Chapter 19
Local Self-Government and Governance During Covid-19 Pandemic in Slovakia

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Abstract The Covid-19 pandemic seriously affected the societies, economies and public sector operations in most of the countries. This is also the case in Slovakia. Although the first wave of the pandemic seemed less critical, the second wave was more devastating in terms of positive case number and the death rate. We identify the scope and timing of Covid-19 spread using health data, combined with related key central state anti-pandemic measures. Within a summary of the public health institutional framework, we focus on the increasing role of local self-government in this field and the retreat from a more centralist approach applied at the beginning of the pandemic. We document and evaluate the impact of Covid-19 on the local self-governmental operations and the most frequent measures adopted in selected cities. Besides directly assessing public health-related measures, we will pay attention to an assessment of the fiscal effects of Covid-19 on local self-government functioning, including the accompanying central–local fiscal relations. We document the rising role of local self-government in a set of measures such as micro-area quarantines, population-wide testing, locally initiated mass testing, and testing centres' network. Finally, we evaluate the anti-pandemic effort in Slovakia from the governance perspective.

Keywords Local and urban governance · Covid-19 pandemic · Measures · Mass testing · Slovakia

19.1 Introduction

The global Covid-19 pandemic seriously hit local communities across Slovakia. Both waves of the pandemic induced serious challenges and new tasks for all levels of government, including local self-government, though it is true that local self-government has minimal powers in the healthcare sector. However, being

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responsible for all aspects of local life and providing many necessary public services, its involvement was inevitable. Its role, less clear initially, grew with the rising complexity of the anti-pandemic effort and the central state's limits in shaping and implementing measures. Studies addressing the Covid-19 pandemic from this point of view are only emerging in Slovakia (e.g. Nemec and Špaček 2020; Takáč 2020), but this issue will certainly elicit extensive coverage.

The anti-pandemic effort in Slovakia substantially influenced the change of the government following parliamentary elections held immediately before the spread of the pandemic (29 February 2020). The shift to a new coalition government led by a populist, the non-system party (Ordinary People and Independent Personalities), the uncertainty and lack of preparedness in addressing the pandemic and the reorganisations and personal changes across state administration (including key ministries) were later accompanied by governmental coalition tensions caused by the different visions of how to address the pandemic (e.g. measures timing, permanent mass testing, the secret purchase of the Russian Sputnik V vaccine, which was unregistered in the EU). The dominant position of Prime Minister Igor Matovič and his unclear communication with citizens were controversial. Although the central government was successful in some policy fields, it was less convincing in the anti-pandemic effort. As Buštíková and Baboš (2020) outlined, we could observe a specific type of populist pandemic response. As a result of many inconsistencies, criticism and loss of population support, Minister of Health (Marek Krajči) and later also PM Matovič resigned from their posts in March 2021.

This study's primary goal is to evaluate local self-governments' role and intergovernmental position during the coronavirus pandemic in Slovakia. In this context, we also intended to provide sufficient detail concerning some specific features of the anti-pandemic effort in Slovakia (e.g. population-wide testing). The Covid-19 challenge is often perceived as a complex intergovernmental issue that requires extensive coordination and co-operation (e.g. Paquet and Schertzer 2020). We begin with an outline of the pandemic's evolution, complemented with the relevant institutional framework outline. Several known approaches and concepts inspire the sections that follow. Because the coronavirus significantly affected intergovernmental relations, we address the changes in central–local relations and the nature and development of multi-level governance (Stephenson 2013). We also focus on the horizontal meaning of governance applied at the central and local levels. We try to reveal the central government's and local self-governments' abilities to develop an efficient partnership with other actors (social partners, professionals). We also focus on the impact of legal and legitimacy issues (input, output, throughput; e.g. Schmidt 2013). This concerns the specific conditions applied during the 'State of Emergency' and the institutional agility and adaptations induced by the pandemic (e.g. Janssen and van der Voort 2020). The legal framework and management of the crisis also influenced the scope of local autonomy (e.g. Pratchett 2004). Another specific issue is spatiality during the pandemic, which is linked to institutions, measures and the perception of spatial differentiation and their conversion into decisions.

We argue that the local self-government role in addressing the coronavirus pandemic increased in Slovakia. This was caused by a worsening of the pandemic

situation and its long duration. In the meantime, there increased the need for more complex and smart measures to balance all aspects of public health along with social and economic life. Local self-governments also confirmed their ability to manage various types of measures. We could observe a slow shift towards systemic, regionally and locally specific measures, with local self-governments playing an inevitable role in their final shaping and implementation. The nature of central–local relations in addressing the coronavirus shifted from a centralised to a more decentralised and governance based. The personal and organisational capacities, communication linkages and local networks of local self-governments were beneficial and irreplaceable. The central state's role shifted towards a general framework of provision, legal backing, the setting of nation-wide measures, the provision and distribution of material resources and the financing of selected local measures. Local self-government demonstrated its role as the most efficient actor at the local level. However, this shift was not straightforward, and it was accompanied by various tensions and periods when local self-governments were in the dark about their role.

The main sources of information used in this chapter are data on Covid-19 development and responses at the national level and the related legislation and guidance adopted by relevant ministries and the Public Health Authority of the Slovak Republic. When focusing on local adaptation and measures, we used local self-government documents (City Council meeting records and decisions) and publicly available official statements of local self-government representatives (primarily mayors), in the respective national and local press, as well as social media (e.g. aktuality.sk 2021). We focus in detail on the experiences and measures adopted by a set of cities of various sizes (Bratislava, Trenčín, Pezinok, Senec), the scope of their powers and activities and various Covid-19-related problems. Two suburban cities in the Bratislava region accompany Bratislava, as the nation's capital, and Trenčín, as a centre of an administrative region. They provide a fair reflection of various approaches and measures adopted in diverse fields of local life. These cities and their city-regions suffered periods of being under the pressure of a high coronavirus incidence rate. This chapter covers the situation until the end of March 2021.

