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Slovakia

Health system review

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PREFACE

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template prepared by the European Observatory, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe and other countries. They are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of health care reform programmes;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including data from national statistical offices, WHO Health for All database, WHO Global Health Expenditure database, Eurostat, the Organisation

for Economic Co-operation and Development (OECD), the International Monetary Fund (IMF), the World Bank's World Development Indicators, the Global Burden of Disease study and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situations. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (www.healthobservatory.eu).

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This 2025 edition was written by Martin Smatana (Slovak Medical University), Ľubica Löffler (Pažitný & Kandilaki), Peter Pažitný (Prague University of Economics and Business) and Daniela Kandilaki (Prague University of Economics and Business). It was edited by Nathan Shuftan (Berlin University of Technology and the European Observatory on Health Systems and Policies). The basis for this edition was the previous HiT on Slovakia, which was published in 2016, written by Martin Smatana, Peter Pažitný, Daniela Kandilaki, Michaela Laktišová, Darina Sedláková, Monika Palušková, Ewout van Ginneken and Anne Spranger.

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The HiT uses data available in October 2024, unless otherwise indicated. The HiT reflects the organization of the health system, unless otherwise indicated, as it was in October 2024.

The European Observatory on Health Systems and Policies is a partnership that includes the governments of Austria, Belgium, Finland, Ireland, Netherlands (Kingdom of the), Norway, Slovenia, Sweden, Switzerland

and the United Kingdom; the Veneto Region of Italy (with Agenas); the French National Union of Health Insurance Funds (UNCAM); WHO; the European Commission; the Health Foundation; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its secretariat is based in Brussels and has offices in London at LSE and LSHTM and at the Technical University of Berlin. The Observatory team working on HiTs is led by Ewout van Ginneken (Director); Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors), Dimitra Panteli and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso.

LIST OF ABBREVIATIONS

	Slovak term	English term
AI		artificial intelligence
AOPP	Asociácia na ochranu práv pacientov SR	Association for the Protection of Patients' Rights
APS	ambulantná pohotovostná služba	Ambulatory Emergency Service
ATC		Anatomical Therapeutic Chemical
CHE		current health expenditure
CHF		congestive heart failure
COPD		chronic obstructive pulmonary disease
CT		computed tomography
DDD		defined daily dose
DRG		diagnosis-related group
ECDC		European Centre for Disease Prevention and Control
EMA		European Medicines Agency
EU		European Union
FFS		fee-for-service
FTE		full-time equivalent
GDP		gross domestic product
GFC		gross fixed capital
GP		general practitioner
HBsAg		Hepatitis B surface antigen
HICs	zdravotné poisťovne	health insurance companies
HiT		Health Systems in Transition

HPI		Health Policy Institute
HSR		Healthcare Spending Review
HTA		health technology assessment
ICCs		integrated care centres
IROP		Integrated Regional Operational Programme
IZA	Inštitút zdravotných analýz	Institute of Health Analysis
LOZ	Lekárske odborové druženie	Trade Union of Physicians
LSPP	lekárska služba prvej pomoci	Medical First Aid Service
LTC		long-term care
MCGs		multi-year cost groups
MDA		medical devices and aids
MIJ	mobilná intenzívna jednotka	mobile intensive care unit
MRC		marginalized Roma communities
MRI		magnetic resonance imaging
MZ SR	Ministerstvo zdravotníctva Slovenskej republiky	Ministry of Health of Slovakia
NCZI	Národné centrum zdravotníckych informácií	National Centre for Health Information
NHIS		National Health Information System
NHPP		National Health Promotion Programme
NIHO	Národný inštitút pre hodnotu a technológie v zdravotníctve	National Institute for Value and Technologies in Healthcare
NKÚ	Najvyšší kontrolný úrad Slovenskej republiky	Supreme Audit Office
NOI		National Oncology Institute
NOP		National Oncology Programme
NTO	Národná transplantačná organizácia	National Transplant Organization
NTS	Národná transfúzna služba	National Transfusion Service

OECD		Organisation for Economic Co-operation and Development
OOP		out-of-pocket
OS ZZS	Operačné stredisko záchrannej zdravotnej služby	National Emergency Centre
OTC		over the counter
PCGs		pharmaceutical cost groups
PROMs		patient-reported outcome measures
QALY		quality-adjusted life year
RLP	rýchla lekárska pomoc	physician-led team (emergency medical service)
RRP		Recovery and Resilience Plan
RZP	rýchla zdravotná pomoc	paramedic team (emergency medical service)
SGRs	Samosprávne kraje Slovenska	self-governing regions
ŠÚKL	Štátny ústav pre kontrolu liečiv	State Institute for Drug Control
ŠÚ SR	Štatistický úrad Slovenskej Republiky	Statistical Office of the Slovak Republic
SZU	Slovenská zdravotnícka univerzita	Slovak Medical University
ÚDZS	Úrad pre dohľad nad zdravotnou starostlivosťou	Health Care Surveillance Authority
ÚVZ SR	Úrad verejného zdravotníctva Slovenskej republiky	Public Health Authority of the Slovak Republic
V4		Visegrad 4
VHI		voluntary health insurance
VšZP	Všeobecná zdravotná poisťovňa	General Health Insurance Company
WHO		World Health Organization
ZR	Zdravé regióny	Healthy Regions

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ABSTRACT

This analysis of the Slovak health system reviews developments in governance, organization, financing and delivery of care, health reforms and health system performance. Slovakia, a central European country with a population of 5.4 million, continues to face significant health and health care system challenges.

Slovakia's health system is founded on universal coverage with compulsory health insurance, a broad benefits package and a competitive insurance model. Although life expectancy improved between 2000 and 2019, the COVID-19 pandemic reversed gains, and in 2023 Slovak life expectancy remained three years below the European Union (EU) average. Circulatory diseases and cancer are the leading causes of death, and noncommunicable diseases such as diabetes and mental illness are rising. Nearly one third of all mortality is linked to behavioural risk factors, including poor diet, high smoking rates, low physical activity and obesity.

Slovakia's health care system features competition among three insurers – one state-owned (Všeobecná zdravotná poisťovňa, VšZP) and two private. Since major reforms in 2004, the system has decentralized responsibilities and adopted selective contracting to enhance efficiency. However, structural weaknesses remain, particularly in financial sustainability, accessibility and equity. Health spending from public sources was 8.3% of gross domestic product (GDP) in 2024, yet out-of-pocket (OOP) payments account for nearly 19% of expenditures, disproportionately burdening low-income households.

Workforce shortages, especially in nursing and primary care, are worsened by emigration and an ageing staff. Urban-rural disparities persist, with modern infrastructure and specialized services concentrated in cities. Digital health advancements, such as the National Health Information System (NHIS), aim to modernize care and facilitate telemedicine, though implementation is uneven.

Ongoing reforms target cost containment, infrastructure optimization and integration of long-term care (LTC). Key priorities include addressing

regional disparities, improving workforce retention, reducing waiting times and enhancing eHealth adoption. Despite universal coverage, Slovakia must address persistent gaps in health outcomes, resource distribution and system resilience to meet the needs of its population.

EXECUTIVE SUMMARY

Slovak life expectancy has bounced back from a drop during the COVID-19 pandemic, while behavioural risk factors pose large risks to the general population health profile

Average life expectancy at birth in Slovakia increased by more than 4 years between 2000 and 2019 before falling by 3 years to 74.6 years in 2021 and then rebounding to 78 years in 2023. Among Slovaks, there are differences in life expectancy along gender (with women living 6.8 years longer) and socioeconomic lines. The rise in life expectancy was partially facilitated by a decrease in mortality rates, particularly for diseases of the circulatory system, though they remain the leading cause of mortality in Slovakia and accounted for 43% of all deaths in 2022. The second leading cause of mortality was malignant neoplasms, as lung and colorectal cancers remain the leading causes of cancer-related deaths. The prevalence of noncommunicable diseases in Slovakia indicates a similar trend to the rest of Europe, and the prevalence of diabetes mellitus and mental ill-health diagnoses has increased.

Dietary risks, alcohol and tobacco consumption have a strong influence on the health of the population, and it is estimated that nearly one third of total mortality resulted from behavioural risk factors. As a direct consequence of poor dietary habits and low physical activity, obesity is a major concern; 17% of adults in Slovakia were obese in 2022, and smoking rates have remained high and stood at 21% in 2022.

At the national level, the Ministry of Health is the main steward of the Slovak health system, while health insurance companies and regional authorities also have key roles

The health system in Slovakia is based on universal coverage, social health insurance and a competitive insurance model with selective contracting of

health care providers and flexible pricing of services. Health insurance companies (HICs) play a key role in collecting, pooling and redistributing resources and purchasing health care services. As of 2024, there are three insurers: one state-owned (VšZP) and two privately owned (Dôvera and Union). VšZP holds the largest market share at 54.8%, but the private insurers have been increasing their market shares. The Health Care Surveillance Authority (*Úrad pre dohľad nad zdravotnou starostlivosťou*, ÚDZS) monitors the health insurance market, while the Ministry of Health (*Ministerstvo zdravotníctva Slovenskej republiky*, MZ SR) is responsible for policy-making, regulation and quality standards.

Slovakia's health system underwent significant restructuring after 1989, transitioning from a Semashko model under Soviet influence to a market-oriented social health insurance system. Comprehensive health reforms in 2004 introduced joint-stock health insurance companies and decentralized provision, transferring responsibility from the state to regions, insurers and providers. These reforms aimed to enhance efficiency and resource utilization but also led to challenges related to health care accessibility and financial sustainability.

Non-state actors, including professional organizations, trade unions, patient groups and private sector entities, influence policy-making through their advocacy. Trade unions have been particularly active in negotiating health care workers' salaries and working conditions in the context of strike and mass resignation threats.

Health system financing in Slovakia comes largely from public sources, though OOP payments comprise around one fifth of all spending and primarily impact low-income residents

Slovakia's health system is predominantly funded through mandatory health insurance contributions collected from the economically active population. Contributions are supplemented by state payments for economically inactive groups, such as pensioners and the unemployed. Public spending on health was estimated at 8.3% of GDP in 2024.

OOP payments are relatively high in Slovakia, accounting for an estimated 18.7% of current health expenditure (CHE) in 2023. This financial

burden disproportionately affects low-income households, impacting health care access and equity. Efforts to reduce OOP costs include regulating co-payments, with ceilings for low-income groups.

Financial sustainability is a key challenge owing to demographic shifts, economic disparities and rising health care costs. For example, Slovakia's ageing population and regional economic inequalities affect revenue collection, contributing to financial challenges in the system.

ÚDZS oversees financial management and solvency requirements for health insurance companies, ensuring financial stability and equitable resource distribution. Public spending constraints and high public debt limit the government's ability to increase health care funding. Furthermore, although health insurance companies compete for members based on service variety, they are not allowed to compete on contribution rates, nor to select insurees.

There are geographic disparities in health care infrastructure, and replacing the ageing workforce is an ongoing challenge

Slovakia faces significant shortages in health care professionals, particularly in nursing and primary care. An ageing workforce and emigration of health professionals to higher-paying EU countries exacerbate these shortages. Some workforce development strategies have been developed and include specialized training programmes and improved working conditions, though regional disparities in workforce distribution persist, affecting health care access and quality in rural and underserved areas.

Health care infrastructure is likewise unevenly distributed, with modern facilities concentrated in urban regions. Digital health and eHealth initiatives are gradually being integrated into service provision, with the NHIS leading efforts to improve data management and health information exchange. This system aims to enhance health information management and improve data-driven decision-making but requires substantial upgrades to achieve system integration and interoperability.

Efforts to modernize health care infrastructure include centralized procurement for medicines and hospital beds to improve cost-efficiency and resource allocation. However, outdated facilities and equipment shortages continue to impact health care delivery, particularly in regional hospitals.

The delivery of health services is through a network of public and private providers

Health care is delivered at three levels: primary, secondary and tertiary care. Primary care is predominantly provided by privately practising general practitioners (GPs) and paediatricians who operate under contracts with health insurance companies. Secondary care is offered by outpatient specialists, while tertiary care is delivered through specialized hospitals and university clinics. Access to specialized services typically requires a referral from a primary care physician, maintaining a gatekeeping role to control health care costs and ensure continuity of care. Public hospitals are mainly state-owned or managed by self-governing regions, while private hospitals and outpatient facilities operate under selective contracting with insurers. The state owns major teaching and specialized hospitals. Selective contracting allows insurers to negotiate with providers based on quality, capacity and pricing criteria.

Ongoing reforms deal with making financing more sustainable over the long term as well as optimizing care networks

The 2004 reforms established a decentralized and contractual system, transferring responsibility from the state to patients, insurers and health care providers. Selective contracting allowed health insurance companies to negotiate contracts based on quality, capacity and cost-effectiveness, fostering competition among providers. To address challenges of regional disparities, a minimum network requirement was introduced, mandating minimum numbers of physicians and hospital beds per region.

Further reforms focused on financial sustainability and cost-containment. Hard budgetary constraints were introduced to improve resource allocation and reduce public spending deficits. User fees were established to moderate health care demand and encourage cost-sharing, although these fees were later reduced or abolished owing to public opposition. Efforts to enhance financial sustainability continued with the implementation of managed entry agreements for pharmaceuticals and centralized procurement of medical equipment to optimize costs.

Ongoing reforms target the optimization of health care networks, reduction of waiting times and better integration of LTC services with health and

social care systems. The 2021 hospital reform introduced a new classification system to ensure timely access to scheduled care, with implementation under way in 2025.

Waiting times are a key hurdle for accessibility while Slovakia currently lacks a comprehensive monitoring system to evaluate the impact of health policy implementation

The basic benefits package is broad and includes inpatient and outpatient care, prescription pharmaceuticals and a certain range of dental procedures, rehabilitation and spa treatments, and official cost-sharing is rare. Nevertheless, 6.1% of Slovaks reported unmet need for medical services in 2023, which was above the EU average (3.8%) and other comparator countries. Slovakia also has the highest unmet dental needs among its comparator countries (Czechia, Hungary and Poland).

A leading reason for unmet need for medical care is waiting times. These have not been measured systematically in Slovakia, and are part of a greater need for improved health system accountability. There is no comprehensive monitoring to ensure up-to-date information about policies' impact on health system goals, such as those in the Strategic Framework for Health 2014–2030 that defines medium- and long-term health policy. Furthermore, given long-term underfinancing and the regular top-ups that HICs receive, the Ministry of Finance has taken a strong role in health system governance through the so-called Health Spending Reviews (HSRs), which have become an integral part of defining the health budget.

1

Introduction

Chapter summary

- Slovakia has a population of 5.42 million people (2023) and is administratively divided into eight self-governing regions. With a low fertility rate of 1.6 children per woman and an ageing population, it faces similar problems to other Member States of the EU.
- The Slovak economy had an unemployment rate of 5.8% in 2023, down from 18.5% in 2000. Within the country, there are differences in unemployment and poverty risk rates across the regions. Following robust economic growth from 2000 to 2008, the country experienced moderate growth interrupted by the financial crisis of the late 2000s and later the COVID-19 pandemic.
- Excessive public spending post-2008 led to a significant deficit in public finances. As of 2022, Slovakia's gross government debt stood at 57.8% of GDP and is projected to increase to 61.4% by 2026.
- Slovakia is a parliamentary democracy with a unicameral chamber consisting of 150 members who are elected by proportional representation for four-year periods.
- Diseases of the circulatory system are the most frequent cause of deaths in Slovakia, accounting for 43% of all deaths in 2022. Mortality from cancer is also very high, with lung and colorectal cancers being the predominant causes of cancer-related deaths among Slovaks.

- There was a notable decline in life expectancy during 2020 and 2021 that reversed substantial growth in this indicator observed in the decade before the COVID-19 pandemic. This rebounded in 2022–2023.
- Around 3 in 10 deaths in Slovakia in 2021 could be linked to poor diet, smoking, alcohol consumption and lack of physical activity, which is higher than the EU average.

1.1 Geography and sociodemography

Slovakia is a landlocked country in Central Europe, whose independence was peacefully established after the dissolution of Czechoslovakia on 1 January 1993. It has a total area of 49 035 km^2 and shares borders with Hungary (654.9 km), Poland (541.1 km), Czechia (251.8 km), Austria (107.1 km) and Ukraine (97.9 km), as shown in Fig. 1.1.

FIGURE 1.1 Map of Slovakia

Source: United Nations, 2016.

According to the Statistical Office of the Slovak Republic (*Štatistický úrad Slovenskej Republiky, ŠÚ SR*), Slovakia had 5.42 million inhabitants in 2023, 51.1% of whom were women (ŠÚ SR, 2024, 2025). Its population density, averaging 111.8 inhabitants per square kilometre, is similar to the EU average of 108.9 inhabitants per square kilometre (Eurostat, 2024a). The terrain is primarily mountainous, with the Carpathian Mountains extending across most of the northern half of the country. This contrasts with the fertile lowland areas in the southwest (Danube plain) and southeast (Eastern Slovak plain) parts of the country. The climate of Slovakia lies on the boundary between continental and temperate, with warm, dry summers and cold, wet winters. In 2023, 84.46% of the population declared their nationality as Slovak, 7.65% as Hungarian, and 1.22% as Roma; other nationalities accounted for 6.67% (ŠÚ SR, 2025).

The territory of Slovakia is administratively divided into eight self-governing regions (*Samosprávne kraje Slovenska*, SGRs), which are subdivided into 79 districts. Although the eight regions are similar in terms of total numbers of inhabitants, age structure and gender distribution, they differ in terms of unemployment rates and poverty risk, as shown in Table 1.1.

TABLE 1.1 Key sociodemographic indicators of Slovak SGRs, 2023

SGR	POPULATION 31.12.2023	MALES 31.12.2023 (%)	REGISTERED UNEMPLOYMENT, 2023 (%)	AT RISK OF POVERTY, 2023 (%)
Bratislava	732 757	48.96	2.94	7.7
Trnava	566 114	49.08	3.45	8.4
Trenčín	568 102	48.80	3.61	8.3
Nitra	668 301	49.25	3.62	13.2
Žilina	687 174	48.63	3.99	11.7
Banská Bystrica	614 356	49.47	7.01	17.6
Prešov	808 810	48.86	8.36	22.6
Košice	779 073	48.18	7.06	21.1
Slovakia	**5 424 687**	**48.18**	**5.08**	**14.3**

Source: ŠÚ SR, 2024.

Slovakia's population is ageing at both ends of the spectrum: there has been a decrease in the number of children aged 0–14 years and an increase in the population aged 65 years and above. The share of the population aged 65 years or older reached 18.4% in 2023 (see Table 1.2), with projections indicating a further increase to 20% by 2030. This is also reflected by a notable increase in the median age of the Slovak population by 4.1 years (from 2011 to 2021), surpassing the EU's average increase of 2.5 years (Votrubová, 2023).

Regarding the fertility rate, a detailed analysis of cohort fertility among Slovak women using data from the 2021 Population and Housing Census shows that for women born in the 1970s, completed cohort fertility fell significantly below the threshold of two children. Despite this decline, Slovakia had a population increase of 1.7% (91 991 inhabitants) from 1995 to 2020, with crude death rates being exceeded by birth rates. The Slovak population did decrease between 2021 and 2023, however, due to the combination of the COVID-19 pandemic and the continuing decline in birth rates.

Alongside the growing proportion of seniors, there will also be an increase in the old-age dependency ratio, defined as the ratio between the number of persons aged 65 and over and the number of persons aged between 15 and 64. Although Slovakia is fifth in the EU in terms of the lowest old-age dependency ratio, this is expected to change in the coming years (Votrubová, 2023). Regional disparities also persist here, as SGRs in the northern and eastern parts of Slovakia have higher marriage and fertility rates (ŠÚ SR, 2025).

1.2 Economic context

Slovakia has transitioned into a market-based economy and expanded its private sector with a gradually changing role for the state, which remains pivotal and has changed significantly since the early 1990s.

Slovakia joined the EU in 2004 and adopted the Euro as its national currency in 2009. From 2000 to 2008, Slovakia experienced an annual GDP per capita growth rate of nearly 6%, which was among the highest in the EU (European Commission, 2015). However, the global financial crisis of 2007–2009 strongly impacted Slovakia, and GDP decreased by 4.7% in 2009. After recovery and moderate growth in the 2010s, Slovakia's GDP declined

TABLE 1.2 Trends in population and demographic indicators, 1995–2023 or latest available year

INDICATORS	1995	2000	2005	2010	2015	2020	2021	2022	2023
Total population[a]	5 367 790	5 378 783	5 389 180	5 392 446	5 426 252	5 459 781	5 434 712	5 428 792	5 424 687
Population aged 0–14 (% of total)[a]	22.3	19.4	16.6	15.4	15.3	15.9	16.1	16.1	16.0
Population aged 65 and above (% of total)[a]	10.9	11.3	11.7	13.1	14.5	17.1	17.4	17.9	18.4
Population density (people per km²)[a]	109.6	110.1	109.9	110.8	110.6	111.3	111.0	110.8	110.7
Population growth (annual growth rate)[b]	0.21%	0.04%	0.02%	0.14%	0.09%	0.05%	-0.17%	3.59%	2.69%
Fertility rate, total (births per woman)[a]	1.52	1.30	1.27	1.43	1.40	1.59	1.63	1.57	n/a
Rural population (% of total population)[c]	43%	44%	44%	45%	46%	46%	46%	46%	46%
Crude birth rate per 1 000 people[a]	11.5	10.2	10.1	11.2	10.3	10.4	n/a	n/a	n/a
Old-age dependency ratio[a]	16.3	16.6	16.4	17.3	20.6	25.5	26.1	27.0	28.0

Source: [a]ŠÚ SR, 2025; [b]Macrotrends, 2024; [c]World Bank, 2025.

by 3.3% in 2020 during the outbreak of the COVID-19 pandemic. While growth reached 4.8% in 2021, it was more moderate in 2022 and 2023 (see Table 1.3).

High levels of public spending after 2008 resulted in a significant deficit in public finances. In 2022 the gross government debt in Slovakia was 57.8% of GDP and is estimated to reach 61.4% of GDP by 2026, exceeding the upper limit set by the debt brake[1]. At the time of writing (in 2024), Slovakia is navigating a challenging economic landscape with a focus on managing deficits, reducing the structural deficit and ensuring sustainable public debt levels in line with European fiscal rules and national economic stability goals (NBS, 2024a).

Since the transition years in the early 1990s, traditional heavy industry has ceded way to foreign direct investments facilitating the expansion of electronics, financial services and automotive industries. The automotive industry accounts for 41.4% of total exports. Among the top five companies in the Slovak market, three are automotive manufacturers – Volkswagen, Kia Slovakia and Stellantis – employing directly over 170 000 people, with aggregate employment reaching 255 000 individuals (Trend, 2023a). This dependence and lack of diversification proved challenging in the late 2000s and again during COVID-19, and is regarded as one of the major challenges to Slovakia's economy.

While the unemployment rate reached a historic low of 5.7% in 2019, issues with employability and labour force participation persist as structural challenges, particularly in certain regions. The Bratislava Region experiences higher productivity rates, greater innovation and improved employment opportunities, while unemployment rates are notably higher in the eastern regions of the country (European Commission, 2023). Changes in employment rates directly affect the social health insurance system that heavily relies on contributions from economically active people (an estimated €5.9 billion in 2024) (Trend, 2024).

1 A Constitutional Act was implemented in March 2012 to set a limit on the amount of public debt, aiming to prevent Slovakia's debt from rising to critical levels by means of sanction and austerity mechanisms.

TABLE 1.3 Macroeconomic indicators for Slovakia, 1995–2023 or latest available year

INDICATOR	1995	2000	2005	2010	2015	2020	2021	2022	2023
GDP per capita (current US$)[a]	4 819	5 427	11 690	16 909	16 391	19 553	21 768	21 279	24 470
GDP per capita, purchasing power parity (current international US$)[a]	8 692	11 378	16 639	25 399	30 054	35 002	37 791	41 057	44 650
GDP annual growth rate (%)[a]	5.84	1.17	6.62	6.72	5.17	-3.33	4.77	1.87	1.60
Public expenditure (Government expenditure as % of GDP)[b]	48	53	40	42	46	45	46	42	n/a
Government deficit/surplus (as a % of GDP)[c]	-3.5	-12.6	-2.9	-7.5	-2.8	-5.3	-5.1	-1.7	-5.2
Central government debt (% of GDP)[a]	n/a	53.94	38.61	45.56	64.83	78.33	78.84	64.51	n/a
Unemployment, total (% of labour force)[a]	13.1	18.5	16.3	14.4	11.5	6.7	6.9	6.1	5.8
Poverty rate (People at risk of poverty or social exclusion, as % of total population)[c]	n/a	n/a	n/a	n/a	17.3	13.8	15.6	16.5	17.6
Income inequality (Gini coefficient of disposable income)[a]	n/a	n/a	29.3	27.3	26.5	24.2	24.1	n/a	n/a

Note: n/a: not available.

Source: [a]World Bank, 2025; [b]WHO, 2024, 2024; [c]Eurostat, 2024b.

1.3 Political context

Slovakia is a parliamentary democracy divided into three administrative levels: the central government, SGRs and municipalities. The Slovak President (directly elected) is the highest formal authority, although in practice this office has limited legislative powers.

The prime minister and the cabinet hold the main executive powers in Slovakia, while legislative power rests with the unicameral parliament (Národná rada or National Council) consisting of 150 members who are elected by proportional representation for four-year periods. A party, or a collation of parties, can create a government if they receive the majority of 76 or more seats in the Parliament.

During the reform period of 2002–2006, some competences of the central government were shifted to SGRs and municipalities. The eight SGRs thus enjoy a high degree of autonomy and are responsible for regional, social, economic and cultural development, while competences in legislation and taxes remain centralized. Each SGR has its own administrative organs and functions, and its representatives are elected in separate elections. SGRs are also in charge of organizing and financing social care services and regulating certain aspects of care provision.

Important interest groups in Slovakia include the Federation of Employers' Associations of Slovakia, the National Union of Employers, the Association of Towns and Municipalities of Slovakia and the Confederation of Trade Unions. Slovakia has been a member of the United Nations (UN) since 1993, a member of the Organisation for Economic Co-operation and Development (OECD) since 2000 and a member of the North Atlantic Treaty Organization (NATO) and the EU since 2004. Slovakia joined the Schengen Area in 2007.

1.4 Health status

Life expectancy at birth in Slovakia saw substantial growth in the decade before COVID-19, then declined between 2019 (77.7 years) and 2021 (74.6 years), following high COVID-19 related mortality (see Table 1.4). In 2022 life expectancy at birth rebounded back to just under 77 years, followed by another increase to 78 years in 2023. The gender gap in life expectancy is

TABLE 1.4 Mortality and health indicators, 1995–2023 or latest available year

	1995	2000	2005	2010	2015	2019	2020	2021	2022	2023
Life expectancy (years)										
Life expectancy at birth, total [a]	72.25	73.05	73.90	75.11	76.56	77.67	76.87	74.61	76.97	78.02
Life expectancy at birth, male [a]	68.40	69.10	70.10	71.60	73.10	74.30	73.50	71.20	73.60	74.70
Life expectancy at birth, female [a]	76.30	77.20	77.90	78.80	80.20	81.20	80.40	78.20	80.50	81.50
Life expectancy at 65 years, male [b]	12.70	12.90	13.30	14.10	15.00	15.70	14.80	13.30	15.00	16.00
Life expectancy at 65 years, female [b]	16.20	16.70	17.100	18.00 0	18.80	19.70	18.90	17.10	18.80	19.80
Mortality										
Circulatory diseases [b] SDR per 100 000 population	n/a	1047.90	1025.40	877.90	662.32	567.83	607.09	641.22	627.77	n/a
Malignant neoplasms [b] SDR per 100 000 population	n/a	349.40	323.60	307.50	320.16	293.29	301.78	275.10	267.67	n/a
External causes of death (V01–Y89) [b] SDR per 100 000 population	n/a	67.60	66.20	61.80	77.45	67.16	58.04	57.14	57.90	n/a
All causes [b] SDR per 100 000 population	n/a	1734.20	1687.90	1507.40	1390.61	1249.35	1365.47	1676.40	1381.00	n/a
Infant mortality rate (per 1 000 live births) [a]	10.10	8.10	6.90	5.70	5.10	4.90	4.90	5.00	5.00	5.10
Maternal mortality ratio (estimate, per 100 000 live births) [a]	11.00	8.00	7.00	5.00	5.00	5.00	4.00	12.00	5.00	4.00
COVID-19 deaths (numbers) [c]	–	–	–	–	–	–	4004	14769	2723	512

Notes: SDR = Standardized Death Rate.

Source: [a] World Bank, 2025; [b] Eurostat, 2025; [c] ŠÚ SR, 2025.

more pronounced in Slovakia than in the EU: life expectancy at birth in Slovakia was 81.5 years for females and 74.7 years for males, or 6.8 years, while it was 5.3 years in the EU (Eurostat, 2025). Moreover, there are also disparities in life expectancy based on socioeconomic status in Slovakia.

Diseases of the circulatory system are consistently the most frequent cause of deaths in Slovakia, causing 43% of all deaths in 2022. Although mortality related to diseases of the circulatory system has been reduced, it is still above the EU average. Mortality due to malignant neoplasms is also very common in Slovakia. Despite decreases in mortality since 2000, lung and colorectal cancer remain the leading causes of cancer-related deaths among Slovaks. In an effort to lower mortality rates and improve life expectancy, Slovakia is now prioritizing the management, prevention and control of oncological diseases. The introduction of the first National Oncology Programme (NOP) aims to tackle these challenges (see Section 6.1.4).

The prevalence of noncommunicable diseases in Slovakia indicates a similar trend to the rest of Europe, and the prevalence of diabetes mellitus and mental ill-health diagnoses has steeply increased in Slovakia. As of 2022, there were 349 595 registered patients with diabetes (6439 per 100 000 population). The majority of these had type 2 diabetes mellitus (91.3% of cases, totalling 319 049 patients). Type 1 diabetes mellitus was treated in 7.3% of patients (25 473 individuals), gestational diabetes mellitus accounted for 0.8% of cases (2734 women), and other types of diabetes were present in 0.7% of patients (NCZI, 2023a). Psychiatric clinics report an enormous influx, which escalated during and after the COVID-19 pandemic. In 2022 affective disorders were the most frequently diagnosed conditions among patients (31.4% of all examined individuals). The second most common diagnoses were neurotic, stress-related and somatoform disorders, affecting 27.2% of individuals, followed by organic mental disorders, including symptomatic cases, which accounted for 19.5% of individuals (NCZI, 2023b).

As with life expectancy, the COVID-19 pandemic significantly altered mortality in Slovakia in 2021, with a total of 73 500 deaths that year. Not only was the COVID-19 mortality rate higher in Slovakia when compared to other EU countries, but the excess mortality rate was also high, indicating that there was also a large indirect death toll from the pandemic (ŠÚ SR, 2022).

Child mortality indicators have been improving significantly. Infant mortality in Slovakia reported in 2023 (5.1 per 1000 live births) has been nearly cut in half since 1995 (10.1 per 1000 live births). Similarly, perinatal,

neonatal and post-neonatal mortality rates have been reduced, although at a slower pace than in neighbouring countries. Czechia reduced infant mortality to 2.6 per 1000 live births, followed by 3.3 in Hungary and 3.7 in Poland (World Bank, 2025). Mortality rates of children under 5 years have improved, as the rate fell from 13.2 deaths per 1000 live births in 1995 to 5.69 in 2021 (ŠÚ SR, 2025). Induced abortions have also declined substantially: from 695 abortions per 1000 live births in 1990 to 86 in 2021 (WHO Regional Office for Europe, 2024b). Slovakia's legislation permits abortions up to the 12th week of pregnancy.

In terms of the drivers of adult mortality, the available data point towards a prevalence of behavioural risk factors which is comparable or above those of EU countries. In 2022 the average consumption of various alcoholic beverages per person in Slovakia was 85.9 litres, equating to 8.5 litres of pure alcohol per capita (Trend, 2023b). Smoking rates have been stable: in 2003, 22.1% of the population aged 15 and older smoked daily, which declined only marginally to 21% reporting smoking daily in 2022.

According to estimates from IHME (2023) as many as 29% of all deaths in Slovakia in 2021 could be linked to poor diet, smoking, alcohol consumption and lack of physical activity, which is higher than the EU average. The largest share of deaths can be attributed to dietary risks, which include low fruit and vegetable intake and high salt consumption (17% of all deaths in Slovakia). Especially worrying is the adult obesity rate, standing at 17% in 2022 (compared to the EU average of 15%), marking a 3 percentage point increase in Slovakia since 2017 (Eurostat, 2025).

2

Organization and governance

Chapter summary

- The health system in Slovakia is based on universal coverage, social health insurance and a competitive insurance model with selective contracting of health care providers and flexible pricing of health services. Services, with exceptions, are provided to insured persons free at the point of delivery through benefits-in-kind.
- HICs are obliged by law to ensure accessible health care by contracting providers and compete for members based on the variety of their contracted services. They cannot compete on contribution rates and they are not allowed to select insurees.
- ÚDZS is responsible for overseeing health insurance, provision and purchasing. After fulfilling certain explicit criteria, there are no barriers to entry to health care provision and health insurance markets.
- As of December 2023, three HICs were operating in Slovakia: one state-owned (with 54.8% market share) and two privately owned: Dôvera, owned by the Slovak private equity group Penta Investments (32.4%) and Union, owned by the Dutch insurance group Achmea (12.6%).

- MZ SR issues permits to emergency medical services providers, specialized, university and teaching hospitals, biomedical research facilities, reference laboratories, epidemiological outpatient clinics and detention centres. SGRs issue permits to all other health care providers (general hospitals, polyclinics, hospices, nursing homes, GPs, outpatient specialists, laboratories, pharmacies, etc.).
- Professional chambers keep registers of health professionals, and they issue or revoke licences. These governance functions are separate from other functions and membership of chambers by health professionals is not compulsory. Professional chambers also provide continuous education of medical staff, cooperate in monitoring the management of health care facilities and issue opinions on ethical issues concerning the health care profession.
- Organized interest groups also participate in policy-making. They are invited to comment on legislative proposals and representatives of employees and employers meet with government representatives at the Tripartite Economic and Social Council, though their mutual agreement is not needed to continue the legislative process.

2.1 Historical background

2.1.1 *Developments until 1989*

Following Czechoslovakia's independence in 1918, the Bismarckian health system of the Austro-Hungarian Empire was expanded and refined. Legislation in 1919 and 1924 extended compulsory sickness insurance to all wage earners and their families, and created the Central Social Insurance Fund (*Ústřední sociální pojišťovna*). In 1925 sickness insurance, including medical benefits, was introduced for public sector employees.

After the Second World War Czechoslovakia fell under Soviet influence, resulting in the 1951 introduction of a Semashko-type health system: the state assumed full responsibility and financed it through general taxation. Health care was made free at the point of delivery and providers were nationalized and incorporated into regional/district institutes of national health. Early progress included combating communicable diseases, improved disease

prevention and availability of new chemotherapies (Solovič et al., 2008). Outcomes deteriorated in the late 1960s, however, due to inaccurate resource allocation decisions of the planned economy. The system was unable to deal with the growing incidence of lifestyle diseases resulting from improved living conditions, hygienic standards and success against communicable diseases. The federal states of the Czech and Slovak Socialist Republics were established in 1969, and MZ SR was established to plan and manage Slovak health care. Previous Health System Reviews provide further details on the historical background (Szalay et al., 2011; Smatana et al., 2016).

2.1.2 *After 1989*

Political and social changes following the Velvet Revolution transformed Czechoslovakia's centrally planned economy into a market economy. The social insurance system was reintroduced in the 1990s, when the National Insurance Fund (*Národná poisťovňa*) was established to fund health, social and pension insurance. In 1994 the Act on Health Insurance introduced health insurance funds and a system financed through contributions by employers and employees, and the state budget (for the economically inactive). Most pharmacists and outpatient physicians (both GPs and non-hospital specialists) went into private practice. MZ SR allowed health insurance funds to contract unlimited numbers of providers on a fee-for-service (FFS) basis, contributing to expenditure increases. Ad-hoc measures, such as restricting hospitalization of non-acute patients and financing hospitals based on prospective budgets, did not stabilize the system, and wage increases in 2001 after protests were not backed up with sufficient resources. Hospitals were confronted with rising liabilities towards health insurance funds and suppliers, making them vulnerable to corruption and resulting in declining care quality. In 2003, as part of broader reforms to public administration, facility ownership and management were mostly transferred to regional and local governments, with the exception of the biggest hospitals (type III hospitals with polyclinics and university hospitals), as well as specialized institutions.

Comprehensive health reforms restructured the system in 2004, including stabilizing measures, provision measures and network measures (liberalization of ownership and market entry, establishing the minimal network of

providers, introduction of legal user fees and the reform of emergency services, among others). Hard budgetary constraints for more effective resource utilization were introduced, and all health insurance funds were transformed into joint-stock HICs operating under the Slovak Business Code; a similar transformation was planned for hospitals, but never completed. A decentralized and contractual system of provision transferred responsibility from the state to providers, HICs and patients. The 2004 reforms were assessed by Slovakia's Constitutional Court and deemed lawful (Constitutional Court of the Slovak Republic, 2005, 2008a, 2008b, 2011).

2.2 Organization

The organizational framework of the current health system was legislatively defined in 2004. Health policy results from the interplay between MZ SR (legislator), HICs (purchasers), providers, professional organizations and the ÚDZS as supervisor (see Fig. 2.1). While patient organizations' influence is not legally codified, their comments on draft legislation are often incorporated.

2.2.1 *The state and its agencies*

Parliament (National Council)

The Slovak Parliament has legislative and oversight powers and may carry out parliamentary inspections. The five members of the ÚDZS Supervisory Board are elected by parliament based on the government's proposal.

Government

The government approves the budgets of HICs, adopts legislative measures (defining cost-sharing such as user fees and setting co-payments, and setting reimbursements for dental and medical emergency care), and appoints the ÚDZS Chair, based on the Minister of Health's proposal. The government also names the seven ÚDZS Board of Directors members based on MZ SR's proposals.

Ministry of Health (MZ SR)

MZ SR's responsibilities include developing health policy and drafting legislation, regulating provision, issuing diagnostic and therapeutic guidelines, managing national health programmes, partial management of health education, determining the scope of the basic benefits package, defining health indicators and setting minimum quality criteria. MZ SR also issues permits for treatments with natural healing/mineral waters and the operation of natural healing spas.

MZ SR prepares budget allocations for health services following consultations with HICs and providers. For inpatient care, MZ SR issues diagnosis-related group (DRG) weights and since 2022 has actively participated in concluding managed entry agreements with pharmaceutical product registration holders (see Section 2.7.4).

MZ SR owns almost all university and faculty hospitals[2], sanatoria, the largest HIC (VšZP) and five highly specialized hospitals. MZ SR is also a founder or co-founder of 21 non-profit organizations, including specialized centres or smaller regional hospitals. The Minister of Health appoints the directors of all state-owned providers. Finally, MZ SR also publishes data on the scope, structure and deadlines for submitting clinical and economic data from providers, as well as price regulation.

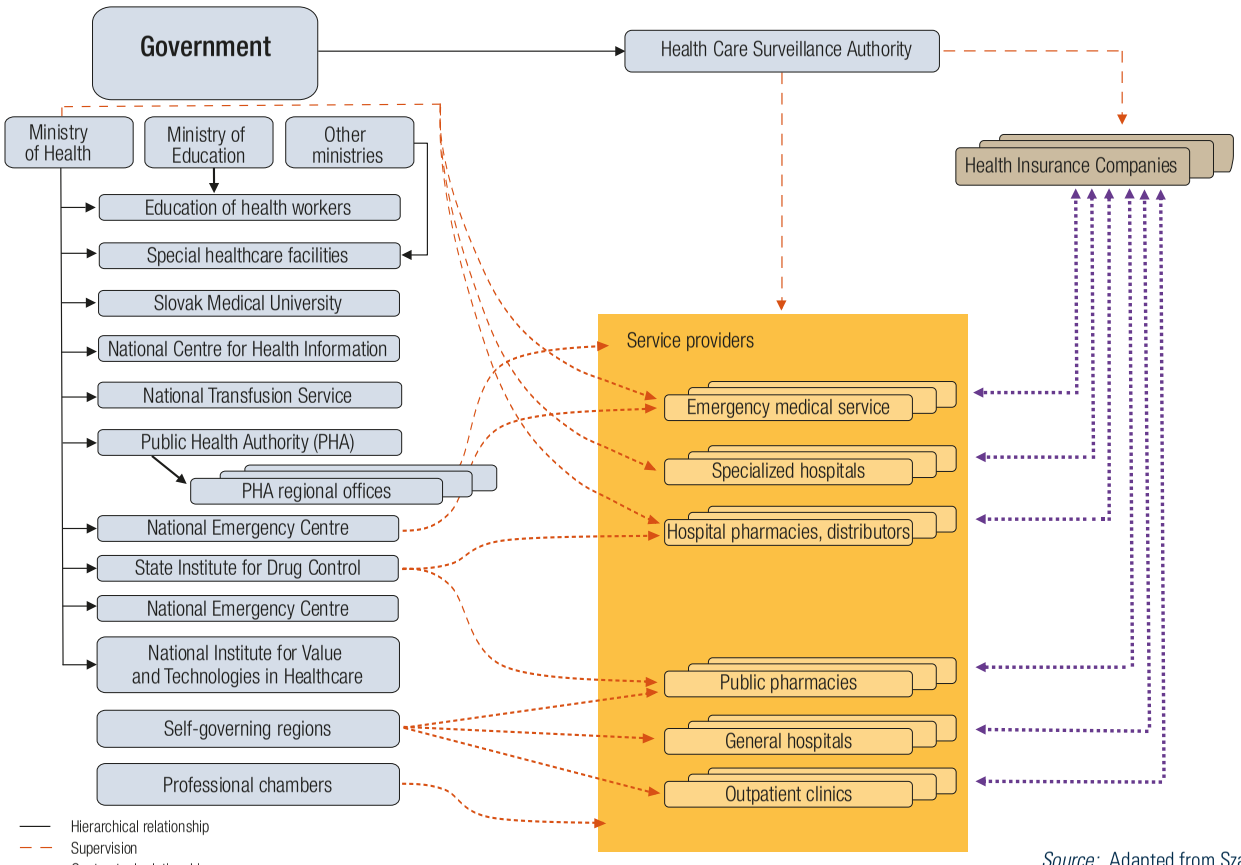
Other ministries

The management and supervision of health education and the curriculum are shared between MZ SR and the Ministry of Education, the latter being responsible for the financing. MZ SR coordinates health research in universities and the Academy of Sciences. The Ministry of Finance also monitors expenditure and reports on cost-saving and value-oriented measures that can be incorporated into public administration budgets, while HICs have to report to the Ministry of Finance.

The organization and funding of social care, including sick leave, is the responsibility of the Ministry of Labour, Social Affairs and Family. The social system and health systems evolved separately, leading to different organizations and sources of funding, even though many services they provide are practically identical. This complicates the sustainable provision of LTC (see Section 5.8).

2 Faculty hospitals have a contract with a university and conduct training for health care professionals in non-medical fields, while university hospitals have a contract with a university and conduct training for medical doctors.

FIGURE 2.1 Overview of the Slovak health system



Source: Adapted from Szalay et al., 2011.

The Ministries of the Interior, Justice, Defence and Transport have established health care facilities, notably the Military Hospital in Ružomberok and St Michal Hospital, and play a marginal role in health care provision.

Health Care Surveillance Authority (ÚDZS)

In 2004, to prevent potential conflicts of interests, the supervisory role of MZ SR was transferred to the newly established ÚDZS, regarding (1) health insurance, (2) provision and delivery of services and (3) purchasing. ÚDZS can sanction, including banning providers from the market. Moreover, it administers the risk-adjustment mechanism between HICs and administers patients' complaints regarding inadequate provision. ÚDZS also acts as a liaison for cross-border provision, and its annual report to the government describes activities and HICs' performance. Between 2010 and 2020 ÚDZS was also responsible for the implementation of Slovakia's DRG system.

ÚDZS Chairs are elected for five-year terms. When introduced in 2004, the Chair's irrevocability from the office was adopted to guarantee their independence and they could only be removed after committing crimes or in case of death. This provision has been repealed and reintroduced twice; currently, the ÚDZS Chair's mandate is revocable from office by the Government at the suggestion of MZ SR. Since ÚDZS' establishment, not one of the seven Chairs has served a full term: their mandates were either revoked (three times) or they resigned on their own (four times). ÚDZS could previously intervene to order a recovery plan in the case of unfavourable management of a HIC (i.e., if the HIC's losses were such that its equity fell below the minimum value of share capital of €16 600 000), but in 2022 this was legislatively altered and ÚDZS can now only suggest this.

Public Health Authority of the Slovak Republic (*Úrad verejného zdravotníctva Slovenskej republiky,* ÚVZ SR)

ÚVZ SR's main objectives are to protect, support and promote public health in Slovakia (see Section 5.1). It is headed by the Chief Public Health Officer. ÚVZ SR acts as the supervisory body over 36 regional public health authorities, including over laboratories and national reference centres. ÚVZ SR oversees the direction and priorities of national policy in the area of public health and also develops vaccination schedules, directly controls radiation protection and issues permits for selling

cosmetics. Through the regional public health authorities, ÚVZ SR carries out epidemiological surveillance, assesses environmental factors' impact on health, and monitors the quality of drinking and bathing water. ÚVZ SR can impose sanctions (for example, for avoiding mandatory vaccinations). Further competencies include promoting food safety and hygiene, national and international cooperation, radiation protection, and preventive and occupational medicine.

ÚVZ SR's importance was demonstrated during the COVID-19 pandemic, regularly issuing measures to protect public health (quarantine, limiting gatherings, banning visits to inpatient facilities, etc.).

State Institute for Drug Control (*Štátny ústav pre kontrolu liečiv,* ŠÚKL)

ŠÚKL is responsible for surveillance of medicines and medical devices. It approves clinical trials, grants marketing authorizations, assesses pharmacies and maintains a pharmacopoeia. ŠÚKL also assesses reports on adverse drug effects (pharmacovigilance) and medical device failures and can withdraw or suspend medicines or medical devices, though it is not involved in reimbursement decisions.

ŠÚKL regulates re-exports that can cause limited availability of some medicines. To limit this practice, it can impose sanctions for those who illegally re-export medicines. To export medicines from the positive list of categorized medicines (i.e., the reimbursement list, see Section 2.7.4), a company must notify ŠÚKL electronically within seven days of the export. Notification regarding non-categorized medicines is longer (quarterly).

National Institute for Value and Technologies in Healthcare (*Národný inštitút pre hodnotu a technológie v zdravotníctve,* NIHO)

NIHO was established in 2022 and is responsible for Health Technology Assessment (HTA) in Slovakia. It publishes evaluations and analyses based on established European methodologies on evidence-based medicine. For pharmaceuticals, its key role is to prepare evaluations of medicines with a potential impact on health insurance for the purposes of categorization and reimbursements.

The director is appointed by the Minister of Health for five years and the appointment can be revoked without specific reason; the Supervisory Board has four members serving three years (Slov-Lex, 2024a).

Emergency Medical Services (*Operačné stredisko záchrannej zdravotnej služby,* OS ZZS)

OS ZZS oversees emergency medical services. It has one central office and eight regional centres that control and coordinate integrated rescue systems, together with key stakeholders. OS ZZS processes all emergency calls and coordinates with emergency ambulance crews; manages, coordinates and evaluates services to ensure smooth operation; provides employee training; and organizes first aid and first aid instructor courses.

National Centre for Health Information (*Národné centrum zdravotníckych informácií,* NCZI)

MZ SR established the NCZI to develop eHealth and standardize health information systems (HIS) and the collection, processing and provision of health statistics. NCZI operates the national health registers as well as providing library and information services for medical research and health. NCZI also operates the NHIS. Although implementation of NHIS has been delayed, only a few functionalities are used regularly (see Section 4.1.3). Future ambitions are to offer electronic services for prescriptions, examinations, vaccinations and laboratory services, health records and coordination of appointments.

National Transfusion Service (*Národná transfúzna služba,* NTS)

NTS was established in 2004 by MZ SR to carry out tasks related to transfusions and blood donations, maintaining high quality and safety.

National Transplant Organization (*Národná transplantačná organizácia,* NTO)

NTO was established by MZ SR in 2013. Tasks include national donation coordination of organs, tissues and cells, and running the national transplant register, which includes waiting lists for transplants, registering donors and keeping records.

Slovak Medical University (*Slovenská zdravotnícka univerzita,* SZU)

SZU operates under MZ SR and has four faculties:

1. Faculty of Nursing and Professional Health Studies
2. Faculty of Medicine

3. Faculty of Public Health
4. Faculty of Health

SZU instructs health care professionals across all three levels of higher education, specialized studies, and continuous medical education in all relevant fields. Additionally, SZU researches medical and pharmaceutical sciences.

Healthy Regions (*Zdravé regióny,* ZR)

ZR carries out initiatives aimed at systematically enhancing conditions of marginalized Roma communities to attain improved population health results. Main activities are targeted around national projects financed by the European Structural and Investment Funds (Zdravé Regióny, 2022).

ZR also aims to reach the Roma community by promoting access to health care, including prevention and health education, as well as reducing health gaps between Roma and the general population. The programme is currently being carried out in 245 locations, mainly in central and eastern Slovakia.

2.2.2 *HICs*

HICs play a key role by collecting, pooling and redistributing resources and purchasing services. With the exemption of DRGs, the rescue emergency system, drugs and medical devices reimbursements, HICs are allowed to develop their own payment mechanisms and arrange pricing policy with contracted providers. Purchasing is based on selective contracting and the contractual relations between HICs and providers are supervised by ÚDZS (see Section 3.3.4).

HICs are joint-stock companies and are obliged to meet solvency criteria. This guarantees scheduled payments within 30 days after the issuing of a provider's invoice. Ownership regulation allows both the state and the private sector to be shareholders of HICs. Although there were seven HICs in 2006, a wave of mergers led to increased consolidation in the market and there are three as of 2024: the state-owned VšZP, and two privately owned ones (Dôvera and Union) (see Table 2.1).

TABLE 2.1 Overview of HICs and their market shares

	INSURED PERSONS AS OF 31 DECEMBER 2008[a]	% SHARE OF THE MARKET	INSURED PERSONS AS OF 31 DECEMBER 2015[b]	% SHARE OF THE MARKET	INSURED PERSONS AS OF 31 DECEMBER 2023[c]	% SHARE OF THE MARKET
VšZP	2 920 629	55.35	3 267 002	63.31	2 845 191	54.86
Dôvera	856 681	16.24	1 440 810	27.92	1 684 087	32.48
Union	336 959	6.39	452 308	8.77	656 444	12.66
SZP	715 882	13.57	–	–	–	–
Apollo	446 161	8.45	–	–	–	–
Total	5 276 312	100.00	5 160 120	100.00	5 185 722	100.00

Source: [a] ÚDZS, 2009; [b] ÚDZS, 2016; [c] ÚDZS, 2023a, 2023f.

2.2.3 *SGRs*

SGRs' responsibilities include issuing permits for the operation of health care facilities (hospitals, outpatient facilities), approving office hours, appointing ethical committees, issuing outpatient emergency service schedules, approving outpatient biomedical research, and archiving medical paper records after a provider's closure or retirement. MZ SR reviews appeals against decisions made by the SGRs. The SGRs also assist in improving the provider networks to guarantee access.

SGRs monitor the provision of care and can sanction providers for neglecting their duties, including financial penalties and – after a recommendation from ÚDZS – permit revocations. SGRs own some facilities and can independently manage them. Since gaining this competence in 2003 (see Section 2.3) most of those facilities were leased to private providers.

During the COVID-19 pandemic, SGRs played a crucial role in mass testing in cooperation with district authorities (i.e., logistics and organization). Moreover, SGRs also organized vaccinations in large-capacity centres and the mobile vaccination service.

SGRs have also played a crucial role in meeting the needs of refugees from Ukraine (see Box 2.1).

BOX 2.1 SGRs' roles in welcoming Ukrainian refugees

SGRs and district-level actors in the health system (doctors supported by representatives of municipalities) have played a leading role in coordinating the response and delivery of care related to health needs of refugees fleeing Ukraine after the full-scale invasion by the Russian Federation (MZ SR, 2023c). Notable examples include:

- The establishment of a care centre in Košice, which boosted available response capacities by calling on Ukrainian health workers that had been living and working in Slovakia (Folentová, 2022).
- The Prešov regional authorities worked in cooperation with paediatricians to integrate refugee children into their clinics.
- In Bratislava, a health centre was set up to provide GP care for both refugee adults and children within weeks of the war's outbreak. Care was provided by staff (including Ukrainian health workers in temporary professional internships overseen by Slovak physicians with the professional competence to perform the relevant specialized activities). According to MZ SR data, the centre assisted about 30 000 refugees.

2.2.4 *Non-state actors*

Professional organizations

Organizations of providers and professional chambers promote and advocate the interests of their members. They comment on draft legislation and represent their members in contract negotiations with HICs. They maintain workforce registers and offer continuous education. Chambers also grant licences and impose sanctions. Since 2005 chamber membership has been voluntary (issuing licences and maintaining registers of health professionals are distinct from membership in the chamber), though the oldest chambers have managed to retain members and thus influence. These include:

- the Slovak Medical Chamber (*Slovenská lekárska komora*)
- the Slovak Chamber of Dental Physicians (*Slovenská komora zubných lekárov*)
- the Slovak Pharmaceutical Chamber (*Slovenská lekárnická komora*)

- the Slovak Chamber of Nurses and Midwives (*Slovenská komora sestier a pôrodných asistentiek*)
- the Slovak Chamber of Medical and Technical Workers (*Slovenská komora medicínsko-technických pracovníkov*)
- the Slovak Chamber of Physiotherapists (*Slovenská komora fyzioterapeutov*)
- the Slovak Chamber of Dental Technicians (*Slovenská komora zubných technikov*)
- the Slovak Chamber of Orthopaedic Technicians (*Slovenská komora ortopedických technikov*)
- the Slovak Chamber of Other Healthcare Workers (*Slovenská komora iných zdravotníckych pracovníkov*)
- the Slovak Chamber of Psychologists (*Slovenská komora psychológov*)
- the Slovak Chamber of Emergency Medical Technicians (*Slovenská komora zdravotníckych záchranárov*)

The most significant organizations of providers are the Association of Hospitals of Slovakia (*Asociácia nemocníc Slovenska*) and the Association of Private Physicians of Slovakia (*Asociácia súkromných lekárov*).

The Slovak Medical Association (*Slovenska lekárska spoločnosť*) comprises medical and pharmaceutical groups and regional associations of physicians and pharmacists. It focuses on technical and ethical issues, as well as the dissemination of scientific knowledge. Professional societies within the Slovak Medical Association delegate their professionals to serve on committees (such as the Reimbursement Committee for Medicinal Products and the Catalogue Committee for medical procedures at MZ SR).

Private sector

Common interests are represented by umbrella organizations, particularly regarding pharmaceuticals and devices:

- the Association of Drug and Health Device Suppliers (*Asociácia dodávateľov liekov a zdravotníckych pomôcok*)
- the Slovak Association of Medical Device Suppliers (*Slovenská asociácia dodávateľov zdravotníckych pomôcok*)
- the Association of Innovative Pharmaceutical Industries (*Asociácia inovatívneho farmaceutického priemyslu*)

- the Association for Generic and Biosimilar Drugs (*Asociácia pre generické a biosimilárne lieky*)
- the Association of Health Insurance Companies Slovakia (*Asociácia zdravotných poisťovní Slovenskej republiky*) represents the three HICs.

Trade unions

The largest trade union (18 000 members) is the Association of Health and Social Trade Unions (*Slovenský odborový zväz zdravotníctva a sociálnych služieb*). It negotiates collective contracts with the employers' representatives. The Trade Union of Physicians (*Lekárske odborové združenie*) is smaller and mainly advocates financial interests. It played an important role in the 2022 mass protests of hospital-employed physicians over pay and work conditions, achieving significant benefits (see Section 3.7.2) (LOZ, 2022).

Patient/consumer groups

These are mostly determined by dedicated individuals and available financial resources and are represented by various umbrella organizations. Their work is often multidisciplinary, given the division of competences between health and social care (i.e., those with disabilities lobby the Ministry of Labour, Social Affairs and Family).

