World Health Organization

European Region

Can people afford to pay for health care? New evidence on financial protection in Slovakia: summary

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

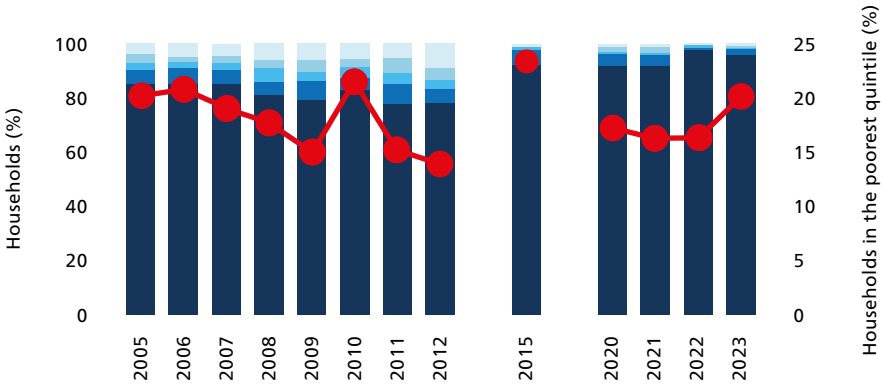
In 2023 3.3% of households were impoverished or further impoverished after out-of-pocket payments (data not shown) and 4.4% of households experienced catastrophic health spending (Fig. 1).

Catastrophic health spending is heavily concentrated in households with low incomes (Fig. 1). It is also concentrated in older people, pensioners and households in the eastern regions of the country, where most Roma people live (data not shown; Pourová & Gallardo Martínez, 2025).

In the poorest quintile catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, followed by dental care (Fig. 2). In other quintiles, it is mainly driven by dental care, followed by outpatient medicines and inpatient care. This is likely to reflect a substantially higher degree of unmet need for dental care in households with lower incomes over time (data not shown; Eurostat, 2025a).

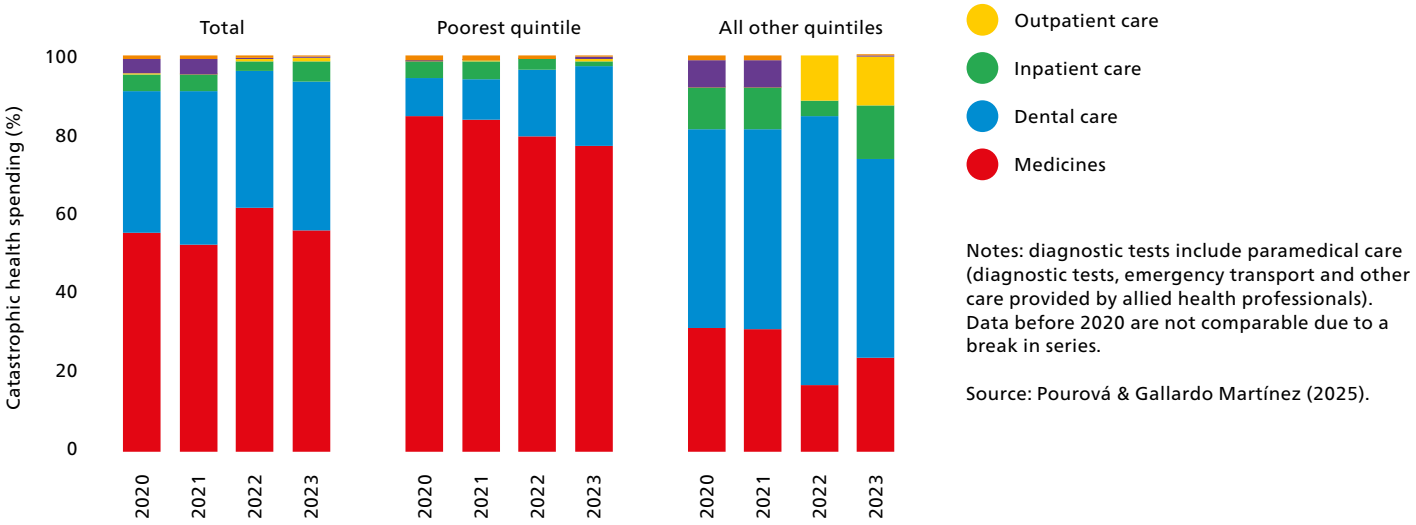
Unmet need is mainly driven by waiting time for health care and cost for dental care. During the study period there was significant income inequality in unmet need for health care, dental care and prescribed medicines (data not shown; Eurostat, 2025a; 2025b).

Fig. 1. Breakdown of households with catastrophic health spending by consumption quintile and incidence of catastrophic health spending in the poorest quintile



Source: Pourová & Gallardo Martínez (2025).

Fig. 2. Breakdown of catastrophic health spending by type of care and consumption quintile



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

Source: Pourová & Gallardo Martínez (2025).

How does Slovakia compare to other countries?