19.2 A Summary of the Covid-19 Pandemic Timing and Key Measures

The first confirmed case of Covid-19 in Slovakia was recorded on 6 March 2020. Nevertheless, preventive laboratory testing started already on 3 February 2020 and the first elementary measures had been adopted on 28 February 2020. At the national level, measures adoption coordinated the Central Crisis Staff introduced at the end of February 2020. The first serious anti-epidemiological measures were adopted after the first positive cases appeared in the Bratislava region (the first introduced Bratislava regional self-government and selected local self-governments). With rising

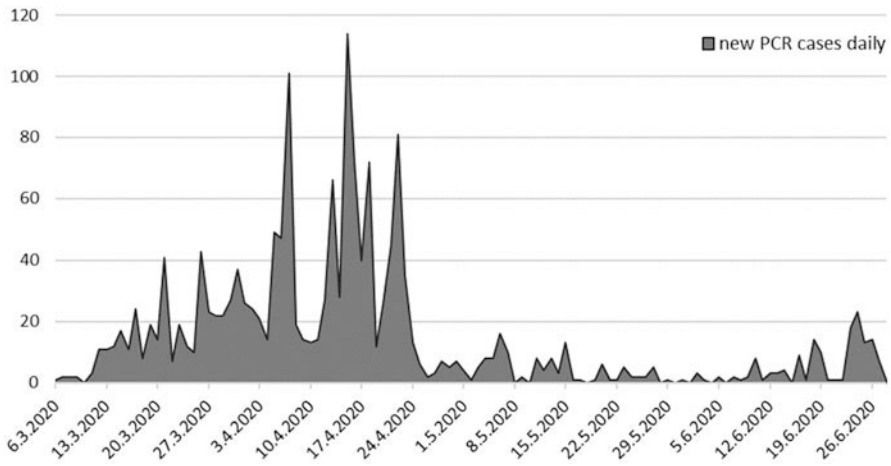

Fig. 19.1 First wave of Covid-19 pandemic in Slovakia: Daily positive cases (March–June 2020) *Source*: korona.gov.sk

numbers, an Emergency Situation (as defined by national legislation) was approved on 11 March 2020, and a stricter State of Emergency was declared from 16 March 2020, and applied until 14 June 2020. This period is usually considered to be the first wave of the Covid-19 pandemic in Slovakia. It is frequently concluded that the country was poorly prepared, lacking critical material resources (tests, personal protective equipment) and with less elaborated crisis management and planning in the field of pandemics (e.g. the Supreme Audit Office of the Slovak Republic 2020). Taking into account the already available experiences of other countries and lack of preparedness in various fields, the new central government adopted stringent measures, including a lockdown, that substantially circumscribed economic and social life. The adopted measures were successful also thanks to the respect for the threat within the whole society and attention to the enforcement of adopted measures. The number of positive cases decreased after a peak in April 2020. As a result, Slovakia ranked among the countries that passed through the first wave of the pandemic with the lowest number of infected (from March to end of June 2020 this was 1687 positive cases, Fig. 19.1) and low level of mortality caused by Covid-19 (28 deaths up to the end of June 2020).

After a moderate level of Covid-19 spread during the summer months, the number of positive cases started to grow again at the end of September 2020. The central government reacted to this situation with a second State of Emergency introduced since 1 October 2020, which is often considered as the start of the second wave of the Covid-19 pandemic in Slovakia. Under the pressure of the quickly expanding number of the positive cases, the central government decided on population-wide antigen (AG) testing from 31 October to 1 November 2020. Additional extensive testing continued in November in the more affected districts and local self-governments. Mass population-wide testing combined with a

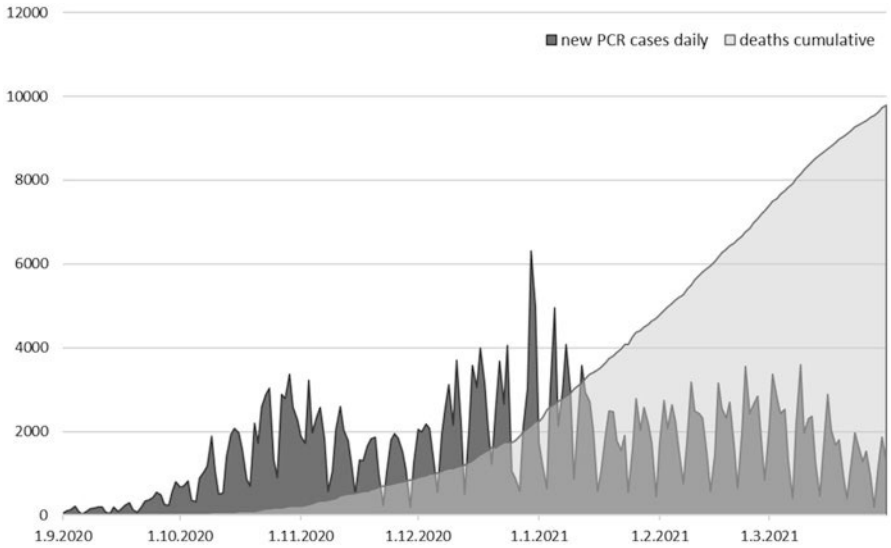

Fig. 19.2 Second wave of Covid-19 pandemic in Slovakia: Daily cases/deaths (until 31 March 2021)
Source: korona.gov.sk

lockdown (e.g. Pavelka et al. 2021) caused an interim decline in the positive cases' growth (see Fig. 19.2). Although the longer-term effect was not achieved, mass testing at least took thousands of infected people out of the circulation (Holt 2021). Nevertheless, the subsequent relaxing of measures caused a new rise in infections starting in early December (including a rapidly rising incidence in selected regions). New and stricter measures were adopted before Christmas. However, due to a lack of discipline, too many exemptions and less attention on enforcement measures, the situation did not improve. Even with stricter measures, adopted since 1 January 2021, it was not easy to mitigate the high incidence due to the transfer of new coronavirus mutations into Slovakia. Despite the combination of intensive testing and strict measures, the situation started to improve only at the end of March 2021.

The second wave was much more demanding compared to the first wave. The anti-epidemic measures were less consistent and less strict (most of the economy continued working) and were accompanied by populist responses and political tension at the central level (e.g. tensions concerning the scope and nature of the measures caused a late response to the rising incidence in December; e.g. Hospodárske noviny 2020; ZMOS 2020). The typical feature had been the emphasis on the role of extensive testing effort (primarily antigen – AG testing) and less strict attention to other measures. This generated the false dilemma that there is a choice between mass testing (primarily population-wide) and lockdowns (a set of measures including social distancing, limits to various social activities and mobility). The most debated was the strong preference given to population-wide testing. Such a huge operation with minor outcome caused a weakening in

population's trust towards the government's anti-epidemic measures (e.g. Leksa in Holt 2021) and was also questionable from a cost-efficiency point of view. It appeared to be hard to mitigate the spread of the pandemic without parallel use of more pillars (e.g. mobility reduction, social distancing, accessible and reliable testing, later accompanied by vaccination), including the strict implementation and enforcement of measures. Vaccination started in Slovakia on 26 December 2020 thanks to the first deliveries of vaccines within the EU distribution scheme (Pfizer-BioNTech). Vaccination progressed at an EU average rate, with almost 1 million (mln) vaccines applied by the end of March 2021.

19.3 Institutional Framework Addressing Public Health and Covid-19

The Slovak Republic has long had developed an administration addressing public health issues. Nevertheless, the coronavirus responses concern the whole health system organisation. During the last 20 years, the health system in Slovakia was liberalised and more privatised. It is based on universal coverage, compulsory health insurance and a basic benefits package (e.g. Smatana et al. 2016). Besides the central state (the Ministry of Health), the other important element consists of a competitive insurance model, currently with three healthcare insurance companies (two of them private). These insurance companies collect compulsory contributions from employees and employers and contract healthcare provisions among various providers.

