

UNIVERZITA PAVLA JOZEFA ŠAFÁRIKA V KOŠICIACH

**PUBLIC ADMINISTRATION  
AS A PROVIDER OF PUBLIC SERVICES  
OF A SOCIAL STATE  
- UTILISING FOREIGN EXPERIENCE  
FOR REFORMS IN THE SLOVAK REPUBLIC**

**Stanislav Konečný**



**Fakulta verejnej správy**

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**PAVOL JOZEF ŠAFÁRIK UNIVERSITY IN KOŠICE**  
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**Stanislav Konečný**

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## Introduction

The topic of our research task of the same name VEGA 1/0757/17 was based on the question – and was likewise defined in its approved project – how public administration as one of the providers of public services can act as efficiently as possible in favour of making these services available from the aspect (place of permanent residence) of the citizen. This can be done with a certain optimality in the structure of public administration, primarily at the local, but also at the supra-local, e.g. regional, level. If, for example, the settlement structure is too disintegrated, or conversely the regional structure is too aggregated (or even too fragmented), various alternative solutions must be sought that are rational and optimal for satisfying citizens and that will not waste public resources. In this, it is also questionable how the system of state administration authorities and local government authorities is reflected in this structure (in the case of known differences in their operation in both these regimes, or in a regime of delegated performance of state administration), including the conditions of funding these services as public services.

This level of the issue relates not just to competences in the field of social assistance, as sometimes emphasised in Slovakia, but relates to all competences that the state delegates to local government. The delegation of competences means not just the amendment of a law, but also creating conditions for its efficient application for which it is necessary that municipalities or regions perform delegated competences for a certain territory (e.g. for an appropriate number of inhabitants) (Bodnárová - Džambazovič 2011, pp. 20-21), or as M. Jílek (2008, p. 39) writes “an optimal number of citizens of a territorial self-government authority for a given quantity of goods provided will be determined by the maximum positive difference between total utility from consumption per person and total costs for providing the goods per person”. The requirement that municipalities and regions have available a public services infrastructure (Dušek 2016) must thus be confronted with certain capacity possibilities and efficiently and appropriately assessed by the need for various public services in relation to the territorial unit for which the infrastructure is to provide these services.

In terms of economic decentralisation, or fiscal federalism, this concerns the well-known Oates decentralisation theorem, according to which any public service should be

provided by a unit governing the smallest possible geographical area in which the costs and utility of the provided service can be internalised (Oates 1999), whereby the author very clearly highlighted the efficiency limits of decentralisation. This was something that was largely disregarded in Slovakia and surrounding countries at the start of the 1990s, with political arguments dominating (to bring the exercise of public power closer to the citizen).

It would thus be possible by means of economic modelling to determine normatively the most suitable size of units for each kind of public service, assuming that for various public services we would arrive at different sizes of these units for different public services – in the end some optimising compromise would still have to be found in order for there to be a meaningful, but in particular, realistic and applicable structure of these units in practice. We chose a different, non-normative approach, an empirical and analytical approach, characteristic (together with a comparison method) for public policy theory. It is based in general on the fact that we compared actually existing units operating as public service providers in various countries, and in this comparison we attempted to identify the limits of their efficient functionality. The benefit of this approach, in contrast to the previous normative approach, is that the solution offered is tangibly available in existing practice and is not simply a theoretical (calculated) concept.

# **1 ANALYSIS METHODOLOGY**

As was clear from the above considerations, it was necessary to create a two-dimensional matrix of methodological criteria for selecting units that can be compared and which must be adequately defined both in the dimension of public administration institutions, and in the dimension of the range of public services. Without sufficient preparation, the comparison could slip easily either into two general conclusions, or easily questionable conclusions.

## **1.1 Operationalisation of sets of public administration**

International comparisons that are meant to focus on the utilisation of their results in a certain country are methodologically demanding. First of all, it is necessary to choose for the comparison set (i.e. samples of compared countries) actually those countries whose overall societal system (form of state, establishment, structure of authorities, territorial breakdown, etc.), and often a very large set of other features makes it possible to reasonably assume that the state, which will be the hypothetical recipient of recommendations arising from this comparison, will adopt these recommendations, and not react as a living organism that immunologically defends itself against any unsuitable implants.

In the framework of this step, it is particularly necessary, in the case of comparisons concerning systems of public administration, to carefully consider the characteristics of its structure in the countries compared. In doing so it is far from sufficient to mechanically rely on generally accepted standards, rather it is necessary to consider the need to modify them in terms of the content that is to be compared.

### **1.1.1 Compared structures of public administration**

In Slovak (and in general also European) literature the standardised classification of territorial units in the Eurostat methodology is commonly used as the starting base for

interregional comparisons. An advantage in such comparisons is primarily the availability of formally compatible databases, but on the other hand a limitation here derives from the fact that NUTS units and LAU units are sometimes economic-statistical constructs, and do not always correspond to historically formed territorial structures, but rather the (original) territorial breakdown of states.

Already NUTS 1, which are intended to include areas with 3 – 7 million inhabitants encompass in some cases the territories of entire states, in other cases a state's territory is covered by a number of units of this level, etc., which causes some difficulties in assessing the appropriateness of competences of the authorities governing units at this level, particularly where this concerns comparisons in issues that are not directly related to economic development, or the infrastructure of the territorial units concerned. The same is true also for other levels. In terms of territorial area, a Polish district (*powiat*) is 5-6 times smaller than that of a Czech or Slovak self-governing county (*samosprávny kraj*) and, from the aspect of the number of inhabitants, the multiple number is even much greater; and although Hungarian counties (*megye*) are smaller than the Czech or Slovak regions, they are still approximately four times larger than the Polish *powiats* – though in all cases this concerns the NUTS 3. The possibility to include in the comparison as a representative of the Polish regions (*województwo*) is tempting, though in the EU methodology these are included at the NUTS 2 level, and in other cases also in NUTS 4 units (the former LAU 1). Thus, for some comparisons, this heterogeneity of comparing units with various adherents to the standardised classification of territorial units in the Eurostat methodology can rather be an advantage, even though it brings problems in terms of the availability of comparable data.

With different definitions of NUTS 2 to NUTS 4 for areas, counties and districts, it is possible to use for the purposes of a comparison that NUTS level that is comparable not just in terms of quantitative parameters, but for example also in terms of the scope of competence of public authorities at the given level, in consequence of which it is possible to obtain more precise and, in particular, more realistic results, when we compare sometimes, for example, NUTS 3 in one country with NUTS 2 or maybe NUTS 4 in a different country.

In the case of the basic level – the level of municipalities – this variability of solution is not possible. Until 2017, there were two levels of LAU. LAU 1 (formerly NUTS 4) was applied in most, but not all, European Union countries. The lower level of LAU 2 (formerly NUTS 5) was defined for the level of municipalities or other equivalent units in all Member States of the European Union. This definition of “equivalent units” was already very vague, resulting in considerable heterogeneity of the LAU 2 units, and making almost impossible, for example, any comparison whatsoever between countries having a consolidated settlement structure and countries having a fragmented settlement structure.

The situation, in our view, changed for the worse after 2017, when only the one LAU level was retained, where the units were defined (1) as administrative units; (2) as parts of NUTS 3 regions; and (3) as units suitable for constructing local typologies. The nature of these criteria varies considerably, and not just Eurostat, but also individual countries quite often change the content of the LAU category, so Eurostat ultimately differentiates NUTS by size (surface area) and by the number of inhabitants, which, while important, is wholly insufficient for the purposes of comparison (<https://ec.europa.eu/eurostat>). The current Eurostat methodology thus mixes not just municipalities that are consolidated multi-thousand administrative municipalities (Swedish *kommunen*, Polish *gminas*, etc.) with fragmented Slovak municipalities, or Hungarian *települes*, but against the preceding status the methodology also adds to them in the joint category the municipalities that are *de facto* “municipalities of municipalities”, i.e. associations of municipalities (German *Landkreisen*, Bulgarian *obštiny*, etc.) with units in countries where, due to industrial-urban development, the original municipalities have disappeared, and public administration actually starts at the regional level (single-tier local government in England, etc.). Thus, in statistics the same “municipality”, or LAU unit, becomes a 60 000 municipality in Denmark alongside a single-digit population in Slovakia or France.

The decisive argument for our decision to attempt an alternative comparison is that all these levels of regional government exist in all comparable V4 countries contain regular administrative - more frequently self-governing authorities, which in principle differentiate from the criterial definition of NUTS regions. Our comparisons are based on a comparison of

the competences of authorities performing public administration at the regional level according to the territorial breakdown of public administration in the given state. It is obvious that we will not achieve here any homogenous and directly internationally comparable structure: on the one or at a comparable level we find either (decentralised) state administration authorities or regional (local) government authorities, which may differ not only in terms of their legitimacy, but also in terms of their competences, which can generally be characterised as the entitlement of public administration authorities to administer a particular substantive area<sup>1</sup>. From our point of view, however, it is not so decisive whether the authority in charge of, for example, establishing providers of any of the social services (school, health, social) is a state administration authority or local government authority, or whether it is a local government competence or delegated competence, but rather to how large a territorial unit the exercise of this competence relates.

Indeed, it appears that quantitative criteria (in particular number of inhabitants and territorial area), characterising the size of administrative regions, are of some importance in terms of the efficiency with which authorities operating in these regions provide public services. Consequently, this should (and could) also be reflected in the entitlement of these authorities to exercise the role of founder for organisations providing various public services. There are several examples where European countries have considered within what boundaries territorial units will be constituted in order that their quantitative parameters are proportionate to the competences that they are to perform precisely in terms of public services.

Sweden could serve as an example here, which after two waves of local government amalgamation in the 1950s and 1970s achieved an average municipality (*kommunen*) size of approximately 35 000 inhabitants, however though it decided not to entrust these local government units with founder competences in relation to hospitals, but, actually almost solely for this competence, created counties (*lan*) with approximately a million inhabitants on

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<sup>1</sup> Competences, i.e. powers and competences, performed by regional self-government authorities, can then be divided into “original”, i.e. self-governing (*zadania własne, saját feladata, samostatná pôsobnosť, samosprávna pôsobnosť*) and “delegated”, i.e. entrusted (*zadanie zlecone - powierzone, kihelyezett feladata, přenesená pôsobnosť, prenesená pôsobnosť*). In the case of both types of competences, though, they may be defined differently in terms of their specific scope, or even to their overlapping, as is the case of joint exercise of state administration and self-government in the Czech Republic. This is another fact we will mostly avoid.

average: with public health services accounting for 80% of all competences of *lans* (Popescu Ljungholm 2014, Konečný 2016). In a way, an example of the efforts to achieve an efficient structure of public administration proportionate to its competences is the Polish reform from the 1990s, in which a two-tier local government, comprising 49 *województwos* (with 268 deconcentrates at the level of district authorities) and 3157 towns and municipalities, was replaced by a three-tier local government with 16 *województwos*, 314 districts and 2477 administrative municipalities - *gminas* (Chojnicki - Czyż 2000, Kraś 2006). Ultimately this characteristic can also be attributed to the Hungarian reform of recent years, even though this is being done at the expense of self-governing authorities (Hajnal - Kádár - Kovács 2018).

In general, it should be true that regions, or in our context it is Slovakia, more precisely **higher territorial units** (similar to the Swedish *lans*), in contrast to lower territorial units are better placed to assess the needs for providing various public services across the given territory (including differences in the spatial characteristics of the services), and, based on this, to establish (or regulate the establishment of) a corresponding volume of services provided, and their spread throughout the region. Generally speaking, it may be said that the territorial broader and greater staffed the framework the given public service has available, the higher the level of public administration is to be delegated with the competence for establishing it, or for deciding on its provider, even if this rule may have exceptions. In the case of specialised public services, it should be borne in mind that it would not be efficient to address their establishment from a lower level of public administration, but it is again necessary to consider how much should be entrusted to authorities at the level of regions, and how much to central authorities, while fully respecting the principle of subsidiarity.

The starting point of our comparison at the basic level of public administration remained also in Slovakia the **municipality** (*obec*) as the basic territorial unit, as it is defined in the relevant legislation in the given country. However, given the content of competences being compared, and which are carried out by the municipalities thus defined, we must take into consideration whether these roles in the given country are not performed also by units “within” municipalities (at the municipal supra-level – such as in Poland the *sołectvos*, similarly such as in Bulgaria the *kmetstvos*, etc.), or whether these roles are not carried out by

public law entities at a supra-municipal level (second and third type municipalities or associations of municipalities in the Czech Republic, similarly as the *Lankreisen* in Germany, etc.). The criterion for including such an intra-municipal or supra-municipal unit in our comparison is that an officially installed (for example legally elected) self-governing authority exists in this unit, and that certain tasks from among those we are comparing are entrusted to such unit. This altogether is a distinction that the Eurostat methodology does not reflect, which in turn sometimes causes a lack of statistical data for the monitored and compared units defined in this way. Only in relation to these units, carrying out certain tasks in providing public services, does it make sense to assess whether the spatial perimeter, but in particular the number of inhabitants falling under the public administration authority in the given area, is appropriate and efficient.

Also in the V4 countries, with all the diversity of public services structure and systems, and with all the diversities of systems of territorial, i.e. regional and local public administration, we notice at least partially, with greater or lesser success, attempts made at such an approach. In the study presented, we have tried to capture the current state of this issue, and indicate certain starting points that could be one of the arguments in optimising the structure of public administration authorities in terms of their competences in relation to the provision of public services in the Slovak Republic.

### 1.1.2 Countries compared

There are actually two questions: size of the sample of the countries compared and its structure (composition), which are though interrelated. Of course, the multitude of the sample makes it possible to achieve a higher universal predicative value of the comparison results against a basic set, though in our case the emphasis does not lie in fulfilling this criterion. Given the selected country in which the results of the comparison can be used, which in our case is Slovakia, this criterion becomes proximity (affinity) to the nature of public administration.

A suitable country for this comparison is clearly the **Czech Republic**. Decades of joint formation of public administration are a strong factor, as is the continuing fragmentation of the

settlement structure at the basic level of public administration, which though at least the Czech Republic has partially overcome by its internal type distinction, but this could represent a certain model of diachronic comparison for the case of such a future solution for communal reform in the Slovak Republic. On the other hand, there is a fundamental difference in the arrangement of the internal structure of public administration, especially in the dimension of state administration – self government, where in the Czech Republic they have chosen a model of combined performance, whereas in the Slovak Republic a dual model has been applied.

Fragmentation of the basic level of public administration is a reality also in another country, which, for reasons of certain common traditions and development of public administration, came into consideration, namely **Hungary**. Here we also considered a common criterion of the state administration – self-government relations, but also an element of paradigms change in these relations, when in the past decade public administration in Hungary has been re-centralisation of public administration, particularly in the field of the core of the compared issue, i.e. in the field of public services provision by public administration entities.

For similar reasons of a certain mutual historical (albeit more distant) tradition there came into consideration also the **Republic of Austria**, though on the other hand its inclusion in the comparisons set was complicated not only by very recent historical development, but also the federal nature of the unitary arrangement of public authority, which in comparison with the unitary nature of Slovakia, as well as other surrounding states, would probably multiply question marks in any comparison of competences, while additionally being complicated by the different structure of public administration in those federal countries, which underwent, or did not undergo consolidation of the settlement structure in the 1970s, which is still today reflected in the structure of public services providers in the various parts of Austria (cf. Konečný 2004b).

In order to maintain a certain greater number and thereby also certain broader comparability, we decided to include as the fourth country in the sample (the third besides Slovakia) also the **Republic of Poland**, which likewise is a unitary state. Its specific four-tier public administration, with two tiers between the local and central level makes it possible to

perceive the specific feature of “major” and “minor” units of regional self-government from the aspect of the suitability of allocating certain competences in the provision of public services. Poland, as the only one of the countries compared, has a nationwide (and not as in the case of Austria, only partially) consolidated settlement structure from the aspect of the lowest level of public administration performance (furthermore while maintaining the existence of certain sub- communal structures) elements of sub- communal structure), which makes it possible to compare the provision of public services at the local level in the conditions of a consolidated and fragmented settlement structure.

The result is the **choice of the Visegrad Group (V4)** – the Czech Republic, the Republic of Poland, Hungary and the Slovak Republic – as the sample in which the comparison of the provision of public services by public administration subjects will be made.

### 1.1.3 Compared units of public administration

Even though right in the conclusion to part 1.1.1 we stated generally that our comparison will cover horizontally two levels – the level of municipalities and the level of regions – in the context of the choice of sample of compared countries, it is again necessary to analyse in greater detail which units of public administration in these four compared countries we have available at the level of municipalities and which at the level of regions, and what their parameters are.

For our approach, it is therefore characteristic that we are not primarily comparing municipalities or regions, rather we are primarily comparing competences carried out by local government authorities with the fact that the result should be a certain (at least partial) evaluation of whether the existing structure (e.g. size) of various types of municipalities corresponds to what competences are exercised within them. Likewise, we are not primarily comparing regions, rather we are primarily comparing competences performed by regional administration authorities, where the outcome should be a certain (at least partial) evaluation of whether the existing structure (e.g. size) of various types of region corresponds to what competences are exercised within them.

Table 1 Basic features of municipalities of the V4 countries

state	municipalities	number	average number of inhabitants	average area km <sup>2</sup>
Poland	<i>gminas</i>	2484	15510	20
	<i>jednostki pomocnicze</i>	57000	676	5
Czech Republic	type 1 municipality	6254	1680	13
	type 2 municipality	383	27520	210
	type 3 municipality	206	51195	383
	associations of municipalities*	710	14845	111
Hungary	<i>település</i>	3198	3077	29
Slovak Republic	municipalities ( <i>obce</i> )	2933	1851	17

\* In 2014, 5 398, i.e. 86.3% of municipalities were incorporated in associations of municipalities (Souhrnná 2014, p. 77). The data in the row is estimated. Source: own processing

We also included certain characteristics of intra-regional institutional infrastructure as a supplementary criterion of the organisational frameworks of our comparison. The differences here between three of the four V4 countries are only minimal, as a result of their related historical development and absence of consolidation communal reform (which in Hungary and in the Czech Republic have been resolved by differentiating municipalities by type) – while in Poland consolidated *gminas* represent a completely different capacity level. This fact must also be taken into account when comparing the competences and tasks that regional self-government fulfils: there are differences in what potential the level that is one stage lower than regional self-government has at its disposal. It is this criterion that leads us to consider the *województwos* to be the primary comparison unit for Poland in our comparison.

In other countries, for the sake of completeness, it is also necessary to state information also concerning the level of public administration lower than the regional level, whether this is state administration (in Hungary and Slovakia) or bodies of the joint execution of state

administration and self-government (in the Czech Republic), whereby in all four countries we reach a comparison at two supra-municipal, regional or sub-regional levels:

Table 2 Basic features of the V4 countries

state	region	NUTS classification	number	average number of inhabitants ('000)	average area km <sup>2</sup>	average number of municipalities	average size of municipality
Poland	<i>województwo</i> s	2	16	2408	19540	155	15510
	<i>powiat</i> s	3	380 <sup>2</sup>	123	1000	8	
Czech Republic	self-governing counties <sup>3</sup>	3	14	749	5630	447	1680
	type 2 <sup>4</sup> municipality		383	28	210	16	
Hungary	<i>megye</i> <sup>1</sup>	3	26	499	4650	123	1670
	<i>járás</i> <sup>5</sup>	LAU1	175	56	530	18	
Slovak Republic	self-governing counties	3	8	674	6130	361	1840
	districts <sup>5</sup>	LAU1	79	69	620	37	

Source: own processing

Simply by looking at this overview, we see considerable heterogeneity of national regional structure in the compared countries, which would be even more complicated if we were to extend it to include various other existing partial levels (in the Czech Republic type-3 municipalities and cohesion regions, in the Slovak Republic and in Hungary to include territorial districts of specialised local state administration, etc.). It is this heterogeneity that advises against attempts to directly compare regions outside the Eurostat methodology.

Despite the obvious limitations, particularly in terms of the availability of statistical data for the territorial units thus defined (which makes us often dependent on various secondary data), we consider our approach to be feasible.

2 314 districts and 66 towns with the standing of a district (town with district rights).

3 Regardless of the fact that Budapest has a different position than a megye and from the fact that Prague has a partially different position than the 13 self-governing counties.

4 In the Czech Republic, 76 districts correspond to an LAU1. Type-3 municipal authorities (municipalities with extended powers) operate in their territorial districts. In total 6258 type-1 municipalities correspond to the LAU2 level. No LAU unit corresponds to municipalities with delegated municipal offices (type-2).

5 State administration only.

## 1.2 Operationalisation of sets of public services

A similar situation may be found in terms of the selection of public services compared.

Without greatly extending our scope, let us begin with a general characterisation of services as a specific kind of goods (as a category indicated by utility), for which today there now applies the classic characteristic that they are predominantly immaterial, non-transferable, non-storable, their production and consumption take place at the same time, and unlike tangible goods (which can be measured and perceived quantitatively) they are evaluable primarily qualitatively (Hollins - Shinkins 2006, p. 8).

The European Union works with the concept of “services of general interest”, which it divides into services of general economic interest (governed by the provisions of the EC Treaty on the internal market and competition, which are subject to regulation) and non-economic services. Social services may be both economic and non-economic in nature: some of them are statutory and supplementary social security systems (including health), others are provided directly to the individual, usually they are organised at the local level, and mostly financed from public funds (e.g. social assistance services) (Commission 2007).

The statistical classification of public administration expenditure (COFOG) also uses the very broad category of general public services, which includes, *inter alia*, out-patient and institutional health care, education and social security (including social services in the framework of it), which is sometimes used in analyses of self-government authority expenditure (Sopkuliak 2016).

Similarly as in the case of the structure of public administration, their structure has again been formed historically, and therefore it is problematic to compare public services in countries where the need for them, and the forms of them, have been formed significantly differently. In support of this fact, it is sufficient to mention the differences in social services which, in the context of the Bismarck, Beveridge and Myrdal approach to social policy, have developed in different European countries and which are very difficult to compare across the boundaries of these approaches. In several countries, social services are also significantly

linked to health services, in others with school services (e.g. the United Kingdom in the field of mental health services).

Different models of the welfare state, though, exhibit different tendencies toward commercialisation of public services and their intersection with market-based services (Golinowska 2018, p. 95). Whatever concept of social policy is chosen, the state considers one of its tasks as being improving the quality of life of its citizens – and one of the possible ways is to develop the public services that the state provides to citizens. In doing so, it can provide them directly – by means of public administration bodies – but using capacities of the private (profit or non-profit) sector, for the development of which it creates the conditions (e.g. contracting out). It can provide them by various techniques – either by creating sufficient conditions for citizens to buy these services at their own discretion and needs, or by taking these funds from them in the form of taxes, etc., and offering them a certain range of services free or at non-market prices (fees). As a rule, this should be about balancing the conditions of the availability of various public services. Mostly this involves providing various public goods that do not result in ownership – so these public services are non-market in nature. On the other hand, there is a natural tendency toward introducing user charges for the provision of public services (which can sometimes be only of a registration nature), which then open doors to the market environment.

### 1.2.1 Compared public services

As indicated in the preceding lines, public services can be seen as important outputs from public sector activity, the founder and/or provider of which are directly public administration bodies: the mission of the public sector is “to ensure public goods for citizens and to remedy and eliminate other consequences of market failure” (Peková - Pilný - Jetmar 2005, p. 22). As a rule, (to a decisive extent) this task is delegated by the central bodies of the state to public entities of a state or self-government nature – to deconcentrates of the central bodies of state administration or to bodies of self-government, particularly territorial self-government. The degree of this transfer of performance differs across different fields of public services. Some, e.g. public transport, telecommunications services, etc., remain largely within the remit of central or regional authorities, because as predominantly material services they

restore or improve tangible goods, they are connected with the repair or maintenance of certain things and, rather, they indirectly satisfy human needs. Conversely, others are predominantly decentralised, since these are activities that are directly focused on a person, they directly concern a person, and thus directly satisfy that person's needs. For our comparison, therefore, it is these so-called personal services, provided as public services, that are much more suitable, and therefore, we will focus primarily on these public services in our comparison.

Most commonly there are included here social services, health services and education services – and less commonly (and with greater internal diversity) also cultural services, recreational services, etc.

