World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Slovakia

Mária Pourová
Marcos Gallardo Martínez

Slovakia

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

A key part of the work of the Office is to assess country and regional progress towards UHC by monitoring affordable access to health care (financial protection). Financial protection is a core dimension of health system performance, an indicator for the Sustainable Development Goals, part of the European Pillar of Social Rights and central to the European Programme of Work, WHO European Region's strategic framework. The Office supports countries to strengthen financial protection through tailored technical assistance, including analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience.

The Office disseminates country-specific and internationally comparable data and policy analysis through UHC watch, a digital platform tracking progress on affordable access to health care in Europe and central Asia.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

Photo: © Robert Ramos/FPHSP

World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Slovakia

Mária Pourová
Marcos Gallardo Martínez

Can people afford to pay for health care? series

ISSN: 2789-5319 (print)
ISSN: 2789-5327 (online)

ISBN: 9789289062329 (PDF)
ISBN: 9789289062312 (print)

Suggested citation. Pourová M, Gallardo Martínez M. Can people afford to pay for health care? New evidence on financial protection in Slovakia. Copenhagen: WHO Regional Office for Europe; 2025. Licence: CC BY-NC-SA 3.0 IGO

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Designed by: Aleix Artigal/Alex Prieto.

Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. Catastrophic health spending is lower in Slovakia than in many European Union countries (particularly those in central Europe) but has increased in recent years. It is almost entirely concentrated in the poorest consumption quintile and in households headed by older people, employed people or pensioners and mainly driven by outpatient medicines in households with low incomes. Despite Slovakia's relatively comprehensive publicly financed benefits package and the presence of mechanisms to protect people from user charges (co-payments), gaps in coverage persist. The system of co-payments for outpatient prescribed medicines is complex and exemptions from and caps on co-payments for outpatient prescribed medicines and medical products do not apply to most working-aged people with low incomes; coverage of dental care is limited and many dentists do not offer covered services or materials; and people who fail to pay mandatory social health insurance contributions, as well as unemployed asylum seekers, homeless people and undocumented migrants have very limited access to publicly financed health care. The Government can reduce unmet need and financial hardship in households with low incomes by ensuring that people can always access outpatient prescribed medicines without co-payments, improving the mechanisms used to protect people from co-payments, expanding access to publicly financed dental care and tackling inefficiencies in the health system that push people to pay out of pocket for covered care.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
POVERTY
SLOVAKIA
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in *unmet need*, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing and catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policymakers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Affordable access to health care is a Sustainable Development Goal and one of the principles of the European Pillar of Social Rights. It is also at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health care (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
apps.who.int/dhis2/uhcwatch

Contents

Figures

Tables

Boxes

Acknowledgements

This series of financial protection reviews is produced by the WHO Barcelona Office for Health Systems Financing, which is part of the Division of Country Health Policies and Systems in the WHO Regional Office for Europe. The series editors are Sarah Thomson, Jonathan Cylus, Tamás Evetovits and Triin Habicht (WHO Barcelona Office).

The review of financial protection in Slovakia was written by Mária Pourová (Health Policy Institute) and Marcos Gallardo Martínez (WHO Barcelona Office). It was edited by Marcos Gallardo Martínez, Jorge Alejandro García-Ramírez and Sarah Thomson (WHO Barcelona Office).

The WHO Barcelona Office is grateful to Henrieta Tulejová (Advance Healthcare Management Institute, Czechia) and Dominika Greisigerová and Elena Jablonická (Ministry of Health, Slovakia) for reviewing the report. Thanks are also extended to Ilaria Mosca for her work on an early draft of this report, to the Statistical Office of the Slovak Republic for making the household budget survey data available to the authors, and to Marija Krishman and other colleagues in the WHO Country Office in Slovakia for their support throughout the process.

Data on financial protection were shared with the Ministry of Health of the Slovak Republic as part of a WHO consultation on universal health coverage indicators held in 2019, 2021, 2023 and 2025. The report was shared with the Ministry of Health for information in May 2025.

WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain.

This publication was co-funded by the EU4Health programme. Its contents are the sole responsibility of WHO and do not necessarily reflect the views of the European Union.

Co-funded by
the European Union

Authors
Mária Pourová
Marcos Gallardo Martínez

Editors
Marcos Gallardo Martínez
Jorge Alejandro García-Ramírez
Sarah Thomson

Series editors
Sarah Thomson
Jonathan Cylus
Tamás Evetovits
Triin Habicht

Abbreviations

COICOP	classification of individual consumption by purpose
COVID-19	coronavirus disease
EHIS	European Health Interview Survey
EU	European Union
EU27	EU Member States as of 1 February 2020
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
HIC	health insurance company
INN	international nonproprietary name
OECD	Organisation for Economic Co-operation and Development
SHI	social health insurance
VAT	value-added tax
VHI	voluntary health insurance
VšZP	public (government-owned) HIC

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Slovakia face financial barriers to access or experience financial hardship when they use health care. It covers the period from 2007 to 2025, using data from household budget surveys carried out between 2007 and 2023, data on unmet need for health services up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025.

The review's main findings are as follows.

- Financial hardship caused by out-of-pocket payments is lower in Slovakia than in many European Union (EU) countries but has increased in recent years. In 2023 (the latest available data year), 4.4% of households experienced catastrophic health spending and 3.3% of households were impoverished or further impoverished after out-of-pocket payments.

- Catastrophic health spending is almost exclusively concentrated in the poorest consumption quintile and driven by outpatient medicines. It is also concentrated in households headed by older people and pensioners and in the eastern regions of the country, where most Roma people live.

- In the poorest quintile catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, followed by dental care. In other quintiles, it is mainly driven by out-of-pocket payments for dental care, followed by outpatient medicines and inpatient care.

- Unmet need for health care and dental care in Slovakia is lower than the EU average and it is mainly driven by waiting time for health care and cost for dental care. During the study period there was significant income inequality in unmet need for both types of care.

Coverage policy in Slovakia has some strengths. The benefits package is relatively comprehensive; despite having co-payments for some types of care, these mostly take the form of fixed co-payments; and there are automatic mechanisms in place (exemptions and caps) to protect some people with low incomes from co-payments (pensioners and people with disabilities).

However, persistent gaps in coverage undermine financial protection (particularly for people with low incomes).

- Entitlement to social health insurance (SHI) benefits is based on payment of mandatory SHI contributions and people who fail to pay contributions for three months – as well as unemployed asylum seekers and homeless people – have very limited access to publicly financed health care. Undocumented migrants are not entitled to any publicly financed health care.

- Coverage of dental care and vision aids (glasses) is limited by legislation and in practice for dental care, as many providers do not offer covered services or materials.

- Waiting times and informal payments are pressing issues in outpatient care.

- The design of co-payments for outpatient prescribed medicines is complex and mechanisms to protect people from co-payments are not sufficient for people with low incomes or chronic conditions. Loopholes in the law allow providers to extra bill for non-clinical services in both outpatient and inpatient care settings.

Since 2015 the Slovak Government has taken several steps to reduce out-of-pocket payments for outpatient medicines, dental care and outpatient care. Building on this, the Government can now focus more on reducing unmet need and financial hardship in households with low incomes, through the following options for action.

- Ensure people have access to outpatient prescribed medicines without co-payments. This can be achieved by: including at least one medicine with a €0 co-payment medicine in every reference group; guaranteeing the availability of this medicine in pharmacies throughout the country; strengthening adherence to clinical guidelines and International Nonproprietary Name prescribing by doctors and generic substitution in pharmacies; and simplifying the system of co-payments.

- Improve the mechanisms used to protect people from co-payments by extending exemptions and caps to all co-payments and ensuring their applicability to all people with low incomes and, ideally, also to people with chronic conditions.

- Reassess the usefulness of co-payments for emergency care by tackling the root causes of overuse of emergency care.

- Expand publicly financed coverage of dental care and find ways to ensure that more providers offer covered services.
- Tackle inefficiencies in the health system that push people to pay out of pocket for covered care (e.g. long waiting times, informal payments and extra billing).
- Soften the link between entitlement to SHI benefits and payment of mandatory SHI contributions by stopping penalizing people who are not able to pay contributions by denying them access to health care.
- Expand the scope of public financed health care available to people who are not eligible for (or not covered by) the SHI scheme.
- Broaden the public revenue base so that is it able to generate sufficient funding as the population ages.

If carefully targeted to reduce financial hardship and unmet need in households with low incomes, these measures will make the health system more efficient, fair and resilient, now and in the future.

1. Introduction

This review assesses the extent to which people in Slovakia experience financial hardship when they use health care. It covers the period from 2007 to 2025, using data from household budget surveys carried out by the Statistical Office of the Slovak Republic between 2007 and 2023 (the latest available year), data on unmet need for health care up to 2023 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to February 2025. See UHC watch (2025) for updates.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019; 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

The Slovak health system is organized through a social health insurance (SHI) scheme operated by three competing profit-making, joint-stock health insurance companies (HICs). Entitlement is based on payment of mandatory contributions to the SHI scheme. User charges apply to emergency care, outpatient prescribed medicines, medical products and dental care treatment, which is reflected in the level of out-of-pocket payments as a share of current spending on health – 19% in 2022 (the latest available year of internationally comparable data), on a par with the European Union (EU) average. In contrast, public spending on health accounted for 6.2% of GDP in 2022, below the EU average of 6.7% (WHO, 2025).

This review is the first in-depth analysis of financial protection in Slovakia. Earlier global studies included some data on Slovakia but did not provide context-specific analysis (Xu et al., 2003; Xu et al., 2007; Saksena, Hsu & Evans, 2014). The methods used in this study are different from those used in previous analyses (Yerramilli, Fernández & Thomson, 2018).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy, drawing on information from UHC watch (2025). Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine this protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019; 2023), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of impoverishing and catastrophic health spending

	Impoverishing health spending
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and *utilities* (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using OECD equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors, where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care; this includes all households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay before or after out-of-pocket payments)
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Notes: see the Glossary provided by UHC watch (2025) for definitions of words in italics. OECD: Organisation for Economic Co-operation and Development.

Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted by the Statistical Office of the Slovak Republic between 2007 and 2012, in 2015 and between 2020 and 2023 (the latest available year). The data sample consisted of 4698 households in 2007 (based on a response rate of 75.6%), 4718 in 2008 (74.7%), 4704 in 2009 (94.6%), 6143 in 2010 (61.9%), 4705 in 2011 (56.5%), 4704 in 2012 (63.6%), 4785 in 2015 (65.1%), 4633 in 2020 (58.8%), 4633 in 2021 (58.8%), 4991 in 2022 (59.1%) and 4881 in 2023 (55.8%).

The following aspects of the household budget survey in Slovakia should be considered when interpreting the results.

- Since 2020 the survey has used a smaller data collection sample; it therefore combines several years of data to create annual microdata (e.g. in 2021 it used data from 2019, 2020 and 2021) and adjusts consumption variables for other years using price indexes and external sources. Imputed rent and household income variables were excluded from this process because income data are taken from the EU Statistics on Income and Living Conditions (EU-SILC) survey. This means that data from 2020 and onwards are not comparable with previous years.

- The 2020 break in series is indicated in figures based on household budget survey data (in sections 4 and 5).

- From 2020 to 2023 the survey includes spa treatment in the inpatient care category rather than the diagnostic tests category, as defined by law for the coverage of inpatient care in spas.

This review also draws on data from national health accounts, which use the standardized System of Health Accounts to collect internationally comparable data on health spending at national level (OECD, Eurostat & WHO, 2017).

All currency units in the study are presented in euros (€), with notes on inflation-adjusted spending where relevant.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health care but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2015), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through EU-SILC (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. EHIS provides information on unmet need among people reporting a need for health care and asks households about unmet need for prescribed medicines, in addition to health care and dental care. EU-SILC typically provides information on unmet need as a share of the population but in recent years it has started to provide this information among people reporting a need for care for a limited number of years (Ingleby & Guidi, 2024).

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health services they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Sources: adapted from WHO Regional Office for Europe (2019; 2023).

3. Coverage policy

This section briefly describes the governance and key dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by voluntary health insurance (VHI). It draws on information from the policy explorer on UHC watch (2025).

3.1 Population coverage

Entitlement to publicly financed health care is based on payment of mandatory contributions to the SHI scheme. There is a minimum contribution base of 15% of wages (4% from the employee and 11% from the employer; the contributions are halved if the employee has a disability). The Government pays contributions (4.5% of the national average wage two years previously, up from 4% in 2024) on behalf of pensioners (the retirement age is 64 years for men and women), unemployed people, parents on parental leave, children and students. This contribution is expected to rise to 5% in 2026.

The SHI scheme is operated by three competing profit-making joint-stock HICs. People can choose their HIC and change HIC once a year. In 2023 the government-owned public HIC (VšZP) covered 55% of the people with SHI, followed by Dôvera (32%) and Union (13%) (Smatana et al., in press).

In 2022 around 5% of the eligible population (246 058 people) was not covered by the mandatory health insurance scheme (Statistical Office of the Slovak Republic, 2023; Health Care Surveillance Authority, 2024). Anecdotal evidence indicates that the majority of these people were working and covered in other EU countries. However, some of them were homeless people. In 2021 there were 71 076 homeless people in Slovakia (Statistical Office of the Slovak Republic, 2024b).

People who fail to pay their contributions for three months and homeless people are only entitled to publicly financed emergency care, maternity care and treatment of communicable diseases.

Asylum seekers who are employed and refugees are entitled to the same benefits as residents. Asylum seekers who are unemployed are entitled to publicly financed emergency care only. Ukrainian refugees can apply for access to a temporary protection system, which currently entitles them to the same health care as residents, although the law allows the Ministry of Health to determine the range of health care to which they are entitled. The VšZP covers the cost of health care for Ukrainian refugees.

Undocumented migrants are not entitled to any publicly financed health care. Eurostat data indicate that in 2023 there were 47 310 undocumented migrants identified in Slovakia (up from 11 705 in 2022) and 410 asylum applications (down from 545 in 2022) (Eurostat, 2025c).

Population coverage is defined by legislation, including bylaws. Legal changes or new laws are proposed by the Government and by members of Parliament. Bylaws are approved by the Government or

the Ministry of Health and prepared by Ministry committees or working groups. Key changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2003–2025

Year	Month	Policy change
2003	June	Introduction of fixed co-payments for outpatient visits (€0.67), emergency visits (€1.99), inpatient care (€1.67 per night of stay) and outpatient prescribed medicines (€0.67 per prescription item)
2004	January	VAT rate on all medicines is increased to 19% (up from 14%)
2004	October	User charges are defined for fully, partially or not-at-all covered services, allowing extra billing at the provider's discretion for services that are not legally defined
2006	September	Fixed co-payments for outpatient visits and inpatient care are lowered to €0
2007	January	The VAT rate on all medicines is reduced to 10% (down from 19%)
2007	April	The retail price for outpatient prescribed medicines is reduced by 6.6%
2008	January	Internal reference pricing is substituted by external reference pricing for medicines using the six lowest prices in the EU
2008	July	The retail price for outpatient prescribed medicines is reduced by 7.4%
2011	January	The law on reimbursement extends mandatory external reference pricing for medicines using the three lowest prices in the EU
2011	April	Introduction of a cap on co-payments for outpatient prescribed medicines for pensioners, people with a severe disability, pensioners with a disability, people with disabilities without a disability pension and people over 60 years old who are not entitled to a pension
2011	December	Introduction of mandatory INN prescribing and a requirement for pharmacists to offer the cheapest available option (generic substitution) except in cases when a more expensive alternative is medically justified by the prescribing doctor
2015	April	All health care providers are prohibited from applying user charges to any covered outpatient visits or inpatient care. Extra billing is regulated for providers who can only charge for non-covered care (e.g. medical examination for a driving or gun licence and above-standard accommodation and meals)
2016	January	The cap on co-payments for medicines is extended to include children under 6 years old
2018	January	E-prescriptions are established, with paper prescriptions continuing to be valid until 1 January 2022
2018	January	The fixed co-payment for outpatient medicines per prescription item (€0.67) is lowered to €0
2018	July	Fixed co-payments for emergency care in hospital emergency units are increased to €10 (up from €1.99) and a €2 fixed co-payment for ambulance transportation is introduced
2021	January	The requirement for annual dental screening in the previous year to receive dental care coverage under mandatory health insurance is suspended for 2021, allowing coverage even without a preventive check-up in the previous year. Defined by the authorities as a response to COVID-19
2021	April	The cap on co-payments for outpatient prescribed medicines and medical products is adjusted so that it is also based on whether people are economically active or not (aside from being a pensioner or having a disability). The cap applies for people with disabilities and pensioners with incomes under 60% of the average monthly wage (if not economically active) or under 180% (if economically active); otherwise the cap is lowered to €0 (equivalent to being exempt). Not defined by the authorities as a response to COVID-19
2021	April	Children under 6 years old are exempt from co-payments for outpatient prescribed medicines. Not defined by the authorities as a response to COVID-19
2022	January	The requirement for annual dental screening in the previous year to receive dental care coverage under mandatory health insurance is suspended for 2022, allowing coverage even without a preventive check-up in the previous year. Defined by the authorities as a response to COVID-19
2024	May	HICs are no longer allowed to offer special dental care benefits to attract new members (e.g. a €100 bonus payment a year to cover dental care)
2025	January	The VAT rate on medicines and selected medical products is reduced to 5% (down from 10%)
2025	January	Maximum waiting time targets are set for 407 elective inpatient care interventions. If the chosen provider cannot meet the target, the HIC must arrange an alternative

Notes: COVID-19: coronavirus disease.
EU: European Union.
HIC: health Insurance company.
INN: international nonproprietary name.
VAT: value-added tax.

Source: UHC watch (2025).

3.2 Service coverage

The benefits package is defined by law and can be changed by Parliament following proposals from the Ministry of Health or members of Parliament. There is a single national benefits package with no variations across the country. The negative list of services is small and focuses on things like cosmetic surgery, abortion without medical indication and ritual circumcision.

There is a positive list of covered medicines (reviewed once a month by the Medicines Categorization Committee) and a positive list of covered medical products (reviewed quarterly by the Medical Products Categorization Committee). Both commissions work under the Ministry of Health and are informed by health technology assessment carried out by the National Institute for Value and Technologies in Healthcare.

The benefits package is relatively comprehensive. However, vision aids (glasses) are not fully covered and although dental care is covered, coverage is limited in scope and materials and not all dentists are willing to provide covered materials and procedures. Dental check-ups are fully covered but X-rays, anaesthesia, extractions and fillings are partially covered.

Although regulations clearly define covered services, HICs can attract new members by offering extra benefits such as reduced co-payments for some medicines, vitamins or non-health services; coverage of co-payments for glasses; reduced waiting times for surgery; expanded preventive screening; or a range of digital support services (Smatana et al., in press).

People usually need a health insurance card to access covered health care. However, health care providers have access to HIC databases so they can check entitlement and payment requirements, making it possible to use different types of identification to access covered services.

People can choose their primary care doctor and any contracted health care provider but require a referral to visit all specialists except gynaecologists, dermatologists, psychiatrists, ophthalmologists and dentists. Covered medicines require a prescription. General practitioners (GPs) must prescribe outpatient medicines by INN and pharmacists must inform patients of cheaper alternatives (generic substitution) unless a more expensive medicine is medically justified by the doctor.

Most benefits are provided in kind. Retrospective reimbursement only applies when care is provided by non-contracted providers (with prior approval from HICs), usually to avoid long waiting times, and limited to the standard amount that would be paid to a contracted provider for the same type of care. There is no cap on the volume of covered health care.