However, the system has been underfinanced over the long term and requires additional transfers from the state budget and private sources (see e.g. OECD/European Observatory on Health Systems and Policies 2019). Hospitals generate large debts (occasionally reduced by subsidies from the state budget), and there is a long-term investment gap in the sector. Private resources flow includes, for example, fees for additional services and co-payment for prescribed pharmaceuticals. The health sector also suffers from a lack of staff (physicians, nurses). In the central coordinating role in health issues is the Ministry of Health, along with other sectoral regulatory institutions (e.g. the Health Care Surveillance Authority, the National Health Information Centre). The largest regional hospitals, university hospitals and specialised hospitals also are subordinated to the Ministry of Health (in various legal forms). Only large state hospitals have departments for infectious diseases.

Public Health Authority plays a decisive role in public health (Public Health Authority of the Slovak Republic 2020). This state-financed administration is responsible for a wide scope of sensitive tasks such as surveillance of communicable diseases, hygiene (including food hygiene) and sanitation, environmental and occupational health and health prevention and promotion. The Public Health Authority is represented and managed by the Chief Hygienist appointed by the Ministry of

Health. It operates across the country through 36 regional offices responsible for practical communicable diseases surveillance and measures implementation and enforcement. These offices can adopt needed measures according to their regions and are responsible for specific tasks, such as contact tracing of infected persons. In the case of Covid-19, measures and guidance issued by the Public Health Authority/Chief Hygienist as a result of central state advisory and the outcomes of decision-making bodies (government resolutions, crisis management bodies' decisions) have critical importance.

The meso-level of government institutions has a limited role within the healthcare system. As far as regional self-government is concerned, it mostly has regulatory powers (Acts 567/2004, 362/2011) in managing selected health and pharmaceutical activities in their regions (e.g. permissions, opening hours, health districts, registry). They also have hospitals, but most of them are already rented out or privatised. The majority of 'regional' hospitals operate like private companies (AGEL Group with 13 hospitals, Svet Zdravia a.s., AGEL SK 2020; Svet zdravia 2020). Only a partial coordinating role in the anti-pandemic effort have District Offices of general state administration (working in 79 districts) with staff and responsibilities in crisis management. However, they have less experience in addressing pandemic issues (usually focusing on, for example, natural risks). Only during the later phases of the second wave of the pandemic did their role increase. Their spatial network is denser compared to public health authorities, and they are also responsible for District Crisis Staff functioning, until now mostly without official involvement of local self-government.

The Covid-19 pandemic was a serious challenge to local self-governments. Public health issues are not among the obligatory local self-government powers (Act 369/1990, as amended). Local self-governments do not have specialised departments and staff. This is understandable when we consider the fragmented self-government system, which has about 2900 local self-governments (with many small ones), and the specific professional aspects of health administration and services. Nevertheless, health issues are essential aspects of local public services provision and local quality of life. Local self-governments pay attention to these issues as an essential factor in local community satisfaction. Under the current local autonomy scope and legislation, local self-governments can act freely and initiate their own measures outside their obligatory powers. However, public health activities are coordinated with other public administration bodies and health-services providers. The accessibility of primary care in particular is considered a sensitive issue (although the outpatient sector is also private). For example, this is expressed by ownership of local health centre buildings or by providing space for physicians' ambulances. Specific is the position of a few larger cities that own and operate local hospitals (usually smaller, with a reduced scope of specialisations and a limited number of beds). During the healthcare transformation processes, many traditional city hospitals were closed or converted into outpatient health centres, privatised, or changed into joint-stock companies with non-public partners with operational know-how.

The Slovak Republic has a well-developed system of crisis management and planning, security, and crisis bodies at all levels in general (central, regional, district, local). However, it was less prepared for a pandemic on such a scale. The Covid-19 pandemic induced a challenge to the crisis management institutional framework, which was changing and less transparent under the pressure of time and circumstances. The decisive role in the managing of the coronavirus pandemic belongs to the central state. After the rise of the coronavirus pandemic, the Central Crisis Staff, based on general crisis management legislation (not focusing explicitly on pandemic issues), served as the tool for managing and coordinating the anti-pandemic effort. Due to the specific nature of the coronavirus threat, an interdisciplinary and cross-sectoral Permanent Crisis Staff (PCS) was spontaneously established in March 2020. It included a set of prominent Slovak scientists, managers, experts in relevant fields and top officials. This staff permanently monitored the pandemic situation (it had its own support staff for data analyses and foreign experiences evaluation) and provided proposals for measures. The PCS operated, with unclear legal backing, within the Government Office, in close contact with the Prime Minister (he nominated the chair) and regularly communicated adopted measures to the public. An interim Council of Experts, primarily professionals in epidemiology and infectology, also had an advisory role. Both finished their functioning at the end of the State of Emergency in June 2020. The Council of Experts continued in affiliation to the Ministry of Health and the Public Health Authority but with less influence than before and it changed its composition. As a result, many previously involved experts were no longer participating. During the second wave, the Pandemic Commission of the Slovak Government (with administrative backing at the Ministry of Health) took on an increasing role in the proposing of measures and their coordination. Surprisingly, despite its longer-term existence in Slovak legislation, it was overlooked and not activated during the first wave (it started to function in June 2020). It is composed of representatives of crucial central state administration bodies (primarily ministries). However, it is without formal local self-government representatives (includes all eight chairs of regional self-governments) and the only minor representation of experts (representing public health, epidemiology and infectology).

19.4 The Covid-19 Pandemic and Local Self-Government Functioning

The rapid spread of the coronavirus pandemic influenced various aspects of local life and local self-governments' functioning. We can divide these aspects into several groups: the functioning of local self-government offices, the impact on selected powers and public services, inevitable direct interventions in the field of local public health, the crisis communication during the pandemic, the financial aspects of local self-government functioning, the implementation of new and specific tasks (such as mass testing) and the position of local self-government associations. Participation of

local self-governments in the anti-pandemic effort was also based on legal requirements of synergy between local self-governments and the central state during a State of Emergency.

19.4.1 Basic Features of Covid-19 Pandemic Impact on Local Self-Government

Besides the standard institutional framework (Council, Office), many local self-governments established or activated their Local Crisis Staff (based on crisis management legislation) for more flexible management of the local anti-pandemic effort. They concentrated on the protection of its decision-making capacity, the offices' elementary functioning and secure public services provision. Most critical for local self-governments in pandemic times is to fulfil the public health standards in their key powers (e.g. primary education, social services, public transport, public spaces).