**Social services** here lack a clear generally accepted definition, given the considerable diversity of social systems in Europe. Most commonly they are understood as either a form of social assistance provided through the action of state administration, self-government and non-governmental organisations in favour of another person, or (more narrowly) as social work in favour of people in social need. What, nevertheless, is essential here is the individualised nature of the services; therefore it is appropriate that they be designated also as personal social services (Filipová 2011, pp. 109 – 110). The European Commission defines social services as “services aimed at individuals whose purpose is to meet basic human needs, in particular the needs of users of this service in a vulnerable position; they provide protection against both general and special life risks and help with personal problems or crises; they are also provided to families in the context of a changing family model, they support the role of the family in caring for their younger and older members as well as disabled people, and offset any shortcomings in families; they are a key tool for protecting fundamental human rights and human dignity” (Commission 2007).

**Public services in education** include as basic services the provision of education (preschool, primary, secondary and tertiary), as well as related scientific-research services, and sometimes also complementary services (catering, accommodation, library services, etc.) (Benčo 2005). Primary education services are particularly appropriate for comparison, and in terms of their scope, particularly services providing primary and secondary education, which

are standard in the countries compared. There is also here, thanks to the ISCED methodology, a relatively good situation in defining the units in which the provision of this kind of public service by various levels of public administration can be monitored.

Public services **in the field of health care** we consider to be the provision of health care which, similarly as in the case of social services, may be very differentiated in form, which may vary from country to country, as European Union bodies have stated: “EU healthcare systems are diverse and reflect different societal decisions” (Council 2006). In general, however, this includes outpatient offices and clinics of general (family) doctors (doctors of first contact) and specialist doctors, polyclinics, hospitals of various types and levels, but also pharmacies, treatment institutions, laboratories, research workplaces, hygiene service, patient transport, etc.

### 1.2.2 Compared units of public services

In addition to the complexity in defining comparable territorial units, as discussed above, problems also arise in defining comparable units of different public services. While their classification is methodologically unified, this is though only at a high level of aggregation. General comparisons are interesting, yet their benefit is somewhat theoretical, since they do not provide starting points for practical decision-making on the efficiency of public services defined in an *en bloc* manner. According to an analysis of public services in the European Union and in its 27 Member States, which was recently published by the European Commission, municipalities in Poland provide primary education and basic social services; in Hungary municipalities provide primary education and elderly care; in the Czech Republic local authorities provide hospital and healthcare services, as well as primary and secondary education; and in the Slovak Republic municipalities provide primary education and elderly care (Bauby - Similie 2010): the categories “basic social services”, “elderly care” etc. may here cover significantly different specific services. For example, the care service is in some places more linked to nursing services, primary schooling is broken down differently, and there is not always a distinction between, for example, fully-organised schools and so-called small-class-sized schools, and even primary health care can sometimes include also doctors for children and youth explicitly, and sometimes not. These differences are, as a rule,

enshrined also in the basic regulations of administrative substantive law of the given country. Even the type of public services, such as elderly care, is in national legislation defined differently, and also the capacity of its various specific forms can also vary widely.

The definitional and organisational competence of public administration authorities in the area of the selected public services is thus presented at an aggregate level that is difficult to compare analytically. We therefore looked more for partial forms that occur the most often and that are actually provided, if not at the municipal level, then at the level closest to municipalities and their inhabitants, or similarly at a comparable regional level. Given these differences, which are reflected in statistics in the form of aggregated data, we attempted to find data whose material content overlapped as much as possible with the definition of the monitored and compared public services in the field of education, health and social services, in a profile in which they are provided at the municipal and regional, or similar area in Slovakia. A reason for this is also the profile of the VEGA task forming the framework of this study, which wants to bring foreign experience in the provision of public services by public administration authorities to Slovakia and for Slovakia.

Here, too, however it applies that this statement is at a highly aggregated level of public services, and what applies at this level need not always apply for all forms of public services within the same category (e.g. the preschool education level is defined quite differently across these countries, making direct comparison difficult). Therefore, we focused our attention on the selected types of health care, social and education services, in the case of which the difference in terminology and difference in the sectoral classifications are minimal. The one exception is the education (schools) system, where the International Standard Classification of Education (ISCED) has been in place since the 1970s, and which was last updated in 2011. On the other hand, it is not quite possible to expect complete conformity of all parameters of any public service in different countries: rather, this concerns conformity of type.

Finally, it is also important to take into account whether in a given country the public sector is indeed involved in the given segment of public services, either as their founder, or as one of their implementers. Here too, however, over-aggregation within categories does not

deliver a greater effect than just an overview, as we see, for example, in the analysis of public services in the European Union and its 27 Member States, which was recently published by the European Commission:

Table 3 Types of providers of selected public services by ownership sector and national-regional criterion

	national public provider	national mixed providers (majority of public share)	subnational public providers	subnational mixed provider (majority of shares)	mixed providers (majority of private shares)	private providers
PL			<ul style="list-style-type: none"> <li>● public health care</li> <li>● primary and secondary education</li> <li>● elderly care</li> </ul>			<ul style="list-style-type: none"> <li>● primary and secondary education</li> <li>● hospital health services</li> <li>● elderly care</li> </ul>
H	<ul style="list-style-type: none"> <li>● hospital health services</li> </ul>		<ul style="list-style-type: none"> <li>● hospital health services</li> </ul>			<ul style="list-style-type: none"> <li>● hospital health services</li> <li>● primary and secondary education</li> </ul>
CZ	<ul style="list-style-type: none"> <li>● primary and secondary education</li> </ul>					<ul style="list-style-type: none"> <li>● primary and secondary education</li> </ul>
SK	<ul style="list-style-type: none"> <li>● hospital health services</li> </ul>		<ul style="list-style-type: none"> <li>● primary and secondary education</li> <li>● elderly care</li> </ul>			<ul style="list-style-type: none"> <li>● hospital health services</li> <li>● primary and secondary education</li> <li>● elderly care</li> </ul>

Source: processed according to Bauba - Similie 2010

This overview (in particular its empty columns, which would surely be filled if other types of public services were of our interest) alerts us to the fact that most health, education and social services in the V4 countries have either a state or territorial (but mostly regional) public provider or private provider, whereas mixed providers are not too common.

From those competences, where we can already at this level find an intersection between all V4 countries, we chose, for deeper comparison **at the municipality level**: as a representative of education services (in the Slovak terminology), the **primary school** (ISCED 1 or ISCED 1 and 2); as a representative of (primary) health services, or health services of first contact, the **general** (practical, family) **doctor, providing outpatient care** for adults and/or

for children and youth; and as the representative of (personal) social services, the (home) **care service**, excluding (or including only in a limited extent) nursing provided (primarily) in households to individuals, in particular elderly persons, who are reliant on the assistance of another person in self-care, home care and basic social activities. **At regional level**, we then selected: as a representative of education services, **secondary schools** (in the ISCED 1997 category 3C: secondary schools with general certificate of secondary education); as a representative of health services, **hospitals** (as an institutional healthcare facility providing continuous health care during hospitalisation for patients with the most severe acute illnesses, injuries, or, where necessary, more demanding surgery); and as a representative of social services, **old people's homes** (as a residential social service facility designed primarily for the elderly).

There are still some differences in the internal parameters of the compared units of public services provided in the above defined units of public administration (different sizes of schools and classes, hospitals or old people's homes in different countries, different criteria for providing care services, etc.). Nevertheless, we consider the units defined in this way to be sufficiently homogenous and mutually comparable in terms of what founder or implementation function the public administration bodies perform in relation to them. For the sake of completeness, however, we also present the relevant country's legislation, which will those interested to view also these different internal parameters, as well as basic information on the mechanisms of financing the given public service.

The subchapters of the following text will specify in greater detail the types of providers in each country, in its traditions and legal definition. From the wide range of options we thus chose for each of the selected competences, in particular those concerning the founding competences in the field of institutions providing public services. The result of this comparison is given in the following overview:

## 2 PUBLIC ADMINISTRATION AS A PROVIDER OF PUBLIC SERVICES

### 2.1 Public administration as a provider of public services in Poland

Public administration in Poland has undergone significant reforms, following the turbulent sociopolitical movement in Poland beginning in the late 1970s. The first steps (similarly as in the other V4 countries) meant a change in the standing of municipalities, through the adoption of the act on territorial self-government in March 1990, and in 1992 the Constitutional Act (the so-called minor Constitution) was adopted, which arranged the standing of municipalities and other legal entities, issues of communal ownership, the exercise of own competences of municipalities and of own resources of municipal finances. Since 1994 the state has handed over to municipalities those assets necessary for fulfilling their tasks. On 1 January 1996 a law entered into effect that transferred to towns (partly under a regime of delegated competences) tasks in the field of health protection, education and training, social assistance, culture, etc., and subsequently associations of municipalities were also able to carry out these tasks. In 1990 laws were then adopted on district and province (*województwo*) self-government, as well as laws on the organisation of integrated and specialised state administration in a *województwo*. Further changes occurred following Poland's accession to the European Union in 2004, including changes at the central level of state administration.

The **local level** is currently represented in Poland by the administrative (consolidated) municipality (*gmina*), of which there are currently 2 477. A municipality is, as a rule, made up of several so-called auxiliary units (*jednostki pomocnicze*), of which there are currently more than 57 000, most common among them being *solectwo*, of which there are 40 057. In towns these units are, for example, urban boroughs (*dzielnica*), while in rural areas, besides *solectvos* there are also small towns or villages (*osiedle*).

Municipalities are divided into several types:

- urban municipality (*gmina miejska*), of which there are 302; these are larger towns in which there may be auxiliary units (most commonly urban boroughs); 66 of these towns also exercise

powers of a district (*powiat*) as a lower level of regional self-government (*miasto na prawach powiatu*);

- urban-rural municipality (*gmina miejsko-wiejska*), of which there are 638; these are smaller towns and other separate settlements, existing within a municipality as auxiliary units;

- rural village (*gmina wiejska*), of which there are 1 537; these are municipalities, consisting of individual small settlements and *solectvos*.

Legal personality always pertains to a municipality that exercises own self-government competences (*zadania własne*) as well as competences entrusted by the state to be carried out by municipalities (*zadania zlecone*). A municipality has two bodies: a directly elected municipal board (*rada gminy*), or council and a directly elected mayor: in rural municipalities this mayor is termed a *wójt*, while the equivalent in towns is *burmistrz*, and in towns with over 100 000 inhabitants and in towns with the competence of district, the mayor is termed a town president (*prezydent miasta*).

Auxiliary units do not have legal personality, but the municipal council (*rada gminy*), as the highest collective body of the municipality, can, by resolution, establish not just an auxiliary unit, but also grant it own statute and entrust it with certain tasks. A *solectvo* is headed by a sheriff termed a *sołtys*, though the bodies of a *solectvo* include also the assembly of inhabitants and *solectvo* board: their competences include cooperation with municipal authorities, which allows the performance of certain tasks in the field of public services through the *solectvo* and analogously also through other auxiliary units (in particular urban boroughs).

**State administration** outside the central level in Poland is organised at two levels – at the *województwo* level and the district (*powiat*) level. **At the district level**, state administration is performed by own authorities of specialised local state administration in the field of police, fire service, health protection and construction proceedings. **At the województwo level**, a key body of state administration is the governor (*wojewod*), who is appointed by the Prime Minister and represents the central government at the level of the whole *województwo*. A *wojewod's* executive apparatus is the *województwo* office (*urząd*

*województki*). The competences of a governor (*wojewod*) include the direct management of certain branches of state administration at the provincial (*województwo*) level (police, fire and rescue service, administration of state property, etc.) as well as coordination of deconcentrates of other department offices acting at the *województwo* level (the environment, some inspection services, etc.). The provincial governor concurrently supervises the performance of state administration in the delegated competence of the local self-government and oversees the entire public administration at the provincial (*województwo*) level.

**Self-government at the district level** takes the form of 314 districts (*powiats*) and 65 towns with district rights (*miasto na prawach powiatu*). The inhabitants of the district directly elect the district board (*rada powiatu*) as a representative body with a four-year term of office. The board elects one of its members as mayor (*starosta*). The mayor heads the district administration (*zarząd powiatu*), which is the executive body at the district level. The activity of the administration is controlled by a standing and temporary commissions, comprising members of the district council. The administration of the district self-government is managed by the mayor's office (*starostwo*). In cities with district rights, the authorities performing the tasks of the district are municipal self-government authorities. These towns, though, remain municipalities. The competence of the mayor and the district administration includes decision-making in the field of education (post-secondary), health protection (district and regional hospitals) transport within the district (co-financing of local bus routes, or respectively urban transport in the case of towns with district rights), district roads maintenance, geodesy, real estate management, environmental protection, public order and public safety, prevention of unemployment, civil defence, social assistance, issuing work permits for foreigners, combating natural disasters and organising district-level assistance, car registration and issuing driving licences. These tasks are mainly financed from a share of central tax revenue. By means of special laws, districts are entrusted with tasks in organising elections. In the case of a justified request from a municipality, a district may entrust the performance of certain tasks into its competence. A district, though, has no right to interfere in the competence of municipalities.

**At the provincial (*województwo*) level**, in addition to the state administration, represented by the governor (*wojewoda*), who also oversees both state administration and **self-government at the provincial level**, there also operates as a body of the provincial self-government the provincial council (*sejmik województwa*), which is directly elected by the province inhabitants for a four-year term of office. It is headed by the province chairman (*marszałek województwa*), who is elected by the council. The collective executive branch of the provincial self-government together with it is represented by the provincial committee (*zarząd województwa*), also elected from the ranks of its members by the province council. The competences of the provincial self-government include the preparation approval and performance of generally binding provincial regulations, conceptual and strategic documents of the province, the province budget, as well as tasks in the field of culture, health and some social services. The province self-government is financed primarily from shares in central taxes.

The basic **legislation** on relevant structures of public administration from the aspect of our topic is comprised of the following regulations:

- Act no. 506/1990 of 8 March 1990 on communal self-government (Collection of Laws of 2019, ref. 506)
- Act no. 511/1998 of 5 June 1998 on district self-government (Collection of Laws of 2019, ref. 511)
- Act no. 512/1998 of 5 June 1998 on provincial self-government (Collection of Laws of 2019, ref. 512)
- Act no. 631/1998 of 24 July 1998 on the implementation of the act on district self-government, on provincial self-government and the act on state administration in provinces (Collection of Laws of 1998, no. 99, ref. 631)
- Act no. 603/1998 of 24 July 1998 on the introduction of a basic three-tier territorial division of the state) (Collection of Laws of 1998, no. 96, ref. 603)
- Act no. 668/1998 of 24 July 1998 amending certain acts defining competencies of public administration bodies (Collection of Laws of 1998 no. 106, ref. 668)
- Act no. 15/2011 of 5 January 2011 the Electoral Code (Collection of Laws of 2017, ref. 15)

- Act no. 206/2009 of 23 January 2009 on provinces and state administration in provinces (Collection of Laws of 2009, no. 31, ref. 206)
- Act no. 1240/2009 of 27 August 2009 on public finance (Collection of Laws of 2009 no. 157, ref. 1240)

### 2.1.1 Education services

Poland has undergone several reforms in the field of education (which, in the wording of a law from 1991, is considered a public service), several of which, in particular that after 2007, significantly improved the level of the Polish schools system, in consequence of which the country, for example, moved from the bottom rankings in the Pisa evaluation to near the top of these tables. In the organisation of the schools system from the aspect of its establishment, this reform followed up on public administration reforms, which eventuated in a better distribution of tasks in the establishment of educational institutions between the different levels of public administration. The Act on the Implementation of Reforms to the Education System of 1999 created a new structure for this system. The zero grade (preparatory year) is obligatory for all six year old children. The six-year elementary school is followed by a three-year lower secondary school (with two compulsory foreign languages); after lower secondary school, pupils may continue on to 4 types of school: a three-year lyceum (grammar school, ending with a general certificate of secondary education), a three-year profiled (vocational) lyceum, a four-year technical school (with general certificate of education) or a vocational school. Municipalities (*gminas*) are responsible for the establishment, administration and management of preschool facilities, primary schools and lyceums; districts (*powiats*) for the establishment, administration and management of specialised primary schools and all types of secondary schools.

In 2016, a new education reform was launched. The basic idea behind this reform is to return to the model that had operated in Poland before 1999. Basic education will last 8 years. Grammar schools are cancelled. Secondary education includes: 4-year general secondary school, 5-year secondary vocational school and industrial secondary school of first and second

level. The introduction of this reform was very controversial. Self-government authority bodies were not ready to introduce such a revolutionary change in this very short time.

At the central level, the Ministry of Science & Higher Education operates separately, whereby competences concerning primary and secondary education are concentrated at the Ministry of Education (which, though, in the case of vocational schools cooperates also with other departmental ministries).

#### Education in the competence of municipalities

An own (original) competence of municipalities in Poland is the establishment and operation of public preschool facilities, primary schools and grammar schools (with the exception of special schools, which are established by the district).

In the 2015/2016 school year, a total of 13 517 primary schools operated in Poland. Of them 85.7% were established by local self-government authority bodies, most commonly by the municipality, which were required by law to do so. Approximately 30% of these schools have fewer than 70 pupils (MEN 2015). Public primary schools formed also 0.3% of schools established by the state administration. The remaining 14% of primary schools comprised non-public primary schools, established both by natural and legal persons. Pupils generally attend schools closest to their home, according to catchment areas, which are also decided by local self-government. Non-public primary schools are established and operated by natural or legal persons on the basis of registration in the register of non-public schools, maintained by a self-government authority body. A non-public school can acquire the rights and status of a public school (for example the issuance of state certificates) if it implements a program minimum, respects the principles of pupil assessment and classification, and employs teachers qualified according to standards set by the relevant ministry (GUS 2017, pg. 22).

As a result of the education reform, the number of lower secondary schools fell by 246 against 2016.

## Education in the competence of regional authorities

As mentioned above, as a result of the 1999 reform, primary education in Poland consists of six-year primary school and three-year compulsory lyceum, which are in principle in the founding competence of municipalities (or private founders).

Regional authorities are primarily responsible for the establishment of secondary schools, though this competence is internally differentiated. The whole range of secondary schools lies in the founding competence of central state administration bodies: the Minister of National Education (*Minister Edukacji Narodowej*) establishes schools at diplomatic missions and experimental schools; public art schools are set up by the Ministry of Culture; public agricultural schools by the Ministry of Agriculture; forestry schools by the Ministry of Environment; marine schools and fishing schools by the Ministry of Marine Economy; healthcare schools by the Ministry of Health; schools in correctional institutions by the Ministry of Justice; and certain powers in this field are held also by the Ministry of the Interior.

Provincial self-government may, in the framework of its original competencies, establish schools of a regional nature, or also specialised schools of a nationwide nature (e.g. ballet schools). The competence of the provinces (*województwos*) in the field of education lie mainly in the activity of the provincial schools supervisor (*kurator oświaty*), who supervises schools on behalf of the provincial governor (not the Ministry of National Education).

All other general secondary schools (*szkoły ponadpodstawowe*) are established under the original competence of districts, including sports schools and, since 2018/2019 also special grammar schools. These include four-year general education lyceums, five-year industrial schools, three-year vocational (apprentice) schools of the first grade and two-year second grade, continuation schools, etc. There are approximately 8000 such schools in Poland and approximately 80% of them are established by the district self-government. Besides public schools, Poland has all types of schools also in the founder competence of churches and other private entities.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 1943/2016 of 7 September 1991 on the education system (Collection of Laws of 2016, ref. 1943)
- Act no. 96/1999 of 8 January 1999 implementing the school system reform (Collection of Laws of 1999, no. 12, ref. 96)
- Act no. 59/2017 of 14 December 2016 on education – the Education Law (Collection of Laws of 2017, ref. 59)
- Act no. 60/2017 of 14 December 2016 implementing the Education Law (Collection of Laws of 2017, ref. 60)
- Act no. 1668/2018 of 20 July 2018 concerning higher education and science – the Act on Higher Education and Science (Collection of Laws of 2018, ref. 1668)
- Act no. 1927/2011 of 15 April 2011 on the education information system (Collection of Laws of 2016, ref. 1927)
- Act of 27 October 2017 on the financing of tasks in education (Collection of Laws, ref. 2203 of 2018, 2245 of 2019, ref. 1287 and 1681)

## Financing

Until 1999, there was a different funding system for primary and secondary schools. Municipalities received state budget funds in the framework of general transfers also for primary schools, while funds for secondary schools were received by the supervisory authorities for education, which were state administration bodies at the provincial level.

The current system of education funding is a result of the gradual transfer of educational institutions to self-government authorities since the start of the 1990s. The previous centralist system of education funding has been replaced by a system of subsidising part of the tasks. An education subsidy (*subwencja oświatowa*) was created, accounting for up to 90% of all education costs in the state budget, determined each year by the state budget act (in 2017 this was 41.5 billion PLN  $\approx$  €10 billion in 2017). In terms of the expenditure structure of education service providers, this subsidy (in 2013) covers 82% of their costs for education (MEN 2015). Funds are divided between individual self-government authorities on the basis of a decision by the Ministry of National Education, where the criteria for allocating resources, expressed by 41 coefficients, are the number of pupils, type of school, qualification structure of the teaching staff, proportion of pupils with special education needs, and school location (city, town, village) etc. Where centrally determined common criteria are used for setting the

volume of block grants (20) or lump sums (21) for covering staff costs as well as operating goods and services, usually one set of criteria is used for determining the amounts allocated for all categories of resources. (Eurydice 2014)

At the same time, it was decided that a role of municipalities would be the operation and funding of preschool facilities, primary schools and lyceums, as well as the transport of pupils to school, if the schools are located outside the perimeter of their home. Subsequently, tasks of districts came to include the operation of post-lyceums, special schools, sports schools, etc. For some of these tasks, self-government authorities receive funds from the education subsidy (mainly for the operation of schools), but for the rest (for example, operating preschool facilities or transporting pupils), they must use their own funds from other sources. In the case of municipalities, this means for example a share in the tax on natural and legal persons, financial transfers tax (*podatek od czynności cywilno-prawnych*), local taxes (on land and real estate property), income from sales and rental. In addition, municipalities have in recent years also received subsidies for developing preschool education. This system meant applying the principle that the money should follow the pupil. At the same time, the so-called standard A (education bonus) was adopted with this subsidy, expressing the criterion that larger schools were preferable to smaller ones, with the aim that even in rural areas it is better to bring pupils to a better equipped larger school with a better qualified teacher than to maintain small schools. It was also to enable the operation of non-state schools. The system, however, did not prove successful, particularly in the case of small schools – rural municipalities sometimes had to co-finance the operation of schools in the same amount as had been the subsidy from the state budget, while in cities this co-financing was at the level of 20 – 40% of the subsidy. Self-government authorities propose moving from funding “per-pupil” to funding “per class”. The situation is similar also in schools established by districts (PAP 2016).

### 2.1.2 Healthcare services

Under the Constitution of the Republic of Poland, every citizen has the right to health protection, regardless of his or her financial situation, since public authorities are obliged to ensure equal access to public health services from public funds.

Healthcare reforms have also been underway in Poland since the 1990s: back in 1991, healthcare service providers gained legal personality, and health care was decentralised into the original competence of municipalities. In addition to public providers, healthcare services could be provided also by churches, employers, foundations and other legal and natural persons. Even following the completion of the public administration system, healthcare institutions, local health centres, specialist outpatient clinics, hospitals of different types and levels, by gaining legal personality, could gradually begin to use their own finances differently than before, when they were regulated by budgetary rules. In 1997, the Health Insurance Act was adopted, introducing health treasuries in each province, which represented decentralisation, and was to have led to greater interconnection of the socioeconomic level of regions, while preserving certain mechanisms of mutual balancing between richer and poorer regions. In practice, however, this did not work, and therefore in 2003 the treasuries were replaced by the National Health Fund. This distributes resources between provinces and directly reports to the Ministry of Health.

Similarly, the first reforms implementing the institution of family doctor did not prove successful, because as these doctors sent patients for expert examination, the payments to them from treasuries were reduced. Overall privatisation led to commercialisation of health care. According to surveys by the Public Opinion Research Centre from 2016, of the 84% of respondents who provided data, 40% of patients use public and private health services, 37% only public and 7% only private services (CBOS 2016).

#### Health care in the competence of municipalities

Under the Act on Municipal Self-Government (§ 7(1)(5)) health care is to serve the needs of the community of the self-government area and is one of the basic tasks of a municipality. This is, though a general formulation, but it is hard to find in the applicable legislation a more detailed definition of this competence. Neither is it clear, whether this is an obligatory or optional task. There is here, though, §6 of the Publicly Funded Healthcare Services Act, which states that the roles of public administration bodies in ensuring equal access to health services include also the creation of conditions for the functioning of a healthcare system. The Polish Constitution in Article 68(2) imposes on public authorities,

including local self governments, the duty to ensure equal access to publicly funded healthcare services. Accordingly, primary health care is one of the original competences of the municipality.