In the health system, patient organizations representing people with chronic conditions include:

- the Slovak Diabetes Society (*Slovenská diabetologická spoločnosť*)
- the Slovak Association of Multiple Sclerosis (*Slovenský zväz sclerosis multiplex*)
- the Slovak Crohn Club
- the League against Rheumatism in Slovakia (*Liga proti reumatizmu na Slovensku*)
- the Club of Cystic Fibrosis (*Klub cystickej fibrózy*)
- Community for Help to People with Autism (*Spoločnosť na pomoc osobám s autizmom*)
- the Slovakian Down Syndrome Association (*Spoločnosť Downovho syndrómu na Slovensku*)

Numerous projects for oncology patients, their relatives and the public are undertaken by the Slovak League against Cancer (*Liga proti rakovine*

Slovenskej republiky), and the civic associations *Nie rakovine* and the *Amazonky*. Psychiatrists, psychotherapists and patient organizations cooperate within the League for Mental Health (*Liga za duševné zdravie*) to advocate for mental health.

The Association for the Protection of Patients' Rights (*Asociácia na ochranu práv pacientov* SR, AOPP) brings together roughly 50 patient organizations to proactively participate in the legislative and categorization processes, and to set standards for diagnosis and treatment, pricing, and patient access to treatment (European Patients Forum, n.d.).

2.3 Decentralization and centralization

The early 2000s saw the establishment of SGRs. This decentralization included transferring ownership (and management) of the majority of state-owned facilities to SGRs, including type II hospitals with polyclinics for secondary care. Type I hospitals with polyclinics were devolved to the districts (see Section 2.1.2)

Slovakia has centralized purchasing of medicines to streamline procurement. HICs carry out this function to achieve cost-savings on medicines, as this approach allows for bulk purchasing (Dôvera, 2021). In 2017 MZ SR commenced the procurement of hospital beds, followed by the initiation of centralized procurement for magnetic resonance imaging and ultrasonography devices in 2022.

2.4 Planning

Slovakia does not have a dedicated national health planning agency. Strategic management is the responsibility of MZ SR (see Box 2.2), which develops proposals and priorities for health policy.

The Strategic Framework for Health 2014–2030 currently serves as the ministry's main strategic management tool. It was the first document to determine medium- and long-term directions of Slovak health policy and formulated goals and priority areas. The timeline and key documents leading to the 2014–2030 strategy are depicted in Fig. 2.2, though an analysis by Slovakia's Supreme Audit Office (*Najvyšší kontrolný úrad Slovenskej republiky,*

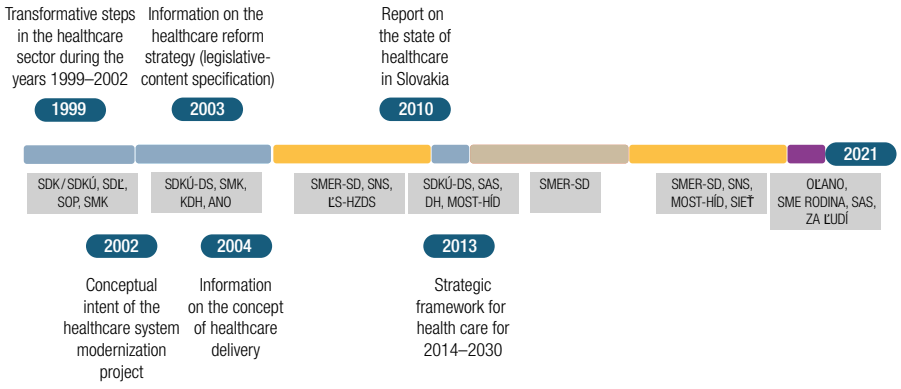
NKÚ) found no established regular acceptance nor evaluation of the overall strategies, and that MZ SR does not regularly monitor its fulfilment. Currently, indicators for the monitoring of implementation are under development, highlighting a change and improvement in planning processes. The NKÚ, in the same report, found that there have been numerous documents defining strategy in various specific areas within the health system through the years and many face similar problems regarding monitoring (NKÚ, 2022).

BOX 2.2 Is there sufficient capacity for policy development and implementation?

Capacities for both policy development and implementation face a number of limitations. For one, MZ SR faces challenges in maintaining a comprehensive overview of current strategic documents, which may impede its ability to effectively monitor and implement official strategies.

According to a 2024 report from Slovakia's NKÚ, a lack of money, people and capital, but also a lack of the necessary ideas that would "heal" the health care system have kept MZ SR from exercising the basic function of creating and implementing public health policy (NKÚ, 2024).

FIGURE 2.2 Timeline of adoption of key strategic documents in planning Slovakia, 1999–2021



Notes: The Strategic Framework for Health 2014–2030 was later updated, but the changes are not reflected in this figure. Abbreviations in grey refer to the political parties that sat in the respective government coalitions during the years indicated.

Source: NKÚ, 2022.

Additionally, in 2022 MZ SR prepared its own gender equality plan for the years 2022–2025 in alliance with Horizon Europe (MZ SR, 2022a). It focuses on the following:

- working conditions
- awareness of gender equality
- preventing harassment/discrimination

2.5 Intersectorality

Health in All Policies

In theory, MZ SR pursues the Health in All Policies approach to engage with other sectors to identify the impact of their policies on health determinants and health with overarching documents like the Strategic Framework for Health 2014–2030. In practice, however, the Framework's monitoring efforts have been deemed lacking by the NKÚ (see Section 2.4), and there is not yet an intersectoral practice to assess all reforms and large projects in Slovakia from the perspective of their impacts on the health of the population. A previous attempt to create a mechanism and methodology for this, that is, to make the consideration of health impact a mandatory part of all legislative processes and large projects, was never completed.

Occupational Health

Since 2008, all employers must offer occupational health services in high-risk environments. These services comprise professional counselling, including health risk assessment and surveillance. It is provided by qualified health professionals or by external bodies that are authorized by ÚVZ SR.

National Anti-Drug Strategy

In 2021 the government approved "Slovakia's National Drug Strategy 2021–25, horizon 2030". The new Strategy builds on a previous strategic

document from 2013, and is based on the European Union Drugs Strategy 2021–2025 (MZ SR, 2021a). The strategy aims to reduce demand (raising awareness of the adverse effects and improving treatment access) and supply (dismantling organized criminality). It also addresses drug-related risks, and the health and social needs of drug users. Furthermore, cooperation within the EU, third countries and international organizations was strengthened.

Strategy for Human Resources Development in the Healthcare and Social Services Sector 2030

This Strategy focuses on improving workforce quality, accessibility and skills within health care and social services. It aims to address challenges like staffing shortages, evolving service needs and the integration of new technologies while ensuring sustainability and efficiency in the long term. It is aligned with demographic trends and the need for workforce adaptation to an ageing population and complex health care demands (HSR, 2022).

2.6 Health information systems

Since 2013 the Act on the National Health Information System requires all providers, HICs, SGRs, ÚVZ SR and legal entities managed by MZ SR to provide data in a systematic structure according to standards set by NCZI.

In practice, this requirement is not fully met owing to (1) no unified information system(s); (2) outdated data structures and standards; and (3) inadequate capacity at NCZI to analyse the data. Thus, the reliability and validity of the data are low, and data on health status, quality and performance of providers do not meet the needs of policy-makers in making qualified decisions. Neither commonly agreed indicators nor standards of their reporting methodologies are available. While information on health insurance performance collected by ÚDZS is accessible, it is more limited: ÚDZS compiles and analyses data from all three HICs, published in annual reports.

Comparisons on performance and quality indicators or waiting lists are prepared by independent organizations and partially by HICs as a result of selective contracting; providers are reimbursed by HICs according to certain

reported indicators. All providers are obligated to report communicable diseases to ÚVZ SR.

Patient-friendly information about the quality of providers has been the focus of a joint effort by MZ SR, NCZI and the American Chamber of Commerce in Slovakia. The project "Health Data Value" was introduced to the public in October 2022 during the Health Data Value Conference (AmCham Slovakia, 2022). Since 2020 participating experts had been working with diverse data sources to align them with system requirements and stakeholder needs. With these preliminary stages completed, the project is currently in its third phase: implementing the suggested technical solutions and necessary legislative changes.

The Bratislava Declaration, signed at the conference, has four objectives:

- to manage and fund the Slovak health system using quality data;
- to create one consolidated, authorized source of quality health care data built on international standards. Data collection has to be well-structured, secure, automatic and timely;
- to utilize data for science, research and innovations in health care; and
- to support high-quality (inter)national reporting.

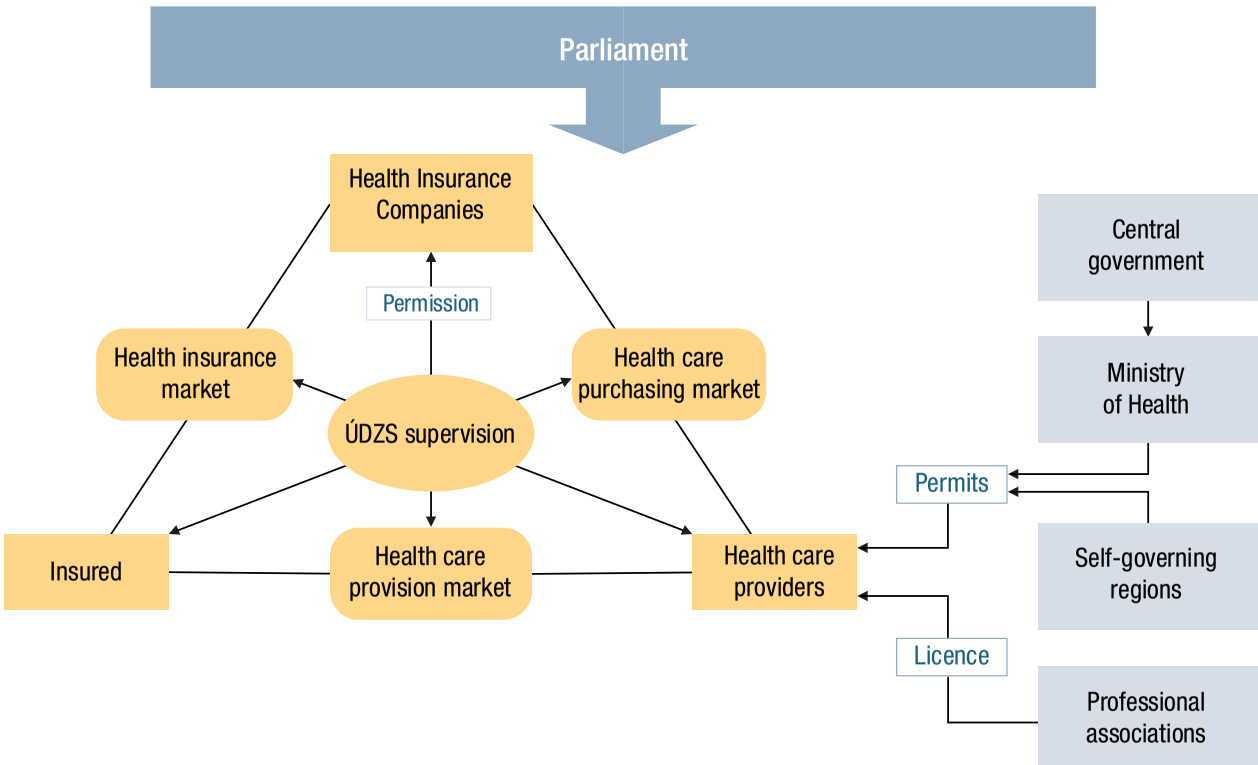
2.7 Regulation

The main actors include parliament, the government, MZ SR, SGRs and ÚDZS. The regulatory environment is significantly shaped by parliamentary laws, including the Commercial Code, the Civil Code and the Labour Code. As executive bodies, the government and MZ SR enact regulations and decrees with legal liability and enforcement. ÚDZS is responsible for monitoring insurance, purchasing and providers (see Fig. 2.3). The Constitutional Court rules on whether laws conflict with the constitution, which stipulates that every person shall have the right to protect their health.

2.7.1 *Regulation and governance of third-party payers*

As of 2004, HICs operate as joint-stock companies. HICs collect contributions, pool resources and purchase services. They must operate nationwide,

FIGURE 2.3 Regulation in the Slovak health system



Source: Adapted from Szalay et al., 2011.

although market shares show significant regional variation. This results in regional differences between HICs' negotiating power vis-à-vis providers.

ÚDZS issues licences for HICs. Legal conditions include an issued share capital (minimum €16.6 million) and transparent leadership. Their shareholders appoint their Boards of Directors and Supervisory Boards. Regulations apply to the shareholders' structure, staffing and purchasing policies, as well as to the financial management of the HICs. ÚDZS enforces these regulations and may impose sanctions. In 2024 VšZP was threatened with sanctions owing to poor economic performance and the threat of insolvency.

HICs, like all other joint-stock companies, are obliged to undergo an external audit of their accounting records. They can propose an auditor, but ÚDZS may refuse this and assign one. ÚDZS submits biannual reports on the financial administration of HICs, as well as an annual budget proposal to both MZ SR and the Ministry of Finance. All HICs must submit their business plans to ÚDZS as well as MZ SR and the Ministry of Finance, and must publish annual reports via the Commercial Register. HICs must publish all contracts with providers on their websites.

The state, represented by the government and MZ SR, plays an important role in regulating HICs (as the government can appoint and dismiss the ÚDZS Chair), defining the (minimum) benefits package via legislation, setting reimbursement policies for drugs, medical devices and dietetic food, and determining whether user fees apply and maximum waiting lists. As MZ SR is the only shareholder in VšZP (the largest HIC), the Ministry has influence over the insurer's operating and purchasing policies, and, due to its market share (54.8%), over a large segment of the health insurance market.

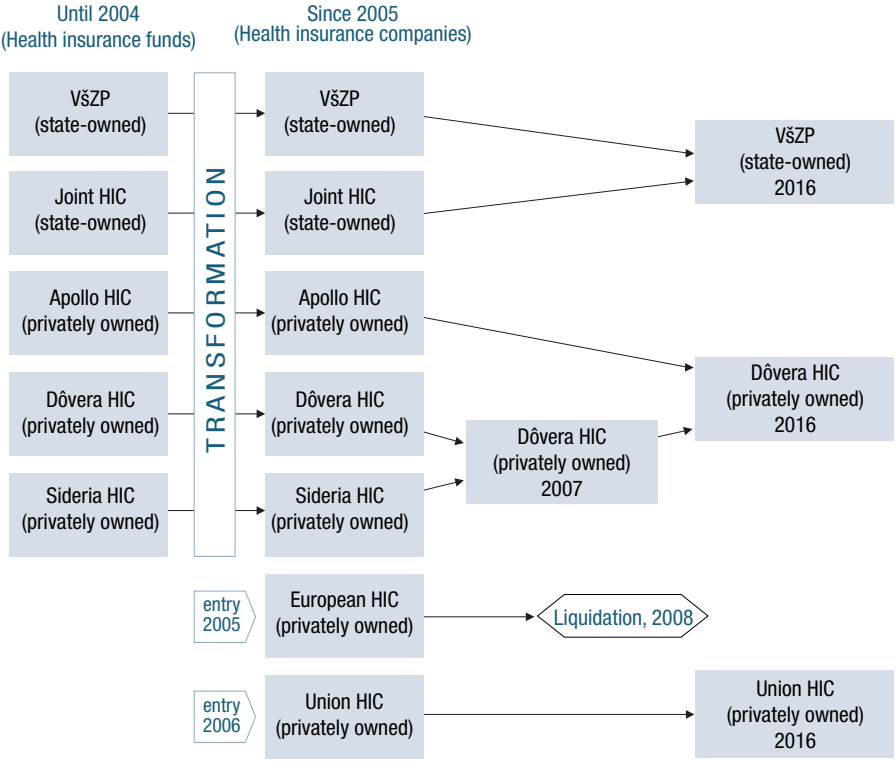
HICs must meet all the health care needs of their insured before being allowed to pay out dividends to shareholders. Initially, after the 2004 reform (see Section 2.1.2), two profit-oriented HICs entered the market, two merged to consolidate their portfolios, and one ceased operating. Beginning in 2008, HICs had been obliged to use all profits towards purchasing services in the following year, though the possibility of making a profit from public health insurance was reintroduced in 2011 after a Constitutional Court ruling. In 2012 the Dutch company Achmea, owner of the Union HIC, won an international arbitration case against Slovakia and Slovakia had to pay €25.5 million in damages as a result of the profit ban between 2008 and 2011.

HICs' profits are an often-reoccurring topic without a clear conclusion. Since 2023 HICs can keep only a small part of their income as profit.

Specifically, they're allowed to retain up to 1% (after the application of a risk adjustment mechanism) of the total insurance premiums they collect. If they make more than that, the extra money does not go to shareholders – it must be put into a special fund called the health quality fund. This fund is used to pay for health services that improve the quality of care for insured people. Furthermore, HICs are required to use at least 95.1% of prescribed premiums for care-related costs.

After two more mergers, the market (as of 2024) consists of the state-owned VšZP and two privately owned HICs (see Fig. 2.4). The market share of VšZP dropped from 76% in 2005 to 54.8% in 2023.

FIGURE 2.4 Health insurance market structure, 2004–present



Source: Adapted from Szalay et al., 2011.

With only three HICs operating in Slovakia, the health insurance market was very concentrated in 2023, with a Herfindahl-Hirschmann Index of 0.42. This indicator measures the amount of competition among

firms in an existing market in relation to their sizes. As such, the index can range from 0 to 1.0, moving from a large number of very small firms to a single monopolistic producer (see Table 2.2). Above 0.25, a market is seen as highly concentrated.

TABLE 2.2 Herfindahl-Hirschmann Index of the Slovak health insurance market, 2005–2023

	2005	2007	2009	2011	2013	2015	2017	2019	2021	2023
Index	0.45	0.36	0.36	0.51	0.49	0.49	0.48	0.47	0.43	0.42

Source: Authors' own calculation based on ÚDZS, 2017, 2019a, 2021a, 2023a data.

2.7.2 *Regulation and governance of provision*

Regulating care focuses on three components: structure, processes and results.

Structure

MZ SR sets minimum criteria for material and technical equipment, as well as qualifications and personnel criteria. The following conditions need to be met to provide health care in Slovakia: (1) a permit to operate the facility and (2) a licence from the relevant professional chamber for the various professionals working there. Both can be requested if material, technical, staff and qualification requirements are met.

Permits for many in- and outpatient facilities are generally issued by SGRs (see Table 2.3). However, the permits for the biggest hospitals are exempted from this rule and are issued by MZ SR. Disputes are settled by MZ SR, which also issues permits for specialized hospitals, facilities for biomedical research, tissue units, biological banks and reference laboratories. Providers willing to operate in several SGRs also fall under MZ SR's regulation.

Permits are granted indefinitely, during which providers are obliged to observe specific legal conditions. Emergency medical service and outpatient emergency service providers are an exception; they can only obtain a permit from MZ SR after winning a tender, while financing from HICs and an identified operating territory must be secured.

TABLE 2.3 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING / ACCREDITATION	PRICING/TARIFF SETTING	QUALITY ASSURANCE	PURCHASING/ FINANCING
Ambulatory care (primary and secondary care)	Act 576/2004 Coll. on health care, health care-related services level	MZ SR for primary care in cooperation with SGR HICs (contracting)	SGRs MZ SR (if more SGRs are involved)	HICs (contracting)	Theoretically ÚDZS, in reality maybe HICs – through contracting	HICs
Inpatient care	Act 576/2004 Coll. on health care, health care-related services level	MZ SR for primary care in cooperation with SGR HICs (contracting)	MZ SR and SGRs	HICs (contracting)	Theoretically ÚDZS, in reality maybe HICs – through contracting	HICs
Dental care	Act 576/2004 Coll. on health care, health care-related services level	HICs (contracting)	SGRs	HICs (contracting)	Theoretically ÚDZS, in reality maybe HICs – through contracting	HICs
Pharmaceuticals (ambulatory)	Act 363/2011 Coll. on the scope and conditions of reimbursement of medicines, medical devices, and dietary foods based on public health insurance	SGRs (opening hours – schedule of pharmacy emergency services)	SGRs (new pharmacy) MZ SR (permit for narcotics) ŠÚKL (permit for drug precursors)	MZ SR (categorized pharmaceuticals)	Theoretically ÚDZS, plus SÚKL (drug safety monitoring)	HICs
LTC	Act 576/2004 Coll. on health care, health care-related services level Act 267/2022	MZ SR (part of the Recovery and Resilience Plan)	SGRs	HICs (contracting)	Theoretically ÚDZS, in reality maybe HICs – through contracting	HICs
University education of personnel	Act 578/2004 Coll. on health care providers, health workers and professional organizations in the health service	MZ SR	MZ SR	n/a	n/a	n/a

Source: Authors' own elaboration.

Independent health professionals who function as entrepreneurs may provide services based only on their licence to perform in an independent medical practice.

Almost all GPs and the vast majority of outpatient specialized physicians provide services in private practices. The state is the owner of the largest (mostly university and faculty) hospitals, almost all of which are 'contributory organizations' (i.e., not-for-profit legal entities). Five state-owned facilities were transformed into joint-stock companies by the 2004 reforms.

Irrespective of legal form, all providers need to compete for contracts with HICs based on quality criteria and prices. By delegating the competences to establish a network of providers from MZ SR to HICs, selective contracting was enabled in the Slovak health system. To guarantee accessibility of providers, a minimum network requirement is set by the government to influence capacity planning. This network is based on calculations of the minimum number of physicians' posts in outpatient care and a minimum number of hospital beds for each SGR. Minimum capacities are calculated per capita.

Process

MZ SR requires providers to have written documentation concerning their quality system, in order to reduce provision shortcomings. However, MZ SR has so far not enforced this and providers are currently not required to undergo external monitoring, or to publish their financial results or quality indicators.

A certain shift in the regulation of processes occurred after 2018, when MZ SR started issuing standard diagnostic guidelines and standard therapeutic guidelines not constituting a generally binding regulation. The standards are issued gradually and should cover a total of 150 specialty areas (MZ SR, n.d.(a)).

In 2025 a delayed regulation on waiting lists is planned for implementation (Dôvera, 2024). It should operate as follows:

- The patient agrees with the provider, and the provider submits a proposal for planned care. The HIC checks and approves the proposal and informs the patient.
- Each proposal has its own identifier, assigned by the provider for mutual communication between the provider, the HIC, the patient and NCZI.

- Depending on the service, the period of time availability is determined; this starts on the day the proposal is submitted.
- The provider will assign the first available date. If the patient's condition is serious or the procedure requires multiple hospitalizations, the provider may choose an earlier date. The patient can also request a later date.
- If the service is not available during the defined period and the patient wants an earlier date, they can try to contact another provider. If the patient goes out of network there may be additional fees. If the patient decides to wait, the agreed performance date remains valid.

Results

This is limited to issuing quality indicators on providers, which serve as criteria for selective contracting. Quality indicators are published yearly and are developed by MZ SR in cooperation with professional organizations, HICs and ÚDZS. According to ÚDZS, the data collected by providers have low validity, which results in the low credibility of the providers' ranking.

Suspicions of malpractice are investigated by ÚDZS. If malpractice is confirmed, ÚDZS can impose sanctions in cooperation with SGRs and MZ SR. In case of a suspected crime, ÚDZS files a motion to bring a contested issue before a court for decision. Such incidents are published by ÚDZS in case report summaries.

2.7.3 *Regulation of services and goods*

Basic benefits package

The Slovak Constitution guarantees access to health care and assumes that the scope of covered health services should be defined by the law (in parliament). The definition of the basic benefits package is very broadly outlined in Act No. 577/2004 on the scope of health care reimbursed under health insurance and payments for health care services. After the Constitutional Court ruled to enable more precise definitions of patient entitlement through subsidiary regulations, several decrees have been implemented to govern specific sectors within health care services but there is no single list of services that constitutes the basic benefits package.

HTA

Since 2022, novel technologies are examined by NIHO. NIHO prepares evaluations and analyses based on established European methodologies (EUnetHTA) according to evidence-based medicine. Their assessments are then passed to the respective reimbursement committee, where members issue final recommendations and MZ SR issues decisions. In regard to pharmaceuticals, its key role is to prepare evaluation of medicines with a potential impact of more than €1.5 million per year for the purposes of categorization (NIHO, 2024).

2.7.4 *Regulation and governance of pharmaceuticals*

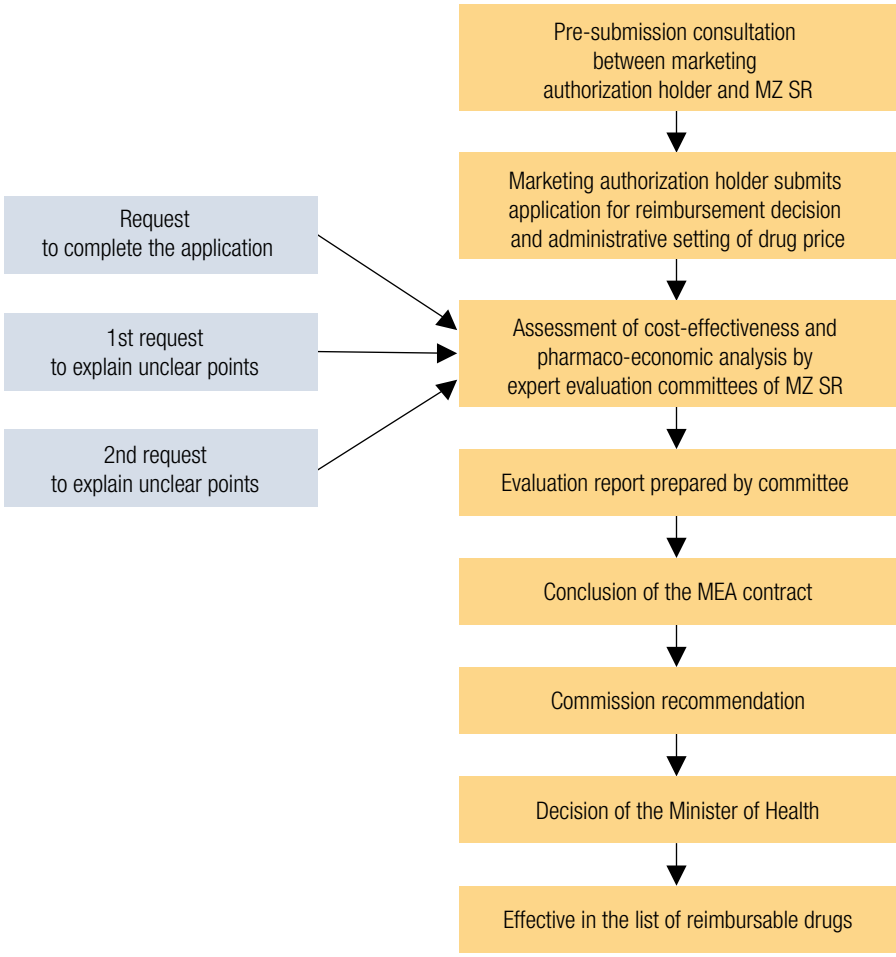
Pharmaceuticals must have an authorization from the European Medicines Agency (EMA), or the national-level ŠÚKL. ŠÚKL closely monitors the safety of drugs in Slovakia and is the national competent body responsible for pharmacovigilance. Monitoring includes reporting of adverse reactions and requiring reports from pharmaceutical companies. Prescribing physicians are obliged to report any adverse effects. In 2023 there were 874 reports received by ŠÚKL, out of which 240 were deemed serious. Another 1640 reports were from the European database reported by pharmaceutical companies (ŠÚKL, 2023).

Market authorization holders are obliged to report adverse effects of drugs. Each market authorization holder appoints a person responsible for pharmacovigilance. In addition to physicians, reporting adverse effects applies to pharmacists, nurses and patients. ŠÚKL has the right to suspend distribution or withdraw a pharmaceutical from the market, can suspend the registration for 90 days or terminate it.

ŠÚKL is in charge of pharmaceutical advertising standards. The content of general public advertisement may not give the impression that medical examination is not necessary or that pharmaceutical effects are guaranteed.

The decision as to whether a pharmaceutical will be covered by social health insurance lies with MZ SR's reimbursement committee. The decision is made after an assessment of the pharmaceutical (see Fig. 2.5). A similar process is used for medical devices and dietary products. MZ SR centrally regulates the scope of services provided by health insurance by defining the list of fully or partially reimbursed drugs, medical devices and dietary products.

FIGURE 2.5 Reimbursement decision processes of pharmaceuticals in Slovakia, 2023



Source: Adapted from MZ SR, 2023e.

First, the marketing authorization holder must submit comparative data on the pharmaceutical, including effectiveness, safety and pharmacoeconomic data. In line with recommendations from MZ SR, the pharmaceutical is assessed using cost-minimization, cost-effectiveness and cost-utility analysis. The recommended threshold of a cost-effective new technology was set at 2x, 3x, 5x respectively 10x GDP at current prices from two previous years according to ŠÚ SR, and thus pharmaceuticals with lower costs per quality-adjusted life year (QALY) are considered cost-effective (Slov-Lex, 2022).

Second, each pharmaceutical is evaluated according to its anatomic, therapeutic and chemical classification by a specialist working group that

evaluates the effectiveness, safety and importance of each pharmaceutical. One working group evaluates the pharmacoeconomic properties of the pharmaceutical. The results produced by the specialist working groups serve as the context for the decisions of the Reimbursement Committee for Medicinal Products. Of its 15 members, four are representatives of MZ SR, six are representatives of the HICs, three are representatives of the professional public, one is a patient representative and one is from NIHO.

Lastly, the Reimbursement Committee puts forward proposals for inclusion, non-inclusion, exclusion or change in the status to the positive list of categorized medicines (those that are reimbursed), along with proposals for reimbursement level, co-payment and conditions for reimbursement. The applicant receives written information on the results of the reimbursement decision, and may appeal the decision. The process of reimbursement decision-making for drugs is updated and published monthly; requests for inclusion in the official price list may be submitted at any time.

Pricing

Slovakia operates a reference pricing system for pharmaceuticals. Reimbursement is set as the maximum price for a standard daily dose in the reference group. The definition of a given reference group is very narrow. All pharmaceuticals included in the reference group contain the same active substance and are administered uniformly. In certain cases, the Reimbursement Committee may decide to form a separate reference group for pharmaceuticals with different administering form and a different amount of active substance per dose. The prices of covered pharmaceuticals are regulated, in both the ambulatory and inpatient sectors. Commercial margins for reimbursed drugs are regulated and VAT is 5%. After obtaining an authorization to enter the market, the ex-factory price of the pharmaceutical is determined by MZ SR through external reference pricing. The ex-factory price may not exceed the average of the three lowest prices of the same pharmaceutical sold in the EU. The prices of over-the-counter (OTC) pharmaceuticals and prescription pharmaceuticals not covered by insurance have been deregulated.

Managed Entry Agreements

Before 2022, if the market authorization holder wanted a specific medicinal product to be reimbursed by public health insurance, they had to enter into

managed entry agreements with all insurers. This process was burdensome and impeded the entry of certain innovative products.

Since the amendment to Act No. 363/2011 Coll. on the scope and conditions of the reimbursement of pharmaceuticals, medical devices and dietetic foods under public health insurance was approved in 2022, managed entry agreements have been established directly with MZ SR instead of with each health insurer individually. This change has shifted the responsibility for determining which therapeutic options are available in Slovakia directly to the state. The specifics of these agreements, including the highest reimbursement amount for a medicine by a health insurer, the total reimbursement limit from all insurers, and any restrictions on indications or prescriptions, are now directly negotiated with MZ SR. Although this agreement is broad in scope, market authorization holders retain the ability to negotiate particular, more advantageous terms with individual health insurers.

Furthermore, the new legislation expanded the conditions under which managed entry agreements can be formed, streamlined the process of creating these agreements and revised the method for assessing the cost-effectiveness of medicines. As a result, it significantly promotes the shift of innovative medicines from the exceptional reimbursement regime to the standard one.

Generic and biosimilar drugs

Slovakia is one of the OECD and EU countries with above-average consumption of generic and biosimilar medicines in financial (payment from public resources) and quantitative (daily doses or number of packages) terms. The last decade, however, has seen a decline in generic and biosimilar consumption, in terms of both financial expenditure and quantity (see Box 5.4 in Chapter 5). According to a regulation implemented in 2011 (Act no. 362/2011), physicians are obliged to prescribe the active substance of a medicine (by International Nonproprietary Names, not by brand names). Furthermore, pharmacists are obliged to inform patients about cheaper alternatives (generics) when filling a prescription. If the physician did not provide any reason not to use the generic substitute, the patient may choose the less expensive option under the supervision and advice of a pharmacist. However, physicians are allowed to add the tradename of the prescribed substance in the prescription form and pharmacists respect their preference. Thus, in practice, substitution for cheaper generic drugs is less common.

2.7.5 *Regulation of medical devices and aids*

Medical devices and aids (MDA) are assessed through a similar categorization process as described for pharmaceuticals. This includes the application by the marketing authorization holder of the medical device, evaluations by working groups and a reimbursement proposal prepared by the Reimbursement Committee.

MZ SR acts as regulator, and defines the administratively defined price at which the medical device manufacturer or the importer is allowed to enter the Slovak market.

Prices of medical devices are subject to categorization and reference pricing and can be changed quarterly. In every subgroup, there is equal reimbursement for the whole subgroup, and there are medical aids with and without co-payments. The full list of categorizations is found at: https://www.health.gov.sk/?zkszm.

2.8 Patient-centred care

2.8.1 *Patient information*

Explicitly defined information on services covered by social health insurance, including which diagnostic and therapeutic procedures this may imply, is lacking. This creates room for arbitrary interpretation by HICs and providers. However, there are areas with more explicit definition of the benefits package, such as outpatient procedures, medicines, medical devices and dietetic foods. Every individual has the right to information on their state of health and to access their health records. Informed consent is requested prior to health care provision.

HICs are obliged to publish the list of their contracted providers and have to inform patients in advance if the provided health service is subject to cost-sharing. Physicians have an obligation to inform patients about co-payments for prescribed medications and must offer a prescription of a generic with a different co-payment. Patients can verify pharmaceutical prices and co-payments in pharmacies, since pharmacies must provide an updated list of pharmaceuticals.

Information on the quality of providers is scarce. Based on their own analyses, HICs publish assessments of hospitals. No institution is actively and systematically monitoring awareness of patient rights or accessibility of information in minority languages. This gap is bypassed by self-supporting patient organizations and think-tanks (see Table 2.4).

TABLE 2.4 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits	Partly	Information on pharmaceuticals paid from health insurance are available online
Information on hospital clinical outcomes	Partly	Some outcomes are available and comparable thanks to HICs and the NGO INEKO
Information on hospital waiting times	Partly	Publishing waiting times for three groups of diagnoses is mandated by law. Some others are available on web of HIC Dôvera
Comparative information about the quality of other providers (for example, GPs)	Partly	Every year, INEKO prepares a Hospital of the Year ranking which also provides patients with information regarding the quality of hospitals to some extent
Patient access to own reimbursement record	Yes	HICs app
Interactive web or 24/7 telephone information	Partly	Telephone service is no longer available and was limited to a COVID-19 hotline; web information is available, though not interactive, via electronic health records (see Section 4.1.3)
Information on patient satisfaction collected (systematically or occasionally)	Yes	HICs regularly distribute questionnaires on patient satisfaction and publish the results
Information on medical errors	Yes	ÚDZS is required to publicly disclose all submissions related to health care oversight, as well as findings outlined in reports

Source: Authors' own elaboration.

2.8.2 *Patient choice*

The abilities of patients to choose coverage, providers and treatments are detailed in Table 2.5.

Free choice of provider via the social health insurance system is restricted to contracted providers irrespective of where they are based. The list of contracted providers is published by individual HICs. Exceptions are made for GPs, paediatricians and gynaecologists; patients have to be registered with one and can only change once every six months. If an insured person insists

on choosing a non-contracted provider, HICs may issue a prior authorization and cover the costs. Providers may not refuse patients except in specified cases, for example work overload or a conflict of interests. However, if a patient lives in the district where the primary care physician operates, they cannot be refused due to work overload. Furthermore, providers may decline to perform certain procedures if these are irreconcilable with their religious or other beliefs. If this situation arises, the chief physician of the SGR identifies a physician who will provide treatment.

TABLE 2.5 Patient choice

TYPE OF CHOICE	IS IT EASILY AVAILABLE?	COMMENTS
Choices around coverage		
Choice of being covered or not	No	Social health insurance is compulsory
Choice of public or private coverage	No	No private coverage available
Choice of purchasing organization	Yes	Free choice of HIC (once a year)
Choices of provider		
Choice of primary care practitioner	Yes	Patients are permitted to change their primary health care provider every six months. Nevertheless, in practice in rural areas the availability of alternative GPs is constrained by distance and capacity
Direct access to specialists	Partly	With the exception of certain specialists (e.g., psychiatrists, dermatovenereologists, ophthalmologists, gynaecologists, dentists), GPs serve as gatekeepers
Choice of hospital	Yes	Free choice
Choice to have treatment abroad	No	Planned care abroad is possible only via Regulation (EC) no. 883/2004 or Directive 2011/24/EU
Choices of treatment		
Participation in treatment decisions	Yes	
Right to informed consent	Yes	
Right to request a second opinion	No	Slovak HICs reimburse duplicate examinations conducted by the same specialist only upon request and with professional justification from an attending physician, who provides a referral form
Right to information about alternative treatment options	Yes	

Source: Authors' own elaboration.

The 2004 health reform gave HICs tools to compete for enrolment. The insured may change their HIC once annually (see Table 2.6). The deadline to switch HICs is 30 September, becoming effective from 1 January the following year. If a person submitted multiple applications, the one submitted earlier is processed. From 1 to 31 October those who expressed a wish to switch HIC can change their mind and withdraw their application. Thus, October is the month of a HIC's retention campaigns.

Patients can decide whether to give informed consent to their health care professionals. In addition, health professionals are obliged to inform patients about alternative treatments. When a prescription is issued, the patient may opt for a generic substitution, unless the physician decides that the branded pharmaceutical must be given. A patient has the right to withdraw their informed consent at any time.

The donation of tissues and organs takes place with the presumed consent of the donor or autopsied person. Individuals who do not consent must opt-out by registering in writing with the national register to protect the integrity of their body after death.

Health professionals may, based on religious or other beliefs, decline to perform certain procedures related to reproductive health, such as artificial insemination, sterilization or induced abortions.

TABLE 2.6 Accepted applications to switch HICs in Slovakia, 2015–2024

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Number of accepted applications	113 528	118 934	123 216	132 523	242 646	168 575	151 905	180 431	146 401	114 643
Share of all insured (%) as of 1 January	2.19%	2.31%	2.39%	2.58%	4.7%	3.2%	2.93%	3.49 %	2.82%	n/a

Source: ÚDZS, 2024b.

2.8.3 *Patient rights*

Patient rights in Slovakia are laid down in several laws and further elements are detailed in Table 2.7. The Patients' Charter (see Table 2.8) was elaborated in 2000 as a project of MZ SR, funded by the European Union's PHARE programme. It was ratified by Slovakia in 2001 (though it is not legally binding). A group of international and Slovak experts drafted the charter according to the laws in force, and several international organizations (UN, WHO, Council of Europe) cooperated in the project. The goal of the Patients' Charter was to explain to patients their basic rights in health care.

In 2003 MZ SR established a patient rights unit. This unit provided consultations for patients and information regarding health care provision, as well as monitoring public awareness in observing patient rights. It was relocated to ÚDZS in 2005 and later dissolved. AOPP actively promotes patient rights (see Section 2.2.4).

Complaint procedures

If patients or their relatives believe that a service was not adequately provided, they can submit a written complaint to the provider. If the provider's response is not satisfactory, the patient has a right to request ÚDZS to assess whether adequate care was provided. Other complaints (for example, concerning user fees, ethics and the organization of care) must be submitted to the relevant body (for example, MZ SR, SGRs or professional chambers). The law prohibits the persecution of a person exercising their right to file a complaint, make a claim or start a criminal prosecution against a health professional or provider.

ÚDZS has become a strong advocate of patient rights by advocating for patients via examining patient complaints. In 2023 ÚDZS received 2133 complaints and resolved 1637 of them. The subject of submissions mainly concerned dissatisfaction with the treatment procedure (918 cases) and death in connection with the provided medical and nursing care (488 cases). Of the 1637 resolved cases, 126 complaints (7.7% of all resolved complaints) were recognized as justified (ÚDZS, 2024d).

TABLE 2.7 Patient rights

	YES/NO	COMMENTS
Protection of patient rights		
Does a formal definition of patient rights exist at national level?	Yes	The Patients' Charter, The European Charter
Are patient rights included in legislation?	Yes	2004 reforms integrated 14 patient rights from the European Charter into the new legislative framework
Does the legislation conform with WHO's patient rights framework?	Yes, to some extent	
Patient complaints avenues		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Yes, to some extent	Public administration bodies including hospitals are required to maintain a central register of complaints separate from the register of other documents In bigger hospitals there is a person or department responsible for collecting and resolving patient complaints Small hospitals do not usually have a designated person, but the CEO of a hospital has to acknowledge the complaint and reply in writing
Is a health-specific ombudsman responsible for investigating and resolving patient complaints about health services?	No	
Are there other complaint avenues?	Yes	ÚDZS has competence over complaints regarding health care
Liability/compensation		
Is liability insurance required for physicians and/or other medical professionals?	Yes	Professional liability insurance is mandatory
Can legal redress be sought through the courts in the case of medical error?	Yes	
Is there a basis for no-fault compensation?	Yes	
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	No	
Can class action suits be taken against health care providers, pharmaceutical companies, etc.?	No	Only individual suits are possible (there has to be one person suing). However, it is possible for one lawyer to represent multiple clients with the same suit (each filed separately) in court

Source: Authors' own elaboration.

TABLE 2.8 Ten articles of the Charter of Patient Rights in Slovakia

	ARTICLES
I	Human rights and freedom in health care provision
II	General patient rights
III	Right to information
IV	Patient's consent
V	Consent of patients with legal incompetence
VI	Confidentiality
VII	Treatment and care
VIII	Care for incurable and mortally ill patients
IX	Complaint submission
X	Compensation for damages

Source: Citizenship Network, 2001

2.8.4 *Patients and cross-border health care*

Those insured by HICs are entitled to receive services that are covered by Slovak social health insurance in other EU countries, the UK, Liechtenstein, Norway, Iceland and Switzerland (European Commission, n.d.). Based on EC Regulation 1408/71 (now 883/2004), insured Slovaks can use the European Health Insurance Card to receive services abroad, paid for by the Slovak system under the same conditions and at the same cost as people insured in that country when on a temporary stay (for example, as tourists). Furthermore, they may ask their HIC for pre-authorization when planning to use the Directive on Cross-border Healthcare, but only in cases where it concerns specified cross-border health care services as listed in Regulation 341/2013.

The conditions for reimbursement of non-urgent (planned) treatment in another country are as follows: (1) pre-authorization by the HIC,

(2) expected health improvement, (3) lack of treatment possibilities in Slovakia, or (4) insufficient providers' capacity. In some cases, the HIC has the right to specify the facility or country in which the person can seek care. In countries outside the EU, the insured may receive reimbursement for urgent care to the same amount as in Slovakia. Furthermore, ÚDZS oversees the National Contact Point (*Národné kontaktné miesto*) for cross-border care. In 2023 Slovaks were provided with planned care mainly in Czechia (80%) and Croatia (10%) and reported total expenditures for planned care were €12.9 million (ÚDZS, 2024d).

Another type of cross-border health care is care provided to insured persons from another EU Member State, with the health care being provided in Slovakia based on registration with a social security institution in that Member State. This mainly includes individuals who commute across borders for work, such as nurses within the EU, employees of European firms stationed in Slovakia, and similar cases. In 2023 the total amount of €48.8 million was spent for full-scope health care services provided to EU insured persons in Slovakia and it predominantly concerned insured persons from Austria (47%), Czechia (27%) and Germany (11%) (ÚDZS, 2024d).

As a result of the large-scale military incursion by the Russian Federation into Ukraine, the Protection Directive facilitates Ukrainian refugees in obtaining residence permits within the EU, granting them the privilege of accessing medical assistance. However, findings by the Institute for Healthcare Analyses (2023) show that Ukrainian refugees were not included by health insurance immediately, as was the case in some of the neighbouring countries (Institute for Healthcare Analyses, 2023). As of 1 September 2023 all Ukrainian refugees who are holders of temporary protection status in Slovakia are entitled to universal coverage and health care delivery with the same scope as residents (with the single exception of spa treatment) (IOM, 2024). The majority of these displaced Ukrainians have found sanctuary in nearby Central and Eastern European countries, including Slovakia (187 719 as of 30 June 2024) (MV SR, 2024).

3

Financing

Chapter summary

- All Slovak residents are entitled to social health insurance and the corresponding services according to conditions set in legislation. All those entitled have an equal right to have their needs met, regardless of their social status or income. Payment of contributions is a condition for receiving benefits.
- Slovakia spent an estimated €10.9 billion on health care in 2024, according to national data, which was roughly 8.3% of GPD in 2024. This excludes spending on LTC and disability benefits by the Ministry of Labour, Social Affairs and Family (roughly €600 million total in 2024).
- Based on internationally comparable data available for 2022, despite spending increases to cover COVID-19 related expenditures, Slovak spending on health per capita was US$ (PPP) 3169, well below the EU average of US$ 5196. However, public funds accounted for roughly 80% of CHE, which was above the EU average (74.8%).
- HICs' expenditures accounted for just over 75% of health spending in 2024, amounting to approximately €8.2 billion, of which 36% was spent on inpatient care, 20% on pharmaceuticals and 17% on outpatient specialist care. Increases in health spending, which have continued since the end of the COVID-19 pandemic, have been primarily driven by increases in the wages of health care

professionals. A key moment in this policy development was the physicians' strike in the autumn of 2022.

- Since 2005, all three HICs compete in Slovakia as joint-stock companies. Across the three HICs, there has been a broad variation in profit and ability to pay dividends to shareholders. As of 1 January 2023, HICs have a regulated profit ceiling of 1% of the net insurance premium. If a HIC achieves a positive economic result that is higher than the 1% of the premium, any difference must be used to finance a health quality fund.
- Cost-sharing mainly takes place through a system of small user fees for certain health services (such as emergency room visits), as well as co-payments for pharmaceuticals and spa treatments. In 2014 a policy abolished the practice of HICs reimbursing co-payments for health services.

3.1 Health expenditure

CHE in Slovakia stood at €9.4 billion in 2023 (7.7% of GDP) and is estimated to have grown to €10.9 billion (roughly 8.3% of GDP) in 2024, according to national data[3]. Primary drivers of recent health spending growth came from MZ SR outlays on COVID-19 initiatives, subsidies to state-owned hospitals and HICs' increased spending to cover higher remuneration for doctors after the physicians' strike in 2022 (see Section 3.7.2).

Table 3.1 presents the most recent internationally comparable health expenditure data from WHO and shows that Slovakia's per capita health spending measured in US$ PPP stood at US$ 3169 in 2022. This is below what Czechia spends (US$ PPP 4617), though represents a large increase since 2000 and is higher than in Poland and Hungary; WHO data also show that nearly 80% of health spending came from public sources in 2022 (see Figs 3.1–3.4). After 2010, health expenditure in Slovakia as a share of GDP decreased and remained relatively stable through to 2020; this decline can be attributed to methodological changes in reporting private expenses (2010 and 2014) and the global financial crisis (in 2010) (see Section 3.4).

3 Due to differences in methodologies, there can be slight variations in the data from national and international sources. For example, debt settlements, direct subsidies to hospitals and other financial instruments for providers of care are not always well captured by the (international) System of Health Accounts (SHA).

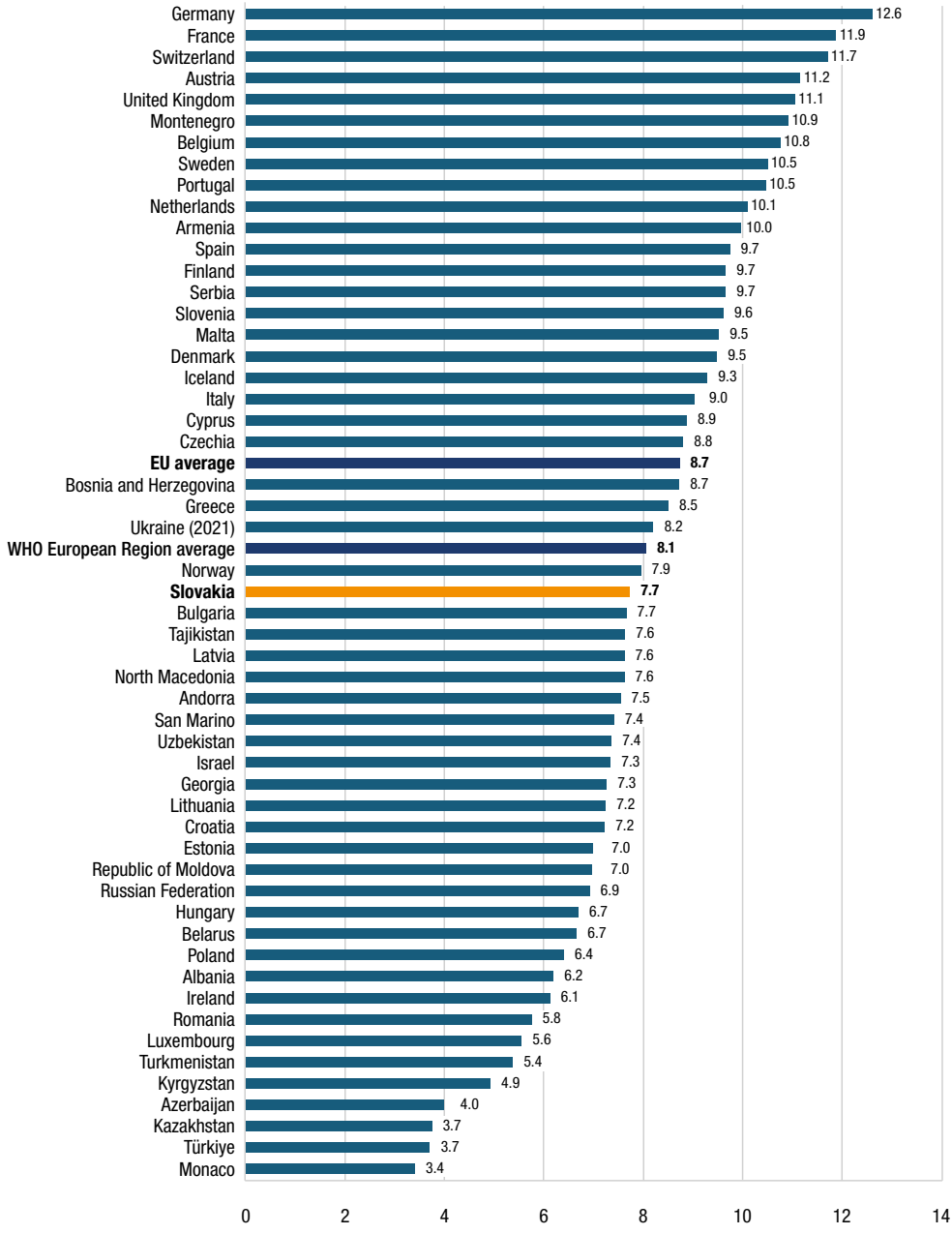
TABLE 3.1 Trends in health expenditure in Slovakia, 2000–2022

	2000	2005	2010	2015	2019	2020	2021	2022
CHE per capita in International US$ (PPP)	602	1096	1948	2033	2350	2495	2925	3169
CHE as % of GDP	5.3	6.6	7.7	6.8	6.9	7.1	7.8	7.7
Public expenditure on health as % of total expenditure on health	89.2	75.3	71.9	79.7	79.8	80.3	79.7	79.9
Public expenditure on health per capita in International US$ (PPP)	587	824	1383	1601	1852	2003	2332	2531
Private expenditure on health as % of total expenditure on health	10.8	24.7	28.1	20.3	20.2	19.7	20.3	20.1
Public expenditure on health as % of general government expenditure	9.0	12.5	13.1	11.8	13.6	12.8	13.6	14.6
Government (public) health spending as % of GDP	4.7	5.0	5.5	5.4	5.5	5.7	6.2	6.2
OOP payments as % of total expenditure on health	10.8	23.6	22.8	18.4	19.2	18.8	19.4	19.3
OOP payments as % of private expenditure on health	100.0	95.5	81.2	90.9	94.8	95.0	95.7	95.7
Private insurance as % of private expenditure on health*	0	4.5	18.8	9.1	5.2	5.0	4.3	4.3

Notes: CHE = current health expenditure; PPP = Purchasing Power Parity; * including also other private schemes that are provided by, for example, employers.

Source: WHO, 2024.

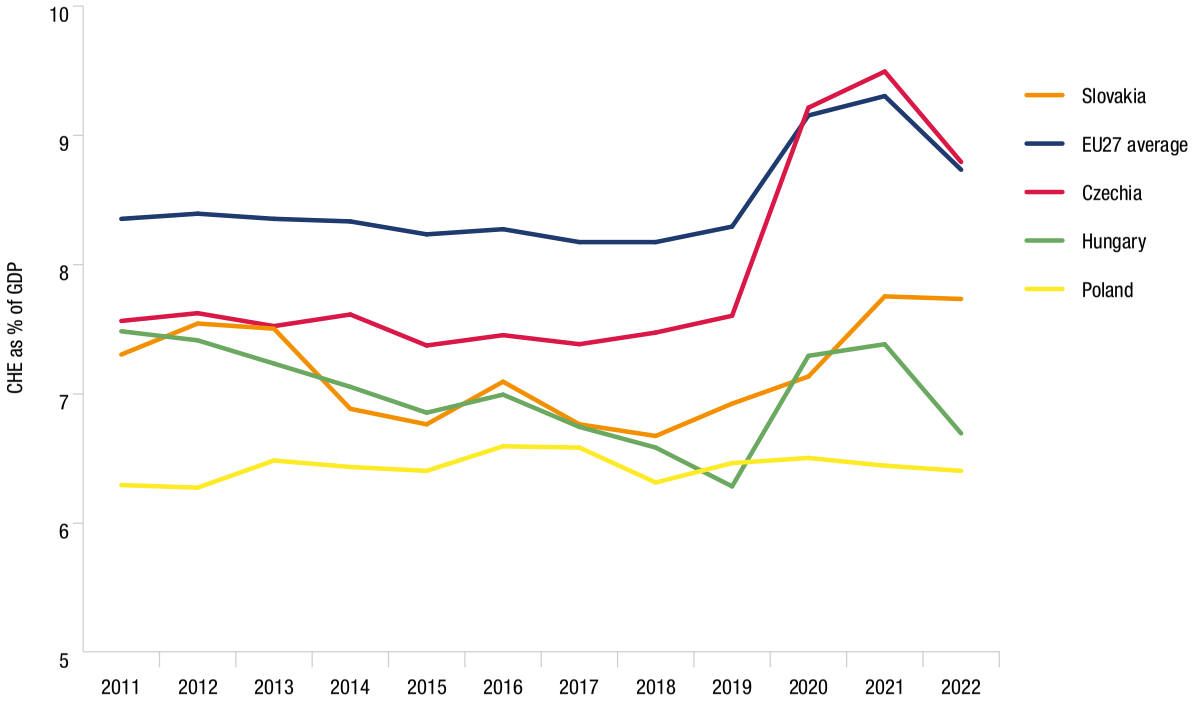
FIGURE 3.1 CHE as a share (%) of GDP, WHO European Region, 2022



Note: The Netherlands (Kingdom of) comprises six overseas countries and territories and the European mainland area. As data for this review refers only to the latter, all figures in this review refer to it as the Netherlands.