Waiting times are a problem for outpatient and inpatient care. HICs are required by law to monitor and publish waiting times for inpatient care for eye, circulatory and musculoskeletal conditions. At the end of 2023 there were 7093 people (0.1% of the population) waiting for some type

of inpatient care procedure (Health Care Surveillance Authority, 2024). Starting in January 2025, 407 elective interventions have maximum waiting time targets. If the chosen provider cannot meet the requirement, the HIC must arrange an alternative provider.

Informal payments are not monitored but international data sources suggest they are higher in Slovakia than in most EU countries (European Commission & Kantar, 2025) and typically occur in outpatient care settings to reduce waiting times or when providers charge people for services such as a first visit to a clinic, setting up a patient file or to contribute to ambulance running costs (see section 4.3 for more on informal payments).

Other access issues include: a shortage of health care workers (particularly in specialized outpatient care), leading to long waiting times; access barriers for Roma people living in segregated settlements in eastern Slovakia, resulting in lower health outcomes than the rest of the population[1] (Macejova et al., 2020); and the fact that health care providers face a relatively heavy administrative burden when providing services to Ukrainian refugees, which lowers their willingness to treat them (Ištokovičová & Rybanská, 2023).

1. In 2019 Roma people accounted for around 9% of the population (Holubová et al., 2021).

3.3 User charges (co-payments)

User charges are applied to emergency visits, outpatient prescribed medicines, medical products and dental care visits (Table 3), mainly in the form of fixed co-payments.

Some categories of outpatient prescribed medicines are free at the point of use: medicines used in ambulances (category A), most medicines that cost more than €250 for specific conditions (category F), vital medicines such as antibiotics and medicines for cancer and cardiovascular diseases (category I) and vaccines included in the national vaccination programme (category V).

A system of fixed co-payments is applied to all other covered outpatient prescribed medicines (categories AS and S), with co-payments ranging from €0 to €40 per item. External reference prices (the three lowest prices in the EU) are used to determine the price and co-payment amount for each covered medicine. Medicines are combined in reference groups based on the same active molecule, comparable dosage form, identical compound per dose and equivalent drug concentration or pack presentation (Bucek Psenkova et al., 2017). The law specifies that one medicine in each reference group should have a co-payment of €0 (38% of medicines in categories AS and S) or less than €1 (26%) but the other medicines can incur co-payments of up to €40 per item (36%) (Ministry of Health, 2025a).

In practice, however, there is no guarantee that people can always access the medicine that is free or less than €1. Although GPs are mandated to prescribe by INN and pharmacists to offer generic substitution, GPs can prescribe the brand name in brackets, in which case pharmacists must

dispense the specified brand; when this happens, people typically incur higher co-payments.

There are fixed co-payments for some medical products but around 94% are free at the point of use; among those that incur co-payments, around 32% require a co-payment of less than €50 (Ministry of Health, 2025b).

All children under 6 years old, pensioners with low incomes and people with disabilities with low incomes are exempt from co-payments for outpatient prescribed medicines and medical products (Table 3). They also benefit from an automatically applied quarterly cap on these co-payments. In the first quarter of 2020 around 14% of the population (773 000 people) benefited from the cap on co-payments for outpatient prescribed medicines, mainly people covered by the VšZP (Ministry of Health, 2020).

There are no user charges for dental care visits and covered dental care treatment if a dental check-up has been carried out at least once in the previous year and when standard materials and procedures are used. Covered dental care includes regular check-ups, examination for acute care issues, some anaesthetics, dental hygiene, basic cavity treatments and standard materials. Non-covered dental care is subject to a range of fixed and percentage co-payments determined by individual providers.

Extra billing is partially allowed, which means inpatient care providers are allowed to charge people for defined premium services (e.g. food and bedding for parents accompanying a child in hospital). However, health care providers can charge for other services which are not legally defined and are technically not permitted (e.g. setting up a medical record or charges towards ambulance operating costs), meaning there is extra billing by some providers who exploit loopholes in the system.

Table 3. User charges (co-payments) for publicly financed health care, 2025

Note: NA: not applicable.

Source: UHC watch (2025).

Type of care	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Outpatient primary care visits	None, but extra billing occurs for non-clinical services (e.g. setting up a medical record) even though it is not allowed	NA	NA	NA
Outpatient specialist visits	None, but extra billing occurs for non-clinical services (e.g. setting up a medical record) even though it is not allowed	NA	NA	NA
Outpatient emergency visits	Fixed co-payment: €10 per visit; €2 per ambulance service	€2 per visit outside ambulance business hours	• Visits: no co-payment if care is provided immediately after the accident or if care lasts longer than 2 hours while pregnant • Ambulance: no co-payment if the emergency requires hospital treatment	No

Table 3. (contd.)

Type of care	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Outpatient prescribed medicines	Fixed co-payments per medicine; updated on a monthly basis No co-payments: category A (medicines used in ambulances), category F (medicines over €250 for specific conditions), category I (vital medicines like antibiotics and medicines for cancer or cardiovascular diseases) and category V (vaccines in the national vaccination programme) Co-payments of €0–€40: categories AS and S (38% of medicines in this category are free and 26% incur a co-payment of under €1)	No	• People with disabilities and pensioners with incomes under 60% of the average monthly wage (if not economically active) or under 180% (if economically active) • Children under 6 years old	Quarterly cap set at: • €12 for people with disabilities with low incomes (see previous column) • €30 for pensioners with low incomes (see previous column)
Medical products	Fixed co-payments per medical product; updated on a quarterly basis No co-payments: category I Co-payments of €0.04–€7646: category S (32% of medical products in this category incur co-payments under €50)	No	• People with disabilities and pensioners with incomes under 60% of the average monthly wage (if not economically active) or under 180% (if economically active) • Children under 6 years old	Quarterly cap set at: • €12 for people with disabilities with low incomes (see previous column) • €30 for pensioners with low incomes (see previous column)
Diagnostic tests	None	NA	NA	NA
Dental care visits	None if screening is done regularly; otherwise full price	No	No	No
Dental care treatment	None if screening is done regularly and if covered materials and procedures are used Fixed and percentage co-payments set by providers	No	No	No
Inpatient care	None, but extra billing is allowed for an above-standard room	NA	NA	NA
Inpatient medicines	None	NA	NA	NA

3.4 The role of VHI

VHI plays an extremely small supplementary role, covering care in case of accident or illness, medical costs incurred abroad or the cost of mountain rescue in emergency cases. In 2015 0.6% of the population had VHI (Smatana et al., 2016). No information is available on the VHI share of current spending on health (WHO, 2025). The National Bank of Slovakia regulates VHI.

Table 4 summarizes the main gaps in publicly financed coverage and describes whether VHI covers these gaps.

Table 4. Gaps in coverage

Source: UHC watch (2025).

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population entitlement	The basis for entitlement to SHI benefits is payment of mandatory contributions by people or by the Government on behalf of selected groups. In 2022 around 5% of the eligible population (246 058 people) was not covered by the SHI scheme – mainly people working in other EU countries and homeless people. People who fail to pay their contributions for three months, homeless people, asylum seekers who are unemployed and other people not eligible for SHI or not covered by the SHI scheme have access only to publicly financed emergency care, maternity care and treatment of communicable diseases. Undocumented migrants are not entitled to any publicly financed health care.	No. VHI plays no role in filling gaps in population coverage.
Service coverage	Coverage of dental care and glasses is limited. Waiting times are an issue for outpatient care. Informal payments are also widespread in outpatient care, mainly because health care providers charge people for services such as a first visit to a clinic, setting up a patient file, or ambulance running costs.	No. VHI does not fill gaps in service coverage.
User charges (co-payments)	User charges are applied to emergency care, outpatient prescribed medicines, medical products and dental care treatment, usually in the form of fixed co-payments. There are protection mechanisms in place, but these are quite narrow: reduced co-payments only apply to emergency care, while exemptions and caps on co-payments for outpatient prescribed medicines and medical products only apply to children under 6 years old, pensioners with low incomes and people who have a disability with low incomes. Extra billing for non-clinical services occurs in outpatient and inpatient care settings.	No. VHI does not cover user charges (co-payments).

3.5 Summary

The basis for entitlement to public financed health care is payment of mandatory contributions to the SHI scheme. In 2022 around 5% of people were not covered by the SHI scheme – mainly people working in other EU countries and homeless people. People who fail to pay their contributions for three months, homeless people, asylum seekers who are unemployed and other people not eligible for SHI or not covered by the SHI scheme have access only to publicly financed emergency care, maternity care and treatment of communicable diseases. Undocumented migrants are not entitled to any publicly financed health care.

The publicly financed benefits package is relatively comprehensive but vision aids (glasses) are not fully covered. Dental care is covered but people need an annual check-up to be eligible for covered materials and procedures and many dentists do not offer covered services or use covered materials.

Waiting times are an issue for both outpatient care (reflecting a shortage of health care workers) and inpatient care. HICs are only mandated to monitor waiting times for inpatient care for eye, circulatory and musculoskeletal conditions.

Informal payments are not systematically monitored but international data sources suggest they are higher in Slovakia than in most EU countries (European Commission & Kantar, 2025) and typically occur in outpatient care settings to shorten waiting times (see section 4.3 for more on informal payments).

User charges are applied to emergency care, outpatient prescribed medicines, medical products and dental care treatment, usually in the form of fixed co-payments. There are protection mechanisms in place, but these are quite narrow: reduced co-payments only apply to emergency care, while exemptions and caps on co-payments for outpatient prescribed medicines and medical products only apply to children under 6 years old and pensioners and people who have a disability who also have low incomes.

Although not permitted, extra billing occurs in outpatient care settings.

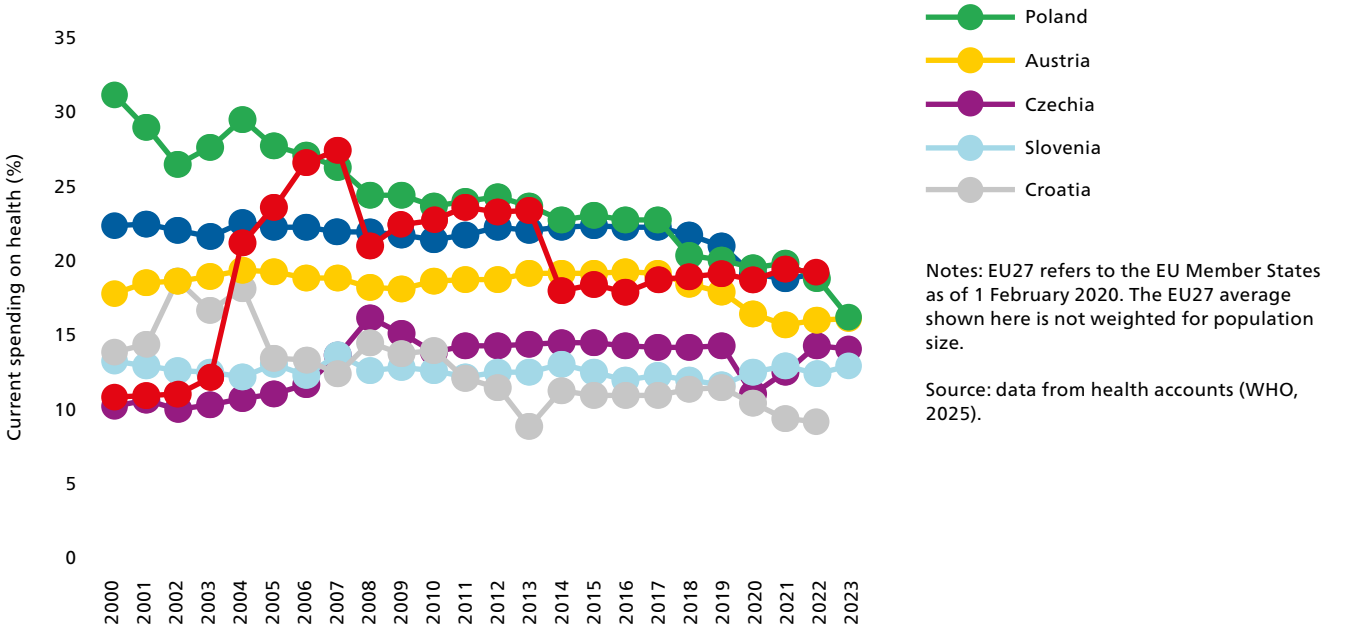
4. Spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system). The fourth part considers the role of informal payments. The indicator explorer on UHC watch (2025) provides further data behind the figures in this section.

4.1 Public and private spending on health

Data from national health accounts indicate that out-of-pocket payments in Slovakia accounted for 19% of current spending on health in 2022 – on a par with the EU average but higher than in Austria (16%), Czechia (14%), Slovenia (13%) and Croatia (9%) (Fig. 1). This share increased sharply from 2004 to 2007, with a drop in 2008 and 2014, remaining somewhat stable since (Fig. 2). Public spending on health has generally increased over time and at a faster pace than out-of-pocket payments (Fig. 2). There was a higher-than-usual increase in public spending on health in 2021 in response to the COVID-19 pandemic.

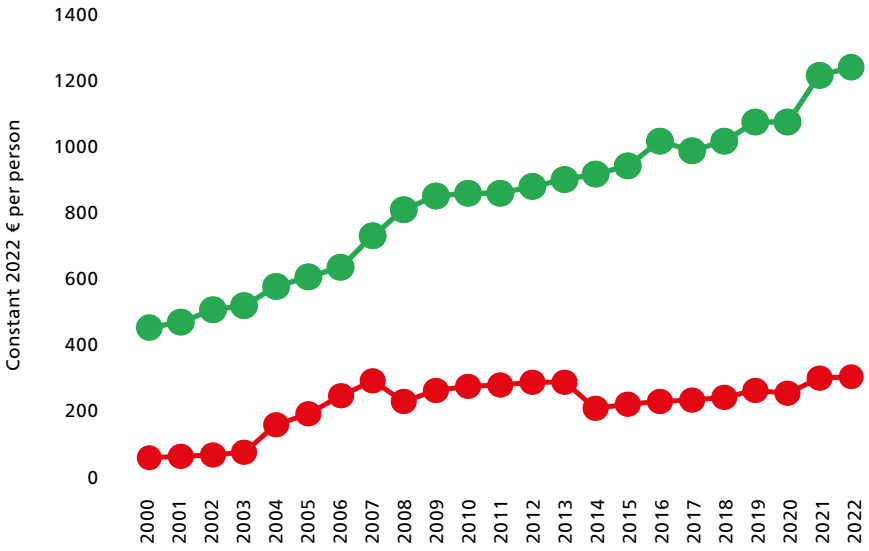
Fig. 1. Out-of-pocket payments as a share of current spending on health, Slovakia and selected EU countries



Notes: EU27 refers to the EU Member States as of 1 February 2020. The EU27 average shown here is not weighted for population size.

Source: data from health accounts (WHO, 2025).

Fig. 2. Current spending on health per person by financing scheme



Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. Data on spending through VHI are not available.

Source: data from health accounts (WHO, 2025).

In 2022 public spending on health accounted for 6.2% of GDP in Slovakia, lower than the EU average (6.7%) and lower than in Austria (8.6%) and Czechia (7.5%) (Fig. 3). Public spending on health accounted for 15% of total government spending in 2022, close to the EU average (15%) but much lower than Austria, Czechia and Slovenia (Fig. 4).

Fig. 3. Public spending on health and GDP per person, Slovakia and the EU, 2022

Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. The list of country codes used here can be found in the Abbreviations. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and Netherlands (Kingdom of the) because the country's data on public spending on health are not internationally comparable.

Source: data from health accounts (WHO, 2025).

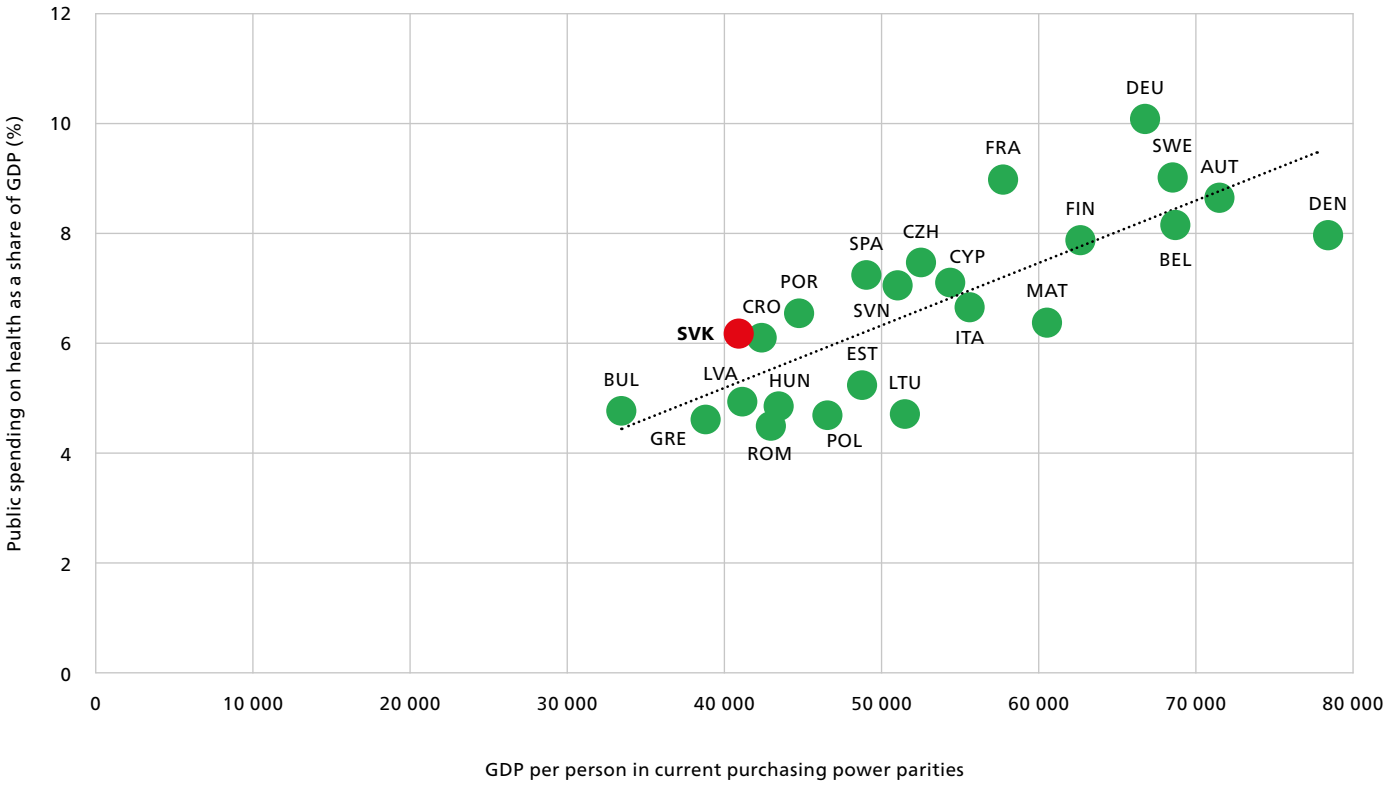
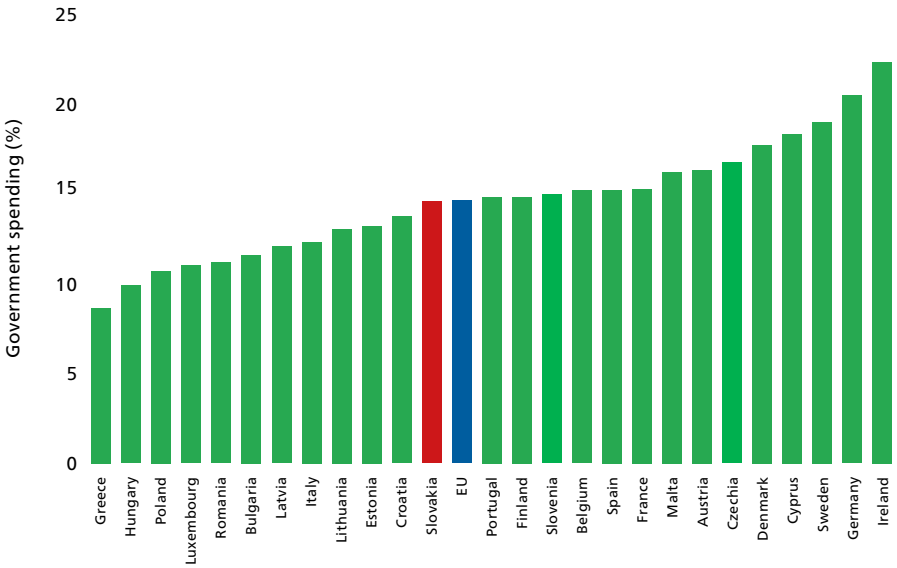