The Polish Healthcare Activities Act of 15 April 2011 states that a healthcare service is any service that means a benefit for maintaining, saving, restoring or improving health, and other medical activities resulting therefrom. A part of the healthcare system in Poland is also primary health care, to be provided to eligible persons in their place of residence. “Municipalities are responsible for primary health care providers” (OECD 2017, p. 6). Healthcare tasks, including primary health care, are usually performed by healthcare entities, which may be businesses or non-businesses. Businesses are usually doctors performing medical activities either individually or collectively (this group includes also foundations and associations, churches, ecclesiastical legal persons, or religious associations). In the field of health care, a municipality may establish healthcare institutions (primarily basic outpatient, but also specialised) in the form of a capital company, or as a government budgetary organisation. Independent businesses and public healthcare units, as well as government budget organisations of state administration and self-government are not considered businesses (Śniecikowski 2013). The municipality also cooperates with non-public healthcare providers, is responsible for health protection and other health factors (Markowska – Kabała 2013, p. 377).

In this situation, it is relatively complicated to identify the share of municipalities in Poland in the provision of healthcare services. Some orientation is provided least by data on the volume of expenditures from public budgets for health protection, in which 73.4% of funds in 2017 came from the state budget, 8.2% from the budgets of towns with district status, 7.1% from the budgets of districts, 6.6% from the budgets of provinces, and just under 5% from the budgets of municipalities (GUS 2018, p. 123). However, from this volume of funds from municipality budgets (618.1 million Zł), some 68.3% was used for combating alcoholism and 6.8% for hospital care (ibid., p. 124). Polish municipalities contributed only 4.0% for covering outpatient healthcare costs, which is also assessed as a minor proportion (Raport 2019, p. 75).

## Health care in the competence of regional authority bodies

The basic type of healthcare facilities in the competence of regional authorities in Poland are independent public healthcare facilities (SPZOZ), primarily hospitals, which do not have the nature of a business. They may be established by the minister, a governor (wojwod), territorial self-government unit (district – *powiat*, province – *województwo*) and the State Medical Faculty. They are exclusively in public ownership, have the nature of a non-business entity, are financed primarily from public health insurance (NFZ), providing services to its insured persons.

In Poland there are currently almost 1000 hospitals operating (951 in 2017), of which the majority are public hospitals, while private hospitals form around 44% (of which three quarters are in the form of a limited liability company). Private hospitals are founded by churches or religious societies, insurance companies, foundations, trade unions, professional self-governments or associations, other domestic or foreign legal entities, as well as natural persons or societies that are not legal entities. But a legal entity that is the founder of a private hospital may also be founded by a town (Jaworzyńska 2016).

A third of all hospitals (more than 300) are founded or owned by a district (a quarter completely, a further approx. 8% in co-ownership), so there is essentially one district-founded hospital per district. These hospitals represent a basic network of general hospitals (with a compulsory basic structure of departments of internal medicine, general surgery, gynaecology and obstetrics and paediatrics, and with anaesthesiology and intensive care services). These are followed up by hospitals founded, as a rule, by provinces (*województwos*) (which, in addition to the above mentioned departments, must have at least four of the following departments: cardiology, neurology, dermatology, pregnancy and neonatal pathology, eye and throat medicine, trauma surgery, urology, neurosurgery, paediatric and eye surgery), furthermore, specialised hospitals (oncological, paediatric, etc. departments, which may also be established by provinces), and clinics (e.g. university clinics) and ministry-departmental hospitals (military, etc.), which are by definition nationwide.

Central state authorities (the Ministry of Health and other ministries) found approximately 50 hospitals (approx. 5%), universities approx. 40 (approx. 4%).

Provinces administer clinics of occupational medicine and clinics of psychiatric medicine.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 153/1997 of 6 February 1997 on general health insurance (Collection of Laws no. 28, ref. 153)
- Act no. 391/2003 of 23 January 2003 on universal insurance in the National Health Fund (Collection of Laws no. 45, ref. 391)
- Act no. 654/2011 of 15 April 2011 on medical care (Collection of Laws no. 112, ref. 654)
- Act no. 2135/2004 of 27 August 2004 on healthcare services financed from public funds (Collection of Laws 2004 no. 210, ref. 2135)
- Act no. 408/2019 of 28 April 2011 on the information system in health protection (Collection of Laws, ref. 408)

#### Financing

The financing of health care in Poland is based mainly on health insurance sources, represented by the National Health Fund (NFZ), with about 98% of the population compulsorily insured at it, including groups for which the state pays the insurance premium. Less than one per cent of the population is insured at it voluntarily. The NFZ has branches in all provinces. The basis for financing of the public healthcare system is therefore compulsory health insurance premiums, which represent 9% of personal income. Insurance premiums are charged together with tax obligations and are paid to the NFZ through the Social Insurance Agency (ZUS). Approximately 70% of all healthcare costs (current costs and investments) came from public sources, of which more than 90% from the NFZ, less than 4% from the state budget and less than 6% from self-government authority budgets. The state budget covers emergency services, prevention, highly specialised activities (transplants and generally very expensive operations), as well as administration and investment (these are also covered from self-government authority budgets).

Of the 30% of healthcare costs covered from private sources, one fifth comprises private insurance, and four fifths by individuals. This relates mainly to contributions to the price of medicines, some laboratory examinations and rehabilitation aids (glasses, etc.), as well as dental services, spa services (accommodation and food), etc.

Primary health care is funded by capitation per person registered at a primary care physician, including costs for consultation and diagnostic tests. In the case of specialised outpatient treatment, a diagnosis fee is charged. Hospital care and specialised outpatient services for all hospital-treated patients (except patients in psychiatric or rehabilitation care) are also funded. (Kluczyńska – Grzywacz 2015).

### 2.1.3 Social services

Social services in Poland are a part of the social assistance system, as one of the pillars of social policy. Social assistance includes assistance at social care facilities (particularly social assistance homes), care services (including day-care centres, assistance centres, dormitories, etc.), and financial and material assistance. In addition to the Ministry of Family, Labour & Social Policy, social assistance centres of each municipality are involved (providing various forms of social work, some social benefits and benefits in kind), but in particular district family assistance centres (these are urban family assistance centres in towns with district status). County (provincial – *województwo*) self-government (in the competence of the provincial assembly) deals with the coordination of social policy in the province, while county state administration (in the competence of provincial offices) performs auditing and supervision over the exercise of delegated competences in the field of social assistance by municipalities, districts and provinces.

#### Social services in the competence of municipalities

In Poland approximately 1.5 million people living alone potentially need social assistance services, while two thirds of people lack support from the side of their relatives (Łuszczńska 2011, p. 358). A specific feature of Poland is that at the same time there is very little demand for elderly care services, ranking among the lowest from among all European Union countries (Genet et al 2012, p. 4), although the objectively measured need for these

services is many times higher (ibid, p. 8). About 11% of adult Poles acknowledge certain problems relating to everyday coping, with these problems rising after the age of 75. Some 30% of seniors aged above 60 hold an official disability certificate. Assistance to the elderly in Poland has traditionally been a matter for the family, with older persons preferring this option, while younger family members declare that providing this care is not a burden for them. However, the more hours such care requires, the more this is reflected in free time, and eventually persons providing care for older family members come to feel it as a burden, as stated by up to 11% of the population in surveys. Yet only 4% of Polish seniors pay for care at private (also unofficial) care providers, and only 4% use this service from a social assistance centre (Badanie 2013, p. 4).

This is related to the fact that in Poland the care service is provided only when this service cannot be provided by the family, and where there is material need, then it is also partially co-funded (Genet et al 2012, p. 40). By law, it is the municipalities which have the obligation to ensure non-specialised care services at home for dependent persons, including seniors.

A municipal (urban) social assistance centre operates in each municipality. It is established by a resolution of the municipal council, which approves its statute and entrusts it with property as its budgetary organisation, fulfilling the tasks of its own (original) municipality competence. It either provides or coordinates the care service centre.

Private care providers (which may be natural or legal persons) are subject to registration in Poland (Genet et al 2012, p. 31), but the market for these services is relatively undeveloped because it is dominated by municipalities as public providers (ibid., p. 35). Moreover, only a small proportion of these providers specialise in the care services, while most also provide nursing services. This is also reflected in the differentiation of professions of these providers, who may be home assistants (*asystent domowy*, who are not required to complete specialised courses), medical carers (*opiekun medyczny*, as a rule, with a two-month certified course), and healthcare nurses (*pielęgniarka*) (Fedorowicz 2016).

Although the number of persons receiving a care service at home is growing in Poland (84 500 people in 2014, and 94 200 people in 2016), this still remains approximately just 1% of the relevant age cohort above 60, and in 2015 as many as 470 municipalities (19% of all municipalities) did not provide a care service, though this number had fallen to 376 (15%) by 2017. These were primarily small municipalities, which justified this non-provision by a lack of funds and high costs for providing these services (in 2016 municipalities spent 433 148 183 PLN  $\approx$  100 mill. € of their budgets on care services), which was further increased by the obligation to pay carers from 2017 at least the minimum hourly wage. The average annual costs to a municipality for one person receiving care in 2016 totalled 4598 PLN ( $\approx$  1200 €) (NIK 2017).

“In some (larger, richer) municipalities, social services are more developed, while in other (smaller, poorer) municipalities, they are almost non-existent. Many social services are provided in the shadow economy, without meeting quality requirements and basic standards. Many recipients for reason of a lack of supply of free public services are forced to use paid market services or unprofessional services provided in the shadow economy by unprepared service providers” (Grewiński - Lizut 2015, p. 115).

Therefore, municipalities in this activity are partially subsidised (including the use of Eurofunds) from government programmes. Over the past five years, “Senior+” day centres have thus been developing in municipalities with a state subsidy (but also from municipal funds and client contributions), often in cooperation with non-state providers. There is currently the program “Care 75+” (*Opieka 75+*), which is aimed at increasing the availability of care services as well as other specialised social services for persons aged above 75 living alone in small villages. So far, 454 (18%) municipalities have engaged in drawing funds from this programme.

In the case that there is no possibility for the provision of care services at home by the family or municipality, the person needing full-time care may apply for placement in an institutional facility (Przybyłka 2013, p. 120).

## Social services in the competence of regional authorities

As regards social assistance services facilities, in 2017 Poland had 659 social service houses, which accounted for 49.9% of all facilities, whose clients are mainly elderly. They can be founded by local self-government units (provinces, districts, or also municipalities), the Catholic Church and other religious societies, foundations and associations, as well as other legal and natural persons.

Statistics from a more analytical nature from a few years ago report a total number of 782 facilities with a supra-municipal competence, the founder of which was in 580 cases the district, and in 202 cases a private founder on behalf of the district. In terms of clientele, these facilities are for the elderly, with the number of these facilities of 119 in Poland (81 founded by the district, and 38 by private entities), for physically ill persons it is 160 (134 : 26), and for mentally ill 177 (154: 23), mentally handicapped adults 140 (108 : 32) and young people 72 (22 : 50), persons with physical disabilities 10 (4 : 6), elderly, physically and chronically ill 76 (58 : 18), etc. (Grabusińska 2013). More recent statistics from 2017 report that districts founded 572 social assistance homes and a further 218 were operated at the district level at the initiative of other founders. Municipalities were also the founders of a further 26 social assistance homes, and a further four operated at the municipality level at the initiative of other founders (<https://stat.gov.pl>).

A person needing 24 hour care due to age, illness or disability, who is unable to cope independently in everyday life and who cannot be covered by the necessary assistance in the form of a care service, has the right to be placed in a social care home. A person who requires this form of support is directed to the social care home closest to their place of residence, unless the circumstances of the case require a different solution (with the consent of that person or his/her legal representative).

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 593/2004 of 12 March 2004 on social assistance (Collection of Laws 2004, no. 64, ref. 593)

- Act no. 59/2004 of 25 February 1964 the Family and Guardianship Code (Collection of Laws 1964, no. 9, ref. 59)
- Act no. 1705/2015 of 11 September 2015 on the elderly (Collection of Laws 2015, ref. 1705)
- Act no. 1240/2009 of 27 August 2009 on public finances (Collection of Laws 2009, ref. 1240)
- Act of 13 October 1998 on the social insurance system (Collection of Laws 1998, no. 137, ref. 887).

## Financing

Social services in Poland are financed from several sources:

- the state budget funds services in the framework of delegated state administration and in the framework of government programmes implemented by provinces;
- self-government authority budgets fund services in the field of self-government authority tasks;
- special-purpose funds such as the State Fund for the Development of Persons with Disabilities (PFRON) or the State Labour Fund;
- European Social Fund resources. Financial resources for 2007 – 2013, reserved in the operational programme Human Capital, intended for the system of social services providers, had available more than €1 billion ( $\approx$  4.5 billion PLN). This was a substantial injection of money for projects that, in Poland, had not previously been implemented in such an extent. According to data, the Ministry of Regional Development was involved in the implementation of projects of almost 74% of social assistance centres;
- from private sources, i.e. from direct payments by individuals. In the case of care services, the minimum pension threshold is set, below which the service is provided free of charge to the client. A stay in a social care home is paid up to the average monthly living costs, but may not exceed 70% of the client's income. (Grewiński - Lizut 2015).

## 2.2 Public administration as a provider of public services in Hungary

At the beginning of the reforms Hungary has undergone over the past three decades, in 1990 a two-tier system of local self-government was created, at the local and county level, replacing the previously existing system of councils (*tanácsrendszer*). Subsequently, local authority bodies in Hungary became key actors in public services at the local and regional level: the Hungarian constitution guaranteed local self-governments the right to decide on local matters, while competence disputes between central and self-government authorities could be settled by the Constitutional Court. The Act LXV of 1990 on local government defined the basic structure, rights and obligations of local self-government authorities, as well as their sources of funding. Local authorities shared responsibility on the basis of the principle of subsidiarity: county offices assumed only those public services that local self-government authorities were not able to provide and were willing to hand over to the county level.

The reforms that took place in Hungary after the Constitutional amendment in 2011, which changed the overall constitutional identity of the state (Halász 2016), were largely reflected also in the responsibilities of towns and municipalities, including their roles in the performance of public services of education, health care and social affairs. The reforms made in this period were driven (besides political motives) by economic motives, primarily constant indebtedness in the field of public service provision. The solution was driven by the state's efforts to seek internal funds, reduce the budget deficit and external debt, which over the years 2001 to 2010 had again grown dramatically (Skiba - Rapkiewicz - Kędzierski 2014, p. 45) and was burdening consumption instead of reducing investment. These trends also came to include massive re-etatisation in the field of public services and a resultant significant weakening of the standing of municipalities and counties as providers of these services.

Local administration is currently represented in Hungary by 3 175 municipalities (*települései*), of which 304 are urban (*város*) (excluding Budapest, which has a special status, and cities with county status). The structure of municipalities, in terms of their size, in Hungary is significantly fragmented, and also in Hungary there are municipalities that have only a few dozen inhabitants. Municipal bodies are the directly elected council (*képviselő-testület*) and mayor (*polgármester*).

Differences in the size of municipalities are reflected in their competences. All municipalities in Hungary have obligatory and voluntary tasks. As regards mandatory tasks, in municipalities with up to 10 000 inhabitants these are limited to cemetery management, municipal waste management, public lighting and public order, ensuring drinking water supplies, preschool management, and, in the past, primary schools, basic health services and some social services, etc. Only municipalities above this size have duties such as setting up fire brigades, organising rescue services, etc. The list of voluntary tasks is not set, and a municipality may voluntarily fulfil also other tasks that do not pertain to it in terms of its size; it may not though by accepting such voluntary role jeopardise the performance of tasks that are mandatory for it, and these assumed voluntary tasks must be fully covered by the municipality from its own funds. The performance of mandatory tasks is taken into account in the income that the municipality receives from the state budget. The performance of a municipality's tasks is ensured by the municipal office, as maintained by a notary. The notary is selected by the municipal council from candidates meeting the qualification requirements (most normally lawyers). The notary co-signs with the mayor all important documents of the municipality and guarantees their compliance with the law. The constitutionality of a municipality's decisions is again supervised by the county office of state administration, the manager of which may submit them to the Constitutional Court for review.

At the county level there are distributed workplaces of specialised local state administration, under the umbrella of the county office of state administration. Hungary is divided into 19 counties (*megye*), which also includes Budapest. However, 23 other towns (other than Budapest) likewise have the standing of counties, meaning that they do not fall under county administration and in their territory the tasks of county authorities are performed by local self-government authorities. The decision-making body of county administration is the county assembly. The competence of counties includes regional development, tourism, environmental protection and, in the past, the establishment of secondary schools, certain social services facilities, etc.

Within a county there are also (as state administration authorities) districts (*járás*), numbering 174. Budapest is divided into 23 city districts (*kerület*).

The basic legislation concerning our topic here comprises the following regulations:

- 2011. évi CLXXXIX. törvény Magyarország helyi önkormányzatairól (Act no. 199/2011 on local self-government in Hungary)
- 2011. évi CLIV. törvény a megyei önkormányzatok konszolidációjáról, a megyei önkormányzati intézmények és a Fővárosi Önkormányzat egyes egészségügyi intézményeinek átvételéről (Act no. 154/2011 on the consolidation of the county councils, on the assumption of county healthcare facilities and certain healthcare facilities of the municipality of the city Budapest)

#### 2.2.1 Education services

The transformation of society and the associated decentralisation processes in the early 1990s also shifted the founding powers regarding various types of schools in Hungary, with this being included in the competence of self-government authorities. However, development over the subsequent years resulted in problems in education funding, leading to the closure of some schools. The liberalisation of education models, along with the cancellation of the vocational school inspection, were further factors that led to the reform launched in 2012, named after the interwar war Minister of Culture in the Horthy government, Kuno Klebersberg.

At the start of 2013, primary and secondary schools (with the exception of kindergartens) were entirely transferred under state administration and only municipalities with a population above 3 000 continued to be responsible for the maintenance of school buildings. Only three “historical churches” (Catholic, Calvinist and Evangelical Lutheran) saw an increase in their number of schools established between 2003 and 2013, from 21% to 37% of the total number of schools of all levels and types. Costs were cut, competences and control were centralised, private and church schools were strengthened, and secondary education were restructured with a view to strengthening vocational training.

The Klebersberg Institutional Maintenance Centre (KLIK) was established as an organisation under the Ministry of Human Resources, which manages 19 school districts at the county level and within them 198 school districts identical to the territory of districts (*járás*) (including the 23 districts of Budapest), established after 2011, whose position as state administration authorities is generally strengthening at the expense of self-governing counties..

Approximately 2 700 public (state) schools of various types and levels are established in these districts.

The founder of schools in Hungary can currently be the state, national self-government, the church, an organisation that carries on religious activities, a municipality, another natural or legal person, etc. Institutions founded by the church are considered to be ecclesiastical; institutions established by a religious organisation or other legal or natural person are considered private. Some public schools also have another operator – in this way the private institutions run schools on the basis of a contract with their founder.

Primary schools are, according to the Hungarian school legislation (2011. évi CXCV törvény), general schools (*általános iskola*), which children begin to attend at the age of six, and which (in two four-year stages) lasts eight years. School districts are determined by the state.

In Hungary, the founders of primary schools currently (2016/2017) are mainly public founders: out of a total of 2 332 schools, 1 857 (79.6%) are public and only the remaining 361 (20.4%) are set up by private founders. Among the public schools, the state is clearly the main founder: the central founder of 1 784 (76.5% of all) primary schools is KLIK. The public founders of primary schools in Hungary are in 45 cases (1.9%) the self-governing authorities (including national self-governments), and in 28 cases (1.2%) these are the state higher education institutions. Private schools are dominated by churches, which are the founders of 361 (15.5%) of all primary schools, foundations and natural persons of 67 (2.9%), and other private founders of 47 (2.0%) of all primary schools. About 90% of all pupils attend public schools (Köznevelési 2018, p. 126).

The 19 school districts, falling under the Klebersberg Centre, include also schools for students aged 14-18. These are grammar schools (second degree), secondary schools (second degree) (*szakközépiskola*), which have either four-year general education programmes or in their last two years contain a vocational focus, and two-year vocational (apprenticeship) schools (*szakiskola*), though these have been in decline, as it is expected that all young people are to achieve full secondary education. Approximately 300 vocational schools passed from

2015 to the founding competence of the Ministry of Economy, 59 agricultural schools under the Ministry of Agriculture, etc. (Temesi 2014), from 2018 under the Ministry of Innovation and Technology, which takes on more and more competences in the sphere of higher education, part of vocational education, science and research.

All schools provide tuition according to a common education plan and common national basic curriculum, through which the government seeks to eliminate inequalities in education. Textbooks were also unified under the purview of the state: initially only one publisher was entrusted with the distribution of textbooks. Following the intervention of the European Court of Human Rights in 2019, schools can order their textbooks from a number of state-licensed publishers – but since 2019 most independent publishers have not obtained this licence (EU 2019).

The basic **legislation** concerning our topic here comprises the following regulations:

- 1993. évi LXXIX. törvény a közoktatásról (Act no. 79/1993 on public education)
- 1993. évi LXXVI. törvény a szakképzésről (Act no. 76/1993 on vocational training)
- 2011. évi CCIV. törvény a nemzeti felsőoktatásról (Act no. 204/2011 on national higher education)
- 2001. évi CI. törvény a felnőttképzésről (Act no. 101/2001 on adult education)
- 2011. évi CXC. törvény a nemzeti köznevelésről (Act no. 190/2011 on national education)
- 202/2012. (VII. 27.) Korm. rendelet and Klebersberg Intézményfenntartó Központról (Government Regulation no. 202 of 27 July 2012 on the Klebersberg Institutional Maintenance Centre)

## Funding

From 2004, public expenditure on education was falling. For small municipalities, particularly in poorer regions of the country, it was becoming increasingly difficult to cover the costs of running schools. This led to disparities between different schools and a visible difference in the quality of education. The centralisation and re-etatisation changes in the organisation of education as described above were also reflected in its funding: in addition to

addressing the issue of the indebtedness of some schools and the lack of funding at some rural and small schools, they also brought changes under which the level of education in the poorest regions is no longer decided by funding possibilities of the territorial self-governments. Since 2013, education resources have been distributed centrally on the basis of a central assessment of social differences in the territory (Skiba - Rapkiewicz - Kędzierski 2014, p. 52). The share of primary education costs (ISCED 1-2) from municipal budgets decreased between 2012 and 2013 from 95% to 23% and the share of secondary education costs (ISCED 3) from county budgets decreased from 76% to 11% over the same period .

The Ministry of Human Resources, through the Klebersberg Centre, pays teachers' salaries and part of the salaries of other staff in education (part of their salaries are covered by local self-governments with more than 3 000 inhabitants). The salaries of some non-teaching staff (including the free-time organisers of pupils and students) are assessed by the Klebersberg Institute according to the number of socially and economically disadvantaged students. Klebersberg determines the number of operating staff of individual schools in municipalities with less than 3 000 inhabitants, depending on the number of pupils of the given school. The running costs of schools and part of the capital costs are also covered in the same way (Eurydice 2013). Municipalities only share in the maintenance costs of the school buildings they own. School districts (Klebersberg Centre local offices) submit to the Centre draft budgets for schools in their scope of competence for approval – in line with this procedure, independent budgeting at the school level was cancelled.

Despite the fact that the establishment of this central body seemed to be a good solution and its original objectives – creating a more efficient and cheaper method of managing educational institutions and closing the gap between schools in poorer and richer areas – were fulfilled, KLIK has been criticised for creating an overly centralised system where teachers prefer buying chalk and office paper for their own cash, as the centralised services represent a high bureaucratic burden that hinders their basic teaching activities. There are also cases pointed out where repair of a broken school window can now take several days to weeks. KLIK has from the very start been in the red, even though it annually receives

billions of forints. This results in teachers not getting paid on time or even in schools being temporarily closed because they were unable to pay gas bills.

Business associations also contribute to the funding of vocational training by means of a contribution to a common fund, which provides resources for additional funding for education at both state and private educational institutions (including undergraduate higher education) in fields requiring vocational experience (CEDEFOP 2011).

Private schools may charge tuition fees or various study fees.

### 2.2.2 Healthcare services

Following a series of reforms launched in 2011, the Hungarian healthcare system, too, became highly centralised. The government is now responsible not only for setting strategic direction, control, financing and issuing legislation, but also for providing outpatient healthcare services and institutional care. The new National Institute for Quality and Organisational Development in Health Care and Medicine (GYEMSZI) was established as a successor organisation to several previously independent organisations, such as the National Institute for Strategic Health Research (ESKI), National Institute of Pharmacy and Nutrition (OGYI), Institute for Basic and Continuing Education of Health Workers (ETI) and National Centre for HealthCare Audit and Inspection (OSZMK). GYEMSZI, inter alia, determines catchment areas of individual healthcare facilities and other things. On 1 March 2015 GYEMSZI was renamed to the State Healthcare Centre (Babarczy 2015).