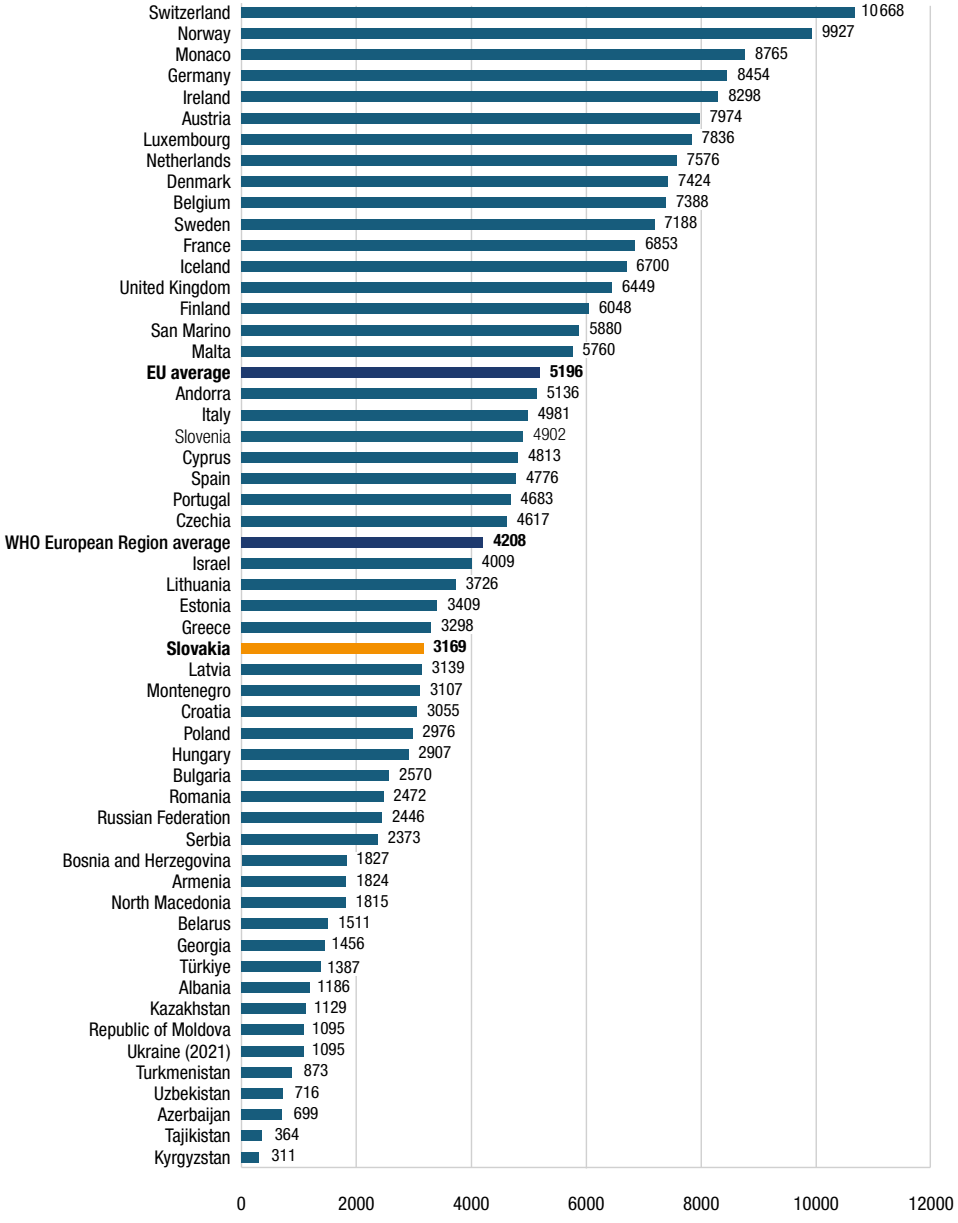
Source: WHO, 2024.

FIGURE 3.2 Trends in CHE as a share (%) of GDP in Slovakia and selected countries, 2011–2022



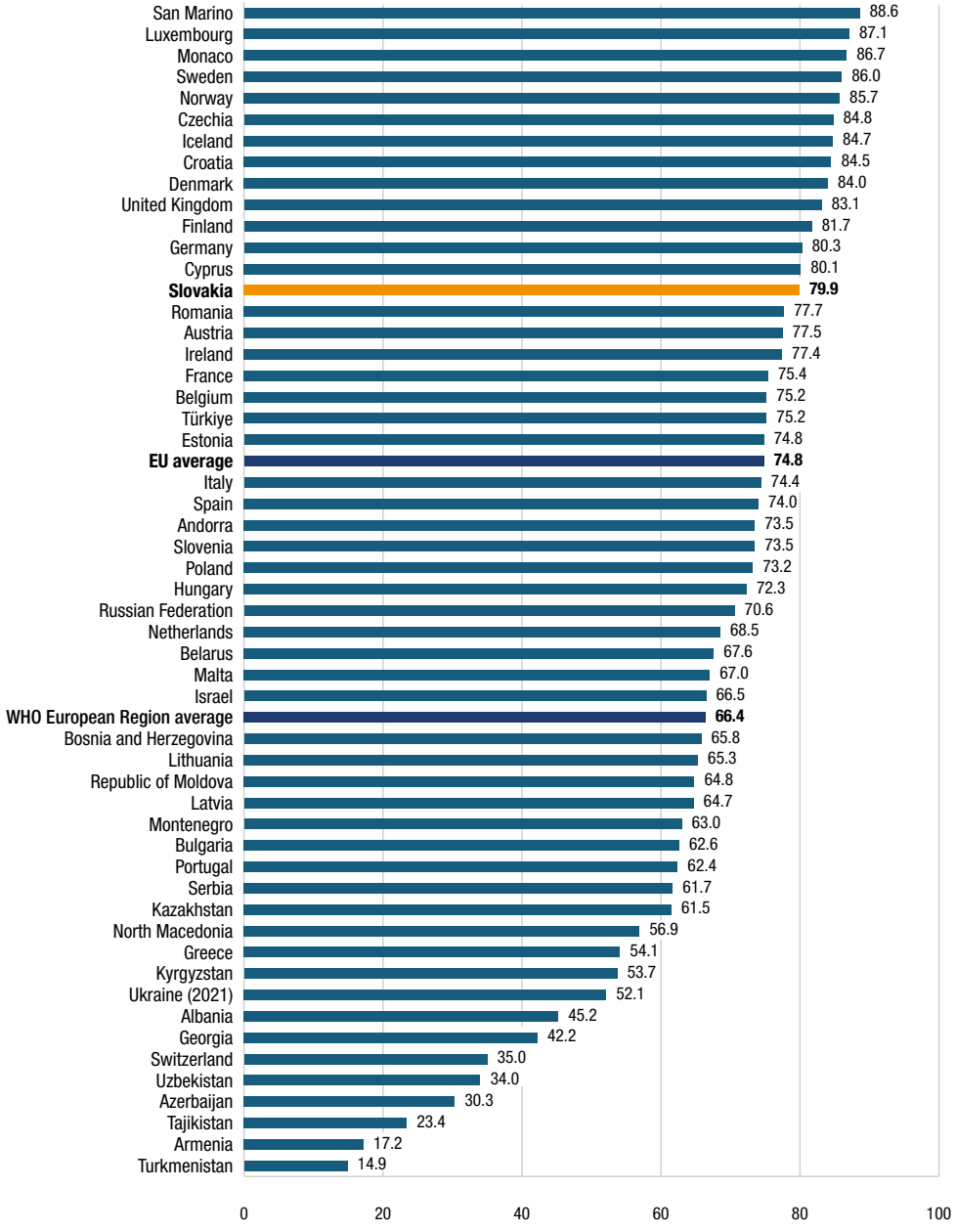
Source: WHO, 2024.

FIGURE 3.3 Current health expenditure in US$ PPP per capita in the WHO European Region, 2022



Source: WHO, 2024.

FIGURE 3.4 Public health expenditure as a share of CHE in the WHO European Region, 2022



Source: WHO, 2024.

National-level data show three main drivers of increased health spending over the past five years. The first were temporary expenditures by MZ SR related to the COVID-19 pandemic and primarily related to the years 2021 and 2022. Compared to the pre-COVID period, MZ SR spending increased up to three-fold, from €277 million per year in 2019 to €939 million in 2022 before falling back in 2023 and 2024 since several COVID-19 related measures ended (see Table 3.2).

Second, HICs' expenditures have grown by nearly 60% since 2019, primarily due to a jump between 2022 and 2024 to mainly compensate for wage increases following a successful strike action by medical unions in 2022 (see Section 3.7.2). HICs spent approximately €8.2 billion in 2024, of which 36% was spent on inpatient care, 20% on pharmaceuticals and 17% on outpatient specialist care (see Fig. 3.5).

Third, OOP expenditures increased by 47% in comparison to 2019, primarily due to costs associated with COVID-19, testing and related services (see Section 3.4).

These overall spending increases have not led to balanced spending, as public providers have regularly recorded liabilities after their due date, necessitating several rounds of debt settlement and causing further burdens on public expenses. Moreover, the cumulative income statement of HICs was negative over 2020–2023, implying an insufficient budget to cover all expenses.

Despite allocating nearly €1.5 billion (see Section 3.6.2) from the national Recovery and Resilience Plan (RRP), MZ SR estimates that there is a further underfunding of public hospitals by roughly €3.5 billion. It should be noted that spending on LTC and disability benefits by the Ministry of Labour, Social Affairs and Family (roughly €600 million in 2024) is not included in national health expenditure data (see Section 5.8). Finally, even though Slovakia began systematically measuring waiting times in 2024, existing budgets do not consider reserves to catch up with patient backlogs (for example from COVID-19 and patients on waiting lists). The exact numbers and the financial amounts needed are not known but are a potential liability.

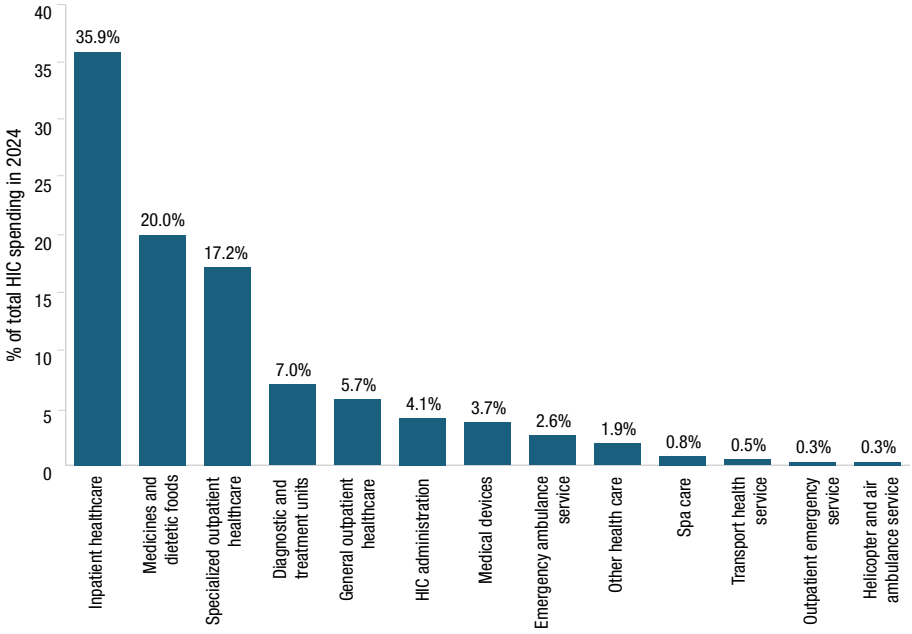
TABLE 3.2 Structure of total health expenditure, in thousands of euros, 2015–2024

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
A. Total HIC expenditure [a]	4 217 213	4 538 851	4 556 065	4 880 034	5 212 826	5 362 828	5 731 033	6 187 982	7 163 696	8 230 394
A.1 insurance expenses [a]	3 985 897	4 292 138	4 318 471	4 533 046	4 935 568	5 064 764	5 486 546	5 930 238	6 949 155	7 896 713
A.2 administrative and other expenses of HICs [a]	231 316	246 713	237 593	346 988	277 258	298 064	244 487	257 744	214 541	333 681
B. Government and other public institutions [b]	141 394	145 695	137 904	207 521	306 989	341 934	1 031 962	974 098	388 413	649 099
B.1 MZ SR expenses [b]	122 194	126 595	110 304	182 521	277 289	324 734	999 062	939 898	363 613	630 299
• of which: EU funds and co-financing [b]	272 390	85 310	14 010	129 537	1 458	18 844	98 087	14 100	17 025	13 782
• of which: Recovery and Resilience fund and VAT [b]	0	0	0	0	0	0	0	0	21 260	323 257
• of which: pandemic expenses [b]	0	0	0	0		73 713	510 863	579 865	95 089	4 802
• of which: capital expenditure contributions to hospitals [b]	37 030	36 473	15 501	78 652	158 852	100 248	92 679	54 741	53 189	60 632
• of which: direct subsidies to hospitals [b]	0	0	0	–	–	–	125 000	121 000	0	0
• of which: expenses of MZ SR [b]	57 925	81 591	93 402	102 574	116 978	131 929	172 434	170 191	177 050	227 826

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
B.2 SGRs' expenses and municipalities [c]	19 200	19 100	27 600	25 000	29 700	17 200	32 900	34 200	24 800	18 800
C. Debt settlement for public hospitals [d]				325 000	259 000			316 830	83 400	166 000
D. Public expenditure total (A+B+C)	4 358 607	4 684 546	4 693 969	5 412 555	5 778 815	5 704 762	6 762 995	7 478 910	7 635 509	9 045 493
E. Private expenditure total [e]	999 318	1 030 948	1 070 563	1 132 844	1 251 912	1 247 830	1 508 560	1 617 900	1 802 500	1 850 000
F. Expenditure total	5 357 925	5 715 494	5 764 532	6 545 399	7 030 727	6 952 592	8 271 555	9 096 810	9 438 009	10 895 493
G. GDP of Slovakia, current prices [f]	80 126 000	81 265 200	84 699 900	89 874 700	94 429 700	93 499 700	100 244 500	109 762 000	122 812 800	131 200 000
H. Expenditure as a % of GDP, current prices [a]	6.7%	7.0%	6.8%	7.3%	7.4%	7.4%	8.3%	8.3%	7.7%	8.3%

Sources: [a] MZ SR and ÚDZS data, processed by authors (ÚDZS, 2024c; Slov-Lex, 2025); [b] Final accounts of MZ SR spending per year, processed by authors (MZ SR, 2024a, 2025a); [c] INESS, 2025; [d] authors' own compilation based on yearly Report on the development of debts in the health sector; [e] ŠÚ SR, 2024; ÚDZS, 2024c for 2023, 2024 is an estimate by authors; [f] GDP estimates are from the Ministry of Finance (Ministry of Finance, 2024a).

FIGURE 3.5 Share of HIC spending on different health care functions, 2024



Sources: data from ÚDZS, 2024c and MZ SR, 2025a, processed by authors.

3.2 Sources of revenue and financial flows

Public sources accounted for 83% of health spending in 2024; of this, contributions to HICs accounted for 74.4% (see Table 3.3). Social health insurance contributions are collected by three HICs: the state-owned VšZP (54.8% share of the market, by number of enrolees, in 2023), and the privately owned Dôvera (32.4%) and Union (12.6%).

Just over one sixth (17.2%) of health spending in 2024 was private (95% of which was OOP payments), according to national data. The remaining private sources included investment activities of private entities and informal payments. Because of the very broad definition of the benefits package, voluntary health insurance (VHI) plays only a very marginal role. Fig. 3.6 visualizes financial flows in the Slovak health system.

TABLE 3.3 Sources of health care revenues (in thousands of euros, and share of the total), 2019–2024

	2019	2020	2021	2022	2023	2024
Public sources [a]	5 923 127	5 632 023	6 727 547	7 495 540	7 811 679	8 890 387
Social insurance income	5 185 438	5 235 518	5 626 821	5 977 032	7 245 205	7 982 765
• of which contribution by employees, self-employed and others	4 011 325	4 068 489	4 333 936	4 688 063	5 163 928	5 870 285
• of which contribution by the state	1 174 113	1 167 029	1 292 124	1 288 969	2 081 277	2 112 480
Other income of HICs	54 700	54 571	68 764	227 580	94 661	81 323
Debt settlement [b]	376 000	0	0	316 830	83 400	166 000
MZ SR, other ministries and SGRs [c]	306 989	341 934	1 031 962	974 098	388 413	660 299
Private sources [d]	1 320 300	1 313 800	1 508 560	1 617 900	1 802 500	1 850 000
OOPs	1 251 900	1 248 700	1 433 809	1 537 732	1 713 184	1 758 331
Sources total	7 243 427	6 945 823	8 236 107	9 113 440	9 614 179	10 729 187
As % of total sources						
Public sources	81.8%	81.1%	81.7%	82.2%	81.3%	82.8%
Social insurance income	71.6%	75.4%	68.3%	65.6%	75.4%	74.4%
• of which contribution of employees, self-employed and others	55.4%	58.6%	52.6%	51.4%	53.7%	54.7%
• of which contribution by the state	16.2%	16.8%	15.7%	14.1%	21.6%	19.7%
Other income of HICs	0.8%	0.8%	0.8%	2.5%	1.0%	0.8%
Debt settlement	5.2%	0.0%	0.0%	3.5%	0.9%	1.5%
Budgets of MZ SR, other ministries and SGRs	4.2%	4.9%	12.5%	10.7%	4.0%	6.1%
Private sources	18.2%	18.9%	18.3%	17.8%	18.7%	17.2%
OOPs	17.3%	18.0%	17.4%	16.9%	17.8%	16.4%
Sources total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Sources: [a] ÚDZS, 2025; [b] authors' own compilation based on yearly report on the development of debts in the health sector; [c] ÚDZS, 2025; INESS, 2025; [d] MZ SR, 2025a, data for 2024 is an estimation.

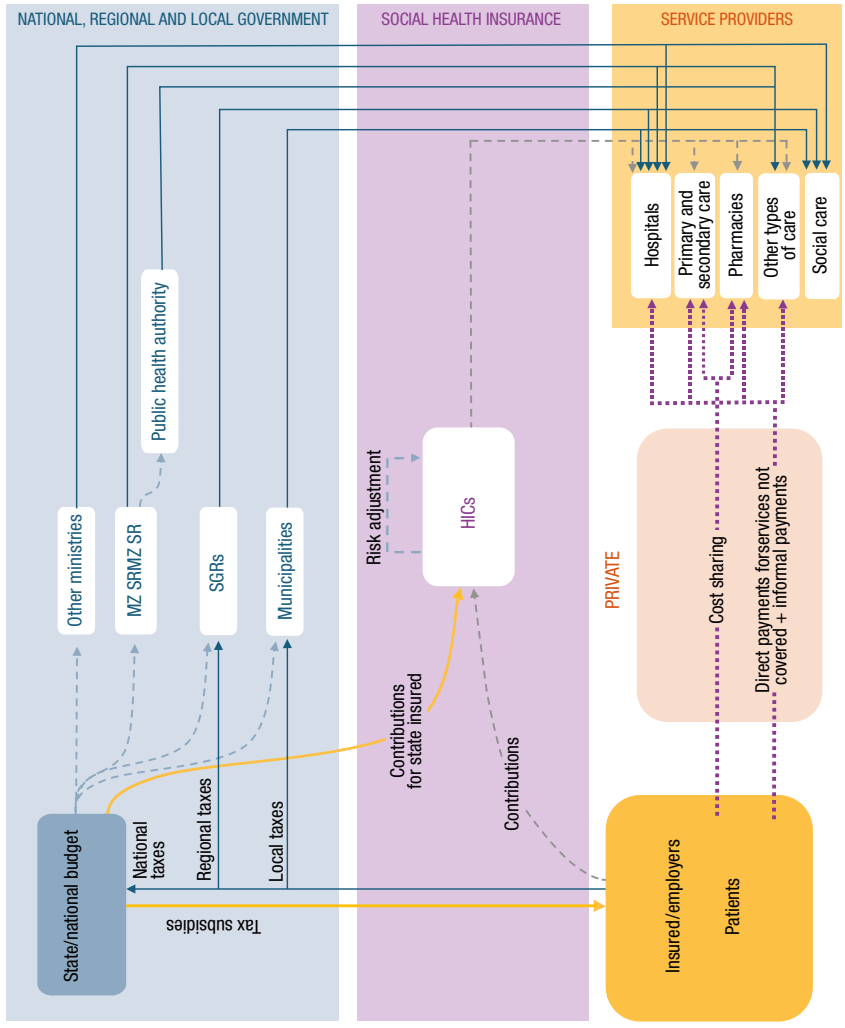


FIGURE 3.6 Financial flows

Source: Adapted from Szalay et al., 2011.

3.3 Overview of the statutory financing system

3.3.1 *Coverage*

Breadth: who is covered?

All Slovak residents are entitled to social health insurance, excluding those with valid health insurance in another country, which may be related to their job, business or long-term residence. People seeking asylum and foreigners who are employed, studying or doing business in Slovakia are also covered. Those insured are entitled to services according to conditions set in legislation and have an equal right to have their needs met, regardless of social status or income. Social health insurance is universal, based on solidarity, and guarantees free choice of HIC for the insured. Payment of contributions is a condition for receiving benefits. With the exception of those covered directly by the state (the state-insured), whose contributions are paid from general tax revenue, the insured are obliged to make monthly advance payments and to settle any outstanding balance on their total social health insurance contributions annually. If this obligation is not met, the insured are only entitled to emergency care, maternity services, mandatory vaccinations and basic care for chronic diseases. In practice, only a small share of residents is not covered: mostly those who are officially living and/or working abroad and paying for health insurance there.

Despite strong regulations on the scope of covered services, HICs can attract new members by offering additional services such as discounts or reimbursements on co-payments for some medicines, vitamins or non-health care services; shorter surgery waiting times; broader preventive examinations; or a variety of supporting electronic services.

Scope: what is covered?

The Slovak Constitution guarantees every citizen health care under the social health insurance system according to the conditions laid down by law. The law outlines a list of free preventive care examinations; a list of essential pharmaceuticals without co-payment; a list of diagnoses eligible for free spa treatment; and a list of priority diagnoses (roughly two thirds of ICD-10 diagnoses). All health procedures provided to treat a priority

diagnosis are provided free of charge. Non-priority diseases may be subject to co-payments, though in practice nearly all non-priority treatments are provided free of charge.

Every provider is obliged to publish a price list which is visible to visitors and reviewed by SGRs. This price list must contain prices for non-medical services and is meant to improve transparency for patients.

Depth: how much of the benefit cost is covered?

Cost-sharing mainly takes place through a system of small user fees for certain health services (for example emergency care), as well as co-payments for pharmaceuticals and spa treatments. A law passed in 2006 lowered some of the user fees and in some cases abolished them completely. In 2014 a policy abolished the practice of HICs reimbursing co-payments for health services. Providers are not allowed to take payments from patients once they have a contract with the patient's HIC, with the exception of some premium services (for example, an option to choose a surgeon in a hospital). However, in many cases providers request payments for services on a voluntary basis, indirectly forcing patients to pay for services that are fully covered (see Section 3.4).

In practice, coverage is also defined by an available budget and a "programme decree" (see Section 3.3.4), which is a legislative tool used by MZ SR for defining each HIC's minimum spending limits for each category of medical services, as well as overall maximal spending, as illustrated in Table 3.4.

3.3.2 *Collection*

Social health insurance is financed through a combination of contributions from the economically active population and contributions on behalf of the state-insured: (1) contributions from employees and employers; (2) contributions from self-employed persons; (3) contributions from the voluntarily unemployed; (4) state contributions for the state-insured. Contributions are collected and administered by HICs.

From 1 January 2023, the "minimum premium" applies when paying employee contribution (that is, the minimum threshold for the employee's share of the monthly contribution, irrespective of their wage/salary level). It is calculated as 15% of the amount of the living wage valid in January of that

TABLE 3.4 "Programme decree" for 2025

TYPE OF MEDICAL SERVICE	MINIMUM TOTAL AMOUNT (€) FOR EACH TYPE OF SERVICE			
	VšZP	Dôvera	Union	Total
Medicines and dietetic foods	1 020 034 608	456 923 060	128 387 979	**1 605 345 647**
Medical devices	195 769 274	81 534 706	23 199 979	**300 503 958**
Inpatient health care	1 798 282 773	860 730 625	252 442 714	**2 911 456 111**
Inpatient health care provided in a general hospital of levels III to V	117 971 744	56 480 908	16 547 347	**191 000 000**
General outpatient care	266 714 547	172 959 916	56 884 784	**496 559 246**
Diagnostic services	374 556 702	161 753 718	67 890 154	**604 200 574**
Specialized outpatient care	891 996 313	448 432 447	157 088 280	**1 497 517 041**
Outpatient emergency service	11 734 739	7 551 173	2 952 960	**22 238 873**
Emergency medical service	121 199 947	79 458 892	27 847 486	**228 506 325**
Spa care	43 595 419	20 756 433	4 613 994	**68 965 846**
Transport medical service	28 986 528	12 451 911	4 836 562	**46 275 000**
Helicopter and air rescue medical service	12 089 757	7 692 151	2 933 792	**22 715 701**
Other type of health services	92 382 976	35 844 204	15 095 640	**143 322 821**
Minimal spending (total per year)	4 975 315 328	2 402 570 145	760 721 670	**8 138 607 143**
Maximal spending (total per year)	5 077 900 632	2 450 484 792	775 444 449	**8 303 829 873**

Sources: Decree no. 64/2025.

year. For January 2025, it was €41.08 per month; if an employee's calculated share based on their wage/salary is less than €41.08 per month, they must pay the difference. The minimum premium does not have to be paid by employees who are also insured by the state (for example, working students, pensioners) or persons with disabilities or the self-employed (*Samostatne zárobkovo činná osoba*). Further details are as follows:

1. Employees pay 15% of their gross monthly income as a mandatory insurance contribution. Out of this percentage, employees

pay 4% and employers 11%. If a person has a disability[4], only half of these premiums (2% and 5.5%) are paid by the employee and employer respectively. The percentage rate of contributions was increased at the beginning of 2024 as part of the public finance consolidation package approved by the government at the end of 2023. The increase was by 1 percentage point (0.5% in the case of disabled employees) and paid as an employer's contribution to the insurance funds.

2. Self-employed people have the minimum assessment base for 2025 set as 50% of the average monthly income two years ago (€1430), that is, €715. The monthly premium is:
   - at least €107.25 for the self-employed without disability. The maximum amount is not determined (the premium, mentioned above, is calculated from the income actually achieved or from the assessment base from business income and at a rate of 15%);
   - at least €53.62 for the self-employed with a disability. The maximum amount is not determined (the advance is calculated from the actual income or from the assessment base from business income and at a rate of 7.5%)
   - for the self-employed person who is also an employee or insured by the state, the premium may be less than the stated minimum amounts. All contributions are paid directly to HICs, and in the case of multiple jobs there is an annual accounting for those insured.
3. The voluntarily unemployed are obliged to pay the same minimal contribution as self-employed individuals (€107.25 per month in 2025).
4. Contributions for the state-insured are paid on behalf of economically inactive individuals, predominantly children, students up to the age of 26, the unemployed, pensioners, persons taking care of children aged up to 3 years, and disabled persons (see Table 3.5). This is around 2.9 million residents in Slovakia. For the period 2004–2019 contributions for the state-insured, which are paid from general taxation by MZ SR, were set by law at 4% of the average wage two years prior to the year in question.

4 Disability is assessed by the Ministry of Labour, Social Affairs and Family.

TABLE 3.5 Resources of the social health insurance system, as a percentage of GDP and contributions of economically active and inactive populations

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Social health insurance as a % of GDP (%)	5.3%	5.3%	5.4%	5.4%	5.5%	5.6%	5.6%	5.4%	5.9%	6.1%
Contributions from the economically active population (in millions of euros)	2880	2953	3292	3630	3982	4069	4335	4668	5163	5866
Contributions for the economically inactive population (in millions of euros)	1349	1392	1299	1189	1203	1128	1290	1288	2081	2112
Contributions from the economically active population as a % of total social health insurance (%)	68%	68%	72%	75%	77%	78%	77%	78%	71%	74%
Contributions for the economically inactive population as % of total social health insurance (%)	32%	32%	28%	25%	23%	22%	23%	22%	29%	26%

Source: Authors' own compilation based on Ministry of Finance data (Ministry of Finance, 2024b); GDP for 2024 is an estimate.

In 2019 the fixed percentage was abolished and instead a calculation based on average wages was introduced – total payment for the state-insured was to be determined as a residual needed to cover expenses. MZ SR and the Ministry of Finance were supposed to calculate the budget for the following year, considering all non-policy changes (such as inflation or ageing), policy changes (such as reforms) and cost-saving initiatives, with the outcome being a final sum of expenditure expected the following year. The contributions for the state-insured were meant to be calculated as the difference between this calculated sum and expected contributions from the economically active population. The Ministry of Finance wanted the system to be more resilient and less dependent on economic activity and political influence in the country: that is should economic activity decline, state contributions should increase to ensure that the health system would have sufficient funds to cover all expenditures.

This mechanism did not work as intended, leading to a decrease in the share of contributions for the state-insured. It turned out to be more prone to political influence compared to the legislative 4% base. The Ministry of Finance refused to provide MZ SR with the required contributions, resulting in losses for HICs and disruptions in contracting. The Ministry of Finance eventually had to increase the contributions for insurees covered by the state (for example in March and November of 2022) but these were not guaranteed, unpredictable and often implemented in a way that only benefited VšZP, further distorting stability. As a consequence, in December 2022 legislation was amended to return to a fixed contribution for the state-insured, defined at 4.5% in 2024 and 5% from 2026 onwards (SITA, 2022a).

3.3.3 *Pooling of funds*

Insurance contributions are collected directly by HICs from employers, the self-employed, the voluntarily unemployed and the state on behalf of economically inactive persons. In order to compensate HICs for more expensive patients (that is, a higher risk portfolio), 96% of social health insurance contributions are redistributed among HICs using a risk-adjusted scheme.

The ultimate beneficiary of the redistribution mechanism is VšZP: from €98 million in 2010 to roughly €449.7 million in 2023. This increase is also seen in the rise of VšZP's income from redistribution: from 4.1% in 2010 to 6% in 2014 to over 9% of total income in 2023 (Dôvera, 2022a; ÚDZS, 2022).

The risk-adjustment scheme and redistribution process are administrated by ÚDZS. Details of the redistribution procedure are regulated by MZ SR on an annual basis. ÚDZS is also responsible for administering the central register of the insured. Risk-adjustment is performed on a monthly basis and is accounted annually. The scheme has been reformed many times (see Table 3.6), out of which two initiatives are of particular importance:

1. INTRODUCTION OF PHARMACEUTICAL COST GROUPS IN 2012

Until July 2012 the redistribution scheme between HICs used the categories of age, gender and economic activity of insured individuals in the risk-adjustment formula. Predictive ability of this model was approximately 3% and hence "penalized" HICs that had chronic and expensive patients in their portfolios (HPI, 2014). This was particularly true for VšZP, which was the only insurer in 1994 and still covers a relatively large group of elderly and more complex insured members (often state-insured).

In order to improve the fairness of the redistribution, a new redistribution mechanism was implemented in July 2012. It added 24 pharmaceutical cost groups (PCGs) to the risk-adjustment system, which are based on the consumption of certain amounts of defined daily doses (DDDs) of drugs within the Anatomical Therapeutic Chemical group classification over a 12-month period. Taking into consideration that approximately 30% of HICs' expenditure went to pharmaceuticals; this model significantly improved the predictability and fairness of the redistribution scheme. As a result, VšZP recorded a 7% increase in revenue in the first year of the new mechanism at the expense of the privately owned Union and Dôvera.

2. 2019–2023: "GUPTA" ADJUSTMENTS

MZ SR and the Association of Health Insurance Companies Slovakia contracted the Dutch consulting group Gupta in 2018 to undertake an unbiased, in-depth overhaul of the redistribution mechanism. Recommendations of the study were approved by all three HICs and are set to be fully implemented in the coming years:

- The first change, implemented in 2019, was an introduction of eight multiple-high-year cost groups that looks into total expenses per

insurees over the past three years. This led to an overall increase in the accuracy (also known as R^2) of the mechanism, despite rendering several PCG groups ineffective. Hence, their number decreased from 26 to 13 since they had no impact on the mechanism. Ex post redistribution of extreme costs was also temporarily taken off to see the impact of changes. The resulting R^2 was estimated to be around 27.5%, a significant increase from the previous accuracy rate of 19.9% (GUPTA, 2018).

- A second stage of changes was introduced in 2023. MZ SR introduced 13 diagnostic cost groups since several diagnoses cannot be efficiently captured by pharmaceutical expenditure and eight groups of medical devices to cover long-term and social care expenses that were also often overlooked by the existing mechanism. MZ SR also changed a threshold for introduction of PCG groups, resulting in the increase of their number to 27. Compared to changes in 2018, the impact on the strength of the mechanisms is expected to be smaller. As of 2023, the risk-adjustment scheme in Slovakia has an estimated predictive ability around 28.7–29% (GUPTA, 2018; ÚDZS, 2022).

Regulation of HICs' profits

Since 2004 all three HICs compete in Slovakia as joint-stock companies. Up until 2023, there was no specific regulation focused on profits and dividends of HICs. Across the three HICs, there has been a broad variation in profit and ability to pay dividends to shareholders. As shown in Table 3.7, even though HICs have not achieved significant profits in recent years, over the long term the profitability of the privately owned HICs has been significant.

As of 1 January 2023 HICs have a regulated profit ceiling of 1% of the prescribed insurance premium in the gross amount, adjusted for the effect of the redistribution of insurance premiums. If a HIC achieves a positive economic result that is higher than the 1% of the premium, the difference must be used to create or supplement a health quality fund which is used to finance, for example, the payment of special medicines, medical procedures or the implementation of preventive programmes (ÚDZS, 2023b).

TABLE 3.6 Development of redistribution mechanisms since 1999

VALID AS OF	RISK-ADJUSTMENT FACTORS	% OF REDISTRIBUTED CONTRIBUTIONS (%)
1.7.1999	Insured were divided into 34 groups by gender and age in five-year cohorts; each group had a specific risk index with the lowest set to 1.0	100
1.8.2002		85
1.1.2005		85.5
1.1.2009		92.5
1.1.2010	Economic activity of insured persons is added to gender and age: insured are divided into 68 groups; each group had a specific risk index with the lowest set to 1.0	95
1.7.2012	24 PCG groups added to economic activity, gender and age. Risk index of PCG groups was set to be adjusted as of 1 January every year	
1.1.2013	List of PCG groups was updated; Glaucoma was replaced by Haemophilia	
1.1.2015	List of PCG groups was updated; Type 2 diabetes was taken off and glaucoma and thyroid diseases were added. Altogether, there were 25 PCG groups as of 2015	
1.1.2017	List of PCG groups was updated, thyroid disorders were taken off; altogether, there were 24	
1.1.2018	Ex post adjustment was introduced. List of PCG groups was updated; altogether there were 26	
1.1.2019	Ex post adjustment was cancelled. Eight multiple-high-year cost groups were introduced; age parameter of insured was expanded to include infants; insured altogether comprised 72 groups; PCG groups were reduced to 13 groups	
1.1.2020	PCG groups were expanded to 15 to include cystic fibrosis and asthma	
1.1.2021	Ex post adjustment reintroduced, PCG groups were updated and reduced to 14	
1.1.2022	PCG groups were updated and reduced to 13	
1.1.2023	13 diagnostic cost groups (DCG) and eight groups of medical devices were introduced; PCG inclusion methodology was loosened, and the number of groups expanded to 27	96

Source: Authors' own compilation.

TABLE 3.7 Profit and loss accounts of HICs, 2009–2023 (in thousands of euros)

		2009	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Profit/loss for the year (in thousands of euros)	VšZP	-17 013	15 586	12 084	17 619	-112 338	35 884	89 976	7 293	-114 180	-87 289	-147 068	8 342
	Dôvera	469 046	46 498	2 262	3 510	12 764	17 023	35 536	14 394	-26 895	10 547	-13 830	19 955
	UNION	-16 513	6 605	-8 926	-1 776	1 873	6 284	9 914	9 770	-4 097	3 534	1 107	2 977
	TOTAL	**435 520**	**68 689**	**5 420**	**19 353**	**-97 701**	**59 191**	**135 426**	**31 457**	**-145 172**	**-73 208**	**-159 791**	**31 274**
as a % of premiums	VšZP	-0.8%	0.6%	0.4%	0.6%	-3.7%	1.1%	2.7%	0.2%	-3.2%	-2.6%	-4.20%	0.18%
	Dôvera	129.3%	4.2%	0.2%	0.3%	1.0%	1.3%	2.5%	0.9%	-1.6%	1.00%	-0.7%	1.0%
	UNION	-8.3%	2.1%	-2.7%	-0.5%	0.5%	1.5%	2.2%	2.0%	-0.7%	0.5%	0.20%	0.42%
	TOTAL	**16.3%**	**1.6%**	**0.1%**	**0.4%**	**-2.1%**	**1.2%**	**2.6%**	**0.6%**	**-2.5%**	**-1.3%**	**-2.6%**	**0.4%**

Sources: ÚDZS, 2021b, 2022, 2024c.

3.3.4 *Purchasing and purchaser-provider relations*

In theory, purchaser-provider relations are based on selective contracting under MZ SR regulation to ensure accessibility and service quality. MZ SR's regulatory power has expanded in recent years, however, leaving HICs with limited scope and resources. MZ SR defines a minimum of clinical full-time equivalents (FTEs) in ambulatory care that a HIC has to cover in each of the SGRs. In hospital care, MZ SR (in consultation with providers, HICs and the Ministry of Finance) defines a list of hospitals with exact medical programmes that HICs must contract.

MZ SR defines neither the values of these contracts nor exact prices, leaving HICs free to define tariffs; hospitals are currently using a DRG mechanism that has unified predefined values for hospitalized cases and MZ SR is finalizing a price list of treatments for outpatient providers. This pilot list is to be put into practice during 2025, further undermining opportunities of HICs to selectively contract providers[5]. Moreover, since 2021 MZ SR has published a binding decree that defines minimal values (that is, spending levels) that HICs have to contract per each type of care. This is called a "programme decree".

Apart from these limitations, HICs are theoretically free to contract with other providers. HICs may have different contracts with different providers and negotiate quality, price and volumes individually. HICs publish lists of contracting criteria, which includes technical and personnel requirements, quality indicators, accessibility and other factors, every nine months. In practice, these criteria are primarily used for sectors that are not yet heavily regulated by MZ SR, such as outpatient diagnostic services or day care services, or are focused on shaping the behaviour of providers, for example via pay-for-performance contracts.

Having met the criteria set by a HIC, the contractual parties can settle on conditions, including the scope and price of health services. The minimum duration of a contract is one year, but in practice contracts are negotiated on a regular basis even several times per year. HICs are required to publish rankings of providers, as well as a list of contracted providers as of 1 January every year.

The purchasing power of HICs to set tariffs and prices and their oligopolistic market power has stimulated health professionals to group into

5 At the time of writing the list had not been released.

networks to strengthen their negotiation position vis-à-vis HICs. Examples include the Zdravita or ZAP association of outpatient physicians, which negotiates on behalf of approximately 5000 outpatient providers.

3.4 OOP payments

OOP payments in Slovakia mainly consist of (1) co-payments for prescribed pharmaceuticals and medical goods; (2) user fees for various health services, dental care and spa treatment; (3) direct payments for OTC pharmaceuticals, vision products and dietetic food; (4) above-standard care, preferential treatment and care not covered by social health insurance; and (5) a few standard fees – for 24/7 first aid medical services (€2), ambulance transport (€0.1/km), for accompanying people during a hospital stay (€3.3), as well as for food and accommodation in spas (€1.7–7.30 per day).

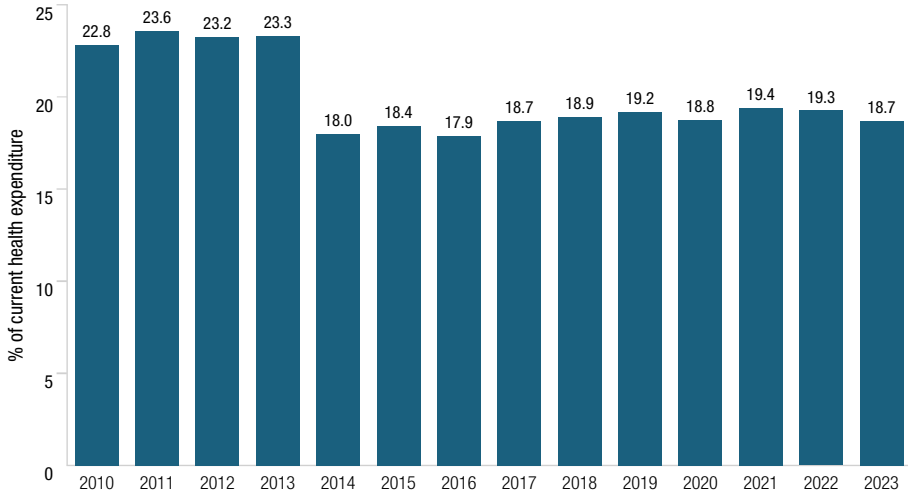
Slovakia supports underprivileged residents in the form of maximum limits for co-payments for prescribed pharmaceuticals, waiving ambulance transport fees for the chronically ill, and a wide range of medical devices with individually reduced cost-sharing. The system of maximum limits for co-payments for prescribed drugs was expanded in 2021 to include pensioners, providing that their net income is below a certain quarterly set threshold. The limit is currently set into three groups, with €0, €12 or €30 maximum co-payments per quarter, depending on fulfilled conditions and the category of a person. In 2023 the cost of covering these co-payments was €73.8 million, aiding 1.4 million insurees in Slovakia. This represents a significant increase compared to 2020, when the cost of covering the co-payments was only €24.5 million, aiding 1 million insurees (ÚDZS, 2021c, 2024c).

Fig. 3.7 illustrates the level of OOP payments over time in Slovakia. Declines seen in the early 2010s were caused by methodological changes by ŠÚ SR in 2011 and 2013.

It is important to also note that despite methodological changes and improvements, the provided OOP expenditure is based on estimations. The methodology of ŠÚ SR for calculating OOPs also includes, besides co-payments for prescribed drugs, items that are sold in pharmacies but are only marginally health-related, such as cosmetics. However, due to the technical limitations of reporting receipts to the Ministry of Finance, these items cannot be always split from pharmaceutical expenditures. This may

overestimate OOPs in Slovakia. On the other hand, OOPs may be under-reported given the weak reporting legislation for non-standard services, which include, for example, different administrative fees and specialists' examinations without referral from GPs.

FIGURE 3.7 Development of OOP payments in Slovakia as a percentage of CHE, 2010–2023



Source: WHO, 2024; data for 2023 are calculations, based on data from ÚDZS, 2024c.

3.4.1 *Cost-sharing (user charges)*

Table 3.8 outlines the cost-sharing framework in Slovakia. A variety of policies have been adopted to contain the increase in cost-sharing, such as the de-facto abolishment[6] of co-payments for outpatient care and hospital stays in 2006 or lowering co-payments for prescribed medicines. Nonetheless, the proportion remains high, since most OTC drugs are not regulated and a small number of services (for example, dental care or ophthalmology care) still incur cost-sharing, along with some anchored fees for emergency services, ambulance transportation and spa treatment.

6 Co-payments have never been abolished in practice; legally, their value was set in legislation to zero.

TABLE 3.8 Cost-sharing in the Slovak health system, 2025

ELEMENT	CO-PAYMENTS	USER FEES
Pharmaceuticals, medical devices, dietary food	Co-payments, e.g. 1 774 medicines out of 4 464	€0
Primary ambulatory care	No co-payment but for dental services, HIC cover costs only for standard materials	€0
Secondary ambulatory care	No co-payment	€0
Inpatient care	No co-payment	€0 for patient, €3.30 per day for a patient's companion*
Spas and other rehabilitation services	No co-payment	According to types, type A: €1.7 per day, type B: €5–7.30 per day
24/7 first aid outpatient medical service	No co-payment	€2
24/7 first aid inpatient medical service	No co-payment	€10*
Transport health services	No co-payment	€0.1 per km*

Note: * there are exemptions from these fees, depending on several factors, such as social status of a patient or disease type.

Source: Authors' own compilation.

3.4.2 *Direct payments*

Direct payments comprise mainly payments for OTC pharmaceuticals and dietetic food and care not covered by social health insurance.

In 2015 MZ SR introduced new legislation restraining possibilities for providers to charge for health care and health-related services. This was a response to the fact that although cost-sharing for medical services was regulated gradually, the providers were free to charge fees related to care (such as payment for air-conditioning in the waiting room, payment for administrative tasks, payment for printed documents, etc.). These payments were identified as one of the key drivers of increasing OOP expenditure but were virtually outside legislative control. The new legislation since 2015

defined which non-medical services can be charged for and enforced greater control by the SGRs. MZ SR in 2019 introduced another amendment to the legislation that enabled providers to charge a fee for an examination during so-called "additional office hours" with a maximum ceiling of €30 per treatment, providing that:

- the range of additional office hours may not exceed 30% of the approved office hours in a calendar week;
- the number of people examined during additional office hours must not exceed 30% of the total number of people examined in the previous calendar month; and
- additional office hours can be after 1PM at the earliest.

A brief overview of some direct payments is given in Table 3.9. Despite these changes, providers still tend to request direct payments for services. There is a grey zone in legislation that enables providers to ask for payments, but on a voluntary basis. Patients are, however, often not aware that such requested fees are a voluntary donation and end up paying directly to the provider. This practice culminated during January 2023 since many outpatient providers did not have sufficient reserves to catch up with rising energy prices and inflation and had to ask patients to voluntarily pay extra for services (Madro, 2023; Surová, 2019).

3.4.3 *Informal payments*

According to a Eurobarometer survey, 9% of Slovaks admitted to paying bribes and donations in the health care sector in 2022, the highest among the Visegrad 4 (V4) countries (Czechia, Hungary, Poland, Slovakia). This is the third highest value in the EU, after Romania and Greece (Eurobarometer, 2023). Moreover, this percentage seems to be growing, as only 4% of Slovaks admitted to any kind of informal payment to a doctor or a nurse in 2017 (Eurobarometer, 2017). The total value of such payments is, however, not known and thus difficult to estimate. See Section 7.1.1 for more information.

TABLE 3.9 Direct payments in the Slovak health system, 2025

	HEALTH SERVICES NOT COVERED BY SOCIAL HEALTH INSURANCE	NON-MEDICAL SERVICES BEFORE 1 APRIL 2015	NON-MEDICAL SERVICES AFTER 1 APRIL 2015
Pharmaceuticals, medical devices, dietary food	e.g. OTCs, dietetic food, vision products	–	–
Primary ambulatory care	e.g. some types of vaccination, medical examination required by an employer, etc.	Direct payments for preferential appointments, timing of appointments, issuing certificates upon request of a third party, etc.	Charges up to €30 possible only during additional office hours Direct payments for issuing certificates, e.g. for driving licence
Secondary ambulatory care	e.g. IVF (first three cycles are co-financed), circumcision, cosmetic plastic surgery, anaesthesia upon the patient's request, etc	Direct payments for preferential appointments, timing of appointments, issuing certificates upon request of a third party, etc. Membership fees, registration fees for individual management of a patient	Charges up to €30 possible only during additional office hours Direct payments for issuing certificates No membership fees are possible
Inpatient health care	e.g. induced abortion upon request of the patient, sterilization, plastic surgery, etc.	Membership fees, registration fees for individual management of a patient Above-standard accommodation and meals	No membership fees are possible Above-standard accommodation and meals
Spa	e.g. medical procedures not covered by HIC or stay upon the patient's request	Above-standard accommodation and meals	Above-standard accommodation and meals
Laboratory diagnostics and radio-diagnostic (x-ray, CT, MRI, PET)	e.g. medical examinations upon the patient's request, e.g. paternity test	Preferential medical examination upon patient's request	Preferential medical examination upon patient's request

Source: Authors' own compilation.

3.5 VHI

The role of VHI, which is offered by commercial insurance companies, is very marginal and despite an increase in prescribed premiums, insurance claims have been stagnant in Slovakia. Common areas of VHI are insurance in case of accident or disease, medical costs incurred abroad or costs of mountain rescue in emergency cases. The surveillance of private VHI is the responsibility of the National Bank of Slovakia.

Although the National Bank of Slovakia stopped publishing detailed information on numbers of contracts and insurance claims, based on historical data roughly 30 000 insurance contracts and 1500 claims are expected per year (NBS, 2024b). See Table 3.10 for an overview of VHI in Slovakia.

TABLE 3.10 VHI overview, 2019–2023

	2019	2020	2021	2022	2023
Prescribed premiums in € (total)	27 546 969	15 756 783	11 567 735	57 655 034	60 882 756
Insurance claims costs (incurred) in €	10 424 446	5 717 701	1 921 231	10 286 121	7 509 011

Note: due to methodological changes, there might be some discrepancies in data sets, especially for 2021.

Source: NBS, 2024b.

3.6 Other financing

3.6.1 *Parallel health systems*

There are some physicians, dentists and ambulatory specialists without contracts with any HIC. These providers are not entitled to any reimbursement from HICs but only from emergency cases. According to MZ SR statistics, out of 10 197 registered outpatient providers in 2022, 7766 providers had a valid contract with HICs and the rest (2431 providers) did not have any contract with HICs (MZ SR, 2023a).

Furthermore, there are three minor parallel health systems in Slovakia: military medical services (two hospitals); Ministry of Interior-run health care facilities for security forces; and prison services. The financing mechanism and all other rules and legislation are the same as in the social health insurance system.

3.6.2 *External sources of funds*

SGRs, municipalities and also some private companies invest in the health infrastructure and medical devices of providers under their management. The key external sources of financing have been EU structural funds and, since 2021, the national RRP co-funded by the EU Recovery and Resilience Facility.

RRP

The Slovak RRP was approved by the European Commission in 2021. It has six areas of investment, amounting to €6.6 billion. The second largest component (€1.5 billion) focuses on health care, subdivided into three components.

Each component mandates a series of milestone reforms and initiatives as conditions to release funds. An overview of these reforms, as well as funding details, can be found in Table 3.11 and Fig. 3.8.

Component 11, the largest in terms of funding, is to secure modern and accessible care through infrastructural renewal of hospitals. The aim is to update existing, outdated inpatient infrastructure by building hospitals with a capacity of at least 2118 beds and to renovate at least 548 additional beds in existing care.

The first two large projects were approved in July 2022: i) the construction of the shell and core at the Bratislava University Hospital in Rázsochy, at €281 million, to have 653 beds; and ii) construction at the Martin University Hospital with 660 beds at €330 million. Due to time constraints, Bratislava University Hospital was replaced in 2023 by the hospital Fakultná nemocnica F.D. Roosevelta Banská Bystrica, with 771 expected beds. The shell and core phases of both projects are expected to be finalized by the end of 2026. In 2023 a further seven medium-sized projects were approved, worth €197 million. In 2024 an additional 15 small projects, worth €53 million, were approved. In May 2025 a military hospital in Prešov was granted funding to the sum of €195 million (Pravda, 2025).

TABLE 3.11 Overview of investment categories of the RRP, before spending revision

TYPE OF COMPONENT AND INVESTMENT	MILLION EUROS
Component 11: Modern and accessible health care	
Investment 1: Project preparation and project management of investments	58
Investment 2: New network of hospitals: construction, renovations and equipment	998
Investment 3: Digitization in health care	41
Investment 4: Construction and renovation of emergency medical service stations	32
Investment 5: Renewal of the emergency medical services fleet	23
Investment 6: Supporting the opening of new primary care clinics in underserved areas	11
Component 12: Humane, modern and accessible mental care	
Investment 2.1: Project management and project preparation of investments	4.3
Investment 2.2: Creation of detention facilities	37.5
Investment 2.3: Building psychosocial centres	24.8
Investment 2.4: Supplementing the network of psychiatric inpatients	6.5
Investment 2.5: Building specialized centres for autism spectrum disorders	2.3
Investment 3.1: Conducting the first epidemiological study in the field of mental disorders	0.3
Investment 3.2: Establishment of a fund for psychodiagnostic methods	8
Investment 3.3: Humanization of departments in institutional care	10.6
Investment 3.4: Restoration of material and technical equipment	1.3
Investment 4.1: Education of personnel in the health sector	3.2
Investment 4.2: Education of experts outside the health sector	3.6
Investment 5: National Pandemic Mental Health Helpline	0.7
Component 13: Accessible and quality long-term health and social care	
Investment 1: Expanding the capacities of community social care, of which: • outpatient providers of health/social care • community day care services • low-capacity social and health care facilities	193 87 70 36
Investment 2: Expansion and restoration of follow-up and nursing care capacities, of which: • institutional follow-up care • home nursing care	32 27 5
Investment 3: Expansion and renewal of palliative care capacities	20
Administrative capacity to implement reforms and investments from the RRP	9

Source: Government Office of the Slovak Republic, 2021.

FIGURE 3.8 Overview of key health sector reforms and investment priorities of the RRP

COMPONENT	REFORMS	INVESTMENTS
Modern and accessible health care (€1163 million)	**Q2 2021** Reform of preparation of investment projects for health care **Q2 2022** Optimization of the acute health care network and a new definition of urgent health care **Q2 2022** Reform of the provision of universal care for adults, children and adolescents **Q2 2025** Centralized management of major hospitals **Q4 2025** Optimization of the hospital network in Slovakia	✓ New network hospitals – construction, renovation and equipment ✓ Digitalization in health care ✓ Transfer and renovation of facilities, vehicle fleet renewal and promotion of telemedicine services of the emergency medical service ✓ Support of new general practitioners' clinics in locations where they are lacking
Mental health care (€105 million)	**Q1 2021** Development of the most underdeveloped areas: preparation of concepts of treating mental diseases, investment plans **Q4 2021** Modernization of diagnostic methods and treatment procedures **Q4 2022** Modernization of the health care personnel training system **Q2 2025** Coordinated interministerial cooperation and regulation	✓ Building of detention and community facilities ✓ Renewal of material and technical equipment ✓ Modernization of diagnostic methods ✓ Humanization of institutional care wards ✓ Personnel education and training ✓ National mental health support hotline
Long-term care (€265 million)	**Q1 2024** Reform of the medical review system **Q1 2024** Reform of the social care oversight **Q4 2025** Integration and change of the financing of long-term social and health care	✓ Extension and renovation of community social care, follow-up health care, nursing care and palliative care facilities ✓ Building of social care oversight infrastructure

Source: Government Office of the Slovak Republic, 2021.

In the meantime, however, the Slovak economy has fared better than expected, and since several milestones (outside the health care sector) have not been met, the total amount of the investment from the RRP will possibly be reduced by the European Commission (Čunderlíková, 2022). The plan was criticized in the media that the goals are unrealistic, and there were concerns that the reforms or various project milestones would not be met (TASR, 2022a). In 2023 the Government Office[7] critiqued delays in health sector projects and established a crisis management procedure for the implementation of the RRP (Čunderlíková, 2023; Krempaský, 2023a).

EU structural funds

There was no dedicated programme for the health sector during the second programming period of EU Structural Funds (2014–2020). Instead, EU funds were primarily allocated via a programme operated by the Ministry of Agriculture and Rural Development, through the Integrated Regional Operational Programme (IROP), with a budget of €289 million. The main aims were modernizing primary health care infrastructure, as well as acute care facilities (IROP, 2021). In 2021 a third goal was added to the IROP: as a part of the government's effort to tackle the COVID-19 outbreak, hospitals could receive additional funding to procure required equipment (SITA, 2021). Altogether, 171 projects were approved, worth €393 million.

In the current programme period (2021–2027), some health funding is planned through several different objectives, amounting to roughly €180 million. In contrast to IROP, the primary focus of these funds are HR measures, research and development, and other operational expenses related to health care services (see Box 3.1).

7 The Government Office is an organization tasked with checking the performance of tasks performed by state administrative bodies (including ministries) (Government Office, 2007).

BOX 3.1 Overview of available sources from the EU structural funds 2021–2027 period

The health care sector in the current programming period has dedicated resources through two specific objectives:

1. Objective ESO4.11: Improving equal and timely access to quality, sustainable and affordable services, including services, including:

- Implementing community health education for health promotion and disease prevention, especially for marginalized members and disadvantaged groups (€55 000 000)
- ensuring sufficient professional capacities of health personnel, reflecting the requirements of modern health care professions (€11 981 982)
- supporting a healthy lifestyle (€8 986 487)
- supporting further education of health care workers (marginalized communities in the amount of €8 986 487 and the rest in the amount of €2 191 690)
- establishing and/or supporting independent clinics in disparate areas (€12 225 000)

2. Objective RSO4.5: Ensuring equal access to health care and increasing the resilience of health care systems, including primary care, and supporting the transition from institutional care to family and community care, including:

- supplementing the network of integrated health care centres with the aim of transforming the provision of health care at the community level and providing affordable health care (€37 490 000);
- integrated territorial investments in the amount of €16.5 million for marginalized communities and €4 million for the remaining groups;
- support for the modernization of material and technical support, especially for clinics of selected specialties, including material and technical support for mobile long-term health care services (€23 635 000); and
- building/establishing community psychiatric care providing LTC (institutional since the buildings for this activity are in the RRP) (€8 150 000).

Source: MIRRI, 2022.

3.6.3 *Other sources of financing*

See Section 5.8 for information on the financing of LTC, as this comes directly from the Ministry of Labour, Social Affairs and Family.

3.7 Payment mechanisms

Providers are paid by HICs according to individual contracts, which determine the amount, the nature and the quality of services. The guiding principles of payment mechanisms differ for primary and specialized ambulatory care, inpatient care, diagnostics, emergency and pharmaceutical services, as illustrated in Table 3.12.