Fig. 4. Public spending on health as a share of the government budget in the EU, 2022

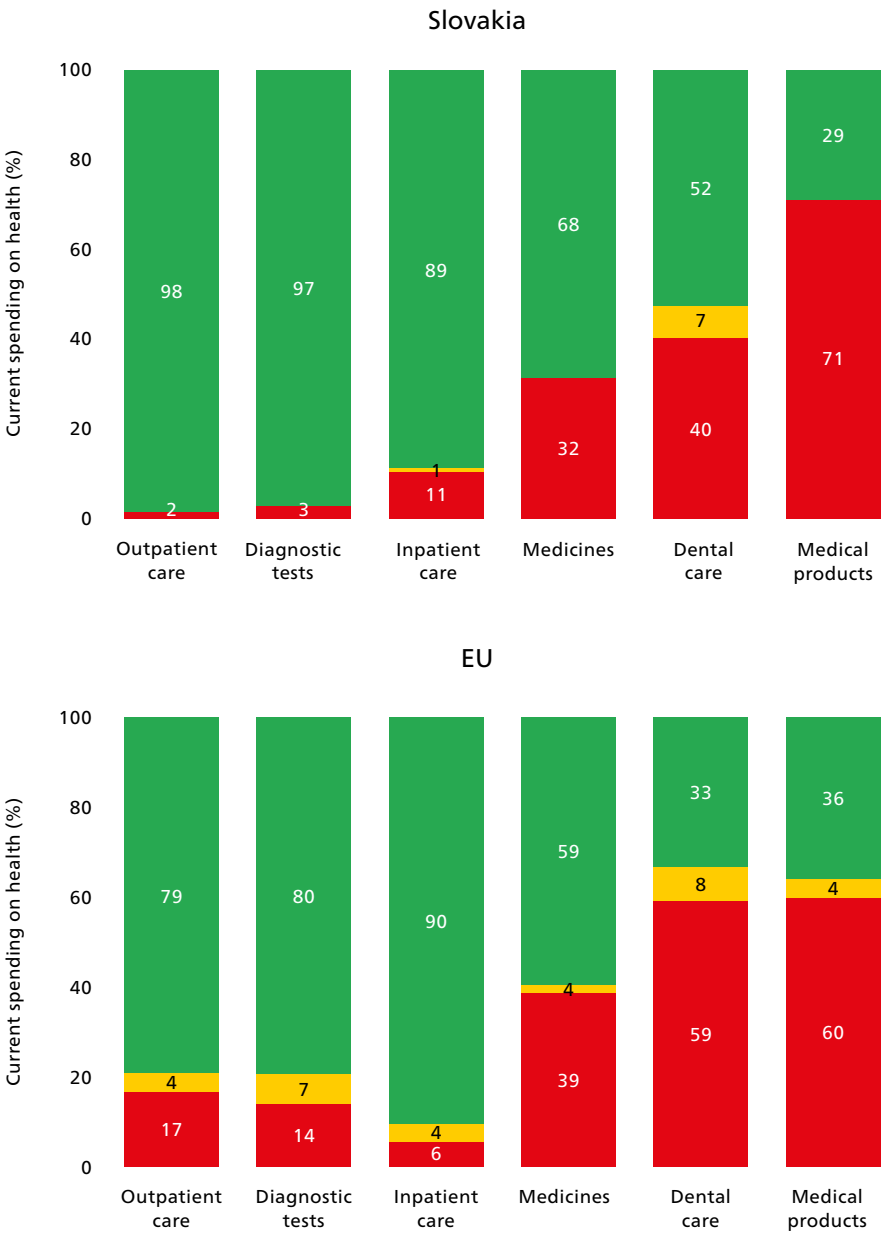


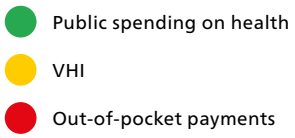
Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. The figure excludes Netherlands (Kingdom of the) because of lack of comparability of the data on public spending on health. The EU average shown here is not weighted for population size.

Source: data from health accounts (WHO, 2025).

Broken down by type of care, the out-of-pocket payment share of current spending on health in Slovakia in 2022 was highest for medical products (71%), dental care (40%) and outpatient medicines (32%) (Fig. 5). The out-of-pocket payment share was above the EU27 average for medical products but below it for dental care and outpatient medicines. In 2022 55% of out-of-pocket payments for outpatient medicines were spent on over-the-counter medicines, which could include some prescribed medicines (Fig. 6). This is similar to Czechia but a much lower share than in Austria, Croatia and Slovenia.

Fig. 5. Breakdown of current spending on health by type of care and financing scheme, Slovakia and the EU, 2022

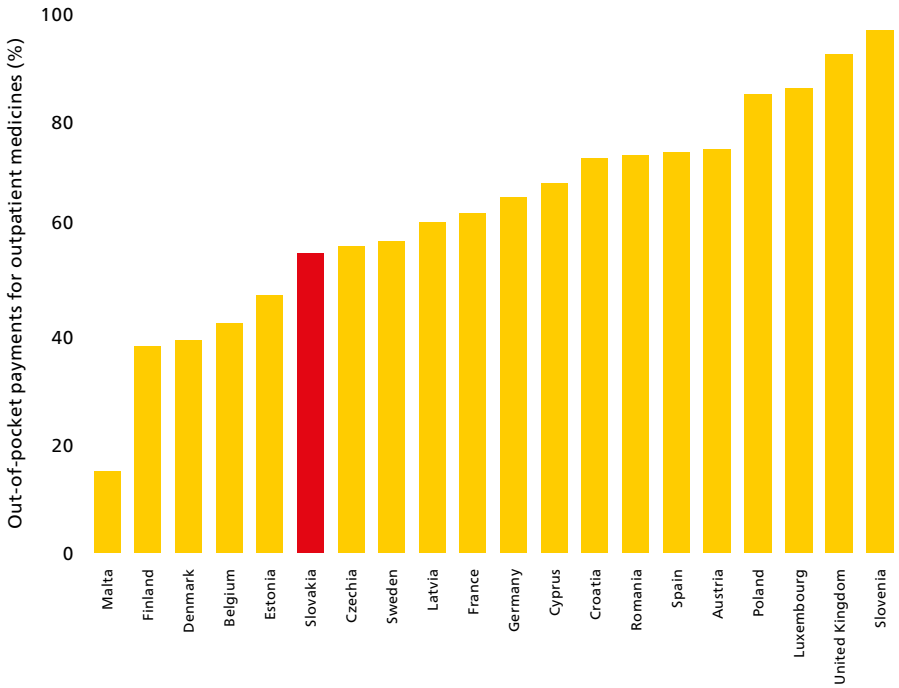




Notes: the EU average for outpatient care excludes Ireland, Italy and Portugal as these countries do not report dental care separately from other types of outpatient care. The EU average for diagnostic tests excludes Denmark, Ireland, Italy and Portugal as these countries do not report patient transport separately from ancillary services. The EU average shown here is not weighted for population size.

Source: data from health accounts (OECD, 2025).

Fig. 6. Over-the-counter medicines as a share of out-of-pocket payments for outpatient medicines in the EU and the United Kingdom, 2022



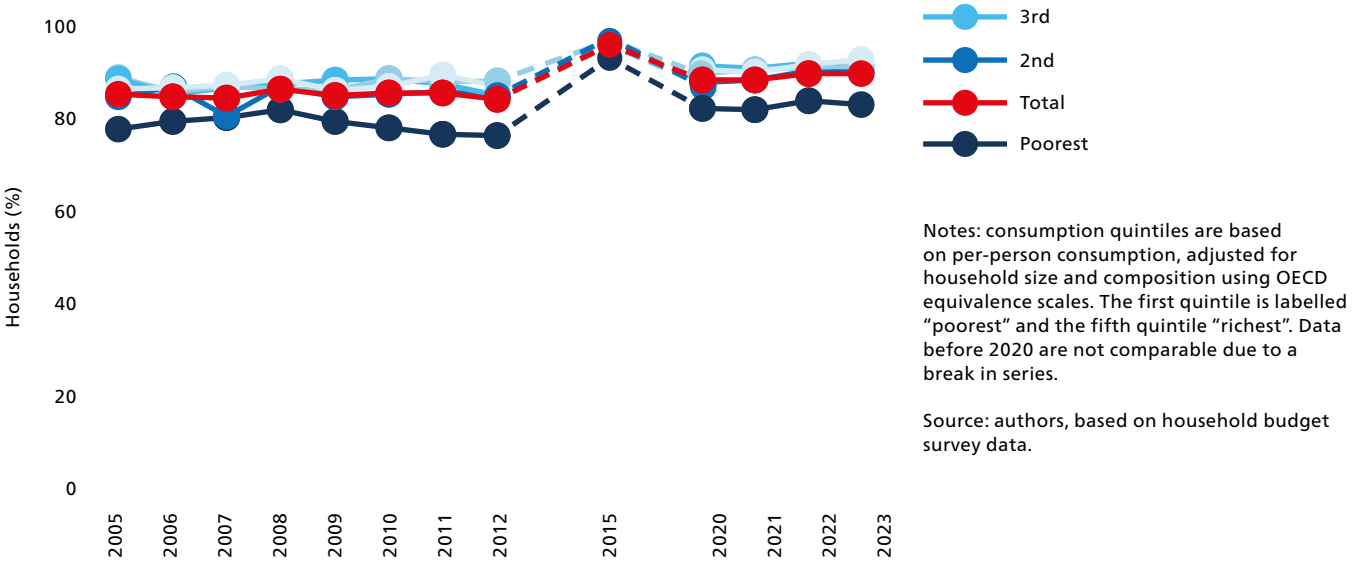
Notes: data are not available for all EU countries.

Source: data from health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Around 90% of households reported out-of-pocket payments in 2023, ranging from 83% in the poorest consumption quintile to 93% in the richest (Fig. 7). These shares have not changed much since 2020.

Fig. 7. Households with out-of-pocket payments by consumption quintile

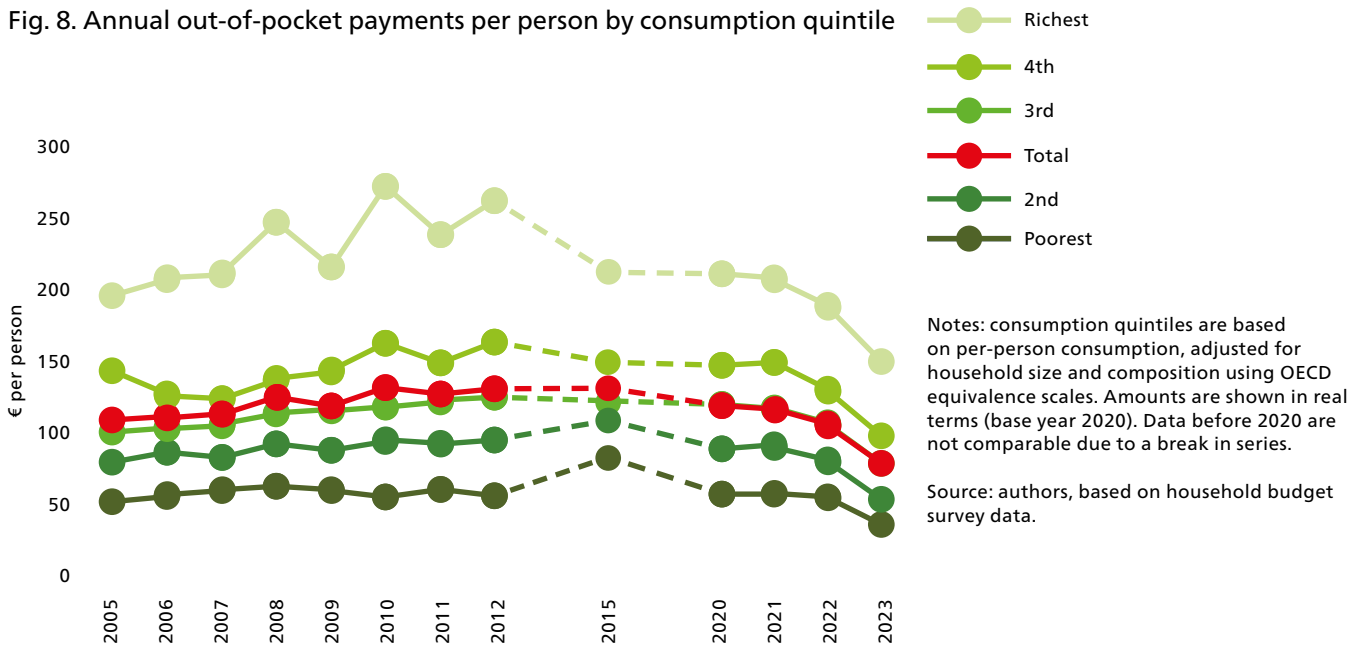


Notes: consumption quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled "poorest" and the fifth quintile "richest". Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

The average amount spent out of pocket per person was €78 in 2023, ranging from €36 in the poorest quintile to €149 in the richest (Fig. 8). The average amount spent generally decreased in all quintiles between 2021 and 2023.

Fig. 8. Annual out-of-pocket payments per person by consumption quintile

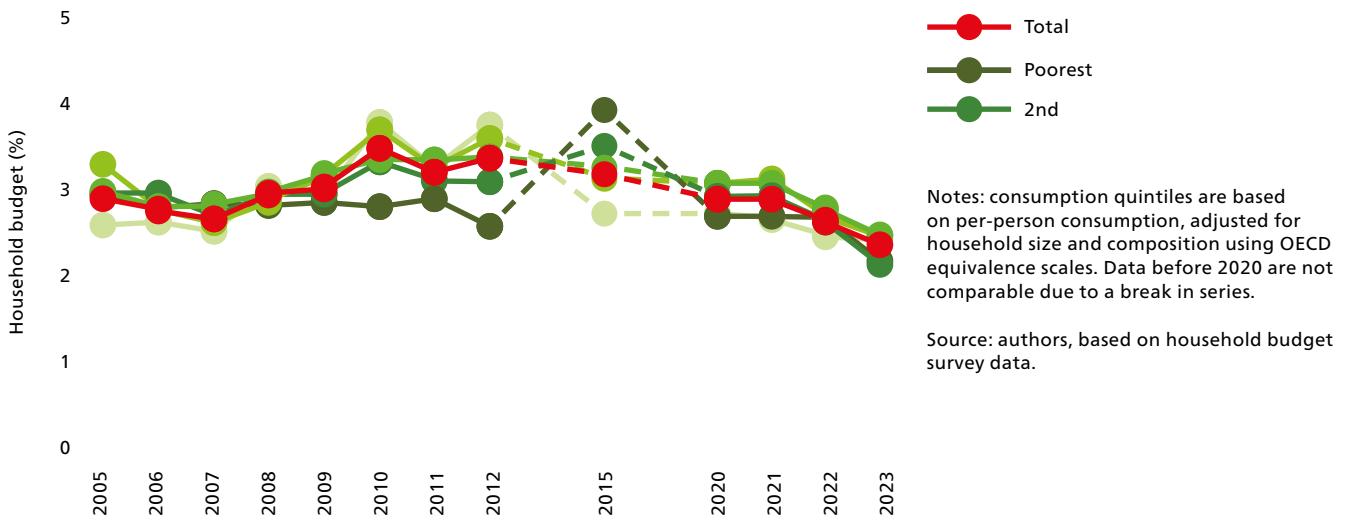


Notes: consumption quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Amounts are shown in real terms (base year 2020). Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

In 2023 out-of-pocket payments accounted for 2.4% of total household spending (that is, the household budget) on average, with little variation across quintiles (Fig. 9). Between 2021 and 2023 this share decreased in every quintile.

Fig. 9. Out-of-pocket payments as a share of household consumption by consumption quintile

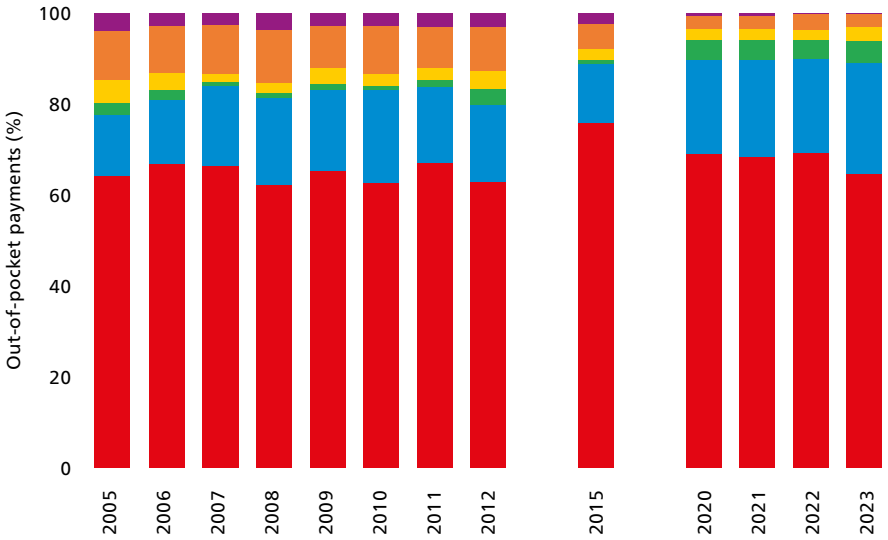


Notes: consumption quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

In 2023 out-of-pocket payments were heavily driven by spending on outpatient medicines (65%), followed by dental care (24%) (Fig. 10). Outpatient medicines consistently accounted for the largest share of out-of-pocket payments over time but their share fell slightly in 2023.

