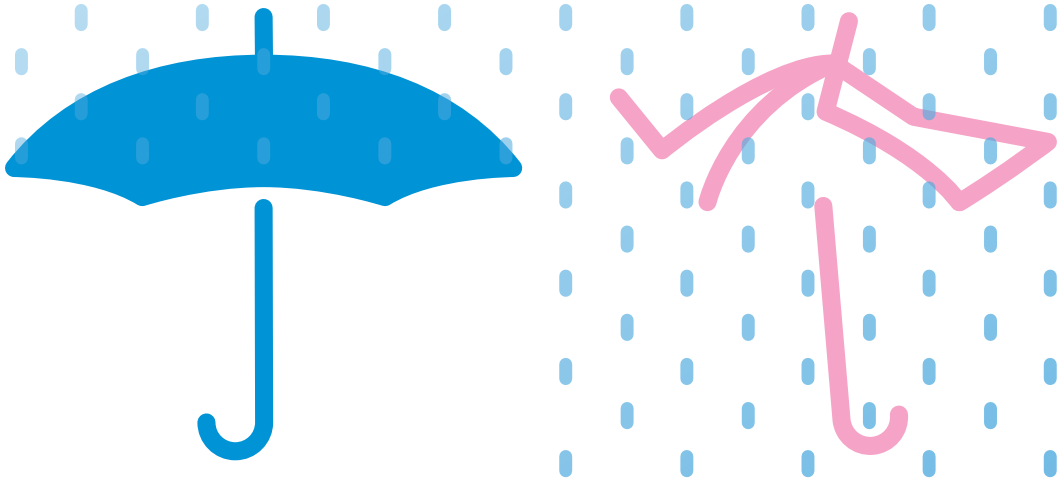
World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Slovenia

Eva Šarec
Dušan Jošar



Slovenia

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.

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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 Slovenia than in most countries in Europe, but levels of unmet need are above the European Union average. Slovenia's low incidence of catastrophic health spending reflects a relatively comprehensive publicly financed benefits package and (before 2024) extensive protection from heavy user charges (co-payments) through carefully regulated complementary voluntary health insurance (VHI). A major reform introduced in 2024 abolished most co-payments – an example of good practice to other countries in Europe and beyond – and replaced premiums for complementary VHI covering Health Insurance Institute of Slovenia co-payments with a new mandatory flat-rate contribution per person. The reform led to a large reduction in user charges, removed the need for complementary VHI covering co-payments and lowered health system complexity and administrative and transaction costs – these are important gains. Several issues continue to require policy attention, however, including: a very heavy reliance on employment to finance the health system, which is a challenge in the context of population ageing; long waiting times; a lack of protection from remaining user charges; gaps in service coverage for medical products (corrective lenses and hearing aids) and dental care for adults; the regressivity of the new mandatory flat-rate contribution; and a small but significant gap in population coverage.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
POVERTY
SLOVENIA
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 policy-makers 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 UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – 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 services (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

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Abbreviations

COICOP	Classification of Individual Consumption According to Purpose
EHIS	European Health Interview Survey
EU	European Union
EU14	European Union Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom
EU27	European Union Member States as of 1 February 2020
EU-SILC	European Union Survey on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
HIIS	Health Insurance Institute of Slovenia
OECD	Organisation for Economic Co-operation and Development
OTC	over-the-counter
OZP	*obvezni zdravstveni prispevek* [compulsory health contribution]
SHI	social health insurance
VHI	voluntary health insurance

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
NET	Netherlands (Kingdom of the)
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 Slovenia experience financial hardship when they use health care. It covers the period from 2012 to 2025 using data from household budget surveys carried out in 2012, 2015, 2018 and 2022 (the latest available year), 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 Slovenia than in most European Union (EU) countries. In 2022 (the latest available year of data) 1.5% of households experienced catastrophic health spending (around 13 000 households in total).

- Catastrophic health spending is concentrated in households with low incomes and mainly driven by dental care, outpatient medicines and outpatient care.

- Levels of unmet need are above the EU average. Unmet need for health care and dental care is mainly driven by waiting times, but cost is also a key driver for dental care.

Before a health financing reform in 2024, which abolished many user charges (co-payments), the low incidence of catastrophic health spending in Slovenia reflected a relatively comprehensive publicly financed benefits package and extensive protection from heavy percentage co-payments through carefully regulated complementary voluntary health insurance (VHI) covering user charges. This type of VHI typically covered 95% of people liable for user charges.

But gaps in coverage persisted, particularly for households with low incomes. This is likely to have reflected a lack of protection from the user charges that were not covered by complementary VHI, a lack of full Health Insurance Institute of Slovenia (HIIS) coverage for around 1% of the population (at the end of 2023) eligible to be covered (mainly self-employed people) and lack of coverage for undocumented migrants.

In January 2024 the Government of Slovenia abolished most co-payments – an example of good practice to other countries in Europe and beyond – and replaced premiums for complementary VHI covering most HIIS co-payments with a new mandatory flat-rate monthly contribution, known as *obvezni zdravstveni prispevek* (OZP) [compulsory health

contribution], of €37 a month per person in 2025. The OZP is paid by about three quarters of the population.

The 2024 reform introduced policy changes that are likely to be beneficial for financial protection: the abolition of all percentage co-payments has reduced user charges and removed the need for complementary VHI covering HIIS co-payments, which has in turn lowered complexity and administrative and transaction costs in the health system. These are important gains.

Several issues continue to require policy attention, however.

- The heavy reliance on mandatory contributions levied on the labour market to finance the health system is a challenge in the context of population ageing: as the working-aged share of the population falls, recent analysis finds that Slovenia is likely to experience a significant decline in public revenue for health, increasing fiscal pressure in the health system. Unless Slovenia takes steps to broaden its public revenue base for health, there is a strong risk that budgetary pressure could push up waiting times and erode coverage.

- Long waiting times lead to higher take up of supplementary VHI offering faster access to treatment, mainly among people with higher incomes, which is likely to increase inequalities in access to health care.

- There is a lack of protection from extra charges for some dental treatment and from "avoidable co-payments" caused by reference pricing for outpatient prescribed medicines and medical products (which means that people pay the difference between the retail and the reference price; 13% of the prescribed medicines dispensed in 2023 incurred these "avoidable co-payments").

- There are remaining gaps in the benefits package for dental care for adults (which is currently being expanded) and limited access to covered vision and hearing aids due to lack of public awareness.

- Although some groups of people are exempt from paying the OZP, it remains a regressive financing mechanism, placing a much heavier financial burden on households with lower incomes.

- Entitlement to the full range of HIIS benefits is linked not only to payment of regular social health insurance contributions but also to payment of the new flat-rate contribution (OZP), which may result in a small but significant gap in population coverage. There is also a gap in population coverage for undocumented migrants.

Building on recent efforts, the Government can consider the following options to continue to improve financial protection, particularly for people with low incomes, and to prevent financial hardship and unmet need from increasing in the future:

- Broaden the public revenue base for the health system to reduce reliance on employment, so that public revenue for health does not shrink as the population ages.
- Continue to address long waiting times.
- Protect people with low incomes from any remaining user charges for covered health care.
- Avoid introducing or increasing user charges in the future.
- Improve the affordability of outpatient medicines, as well as dental care for adults, corrective lenses and hearing aids.
- Address the regressivity of the new flat-rate contribution, so that it no longer imposes a much heavier financial burden on people with lower incomes.
- Find ways to ensure the HIIS covers the whole population.

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

1. Introduction

This review assesses the extent to which people in Slovenia face financial barriers that prevent them from accessing health care, or experience financial hardship when they use health care. It covers the period from 2012 to 2025 using data from household budget surveys carried out in 2012, 2015, 2018 and 2022 (the latest available year), data on unmet need for health care up to 2024 (the latest available year) and information on health coverage policy (population coverage, service coverage and user charges) up to May 2025.

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, 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.

Slovenia's mandatory social health insurance (SHI) scheme was established in 1992. It operates through a single national health insurance fund, the Health Insurance Institute of Slovenia (HIIS), which is financed predominantly through payroll taxes and covers over 99% of the population (HIIS, 2025a).

Between 1993 and 2023 complementary voluntary health insurance (VHI) also played a key role in the health system, covering user charges (co-payments) for around 70% of the total population and about 95% of those who were liable to pay user charges (Ministry of Health, 2024).

In January 2024 the Government of Slovenia abolished most user charges and replaced premiums for complementary VHI covering most HIIS co-payments with a new mandatory flat-rate contribution to the HIIS (alongside the regular SHI contributions), signalling a major break from the past. Some co-payments remain: reference pricing for outpatient prescribed medicines and medical products (which means users must pay the difference between the retail and the reference price) and extra charges for non-standard material for selected dental treatment.

Slovenia's unusually high level of complementary VHI coverage reflected the widespread application of heavy co-payments (including percentage co-payments for inpatient care) and decades of stringent regulation to make this type of VHI accessible (Sagan & Thomson, 2016; Thomas, Thomson & Evetovits, 2016; Albreht et al., 2021; WHO Regional Office for Europe, 2023).

As a result of high take-up of complementary VHI, VHI accounted for 12% of current spending on health in 2023 (the latest available year of internationally comparable data for Slovenia) – higher than in any other country in Europe (WHO, 2025). This in turn has kept the out-of-pocket payment share of spending on health relatively low: in 2023 out-of-pocket payments accounted for 13% of current spending on health (WHO, 2025).

Public spending on health as a share of GDP (7.1% in Slovenia in 2023) is on par with the European Union (EU) average but lower than in other EU countries with comparable levels of GDP per person, such as Czechia

or Spain. The share of the government budget allocated to health in Slovenia was similar to the EU average but well below countries like Austria or Czechia.

This is the first comprehensive analysis of financial protection in Slovenia. Earlier research included Slovenia as part of multi-country studies that used different methods or different data sources from this study and only drew on data up to 2010 (Xu et al., 2003, 2007; Baird, 2016a, 2016b; Yerramilli, Fernández & Thomson, 2018).

The analysis of financial hardship in this study goes up to 2022, reflecting the latest available year of household budget survey data. It covers the years preceding the 2024 reform and provides a baseline for assessing the reform's impact.

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 on financial protection, 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 results of the financial protection analysis and identifies factors that strengthen and undermine financial 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 catastrophic and impoverishing spending on health

	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 Organisation for Economic Co-operation and Development (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

Note: see the Glossary provided by UHC watch (2025) for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from national household budget surveys. This study analyses anonymized microdata from the Slovenia household budget survey carried out by the Statistical Office of the Republic of Slovenia.

The household budget survey data samples consisted of 7000 households in 2012 and 7400 households a year in 2015, 2018 and 2022, with a response rate ranging from 55% in 2012 and 2015 to 33% in 2022.

Household budget surveys typically collect information on health spending in a structured way, dividing it into six broad categories: medicines, medical products, outpatient care, dental care, a category on diagnostic tests (which includes other paramedical care until 2018) and inpatient care. These categories are agreed at international level through the Classification of Individual Consumption According to Purpose (COICOP) and the European COICOP systems.

Data are collected and coded according to the European COICOP. Since 2022 the classification system has been updated to COICOP 2018 to ensure greater comparability and relevance. In the case of data on household spending on health, COICOP 2018 allows data to be collected in alignment with the International Classification of Health Accounts (United Nations Department of Economic and Social Affairs, 2023). This led to changes in health spending categories including:

- dental care: dentures moved from medical products to dental care and outpatient dental care was grouped under dental care;
- inpatient care: overnight dental care shifted to inpatient care;
- diagnostic tests: medical analyses and x-rays moved from inpatient care to diagnostic tests; and
- outpatient care: immunization, preventive care and general medical services provided in hospitals (without an overnight stay) moved from inpatient care to outpatient care; laboratory and imaging services for preventive care, when billed with health workers' time and skills, moved from diagnostic tests to outpatient care; some outpatient curative and rehabilitative care, like physical, psychological and speech therapy moved from paramedical services (diagnostic tests) to outpatient care.

Due to these changes in the Slovene survey, data for 2022 should be compared to earlier data with caution.

The HIIS and private insurers offering VHI generally do not reimburse people retrospectively for health spending, so the risk of overestimating household spending on health is negligible.

All currency units are presented in euros.

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 services 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, 2014), 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. 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. 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 (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.

Source: WHO Regional Office for Europe (2019, 2023).

3. Coverage policy

This section describes the three main dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by VHI. It aims to give a broad overview. See UHC watch (2025) for more detailed information on coverage policy, including information on policy changes since 1992.

The Health Care and Health Insurance Act (1992) (National Assembly of the Republic of Slovenia, 1992) defines and regulates health care coverage, managed by the HIIS.

A major reform to health financing policy took place in January 2024, when the Act on Amendments and Supplements to the 1992 Act (National Assembly of the Republic of Slovenia, 2023) abolished most user charges (co-payments) for health care and replaced premiums for complementary VHI covering most HIIS co-payments with a mandatory flat-rate contribution to the HIIS (alongside the regular SHI contributions). About three-quarters of the population are now required to pay the new flat-rate contribution. The reform has implications for all dimensions of coverage policy in Slovenia.

3.1. Population coverage

Entitlement to the full range of publicly financed health care is based on legal residence and payment of mandatory contributions to the HIIS. Permanent residents and temporary residents with a working permit must register in one of 25 mandatory health insurance entitlement categories, which can be summarized in four main groups:

1. **economically active people covered through payment of mandatory contributions** (about 45% of the population in 2023): employees, employers and self-employed people pay contributions set as a share of gross earnings;

2. **people covered through state contributions** (about 30% of the population in 2023), including pensioners, registered unemployed people, people receiving social benefits and disability benefits, homeless people, children under 18 not covered as family members, refugees, asylum-seekers under 18, people undergoing mandatory psychiatric treatment or treatment related to substance abuse, war veterans, war victims, war invalids, military reserve members and prisoners;

3. **people covered as dependants** (about 25% of the population in 2023), including children and students under 26 and other non-active family members; and

4. **people covered through an annual flat-rate contribution** (less than 3% of the population in 2023), e.g. citizens who are permanent residents but not employed and do not meet any other entitlement criteria (€33 in 2024) and foreign students and foreigners who are permanent residents but not in regular employment and do not have coverage from their home country (€181 in 2024).

People in group 1 and 4 who are required to pay the mandatory contribution and do not do so are no longer entitled to all HIIS benefits, but their dependent children continue to be covered.

Adult asylum seekers are not eligible for HIIS coverage but can access most publicly financed health care, without having to pay out of pocket, once they have received approval from the Asylum Centre Commission. Eurostat data indicate that in 2023 there were 7260 asylum applicants in Slovenia (Eurostat, 2025c).

Undocumented migrants are not eligible for HIIS coverage. According to Eurostat, 61 245 third-country nationals were found to be illegally present in Slovenia in 2023 (Eurostat, 2025c).

People need a permanent or temporary residence permit and a work permit to access HIIS benefits. Some foreign residents, people with temporary protection status, Slovenians living abroad (including those in border zones) and Roma people may face difficulties in proving permanent residence status. Homeless people have been allowed to register as permanent residents in municipalities and Centres for Social Work since 2017.

At the end of 2023 around 0.8% of the population eligible for HIIS coverage (17 876 people) were not fully covered by the HIIS due to non-payment of mandatory contributions; 0.3% (5666 people) were in this position for more than a year (HIIS, 2024), comprising mainly self-employed people, non-registered unemployed people and other groups subject to the annual flat-rate contribution. Around 0.1% of the population (2798 people) were not fully covered by the HIIS for more than 2 months for other reasons, mainly people with an unclear administrative status, such as people waiting to be recognized as pensioners or as unemployed (HIIS, 2024).

Everyone in Slovenia, regardless of residence status or payment of contributions, is entitled to publicly financed emergency care and a few other services (e.g. selected outpatient medicines, selected dental care, pregnancy and childbirth care, contraception and termination of pregnancy) but they must pay for all other care out of pocket. People who are eligible for HIIS coverage but have not paid the required contributions can request retrospective reimbursement of out-of-pocket payments incurred for HIIS benefits care once they have settled their debt to the HIIS. Nongovernmental organizations provide health care for non-covered people in the larger cities.

In January 2024 the Government abolished most co-payments and replaced premiums for complementary VHI covering most HIIS co-payments with a flat-rate monthly contribution, known as *obvezni zdravstveni prispevek* (OZP) [compulsory health contribution], which is paid in addition to the regular HIIS contribution. The OZP is set at €37 per person a month in 2025 (up from €35 in 2024). There are discussions about whether to make the OZP less regressive by linking it to income but, as of early June 2025, no decision has been taken in this regard.

The new contribution is mandatory for most residents, including the following groups of people who do not have to pay the regular HIIS

contribution: pensioners, registered unemployed people who are not liable for social benefits, adult dependants of covered people (e.g. spouses and parents), asylum seekers and homeless people. However, around one-quarter of the population is exempt from paying the OZP – mainly children and students under 26, people with disabilities, people receiving social benefits, refugees, people undergoing mandatory psychiatric treatment or treatment related to substance abuse, war veterans, military reserve members and prisoners.

When the OZP was introduced, outstanding HIIS debts were forgiven for adult dependants of covered people who had accumulated debts in the past (e.g. during periods when they were registered as self-employed). The 2024 reform also introduced a contribution debt threshold. As a result, people who are required to pay the OZP or regular HIIS contributions but do not do so only lose their entitlement to the full range of HIIS benefits if they exceed the debt threshold of €177 (equal to 8% of the average gross monthly salary in the previous year).

The first wave of available data show a reduction in the number of people who lacked some HIIS coverage due to non-payment of contributions in 2024 compared to 2023: at the end of 2024 around 0.5% of the population eligible for HIIS coverage was not fully covered by the HIIS due to non-payment of mandatory contributions (10 381 people, down from 17 876 at the end of 2023). This is likely to reflect measures such as the debt forgiveness granted to adult dependants and the introduction of the debt threshold.

3.2. Service coverage

The Health Care and Health Insurance Act (1992) broadly defines the publicly financed benefits package, which does not vary across the country. See UHC watch (2025) for further information on the procedures used to define the benefits package.

The HIIS provides a relatively comprehensive benefits package, including dental care, orthodontic treatment (for children), physiotherapy and long-term care.

Coverage of medicines and medical products is regulated by the Minister of Health through the Medicinal Products Act (1999), (National Assembly of the Republic of Slovenia, 1999a) which is further specified through a positive list and a negative list. Over-the-counter (OTC) products are generally not covered.

Coverage of most medical products is relatively comprehensive, including hearing aids, mobility aids and corrective lenses. However, access to such covered medical products may be hindered due to limited public awareness of entitlements, unclear administrative procedures and misleading advertising by providers (Zveza potrošnikov Slovenije, 2025).

Dental treatment for adults mainly covers standard materials. However, materials for treatments such as fillings and protheses are gradually being upgraded as part of recent regulations to be implemented between 2024 and 2026, in accordance with EU standards. Limited public awareness of entitlements and misleading advertising by providers may also hinder access to covered dental care (Zveza potrošnikov Slovenije, 2025). Starting in 2025, dental care providers must clearly present to people the advantages and additional costs of upgraded versus standard materials and obtain written consent before using the upgraded materials.

Publicly financed health care is provided by a mix of public and private contracted providers. People must register with a general practitioner (GP) to access non-emergency health care. Without a GP it is only possible to access primary care (including primary services for gynaecology, mental health and dental care) in dedicated offices for people with no registered GP. Despite the introduction of several regulations (summarized in Table 2), about 7% of covered people were not registered with a GP at the end of 2024[1] – a quarter of whom were migrant workers (Ministry of Health, 2023).