3.7.1 *Paying for health services*

Inpatient care

Inpatient care is defined as an overnight stay longer than 24 hours in any licensed health care institution (not only hospitals but also sanatoriums or nursing homes). Around 95% of all hospital revenues come from HICs. There are three different types of inpatient payment mechanisms:

1. Inpatient care is overwhelmingly compensated via DRG payments, calculated as a respective relative weight multiplied by the basic rate of a hospital. Basic rates are not uniform in Slovakia. At the time of writing, there are six groups of rates. See Table 3.13 for an overview of development of the rates over time.
2. A few types of hospitalizations are paid with per diem payments, mostly long-term hospitalizations in rehabilitation medicine and psychiatry, as well as balneal treatment.
3. Certain short-term hospitalizations, especially one-day and short-stay surgeries (that is, inpatient stay of 24–72 hours), are reimbursed as FFS.

TABLE 3.12 Overview of payment mechanisms

TYPE OF CARE	MECHANISM	DESCRIPTION
Primary care (GPs, paediatricians, gynaecologists)	1. Fixed capitation payment	Fixed monthly payment for each insured registered for primary care with given provider
	2. Variable capitation payment	Monthly payment for each insured registered for primary care with given provider; amount set based on performance criteria
	3. FFS	Extra payment for a few specified services, e.g. preventive services, vaccinations or pre-operative examinations
Specialized outpatient care	1. FFS	Based on list of services with weights (in points), issued by MZ SR, but used voluntarily; negotiations on price per point between HICs and providers
Inpatient care	1. Per diem payment	A few types of hospitalization are paid with per diem payment, mostly long-term hospitalizations in rehabilitation medicine or psychiatry
	2. Payment per completed hospitalization case (DRG)	Dominant part of hospitalizations are paid via DRG mechanism. Hospitals have, however, prospective budgets, to facilitate proper coding of treatments.
	2.1 Prospective budgets	Hospitals have prospective budgets, set at the beginning of the year with lower and upper productivity limitations with an aim to completely abandon prospective budgets and replace it with payment based on DRG production. The aim for 2025 is to reimburse, based on production, at least 15% of all inpatient admissions. This percentage should, according to the contract with the physicians union, grow to 40% by 2027 (Government Office of the Slovak Republic, 2024). Depending on the HIC, the prospective budget includes certain imaging and laboratory services and outpatient care.
	3. FFS	One-day surgeries and specific surgical treatments (with a hospitalization of less than three days) are paid based on list of fees for provided services
Diagnostic examinations	1. FFS with monthly budget	Based on list of services with weights (in points), issued by MZ SR, but used voluntarily; negotiations on price per point between HICs and providers. HICs limit monthly revenue of providers paid as fees.
Emergency medical services (ambulances, outpatient emergency practices, emergency departments)	1. Fixed monthly fee	Fixed monthly payment for each provider in the network or selected by MZ SR, depending on the type of service. Extra payment for a few specified services or km driven.

Note: FFS = fee-for-service.

Source: Authors' own elaboration.

TABLE 3.13 Overview of the annual development of DRG rates (in €) by groups of hospitals, 2020–2024

	2020	2022	2024
General hospitals 1	1148	1294	2830
General hospitals 2	1160	1302	2830
General hospitals 3	1279	1498	2903
General hospitals 4	1449	1775	3242
Specialized cardiovascular institutes	2053	2429	3646
Specialized oncological institutes	1551	1875	3318

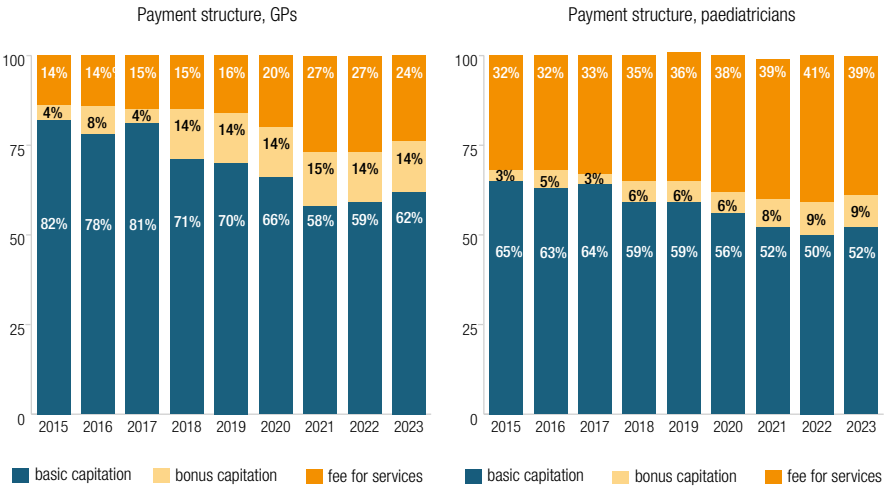
Sources: CKS DRG, 2022, 2024; ÚDZS, 2024c.

Outpatient care

The payment mechanism for primary outpatient health care is a combination of capitation and FFS. The amount of an insured person's capitation payment is mostly age-dependent, but some HICs try to motivate GPs and offer them higher capitations (bonus capitation) after fulfilling some quality criteria. These vary across HICs, but generally include factors such as subjective patient satisfaction; ambulance equipment; proportion of preventive examinations; and eHealth uptake.

In 2023 the basic monthly capitation for GPs per insured adult ranged from €3 to €7.5; for children and adolescents it ranged from €3 to €15 (ÚDZS, 2024c). The system of capitation payment allows HICs to control costs, but it does not motivate GPs to perform costlier or additional medical procedures since they bear all the risk. For this reason, HICs have been trying to gradually increase the proportion of services paid via FFS. Fees apply to certain medical services not covered by the capitation but included in social health insurance benefits, such as preventive care, some costly examinations like C-reactive protein, ECG or colorectal cancer screening, pre-surgical examinations, laboratory testing and treatment of some chronic diseases, such as obesity, hypertension and dyslipidaemia. The overview of the payment structure of GPs can be found in Fig. 3.9.

FIGURE 3.9 Payment structure of Slovak GPs and Paediatricians, 2015–2023



Note 2021 saw an increase in FFS payments due to an extra payment for teleservices during the COVID-19 pandemic.

Sources MZ SR, 2023b; ÚDZS, 2024e.

Specialized outpatient providers are remunerated based on contracts with HICs, in some cases through a mix of capitation fees (for example, gynaecologists) and FFS (for example, preventive examinations, ultrasonography examinations, etc.). The median price per complex visit in 2022 was roughly €13 in several critical specialties (for example, pneumology, diabetology and dermatology) (HCSA, 2023), which also contributes to patients being rotated between outpatient clinics unnecessarily, to unnecessary services or to informal payments, as HICs' transfers do not cover the costs of running outpatient clinics (SLK, 2022b).

Slovakia's outpatient sector is fairly concentrated under a few associations (primarily Zdravita and ZAP). These tend to negotiate terms for all their members on uniform bases. This has caused a problem since some specialists historically had insufficient payments and such negotiations just maintain the status quo.

The extent of financial undervaluation of some specialist providers was calculated by the Slovak Medical Chamber in October 2022 (SLK, 2022a). Based on their calculations, specialities focused on internal clusters, such as pneumologists, diabetologists and immunologists, do not earn a sufficient amount from HICs to cover their monthly expenses and are forced to cut costs, postpone patients or request illegal payments from patients. For

example, pneumologists earned €6500 monthly on average in 2022, whereas monthly expenses were expected around €10 500 (see Table 3.14). The median price per complex visit in 2022 was in several critical specialties (for example, pneumology, diabetology and dermatology) only around €13 (ÚDZS, 2023c).

TABLE 3.14 Expected cost of a single specialized practice, 2022–2023, per month

COSTS	€
Overhead costs of a standard practice	
Operating costs (rent, energy, premises maintenance)	950
Equipment, basic devices and consumables	700
Services, administration, accounting, IT	500
Meal vouchers	150
Insurance, education, fees (e.g. membership)	230
Creation of reserves, technical items	400
Labour costs of a standard practice	
Salary nurse	2 722
Salary doctor	4 882
Total minimal costs per practice	**10 534**

Source: SLK, 2022a.

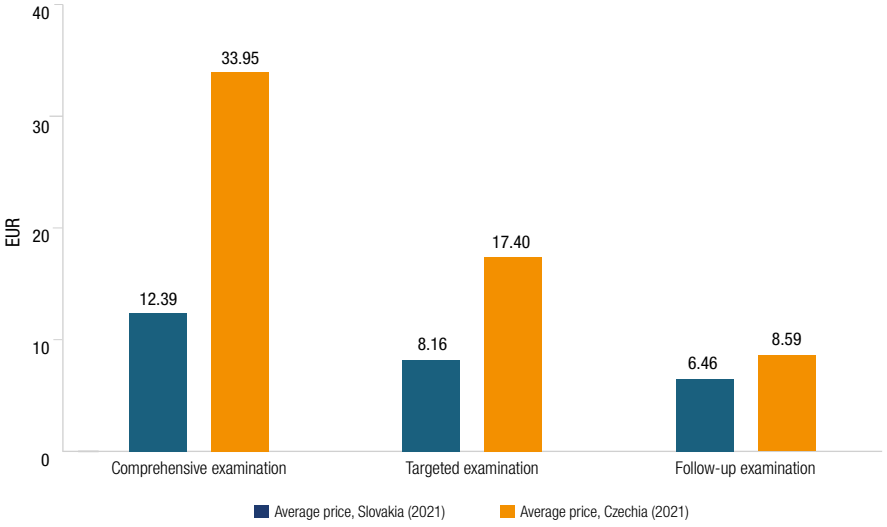
The underfinancing of specialized outpatient care is also confirmed by price comparisons between Slovakia and Czechia carried out by ÚDZS in 2022 (ÚDZS, 2022) (see Fig. 3.10).

Diagnostic examinations

Diagnostic examinations (in outpatient settings) are reimbursed by the same mechanism as specialists. However, since eHealth solutions that would monitor and negate duplicate treatments and offer real-time cost control are not yet available, diagnostic providers tend to overspend their budget. This often leads to the creation of "over-limits" or, in other words, performed, medically recognized but not reimbursed services that HICs can fully, or partially, reimburse, depending on the contract with a provider.

The total amount of services performed by providers in outpatient diagnostic facilities in excess of the contracted volumes and therefore not fully reimbursed exceeded €33.6 million in 2023 (that is, roughly 6% of the yearly expenditure) (ÚDZS, 2024c).

FIGURE 3.10 Average payment for selected key treatments in pneumology in Slovakia and Czechia, 2021



Source: ÚDZS, 2022.

Emergency medical services

Selected emergency services, that is, ambulances, emergency departments and outpatient emergency practices, receive monthly payments from MZ SR. These payments are updated annually and are meant to cover all costs. Additionally, providers can charge for certain services or per kilometre driven (in the case of ambulances). For each registered patient, an ambulance service receives a fixed capitation from the patient's HIC.

3.7.2 *Paying health workers*

Prior to 2005, health care personnel in inpatient care facilities were paid according to a uniform system for public servants. Since January 2005 the

financing of personnel in inpatient health care facilities has been governed according to the Labour Code, allowing for individual agreements. Salaries depend on the outcome of collective agreements between the employees or employees' representatives (trade unions) and the employers' representatives. These agreements are decentralized, and consequently salary levels vary across the country.

In 2011 physicians' dissatisfaction with their salaries led to mass strikes. The government was forced to adopt a memorandum that legally declared the minimum threshold of salaries, for both certified and non-certified hospital doctors. Hospital physicians' wages thus have gradually increased. As of January 2015, hospital physicians without specialization earned a minimum of 1.25 times the national wage average of the industrial sector, while those with a specialization earned at least 2.3 times the average sector wage. The process of increasing salaries was divided into four stages from January 2012 to January 2015 to make sure that providers had sufficient time to prepare for budgetary pressures.

Since the approved system was cyclical, that is, a fixed multiple linked to the national average wage, it created an automatic system that increased minimum wages of health care personnel in hospitals annually. By 2017 Czechia had introduced a similar remuneration system in its state hospitals (Kubáň, 2022; MPSV CZ, 2025), which also included extra bonuses for years of experience. However, since most of the state-owned Slovak hospitals are in debt (see Box 3.2 and Fig. 3.11), they have limited options to increase wages above the minimal legal threshold and collective bargaining agreements.

These challenges led to an increase in the difference in the salaries of medical professionals between Czech and Slovak hospitals that was further exacerbated during the COVID-19 pandemic in 2020–2022. Czechia, as well as the other V4 countries, for example Hungary (Szalay, 2021), introduced a variety of significant COVID-19 related bonuses and wage increases, which were not matched by Slovak hospitals. As a consequence, comparative wages between Slovak hospitals and hospitals in other V4 countries decreased. Fig. 3.12 shows that the average wage in Czech and Slovak hospitals was on par up to 2017. By 2022 this wage gap stood at €516 per month.

As a result of this growing gap, the trade union of doctors in Slovakia (LOZ) demanded an increase in wages and a series of reforms to improve working conditions during 2020–2021. When MZ SR did not respond,

LOZ announced an emergency, with the intent to strike in April 2022. Other unions and chambers of medical professions also decided to join LOZ's declaration, and the Slovak Parliament approved a wage increase for hospital workers on 5 October 2022, days after more than 2100 doctors had handed in their notices on 1 October, starting their two-month resignation notice period.

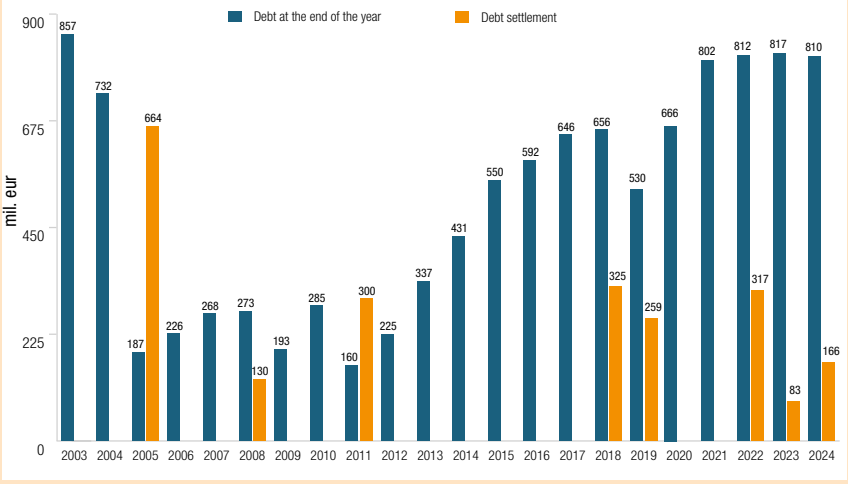
BOX 3.2 Debt relief for Slovak hospitals, 2003–2024

Most of the public and state-owned hospitals have been struggling with debt, preventing them from increasing wages above the minimal legislative thresholds. Hence, most of them cannot compete on salary terms with Czech hospitals, which have more stable and balanced financial results.

There are several reasons for the Slovak hospitals' debt. According to the Value for Money Project, hospitals suffer from poor efficiency, lack of centralized leadership and payment mechanisms that do not cover all expenses, especially of complex, tertiary hospitalizations (Ministry of Finance, 2019, 2022).

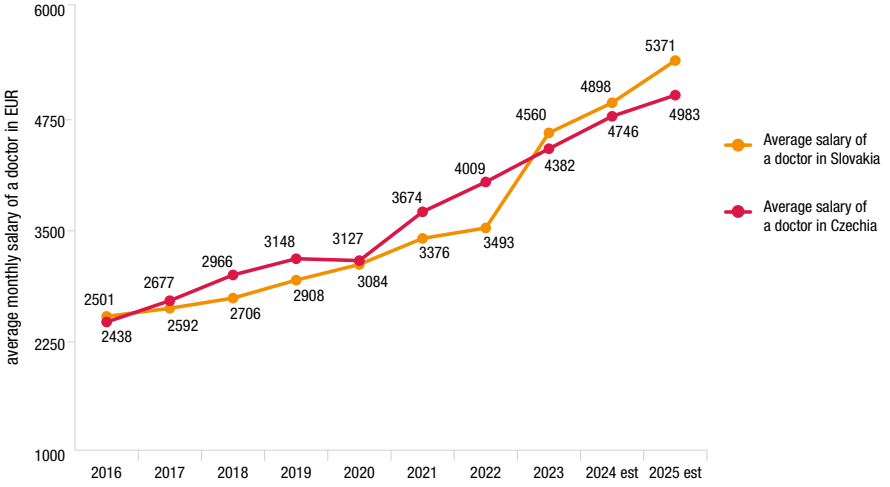
As a consequence, hospitals rely on debt relief initiatives by the government that happen every couple of years. The latest debt relief strategy was approved in December 2022 (Trend, 2022; MZ SR, 2025f).

FIGURE 3.11 Debt relief for Slovak hospitals, 2003–2024



Source: authors 'own compilation based on (MZ SR, 2024).

FIGURE 3.12 Average monthly wage of hospital doctors, Slovakia and Czechia, 2011–2025



Note: wages include bonuses and overtime.

Sources: authors' own compilation based on NCZI, 2025c; ÚZIS, 2025 data; data for 2024 and 2025 are estimates.

The government's increase comprised a two-fold change in the legislation governing hospital workforce remuneration: first, every hospital employee would receive a bonus based on every year of experience (up to 20 years) by a 0.01 multiple of average wage in Slovakia, and second, every profession would see a base salary increase based on a predefined multiple of the average wage in the industry. Thus, each profession received a profession-specific increase, depending on a relative wage comparison between Slovakia and Czechia; the aim was to ensure that relative wages (compared to the average industry wages of the respective countries) would be the same or better in Slovak hospitals.

The government and LOZ wound up reaching an agreement in the hours just before 1 December (that is, the end of the resignation notice period), and the average wage of a hospital doctor was set at roughly €4560 in 2023, i.e. 30% more than in 2022. Table 3.15 provides an overview of changes in physicians' remuneration. The changes caused the average wage of Slovak doctors to overtake those of their Czech counterparts in 2023 (see also Fig. 3.12). The average wage gap of other professions varies, especially for nurses, who still have a gap in comparison to nurses in Czech hospitals of an estimated €300–400 per month.

In 2024, as part of austerity measures, MZ SR proposed a change in the salary coefficients of health care professionals so the growth for 2025 would

be capped at 3%, compared to the original expected growth of 9.7%. As a consequence, LOZ announced another strike in the autumn of 2024, collecting nearly 3400 resignation notices. The strike was called off on 20 December, just days before the end date of the notice period. The coefficients eventually remained unchanged, but they apply only to those doctors (and medical professionals) working in hospitals that have at least 0.5 FTE contract in a hospital and do not work in private outpatient providers (Government Office of the Slovak Republic, 2024).

TABLE 3.15 Changes to the minimum threshold of salaries of physicians

PHASE	YEAR	COEFFICIENT OF MULTIPLICATION FOR DOCTORS WITHOUT SPECIALIZATION	COEFFICIENT OF MULTIPLICATION FOR DOCTORS WITH SPECIALIZATION
1st tranche	January 2012	1.10	1.6
2nd tranche	July 2012	1.20	1.9
1st part of 3rd tranche	2014	1.25	2.1
2nd part of 3rd tranche	2015	1.25	2.3
Approved increase, October 2022	January 2023	1.4 + 0.01 per year of experience (up to 20)	2.3 + 0.01 per year of experience (up to 20)
Negotiated increase, November 2022	January 2023	1.5 + 0.015 per year of experience (up to 30)	2.3 + 0.025 per year of experience (up to 30)
2nd tranche of negotiated increase	2025	1.5 + 0.015 per year of experience (up to 30)	2.5 + 0.03 per year of experience (up to 30)

Source: Decree no. 578/2004.

4

Physical and human resources

Chapter summary

- Slovakia's health care infrastructure is characterized by outdated buildings, although mostly equipped with modern devices and equipment, albeit with a low level of intellectual assets (that is, software, advanced machinery). Hospital bed levels per 100 000 population are high.
- The bulk of health funding from Slovakia's RRP is earmarked for hospital equipment. In contrast, primary care receives under 1% of the total health allocation, despite strategic calls for its development.
- Despite launching the national eHealth system in 2018, only a few modules, such as ePrescriptions, are functional. Artificial intelligence (AI)-based tools are mostly used by private insurers and laboratories, with limited public financing and unclear governance frameworks for broader deployment.
- Compared to the EU average, Slovakia has low levels of practising doctors and nurses. There is also an uneven regional distribution of staff, particularly between the capital Bratislava and less populated areas in the countryside. These exist for physicians, pharmacists, dentists and nurses.

- Slovakia is a net exporter of health care professionals (either born or educated in Slovakia). Slovakia has seen a long-term decline in the density of nurses and a high emigration rate for doctors, many leaving for economically stronger countries. Almost 15% of Slovak-born doctors and more than 25% of Slovak-trained doctors leave to work in other OECD countries.

4.1 Physical resources

4.1.1 *Infrastructure, capital stock and investments*

Until the early 2000s nearly all hospitals were owned by the state, with major challenges being the oversupply of acute beds, and a lack of medical technology and efficient coordination. Attempts to reduce numbers of hospital beds faced opposition from hospital management and local authorities. In 2003 MZ SR's centrally organized capital budget was largely abolished to promote greater transparency in modernization of capital stock. Funds are now redistributed to HICs to be included in their payments to providers and cover capital investments, replacing a system in which investments were not based on transparent, relevant economic or health indicators, which resulted in unpredictable allocations of funds. Thus, in theory, capital investments in hospitals have been financed by HICs through reimbursements for hospital services. However, providers do not see these revenues as sufficient and often invest additional funds into their health facilities, bearing the investment costs themselves. MZ SR may also provide capital grants.

The undercapitalization of the Slovak health system can be further illustrated by comparison with its closest neighbour and benchmark, Czechia. Between 1995 and 2022, gross fixed capital (GFC) in the Slovak health system reached a total of €6.3 billion, while this figure stood at €20.7 billion in Czechia (see Table 4.1)[8].

8 This is seen across the full economy (not just in the health system), as GFC in Slovakia overall was just 36% of that in Czechia – the low level of investments in health is largely a function of the greater economic context, and the difference between the two represents the additional financial resources needed to reach the investment level of Czechia.

TABLE 4.1 Gross capital formation for health in Slovakia and Czechia since 1995, in millions of euros

YEAR	SLOVAKIA	CZECHIA	SLOVAKIA, CUMULATIVE	CZECHIA, CUMULATIVE
1995	18.9	219.2	18.9	219.2
2000	75.3	419.7	579.1	1 554.2
2005	103.6	563.2	1 173.7	4 426.8
2010	325.2	908.2	2 516.2	8 096.5
2015	257.5	886.4	3 701.0	11 845.7
2016	269.7	712.5	3 970.7	12 558.2
2017	222.2	853.1	4 192.9	13 411.3
2018	241.4	866.5	4 434.3	14 277.8
2019	396.9	837.0	4 831.2	15 114.8
2020	418.1	1 030.5	5 249.3	16 145.3
2021	347.0	1 233.2	5 596.3	17 378.5
2022	355.0	1 442.5	5 951.3	18 821.0
2023	395.4	1 913.8	6 346.7	20 734.8

Source: Eurostat, 2024d.

When controlled for population (Slovakia's population is roughly half the size of Czechia's), this investment gap vis-à-vis Czechia stands at €4.3 billion, which represents €172.7 million per year in a 25-year horizon. Compared with previous findings from the Health Policy Institute (HPI), where Pažitný et al. (2014), determined that the investment gap with Czechia stood at €110.9–136.5 million per year, this investment gap has increased.

The structure of the investments also plays a key role. While detailed data for health are not available, Morvay's (2017) analysis of the structure of GFC showed an extremely high proportion of machinery and equipment in the Slovak economy, while investments in intellectual assets lagged behind compared to other countries such as Finland, Sweden and France. While Slovakia's hospitals are generally outfitted with modern devices, the buildings are outdated (see Table 4.2).

TABLE 4.2 Status of the infrastructure of state-owned University and Faculty hospitals

HOSPITAL	STATUS OF INFRASTRUCTURE	NO. OF BEDS (2018)
Faculty hospital in Banská Bystrica	Construction years: 1960 (old part), 1981 (new part)	910
Faculty hospital in Prešov	Construction years: 1947, 1963, 1967, 1989 (surgery), 2013 (internal medicine)	1233
Hospital Poprad	Construction year: 1970	581
Faculty hospital Žilina	Construction years: 1930, 1960, 1970	779
Faculty hospital Trnava	Construction years: 1940 (neurology, gynaecology), others more than 80 years old; Additions in 2008	641
University hospital Martin	Construction years: 1888, 1910, 2005-2015	838
University hospital Bratislava	Construction years: 1860–1963 (Staré Mesto), 1967 (Kramáre), 1986 (Ružinov), 1997 (Antolská)	2505
Faculty hospital Trenčín	Construction years: 1848, 1910	808
University hospital Košice	Construction years: 1920–1940, 1977 (Rastislavova), urgent care + traumatology (2011)	1356
Faculty hospital Nitra	Construction years: 1890, 1947, 1972, 1991, 1997	722

Source: Ministry of Finance, 2021.

The outdated nature of existing infrastructure (particularly in state hospitals) was confirmed both by the RRP (Ministry of Finance, 2021) and by the Slovak National Bank's document on Structural Challenges (NBS, 2021), though neither of these provides new evidence. The RRP, as a key document for drawing resources from the EU Recovery and Resilience Facility, relies on the HPI (an independent think tank) report to evaluate hospital infrastructure and provides only very limited information about the year of construction of state hospitals. The HPI report detailed that a typical acute care hospital in 2014 was more than 40 years old, with approximately 30 buildings. Since 2014 these hospitals have received limited capital investments.

As information on how much individual hospitals invest is also not available, media and news reports provide an alternative method to construct an overview of the largest investments in the hospital sector in the last 25 years. Reporting on the largest hospital investments in recent years is presented in Table 4.3.

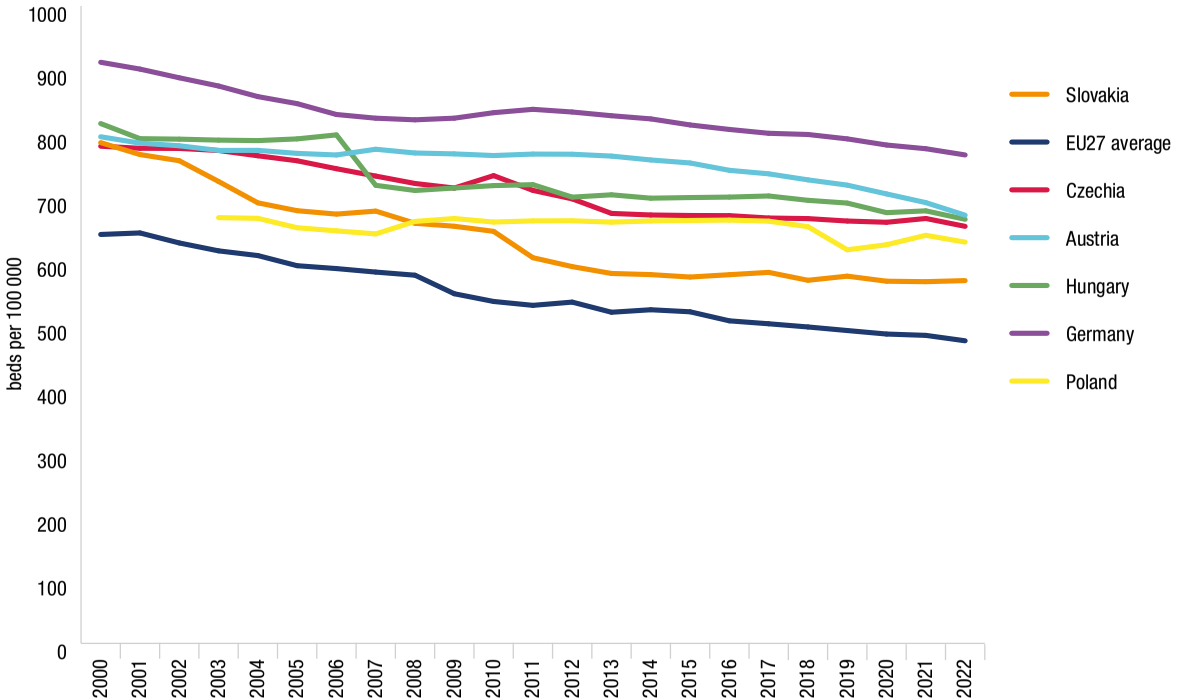
TABLE 4.3 Largest hospital investment projects since 1997

HOSPITAL	INVESTOR	PROJECT	INVESTMENT
Cardio centre in Košice	State-owned	New building (2003–2009), Diagnostic, preventive and research centre (2019)	€14.8 million
Cardio centre in Banská Bystrica	State-owned	Preventive-ambulatory and diagnostic centre (2019–2020)	€9 million
Hospital of Sv. Michal, Bratislava	State-owned	New hospital (2009)	€60 million
Hospital Michalovce	Penta (private)	New hospital (2017)	€34 million
Cardio centre in Bratislava	State-owned	New building with heliport + child cardio centre (2020–2021)	€31 million
Hospital Bory	Penta (private)	New hospital (opening in 2023)	€263 million

Source: Authors' own compilation.

Though construction of new hospitals and new hospital buildings has occurred in recent years, there has been no movement to eliminate excess beds or merge facilities (see Box 4.1). According to Eurostat (2024d), although the number of beds in Slovakia is decreasing (569.1 per 100 000 inhabitants in 2022) (see Fig. 4.1), it is still above the EU average (474.7 per 100 000 inhabitants). Based on research from Kališ and Stracová (2019), the number of beds should be reduced by between 68 and 113 beds per hospital.

FIGURE 4.1 Hospital beds in acute care hospitals per 100 000 population in Slovakia and selected countries, 2000 2022



Source: Eurostat, 2024d.

BOX 4.1 Are health facilities appropriately distributed?

Legally defined (Act 540/2021), the geographical availability of institutional care is the distance from the place of residence of the insured person to the nearest hospital of the appropriate level expressed by travel time. Travel time, expressed in minutes, corresponds to the effective availability of the place of provision of institutional care for at least 90% of the population in the catchment area by motor vehicle at a driving speed that is appropriate for the type of land transportation and is in accordance with traffic regulations. According to the Institute of Health Analysis (*Inštitút zdravotných analýz*, IZA) (2022), the geographical availability of care was met in 2022 for each level of hospitals (see Table 5.5). The average travel time (for 90% of the target population) for each level of hospital is shown in Table 4.4.

TABLE 4.4 Measured geographic availability for Slovak hospitals by SGR, 2022

REGION	TRAVEL TIME (IN MINUTES)			
	LEVEL V (MAX 300 MIN.)	LEVEL IV (MAX 90 MIN.)	LEVEL III (MAX 60 MIN.)	LEVEL II (MAX 30 MIN.)
Bratislava	12	12	11	11
Trnava	41	41	24	12
Trenčín	85	70	25	13
Nitra	71	64	32	13
Žilina	135	70	26	11
Banská Bystrica	128	40	40	17
Prešov	239	56	38	14
Košice	250	34	31	14

Note: This analysis was completed by IZA, an independent analytical and advisory unit of MZ SR. The original IZA analysis excluded Level I hospitals.

Source: IZA, 2022.

4.1.2 *Medical equipment*

The use of high-tech medical devices and equipment reflects the adoption of innovative practices in medicine. At the time of writing, in comparison with Czechia, Slovakia has fewer high-tech medical devices. While there are 12 Da Vinci (robot-assisted surgery) devices in Czechia today (FN HK, 2022), there are only three in Slovakia (two in the Faculty Hospital Banská Bystrica and one in the new (private) Bory Hospital in Bratislava, which opened in 2023) (Nový Čas, 2021; Bory Hospital, 2023). There are also two CyberKnife devices in use in Czechia (ÚVN Praha, n.d.), while the sole Cyberknife in Slovakia is in the Bory Hospital in Bratislava (Bory Hospital, 2022). As a result of this, Slovak HICs (Dôvera, 2022b) have contracted facilities in Czechia for some treatments for their members, such as the Proton Centre in Prague. As hospitals are planned to receive the large majority of RRP funding for health (see Box 4.2), the plan foresees the procurement of critical advanced machinery and equipment, including:

- 5–7256-slice CT scanners;
- 5–7 medical linear accelerators;
- 12–17 biplanar angiography machines;
- 2–4 Da Vinci robots; and
- other equipment for stereotactic radiosurgery.

BOX 4.2 **Slovakia's national RRP**

A large majority of the €1.5 billion targeted for health is planned for equipment in hospitals (see Section 3.6.2). This comes at the expense of generating investments and a strategic perspective for strengthening primary care, which is due to receive €11 million, less than 1% of the total funds, even though key documents have long drawn attention to the importance of primary care. Furthermore, only €41 million will go towards digitalization efforts, meaning more will be spent on project preparation and management (a total of €58 million) than on strategic investments for primary care and digitalization combined, which are two critical components of a competitive and modern health system.

With 1.1 magnetic resonance imaging (MRI) units per 100 000 inhabitants in 2022, Slovakia was below the EU average of 1.9 (see Table 4.5). There were also fewer computed tomography (CT) scanners in Slovakia per 100 000 inhabitants (2) compared to the EU average (2.7).

TABLE 4.5 Items of functioning diagnostic imaging technologies (MRI units, CT scanners) per 100 000 inhabitants in Slovakia and the EU, 2022

	SLOVAKIA	EU AVERAGE
MRI units	1.1	1.9
CT scanners	2	2.7

Source: Eurostat, 2024d.

4.1.3 *Information technology and eHealth*

In 2008 the establishment of health information infrastructure was declared a health policy priority and legislation was passed in 2013 to create a national eHealth system. This law put NCZI in charge of implementing the eHealth strategy, including authorized electronic communication, ePrescription, electronic patient records, reporting of medical procedures and systematic data collection. The requirement to collect and store all new patient data in electronic health records came into effect with the launch of the system in 2018, with GPs overseeing patient health records as the only physicians with access to all available patient information. In practice, however, not all eHealth modules are active. At the time of writing, the only functioning modules are ePrescription and electronic sick notes.

HICs have also been active in this area by building their own information systems, applications and tools. The (private) HIC Dôvera offers various eHealth solutions, such as "Safe drugs", "DôveraLab" and "HospiCOM". These are online services which link doctors, patients, pharmacists and Dôvera more directly and allows for services such as ePrescription, electronic communication and data exchange. Additionally, Dôvera introduced unique services for informing patients about their registration and approval of

planned hospitalization via SMS, email or smartphone applications, which have become a model for similar services for the other two HICs.

Insurees of the other privately owned HIC, Union, can use its online services to claim benefits, search for contracted providers or activate notifications for preventive care, among other functionalities. Besides these, Union also produces podcasts and videos to inform insurees on improving their overall physical and mental health.

The publicly owned VšZP has also invested in some eHealth schemes (eHospik, ePobočka and a mobile application) that facilitate communication and data exchange between HIC providers and the insured. VšZP also provides a "health wallet", an electronic reward programme with a bonus of €100 per person, which can be expanded up to eight persons (including non-family) with a bonus of €800 (VšZP, 2025).

In terms of using AI solutions, including software, databases and intellectual property, the analytical units of HICs are testing fraud detection routines and protocols based on AI methods. Additionally, Dôvera has implemented several AI-facilitated tools, such as intelligent character recognition in claim processing, a symptom checker application for self-referral and the development of a predictive model for disease management programmes for diabetic patients. Furthermore, the firm PWC produced a National Strategy for AI in Healthcare (European Commission, 2025) and found that only a handful of stakeholders in the Slovak health system had experience with the deployment of AI-supported tools. Most are present in labs and diagnostic practices, where image-based diagnostic tools supported by AI algorithms, such as IcoBrain (IcoMetrix), Brainomix (e-Stroke suite) or AI RAD Companion are used on a daily basis. According to the PWC report, there are several barriers to overcome and challenges to tackle. From the governance and regulatory perspective, Slovakia has limited capacity to perform supervision of AI solutions in health care. From the data and technology perspective, a lack of digitization limits deployment in several areas and the secondary use of data is not yet covered by legislation in a systematic way. Finally, the report found that while public opinion does not currently represent a barrier, opinion on the application of AI in health care has not yet been fully formed.

4.2 Human resources

4.2.1 *Planning and registration of human resources*

Since June 2022 MZ SR has been working on a national strategy for the planning and stabilization of human resources in health care, though it has not been published, discussed publicly or adopted (MZ SR, 2022b). On the other hand, the Ministry of Labour, Social Affairs and Family completed a project on "Sectorial managed innovation" in 2022, which presented a comprehensive set of detailed national standards for 193 health care professions, including information about the required compulsory educational level for each job (SRI, n.d.). This, however, took more a technical than a strategic approach. At the time of writing, there is no official strategy for human resources in health care and there is no mechanism for regulating the number of health workers in each category and specialization according to the population's needs.

Human resource planning in hospitals is the responsibility of hospital management, and planning in outpatient care is the purview of HICs and SGRs. In hospitals (71 general and 45 specialized), physicians are employed as staff, whereas in outpatient settings they are usually self-employed or business owners of their clinics (NCZI, 2021). Trade unions have described the situation in hospitals as "lacking staff, exhausted medical professionals, unnecessary deaths and the need for dialogue". This resulted in the strike action in 2022 (see Section 3.7.2).

Licensing and recognition

To obtain a licence, a physician must meet five criteria defined by law (Act 578/2004): (1) have full legal capacity, (2) be medically fit (annual check-up required after 65+), (3) be professionally educated (diplomas and certificates), (4) have integrity (proven through a criminal record check) and (5) be officially registered (maintained by the Slovak Medical Chamber). There are several types of licence, which differ from each other according to the medical field (SLK, 2024).

The application for the issuance of a licence is submitted to the regional chamber of which the doctor is a member. The regional chamber will issue a

licence if the applicant has proven that all conditions have been met. Licence holders can also apply for a temporary suspension for a maximum of one year. To practise in the outpatient setting, a licensed physician must also submit an application to operate a practice to the relevant SGR (or MZ SR, if the physician wants to provide care in more than one SGR). There is no system of recertification of licences in the Slovak health system.

Education recognition systems have been adopted from EU legislation (Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications). Documents on certain specializations of physicians and dental practitioners, whose specialized training is harmonized across the entire EU, are recognized under an automatic system.

The recognition of a foreign diploma or qualification for the pursuit of regulated professions is handled by the Centre for Recognition of Diplomas at the Ministry of Education (Ministry of Education, Research, Development and Youth of the Slovak Republic, n.d.(a)). Recognition of any other educational qualifications of health care professionals acquired in non-EU Member States necessitates a further application for validation of their diploma followed by a supplementary exam to demonstrate the required skills (Ministry of Education, Research, Development and Youth of the Slovak Republic, n.d.(b)). Applicants must also have working knowledge of Slovak; for health care professionals, MZ SR is responsible for the official language verification.

4.2.2 *Trends in the health workforce*

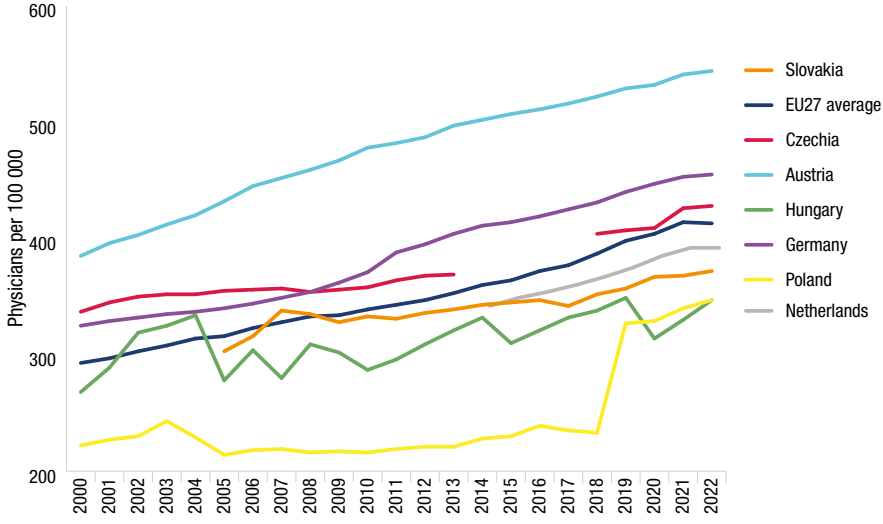
Compared to the EU average, Slovakia has low levels of practising doctors and nurses. Slovakia also lags behind Czechia, though has higher densities than the other V4 countries (Poland and Hungary) (see Fig. 4.2).

Slovakia reached its historical minimum in 2005 with 304 physicians per 100 000 inhabitants. In 2022 this improved to 372 per 100 000 (see Fig. 4.3). As a result of differing trends (fewer nurses with more doctors), the nurse-to-doctor ratio fell from 2.2 in 2000 to 1.5 in 2022. This is comparable to Hungary (1.6) and Poland (1.6), but significantly lower than Austria (2.0) or Czechia (2.1).

FIGURE 4.2 Densities of practising nurses and doctors per 100 000 population, 2022

Source: OECD, 2024b.

FIGURE 4.3 Practising physicians per 100 000 population in Slovakia and selected countries, 2000–2022

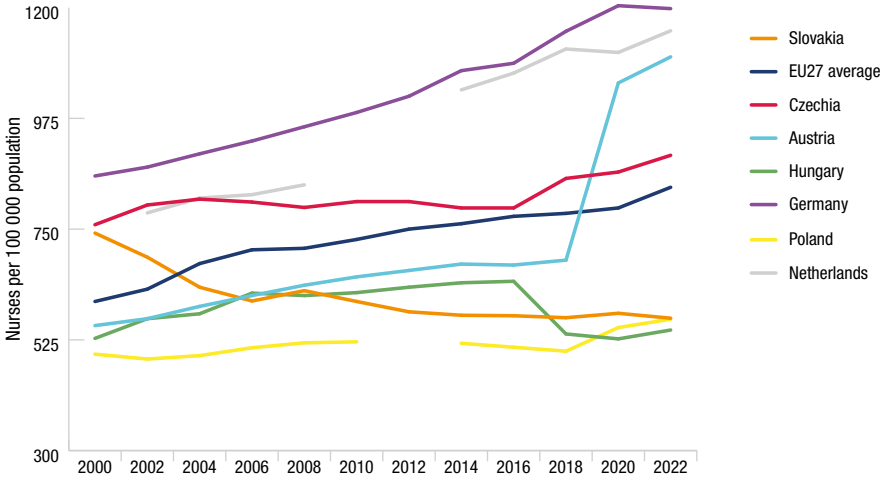


Note: professionally active for Slovakia; practising for other countries.

Source: OECD, 2024b.

There is a clear long-term decline in the number of nurses. Low staffing of nurses, their age structure (and gradual retirement), emigration, and low interest among younger generations are significant concerns. In 2000 Slovakia had 744 nurses per 100 000 inhabitants, while in 2022 it was only 569 per 100 000 (see Fig. 4.4). Estimations from the Chamber of Nurses and Midwives from 2023 are that Slovakia has a current shortage of 16 000 nurses and within 10 years the shortage will be 25 000 nurses (SITA, 2023a). The Chamber thus welcomed the simplified process for recognizing professional qualifications for nurses from Ukraine in mid-2023. In terms of leaving Slovakia to work elsewhere, Austria and Czechia present opportunities for nurses owing to more favourable working conditions and their proximity.

FIGURE 4.4 Practising nurses per 100 000 population in Slovakia and selected countries, 2000–2022



Note: professionally active for Slovakia; practising for other countries.
Source: OECD, 2024b.

The regional distribution of health professionals within Slovakia is very skewed (see Table 4.6) – for example, the Bratislava Region has 6.6 doctors per 1000 inhabitants, while five regions have around 3 doctors per 1000 inhabitants. These regional disparities are also present among dentists, pharmacists and nurses.

TABLE 4.6 Health profession densities per 1000 by SGR, 2023

REGION	DOCTORS	DENTISTS	PHARMACISTS	NURSES	MIDWIVES
Bratislava	6.8	0.8	1.5	8.3	0.4
Trnava	2.8	0.5	0.5	4.4	0.3
Trenčín	2.7	0.5	0.5	4.6	0.3
Nitra	3.0	0.4	0.5	4.9	0.2
Žilina	4.0	0.6	0.5	6.0	0.4
Banská Bystrica	3.3	0.4	0.5	5.5	0.3
Prešov	3.3	0.5	0.7	5.5	0.4
Košice	4.2	0.6	1.9	6.1	0.4
Total	**3.8**	**0.5**	**0.9**	**5.7**	**0.3**

Source: NCZI, 2023d.

As of 2023, 121 082 people were employed in the health sector, representing 4.6% of the Slovak workforce. Roughly half (60 413) were working in the private sector, marking a rise in the share of private sector workers since 2014 (see Table 4.7).

Ageing of the workforce is also a concern in Slovakia. There were 3551 doctors older than 65 years of age in 2023, representing almost 17% of all doctors (see Table 4.8). Table 4.9 shows that the health workforce in Slovakia is dominated by women, accounting for 78.3% of all health care employees; nurses are almost exclusively women (97.6%). Midwives are 99.9% female, while 59.5% of physicians and dentists are women (NCZI, 2023d).

TABLE 4.7 Share (%) of health professionals by employer, 2014–2023

YEAR	MZ SR ORGANIZATIONS*	OTHER MINISTRIES**	SGRS	MZ SR + ESTABLISHED BY LAW IN 2020***	OTHERS (PRIVATE)
2014	39.2	1.7	11.3	.	47.8
2015	39.2	1.7	9.1	.	49.9
2016	39,3	1.8	7.7	.	51.2
2017	39.6	1.8	6.4	.	52.3
2018	39.6	1.8	6.3	.	52.3
2019	39.6	1.9	6.4	.	52.1
2020	37.4	1.8	6.4	3.0	51.5
2021	37.3	2.1	6.3	3.2	51.2
2022	37.6	2.8	6.3	3.2	50.1
2023	37.9	2.8	6.2	3.2	49.9

Notes: *owned by MZ SR and operated by managers appointed by the Minister of Health; ** Ministry of the Interior, Ministry of Defence; *** Mobile Sample Collection Points and Epidemiological clinics.

Source: NCZI, 2023d.

TABLE 4.8 Health care personnel aged 65+

	DOCTORS 65+	DENTISTS 65+	NURSES 65 +	MIDWIVES 65+
2014	1788	409	521	30
2015	1948	425	564	34
2016	2177	482	647	44
2017	2367	528	701	48
2018	2720	573	784	65
2019	3014	604	906	77
2020	3269	613	968	71
2021	3355	641	1012	71
2022	3480	625	1120	86
2023	3551	615	1295	113

Source: NCZI, 2023d.

TABLE 4.9 Number of health personnel by categories, 2023

WORKFORCE	MEN	WOMEN	TOTAL	SHARE OF WOMEN
Total labour force	26 319	94 763	121 082	78.3%
Physicians	9 606	14 108	23 714	59.5%
Nurses	737	30 437	31 174	97.6%
Midwives	1	1 781	1 782	99.9%

Note: data available only as summed up for both categories; no data for pharmacists available.
Source: NCZI, 2023d.

4.2.3 *Professional mobility of health workers*

Slovakia is a net exporter of health care professionals (either born or educated in Slovakia), with a high emigration rate of doctors, many leaving to work in economically stronger countries. According to the OECD (2024a), almost 15% of Slovak-born doctors and more than 25% of Slovak-trained doctors leave to work in other OECD countries. Most doctors trained in Slovakia went to Czechia (2218 doctors), Germany (1062), Norway (406) and Greece (193). This dynamic is even more pronounced with nurses, and surveys indicate that younger nurses with less work experience are more likely to leave Slovakia (Poliaková et al., 2022).

An analysis on the outlook of doctors and nurses up to 2030 formulated two main conclusions (Bárta, 2023):

1. despite an increase in the number of doctors, demographic changes will cause the average medical doctor to have a heavier workload by 2030; and
2. the situation for nurses will exacerbate, as their numbers are projected to decrease. As a result, the decline in health care accessibility is likely to be even more significant.

Proposed strategies to head off these challenges include deregulating the health sector to draw in foreign doctors, adjusting the balance of international and Slovak medical students, and potentially boosting the number of

medical students. Improving the retention rate of health professionals would also help (some reports suggest that only 40% of nursing graduates enter the profession), including enhancing the appeal of health professions, for example by increasing salaries, supporting work-life balance and providing opportunities for further education (Bárta, 2023).

Similarly, the Council for Budget Responsibility (Rada pre Rozpočtovú Zodpovednosť) found the modest growth in doctors in recent years is insufficient to maintain the current level of care for the ageing population (RRZ, 2023). Achieving this will require a long-term increase in the number of doctors by 4% compared to the current trend, which can be achieved through changes in the policies of medical faculties. The current practice has resulted in medical faculties admitting up to 40% of foreign students (see Section 4.2.4).

4.2.4 *Training of health personnel*

Professional qualifications can be obtained from universities, colleges or high schools, and this can be done through higher education of the first or second degree, higher vocational education, full secondary vocational education, or secondary vocational education. Physicians are educated in one of three universities (Comenius University and the Slovak Medical University in Bratislava, or PJ Safarik University in Košice) among four faculties that provide accredited study programmes in general medicine and dentistry.

Study programmes are comparable to those in other EU countries and are carried out in accordance with Directive 2005/36/ EC (the recognition of professional qualifications). The number of medical students is limited predominantly by the capacities of the universities. There are around 4300 Slovak students studying general medicine annually. On the other hand, the number of foreign students has been rising rapidly. In 2009 the share of foreign students was around 19%; in 2023 it was 39%, meaning 2800 foreign students, who study general medicine (in English) (see Table 4.10). The reason for the rise of English-speaking foreign students is predominantly financial. Universities obtain €7000–7500 annually for a Slovak student from the state budget (Struhárňanská, 2023), while they charge €9000–11 900 annually for foreign students that are usually recruited via specialized agencies.

TABLE 4.10 Number of Slovak and foreign students studying general medicine, 2009–2023

YEAR	SLOVAK STUDENTS	FOREIGN STUDENTS	TOTAL	SHARE OF FOREIGN STUDENTS
2009	3989	965	4954	19%
2010	3932	1181	5113	23%
2011	4051	1418	5469	26%
2012	4051	1645	5696	29%
2013	3890	1977	5867	34%
2014	3997	2273	6270	36%
2015	3992	2419	6411	38%
2016	3996	2608	6604	39%
2017	3947	2846	6793	42%
2018	4062	2789	6851	41%
2019	4104	2784	6888	40%
2020	4348	2794	7142	39%
2021	4366	2801	7167	39%
2022	4310	2773	7083	39%
2023	4318	2793	7111	39%

Source: (Páleník, n.d.(b)).

A medical degree programme usually lasts for six years and is divided into two parts:

- Preclinical Years: The first three years focus on basic sciences like anatomy, physiology, biochemistry and pathology. Students learn about the structure and functions of the human body.
- Clinical Years: Students rotate through different specialties, gaining practical experience under the supervision of experienced

physicians. They learn how to diagnose and treat patients, as well as developing skills in communication and teamwork.

Pharmacists complete a five-year master's programme (Title "Mgr."), which consists of at least four years of theoretical and practical teaching at a university and at least six months of experience in a public or hospital pharmacy. Graduates of the pharmaceutical programme may also choose a doctorate programme.

Nurses are differentiated by education level: bachelor or master, practical nurse (assistant), and certified nurse (see Table 4.11). The role of practical nurse (assistant) is distinct from the profession of certified nurse and they have varying education requirements. When students complete their four-year studies with a high school diploma ("full secondary vocational" education), this qualifies them for the position of medical assistant (practical nurse). They can continue to university, where after a three-year study course they will receive a bachelor's degree, or later a master's degree (nurse). As an alternative, candidates can continue their higher professional studies at a technical institution (as an alternative to the bachelor study) and in three years they will become a certified nurse (Gdovinová, 2018).

To perform the professional work activities of a nurse, candidates are required to obtain higher education in the field of nursing (MZ SR, 2011a). Nurses receive an academic bachelor's degree comparable to those in other EU countries and the professional title of Nurse. Graduates can pursue a master's degree. Another possibility is higher professional education in the "certified general nurse" field of study. To perform the professional work activities of a practical nurse, candidates are required to obtain a complete secondary professional education in the "practical nurse" field of study (MZ SR, 2011b). Midwifery is taught in accordance with Directive 2005/36/EC.

Each health professional is obliged to register in the relevant professional chamber and regularly update their occupational and educational activities. Health care professionals can be providers themselves (as business owners) or employees of a provider. As providers they need both a permit and a licence, but as employees they need only a registration from the professional chamber. A licence is also issued by the professional chamber and provides proof of qualification (education and years of practice).

Subsequently, health workers can specialize in the system of further education or be certified and obtain professional competence for the

TABLE 4.11 Certified Nurses according to education, 2009–2023

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Full secondary vocational	67.6%	65.0%	63.0%	61.3%	59.6%	58.6%	57.0%	55.6%	54.8%	53.4%	52.8%	51.7%	50.5%	48.8%	46.5%
Higher professional	15.2%	15.0%	14.0%	13.7%	13.7%	13.4%	13.7%	13.6%	13.3%	13.1%	12.6%	12.6%	12.4%	12.4%	12.4%
Bachelor's	9.6%	11.1%	12.0%	12.4%	13.0%	13.2%	13.7%	14.6%	14.9%	15.9%	16.7%	17.1%	17.7%	18.5%	19.8%
Master's	7.6%	8.9%	10.9%	12.5%	13.8%	14.7%	15.6%	16.2%	17.1%	17.6%	17.9%	18.5%	19.4%	20.3%	21.3%

Source: NCZI, 2023d.

performance of specialized and certified work activities. Further education of health care workers is provided by:

- specialization studies (also called attestation);
- certification training; and
- continuous education.

Continuous education for health workers of the relevant health profession is provided by the employer, professional societies of the Slovak Medical Association and the chamber in which the health worker is registered, independently or in cooperation with educational institutions or other internationally recognized professional societies or professional associations and providers. Educational evaluation is carried out in regular five-year cycles (Zákony pre ľudí, 2019).

While the Ministry of Education oversees general educational standards, MZ SR is typically involved in setting standards specific to health care professions. This can include requirements for medical schools, nursing programmes and other health care-related educational institutions.

Accreditation of specialized and certification education, continuous education, first aid courses and first aid instructor courses for health workers is dealt with by the Accreditation Commission of MZ SR for further education of health professionals, which is an advisory body in matters of further education of health workers. Minimum standards for programmes are set by MZ SR.

4.2.5 *Physicians' career path*

Professional development for doctors depends on individual motivation and ambition, which leads to variations in possible nationwide career paths:

1. Doctors can stay without further specialization and work in a hospital with limited scope of practice;
2. Doctors can obtain a specialization in one of the specialty fields acknowledged by the EU (for example, surgery, internal medicine, obstetrics, and gynaecology) and practise across all EU Member States without limitation on their scope of specialization. Certain

requirements exist for each specialization in terms of length of training, rotations and numbers of procedures performed.

3. In hospitals, doctors can progress from senior physician to assistant medical director and medical director. In university hospitals doctors may combine clinical duties with research activities.
4. Doctors can obtain a licence that enables them to provide medical services as sole proprietor or become sponsors of another entity that provides medical guarantees for provision of care.
5. Doctors can pursue research and conduct pure biomedical research or focus on lecturing at one of the medical universities while receiving a PhD degree.

However, survey data from 2024 show that more than one quarter of medical students want to leave Slovakia after finishing their studies (see Table 4.12).

TABLE 4.12 Shares of Slovak and foreign medical students wanting to stay in Slovakia or go elsewhere after their studies, 2024

	SLOVAK STUDENTS	FOREIGN STUDENTS
Stay in Slovakia	72%	22%
Leave for another country	28%	78%

Source: HCI, 2024.

A specific residency programme was introduced to secure a sufficient number of physicians in the specializations of general medicine and paediatrics across Slovakia and to support their further education (MZ SR, 2011c). The residency programme started as a pilot project in the academic year 2014/2015 at three universities across the country. Since then it has continued and graduates of medical faculties can enrol in either of these specialization fields upon completion of their medical studies. After completion of the residency programme, students are obligated to provide health care in a general outpatient clinic for adults or in a general outpatient clinic for children and adolescents. After the initial five years of the pilot, and costs of €22.2 million,

the NKÚ identified a number of shortcomings, such as frequently changing conditions, restrictions in the form of sanctions, curtailment of maternity and parental leave, the requirement to stay in a specific region and missing evaluations (NKÚ, 2020).