The incidence of catastrophic health spending is lower in Slovakia than in many European Union (EU) countries (particularly those in central Europe) but higher than in Austria, Finland and Spain – countries with a similar level of out-of-pocket payments as a share of current spending on health (Fig. 3). Catastrophic health spending in the poorest quintile is more heavily driven by our-of-pocket payments for outpatient medicines than most EU countries (Fig. 4). Unmet need for health care, dental care and prescribed medicines in Slovakia is lower than the EU average (data not shown; Eurostat, 2025a; 2025b).

What strengthens and undermines financial protection in Slovakia?

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

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

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

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

Waiting times and informal payments are an issue in outpatient care settings.

The system of fixed co-payments for outpatient prescribed medicines is unusual and complex, involving different co-payments for every medicine in categories AS and S. Because these co-payments are fixed per medicine they vary depending on a medicine's price. This means that people who require more expensive medicines have to pay more out of pocket and people may not know in advance how much they will have to pay for their treatment.

Mechanisms to protect people from co-payments (exemptions and caps) are not sufficient for people with low incomes or chronic conditions and loopholes in the law allow providers to charge people for non-clinical services in both outpatient and inpatient care settings (extra billing).

Fig. 3. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year, except for Greece, the Republic of Moldova and Slovakia where out-of-pocket payments are for 2022. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red > 15%. See page 5 for country codes.

Source: UHC watch (2025) and WHO (2025) for data on out-of-pocket payments.

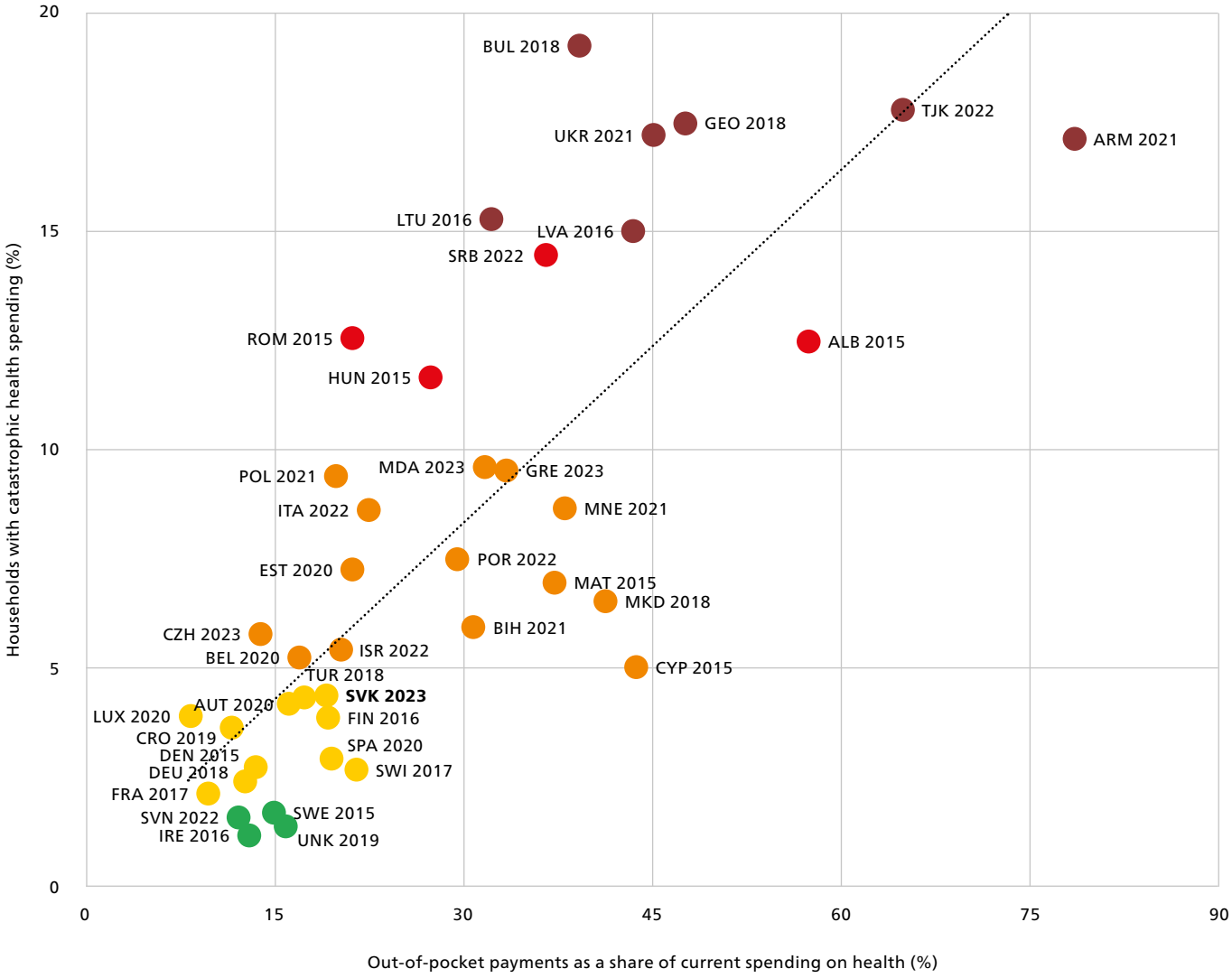
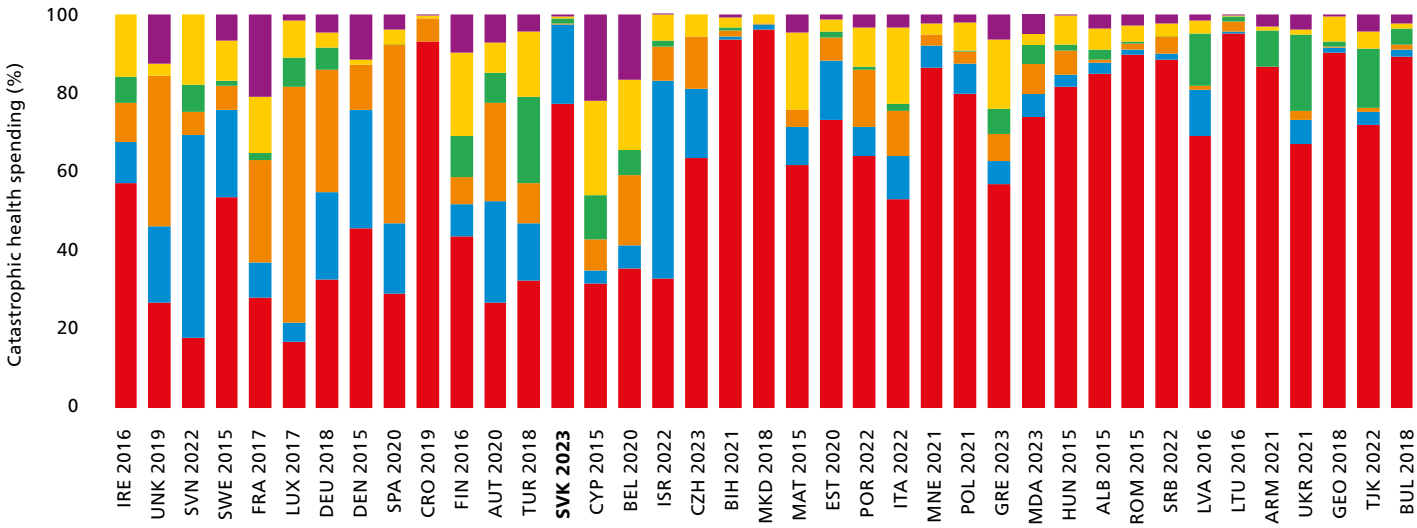