Waiting times are an issue for outpatient specialist care (including dental care), inpatient care (mainly elective surgery) and some diagnostic tests, and are the main reason people give for unmet need for health care and dental care (Eurostat, 2025a). The Government has introduced many initiatives to address long waiting times (summarized in Table 2) but the number of people on waiting lists has continued to grow (Fig. 1), reflecting a shortage of doctors in some specialities (anaesthesiology, rheumatology, emergency care, family medicine and paediatrics), the substantial disruption caused by the coronavirus disease pandemic and budgetary pressures (Albreht et al., 2021; Kuhar et al., 2023). However, data for 2024 show a slowdown in the growth rate of the total number of people on waiting lists in the second half of the year (a growth rate of 1.5% in the second semester of 2024, down from 9.8% in the first semester) (Institute of Macroeconomic Analysis and Development, 2025).

Significant variation in the geographical distribution of doctors and health facilities is also an issue (Albreht et al., 2021; OECD, European Observatory on Health Systems and Policies, 2023).

1. HIIS, personal communication, 2025.

Table 2. Policy changes affecting service coverage

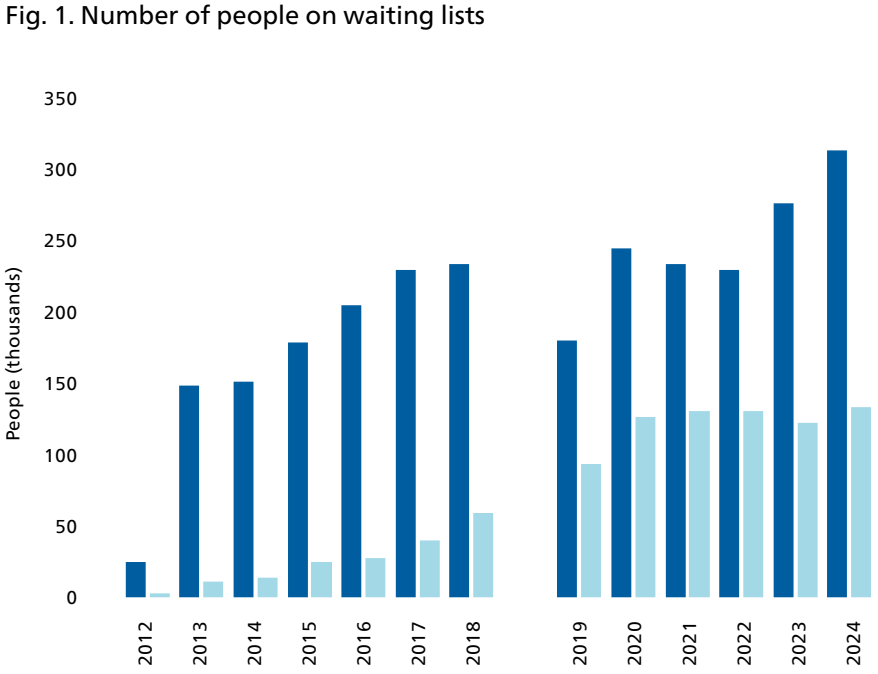
Year	Policy change
2008	The Patients' Rights Act (National Assembly of the Republic of Slovenia, 2008) is introduced to improve access to health care by enhancing and monitoring patient rights and redefining the referral system
2010	Acceptable waiting times are introduced based on three levels of urgency, and exceptions to their application
2014	People are entitled to seek covered health care in other EU countries if acceptable waiting times are exceeded (in accordance with EU regulations)
2017	Earmarked funds from the state budget (around €8 million) are made available to reduce waiting times for surgeries and other treatments
2017	Maximum waiting times are redefined according to the urgency of the care required care (as amendments to the Patients' Rights Act)
2017	An online patient portal (zVem) is launched to facilitate appointment management and electronic referrals
2018	An eHealth information system (*eNaročanje* [eAppointment]) is introduced to monitor waiting times and waiting lists
2018	Additional funding (€35 million) is allocated to reduce waiting times and improve access to health care (mainly in orthopaedics, cardiology, traumatology, dermatology and urology)
2019	New regulations are introduced to manage waiting lists and referrals, maximum waiting times and the working hours of health care providers and to facilitate patient access to information on health care provision
2019	A pilot project is introduced to reduce waiting times by improving and enhancing the contracting of providers (with extra funds of around €14 million)
2020	Additional funding (around €10 million) is allocated from the state budget to reduce long waiting times
2021	Salary incentives are introduced to attract primary care doctors
2022	Salary supplements per patient treated are introduced for all members of primary care teams
2022	The cap on the annual volume of health care paid to providers is removed, ensuring payment to providers for all services rendered
2023	Dedicated GP offices are opened for people with no registered GP (with extra funds of around €10 million)
2023	The cap on the annual volume of health care paid to providers is reintroduced for most health care, as the abolition of the cap did not show any impact on waiting times
2023	Additional incentives are introduced to boost the number of primary care doctors, including a monthly allowance of €1000 for trainees
2024	Fifteen new GP offices, with health care provided by doctors in the final year of their specialization in family medicine, are opened enabling an additional 16 000 people to access family doctors
2024	Additional health services are financed without the cap on the annual volume of health care paid to providers
2024	Additional funding is allocated to improve access to dental care: €4.3 million to reduce waiting times for dental care and €2.5 million to finance additional dental care teams
2024	New incentives are introduced to improve access to first outpatient specialist visits (30% of additional funding), as are new clinical standards to strengthen collaboration between specialist and primary care
2024	Salary supplements per patient treated for all members of primary care teams are extended (first introduced in 2022)
2024	Incentives for doctors to specialize in primary care (a monthly allowance of €1000) are extended until 2030 (first introduced in 2023)
2024	Additional dedicated GP offices are opened for people with no registered GP (the first were opened in 2023)

Source: authors and UHC watch (2025).

Table 2. Contd

Year	Policy change
2024	The prices paid by the HIIS to providers for computed tomography and magnetic resonance imaging scans are reduced. Only private providers are now subject to the budget cap on the annual volume of tests
2025	A new funding model for primary care is introduced, including measures to facilitate access to GPs, reward teams based on workload and reduce administrative barriers to access
2025	Additional funding (around €3 million) is allocated from the HIIS budget for additional dentist teams.

Fig. 1. Number of people on waiting lists



Notes: data are monitored for about 400 types of care. Break in series in 2018 due to changes in the data collection method.

Source: Kuhar et al. (2023) and National Institute of Public Health, data provided to the authors on request, 2025.

3.3 User charges (co-payments)

In January 2024 most co-payments were abolished. User charges (Table 3) are now applied in two ways, namely through:

- reference pricing for outpatient medicines and medical products, which means that users pay the difference between the retail and the reference price – 13% of the prescribed medicines dispensed in 2023 incurred these "avoidable co-payments" and the amount paid out of pocket per prescription was often < €3 (59% of cases) and nearly always < €10 (97%);[2] and

2. HIIS, data provided to the authors on request, 2025.

- all contracted dental care providers can charge people extra for non-standard materials for selected dental treatment (e.g. protheses and fillings), although some treatments and some groups of people are exempt from these charges (Table 3).

Coverage of non-standard materials is being gradually expanded by the HIIS, in alignment with an EU ban on dental amalgam from 2025, and additional treatment is expected to be provided without co-payment in the near future (e.g. dental prosthetics with contemporary standard materials by July 2025 and white composite fillings for adults in visible teeth by 2026).

Before 2024 heavy user charges in the form of percentage co-payments were applied to most HIIS benefits, including inpatient care (Table 4). Percentage co-payments ranged from 5% to 90%, depending on the type of care, and had progressively increased since their introduction in 1992, reaching the maximum allowed by the Health Care and Health Insurance Act (National Assembly of the Republic of Slovenia, 1992) by 2013.

Many groups of people (around 25% of the population) were exempt from this percentage co-payments (Table 4). Complementary VHI covering HIIS co-payments also played a major role (see section 3.4). As a result, only about 5% of the population was exposed to most co-payments in 2023 – mainly people with low incomes (but above the income threshold for social benefits), foreign workers without permanent residence status and young people having to arrange complementary VHI cover for the first time.

Administrative barriers prevented some people from benefiting from protection mechanisms. Exemptions from co-payments were not always applied automatically and, although people receiving social benefits were entitled to state-financed complementary VHI covering co-payments (between 2008 and 2012), they had to apply for complementary VHI coverage and, as a result, many remained unprotected. This mechanism was replaced in 2012 by an automatic exemption from all co-payments for people eligible for social benefits (Zver, 2021). By 2023 around 74 000 social beneficiaries (3.5% of the Slovene population) were exempt from co-payments (Government of Slovenia, 2022).

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

Source: authors and UHC watch (2025).

Type of health care	User charges apply	Type of user charge	Reduced user charges	Exemptions from user charges	Cap on user charges
Outpatient prescribed medicines	Yes	**Reference pricing:** users pay the difference between the retail and the reference price	No	No	No
Medical products	Yes	**Reference pricing:** users pay the difference between the retail and the reference price	No	No	No
Dental care treatment	Yes	**Extra billing** for selected treatment (e.g. protheses, fillings): users pay for non-standard material	No	Selected groups of people for specific treatments, e.g. upgraded materials for fillings for: • people < 26 and during pregnancy and breastfeeding for all teeth • adults for visible teeth only	No

Table 4. User charges (co-payments) for publicly financed health care, 2023 (before the 2024 health reform)

Note: NA: not applicable.

Source: authors and UHC watch (2025).

Type of health care	User charges apply	Type of user charge	Reduced user charges	Care exempt from percentage co-payments	People exempt from percentage co-payments	Cap on user charges
Outpatient primary care visits	Yes	**Percentage co-payment:** 20% of the visit price	No	• long-term nursing care: home visits and care in nursing homes and other social care institutions • preventive services: mandatory vaccination and other preventive treatments • work-related illness and injuries • reproductive care: contraception, infertility treatment and maternal, pregnancy and childbirth care • organ and tissue donation and transplants • health care for selected conditions: communicable diseases, diabetes, epilepsy, haemophilia, psoriasis, multiple sclerosis muscular or muscular nerve diseases, paraplegia, quadriplegia, cerebral palsy, cancer and other malignant diseases, neurological diseases and mental health conditions	Age: • children < 18 • students < 26 Income: social beneficiaries Health status: • people with severe disabilities • people being treated for addiction • people undergoing mandatory psychiatric treatment Other: • refugees • professional foster carers Together these groups of people amounted to about 25% of the population	No
Outpatient specialist visits	Yes	**Percentage co-payment:** 20% of the visit price (10 –30% for physiotherapy visits; 30% care related to injuries)	No			
Outpatient prescribed medicines	Yes	**Percentage co-payments:** • 30% for selected medicines on the positive list • 90% for medicines on the intermediate list **Reference pricing:** users pay the difference between the retail and the reference price (12% of all prescribed medicines in 2023)	No	Medicines for: • selected conditions (as above) • work-related illness and injuries • reproductive and preventive care		
Medical products	Yes	**Percentage co-payment:** 4% to 90% depending on the product Reference pricing: users pay the difference between the retail and the reference price	No	Medical products for: • selected conditions (as above) • blind, visually impaired and deaf-blind people • work-related illness and injuries • reproductive and preventive care		
Diagnostic tests	Yes	**Percentage co-payment:** 10% or 30% depending on the diagnostic test	No	Diagnostic tests for: • selected conditions (as above) • work-related illness and injuries • reproductive and preventive care • organ and tissue donation and transplants		

Table 4. Contd

Type of health care	User charges apply	Type of user charge	Reduced user charges	Care exempt from percentage co-payments	People exempt from percentage co-payments	Cap on user charges
Dental care visits	Yes	**Percentage co-payment:** 20% of the visit price	No	Dental care for work-related illness and injuries and emergency treatment, including tooth extraction Selected groups of people for specific treatments, e.g. upgraded materials for fillings for: • people < 15 and during pregnancy and breastfeeding for all teeth • adults for visible teeth only		
Dental care treatment	Yes	**Percentage co-payments for standard treatment:** • 90% for dental prostheses • 50–80% for dental and orthodontic treatment for adults • 20% for other covered treatment **Extra billing** for selected treatment (e.g. protheses, fillings): users pay for non-standard material	No			
Inpatient care	Yes	**Percentage co-payment:** 20%	No	Treatment for: • selected conditions (as above) • work-related illness and injuries (including care and rehabilitation) • reproductive care • organ and tissue donation and transplants		
Inpatient medicines	No	NA	NA	NA	NA	NA
Outpatient emergency care	No	NA	NA	NA	NA	NA

3.4 The role of VHI

Since the beginning of 2024 (after the abolition of most co-payments), VHI has played a minor role in the health system, offering people faster access to private providers for diagnostic services and other specialist care with long waiting times (supplementary VHI) or cover of extra charges for dental care and non-covered care in hospitals and health spas (complementary VHI). It also plays a very minor substitutive role, covering people who are not eligible for HIIS coverage (non-permanent residents without a work permit).

VHI is regulated by the Insurance Supervision Agency, sold by six private for-profit entities and typically purchased by people with higher incomes and employers on behalf of employees.

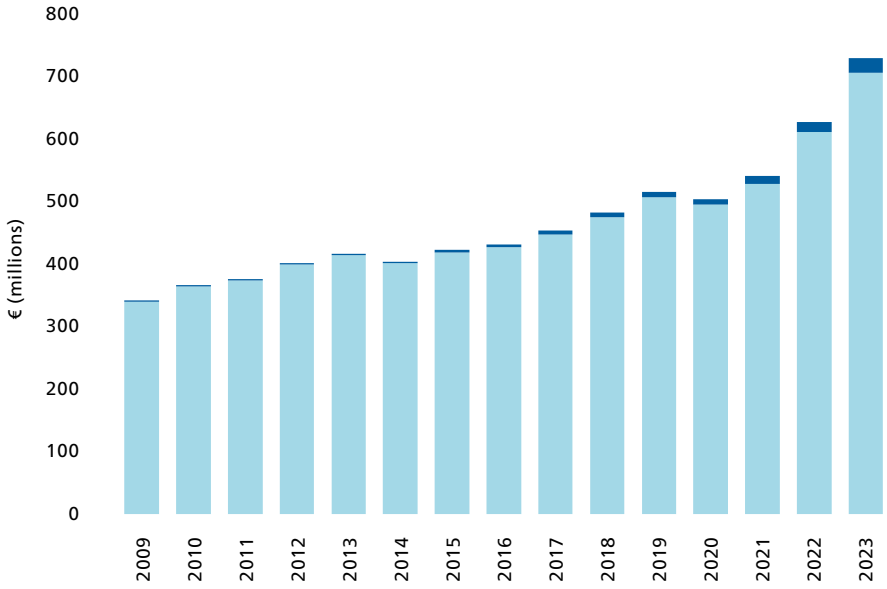
Although very small in terms of its contribution to spending on health, supplementary VHI has grown rapidly in the past 15 years. In 2023 it covered about a third of the population (36%), up from 5.6% in 2011, reflecting rising waiting times, the development of new policies by insurers and economic growth (Albreht et al., 2021).

The remainder of this section focuses on the role VHI played from 1993 to 2023.

Between 1993 and 2023, VHI played a much more significant complementary role, covering most co-payments for HIIS benefits for around 70% of the population – about 95% of those liable for co-payments (Albreht et al., 2021; Slovenian Insurance Association, 2024). Other types of VHI also played a small role, mainly providing faster access to health care, but over 97% of VHI premium income came from complementary VHI covering co-payments (Fig. 2). In 2023 (the latest available year of internationally comparable data for Slovenia), VHI accounted for 12% of current spending on health – higher than in any other country in Europe (WHO, 2025).

3. Ministry of Health of Slovenia, unpublished data, 2025

Fig. 2. VHI premium income by VHI role before the 2024 abolition of most co-payments



Notes: gross insurance premium income in nominal values.

Source: Slovenian Insurance Association (2024).

VHI covering co-payments was offered by three non-profit and for-profit entities: Vzajemna, (40% of the market in 2023; a mutual insurer formerly part of HIIS limited to complementary VHI by 1999), Triglav (25%) and Generali (18%).[3] It was regulated by the Insurance Supervision Agency.

The unusually high take-up of complementary VHI covering HIIS co-payments reflected two factors. First, people faced very heavy percentage co-payments for almost all health care, including for inpatient care (see Table 4). As a result, unless they were exempt from co-payments, it was in their interest to purchase VHI to cover the risk of having to pay 20% of the cost of inpatient care.

Second, the Government introduced multiple regulations to ensure that VHI would be accessible to and affordable for people liable to pay user charges. Consequently, VHI covering co-payments in Slovenia was subject to one of the most stringent regulatory frameworks in Europe (Box 2) (Sagan & Thomson, 2016).

Box 2. Regulation of complementary VHI covering HIIS co-payments

All insurers offering complementary VHI covering HIIS co-payments had to adhere to the following policies:

- open enrolment (from 2005): insurers could not reject applications;
- lifetime coverage (from 2005): insurers could not terminate contracts unless people stopped paying premiums;
- community rated premiums (from 2005): insurers had to offer the same premium to everyone irrespective of age, gender or health status; as a result, premiums did not vary by more than €1 a month between insurers;
- penalties for adults who did not enrol as soon as they became liable for co-payments (people aged over 18 and students aged over 26) (from 2005): premiums increased by 3% for each year of delayed enrolment, capped at a maximum increase of 80%; and
- a risk equalization scheme (introduced in 2006), managed by the Ministry of Health, to support community rating and prevent risk selection.

All insurers offering complementary VHI covering co-payments were prohibited from:

- selling policies that combined complementary and supplementary benefits (from 1999);
- using switching penalties: insurers could not terminate a contract unless the premium was not paid after multiple reminders (from 2005);
- forming ageing reserves (from 2005); and
- offering premium discounts of more than 3% of the premium (from 2006).

In addition, the Government:

- paid premiums on behalf of military staff, prisoners and war veterans and victims who applied for this benefit (from 1992);

Source: authors, Sagan & Thomson (2016), Albreht, Kuhar & Rupel (2022) and UHC watch (2025).

Box 2. Contd

- paid premiums on behalf of people receiving social assistance who applied for this benefit (from 2008–2012) – many eligible people did not apply, probably due to administrative barriers, so in 2012 the Government automatically exempted this group of people from all co-payments, removing the need for them to be covered by complementary VHI covering co-payments (Zver, 2021); and
- exempted insurers selling complementary VHI covering co-payments from insurance business tax (from 2000).

Despite the strong regulation in place, ensuring that all those who needed complementary VHI covering co-payments was a persistent challenge for the Government. About 5% of people liable for co-payments lacked VHI cover – mainly people with low incomes (but above the income threshold for social benefits), foreign workers without permanent residence status and young people having to arrange complementary VHI cover for the first time.

Affordability was an issue, particularly for people with low incomes. Set as a flat rate, rather than a share of income, complementary VHI premiums imposed a heavy financial burden on households with low incomes (Albreht, Kuhar & Rupel, 2022). They also rose over time, sometimes more than once a year. During the economic crisis in the early 2010s, the Government addressed budgetary pressures by shifting costs to complementary VHI, leading to an increase of 20% in the monthly premium between 2010 and 2012 (Slovenian Insurance Association, 2024). Monthly premiums rose by a further 20% between 2012 and 2023, from €29 to €35 (Slovenian Insurance Association, 2024).

Premium increases fuelled public debate about the regressive nature of complementary VHI and its associated inefficiencies: high administrative costs (€70 million annually), incentives for health care providers to offer services with higher co-payments to boost their revenue, a lack of transparency and the added complexity of monitoring and regulation. Over time public opposition grew but faced strong resistance from insurers.

In April 2023, when insurers announced a 30% increase in complementary VHI premiums, the Government used the Price Control Act (National Assembly of the Republic of Slovenia, 1999b) to freeze these premiums in the same way it had addressed rising energy prices. Later that year parliament passed legislation to abolish all percentage co-payments, leaving only a few co-payments in place (see Table 3). This effectively removed the need for people to buy complementary VHI covering co-payments.

Table 5 highlights the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 5. Gaps in coverage

Source: authors and UHC watch (2025).