Fig. 10. Breakdown of out-of-pocket payments by type of care

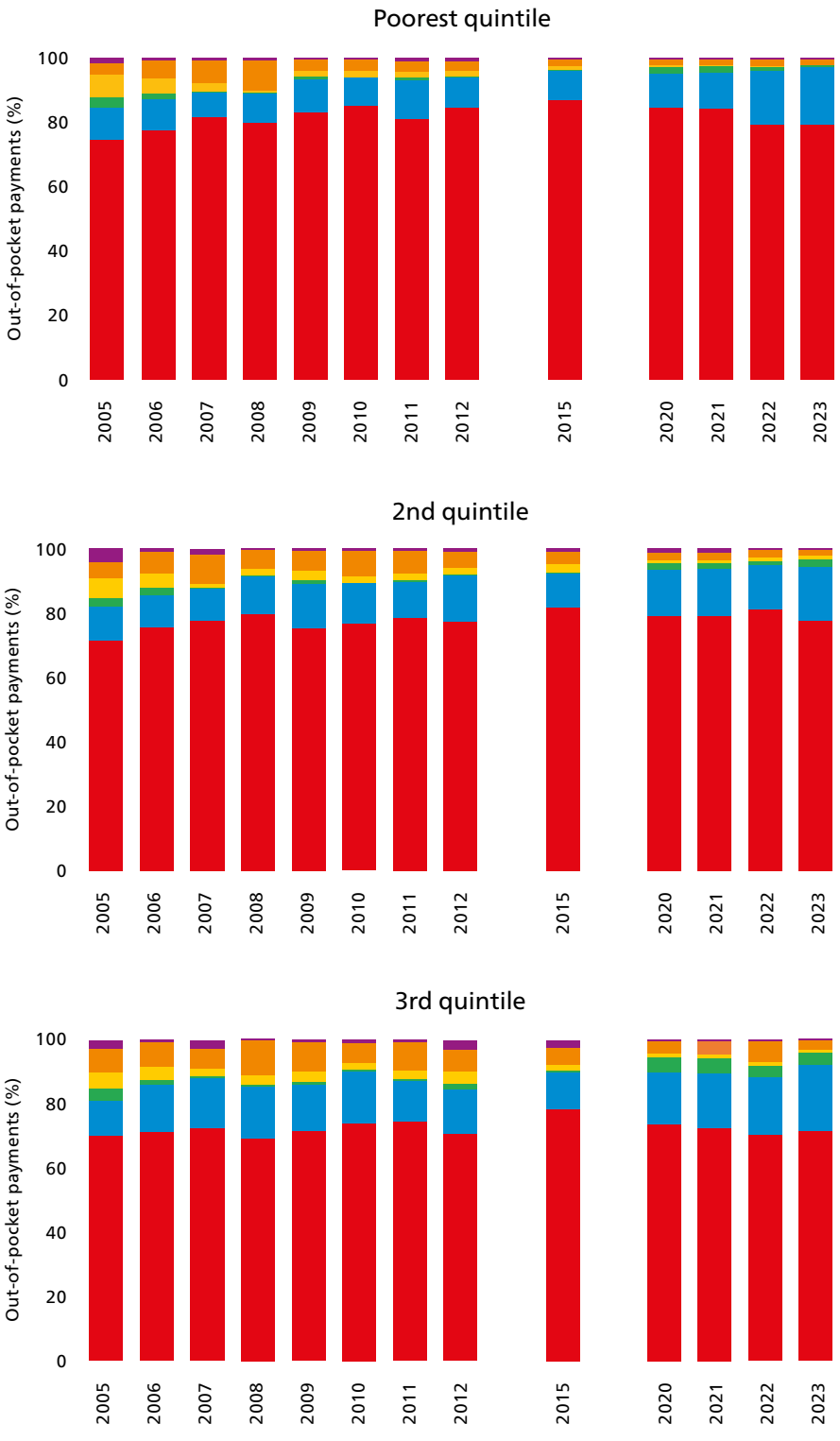


Notes: diagnostic tests include paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

Outpatient medicines are consistently the main driver of out-of-pocket payments in all quintiles (Fig. 11). In 2023 outpatient medicines accounted for 87% of out-of-pocket payments in the poorest quintile compared to 51% in the richest quintile (Fig. 11). The much lower share of spending on dental care in the poorest households compared to the richest is likely to reflect a higher degree of unmet need among the poorest households.

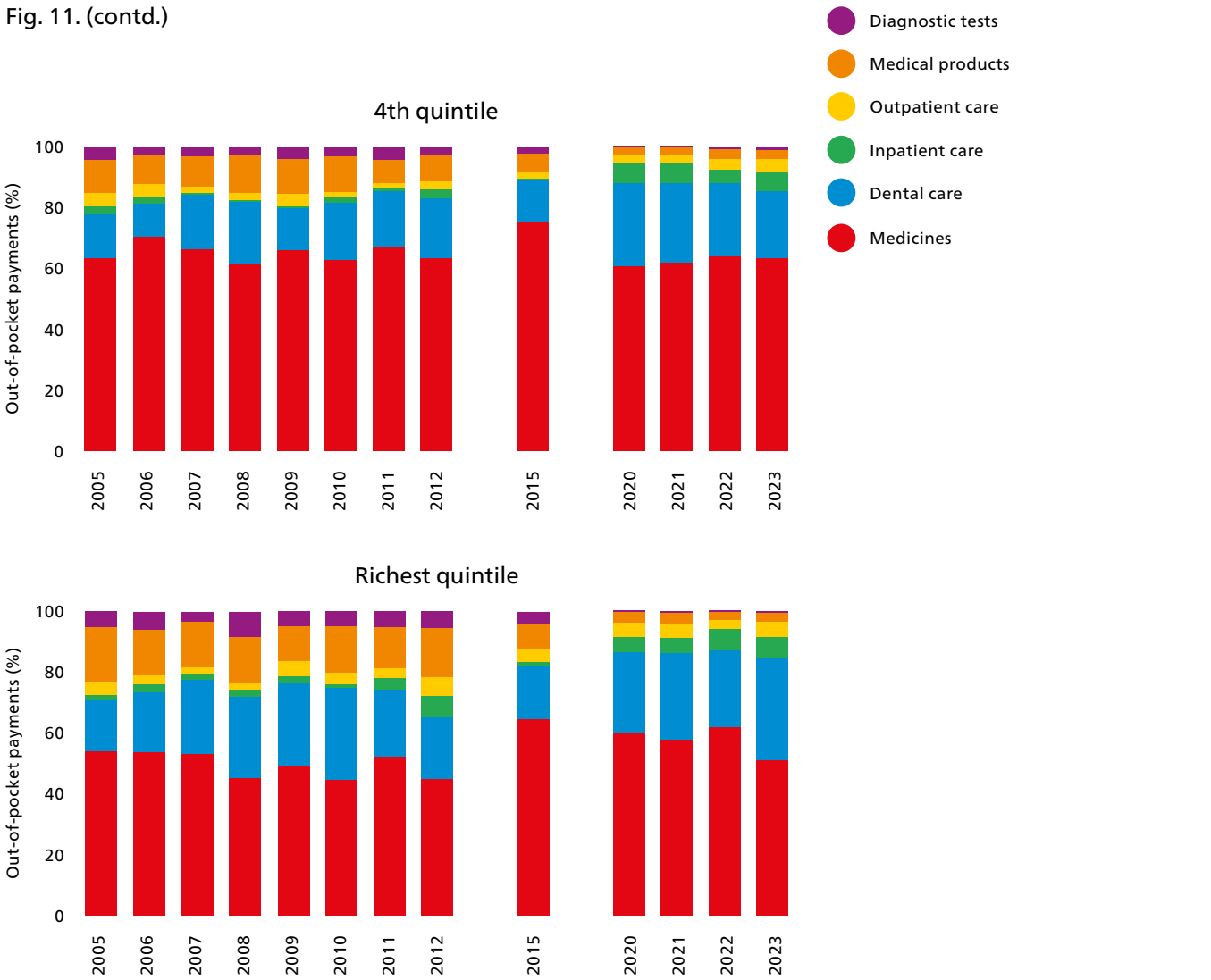
Fig. 11. Breakdown of out-of-pocket payments by type of care and consumption quintile



Notes: diagnostic tests includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data before 2020 are not comparable due to a break in series.

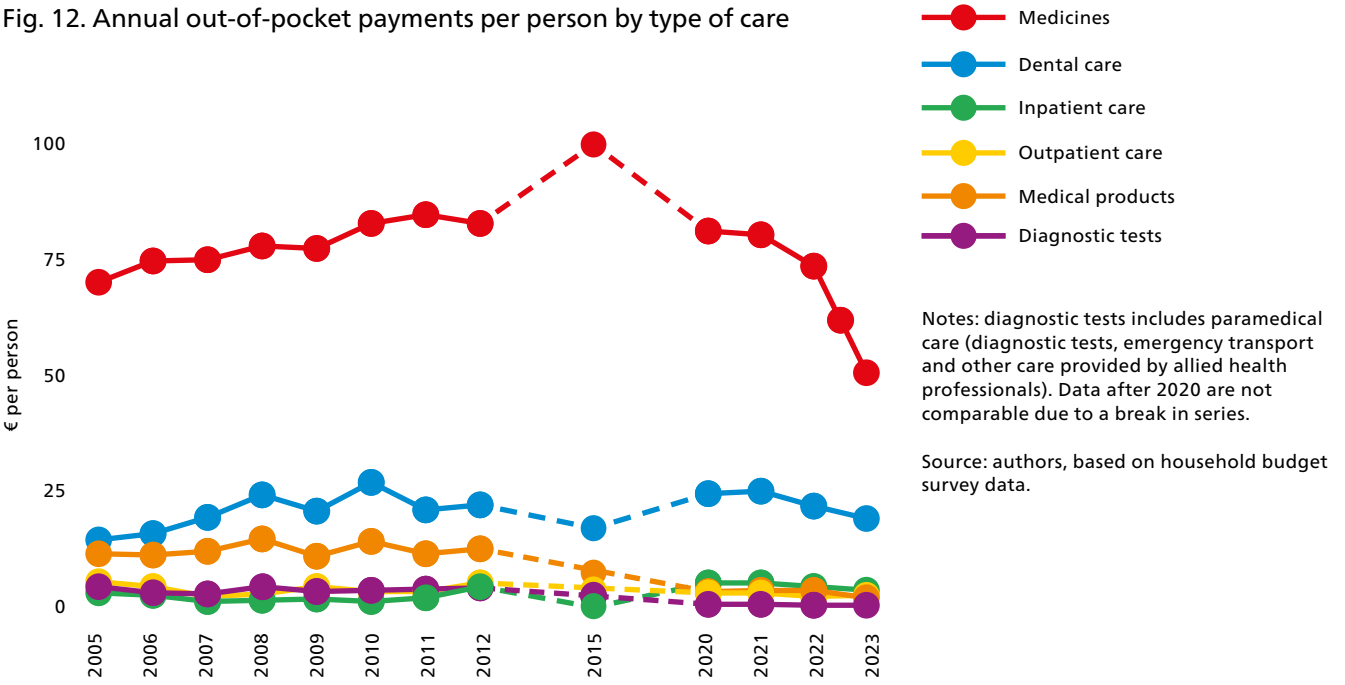
Source: authors, based on household budget survey data.

Fig. 11. (contd.)


4th quintile
Out-of-pocket payments (%)
100
80
60
40
20
0
2005
2006
2007
2008
2009
2010
2011
2012
2015
2020
2021
2022
2023
Richest quintile
Out-of-pocket payments (%)
100
80
60
40
20
0
2005
2006
2007
2008
2009
2010
2011
2012
2015
2020
2021
2022
2023
Diagnostic tests
Medical products
Outpatient care
Inpatient care
Dental care
Medicines

In 2023 people spent on average €51 out of pocket on outpatient medicines, followed by dental care (€19) (Fig. 12). Out-of-pocket payments per person decreased between 2021 and 2023 for all types of care, with a steeper decrease in outpatient medicines. These reductions occurred in all quintiles and for all types of care (Fig. 13).

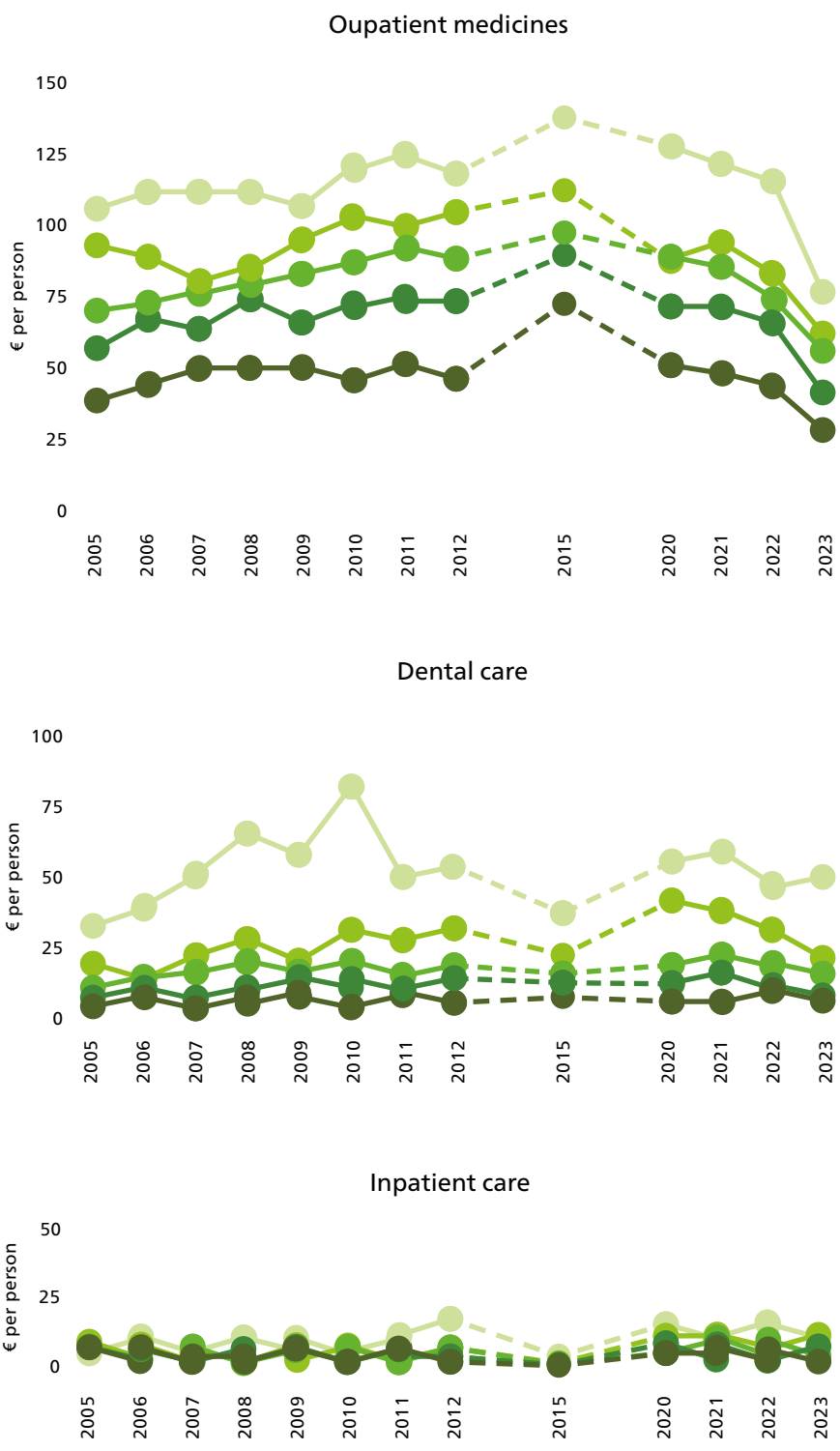
Fig. 12. Annual out-of-pocket payments per person by type of care



Notes: diagnostic tests includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data after 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

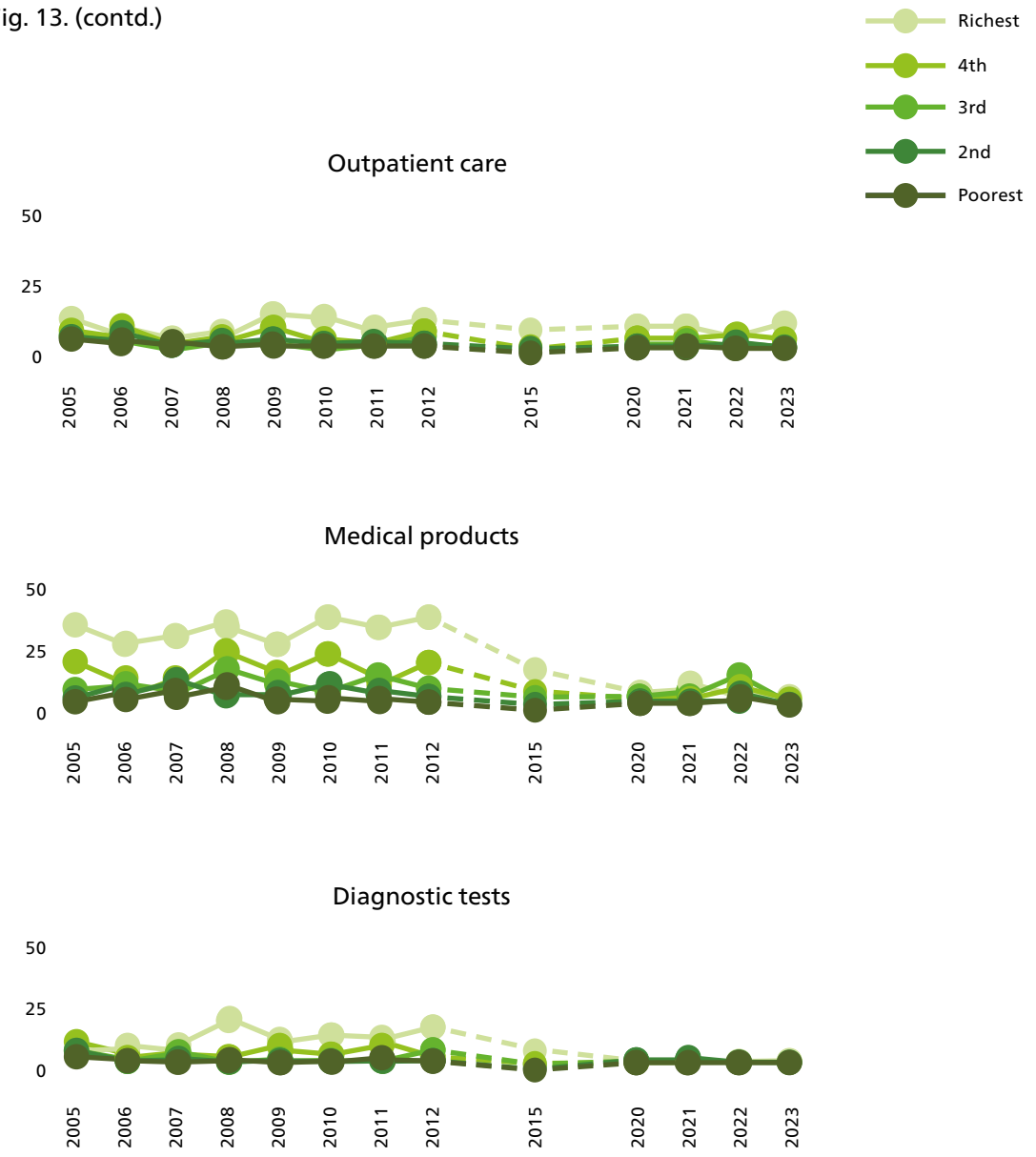
Fig. 13. Annual out-of-pocket payments per person by type of care and consumption quintile



Notes: amounts are shown in real terms (base year 2020). Diagnostic tests includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data after 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

Fig. 13. (contd.)


Richest
4th
3rd
2nd
Poorest
Outpatient care
50
25
0
2005
2006
2007
2008
2009
2010
2011
2012
2015
2020
2021
2022
2023
Medical products
50
25
0
2005
2006
2007
2008
2009
2010
2011
2012
2015
2020
2021
2022
2023
Diagnostic tests
50
25
0
2005
2006
2007
2008
2009
2010
2011
2012
2015
2020
2021
2022
2023

4.3 Informal payments

The 2024 Special Eurobarometer survey on corruption found that 5% of respondents in Slovakia who had visited a public health care provider in the previous 12 months reported informal payments, compared to an EU average of 3% (European Commission & Kantar, 2025).