Surprisingly, among the first problems that local self-government was confronted with were the difficulties in organising local/city councils' meetings and voting under the conditions of the suddenly introduced lockdown and State of Emergency. There emerged a dispute concerning the threat of democratic decision-making at the local level. This was a serious issue, especially when urgent local decisions concerning Covid-19 measures were to be adopted. As a result, some local self-governments organised their council meetings in large halls (sports halls, cultural centres) or even held open-air council meetings to respect the adopted national measures. Under the pressure of local self-governments, the Slovak Parliament then adopted new legislation (Act 73/2020) allowing under the crisis conditions (e.g. under the declared State of Emergency) council meetings to take place through videoconferencing, with online voting, as well as the use of information technologies in general to replace in-person meetings. It specified rules to guarantee democratic decision-making and transparency (e.g. required documentation before meetings, complete video record published). It also focused on inevitable measures and decisions and restricted decisions in specific matters (e.g. they can be valid only for a limited period of time). This legislation was applied occasionally during both waves of the pandemic.

Local self-governments had to adjust and adopt numerous measures to prevent the spread of the pandemic. Lockdowns and the rising incidence (e.g. office staff quarantine) caused reduced office hours. A significant side effect is a considerable shift in favour of e-government practices, which were introduced during the pandemic. A similar impact could be observed in the reductions and rescheduling of local public transport. Many local cultural and sports facilities closed, and local events were cancelled. Among specific effects, we can mention the much larger volume of waste generated by households during lockdowns. During the pandemic, local staff affiliated with local self-government often had to fulfil different tasks than usual. Under the pressure of pandemic circumstances, local self-government

initiatively intervened in the field of local public health. They increased sanitation, disinfection and cleaning activities and introduced new hygienic standards and technologies in public facilities and spaces (e.g. in local offices, schools and cultural facilities). Specific measures were adopted to protect local public sector staff responsible for providing public services by specialised protective material (social services workers, municipal police, teachers, first contact local government staff). A large amount of protective material was distributed among various local institutions, including those outside of local self-government powers. Some local self-governments co-operated in strengthening the disinfection of open public places with a large concentration of people, like bus stops, local open-air markets, playgrounds for children, sports grounds and parks. Additional treatment addressed hygiene and disinfection in means of local mass transport (interior surfaces and air). Local self-governments had a critical role in the dissemination of information on proper behaviour. Bratislava's self-government implemented its own Covid-19 semaphore, as a permanent monitoring and warning system against the uncontrolled spread of coronavirus, and the possibility of quick and planned responses at the local level. The municipal police units (managed by local self-government) also played a locally relevant role in implementing and enforcing these measures.

Due to the higher vulnerability, local self-governments paid extra attention to their elderly population. They addressed the elderly population, the residential care homes for the elderly, and daily care centres for the elderly managed by local self-governments (elderly care homes are owned mostly by local and regional self-governments, or they are private). They used their social services capacities to arrange care and monitor all elderly, especially those living alone. In co-operation with volunteers and NGOs, local self-government social services centres provided them with extended assistance (meals, shopping, medicine and so on). For example, face masks were distributed to the elderly population in some cities. Most Covid-19 victims during the first wave in Slovakia were living in elderly homes. For example, 17 deaths occurred in one elderly care home in Pezinok (there were 28 Covid-19 deaths in Slovakia during the first wave, until 15 June 2020). The city of Pezinok's local self-government co-operated in settling a complicated situation (with the regional public health office and regional self-government, as the owner of this elderly care home), including the isolation of the elderly home building as well as the surrounding area.

Among specific anti-pandemic measures with more extensive local self-government involvement, we must mention the quarantine of selected local communities. This concerned the quarantine of marginalised Roma communities, where the central government have imposed a mandatory quarantine (lockdowns in selected micro-areas, not over the whole local self-government territory). This decision was based on the risk related to the return of these communities' members from abroad (from areas with a higher incidence of coronavirus, primarily the United Kingdom), combined with low hygienic standards (including a lack of protective equipment), overcrowding (problems with contacts tracing, distancing) and the worse social and economic background in these settlements and the subsequent potential spread of Covid-19. Roma settlements were selectively targeted, and the quarantine did not

apply to other communities. This approach was imposed by the central state according to the 'Plan for Covid-19 disease management in marginalised Roma communities' (Government Office 2020a, b). However, aside from central state authorities (including the Government Plenipotentiary for Roma Issues), this plan was initiated by representatives of selected local self-governments aware of the threat to their communities. It started by mass testing of more than 9000 Roma in more than 290 localities around Slovakia. As a result of the higher coronavirus incidence, five Roma communities (with about 6200 inhabitants) were closed into a mandatory quarantine supervised by the armed forces and police (which also provided repeated testing and healthcare). Most of these communities were isolated for three to four weeks. During these 'micro-area lockdowns', local self-governments (with their own municipal police, Roma civic patrols, office staff and social workers), volunteers, NGOs and local entrepreneurs substantially complemented the army and police to maintain acceptable living conditions within the closed communities. The provision of drinking water, food, shopping, medicines, protection equipment (e.g. face masks, disinfectants), communication concerning appropriate behaviour and all other everyday issues was possible, thanks to their involvement. Nevertheless, the central government approach was criticised as selectively addressing only Roma communities and as an inappropriate use of state power (see e.g. Amnesty International 2020). Only a few similar cases occurred during the second wave of the pandemic (with lesser populations and of shorter duration).

19.4.2 Local Finance Adaptation

The above-mentioned pandemic circumstances and adopted measures were also reflected in the local finance situation. This has been only rarely studied until now (see e.g. Nemec and Špaček 2020), due to the lack of availability of final annual fiscal documentation (e.g. final accounts). We can identify such consequences according to the local budgets' sections (revenues and expenditures, current budget, capital budget, financial operations) and also according to the already adopted measures. It is also important to notice that measures adopted during the first wave (Spring 2020) were much stricter compared to the second wave (Autumn 2020–Spring 2021), when measures were more moderate (less strict lockdowns, more exemptions, the majority of the economy still working).