4.2.6 *Other health workers' career paths*

Dentists

Given the potential for high earnings, the dental profession has become very attractive among students over the last 10 years (see Table 4.13). Data from Profesia.sk (n.d.), the biggest HR portal in Slovakia, show that the monthly gross salary (in 2023) of a dentist is around €5 000 (roughly four times the average Slovak salary of €1304).

After finishing university, dentists do not need to pass a specialization exam and they usually begin to practise just after graduation as employees before opening their own clinics. This requires a permit, and is first based on the decision of the Slovak Chamber of Dentists on the issuance of a licence. This licence is tied directly to the commercial entity that will operate the clinic. The licence is officially issued by the Slovak Chamber of Dentists and an applying dentist needs to submit (1) verified diplomas and certificates, (2) a health certificate from a GP, (3) a criminal background check not older than three months and (4) their record of previous experience and practice.

A hygiene certificate is also required from the Regional Public Health Authority (as for other providers), which certifies that the operating procedures of the clinic meet all criteria regarding material and personnel. The dentist may then submit a request for a permit to their SGR to open the clinic (or to MZ SR if applying for offices across multiple regions), providing business operating hours and a price list. There is no guarantee that new dental clinics will obtain contracts with HICs right away, and usually new clinics start taking OOP payments first.

According to Igor Moravčík (Štenclová, 2019), the president of the Slovak Chamber of Dentists, an issue in Slovakia is dentists' non-proportional geographical distribution (the national average is 55 per 100 000 inhabitants). This is confirmed by analysis from 2022 which found that in Bratislava there were 81 dentists per 100 000 inhabitants, but only 41 per 100 000 inhabitants

in the Nitra Region, followed by Banská Bystrica with 44 and Prešov with 48 (Páleník, 2022).

TABLE 4.13 Share of doctors and dentists under 40, and number of dentistry students, 2009-2023

	DOCTORS UNDER 40	DENTISTS UNDER 40	NUMBER OF DENTISTRY STUDENTS[a]
2009	32.6%	24.8%	544
2010	33.0%	25.0%	514
2011	31.9%	24.8%	538
2012	30.9%	25.6%	547
2013	30.8%	26.4%	565
2014	30.6%	26.9%	578
2015	31.0%	28.7%	614
2016	31.3%	31.3%	632
2017	31.9%	33.6%	657
2018	32.5%	35.2%	670
2019	33.1%	38.5%	662
2020	33.7%	39.9%	674
2021	34.2%	40.4%	668
2022	34.9%	43.0%	664
2023	34.8%	43.1%	672

Note: a students with Slovakian nationality, excluding foreign students.

Sources: NCZI, 2023d; Páleník, n.d.(a).

Pharmacists

Pharmacists can decide to pursue a career in the pharmaceutical sector or choose to work for or run a pharmacy. The criteria and the process to open a pharmacy include (Podnikatelsko.sk, 2024):

1. establish a limited liability company (other options are also possible, but this is the most common);
2. obtain a type C licence. This requires second-level university education in the field of pharmacy and professional experience of at least five years in a public pharmacy or a hospital pharmacy, or a specialization in the specialized field of pharmacy;
3. obtain a permit to operate a public pharmacy. This permit is issued by the relevant SGR, according to the intended place of operation of the pharmacy; and
4. entry of the permit in the commercial register.

Nurses

Unlike doctors, there is no binding nationwide career path for other health workers. Nurses can work in a hospital and progress to different specializations and levels of patient responsibility. Furthermore, nurses can choose to work in ambulatory settings or obtain a licence to provide either nursing services as a sole proprietor or run a nursing home and nursing care services. Other health care professionals, such as hospital auxiliary staff, do not follow a defined career path either.

4.2.7 *Outlook*

Slovakia's approach to its health workforce necessitates the implementation of modern human resource management strategies, their organization, substitution, or on-site and online compensation. If Slovakia hopes to maintain or try to increase health workforce, current class cohort sizes, and their flexibility in choosing specialties, are concerns to address. Greater recruitment of foreign professionals may also help, particularly to support the return of Slovak professionals who have previously left to work elsewhere.

Achieving greater productivity and value for patients with existing or fewer physicians requires attention to strengthen primary care, with a modern type of GP that is clinically, technically and managerially skilled. Here, new curricula during the training of the next generation of GPs can impart these skills. Strengthening the function and competence of nurses and other workers can also further aid the transition from reliance on specialists and hospitals to primary care, as many hospitalizations can be avoided if primary care is strengthened (OECD/European Observatory on Health Systems and Policies, 2023). Support staff, as well as the implementation of new technologies (digitization, AI) are also critical to pursuing new ways of organizing health services. Regions with a higher degree of fragmentation of health services rely to a greater extent on more intensive contact with specialists and less use of primary care. They also have higher numbers of hospitalizations, emergency room visits and repeated use of imaging and diagnostic methods (Agha, Frandsen & Rebitzer, 2019). Reducing the level of fragmentation of the Slovak health system thus appears to be one of the key strategies for compensating for the future shortage of human resources. The government has also launched a support scheme incentivizing the return of specialists from abroad (Ministry of Education, Research, Development and Youth of the Slovak Republic, n.d.(c)).

5

Provision of services

Chapter summary

- MZ SR has a strategic, coordinating and regulatory role in public health. Implementation of measures for health promotion, health protection and disease prevention is the responsibility of ÚVZ SR, via 36 regional public health authorities, which played a key role during the COVID-19 pandemic.
- National vaccination coverage rates have declined slightly over the last decade. There are significant and growing regional differences and county vaccination rates range from 77% to almost 100%. Vaccination rates for older adults are among the lowest in the EU, as influenza vaccination rates in the 65+ group reached only 5.6% in 2022.
- Gatekeeping has been in place since 2013, and patients cannot access other specialists without a referral from their registered primary care physician, with the exception of psychiatrists, dentists, gynaecologists, dermatologists and ophthalmologists.
- If a specialist determines that surgery or hospitalization is needed, a patient is referred to a hospital. Referral to hospital care is possible also via a GP, if a patient's condition requires immediate inpatient treatment. A patient is free to choose a provider of inpatient care.
- Over a five-year period the total pharmaceutical expenditure in outpatient and inpatient care grew by €548 million, to €2.45 billion in 2024.

The overall consumption of medicine packs reached 163.5 million packs in 2024; the primary driver of the increase since 2019 is OTC medicines, largely due to the COVID-19 pandemic.

- Long-term (health and social) care is provided in various forms, but there is no integrated model of care, despite recent efforts by MZ SR and the Ministry of Labour, Social Affairs and Family having prepared a joint strategy for the development of social and health care in 2021.
- Mental health care is provided in outpatient and inpatient settings, and is covered by social health insurance. Mental health care has been given high priority in Slovakia's RRP, with its own component for reforms and investments. Several are being implemented, such as the approval of the National Mental Health Programme and the Action Plan of the National Mental Health Programme for 2024–2030.
- Dentists are directly accessible for patients without referral, and a small part of preventive and treatment procedures is completely covered by social health insurance (for example preventive screening, ruptures). A second group of procedures is partially covered by patients (e.g. specific tooth fillings, fixed dentures), and a third, the largest, group requires full private coverage by the patients. Dental practices, except for a few cases, are privately owned, providing good geographic coverage.

5.1 Public health

Public health in Slovakia is anchored in law (Act 355/2007). MZ SR has a strategic, coordinating and regulatory role in public health, while execution of measures itself falls under ÚVZ SR. ÚVZ SR adopts measures for health promotion, health protection and disease prevention, and organizes international cooperation in public health (including harmonization with EU norms). ÚVZ SR furthermore conducts research, provides methodological advice and closely cooperates with the 36 regional public health authorities.

ÚVZ SR is financed solely from the state budget and is led by the Chief Public Health Officer. Its main tasks include:

- health promotion and disease prevention by monitoring environmental factors and population health status, as well as promoting

healthy lifestyles through prevention programmes; and
- epidemiological surveillance of communicable diseases and laboratory investigations, and containment or preventive measures (as necessary) in collaboration with state veterinary authorities in cases of food contamination or poisoning.

ÚVZ SR played a key role during the COVID-19 pandemic, as the office was tasked with issuing pandemic measures, verifying positive tests and setting standards. In practice, however, ÚVZ SR in most cases only implemented governmental decisions. ÚVZ SR and the Chief Public Health Officer became symbols of the pandemic in Slovakia and were often the targets of political attacks in the media (SITA, 2024).

Health promotion and disease prevention

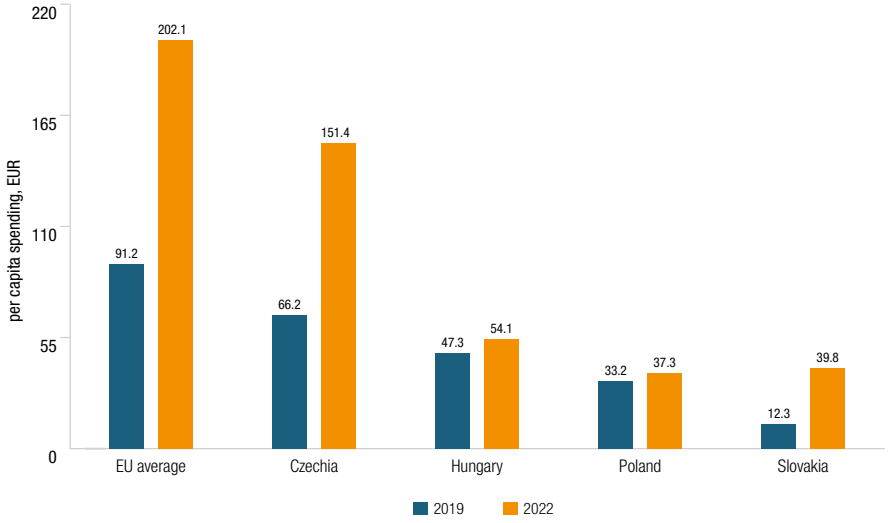
Before the COVID-19 pandemic, per capita expenditure on prevention was eight times lower than the EU average and the lowest among EU Member States. While the response to the pandemic caused an increase in spending on preventive measures, per capita expenditure remained the second lowest in the EU, with only Poland spending less on prevention in 2022 (see Fig. 5.1).

ÚVZ SR carries out activities related to the National Health Promotion Programme (NHPP). The latest version (at the time of writing), approved in January 2022, guides public health policy-making in Slovakia, though without specific financing or monitoring. The NHPP (2021–2030) aims to improve the health status of the Slovak population and reduce the incidence of chronic noncommunicable diseases by improving awareness and promotion. Main focal points include:

- Nutrition and diet
- Physical activity
- Tobacco, alcohol and drugs
- Mental health promotion
- Healthy working and living conditions

Another objective is to increase healthy lifestyles via preventive measures and lower risks of infectious diseases, with raising awareness of the importance of vaccinations being a key goal. Implementation of the NHPP is realized through several initiatives, either regionally (children and adolescent health) or nationwide, and in collaboration with HICs, providers, MZ SR and others (see Box 5.1).

FIGURE 5.1 Expenditure on prevention, 2019 and 2022, selected countries



Notes: Slovak data also includes expenditure by HICs, as well as ÚVZ SR; despite harmonization of expenditure data according to SHA 2011 methodology, there might be discrepancies in allocation of expenditure on prevention among EU countries, especially during the COVID-19 pandemic.

Sources: Eurostat, 2024d; OECD, Eurostat & WHO, 2017.

BOX 5.1 Key national public health initiatives, 2024

- National Programme for Active Ageing 2021–2030
- National Tobacco Control Programme
- National Action Plan for Tobacco and Related Products Control 2023–2030
- National Action Plan on Alcohol Problems 2021–2030
- National Action Plan for the Prevention of Obesity 2015–2025
- National Action Plan for the Promotion of Physical Activity 2024–2030
- National Action Plan of the National Oncology Programme 2021–2025
- Food and Nutrition Action Plan 2017–2025
- Action Plans for the Roma Equality, Inclusion and Participation Strategy 2030 for 2022–2024
- National Drugs Strategy for the period 2021–2025 with a view to 2030
- National Strategy of the Slovak Republic for BECEP for 2021–2030
- National vaccination strategy against COVID19 in the Slovak Republic
- Slovak Environmental and Public Health Action Plan (NEHAP V.)
- Protocol on Water and Health

Sources: NKÚ, 2022; ÚVZ SR, 2024b

Each regional public health office advises on risk factors, healthy nutrition and physical activity, smoking cessation, mental health and stress management, and occupational health in their counselling centres. They also provide non-pharmacological treatments, advise on environmental factors, housing quality, drinking and recreational waters, and can provide flu vaccinations. Due to insufficient state funding of promotion and prevention programmes, their activities and campaigns are often conducted and co-financed in partnership with NGOs.

In 2018 the NOP was approved, and a subsequent action plan in 2021 for the period 2021–2025 established the National Oncology Institute (NOI). NOI (funded by the EU until 2025) oversees clinical research and an educational platform to reduce cancer burdens, including evaluating and adjusting screening programmes for cervical, breast and colon cancers:

- A breast cancer screening programme started in September 2019 with invitations to asymptomatic women nationwide aged 50–69 years who met inclusion criteria for screening by a HIC. According to an OECD analysis, only 31% of the roughly 720 000 targeted women participated in Slovakia, compared to an EU average participation rate of around 60% (Berta et al., 2024). However, according to the latest national data for 2023, the share of targeted women who undertook the breast screening increased to 45% (NOI, 2024a).
- Cervical cancer screenings were launched nationwide in August 2021 with invitations to asymptomatic women aged 23–64 years who were not attending preventive gynaecological check-ups at regular intervals and met the inclusion criteria for screening by a HIC. Participation was 42% of the target group (just over 1.5 million women) in 2023.
- The first phase of a nationwide colorectal cancer screening programme was launched in January 2019 and had screened 20 000 people aged 50–75 years by October 2019. The second phase has been ongoing since September 2021: HICs send a screening test for hidden gastrointestinal bleeding to insurees who meet inclusion criteria. The target population in Slovakia in 2023 was a total of 1 688 804 men and women aged 50–75 years. Out

of 435 744 people screened, 8.7% of the samples were positive in 2023 (NOI, 2024a).

Further screenings for lung, prostate and stomach cancers are in development and targets are included in the government's Programme Statement for 2023–2027. An initiative to build a comprehensive cancer centre has been launched by MZ SR together with the oncological care hospitals at national level.

While Act no. 355/2007 broadened ÚVZ SR's mandate to reflect the rising prevalence of noncommunicable diseases, the majority of ÚVZ SR's activities remain related to surveillance of communicable diseases and conducting health-hygiene investigations.

Surveillance and management of communicable diseases

ÚVZ SR runs a communicable disease register as part of an epidemiological information system that supplies data to WHO and the European Centre for Disease Prevention and Control (ECDC). This register is the focus of infection control for Slovakia and in 2023 key shares of morbidity for communicable diseases were:

- 26.7% food-borne infections
- 5.8% respiratory infections (50.7% of which were caused by COVID-19; tuberculosis (TB) accounted for 0.4% of respiratory infections)
- 3.3% zoonoses
- 2.3% viral hepatitis
- 0.42% vaccine-preventable diseases.

Slovakia's National Immunization Plan aims to eliminate and eradicate vaccine-preventable communicable diseases by immunizing children. It is updated annually based on WHO recommendations and reported incidences from the previous year. Vaccination against diseases listed in the Plan remains compulsory as stipulated by Act no. 355/2007 (see Table 5.1). Vaccines and vaccination under the Plan are fully covered by HICs.

TABLE 5.1 Compulsory vaccination schedule

AGE	TYPE OF VACCINE	DOSAGE	VACCINATION RATE (2023*)
3rd month of life	diphtheria, tetanus, whooping cough (acellular vaccine), viral hepatitis B, invasive haemophilus infections, transmissible polio (DTaP-VHB-Hib-IPV) and pneumococcal invasive diseases (conjugated vaccine simultaneous administration with hexavaccine)	I. dose	basic vaccination of infants with three doses of hexavalent vaccine against DI-TEPER-VHB-HIB-POLIO: 96.3% basic vaccination of infants with three doses of conjugated vaccine against invasive pneumococcal disease: 96.1%
5th month of life		II. dose	
11th month of life		III. dose	
earliest on the first day of the 15th month of life, latest at the 18th month of life	measles, mumps, rubella (MMR)	I. dose	basic MMR vaccination at 15 to 18 months of age with the first dose: 94.4%
5th year of life	measles, mumps, rubella (MMR)	II. dose	basic MMR vaccination at 5 years of age: 93.9%
6th year of life	diphtheria, tetanus, whooping cough (acellular vaccine), transmissible polio (DTaP-IPV)	inoculation	DI-TE-PER-POLIO vaccination at 6 years of age: 94.5%
11th year of life	measles, mumps, rubella (MMR)	Dose II	MMR vaccination at 11 years of age with the second dose of the vaccine: 94.5%
13th year of life	diphtheria, tetanus, whooping cough (acellular vaccine) transmissible polio (dTap-IPV)		DI-TE-PER-POLIO vaccination at 13 years of age: 95.6%
Adults aged 30 years	diphtheria, tetanus (dT**)	revaccination every 15 years	N/A
Other types of non-mandatory (for the whole population) selected vaccination rates			
Vaccination of newborns of Hepatitis B surface antigen (HBsAg) positive mothers (2022)		85 newborns of HBsAg-positive mothers received vaccination in 2022, of which up to 63 infants (74.1%) were from the Košice and Prešov Regions. This vaccination rate was 100%.	
Influenza vaccination		Influenza vaccinations are fully reimbursed by HICs to all willing insured persons. In the 2022/2023 influenza season, 260 947 persons were protected against influenza in Slovakia. The vaccination coverage of the Slovak population was 4.8%, which represents a decrease of 1.2% compared to the previous influenza season.	

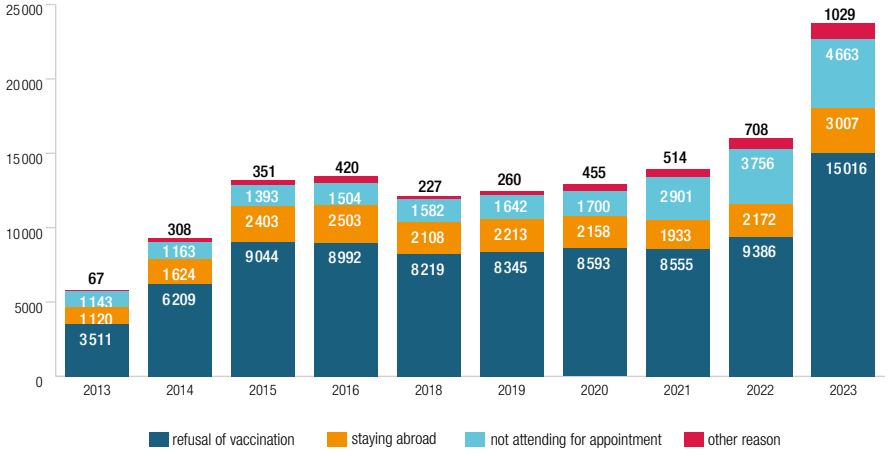
AGE	TYPE OF VACCINE	DOSAGE	VACCINATION RATE (2023*)
Other types of non-mandatory (for the whole population) selected vaccination rates			
	Influenza vaccination (population at risk)		In the 2022/2023 influenza season a total of 25 690 (66.9%) persons were vaccinated out of a total 38 379 persons placed in social service facilities. Compared to the previous year, the number of persons vaccinated against influenza in social service facilities slightly decreased by 1%.
	HPV vaccination (children up to 15 years of age)		HPV vaccination is fully covered for 12–14 years old, both girls and boys. In 2023, out of 175 000 children aged 12–14, 32 376 children received the HPV vaccination, which is a significant increase compared to pre-COVID data. In 2019 only 5 456 children received the vaccination.
	Tick-borne encephalitis (children up to 15 years of age)		In 2023, 14 054 children were vaccinated against tick-borne encephalitis, which is also a significant increase from 2019, when only 5 789 children were vaccinated.

Note: *data are as of 1 August 2023, i.e. "vaccination year".
Sources: ÚVZ SR, 2024b, 2024c.

Historically, vaccination rates against major communicable diseases hovered just below 100% and there were low incidence rates of vaccine-preventable diseases. The last registered cases of poliomyelitis and diphtheria were in 1960 and 1980, respectively. In 2023 national vaccination coverage rates for routine compulsory childhood vaccinations exceeded the 95% threshold in five types of vaccine but did not reach the target of 95% in four types of vaccination. Despite a slight decline since the early 2000s, this is still one of the highest rates in the EU. However, there are significant and growing regional differences in Slovakia, and county vaccination rates range from 77% to almost 100% (ÚVZ SR, 2024b). In 2023, at the level of paediatric districts, 34.3% of the total number of districts did not reach the 90% vaccination rate, an increase by 46.8% compared to 2022. The highest number of districts with vaccination coverage below 90% were in Trenčín (57.9%) and Košice (46.2%) Regions.

The main reason for not getting vaccinated remains refusal, which has increased dramatically since 2013 (see Fig. 5.2). This is despite the instruction of paediatricians and epidemiologists on the importance of vaccinations, and a 2014 decision by the Constitutional Court confirming that mandatory vaccination does not violate one's right to privacy and integrity, but rather protects public health. Thus, parents who refuse to have their children vaccinated can be, in theory, penalized (SITA, 2014).

FIGURE 5.2 Number and reasons for declining mandatory vaccinations, 2013–2023



Note: 2017 data not available due to collection irregularities.
Source: ÚVZ SR, 2024a.

Vaccination rates for older adults in Slovakia are low. Influenza vaccination rates in the 65+ group reached only 5.6% in 2022, the lowest in the EU according to OECD data (OECD, 2024a) and a decline from 12.9% in 2021. National-level data reported the same trend in 2023, with 5.6% of the population age group of 59 years and older being vaccinated against influenza for the 2022/2023 season (ÚVZ SR, 2023c).

Slovakia also recorded the lowest vaccination rates against COVID-19 in the V4 (51% primary course), and also well below the EU average of 73% in 2021. One of the reasons for low uptake is related to problems with the supply and quality of vaccines. Despite an initially greater demand than supply for vaccinations, MZ SR did not use all of the registered vaccines on offer via the EU joint procurement process and ordered less than Slovakia's set quota (Chrenková & Kováčik, 2021; Sladkovská, 2021). Rather than just purchasing EMA-approved vaccines, the government prioritized Sputnik V vaccines from the Russian Federation in March 2021.[9] In April 2021 ŠÚKL found that the dosages supplied to Slovakia differed in characteristics and properties from the substance used in pre-clinical tests published in the Lancet (SITA, 2021). Out of the initial 2 million doses, only 200 000 were eventually delivered, of which 160 000 were returned; approximately 15 000 people

9 This decision was taken by the prime minister and health minister without consultation with coalition partners or experts and would eventually contribute to their resignations (Folentová & Kern, 2021).

were vaccinated with Sputnik V (Čunderlíková, 2021). Two further factors attributed to low uptake of COVID-19 vaccinations:

- Unclear guidelines – on 11 December 2020 the stated aim was to vaccinate 65% of the population (3.3 million inhabitants), with four planned vaccination groups (SITA, 2020a). On 20 January 2021 new groups were determined, expanding from four to 11 (Pravda, 2021). On 11 February another change took place when some were vaccinated out of the planned order (though many teachers opted out). Changes to the waiting line were made again on 26 February and 8 March 2021 (Folentová & Kern, 2021; MZ SR, 2021b). During this time, the incumbent prime minister publicly stated a preference for a non-EMA-approved vaccine (Sputnik V) instead of an approved one (AstraZeneca).
- Disinformation – According to the Centre for Bioethics at the University of St Cyril and Methodius in Trnava, Slovakia reached a value of 30.3 on the so-called "conspiracy index" in 2022, one of the highest values of all countries where the survey was carried out. In Slovakia the largest number of respondents agreed that the truth about harmful effects of vaccines is purposefully hidden (46.6%), and with the statement that there is a group of people who secretly control the course of the world (45%) (UCM, 2022). This confirms long-term trends identified by GLOBSEC, namely that 52% of Slovaks believe that world events are not determined by elected representatives but by secret groups. Some 50% of responding Slovaks also distrust the mainstream media (GLOBSEC, 2022, 2024).

TABLE 5.2 COVID-19 vaccination rates as a % of total population, as of October 2023

	ONE DOSE	PRIMARY COURSE	FIRST BOOSTER	SECOND BOOSTER	THIRD BOOSTER
EU average	75.6%	73.0%	54.8%	14.7%	2.4%
Slovakia	52.0%	51.1%	30.9%	1.4%	n/a
Czechia	65.2%	64.5%	40.9%	7.5%	1.0%
Poland	60.8%	60.0%	33.1%	7.7%	n/a
Hungary	65.3%	63.2%	39.8%	4.3%	0.1%

Note: ECDC changed the reporting of their data after October 2023.

Source: ECDC, 2024.

5.2 Patient pathways

For non-emergency conditions, a patient's point-of-entry is the first-contact physician: either a GP (for adults), a paediatrician (for children), a dentist or a gynaecologist, who can also coordinate care with other providers (see Fig. 5.3). These visits do not require prior referral or approval from HICs, only registration with that particular provider.

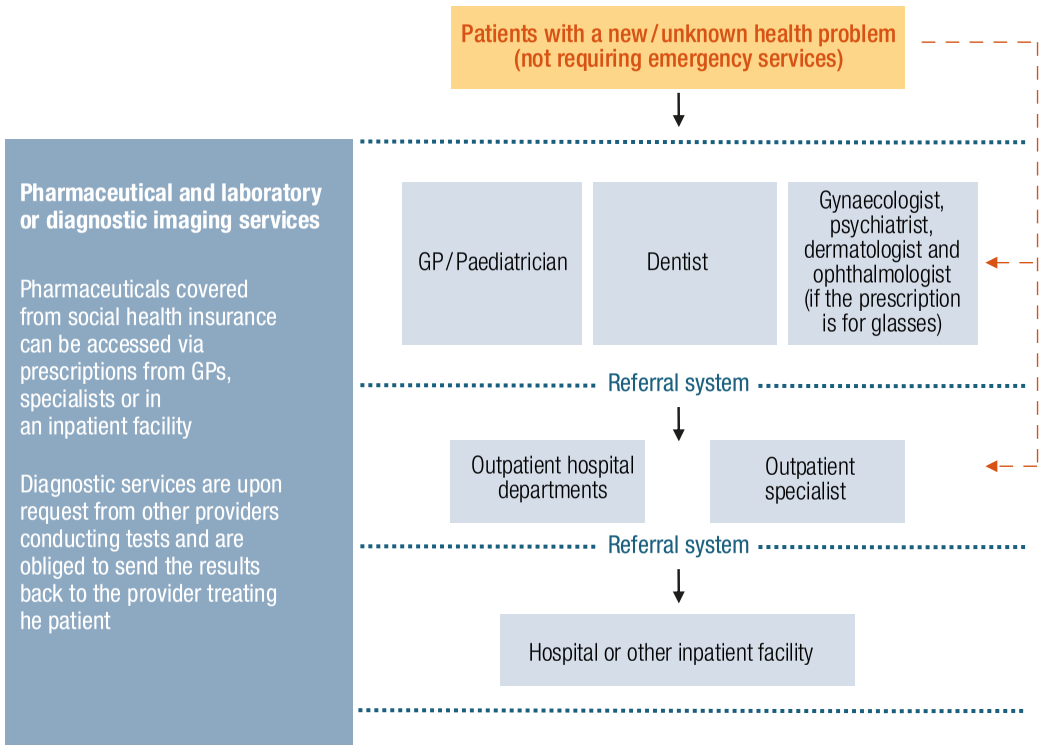
Gatekeeping has been in place since 2013, except for emergencies (including psychiatric care) and patients with a diagnosed chronic disease. Patients cannot access other specialists without a GP or paediatrician referral, unless they pay for the full service(s) out of pocket. If requiring specialized care, the primary care physician refers the patient to an appropriate specialist contracted with the patient's HIC and informs the specialist about examination results to date. In an effort to reduce the number of unnecessary contacts during the pandemic, a temporary exception to this was implemented and then abolished in 2022 (VšZP, 2022).

A patient is free to choose a specialist, provided the specialist is contracted with the patient's HIC and has sufficient capacity. Should a patient be unable to find a specialist, they can contact their HIC for assistance. However, this often does not help, as there are no defined maximum waiting times in outpatient care. This has contributed to the growing proportion of Slovaks self-reporting unmet need due to "waiting times" over the past 10 years (1.0% in 2013 vs 2.3% in 2023) (Eurostat, 2024d); see also Section 7.2.

If a specialist determines that surgery or hospitalization is needed, a patient is referred to a hospital. This is possible also via a GP if a patient requires immediate inpatient treatment. A patient is also free to choose a provider of inpatient care; the patient chooses often the nearest one and/or by recommendation of an acquaintance: quality indicators are outdated, neither collected nor evaluated by MZ SR, and waiting lists are organized only for a fraction of care. According to a 2019 survey, up to 92.6% of patients were willing to travel (63.3% for more than 30 minutes and 29.3% to the second nearest provider) for a guarantee of better care quality and outcomes (MZ SR, 2019).

INEKO, an NGO, publishes a ranking of hospitals in Slovakia (nemocnica roka), but it is focused only on inpatient care and based on existing available data. As part of the 2021 reform (see Section 6.1), hospital waiting times were defined for approximately 620 (40%) of all medical services, to

FIGURE 5.3 Patient pathways in Slovakia



Patients with a health problem diagnosed by a specialist and patients with chronic conditions do not need a referral

Patients, in urgent cases, can access emergency departments in hospitals or medical first aid outpatient services

In theory, patients can access all services without a referral, providing providers do not have a contract with a HIC, but they have to pay all expenses out-of-pocket and doctors are not allowed to prescribe diagnostics nor medicines covered via social health insurance

Source: adapted from Alexa et al., 2015.

be measured from 2024. In December of 2024 MZ SR revised these waiting times and services and roughly 400 medical services are to be enforced from 2025 (Krempaský, 2024). This will replace current waiting lists, which are currently in place for only 15 groups of procedures (that is, less than 2% of inpatient care), and therefore in practice patients do not make decisions based on publicly available waiting times.

Following surgery or hospitalization, and primary rehabilitation in the hospital, a patient can return to their GP or specialist if needed. The primary care physician can then prescribe homecare or long-term rehabilitation services, or refer for further outpatient or inpatient rehabilitation care. These services are fully covered but limited in available capacity.

5.3 Primary care

Primary care is provided predominantly in privately owned facilities. In cities, GP practices are often linked to a local polyclinic with specialists. In rural areas, GPs often work in solo practices. HICs are legally required to contract each GP and paediatrician licensed to provide ambulatory care. Due to gatekeeping, GPs and paediatricians perform a wide range of tasks, including assessing and verifying health status, dependency status and other social protection measures linked to health or disability. Primary care physicians can also provide visiting services to immobile patients or prescribe homecare.

Patients can change GPs every six months. Primary care providers can only refuse a patient if their capacity and workload prevent them from providing quality care, they have a personal relationship with a patient, or the service required is against their belief (such as contraception and abortion, assisted reproduction and sterilization).

According to Decree no. 11/2022, the set number of insurees should be 1600 per GP and 1100 per paediatrician. In practice, however, these values are significantly exceeded owing to shortages of primary care physicians. In 2024 there were 1917 FTE GPs in practice in Slovakia, 533 fewer than the estimated optimal number. The deficit of paediatricians is proportionally even larger, at almost 21% (that is, a deficit of 236 out of 1155 required FTEs) (MZ SR, 2025b) This deficit is likely to grow further, since the average age of paediatricians was 60 years, and 58 years for GPs, in 2024. Despite

the first-ever primary care strategy (up to 2030) in 2023, it is unlikely that sufficient changes will be implemented to stop the decline in coming years (see Box 5.2) (SITA, 2023b).

BOX 5.2 Primary care until 2030 and key audit findings

MZ SR conducted a detailed audit of primary care in 2022, which led to the development of a strategy until 2030, published in January 2023. The audit identified the following:

- low numbers of GPs and paediatricians with high average ages
- low attractiveness of general practice as a profession among medical students
- untapped potential of nurses
- insufficient link between the education system and the need for new GPs
- insufficient gatekeeping function in the health system
- unsustainability of outpatient clinics with one GP and one nurse
- the absence of a managed regional distribution of new GPs to vulnerable areas
- low expenditure compared to countries with strong primary care systems
- capitation as a heavy reimbursement component (60–70% of total general practice reimbursement)

MZ SR thus prepared a three-part reform:

Phase I – A new public minimum network. MZ SR has annually assessed accessibility of primary care at the district level since 2022 under new rules adopted at the end of 2021. These rules also provide financial contributions to create outpatient clinics in the most deficient districts, which GPs, paediatricians or existing providers can apply for.

Phase II – Strengthening GPs and paediatricians, and reviewing reimbursement mechanisms. The main objectives here include expanding the competences of GPs and paediatricians, giving nurses more responsibility, and financially supporting new ways of organiing work and strengthening the performance component of reimbursement for primary care.

Phase III – Reducing administrative burden. The first step is a bureaucratic burden audit to map the current situation. The second step, together with providers' representatives and external actors, is to develop solutions to reduce the administrative burden on health care professionals, thus allowing more time for patients.

Source: MZ SR, 2023d.

Regional distribution of primary care physicians is also an issue. While all but two districts have access to a GP/paediatrician within 25 minutes' driving time (that is, under the legislative limit), unmet need for primary care services differ nationwide. MZ SR analyses this via demographic trends of physicians and a range of other factors that influence the supply and demand for primary care, and classifies regions into "at risk" groups, as shown in Figs 5.4 and 5.5. With a few exceptions, almost all districts are at some risk – that is, providers are unable to meet the needs of citizens in most districts.

The building up of Integrated Care Centres (ICCs), supported by EU funds, has been a major focus of MZ SR for primary care in recent years. ICCs provide integrated services in one outpatient setting for adults and children; some also provide specialized gynaecological care and sometimes dental care. MZ SR's aim is to provide ICCs with resources to open in selected areas with high unmet need for primary care, and serve as a local hub for outpatient care. Between 2016 and 2020, 59 projects worth €47 million were supported, and projects will continue from the new programming period, that is, the Operational Programme Slovakia, where inclusion of social care is planned along with expanding the number and structure of compulsory specialties (BEET, 2024). A second MZ SR project to support the establishment of stand-alone practices began in 2022, with RPP funding of €60–80 000 per practice.

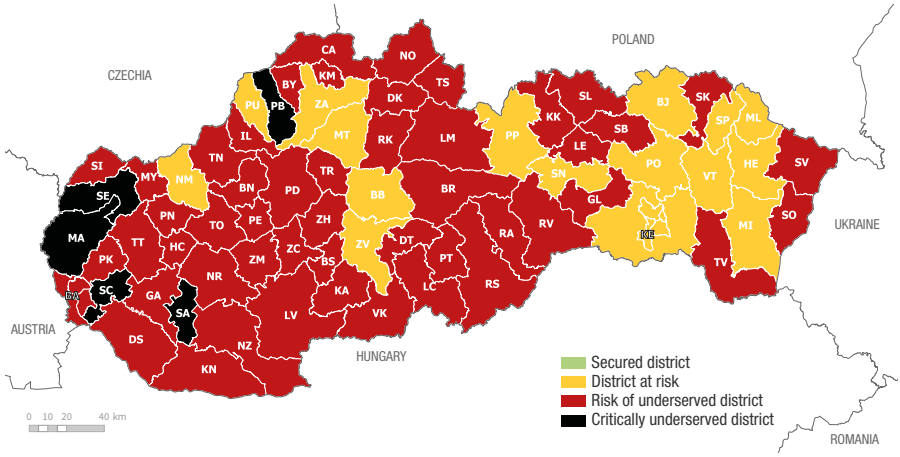
5.4 Specialized care

5.4.1 *Specialized ambulatory care (outpatient)*

Specialist outpatient services[10], like primary outpatient care, are primarily provided in privately owned solo or group practices, health centres or polyclinics, or as part of hospital outpatient care. In 2022 there were 8817 outpatient clinics of specialized care, employing 5455 FTE physicians. The total number of visits was 33.3 million, amounting to 6.13 specialist visits per person (NCZI, 2023c). The regional distribution of specialist physicians is

10 Defined as services with specialties other than general medicine, general child and adolescent care, fixed outpatient emergency service, dentistry, dental medicine, paediatric dentistry, dental emergency service, gynaecology and obstetrics, and paediatric gynaecology.

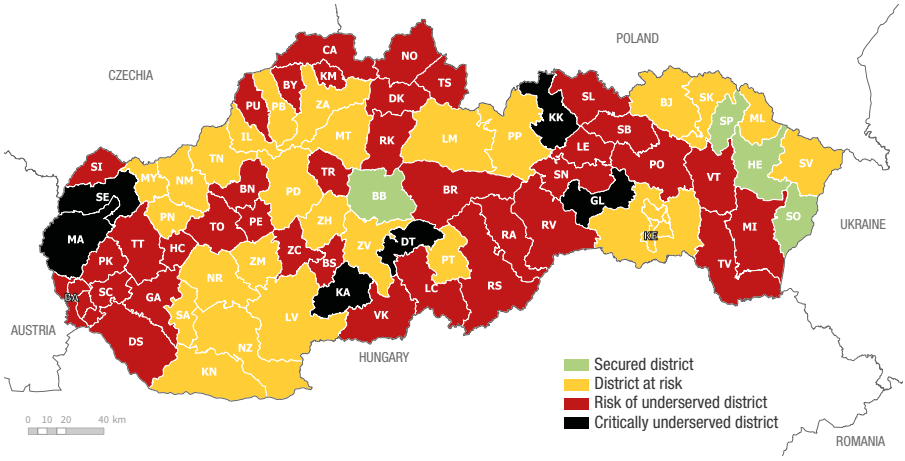
FIGURE 5.4 Estimated evolution of GP density by district, 2024



Note: the assessment of districts is based on a mathematical model with a maximum of 1000 points, with individual threat levels corresponding to the following ranges of points: Secure district = 0–99 points; District at-risk = 100–298 points; Risk of underserved district (that is, at-risk district with shortages) = 299–599 points; Critically underserved district (that is, at-risk district with large shortages) = 600–1 000 points. Three parameters are used for scoring: local availability, demographic structure of doctors, and the degree to which the necessary capacity for primary care services is met.

Source: produced by WHO GIS, data from MZ SR, 2025b.

FIGURE 5.5 Estimated evolution of paediatrician capacity by district, 2024



Note: he assessment of districts is based on a mathematical model with a maximum of 1000 points, with individual threat levels corresponding to the following ranges of points: Secured district = 0–99 points; District at-risk = 100–298 points; Risk of underserved district (that is, at-risk district with shortages) = 299–599 points; Critically underserved district (that is, at-risk district with large shortages) = 600–1000 points. Three parameters are used for scoring: local availability, demographic structure of doctors, and the degree to which the necessary capacity for primary care services is met.

Source: produced by WHO GIS, data from MZ SR, 2025b.

uneven: the least amount of FTE physicians per 100 000 inhabitants is in the Trnava Region (73.38) and the most are in the Bratislava Region (152.76 per 100 000). This is caused by several factors, such as the natural concentration of larger care providers in large cities, but also by the fact that the last update of the minimum network of outpatient providers defining the minimum number of FTEs for each specialty that insurers are obliged to contract occurred in 2008 (Government Regulation No. 640/2008). Additionally, these minimums were set regionally, which has not guaranteed balanced accessibility within the SGRs' different districts. This results in long waiting lists for examinations in some specializations and access difficulties, especially for rural patients. MZ SR announced a plan to update the standards in 2022 (MZ SR, 2023f), similar to those for primary care physicians, but new standards were still to be approved by parliament, to be put in practice during 2025 (TASR, 2024a).

Three of every four outpatient clinics in Slovakia were under contract with HICs in 2022, with the remainder reimbursed directly by patients (MZ SR, 2023f). Of those contracted, approximately 65% were in outpatient clinics, and the rest were part of hospitals. These outpatient clinics primarily serve to receive patients before and after hospitalizations and are thus not available to the public on a regular basis. Although the total number of outpatient clinics is increasing, the number of physicians is not (see Table 5.3). The growth in outpatient clinics is primarily due to physicians opening branch offices, or outpatient clinics that are non-contracted so they can charge according to preference. Additionally, some specialists share time between their practice and working at inpatient facilities where they can continue to assist their own patients (that is, gynaecologists assist in giving birth and perinatal health care).

5.4.2 *Day care*

Day care is defined as continuous care for no longer than 24 hours and such services are provided by hospitals or facilities without inpatient departments if they fulfil specific hygienic, technical and personnel criteria. Day care is provided for the following specialties: dentistry, ophthalmology, gynaecology and obstetrics, orthopaedics and traumatology, surgery, urology, plastic surgery, gastroenterological surgery and gastroenterology, and otorhinolaryngology. Ophthalmology has the highest number of procedures, accounting for almost every second single-day procedure in Slovakia in 2022 (see Table 5.4).

TABLE 5.3 Overview of selected outpatient indicators, 2018–2022

	NUMBER OF PRACTICES	NUMBER OF FTEs OF PHYSICIANS	PER 100 000 INHABITANTS	NUMBER OF VISITS	NUMBER OF VISITS PER INHABITANT
Slovakia 2022	8817	5545.46	102.15	33 293 541	6.13
• Bratislava Region	1747	1112.64	152.76	5 195 821	7.13
• Trnava Region	683	415.00	73.38	3 021 442	5.34
• Trenčín Region	784	513.30	89.95	3 205 323	5.62
• Nitra Region	919	594.34	88.62	3 822 507	5.70
• Žilina Region	1116	750.64	109.09	4 089 104	5.94
• Banskobystrický Region	1007	572.02	92.59	3 686 882	5.97
• Prešov Region	1210	721.14	89.24	5 158 926	6.38
• Košice Region	1351	866.38	111.14	5 113 536	6.56
Slovakia 2021	9110	5684.09	1040.59	32 195 808	5.92
Slovakia 2020	8853	5691.91	10.25	29 294 026	5.37
Slovakia 2019	8409	5450.52	99.87	32 595 575	5.97
Slovakia 2018	8420	5439.78	99.80	32 034 259	5.88

Source: NCZI, 2023c.

TABLE 5.4 Day care surgeries per specialization, age group 19+, 2019–2022

	NUMBER OF SURGERIES			
SPECIALIZATION	2019	2020	2021	2022
Ophthalmology	117 591	94 600	111 641	146 355
Gynaecology and obstetrics	39 820	33 926	37 164	38 502
Orthopaedics and traumatology	31 309	26 859	29 315	29 636
Surgery	29 203	23 132	23 150	29 080
Urology	14 800	16 656	17 759	20 555
Otorhinolaryngology	9 848	6 087	5 078	6 953
Gastroenterological surgery and gastroenterology	8 693	8 087	9 671	12 446
Plastic surgery	7 344	5 577	10 108	13 153
Dentistry	4 702	2 808	3 114	3 840

Source: NCZI, 2023c.

The number of day care interventions has grown since 2009, when MZ SR defined 450 surgical procedures that could be officially undertaken as day care. Although there have not been initiatives since then to improve access to same-day care, the number of procedures has been gradually increasing through the evolution of the DRG payment system in hospitals and advances in medicine. Same-day procedures represent only about a third of all surgeries, indicating that this is still underdeveloped (SITA, 2023c). However, the share of patients staying as inpatients after the procedure is improving, reaching only 4.5% in 2022 (NCZI, 2023c).

In 2022, 311 748 same-day procedures were performed, 23% more than in 2018. Part of this increase is due to pandemic-influenced backlogs, when total procedures fell to 217 732 and 247 000 in 2020 and 2021, respectively.

5.4.3 *Inpatient care*

Inpatient care in Slovakia is defined as care for patients who require continuous treatment for over 24 hours. Hospitals are divided into general and specialized hospitals depending on their offered services. Hospitals have an ambulatory component, in which hospital-based specialists provide specialized ambulatory care. Other inpatient health care facilities include sanatoriums, hospices, natural healing spas, balneotherapy institutions and forensic detention centres. In total, in 2022 there were 42 414 inpatient beds in all of the 182 different providers of hospital care. Out of these, there were 64 general hospitals (23 456 beds) and 44 specialized hospitals (6158 beds).

Even though MZ SR runs 17 of the largest general and specialized hospitals in the country, representing roughly 60% of all HIC expenses in the hospital sectors in 2024, these hospitals do not share resources, rarely procure goods and services together and are run as separate entities, despite several attempts to introduce joint management (Feketová, 2023). In a state-owned hospital, directors are vulnerable to political opportunism because they are directly appointed and dismissed by the Minister of Health. The absence of corporate governance of the state-owned hospitals, along with the legal form of a contributory organization, allows hospitals to generate losses and debts, since there is no external pressure on politically appointed management.

MZ SR grants permits for state-owned general hospitals and all specialized hospitals, while all others are granted by SGRs. In both cases, predefined requirements have to be met. In 2021 Act 540/2021 was approved, which, together with Decree No. 316/2022 and consequent Decree no. 531/2023, defined a new minimum network of inpatient providers, including the content and scope of activities of hospitals, quality requirements and maximum waiting times. Inclusion in the network of inpatient providers is issued by MZ SR, as a part of the categorization process. General hospitals are further divided into five groups according to their focus, with each group of hospitals having defined mandatory, optional and complementary programme structures. Within the categorization, there are 63 of these programmes and each consists of the medical services that a hospital must provide at that level.

In terms of hospital activity, there are so-called mandatory, complementary and optional programmes. Mandatory programmes must be fulfilled by each hospital at the respective level. Complementary programmes expand the portfolio of medical services that a hospital provides, or which a hospital may apply to MZ SR to provide; a decision to include them is made if there is sufficient regional need for the services and the hospital fulfils all the quality and production criteria. Optional programmes are neither approved nor evaluated by MZ SR and it is up to an agreement between the provider and HICs whether to contract the programme. Specialized hospitals are also included in the network, according to the same law, but under a specific regime. Programme classifications are updated on an annual basis (currently in force in the version of Decree no. 531/2023, which itself is to be updated on a yearly basis).

HICs are legally required to contract with each in-network provider to the extent of the approved mandatory and complementary programmes, and the provider is also required to contract with each HIC to the extent of the mandatory programmes of that level of hospital and any supplemental programmes according to the hospital's approved programme profile.

The categorization of hospitals furthermore defines the requirements for geographical (time) availability (see Table 5.5), minimum number of procedures, staffing and physical resources, which must be met by the hospital in order to receive reimbursement from HICs or to maintain its level of inclusion in the annual evaluation of the network. All these data at hospital level are updated, adjusted and publicly published by MZ SR annually with quality indicators as part of the network assessment.

TABLE 5.5 Minimum catchment and geographical accessibility categories of hospitals, Slovakia, 2022

HOSPITAL LEVEL	EXPECTED NUMBER OF PROVIDERS	GEOGRAPHICAL ACCESSIBILITY	CATCHMENT AREA (NUMBER OF PEOPLE)	VOLUME OF CARE
National level (5)	1		Nationwide	Less than 1%
Highest tier level (4)	3–4	• Min. 90% of the population have availability within 90 min • Max 1.5% of residents have availability over 120 min	1.4–2.0 million inhabitants	8%
Comprehensive level (3)	8–10	• Min. 90% of residents have accessibility within 60 min • Max 1.5% of residents have accessibility over 60 min • No district has average accessibility over 90 min	450 000–900 000 inhabitants	17%
Regional level (2)	28–32	• Min. 90% of residents have accessibility within 30 min • Max 1.5% of residents have accessibility over 45 min • No district has average accessibility over 45 min	100 000–200 000 inhabitants, exceptions for poor geographical accessibility	75%
Community level (1)	No limit	• Min. 90% of residents have accessibility within 20 min • Max 1.5% of residents have accessibility over 35 min • No district has average accessibility over 35 min		

Sources: MZ SR, 2021c, 2024b.

Waiting times and quality started to be evaluated during 2024 with enforcement from 2025, after a one-year delay, as the necessary methodological documents were not ready in time (TASR, 2023a). The target vision of the reform is expected by 2030, when MZ SR expects almost 38% fewer acute beds than in 2020 and a fully reorganized network of hospitals in Slovakia (MZ SR, 2021c). As of August 2024, there are 67 356 insurees listed on the waiting list, which is nearly nine-fold in comparison to the waiting list, comprising just 15 treatment groups, that was held up to 2024 (NPZ, 2024). Section 7.2 has further information on waiting times and access, while Box 5.3 describes ongoing efforts to integrate care in Slovakia.

BOX 5.3 Are efforts to improve integration of care working?

Cooperation between outpatient and inpatient care is often limited to an exchange of health records, in most cases in paper form. Lack of trust in medical test results from other facilities often results in physicians ordering duplicate examinations, such as pre-operation examinations. Cooperation with social care institutions is complicated due to the fact that they belong to the social sector, which is the responsibility of the Ministry of Labour, Social Affairs and Family. For these reasons, inpatient services are disconnected from the rest of care provision, which may lead to duplications in medical care provision and poorer after-treatment results (for example, recovery rates, rehospitalization rates, etc.).

One area of positive development in recent years is the Strategic Long-Term Care Strategy in Slovakia (see Section 6.1.7). Introduced in 2021, this plan recognizes the need to link the provision of social services and health care, especially within the scope of nursing care and physiotherapy.

The most common causes of hospitalization in Slovakia remain temporary hospitalizations associated with unclear conditions and observation of the patient, followed by childbirth, diseases of the circulatory system and injuries, as shown in Table 5.6. Between 2012 and 2022 there was a fairly significant increase in the rate of heart failure hospitalizations (from 302.9 in 2012 to 440.3 in 2022), but a decrease in chronic ischaemic heart disease and atrial fibrillation.

TABLE 5.6 Overview of the most common causes of hospitalization, 2012 and 2022

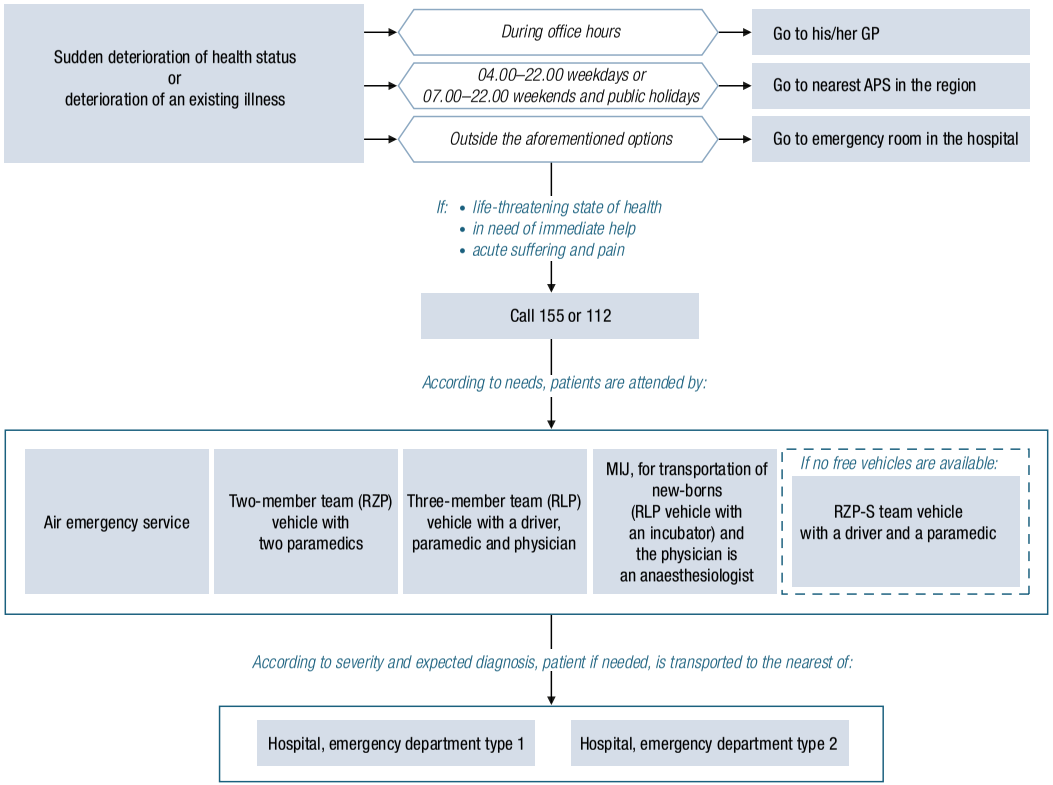
	DIAGNOSIS	HOSPITALIZATIONS PER 100 000 INHABITANTS	DIAGNOSIS	HOSPITALIZATIONS PER 100 000 INHABITANTS
	2022		**2012**	
1.	Persons encountering health services in other circumstances	858.3	Persons encountering health services in other circumstances	827.8
2.	Single liveborn infant, born in hospital	723.2	Single liveborn infant, born in hospital	700.4
3.	Full-term uncomplicated delivery	513.7	Full-term uncomplicated delivery	660.0
4.	Heart failure	440.3	Chronic ischaemic heart disease	419.7
5.	Cerebral infarction	373.6	Cerebral infarction	367.6
6.	Acute myocardial infarction	270.9	Caesarean delivery without indication	311.9
7.	Cholelithiasis	267.8	Heart failure	302.9
8.	Fracture of femur	249.6	Intracranial injury	300.5
9.	Atrial fibrillation and flutter	243.5	Cholelithiasis	296.2
10.	Chronic ischaemic heart disease	228.5	Atrial fibrillation and flutter	283.3

Source: NCZI, 2023c.

5.5 Emergency care

Emergency care is for sudden life-threatening situations or care during childbirth. The standard emergency number for Slovakia (155) connects callers to triagers directly in one of eight command centres; callers can also dial the European emergency number (112) (see Fig. 5.6). Emergency calls are received at the state-run National Emergency Centre (Operačné stredisko záchrannej zdravotnej služby, OS ZZS), which dispatches ambulances. OS ZZS is fully financed by HICs and employs 445 people with a 2024 budget of approximately €25 million (OS ZZS, 2024).

FIGURE 5.6 Emergency care pathways in Slovakia



Source: Authors' own compilation.

Ambulance services are provided by both public and private entities and are subject to a procurement process administered by ÚDZS. Licences for the provision of emergency medical services are issued for a period of six years based on the tender and licensed providers are awarded with social health insurance contracts. The expected budget for these services is €221 million for 2024 (Ministry of Finance, 2024b). The next bidding process will be in 2025, administered by MZ SR, owing to a scandal during the last bidding process that led to the removal of the ÚDZS President (TASR, 2020).

In 2024, 81 out of 328 emergency medical service points consisted of a three member and physician-led team (*rýchla lekárska pomoc*, RLP), 187 points were operated by two paramedics (*rýchla zdravotná pomoc*, RZP), and there were seven emergency medical service helicopters and five mobile intensive care units (mobilná intenzívna jednotka, MIJ) for the transport of, for example, newborn babies. In 2020 a new type of provider (*rýchla zdravotná pomoc – sekundárne prevozy*, RZP-S) was commissioned to be primarily in charge of inter-hospital transport. There are 48 of these points in 2024. The law requires ambulances to dispatch within two minutes' notice.

There are 13 emergency medical service providers in Slovakia, of which the state operates two (but comprising about half of all points), and the rest is split among three larger private providers, with smaller regional hospitals having a few points (UDZS, 2019b; OS ZZS, 2024). Emergency health service points are based on a 2004 reform, which set the goal of achieving availability of urgent health care within 15 minutes after receiving an emergency call for 95% of the population. The average response time in 2023 was 10:47 minutes for primary calls with a physician onboard and 12:39 minutes for RZP transports. In fact, the availability for 95% of the population was approximately 25 minutes and has been increasing recently, despite the inclusion of 46 ambulance RZP-S vehicles, which were supposed to relieve primary transports. These vehicles started to be used to cover for overloaded primary vehicles and in 2023, 60% of RZP-S interventions were primary transports that RZP-S vehicles were not supposed to perform at all.

As part of the RRP, MZ SR has prepared a new network of emergency services. The new goals were lenient, intended to cover 90% of the population

within 15 minutes, and 80% of patients with a quintet[11] diagnosis in the first hour responded to with an ambulance within eight minutes of dispatch (Recovery and Resilience Plan, 2021a). The first draft of the new network was published in December 2023 but was criticized by experts for falling short of targets (Krempaský, 2023b); MZ SR pledged to rework the analysis. MZ SR prepared new legislation in winter 2024, but as of the time of writing, it is still to be approved by the government (MZ SR, 2024h).