Fig. 4. Breakdown of out-of-pocket payments by type of care in households in the poorest quintile with catastrophic health spending, WHO European Region, latest available year

Notes: countries are ranked from left to right by the incidence of catastrophic health spending. Types of care are sorted by unweighted average across all households and all countries. See page 5 for country codes.

Source: UHC watch (2025).



How can Slovakia improve financial protection?

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

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

- Improve the mechanisms used to protect people from co-payments by extending exemptions and caps to all co-payments and ensuring their applicability to all people with low incomes and, ideally, also to people with chronic conditions (WHO Regional Office for Europe, 2023; Cylus et al., 2024, García-Ramírez et al., 2025).

- Reassess the usefulness of co-payments for emergency care by tackling the root causes of emergency care overuse – so that the health system can offer alternative solutions without resorting to user charges.

- Expand publicly financed coverage of dental care and find ways to ensure that more providers offer covered services.

- Tackle inefficiencies in the health system that push people to pay out of pocket for covered care (e.g. long waiting times, informal payments and extra billing).

- Soften the link between entitlement to SHI benefits and payment of mandatory SHI contributions by stopping penalizing people who are not able to pay contributions by denying them access to health care.

- Expand the scope of publicly financed health care available to people who are not eligible for (or not covered by) the SHI scheme.

- Broaden the public revenue base so that is it able to generate sufficient funding as the population ages (Cylus et al., 2025).

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

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1. All references were accessed on 18 July 2025.

Countries

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

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Monitoring financial protection in Europe

This study is part of a series of country reports generating new evidence on financial protection – affordable access to health care – in health systems in Europe and central Asia. Financial protection is central to universal health coverage, an indicator of the Sustainable Development Goals, part of the European Pillar of Social Rights and at the centre of the European Programme of Work, WHO's strategic framework for the European Region. The WHO Regional Office for Europe monitors financial protection in over 40 countries through the WHO Barcelona Office for Health Systems Financing. See UHC watch for data, analysis and other resources (https://apps.who.int/dhis2/uhcwatch).

WHO Barcelona Office for Health Systems Financing

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