The impact of coronavirus on local finance during Spring 2020 was unclear (e.g. duration, acuteness), so many local self-governments adopted the prudent preventive approach and prepared more scenarios. Later on, the situation was partially relieved and more moderate scenarios prevailed. During 2020, most local self-governments approved new and often modified budgets. Some other smaller savings/expenditures transfers were initiated during the year, according to the current financial development. It seems that local self-governments were able to cope with the pandemic without any devastating impact on their functioning. They

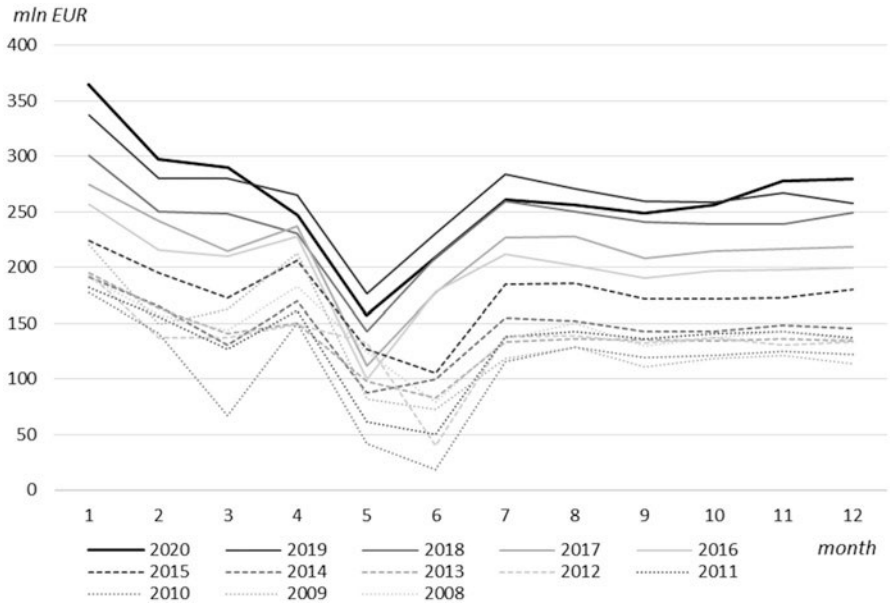

Fig. 19.3 Monthly personal income tax transfers to sub-national budgets 2008–2020
Source: Financial Administration of the Slovak Republic (2021)

were able to initiate their own policy measures or participate in local implementation of nation-wide measures. Despite the uncertainty in their own fiscal situation, due to the temporary closure of many local businesses, local self-governments frequently decided to provide them with assistance (especially for small businesses in local tourism, catering and so on.). This usually included a reduction/postponement of property tax payments and reduced rents for those operating in public buildings or using public spaces.

The usual problems of Slovak local self-government revenues during any crisis are related to a substantial decrease in personal income tax yield – PIT (Buček and Sopkuliak 2014). This tax yield is the primary source of local tax revenues (local self-governments obtain 70% and regional self-governments 30%). Any economic slowdown immediately causes a lower yield from this tax. The Ministry of Finance quickly calculated a decline in PIT revenues according to the public finance forecast for each local self-government. This meant a loss of 121 mln EUR in total for all local self-governments in Slovakia in 2020 (e.g. almost 10 mln EUR for Bratislava, Ministry of Finance 2020a). This less devastating decline in PIT yield was thanks due to the central state measures to prevent mass business bankruptcies or unemployment growth. Local self-governments were also aware and prepared for the usual interim decline in this revenue during the second quarter of the year (see Fig. 19.3). Reduced income from property taxes (real estate) due mainly to the permitted postponement of tax declaration filling and payments was less important.

Among other sources of revenue decline, those related to local self-government measures linked to the postponement of rent payments by business entities operating on their land or buildings can be mentioned. The more serious impact was the decrease in the fees paid for public services, caused by lockdowns and reduced population mobility. The most considerable impact concerned the much-reduced need for public transport (critical in large cities), which was reflected in a substantial decline in mass transport and in the public companies' income (30–50% in the lockdown months). This resulted in a need for additional subsidies provided by local budgets. The absence of parents' contributions to the operating of some additional school services (e.g. meals, school clubs, art schools) and reduced user fees in cultural and sports facilities were less critical. Due to social distancing requirements, many social activities that regularly contributed to local budgets (e.g. traditional markets, festivals, mass sports events) were cancelled (or organised with reduced capacities). State subsidies (e.g. for primary education) and other transfers from the state budget, which were provided without a reduction, had a stabilising role. Capital revenues declined due to the economic slowdown and less interest in investment (e.g. property transactions). EU-funded projects in progress remained financed; however, some planned project schemes financed by the EU were postponed due to the reorientation of funds to anti-pandemic measures. Among the usual steps for balancing the revenue side, we can find transfers from reserve funds (although also planned for different purposes). To a lesser extent, local self-governments turned to municipal borrowing. The better financial situation of local self-governments in general allowed additional borrowing within local debt caps.

Local self-government expenditures were also put under pressure. The usual responses included a search for savings and transfers among expenditure items within the year. Expenditures in everyday operation and local public services provision had a natural priority in this period. The financial coverage of anti-pandemic measures (own measures and participation in nation-wide measures) required additional attention. Immediately after the first weeks of the Covid-19 pandemic spread, many local self-governments adopted finance-saving measures. The savings were to come from salary freezing (during the first wave), or other personnel cost reductions (often linked to reduced office hours, part-time jobs and interim contract reductions). We can frequently find reduced subvention programmes for various local entities (e.g. in culture, sport) and participatory budgets.

At the same time, there were much higher personnel costs concerning, for example, social workers, municipal police and the salaries of those involved in the testing effort (additional staff, overtime work). Coronavirus caused many other expenditures to rise (e.g. material, equipment, online work hardware and software). Local self-government also had to pay external contractors for various additional specialised services related to public hygiene. Cancelled cultural and sporting activities due to preventive measures provided some savings as well. Among the most relevant fiscal expenditure measures were the reduction in investments with a planned start in 2020 and preparing new planning documents for future investments.

Some cities also negotiated more relaxed conditions for older debt payments with banks.

The central state recognised the worsening of the financial situation of local self-governments. However, its approach to mitigating local fiscal stress was different from previous crises (Buček and Sopkuliak 2014). Considerations made by the Ministry of Finance influenced coronavirus-related PIT reductions and the long-term increase in personal income tax yields during previous years (see Fig. 19.3). The central state also took on most of the heavy load of extra pandemic-related costs into the state budget deficit and debt. As the primary mitigation tool, it offered to all local self-governments financial assistance in the form of a soft loan, available at zero rates and with payment postponement (these are to be paid between 2024 and 2027). The size of such loans was up to the total PIT loss of individual local self-governments calculated by the Ministry of Finance. Local self-governments could decide based on their own considerations if they wanted to take this loan, and more than 1700 local self-governments chose to do so (Ministry of Finance 2020b). Despite the central state proclamation, local self-governments were not compensated for all coronavirus-related extra costs and losses (e.g. mass transport companies losses). Transfers of resources for selected activities and measures implemented during the State of Emergency (e.g. testing) were delayed, and not all costs were accepted. Relief in budgetary rules in the free use of specific resources (e.g. reserve funds) for current expenditures until the end of 2021 was a specific form of support.

19.4.3 The Role of Local Self-Government in Mass Population Testing

Among the inevitable tasks of any anti-pandemic effort is to cope successfully with the concentration of positive cases in a particular territory or even on the national scale. One of the possible strategies is mass nation-wide testing (usually with some exceptions based on age, e.g. children, elderly persons). While mass testing experiences are more frequent at the city or regional levels, country population-wide testing is unique in Europe (see, e.g., Frnda and Durica 2021). In the Slovak case, we can observe the experiences of population-wide mass testing at all levels of territorial organisation, which provide useful experiences concerning the local self-government role. The Slovak experience demonstrates local self-governments' inevitable role in managing mass operations at the local level under the existing institutional framework. However, population-wide testing was a more complex operation than they regularly manage, comparing, for example, to elections.