Emergency care pathways have undergone several changes over the last five years. Until 2018 emergency services were defined as the Medical First Aid Service (*lekárska služba prvej pomoci,* LSPP) in the outpatient setting and inpatient emergency services in hospitals. Both types functioned around the clock, with the outpatient emergency service aimed at those patients who were not acute (for example, those with fevers, allergic reactions, minor injuries). In contrast, the inpatient emergency service dealt with urgent medical care (more severe injuries, fractures, suspected heart attacks, strokes) and patients brought in by emergency medical services.

Both the LSPP and the emergency room departments were, in theory, open to provide 24/7 services for patients. In practice, however, regional accessibility, opening hours and quality of services differed, due to a lack of physicians and/or equipment. In 2018 changes were approved including:

1. LSPP services would be renamed as the Ambulatory Emergency Service (*ambulantná pohotovostná služba*, APS) with a precise named list of locations, a fixed flat fee for the provision of services and legally defined opening hours (4pm–10pm on weekdays and 7pm–10pm at weekends). Pharmacy services were also linked to the new APS points (Bendová, 2018) to ensure full outpatient access for patients. As of 1 July 2024, APS for children is open until 8pm, due to shortages of paediatricians (TASR, 2024c). The fee for using the service is fixed at €2 per visit.
2. Regulating the functioning of hospital emergency rooms. As of 15 January 2018, with a transitional provision from 2020 (to allow hospitals to prepare), a fixed network of emergency admissions that HICs are obliged to contract was defined in two levels: urgent

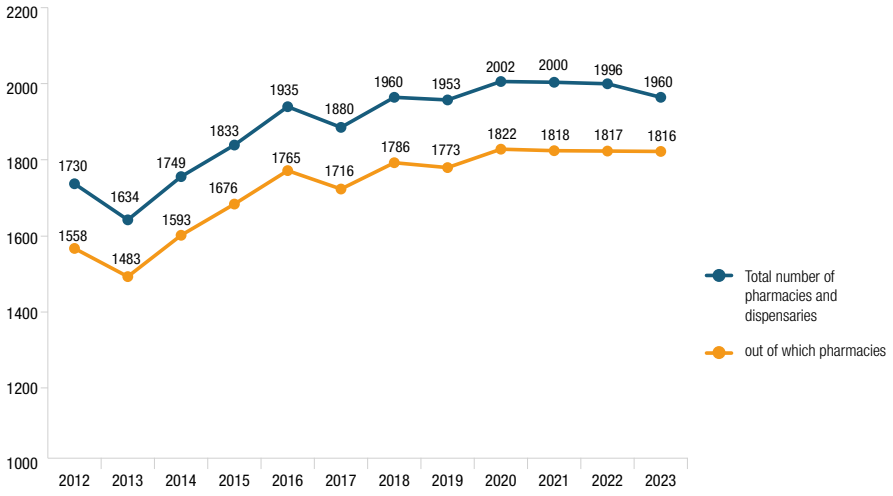
11 A group of conditions where immediate treatment is critical and EMS can provide substantial benefit. Includes: cardiac arrest/circulatory arrest, difficulty breathing, chest pain, stroke and severe trauma.

admission type 1 (with a flat rate of €55 380 monthly) and urgent admission type 2 (€157 629 per month for a general hospital in 2023) (ÚDZS, 2023d). In 2024, 32 type 1 and 13 type 2 emergency admissions are included in the fixed network in the decree. Both types have clearly defined minimum staffing norms, availability of specialties and emergency room equipment, but type 2 departments are more complex and can further specialize into trauma centres. This division was intended to ensure population accessibility while centralizing resources and became the basis for the hospital network reform of 2021. The fee for using the hospital emergency room was introduced in 2018 as €10 per visit, providing the patient is not hospitalized.

5.6 Pharmaceutical care

There were 1960 pharmacies and dispensaries in Slovakia in 2023, including 1777 public pharmacies (up from 1483 in 2013), 39 hospital pharmacies, 144 dispensaries and one teaching site (see Fig. 5.7). These numbers have grown since liberalization in 2011 (Act no. 362/2011) and the entry of new chain pharmacies, which are often located in shopping malls (Marko, 2023).

FIGURE 5.7 Number of pharmacies in Slovakia, 2013–2023



Source: NCZI, 2025b.

Margins on medicines fully or partially covered by social health insurance are subject to capped regulation, and market growth is driven primarily by reimbursed medicines. The last update of the degressive margins took place in 2008. For several years representatives of pharmacies and distributors have been demanding, unsuccessfully, an update. This helps to explain why the growth in the number of pharmacies is primarily due to the opening of branches of large chain pharmacies (Dr. Max, Benu and others), which often also buy out individual providers, as in Czechia.

A positive aspect of the increase in the number of pharmacies is that regional disparities have declined. In 2023 the Bratislava Region was the densest (1 pharmacy per 2678 people), while the least dense was the Košice Region (1 pharmacy per 3221 people) (see Table 5.7).

TABLE 5.7 Number of inhabitants per pharmacy in SGRs, 2000, 2012 and 2023

COUNTY	2000	2012	2023
Bratislava Region	3532	2888	2678
Trnava Region	4805	3174	2856
Trenčín Region	5455	3558	2912
Nitra Region	4591	3347	3149
Žilina Region	5313	3748	3031
Banskobystrický Region	4225	3511	2900
Prešov Region	4691	3866	3169
Košice Region	5197	3654	3221

Source: NCZI, 2025b.

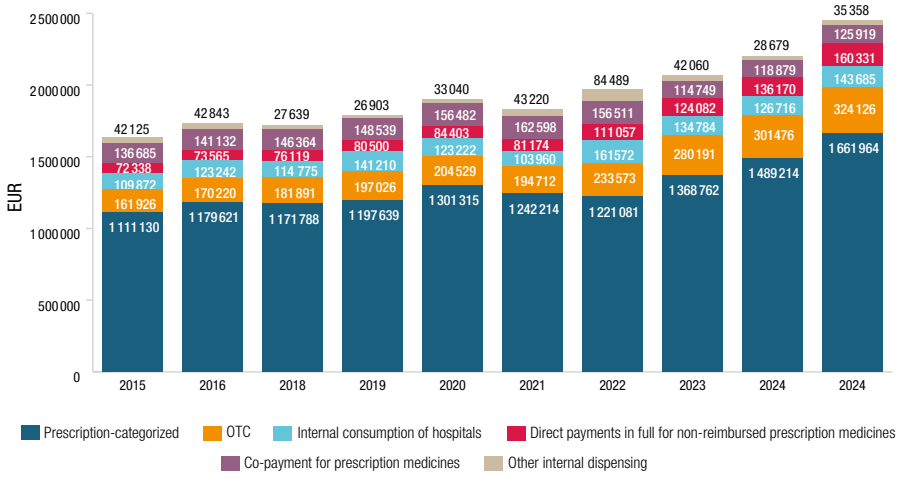
A 2018 amendment to Act 362/2011 defined a minimal network of emergency pharmacies, based on the availability of other emergency services. In large cities this used to be less of a problem, as pharmacies often operated 24 hours a day, but as of the time of writing, there is not a single pharmacy in Slovakia operating 24/7.

Before entering the market in Slovakia, all pharmaceuticals must have an authorization from the EMA, ŠÚKL or any other similar entity operating in EU countries. As of January 2025, 52 944 pharmaceuticals and 56 761 devices are registered for use in Slovakia (ŠUKL, 2025). Some 4464 pharmaceuticals are on the positive list of categorized medicines, out of which 1774 are without any form of co-payment (MZ SR, 2025c). Since 2021, pharmaceutical cost-sharing has been set at three levels, €0, €12 or €30 maximum co-payments per quarter, depending on the average wage, employment and disability status of a person. In 2023 the cost of covering these co-payments for some 1.4 million insurees was €73.8 million (ÚDZS, 2021c; HCSA, 2024).

In 2024 total pharmaceutical expenditure in outpatient and inpatient care was €2.45 billion (that is, €451 per capita; see Fig. 5.8). This represents an increase of €548 million over five years. This was primarily due to:

- two amendments to Act no. 363/2011 (in 2018 and 2022) that contributed to the entry of new innovative medicines covered by social health insurance; and
- the growth driven by the increase of OTC medicines in 2021–2023 due to the COVID-19 pandemic, though a gradual decline towards pre-pandemic levels is expected in the coming years.

FIGURE 5.8 Pharmaceutical expenditure, according to type and form of payment, in Slovakia, 2015–2024



Source: NCZI, 2025b.

Slovakia spends a large share of the health budget on medicines and other medical supplies (29.1% in 2022). This percentage is the third highest in the EU, but its interpretation is necessary within the limits of data reporting, specifically medical devices (see Section 7.6.1). For many years it seemed that Slovakia had high pharmaceutical overconsumption, based on the comparison of defined daily doses (DDDs) within OECD countries. An audit in 2016 showed that this was primarily due to a bad conversion on the output between a metric used in Slovakia, a standard defined dose and OECD-used DDDs, which was corrected in the statistics as of 2017. There is still poor reporting of Anatomical Therapeutic Chemical (ATC) B group; when corrected, Slovakia achieves comparable DDD values in OECD databases as other reporting countries (see Box 5.4) (MZ SR, 2018a).

The overall consumption of packs has increased, according to NCZI. In 2024 it reached 163.5 million packs, an increase of 6.9 million packs in the last five years; the primary driver of the increase was OTC medicines, due in part to the COVID-19 pandemic (NCZI, 2023c). Consumption of reimbursed medicines in packs has actually been declining, potentially also due to the austerity measures in Slovakia's HSRs, which began in 2016–2017 (see Section 7.1).

The 2011 Medicines Act (no. 363/2011) introduced compulsory price referencing of medicine prices to the three lowest prices within the EU reference countries in order to reduce spending on medicines. This de facto gave Slovakia some of the cheapest medicines in the EU, though this move had unintended consequences. Strict referencing made medicines on the market attractive for export, creating an opportunity for parallel trading, that is, re-export of medicines from Slovakia. ŠUKL observed parallel exports and hinted towards the occurrence of pharmaceutical shortages as early as 2012. Fraudulent attempts have primarily involved oncological, psychiatric or neurological medicines.

Therefore, in 2013 the first steps were taken to curb re-exports. These continued in 2017, 2020 and 2022, though the situation has still not stabilized (TASR, 2023b). Therefore, another change in the law on re-exporting was included in the current government's manifesto. The change, implemented as of 2017, was of particular importance since it made a pharmaceutical company (or their representative company) responsible and liable for the supply shortage if their drug is out of stock on the market and introduced a so-called "emergency system" for monitoring and reporting shortages of medicines.

Electronic prescribing via ePrescription was introduced in January 2018. Traditional paper prescriptions remained valid until 1 January 2022, until

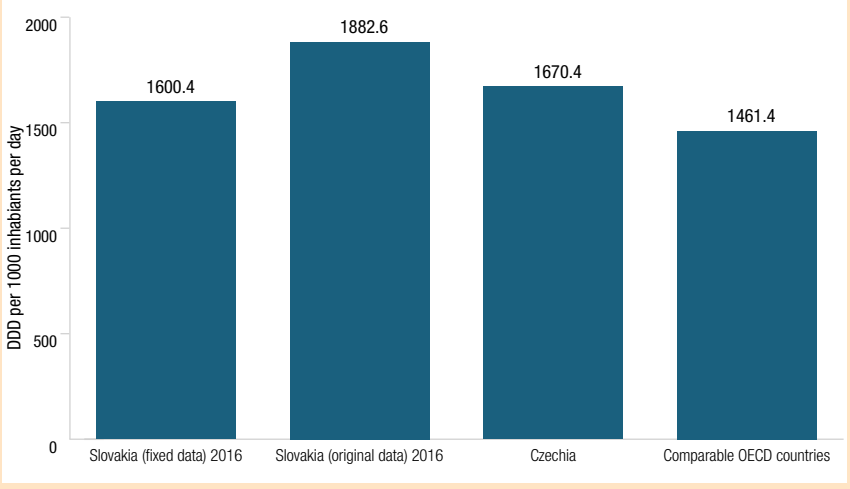
which time a transitional period applied. As part of its introduction, the €0.17 prescription fee was abolished. A general prescription is valid for seven days, an antibiotic prescription for three days, an emergency prescription for one day, and a device/voucher prescription for up to one month (ADL, 2019).

BOX 5.4 Consumption of medicines in Slovakia

The first mention of inefficient consumption of medicines in Slovakia was in 1997, when Slovakia had the second highest consumption, after neighbouring Czechia, in a comparison of expenditure within European countries (SME, 1997).

The theme of enormously high overconsumption, in all internationally monitored groups (DDD per capita), persisted until 2016. At that time an analysis by ŠUKL, the Association of Innovative Pharmaceuticals and MZ SR found that Slovakia had incorrectly converted between local consumption and reporting DDDs for years in OECD statistics. After correction, DDD drug consumption fell by 17%, and below Czechia (see Fig. 5.9). Furthermore, there were some other issues with reporting (mainly with the ATC B group) that MZ SR could not fix, further artificially increasing Slovak DDD per capita.

FIGURE 5.9 Reported DDDs to OECD for Slovakia before and after update, selected countries, 2016



Note: comparable OECD countries are countries that actually reported all data to the OECD database.

Sources: Krempaský, 2018; Ministry of Finance, 2019; and authors' own compilation.

After the first HSR in 2016–2017 (see Section 7.1), a number of cost-saving measures (ePrescriptions, improved prescription pattern reviews) were implemented, and the growth in spending on medicines stabilized.

(continues)

(continued)

Recent HSRs continue to rationalize the consumption of medicines, but more in the form of a natural process of entry of generics and biosimilars or better allocation of resources to exempt medicines (see Section 7.5). According to the latest available OECD data (OECD, 2023a), in 2021 Slovakia had a 63.8% share of generic and biosimilar medicines in the volume of drug consumption, which was the second highest of the reporting countries in the EU, after Latvia. Generic and biosimilar drugs accounted for 28.8% of reimbursement volume by HICs in 2021, the highest value in the EU after Latvia. However, this is a significant drop compared to 2011 (41.3%).

5.7 Rehabilitation/intermediate care

Rehabilitation and intermediate care are part of the benefits package, both inpatient and outpatient, provided that they are prescribed by a physician. Inpatient care is provided in rehabilitation facilities, highly specialized facilities or spas. Outpatient rehabilitation facilities provide physiotherapeutic services that include specialized services in psychiatry, balneology and treatment rehabilitation.

The limited capacity of public rehabilitation services has seen the establishment of several private inpatient rehabilitation care providers (for example, Sanom in Bratislava or Rehabilitation Hospital Hlohovec). A key reason for this is underfinancing. Rehabilitation spending amounted to €124 million in 2022 (accounting for 1.46% of health spending), which is significantly lower than pre-COVID-19 years: for example, in 2019 expenditure on rehabilitation was approximately €163 million.

Balneotherapy, a regional tradition that combines spa visits with various therapeutic treatments, is provided in natural healing spas or balneal facilities. Rehabilitation and balneal facilities have two main sources of funding:

1. Act no. 577/2004 (Annex 6 in particular) distinguishes between serious (category A) and less serious (category B) diagnoses, which is the basis for reimbursement by HICs.
   - For category A, care is fully covered by social health insurance and services are partially covered. Meals and accommodation are covered only up to the standard. Standard accommodation means

a single accommodation unit with at least two beds, with shared sanitary facilities. It is the responsibility of the spa to determine the amount of the supplementary payment for the higher standard of accommodation and meals, which is not covered by social health insurance. The compulsory charge of €1.70 per day is a standard charge, plus the accommodation tax set by the city or municipality (approximately €1; the first and last days are counted as one).

- For category B, care is covered by social health insurance with the exception of accommodation expenses. The insured person pays for accommodation and meals; a spa fee of €1.70 per day of stay and accommodation tax applies. If the spa offers standard accommodation (at least a double room with a bathroom located outside the room), they can legally charge a maximum of €7.30 per day in the high season (Q2 and Q3) and €4.98 per day in the low season. However, such rooms are in short supply and in most cases patients have to choose a superior room and pay the spa's set price.

2. Direct OOP payments for accommodation and associated services.

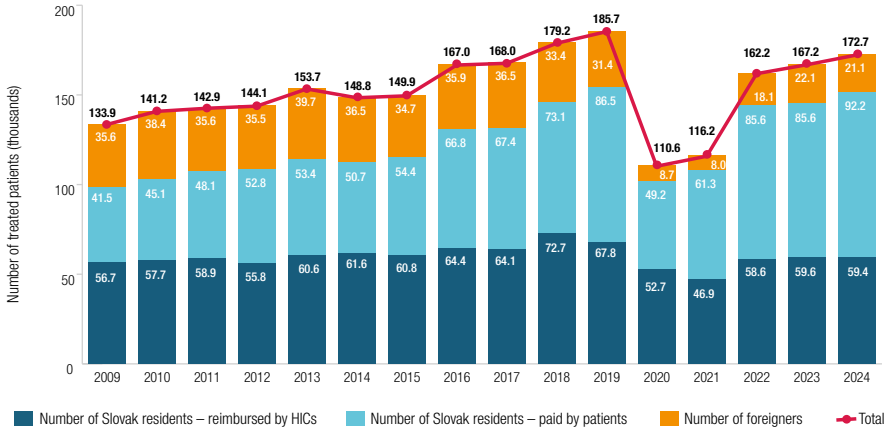
In 2024 balneal treatment was provided in 21 natural healing spas and nine facilities (NCZI, 2025a) which treated 172 651 patients (151 543 Slovaks and 21 108 foreigners; see Fig. 5.10). The years prior to COVID-19 indicated a gradual increase in the number of patients, primarily in those self-paying (60.8% of all patients in 2023). This is a significant change, as the situation was exactly the opposite in 2009, when roughly 58% of patients were covered by social health insurance. A main reason for this change was the long-standing low payments and budgets of HICs for curative treatment. According to approved budgets, spending on balneal care amounted to only 0.7–0.8% of public expenditure over the years (Drozdíková, 2023). However, 2023 brought a significant increase in funding, with an annual increase of up to 29% compared to 2022. Even after this increase, however, the share of expenditure is only 0.88% of public expenditure, that is, approximately €63 million in 2023 (Ministry of Finance, 2024b).

The largest recipients of spa care among Slovaks in 2024 were persons aged 65 years and over (6667.5 persons per 100 000 inhabitants) and 55–64 years (6410.2 persons per 100 000 inhabitants). For adults permanently residing in Slovakia, musculoskeletal disorders have long been a significantly

predominant indication for spa treatment, with patients with these disorders accounting for up to 74.3% (108 284 persons) of all adults treated in 2024. Non-tuberculous respiratory diseases were the indication in 13.3% of cases (numbering 19 343 persons) and diseases of the circulatory system in 4.7% of spa treatment cases (numbering 6790 persons).

Out of the 21 108 non-residents treated in Slovakia in 2024, patients were mainly from Czechia (58.6%; 12 366 persons), Germany (9.0%; 1892 persons) and Israel (7.0%; 1471 persons) (NCZI, 2025a).

FIGURE 5.10 Number of registered patients in Slovak spas, 2009–2024



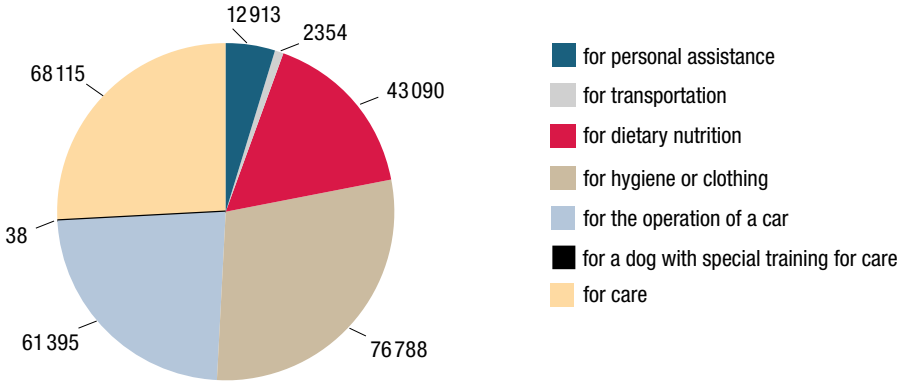
Source: NCZI, 2025a.

5.8 LTC

Long-term (health and social) care is provided in various forms, but there is no integrated model. The Ministries of Health and Labour, Social Affairs and Family prepared a joint strategy for the development of social and health care in 2021 and have linked financial resources and reforms from Component 13 of the RRP (MPSVaR & MZ SR, 2021) to this strategy. However, as of the time of writing, they remain two separate systems with minimal interconnection, both in terms of legislation and direct coordination. Generally speaking, providing LTC across both sectors comprises two parts: informal care (see Section 5.9) and formal care.

Persons with severe disability receive in-kind and cash benefits from the Ministry of Labour, Social Affairs and Family to cover their social care needs. In December 2023 there were 143 392 recipients, worth €610 million (see Fig. 5.11). Of these, the number of severely disabled persons reliant on home social care was approximately 68 000 (Bureau of social affairs, 2024). The basic monthly allowance in 2024 is €615.5 to care for one disabled person. However, this is often inadequate to pay for living costs, travelling to hospitals, buying pharmaceuticals, etc. There are several NGOs that provide support to some of the most vulnerable groups. Some provide support to families with a member suffering from cancer, including organizations such as "*Dobrý anjel*" (Good Angel), "*Liga proti rakovine*" (The League against Cancer), "*Nadácia pre výskum rakoviny*" (The Foundation for Cancer Research) and "*Nadácia Kvapka Nádeje*" (The Foundation of Paediatric Oncological Patients).

FIGURE 5.11 The number of recipients of repeated cash contributions for compensation of disabled persons, December 2023



Note: some recipients can receive several in-kind benefits, hence the numbers do not represent unique recipients.
Source: Bureau of social affairs, 2024.

Formal care is mainly provided either in institutions or through home-care services. Social care institutions include social service homes, facilities for the elderly, nursing care facilities and facilities for the social protection of children. Specialized facilities are particularly significant in terms of the range of clients requiring social care services, as only within these social assistance facilities does Act no. 576/2004 allow for the provision of nursing care.

Beneficiaries pay a fee for social services to providers, while financial protection measures apply under the Social Services Act, according to the types of

social services and their forms in relation to the minimum subsistence amounts. Funds from public sources account for up to 65% of revenue (23% from the state budget and 42% from local government budgets) and income from reimbursements accounts for 30% of the total revenue for the provision of social services. However, the funding system significantly disadvantages the provision of outreach services and contributes to the institutionalization of LTC. The state provides a contribution to outpatient and residential forms of care but does not participate in the financing of outreach services (MPSVaR & MZ SR, 2021).

A total of 1959 social service providers were registered in 2023 to provide services for people with adverse health conditions, including 1044 nursing service providers, 445 facilities for the elderly, 293 social service homes, 264 specialized facilities, 163 day care centres and 31 rehabilitation centres. The total capacity of these providers was 50 393 in 2023. According to data from the Ministry of Labour, Social Affairs and Family, there were 59 711 clients in 2023 receiving social services. Table 5.8 shows that most clients had some form of mental health diagnosis and disability (MPSVaR, 2024a).

TABLE 5.8 Structure of clients receiving social services, 2023

	NURSING CARE	DIABETES	WITH PSYCHOTIC MEDICATION	TAKING ANTIDEPRESSANTS	BEDRIDDEN	WITH MENTAL DISORDERS	WITH PHYSICAL DISABILITIES	WITH SENSORY DISABILITIES	WITH HIV/AIDS
Social services home	6166	687	6776	2988	1696	5654	4290	771	3
A facility for the elderly	14743	4199	7591	6425	6713	10208	13870	2851	31
Specialized facility	7184	1206	6313	3603	2950	10195	3004	653	5
Nursing care facility	2446	533	1092	768	968	1469	2673	347	4
Supported living facility	0	23	404	243	7	443	84	25	0
Day care centre	0	295	314	384	276	861	1623	345	2
Rehabilitation centre	0	5	182	113	6	247	125	35	0
Total	**30539**	**6948**	**22672**	**14524**	**12616**	**29077**	**25659**	**5027**	**45**

Source: MPSVaR, 2024a.

Furthermore, patients themselves can receive compensation to cover the costs of their treatment and services. In 2023 total benefits for health compensation were paid out in the amount of €234 million (see Table 5.9).

TABLE 5.9 List, number of recipients and total spending on financial benefits to compensate for health conditions in 2023

FINANCIAL BENEFITS TO COMPENSATE DISABILITIES, ACCORDING TO ACT NO. 447/2008	NUMBER OF RECIPIENTS AS OF DECEMBER 2023	FINANCIAL BENEFITS PAID IN 2023 IN €
Compensation for personal assistance	12 913	123 473 652
Compensation for transport	2 354	3 474 491
Compensation for compensation of health limitations	137 010	
• dietary allowance	43 090	17 335 468
• hygiene or wear and tear	76 788	23 660 363
• operation of a private motor vehicle	61 395	34 214 069
• dog with special training	38	29 257
Compensation for the purchase of aids	125	2 083 885
Compensation for the purchase of lifting equipment	100	12 689 904
Compensation for the modification of a personal motor vehicle	19	697 443
Compensation for the adaptation of a dwelling	18	737 357
Compensation for the adaptation of a family home	33	1 319 288
Compensation for the repair of an aid	60	293 114
Compensation for the purchase of a personal motor vehicle	182	14 168 660
TOTAL		**234 176 951**

Source: ÚPSVAR, 2024.

Formal LTC in the health system is provided through: home care agencies (*agentúra domácej ošetrovateľskej starostlivosti*, ADOS); specialized outpatient care (mobile hospices, geriatric outpatient clinics); in the form of

inpatient care (long-term wards, geriatric and palliative wards in hospitals); in specialized facilities (psychiatric hospitals); as well as nursing homes and social assistance facilities. These are mainly financed by HICs on a flat-rate basis, per patient or per particular examination.

5.9 Services for informal carers

Cash allowances for care and several other forms of cash allowance exist for personal assistance or compensation for home adaptations, vehicles or purchase of necessary aids. These benefits are provided and financed by the state budget via the Ministry of Labour, Social Affairs and Family. In 2023 the cash allowance for care was granted to 66 366 people on average per month, amounting to €375.7 million, as shown in Table 5.10.

TABLE 5.10 Number of persons providing informal care and total amount of benefits paid in 2023

FINANCIAL ALLOWANCE FOR A CARING PERSON, ACCORDING TO THE CARE ACT NO. 447/2008	AVERAGE NUMBER OF PERSONS, 2023	FINANCIAL BENEFITS PAID IN 2023 IN €
A person receiving a pension, caring for:	24 207	96 837 180
• 1 person	23 796	94 675 136
• more than one person	411	2 162 043
A person, receiving pension benefit, under special provision	195	776 138
Other persons, caring for:	41 964	274 933 055
• 1 person on a daily basis	39 697	256 633 502
• partially 1 person	770	5 384 284
• more than one person on a daily basis	1 445	12 445 270
• partially more persons	13	114 553
• combined multiple persons	39	355 445
Supplement to compensation for personal assistance	644	3 235 368
Total	**66 366**	**375 781 741**

Source: ÚPSVAR, 2024.

5.10 Palliative care

Palliative care is covered by social health insurance. Specialized palliative care is provided by a specialist palliative medicine doctor and basic palliative care is provided by another doctor, while clear processes and procedures for the provision of palliative and hospice care have been set. A terminally ill patient is eligible for palliative care if their state of health is deteriorating and requires constant monitoring. The eligibility criteria set by HICs are as follows: chronic, untreatable and progressive disease with time-limited survival.

A significant update to the legislation (Act no. 576/2004) was implemented in 2022, defining concepts and capacities needed for specialized and basic palliative care, as, according to estimates, approximately 10% of all available system resources went to less than 1% of dying patients (Škripeková, 2022). Under the new legislation, specialist palliative care in a hospital palliative care unit is provided for a maximum of one month from the date of admission to inpatient care. In the case of inpatient hospice care, this period is no longer than six months from the date of admission to inpatient care and may be extended. Consent of the HIC is required for the extension, which may be repeated.

In 2023 there were 12 registered hospices in Slovakia, providing 215 beds. Moreover, there were 35 mobile hospices. In both cases, these numbers were below optimal, as defined by Decree no. 640, updated in March of 2023 (that is, 18 hospices and 45 mobile hospices) (NOI, 2024b).

5.11 Mental health care

Mental health care is provided in outpatient and inpatient settings, is covered by social health insurance and regulated by general legislation, also for forced hospitalization by criminal law (since 2005), social welfare law (since 2008) and for occupational health by the Employment Services Act no. 5 (since 2004).

Years on the periphery of the policy agenda made regional and temporal availability of services low and resulted in a lack of staff and adequate material and technical support. As such, mental health had a high priority in Slovakia's RRP, where it has its own component (see Box 5.5), reforms and investments.

The RRP also brought about the updating and creation of several key conceptual materials that define the vision and direction of mental health care in Slovakia. Specifically, these were:

1. The concept of health care in the field of psychiatry, published in MZ SR's Bulletin on 29 December 2021
2. The concept of humanization of institutional health care in the field of psychiatry, published in MZ SR's Bulletin on 28 March 2022
3. The concept of health care in the field of child psychiatry, published in MZ SR's Bulletin on 1 March 2022
4. The concept of health care in the field of addiction medicine, published in MZ SR's Bulletin on 18 May 2022

Furthermore, in August 2024 the National Mental Health Programme and the Action Plan of the National Mental Health Programme for 2024–2030 was approved by the Slovak Government. This strategic programme aims to advance the mental health care system in Slovakia by introducing a range of measures designed to bring about systemic and sustainable improvements. Its primary goal is to ensure that all Slovak residents have access to humane, modern and accessible mental health care. Key priorities include enhancing mental health support, promoting prevention and early intervention, and ensuring the availability, coordination, quality and long-term sustainability of services. The programme also addresses destigmatization, fosters inclusion, upholds respect for individual rights and focuses on meeting the needs of vulnerable populations. It also seeks to build capacity for training, education and effective human resource management across relevant sectors.

Outpatient care

There were 2 106 905 visits to psychiatric outpatient clinics in Slovakia in 2023, an increase of 6.3% year-on-year; an increase in the number of patients can also be observed compared to the pre-COVID-19 period. Compared to the average number of persons examined in 2015–2019 (390 786 on average per year), in 2023 there were 427 764 persons examined, that is, an increase of 9.5% (NCZI, 2024b). This increase has put further strain on psychiatric outpatient clinics (MZ SR, 2024f). Various online projects have also been established, such as the charitable helpline for young people, *IPčko*.

While this provides access to growing demand in the context of a currently overburdened system, these online psychological services are not regulated.

Affective disorders were the most common reason for outpatient treatment in 2023 (133 905 patients) (NCZI, 2024b). This was followed by neurotic, stress-related and somatoform disorders, which accounted for 112 689 persons examined, and organic mental disorders (84 709 persons). In 2023, 63 679 persons were diagnosed with a mental disorder for the first time, an annual decrease of 5.2%; 54.1% of the new diagnoses were for women. Broken down by age group, the highest number of persons examined in psychiatric outpatient clinics for the first time were aged 75 and over (290.9 persons per 10 000 population). This was followed by 15–19-year-olds (157.6 per 10 000 population), with young girls and women (195.1 per 10 000 females) rather than boys and men (121.9 per 10 000 males) predominating those examined.

Inpatient care

Psychiatric inpatient wards recorded 40 320 admissions in 2023 for patients with mental and behavioural disorders, which was 376 more than in 2022 but still below the pre-COVID-19 average (2015–2019) of 43 619 hospitalizations. A total of 4320 psychiatric beds were available in Slovakia, of which 223 were dedicated for children and adolescents, 644 for medicines for drug addiction, 214 for gerontopsychiatry and 50 for neuropsychiatry. The number of beds recorded a slight decline in comparison to the pre-COVID-19 average (4405 in 2015–2019) but since the average occupancy was 79% in 2023, this decrease did not pose a bottleneck to the available capacities (NCZI, 2024b).

According to a Ministry of Finance report, there is sufficient capacity in residential care, but it needs to be humanized and supplemented with detention and protective treatment (Grajcárová, 2020). Historically, Slovakia has been relatively deinstitutionalized in terms of inpatient psychiatric care, for example, compared to Czechia. For example, the first detention centre opened in Slovakia at the end of 2022 (MZ SR, 2022c). Per 10 000 hospitalizations, men were more hospitalized than women (85.7 per 10 000 vs 63.4 per 10 000). The highest prevalence of males was in hospitalizations for mental and behavioural disorders caused by alcohol use. Women were more likely to be hospitalized with diagnoses of affective disorders and organic mental disorders, including symptomatic ones.

Data on the prevalence and costs of mental disorders in Slovakia are likely to be underestimated, since there has not yet been a proper, large-scale epidemiologic study. According to research by Bražinová et al. (2019), initial results in Slovakia suggest that up to 67% of people with symptoms of depression and 80% of those with alcohol dependence are untreated and thus do not make it into the statistics. For anxiety disorders, the number of untreated persons reaches up to 84%, which explains why, compared to OECD countries, Slovakia seems to have a below-average prevalence of mental disorders.

The Grajcárová study for the Ministry of Finance (2020) further estimated that the direct and part of the indirect costs associated with mental health problems in Slovakia can be estimated at €2.1 billion, that is, 2.4% of GDP (in 2019):

- €740 million (35%) is direct health costs: medication, hospitalizations and doctors' visits related to mental disorders. The majority is made up of costs associated with the treatment of physical illnesses, which are a consequence or concomitant factor of a large proportion of mental disorders.
- €420 million (20%) is the direct cost of social security expenditure: benefits during incapacity for work, disability pensions, support and social benefits during unemployment.
- €940 million (45%) is made up of indirect labour market costs: unemployment, lower productivity during working hours, fewer hours worked, and also higher mortality rates among working-age people.

Of the measures mentioned above, several have started to be implemented, such as the creation of a multisectoral Government Council for Mental Health in 2021. The Government Council is tasked with developing the necessary strategic materials, creating the environment for their implementation, overseeing and ensuring compliance with all international commitments in the area of mental health, and ensuring a multisectoral and multistakeholder approach to improving mental health in the country (MZ SR, 2021d). The government decided to address the mental health situation through a series of investments and reforms, under the heading of a separate component in the RRP.

BOX 5.5 Overview of the main reforms and investments of RRP for mental health care

Component 12 Goal: Create modern and accessible mental health care that builds on strong interagency collaboration. Specifically, there is a need to modernize psychiatric and psychological health and social care, strengthen mental health promotion and prevention of disorders, strengthen health and social care and increase its accessibility.

Selected key target indicators:

- Increase in the proportion of patients treated in community health care
- Increase in the number of staff providing specific modern treatments and diagnostics
- Reduction in waiting times for specialist mental health care

The reforms and investments are grouped under five main headings:

1 Coordinated interministerial cooperation and regulation

Reform 1.1: Establishment of a functional transministerial coordinating body (€400 000)

Reform 1.2: Establishment of supraministerial professional organizations for psychologists, speech therapists and therapeutic educators (€1.3 million)

2 Accessible health and social care with an emphasis on community-based solutions

Reform 2: Development of under-capacity areas in mental health care

Investment 2.1: Project management and investment preparation (€4.3 million)

Investment 2.2: Establishment of detention facilities (€37.5 million)

Investment 2.3: Establishment of psychosocial centres (€24.8 million)

Investment 2.4: Completion of the network of psychiatric inpatient units *(€6.5 million)*

Investment 2.5: Establishment of specialized centres for autism spectrum disorders (€2.3 million)

3 Modern diagnostic and therapeutic procedures

Reform 3: Modernization of diagnostic methods and treatments

Investment 3.1: Conduct the first epidemiological study on mental disorders (€300 000)

Investment 3.2: Establishment of a pool of psychodiagnostic methods (€8 million)

Investment 3.3: Humanization of wards in inpatient care (€10.6 million)

Investment 3.4: Renewal of material and technical equipment (€1.3 million)

(continues)

(continued)

4 Modern staff training
Reform 4: Rethinking staff training in mental health care
Investment 4.1: Staff training in the health sector (€3.2 million)
*Investment 4.2: T*raining of non-health professionals (€3.6 million)

5 Reducing the negative impact of the COVID-19 pandemic
Investment 5: National mental health support line during the pandemic (€0.7 million)

Original total estimated cost: €105 million from the RRP.

Source: Recovery and Resilience Plan, 2021b.

5.12 Dental care

Dentists are directly accessible for patients. They offer services in independent practices for adults and children. Dentists focus both on prevention and curative care. Oral health care is provided by contracted and non-contracted dentists. In most cases, social health insurance only covers basic dental costs under the condition that the insured patient has had a periodic oral examination in the past calendar year and patients often pay a top-up on the basic version of treatment. This condition was introduced in 2005 with the intention of promoting oral disease prevention. Part of preventive and treatment procedures are fully covered by social health insurance (such as preventive screening, ruptures). A second group of procedures is partially covered by patients (for example, specific tooth fillings, fixed dentures), and a third group requires full private coverage by the patient.

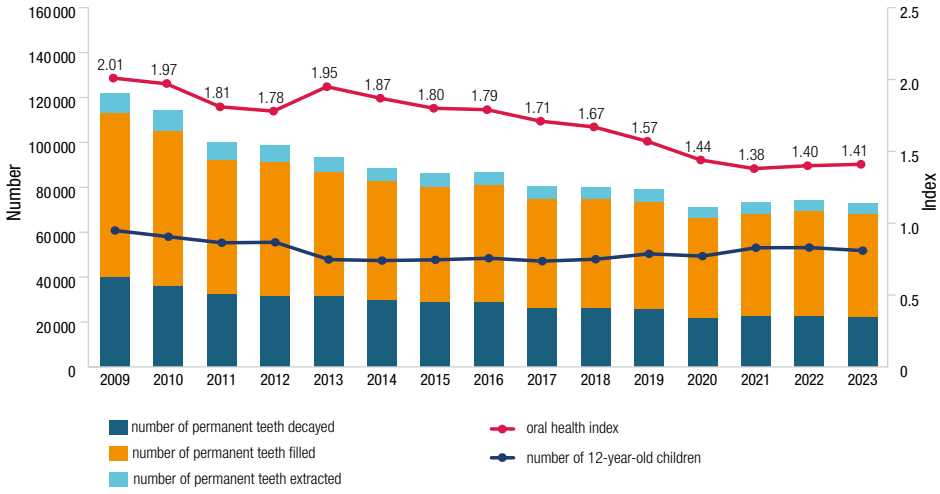
Dental practices, except for few cases, are privately owned, providing good geographic coverage. On the other hand, unmet need for dental care due to financial reasons was 1.5% in 2023, with the lowest quintile reporting 2.8% unmet need because of financial barriers (see Section 7.3) (Eurostat, 2024d).

In 2023 dental clinics registered 5 219 968 patients under their care, with 6 639 441 visits made by these patients, representing 1.27 visits per capita. In all, 48% of registered patients (2 501 975) received a preventive check-up. Compared to 2022, the number of preventive check-ups increased by 1.2%, but when compared to the average number of preventive check-ups

for 2015–2019, it was a decrease of 9.6%. Of the total number of people who had a preventive check-up, 64.9% needed dental treatment.

The oral health index for 15-year-olds in 2023 was 2.26. Since 2014 (oral health index of 2.92), Slovak teenagers have seen a yearly decrease in the oral health index. The index measures the ratio of the number of decayed, filled and extracted permanent teeth in children of a particular age, compared to the number of children in the systematic care of the outpatient clinic at that age. Comparing 2009 with 2023, the index value for 15-year-olds has fallen by nearly 20% (see Fig. 5.12) (NCZI, 2024c).

FIGURE 5.12 Trends in the oral health index in Slovak 15-year-olds, 2009–2023



Source: NCZI, 2024c.

6

Principal health reforms

Chapter summary

- There have been no major structural reforms implemented in Slovakia in the last 20 years. The foundation of the modern Slovak health system is still based on legislation implemented between 2002 and 2006, although it has been altered incrementally since then, with more reforms and policy changes in development at the time of writing.
- The government's hospital network reform is the long-awaited introduction of an optimized network of hospitals, dividing hospitals into five levels based on breadth and complexity of care provided. These new classifications aim to bring clarity into the system, secure availability of high-quality care, and support the development of community and LTC, with the first changes being implemented in 2025.
- New legislation on the scope and conditions of the reimbursement of pharmaceuticals, MDAs and dietetic foods under social health insurance was approved in June 2022. With this, it is expected that patients will have better access to demonstrably effective, innovative pharmaceuticals.
- In 2021 MZ SR presented a new primary care reform divided into three separate phases. The first phase sees MZ SR correct

for shortages of GPs and paediatricians through the allocation of financial contributions (since 2022) to support the establishment of outpatient practices in the areas with insufficient workforce. The second phase, focused on strengthening competence status and revising the reimbursement mechanism, is under development, with some new competencies already introduced. Meanwhile, a third phase, aimed at reducing administrative burdens, is under way, with an audit completed and some administrative tasks, such as issuing of certificates, already removed.

- Improvements in stroke management and the introduction of population-wide screenings for cancer are examples of policies that are specifically targeted to manage the diseases that strongly impact the health of the Slovak population, and where Slovakia trails other EU countries.
- Changes over the past few years to the redistribution mechanism between HICs aim to increase its predictive ability and improve overall fairness.
- Despite the digitalization of the Slovak health system being a topic at the centre of reform debates for several years, there have been few major advancements and the private HICs are often the ones driving developments.
- Key areas for future reforms that are now in focus are specialized care and LTC.

6.1 Analysis of recent reforms

The following text describes the development, implementation and impact of health system reforms and policy changes introduced between 2016 and 2024. Detailed information about previous reforms and policy changes can be found in previous editions of this report (see Szalay et al., 2011; Smatana et al., 2016). Table 6.1 provides a chronological overview of the most important reforms and policy changes since 2016.

TABLE 6.1 Chronology of main reforms and policy changes in Slovakia, 2016–2023

YEAR(S)	REFORMS AND POLICIES	DESCRIPTION
2017, 2021	Stroke management	• 2017: - Guidelines for stroke management – acute phase - Ambulance transfer to hospital – mobile phone app STEMI helps rescuers to score the patient's health status - Door-to-needle time is guaranteed within 60 minutes • 2021: Guidelines for rehabilitation after stroke, 2021
2018	eHealth system (eZdravie)	• Beginning of the ePrescription function of the NHIS (eZdravie), which was legislatively established in 2013 • A further function was introduced in 2022 to replace paper forms for sick leave with an electronic system, fully operational since 2024 • Additional functionalities under development
2018, 2022	Redistribution mechanism between HICs	• Numerous changes to redistribution (risk-adjustment) scheme between the three HICs • 2018: Parameter MCGs and compensation of over-limit performances for highly expensive patients (Amendment no. 351/2018) • 2022: Introduction of new parameters, Diagnostic Cost Groups and Consumption of medical devices (Amendment no. 392/2022)
2018, 2021	NOP, Cancer screening	• Approval of the NOP with Action plans (AP) for 2019–2020 (https://www.health.gov.sk/Clanok?vlada-schvalila-narodny-onkologicky-program) • Later updated NOP with APs for 2021–2025 • Launch of national screening programmes for cervical cancer, colorectal cancer and breast cancer
2021	Hospital network	• New typology of hospitals (levels 1–5) with defined medical programmes and waiting times (Act no. 540/2021) • Benchmarking between hospitals (quality), annual evaluation and publishing of results (transparency), maximum waiting times for specific surgical procedures or treatments (accessibility)
2021–2022	Primary care	• A new public minimal network of GPs and paediatricians determined at district level • Allocation of non-refundable financial contributions for the establishment of outpatient practices
2022	Pharmaceuticals	• Law 266/2022 amending and supplementing Act no. 363/2011 on the scope and conditions of the reimbursement of pharmaceuticals, medical devices and dietetic foods under public insurance with the goal of boosting entries of innovative medicines onto the reimbursement list • Changes to managed entry agreements; newly established the NIHO in Healthcare (HTA agency)

Source: Authors' own elaboration.

6.1.1 *Hospital network*

Approved in December 2021 as a major piece of legislation, Act 540/2021 Coll. on hospital network reform set in motion the process to newly categorize institutional health care by introducing an optimized network of hospitals, with hospitals divided into five levels. This was a long-awaited reform that had been in preparation for several years. The approval of the legislation on the optimization of the hospital network was a condition for accessing RRP funds. Under the section "*Modern and affordable healthcare*", €998 million (65% of all resources for health care in the RRP) have been allocated for construction, reconstruction and equipment of hospitals (see Section 3.6.2).

These new hospital classifications define exactly where and what extent of care patients will receive; the main idea behind this new design is to keep outpatient and acute care close to patients' homes while at the same time concentrating planned and high-complex care across fewer hospitals overall. The five levels are set according to the breadth and complexity of care provided, scaling from very basic care (outpatient care, same-day surgery) focused on local needs (community care and LTC) in type I hospitals to highly specialized unique surgical procedures in a type V hospital (see Table 6.2).

TABLE 6.2 Typology of Slovak hospitals

	LEVEL V	LEVEL IV	LEVEL III	LEVEL II	LEVEL I
Level of care	Highly specialized care	Specialized care with limited volume	Complex acute and planned care	Standard acute care at regional level	Urgent outpatient care, LTC and community care, one-day surgery
Geographical distribution	One in country	Catchment area for 1.4–2 million population	Catchment area for 450 –900 000 people	Catchment area for 100–220 000 people	regional
Distance to travel (by car)	One in country	Within 90 minutes	Within 60 minutes	Within 30 minutes	local
Types of procedure	Highly specialized unique procedures	Specialized care, low volumes	Complex programme	Basic standard care including small surgeries	LTC, urgent outpatient practices and one-day surgery

Sources: MZ SR, 2021c, 2021e.

The newly established system of clear competencies for each level of hospital aims to bring clarity into the health system, concentrating on provision of care, quality assurance and the optimal use of scarce resources. To secure this, HICs can only contract services that hospitals are authorized to provide according to their programme profile.

Medical programmes with strictly defined waiting times, requirements on technical equipment, personnel and a minimum number of procedures per hospital aim to benefit patients. This reform also envisages the introduction of quality monitoring in hospitals that will be controlled by national authorities to regularly benchmark hospitals and the care provided. The first real changes in provision of care will be put in practice from late in 2025, such as closing certain wards that some hospitals are no longer designated to have (Slov-Lex, 2024b); implementation of maximum waiting times for specific surgical procedures or treatments was postponed by amended legislation at the end of 2024 (MZ SR, 2023g; Jeseňák, 2024).

Due to numerous delays in the preparation and roll out of the hospital network optimization and RRP implementation, the mutual linkage of these two pivotal components in the development of the hospital sector is at risk. The risk also lies in launching the hospital network reform without a functional solution to the patients' travel map, which is closely related to the planned new emergency medical service network and its connection to the transportation medical service. Unresolved issues related to the transfer of patients from larger hospitals to smaller ones and vice versa can also pose a risk to the successful implementation of the hospital network reform. Furthermore, further efforts to reclassify individual hospitals pose potential obstacles to ongoing implementation (Asociácia nemocníc Slovenska, 2023; Pavelek, 2023; TASR, 2024b).

6.1.2 *Pharmaceuticals*

In June 2022 an amendment to Act no. 363/2011 Coll. on the scope and conditions of the reimbursement of pharmaceuticals, MDAs and dietetic foods under public health insurance (the Reimbursement Act) was approved.

This was done in response to an increasing trend of medicines being reimbursed under the so-called exceptional regime with no clear procedure

in place. Prior to this amendment coming into effect (in August 2022), the existing rules for categorization and reimbursements did not allow innovative medicines to get onto the positive list of categorized medicines and they were mainly included via exceptions from HICs (see Section 2.7.4). Thus Slovak patients did not have standardized access to innovative medicinal products; legislators wrote the new amendment to (1) change this and (2) open new possibilities for the entrance of innovative drugs into the Slovak market. The key changes include simplified managed entry agreements, transparent rules for decision-making regarding innovative drugs for HICs, reimbursement of innovative medicines that ask for exceptional reimbursement, and changes to the QALY threshold.

The previous QALY threshold calculation was based on an average monthly wage from two years prior. Lower limit λ1 (the average monthly wage multiplied by 24, later 28) and upper limit λ2 (multiplied by 35, later 41) set the boundaries for reimbursement. Medicines under the lower threshold value were included, those over the upper value were not and those in-between were only conditionally included for two years and then reviewed once again. The new amendment sets threshold values based on GDP per capita from two years prior (aligned with WHO recommendations). For regular medicines, 3x GDP per capita (for 0.33–1 QALY gained) or 2x GDP per capita (for 0–0.33 QALY gained) is applied; medicines for a rare disease or an innovative treatment have higher thresholds of up to 10x GDP per capita.

As shown in Table 6.3, QALY thresholds calculated from average monthly wages (2011–2022) were significantly lower than they would have been if calculated from GDP per capita. Lower thresholds make it difficult for expensive innovative pharmaceuticals to get onto the positive list, and Slovakia's threshold was traditionally lower than in other EU countries, helping create a mismatch (along with the managed entry agreement process) in access to innovative medicines.

At the end of 2023, the first results of the legislative change could be seen. In 2023 approximately 50 pharmaceuticals (originator) were included on the positive list of categorized medicines (Kolesár et al., 2024). Since August 2022 (the effective date of the amendment), more than 20 pharmaceuticals previously funded through an exemption regime have been successfully included on the list. The lack of allocated funds for medications may be a potential obstacle to further inclusion in the list (Lekárnik, 2023).

TABLE 6.3 Development of QALY thresholds, 2011–2023

YEAR	λ1 THRESHOLD VALUE (LOWER LIMIT)	λ2 THRESHOLD VALUE (UPPER LIMIT)	PROJECTION OF PRE-2022 YEARS WITH CURRENT THRESHOLD (3X GDP PER CAPITA FROM PREVIOUS TWO YEARS)	λ2 THRESHOLD VALUE AS % OF 3X GDP FROM PREVIOUS TWO YEARS
	Coefficient 24	**Coefficient 35**		**(%)**
2011	17 868.00	26 057.00	35 491.91	73.41
2012	18 456.00	26 915.00	37 991.87	70.84
2013	18 864.00	27 510.00	39 895.01	68.96
2014	19 320.00	28 175.00	40 869.00	68.94
2015	19 776.00	28 840.00	41 285.47	69.85
2016	20 592.00	30 030.00	42 273.89	71.04
2017	21 192.00	30 905.00	44 331.05	69.71
	Coefficient 28	**Coefficient 41**		
2018	25 536.00	37 392.00	44 891.25	83.29
2019	26 712.00	39 114.00	46 706.78	83.74
2020	28 364.00	41 533.00	49 508.54	83.89
2021	30 576.00	44 772.00	51 953.01	86.18
2022	31 724.00	46 453.00	51 321.45	90.51
2023	33 908.00*	49 651.00*	54 325.93	91.39

Note: *projections if the old threshold had been kept.

Source: Authors' own elaboration using data (GDP per capita) from ŠÚ SR, 2024.

HTA is newly overseen by NIHO, which was established in 2022 (see Section 2.2.1). This advisory body of MZ SR publishes evaluations and analyses based on established European methodology according to evidence-based medicine. In regard to pharmaceuticals, its key role is the preparation of the evaluation of medicines with a potential impact on health insurance of more than €1.5 million per year for the purposes of categorization. The HTA agency has 110 days for issuing its recommendation in the matter of categorization.

6.1.3 *Primary care*

Given the ageing of the overall population and of GPs in Slovakia, the current organization of primary care delivery in Slovakia faces long-term sustainability challenges. Recent governments have consistently declared primary care to be a main focus for reform, though no structural changes have taken place. The most important issues include workforce shortages, the high average age of GPs and paediatricians, limited competencies, problems with reimbursements (that is, not fully covering a practice's operating costs due to energy crises), unexpected changes in the referral system and changes in the residency training programme.

In 2021, a proposal from MZ SR to reform primary care was introduced and divided into three phases (see Section 5.3):

1. A new public minimal network – implemented
2. Strengthening the competence status and revision of the reimbursement mechanism – in development, with a few new competencies already implemented (MZ SR, n.d.(c)).
3. Reduction of administrative burden – currently in progress, audit completed, and several administrative tasks have been eliminated.

With the first phase, the objective is to newly define GP and paediatrician networks, considering specific parameters, such as the number of insured persons and the number of doctors operating in a given district. Annual evaluations will map the districts and show areas where there is insufficient coverage. According to Regulation 11/2022, there must be a GP within 25 minutes by car, and the number of covered insured adults

for one GP was set (normatively) at 1600, and at 1100 for children. This subsequently allows MZ SR to evaluate the most endangered districts that are eligible for targeted funds. At the time of writing, regular monitoring of shortages of GPs and paediatricians at the district level has been achieved (MZ SR, n.d.(b)).

The core of the second phase is the creation of a new concept of general medicine and paediatrics (Concept of general health care until 2030) and agreeing on changes to the reimbursement mechanism to ensure financial stabilization. The proposal, approved by MZ SR in January 2023, includes an expansion of competences for GPs and nurses, and changes in the organization of their work; it will also reinforce the roles of non-medical staff in general clinics and adjust funding for primary care (MZ SR, 2023d). The ambition is to transform GPs into true gatekeepers, which requires a gradual expansion of competences, continuing education for GPs and the implementation of new standard diagnostic and therapeutic procedures, while removing previous restrictions.

The third phase is focused on reducing administrative burden. In 2023 MZ SR conducted an audit of bureaucratic burden with representatives of the outpatient sector, aimed at mapping the current administrative obligations of outpatient providers (MZ SR, 2023h). Subsequently, the obligation for paediatricians to issue certain certificates was abolished, including in cases of a child's absence due to illness or for a child's fitness to participate in sports training (MZ SR, n.d.(d)).

6.1.4 *Cancer screening and stroke management*

The top five leading causes of death in 2019 in Slovakia were ischaemic heart disease, stroke, lung cancer, pneumonia and colorectal cancer. To lower mortality rates and increase life expectancy, Slovakia has shifted its focus specifically to target stroke and oncological diseases. Regarding cancers, Slovakia had the second highest mortality rate in the EU in 2019; this has mainly been attributed to very late detections (see Section 5.1). The first NOP therefore focuses on secondary prevention with the introduction of population-wide screenings according to EU recommendations to reduce mortality of selected cancer types (breast cancer, colorectal cancer, cervical cancer and lung cancer). The initial implementation in 2019 was then slowed

by the outbreak of the COVID-19 pandemic, and the 2021 State of Cancer Screening annual report from the NOI had the following to say in regards to screening: "*Participation rates in screening examinations based on invitation from health insurance companies was, according to information from HICs we have at the moment, woefully low.*"

As a result, the NOP was updated in 2021 with Action Plans for 2021–2025. The main goal of this newer version is to reduce both incidence and mortality while improving quality of life for cancer patients. The action plans (for now still theoretical and yet to be implemented) anticipate active cooperation with patient organizations and progress is foreseen in the following areas:

1. Primary prevention
2. Secondary prevention (that is, screening)
3. Diagnosis and treatment, including supportive and terminal care
4. Research, development, education
5. Health data and information

At the time of writing, there have been no reported results or evaluations of the NOP, though one positive development resulting from the pharmaceutical reimbursement detailed above is that numerous innovative medicines were classified in both 2022 and 2023, indicating a potential improvement in treatment standards in the years ahead.

Despite significant reductions in stroke mortality since 2000, it remains an area of focus for Slovakia's health authorities. In 2017 MZ SR introduced a pathway for managing acute stroke patients with an exact procedure including an emergency call, transport and patient admission to a suitable facility. Responders take distance, available equipment and staff into account with the mobile phone app STEMI, which was designed for managing stroke patients and is installed in all ambulances. It helps emergency health workers score the patient's health status, inform them about the availability/capacity of nearby stroke centres in real time and report their estimated arrival time to those centres in order to ensure a smooth handover of an emergency admission stroke patient. As a result, STEMI is helping reduce the time to receive treatment.

Furthermore, MZ SR also created a list of 43 workplaces across the country that can continuously provide intravenous thrombolysis to stroke patients, and perform CT scans of the brain and cerebral vessels, and nine specialized workplaces that perform mechanical thrombectomy or thrombosuction. These facilities should have a door-to-needle time within 60 minutes.

Whereas the acute phases of stroke have been reorganized, rehabilitation after a stroke episode is not sufficiently developed in Slovakia. In the 2020 guidelines for rehabilitation after stroke, the gap in long-term rehabilitation (mainly neurorehabilitation and physiotherapy) is clearly identified as problematic, with no quick solution at hand. Despite the adoption of the new guidelines, the limited number of specialists (speech therapists, psychologists, physiotherapists), as well as rehabilitation centres (very few have contracts with HICs), means that concrete actions will require more financial resources.

