2005. The introduction of a so-called second pension pillar, based on mandatory pension savings in personal accounts, and redirecting part of the contributions to this second

[8] The contributions paid by the state are rather small, due to the smaller assessment base used for their calculation. The assessment base is defined as 60% of the average wage reported two years previously for persons caring for children and 50% of the average wage for persons caring for disabled persons.

[9] Payments from other benefit recipients (voluntary contributors) represented 0.6% of all receipts.

[10] General government contributions are financed through general revenues. Earmarked taxes don't play any role.

[11] The significant increase in the share of government contributions (as well as in the absolute volume of financial resources provided by government) between 2010 and 2011 can be explained by the time lag between the effects of the crisis and the implementation of social protection measures.

[12] The latest available data on financing structures by social protection functions refer to 2015. See Spasova and Ward, 2019: Annex ESSPROS tables.

pillar (managed by private pension management companies), created a deficit in the overall old-age insurance fund (financing the first pension pillar). The first pension pillar, funded on an ongoing 'pay-as-you-go' basis, is administered by Social Insurance Agency, which covers deficits in the first pillar using surpluses on other insurance funds[13] and by transfers from the state budget.

But the deficit in the pension system in Slovakia cannot be attributed solely to the launching of the second pillar. As the Council for Budget Responsibility pointed out (Porubský and Novysedlák, 2018: 11), the pension system would have generated a deficit irrespective of the existence of the second pillar, as a result of the system's parameters and socio-demographic processes.

The financing of the sickness/healthcare function was strongly oriented toward social contributions, which amounted to 70.7% of all financial resources in this branch in 2015. Employer contributions represented the most important part (44.9%). Receipts from employee social contributions amounted to 19.4%. This picture was very different from the rest of the EU, where the role played by social contributions was more limited: in the EU the share of employer contributions was significantly lower (21.8%). Conversely, the share of government revenues in the EU as a whole was much higher than in Slovakia (49.9% vs. 29.1% in 2015).

Unemployment benefits were predominantly financed through social contributions (82.8% in 2015), which mainly came from employers (53.6%). Employee contributions represented only just over half of the employer share (28.5%). The role of government revenues was limited (9%). Again, this profile of unemployment receipts differed from the EU average, in which government revenues had a greater weight (35.8%).

On the other hand, the financing patterns for the family/children function were similar to the EU average. Family benefits were funded mainly by general revenues (86.3% in Slovakia, 83.1% in the EU) in 2015, leaving limited room for social contributions (12.7% and 13.7%, respectively). But the share of employer contributions in Slovakia (5.9%) was lower than that in the EU as a whole (10.8%).

Table 2: Division of financing of social protection functions in Slovakia (%, 2015)

	Main sources			Sources of social contributions			
	Social contr.	Govt. revenue	Other receipts	Employers	Employees	Self-employed	Benefit recipients
Old-age	50.6	15.4	34.0	35.3	12.6	2.7	0.1
Healthcare/ sickness	70.7	29.1	0.2	44.9	19.4	5.0	1.5
Unemployment	82.8	9.1	8.1	53.6	28.5	0.5	0.2
Family/children	12.7	86.3	1.0	5.9	5.7	1.1	0.0
Disability	67.6	26.8	5.6	36.2	28.1	3.2	0.1
Survivors	41.1	6.5	52.3	25.4	13.5	2.2	0.1
Housing	0.0	100.0	0.0	-	-	-	-
Social exclusion	0.0	93.5	6.5	-	-	-	-

Source: Spasova and Ward (2019), Annex ESSPROS tables.

[13] In addition to pension insurance, the Slovak Insurance Agency administers sickness insurance, unemployment insurance, accident insurance, and the guarantee insurance.

2.2 Policy reforms and shifts

The evolution of social protection financing in Slovakia between 2005 and 2016 was marked by several policy shifts that influenced the way financial resources were collected and allocated. Some significant welfare state reforms took place before, and at the onset of, the period examined. Between 2002 and 2005 reforms of pension systems, the labour market, and tax policies were implemented, prompted by an effort to abandon 'state paternalism', increase the role of targeting, and emphasise the notion of 'deservingness' – framed by ideas concerning the role of individual merit and responsibility. This wave of reforms is sometimes called Slovakia's 'neoliberal turn' (Fisher et al., 2007).

In 2004, the current design of the social insurance system in Slovakia was established. Act461/2003, which came into force in January 2004, defined its content and organisation, as well as its financing. Contributions to old-age, invalidity, and survivor insurance, which initially formed one package, were divided, and separate contributions were redirected to separate funds.