The Ministry of Human Resources currently administers the healthcare system through the National Healthcare Centre (Állami Egészségügyi Ellátó Központ - ÁEEK), whose competence includes coordination of care, planning of hospitals, etc. ÁEEK also serves as an umbrella organisation for regional agencies of the local healthcare system.

The National Health Programme adopted in 2018 defines the cardiovascular diseases, oncological and rheumatological diseases as well as mental health and children's health as the sole governmental priorities ensured at the central level in the healthcare sector (OECD 2017b).

## Health care in the competence of municipalities

The Municipal Establishment Act of 1990 entrusted local self-government authorities with the planning and provision of local healthcare services. The responsibility for primary care was entrusted to municipalities and the responsibility for secondary care to counties, but both levels were able to contract out services to private providers. The majority of primary care was contracted to family doctors from private practices as part of a functional privatisation scheme. Similar measures have become increasingly common in secondary care since the late 1990s. The same law transferred ownership of the majority of primary care facilities, as well as polyclinics and hospitals from central authorities to local authorities, as a result of which local authorities became the main providers of health care in the Hungarian health care system. Municipalities usually owned primary care facilities and, in the case of larger municipalities, were also able to own and operate outpatient clinics and municipal hospitals. County authorities usually owned larger hospitals providing secondary and tertiary care. Unfortunately, an accompanying characteristic of healthcare's decentralisation has been its overindebtedness (Ádány - Vóko 2014).

Since 2012, re-etatisation has concerned: takeover of debt in health care (particularly that of hospitals) in the framework of the Semmelweis Plan, in which the state took on the state budget and also a decisive role in the provision of health care services (2011 Package). Although this reform has been the subject of massive criticism (particularly as regards the operation of hospitals), relatively few problems have appeared in the field of primary care, which in a certain, even if only limited, degree remains in the competence of municipalities.

The objective of primary health care in Hungary is that those entitled to health insurance can get non-stop health care at their place of residence or close to it, according to their choice, regardless of sex, age or the nature of illness. The services of a family (general practitioner) doctor and paediatric care are provided as primary health care. Local authorities are responsible for creating the conditions for general practitioners and for determining the catchment area in which they are to operate (list of streets), which though does not mean that the doctor cannot accept patients also from outside their catchment area. Local authorities have the right to change healthcare catchment area to suit the requirements of the population.

The local authority issues a licence to a doctor for the respective catchment area. Outpatient care in Hungary is provided in private practices and at facilities (polyclinics), created with the support of local authorities: family doctors are the point of first contact for patients.

The general practitioner thus performs tasks in his/her catchment area on the basis of an agreement with the local authority; to takeover a practice, new doctors must pay the doctor who was their predecessor or, if the doctor died, his/her survivors (Rurik 2012). Consequently, family doctors usually have a stable clientele in their catchment areas. According to the WHO, in 2002 the density of doctors in Hungary was 319 doctors per 100 000 inhabitants (Germany, for example, has 336 doctors), so from a purely quantitative point of view it can be assumed that this service is relatively well-balanced. According to the Hungarian portal HRportal.hu (11 July 2019), referring to the National Health Centre, 373 GPs were vacant for at least six months, which compared to the 6 082 general practitioners employed according to official statistics (www.ksh.hu), is just a small fraction.

General practitioners thus conclude two basic contracts; one with the local government on health care provision, the other with the Operator of National Health Insurance Fund (NEAK) on financing. Financial rules are regulated by the government; there is no market system with competition between providers; the professional, content, personal and material conditions of a general practitioner's activity are set by law. The operation of the family doctor service is financed by the Operator of National Health Insurance Fund (NEAK) from the Health Insurance Fund under a contract. The remuneration for family doctors is paid by capitation according to patient age structure, the doctor's age and qualification, as well as the place and extent of his/her experience. However, it is only given to a certain number of patients. The motivation for extensive and high-quality treatment is therefore weak, particularly for reason that recommendation to a specialist has no affect on capitation. For example, at the end of the 1990s, primary care accounted for just over 10% of healthcare expenditure (against 40% for institutional care, in comparison with 32.4% in Germany in 2001).

## Health care in the competence of regional authorities

In recent years, there has also been running, since 2011, the Semmelweis Plan healthcare reform (named after a famous Hungarian physician, a 19th century epidemiologist). Originally, after the decentralisation reforms of the 1990s, counties were responsible for specialised healthcare services, including hospitals. Decentralisation, associated with devolution of founding powers to regional authorities, was, though, assessed as unsuccessful (Ádány - Vóko 2014). The Semmelweis Plan created 8 geographical territories (each comprising approximately 1 to 1.5 million inhabitants), independent of the current territorial division of the country in which a new institutional system of hospitals was applied, in which a possible solution for freezing hospital debt was to be a reduction in the number of hospitals, primarily by means of combining them. The basis for the new system is professional specialisation of hospital facilities and their availability for patients (urban, regional, large-scale, national and outpatient hospitals). Eight large-scale hospitals will be in charge of the most serious cases. Alongside this there should function flexible definition of healthcare financing, particularly for given territories, making it possible to take account of regional differences and thus flexibly adjust the flow of funds to individual hospitals and healthcare providers.

Hospitals that were founded by self-government authorities were, as of 1 May 2012 (under the Act CLIV of 2011), transferred back to the founding powers of the state, which though ran into resistance from local self-governments (Gaal 2015). Before the reform, there were as many as 112 hospitals under the founding powers of local and regional authorities in Hungary. As at 31 December 2017 there were 164 hospitals in Hungary, of which 92 (56.1%) were founded by the state, 27 (16.5%) founded by business entities, 18 (11.0%) by community organisations, foundations, etc., with only 15 (9.1%) set up by self-government authorities, primarily counties, 7 (4.3%) by churches, 4 (2.4%) by universities and 1 (0.1%) by the prison service (Nemzeti 2018).

The basic legislation concerning our topic here comprises the following regulations:

- 2011. évi CLIV. törvény a megyei önkormányzatok konszolidációjáról, a megyei önkormányzati intézmények és a Fővárosi Önkormányzat egyes egészségügyi intézményeinek

átvételéről (Act no. 154/2011 on the consolidation of the county councils, on the assumption of county healthcare facilities and certain healthcare facilities of the city of Budapest)

- 27/2015. (II. 25.) Korm. rendelet az Állami Egészségügyi Ellátó Központról (Government Regulation no. 27/2015 on the State Health Care Centre)

## Funding

Hungary spends much less on health than the EU average. Moreover, only slightly more than two thirds of healthcare expenditure is publicly funded, leading to a high share of direct payments, which are twice the EU average. All in all, it may be noted that the healthcare system remains primarily dependent on hospital care, while primary care is insufficiently equipped to play a more prominent role (OECD 2017b). Of total healthcare expenditure, just over two thirds of the total is taken up by public funds – government sources and healthcare insurance. Government sources are often in the form of special-purpose subsidies – for example hospitals that do not perform abortions receive a special government subsidy.

Direct payments by the public for health care form some 27% of health care spending, which is almost twice the EU average of 16% (OECD 2017b)

The main source of health funding is the National Health Insurance Fund (Nemzeti Egészségbiztosítási Alapkezelő, NEAK), which provides benefits in kind and monetary remuneration. Benefits in kind include free healthcare services, such as preventive checkups, specific primary care, institutional care, outpatient specialised and dental care, as well as rehabilitation, medical transport and emergency care, price support for pharmaceutical products, price support for medical devices, etc. Increased expenditures of the National Health Insurance Fund necessitated an increase in insurance contributions to the Fund in 2012 (Skiba - Rapkiewicz - Kędzierski 2014, p. 88)

### 2.2.3 Social services

The organisation of long-term care for the elderly, which we compare in the V4 countries in this study, is in Hungary partially divided between the healthcare and social care systems. Most institutional long-term care is provided by central government and NGOs,

while local authorities provide most home-based care. This organisation, though, is not sufficiently coordinated and there are overlaps, leading to inefficiencies that should be eliminated by a new integrated system of long-term care (Czibere - Gal, 2010).

Access to more effective home-based care is often limited by the lack of workforce in home-based care, and by lack of funding. The result is pressure on more expensive long-term care. A solution should come in the form of the introduction of monetary benefits (income-tested) and the offer of quality retirement homes and a voucher system that allows recipients to choose between different providers of these services (OECD 2019, p. 62).

#### Social services under the competence of municipalities

In Hungary, too, there is a growing need for the provision of social services, both in consequence of the general European trend of an ageing population, as well as the fact that according to estimates some 1.3 million residents may be grouped under some form of health disability. At the same time, social services in households are available only for 7% of the age cohort above 65 years, and only 3% of persons in this age group have the possibility to use the capacities of permanent or long-term residents. The number of persons waiting is rising, while capacities are not rising, rather the opposite. The number of professional carers is falling, as their wages are the lowest in the entire national economy, and the number of vacancies in this segment has been growing rapidly for 10 years now. The average age in these professions is already around 50 years and soon there will be a massive retirement. More and more jobs are being filled by unskilled labour (Gyarmati 2019, p. 1).

As regards the care service, provided (primarily) to elderly persons in their households (*gondozási*), this is the responsibility of the county authorities and is realised in the form of a contribution paid to the carer (in 2019 this was HUF 32 600). The second component of a carer's income comprises fees for certain acts paid for by the care recipient. A large part of these services are provided to care recipients free of charge by their relatives, which places a disproportionate burden on the functioning of their families.

The county authority provides a care service only in the scope, if it has available carers, of whom, as we mentioned above, there is a long-term shortage. Therefore, it calls on

municipalities to be more involved in fulfilling this task, for example by providing additional forms of remuneration – wage supplements (from municipality’s own funds) that would raise the attractiveness of carer work, or by involving volunteers in this activity, particularly from the ranks of still active pensioners (who have sufficient time, experience in various household chores). Support in preparing these volunteers for performing care services (in the form of mentoring) would be performed by a special service organisation with expertise from the field of care. A solution is sought also in raising payments for provided services from the side of their users, depending on their current financial situation (Gyarmati 2019).

#### Social services in the competence of regional authorities

According to the above-mentioned Act CLIV of 2011, as of 1 January 2012, state social security and child protection institutions, previously established by counties, came under the founding powers of the state. This process was supported by Act CXCII of 2012 on the adoption of certain specialised social care and childcare institutions and on the amendment of certain acts. Under the Act, as of 1 January 2013, the state took on the obligation to organise the provision of temporary and long-term residential care.

Social services were thus also centralised after 2012, particularly in the field of long-term stay facilities. The share of places in facilities founded by territorial self-government authorities (local and regional) in the total number of these places fell from two-thirds to one-third (just between 2006 and 2012 from 59.1% to 30.7%), whereby there correspondingly grew the share of facilities founded by central state administration and so-called historical churches (which improved their position in part due to better financing from state grant schemes). The share of places in state-founded facilities thus increased from 1.2% to 26.9% between 2006 and 2012. Church founders are also favoured in providing outpatient and field care services (Horváth 2016).

In 2019, there were 865 retirement homes (*idősek otthona*) operating in Hungary, of which 36.4% were founded by self-government authorities (county and local) and 27.6% by the state administration. In Hungary, retirement homes, as well as other state-provided social services, fall under the Directorate-General for Social Affairs and Child Protection (Szociális

és Gyermekvédelmi Főigazgatóság - SZGYF), which is under the Ministry of Human Resources. It was set up by the government in 2012. The Directorate-General has 20 territorial offices: 19 of them in the districts and one in Budapest (Temesi 2014). Other founders are NGOs (14.7%) and others, in particular church organisations (13.7%) (Gyarmati 2019). The rest comprise business entities as founders (7.6%). The growth in the importance of the state is reflected not only in the scope of its significant direct founding powers, but also in the fact that unit costs for institutional care per person in social services facilities are also set centrally, whereby a provider founded by the state administration has these costs covered to 100%, while a self-government or non-profit organisation has these costs covered to approximately 70%, while for-profit companies receive only 30% (Bulain – Panov 2012).

The basic **legislation** concerning our topic here comprises the following regulations:

- 1993. évi III. törvény a szociális igazgatásról és szociális ellátásokról (Act no. 3/1993 on social administration and social benefits)
- 2011. évi CLIV. törvény a megyei önkormányzatok konszolidációjáról, a megyei önkormányzati intézmények és a Fővárosi Önkormányzat egyes egészségügyi intézményeinek átvételéről (Act no. 154/2011 on the consolidation of the county councils, on the assumption of county healthcare facilities and certain healthcare facilities of the city of Budapest)
- 2012. évi XXXVIII. törvény a települési önkormányzatok fekvőbeteg-szakellátó intézményeinek átvételéről és az átvételhez kapcsolódó egyes törvények módosításáról (Act no. 38/2012 on the takeover of municipal specialised facilities for institutional care and on the amendment of certain acts)

## Funding

The basic instrument for funding services for seniors (as well as for disabled, long-term ill, or in some cases also childcare) is the state's (through district authorities, not counties) provision of the nursing allowance (*ápolási díj*), which is paid to persons providing long-term care. Local authorities can also provide support to those providing long-term care, but are not obliged to do so. Local self-government authorities assess the fulfilment of criteria for the provision of this allowance, and accordingly the allowance is linked to the various scope of services provided and to a various level of allowance in three bands, representing 115%, 173% and 207% of the amount, set annually in the state budget (currently HUF 37 490  $\approx$  €112, HUF 56 400  $\approx$  €169 and HUF 67 485  $\approx$  €193).

The Hungarian government has committed to increasing this allowance so that it reaches the level of the minimum wage, whereby it would become a tool for strengthening the provision of the home-based care service and would prevent growing pressure on the provision of services in institutional facilities.

## **2.3 Public administration as a public services provider in the Czech Republic**

Although the Czech Republic and the Slovak Republic share a long common history, back in times of their common state there were prerequisites laid down to give rise to certain differences in their further development. These included a decision adopted still in the context of the formal federalisation of Czechoslovakia after 1989, according to which both national republics (and not the federal authorities) held the power to arrange the structure of local state administration authorities. The episodic attempt with a different arrangement of regions had only a short duration, but after 1990 both parts of the already functioning federation took advantage of this possibility and the public administration in the Czech Republic has since been organised in the so-called combined model of the performance state administration and self-government. This applies at both the regional and local level.

In total, there are 6 254 municipalities in the Czech Republic, which already suggests that the settlement structure is highly fragmented and that small municipalities form a significant proportion of them: out of the given number of municipalities, as many as 4 856 municipalities have fewer than 1 000 inhabitants, representing 77.7% of all Czech municipalities. However, due to the combined model of public administration, this problem could be solved by differentiating municipalities with different competences in principle (although not literally) according to their size into several categories for which the designation “type” was used in practice. In the Czech Republic we distinguish in this manner the following:

- type-1 municipalities, of which there are 6 254 (100% of all municipalities), which perform almost exclusively only self-governing tasks and of the state administration tasks they perform only those that are explicitly entrusted to municipalities by law. All municipalities thus perform state administration in the basic extent in the area of population registration, fire protection, protection of land and forest fund, ensure the organization of elections of all kinds (from elections to municipal authorities through to elections to bodies of self-governing regions, elections to the parliament and senate and through to election to the European Parliament), similar tasks in censuses etc. The territory of the municipality is an administrative district in terms of the performance of state administration;

- type-2 municipalities, i.e. municipalities with authorised municipal offices, of which there are 383 (6.1% of all municipalities): the delegated performance of state administration is carried out by the municipal office of the respective municipality in the territorial district designated by law (i.e. also for neighbouring municipalities). This concerns the performance of the state administration in such areas as tasks regarding the protection of nature and waters, deciding in administrative proceedings of first instance concerning the rights and interests protected by law and obligations of persons (unless depleted otherwise by law) etc.. At the same time, each type-2 municipality is a type-1 municipality, i.e. it performs (but only on its own territory) all original (self-government) tasks and tasks entrusted by the state to be performed by type-1 municipalities;

- type-3 municipalities, i.e. municipalities with extended powers, of which there are 206 (3.3% of all municipalities) and whose municipal authorities essentially took over the tasks previously performed by district authorities, also in their territorial districts. Type-3 municipalities thus happened to include former district towns (of which there were 91) and in addition to these also other municipalities (so their territorial districts acquired the name “small districts”). For all the municipalities within their district, municipalities with extended powers perform state administration in such areas as maintaining a population register, issuing identity cards and passports, tasks concerning social and legal protection of children, protection of cultural monuments, freelance licences, protection of nature and air, protection of agricultural soil fund, etc.. At the same time, each type-3 municipality is also a type-2

municipality and thereby it performs state administration in a different (more narrowly) defined territorial district in the areas as listed above. And of course it is also a type-1 municipality, i.e. it performs all self-governing tasks (original competencies) and the performance of state administration in its own territory, which is delegated to all municipalities – however, they perform these tasks only and exclusively in its own territory.

In order to perform their functions, municipalities may also create public-law associations of municipalities, which may also fulfil the public administration tasks in the fields of education, social care, health care, etc.

There are 23 statutory towns in the Czech Republic, which can be divided into town districts or town districts with self-government established. However, such self-government of town districts is not a legal entity and within the original competences performs only the tasks entrusted to it by the town. On the other hand – since the town district also performs some tasks under the delegated state administration regime – the town district authority has legal personality.

The most important self-governing body of the municipality is the municipal council, elected directly for a four-year term of office, which decides on all fundamental issues of the functioning and development of the municipality – i.e. in principle on matters belonging to independent (original) competence of municipalities. The municipal council elects the mayor from its members (only in statutory towns it is the town mayor) and in municipalities with more than 15 council members, it elects also a 5 – 11 member board, which is – unlike Slovakia – a full executive body: it is formed by the mayor, mayor deputies and other council members. The importance of the board is greater than the position of the mayor, but where the board is not elected, its function is assumed by the mayor. The mayor otherwise heads the municipal or town office (in statutory towns it is the town council office) and has the right to appoint and dismiss the secretary of the municipality. The secretary of the municipality is responsible for the exercise of delegated competences, which the municipality performs on behalf of the state – and therefore this function is not established in type-1 municipalities, where the mayor is responsible for this agenda.

Czech legislation thereby distinguishes between the autonomous (original) competence of municipalities, i.e. the matters that are in the interest of the municipality and its inhabitants (§ 35(1) of the Act on Municipal Establishment) and those which are not entrusted by law to, for example, regions or which are not entrusted into the performance of state administration. Part of these competences can then be entrusted to municipalities (as a rule, to be performed by type-2 and type-3 municipalities) under the regime of delegated powers.

At the regional level, thirteen self-governing regions and the Capital City of Prague represent the public administration in the Czech Republic. These fourteen territorial units are divided into 91 districts and 223 administrative boroughs. As a rule, no separate state administration bodies are established in districts and boroughs. Regional self-government is carried out by the population of the self-governing region through a regional council elected directly for a period of four years. The regional council elects a regional board from its members, which is the executive body of the regional self-government. The regional governor is elected indirectly, and represents the region externally. The regional council is required to set up three committees: committees for the audit, finance and education & employment. The competence of the region includes, for example, territorial development, environmental protection, cultural development, education, some issues of social care, etc.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 128/2000 Coll. the Municipalities Act (municipal establishment)
- Act no. 172/1991 Coll. on the transfer of certain things from the property of the Czech Republic to the ownership of municipalities
- Act no. 152/1994 Coll. on elections to municipal councils
- Act no. 347/1997 Coll. Constitutional Act on the creation of higher territorial self-governing units
- Act no. 129/2000 Coll. on regions
- Act no. 157/2000 Coll. on the transfer of certain things, rights and obligations from the property of the Czech Republic to the property of regions
- Act no. 176/2001 Coll. Constitutional Act amending Constitutional Act no. 347/1997 Coll. on the creation of higher territorial self-governing units and amending Constitutional Act of the Czech National Council no. 1/1993 Coll., the Constitution of the Czech Republic

- Act no. 491/2001 Coll. on elections to municipal councils
- Act no. 290/2002 Coll. on the transfer of certain other things, rights and obligations of the Czech Republic to regions and municipalities, civic associations acting in the field of physical education and sport and on related changes and on amendment to Act no. 157/2000 Coll. on the transfer of certain things, rights and obligations from the property of the Czech Republic, as amended by Act no. 10/2001 Coll. and Act no. 20/1966 Coll. on the human health care, as amended
- Act no. 314/2002 Coll. on the setting of municipalities with authorised municipal authority and the setting of municipalities with extended powers
- Decree no. 59/2002 Coll. on the implementation of the Act on elections to municipal councils
- Act no. 420/2004 Coll. on the review of the management of territorial self-governing units and voluntary associations of municipalities
- Decree no. 361/2006 Coll. amending Decree no. 388/2002 Coll. on determining administrative districts of municipalities with authorised municipal authority and administrative districts of municipalities with extended powers, as amended by Decree no. 388/2004 Coll. and Decree no. 564/2002 Coll. on the determination of the territory of the districts of the Czech Republic and the territory of the town districts of the Capital City of Prague, as amended by Decree no. 623/2004 Coll.
- Act no. 270/2007 Coll., amending Act no. 337/1992 Coll. on administration of taxes and fees, as amended, and other related acts
- Act no. 261/2007 Coll. on stabilisation of public budgets
- Act no. 174/2012 Coll., amending Act no. 565/1990 Coll. on local fees
- Act no. 24/2015 Coll., amending Act no. 250/2000 Coll. on budgetary rules of territorial budgets
- Act no. 128/2000 Coll. on municipalities (municipal establishment)
- Act no. 129/2000 Coll. on regions (regional establishment)
- Act no. 131/2000 Coll. on the Capital City of Prague
- Act no. 106/2016 Coll., amending Act no. 128/2000 Coll. on municipalities (municipal establishment), as amended, Act no. 129/2000 Coll. on regions (regional system), as amended, Act no. 131/2000 Coll. on the Capital City of Prague, as amended, and Act no. 256/2013 Coll. on the land register (Cadastral Act)
- Act no. 257/2017 Coll., amending Act no. 128/2000 Coll. on municipalities (municipal establishment), as amended, Act no. 129/2000 Coll. on regions (regional system), as amended, and Act no. 131/2000 Coll. on the Capital City of Prague, as amended

- Decree no. 39/2019 Coll. amending decrees implementing electoral laws
- Act no. 263/2019 Coll., amending Act no. 128/2000 Coll. on municipalities (municipal establishment), as amended, Act no. 129/2000 Coll. on regions (regional system), as amended, and Act no. 131/2000 Coll. on the Capital City of Prague, as amended
- Decree no. 265/2019 Coll. amending decrees implementing electoral laws
- Decree no. 219/2019 Coll. on the percentage share of individual municipalities in parts of the national gross revenue from value-added tax and income tax

### 2.3.1 Education services

The Czech Republic is considered – including OECD comparisons – as having one of the highest decentralisation rates in education management. Naturally, this applies to primary and secondary schools, which externally act as independent legal entities, the headmaster/headmistress has the status of a statutory body, other decisions are in the competence of the founder and the Ministry decides only on legislative proposals and carries out control (Roupec 2006, p. 83).

#### School system in the competence of municipalities

§ 35(2) of the Czech Act on Municipal establishment defines the scope of tasks falling within the independent competence of the municipality (with reference to § 84, § 85 and § 102) through the application of the scope of other laws. For instance, the School Act no. 561/2004 Coll., in § 178, defines the duties of the municipality primarily as ensuring the conditions for the fulfilment of compulsory school attendance of children having their permanent residence in their municipality's territory. For this purpose, the municipality establishes or cancels an elementary school, or, if applicable, ensures the fulfilment of compulsory school attendance at a primary school established by another municipality or an association of municipalities (in the case, where the school is more than 4 km away, commuting to the school must be provided by the region). Pursuant to § 179, a municipality or an association of municipalities also establishes and cancels child day-care schools, kindergartens and elementary schools with minority language of instruction, school canteens

at schools within their founding powers, elementary art schools, school facilities for leisure education and special-purpose school facilities.

Of the total number of 4 141 primary schools in the Czech Republic, 3 616 (84.4%) were founded by municipalities in the academic year 2018/2019. Under the School Act, primary schools may, however, also be founded by regions (232 schools, i.e. 5.6%), private entities (208, i.e. 5.0%), church (42, i.e. 1.0%) and ministries (in the case of primary school it is the Ministry of Education, Youth and Sport of the Czech Republic only, with 40 schools, i.e. 1.0%) (MŠMT 2019). Municipalities in their original competence (although financed from the state budget), thereby meaning all municipalities (as type-1 municipalities), are thus the dominant founder of primary schools in the Czech Republic.