	Main gaps in publicly financed coverage	Is VHI able to cover these gaps?
Population coverage (current situation)	Entitlement to HIIS benefits is based on legal residence and payment of mandatory contributions to the HIIS. Undocumented migrants are not eligible for HIIS coverage. At the end of 2024 about 0.6% of the eligible population was not fully entitled to HIIS benefits; 0.5% due to non-payment of contributions (mainly self-employed people) and 0.1% due to administrative barriers (e.g. people waiting to be recognized as pensioners or unemployed). Although everyone in Slovenia, regardless of residence status or payment of contributions, is entitled to publicly financed emergency care and a few other services (e.g. selected outpatient medicines, selected dental care, pregnancy and childbirth care, contraception and termination of pregnancy) they must pay for all other care out of pocket. People who are eligible for HIIS coverage but have not paid the required contributions can request retrospective reimbursement of out-of-pocket payments incurred for HIIS benefits care once they have settled their debt to the HIIS.	No. VHI does not generally fill gaps in population coverage.
Service coverage (current situation)	Although the HIIS benefits package is generally comprehensive, there are limitations in the coverage of dental care for adults (which is gradually being expanded) and medical products for visual impairment. Access to covered medical products (corrective lenses and hearing aids) may be hindered by limited public awareness of entitlements and misleading advertising by providers. Waiting times are an issue for outpatient specialist services (including dental care), inpatient care (mainly elective surgery) and some diagnostic tests. They are the main reason for self-reported unmet need for health and dental care and have grown over time.	Supplementary VHI offers faster access to health care for diagnostic tests and other specialist care with long waiting times but take up of this type of VHI is concentrated in people with higher incomes.
User charges (current situation)	Reference pricing is applied to outpatient prescribed medicines and medical products and there are no mechanisms to protect people from these “avoidable co-payments”. Providers can charge covered people extra for non-standard dental treatment for selected procedures (e.g. prostheses and fillings). A few treatments and groups of people are exempt from some of these charges.	VHI can cover extra charges in dental care but take up is limited and concentrated in people with higher incomes.
User charges (situation before 2024)	High percentage co-payments were applied to most health care, including 20% of the cost of inpatient care; several groups of people were exempt from most co-payments (based on age, income and other criteria) but there was no cap on co-payments.	Most (95%) of the population liable for user charges had complementary VHI covering HIIS co-payments; those who lacked this coverage were mainly people with low incomes (but above the income threshold for social benefits), foreign workers without permanent residence status and young people having to arrange complementary VHI cover for the first time.

3.5 Summary

In January 2024 most user charges (co-payments) were abolished and premiums for complementary VHI covering most HIIS co-payments were replaced with a mandatory flat-rate contribution (the OZP) to the HIIS. The OZP was set at €35 in 2024 and increased to €37 in 2025. The reform has implications for all dimensions of coverage policy in Slovenia.

Entitlement to HIIS benefits is based on legal residence and payment of mandatory contributions to the HIIS (including the OZP). Undocumented migrants are not eligible for HIIS coverage. At the end of 2024 less than 1% of the eligible population was not fully entitled to HIIS benefits: 0.5% due to non-payment of contributions (mainly self-employed people) and 0.1% due to administrative barriers (e.g. people waiting to be recognized as pensioners or unemployed).

Everyone in Slovenia, regardless of residence status or payment of contributions, is entitled to publicly financed emergency care and a few other services (e.g. selected outpatient medicines, selected dental care, pregnancy and childbirth care, contraception and termination of pregnancy) but they must pay for all other care out of pocket. People who are eligible for HIIS coverage but have not paid the required contributions can request retrospective reimbursement of out-of-pocket payments incurred for HIIS benefits care once they have settled their debt to the HIIS.

The HIIS provides a relatively comprehensive benefits package, including dental care, orthodontic treatment (for children), corrective lenses, physiotherapy and long-term care. However, there are gaps in dental care (currently being expanded). Access to covered medial products (corrective lenses and hearing aids) and dental care may be hindered by limited public awareness of entitlements and misleading advertising by providers.

Waiting times are an issue for outpatient specialist services, elective surgery and some diagnostic tests. They are the main reason for self-reported unmet need for health and dental care and have grown over time. As a result, supplementary VHI offering faster access to health care has also grown and covered about a third of the population in 2023 – mainly people with higher incomes, which exacerbates inequalities in access to health care.

User charges are applied to outpatient prescribed medicines and medical products (reference pricing) and to dental treatment (extra charges for non-standard material for prostheses and fillings). There are no mechanisms in place to protect people from the “avoidable co-payments” caused by reference pricing. Some treatments and some groups of people are exempt from the extra dental charges.

Before 2024 heavy user charges in the form of percentage co-payments were applied to most HIIS benefits, including inpatient care, with no cap. However, around 25% of the population were exempt from most co-payments (excluding reference pricing) and around 95% of those liable

to pay user charges were covered by complementary VHI covering most co-payments (not reference pricing).

Complementary VHI covering HIIS co-payments was heavily regulated by the Government to ensure it was accessible for most people. Those who were liable to pay user charges but did not have this type of VHI were mainly people with low incomes (but above the income threshold for social benefits), foreign workers without permanent residence status and young people having to arrange VHI cover for the first time.

4. Household spending on health

The first part of this section uses data from health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review household spending through 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) and VHI premiums. The fourth part considers the role of informal payments. Most of the data in this section cover the years preceding the 2024 reform and provide a baseline for assessing the reform's impact.

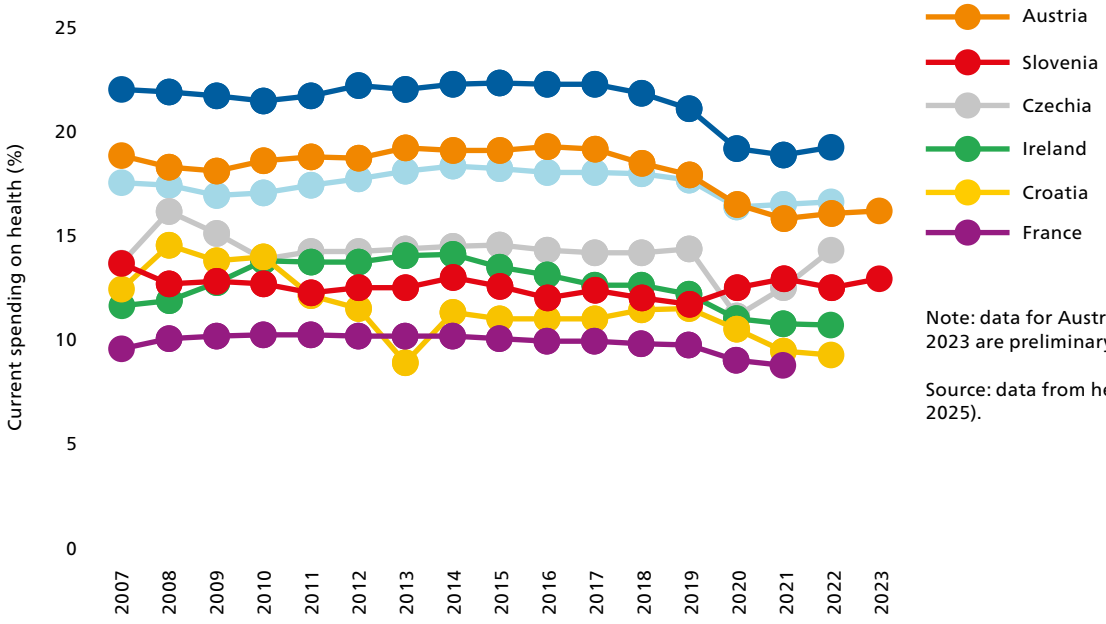
4. EU Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom.

5. European Union Member States as of 1 February 2020.

4.1 Public and private spending on health

Data from national health accounts indicate that Slovenia has a low level of out-of-pocket payments as a share of current spending on health. In 2023 of out-of-pocket payments accounted for 13% of current spending on health in Slovenia compared to an EU14[4] average of 17% and an EU27[5] average of 19% in 2022 (Fig. 3). It was higher than in several EU countries, however (e.g. Croatia, France, Germany, Ireland, Luxembourg, Netherlands (Kingdom of the) and Sweden) (WHO, 2025).

Fig. 3. Out-of-pocket payments as a share of current spending on health, Slovenia and selected EU countries

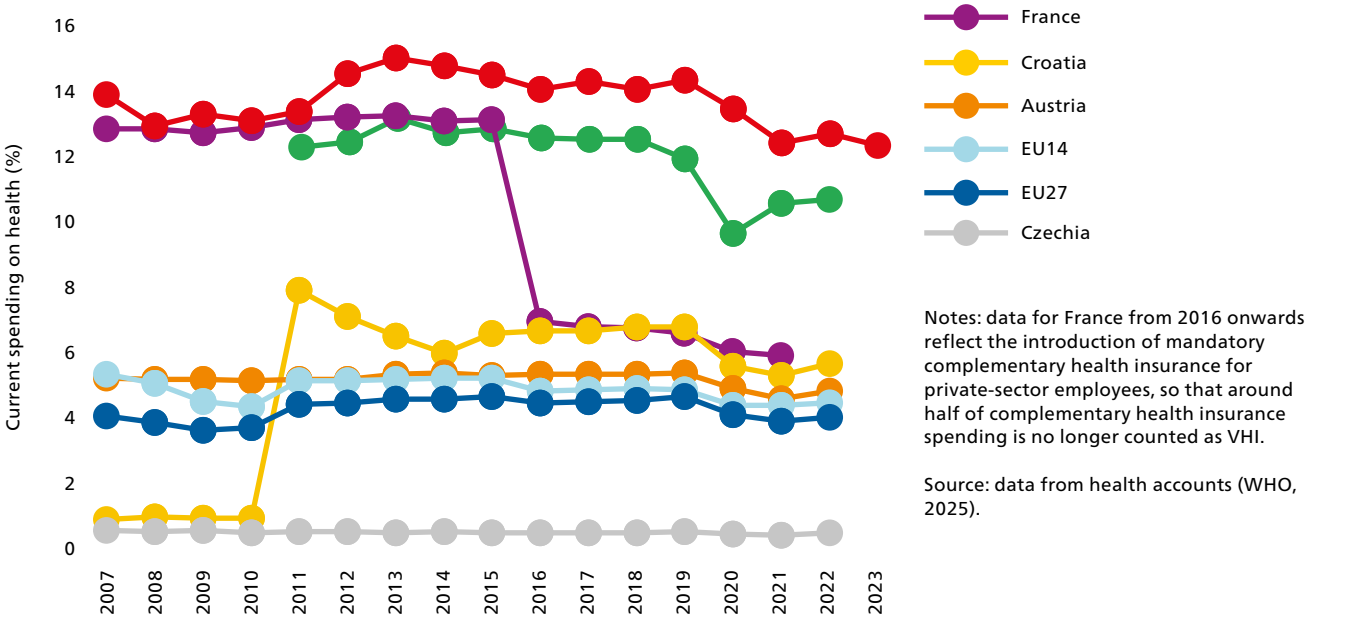


Note: data for Austria and Slovenia for 2023 are preliminary as of April 2025.

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

Slovenia's relatively low reliance on out-of-pocket payments reflects the major role played by complementary VHI covering co-payments before the 2024 reform (which abolished most co-payments; see section 3.4). In 2023 VHI accounted for 12% of current spending on health, the highest share in Europe (Fig. 4) (WHO, 2025). Following the 2024 reform, this share is expected to have fallen to less than 1% (Statistical Office of the Republic of Slovenia, 2025).

Fig. 4. VHI as a share of current spending on health, Slovenia and selected EU countries

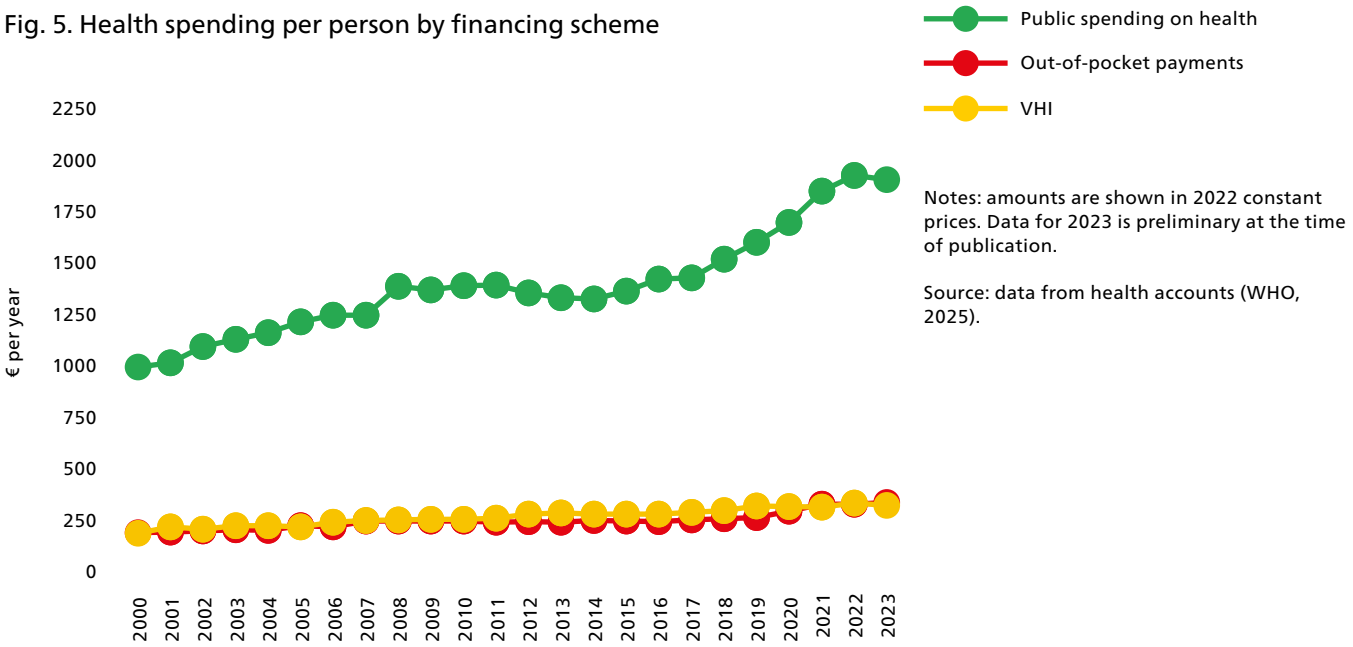


Notes: data for France from 2016 onwards reflect the introduction of mandatory complementary health insurance for private-sector employees, so that around half of complementary health insurance spending is no longer counted as VHI.

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

The out-of-pocket payment share of current spending on health fell between 2015 and 2019, as Slovenia recovered from the economic crisis of the early 2010s and there was a significant increase in public spending on health per person (see Fig. 3; Fig. 5). The out-of-pocket payment share grew again in 2020, 2021 and 2023, however, as out-of-pocket payments per person rose in 2020 and 2021 and public spending on health per person fell in 2023 (see Fig. 3; Fig. 5).

Fig. 5. Health spending per person by financing scheme



Notes: amounts are shown in 2022 constant prices. Data for 2023 is preliminary at the time of publication.

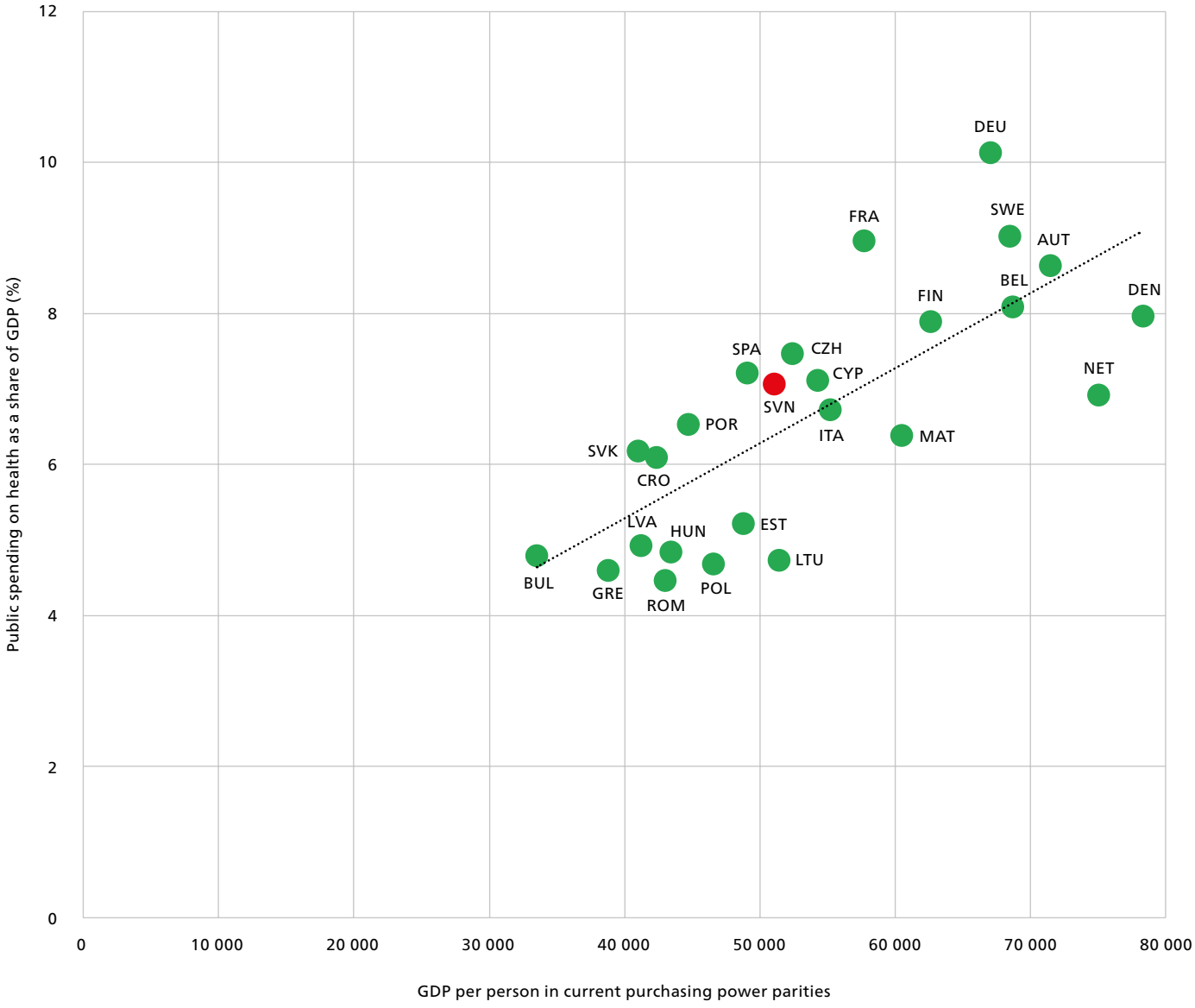
Source: data from health accounts (WHO, 2025).

Public spending on health as a share of GDP was 7.1% in 2022, below the EU14 average of 7.3% and lower than in other EU countries with comparable levels of GDP per person, such as Czechia (7.5%) and Spain (7.2%) (Fig. 6). Over the last decade this ratio has been relatively stable in Slovenia, varying by about 1%, in line with the EU27 average (data not shown).