At the beginning of the 2000s, the Slovak pension system was based on the pay-as-you-go principle. In 2005, it underwent a significant reform which established two pension programmes: (1) a defined-benefit, pay-as-you-go scheme (the first pillar), administered by the Social Insurance Agency; and (2) a funded defined-contribution scheme (the second pillar).[14] As a result, pension contributions were partially redirected to personal accounts managed by private companies. After the introduction of the funded scheme, around 60% of the economically active population decided to transfer a part of their pension contributions to their personal accounts. The deficit in the pension fund of the Social Insurance Agency was covered by surpluses out of other funds. After exhausting these resources (and transfers from privatisation), the deficit was covered by transfers from the state budget.

In 2012, another major reform of the pension system was adopted. Act 252/2012 focused on the parameters of the first pension pillar. It brought three major changes. Firstly, it changed the method of indexing the old-age pension. Until 2012, old-age pensions were indexed annually by reference to the arithmetic average of wage growth and inflation. Reform took place into two steps. In the period 2013-2017 the weighting within the indexation formula was shifted gradually from wages to consumer prices.[15] And starting from 2018, pensions were indexed by reference to consumer prices for pensioner households (their consumption basket) – so-called 'pensioner's inflation'. But it was also decided in 2017 that annual increases in the period 2018-2021 must be of a minimum of 2% (in order to compensate for 'too low' pensioner's inflation).

The 2012 reform also linked the retirement age to average life expectancy (men and women taken together), with automatic adjustments based on changes in 5-year averages of life expectancy at the applicable pensionable age. In line with the expected longevity gains, the pensionable age was expected to increase by approximately 50 days per year. The introduction of this change was postponed until 2017.

In 2018, ways to stop the retirement age increasing, and fix it at a certain level, were widely discussed. Two coalition political parties expressed their intention to fix the retirement age at 64.[16] Due to an absence of consensus across the political parties, no final proposal has been adopted yet. The Institute for Financial Policy points out that Slovakia is the last Visegrad country that hasn't adopted such a measure.[17] On the other hand, the Institute warns that introducing a ceiling on the retirement age will require

[14] In addition, there is a voluntary supplementary pension scheme in Slovakia.

[15] The explanatory memorandum to the law explained this as a mechanism to partially reduce the differences between low and high pensions.

[16] https://spectator.sme.sk/c/20836808/smer-wants-retirement-age-capped-at-64-years.html.

[17] Institute for Financial Policy (2018): *Šedivieme pomalšie*.

reform of the pension system in order to compensate for the potentially negative effects on its sustainability.

The third change was related to contribution rates for the second pillar. From 2012, the contribution rate for the second pillar was cut from 9% to 4% of gross wages. As result, the ratio of contributions paid to the first and second pillar has changed: while prior 2012 both pillars absorbed 9 % of gross wage, after 2012 it was 14 % for the first and 4 % for the second pillar. Since 2017, the contribute rate for the second pillar has started to increase automatically, each year by 0.25%. As result, the rate for the second pillar amounts to 4.75% and 13.25% for the first pillar in 2019. The aim is for the process to continue until the second-pillar rate reaches 6%, and the first-pillar rate 12%).

The 2002-2005 reform wave also included the 2004 healthcare reform. This entailed, inter alia, budgetary constraints aimed at a more effective utilisation of resources, as well as 'a decentralised and contractual system of health service provision' (which 'transferred responsibility form the state to the patient, health insurance companies, and providers.') (Smatana et al., 2016: 24). More specifically, there were several elements of the reform that were relevant in terms of social protection financing, including opening up the possibility of user fees, tying state payments on behalf of economically inactive insured persons to the average wage, and transforming (some) hospitals into joint stock companies.[18]

As regards the financing of sickness insurance, a gradual increase in the maximum thresholds (ceilings) for contribution payments is noteworthy. Between 2005 and 2012, the ceiling was defined as 1.5 times the average monthly wage (reported two years previously). In the period 2013-2016 it was increased to 5 times the average monthly wage. The last increase came into force in January 2017, and the ceiling now represents 7 times the average monthly wage.

Sickness insurance is important for the parents of newly born children, as it defines the conditions and scope of maternity benefit. The latter underwent reforms that have attracted an increasing number of fathers to claim it. From 2003, fathers who had paid contributions for at least 270 days in the two years preceding the birth were entitled to maternity benefit. The length of a father's entitlement was shorter than that of the mother. Parents could receive the benefit consecutively, not simultaneously. Despite this, interest in claiming maternity benefit was weak among fathers, as Table 2 shows. The number of fathers receiving the benefit grew in response to increases in the level of the benefit, which is defined as a percentage of the assessment base. In 2011, the previous rate (55%) was increased to 60%. One year later, it rose to 65%. From January 2016 it jumped to 70%, with the further rise to 75% in 2017. As result, the number of fathers and their share in the total number of recipients increased between 2012 and 2016.