6.1.5 *Changes to the health insurance redistribution mechanism (monthly and annually)*

The predictive ability of the mechanism that determines the redistribution of funds between HICs (risk-adjustment scheme) has increased significantly over time in Slovakia. The introduction of a new extended parameter in 2012 (PCGs), improved overall fairness of redistribution among HICs (see Section 3.3.3). As a result, the biggest (and only public) HIC, VšZP, was entitled to a larger share of collected contributions to cover expenses for its often more chronically ill and more expensive patients.

A further change to the redistribution mechanism was implemented in 2018 (Amendment no. 351/2018) and set a new parameter called Multi-year Cost Groups (MCGs) to reflect the costs of insured in the past three years. As shown in Table 6.4, this resulted in another shift in redistribution, with VšZP being the greatest beneficiary. Compensation of over-limit performances for highly expensive patients executed ex-post was additionally introduced in 2020, despite objections from the two private HICs.

TABLE 6.4 Effects of the redistribution mechanism among HICs in Slovakia, 2017–2022, in millions of euros

		2017	2018	2019	2020	2021	2022
Total amount collected from premiums		**4618**	**4825**	**5111**	**5140**	**5574**	**5895**
	VšZP	2969	3062	3196	3055	3216	3359
	Dôvera	1263	1359	1474	1552	1733	1846
	Union	386	404	441	534	625	690
The basis for redistribution (95%)		**4388**	**4585**	**4856**	**4883**	**5295**	**5600**
Cumulative result of monthly redistributions	VšZP	181	203	272	261	327	379
	Dôvera	-120	-133	-182	-152	-192	-221
	Union	-61	-70	-90	-109	-135	-159

Source: Authors' own elaboration according to ÚDZS, 2024c data

Finally, under the risk adjustment scheme, 96% of social health insurance contributions are now redistributed (annually and monthly) – previously this was 95% – and two new parameters were added to the redistribution scheme in December 2022. Diagnostic Cost Groups and consumption of MDAs are likely to further change the redistribution among HICs in the future.

6.1.6 *eHealth*

For more than a decade, Slovakia has tried to establish a well-functioning national eHealth information system (called eZdravie). Despite concerted efforts, eHealth still lacks the necessary sophistication of functionalities, complexity and user-popularity (see Section 4.1.3). Indicators such as the share of

health care providers connected to the system, the number of entries in the electronic health record, the number of prescribed electronic prescriptions, and visits to the national health portal, which measure the use of eHealth, have been approaching set target values very slowly in recent years, showing little progress (MZ SR, 2024c).

The functionality of ePrescription is an exception to this, and it came about through development by the private HIC Dôvera, and was then provided to the state-owned eHealth system for free. Officially, ePrescription replaced paper prescriptions in 2018, and the electronic prescribing and dispensing of medicines, MDAs and dietetic food provides an overview on potential drug interactions, or duplicates. The benefit of the system became very clear after the outbreak of the COVID-19 pandemic, with the share of electronically prescribed prescriptions reaching 97.2% in March 2020, making a significant contribution to the fight against the spread of the coronavirus in the Slovak population.

A similar development may be expected in the near future concerning an eLAB functionality, which is intended to allow physicians access to all laboratory test requests for their patients, as well as the results of tests they have already undergone. The service, which is estimated to save €3.4 million, was supposed to be implemented in 2023 (the initiative for its creation has been ongoing since 2019), but may ultimately be addressed by once again integrating an existing solution from the private HIC Dôvera (Kolesár et al., 2024).

A good example of how digitalization can significantly ease people's lives is the successfully implemented ePN functionality, a joint project of NCZI and the Social Insurance Agency (*Sociálna poisťovna*). In 2022 it introduced the electronic sick leave certificate as a replacement for the five-part paper forms, covering everything from the doctor's visit to the payment of income compensation by the employer and social benefits by the Social Insurance Agency.

Unlike ePrescription or electronic sick notes, other functionalities related to booking appointments (*eObjednávka*), recording vaccination records (*eOčkovanie*) or receiving electronic referrals (*eŽiadanka*) rounding out a patient's electronic health record are underdeveloped and with limited use.

The system as a whole is considered overpriced and unreliable (often out of order), with safety issues (reported data breaches) and even an unnecessary duplication of already functioning solutions from private HICs who are more often drivers of change and the ones shaping eHealth policies (SITA, 2020b; Kováčik, 2022; Hanker & Kosno, 2023; Zdravotnický Deník, 2024).

6.1.7 *Other reforms and policy changes*

The profits of HICs operating as joint-stock companies have frequently sparked contentious discussions (see Section 2.7.1). Profit-making that was prohibited in 2007 was reintroduced in 2011, after the Constitutional Court ruled that the provision of health insurance can take place in the sphere of competition and that insurers may make profits (Constitutional Court of the Slovak Republic, 2011). An amendment of Act no. 581/2004 from 2022 that came into effect in January 2023 stipulates that if an HIC achieves a positive financial result exceeding the reasonable financial result set at 1% of the premium, the difference must be used to establish or supplement a health quality fund (see Section 3.3.3).

Additionally, efforts to prevent or diagnose mental illnesses early, implement modern diagnostic and treatment procedures, and invest in renovating health care departments to enhance patient care have shown some success. Building on the establishment of the Government Council for Mental Health in 2021, the National Mental Health Programme and its Action Plan for 2024–2030 were officially approved in 2024 (see Section 5.11). Despite some delays, MZ SR is also steadily advancing its efforts to strengthen capacities in mental health support (Kolesár et al., 2024).

Greater integration of the social and health systems has also been an area for reform (see Box 5.3). The Strategic Long-Term Care Strategy in Slovakia prepared by MZ SR and the Ministry of Labour, Social Affairs and Family was introduced in 2021. This document recognized the need to link the provision of social services and health care, especially within the scope of nursing care and physiotherapy (MPSVaR & MZ SR, 2021). The strategy has been developed in accordance with the RRP to allocate €265 million to guaranteeing affordable and high-quality long-term social and health care. With this investment, three reforms were planned:

1. Integration of financing for long-term social and health care
2. Reforming the medical review system
3. Reforming oversight of social care

In line with the strategy, a new legislative framework governing long-term health and palliative care was developed and approved in 2022. At the same time, a supportive team for doctors was defined in the context

of a multidisciplinary approach to patient care, and contractual conditions between HICs and providers of nursing care (including in social care facilities) were adjusted to introduce the obligation to collect data for the purpose of monitoring the availability and evaluating the quality and effectiveness of nursing care within long-term health care. Related regulations and implementing rules were also approved.

Furthermore, a reform of the medical review system was also launched. The law, approved in November 2024 with an effective date of September 2025, introduces client assessment based on a unified methodology (WHODAS) and at a single location – exclusively at the labour offices (MPSVaR, 2024b). The result will be a unified health-social, that is, integrated assessment for the purposes of compensation and social services. This means that after submitting a single application, the client will undergo only one assessment, covering multiple purposes at once.

The third part of the strategy, focused on infrastructure development, is delayed due to the timeline in the optimization of the hospital network.

6.2 Future developments

With an ageing population, growing health workforce shortages and low levels of efficiency in the health system (see Section 7.6), Slovakia faces long-term structural challenges. Approved reforms that have not yet been implemented remain on the agenda, with the full implementation of the hospital network reform being key to balancing the needs of the population and the resources available (financial, physical and human).

One additional area of future development is reimbursements in outpatient clinics. At the time of writing, outpatient clinics continue to be reimbursed based on a medical procedure catalogue that lacks numerous common outpatient procedures. The valuations assigned to these procedures were introduced approximately 30 years ago and are currently regarded as insufficient across a wide range of specialties (Zdravotnický Denník, 2023). After several years of preparatory work, a new catalogue has been developed. A pilot phase for five specializations (neurology, internal medicine, geriatrics, pneumology and dermatovenerology) began, after delays, in July 2025 and is planned to last six months (MZ SR, 2025g). A potential obstacle to full

implementation of the new catalogue is a lack of financial resources during the continuing era of state budget consolidation.

In addition to the approved reforms, there is also an MZ SR plan for the period 2024–2028 with 30 projects focused on the following areas: 1) long-term vision and sustainable development; 2) quality and accessible health care; 3) prevention as a fundamental pillar of health; 4) stabilization and development of human resources capacity; 5) stable financing and efficient resource utilization; and 6) transparent and effective management.

7

Assessment of the health system

Chapter summary

- The Strategic Framework for Health 2014–2030 that defines medium- and long-term health policy in Slovakia was updated in 2022. However, there is no comprehensive monitoring to ensure up-to-date information about the policies' impact on health system goals and there is little stakeholder involvement. Given the long-term underfinancing of the health system and the regular top-ups that HICs receive nearly annually, the Ministry of Finance has historically had a strong say in health system governance.
- Some 6.1% of Slovaks reported unmet needs for medical services in 2023. This is above the EU average (3.8%) and that of other V4 countries. Slovakia also has the highest unmet dental need of the V4 countries, though it is below the EU average. Moreover, there are also large differences in unmet needs in Slovakia according to socioeconomic status. The leading reason for unmet medical needs is waiting times, which are not measured systematically.
- Financial protection is reported to be high, and just 0.5% of self-reported unmet needs were attributed to cost in 2023. This share has also declined compared to pre-2021, and accounts for under

10% of total unmet medical needs in Slovakia (for all reasons), despite a gradual increase in OOP payments.

- In 2023 average life expectancy at birth in Slovakia was roughly 78 years. Although life expectancy has improved over the last twenty years at a faster rate than the EU average, it is still the second lowest in the V4 countries and Slovakia lags behind the EU average by 3.4 years. There are significant disparities in most health outcome indicators based on place of residence, educational attainment or income. Disparities are particularly large for the Roma population, which is the largest ethnic minority in Slovakia.
- There were 421 avoidable deaths per 100 000 population in Slovakia in 2022, the sixth highest rate in the EU and the second highest among V4 countries. Deaths related to COVID-19 accounted for 4.9% of avoidable deaths in 2022, a significant drop compared to nearly 25.5% of avoidable deaths in 2021. The largest cause of avoidable deaths in Slovakia in 2022 was ischaemic heart diseases (22.7%), followed by alcohol-specific disorders and poisonings (8.5%) and cerebrovascular diseases (7.8%).
- Since 2016 the efficiency of the Slovak health system has been regularly monitored through HSRs, which analyse health expenditure in detail and recommend measures based on specific benchmarks. Some of these measures are annually tied to the budget, creating pressure for their implementation in practice.
- Concerns about allocative efficiency in Slovakia include the number of outpatient visits and their structure. Slovakia has long had the highest number of visits to a doctor per person in the EU, with 17.6 million more visits to specialists (that is, 3.2 more per capita) in 2019 compared to the average of other V4 countries, and at the same time 5.6 million fewer visits to primary care physicians (that is, 1 less per capita).
- Slovakia's technical efficiency has been gradually improving and, unlike in other countries, this has been accompanied by a lower increase in CHE per capita. This indicates that HSRs have gradually achieved their objective of realizing internal savings. However, other countries have lower amenable mortality rates at comparable expenditure.

7.1 Health system governance

MZ SR sets strategies and implements reforms, currently through the Strategic Framework for Health 2014–2030. Created in 2013 and significantly updated in 2022, it defines medium- and long-term health policy in Slovakia (MZ SR, 2023i). It also identifies a set of indicators to be measured and evaluated. However, this was primarily developed to access EU funding and has not been used in practice; there is no systematic monitoring to ensure up-to-date information about the policies' impact on health system goals. There is little formal stakeholder involvement, with limited impact on accountability. Nevertheless, public participation in the Slovak health system is reflected in the large number of patient organizations (which have AOPP as their umbrella organization, see Section 2.2.4). Representative organizations and associations have an opportunity to comment on new legislation but are limited to only voicing recommendations. They also advocate their interests by lobbying legislators and by courting public opinion.

In practice, policy development and governance have largely been guided by the incumbent government's or health minister's policy statements or priorities. As the average ministerial tenure since 1993 is approximately 20 months, initiatives with medium- to long-term impact are rarely implemented (MZ SR, 2023j). Furthermore, an analysis of strategic health policy documents by NKÚ found that MZ SR does not have a system of evidence or strategy evaluation in the health sector, and that most strategic documents from MZ SR lack sufficient descriptions of financing or implementation monitoring (NKÚ, 2022).

Given long-term underfinancing and the regular top-ups that HICs receive, the Ministry of Finance has taken a strong role in health system governance. This has increased considerably since 2016, with the first HSR. Written by the analytical units of the Ministries of Health and of Finance, the HSR detailed where to improve technical and allocative efficiency in the health system via savings (Ministry of Finance, 2016a). This was subsequently updated in 2018, 2019 (Ministry of Finance, 2019) and 2022 (Ministry of Finance, 2023) and gradually morphed from a document describing savings to one also focusing on where the state should invest and increase social health insurance funding to improve overall care quality and/or accessibility (Ministry of Finance, 2023). The HSR has thus become a key document linking policy and investments to the budgeting process, and has led to the establishment of an Implementation Unit in the Cabinet Office. The latest

HSR, published in March 2025 (Ministry of Finance, 2025), is not focused on the entire sector: instead, it provides an in-depth overview of the efficiency of state hospitals. Future HSRs are planned to be thematic as a way to increase their applicability in practice.

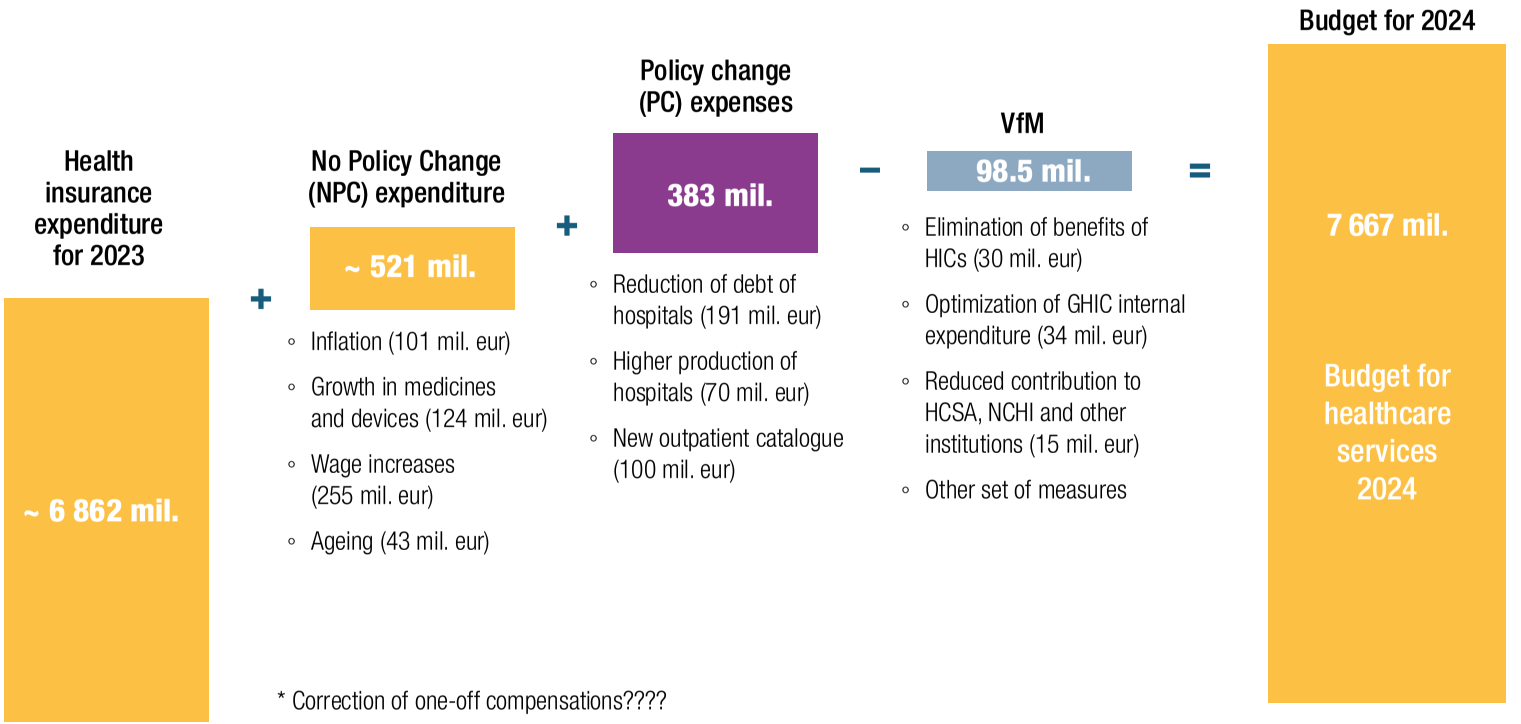
Budget preparation changed significantly in 2017, when the analytical units of the Ministries of Health and of Finance began preparing exact calculations of expected health system costs (previously, the state budget neither determined nor justified resources needed for the upcoming year). This is done by adding:

1. the expected expenditure of the current year, based on the HICs' reports,
2. expenses deemed unavoidable (such as inflation, wages and ageing); also known as the no-policy-change scenario, and
3. the policy-change scenario, consisting of the expected new expenditure associated with reforms.
4. Then the (value for money) savings based on the approved HSR are subtracted and the result is the expected health expenditure for the following year (see Fig. 7.1).

Given the financing change in 2020, and that payments for state insurees were set as the residual of the expected expenditure and the expected collection of contributions from the economically active population, the HSR has thus become an integral part of defining the health budget. Even though at the time of writing, the contribution for state insurees was once again a fixed percentage of the average wage, the process of budgeting remains unchanged and MZ SR must take heed of the HSR. If HSR actions are not implemented, there is a theoretical budget deficit. In practice, even stringent austerity measures achieve only up to 70% of identified savings and the continual losses by the HICs necessitate regular funding infusions (Implementation Unit, 2022; ÚDZS, 2023c).

Compliance with non-fiscal measures from the HSR is also monitored by the Implementation Unit of the Cabinet Office, which transforms HSRs into so-called Implementation Plans. Each Plan is prepared jointly with relevant ministries, contains a detailed timetable and responsibilities, and its approval is subject to standard lawmaking processes. Thus, HSRs have become the dominant instrument influencing health system governance and the distribution of responsibilities.

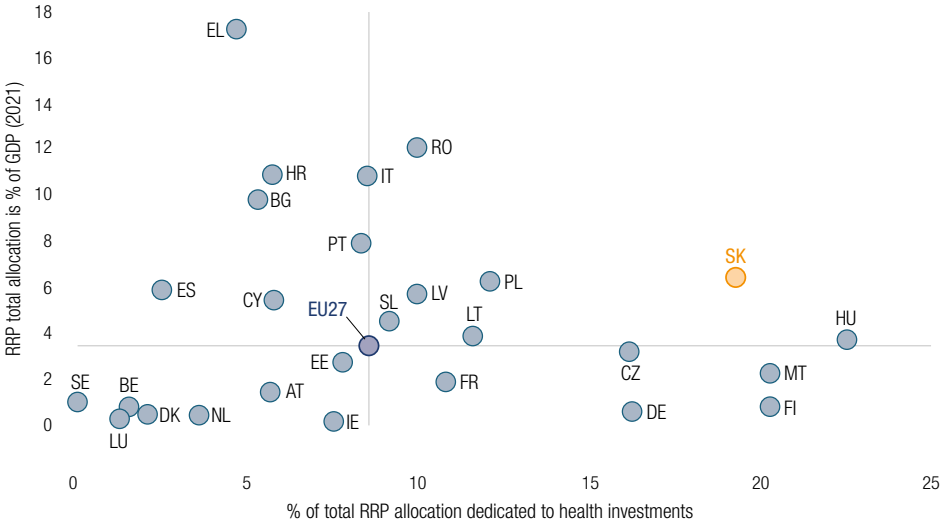
FIGURE 7.1 Illustration of HSR for the 2024 budget process



Source: Authors' own compilation based on (MZ SR, 2024e).

In 2021 the approved RRP entered the health system governance process, the conclusions of which were reflected in both the Strategic Framework and in the updated HSR in summer 2022. The primary difference between them is that the HSR focuses on social health insurance spending and the internal cost-efficiency of MZ SR and state-owned hospitals, and implementation largely does not require legislative changes. The RRP discusses capital spending and defines the reforms that MZ SR must implement if it is to receive the promised funds. As health was a main priority of the RRP (see Fig. 7.2), this document shapes the design and implementation of policies and reforms.

FIGURE 7.2 RRP funding for health compared to total investment as a share of GDP



Source: OECD/European Observatory on Health Systems and Policies, 2023.

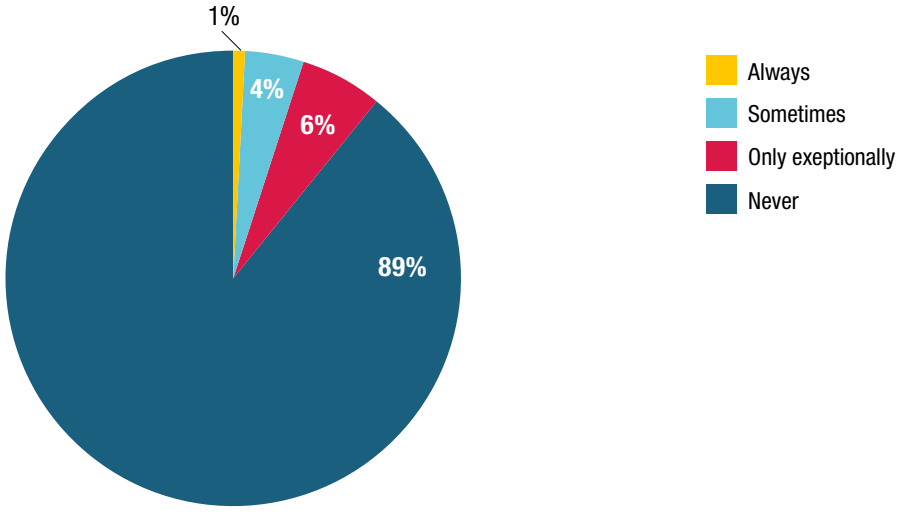
7.1.1 *Transparency*

The overall perception of corruption in Slovakia has been gradually improving. According to Transparency International surveys, the share of cases in which some form of bribery occurred in the public sphere fell from 40.3% in 1999 to 10.2% in 2022 (Transparency International, 2023).

Lack of health system transparency is primarily associated with wasteful procurement. Following the 2016 parliamentary elections in which non-transparent tenders were a key issue, changes were introduced to improve both procedures and outcomes. These included mandatory price referencing of state hospital purchases, public disclosure of purchases, and central procurement of expensive medical equipment. Many of these were temporarily suspended during 2020–2023 to speed up procurement during the COVID-19 pandemic, however. Perceptions of the presence of corruption in the health system stood at 58% in 2022 according to Eurobarometer, below only Greece and Lithuania among EU countries (Eurobarometer, 2022).

In theory, transparency regarding health benefits should be mediated by the broad and standardized benefits package and near universal population coverage. According to Eurobarometer, though, 9% of all doctor visits in 2022 resulted in some form of informal payment or gift over and above the official fees. This increased from 5% in 2019 and was the highest percentage in the EU after Romania (18%) and Greece (13%). Similar figures were found by a ÚDZS survey in summer 2023: up to 11% of patients reported that they had paid more than official fees for care (see Fig. 7.3) (ÚDZS, 2023e)

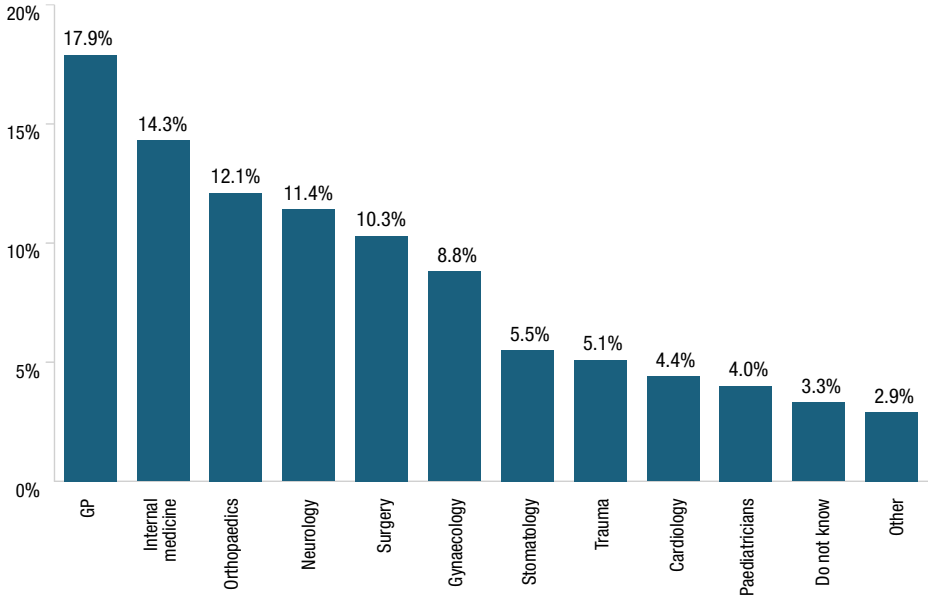
FIGURE 7.3 Share of patients paying over and above official outpatient clinic or hospital fees



Source: ÚDZS, 2023e.

The distribution, amount and motivations of informal payments vary. According to a Transparency International survey (Transparency International, 2021), the majority are made to primary care physicians, potentially due to their significant shortage. A breakdown of specialties in which informal payments were most likely to be solicited is shown in Fig. 7.4.

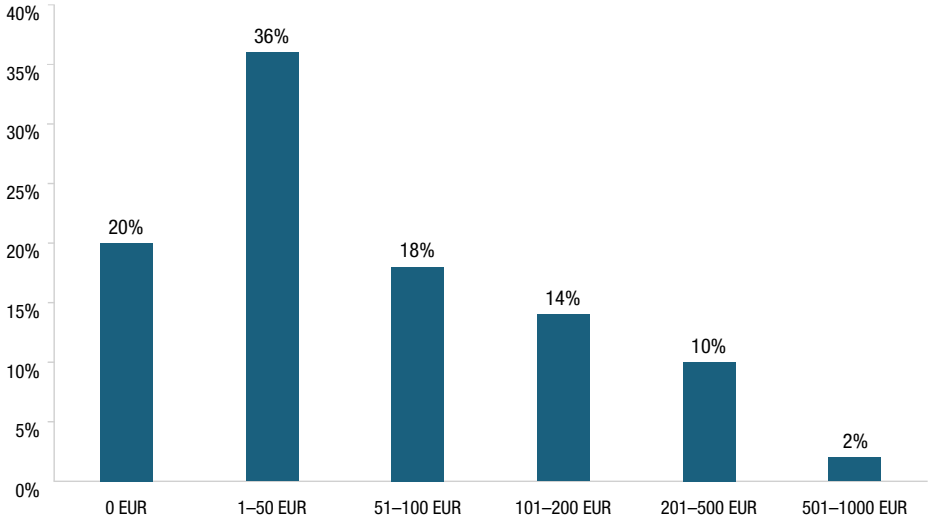
FIGURE 7.4 Specialties that were reported to ask for/receive an informal payment, 2021



Source: Transparency International, 2021.

The survey also focused on the activities in which informal payments are most frequent. Their conclusion was that up to nearly 80% of all patients who underwent surgery made an informal payment to a doctor or nurse (that is, outside the official price list). The average amount of such payments reached, according to ÚDZS (2023e), as high as €115 in 2023; specific breakdowns are shown in Fig. 7.5. These payments do not enter official statistics on health spending, however, and reasons for these payments also vary. According to Eurobarometer (2022), up to a quarter of all informal payments were given to obtain better or earlier care for the patient.

FIGURE 7.5 Informal payments that patients paid surgeons, 2023



Source: ÚDZS, 2023e.

7.2 Accessibility

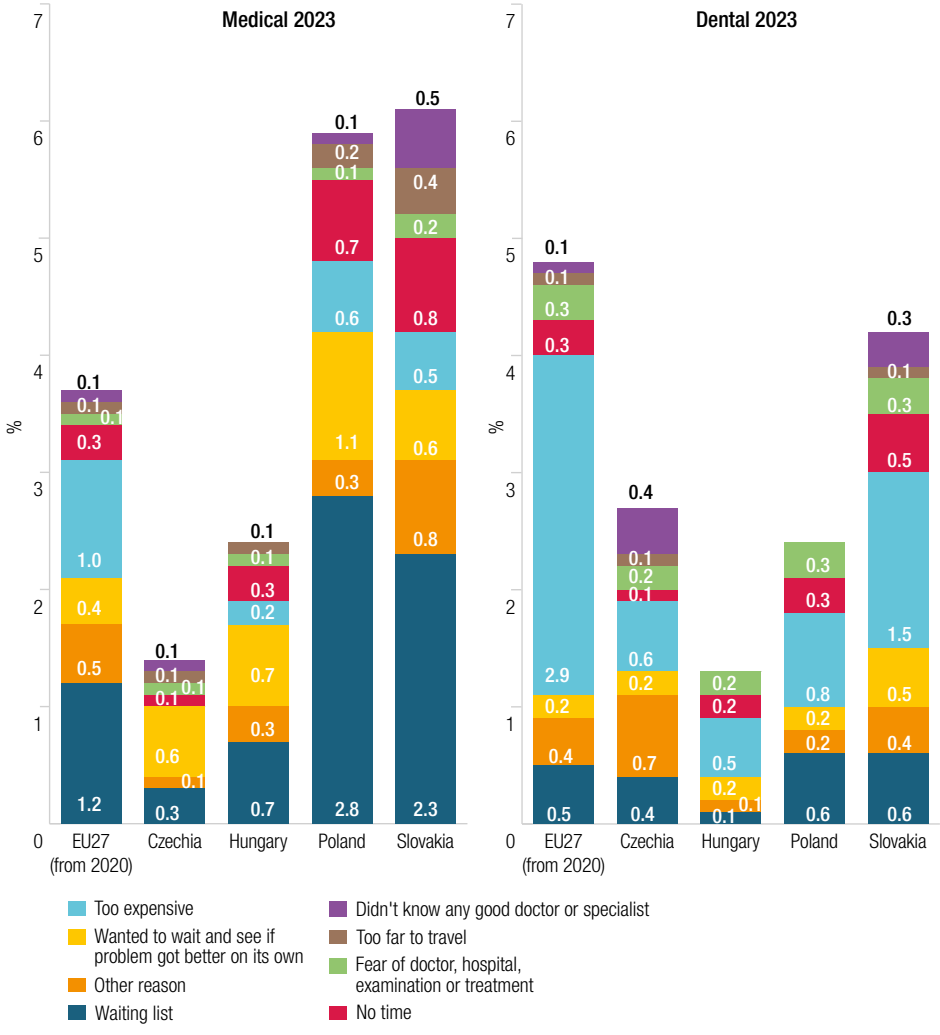
Social health insurance operates on the principle of obligation for both parties, that is, HICs must accept all applicants with a legal basis for entitlement and residents with permanent residence in Slovakia are obliged to have insurance, with few exceptions (see Chapter 3). In 2023, 5.18 million people were insured in Slovakia, approximately 95.2% of the population (ÚDZS, 2024c). The remainder are people residing in Slovakia but working abroad (for example, in Czechia or Poland), those experiencing homelessness (roughly 71 000, some facing challenges proving their identity to gain coverage (Smatana, Barteková & Štofko, 2024), and a small proportion of voluntarily uninsured people with private coverage.

The basic benefits package is broad and includes inpatient and outpatient care, prescription pharmaceuticals and a certain range of dental procedures, and rehabilitation and spa treatments (see Chapter 3.3.1). Official cost-sharing is rare (mostly for pharmaceuticals and dental services) and virtually all health services are free at the point of use.

Although this set-up should mean that unmet needs for medical care are low, 6.1% of Slovaks reported them in 2023. This is above the EU average

(3.7%) and that of the other V4 countries (see Fig. 7.6). Slovakia also has the highest unmet dental care needs of the V4 countries (4.2% vs 2.1% average of Czechia, Hungary and Poland), though below the EU average (4.8%).

FIGURE 7.6 Self-reported unmet needs for medical (left) and dental (right) examinations, by main reason declared in selected countries, 2023

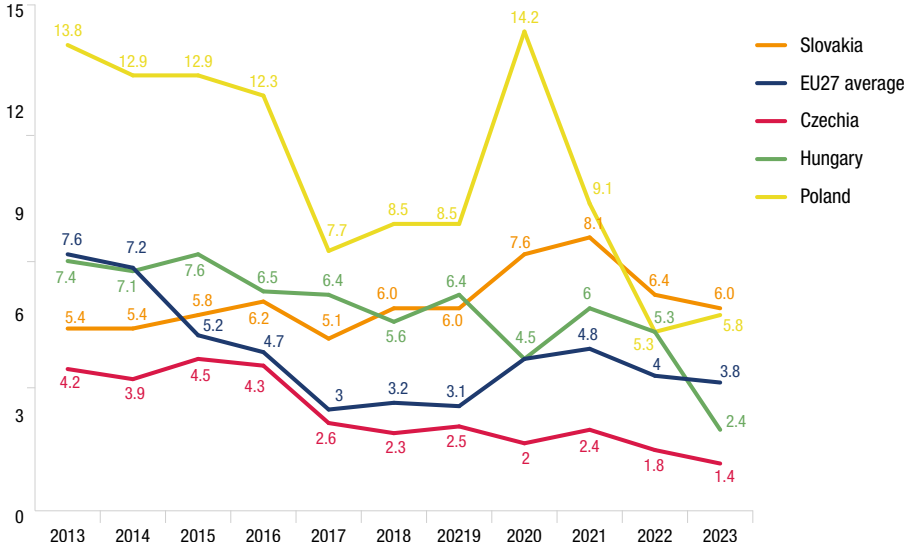


Source: Eurostat, 2024e.

In contrast to other V4 countries, the share of self-reported unmet medical needs over time has increased overall, that is, since 2013 (see Fig. 7.7).

During the COVID-19 pandemic this share rose to 8.1% before dropping back down to 6.1% in 2023.

FIGURE 7.7 Self-reported unmet needs for medical examination, selected countries, 2013–2023



Source: Eurostat, 2024a.

There are also large differences in unmet needs in Slovakia according to socioeconomic status. In 2023 the lowest income quintile in the population (1st quintile) had 1.9 times greater unmet medical needs than the highest earners (5th quintile) (Table 7.1). The increase in unmet needs since 2013 has been primarily driven by the bottom quintile, while unmet needs for the highest income quintile have remained largely unchanged. In 2013 the top quintile had unmet medical needs at 8.6%, and in 2023 it was 8.4%. For the bottom quintile, 11.8% of population reported unmet needs in 2013, while in 2023 it was 16.4%. This group is more vulnerable to external shocks, such as during the COVID-19 pandemic, when vulnerable communities fared worse (Hidas et al., 2022) (see Section 7.5).

The leading reason for unmet medical needs is waiting times, which are not measured systematically. While just 1% of Slovaks indicated an unmet need due to waiting times in 2013, this stood at 2.3% in 2023. Care accessibility, as defined by the number of FTEs and beds for certain specialties in a given region, is used as a proxy of access. Although HICs were obliged

to measure waiting times if a patient does not receive a hospital appointment for a procedure within three months, this applied to just 15 (primarily elective) procedures. These procedures and their methodology were defined by several decrees (for example, Decree nos 412/2009 and 396/2013), and began to be measured in December 2013. Waiting times are now collected and published by NCZI.

TABLE 7.1 Self-reported unmet needs for medical care, Slovakia, 2023, according to income quintile

	WAITING LIST	OTHER REASON	WANTED TO WAIT AND SEE IF PROBLEM GOT BETTER ON ITS OWN	TOO EXPENSIVE	NO TIME	FEAR OF DOCTOR, HOSPITAL, EXAMINATION OR TREATMENT	TOO FAR TO TRAVEL	DIDN'T KNOW ANY GOOD DOCTOR OR SPECIALIST	TOTAL
Fifth quintile	1.7	0.9	0.5	0.4	0.8	0.2	0.1	0.4	5.0
First quintile	3.7	1.3	1.1	0.7	0.9	0.2	0.9	0.6	9.4
Total	2.3	0.8	0.6	0.5	0.8	0.2	0.4	0.5	6.1

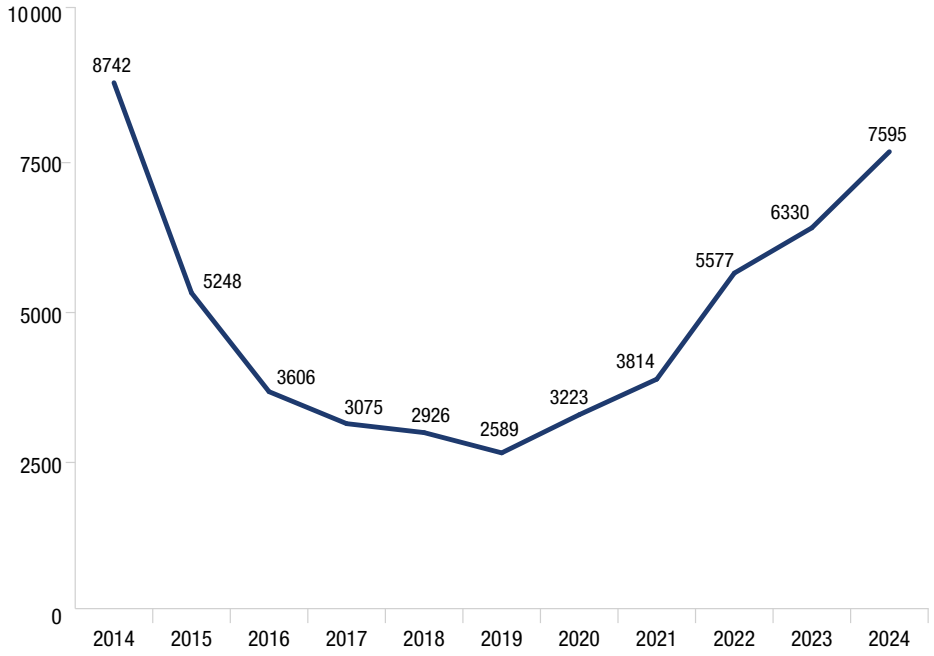
Source: Eurostat, 2024e.

Notwithstanding that these 15 procedures represented a small proportion of all hospital admissions, data on those waiting for these procedures showed improvements until the COVID-19 pandemic (2014: 8742 patients, 2019: 2589 patients). However, the postponement of elective care due to COVID-19 led to a backlog of procedures (AOPP, 2023) (see Fig. 7.8). In 2023 the largest wait lists were for knee (2943 patients) and hip (1779 patients) replacements (ÚDZS, 2024a). Available data on average waiting times vary, with 17% of patients waiting less than three months from listing, whereas 45% patients wait more than a year after being listed.

As part of the hospital network reform (see Section 6.1.1), MZ SR defined new waiting times for roughly 40% of elective procedures in hospitals, replacing the original list of 15 procedures. The first pilot measurements started in January 2024, on the basis of which the legislation on mandatory maximum waiting times was updated as of January 2025 and will be regularly monitored and

adjusted to the situation and needs of patients (Hospodárske noviny online, 2024; MZ SR, 2024b). If a patient waits longer than the set maximum and a HIC cannot find a provider that can manage the patient within maximum times, the patient has the right to go abroad for care and will have all costs covered by insurance.

FIGURE 7.8 Number of patients on a waiting list, 2014–2024

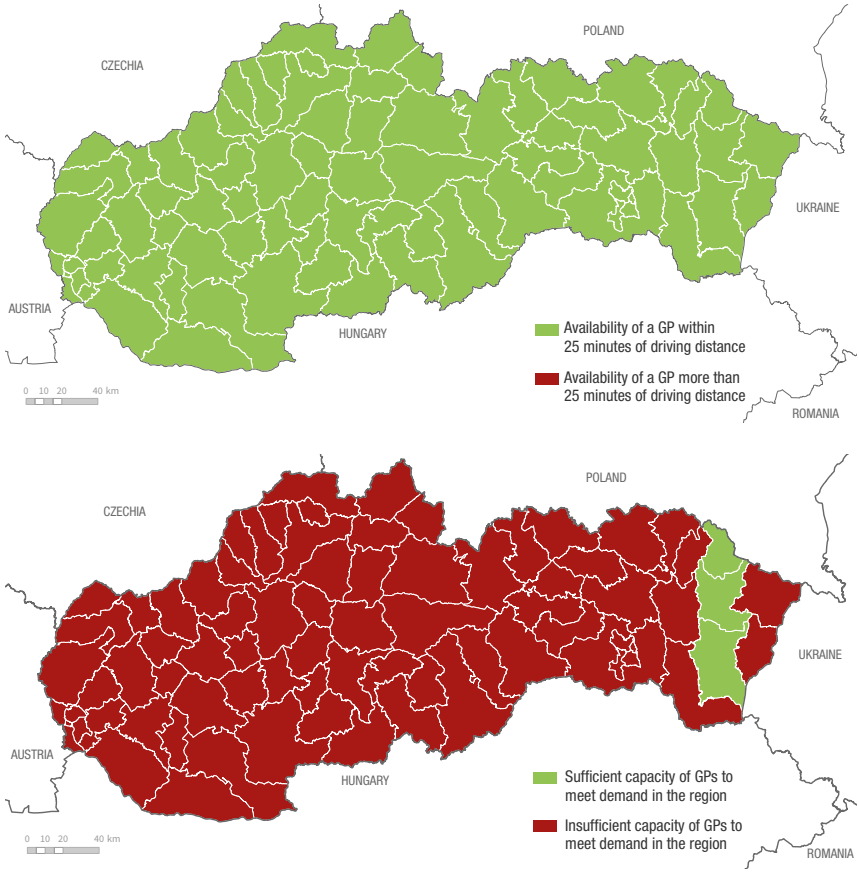


Note: waiting lists as of the first month of a given year.
Source: ÚDZS, 2024a.

As of December 2024, there were 67 356 people on the waiting lists according to the defined new waiting times as part of the hospital reform; this is approximately nine times the number of waiting list holders compared to the original waiting list system (of 15 procedures). The most common reasons for placement on the waiting list are therapeutic administration of substances to the eye (18 550 patients), lens extraction and implantation (18 194), total knee arthroplasty (7691), hernia surgery (7028) and cataract surgery (5682) (NPZ, 2024). Using the proxies of the minimal number of FTE physicians for outpatient care, and beds and emergency departments for inpatient care for

a certain territory to evaluate care, accessibility and capacity have historically been defined in Regulation 640/2008. While geographical accessibility in travel time (minutes) seemed adequate at first, the capacity of doctors has not been sufficient to cover demand in most parts of Slovakia, as shown in Fig. 7.9.

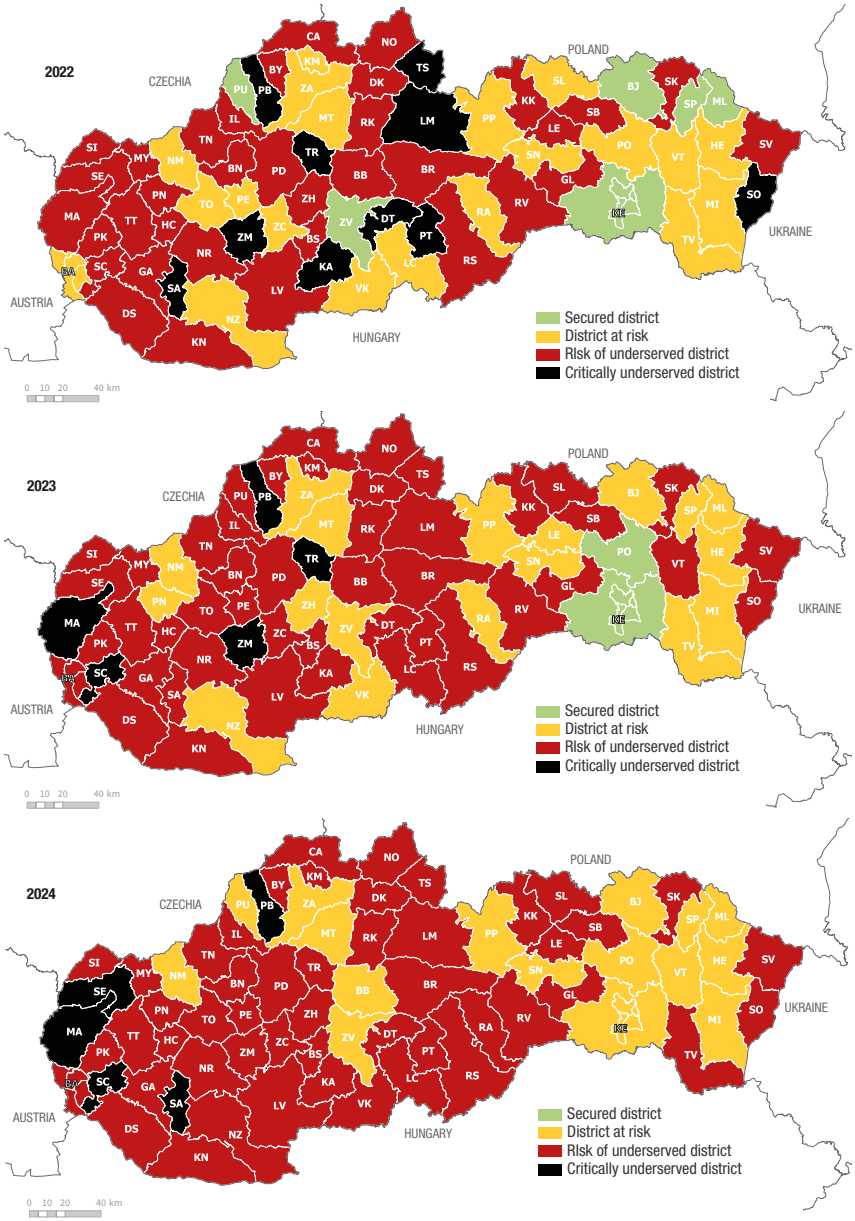
FIGURE 7.9 Map of local availability (top) and required capacity (bottom) of adult general outpatient care providers as of 1 January 2024



Source: produced by WHO GIS, data from MZ SR, 2025d.

Despite updating the 2008 Regulation and replacing it with a new system for calculating the minimum public network of GPs (in 2021) and the approval of the Primary Care Reform Concept (MZ SR, 2023c) in January 2023, MZ SR does not anticipate favourable future developments in the availability of outpatient care in the near future, as illustrated by the reduction in the availability of adult GPs over the past three years (see Fig. 7.10).

FIGURE 7.10 Reduction in the availability of general outpatient care for adults by district, 2022–2024

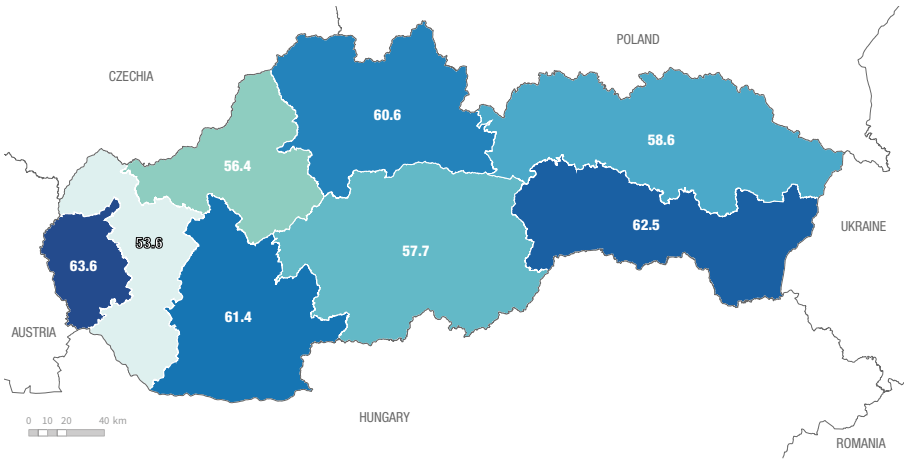


Note: the assessment of districts is based on a mathematical model with a maximum of 1000 points, with individual threat levels corresponding to the following ranges of points: Secure district = 0–99 points; District at-risk = 100–298 points; Risk of underserved district (i.e. at-risk district with shortages) = 299–599 points; Critically underserved district (i.e. at-risk district with large shortages = 600–1000 points. Three parameters are used for scoring: local availability, demographic structure of doctors, and the degree to which the necessary capacity for primary care services is met.

Source: produced by WHO GIS, data from MZ SR, 2025d.

In summer 2023 MZ SR prepared a network update for specialist outpatient doctors. Although the new legislation was approved by Parliament at the end of 2024, first results and data will be publicly available at the end of 2025 (RTVS, 2024). However, even a simple comparison of the number of full-time outpatient specialists per population demonstrates that regional capacity and availability problems exist for most specialties (see Fig. 7.11).

FIGURE 7.11 Number of specialist outpatient doctors per 100 000 population of SGRs, 2023



Note: values do not include primary care physicians and doctors working in hospitals.
Source: produced by WHO GIS, data from NCZI, 2025b.

The availability of inpatient care was for years defined only through the minimum number of beds that HICs had to contract for a given territory (Regulation no. 640/2008). In 2022 an implementation tool of the hospital reform was published that not only updated the minimum numbers of beds in each specialty and region, but also defined the typology (level) of hospitals and the maximum time availability in minutes of the commute[12] for each type of hospital (Decree no. 316/2022 of 2022 and its later amendments, for example, Regulation no. 531/2023). Table 7.2 shows the accessibility results by hospital level in 2022.

12 A commute corresponds to the effective accessibility of inpatient care provision for at least 90% of the population in the catchment area by motor vehicle.

TABLE 7.2 Geographic availability per hospital level in minutes, 2022

LEVEL OF HOSPITAL	LOWER LIMIT (MIN)	UPPER LIMIT (MIN)	REAL AVERAGE ACCESSIBILITY (MIN)	% OF HOSPITALS FULFILLING MIN CRITERIA	NUMBER OF HOSPITALS
V.	300	350	125.07	100%	1
IV.	90	120	47.66	100%	3
III.	60	90	28.41	100%	9
II.	30	45	13.07	100%	33

Note: geographic availability calculations are not available for Type I hospitals.
Source: MZ SR, 2022d.

As there is only one category V hospital and three category IV hospitals in Slovakia, time availability varies by region. However, these hospitals provide the most specialized and rare types of services. Category II and III hospitals, which produce the highest volume of care, have more evenly balanced availability (see Table 4.4).

7.3 Financial protection

Slovakia's health system places strong emphasis on financial protection. This has been reinforced by successive health ministers ever since the pro-market government of Prime Minister Dzurinda and Health Minister Zajac (2002–2006). Financial protection is reported to be high, as seen in the unmet needs data in Section 7.2: in 2023 just 0.5% of self-reported unmet needs were attributed to care being (too) expensive.

In 2022 OOP payments as a share of all health spending were 19.3% (see Table 7.3), similar to Poland (18.84%) but significantly higher than Czechia (14.3%). OOP payments mainly consist of co-payments for prescribed pharmaceuticals and medical goods (50%), direct payments for OTC pharmaceuticals, vision products and dietetic food (17%) and user fees for various inpatient (15%) and outpatient services and rehabilitation (12%) (see Section 3.4). National data show that increases in OOP payments in 2021, 2022 and 2023 were driven primarily by OTC medicines, vitamins, dietetic food and protective equipment related to COVID-19.

TABLE 7.3 Development of OOP payments in Slovakia, 2013–2022

	2013	2014*	2015	2016	2017	2018	2019	2020	2021	2022
Total OOP (in millions of euros)	1302.1	946.6	999.3	1031.0	1070.6	1132.8	1251.9	1248.7	1508.9	1617.9
OOP as a % of CHE	23.3	22.6	18.4	18.2	18.7	18.9	19.2	18.8	19.4	19.3

Note: * a change in methodology of reporting of OOP payments.
Source: Eurostat, 2024e.

A main factor that explains the decline in unmet needs due to cost is the expansion of the system of capping co-payments for prescribed drugs to include pensioners and other groups, providing that their net income is below 180% of the average wage (see Section 3.4.) This reduced co-payments for medicines on the basis of individuals' income, increasing financial protection of vulnerable groups.

However, significant differences in unmet needs due to financial reasons between different income groups persist in Slovakia (see Table 7.4). The fifth (highest) income quintile shows only a small percentage of people with unmet needs due to financial reasons, which is similar to other V4 countries. Their average over the past 10 years is 0.2%, which is eight times lower than the average for the first quintile (1.6%) over the same period. In 2023 the level of unmet needs of the first quintile was significantly higher than in Czechia, but still only a third of the EU average (2.2%).

Dental services, not fully covered by social health insurance, play a crucial role in unmet needs due to cost; most dentists require co-payments for services or patients pay fully OOP. Thus, the overall value, as well as the values for the first and fifth quintiles, show a higher rate of unmet needs than for medical care. Disparities between income groups are even higher, up to three times between the quintiles in 2023. A slight decline in the level of unmet needs for dental services during 2021 and 2022 was caused by an expansion of benefits offered by HICs under voluntary programmes that subsidized dental care expenses, as long as a patient attended to set preventive care treatments and fulfilled other criteria set by a HIC. These benefits were originally used as a marketing tool to differentiate among the three HICs, but eventually became a standard of care. However, since this standard cost more than €60 million per year and was using up resources aimed at other types of care, MZ SR forced HICs to reduce them by half in April 2024 (Mihoková, 2024).

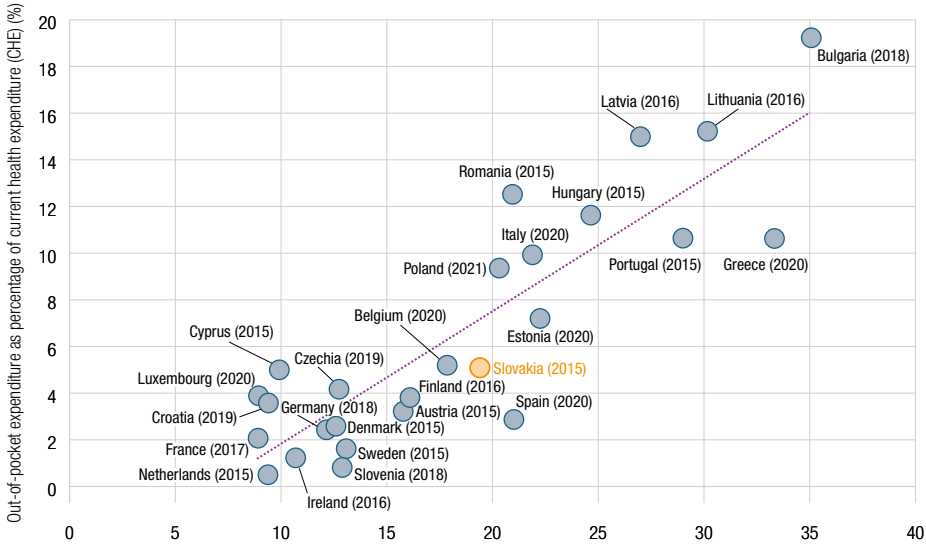
TABLE 7.4 Unmet need for medical and dental examination due to financial reasons for selected quintiles and years (%)

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Percentage of unmet needs for medical services due to financial reasons, 2013–2023											
Total	0.8	0.9	0.7	0.8	0.7	0.6	0.6	0.8	0.4	0.4	0.5
First quintile	2.2	2.6	1.7	1.7	1.7	1.1	1.4	2.1	0.7	1.2	0.7
Fifth quintile	0.2	0.4	0.2	0.1	0.1	0.0	0.2	0.3	0.3	0.0	0.5
Percentage of unmet needs for dental services due to financial reasons											
Total	1.9	2.0	1.9	1.7	1.4	1.6	1.6	1.9	0.9	1.1	1.5
First quintile	4.2	5.8	5.0	4.8	3.3	3.3	3.6	5.3	2.6	2.7	2.8
Fifth quintile	0.6	1.0	0.4	0.2	0.2	0.7	0.5	0.2	0.2	0.3	0.9

Source: Eurostat, 2024e.

The proportion of total households that experienced catastrophic health spending in Slovakia was 5.1% in 2015, the latest year available (see Fig. 7.12). Because developments in the 2021 protection limits improved financial protection for the lowest income groups, the estimate is that this percentage would be even lower in 2022 or 2023 (ÚDZS, 2023c). In 2022, 2.5% of overall household spending was on health according to Eurostat (2024e), lower than the EU average of 4.5% and the lowest among the V4 countries.

FIGURE 7.12 Share of households that experienced catastrophic health spending and OOP spending as a % of CHE, latest year for all countries with data available



Sources: WHO Regional Office for Europe, 2024a, for data on catastrophic incidence; WHO, 2024, for data on OOP payments.