Fig. 6. Public spending on health and GDP per person, Slovenia and the EU, 2022

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

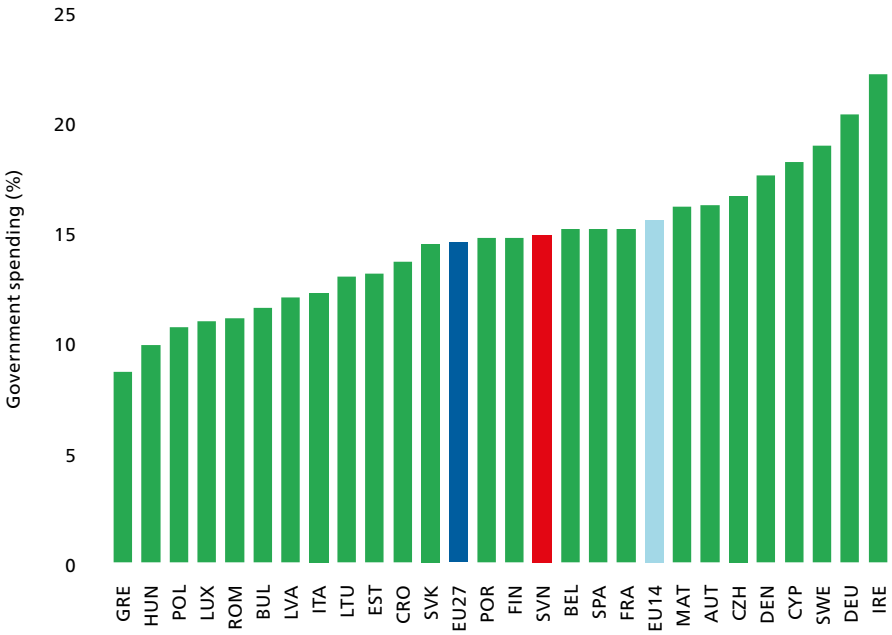
Source: data from health accounts (WHO, 2025).



In 2022 the share of the government budget allocated to health in Slovenia (14.9%) was similar to the EU27 average (14.6%) but below the EU14 average (16%) and countries such as Austria or Czechia (Fig. 7). This ratio has generally grown over time, in line with the EU27 average, except for a sharp drop to 10% in 2013 (data not shown) due to budget adjustments following the economic crisis.

Fig. 8 shows how Slovenia relied much more heavily than the EU14 average on VHI to finance every type of health care except medical products. Slovenia's heavy reliance on VHI was particularly striking for outpatient medicines (22% in Slovenia in 2022 versus an EU14 average of 1%). As a result, Slovenia relied much less than the EU14 average on out-of-pocket payments to finance dental care, diagnostic tests and inpatient care and slightly less to finance outpatient care and outpatient medicines. In 2022 out-of-pocket payments accounted for 62% of spending on medical products in Slovenia, well above the EU14 average of 55% (Fig. 8).

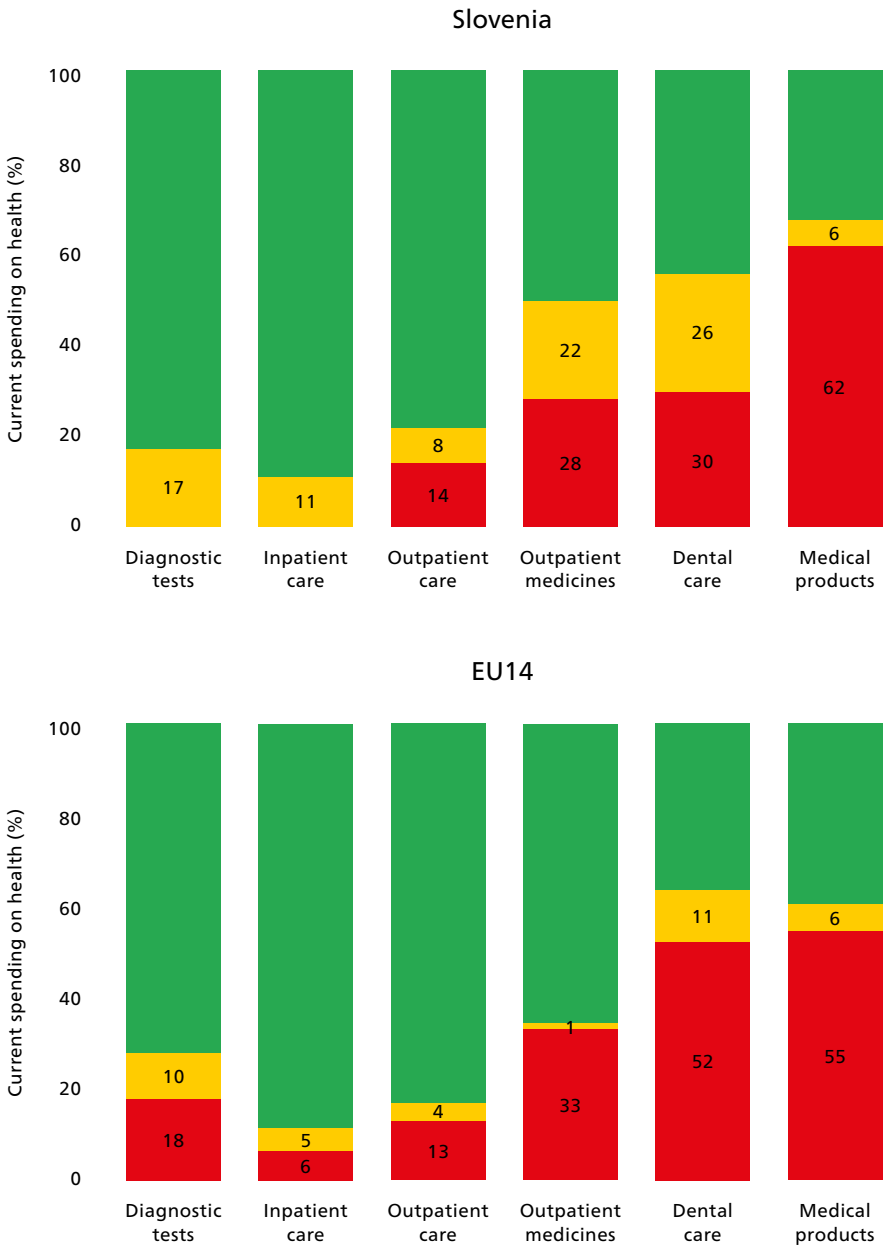
Fig. 7. Public spending on health as a share of the government budget, Slovenia and the EU, 2022



Notes: the figure excludes Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable.

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

Fig. 8. Breakdown of current spending on health by type of care and financing scheme, Slovenia and the EU14, 2022



Public spending on health
VHI
Out-of-pocket payments

Notes: types of care sorted from left to right by extent of financing through out-of-pocket payments in Slovenia. Outpatient care in the EU14 average excludes Ireland, Italy and Portugal as these countries do not report dental care separately from outpatient care.

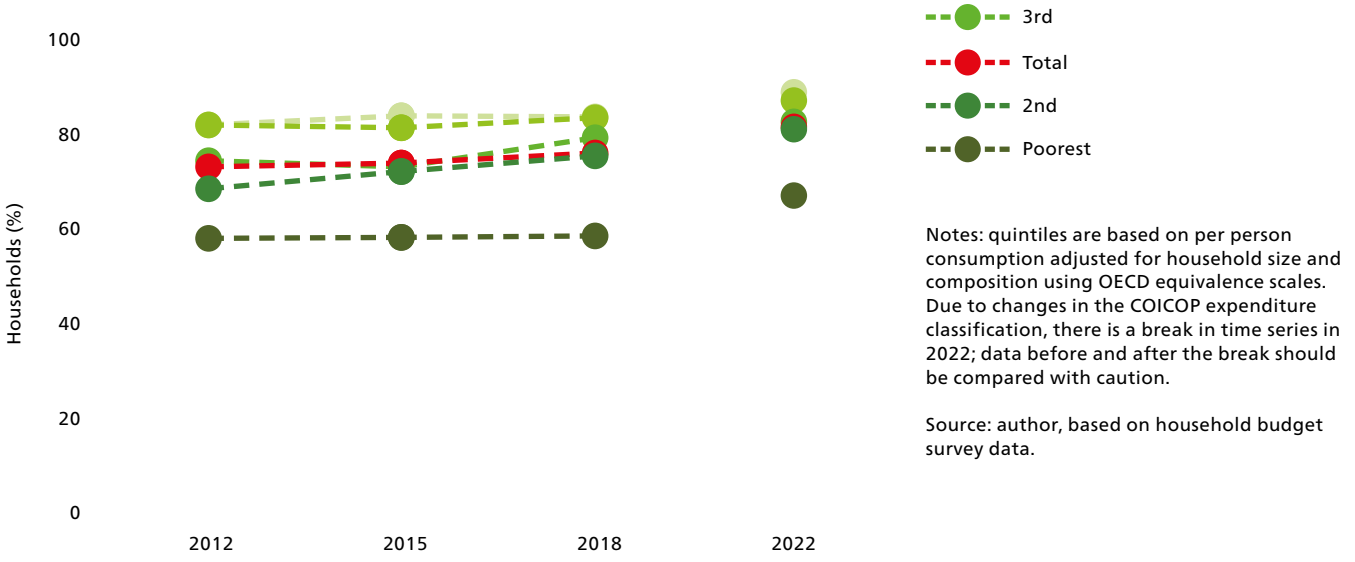
Source: data from health accounts (OECD, 2025).

Health accounts data indicate that around 80% of out-of-pocket payments for medical products in Slovenia in 2022 were spent on corrective lenses, while around 85% out-of-pocket payments for outpatient medicines were spent on OTC products (Statistical Office of the Republic of Slovenia, 2025). The high share spent on OTC products in Slovenia is largely due to the fact that complementary VHI covered most co-payments for most people liable for user charges (see section 3.4).

4.2 Out-of-pocket payments

Data from the Slovene household budget survey show that 85% households paid out of pocket for health care in 2022 on average, ranging from 73% of households in the poorest consumption quintile to 91% in the richest (Fig. 9). The share grew in all quintiles between 2012 and 2018 but with a sharper increase in the second and third quintiles.

Fig. 9. Share of households with out-of-pocket payments by consumption quintile

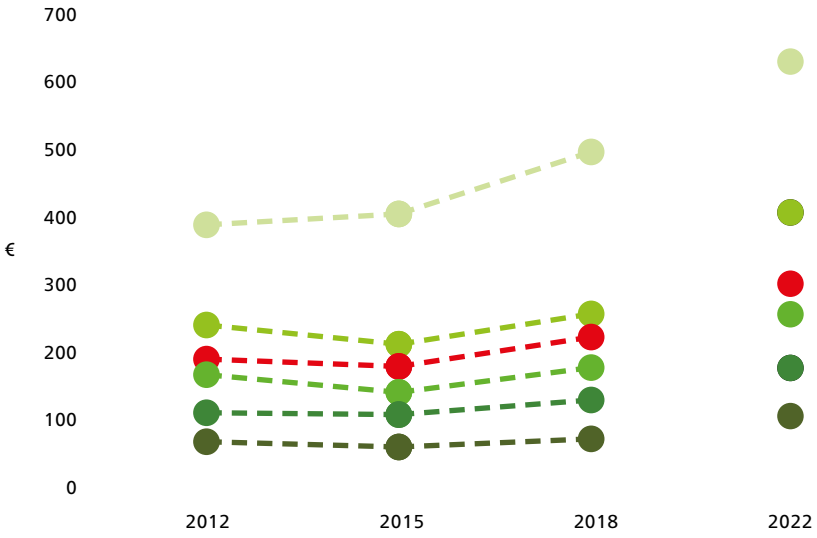


Notes: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: author, based on household budget survey data.

The average amount spent out of pocket per household member was €303 in 2022, with the richest households spending around six times more (€629) than the poorest households (€108) (Fig. 10). Average spending grew in real terms between 2012 and 2018, with the sharpest increases in the second and richest quintiles.

Fig. 10. Annual out-of-pocket payments per household member by consumption quintile

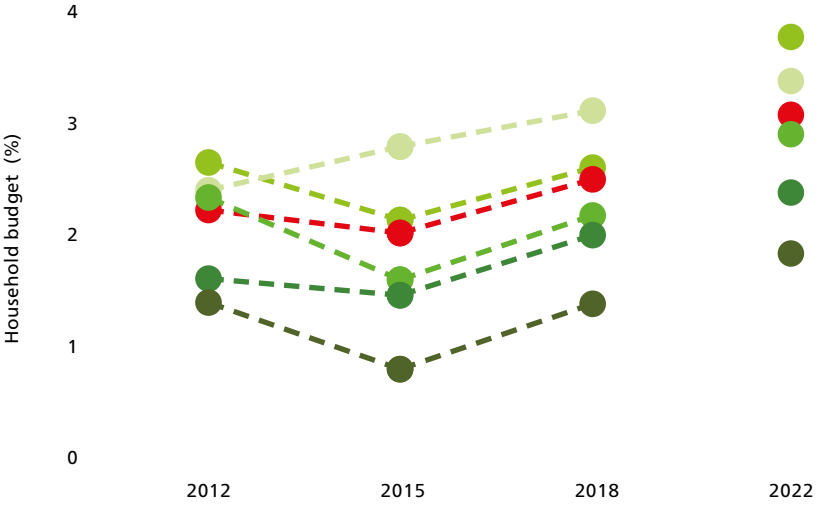


Notes: amounts are shown in real terms (base year 2020). Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Out-of-pocket payments accounted for 3% of total household spending (the household budget) in 2022, ranging from 2% in the poorest quintile to 3% in the richest (Fig. 11). Between 2012 and 2015 the out-of-pocket payment share of household budget decreased in all except the richest quintile, followed by an overall increase in 2018.

Fig. 11. Out-of-pocket payments as a share of total household spending by consumption quintile



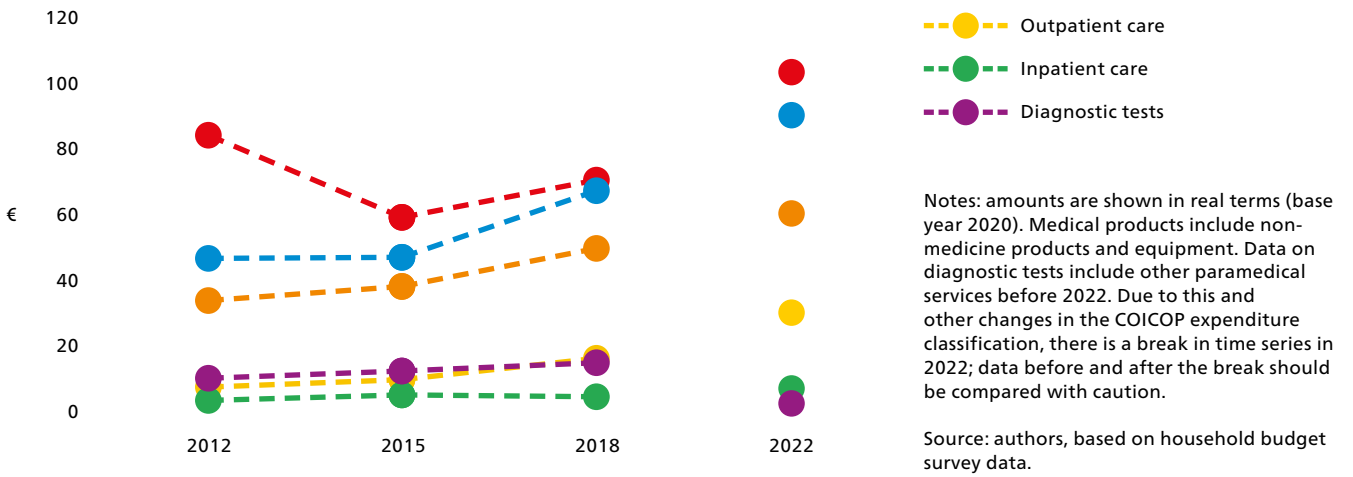
Note: due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Annual out-of-pocket payments per person by type of care were highest for outpatient medicines in 2022 (€108), followed by dental care (€94), medical products (€62) and outpatient care (€31) (Fig.12).

Between 2012 and 2015 spending on outpatient medicines dropped in all quintiles but had grown again by 2018 (Fig. 13). Spending on dental care doubled between 2015 and 2018, mainly driven by sharp increases in the two richest quintiles (Fig. 13). An increase in spending on outpatient care between 2012 and 2018 was entirely driven by an increase in the richest quintile. There was a doubling in spending on medical products in the poorest quintile between 2015 and 2018.

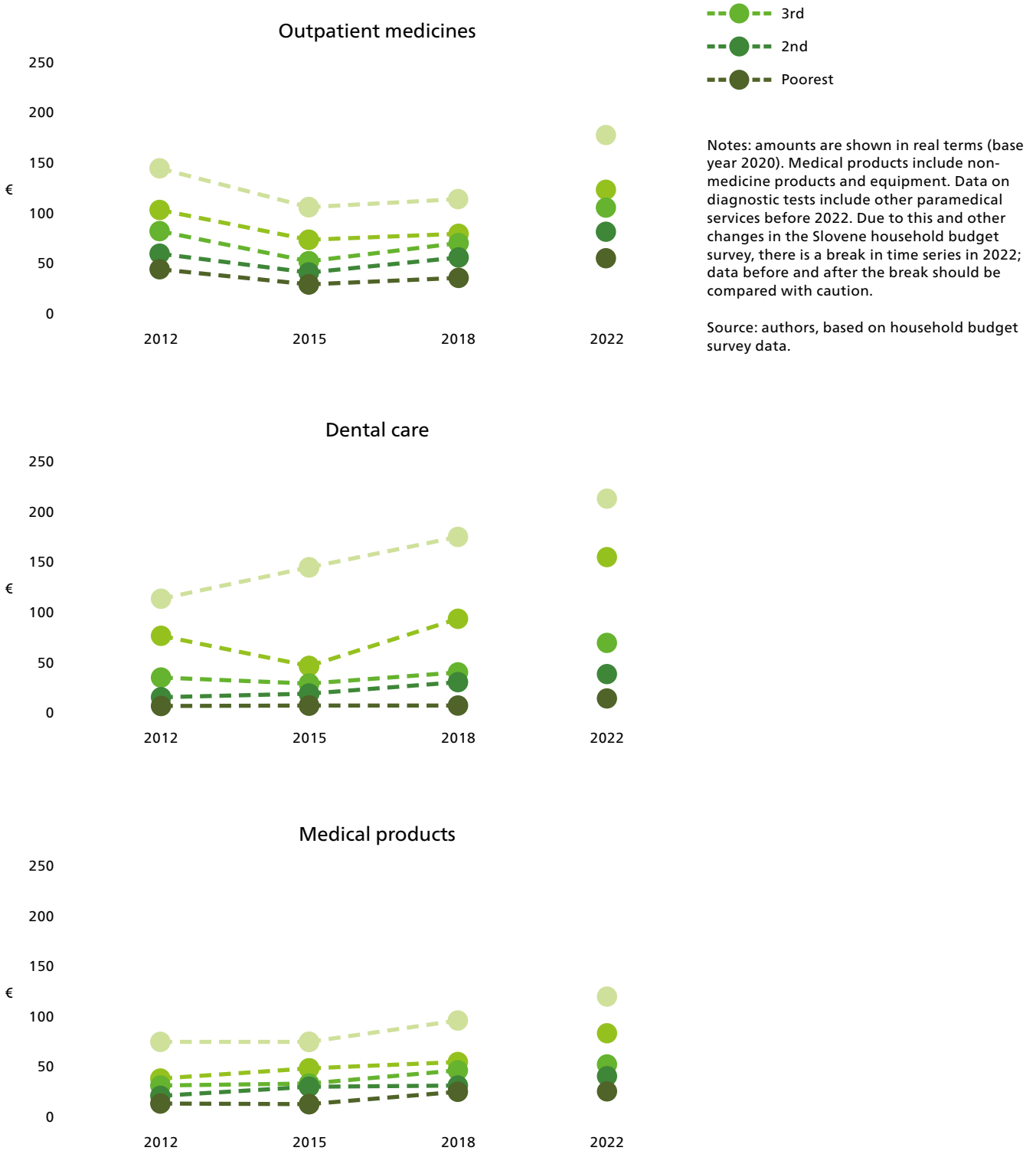
Fig. 12. Annual out-of-pocket payments per person by type of health care



Notes: amounts are shown in real terms (base year 2020). Medical products include non-medicine products and equipment. Data on diagnostic tests include other paramedical services before 2022. Due to this and other changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