19.4.3.1 The Role of Local Self-Governments During Country Population-Wide Mass Testing

The Slovak government decided on population-wide testing in mid-October 2020 (Government Office 2020b), to be carried out from 31 October to 1 November 2020. However, this country-wide measure had been quietly prepared much earlier within a very narrow group of officials and experts around the PM I. Matovič. It was based on an effort to buy a large number of AG tests quickly and at a reasonable price (13 mln units for 52.3 mln EUR, Transparency International Slovensko 2020). The intention also was to avoid opponents' attacks based on various grounds and to react to an accelerating number of positive cases. It was accompanied by a set of other measures valid from 1 October 2020 and strengthened by a strict lockdown from mid-November, when only negatively tested citizens could move freely. Although population-wide testing was initiated as voluntary, most of the population considered it obligatory (otherwise they would have to remain in a two-week quarantine). Population-wide testing generated tension on the Slovak political scene between its proponents (primarily around the Prime Minister) and opponents (including some government coalition parties, ZMOS - Association of Towns and Communities of Slovakia, health sector representatives, experts).

Box 19.1 Population-Wide Testing Timing and Results in Slovakia (October–November 2020)

Population-wide testing, known as operation 'Joint Responsibility', included four rounds of AG testing within one month. Mass testing started with a first (pilot) round (23–25 October 2020) in selected regions already suffering from a higher rate of infected citizens (four districts). Almost 141 thousand citizens took part, with a positive case rate of 3.91%. Participation in the main second round of population-wide testing exceeded 3.63 mln people (with 38,359 positive cases, 1.05% positive). High-prevalence districts (those with a prevalence above 0.7%; 45 districts) were targeted with a subsequent third round on 7–8 November (2.04 mln tested; 13,509 positive cases, 0.66%). The fourth round of testing (21–22 November 2020) took place in 458 urban and rural self-governments with a positive test rate above 1% in the previous round. Participation in the fourth round exceeded 110 thousand citizens and showed positivity rate of 2.26%.

Source: Ministry of Defence of the Slovak Republic, 2020

During all the rounds, 5.9 mln AG tests were carried out with almost 60 thousand positive persons, who subsequently went into quarantine (Ministry of Defence 2020). Due to differences in a pandemic situation, some citizens participated in one round of testing, while others had to participate in all four rounds. The next population-wide testing rounds, scheduled for December 2020, were cancelled due to a dispute on testing strategies and lack of testing kits. Permanent country population-wide testing is quite exhaustive for the main actors (the healthcare sector, military and police capacities, local self-government, volunteers). The main round of

population-wide testing in particular required the mass mobilisation of resources and personnel capacities. It was also a logistic challenge in distributing testing kits to all sites.

The Ministry of Defence estimates the total cost of this operation at 100–105 mln EUR. Because it was combined with other restrictions, the effect of population-wide testing as such was not so apparent (Mahase 2020) and less efficient in less infected regions. Nevertheless, a combination of population-wide testing with a certain kind of lockdown contributed to the mitigation of the spread of Covid-19. It provided additional time and a few weeks of more relaxed restrictions (later questioned) from the end of November 2020.

Population-wide testing was managed as a central state operation, with the Slovak armed forces playing a leading role. However, practical experiences confirmed the more critical role of local self-governments as was initially expected. The success of the testing ultimately depended on the effort and capacities of local self-governments and local communities, their cohesion, including the mobilisation of local medical and support staff. Mass testing meant 4961 sites (two days) with testing teams across the country. Each testing team was to consist of six to eight persons, including two to four medical staff for rotation, one military person, one policeman and two administrative staff. Overall, more than 40,000 persons participated in the testing teams (e.g. approximately 15 thousand medical staff and 8 thousand military staff, in the main population-wide round). The demanding nature of population-wide testing indicated that only 60% of testing teams' staff were available one day before the testing was to start (as reported by the Slovak Army Forces representatives to Z. Čaputová, President of the Slovak Republic, 2020). Thanks to local self-governments' mobilisation activities, almost all testing teams were supplemented and all sites prepared, combined with the increase in testing staff payment provided by the central government. As a result, 98% of the testing teams were complete on the first day of testing.

Slovakia experienced a shift from top-down to a more balanced mass testing approach as one of the most demanding activities during its anti-pandemic effort. While in the beginning, the role of local self-government should be secondary, its role began growing when testing preparations began getting complicated. Initially, the local self-governments were to be responsible only for testing site preparation and administrative staff provision. Later on, other tasks appeared: material support, disinfection, the filling out of testing teams (healthcare workers), covering additional costs and the extensive involvement of local offices (with many regular tasks being left aside). This was repeated in many local self-governments for four weeks. Such a model led to the exhaustion of those involved in the testing. The high frequency, waiting in discomfort and the nature of AG testing (limited reliability) led to frustration also among citizens. This caused the unwillingness of local self-government to participate in the next planned population-wide testing. They also preferred to organise testing by themselves, within their own capacities and without the central state's lack of clarity in management. The central state should provide local self-governments testing kits, logistic support, protective equipment (for testing teams) or sufficient financial compensation.

19.4.3.2 The Role of Local Self-Government in the City of Trenčín's Mass Testing

The mass testing carried out on 19–20 December 2020 in the city of Trenčín (55 thousand inhabitants, 2019) represents the opposite case in approach to population-wide testing. This mass testing was the outcome of a rapidly rising number of positive cases in this region and pressure on hospital capacities in the region. The city's mayor, in co-operation with the Regional Hygienist office and the local university hospital, initiated mass testing in the city in order to mitigate the spread of the disease (with a possibility for testing also for residents living in Trenčín's urban functional region). In this case, the testing of residents was entirely voluntary. The central state (ministries of interior and defence) provided 40 thousand AG tests for free. Additional PCR tests for confirming problematic cases were provided by a private sponsor (the Slovak PCR tests producer). The whole procedure was also the subject of consultations with specialised scientific advisors. The city's self-government used its own organisational and communication capacities, knowledge of the local environment, good relationships with local partners (with the critical role of the local healthcare sector) and operated 33 testing sites. This was accompanied by stricter measures addressing distancing (e.g. a ban on all events with more than six persons). The participation of residents exceeded expectations (at about 60% of the relevant population). In total, 21,660 persons were tested, 560 of whom were positive (2.59%). Those asymptomatic were invited for PCR tests (159 persons participated, 148 of whom were confirmed as positive by PCR tests). The Mayor of Trenčín prepared testing within four days, and local self-government total costs did not exceed 60 thousand Euros (City of Trenčín 2020). As a result of these experiences, other local self-governments also decided to organise local population-wide testing (e.g. Košice, Nitra in January 2021).