Schools system in the competence of regional authorities

The competence of regional authorities (self-governing regions) includes in particular the founding of schools providing two-year secondary education, secondary education with vocational certificate, secondary education with a school-leaving exam certificate, which may be general (grammar schools), vocational non-occupational (lyceums) or vocational occupational (industrial secondary schools), as well as education at art academies and higher vocational schools (which are part of tertiary education). Regions are founders of about three quarters of secondary schools, roughly one fifth of secondary schools have private or church founders, about 3% of secondary schools are established by the Ministry of Education, Youth and Sport or other state administration authorities, and a number of secondary schools have also been established by municipalities (or associations of municipalities) (Rychlá 2010).

The founder of schools at the regional level is represented by the regional council (executive body of the regional self-government), where at the municipal level it is the municipal board, or where a municipal board is not established, this competence is divided between the mayor and the council. In the case of an association of municipalities, the function of the school founder is fulfilled by the authority defined in the statutes of the association of municipalities.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 561/2004 Coll. on pre-school, secondary, tertiary vocational and other education (Education Act)
- Act no. 563/2004 Coll. on pedagogical staff
- Act no. 564/1990 Coll. on state administration and self-government in education
- Act no. 111/1998 Coll. on higher education institutions and on the amendment of certain acts (University Act)
- Act no. 130/2002 Coll. on support of research and development from public funds and on the amendment of certain related acts (Act on Support of Research and Development)
- Act no. 341/2005 Coll. on public research institutions
- Act no. 218/2000 Coll. on budgetary rules and on the amendment of certain related acts (Budgetary Rules)
- Act no. 250/2000 Coll. on budgetary rules of territorial budgets
- Act no. 306/1999 Coll. on providing subsidies to private schools, pre-school and school facilities

#### Funding

Education is a public service, primarily financed from public budgets, but in some cases co-financing by consumers of this public service is also envisaged. The share of public resources dominates in compulsory education; funds used here come from tax revenues transferred to municipal budgets and higher territorial units from the state budget, from the budget chapter of the Ministry of Education, Youth and Sport. From the latter, funds are subsequently provided for education at schools and school facilities on the basis of the rules laid down in the current Education Act. The state budget may contribute to education funding at schools also from the chapter of the National Treasury Administration (Adámková 2007). As regards secondary schools, the financing of schools is carried out through the budgets of regional authorities.

Funding is carried out using the method of normative contributions, i.e. the amount of non-investment funds per pupil (student), regardless of whether it is a pupil of a public (state) or private school. There are national, regional and local normatives. National normatives represent the amount per pupil of a certain type of school. These funds come from the state budget to the region's account from which the regional authority, using regional normatives, allocates funds to secondary schools established by the region, but also to primary (and pre-

school) facilities established in the territory of the region by a municipality or an association of municipalities. Local normatives express discrepancies in non-investment costs between schools of the same type. The total amount of funds received by a school is then the result of the compilation of these three normatives. The normatives for non-state (e.g. church) schools are set in the same way, except that they come from the budget of the ministry and go directly to the budgets of schools. National normatives also include limits on the number of school staff. Another part of the funds, e.g. for development schemes, which cannot be expressed by means of normatives, is received by schools from the Ministry's budget outside the normatives, similarly as funds for investment needs (MŠMT 2017). However, from 2020 there will be a change and the normatives per pupil will be replaced by a per teacher normative and the schools will receive funding according to the number of lessons taught; the Ministry of Education will be setting limits for individual types of schools and class sizes.

### 2.3.2 Healthcare services

The system of healthcare provision in the Czech Republic currently includes outpatient care, institutional (inpatient) care, but also preventive care, spa care and other subsystems. Healthcare reforms following 1990 aimed from the very beginning to provide health care in a competitive environment, a free choice of doctor and of a healthcare facility, healthcare guarantee for all citizens, statutory health insurers, etc.. The transformation following 1993 concerned firstly outpatient care where in total 4 240 units were privatised, of which 757 were transferred over to the municipalities free of charge. At the end of 1996, out of a total of 208 hospitals, 111 remained state facilities and 55 private (Gladkij - Strnad 2002). In 2005, only 19 of the 195 hospitals were established by the Ministry of Health (and six others were established by other central state administration authorities), 95 were private, 52 were in the founding competence of regions and 23 were in the founding competence of towns and municipalities (IHIS 2005).

#### Health care in the competence of municipalities

Regarding the independent (original) competence of municipalities in the Czech Republic, the Czech Act on Municipalities does not specify any particular activities that the

municipality should undertake in this area: however, pursuant to § 35(2) of the Act, the municipality performs such competence by creating conditions for satisfying the need for health protection and development “in accordance with local requirements and local customs”. The Amended Act on Municipalities no. 128/2000 Coll., in § 84(2)(x), directly entrusts into the competence of the council the decision-making on the establishment, merger, divisions and cancellation of a public non-profit constitutional facility.

In the framework of its independent competence, a municipality may also establish legal entities and organisational units. By the end of 2011, the applicable Act no. 245/2006 Coll. on public non-profit institutional healthcare facilities explicitly authorised municipalities to establish public healthcare facilities (SMO 2005, p. 26). Some healthcare facilities of municipalities, which were established during the validity of this act continue to exist to this day, though new ones are no longer being established, despite the efforts to revive as well as financially support these activities from the side of regional self-governing authorities’ budgets (e.g. for small municipalities in the Pilsen region). The same applies to medical outpatient clinics, which are as a rule the point of first contact and which are from the focal point in providing healthcare services at local level.

Currently (2013) there are 24 979 independent outpatient facilities in the Czech Republic, of which only 60 are established by the municipality. Out of the total number of 203 associated outpatient facilities, only 12 are established by the municipality; out of 130 healthcare centres, only one is established by the municipality; out of 4 449 independent general practitioners’ clinics for adults, only two are established by the municipality; out of 7 127 independent clinics of specialists, five are established by the municipality; and out of 4 258 other specialist facilities, the municipalities established 40 (IHIS 2015, p. 26, 47). The direct share of municipalities in the establishment of healthcare services in the Czech Republic is therefore negligible.

Under the delegated competence, Act no. 372/2011 Coll. on healthcare services imposes upon municipalities some, but not extensive, obligations: for example, the provider should publish on the official notice board information about the termination of the provision of healthcare services. The municipality also has obligations ensuing from § 96 of Act no.

258/2000 Coll. on public health protection, when it can determine, by way of a generally binding decree, the performance of protective disinfestation and extermination for the municipality's territory or part thereof.

Broader tasks in the area of healthcare services are performed by type-3 municipalities. Municipal authorities of municipalities with extended powers create their own organisational unit, usually also a healthcare department. These municipalities and associations of municipalities also participate in the establishment of hospitals, despite forming only a small share among the founders.

Health care in the competence of regional authorities

From our point of view, as well as from the point of view of regional authorities' competence in the Czech Republic, we can justifiably concentrate here on the issue of establishing hospitals, which are divided into state and non-state.

State healthcare facilities mostly fall within the founding competence of the Ministry of Health of the Czech Republic (or other central authorities of the state – the Ministry of Defence of the Czech Republic, the Ministry of the Interior of the Czech Republic, etc.) – so-called directly managed organisations. These are mainly university hospitals and other medical facilities providing highly specialised care (IKEM, Brno Casualty Hospital, etc.).

Non-state healthcare facilities are considered to include not just private facilities but also facilities set up by the territorial units – i.e. regions and municipalities – which establish them on the basis of their independent competence. Regions and municipalities can thus set up hospitals, treatment centres, etc., which may take the form of community-benefit companies or even commercial companies (liability-limited companies, joint-stock companies). The Ministry of Health sets the catchment areas for these facilities. In the framework of delegated performance, regions are required to establish healthcare and emergency medical services in the form of contributory organisations (with co-financing from the Ministry of Health), emergency medical services (including dental medicine) and pharmacy, they also establish alcoholism prevention stations, smoking counselling centres, etc..

Private healthcare facilities are hospitals, various treatment facilities and recovery centres, clinics, day care centres, transport services for the sick and injured, etc., which are owned by natural or legal persons.

At the same time, self-governing regions in the Czech Republic are the founders of only about 13% of hospitals, municipalities (or associations of municipalities) of another 9% (but counting for only 6% of beds, i.e. they are the smallest hospitals). The largest hospitals are set up by the Ministry of Health (28% of beds), most hospitals are set up by other legal entities – churches, insurance companies, etc. (50% of beds).

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 258/2000 Coll. on public health protection
- Act no. 372/2011 Coll. on healthcare services
- Decree no. 99/2012 Coll. on requirements for minimum staffing for healthcare services
- Government Regulation no. 307/2012 Coll. on local and temporal availability of healthcare services
- Act no. 466/2011 Coll., repealing Act no. 245/2006 Coll. on public non-profit institutional healthcare facilities

#### Funding

Health care in the Czech Republic is financed from several sources, with the predominant share of public sources.

The largest share – about two-thirds – of health care funding comes from compulsory health insurance. Contractual doctors in outpatient care are rewarded by the capitation payment, which is a fixed amount for each registered patient combined with a point payment for provided services. Outpatient care providers operating in municipalities with small or scattered settlements may have the inadequate coverage of the cost of performance offset by a capitation payment. Negotiations regarding the offsetting with the health insurance company must be initiated by the municipality, otherwise the municipality itself should cover the increased costs (Ryšavý 2012). Hospital care is funded through the Diagnosis Related Group (DRG) system, which is considered the most objective, transparent and fair system of hospital

financing in the world. The DRG system measures and evaluates hospital production. It measures the efficiency of how the hospitals use diagnostics, treatment and services, though it fails to take into sufficient account the building equipment, cost of building management, etc., so hospitals often have to be subsidised from the municipal and regional budgets (provided that municipalities and regions are their founders) in order to maintain the quality of health care. (Kebza et al., 2017, p. 22).

According to the figures for 2015, the state budget's contribution makes roughly 15% of the health care financing, with a further less than 3% coming from the local self-government budgets. Together, public sources make up approximately 84% of funds for health care, less than 14% are direct payments from citizens and the rest – approximately 2% - are resources from private insurance (ČSÚ 2017).

### 2.3.3 Social services

§ 38 of the Social Services Act defines social care services as services that help people to ensure their physical and mental self-sufficiency in order to support life in their natural environment and to enable them, as far as possible, to participate in the everyday life of society, and when this is precluded by their condition, provide for them a dignified environment and interaction. Everyone has the right to social care services in the least restrictive environment. It is estimated that 13% of the elderly in the Czech Republic need routine home assistance, 7% – 8% need systematic home-based care and 5% need institutional care (Káčerová - Mládek - Ondačková 2013, p. 52).

There are currently around 2 150 social service providers in residential facilities, outpatient and field services (Boříková 2018). The aim of the transformation of institutional (residential) social services was to create a coordinated network of services for users enabling life in their natural community. This means, above all, a change in investment policy: a move away from building social care institutions and greater support for investment in the development of field and outpatient services (Ministry of Labour and Social Affairs of the CR 2007, p. 13).

Social services under the competence of municipalities

If we wish to capture the widest possible spectrum of municipalities as social service providers, given the existing fragmentation in the Czech Republic, the care service yet again appears to be the most suitable segment, especially if provided in field, i.e. in the form of care at home. The register of social service providers (currently 3 040 in the Czech Republic), too, reports care service providers as the largest share – up to 27%.

The care service in the Czech Republic is defined as a field or outpatient service provided to the persons with reduced self-sufficiency due to age, chronic disease or health disability and to families with children whose situation requires assistance of another individual – nevertheless, we lack precise statistics concerning the share of individual groups and have available only qualified estimates indicating the provision of care service at 10% of people above 65 years of age. A care service is provided in a limited period of time at homes of given persons or at outpatient facilities, but yet again we have no data available on the share of services provided at home or at such facilities. The service is provided for a fee from the user. The use of care services, for example, allows seniors to continue to live at their own homes while it enables them to better cope with everyday situations that are becoming more challenging for them. Only people who have undergone a qualification course can provide care service: they help their clients with personal hygiene, movement around their homes, catering and small purchases (Halásková 2013, p. 87).

This segment in the competence of municipalities was significantly strengthened in 2002 as part of the transfer of this task from district authorities to municipalities that provided the services under Act no. 248/1995 Coll. on public benefit companies in the form of these companies or in the form of their own organisational unit. The act was repealed on 31 December 2013. However, there is still applicable the Act on Social Services, which in § 5(1)(c) imposes upon the municipal authorities within the municipalities with extended powers (i.e. type-3 municipalities) to carry out competence in the area of social services as delegated performance of state administration. Pursuant to § 92 of the act, a municipal authority with extended powers provides social service in the necessary scope to a person at risk (who is not a recipient of a social service), while in doing so it is governed by the place of the person's permanent residence. The municipality otherwise coordinates the provision of

social services within its administrative borough (by a number of providers). Thus, only municipal authorities of municipalities with extended powers decide, in delegated competence, not only on the provision of benefits in kind and cash, but also on the provision of social services (SMO 2005, p. 27).

As regards the care service, the municipality is only one of the possible providers – according to the Social Services Act the service can be provided also by a non-state non-profit organisation, a legal or natural person. It can be provided as a field or outpatient service and its clients may also include the elderly. Providers are registered with the authority of the self-governing region. The municipality may also conclude a contract on the provision of care services (including a family member) with the provider – the provider is remunerated from the payment paid by the client but also from other sources: from the founder's funds, subsidies from the state budget, from the subsidies from the regional budget, etc..

Of the 816 care service providers, the largest share (301, or 36.9%) is directly made up of towns and municipalities. The second highest share is held by non-state non-profit organisations, i.e. civic associations, community services, church legal entities (279, i.e. 34.2%), where some of them (mainly community service) were established by municipalities; the same applies to the third most frequent group of providers – government-subsidised organisations (of which there are 179, or 21.9%). Other providers (30 natural persons, 20 companies and 7 others) together make up only a negligible share (Ministry of Labour and Social Affairs of the Czech Republic 2011).

There are significant territorial disparities in the provision of this service: from about 40 to about 60 clients from the age cohort over 65 in some regions in the northwest of the Bohemia to a share of over 120, perhaps over 180 clients in some Moravian regions (Halásková 2013, p. 89). “Serviceability of regions in care services provided at individual clients' homes is significantly determined by the regional profile – while the high values are usually achieved by regions with a predominantly flat surface (South Moravian and Central Bohemia region), the lowest values are usually reported by regions with a predominant mountainous terrain” (Víšek - Průcha 2012, p. 20). Since it is also proven that the former type of regions shows significantly larger (more populous) municipalities on average, while on the

contrary the latter ones have smaller municipalities (Konečný - Konečný 2009, p. 42), it is clear that even care service is more accessible in larger municipalities, although the elderly population is represented rather in smaller municipalities. Therefore, these differences are even more noticeable at the local level, and according to expert analyses, in the Czech Republic “the minimum size of a municipality in which social services can be operated is about 2000, or, if applicable, 5000 inhabitants, and as significant are considered municipalities of roughly 10 000 inhabitants” (Víšek - Průcha 2012, p. 21).

#### Social services in the competence of regional authorities

Since we decided, in the framework of methodological considerations of our comparative study, to compare among the social services at the regional level the institutional (residential) services, then in the case of the Czech Republic we must begin by stating that the founders of certain top-level specialised social services of this type include directly central state administration bodies, primarily the Ministry of Labour & Social Affairs of the Czech Republic, which is, though, the founder of only five organisations providing social services (four in the form of the state, and one government-subsidised organisation). These are highly specialised institutes with nationwide scope. From among public providers, state providers thus represent the smallest share (approximately only 1%).

The Ministry of Labour & Social Affairs of the Czech Republic also draws up the national strategy for the development of social services for the particular year, which is concurrently one of the starting points for medium-term planning of the development of social services, which must be drawn up by self-governing regions. Founder competences in the field of social services are thus coordinated in this way at the highest hierarchical levels of public administration. Municipalities do not have this obligation, but rather in cooperation with the region they can also draw up plans for their own competence. Self-governing regions also ensure the registration of all social service providers.

Similarly as in the case of municipalities, the regions likewise provide social services as part of their self-government (original) competence.

Self-government regions should primarily be the founders of other specialised social services, unless already provided in the region by a different entity, and the need for them has been identified in the medium-term plan for the development of social services in the region. A self-government region founds social services facilities (e.g. old people's homes, day care centres, etc.) in the framework of its self-government (original) competence. Social services facilities may be founded as an organisational component of the self-government region (without legal personality) or as a legal entity providing social services. In the case of social services that do not entail great demands on personnel, equipment and premises, mostly the form of organisational component of the region (or municipality) is used, whereas in the case of more demanding services a legal entity is founded, which may be of various forms.

Regions, though, are not actually the most important providers of institutional social services. If we assume that 1% of them are established by central state administration, then this means that of the remaining 99%, non-state entities provide these services in a 50% share. Civic associations dominate (27%) among these non-state providers, whilst a lesser share is represented by church and religious associations (11%). Other legal entities (limited liability companies, joint-stock companies) are also represented (forming 9%), as well as natural persons (3%).

Of the remaining 49% of public providers, municipalities and towns form a 29% share, and regions only a 20% share.

From among the public providers of this group of services, a decisive role is played by the local self-government authority, primarily municipalities with extended powers, which both coordinate the provision of social services to persons in their administrative district, as well as provide subsidies to registered providers of social services, and also directly provide certain institutional social services, from which it logically follows that these are especially those most frequented, most needed, i.e. institutional services for seniors (but also, for example, a care service, as mentioned above).

In the catchment area of municipalities with extended powers, which can be framed as having a population of approximately 20 000, "all social and population groups are usually so

large that the social needs of their *problematic segments* can be met at a professionally and economically acceptable capacity level” (Víšek - Průcha 2012, p. 21). The creation of a level of public administration at the level of municipalities with extended powers, sometimes termed small districts, thus created a functional structure better suited and proven by practice as more appropriate both in comparison with the level of regions and the level of ordinary municipalities.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 108/2006 Coll. on social services
  - Decree no. 505/2006 Coll., implementing certain provisions of the Social Services Act
- Funding

The field of social services in the Czech Republic is currently funded from multiple sources. In 2017, the largest share of funds were state funds, forming four fifths (80.2%) of all funds, of which the largest share (44.7% of all funds, or 54.5% of public funds) comprised the contribution for care, with a smaller share (20% of all funds) comprising other subsidies from the state budget, still less (12% of all funds) comprising contributions and subsidies from the budgets of territorial self-government (regions and municipalities), a smaller part (3.5% of all funds) comprising reimbursement from health insurance companies, and finally a minor part (1.8% of all funds) comprising other public expenditure. Payments by users formed 14.4% of all funds, with 3.6% of all funds coming from unspecified sources (Boříková 2018).

The contribution for care is provided to persons dependent on the assistance of another natural person. Through this contribution, paid from the state budget, the state participates in the provision of social services. The contribution is addressed directly to the potential user of such services, enabling the user to choose the one best suiting his/her needs. The contribution is differentiated into four levels individually, according to the degree of support needed. At the same time, they enabled the beneficiary to consider their own possibilities of any additional financial participation in the type of selected service (Ministry of Labour & Social Affairs of the Czech Republic 2007, p. 5).

## **2.4 Public administration as a provider of public services in the Slovak Republic**

Reforms of public administration in the Slovak Republic, with the exception of the constitution of the full structure of central state authorities following the founding of the independent Slovak Republic, have, in recent decades, been focused almost exclusively on the local and regional level.

Since its founding, the organisation of the performance of local state administration in the Slovak Republic has been characterised by frequent changes to its structure, varying between a model of specialised and a model of integrated local state administration. The current situation is represented by single-tier local state administration, which in the basic model is represented by 72 district offices, exercising powers in the field of civil defence of the population and state management in crisis situations outside wartime and states of war, economic mobilisation, real estate cadastre, state defence and environmental care. Of these, 49 also exercise powers, in the wider territorial borough, that include the areas of road transport and land communications, agriculture, forestry, hunting, land modifications, general internal administration and trade licensing. Eight district offices at regional seats manage, control and coordinate the performance of state administration, carried out by district offices in the region's borough, and in the second tier perform state administration in areas where it is performed by district authorities at the first tier. In addition to district authorities, as bodies of general local state administration, the performance of this administration in the territory is provided also by several systems of specialised state administration bodies within the competence of the Ministry of Labour, Social Affairs & Family (Offices of Labour, Social Affairs & Family), Ministry of Health (public health authorities), Ministry of Finance (tax authorities) and other ministries, as well as the system of local state administration authorities in the competence of other central state administration bodies (regional branches of the statistical office, heritage authorities, etc.).

A significant share of the performance of state administration at the regional and local level was delegated to the competence of territorial self-government bodies, particularly in the years 2002 – 2004.

The delegation of powers to municipalities ran into the problem that the settlement structure in Slovakia is characterised by a high degree of fragmentation, with 2 933 municipalities, of which 140 are towns. Some 68% of municipalities have a population of less than 1 000, and the smallest municipalities have only about 10 inhabitants. The capital of the Slovak Republic, Bratislava, (with a population of more than 417 000) and Košice (almost 240 000) are broken down into town districts, with self-government established, and thus have a slightly different framework of competences. Municipalities and urban municipalities provide, in the framework of their self-government competence, for the fields of local roads, public transport, public spaces and greenery, nature conservation and environmental protection, water management, sewerage and communal waste, land-use planning, local development, housing, preschool and school facilities, social facilities, healthcare facilities, culture, certification of documents, local police, collection of local taxes and fees, as well as participation in regional plans and, in the framework of delegated powers of state administration, the fields of registry offices, elections, land-use planning and the building code, water management, nature conservation, health care and part of competences in education and physical education. The bodies of local self-government are the municipal council or town council. They are directly elected for the term of 4 years, equally as the municipal mayor (city mayor, town district mayor). Municipalities may fulfil tasks independently, may cooperate with private legal entities or may set up budgetary, subsidised and non-profit organisations.

The performance of territorial self-government at the regional level is delegated to 8 higher-territorial units operating in the territorial boroughs of regions as units of the territorial-administration division of the state. Higher-territorial units, or also self-governing regions, administer in the framework of the self-government competences 2<sup>nd</sup> and 3<sup>rd</sup>-class roads, land-use planning, regional development, own investment activity, secondary education, healthcare facilities, social service facilities, cultural facilities, civil defence, pharmacy licensing and

private doctor licensing, etc., and in the framework of delegated state administration part of competences in education, physical education, health care, railways, road transport, civil defence, land-use planning and the building code. The bodies of a self-governing region are the council and chairman. The council of a self-governing region is composed of deputies elected in direct elections for the period of four years, similarly as the chairman of the self-governing region. Self-governing regions may fulfil tasks independently, may cooperate with private legal entities or may set up budgetary, government-subsidised and non-profit organisations.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 369/1990 Coll. on municipal establishment
- Act no. 518/1990 Coll. on the transfer of the founding or founding function national committees to municipalities, central state administration bodies and local state administration bodies
- Act no. 222/1996 Coll. on the organisation of local state administration
- Act no. 302/2001 Coll. on the self-government of higher territorial units (Act on Self-Governing Regions)
- Act no. 416/2001 Coll. on the transfer of certain competences from central government bodies to municipalities and higher-tier territorial units
- Act no. 575/2000 Coll. on the organisation of the activity of government and the organisation of central state administration
- Act no. 523/2004 Coll. on budgetary rules of public administration
- Act no. 180/2013 Coll. on the organisation of local state administration

#### 2.4.1 Education services

After 1989, the entire education system in the Slovak Republic underwent significant changes. Straightaway in 1990, the project “The Spirit of School” was drawn up, which envisaged, among other things, the establishment of private and church schools, as well as alternative schools, the improvement of the funding and management of the school system, and others. Despite the fact that it was not fulfilled, some of its ideas had an impact on the first

post-revolution laws in the field of education (Zelina 2010, p. 85). In 1991, there followed the draft project Renewal & Development of the Slovak Education System to 2000, which was followed in 1994 by the National Education & Training Programme (originally: Constantine), which, though, “fell into oblivion” (Humajová - Križ - Pupala - Zajac 2008) p. 14) and in the end as did other adopted concepts. There then followed in 1999 the Millennium project, on the basis of which the SR Government (2001) and Parliament (2002) adopted the National Programme of Education & Training for the Coming 10 – 15 years. After a break of several years, there then followed in 2017, the National Learning and Development Programme, the “Learning Slovakia”, which was intended to be a starting point for implementing fundamental reform of the education system.