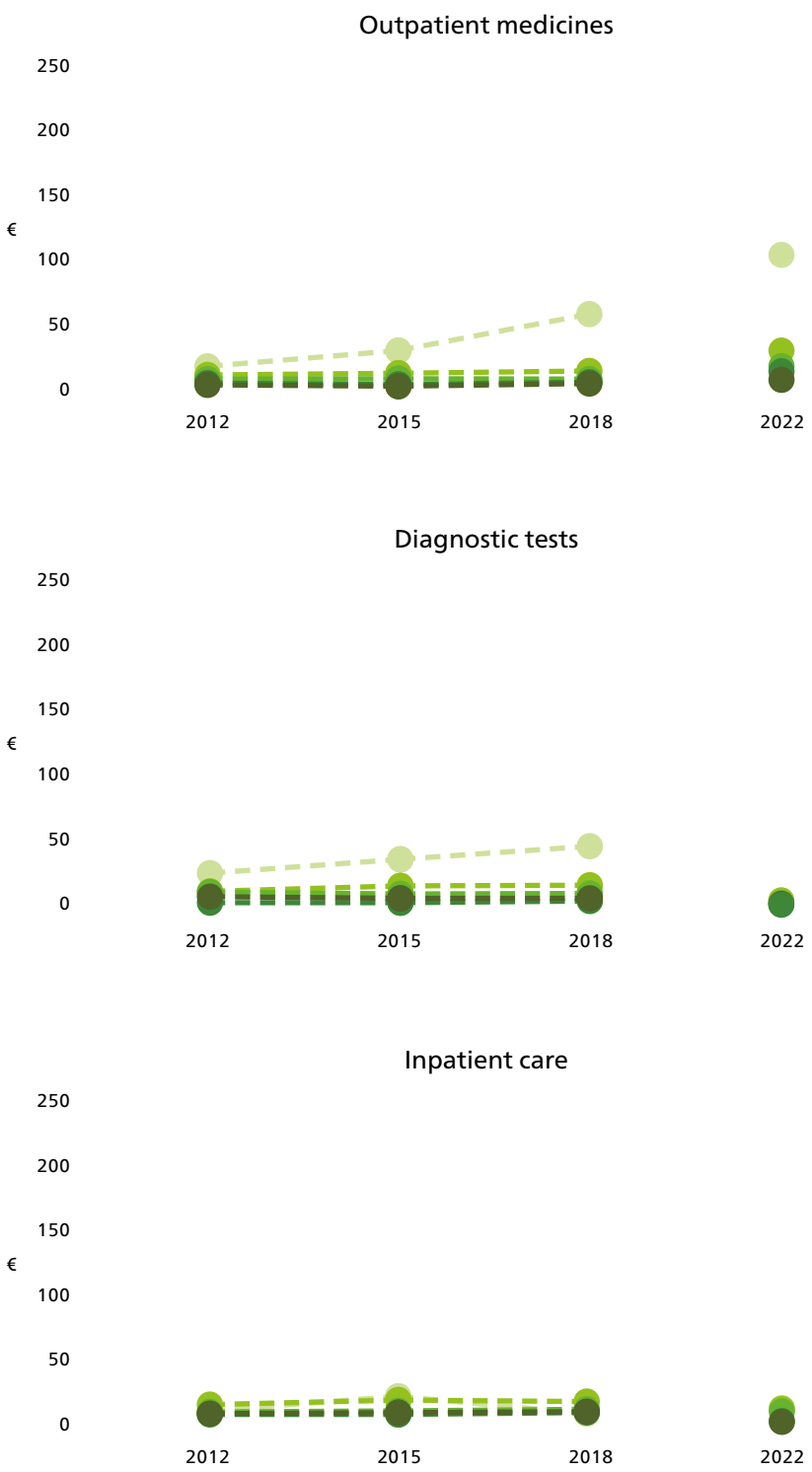
Fig. 13. Annual out-of-pocket payments by type of health care per person per consumption quintile



Notes: amounts are shown in real terms (base year 2020). Medical products include non-medicine products and equipment. Data on diagnostic tests include other paramedical services before 2022. Due to this and other changes in the Slovene household budget survey, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Fig. 13. Contd



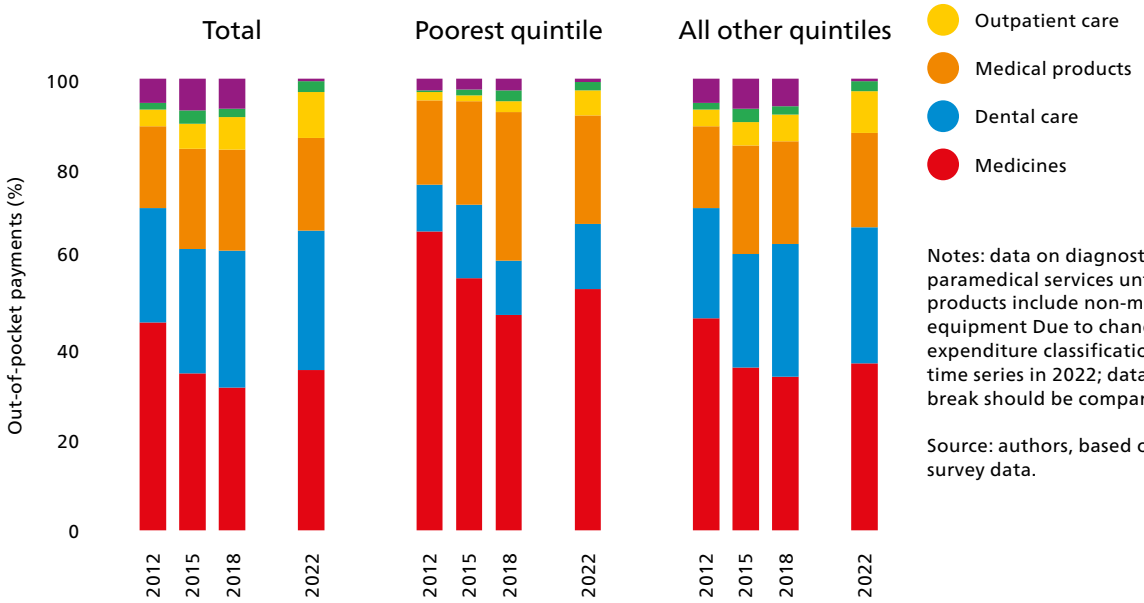
Notes: amounts are shown in real terms (base year 2020). Medical products include non-medicine products and equipment. Data on diagnostic tests include other paramedical services before 2022. Due to this and other changes in the Slovene household budget survey, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

In 2022 out-of-pocket payments were mainly driven by outpatient medicines (35%), dental care (31%), medical products (21%) and outpatient care (10%) (Fig. 14). As observed in the trend on spending per person, the outpatient medicines share fell from 46% in 2012 to 32% in 2018, while the dental care share rose from 25% to 30%.

There is a social gradient in out-of-pocket spending on dental care, outpatient medicines and medical products (Fig. 15). The poorest quintile devotes a larger share to outpatient medicines and (to a lesser extent) medical products; richer households devote a larger share to dental care and outpatient care.

Fig. 14. Breakdown of out-of-pocket payments by type of health care and consumption quintile



Notes: data on diagnostic tests include other paramedical services until 2018. Medical products include non-medicine products and equipment Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

4.3 VHI premiums

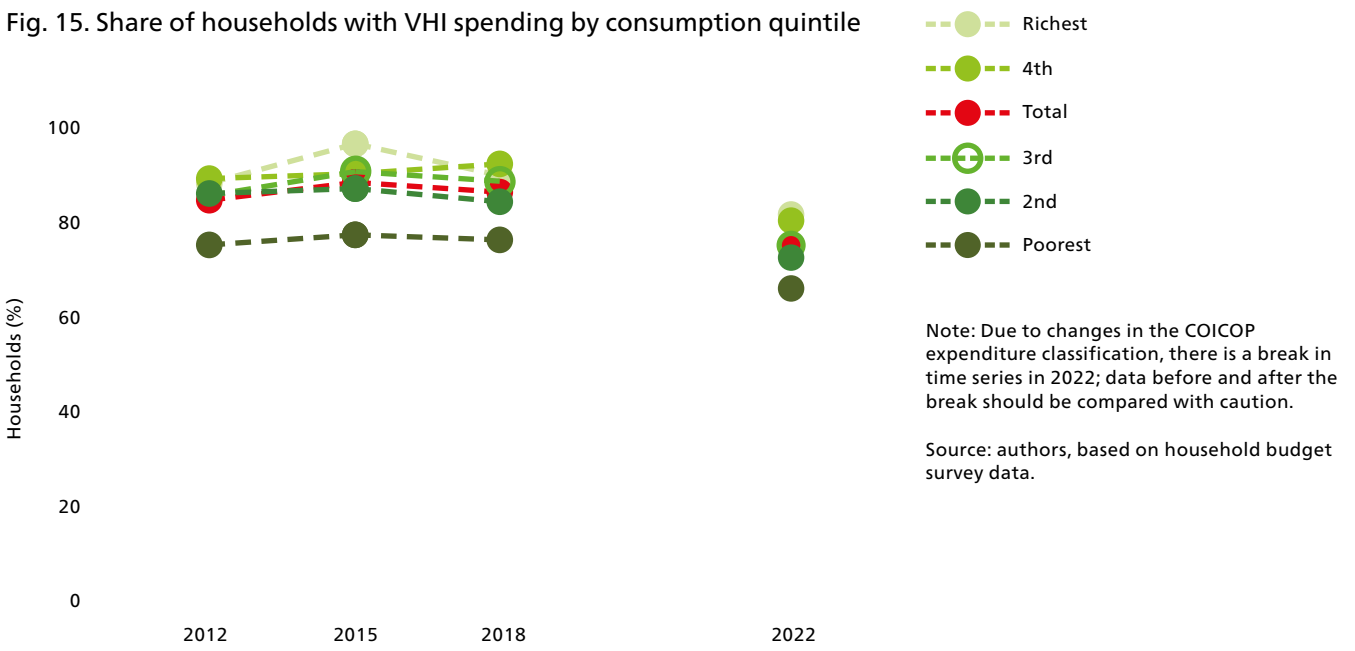
The Slovene household budget survey collects data on spending on complementary VHI covering user charges and supplementary VHI offering faster access to treatment. It does not distinguish between the two roles but the vast majority of VHI premiums are for complementary VHI (see Fig. 2).

About 76% of households reported spending on VHI premiums in 2022, ranging from 66% in the poorest quintile to 82% in the richest (Fig. 15). There are three main reasons for the variation in take up by quintile. First, several groups likely to be in the poorest quintile were exempt from most

co-payments and did not need to buy complementary VHI (about 25% of the population). Second, complementary VHI premiums were set at a flat rate (rather than being linked to income) and were therefore less affordable for poorer households. Third, household budget survey data include spending on supplementary VHI as well, which is more likely to be taken up by richer households.

The share of households spending on VHI premiums remained relatively stable between 2012 and 2018 in most quintiles (Fig. 15). A small peak in 2015 might reflect the increase in percentage co-payments to the maximum allowed by law in 2013, pushing more people to buy complementary VHI (Slovenian Insurance Association, 2024).

Fig. 15. Share of households with VHI spending by consumption quintile

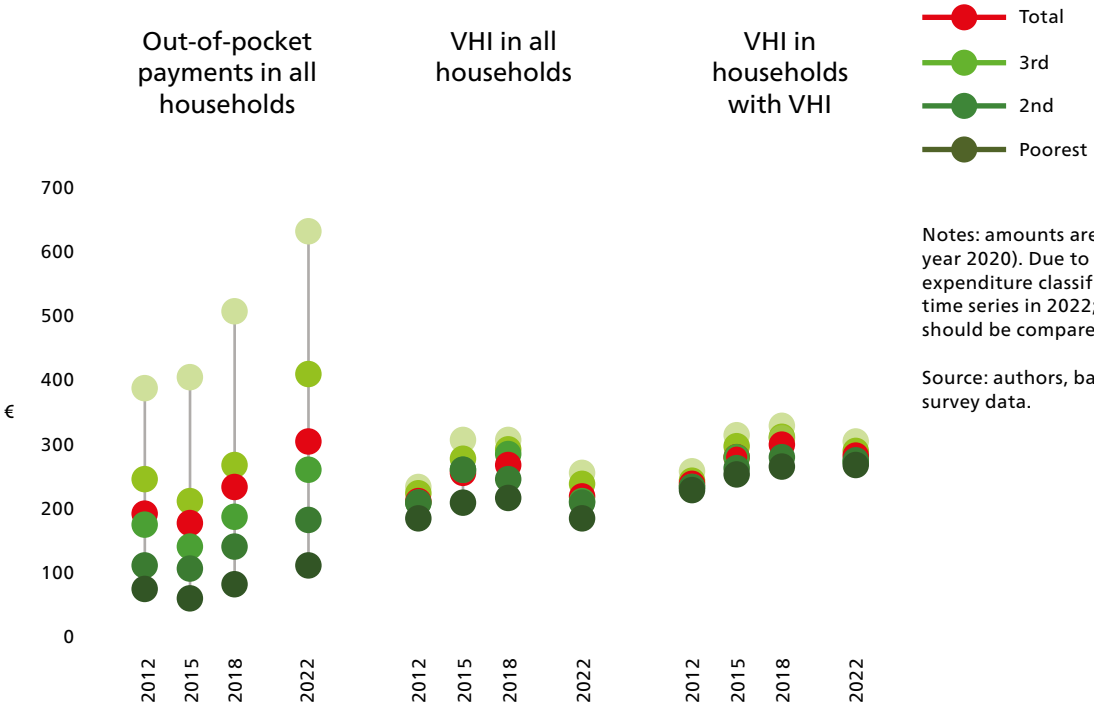


Note: Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

In 2022 people spent much less on average on VHI premiums (€216) than on out-of-pocket payments (€303) (Fig. 16). In contrast to out-of-pocket payments, however, there is much less variation in the amount spent on VHI premiums by quintile; as a result, people in the two poorest quintiles spent about twice as much on VHI premiums as on out-of-pocket payments in 2022 (Fig. 16).

Fig. 16. Annual spending on VHI premiums per person by consumption quintile in all households and in households with VHI



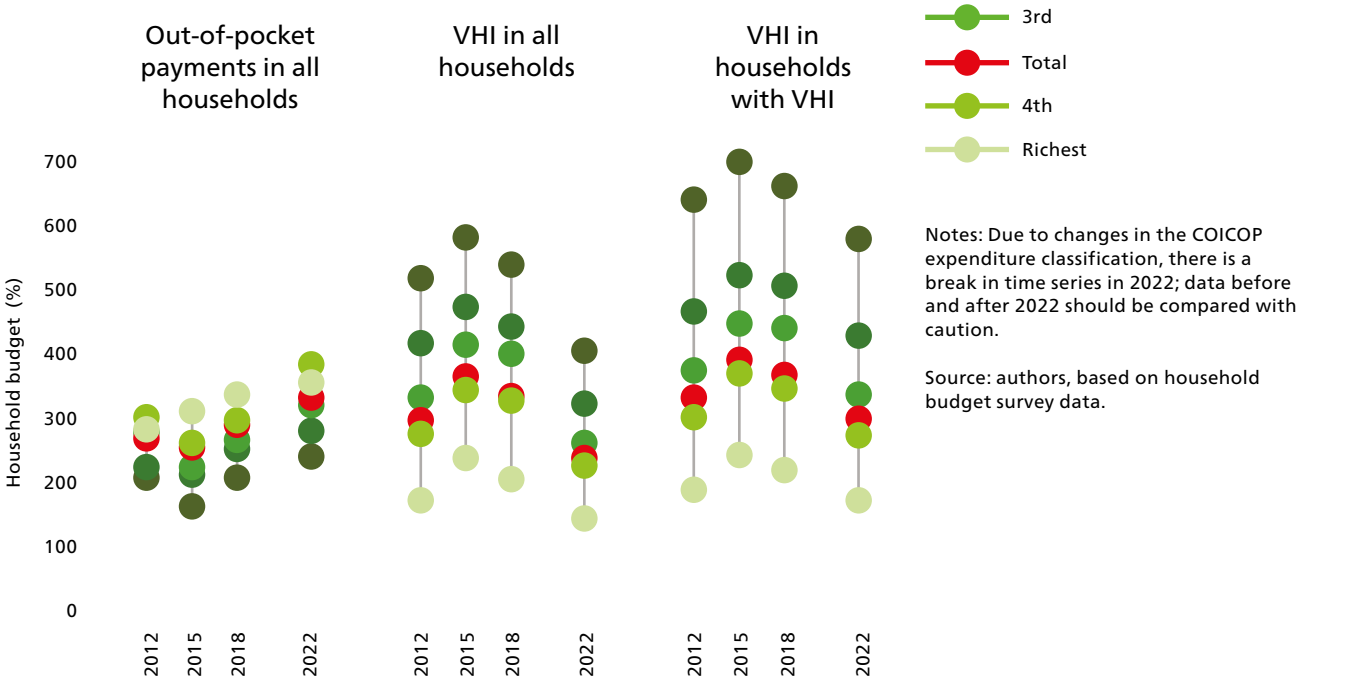
Notes: amounts are shown in real terms (base year 2020). Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after 2022 should be compared with caution.

Source: authors, based on household budget survey data.

On average VHI premiums accounted for a lower share of total household consumption (a household's budget) in 2022 than out-of-pocket payments (2.4% versus 3.4%, respectively) (Fig. 17). The distribution of out-of-pocket payments across quintiles is slightly progressive, which could reflect higher unmet need among households with lower incomes and greater use of health care among richer households. The distribution of VHI premiums is highly regressive, ranging from 4.0% of the household budget in the poorest quintile in 2022 to 1.4% in the richest. Focusing only on households with VHI, the distribution is even more regressive (5.8% in the poorest versus 1.7% in the richest).

When added together, out-of-pocket payments and VHI premiums accounted for nearly 6% of a household's budget on average in 2022 (data not shown), indicating a heavy financial burden.

Fig. 17. Household spending on VHI and out-of-pocket payments for health care as a share of total household spending by consumption quintile

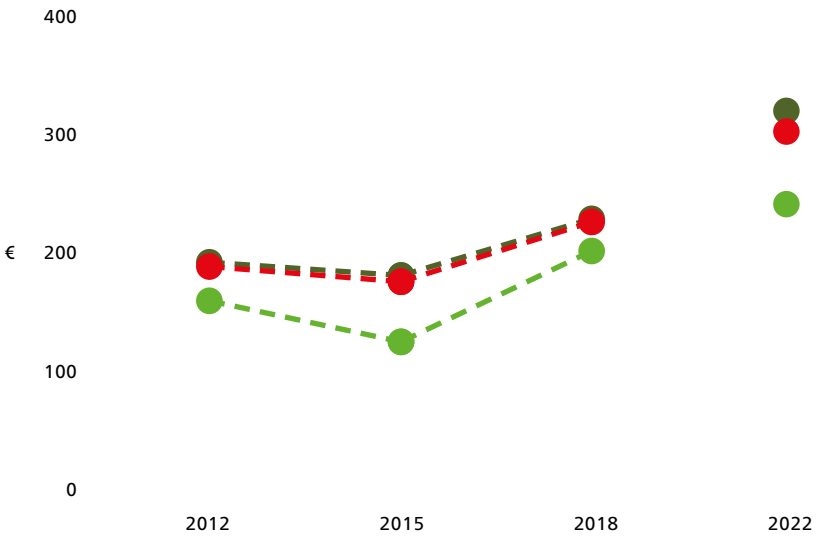


Notes: Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after 2022 should be compared with caution.

Source: authors, based on household budget survey data.