The growing involvement of fathers in maternity benefit schemes could affect the level of social protection expenditure. Fathers entering the scheme earn, on average, higher wages, and thus receive a higher level of maternity benefit (though there is a maximum threshold of double the national average gross wage). Increasing the maternity benefit level above 65% attracted higher earners to interrupt their work career and take part in childcare and bringing up children.

[18] For a longer list of the key elements of the 2004 healthcare reform, see Smatana et al. (2016: 25).

Table 3: Maternity benefit in Slovakia – key characteristics, 2012-2016

	2012	2013	2014	2015	2016
Total number of claimants of maternity benefit	59,548	58,223	57,597	59,383	63,937
Number of men receiving maternity benefit	222	314	717	1,731	3,079
Share of men receiving maternity benefit (%)	0.37	0.46	0.89	2.69	4.43
Women's average time in weeks in receipt of maternity benefit	34	34	34	34	34
Men's average time in weeks in receipt of maternity benefit	28	28	28	28	28

Source: Eurofound (https://www.eurofound.europa.eu/publications/article/2017/slovakia-incentives-for-men-to-take-time-off-work-for-family-life).

The process of decentralising power played a role in changing the structure of social protection financing. As mentioned above, the fact that a number of competences were transferred to regional and local government level led to an increase in the share of local government contributions at the beginning of the 2000s (Statistical Office of the Slovak Republic, 2019). There were several stages of the decentralisation process, which had begun in the early 1990s. But it was only in 2002-2004 that competences were shifted from the state administration to the higher territorial units (responsibility for secondary schools, social issues, culture, etc.) and local government (transport, community care, some parts of educational system, etc.).

This process was accompanied by fiscal decentralisation, which started in 2005. Whereas municipalities were originally financed mainly by transfers from the state budget, fiscal decentralisation meant taxes became their main source of revenue. In the period 2005-2012, municipalities received 70.3% of their revenues from personal income taxes, 23.5% from higher territorial units, and 6.2% from the state budget. After 2016, the state no longer received any of the proceeds of personal income taxes, which were divided between municipalities (70%) and higher territorial units (30%).

One of the measures with a strong potential to affect the level and structure of social protection financing is Act 493/2011 on fiscal responsibility. This created a regulatory framework designed to enhance the long-term sustainability of public finances in Slovakia. Based on it, the Council for Budget Responsibility was established with the aim of monitoring compliance with fiscal responsibility (and fiscal transparency) rules. Social protection financing is potentially affected by one of the rules, which sets the gross debt limit at 50% of GDP (after 60% during a transitional period).

3 Strengths and weaknesses of the existing mix of financing options and potential future sources of financing – national debate on the topic

When identifying the strengths and weaknesses of existing and potential future sources of finance for social protection, we rely heavily on the results of the systematic review of public expenditure carried out by the Value for Money Unit at the Ministry of Finance.[19] This analytical unit has prepared – in co-operation with analytical units at other ministries – a series of reviews that identify the main challenges related to the effectiveness of expenditure (and financing) in various areas. The results of such exercises have enriched the public debate and contributed to focusing attention on the effective use of public resources and on better-quality public interventions.

Starting with a general assessment, according to the Council for Budget Responsibility (2018: 4), expenditure sensitive to demographic changes worsened fiscal sustainability by 0.5% of GDP between 2016 and 2017. The most negative impact was produced by increasing expenditure on healthcare and long-term care (0.8%), which was mitigated by decreasing expenditure on pensions. The Council argued that there was an urgent need for structural changes in areas that were sensitive to population ageing and related developments, in order to achieve the long-term sustainability of public finances in Slovakia. This applied to both old-age and healthcare spending, which account for the largest shares of expenditure and receipts.

The pension system has undergone several reforms which have affected the level and structure of expenditure as well as its financing. The latest changes in the pension system have increased its distributional fairness for pensioners and increased pension adequacy (European Commission, 2018: 18). On the other hand, the minimum annual pension increases of 2% approved for 2018-2021 will increase the deficit in the pension system and undermine its long-term sustainability (ibid.). That measure was criticised on several grounds (Porubský and Novysedlák, 2017). Critics pointed out that the measure was not part of a systematic change, and also that it was not necessary – because indexation based on pensioner inflation secures purchasing power of pensions. Furthermore, although this step was aimed at compensating for periods of low pensioner inflation, in fact it increases the long-term costs of indexation. According to the experts from the Council for Budget Responsibility (Porubský and Novysedlák, 2017: 5), it will increase the costs of indexation by 20%, compared with 'standard' inflation.