One of the most fundamental changes that Slovakia’s education system underwent in this period was the abandonment of the concept of the uniform school and plurality of the school system, in the framework of which part of the founding competence regarding schools were transferred to local and regional self-government authority bodies. The founder of a school or school facility in the Slovak Republic may be a municipality, self-governing region, district office in the seat of the region, a state-recognised church or religious society or other legal entity or natural person.

#### Educational services in the competence of municipalities

Under § 3(3)(h) of Act no. 369/1990 Coll. on municipal establishment, a municipality in performing self-government (i.e. in the framework of self-government, i.e. original competences) shall create conditions for the education of the municipality’s inhabitants. Under § 2(g)(3.1) of Act no. 419/2001 Coll. on the transfer of certain competences from state administration bodies to municipalities, the establishment of primary schools is, *inter alia*, transferred into the competence of municipalities. This competence is therefore performed in the framework of the delegated performance of state administration.

Primary school system, lies primarily in the competence of local authority bodies in the Slovak Republic. It is represented here by fully-organised and non-fully-organised primary schools providing pupils with basic knowledge, skills and abilities in the field of language,

natural science, social science, arts, sports, health, transport, etc. A municipality founds a primary school in the framework of the delegated performance of state administration, where the state finances the school's activity through normatives and other financial transfers: the state also maintains a list (termed a "network") of schools accredited by it. In addition to schools established in this way, primary school founders may also be churches (in 2018/2019 these totalled 116 primary schools, i.e. 5.6% of all primary schools), or private founders (61 primary schools, 2.9%), whilst state primary schools in the founder competence of municipalities thus represent 91.5% (1 910 schools) (Ministry of Education, Science, Research & Sport of the Slovak Republic 2018).

Education services in the competence of regional authorities

Secondary education lies primarily in the competence of regional authority bodies in the Slovak Republic. It is represented by

- secondary vocational schools and combined secondary schools, where study lasts two years, three years (with in apprenticeship certificate) or four years, or five years (including a certificate of secondary education): these are apprenticeship fields such as engineering, construction, woodworking, railway, electrical engineering, various fields of services (cook, waiter, hairdresser, shop assistant, baker, confectioner, butcher, etc.);

- secondary schools and grammar schools. Secondary schools may specialise in electrical engineering, geodesy, hotel services, music academy, industrial, business academies, sports, arts, agriculture, timber, pharmaceutical, chemical, pedagogical, and others, and have four-year study, music academies (in music, dance and acting) have six to eight-year study. Grammar schools in Slovakia provide four-year study or eight-year study (if the pupil applies to a grammar school after completing the first stage of primary school). A grammar school provides general education, ending with a general school-leaving exam certificate. An exception is formed by secondary healthcare schools and military and police academies, which are in the founder competence of the respective ministries.

In total approximately 60% of all secondary schools in Slovakia are public schools, the remainder being church or private schools. In 2017, there were 241 grammar schools and 463

secondary vocational schools in Slovakia. Of the grammar schools, 147 (61.0%) had self-governing regions as their founder, 40 (16.6%) had private founders, and 54 (32.4%) had church founders. Of the vocational schools, 345 (74.5%) had self-governing regions as their founder, 99 (21.4%) had private founders, and 19 (4.1%) had church founders. (Zacharová - Herich - Kvassay - Kováč 2018, Kušnirik 2017).

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 245/2008 Coll. the Education Act
- Act no. 596/2003 Coll. on state administration in education and on school self-governance
- Act no. 597/2003 Coll. on the financing of primary schools, secondary schools and school facilities

#### Funding

The decisive share of income at schools within regional education, i.e. primary and secondary schools, is specified by Act no. 597/2003 Coll. on the financing of primary schools, secondary schools and school facilities. The law recognises the **normative** as the compulsory economic instrument, i.e. a normative contribution for a school for a calendar year, which is determined by the number of its pupils and the normative volume of funds per pupil per calendar year. The normative is the sum of the wage normative and operating normative. The wage normative expresses the standardised annual cost of wages and salaries, including insurance and the employer's contribution to insurance companies (hereinafter referred to as "personnel costs") of employees responsible for the education process, and employees who ensure the running of the school, per pupil. The wage normative is determined depending on the kind of school, type of school, salary grade of teaching staff, demands on personnel in the study field or vocational field, the form of study and language of tuition. The size of the school may also be taken into account in determining the normative for primary schools. The normative may be increased due to school size by at most double. The operating normative expresses the standardised annual costs for the education process and school operation, excluding personnel costs (hereinafter referred to as "operating costs"), per pupil. The operating normative is determined depending on the kind of school, type of school, economic

demands of the field of study, or field of teaching, form of study, language of tuition, and temperature conditions at the school location. The size of the school may also be taken into account in determining the normative for primary schools. The normative may be increased due to school size by at most double.

Other instruments already have the nature of mixed instruments, since they are claimable, but only on the basis of a request. These instruments, under the Act, are:

- funds for specifics, namely:
  - costs for transporting pupils from home to school and back
  - wage and salary costs (including insurance contributions) for teacher assistants for pupils with disabilities or for gifted pupils

The third group of instruments to which the Act refers can be characterised as voluntary instruments, since they may be provided only from the budgetary chapter of the Ministry of Education

- funds for financing pupils' extraordinary achievements in competitions, nationwide school subject competitions and for a school's participation in international projects or programmes;
- special-purpose funds for current expenditures to deal with emergency situations and for capital expenditures to deal with emergency situations, namely an event that has seriously endangered the lives and health of persons, or an event that caused damage to the property of the school or school facility and which jeopardises its operation;
- special-purpose funds for the implementation of a submitted development project aimed at developing education and training in the field of information and communication technologies, language skills, upgrading and updating of compensatory aids for pupils with special needs, upgrading and updating of teaching aids, a healthy lifestyle, environment, costs for equipment for developing manual skills, upgrading of material and technical equipment, updating of education and training, drug prevention activities, activities aimed at promoting

the awareness of the historical and cultural heritage of Slovakia, business education, skills and competences, promotion of vocational education and training, the operation of vocational education & training centres, prevention of crime and other antisocial activity;

- a subsidy for developing education and training, for supporting activities related to the provision of practical training for pupils on children's traffic playgrounds, for supporting the publication of professional journals for school and school staff, and for children, pupils and students of school and school facilities, support for publications and data media for schools and school facilities used as a supplement to textbooks, for providing experimental verification in primary arts schools, kindergartens, language schools and school facilities, for ensuring the transcription of publications used as a supplement to textbooks into form suitable for perception by pupils with disabilities, for supporting activities related to art education in primary arts schools, for arranging nationwide competitions for teaching staff and professional staff of schools and school facilities, for supporting the operation and further expansion of the infrastructure used by schools and school facilities (technological-communication environment ensuring in particular the implementation and operation of information systems, the provision and development of electronic services, for awarding winners of competitions organised or co-organised by the Ministry other than competitions for teaching staff and professional staff and competitions for children and pupils of schools and school facilities.

The Ministry may also award to the founder of a primary school a contribution for improving the quality of conditions for the education and training of pupils from socially disadvantaged backgrounds.

From its budgetary chapter, the Ministry of Education also finances interest education of primary and secondary school pupils, provided by schools and school facilities in the form of the provision of **education vouchers** for each pupil of the schools. The provider of interest education funded through education vouchers may organise for pupils, at a time outside teaching hours, activities focused on interest, recreation, physical and social activities for pupils. The content of activities is different from the curriculum of compulsory subjects, elective subjects and optional subjects. Interest education is provided for at least 60 hours per school year.

Given that primary and secondary schools, as budgetary organisations, may manage also incomes from other entities, for example through a donation agreement, an association agreement, a subsidy or grant, from the business income-cost difference after taxation, from insurance indemnity, catering reimbursements, etc., while as a rule this is not revenue from public budgets (as is the case for EU grants, for example), these incomes may also be considered as economic instruments of public policy.

An important economic tool of education policy are **tuition fees**, or other payments and fees for study, paid primarily from the private funds of education recipients. Tuition fees may be regulated, or market, unregulated.

#### 2.4.2 Healthcare services

In Slovakia, health care, too, has undergone major systemic changes since 1990, including privatisation, decentralisation and commercialisation. This has been accompanied by contradictory views on the current state of health care in the Slovak Republic. On the one hand, it is stated that Slovak health care is the 13<sup>th</sup> best in Europe (<https://healthpowerhouse.com/euro-health-consumer-index-2017>), on the other hand, according to Eurostat data on unnecessary deaths for 2013, Slovak health care is the fourth worst from among the European Union countries. In its SWOT analysis, the National Investment Plan of the Slovak Republic for 2018-2030 states that public health indicators rank the Slovak Republic below the OECD average. It also states that “outpatient healthcare is currently fragmented, due to a lack of coordination and different motivations, resulting in inefficient use of resources. Fragmentation has a negative impact on quality, costs and results” (NIP 2018. p. 26). In the area of institutional care, the document states that “a chronic problem is an overly dense, inefficient network of hospitals and their operation. Despite several rounds of debt relief, state hospitals continue to be indebted” (ibid., p. 27), with too many hospital beds as one of the causes.

#### Health care in the competence of local authorities

Under § 3(3)(h) of Act no. 369/1990 Coll. on municipal establishment, a municipality in exercising self-government (i.e. in the framework of self-government, i.e. original,

competences) shall create the conditions for ensuring health care of its inhabitants. Under § 2(j)(1) of Act no. 419/2001 Coll. on the transfer of certain competences from state administration bodies to municipalities, the establishment of outpatient clinics is transferred, *inter alia*, into the competence of municipalities. This competence is therefore performed in the framework of the delegated performance of state administration. Outpatient clinics are organisational units providing outpatient health care to persons whose state of health does not require continuous provision of health care exceeding 24 hours.

In the past, healthcare centres were typical for towns, or nodal municipalities. There was a general practitioner for adults, for children, a dentist, gynaecologist, or other specialists and a pharmacy (Almášiová 2019). Following the change of establishment, these facilities in the first stage of the transformation of health care transferred free of charge to towns and municipalities (under Act no. 416/2001 Coll.), while the following second stage (under Act no. 578/2004 Coll.) saw the privatisation of most of them (particularly due to economic problems with their functioning in the founding competence of municipalities). Consequently, in 2015 there were 2 837 general outpatient healthcare clinics in Slovakia, however, 55 of those (2.0%) were founded by the SR Ministry of Health and others by central state administration bodies, while only one was reported in the founding competence of regions and municipalities, while 98% had other founders (church, business, private) (NCZI 2015). Nevertheless, the availability of general health care in Slovakia is acceptable: 70% of Slovakia's population lives in a municipality where there is such an outpatient clinic, and for more than 99%, an outpatient clinic is accessible within 10 minutes (HPI 2006, p. 28).

#### Health care in the competence of regional authorities

Self-governing regions, in the Slovak Republic, in the framework of the delegated performance of state administration for the field of healthcare, provide for a whole range of tasks relating to the smooth functioning of health care, issuing for example permits for the operation of healthcare facilities, archiving health care documentation following the closure of a provider, assigning a replacement doctor to patient, as well as helping in filling the network of providers in the region. As of 1 January 2003, self-governing regions became, by delimitation, the owners of some healthcare facilities, and in the subsequent decision-making

on their operation, they could act independently of the opinion of state authorities. Over the course of the following years, most of these facilities (in particular hospitals) were transformed into joint-stock companies, non-profit organisations, privatised or leased long-term to private providers (SR Ministry of Health 2011, p. 95).

All hospitals operating in the Slovak Republic, regardless of their legal form or ownership, are divided into:

- specialised hospitals, operating on the basis of a licence issued by law by the SR Ministry of Health. Besides national institutions, there are in Slovakia established several specialised institutions and hospitals, e.g. psychiatric hospitals, hospitals for orthopaedic prosthetics, cardio centres, hospitals for accused and convicted criminals, central military hospitals, etc., also large hospitals with a type-3 polyclinic, university hospitals and faculty hospitals;
- general hospitals, operating on the basis of a licence issued by law by the self-governing region in the framework of the delegated performance of state administration. Ownership and managerial control of hospitals with a type-2 polyclinic for secondary health care were transferred to self-governing regions; hospitals with a type-1 polyclinic for primary health care passed to municipalities. If the institutional or outpatient network of healthcare providers does not meet the requirements set for the minimum network of providers, self-governing regions resolve this situation in cooperation with the Ministry of Health (Smatana et al. 2016).

Self-governing regions owns some healthcare facilities and can independently decide on their management: Some hospitals have thus been transformed either into joint-stock companies, non-profit organisations, or have been fully privatised by private companies, others have been leased to private healthcare providers.

The results of these processes is the current (2014) state in the structure of healthcare service providers in bed facilities in Slovakia: from among the 138 such establishments, i.e. various types of hospital, the largest group, with 53 (38.4%) hospitals, have a private founder (of which 25 in the form of a private limited liability company, 19 in the form of a joint-stock company, eight in the form of non-profit organisations, and one has a different form). The second largest founder is the state, for 49 (35.5%) of hospitals (of which 31 are government-

subsidised organisations, 10 non-profit organisations, 7 joint-stock companies, and one has a different form). Self-governing regions are founders of 11 (only 8.0%) of hospitals (of which 7 are government-subsidised organisations and 4 are non-profit organisations). Towns are the founders of three hospitals (2.2%) (of which one is a government-subsidised organisation, one is a non-profit organisation, and one is a private limited liability company). Nine hospitals (6.5%) have mixed ownership (of which six are non-profit organisations, two are joint-stock companies and one is a private limited liability company). Finally, 13 hospitals (9.4%) have other founders, such as church, foundation and other organisations (which is also reflected in the fact that eight of them are non-profit organisations, one is a joint-stock company and four have a different form). In terms of legal form, the most common are government-subsidised organisations, of which there are 39 (28.3%) (of which 31 are state, 7 regional, and 1 town). The second most common form are non-profit organisations, of which there are 37 (26.8%) (of which 10 are state, eight are private, four are regional, one is town, and six with a mixed founder structure, and eight with a different founder). The third most common form is joint-stock company, which is used in the case of 29 (21.5%) of hospitals (19 private, as well as seven state, two with mixed ownership, and one with a different type of founder). Some 27 (19.6%) hospitals have the form of a private limited liability company (with some 25 of them having a private founder, one town and one founder with a mixed ownership structure). The remaining 6 hospitals (4.3%) have a different legal form (SR Ministry of Health 2014).

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 576/2004 Coll. on healthcare and healthcare-related services
- Act no. 577/2004 Coll. on the scope of health care covered by public health insurance, and on reimbursement for services related to healthcare provision
- Act no. 578/2004 Coll. on healthcare providers, healthcare workers, professional organisations in healthcare
- Act no. 579/2004 Coll. on the emergency medical service
- Act no. 580/2004 Coll. on healthcare insurance
- Act no. 581/2004 Coll. on health insurance companies, healthcare supervision

## Funding

Some 77% of healthcare expenditure goes to 3 areas: medicines (22%), institutional (30%) and outpatient healthcare (24%). Over 40% of expenditures are expenditures on wages for healthcare personnel. Direct payments from individuals cover 18.7% of healthcare expenditure (2017) (SR Ministry of Finance, SR Ministry of Health 2019).

More than three quarters of healthcare funding in Slovakia is formed by sources that are classified as public: but resources from the state budget form only approx. 5% of total funds. More than 70% of total healthcare funding is covered by public health insurance, the economically active population contributes 2/3 to the creation of this source, while approximately one third is jointly created by the state in the form of contributions for the economically inactive population. “Roughly 57% (children, students, seniors, disabled, unemployed) are state insured, and their insurance premium is not paid. Their health care is financed from the state budget in the form of payment to health insurance companies.” (Barto 2019) If then we add approximately the quarter share of private sources of healthcare funding, we find that the state’s share (primarily tax sources) in healthcare funding is only approximately a third, and most of the funds flow into health care indirectly (via health insurance contributions) or directly from citizens (SR Ministry of Health 2011).

Voluntary supplementary insurance is significantly underrepresented here, but its extension would in particular require clarification of the scope of entitlement to health care covered by compulsory health insurance.

It should be pointed out that self-governing regions and towns and municipalities contribute only a fraction of a percentage to the financing of health care, in absolute figures an amount of less than €20 million annually (SR Ministry of Health 2011).

### 2.4.3 Social services

The change in the social system at the turn of the 1980s and 1990s brought significant changes to the entire system of social policy in Slovakia. The statist, paternalistic and centralist system of social security was gradually replaced by destatised subsystems of social

insurance and social assistance. It should be noted, though, that the first attempts at a certain minimum decentralisation of minor social services (pensioners clubs, pensioners catering, personal hygiene centres, etc.) were transferred into the competence of the then local national committees before the restoration of self-government in Slovakia, but, on the other hand, Slovakia, in its further development up to the present, “in the intentions of the established care patterns from the preceding period. Among other things, this is also reflected in the representation of three types of services – outpatient, field and residential services” (Káčerová - Mládek - Ondačková 2013, p. 51).

### Social services in the competence of municipalities

Under § 3(3)(b) of Act no. 369/1990 Coll. on municipal establishment, the municipality performs tasks in the field of social assistance in the extent according to a special regulation, which is Act no. 448/2008 Coll. on social services. Under § 7(2), a municipality either provides social services itself (if it is entered in the register of social service providers) or ensures social service provision at a registered provider. Under § 2(d)(2.1) of Act no. 419/2001 Coll. on the transfer of certain competences from state administration bodies to municipalities, things that were transferred to municipalities include, *inter alia*, decision-making regarding the provision of care services.

The provision of care services from local state administration bodies passed to municipalities in 2003, and from the outset has not been without problems: 19% of municipalities refused to take over this role from the state (Konečný 2004a, p. 107). The reasons lay primarily in the lack of financial and personnel support for providing this service, and essentially these reasons persist to the present day.

Under Act no. 185/2012 Coll. municipalities set the amount of remuneration for the provision of this service from 0% to 100% of economically justified costs, but in practice with regard to the income situation of recipients, this reimbursement covers on average less than 20% of costs. Nevertheless, municipalities must subsidise this service considerably: the difference between incomes and expenditures for care services, for example in 2013, represented €20.8 million, which is an amount that municipalities had to pay from their own

budgets. Partly in consequence of this, there seemingly has fallen the number of recipients of home-based care services provided by municipalities, falling from 15 704 persons in 2010 to 11 792 in 2013; over the same time, though, the number of these people at non-public providers fell from 1 881 to 1 738. At the same time, however, the share of municipalities in the total number of recipients also fell from 89.30% in 2010 to 87.15% in 2013. There also fell the number of employees of municipalities providing home-based care services (for example only between the years 2012 and 2013, from 5 303 to 4 465), the number of non-public providers (from in 2012 to 92 in 2013). In the following years 2014-2015, the national project “Support for Care Services” was implemented, which partially reversed these trends (SR Ministry of Labour, Social Affairs & Family, p. 16 – 17). Since currently (2019) 859 587 persons belong to the age cohort of persons above 65 years of age, the proportion of persons to whom home-based care is provided is only about 1.4% of persons in this cohort. Under § 41(1) of the Act on Social Services, the care service is a social service provided to a natural person, who is dependent on the help of another person, and is dependent on assistance in acts related to personal care, acts of household care and basic social services. The very wording of this definition implies that it is primarily the elderly who will be the recipients of care services.

The largest share of municipalities performs in its own competence the agenda designated as social services (53.1%), with 36.2% having transferred this to a common office, and a further 10.7% stated a different solution (Bodnárová - Džambazovič 2011, p. 33-34).

#### Social services in the competence of regional authorities

Social services in Slovakia are considered part of the social assistance system, as one of the pillars of social policy (social protection). According to applicable legislation, these include a whole range of forms: crisis intervention services, family support services, services for dealing with an adverse social situation due to severe disability, poor health, or retirement age, services connected with the use of telecommunications technology and support services. A social services provider may be a municipality, a legal entity established or founded by a municipality, may be a legal entity established or founded by a higher territorial unit (public providers) or other person (a non-public provider). From our point of view, the most

interesting are residential forms of social services, which include accommodation as a service activity. They are provided on a year-round or weekly basis (Repková 2012).

Higher territorial units (self-governing regions), in the field of social services, both draw up concepts of social services development for their region and keep registers of social services providers in their region, they are also providers of several social services, including residential (shelter, halfway house, emergency housing facilities, temporary childcare facilities, supported housing facilities, rehabilitation centres, social services homes, etc.). They can order and financially contribute to services provided by non-public providers.

Originally a mixed model for the provision of residential services was envisaged, focusing regional self-government on persons with severe disabilities, and local self-government on the elderly (Repková 2012). According to data from the Central Register of Social Services Providers, there are currently 483 providers in the category of facilities for seniors with year-round stay, of which 266 (55.1%) were non-public, 142 providers were established by towns and municipalities, or directly had towns and municipalities as founders (29.4%), and the lowest share comprised 75 providers (15%) established by higher-territorial units. According to other statistical sources, though, almost half of them were facilities with a capacity of more than 100 residents.

The basic **legislation** concerning our topic here comprises the following regulations:

- Act no. 416/2001 Coll. on the transfer of certain competences from central government bodies to municipalities and higher territorial units
- Act No. 453/2003 Coll. on state administration in the field of social affairs, family and employment services
- Act no. 448/2008 Coll. on social services

## Funding

Social services are a typical example of multi-source funding.

This is also applies to the care service, where there is a lack of complete information on the shares of the individual sources from which the costs of providing this service are paid.

However, as mentioned above, user fees from clients cover about one fifth of the cost of care services provided by municipalities. The low ability of clients to pay and the lack of resources in the municipal budgets, despite the low wages of caregivers, caused a long-term shortage of this service, which indirectly increased pressure on the capacities of institutional facilities for seniors: we reiterate that the provision of care services was entrusted into the municipalities' regional competences on the basis of initiative coming from the side of municipalities and therefore the state was under no obligation to contribute to this exercise. After a decade of searching, a solution was finally found in the form of co-financing from the European Funds.

The aim of the National Project: Support of Care Service was to increase the availability of field care services for people with severe disabilities, in adverse health condition and for seniors using the support of care services in small municipalities. The project was intended for public social service providers, in this case municipalities with population up to and including 1 000, legal entities established or set up by municipalities with population up to and including 1 000, or joint municipal office established by municipalities with population up to and including 1 000, who had no previous history of providing care service for pursuant to Act no. 448/2008 Coll. on social services. In the framework of the project, over the period from April 2014 to April 2018, support was provided to 251 entities, 3 795 caregivers and thanks to the project there were 5 537 recipients of such care (this may only be 0.6% of their given age cohort, meaning that the total share of this age cohort covered by care service grew to approximately 2%), and thereby at least succeeding in stopping the fall in the number of care recipients that was happening in the preceding period. The project continues to operate to present date.

The provision of social services in facilities for seniors is funded from multiple sources, as well.

The financial contribution for the provision of social services in facilities conditioned by the dependency on care pursuant to §71 (6) and §78a of Act no. 448/2008 Coll. on social services and on the amendment of Act no. 455/1991 Coll. on trade licensing (Trade Licensing Act) as amended (hereinafter referred to as the "Social Services Act") is provided according to the form of social service, structure of social service recipients according to the degree of

dependence on assistance of another natural person and number of places at a facility entered in the register of social service providers in a particular social service facility and is purposefully intended to cover part of the wage and contributions of the social service provider's staff in that particular facility. The Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR - MPSVR SR) may provide a financial contribution for co-financing the provision of social services to a municipality that provides social services in selected types of social services facilities or to a municipality that established or set up selected types of social services facilities, including a facility for seniors, care service facility, social service homes, day care centres etc. or to a non-public social service provider in selected types of social service facilities. Depending on the degree of dependence of the natural person on the assistance of another natural person, the amount of the financial contribution for the provision of home-based social services per one place per month amounts to €96 – €504 and €64 – €336 for outpatient care.

Another, additional source of funding is the reimbursement for the social service provided, the amount of which is set out in a generally binding regulation of the town, which is the founder of the relevant social services facility. In the case of a facility providing year-round social services, the amount of the reimbursement cannot exceed their remaining 25% of the client's subsistence minimum after payment of the reimbursement for the year-round residential social service. Given the well-known low level of pensions of citizens using this service, this resource is very inadequate and insufficient, requiring subsequent offsetting of any budget deficit from own budget (from own income) by the self-government, which is the founder of the facility.

### **3 SECTORAL COMPARISONS AND RECOMMENDATIONS FOR REFORMS IN THE SLOVAK REPUBLIC**

In the previous chapter, using a vertical breakdown, we analysed the situation in the provision of public education, health and social services by public administration authorities at local and regional level in Poland, Hungary, the Czech Republic and Slovakia. Despite the not always ideal availability of information of the same level, we tried to create prerequisites for a horizontal comparison of the situation in these services at these levels and in these countries so that the results of this comparison could be confronted with solutions for Slovakia.