Informal payments are an issue, mainly in outpatient care settings where people pay to get faster access to treatment or because providers use loopholes in the law to top up their revenue by charging people for services such as a first visit to a clinic, setting up a patient file, or ambulance running costs. In 2023 informal payments were estimated to amount to €280 million, equal to almost a third of public spending on outpatient care (excluding medicines and dental care) (Tulejová & Šebová, 2023). In the same year the average amount people paid informally ranged from €30 in pharmacies, €50 for GPs and €171 for inpatient care to €475 for outpatient specialist care in hospitals and €1321 for dental care (Tulejová & Šebová, 2023).

People with low incomes are heavily affected by informal payments. In 2023 35% of people with a monthly income of less than €600 did not seek care due to fear of informal payments (or had paid informally) in the last year compared to only 8% of people with a monthly income of between €1501 and €3000) (Tulejová & Šebová, 2023).

Informal payments reduce transparency and increase barriers to access, contributing to financial hardship. They are likely to be regressive and affect the poorest households most (Jakab, Akkazieva & Kutzin, 2016). A major challenge in health systems with pervasive informal payments is that it is difficult to introduce policies to protect people with low incomes and regular users of health care from exposure to out-of-pocket payments.

4.4 Summary

Data from national health accounts indicate that out-of-pocket payments in Slovakia accounted for 19% of current spending on health in 2022, which is on a par with the EU average but higher than Austria (16%) and Czechia (14%).

In 2022 public spending on health accounted for 6.2% of GDP in Slovakia – lower than the EU27 average (6.7%), Austria (8.6%) and Czechia (7.5%). Public spending on health as a share of government spending is similar to the EU27 average but well below the levels in Austria, Czechia and Slovenia.

Broken down by type of care, the out-of-pocket payment share of current spending on health in Slovakia is highest for medical products and well above the EU27 average.

Around 90% of households in Slovakia reported out-of-pocket payments in 2023, ranging from 83% in the poorest consumption quintile to 93% in the richest. These shares have not changed much since 2020. The average amount spent out of pocket per person decreased in all quintiles between 2021 and 2023.

Out-of-pocket payments are consistently most heavily driven by spending on outpatient medicines, accounting for 65% of spending in 2023, followed by dental care (24%). The share of out-of-pocket spending on dental care share is lower in poorer quintiles.

Informal payments are an issue in Slovakia. Although co-payments for outpatient visits and inpatient care are prohibited, health care providers exploit a loophole in the law to charge people for services in outpatient care settings such as a first visit to a clinic, setting up a patient file, or ambulance running costs. These informal payments were equal to almost a third of public spending on outpatient health care (excluding medicines and dental care) in 2023. The average amount people paid informally in 2023 ranged from €30 in pharmacies, €50 for GPs and €171 for inpatient care to €475 for outpatient specialist care in hospitals and €1321 for dental care.

5. Financial protection

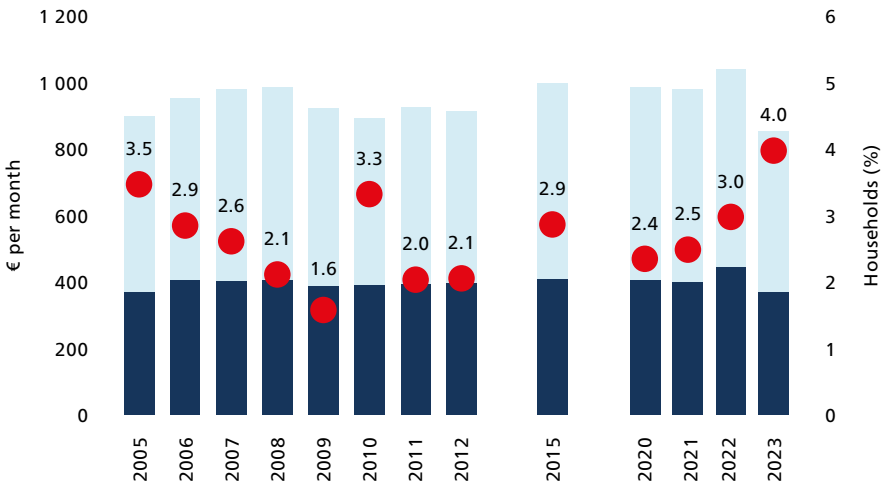
This section uses data from the Slovak household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health care. The indicator explorer by UHC watch (2025) provides further data for most of the figures in this section.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. In this study, basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and fuel) among a relatively poor part of the Slovak population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2023 the monthly cost of meeting these basic needs (the basic needs line) was €374, which was below the Slovak monthly national poverty line of €461 in the same year (60% of median income) (Statistical Office of the Slovak Republic, 2024a).

The cost of meeting basic needs and household capacity to pay for health care fell sharply in 2023. The share of households living below the basic needs line rose from around 2.4% in 2020 and 2021 to 4.0% in 2023 (Fig. 14).

Fig. 14. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



Average household capacity to pay

Cost of meeting basic needs

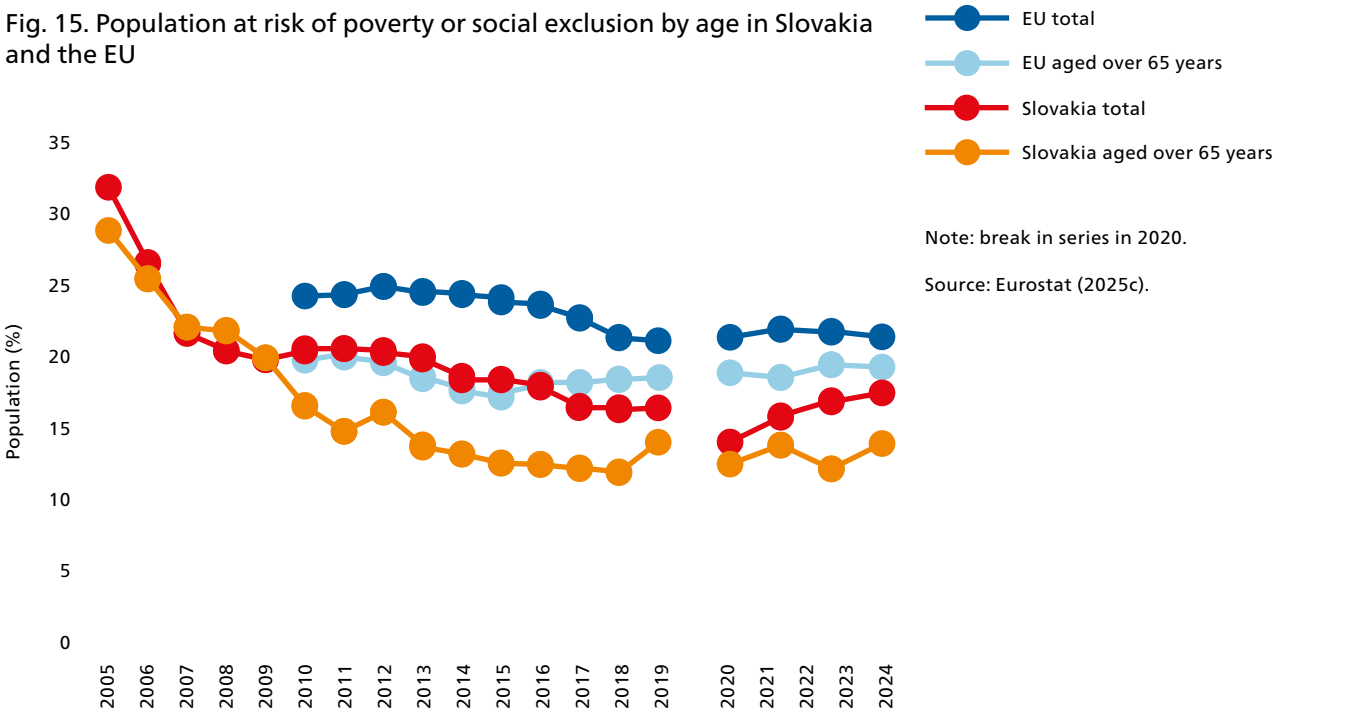
Share of households living below the basic needs line (%)

Notes: capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. Amounts are shown in real terms (base year 2020). Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

The share of the population at risk of poverty or social exclusion in Slovakia in 2023 was below the EU average both for the total population and for people aged over 65 years (Fig. 15). However, poverty rates have increased in Slovakia since 2020, following a long period of improvement between 2005 and 2018.

Fig. 15. Population at risk of poverty or social exclusion by age in Slovakia and the EU



Note: break in series in 2020.

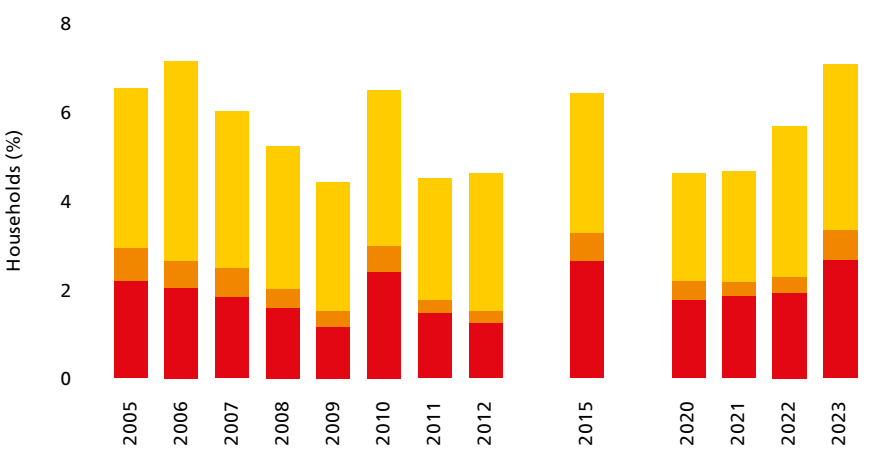
Source: Eurostat (2025c).

5.2 Financial hardship: impoverishing and catastrophic health spending

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2023 3.3% of households were impoverished or further impoverished after out-of-pocket payments (Fig. 16). This share has increased since 2020, mainly driven by an increase in the further impoverished category. The share of households at risk of impoverishment also increased sharply between 2021 and 2023.

Fig. 16. Households at risk of impoverishment after out-of-pocket payments



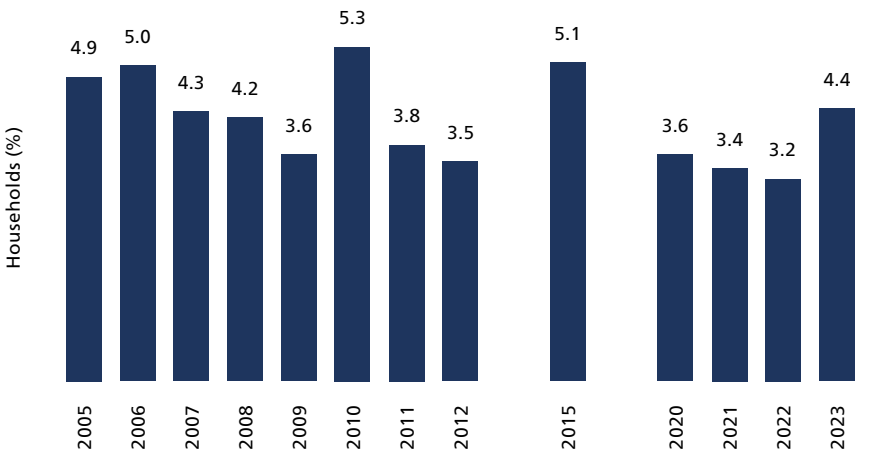
Notes: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line. Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

Households with catastrophic levels of out-of-pocket spending are defined (in this review) as those who spend more than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2023 4.4% of households – around 230 000 people – experienced catastrophic health spending (Fig. 17). This represented a sharp increase after a downward trend between 2020 and 2022.

Fig. 17. Households with catastrophic health spending



Notes: households with catastrophic health spending are households with out-of-pocket payments that are greater than 40% of their capacity to pay for health care, which may mean that they can no longer afford to meet other basic needs (food, housing and utilities). Data before 2020 are not comparable due to a break in series.

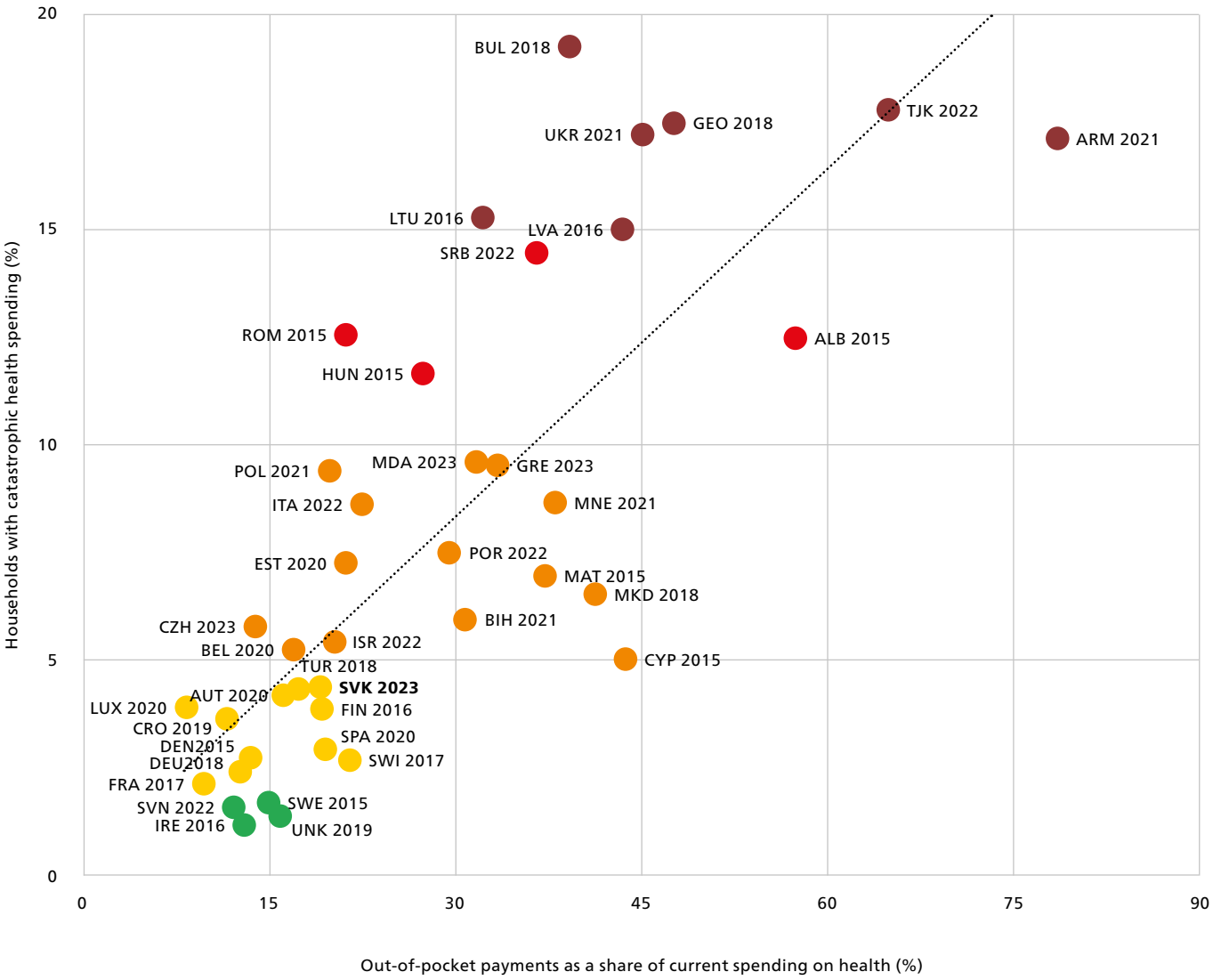
Source: authors, based on household budget survey data.

The incidence of catastrophic health spending is lower in Slovakia than in many EU countries (particularly those in central Europe) but higher than in Austria, Finland and Spain – countries with a similar level of out-of-pocket payments as a share of current spending on health (Fig. 18).

Fig. 18. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year, except for Greece, the Republic of Moldova and Slovakia, where figures are for 2022. Dots are coloured by the incidence of catastrophic health spending: green under 2%, yellow under 5%, orange under 10%, red under 15%, dark red over 15%. The list of country codes used here can be found in the Abbreviations.

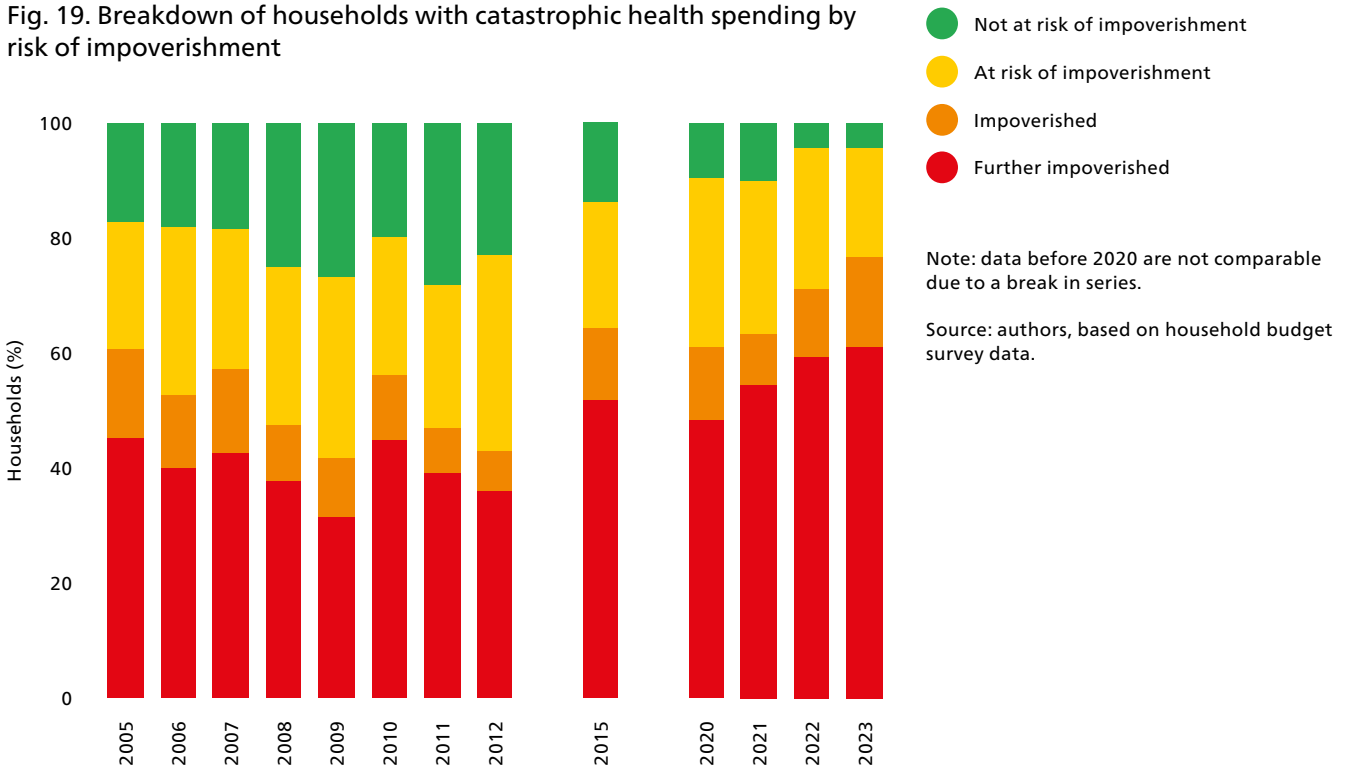
Sources: data on catastrophic health spending from UHC watch (2025) and data on out-of-pocket payments from WHO (2025).