Out-of-pocket payments are consistently higher in households with VHI premiums than in households without VHI premiums (Fig. 18). People without VHI include those exempt from percentage co-payments who did not need to buy complementary VHI (such as children, students under 26 and social beneficiaries), as well as those liable for user charges who did not have complementary VHI to cover co-payments (mainly people with low incomes but above the threshold for social benefits and young adults arranging complementary VHI coverage for the first time). This could reflect higher unmet need in households with lower incomes and less need for health care in younger adults.

Fig. 18. Annual out-of-pocket payments for health care per person by VHI status



Notes: amounts are shown in real terms (base year 2020). Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after 2022 should be compared with caution.

Source: authors, based on household budget survey data.

4.4 Informal payments

The 2024 Special Eurobarometer survey on corruption found that 2% of Slovene respondents who had visited a public health care provider in the previous 12 months reported having had to make an extra payment or give a valuable gift to a nurse or doctor or make a donation to a hospital, compared to an EU27 average of 3% (European Commission, 2024). Informal payments are not considered to be a major issue in the Slovene health system.

4.5 Summary

Data from health accounts indicate that out-of-pocket payments as a share of current spending on health are low in Slovenia (13% in 2023) compared to many other EU countries but higher than in countries such as Croatia, France and Ireland.

Slovenia's relatively low reliance on out-of-pocket payments reflects its high reliance on VHI until 2024. VHI accounted for 12% of current spending on health in 2023 (before the 2024 reform) – the highest share in Europe.

Public spending on health as a share of GDP is similar in Slovenia (7.1% in 2022) to the EU14 average (7.3%) but lower than in other EU countries with comparable GDP per person, such as Czechia and Spain.

As in other EU countries, the types of care that are most heavily financed through out-of-pocket payments in Slovenia are medical products, dental care and outpatient medicines. While reliance on out-of-pocket payments is generally lower in Slovenia than the EU14 average, it is markedly higher than the EU14 average for medical products.

Household budget survey data show that household members spent an average of about €300 a year on out-of-pocket payments in 2022, with the richest households spending six times more than the poorest. Out-of-pocket payments amounted to an average of 3% of total household spending (the household budget), ranging from 2% in the poorest quintile to 3% in the richest.

In 2022 out-of-pocket payments were mainly driven by spending on outpatient medicines (35%), dental care (31%), medical products (21%) and outpatient care (10%). The poorest quintile devotes a larger share of out-of-pocket spending to outpatient medicines and (to a lesser extent) medical products; richer households devote a larger share to dental care and outpatient care.

In 2022 people spent much less on average on VHI premiums (€216) than on out-of-pocket payments (€303) but people in the two poorest quintiles spent about twice as much on VHI premiums than on out-of-pocket payments.

In contrast to out-of-pocket payments, which have a slightly progressive distribution (likely to reflect higher unmet need in households with lower incomes and a greater use of health care in richer households), VHI premiums were highly regressive, accounting for 4% of a household's budget in the poorest quintile compared to only 1.4% in the richest.

When added together, out-of-pocket payments and VHI premiums accounted for nearly 6% of a household's budget on average in 2022, indicating a heavy financial burden, especially for people with lower incomes.

Informal payments are not considered to be an issue in Slovenia.

5. Financial protection

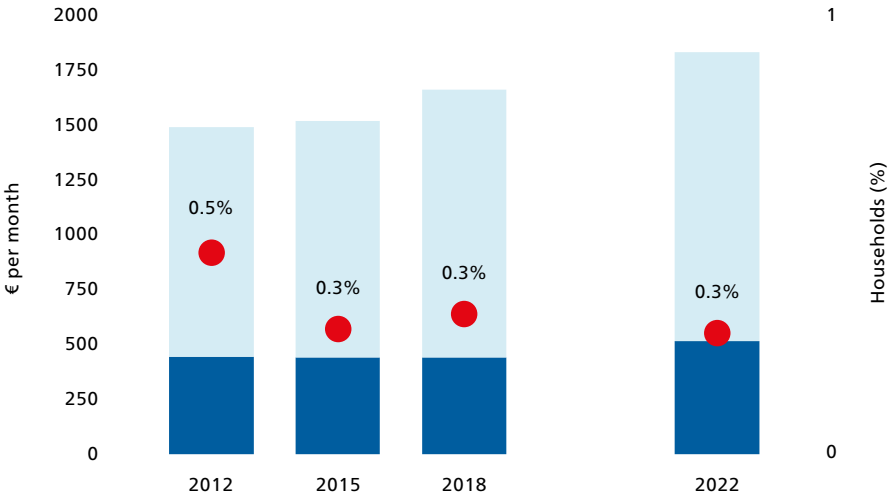
This section uses data from the Slovene household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The analysis of financial hardship in this study goes up to 2022, reflecting the latest available year of household budget survey data. It covers the years preceding the 2024 reform and provides a baseline for assessing the reform's impact. Some of the results reported in this section are based on a very small number of observations (households) and therefore must be interpreted with caution. The section also draws on other survey data to assess unmet need for health services.

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 Slovene population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2022 the monthly cost of meeting these basic needs (the basic needs line) was €512, up from €439 in 2018 (Fig. 19), which is very low compared to Slovenia's monthly national poverty line of €827 in 2022 (55% of average net earnings) (Statistical Office of the Republic of Slovenia, 2024).

On average household capacity to pay for health care and the cost of meeting basic needs increased during the study period. The share of households living below the basic needs line decreased slightly between 2012 and 2015 (Fig. 19).

Fig. 19. Changes in the monthly cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic-needs line



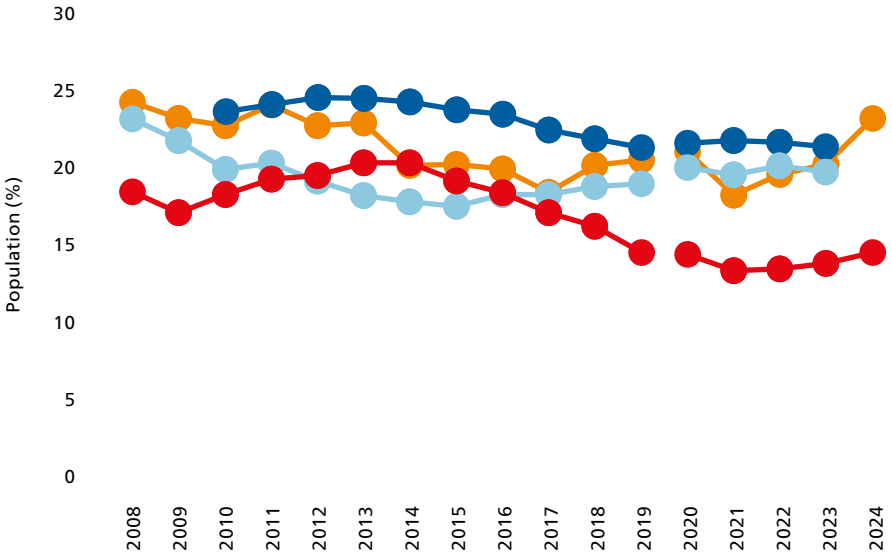
Average household capacity to pay
Cost of meeting basic needs
Share of households living below the basic needs line (%)

Notes: amounts are shown in real terms (base year 2020). Capacity to pay for health care is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Poverty rates are generally low in Slovenia compared to other EU countries. In 2023 about 14% of the Slovene population were at risk of poverty or social exclusion, compared to an EU27 average of 21% (Fig. 20). However, this rate was substantially higher than average among older people in Slovenia, on a par with the EU27 average for this age group in 2023.

Fig. 20. Share of the population at risk of poverty or social exclusion by age in Slovenia and the EU27



Slovenia > 65 years
EU27 total
EU27 > 65 years
Slovenia total

Note: break in the series in 2020.

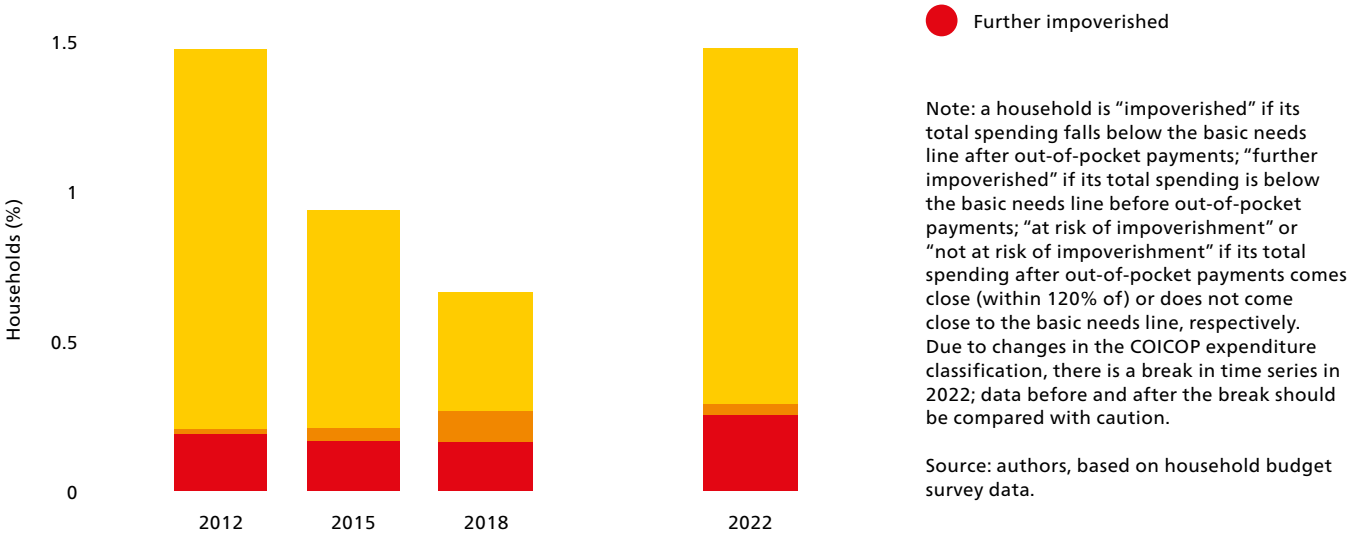
Source: Eurostat (2025d).

5.2 Financial hardship

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 2022 0.2% of households were impoverished or further impoverished after out-of-pocket payments; this share grew slightly between 2012 and 2018 (Fig. 21). In 2022 1% of households were at risk of impoverishment; between 2012 and 2018 this share fell from 1.1% to 0.3% (Fig. 21).

Fig. 21. Share of households at risk of impoverishment after out-of-pocket payments



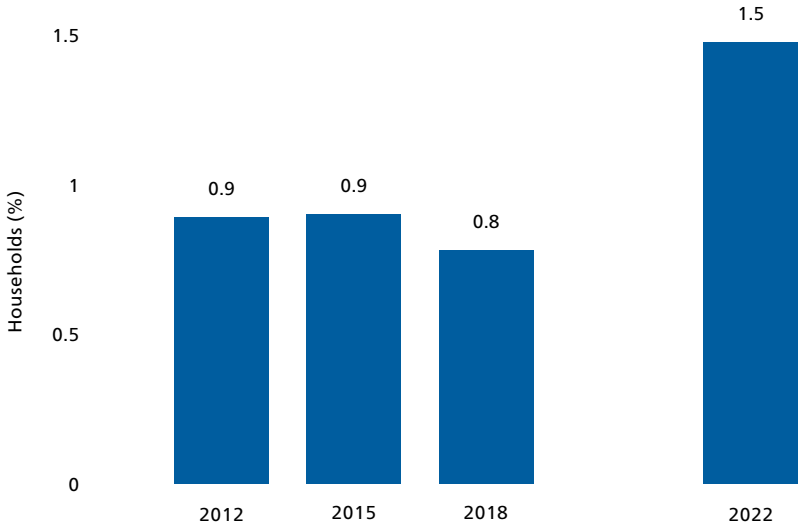
Note: a household is "impoverished" if its total spending falls below the basic needs line after out-of-pocket payments; "further impoverished" if its total spending is below the basic needs line before out-of-pocket payments; "at risk of impoverishment" or "not at risk of impoverishment" if its total spending after out-of-pocket payments comes close (within 120% of) or does not come close to the basic needs line, respectively. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Households with catastrophic health spending are defined in this study 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 have no capacity to pay).

About 1.5% of households (around 13 000 households) experienced catastrophic health spending in 2022 (Fig. 22). This share was below 1% between 2012 and 2018 (around 7 000 households). The incidence of catastrophic health spending in Slovenia is among the lowest in Europe (Fig. 23).

Fig. 22. Share of households with catastrophic health spending



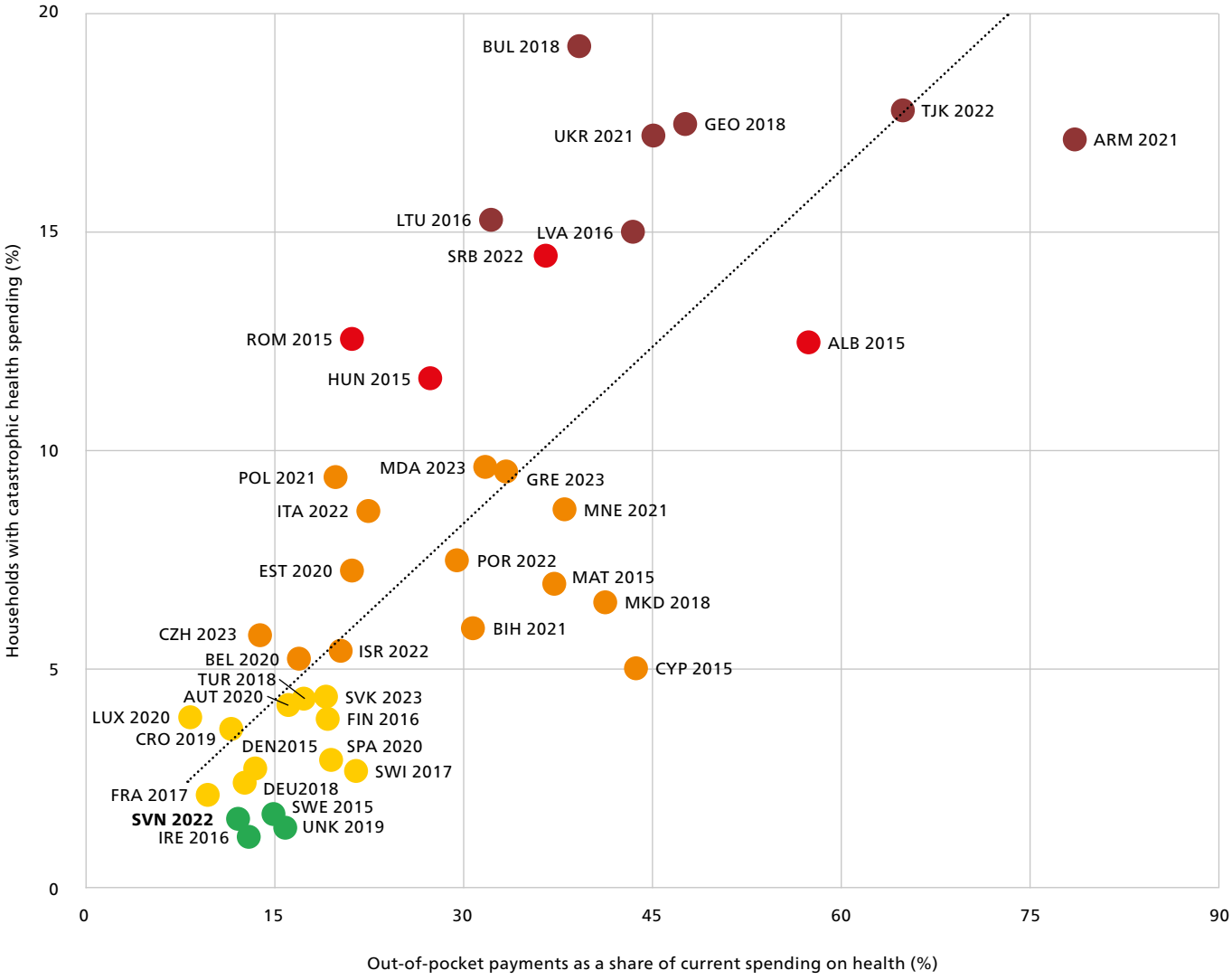
Notes: Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Fig. 23. Incidence of catastrophic health spending and the out-of-pocket payment share of current spending on health, 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 out-of-pocket payments are for 2022. The list of country codes used here can be found in the Abbreviations.

Source: UHC watch (2025).



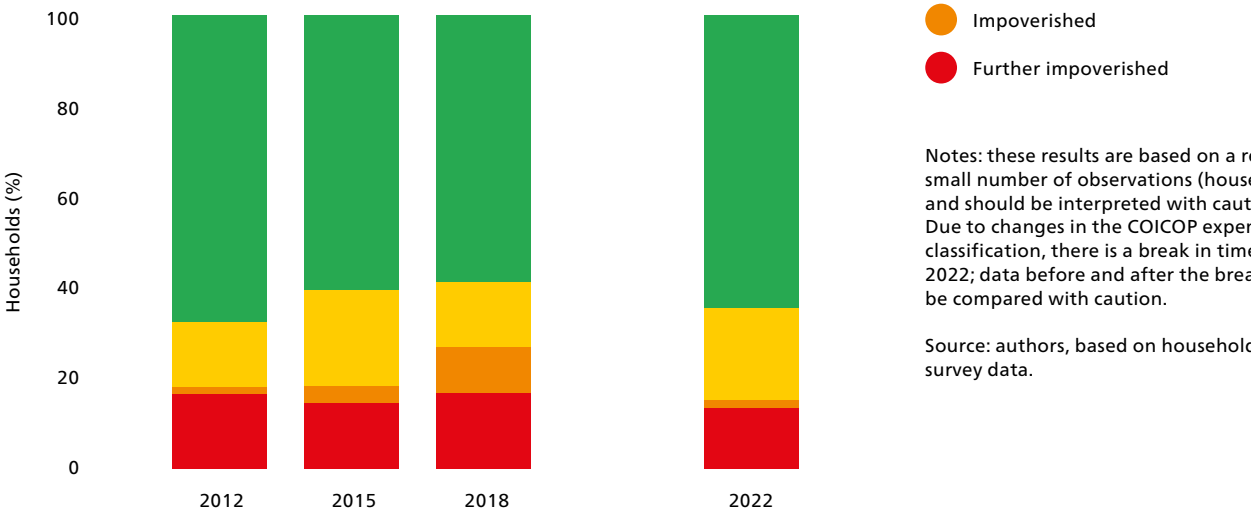
Who experiences financial hardship?

In 2022 just over a third (36%) of households with catastrophic health spending were further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 24).

Households experiencing catastrophic health spending are concentrated in the poorer consumption quintiles (Fig. 25). In 2022 households in the poorest quintile accounted for 43% of households with catastrophic health spending. However, there is less inequality across quintiles in Slovenia than in many other countries in Europe. Just over 3% of households in the poorest quintile experienced catastrophic health spending in 2022, compared to under 1% in the richest.

Due to the small number of households with catastrophic health spending, it is not possible to disaggregate them by age or other factors.