In general, we can state that, even in terms of the competence for establishing public services, in Poland we are dealing with a consolidated and functionally organised local and regional self-government. The situation is similar in the Czech Republic. In Hungary, after 2012, there was a strong de-municipalisation and re-centralisation of public administration, which changes the functioning of the authorities also at the local level. Finally, the most problematic in this respect is the situation in Slovakia. The basic problem is settlement structure dating back to feudal times (Konečný - Konečný 2009), on which the structure of local self-government authorities is built. It is clear – already appearing in comparison with the V4 countries – that such a structure is not able to effectively perform the functions expected of local self-government in the context of a modern social state. Units of fragmented local self-government are unable to cope in terms of their capacities (especially economically, but also in terms of staffing, professionally, etc.) which are transferred to them by the state in decentralisation processes. The result is – as seen in Slovakia – the de facto elimination of local self-governments from their participation in the provision of health care services, the problematic provision of education services, and given the entrusting of these services to the original competence of municipalities (e.g. social services), there arises the need for additional interference by the state (by channelling financial flows from the Eurofunds) in order to avoid an overall collapse in the provision of these services by municipalities.

A number of problems also arise from the conceptual lack of clarity in the creation of regional self-government. Higher territorial units have different hospital capacities (also in terms of population), different attitudes towards the privatisation of hospitals and constant

problems with the indebtedness of those hospitals they were left with. It has repeatedly occurred that as founders of secondary vocational schools, they cancel those schools that are in their territory but which become due to their uniqueness in Slovakia superfluous from a narrow regional perspective. Several retirement homes have come under the founding powers of towns, although they perform distinctly supra-municipal, regional functions, etc.

It is obvious that yet again in this area there is a reason to take notice of experience and practices of the neighbouring countries, with which we are associated not only with our Visegrad Group membership, but also with many historical as well as current socio-economic features influencing the methods of addressing these issues.

### **3.1 Education services under the founding powers of municipalities and regions in the V4 countries**

In all the countries compared, in addition to public schools, there are church and private schools, with a varying share: in general, the non-public schools in primary education have a lower share (PL 14%, H 20%, CZ 6%, SK 9%) compared to their share in secondary schools (PL 20%, H 37%, CZ 20%, SK 30%). It can be hypothesised that the share of non-public primary schools should reach about one-tenth of all primary schools, and as for secondary schools it should be one-fifth to one-third of all secondary schools, with regard to the particular cultural traditions of the countries under comparison. Within this category, the next, even more interesting, share is that of church primary and secondary schools, which reflects the degree of secularisation or sacralisation of the society (Poland and Slovakia versus the Czech Republic) – but in Hungary it clearly seems to replace the share of other non-state founders by preferencing church founders. All in all, the presence and share of non-state providers of these education services in the compared countries does not in any way limit the predominance of public administration as a provider of education services at the level of primary and secondary schools.

In some countries, selected types of secondary schools (exceptionally elementary schools, too) are also set up by central state authorities (CZ, PL), in some countries there are

established certain specialised vocational schools by the relevant departmental ministries (SK departments of health, interior, the army; CZ department of interior, the army; H department of economy; PL culture, agriculture, environment, marine economy, health care, interior...). This though does not show any link to the structure of these authorities in the territory, but rather two tendencies: (1) the “power departments”, with virtually zero presence of the private sector, also retain their own education competences as well as their own education institutions (e.g. three own state universities in Slovakia); (2) the assumption that the substantive department are better at estimating the quantitative and qualitative parameters of vocational education in their competence in contrast to its inclusion among other secondary schools.

The basic founder of elementary schools is

- in Poland: municipality (on average 15 000 inhabitants and approx. 20 km<sup>2</sup>);
- in Hungary: specialised state administration – school borough at district level (on average 56 000 inhabitants and 530 km<sup>2</sup>, including on average 18 fragmented municipalities);
- in the Czech Republic: type-1 municipalities (on average 1 680 inhabitants and 13 km<sup>2</sup>) and associations of municipalities (on average 15 000 inhabitants and 111 km<sup>2</sup>) (with the obligation of the region to provide transport);
- in the Slovak Republic: municipalities (on average 1 850 inhabitants and 17 km<sup>2</sup>).

Allocation of this competence to administrative units having at least 15 000 inhabitants may be labelled as a certain tendency here.

The basic founder of secondary schools is

- in Poland: the district within its original competencies (on average 123 000 inhabitants and around 1 000 km<sup>2</sup>, including on average eight consolidated administrative municipalities) establishes mainly general secondary schools, with vocational or special secondary schools being set up by higher levels of state administration;

- in Hungary: the specialised state administration – district-level school borough (on average 56 000 inhabitants and 530 km<sup>2</sup>, which includes on average 18 fragmented municipalities) does not establish industrial secondary schools;
- in the Czech Republic: self-governing regions (on average 749 000 inhabitants and 5630 km<sup>2</sup>, which include an average of 447 fragmented municipalities) set up almost all types of secondary schools;
- in the Slovak Republic: higher territorial units within the transferred execution of state administration (on average 674 000 inhabitants and 6 130 km<sup>2</sup>, which include an average of 361 fragmented municipalities) establish almost all types of schools; they do not establish healthcare secondary schools.

The following may be identified as prevailing tendencies

- founding power as an original competence of regional self-government;
- founding power concerning rather general and not vocational or specialised education;
- under these conditions the founding power may also be carried out by the self-governing authorities (alternatively also state authorities) for the territory (catchment area, school borough) with the capacity of the order of 100 000 inhabitants.

### **3.2 Healthcare services under the founding powers of municipalities and regions in the V4 countries**

In the healthcare segment, in contrast to the other two comparative segments – education and social services – the compared countries (with the exception of Hungary over the last decade) show the most marked penetration of market relations into the public sector. Although health care funding continues to be carried out from public sources (if that we consider as such the resources of health insurance companies, despite such income being dominated by the contributions of the economically active population), the impact of public

power, the public sector or even public administration on healthcare services (excluding the creation of the legislative framework) dropped considerably.

As far as general practitioner clinics are concerned, their founders are the municipalities, though only in a minimal extent. As these services are to a great degree saturated, as far as funding is concerned, from the sources of health insurance in all the countries under comparison, the competence of municipalities is restricted solely to the generally formulated creation of conditions for this activity.

Regarding the hospital network, churches and private hospitals exist in all the countries under comparison in addition to public hospitals, but their share varies considerably (PL 44%, CZ 55%, SK 38%, H 22%). In all these states, the state is a significant founder, represented by its central authorities (besides the ministries of health, most frequently these are the ministries of the “force departments”). Hospitals, set up by regional authorities, play a rather complementary role:

- in Poland: districts set up a basic network of hospitals (one hospital in each district), this being the basic type of hospitals (with an obligatory structure of four basic departments) (on average for 123 000 inhabitants and 1 000 km<sup>2</sup>, on average for eight consolidated administrative municipalities); regions set up only a complementary network of hospitals of higher types;
- in Hungary: self-government (only one-tenth of all hospitals are currently set up by municipalities (counties or towns, if applicable) currently establishes less than one tenth of all hospitals; county-level hospitals are set up by regional authorities of the state, eight in number (an average of 1 230 000 inhabitants and 11 630 km<sup>2</sup>, 400 fragmented municipalities);
- in the Czech Republic: since most hospitals are private or state, the establishment of hospitals by self-governing regions (on average for 749 000 inhabitants and 5 630 km<sup>2</sup>, 447 fragmented municipalities) is only of complementary nature and is to merely fill in the network created by other founders; establishing hospitals by towns and municipalities is solely of a marginal nature;

- in Slovakia: yet again, most hospitals here have private or state founders. The establishment of hospitals by higher territorial units (on average for 674 000 inhabitants and 6 130 km<sup>2</sup>, 361 fragmented municipalities) may be of only a complementary nature but again is to merely fill in the network created by other founders, with the establishment of hospitals by towns having solely a marginal nature.

The following may be listed as the prevailing tendencies:

- under a strong market influence and not always successful efforts to achieve a certain proportion of state and private hospitals, the states under comparison are managing to hold on to their leading position in setting up hospitals of the highest types (together with universities), while they keep a balanced position also in highly specialised hospitals;
- regional authorities most frequently have the function of completing the structure of hospitals in the territory: here this competence is executed in terms of the territory of an area of more than half a million to one million of inhabitants. Where the regional authorities are entrusted with a broader scope of competence, it concerns the establishment of a network of the basic type of hospitals with territorial scope for approx. 150 000 inhabitants – representing an alternative solution in comparison with this competence held in the hands of the state;
- establishment of hospitals by local self-governing authorities is only a marginal phenomenon and, all in all, local self-governing authorities are pushed out from their position of a healthcare service provider.

### **3.3 Social services under the founding powers of municipalities and regions in the V4 countries**

Here too, in all the countries under comparison, private providers and founders operate alongside public providers and founders.

The compared forms of care services, we focused on in terms of competence of municipalities, are quite different in the countries compared. Their common features are that

municipalities are more important providers of care services than other entities (private, church) in all the countries compared.

Another common feature is that it is a scarce service in all these countries, covering only a small proportion of the relevant age cohort (PL 1%, HU 7%, CZ 10%, SK 2%). This is mainly related to the lack of funding in the budgets of municipalities (especially small municipalities) for executing the service, since only a negligible proportion of people in need of this service has available enough of its own private resources to pay for the service in full, even though the client everywhere makes a contribution (or should contribute) towards the reimbursement of service:

- in Poland, as a result of greater representation of the traditional multi-generation family model, the pressure put on the capacity of care services has been so far lower. Even so, the municipalities were forced to subsidise these services by the state (given their consolidated capacity nature of an average population of 16 000 per Polish municipality);
- in Hungary, the coverage of the relevant population of the countries under comparison is the second highest, a result of covering a significant part of the cost of this service in the form of a state-funded and county-subsidised contribution paid to the county caregivers. The counties that also provide for the care services, as regional administration authorities, at the same time cover areas with an average of over 400 000 inhabitants;
- in the Czech Republic, the coverage of the relevant population of the countries under comparison is the highest; it is an outcome of covering a significant part of the cost of this service by the state through the provision of care allowances paid to the care recipients. The care service is not provided by all municipalities, but only by the municipalities with extended powers, covering on average an area of 210 km<sup>2</sup> and approximately 27 000 inhabitants;
- in the Slovak Republic, despite the persistent presence of a multi-generation family model, particularly in rural areas, the need for care services exceeds the current situation. The low financial potential of clients and the lack of own resources in the budgets of municipalities (where each municipality of an average size of 1 800 inhabitants is required to provide this service) ultimately led to this service being maintained only through the subsidies from the EU

Funds, where the service is linked only to the municipalities having less than 1 000 inhabitants (68% in Slovakia).

The following may be listed as the prevailing tendencies

- it appears to be more efficient to entrust this task into the competence of such level of government that meets the needs of at least 15 – 25 thousand inhabitants;
- it seems more efficient to fund this service from public budgets, by transferring it over not to the municipalities but to the users of the services, which ultimately makes it possible to develop a wider variability of service providers;
- it seems more efficient to perform this service as the performance of state administration (e.g. if the above-mentioned transfer is more beneficial than a state social welfare allowance) and not under the self-government regime.

With regard to such facilities as social care homes for the elderly (retirement homes), this share is relatively significant in most of the countries under comparison (PL 28%, H 36%, CZ 50%, SK 55%). Nevertheless, regional authorities still have an important role:

- in Poland: districts (123 000 inhabitants, 1 000 km<sup>2</sup>, eight consolidated administrative municipalities) are clearly the predominant founder of this type of social services;
- in Hungary, in particular the counties (499 000 inhabitants, 4 650 km<sup>2</sup>, 123 fragmented municipalities) retained an important position in this area, although the state initiative, characterising the development here with a view to increasing the efficiency, is also implemented through districts (56 000 inhabitants, 530 km<sup>2</sup>, 18 fragmented municipalities), whereby the position of municipalities is maintained only in the founding powers of the capital city and other larger cities;
- in the Czech Republic, with a high share of non-state founders and social service providers, the largest share in the establishment of retirement homes is represented by towns and municipalities with extended powers (28 000 inhabitants, 210 km<sup>2</sup>, 16 fragmented municipalities) as well as by self-governing regions (749 000 inhabitants, 5 630 km<sup>2</sup>, 447 fragmented municipalities);

- in Slovakia, again with a high share of non-state founders and social service providers, towns and municipalities have the highest share in establishing retirement homes, though the data on their average size (8 442 inhabitants) is distorted by almost a quarter of municipalities with less than 1 000 inhabitants (forming 68% of municipalities in Slovakia) among the founders, where the second most important public founder is made of self-governing regions (674 000 inhabitants, 6 130 km<sup>2</sup>, 361 fragmented municipalities).

The following may be listed as the prevailing tendencies

- obvious predominance of the supra-municipal founders of retirement homes
- with regional founders and with a large dispersion rate of their personnel capacity (from tens of thousands to hundreds of thousands of inhabitants), the median ranges between 50 and 100 thousand inhabitants.

Most public services are carried out in the regime of transferred execution of power within municipalities and regions.

### **3.4 Recommendations**

Based on the above, we can conclude that in the Central European context, as a result of certain practices as well as certain elements of deeper cultural-social identity in the society, there exist preferential parameters in choosing administrative units, which can be deemed as suitable for the founding function of hospitals (about 100-150 thousand inhabitants), general secondary schools (up to 100 000 inhabitants) and retirement homes (50-100 thousand inhabitants). These public services (or public services of this type, if applicable) should be provided, as a rule, within regional units of this size, given the number of inhabitants and, naturally, also taking account of the spatial perimeter or structure of settlements in the region and thereby the related transport services, etc. Likewise, where the choice of administrative units is concerned that could be considered as suitable for the founding function of primary schools, the units of local administration of the size of roughly 15 000 inhabitants can be recommended (even though they may include the establishment of multiple schools, or the

creation of multiple school boroughs), and a similar size may be also recommended for entrusting the founding powers to carry out the implementation (or provision) of care services. At the same time, it is necessary to consider whether municipalities (at least in a fragmented structure) should have any tasks at all in the field of healthcare services.

Each country, as part of its reform efforts to optimise and streamline the provision of public services, will, with regard to the founding powers for providing these services, either opt for those existing units that meet these parameters (as they did in Poland) or create them (as they did in the Czech Republic or in Hungary).

At the same time, given a potential communal reform in Slovakia this means a recommendation for the creation of consolidated units either of the type similar to the municipalities (gminas) in Poland or municipalities with delegated local authorities (type-2 municipalities) in the Czech Republic. It is also necessary to consider what structure of public administration (probably rather territorial state administration) would be appropriate to create in Slovakia in order that its units (in the number of roughly 50, or about 30 - 50), with an average number of about 100 thousand inhabitants (or 100 – 150 thousand inhabitants), are optimal as founders of the basic types of secondary schools (grammar schools, etc.), with the exclusion of the founding function for vocational secondary schools within the competence of regions (higher territorial units) and (in the case of unique schools) within the competence of the central state administration body or in general within the competence of several respective departments. These units would concurrently be required to set up hospitals with a basic structure of hospital departments. It appears that the breakdown of Slovakia into 38 districts in the period between 1990 and 1996 (at the time when the problem of entrusting founding competence in today's parameters was not addressed) would be better suited to this requirement than the current existence of 79 districts, whose functionality is unidentifiable in this respect.

## **Conclusion**

In this study, we sought to synthesise several pieces of knowledge we have acquired in the process of addressing a number of partial questions in the issue of the role of VEGA 1/0757/17 Public administration as a public service provider of a welfare state - using foreign experience for reforms in the Slovak Republic. The solution was limited not only by the availability of various information (e.g. a number of data on the reform ongoing over the recent years in Hungary has not yet been reflected in officially published statistics), but also by the capacities of the research team.

Nevertheless, we are convinced that the objectives set out by the research team in the project have been met and that the conclusions and recommendations we have reached, despite having *de lege ferenda* nature only and not the nature of normative conclusions, may be adequately exploited in the steps taken toward the future reform in public administration at national level – may that be local or regional.

## References

ADÁMKOVÁ, P. (2007) Školství jako veřejná služba. In: Sborník příspěvků z mezinárodní vědecké konference „Problematika zabezpečování veřejných služeb“. Brno: ESF MU 2007, ISBN 978-80-7399-030-5

ÁDÁNY, R. - VOKÓ, Z. (2014) Hungarian public health – ups and downs in the last 20 years. *European Journal of Public Health*, Volume 24, Issue 3, June 2014, Pages 352–353, ISSN 1101-1262

ALMÁŠIOVÁ, M. (2019) Do miest a obcí sa vrátiť obvodné zdravotné strediská. *Košice: Korzár* 12. 10. 2019. ISSN 1335-4566,

BABARCZY, B. (2015) Regional management of healthcare in Hungary. V4 and CEE Health Expert Meeting. Bratislava: Ministerstvo zdravotníctva SR, 2015. Available at: <https://www.health.gov.sk/?V4-a-CEE-meeting>

BADANIE (2013) branży usług opiekuńczych dla seniorów. Poznań: Fundacja św. Jadwigi 2013. [http://www.jadwiga.org/uploads/biblioteka/Badanie %20bran %C5 %BCy %20us %C5 %82ug %20opieku %C5 %84czych %20dla %20senior %C3 %B3w %20w %20subregionie %20kaliskim.pdf](http://www.jadwiga.org/uploads/biblioteka/Badanie%20bran%C5%BCy%20us%C5%82ug%20opieku%C5%84czych%20dla%20senior%C3%B3w%20w%20subregionie%20kaliskim.pdf)

BALÍK, P. (2011) Analýza systému zdravotnej starostlivosti v Maďarsku. In *HPI: Zdravotná politika*, 2011, roč. 6, č. 7, s. 8 - 14. ISSN 1338-1172

BAREŠ, P. (2013) Sociální služby v České republice a význam institucí veřejné správy při jejich poskytování. Dizertační práce. Praha: FSV UK, 274 s. Available at: <https://is.cuni.cz/webapps/zzp/detail/105947/>

BARTO, M. (2019) Nezačneme financovať zdravotníctvo trochu inak? *Sme.sk*: 23. 5. 2019. Available at: <https://barto.blog.sme.sk /c/509593/nezacneme-financovat-zdravotnictvo-trochu-inak.html>

BAUBY, P. - SIMILIE (POPA), M. M. (2010) Public Services in the European Union & in the 27 Member States. States, Organisation and Regulations. *Public Services in the European Union*. 2010. 492 p. Available at: <https://www.epsu.org/article/public-services-european-union-27-member-states-mapping-ofthe-public-services-may-2010>

BENČO, J. (2005) Veřejný sektor a veřejné služby. Kunovice, Evropský polytechnický institut. 2005. ISBN 80-7314063-2

BODNÁROVÁ, B. - DŽAMBAZOVIČ, R. (2011) Pripravenosť miestnej samosprávy na prevzatie kompetencií v oblasti hmotnej núdze. Bratislava: Inštitút pre výskum práce a rodiny 2011. Available at: [https://www.ceit.sk/IVPR/images/IVPR/vyskum/2011/Bodnarova /bodnarova\\_2254.pdf](https://www.ceit.sk/IVPR/images/IVPR/vyskum/2011/Bodnarova/bodnarova_2254.pdf)

BOŘÍKOVÁ, H. (2018) Financování péče o staré a potřebné se musí změnit. *Euro.cz* 20. 7. 2018. Available at: <https://www.euro.cz /politika/financovani-pece-o-stare-a-potrebne-se-musi->

zmenit-jinak-se-stat-nedoplati1458742#utm\_medium=selfpromo&utm\_source=euro&utm\_campaign=copylink

BULLAIN, N. - PANOVA, L. (2012) A Handbook on Non-State Social Service Delivery Model. UNDP Regional Bureau for Europe and the Commonwealth of Independent States, 2012. ISBN 978-92-95092-49-5

CEDEFOP (2011) Berufsbildung in Ungarn. Kurzbeschreibung. Luxemburg: Amt für Veröffentlichungen der Europäischen Union, 2011. ISBN 978-92-896-0817-6.

CBOS (Centrum Badań Opinii Społecznej) (2016) Zdrowie i prozdrowotne zachowania Polaków. Warszawa: CBOS 2016. Available at: [https://www.cbos.pl/SPISKOM.POL/2016/K\\_138\\_16.PDF](https://www.cbos.pl/SPISKOM.POL/2016/K_138_16.PDF)

CZIBERE, K. - GAL, R. I. (2010) Long-term care in Hungary. ENEPRI Research Report No. 79. ISBN 978-94-6138-321-0

ČSÚ (Český statistický úřad) (2015) Školy a školská zařízení v České republice. Praha: ČSÚ 2015. Available at: <https://www.czso.cz/documents/10180/20555525/23004215.pdf/02c74450-3917-4a73-8827-d54f238ee05b?version=1.1>

ČSÚ (2017) Výsledky zdravotnických účtů ČR v letech 2010 až 2015, Praha: ČSÚ 2017. Available at <https://www.czso.cz/csu/czso/vysledky-zdravotnickych-uctu-cr-2016>

DUBAS-JAKÓBCZYK, K. - KAMIŃSKA, K. (2017) Szpitale prywatne w Polsce – znaczenie w systemie leczenia oraz potencjał rozwoju. Zdrowie Publiczne i Zarządzanie 2017, nr 15 (3), s. 185–196. ISSN 1731-7398

DUŠEK, J. (2016) Dostupnost základního zboží a služeb v městech a obcích Jihočeského kraje. In KLÍMOVÁ, V. - ŽÍTEK, V. (eds.) XIX. mezinárodní kolokvium o regionálních vědách. Sborník příspěvků. Brno: Masarykova univerzita, 2016. s. 546 - 555. ISBN 978-80-210-8273-1.

ELŐHÁZI, Z. (2012) Public Services. In: PATYI, A. - RIXER, Á. (eds.) (2014) Hungarian Public Administration and Administrative Law. Passau: Schenk Verlag, 2014, pp. 402 - 418. ISBN 978-3-944850-12-2.

EU (2019) Education and Training MONITOR 2019. Country analysis. Luxembourg: Publications Office of the European Union, 2019. ISBN 978-92-76-08740-3

EURYDICE (2013) National Sheets on Education Budgets in Europe 2013. Brussels: Education, Audiovisual and Culture Executive Agency, 2013. ISBN 978-92-9201-808-5.

EURYDICE (2014) Financovanie škôl. Mechanizmy, metódy a kritériá vo verejnom financovaní v Európe. Správa Eurydice. Brussels: Education, Audiovisual and Culture Executive Agency, 2014. ISBN 978-92-9201-666-1

FÁZIKOVÁ, M. - PETRÁŠOVÁ, V. (2010) Sociálne služby neznamenajú ohrozenie rozvoja vidieka, ale sú najmä výzvou pre jeho novú politiku. In: Obecné noviny, roč. 8, č. 23, s. 8 - 9. ISSN 1335-650X

FEDOROWICZ, A. (2016) Opieka nad osobami starszymi. Pierwszy w Polsce przewodnik po prywatnej opiece domowej. wyborcza.pl 25. 11. 2016. ISSN 0860-908X

FILIPOVÁ, M. (2011) Decentralizácia sociálnych služieb, posilnenie roly samospráv a financovanie. In KAMANOVÁ, I. - ŠTEFÁKOVÁ, L. - JUHÁSOVÁ, L. (eds.) Inovácie, plánovanie a kvalita sociálnych služieb. Ružomberok: Verbum 2011, s. 109 - 118. ISBN 978-80-8084-781-4

GAAL, P. (2015) Recent changes of the organizational structure of the Hungarian health care system. European Observatory on Health Systems and Policies: The Health Systems and Policy Monitor/Hungary. <https://www.hspm.org/countries/hungary25062012/countrypage.aspx>

GENET, N. - BOERMA, W. - KRONEMAN, M. - HUTCHINSON, A. - SALTMAN, R. B. (2012) Home Care across Europe. Current structure and future challenges. Copenha-gen: The European Observatory on Health Systems and Policies 2012. ISBN 978 92890 02882

GLADKIJ, I. - STRNAD, L. (2002) Zdravotní politika, zdraví, zdravotnictví. Olomouc : Univerzita Palackého v Olomouci, 2002. ISBN 80-244-0500-8.