Who experiences financial hardship?

Most households with catastrophic health spending are at risk of impoverishment, impoverished or further impoverished after out-of-pocket payments (Fig. 19). In 2023 further impoverished households accounted for 61% of households with catastrophic health spending. This share has increased since 2020.

Fig. 19. Breakdown of households with catastrophic health spending by risk of impoverishment

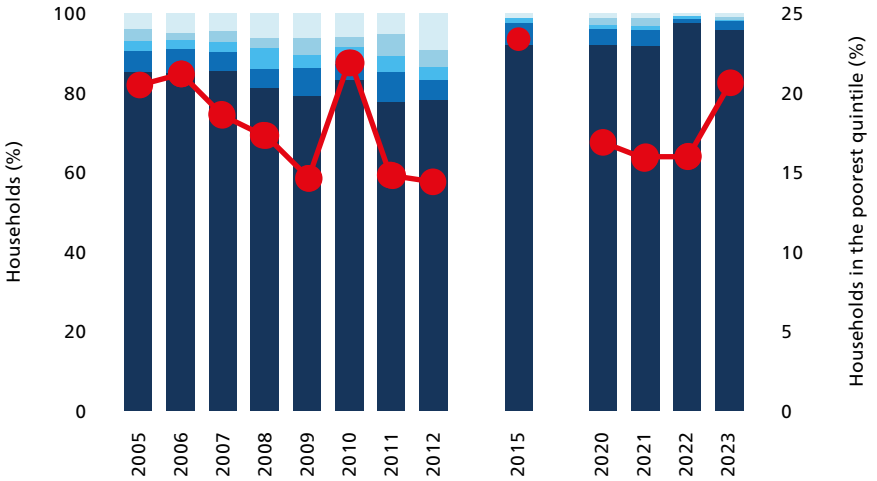


Note: data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

Households experiencing catastrophic health spending are consistently very heavily concentrated in the poorest consumption quintile (Fig. 20). In 2023 21% of households in the poorest quintile experienced catastrophic health spending (Fig. 20), compared to only 0.9% in the other quintiles (data for the other quintiles not shown). This was a sharp increase from around 16% in 2021 and 2022 (Fig. 20).

Fig. 20. Breakdown of households with catastrophic health spending by consumption quintile and incidence of catastrophic health spending in the poorest quintile

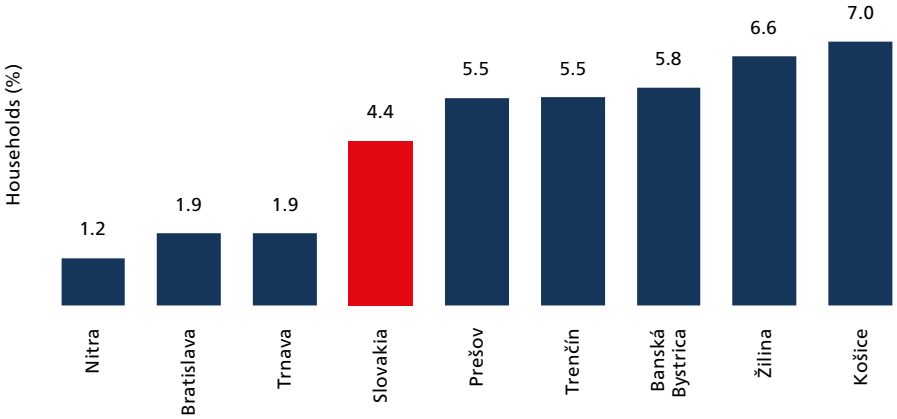


Note: data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

In 2023 the incidence of catastrophic health spending was higher than the national average in most regions except Trnava, Bratislava and Nitra (Fig. 21). Although Košice and Prešov are two of the richest regions in terms of GDP per person, they have the highest rate of people at risk of poverty or social exclusion (23% and 28%, respectively), the largest share of Roma people (Statistical Office of the Slovak Republic, 2025) and the highest incidence of catastrophic health spending, indicating substantial income inequality.

Fig. 21. Households with catastrophic health spending by region, 2023



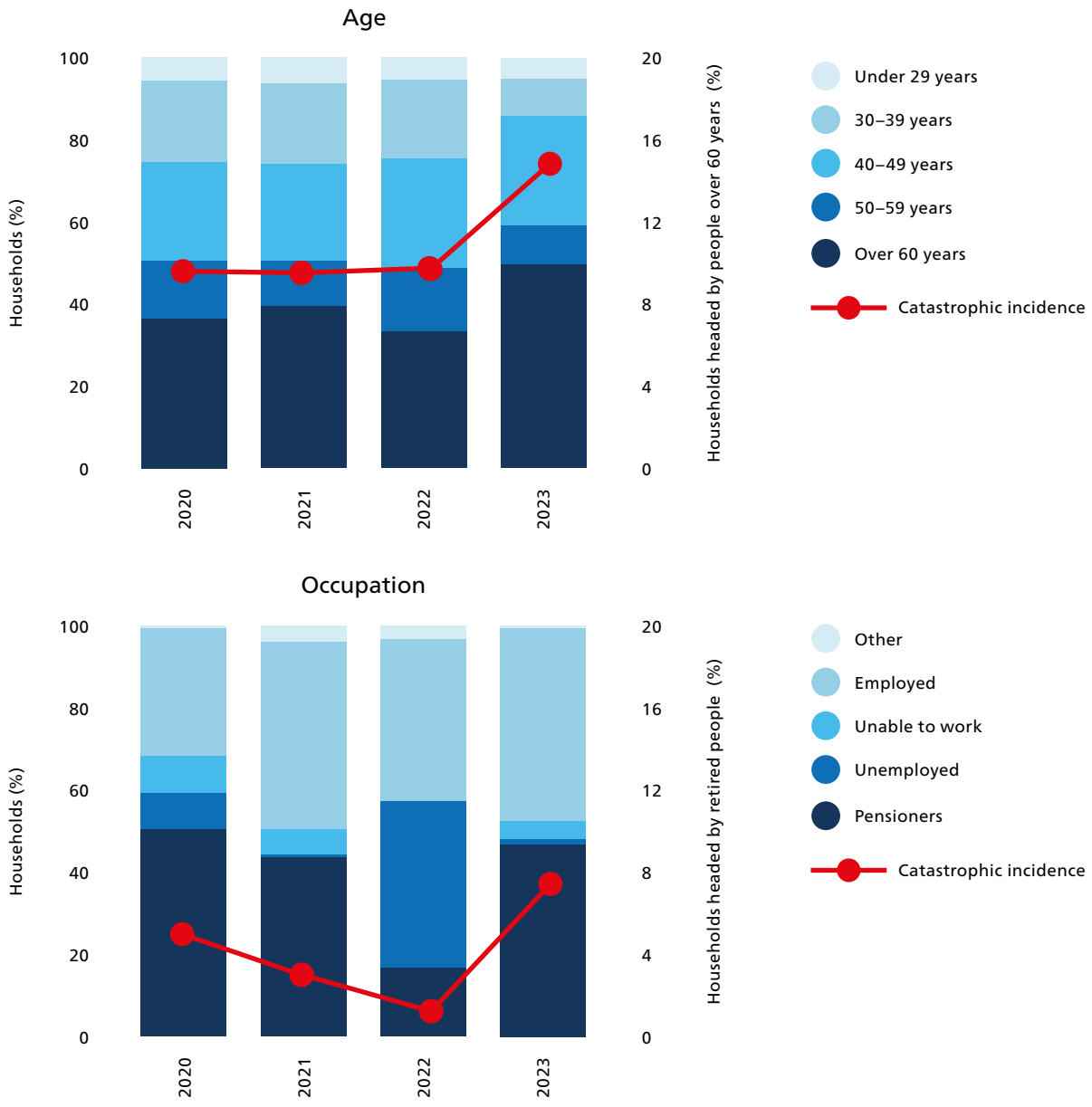
Source: authors, based on household budget survey data.

Looked at by age and occupational status, catastrophic health spending is heavily concentrated in households headed by older people, employed people or pensioners (Fig. 22) and in households in rural areas (data for rural areas not shown). The incidence of catastrophic health spending is also generally much higher than average (4%) in households headed by older people (15%) or pensioners (8%) (Fig. 22).

Fig. 22. Breakdown of households with catastrophic health spending by age and occupation of the head of the household and incidence of catastrophic health spending in households headed by older people and pensioners

Note: these results are based on a relatively small number of observations (households) and should be interpreted with caution.

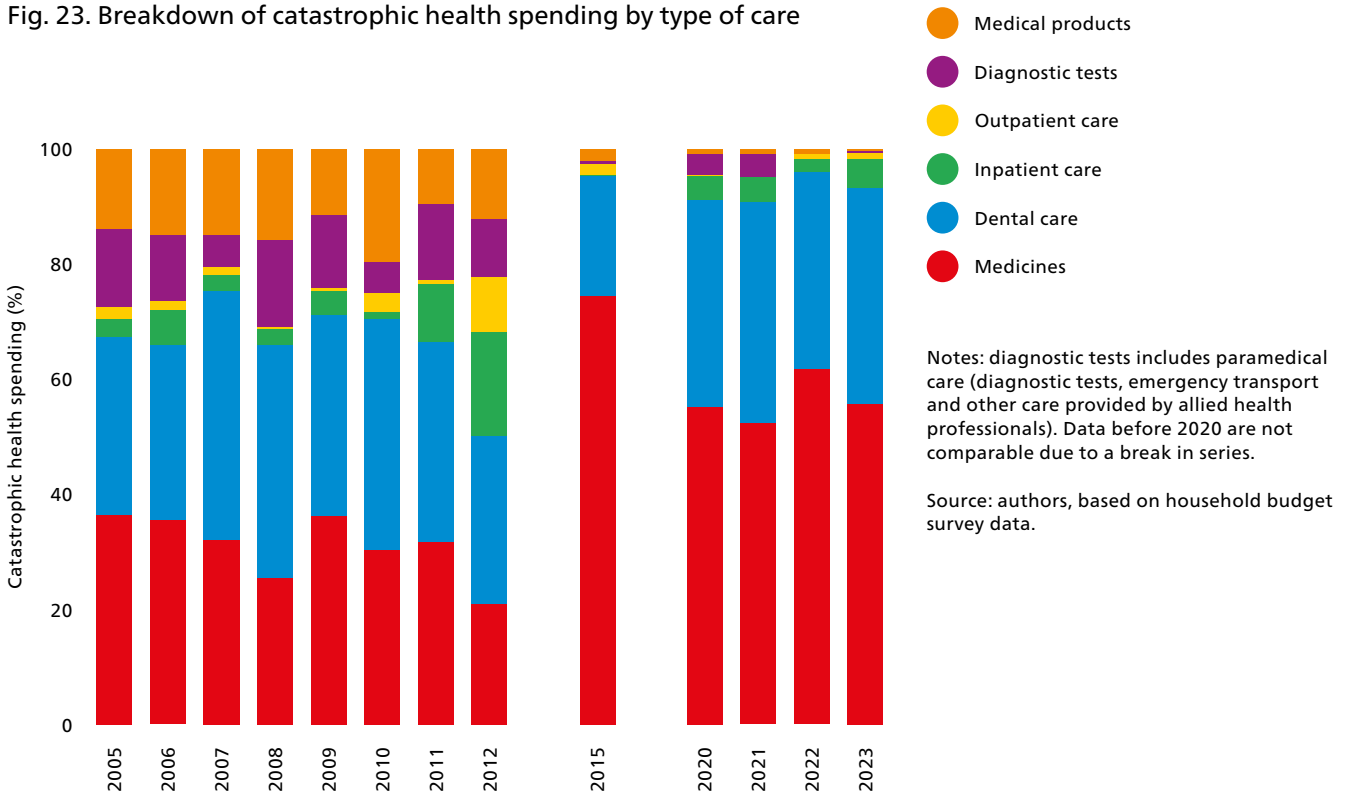
Source: authors, based on household budget survey data.



Which health services are responsible for financial hardship?

In 2023 catastrophic health spending was mainly driven by outpatient medicines (56%), followed by dental care (38%) (Fig. 23). The share of catastrophic out-of-pocket spending on outpatient medicines decreased in 2023 (returning to 2020 levels) but the dental care share was higher in 2023 than in 2020.

Fig. 23. Breakdown of catastrophic health spending by type of care

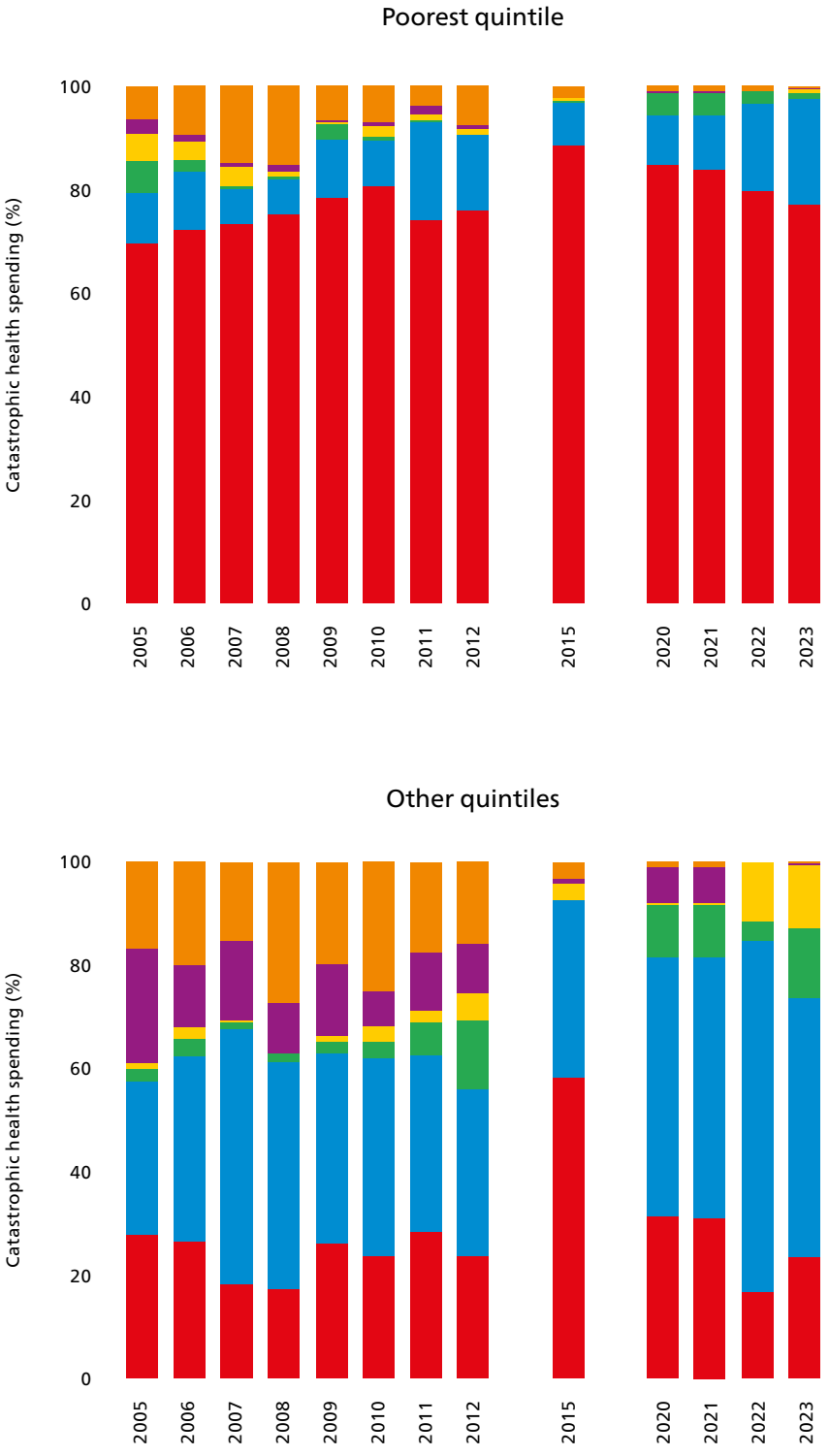


Notes: diagnostic tests includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

Outpatient medicines are consistently the largest driver of catastrophic health spending in the poorest quintile (77% in 2023), followed by dental care (20%) (Fig. 24). The outpatient medicines share has fallen in the poorest quintile since 2020. Dental care is the main driver of catastrophic health spending in the other quintiles (50% in 2023). The outpatient care share grew substantially in the other quintiles in 2022.

Fig. 24. Breakdown of catastrophic health spending by type of care and consumption quintile



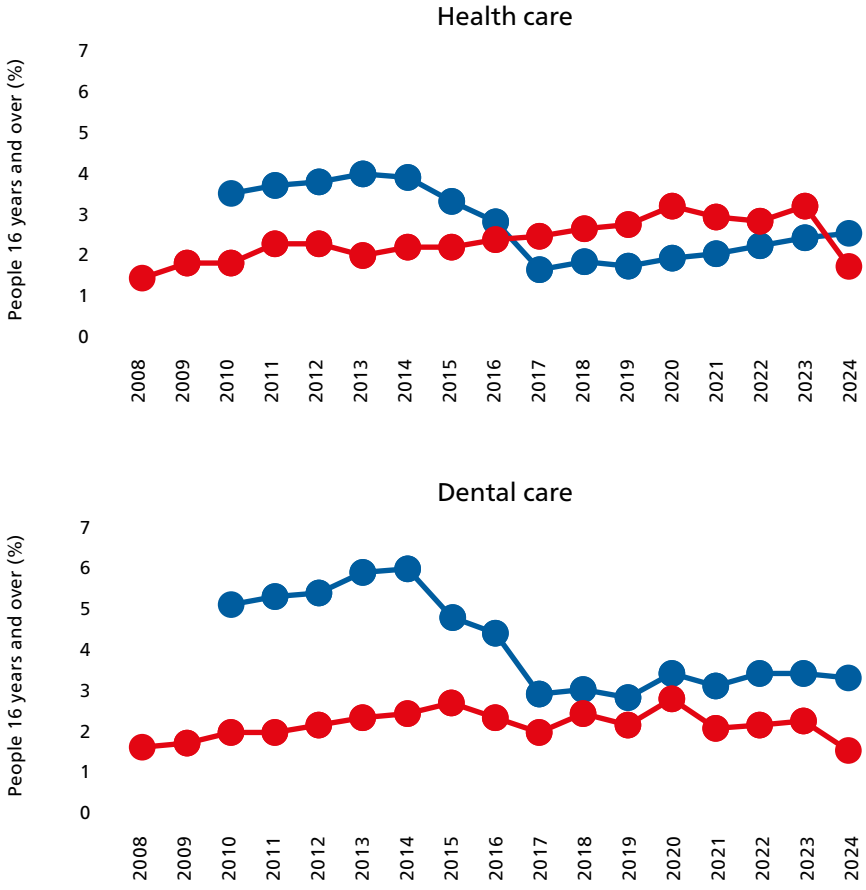
Notes: diagnostic tests includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). Data before 2020 are not comparable due to a break in series.

Source: authors, based on household budget survey data.