According to the Council for Budget Responsibility (2018: 7), the measures adopted on healthcare may have a more significant impact on the long-term sustainability of public finances than demographic changes. According to the report published by the Value for Money Unit at the Ministry of Finance (2017), although health/sickness spending as a share in GDP in Slovakia is higher than the average of three neighbouring countries (Czech Republic, Poland, and Hungary), the Slovakian healthcare system produces worse results and is less efficient. The expenditure review resulted in several proposed new policy measures, and it identified sources of cost savings that could cover part of the costs of implementing them. The costs of all the proposed measures amounted to EUR 180 million for the year 2019. Policies aimed at improving the quality and accessibility of healthcare will cost EUR 87 million in 2019. With regard to social protection financing, two measures are noteworthy: an increase in wages for non-medical staff in the healthcare system, and 'stratification' of public hospitals aimed at improving their quality and the effectiveness of the whole system of institutional healthcare. In addition, there are other proposed measures affecting the level and structure of expenditure, including an extension of the limit for co-payments for pharmaceuticals, and an increase in allowances for night work or weekend work, or work during the holidays. The costs of 'other' measures amounted to EUR 97 million.

[19] The unit was established with the aim of reviewing government expenditure and contributing to improvements in its effectiveness (https://www.finance.gov.sk/en/finance/value-money/about-value-money).

In order to cover part of the costs of these proposals, the review recommended measures with expected savings of EUR 137 million – focusing, for example, on overconsumption of pharmaceuticals, price referencing of medical durables, and cost optimisation in public hospitals.

These recommendations and proposals address long-term problems of the Slovak healthcare system. The level of healthcare expenditure and source of financing (social contributions) are not seen as a problem. Instead, attention is paid to the overall effectiveness and structure of expenditure.

The Value for Money Unit has also prepared a review of expenditure on social exclusion and poverty reduction (Ministry of Finance, 2019), focusing on a range of policy areas (including education, family policy, the minimum-income scheme, and social work). Although total public expenditure on people at risk of poverty or social exclusion represented 0.51% of GDP (approximately EUR 436 million) in 2016, 29% of the relevant finance came from EU funds and co-financing. The review pointed to several challenges in the effectiveness of social inclusion policies.

The largest share of the social inclusion budget in 2017 (85%) was absorbed by employment services and social protection. The review showed that jobseekers receiving minimum-income support have significantly fewer chances to participate in active labour market policy measures, compared with other jobseekers. The most deprived persons have to rely on 'activation works' which, however, doesn't lead to an improvement in skills and motivation.[20]

The inadequacy of the minimum-income scheme has been confirmed repeatedly (see for example Gerbery - Miklošovič, 2018). Its low level, in combination with an in-work benefit (special allowance), is expected to motivate recipients to leave the system and enter the labour market. However, the short period of the special allowance (12 months) may not lead to financial stability and independence, as the most of recipients earn low wages.

As regards the minimum-income scheme, the review confirmed the well known fact that the scheme's sensitivity to (and adequacy in meeting) the needs of families with children is low. Child benefit mitigates this effect only to a limited extent.

Furthermore, there is low coverage by policy measures in the area of social inclusion in the educational system. While spending on social inclusion represented 14% of total expenditure, less than half of children at risk of poverty receive the support concerned (Ministry of Finance, 2019: 7). For example, only 37% of children at risk of poverty in kindergartens, and 48% of those in primary schools, benefited from subsidies for food, which are intended to help children from low-income families. Similarly, subsidies for school supplies only reached 38% of pupils in primary schools.

Among other shortcomings of the educational system, there is low participation by children from families receiving minimum-income support, and those from marginalised Roma communities, in pre-school education. There is also too high a share of children from Roma communities in so-called 'special schools' which focus on children in need of special treatment and assistance.

Based on the data and findings mentioned in this report, the following recommendations are put forward.

The process of reviewing public expenditure should be continued. It has proved to be an important method for identifying the challenges to, and gaps in, public policies.

Steps should be taken to ensure that efforts to increase the adequacy and fairness of the pension system are not in conflict with the aim of long-term stability.

[20] Other empirical analyses also confirmed that activation works don't increase the chances of entering the labour market. For a review, see Gerbery (2018).

A discussion should be opened on the design of long-term care and its role within the systems of healthcare and social policy.

Steps should be taken to improve the effective use of public resources in the area of social inclusion, including support schemes for pupils and children in kindergartens.

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