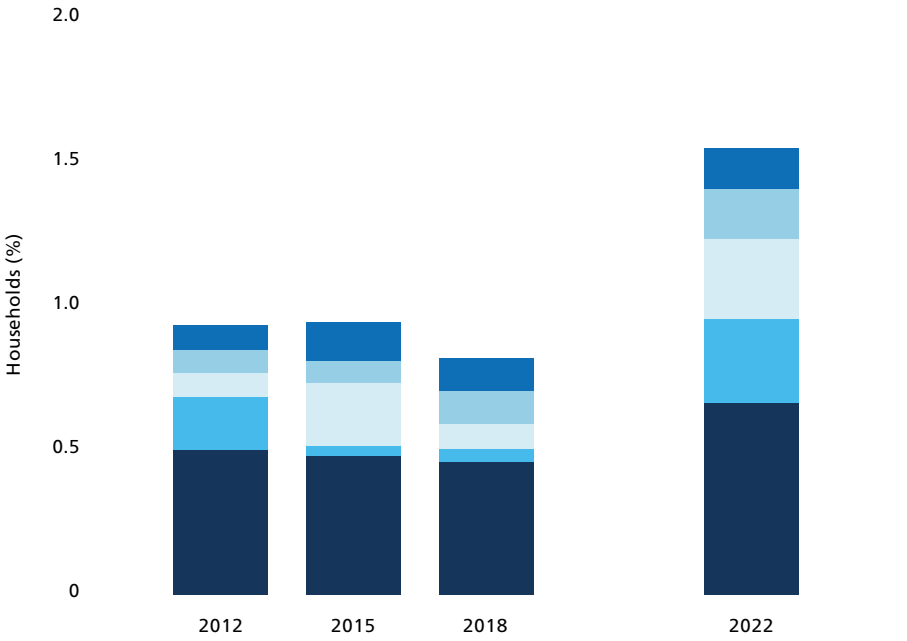
Fig. 24. Breakdown of households with catastrophic health spending by risk of impoverishment



Notes: these results are based on a relatively small number of observations (households) and should be interpreted with caution. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

Fig. 25. Share of households with catastrophic health spending by consumption quintile



Notes: these results are based on a relatively small number of observations (households) and should be interpreted with caution. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

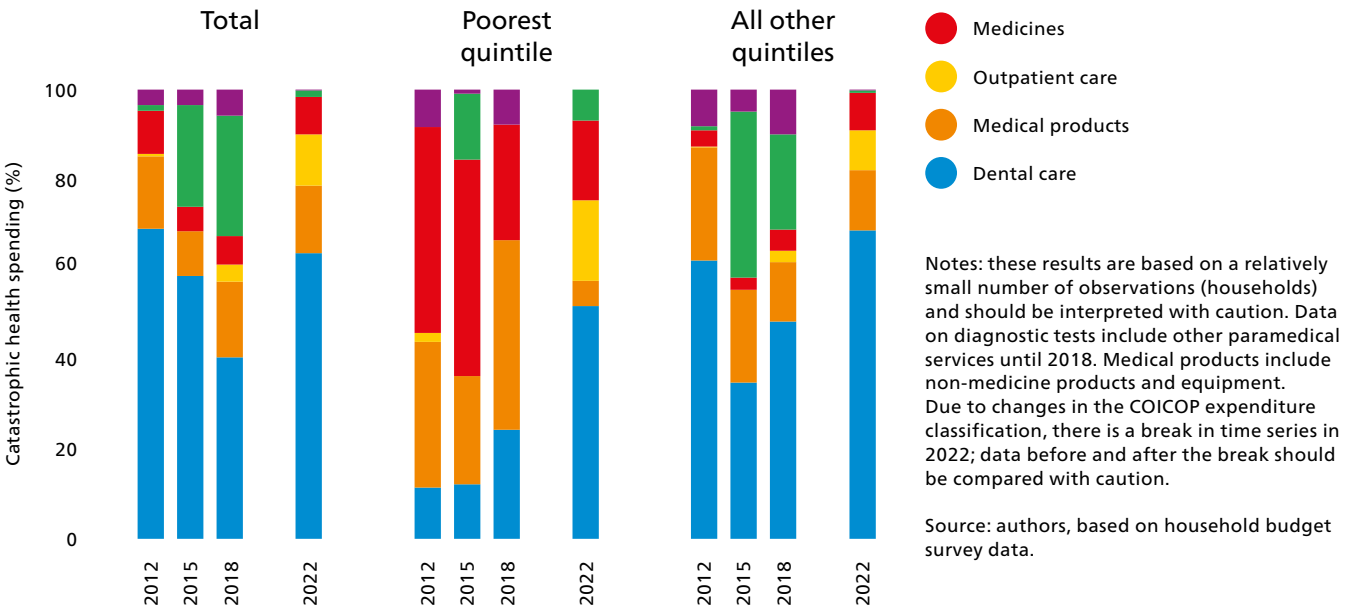
Source: authors, based on household budget survey data.

Which health services are responsible for financial hardship?

In 2022 catastrophic health spending was mainly driven by dental care (64%), followed by medical products (15%), outpatient care (11%) and outpatient medicines (8%) (Fig. 26). The dental care share fell from 69% in 2012 to 40% in 2018 but has consistently been the main driver. Inpatient care was a negligible driver in 2022 and 2012 but its share grew to 23% in 2015 and 27% in 2018.

The main drivers of catastrophic health spending in the poorest quintile in 2022 were dental care (52%), followed by outpatient care (18%), outpatient medicines (18%), inpatient care (7%) and medical products (6%) (Fig. 26). Medical products and outpatient medicines were a much larger driver in this quintile in earlier years.

Fig. 26. Breakdown of catastrophic health spending by type of health care and consumption quintile



Notes: these results are based on a relatively small number of observations (households) and should be interpreted with caution. Data on diagnostic tests include other paramedical services until 2018. Medical products include non-medicine products and equipment. Due to changes in the COICOP expenditure classification, there is a break in time series in 2022; data before and after the break should be compared with caution.

Source: authors, based on household budget survey data.

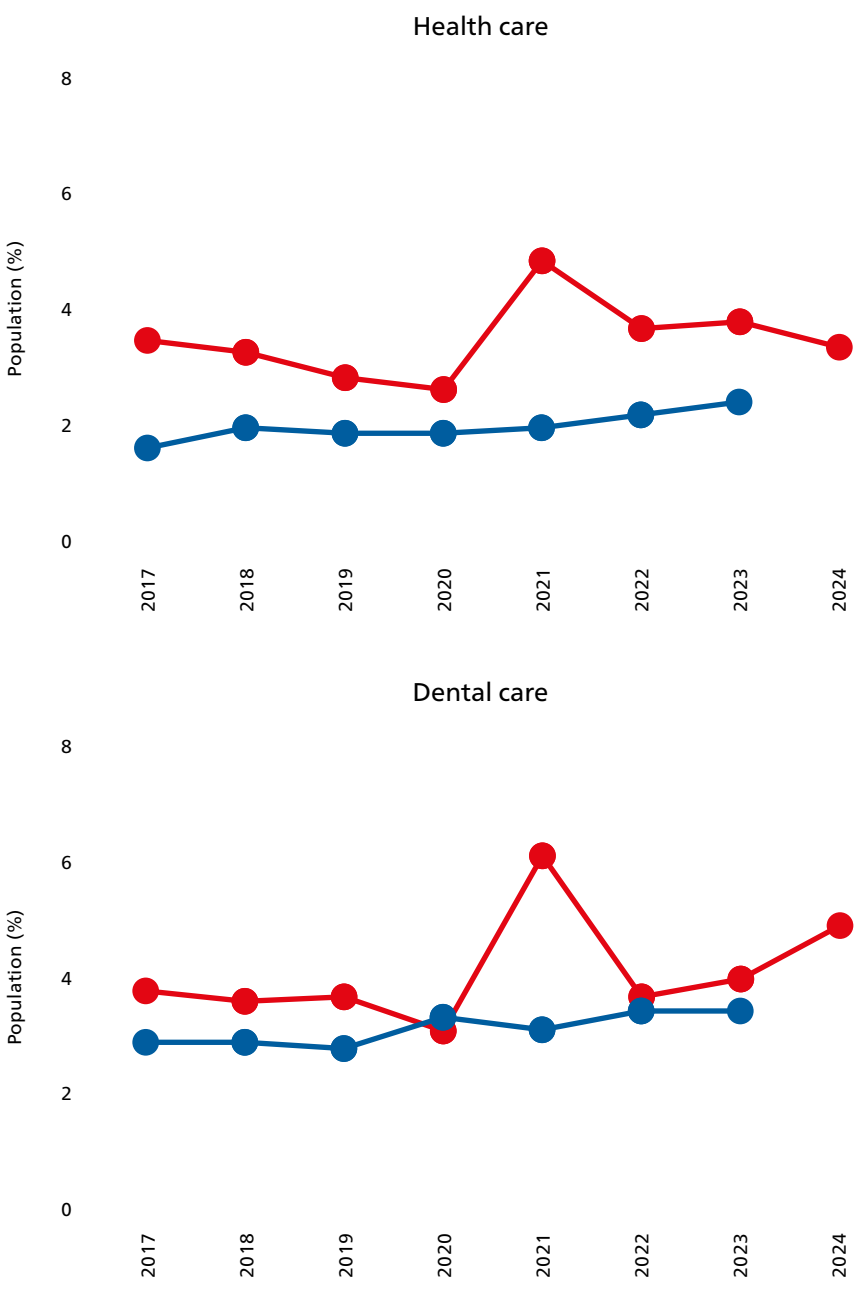
5.3 Unmet need for health care

EU-SILC data on unmet need (see Box 1) due to cost, distance or waiting time show that unmet need for health care and in Slovenia is above the EU27 average (Fig. 27). Unmet need for both types of care is consistently mainly driven by waiting times in Slovenia, unlike in many other EU countries (data not shown). In 2023 rates of unmet need due to waiting time were much higher in Slovenia (around 4% of the adult population) than the EU27 average for dental care (under 1%) and health care (about 1%) (data not shown).

Unmet need for health care and dental care has increased over time in Slovenia, with a particularly sharp increase in 2021, during the coronavirus disease pandemic (Fig. 27).

In 2024 the share of people experiencing unmet need rises to 4.6% when looking specifically at people needing health care (up from 3.4% in the total population) and to 6.4% (up from 3.9%) when looking at people needing dental care (data not shown). The share of people needing care with unmet need peaked in 2021 both for health care (7.9%) and dental care (10.7%) (data not shown) (Eurostat, 2025a).

Fig. 27. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Slovenia and the EU27



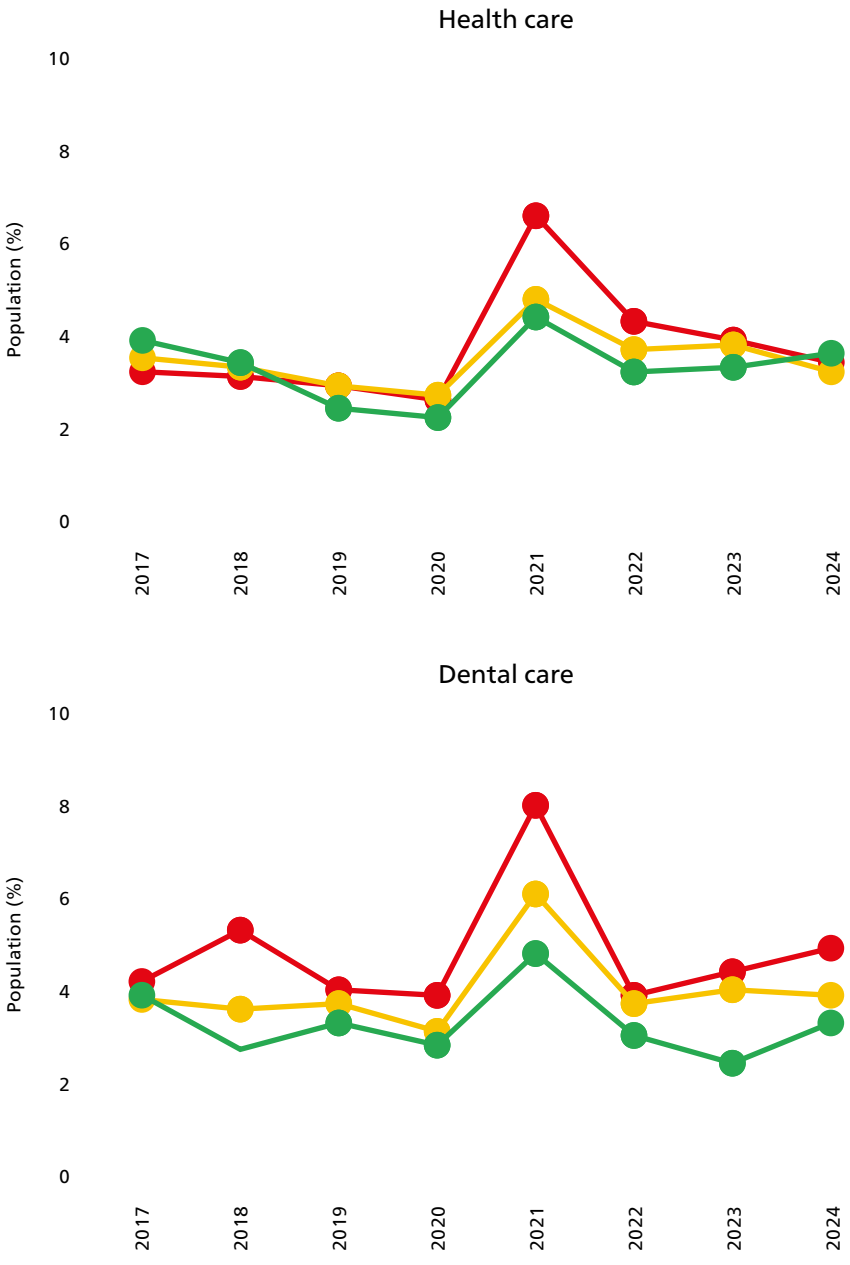
Slovenia
EU27

Notes: the EU-SILC denominator for unmet need is people aged 16 and over. Data before 2017 are not comparable due to differences in survey methods.

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

Income inequality in unmet need is more evident for dental care than health care but it increased for both types of care in 2021 (Fig. 28). The gap between the poorest and richest quintiles narrowed in 2022 but widened again in 2023 for dental care.

Fig. 28. Self-reported unmet need for health care and dental care due to cost, distance and waiting time by age and income

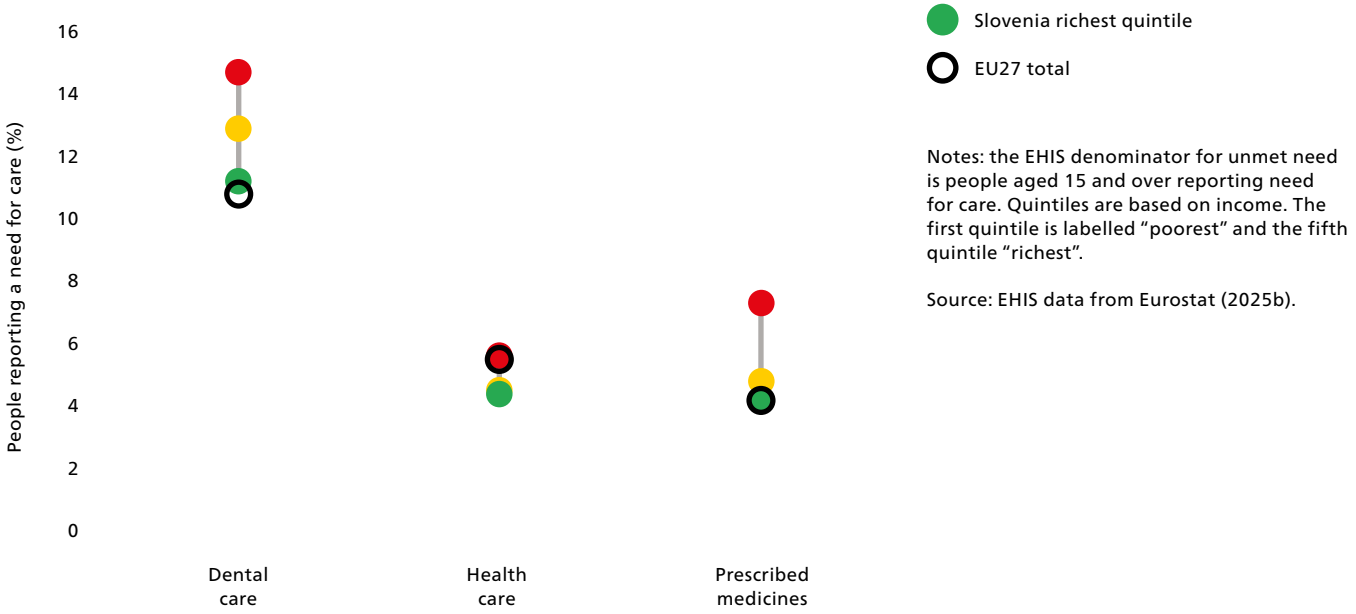


Notes: the EU-SILC denominator for unmet need is people aged 16 and over. Quintiles are based on income. Data before 2017 are not comparable due to differences in survey methods.

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

EHIS data show that, on average, unmet need due to cost is highest in Slovenia for dental care, followed by health care and prescribed medicines (Fig. 29). Income inequality in unmet need due to cost is much more marked for dental care and prescribed medicines than health care (Fig. 29).

Fig. 29. Self-reported unmet need for dental care, health care and prescribed medicines due to cost by income, Slovenia and EU27, 2019



Notes: the EHIS denominator for unmet need is people aged 15 and over reporting need for care. Quintiles are based on income. The first quintile is labelled "poorest" and the fifth quintile "richest".

Source: EHIS data from Eurostat (2025b).

5.4 Summary

The analysis of financial hardship in this study goes up to 2022, reflecting the latest available year of household budget survey data. It covers the years preceding the 2024 reform and provides a baseline for assessing the reform's impact.

The incidence of catastrophic health spending in Slovenia is among the lowest in Europe.

In 2022 1.5% of households experienced catastrophic health spending (up from 0.8 in 2018), and 0.2% of households were impoverished or further impoverished after out-of-pocket payments (this share grew slightly between 2012 and 2018).

Catastrophic health spending is concentrated in households with low incomes. In 2022 about 43% of households with catastrophic health spending were in the poorest quintile. There is, however, less inequality across quintiles in Slovenia than in other countries.

The main drivers of catastrophic health spending in 2022 were dental care, outpatient medicines and outpatient care in the poorest quintiles. Medical products were a driver in the other quintiles in 2022 and a key driver in the poorest quintile in earlier years.

EU-SILC data show that unmet need for health care and dental care due to cost, distance and waiting time is above the EU27 average in Slovenia and mainly driven by waiting time. EHIS data show that, on average, unmet need due to cost is highest in Slovenia for dental care, followed by health care and prescribed medicines. Income inequality in unmet need due to cost is much more marked for dental care and prescribed medicines than health care.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Slovenia, and which may explain the trend between 2012 and 2022. The first half discusses the period before the 2024 reform, which abolished most user charges (co-payments) for health care, removing the need for complementary VHI covering co-payments. The second part discusses the current situation.

6.1 The situation before the 2024 reform

The incidence of catastrophic health spending in Slovenia is among the lowest in Europe, reflecting the following factors (before the 2024 reform).

- The HIIS benefits package was (and is) relatively comprehensive, including dental care for adults, orthodontic treatment for children, medical products (including coverage of corrective lenses for most sight problems) and long-term care.

- Although there were heavy co-payments in place for all types of care before 2024, around 25% of the population were exempt from most co-payments (not reference pricing) and around 95% of people liable to pay user charges were covered by complementary VHI covering most co-payments (not reference pricing). This type of VHI was heavily regulated by the Government to ensure it was accessible for most people (see section 3.4). However, it was highly regressive in terms of financing health care (see Fig. 17).

As a result of very high take up of complementary VHI covering co-payments, the out-of-pocket payment share of current health spending was low – 13% in 2023, well below the EU14 average of 17% (see Fig. 3) – and the out-of-pocket payment share of spending on different types of care was lower than the EU14 average for all except medical products (see Fig. 8).

In spite of this, around 85% of the population paid out of pocket for health care in 2022 (see Fig. 9) and out-of-pocket payments accounted for about 3% of total household spending (see Fig. 11), reflecting some remaining gaps in coverage, particularly for people with low incomes. Levels of unmet need for health care and dental care were also above the EU average (see Fig. 27), and heavily driven by waiting times, although cost is also a key driver for dental care (see Fig. 29).

The main drivers of catastrophic health spending in 2022 were dental care, outpatient medicines and outpatient care in the poorest quintile; medical products were a driver in the other quintiles in 2022 and were a key driver in the poorest quintile in earlier years (Fig. 26).