5.3 Unmet need for health care

EU-SILC data on unmet need (see Box 1) due to cost, distance or waiting time show that in 2024 unmet need was below the EU average for health care and dental care (Fig. 25). When measured as a share of people aged 16 years or over needing care, in 2024 unmet need for health care is 2.6% (up from 1.6% in the same year when measured as a share of people aged 16 or over) and 2.7% for dental care (up from 1.4%) (Eurostat, 2025c). This indicates that unmet need in Slovakia might be higher than what is currently reported (Ingleby & Guidi, 2024). Waiting time is the main driver of unmet need for health care in Slovakia, and cost is the main driver of unmet need for dental care. Unmet need for health care was slightly higher than that for dental care during the study period. Unmet need for health care has grown over time, particularly in 2020 and 2023, but dropped sharply in 2024. Unmet need for dental care has increased slightly over time and also fell quite sharply in 2024. There is no clear explanation for the sharp drop in 2024.

Fig. 25. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Slovakia and the EU

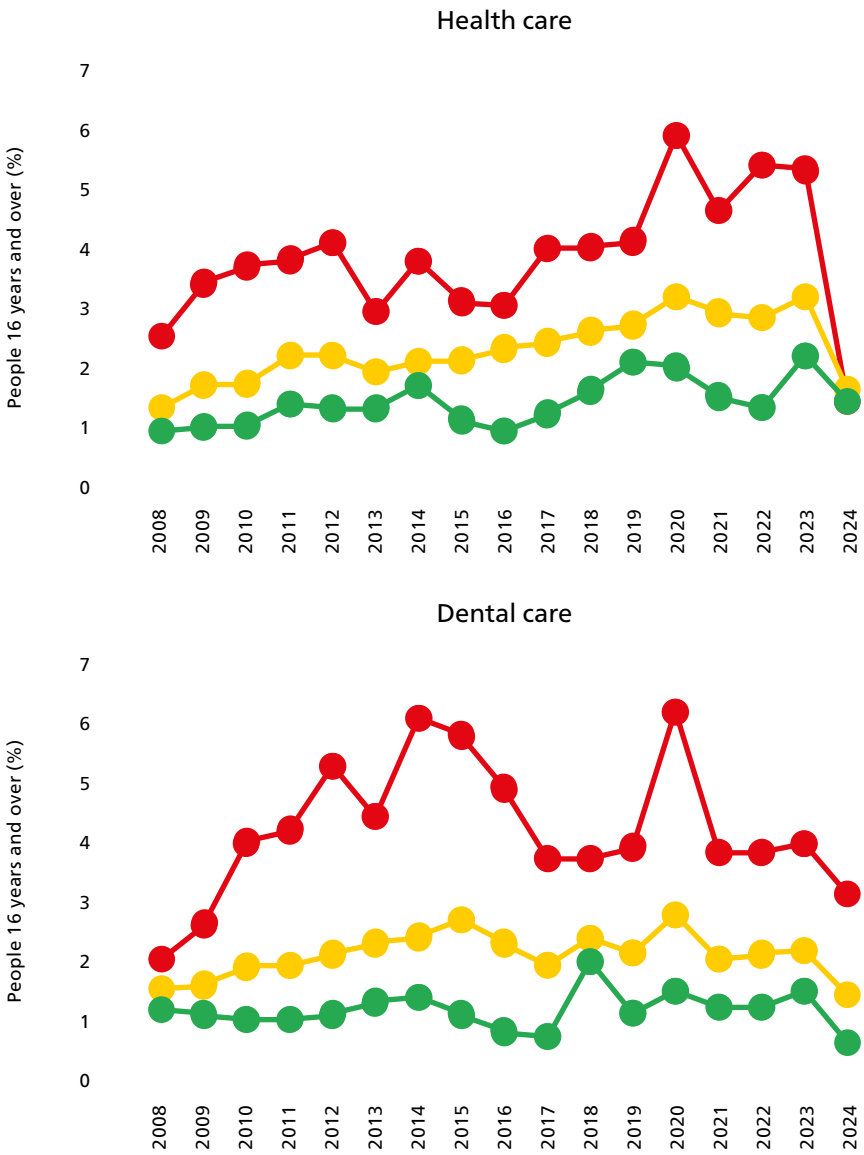


Note: the EU-SILC denominator for unmet need is people aged 16 years and over.

Source: EU-SILC data from Eurostat (2025c).

During the study period there was significant income inequality in unmet need for health and dental care. In 2024 a sharp drop in unmet need in the poorest quintile eliminated income inequality in unmet need for health care (Fig. 26). People with low incomes are more likely than richer people to experience unmet need due to fear of informal payments. In 2023 35% of people with a monthly income of less than €600 did not seek care due to fear of informal payments (or had paid informally) in the last year compared to only 8% of people with a monthly income of between €1501 and €3000) (Tulejová & Šebová, 2023).

Fig. 26. Income inequality in self-reported unmet need for health care and dental care due to cost, distance and waiting time

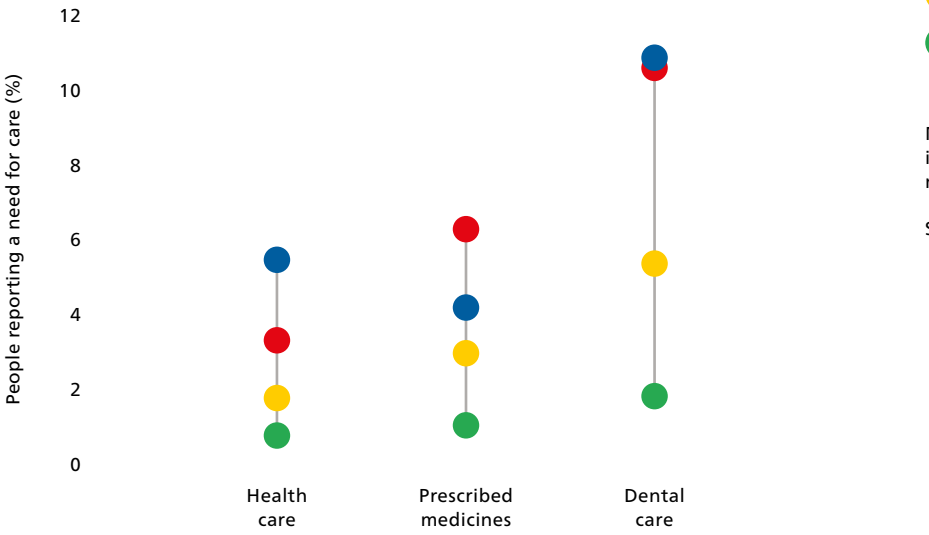


Notes: the EU-SILC denominator for unmet need is people aged 16 years and over. Quintiles are based on income.

Source: EU-SILC data from Eurostat (2025c).

EHIS data show that in 2019 unmet need for health care, prescribed medicines and dental care due to cost in Slovakia was below the EU average (Fig. 27). There is significant income inequality for all three types of care but especially for dental care.

Fig. 27. Income inequality in unmet need for health care, prescribed medicines and dental care due to cost, Slovakia and the EU, 2019



Notes: the EHIS denominator for unmet need is people aged 15 years and over reporting need for care. Quintiles are based on income.

Source: EHIS data from Eurostat (2025c).

5.4 Summary

In 2023 3.3% of households were impoverished or further impoverished after out-of-pocket payments, up from 2.4% in 2020. In the same year 4.4% of households – around 230 000 people – experienced catastrophic health spending, up from 3.2% in 2022. This share increased in 2023 after a downward trend between 2020 and 2022.

The incidence of catastrophic health spending in Slovakia is lower than in many EU countries (particularly those in central Europe) but higher than in Austria, Finland and Spain – countries with a similar level of out-of-pocket payments as a share of current spending on health.

Catastrophic health spending is heavily concentrated in the poorest quintile. In 2023 21% of households in the poorest quintile experienced catastrophic health spending, up from around 16% in 2021 and 2022 (Fig. 20).

Looked at by age and occupational status, catastrophic health spending is heavily concentrated in households headed by older people, employed people or pensioners and in households in rural areas.

Catastrophic health spending is driven by outpatient medicines (on average and especially in the poorest quintile), followed by dental care. Dental care is the main driver in other quintiles.

EU-SILC data show that unmet need was below the EU average for health care and dental care in Slovakia in 2024, where it is mainly driven by waiting time for health care and cost for dental care. Before 2024 unmet need for health care was above the EU average; there is no clear explanation for the sharp drop in 2024. Unmet need for health care has been slightly higher than unmet need for dental care since 2015. There is significant income inequality in unmet need for both types of care before 2024.

EHIS data show that in 2019 unmet need for health care, prescribed medicines and dental care due to cost in Slovakia was below the EU average. There is significant income inequality for all three types of care – especially for dental care.

6. Health system factors affecting financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Slovakia and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in Slovakia has some strengths.

- The SHI scheme's benefits package is relatively comprehensive.
- Despite the existence of co-payments for some types of care, most of them are in the form of fixed co-payments (which are more transparent than percentage co-payments); two thirds of the outpatient prescribed medicines that require co-payments are available with a co-payment of less than €1; and there are automatic mechanisms in place (exemptions and caps) to protect some people with low incomes from co-payments (pensioners and people with disabilities).

However, persistent gaps in coverage undermine financial protection, particularly for people with low incomes, as reflected by the following findings.

- Although out-of-pocket payments decreased in absolute terms and as a share of the household budget between 2020 and 2023 (see Fig. 8 and Fig. 9), catastrophic health spending grew to 4.4% in 2023 (a relatively sharp increase after a downward trend from 2020 to 2022) (see Fig. 17).
- Catastrophic health spending is almost exclusively concentrated in the poorest consumption quintile (see Fig. 20) and is also heavily concentrated in households headed by older people, employed people or pensioners (see Fig. 22).
- Catastrophic health spending is largely driven by outpatient medicines and dental care on average, but in the poorest quintile outpatient medicines are a much larger driver than dental care.
- There is marked income inequality in unmet need for prescribed medicines (see Fig. 27).

The main gaps in all three dimensions of coverage (see Table 4) and their impact on financial protection are discussed in more detail in the remainder of this subsection.

Entitlement to health care is based on payment of mandatory SHI contributions, leading to a gap in **population coverage**; in 2022 around 5% of the eligible population (246 058 people) was not covered by the SHI scheme – mainly people working in other EU countries and homeless people (Statistical Office of the Slovak Republic, 2023; Health Care Surveillance Authority, 2024). People who fail to pay mandatory SHI contributions for three months, unemployed asylum seekers and homeless people have very limited access to publicly financed health care and

undocumented migrants are not entitled to any publicly financed health care. These groups of people are at high risk of experiencing unmet need and catastrophic health spending.

Although the SHI scheme's **benefits package** is relatively comprehensive, coverage of dental care and glasses is limited. This might explain why dental care is the second-largest driver of catastrophic health spending in all quintiles, despite Slovakia having lower levels of unmet need for dental care compared to the EU average. People are also likely to pay out of pocket for covered dental care because most dentists are not willing to use covered materials or covered procedures and are free to set their own prices.

Waiting times are an issue in outpatient care settings (due to a shortage of health workers) and are one reason why levels of unmet need for health care were above the EU average before 2024 (see Fig. 25). Despite the fact that HICs are required by law to monitor and publish waiting times, this is limited in inpatient care to eye, circulatory and musculoskeletal conditions. Starting in January 2025 the Government set targets for waiting times but these are only mandated for inpatient care interventions.

Informal payments are also widespread in outpatient care, mainly because health care providers exploit a loophole in the law to charge people for services such as a first visit to a clinic, setting up a patient file, or ambulance running costs. The average amount people paid informally in 2023 ranged from €30 in pharmacies, €50 for GPs and €171 for inpatient care to €475 for outpatient specialist care in hospitals and €1321 for dental care.

Although the design of **user charges (co-payments)** has some strengths, and there are mechanisms in place to protect people, co-payments do not seem to be sufficiently protective for people with low incomes. This may explain why catastrophic health spending is very heavily concentrated in the poorest quintile and why it increased in 2023 when rates of poverty increased (see Fig. 20 and Fig. 15).

There are several potential reasons for this.

- First, the system of fixed co-payments for outpatient prescribed medicines is unusual and complex, involving different co-payments for every medicine in categories AS and S. Because these co-payments are fixed per medicine – as opposed to having the same co-payment for all covered outpatient prescribed medicines (the approach in most countries with fixed co-payments (WHO Regional Office for Europe, 2023; UHC watch, 2025)) – they vary depending on the price of the medicine. This means that people who require more expensive medicines have to pay more out of pocket and people may not know in advance how much they will have to pay for their treatment. It would be more transparent, equitable and efficient to shift to a system in which there is a single fixed co-payment for all medicines with co-payments over €1.

- Second, the system of fixed co-payments for outpatient prescribed medicines aims to ensure that one medicine in each reference group is available without any co-payment or with a co-payment of less than €1 (for medicines in categories AS and S). Since 2011, this policy has been supported by mandatory INN prescribing and mandatory generic substitution. However, GPs can prescribe the brand name in brackets, making generic substitution less common (Smatana et al., in press). As a result, people may be paying more in co-payments than the law envisages – particularly people who access care regularly.

- Third, exemptions from and caps on co-payments for outpatient prescribed medicines and medical products only apply to children under 6 years old, pensioners with low incomes and people who have a disability with low incomes. They do not apply to people with no disabilities of working age with incomes, to people with chronic conditions or to all children (as is the case in many countries). In 2023 there were over 700 000 people at risk of poverty or social exclusion but only a fifth of them received social benefits (Statistical Office of the Slovak Republic, 2024a). Consequently, many people with low incomes (including many children living in low-income households) are likely to be paying out of pocket for essential medicines and medical products.

- Fourth, the quarterly cap on co-payments for outpatient prescribed medicines benefited 14% of the population – around 773 000 people – in the first quarter of 2020 (Ministry of Health, 2020). International evidence and experience shows that to ensure equitable access to health care without financial hardship, caps should: be extended to all households with low incomes (and ideally to all households); cover all co-payments; be applied automatically, reducing administrative barriers; and be regularly monitored and adjusted as needed (García-Ramírez et al., 2025).

Some other factors may contribute to the catastrophic health spending driven by outpatient medicines. First, although Slovakia has implemented many policies aimed at decreasing the price of medicines (e.g. lowering VAT rates for medicines to 10% in 2007 and then 5% in 2025 and introducing external reference pricing, mandatory INN prescribing and mandatory generic substitution in 2011) – which seem to have had an impact by reducing the average amount spent out of pocket on outpatient medicines (see Fig. 12) – this has not been enough to protect households with low incomes, especially in 2023 when poverty increased and capacity to pay decreased. There is also evidence that current patterns of prescribing and dispensing encourage inappropriate use of medicines – for example, a study carried out in 2019–2020 found that 73% of older people in Slovakia showed signs of potentially inappropriate use of medicines (Kosirova et al., 2023), which is likely to result in people incurring unnecessary co-payments.

Although outpatient care is not a key driver of catastrophic health spending, extra billing in outpatient settings (which may occur, even though it is prohibited) can lead to financial hardship for some households, as well as reducing transparency.

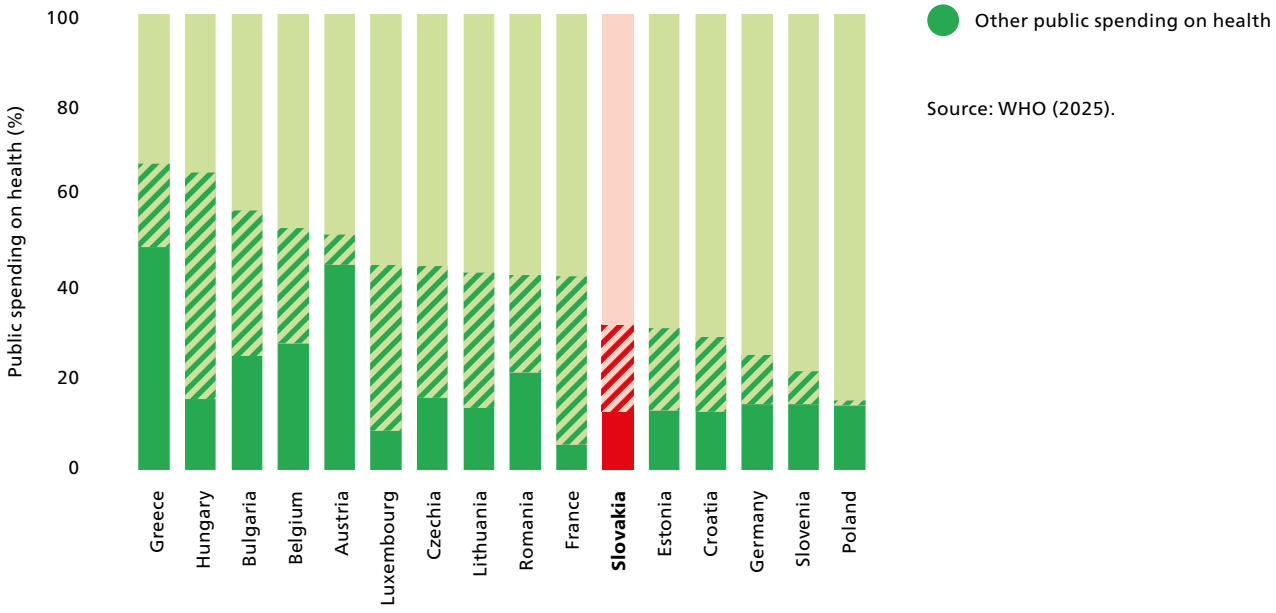
6.2 Public spending on health

At 6.2% of GDP in 2022, public spending on health in Slovakia seems to be higher than in other countries with similar economic development. However, priority to health could be increased as in 2022 it was on par with the EU27 average (15% of public spending on health as a share of the government budget).

Public spending on health may not be adequately targeted towards protecting people from out-of-pocket payments for outpatient medicines, which are the largest driver of financial hardship for households and especially for people with low incomes. This situation could explain why catastrophic health spending in Slovakia is higher than in other countries with a similar level of out-of-pocket payments as a share of current spending on health (see Fig. 18).

In addition, Slovakia's heavy reliance on the labour market to finance health care poses a challenge for financial sustainability in the context of population ageing. As the working-aged population declines, revenue generated through employment will decrease, putting pressure on the health budget. In 2022 SHI contributions levied on wages accounted for nearly 68% of public spending on health in Slovakia, which is higher than in many other EU countries with SHI schemes (Fig. 28).

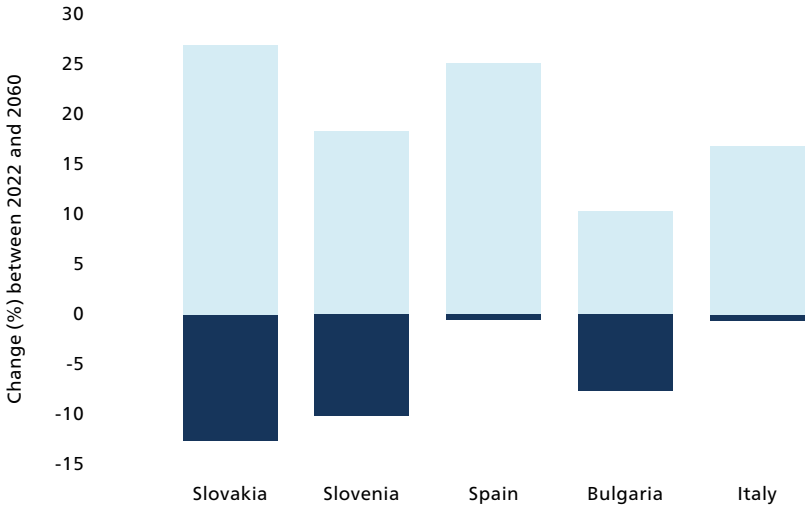
Fig. 28. Breakdown of public spending on health in EU countries predominantly financed through SHI schemes, 2022



Source: WHO (2025).