19.4.3.3 Mass AG Testing System

Since mid-November 2020, Slovakia applied various alternatives of lockdowns combined with free AG testing. In parallel, PCR testing remained available as before. Massive AG testing was considered an important tool for imposing only moderate measures. For example, the share of AG and PCR tests was firmly in favour of AG testing (76.6:23.4) in December 2020. The rising testing capacities enabled to test about 10% of the population (400–500 thousand tests) within 7–10 days in December 2000. Such massive expansion of testing allowed for testing decentralisation, compared to the previous testing, which was concentrated into health facilities and specialised companies mostly operated by 'biomed' laboratory capacities.

Testing decentralisation and expansion started with a less dense network of mobile testing sites (so-called MOMAG in Slovak) in all district cities. Later on, it was extended into all settlements above 5000 inhabitants to improve access and

reduce the risks of too much population concentration during testing and mobility. This network of MOMAGs reached 230 testing sites across the whole of Slovakia at the end of December 2020. The Ministry of Health covered the costs of free testing and also provided enough testing kits.

The ministry also issued a standard for the provision and staff qualifications (at least one healthcare worker in the case of AG testing sites, a total of four persons at minimum per one site, inevitable equipment and so on). Clear rules and financial support allowed MOMAG to be opened by all entities able to fulfil the required standards. Among operators of MOMAGs we can find standard healthcare providers (public, private), public health authority regional centres, non-profit entities active in this sector, emergency rescue and fire services centres, local Red Cross branches and others. Local self-government initiated and supported these centres, e.g. by providing suitable spaces (often not used during lockdowns). They were aware that such testing is also crucial for their elderly care centres or the schools they manage. Decentralisation of testing also responded to citizens' demand for more accessible testing opportunities. So-called commercial MOMAGs (paid testing) were established in winter tourist centres according to rules allowing recreational activities with the negative test not older than 72 hours (in this case paid for by the tourists) around Christmas.

The experiences with MOMAGs were core for the next population-wide testing (so-called screening) organised during a more extended period (18–26 January 2021; 2.9 mln tested; 1.24% positive cases). In this case, central state institutions transferred this task to local self-governments (and large employers, if interested). In co-operation with partners (having the right to test approved by a public health authority), local self-government increased the number of testing sites enormously (e.g. on 22 January 2021 there operated more than 1000 testing sites, often with more testing teams; e-VUC, 2021). The central state distributed testing kits (to district offices) and guaranteed financial compensation according to the number of tests performed. Mass AG testing remained one of the key tools of the anti-pandemic strategy (e.g. a negative test not older than seven days was obligatorily required for many activities) with almost 800 testing sites operating permanently throughout the country during February and March 2021. More than 23 mln AG tests were completed in Slovakia between October 2020 and March 2021 (in a country with a population of 5.4 mln). Testing progress was improved by online registration and ordering for a particular place and time of testing. This population screening was also accompanied by a longer lockdown period.

19.4.3.4 Participation of Local Self-Governments in Vaccination

Although vaccination started in Slovakia already at the end of December 2020, it accelerated only from March 2021. This reflected the initial lack of vaccines needed for a massive application. The first experiences confirmed the minor role of local self-governments in this field. Nevertheless, they remain an important partner in achieving a reasonable level of vaccination, focusing mainly on the vaccination of

the more vulnerable groups of their citizens (e.g. elderly, marginalised communities). They will contribute to overcoming the 'digital divide' and the accessibility of vaccination to such groups of citizens (e.g. assistance with online registration, transport to vaccination centres, invitation and support of mobile vaccination units). It has to be mentioned that local physicians were not included in the early stages of the vaccination strategy in Slovakia.

19.4.4 The Role of Local Self-Government Associations

Associations of local self-governments covering almost all local self-governments in Slovakia (ZMOS – Association of Towns and Communities of Slovakia, UMS – Union of Slovak Cities) have important intermediary roles between central state and local self-governments. There is a long-term tradition of close partnership and co-operation between the central government and these representative bodies (expressed, for example, by joint meetings and participation in public policies preparation). The new central government did not follow this tradition on such a scale. Despite many local aspects of the anti-coronavirus effort, it did not co-operate extensively with local self-government associations. Systematic participation and the coordination of tasks were absent.

Communication often rested on media statements, an occasional informal meeting with selected representatives (e.g. mayors also serving as MPs), and key decisions came at the last possible moment. The reduced partnership was reflected in repeated demands of the associations to be fully involved (not as invited, or with observer status) in crisis management bodies at all levels (central, regional, district; Ministry of Interior 2020; ZMOS 2021). Under such a situation, the associations of local self-governments and their offices attempted to effectively assist their members in coping with coronavirus and fulfilling the initiated tasks, but less in the details elaborated by the central state. The associations prepared guidelines, sample documents and forms, identified good practices and experiences and distributed them to all their members.

Such limited involvement of local self-government led to various tensions. They culminated in October 2020 concerning population-wide testing and in December–January 2020, when the central state approach was vague and did not respond sufficiently to the changing pandemic situations. ZMOS (2020) asked the President of the Slovak Republic and Ombudsperson of the Slovak Republic to appeal to central state bodies for clearer, justified and legally well-grounded decisions. Slovak President Zuzana Čaputová stated that self-government is a natural authority in their territory and should be considered a partner and not a subordinated entity. The central–local relations were also undermined by the comments of PM Igor Matovič (January 2021) on the possible centralisation and a command-based approach to local self-government through the new legislation. ZMOS, the Union of Cities and many mayors categorically refused such subordination to the central government

(e.g. ZMOS 2021). They emphasised that local self-governments are a reliable partner that had provided interoperability during the whole pandemic period.

19.5 Conclusion

The pandemic period has been a test of the local self-government's role and position under specific conditions accompanied by a different and evolving institutional and legal framework and an inevitable search for new policies to manage the crisis successfully. We could observe a shift in favour of the role of local self-governments compared to that at the beginning of the pandemic. They provided the most efficient capacities available at the local level, capacities not easily replaced by other institutions. The Covid-19 period also confirmed the stable position of local self-governments in local life and the suitability of the already developed local governance structures and networks. However, the pandemic situation was also accompanied by central–local tensions, including their partial subordination to the central state and a threat to their autonomy within the State of Emergency legislation. The experiences of the pandemic times confirmed the need for their deeper involvement in the institutional and legal framework during times of crisis. However, local capacities should be exploited carefully to prevent their exhaustion and overloading with too many tasks imposed outside of their main powers. Nevertheless, the pandemic initiated large-scale mobilisation of all involved and allowed the pandemic's impact to be reduced at the local level.