Catastrophic health spending driven by **dental care** may reflect the following gaps in coverage (both before and after the reform).

- Between 2012 and 2024 the HIIS benefits package mainly covered standard dental material for treatment such as prostheses and fillings. Most people still have to pay extra for some non-standard dental material and there are no income-based exemptions from these extra charges. Dental care coverage is currently being expanded (see below).

- Long waiting times push those who can afford it to pay out of pocket for privately provided treatment while the remainder experience unmet need for dental care, which is mainly driven by waiting time in Slovenia, unlike in most other EU countries (Eurostat, 2025a), although cost also plays an important role (Eurostat, 2025b).

- Limited public awareness of entitlements and misleading advertising by providers may also hinder access to covered dental care (Zveza potrošnikov Slovenije, 2025), leading people to pay more than necessary out of pocket.

Catastrophic health spending is driven by **outpatient medicines** in Slovenia, but to a lesser extent than in many other countries in Europe, especially in the poorest quintile (WHO Regional Office for Europe, 2023; UHC watch, 2025). This may reflect the following gaps in coverage (both before and after the reform).

- Reference pricing is applied to all covered outpatient prescribed medicines (and medical products) and in 2023 around 13% of all prescribed medicines incurred co-payments due to reference pricing.[6] There are no exemptions from these "avoidable co-payments", not even for people with low incomes. Although the amount paid through reference pricing is generally under €10 per item, even relatively small amounts can lead to financial hardship for people with low incomes or chronic conditions.

- Around 5% of people liable for user charges did not have complementary VHI covering co-payments, mainly people with low incomes (but above the income threshold for social benefits), foreign workers without permanent residence status and young people having to arrange complementary VHI cover for the first time.

- Health accounts data indicate that in 2022 around 85% of out-of-pocket payments for outpatient medicines were for medicines that were dispensed over the counter (Statistical Office of the Republic of Slovenia, 2025). OTC medicines are not covered by the HIIS and their prices are not regulated, which could be a source of financial hardship for some households.

Catastrophic health spending driven by **outpatient care** is likely to reflect long and growing **waiting times** for outpatient specialist care (both before and after the reform) (see section 3.3). Given that waiting times are the main reason people give for unmet need for health care and dental care, it is likely that those who can afford private treatment either pay out of pocket or use supplementary VHI offering faster access to health

6. HIIS, data provided to the authors on request, 2025.

care for diagnostic tests and other specialist care, while the remainder experience unmet need. Supplementary VHI has grown rapidly to cover about a third of the population (36%) in 2023 (up from 5.6% in 2011) but take up is concentrated in people with higher incomes, exacerbating inequalities in access to health care.

Catastrophic health spending driven by **medical products** is likely to reflect limited access to covered corrective lenses (both before and after the reform) – health accounts data indicate that in 2022 around 80% of out-of-pocket payments for medical products were spent on corrective lenses (Statistical Office of the Republic of Slovenia, 2025). Although coverage of corrective lenses is generally comprehensive (people mainly pay for more expensive frames or for selected non-covered products such as reading glasses, which are only covered for people aged over 63) there are barriers to accessing publicly financed benefits, including long waiting times for ophthalmology visits (HIIS, 2025), limited public awareness of entitlements and misleading advertising by providers (Zveza potrošnikov Slovenije, 2025). The very small share medical products play in driving catastrophic health spending in the poorest quintile in 2022 is likely to reflect unmet need.

There is one other small but significant gap in coverage (before and after the reform). Because entitlement to HIIS benefits is linked to payment of mandatory contributions, around 1% of the population eligible for coverage was not fully covered by the HIIS at the end of 2023 (HIIS, 2024). This includes people who lacked some HIIS coverage due to non-payment of contributions (0.8% of the eligible population, typically self-employed people, including farmers; non-registered unemployed people; and other groups subject to the annual flat-rate contribution) and other groups of people excluded for administrative reasons (0.1% of the eligible population, e.g. people waiting to be recognized as pensioners or unemployed). Undocumented migrants are not eligible for HIIS coverage. Those who lack HIIS coverage are likely to have lower incomes and may therefore be at high risk of experiencing financial hardship or unmet need.

6.2 The current situation (2025)

In January 2024 most co-payments were abolished and premiums for complementary VHI covering most HIIS co-payments were replaced by a new mandatory flat-rate monthly contribution, of €37 per person in 2025 (up from €35 in 2024) mandatory for three-quarters of the population, including pensioners.

The reform introduced some policy changes that are likely to be beneficial for financial protection: the abolition of all percentage co-payments has reduced user charges and removed the need for complementary VHI covering co-payments, which has in turn lowered complexity and administrative and transaction costs in the health system. These important gains are an example of good practice to other countries in Europe and beyond.

The reform has not addressed other key issues, however.

- Gaps in population coverage, remaining gaps in the benefits package for dental care for adults (which is currently being expanded, in part to align with EU directives banning the use of amalgam from 2025), limited access to corrective lenses and hearing aids (due to lack of public awareness) and long waiting times persist.

- User charges that were not abolished in 2024 also create gaps in coverage: reference pricing for outpatient prescribed medicines and medical products and extra charges for the use of non-standard materials for some dental treatments, with very few protection mechanisms (see Table 3).

- The regressivity of complementary VHI premiums continues via the new mandatory contribution (the OZP), which is set as a flat rate per adult (€37 a month or €444 a year in 2025). VHI premiums (which were also set as a flat rate) were highly regressive in 2022 (see Fig. 17). There has been discussion about replacing the OZP with an increase in regular mandatory HIIS contributions, to increase progressivity, but no decision had been taken as of early April 2025.

Some of these issues are being addressed, including the introduction of measures to reduce waiting times (e.g. financial incentives for primary care doctors, the opening of new GP offices and strategies to strengthen coordination between primary and specialist care) and measures to improve access to dental care (e.g. additional funding to increase the number of dental care teams, expanded coverage of non-standard materials and, in the near future, the addition of treatment without co-payments – including dental prosthetics using contemporary standard materials by July 2025 and white composite fillings for adults in visible teeth by 2026).

Two other longstanding challenges require policy attention.

First, the current design of the OZP could increase the small but significant gap in population coverage because entitlement to the full range of HIIS benefits is now linked not only to payment of regular HIIS contributions (mandatory for about half of the population) but also to payment of the OZP (mandatory for about three-quarters). Although around one-quarter of the population is exempt from paying the OZP (mainly children and students under 26, people with disabilities, people receiving social benefits, refugees, people undergoing mandatory psychiatric treatment or treatment related to substance abuse, war veterans, military reserve members and prisoners), the new contribution is mandatory for most residents, including the following groups of people who do not have to pay the regular HIIS contribution: pensioners, registered unemployed people who are not liable for social benefits, adult dependants of covered people (e.g. spouses and parents), asylum seekers and homeless people.

When the OZP was introduced, outstanding HIIS debts were forgiven for adult dependants of covered people who had accumulated debts in the past (e.g. during periods when they were registered as self-employed). The 2024 reform also introduced a contribution debt threshold. As a result, people who are required to pay the OZP or regular HIIS contributions but

do not do so only lose their entitlement to the full range of HIIS benefits if they exceed the debt threshold of €177 (equal to 8% of the average gross monthly salary in the previous year). Their access to publicly financed health care will be limited to emergency care and a few other services (e.g. selected outpatient medicines, selected dental care, pregnancy and childbirth care, contraception and termination of pregnancy). They can request retrospective reimbursement of out-of-pocket payments incurred for HIIS benefits once they have settled their debt to the HIIS.

The first wave of data in 2024 shows a reduction in the number of people who lacked some HIIS coverage due to non-payment of contributions, compared to 2023. At the end of 2024 around 0.5% of the population eligible for HIIS coverage was not fully covered by the HIIS due to non-payment of mandatory contributions (10 381 people, down from 17 876 at the end of 2023). This is likely to reflect measures described above, such as the debt forgiveness granted to family dependants and the introduction of the debt threshold. However, more time is needed to monitor the potential impact of the OZP in widening gaps in population coverage.

Second, Slovenia's heavy reliance on employment (the labour market) to finance the health system is an issue in the context of population ageing (Šarec, 2024). In 2022 SHI contributions levied on wages accounted for nearly 80% of public spending on health in Slovenia, which was the second-highest share in the EU after Poland (Fig. 30) (WHO, 2025). Recent analysis finds that as the working-aged share of the population falls, Slovenia is likely to experience a significant decline in public revenue for health, increasing budgetary pressure in the health system (Cylus et al., 2025) – a finding that is useful to consider in current debates about how to address the regressivity of the OZP.

In contrast to Slovenia, 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 are likely to exhibit greater resilience to population ageing. For example, starting in the late 1990s, France began to broaden its public revenue base for health in two ways (Bricard, 2023; WHO Regional Office for Europe, 2019):

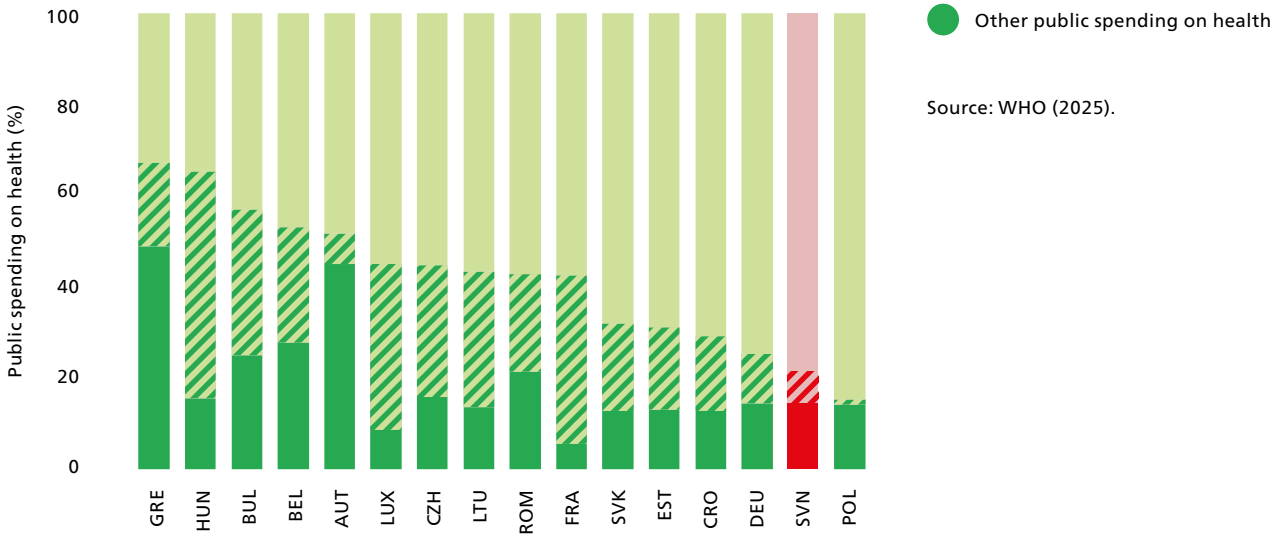
- replacing employee wage-based contributions with a contribution levied on all sources of income (including wages, pensions, unemployment benefits, rental and investment income and capital gains) and paid by all resident adults – the new income-based contributions now account for a large share of the SHI scheme's revenue; and

- increasing the level of government budget transfers to the SHI scheme.

The French Government also changed the basis for entitlement to SHI benefits from payment of contributions to residence, granting all legal residents an individual, automatic and continuous right to health care, without the need for administrative formalities when a person's circumstances change (Bricard, 2023; WHO Regional Office for Europe, 2023). This has helped France to ensure that all legal residents are covered and have access to all SHI benefits, regardless of employment status.

Unless Slovenia takes steps to broaden its public revenue base for health, there is a strong risk that budgetary pressure could push up waiting times and erode coverage, increasing financial hardship and unmet need in the future (Cylus et al., 2025).

Fig. 30. Breakdown of public spending on health in EU countries predominantly financed through SHI schemes, 2022



Source: WHO (2025).

6.3 Summary

Before the 2024 reform, which abolished most co-payments, the incidence of catastrophic health spending in Slovenia (2012–2022) was among the lowest in Europe, reflecting a relatively comprehensive publicly financed benefits package and extensive protection from heavy co-payments through carefully regulated complementary VHI, which covered 95% of people liable for user charges.

Some people with low incomes experienced unmet need and financial hardship, particularly due to long waiting times and out-of-pocket payments for dental care, outpatient medicines and outpatient care, probably reflecting: a lack of protection from extra charges for some dental treatment; long waiting times for dental care and outpatient care; limited public awareness of entitlements to medical products and dental care; a lack of protection from "avoidable co-payments" due to reference pricing for outpatient prescribed medicines and medical products; and lack of full HIIS coverage for people failing to pay mandatory HIIS contributions (typically self-employed people) or people not eligible to be for regular HIIS coverage (adult asylum seekers and undocumented migrants).

In January 2024 most co-payments were abolished and premiums for complementary VHI covering HIIS co-payments were replaced by a new mandatory flat-rate monthly contribution (the OZP) of €37 a month per person in 2025. The reform introduced some policy changes that are likely to be beneficial for financial protection: the abolition of all percentage co-payments has reduced user charges and removed the need for complementary VHI covering co-payments, which has in turn lowered complexity and administrative and transaction costs in the health system. These important gains are an example of good practice to other countries in Europe and beyond.

However, the 2024 reform has not addressed the following issues: gaps caused by the lack of any protection from user charges that were not abolished (reference pricing for outpatient prescribed medicines and medical products and extra charges in dental care); remaining gaps in service coverage for medical products (corrective lenses and hearing aids) and dental care for adults; a small but significant gap in population coverage; the regressivity of the new flat-rate OZP, which must be paid by most adults, including pensioners; and long waiting times.

Waiting times are the main driver of unmet need in Slovenia and have led to a large increase in the sale of supplementary VHI offering faster access to health care, which now covers over a third of the population – mainly people with higher incomes – and exacerbates inequalities in access to health care. Recent Government efforts slowed the growth rate of waiting times in 2024.

Two other longstanding challenges require policy attention.

- First, the current design of the OZP could increase the small but significant gap in population coverage because entitlement to HIIS benefits is now linked not only to payment of regular HIIS contributions (for about half of the population) but also to payment of the OZP (applicable to around three-quarters, including pensioners, unemployed people and adult dependants). Many of those who lack HIIS coverage are likely to have lower incomes and be at high risk of experiencing financial hardship or unmet need.

- Second, Slovenia's heavy reliance on employment to finance the health system is an issue in the context of population ageing. As the working-aged share of the population falls, recent analysis finds that Slovenia is likely to experience a significant decline in public revenue for health, increasing fiscal pressure in the health system.

Unless Slovenia takes steps to broaden its public revenue base for health, there is a strong risk that budgetary pressure could push up waiting times and erode coverage, increasing financial hardship and unmet need in the future.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is lower in Slovenia than in most EU countries. In 2022 (the latest available year of data) 1.5% of households experienced catastrophic health spending (around 13 000 households in total). The incidence of catastrophic health spending in Slovenia is among the lowest in Europe (Fig. 23).

Catastrophic health spending is concentrated in households with low incomes and mainly driven by dental care, outpatient medicines and outpatient care.

Levels of unmet need are above the EU27 average. Unmet need for health care and dental care is mainly driven by waiting times, but cost is also a key driver for dental care. Inequality in unmet need due to cost by income quintile is particularly striking for dental care and prescribed medicines.

Before the 2024 reform, carefully regulated complementary VHI covering co-payments played an important role in protecting most people from heavy co-payments. This type of VHI typically covered 95% of people liable for user charges.

However, gaps in coverage persisted, particularly for households with low incomes. This is likely to have reflected a lack of protection from the user charges that were not covered by complementary VHI, lack of full HIIS coverage for around 1% of the population (at the end of 2023) eligible to be covered (mainly self-employed people) and lack of coverage for undocumented migrants.

In January 2024 the Government of Slovenia abolished most co-payments – an example of good practice to other countries in Europe and beyond – and replaced premiums for complementary VHI covering most HIIS co-payments with a new mandatory flat-rate monthly contribution (the OZP).

The 2024 reform introduced some policy changes that are likely to be beneficial for financial protection: the abolition of all percentage co-payments has reduced user charges and removed the need for complementary VHI covering co-payments, which has in turn lowered complexity and administrative and transaction costs in the health system. These are important gains.

Several issues continue to require policy attention, however.

- Heavy reliance on mandatory contributions levied on the labour market to finance the health system is a challenge in the context of population ageing: as the working-aged share of the population falls, recent analysis finds that Slovenia is likely to experience a significant decline in public revenue for health, increasing fiscal pressure in the health system (Cylus et al., 2025). Unless Slovenia takes steps to broaden its public revenue base for health, there is a strong risk that budgetary pressure could push up waiting times and erode coverage.

- Long waiting times lead to higher take up of supplementary VHI offering faster access to treatment, mainly among people with higher incomes, which is likely to increase inequalities in access to health care.

- There is a lack of any protection from "avoidable co-payments" caused by reference pricing for outpatient prescribed medicines and medical products and extra charges for some dental treatment.

- There are remaining gaps in the benefits package for dental care for adults (which is currently being expanded) and limited access to covered vision and hearing aids due to lack of public awareness.

- Although some groups of people are exempt, the new flat-rate contribution to the HIIS (the OZP) is regressive, placing a much heavier financial burden on households with lower incomes.

- Entitlement to the full range of HIIS benefits is linked not only to payment of regular social health insurance contributions but also to payment of the new flat-rate contribution (OZP), which may result in a small but significant gap in population coverage. There is also a gap in population coverage for undocumented migrants.

Building on recent efforts, the Government can consider the following options to continue to improve financial protection, particularly for people with low incomes, and to prevent financial hardship and unmet need from increasing in the future.

- **Broaden the public revenue base for the health system to reduce reliance on employment, so that public revenue for health does not shrink as the population ages.** Options include greater use of government budget transfers to the SHI scheme and extending the levy base for some or all of the HIIS contribution to non-wage forms of income.

- **Continue to address long waiting times.** The Government should find ways to bring down waiting times to more acceptable levels and ensure that supplementary VHI offering faster access to treatment does not exacerbate inequalities in access to health care.

- **Protect people with low incomes from any remaining user charges for covered health care by:** exempting them from reference pricing for outpatient prescribed medicines and extra charges for dental treatment; introducing a cap on all co-payments, ideally linked to income (WHO Regional Office for Europe, 2023; Cylus et al., 2024; García-Ramírez et al., 2025); and applying these protection mechanisms automatically, using digital tools, to ensure all eligible people benefit (Kasekamp & Habicht, 2025).

- **Avoid introducing or increasing user charges in the future.** A large body of evidence shows that user charges are not an effective way of directing people to use health care more efficiently and have negative effects on affordable access to health care and other aspects of health system performance (WHO Regional Office for Europe, 2023).

- **Improve the affordability of outpatient medicines, as well as dental care for adults, corrective lenses and hearing aids.** Around 13% of all outpatients prescribed medicines dispensed incur "avoidable co-payments" arising from reference pricing. This share could be reduced by ensuring that health care workers have incentives to prescribe and dispense the cheapest alternatives. It may also be useful to explore why households are spending on OTC medicines. Ensure affordable access to adult dental care, corrective lenses and hearing aids by granting standard-quality benefits and promoting proper awareness of entitlements among the public and providers.

- **Address the regressivity of the new flat-rate contribution,** so that it no longer imposes a much heavier financial burden on people with lower incomes.

- **Find ways to ensure the HIIS covers the whole population.** Options include changing the basis for entitlement to residence (as France did in 2000) or continuing to give people full access to HIIS benefits, even if they have not paid mandatory contributions (as in Czechia) (WHO Regional Office for Europe, 2023; UHC watch, 2025). This is particularly important now that entitlement to HIIS benefits depends not just on payment of regular HIIS contributions but also on payment of the OZP.

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

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