Recent analysis focusing on five EU countries, including Slovakia, found that as the working-aged share of the population decreases, countries that rely more heavily on SHI contributions to finance health care (like Bulgaria, Slovakia and Slovenia) are likely to experience a significant decline in public revenue for health over the next 30 years, increasing budgetary pressure in the health system. In contrast, public revenue for health is likely to be more resilient to population ageing in countries that have broadened the public revenue base for the health system and draw on a more diverse mix of taxes to finance health care (like Italy and Spain) (Fig. 29). The study finds that Slovakia is projected to have the largest ageing-related gap in public spending on health by 2060 (compared to 2015) (Fig. 29), with a relatively large decrease in public revenue for health (by 13%) compared to other countries (Fig. 30).

Fig. 29. The population ageing-related gap in public spending on health and public revenue for health in selected EU countries, 2022 to 2060

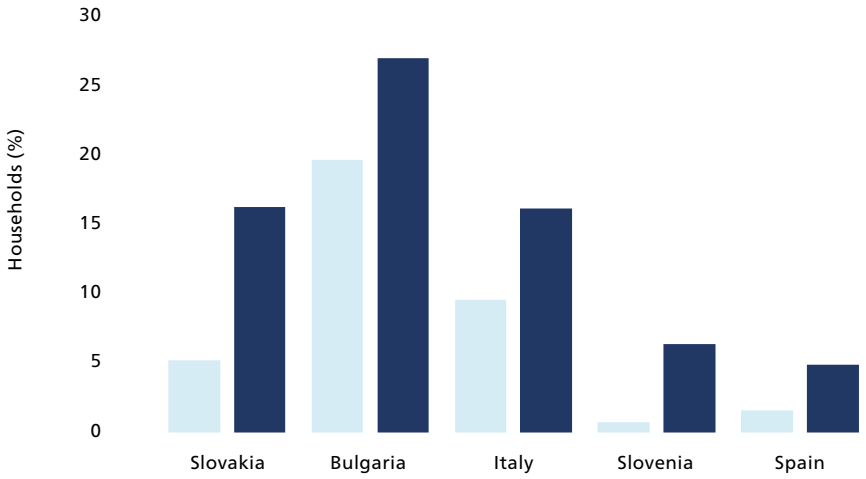


Notes: revenue and spending refer to public revenue for health and public spending on health per person. Countries are sorted from left to right from largest gap (Slovakia) to smallest (Italy). Countries were selected based on the availability of data and to reflect a range of health financing mixes.

Source: Cylus et al. (2025).

The same analysis looked at what would happen to catastrophic health spending if the population ageing-related financing gap were to be filled through out-of-pocket payments rather than an increase in public spending on health. It found that there would be sharp increases in the share of households with catastrophic health spending, even in countries with relatively strong financial protection now (Fig. 30). For Slovakia, catastrophic health spending is expected to triple by 2060 (compared to the baseline year of 2015) if public spending on health does not increase.

Fig. 30. Increase in the share of households with catastrophic health spending if the gap is filled through out-of-pocket payments in selected EU countries, baseline to 2060



Notes: countries are sorted from left to right from largest absolute increase over time (Slovakia) to smallest (Spain). The largest relative increase is in Slovenia (baseline year 2018), followed by Slovakia (2015), Spain (2019), Italy (2019) and Bulgaria (2018).

Source: Cylus et al. (2025).

These findings suggest that countries with SHI schemes should take steps to reduce reliance on wages to finance health care and to strengthen coverage policy so that out-of-pocket payments are not borne by households that cannot afford them (Box 2). This will protect households now and help to future-proof the health system against demographic changes and other shocks.

Box 2. How France broadened the SHI revenue base and changed the basis for entitlement to SHI benefits

Starting in the late 1990s, France began to broaden the revenue base for the SHI scheme in two ways.

- It replaced employee wage-based contributions with a contribution levied on all sources of income (including wages, pensions, unemployment benefits, rental and investment income and capital gains) and paid by all resident adults. The new income-based contributions now account for a large share of the SHI scheme's revenue.
- It increased the level of government budget transfers to the SHI scheme.

The French Government also changed the basis for entitlement to SHI benefits from employment and payment of contributions to residence (in 2000) and granted all legal residents an individual, automatic and continuous right to health care, without the need for administrative formalities when a person's circumstances change (the latter since 2016). This has helped to ensure that all legal residents are covered and have access to all SHI benefits, regardless of employment status or whether they have paid mandatory contributions.

Sources: adapted from WHO Regional Office for Europe (2019; 2023); Bricard (2024).

6.3 Summary

Coverage policy in Slovakia has some strengths. The benefits package is relatively comprehensive; despite having co-payments for some types of care, most of them are in the form of fixed co-payments; and there are automatic mechanisms in place (exemptions and caps) to protect some people with low incomes from co-payments (pensioners and people with disabilities).

However, persistent gaps in coverage undermine financial protection (particularly for people with low incomes) and explain why levels of catastrophic health spending have increased in recent years, are almost exclusively concentrated in the poorest households and in households headed by older people, employed people or pensioners and are largely driven by outpatient medicines.

Entitlement to health care is based on payment of mandatory SHI contributions and people who fail to pay contributions for three months (as well as unemployed asylum seekers and homeless people) have very limited access to publicly financed health care. Undocumented migrants are not entitled to any publicly financed health care.

Although the SHI scheme's benefits package is relatively comprehensive, coverage of dental care and glasses is limited. This might explain why dental care is the second-largest driver of catastrophic health spending in all consumption quintiles.

Waiting times are an issue in outpatient care due to the shortage of health workers and informal payments are also widespread in outpatient care settings, mainly because health care providers exploit a loophole in the law to charge people for services.

The system of fixed co-payments for outpatient prescribed medicines is unusual and complex, involving different co-payments for every medicine in categories AS and S. Although there is mandatory INN prescribing and mandatory generic substitution, GPs can prescribe the brand name in brackets, making generic substitution less common and pushing some people to pay more in co-payments than the law envisages.

Exemptions from and caps on co-payments for outpatient prescribed medicines and medical products do not apply to non-disabled people of working age with low incomes, people with chronic conditions or to all children (as is the case in many countries).

Although public spending on health in Slovakia seems to be higher than in other countries with similar economic development, there is room to increase the priority given to health in the government budget. Public spending on health may not be adequately targeted towards protecting people from out-of-pocket payments, particularly for outpatient medicines.

When considering potential sources of additional public funding, it is worth noting that Slovakia's heavy reliance on the labour market to finance health care poses a challenge for the financial sustainability of the health system in the context of population ageing.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is lower in Slovakia than in many EU countries but has increased in recent years. In 2023 (the latest available year of data) 4.4% of households – around 230 000 people – experienced catastrophic health spending. This share increased in 2023 after falling between 2020 and 2022. It is higher than in several countries with a similarly low reliance on out-of-pocket payments to finance the health system.

Catastrophic health spending is heavily concentrated in the poorest consumption quintile. In 2023 one in five households in the poorest quintile experienced catastrophic health spending (up from around 16% in 2021 and 2022). The incidence of catastrophic health spending is also concentrated in households headed by older people and pensioners, and in the eastern regions of the country, where most Roma people live.

In the poorest quintile catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, followed by dental care. In other quintiles, it is mainly driven by out-of-pocket payments for dental care, followed by outpatient medicines and inpatient care.

Unmet need for health care and dental care in Slovakia is lower than the EU average. It is mainly driven by waiting time for health care and cost for dental care. During the study period there was significant income inequality in unmet need for both types of care.

Coverage policy in Slovakia has some strengths. The benefits package is relatively comprehensive, user charges (co-payments) are not widely applied and there are some mechanisms to protect people from co-payments, including exemptions from and caps on co-payments for some people with low incomes (pensioners and people with disabilities).

However, income inequality in financial hardship and unmet need reflect persistent gaps in coverage that mainly affect people with low incomes.

- The design of co-payments for outpatient prescribed medicines is complex and mechanisms to protect people from co-payments are not sufficient for people with low incomes or chronic conditions. Loopholes in the law allow providers to extra bill for non-clinical services in both outpatient and inpatient care settings.

- Coverage of dental care and vision aids (glasses) is limited by legislation and in practice for dental care as many providers do not offer covered services or materials. Waiting times and informal payments are growing issues for outpatient visits.

- Entitlement to SHI benefits is based on payment of mandatory SHI contributions and people who fail to pay contributions for three months – as well as unemployed asylum seekers and homeless people – have very limited access to publicly financed health care. Undocumented migrants are not entitled to any publicly financed health care.

Since 2015 several steps have been taken to reduce out-of-pocket payments for outpatient medicines, dental care and outpatient care in Slovakia. Building on this, the Government can now focus more on

reducing financial hardship among people with low incomes, taking into account the following options for action.

Ensure people have access to outpatient prescribed medicines without co-payments. This can be achieved by: including at least one medicine with a €0 co-payment medicine in every reference group; guaranteeing the availability of this medicine in pharmacies throughout the country; and strengthening adherence to clinical guidelines and INN prescribing by doctors, as well as generic substitution in pharmacies. The Government can also consider simplifying the system of co-payments for outpatient prescribed medicines to a single co-payment for all medicines incurring co-payments over €1 – this would also enhance transparency, equity and efficiency.

Improve the mechanisms used to protect people from co-payments by extending exemptions and caps to all co-payments, to all people with low incomes and, ideally, to people with chronic conditions. These mechanisms should be applied automatically to ensure everyone eligible benefits from them along with regular monitoring to ensure their scope is appropriate.

Reassess the usefulness of co-payments for emergency care by tackling the root causes of overuse of emergency care. Although these co-payments are relatively low and transparent fixed co-payments, and some people are exempt in certain circumstances, they are unlikely to address the real reasons why people use emergency services – that is, because of a lack of sufficient access to primary care (including treatment in primary care settings).

Expand publicly financed coverage of dental care, including the use of higher-quality materials, and find ways to ensure that more providers offer covered services.

Tackle inefficiencies in the health system that push people to pay out of pocket for covered care, including by systematically monitoring and enforcing waiting time targets (e.g. those introduced for elective surgery from 2025). The causes and effects of informal payments should also be closely monitored by establishing regular surveillance and reporting mechanisms. The Government should also close loopholes in the law that enable providers to extra bill people in outpatient and inpatient care settings.

Soften the link between entitlement to SHI benefits and payment of mandatory SHI contributions. This means stopping penalizing people who are unable to pay contributions by denying them access to health care.

Expand the scope of publicly financed health care that is available to people who are not eligible to be covered by the SHI scheme.

Broaden the public revenue base so that is it able to generate sufficient funding as the population ages.

If carefully targeted to reduce financial hardship and unmet need in households with low incomes, these measures will make the health system more efficient, fair and resilient, now and in the future.

References[2]

Bricard D (2024). Can people afford to pay for health care? New evidence on financial protection in France. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/376550). Licence: CC BY-NC-SA 3.0 IGO.

Bucek Psenkova M, Visnansky M, Mackovicova S, Tomek D (2017). Drug policy in Slovakia. Value Health Reg Issues. 13:44–49 (https://doi.org/10.1016/j.vhri.2017.07.002).

Chaupain-Guillot S, Guillot O (2015). Health system characteristics and unmet care needs in Europe: an analysis based on EU-SILC data. Eur J Health Econ. 16:781–796 (https://doi.org/10.1007/s10198-014-0629-x).

Cylus J, Thomson S, Evetovits T (2018). Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bull World Health Organ. 96(9):599–609 (http://dx.doi.org/10.2471/BLT.18.209031).

Cylus J, Thomson S, Serrano Gregori M, Gallardo Martínez M, García-Ramírez M, Evetovits T (2025). How does population ageing affect health system financial sustainability and affordable access to health care in Europe? Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380710). Licence: CC BY-NC-SA 3.0 IGO.

European Commission, Kantar (2025). Citizens' attitudes towards corruption in the EU in 2024. Special Eurobarometer 548 Report. Brussels: European Commission (https://www.doi.org/10.2837/237452).

Eurostat (2025a). European Union statistics on income and living conditions (EU-SILC) [website]. Statistical Office of the European Union (https://ec.europa.eu/eurostat/web/microdata/european-unionstatistics-on-income-and-living-conditions).

Eurostat (2025b). European Health Interview Survey (EHIS) [website]. Statistical Office of the European Union (https://ec.europa.eu/eurostat/cache/metadata/en/hlth_det_esms.htm).

Eurostat (2025c). Database [online database]. Luxembourg: Statistical Office of the European Union (https://ec.europa.eu/eurostat/data/database).

García-Ramírez J, Thomson S, Urbanos-Garrido R, Bouckaert N, Czypionka T, Blümel M et al. (2025). Using income-based caps to protect people from user charges for health care. Lessons from Austria, Belgium, Germany and Spain. Improving affordable access to health care series. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380709). Licence: CC BY-NC-SA 3.0 IGO.

2. All references accessed on 24 April 2025.

Gibson G, Grignon M, Hurley J, Wang L (2019). Here comes the SUN: Self-assessed unmet need, worsening health outcomes, and health care inequity. Health Econ. 28(6):727–735 (https://doi.org/10.1002/hec.3877).

Health Care Surveillance Authority (2024). Informácia o počtoch poistencov čakajúcich na poskytnutie plánovanej zdravotnej starostlivosti [Information on the number of insured people waiting for planned health care] [website]. Health Care Surveillance Authority (https://www.udzs-sk.sk/dohlad-nad-zdravotnou-a-osetrovatelskou-starostlivostou/informacie-pre-obcanov/informacia-o-poctoch-poistencov-cakajucich-na-poskytnutie-planovanej-zdravotnej-starostlivosti/) (in Slovak).

Holubová B, Kahanec M, Kováčová I, Poláčková Z, Sedláková M (2021). The social and employment situation of Roma communities in Slovakia. Luxembourg: European Parliament Policy Department for Economic, Scientific and Quality of Life Policies (https://www.europarl.europa.eu/RegData/etudes/STUD/2021/695466/IPOL_STU(2021)695466_EN.pdf).

Ingleby D, Guidi C (2024). Time to reap the fruits of EU-SILC's new way of measuring unmet needs. Eur J Public Health. ckea125 (https://doi.org/10.1093/eurpub/ckae125).

Ištokovičová P, Rybanská V (2023). Poskytovanie zdravotnej starostlivosti odídencom z ukrajiny. [Providing health care to refugees from Ukraine]. Bratislava: Health Analyses Institute of the Ministry of Health (in Slovak).

Jakab M, Akkazieva B, Kutzin J (2016). Can reduction in informal payments be sustained? Evidence from Kyrgyzstan, 2001–2013. Copenhagen: WHO Regional Office for Europe (WHO/EURO:2016-6552-46318-67003; https://iris.who.int/handle/10665/369410).

Kosirova S, Urbankova J, Klimas J, Foltanova T (2023). Assessment of potentially inappropriate medication use among geriatric outpatients in the Slovak Republic. BMC Geriatr. 23:567 (https://doi.org/10.1186/s12877-023-04260-y).

Macejova Z, Kristian P, Janicko M, Halanova M, Drazilova S, Antolova D et al. (2020). The Roma population living in segregated settlements in eastern Slovakia has a higher prevalence of metabolic syndrome, kidney disease, viral hepatitis B and E, and some parasitic diseases compared to the majority population. Int J Environ Res Public Health. 17(9):3112 (https://doi.org/10.3390/ijerph17093112).

Ministry of Health (2020). Poistencom sa vráti za doplatky za lieky viac ako 6 miliónov eur [Insured people will be reimbursed more than €6 million for co-payments for medicines] [press release]. Bratislava: Ministry of Health; (https://health.gov.sk/Clanok?lieky-doplatky-vratenie-poistovne) (in Slovak).

Ministry of Health (2025a). Zoznam kategorizovaných liekov 1.5.2025 – 31.5.2025 [List of categorized medicines 1 May 2025 – 31 May 2025] [website]. Ministry of Health (https://www.health.gov.sk/Clanok?lieky202505) (in Slovak).

Ministry of Health (2025b). Zoznam kategorizovaných špeciálnych zdravotníckych materiálov 1. 4. 2025 – 30. 6. 2025 [List of categorized special medical products 1 April 2025 – 30 June 2025] [website]. Ministry of Health (https://www.health.gov.sk/Clanok?zkszm-202504) (in Slovak).

OECD (2025). OECD health statistics [online database]. Paris: Organisation for Economic Co-operation and Development (https://www.oecd.org/health/health-data.htm).

OECD, Eurostat, WHO (2017). A system of health accounts 2011: revised edition. Paris: OECD Publishing (https://doi.org/10.1787/9789264270985-en).

Saksena P, Hsu J, Evans DB (2014). Financial risk protection and universal health coverage: evidence and measurement challenges. PLoS Med. 11(9):e1001701 (https://doi.org/10.1371/journal.pmed.1001701).

Statistical Office of the Slovak Republic (2023). Stock of population in the Slovak Republic on 31 December 2022. Bratislava: Statistical Office of the Slovak Republic.

Statistical Office of the Slovak Republic (2024a). EU-SILC 2023 – Indikátory chudoby a sociálneho vylúčenia [EU-SILC 2023 – poverty and social exclusion indicators]. Bratislava: Statistical Office of the Slovak Republic (in Slovak).

Statistical Office of the Slovak Republic (2024b). Population and housing census 2021. In: Demography and social statistics. Bratislava: Statistical Office of the Slovak Republic.

Statistical Office of the Slovak Republic (2025). Chudoba a jej dimenzie na Slovensku v roku 2024 [Poverty and its dimensions in Slovakia in 2024]. Bratislava: Statistical Office of the Slovak Republic (in Slovak).

Tulejová H, Šebová D (2023). Koľko platia pacienti v bezplatnom zdravotníctve a aké riešenia dofinancovania preferujú? [How much do patients pay in free health care and what financing solutions do they prefer?]. Prague: Advance Institute (https://www.advanceinstitute.cz/uploads/1731518268_Kolko%20platia%20pacienti%20a%20ake%20riesenia%20dofinancovania%20preferuju.pdf) (in Slovak).

UHC watch (2025). UHC watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch/).

Wagstaff A, van Doorslaer E (2003). Catastrophe and impoverishment in paying in health care: with applications to Vietnam 1993–1998. Health Econ. 2(11):921–934 (https://doi.org/10.1002/hec.776).

WHO (2010). The world health report. Health systems financing: the path to universal health coverage. Geneva: World Health Organization (http://www.who.int/whr/2010/en/).

WHO (2025). Global Health Expenditure Database [online database]. Geneva: World Health Organization (http://apps.who.int/nha/database/Select/Indicators/en).

WHO Regional Office for Europe (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/311654). Licence: CC BY-NC-SA 3.0 IGO.

WHO Regional Office for Europe (2023). Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/374504). Licence: CC BY-NC-SA 3.0 IGO.

Xu K, Evans D, Kawabata K, Zeramdini R, Klavus J, Murray C (2003). Household catastrophic health expenditure: a multicountry analysis. Lancet. 362(9378):111–117 (https://doi.org/10.1016/S0140-6736(03)13861-5).

Xu K, Evans D, Carrin G, Aguilar-Rivera A, Musgrove P, Evans T (2007). Protecting households from catastrophic health spending. Health Aff. 26(4):972–983 (https://doi.org/10.1377/hlthaff.26.4.972).

Yerramilli P, Fernández Ó, Thomson S (2018). Financial protection in Europe: a systematic review of the literature and mapping of data availability. Health Policy. 122(5):493–508 (https://doi.org/10.1016/j.healthpol.2018.02.006).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands (Kingdom of the)
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Türkiye
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

9789289062329
9 789289 062329