Governance-based, partnership and participatory approaches to public policy issues were underestimated under the new central government and the coronavirus challenge. Despite understandable centralisation of decision-making during crises, the anti-pandemic management was too dependent on the central government as a single dominant actor, with the key role being taken by the Government Office and selected ministries (health, defence, interior) and their deconcentrated field capacities. Such a limited perspective influenced the efficiency of particular anti-pandemic measures. More extensive co-operation with social partners, such as employers' associations, professional associations, local authorities and others, was not initiated and thus neither was societal support. Even less rational was the fact that crisis-addressing bodies did not directly include local self-government representatives (e.g. their associations). This restricted possible practical proposals in adopting suitable measures and the reasonable use of local self-government capacities. Part of the problem was known obstacles in co-operation and coordination of institutions that had previously not co-operated on such an issue, and on such a scale (see e.g. Paquet and Schertzer 2020). All the anti-pandemic efforts were influenced by the long duration of the crisis and the changing dynamics of the coronavirus spread after mutations. While a short-term crisis is possible to overcome even with a certain scope of improvisations, a more elaborated and coordinated approach across the whole society is needed during a longer-time crisis.

The insufficient application of multi-level governance seems to be among the weaknesses of the anti-coronavirus effort. In the beginning, a top-down, centralist approach predominated and only slowly changed under the pressure of circumstances to a more intergovernmental and more decentralised approach. There was the problem of institutional inclusion and incorporation of various levels and tiers of public administration, as well as sub-state crisis management bodies. Nevertheless, during the second wave, their role increased step by step. Even the central state recognised that more complex measures could go into effect only with extensive local-level involvement and adaptation to local conditions. Rising expectations concerning implementation at the local level revealed a less prepared framework for co-operation among local self-governments and state administration below the centre.

A more elaborated incorporation of institutions at the regional and local levels was absent. The central state attempted to manage many pandemic affairs by using limited capacities of specialised state territorial administrative structures (primarily regional public health authorities). Population-wide testing was organised according to the 16 regional military regions/headquarters of the Slovak Army Forces, and not according to standard administrative division into regions and districts. Clear communication was lacking, as was a clear flow of tasks and instructions to public institutions operating at the sub-state level (either state administration or self-government). This limited the opportunities to share responsibility and to adopt measures suitable to the situation in the regions and localities. The regional, district and local crisis staff's potential was also not used extensively. During the pandemic, accumulated experiences should have been exploited, leading to inevitable changes concerning crisis management and planning at the sub-state levels. Issues of their autonomy, powers and partnership among various local/district bodies should have been addressed. Clarified should also have been vertical intergovernmental linkages. The ambiguities of anti-pandemic institutional framework were long-term and there was no effort to solve them immediately when shortcomings appeared (e.g. clarification of roles among crisis bodies). Regional self-governments were unable to find a relevant role and were marginalised during most of the pandemic. Nevertheless, they took on a very serious role during the vaccination by initiating and managing mass vaccination centres serving their regions.

Unitary approaches to crisis management prevailed and the perception of spatial differentiation and its use in anti-pandemic decision-making was absent. More targeted measures addressing diversely affected regions with their specific conditions were rejected during most of the pandemic period (first and second waves). Prime Minister Matovič criticised regional differentiation in measures and preferred the perception of Slovakia as an integrated territory, claiming that Slovakia is not a country of city-states and that measures focused on regions are not helpful (TASR 2020). The central state addressed only selected regions and localities with very high incidence (quarantines, mass testing). Calls for more sensitive regional differentiation in adopting measures across the country were adopted, still with doubts, only during the culmination of the pandemic's second wave. However, even at that time regional (district) differences could be applied only after fulfilling selected national

criteria and with many ambiguities (Ministry of Health 2021 – Covid Automat alert system). Besides these shortcomings, flexible spatial approaches appeared that perceived realistically the regional dimension initiated by local self-governments. We could observe the city-region perspective (large cities with their hinterland) and numerous cases of inter-municipal co-operation used in the adopting and implementation of anti-pandemic measures.

The local governance mode that has developed under the leadership of local self-governments during the last 20 years confirmed its usefulness. The experiences of various local collaborations, joint documents preparation and networking developed over many areas helped in the preparation and implementation of anti-pandemic measures at the local level. Local self-governments mobilised their local partners and community members to execute and share responsibilities under the pandemic threat. This confirmed the decision-making capacity and implementation potential based on co-operating local institutions under local self-government leadership. However, local self-governments cannot execute enormous new tasks regularly for a long time without systematic arrangements (e.g. population-wide testing on a weekly basis in small local self-governments with just a few hundreds of inhabitants). Local self-government should have a reasonable and well-defined level of autonomy in addressing the local situation through their own measures during crises.

Among the problems that emerged during the anti-pandemic effort at the central level was a lack of respect for professional, scientific and fact-based decision-making. The expert background of some decisions was less transparent. Less compact approaches caused partial data incompatibilities. During the pandemic, several analytical teams at the ministries collapsed (health, education) and broader scientific and professional expertise (experts outside government) had shifted to a second track. Except for the first two to three months, there were repeated tensions among representatives of the central state and scientific community (experts active in various disciplines, specialised associations, Slovak Medical Chamber, the Slovak Medical Association, the 'Data without Pathos' initiative). With less clear professional backing, the central government in some cases supported less balanced and poorly timed measures (e.g. the emphasis on permanent population-wide AG testing). Many rigorous analytical results were permanently left aside and overlooked, misunderstood or openly criticised by the Prime Minister (e.g. Čunderlíková and Hopková 2021). The lack of generally respected expertise of selected central-level measures also complicated the situation of local self-governments in their implementation among citizens. Local expertise accumulated by local self-governments was not taken into account on a more extensive scale, and they responded with their own modifications, if possible, thanks to incorporating health sector experts into their crisis management bodies.

Some of the already mentioned obstacles influenced the overall legitimacy of anti-pandemic effort. We could observe a perhaps unintentional but not negligible delegitimisation process. Many typical dimensions of legitimacy (e.g. Suchman 1995, Schmidt 2013) were underestimated. The absence of broader participation and consensus building in decision-making threatened political legitimacy. Discussions concerned output legitimacy – many measures were implemented with

complications, wrongly communicated and without convincing results. The leadership qualities and respect, trustworthiness, managerial and professional abilities of the new political elite were also in question and threatened their legitimacy. Legality aspects (clear legal grounds, stable rules, fair procedures, adoption of decisions, proper use of institutional framework) were also vulnerable. During the second pandemic wave, the government lost its strong technocratic background of prominent experts. Such challenges to legitimacy endangered the trust in anti-pandemic measures among citizens, as well as other societal partners, including local self-government. Under such developments, local self-governments confirmed their high legitimacy among citizens. Their position was sustained thanks to available local autonomy as an immunity against selected decisions and the possibility for an initiative, agile approach to the pandemic in their communities.

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