GOLINOWSKA, S. (2018) Modele polityki społecznej w Polsce i Europie na początku XXI wieku. Warszawa: Fundacja im. Stefana Batorego 2018. ISBN: 978-83-65882-36-3

GRABUSIŃSKA, Z. (2013) Domy pomocy społecznej w Polsce. Warszawa: Centrum Rozwoju Zasobów Ludzkich, 2013. ISBN 978-83-61638-85-8

GREVE, B. (ed.) (2017) Long-term Care for the Elderly in Europe. Development and Prospects. New York: Routledge 2017. ISBN 978-1-315-59294-7

GREWIŃSKI, M. - LIZUT, J. (2012) Pomoc społeczna jako realizator efektywnych usług społecznych. Toruń: Regionalny Ośrodek Polityki Społecznej 2012. ISBN 978-83-63907-00-6

GUS (Główny Urząd Statystyczny) (2017) Oświata i wychowanie w roku szkolnym 2016-2017. Warszawa: GUS 2017. ISSN 1506-056X

GUS (Główny Urząd Statystyczny) (2018) Zdrowie i ochrona zdrowia w 2017 r. Warszawa: GUS 2018. ISSN 2084-0470

GYARMATI, A. (2019) Idősödés, idősellátás Magyarországon. Helyzetkép és problémák. Budapest: Friedrich Ebert Stiftung 2019, 24 s. Available at: <http://library.fes.de/pdf-files/bueros/budapest/15410.pdf>

HAJNAL, G. - KÁDÁR, K. - KOVÁCS, É. (2018) Public administration characteristics and performance in EU28: Hungary. Luxembourg: Publications Office of the European Union, 2018. ISBN 978-92-79-90900-9

HALÁSKOVÁ, R. (2013) Význam standardizace sociálních služeb v době jejich liberalizace. Praha: VÚPSV 2013. ISBN 978-80-7416-118-6

HALÁSZ, I. (2016) Zmeny v maďarskom súdnictve po prijatí nového základného zákona v roku 2011. Právo a bezpečnosť, roč. 2016, č. 2, s. 42 - 49. ISSN 2336-5323

HANSENS, K. - SZIRÁKI, E. (2015) The Hungarian Healthcare Sector .Brussels: Invest-Export 2015. Available at: <http://invest-export.brussels/documents/16349/69714/The+Hungarian+healthcare+sector/48e0f94e-176b-47d1-9a1c-293d59bcf7d9>

HEALTH (2012) Systems in Transition (HiT) profile of Hungary. WHO: European Observatory on Health Systems and Policies. <https://www.hspm.org/countries/hungary25062012/livinghit.aspx?Section=2.3%20Organization&Type=Section>

HERBST, M. - HERCZYŃSKI, J. - LEVITAS, A. (2009) Finansowanie oświaty w Polsce - diagnoza, dylematy, możliwości. Warszawa: Wydawnictwo Naukowe SCHOLAR, 2009. ISBN 978-83-7383-355-5

HLADKÁ, M.: Veřejné služby ve vzdělání. In: HYÁNEK, V., PROUZOVÁ, Z., ŠKARABELOVÁ, S. a kol.: Neziskové organizace ve veřejných službách. Brno: Masarykova univerzita, 2007. ISBN 978-80210-4423-4

HOLLINS, B. - SHINKINS, S. (2006) Managing Service Operations: Design and Implementation, Thousand Oaks, CA: SAGE publications, 2006. ISBN 978-1-4129-2953-0

HORVÁTH, T. M. (2016) From Municipalisation to Centralism: Changes to local Public Service Delivery in Hungary. In: Wollmann, H. - Koprić, I. - Marćou, G. (eds.): Public and Social Services in Europe. From Public and Municipal to Private Sector Provision. Palgrave Macmillan 2016, pp. 185 - 199. ISBN 978-1-137-57498-5

HPI (2006) Minimálna sieť. Bratislava: Health Policy Institute 2006. Available at: [http://www.hpi.sk/cdata/Documents/minimalna\\_siet\\_HPI.pdf#c-new-window](http://www.hpi.sk/cdata/Documents/minimalna_siet_HPI.pdf#c-new-window)

HUMAJOVÁ, Z. - KRÍŽ, M. - PUPALA, B. - ZAJAC, P. (2008) Vzdelávanie pre život. Reforma školstva vsúvislostiach. Bratislava: Konzervatívny inštitút M. R. Štefánika 2008. ISBN 978-80-89121-12-0.

CHOJNICKI, Z. - CZYŻ, T. (2000) Nowa organizacja terytorialna. Polski układ regionalny. Czasopismo Geograficzne, 2000, LXXI, nr 3-4 , s. 261 - 277. ISSN 0045-9453

ITRICH-DRABAREK, J. - FILAK, A. - MROCZKA, K. (red.) (2013) Administracja rządowa XXI wieku. Szanse, wyzwania i zagrożenia. Vol. 2. Warszawa: Elipsa 2013. ISBN 978-83-7151-945-1

JAWORZYŃSKA, M. (2016) Publiczne czy niepubliczne zakłady opieki zdrowotnej – analiza porównawcza. Studia Prawno-ekonomiczne, t. XCIX, 2016, s. 243–256. ISSN 0081-6841

JÍLEK, M. (2008) Fiskální decentralizace, teorie a empirie. Praha: ASPI 2008, ISBN 978-80-7357-355-3.

KÁČEROVÁ, M. - MLÁDEK, J. - ONDAČKOVÁ, J. (2013) Sociálne služby pre seniorov, typy, veľkosť a priestorová diferencovanosť - komparácia Českej republiky a Slovenskej republiky. In: Regionální studia 2013, č. 1, s. 51-66. ISSN 1803-1471

KEBZA, V. a kol. (2017) Psycholog ve zdravotnictví. Praha: Nakladatelství Karolinum, 2017. ISBN 978-80-246-3657-3

KLUCZYŃSKA, M. - GRZYWACZ, J. (2015) System finansowania publicznej opieki zdrowotnej w Polsce. In: Zeszyty Naukowe PWSZ w Płocku. Nauki Ekonomiczne, t. XXII, 2015, s. 121 - 132. ISSN 1644-888X

KOMISIA (2007) Európskych spoločností: Oznámenie Komisie Európskemu parlamentu, Rade, Európskemu hospodárskemu a sociálnemu výboru a Výboru regiónov - Služby všeobecného záujmu vrátane sociálnych služieb všeobecného záujmu: nový európsky záväzok. KOM (2007) 724 v konečnom znení. Brusel: EK 2007. Available at: <https://ec.europa.eu/transparency/regdoc/rep/1/2007/SK/1-2007-725-SK-F1-1.Pdf>

KONEČNÝ, S. (2004a) Komunálna sociálna politika - k vymedzeniu pojmu. In: Nový model sociálneho zabezpečenia. Bratislava: Slovak academic press 2004, s. 107 - 126. ISBN 80-89104-62-2-

KONEČNÝ, S. (2004b) Miestna samospráva v Rakúsku a jej úlohy v sociálnej pomoci. - Bratislava : Mayor, 2004. ISBN 80-969133-0-1.

KONEČNÝ, S. - KONEČNÝ, B. (2009) Otvorená komunálna politika. Teória a prax. Bratislava: Mayor 2009. ISBN 978-80-969133-3-6.

KONEČNÝ, S. (2016) Verejná správa v členských štátoch Európskej únie. Bratislava: Mayor 2016. ISBN 978-80-969133-8-1.

KOVÁCS, N. - VARGA, O. - NAGY, A. - PÁLINKÁS, A. - SIPOS, V. - KÖRÖSI, L. - ÁDÁNYI, R. - SÁNDOR, J. (2019) The impact of general practitioners' gender on process indicators in Hungarian primary healthcare: a nation-wide cross-sectional study. *BMJ Journals Public Health*, Volume 9, Issue 9. ISSN 2044-6055

KÖZNEVELÉSI (2018) Statisztikai Évkönyv 2016/2017. Budapest: Emberi Erőforrások Minisztérium <https://www.kormany.hu/download/5/0a/81000/K%C3%B6znevel%C3%A9s-statisztikai%20%C3%A9vk%C3%B6nyv-2016-%C3%BAj.pdf>

KRAŚ, J. (2006) Reforma samorządu terytorialnego jako jeden z kluczowych elementów reformy administracji publicznej w III RP. In: *Resovia Sacra. Studia Teologiczno-Filozoficzne Diecezji Rzeszowskiej*, nr. 13, s. 291-310. ISSN 1234-8880

KRINGOS, D. S. - BOERMA, W. G. W. - HUTCHINSON, A. - SALTMAN, R. B. (eds.) (2015) *Building primary care in a changing Europe. Case studies*. Copenhagen: World Health Organization, European Observatory on Health Systems and Policies, 2015. ISBN 978 92 890 50 333

KUŠNIRIK, A. (2017) Regionálne školstvo na Slovensku: demografický vývoj a jeho vplyv na štruktúru škôl. Analýza. Bratislava: INEKO 2017. Available at: [http://www.ineko.sk/file\\_download/1212/Region%C3%A1lne+%C5%A1kolstvo+na+Slovensku+-+demografick%C3%BD+v%C3%BDvoj+a+jeho+vplyv+na+%C5%A1trukt%C3%BAru+%C5%A1k%C3%B4l.pdf](http://www.ineko.sk/file_download/1212/Region%C3%A1lne+%C5%A1kolstvo+na+Slovensku+-+demografick%C3%BD+v%C3%BDvoj+a+jeho+vplyv+na+%C5%A1trukt%C3%BAru+%C5%A1k%C3%B4l.pdf)

LEWANDOWSKI, R. - KAUTSCH, M. - SUŁKOWSKI, Ł. (red.) (2013) Współczesne problemy zarządzania w ochronie zdrowia z perspektywy systemu i organizacji, Przedsiębiorczość i Zarządzanie. tom XIV, zeszyt 10. Część I. Łódź: Społeczna Akademia Nauk, 2013. ISSN: 1733-2486

ŁUSZCZYŃSKA, M. (2019) Usługi społeczne dla rodziny seniorskiej - stan obecny i perspektywy rozwojowe. In: KUBOWA, A. - SZCZEPANIAK, J. (red.) Usługi społeczne wobec rodziny. Prace naukowe Uniwersytetu Ekonomicznego we Wrocławiu, nr. 239. Wrocław: Wydawnictwo UE 2019, s. 352-362. ISSN 1899-3129

MARKOWSKA-KABAŁA, I. (2013) Wybrane programy polityki zdrowotnej finansowane przez samorząd terytorialny. Przedsiębiorczość i Zarządzanie tom XIV, zeszyt 10, część I, ss. 375–383. ISSN 1733-2486

MEN (Ministerstwo Edukacji Narodowej) (2015) Finansowanie zadań oświatowych w świetle ostatnich zmian w sposobie naliczania części oświatowej subwencji ogólnej. Warszawa, 27. 04. 2015. Available at: [zgwrp.pl/attachments/article/707/Finansowanie %20zadan %20oswiatowych %20MEN.pdf](http://zgwrp.pl/attachments/article/707/Finansowanie%20zadan%20oswiatowych%20MEN.pdf)

MOLNÁR, T. - SCHARLE, Á. – TÓTH, E. – VÁRADI, B. (2019) Mit tehetnek a települési önkormányzatok az idősekért? Budapest: Friedrich Ebert Stiftung 2019 <http://library.fes.de/pdf-files/bueros/budapest/15637.pdf>

MF SR - MZ SR (2019) Revízia výdavkov na zdravotníctvo II. Záverečná správa. Bratislava: Ministerstvo financií SR - Ministerstvo zdravotníctva SR, október 2019. Available at: <https://www.finance.gov.sk/files/archiv/31/priloha8.pdf>

MPSV ČR (2007) Koncepce podpory transformace pobytových sociálních služeb v jiné typy sociálních služeb, poskytovaných v přirozené komunitě uživatele a podporující sociální začlenění uživatele do společnosti. Praha: MPSV ČR 2007. Available at: [https://is.muni.cz/el/1423/jaro2011/SPR406/um/Koncepce\\_podpory.pdf](https://is.muni.cz/el/1423/jaro2011/SPR406/um/Koncepce_podpory.pdf)

MPSV ČR (2011) Vybrané statistické údaje o financování sociálních služeb a příspěvku na péči. Praha: MPSV ČR [2011] [https://www.mpsv.cz/files/clanky/9198/Analyza\\_fin\\_SS.pdf](https://www.mpsv.cz/files/clanky/9198/Analyza_fin_SS.pdf)

MPSV ČR (2019) Registr poskytovatelů sociálních služeb. Dostupné [http://iregistr.mpsv.cz/socreg/rozsirene\\_hledani\\_sluzby.fw.do?SUBSESSION\\_ID=1557085264475\\_3](http://iregistr.mpsv.cz/socreg/rozsirene_hledani_sluzby.fw.do?SUBSESSION_ID=1557085264475_3)

MPSVR SR (2014) Národné priority rozvoja sociálnych služieb na roky 2015-2020. Bratislava: MPSVR SR 2014. Available at: <https://www.employment.gov.sk/files/slovensky/rodina-socialna-pomoc/socialne-sluzby/nprss-2015-2020.pdf>

MRPPS (2017) Informacja o sytuacji osób starszych w Polsce za rok 2017. Warszawa: Ministerstwo Rodziny, Pracy i Polityki Społecznej 2017. Available at: [https://www.gov.pl/documents/1048151/1060973/Informacja\\_o\\_sytuacji\\_osob\\_starszych\\_za\\_2017.pdf/1d23a7b9-4f2f-1a92-41d1-5bf51598d261](https://www.gov.pl/documents/1048151/1060973/Informacja_o_sytuacji_osob_starszych_za_2017.pdf/1d23a7b9-4f2f-1a92-41d1-5bf51598d261)

MŠMT ČR (2015) Dlouhodobý záměr vzdělávání a rozvoje vzdělávací soustavy České republiky na období 2015-2020. Praha: MŠMT ČR 2015. Available at: [http://www.vzdelavani2020.cz/images\\_obsah/dokumenty/strategie/dz-rgs-2015-2020.pdf](http://www.vzdelavani2020.cz/images_obsah/dokumenty/strategie/dz-rgs-2015-2020.pdf)

MŠMT ČR (2017) Výroční správa o stavu a rozvoji vzdělávání v České republice v roce 2016. Praha: MŠMT 2017. ISBN 978-80-87601-38-9

MŠMT ČR (2019) Statistická ročenka školství - Výkonové ukazatele do r. 2018/2019. Praha: MŠMT ČR 2019 <http://www.msmt.cz/vzdelavani/skolstvi-v-cr/statistika-skolstvi/statisticka-rocenka-skolstvi-vykonove-ukazatele-2017-18>

MŠVVŠ SR (2019) Štatistická ročenka - základné školy. Bratislava: CVTI SR 2019. Available at: [https://www.cvtisr.sk/cvti-sr-vedecka-kniznica/informacie-o-skolstve/statistiky/statisticka-rocenka-publikacia/statisticka-rocenka-zakladne-skoly.html?page\\_id=9601](https://www.cvtisr.sk/cvti-sr-vedecka-kniznica/informacie-o-skolstve/statistiky/statisticka-rocenka-publikacia/statisticka-rocenka-zakladne-skoly.html?page_id=9601)

MZ SR (2011) Správa o stave zdravotníctva na Slovensku. Bratislava: Ministerstvo zdravotníctva SR 2011. ISBN 978-80-969507-9-9.

MZ SR (2015) Správa o stave v zdravotníctve pre výbor NR SR pre zdravotníctvo. Bratislava: Ministerstvo zdravotníctva SR 2015, 158 s. Available at [www.ineko.sk/file\\_download/851](http://www.ineko.sk/file_download/851)

NCZI (Národné centrum zdravotníckych informácií) (2017) Sieť zdravotníckych zariadení a pracovníci v zdravotníctve v SR 2015. Bratislava: NZCI 2017. Available at: <http://www.nczisk.sk/Documents/publikacie/2015/zs1650.pdf>

NEMZETI (2018) Egészségbiztosítási Alapkezelő Kórházi Ágyszám- és Betegforgalmi Kimutatás 2017. Budapest 2018. Available at: [http://www.neak.gov.hu/data/cms1020087/Korhazi\\_agyszamkimutatas\\_2017.pdf](http://www.neak.gov.hu/data/cms1020087/Korhazi_agyszamkimutatas_2017.pdf)

NIK (Najwyższa Izba Kontroli) (2017) Usługi opiekuńcze świadczone osobom starszym w miejscu zamieszkania. Warszawa: NIK 2017. Available at: <https://www.nik.gov.pl/plik/id,17440,vp,20012.pdf>

NIP (2018) Národný investičný plán SR na roky 2018-2030. Pilotná verzia. Bratislava: Úrad podpredsedu vlády SR pre investície a informatizáciu, 2018. Available at: <https://www.vicpremier.gov.sk/wp-content/uploads/2018/10/03-NIP-SR-Vlastny-material-2018-04-25.pdf>

NKÚ (2018) Záverečná správa. Sociálne služby pre seniorov. Bratislava: NKÚ 2018. Available at: <https://www.nku.gov.sk/documents/10157/b8e2a0e2-4a1e-4d0a-8a1a-c1a3a31ce873>

OATES, W. E. (1999) An Essay on Fiscal Federalism. In: Journal of Economic Literature, Vol. XXXVII (September 1999), pp. 1120-1149. Dostupné na: [https://www.jstor.org/stable/2564874?seq=1#page\\_scan\\_tab\\_contents](https://www.jstor.org/stable/2564874?seq=1#page_scan_tab_contents)

OECD (2015) Education Policy Outlook: Hungary. Paris: OECD Institute 2015. Available at: <http://www.oecd.org/education/Hungary-Profile.pdf>

OECD (2017a) /European Observatory on Health Systems and Policies: Polska. Profil systemu ochrony zdrowia 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. ISBN 9789264285378

OECD (2017b) Hungary: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. ISBN 9789264283411

OECD (2017c) Education at a Glance 2017: OECD Indicators. Paris: OECD Publishing 2017. ISBN 9789264279834

OECD (2019) Economic Surveys: Hungary. January 2019. OVERVIEW. Available at: <http://www.oecd.org/economy/surveys/Hungary-2019-OECD-economic-survey-overview.pdf>

PAP (Polska Agencja Prasowa) (2016) Samorzady: obecny system finansowania oświaty nie przystaje do rzeczywistości. Warszawa: PAP 12. 09. 2016. Available at: <https://www.pb.pl/samorzady-obecny-system-finansowania-oswiaty-nie-przystaje-do-rzeczywistosci-841682>

Peková, J.- Pilný, J.- Jetmar, M. (2005) Veřejná správa a finance veřejného sektoru. ASPI, Praha 2005. ISBN 80-7357-052-1.

POPESCU LJUNGHOLM, D. (2014) Public Health System In Sweden. In: AGORA International Journal of Juridical Sciences, 2014, No. 1, pp. 141-147. ISSN 1843-570X

PRZYBYŁKA, A. (2013) Świadczenia dla osób starszych i niepełnosprawnych w ramach systemów ochrony zdrowia i pomocy społecznej (wybrane zagadnienia). Acta Universitatis Lodzianis, Folia Oeconomica 297, 2013, s. 183 - 193. ISSN 0208-6018

RADA (2006) Závěry Rady o společných hodnotách a zásadách v zdravotnických systémech Evropské unie (2006/C 146/01). <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:SK:PDF>

RAPORT (2019) „Podstawowa opieka zdrowotna w Polsce - diagnoza i projekty zmian”. Lublin: Instytut Medycyny Wsi im. Witolda Chodźki 2019. <http://www.zdrowie.gov.pl/epublikacje/Pobierz/id/57.html>

REPKOVÁ, K. (2012) Sociálne služby v kontexte komunálnej sociálnej politiky. Bratislava: Inštitút pre výskum práce a rodiny, 2012. ISBN: 978-80-7138-135-8

ROUPEC, P. (2006) Správa regionálního školství a financování vzdělávání. In.: KALOUS, J. - VESELÝ, A.: Vzdělávací politika České republiky v globálním kontextu. Univerzita Karlova v Praze. Nakladatelství Karolinum, Praha 2006. ISBN 80-246-1261-5

RURIK, I. (2012) Primary Care in Hungary. Utrecht: European Forum for Primary Care. 14. 02. 2012. Available at: <http://euprimarycare.org/column/primary-care-hungary>

RYCHLÁ šetření. Praha: Ústav pro informace ve vzdělání 2010. Available at: [www.msmt.cz/file/210\\_1\\_1/download/](http://www.msmt.cz/file/210_1_1/download/)

RYŠAVÝ, I. (2012) Zlepší limity venkovu dostupnost zdravotní péče? Moderní obec. 4. 10 2012. Available at: <https://www.moderniobec.cz/zlepsi-limity-venkovu-dostupnost-zdravotni-pece/>

SKIBA, L.- RAPKIEWICZ, M. - KĘDZIERSKI, M. (red.) (2014) Węgry Orbána - wzór czy przestroga? Warszawa: Instytut Sobieskiego 2014. ISBN 978-83-935407-5-4

SKÓBEL, B. - RUDKA, R. (2019) Sytuacja szpitali powiatowych i perspektywy na przyszłość. Warszawa: Związek Powiatów Polskich 2019. 55 s. Available at: <http://zpp.pl/storage/files/2018-08//eec31605e805ae9982aa5a34c0b75cd24053.pdf>

SMATANA, M. - PAŽITNÝ, P. - KANDILAKI, D. - LAKTIŠOVÁ, M. - SEDLÁKOVÁ, D. - PALUŠKOVÁ, M. - Van GENNEKEN, E. - SPRANGER, A. (2016) Slovakia. Health system review. In: Health Systems in Transition, 2016; 18(6):1–210. ISSN 1817-6127

SMO (Svaz měst a obcí ČR) (2007) Transformace: Česká zkušenost. Místní samospráva. Praha: SMO 2007. ISBN 978-80-86-961-20-0

ŚNIECIKOWSKI, W. (2013) Podstawowa opieka zdrowotna należy do zadań własnych gminy. Prawo.pl 05.06.2013 <https://www.prawo.pl/samorzad/podstawowa-opieka-zdrowotna-nalezy-do-zadan-wlasnych-gminy,89179.html>

SOPKULIAK, A. (2016) Štruktúry výdavkov miestnej samosprávy na Slovensku v rokoch 2012-2014. In KLÍMOVÁ, V. - ŽÍTEK, V. (eds.) XIX. mezinárodní kolokvium o regionálních vědách. Sborník příspěvků. Brno: Masarykova univerzita, 2016. s. 774 - 780. ISBN 978-80-210-8273-1.

SOUHRNNÁ (2014) zpráva k analýzám DSO. Praha: SMO [2014]. Available at: [http://www.smoc-r.cz/obcesobe/200001331-3beed3ce90/01\\_Z\\_v\\_re\\_n\\_zpr\\_va.pdf](http://www.smoc-r.cz/obcesobe/200001331-3beed3ce90/01_Z_v_re_n_zpr_va.pdf)

STOLIŃSKA-POBRALSKA, N. (2014) Dom pomocy społecznej jako instytucja polskiego systemu zabezpieczenia społecznego osób starszych. Pedagogika Rodziny 2014, nr. 4/3, s. 101-118. ISSN 2082-8411

TEMESI, I. (2014) Territorial public administration. In: PATYI, A. - RIXER, Á. (eds.) Hungarian Public Administration and Administrative Law. Passau: Schenk Verlag, 2014, pp. 304 - 319. ISBN 978-3-944850-12-2.

ÚZIS (2006) Aktuální informace č.4/2006 : Nemocnice v České republice v roce 2005. Praha : ÚZIS ČR, 2006. Available at: [http://www.uzis.cz/news.php?mnu\\_id=1100&archiv=1](http://www.uzis.cz/news.php?mnu_id=1100&archiv=1).

ÚZIS (Ústav zdravotnických informací a statistiky ČR) (2015) Síť zdravotnických zařízení 2013. Praha: ÚZIS ČR 2015. ISBN 978-80-7472-141-0

VÍŠEK, P. - PRŮCHA, L. (2012) Optimalizace sociálních služeb. Praha: Národní centrum sociálních studií - Výzkumný ústav práce a sociálních věcí, 2012. ISBN 978-80-7416-099-8

ZACHAROVÁ, E. - HERICH, J. - KVASSAY, A. - KOVÁČ, M. (2018) Sprievodca nešťátnymi školami a školskými zariadeniami (Regionálne školstvo, 1990-2017). Bratislava:

Centrum vedecko - technických informácií SR, 2018, 261 s. Available at:  
[http://www.cvtisr.sk/buxus/docs//JH/Sprievodca\\_NS18.pdf](http://www.cvtisr.sk/buxus/docs//JH/Sprievodca_NS18.pdf)

ZELINA, M. (2010) Teória výchovy alebo Hľadanie dobra. Bratislava : Slovenské pedagogické nakladateľstvo – Mladé letá 2010. ISBN 978-80-1001-884-0

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