7.4 Health care quality

The framework for measuring quality is anchored in Act no. 581/2004, which delegated responsibilities for measuring and evaluating quality to HICs by allowing them to contract providers based on price and quality. In practice, however, quality-based contracting has not happened. The reasons for this include:

1. the decree defining quality indicators was only issued in 2009 and corrected to a workable form in 2013. Until then, neither insurers nor MZ SR systematically measured and published quality results.
2. HICs' data are not combined into a single overview, with the exception of an initiative by one NGO, the INEKO Institute[13], even though the decree defined a full spectrum of medical and economic indicators for inpatient and outpatient care.

The quality of the data outputs from the indicators is also questionable. Since HICs have never selectively contracted providers based on quality indicators and no single IT platform has been created for public use, several indicators have been reported pro-forma. An illustration of this is the rate of nosocomial infections, where, according to the latest pre-COVID data (2019), Slovakia had only a 0.8% annual incidence rate (that is, 13 995 cases) (EPIS, 2020). This is significantly less than the WHO average (7–8%) or that of the world's best clinics (3–4%), due to the fact that Slovak hospitals simply do not measure and report this (Eliáš, 2018).

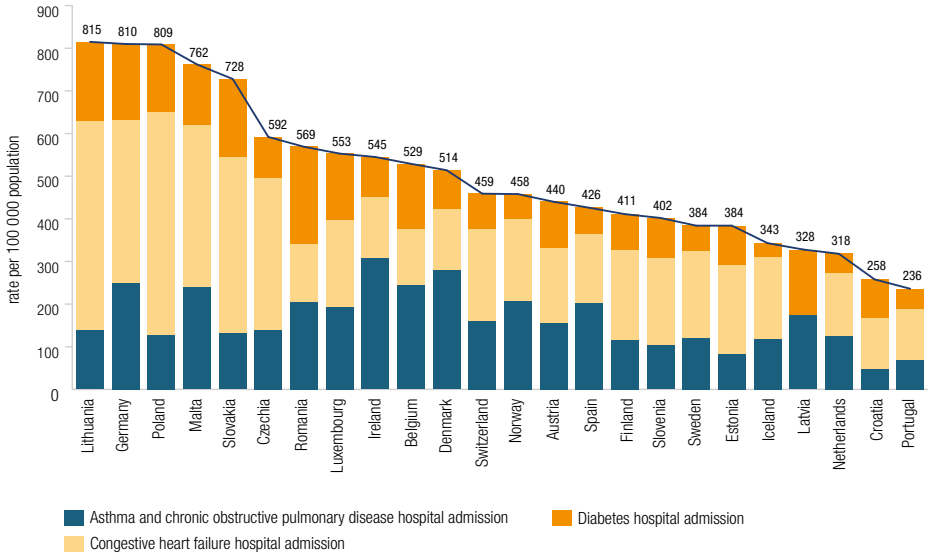
The situation with quality indicators is set to change with the hospital network reform, at least for inpatient care, which has defined a new set of indicators under Decree no. 531/2023. However, the decree still lacks methodological guidelines, despite being updated in January 2025 (Decree no. 435/2024), and is therefore not expected to be fully deployed until 2026 at the earliest. Bearing in mind the limitations of the data, measuring (and being able to assess) the quality of preventive and acute care remains underdeveloped.

13 INEKO's portal launched in 2014, reporting all relevant information in a unified system; to date it primarily ranks hospital care on an annual basis.

Primary and outpatient care

Among selected countries, Slovakia ranked fifth-highest for avoidable hospital admissions for asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes-related complications, just behind Lithuania, Germany, Poland and Malta, with 728 avoidable hospitalizations per 100 000 inhabitants (see Fig. 7.13). In 2023 Slovakia had comparatively fewer avoidable hospitalizations for asthma (131.3 per 100 000, that is, the 10th lowest among selected countries). In contrast, Slovakia had 413.9 per 100 000 avoidable hospitalizations for CHF (the third highest among countries reporting data) and 182.8 per 100 000 for diabetes (also the third highest).

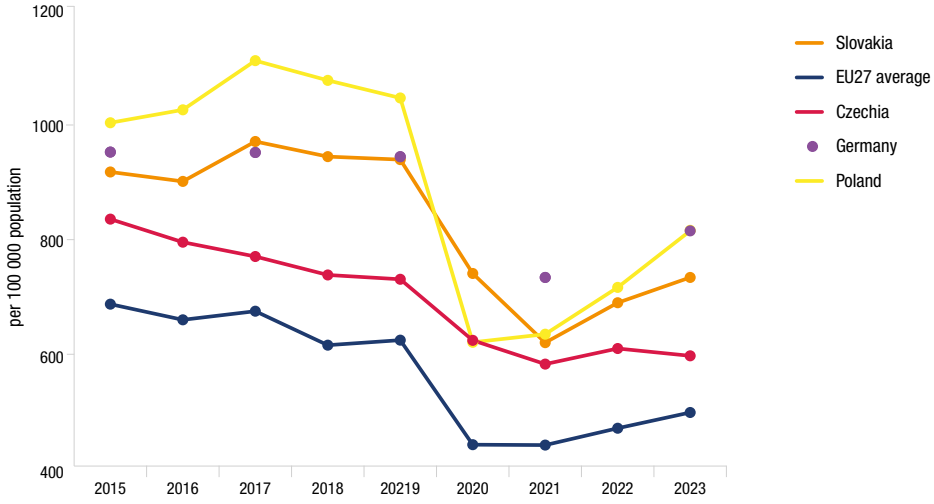
FIGURE 7.13 Avoidable hospital admission rates for asthma, COPD, CHF and diabetes-related complications, selected countries, 2023 or latest available data



Source: OECD, 2025.

The rate of avoidable hospital admissions in Slovakia seems to be declining over the long term, falling by around 20% over the last eight years, from 911 admissions per 100 000 inhabitants in 2015 to 728 in 2023, though this period also covers the outbreak of the COVID-19 pandemic when all hospital admissions reduced considerably (see Fig. 7.14).

FIGURE 7.14 Avoidable hospital admission rates for asthma, COPD, CHF and diabetes-related complications, selected countries, 2015–2023 or latest available data



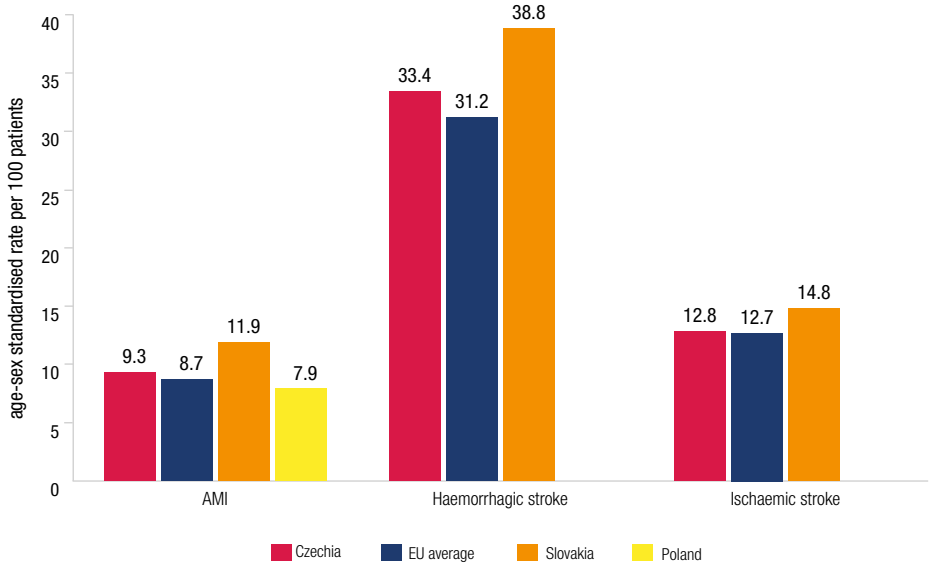
Source: OECD, 2025.

Inpatient care

Slovakia's ratio of in-hospital mortality following admission for acute myocardial infarction (AMI), ischaemic stroke and haemorrhagic stroke are among the highest in the EU and V4 countries – 11.9, 14.8 and 38.8 per 100 patients aged 45 years and older, respectively (see Fig. 7.15). Pre-pandemic data show that case fatality rates were on a slight, but stable decline, primarily due to the introduction of disease-specific treatment guidelines, IT systems connecting emergency departments and ambulances, and investment into the emergency care infrastructure of hospitals going back to 2016 (MZ SR, 2018b, 2020).

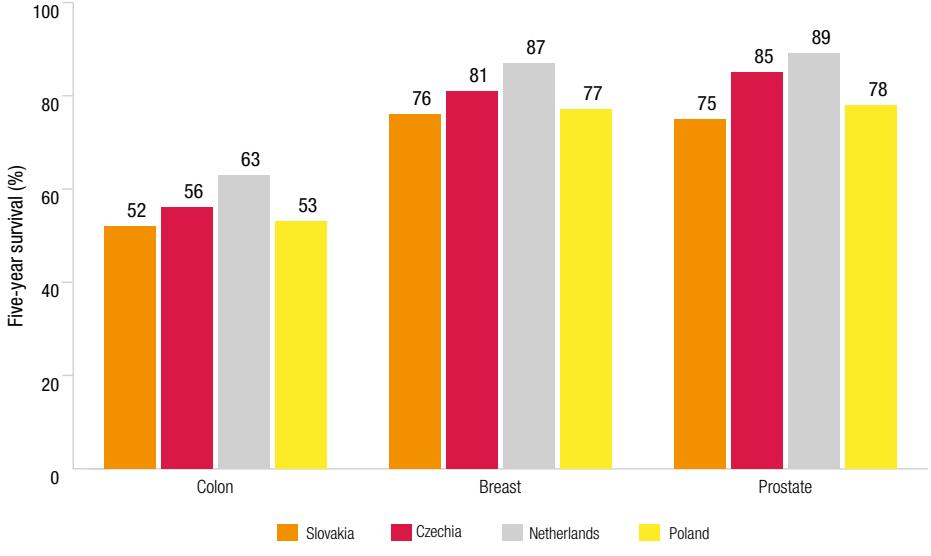
In terms of cancer treatment, and according to the latest available data for Slovakia (2010–2014), the five-year survival rate was below the EU average, as well as that of other V4 countries (see Fig. 7.16). Since the rate of preventive examinations and the availability of cancer treatment medicines have been limited for a long time, it is not expected that current survival rates would be significantly better than those presented in the historical data. According to the AIFP study (2025), as of January 2025 Slovakia had only 36% of innovative cancer treatments available (approved by the EMA since 2015). This is a significant jump from the spring 2022 level of 18%, which is related to the amendment of the Medicines Act in summer 2022 (AIFP, 2022); see Section 6.1).

FIGURE 7.15 In-hospital mortality rates (deaths within 30 days of admission) for admissions following AMI, haemorrhagic stroke and ischaemic stroke, selected countries with linked data, 2023 or latest available data



Source: OECD, 2025.

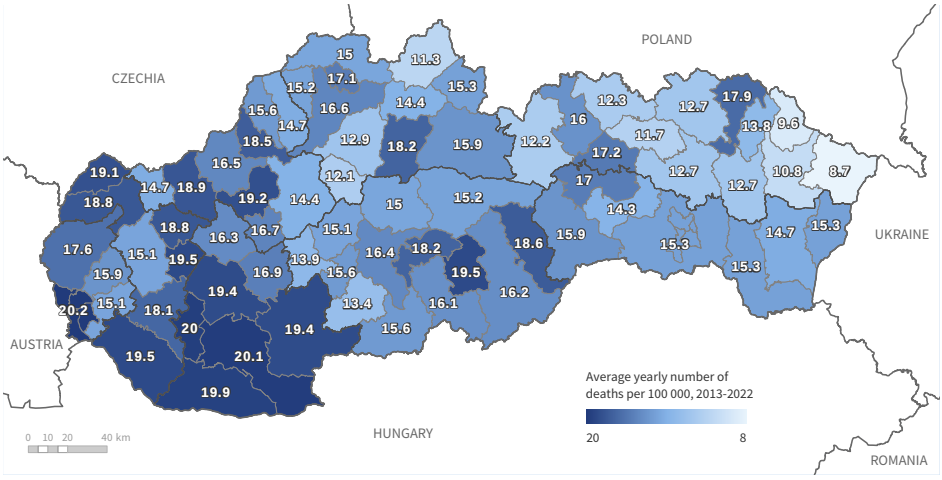
FIGURE 7.16 Five-year survival rates for colon, breast (among women) and prostate (among men) cancer in 2010-2014



Source: Allemani, 2018.

Furthermore, there are considerable regional differences in cancer health outcomes. According to the latest MZ SR study (Berta et al., 2024), there is considerable variation in the mortality of women with, for example, breast cancer. Although changes in mortality rates are influenced by several factors (changes in the health status of the population, health services or professional and administrative factors), the data also reflect to some extent the quality of health care and treatment outcomes for patients living in different regions of Slovakia, as shown in Fig. 7.17. These studies are, however, not available for all diseases, although Berta et al. (2024) conclude that similar results are expected for most oncological diseases in Slovakia.

FIGURE 7.17 Age-standardized mortality rate for breast cancer per 100 000 women by districts in Slovakia, 2013–2022



Source: produced by WHO GIS, data from Berta et al., 2024.

The use of patient-reported outcome measures (PROMs) is uncommon in Slovakia, though most hospitals have their own internal quality of care/satisfaction questionnaire system. As part of Decree no. 435/2024 (MZ SR, 2024g), uniform PROMs will start to be introduced in practice during 2025, although full deployment is expected at the earliest during 2026.

7.4.1 *User experience*

Slovakia does not have a universal health service user experience questionnaire. Legislation from 2004 (Section 7 of Act no. 581/2004, related Regulation no 752/2004 and methodological guidelines from 2013) define a list of quality indicators that HICs must measure. User experience is among them, but only in inpatient health care and via a subjective questionnaire consisting of 12 questions that each HIC collects differently (for example, via anonymous unsecured internet surveys, sending questionnaires by post, electronically, or telephone enquiries (INEKO, 2023; VšZP, 2023). MZ SR does not collect and evaluate these questionnaires for individual providers. This is done by NGOs such as INEKO (INEKO, 2023).

In 2019, as part of the analytical preparatory work for the recent hospital reform, MZ SR planned to collect data based on OECD patient reported experience measures questionnaires, and a pilot project to collect data from selected providers was implemented. However, following the change of government in 2020 and the onset of the COVID-19 pandemic, the project was halted and only restarted in 2022 (Decree 316/2022 and its updates nos 531/2023 and 435/2024). The decree defines the content of the hospital reform, including all the quality and satisfaction indicators. User satisfaction is planned to be measured from 2026, but only for inpatient health care.

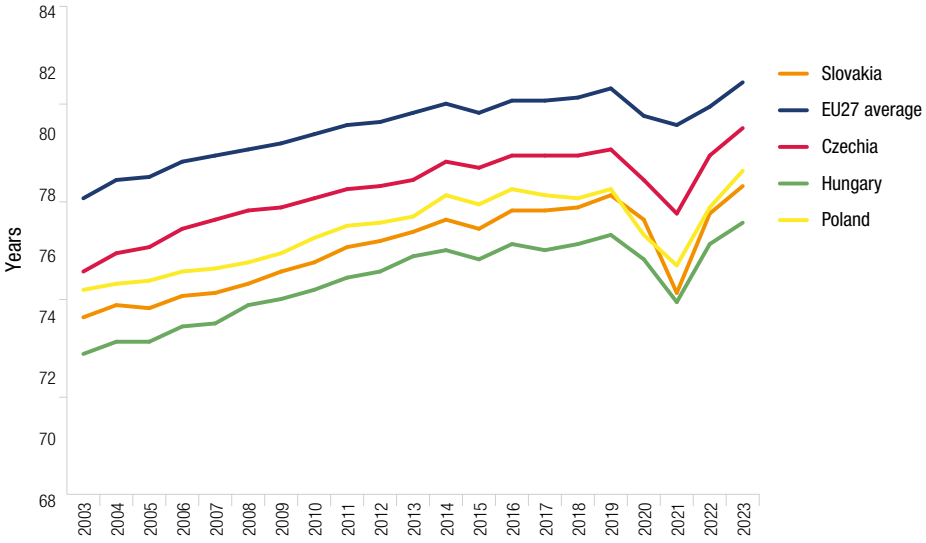
Although there is no universal questionnaire, polling agencies regularly conduct surveys of the population's views on health care. According to AKO (an NGO in Slovakia), in 2022 nearly half of respondents thought that health care was not a priority for the State. Just over 50% of respondents also said that one of the main problems was lack of funding for health care as a whole, and 36% perceived a lack of modern diagnostics and treatments. Almost half of Slovaks also considered the level of the health system to be the worst in the V4 countries (TASR, 2022b).

7.5 Health system outcomes

Although life expectancy has improved in Slovakia over the last twenty years at a faster rate than the EU average (4.6 years in Slovakia compared to the

EU average of 3.8 years), it is still the second lowest in the V4 countries and lags behind the EU average by 3.4 years (see Fig. 7.18).

FIGURE 7.18 Life expectancy at birth, selected countries, 2003–2023



Source: Eurostat, 2024e.

There are significant disparities in most health outcome indicators based on place of residence, educational attainment or income (see Table 7.5). Disparities are particularly large for the Roma population, which is the largest ethnic minority in Slovakia (up to 440 000 inhabitants according to the 2019 Atlas of Roma Communities) (Government Office of the Slovak Republic, 2020).

Looking at socioeconomic groups, the difference in life expectancy between the population living in marginalized Roma communities (MRCs), where households are receiving material hardship benefits, and the population living outside these communities and not receiving social assistance was around nine years, according to a study by the Ministry of Finance, using data from 2015 (see Table 7.6).

There are similar disparities in other health indicators for MRCs. The most striking are for infant mortality (Fig. 7.19). The average infant mortality rate per 1000 live births was 4.6 in 2006–2015 in non-MRC areas, while some MRC areas experienced up to 12.3 deaths per 1000 live births.

TABLE 7.5 Selected health indicators in each of the SGRs, 2022

	LIFE EXPECTANCY AT BIRTH, MALES	LIFE EXPECTANCY AT BIRTH, FEMALES	MORTALITY RATE PER 1 000	INFANT MORTALITY PER 1 000 LIVE BIRTHS	NUMBER OF HOSPITALIZATIONS PER 1 000	TB CASES PER 100 000	NEW CASES OF DIABETES (BOTH TYPES) PER 100 000	NEWLY DIAGNOSED PERSONS WITH PSYCHIATRIC DISEASES PER 10 000
Slovakia	**73.6**	**80.3**	**11.0**	**5.4**	**183.6**	**2.9**	**476.1**	**123.7**
Bratislava	75.2	81.3	9.6	2.5	148.0	2.5	493.7	147.8
Trnava	73.2	79.9	11.3	2.8	161.3	1.2	332.8	82.0
Trenčín	73.3	80.0	12.0	2.6	195.2	1.4	387.8	119.4
Nitra	72.0	79.4	12.5	4.1	169.0	1.0	767.3	86.8
Žilina	74.2	80.2	10.6	2.7	216.3	1.5	303.0	97.7
Banská Bystrica	72.0	79.1	12.1	4.4	182.1	2.7	568.3	78.0
Prešov	72.6	79.5	9.6	10.6	201.8	6.2	414.8	109.9
Košice	71.9	78.6	10.7	8.7	190.5	4.9	521.2	200.2

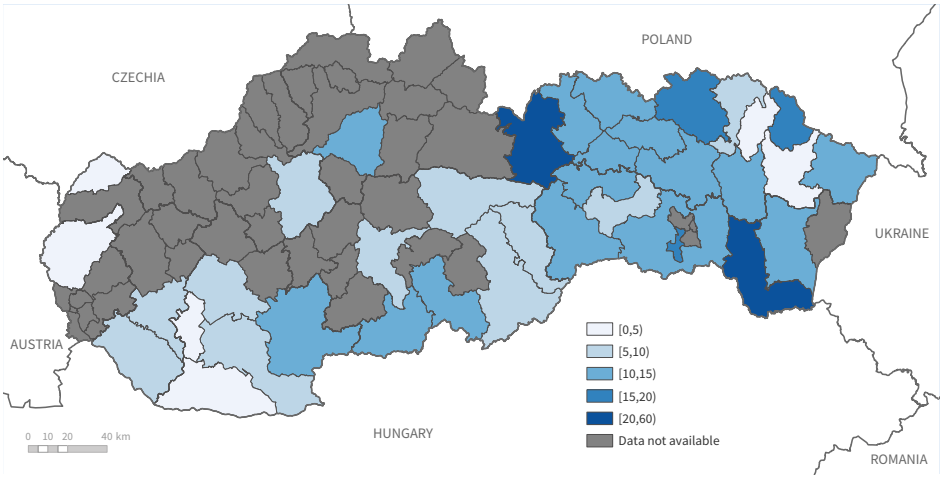
Source: NCZI, 2023c.

TABLE 7.6 Life expectancy at birth, 2015, selected population groups

	MRCS	REST OF POPULATION	TOTAL
People with benefits for material hardship	67.7	69.7	69.3
Rest of population	70.3	76.7	76.5
Total	**69.6**	**76.4**	**76.0**

Source: Ministry of Finance, 2020.

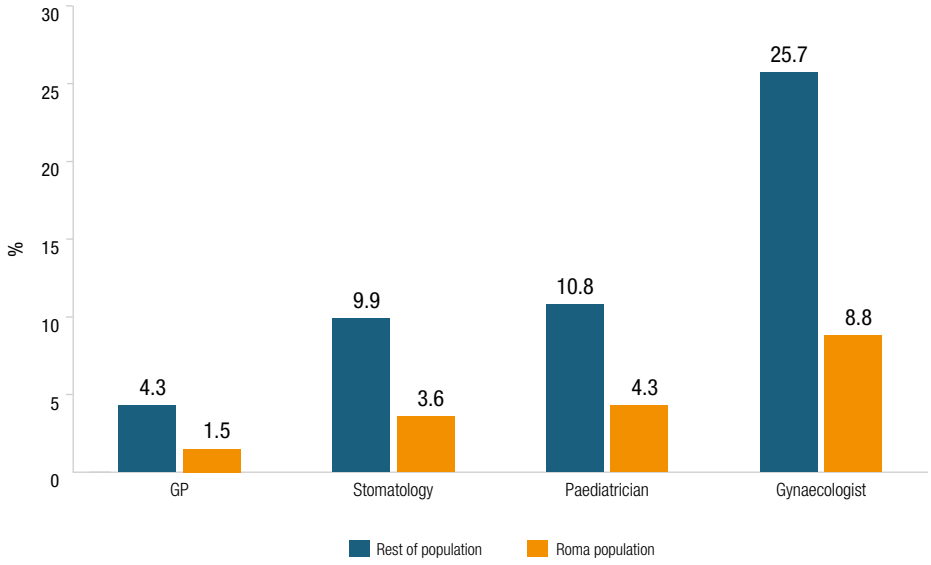
FIGURE 7.19 Infant mortality in MRCs in Slovakia, per 1000 live births, average of 2006– 2015



Source: produced by WHO GIS, data from Ministry of Finance, 2020.

There are many reasons why MRCs lag behind the rest of the population. Apart from financial resources, physical accessibility to health services is also a big problem. While 8% of the population outside MRC areas have access to a gynaecologist's clinic only 10 km or more away, this was as high as 25% for the MRCs in 2019 (see Fig. 7.20).

FIGURE 7.20 Share of the population living 10 km or more from the nearest medical outpatient clinic (%), 2019



Source: Ministry of Finance, 2020.

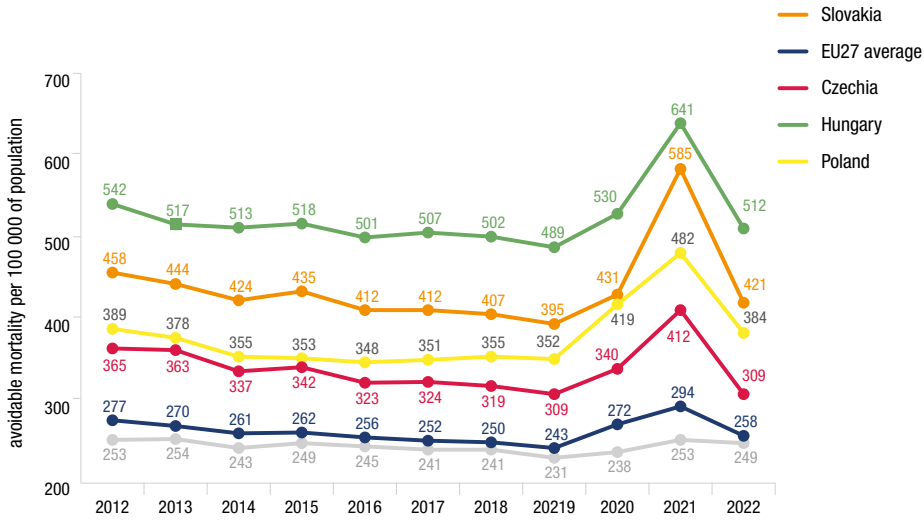
COVID-19 had a significant impact on health outcomes. Average life expectancy in Slovakia experienced a significant decline of just over three years between 2019 and 2021, the highest in the V4 and almost three times the EU average, though it did rebound in 2022, as in other EU countries.

Barančok et al. (2024) found that during the first three waves of the pandemic, Slovakia experienced 31 789 more deaths than the national standard between 2020 and 2022. These excess deaths were among the highest in the EU as a proportion of the population. According to the authors of another study, these excess deaths were largely avoidable: based on a number of different scenarios comparing Slovakia's pandemic response policies to those of other countries, it is estimated that the number of excess deaths between March 2020 and February 2022 could have been reduced by between 3500 and 21 000 (Pažitný et al., 2022).

Beyond COVID-19, Slovakia performs poorly in composite indicators such as avoidable mortality, which measures how many premature deaths in those aged 75 years and under could have been prevented if the country had appropriate preventive care (preventable mortality) or effective and quality health care (treatable mortality). Slovakia totalled 421 avoidable

deaths per 100 000 in 2022, the sixth highest rate in the EU and the second highest among V4 countries (see Fig. 7.21). Deaths related to COVID-19 accounted for 4.9% of avoidable deaths in 2022, a significant drop compared to nearly 25.5% of avoidable deaths in 2021. The largest cause of avoidable deaths in Slovakia in 2022 were ischaemic heart diseases (22.7%), followed by alcohol-specific disorders and poisonings (8.5%) and cerebrovascular diseases (7.8%). Although Slovakia has historically performed poorly in this indicator, the rate of avoidable deaths had been gradually improving until the onset of the COVID-19 pandemic: between 2012 and 2019 the total rate of avoidable mortality declined by 14%. However, in 2021, due to the impact of the COVID-19 pandemic, the number of deaths was 28% higher than in 2012, but, as seen in Fig. 7.21, the rate returned to roughly pre-COVID levels in 2022.

FIGURE 7.21 Development of avoidable mortality, selected countries, 2012–2022



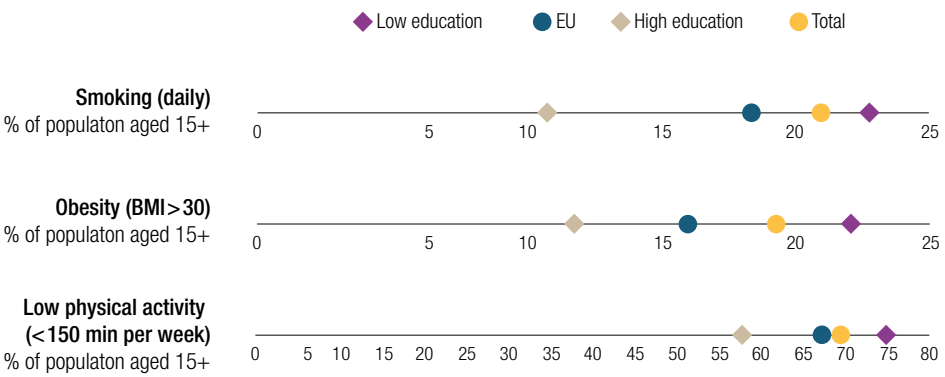
Note: avoidable mortality rates are derived by combining the rates for preventable mortality and treatable mortality.

Source: Eurostat, 2024e.

Prevalence of behavioural factors, such as smoking, with noted disparities among population groups, is also a concern. Smoking rates are almost twice as high among people with lower education, compared to those who have reached a high education level (21% vs 11%) (see Fig. 7.22). The obesity rate is also much higher among people with lower (22%) than higher

(12%) education levels (OECD/European Observatory on Health Systems and Policies, 2023). In 2023 Slovakia updated nicotine control legislation to ban the sale of new nicotine products and consumption by people under 18. In 2025 a ban was proposed on the sale of disposable e-cigarettes and most flavours for e-cigarettes. There are also plans to increase excise taxes on tobacco, alcohol products, sweetened beverages and other unhealthy products (Zemko, 2023; MZ SR, 2025e).

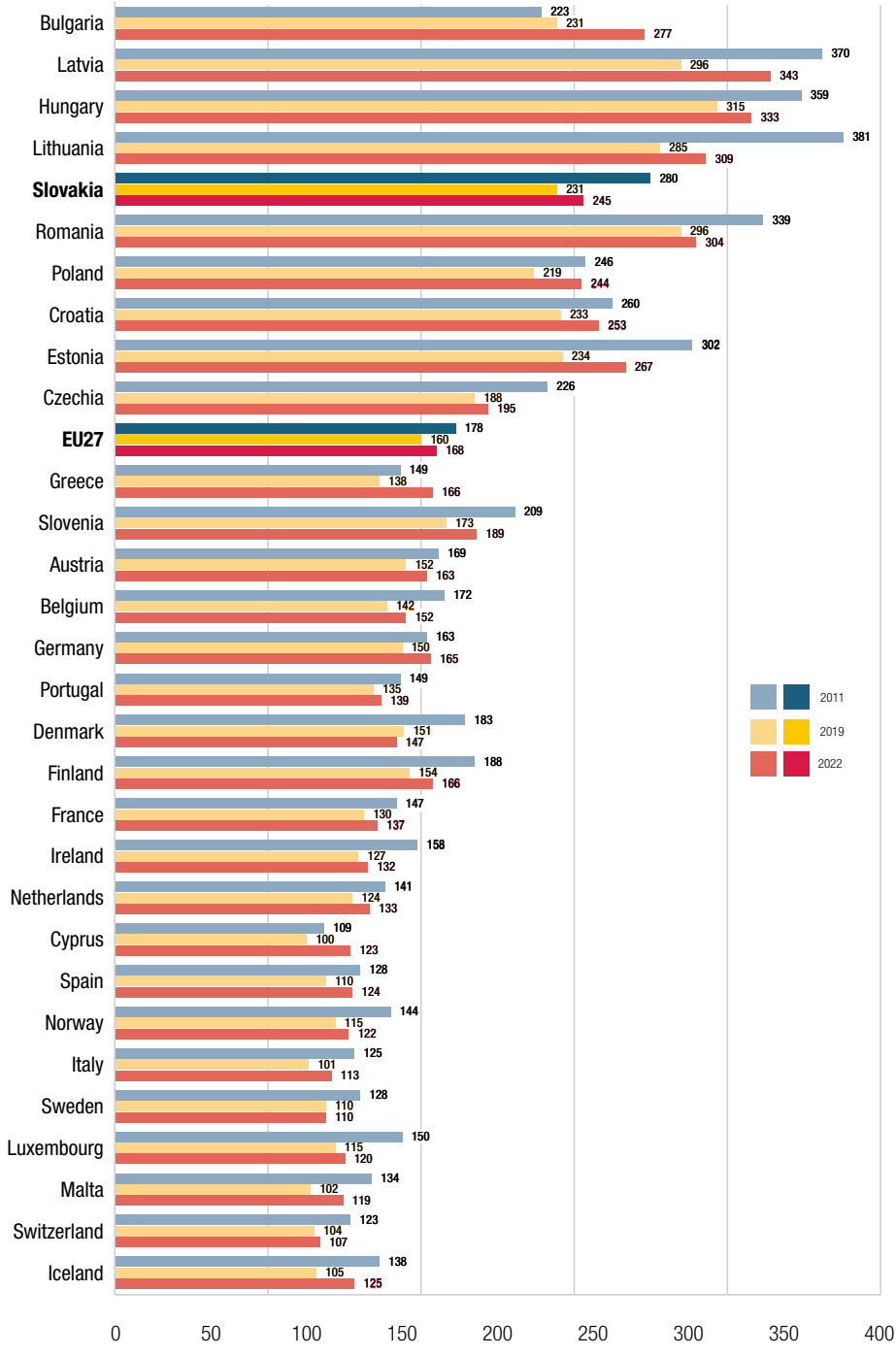
FIGURE 7.22 Behavioural risk factors by level of education in Slovakia, 2021 or latest available data



Source: OECD/European Observatory on Health Systems and Policies, 2023.

Although Slovakia achieved a 12.5% decrease in the single indicator of preventable mortality between 2011 and 2022 (and 17.5%, if looking at rates between 2019 and 2022, see Fig. 7.23), it lags behind in key determinants of health and activities that influence preventable mortality. For example, Slovakia allocated only 2.0% of health expenditure to prevention activities in 2022, at only €40 per capita (PPP), the second lowest among the V4 countries (Poland spent €36, Hungary €55 and Czechia €144).

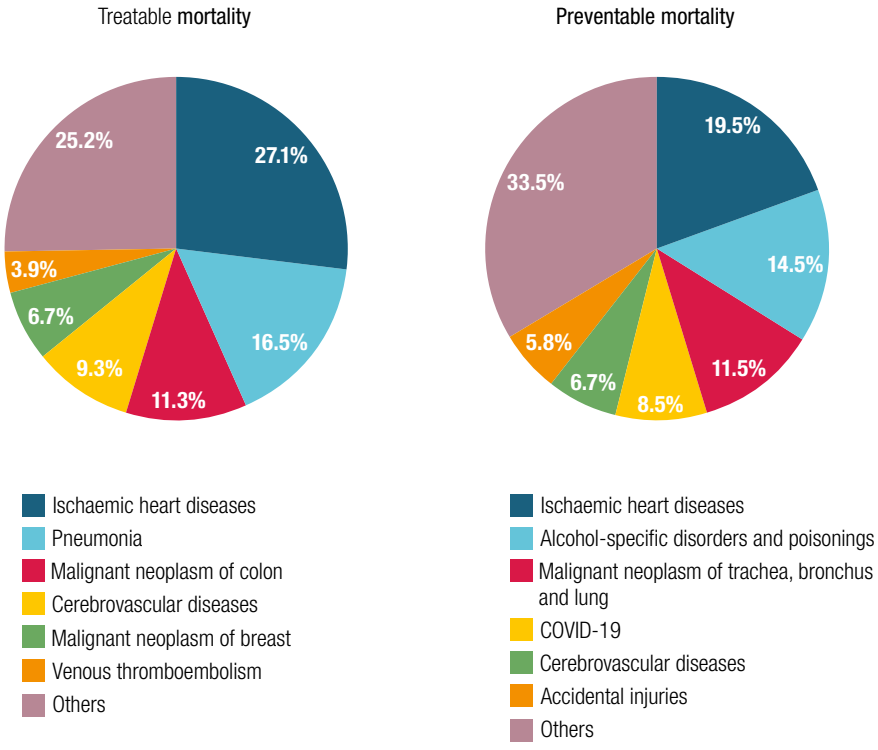
FIGURE 7.23 Preventable mortality rates per 100 000 population in Slovakia, the EU and selected countries, 2011, 2021 and 2022



Source: Eurostat, 2024e.

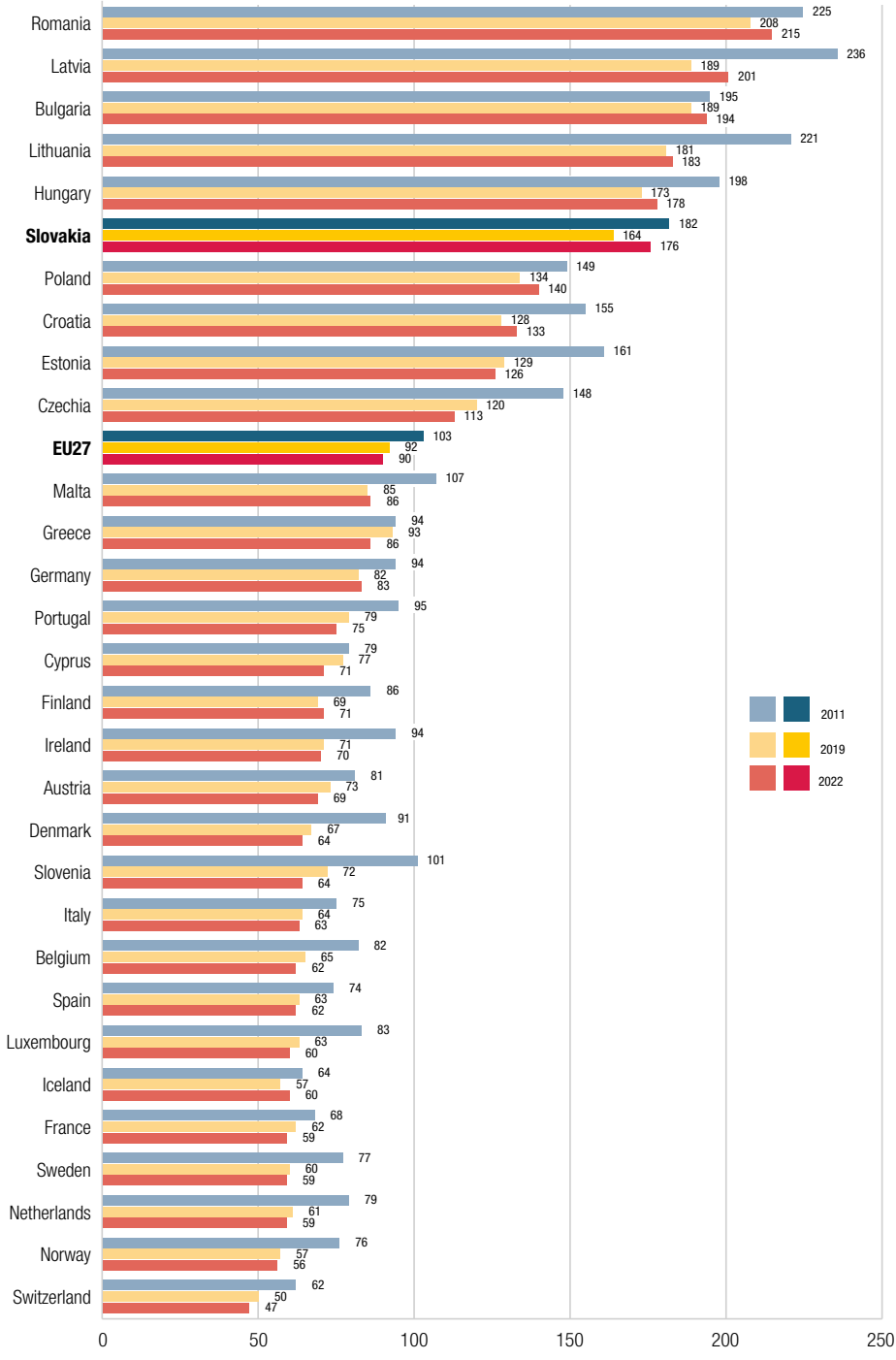
With regard to mortality from treatable causes, the leading causes of treatable mortality in 2022 were ischaemic heart diseases (27%), pneumonia (16.5%), colorectal cancer (11%) and cerebrovascular diseases (9.3%) (see Fig. 7.24). Slovakia's higher rate of treatable mortality compared to the EU average is due to several factors, including the population disease profile, but also that Slovakia has long had low availability of innovative medicines as well as insufficient infrastructure and resources. The rate of deaths per 100 000 from treatable causes in 2022 was nearly double that of the EU average (see Fig. 7.25). However, even before 2020 Slovakia recorded nearly 78% more treatable deaths per 100 000 than the EU average, although overall the trend since 2011 had been steadily improving.

FIGURE 7.24 Causes of treatable (left) and preventable (right) deaths, Slovakia, 2022



Source: Eurostat, 2024e.

FIGURE 7.25 Treatable mortality rates per 100 000 population in Slovakia, the EU and selected countries, 2011, 2021 and 2022



Source: Eurostat, 2024e.

7.6 Health system efficiency

Since 2016 the efficiency of the Slovak health system has been regularly monitored through HSRs (see Section 7.1). HSRs analyse health expenditure in detail and recommend measures based on specific benchmarks. Some of these measures are annually tied to the budget, creating pressure for their implementation in practice. According to the HSR published in September 2022 (Ministry of Finance, 2022), the total potential for improving financial efficiency in the Slovak health system amounts to €426 million, which equates to approximately 7% of 2022 spending (see Table 7.7 and Section 7.6.1). However, a number of measures in HSRs require the implementation of reforms or many years of intensive work, such as the transfer of competences, reforms of the ambulance service or reducing the number of visits to outpatient clinics.

For this reason, each year the Ministries of Finance and Health agree on measures they will include as savings measures in the budget. In practice, however, the success of their implementation varies. The first three years of HSRs (2016–2019) achieved average savings of 70% of the planned savings in the HSR (that is, €103–121 million per year), primarily from reductions in price units and consumption of medicines and devices, MRI and CT unit prices, and targeting overconsumption of certain services (Implementation Unit, 2021). The 2020–2022 HSRs were hardly implemented at all, owing to the change of government and the COVID-19 pandemic. The 2022 HSR included only those measures that could not be eliminated. Despite this, its primary focus for improving efficiency is medicines (41% of potential savings), followed by reducing outpatient visits (20%).

TABLE 7.7 HSR 2022, summary table of potential savings

PRICE (REDUCTIONS) EXPRESSED IN MILLIONS OF EUROS	2023	2024	2025	POTENTIAL
Total potential savings	**-127**	**-241**	**-309**	**-426**
Measures taken by VšZP, a.s.	**-40**	-75	-75	-75
• VšZP, a.s. – optimization of prices for health care services	**-34**	-67	-67	-67
• VšZP, a.s. – central purchase of medicines	**-6**	-8	-8	-8
Inpatient care	**-2**	-3	-5	-13
• Reduction of the number of avoidable hospital admissions to the V3 level	**-2**	-3	-5	-13

PRICE (REDUCTIONS) EXPRESSED IN MILLIONS OF EUROS	2023	2024	2025	POTENTIAL
Outpatient care	**-0.2**	-0.5	-0.7	-87
• Reduction in the number of visits	**0**	0	0	-86
• Obstetrics – fewer pregnancy examinations	**-0.2**	-0.5	-0.7	-1
Medicines	**-67**	-126	-175	-175
• International comparisons of medicine prices twice a year	**-5**	-7	-8	-8
• Cost-effectiveness of medicines (excluding orphans)	**-10**	-20	-25	-25
• Cost-effectiveness of included orphans	**-2**	-7	-10	-10
• Promoting the entry of generics and biosimilars	**-23**	-46	-69	-69
• Exempt medicines	**-14**	-25	-35	-35
• Active enforcement of the equivalence gap	**-11**	-11	-11	-11
• Overconsumption of medicines (antibiotics)	**0**	-2	-3	-3
• Overconsumption of medicines (other medicines excluding antibiotics)	**0**	-2	-5	-5
• eHealth – improving prescribing	**-1**	-3	-4	-4
• Review activity (interactions, duplicate prescribing, etc.)	**-1**	-3	-5	-5
Diagnostic services	**-14**	-27	-39	-39
• Imaging services – price referencing of procedures with foreign countries	**-5**	-8	-11	-11
• Imaging services – redundant examinations	**-5**	-11	-16	-16
• Laboratory tests – reimbursement	**-3**	-7	-10	-10
• Reduction in the price of PCR tests	**0**	-2	-2	-2
Medical devices	**-5**	-9	-13	-13
• Incontinence devices – health and social care department	**-3**	-5	-8	-8
• Medical devices – extension of international price comparison	**-0.4**	-0.4	-0.4	-0.4
• Medical devices – optimizing prescribing	**-2**	-3	-5	-5
Emergency Medical Service	**0**	0	0	-23
• Optimization of staffing norms	**0**	0	0	-23

Note: a.s. is the Slovak abbreviation for joint-stock company.

Source: Ministry of Finance, 2022.

Other ways of monitoring efficiency, such as macroeconomic international comparisons, are not regularly carried out by relevant ministries. The last such analysis was published in 2012 (Filko, Mach & Zajíček, 2012) and since then they have only been replaced, to some extent, by NGOs or third sector organizations such as INEKO (Zachar, 2013) or Pažitný et al. (2023).

7.6.1 *Allocative efficiency*

Allocative efficiency deals with the efficiency of resource use between different types of health care. Despite several years of HSR implementation, the macro-outlook of the Slovak health system indicates serious deficits in allocative efficiency. In view of the limitations of data reporting, and the fact that Slovak health expenditure is among the lowest in the EU and spending is skewed:

1. Only 2% of financing went to preventive care in 2022, which was the third lowest EU percentage after Malta and Poland (and the second lowest in the EU as a whole when calculated on a per capita basis, after Poland). Low spending on prevention is a contributing factor to why Slovakia has a high rate of preventable deaths, as well as stagnating results on addressing key determinants of health, such as tobacco and alcohol use, and sugar consumption.
2. Slovakia had the lowest share of spending on rehabilitation care among V4 countries in 2022. Only 1.46% of all resources goes to rehabilitation, which is 2 times lower than Hungary, 3.5 times lower than Czechia and 3.2 times lower than Poland (see Table 7.8).
3. Slovakia spends disproportionately more on medicines and other medical supplies (that is, 29.1% of financing). This share represented the third-highest value in the EU in 2022, but its interpretation is necessary within the limits of data reporting. That is, recalculating this spending into EUR PPP per capita, Slovakia spent €566 per person in 2022, which was below the EU average, but more than the other V4 countries. However, the reporting of medicine and medical supply spending data is unclear in Slovakia, and it is suspected that, primarily in the medical devices group, a large part of the expenditure belonging to inpatient care is reported in this category. This is also why spending on medicines alone is even lower than the EU average (€414 per capita vs €500 per capita) and also lower per capita than Hungary.

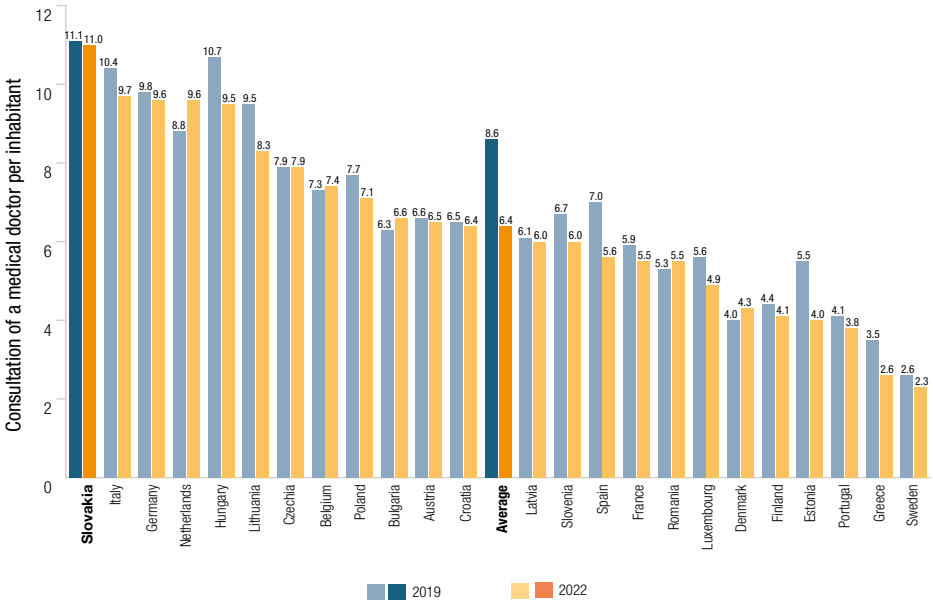
TABLE 7.8 Selected categories of health care spending as a percentage of CHE in the V4 countries, 2022

	CURATIVE CARE	OUT OF WHICH INPATIENT CURATIVE CARE	OUT OF WHICH OUTPATIENT CURATIVE CARE	REHABILITATIVE CARE	LTC (HEALTH)	ANCILLARY SERVICES (NON-SPECIFIED BY FUNCTION)	MEDICAL GOODS (NON-SPECIFIED BY FUNCTION)	PHARMACEUTICALS AND OTHER MEDICAL NON-DURABLE GOODS	PREVENTIVE CARE	GOVERNANCE AND HEALTH SYSTEM AND FINANCING ADMINISTRATION
Czechia	53.12	**26.12**	**25.63**	5.12	12.71	4.82	16.13	**13.92**	5.21	1.99
Hungary	55.25	**29.05**	**23.52**	2.99	3.98	5.82	25.09	**22.39**	2.9	3.66
Poland	60.06	**32.42**	**24.98**	4.71	8.14	4.39	19.04	**17.37**	1.90	0.98
Slovakia	51.24	**28.51**	**22.46**	1.46	0.40	8.65	29.09	**21.26**	2.04	7.11

Source: Eurostat, 2024e.

The Slovak health system has several other areas that raise questions about its allocative efficiency, primarily regarding the number of outpatient visits and their structure. Slovakia has long had the highest number of visits to a doctor per person in the EU, as shown in Fig. 7.26. This high number is due to several factors, such as an insufficient catalogue of outpatient clinic procedures and poorly set competences between GPs and specialists. Additionally, a general shortage of doctors causes the patient to be "rotated" across specialists because they do not have enough time to see them. The COVID-19 pandemic had a significant impact on these figures, with a 22% drop in visits across the EU between 2019 and 2020 to 5.8 visits per year. Slovakia has also seen a decline in visits, but only by 9% to 10.1 in 2020, and recorded a return to pre-pandemic numbers in 2021 and 2022, with a value of 11.0 visits per person in 2022.

FIGURE 7.26 Number of doctor consultations per capita, 2019 and 2022



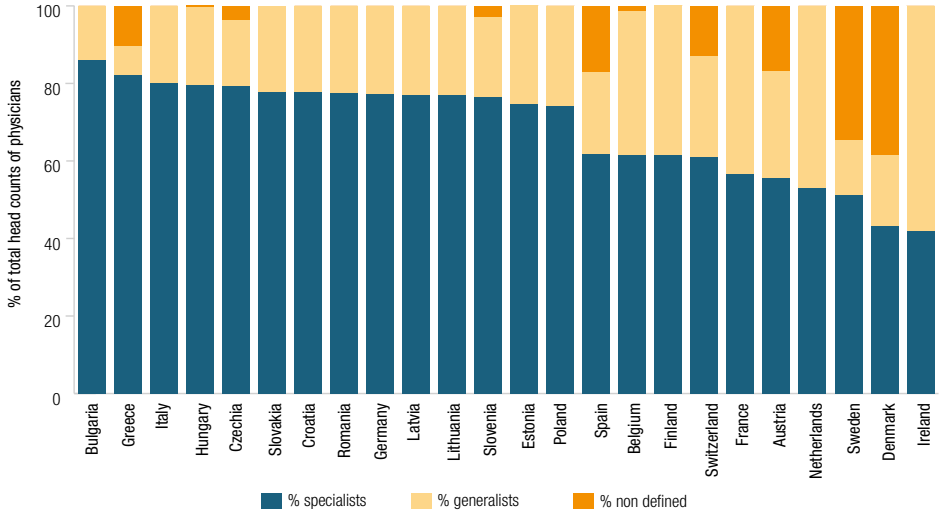
Note: data for Slovakia, Austria and Latvia for 2022 are preliminary estimates.
Source: Eurostat, 2024e.

This challenge is not limited to the high number of outpatient visits, but also concerns their structure. According to a 2019 study by the Ministry of

Finance (Ministry of Finance, 2019), Slovakia had 17.6 million more visits to specialists (that is, 3.2 more per capita) compared to the average of other V4 countries, and at the same time 5.6 million fewer visits to primary care physicians (that is, 1 less per capita).

This disproportion caused an inefficiency in resource allocation of €207 million (in 2018 output prices) and stems from the fact that Slovakia has too few first-contact physicians compared to specialists and GPs cannot properly fulfil their gate-keeping function (see Fig. 7.27).

FIGURE 7.27 Proportion of generalist vs specialist doctors, OECD countries, 2021 or latest available data*



Note: *Slovakia does not report this data to OECD; the calculation is based on Ministry of Finance, 2016b, based on 2018 data according to OECD methodology.

Source: OECD, 2023b.

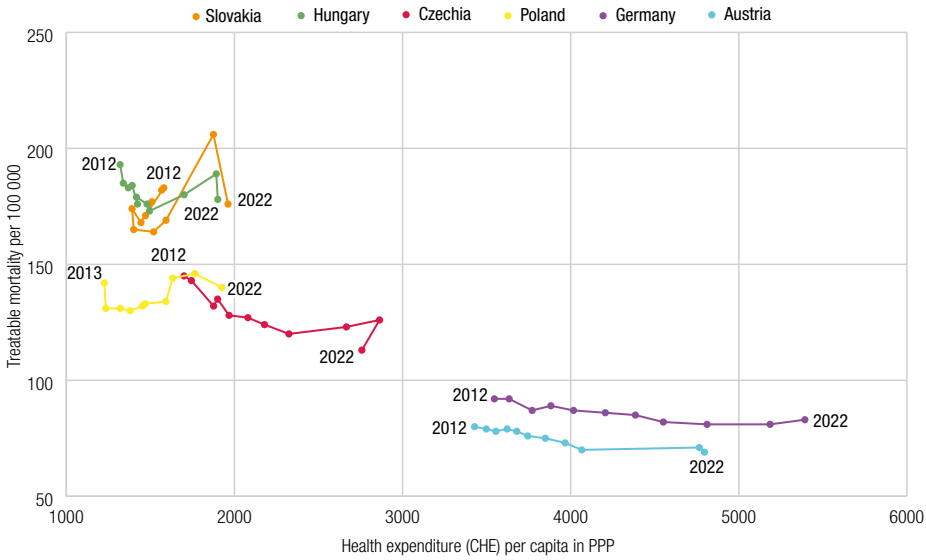
Another source of allocative efficiency in systems with several insurers can stem from unfair distribution to individual funds if the risk-adjustment system is not working properly or if it has low predictive ability. As described in Section 3.3.3, Slovakia's redistribution mechanism suffered from unfair distributions among HICs; however, after amendments between 2010 and 2020 the risk-adjustment scheme in Slovakia has an estimated predictive ability around 29% (GUPTA, 2018; ÚDZS, 2023c) and is regarded as fairly strong.

7.6.2 *Technical efficiency*

Technical efficiency deals with the relationship between the resources used in the sector and the output results of production. One cursory illustration of the health system's performance in terms of input costs and outcomes can be obtained by plotting CHE against the treatable mortality rate (see Fig. 7.28).

Even though the steady improvement in technical efficiency was interrupted by an increase in treatable mortality associated with the COVID-19 pandemic, Slovakia's technical efficiency had been gradually improving, and, unlike in other countries, the improvement had been accompanied by a lower increase in CHE per capita. This indicates that HSRs have gradually achieved their objective, to improve efficiency based on the realization of internal savings. Despite improvements, health system efficiency in Slovakia could still see improvements; for example, there are other countries in the EU that have lower treatable mortality rates at comparable expenditure.

FIGURE 7.28 Mortality from treatable causes per 100 000 population vs CHE per capita, Slovakia and selected countries, 2012–2022



Notes: CHE: current health expenditure; PPP: purchasing power parity; Polish data for 2012 not available

Sources: Eurostat, 2024e; WHO, 2024.

Bed occupancy rates also indicate a lower efficiency of the use of staff capacities; Slovakia's rate has long been below the EU average (around

65% pre COVID-19). The gradual decrease in the number of beds has not helped to improve occupancy. In 2013 Slovakia had 580 beds per 100 000 inhabitants; in 2022 it had 569.1. To address this, MZ SR launched the reform of the hospital network in 2021 (see Section 6.1.1).

Based on an MZ SR survey in 2023, there is a shortfall of about 3400 doctors to meet the required demand of patients, that is, a 17% deficit compared to the current number of staff. The shortage of nurses in absolute figures is even greater, with one in seven nurses "missing" – that is, approximately 4200 nurses (MZ SR, 2024d).

The scope for efficiency improvements was also confirmed by a study by Pažitný et al. (2023), which evaluated the efficiency of outputs (life expectancy, infant mortality and years of life lost) based on a data envelopment analysis examination of inputs (CHE, number of doctors and number of hospital beds). The results show that Slovakia ranks (among countries in the study) among the countries with the least efficient health systems. Countries such as Austria, Switzerland and Germany also ranked among the least efficient countries, though this is mainly due to high CHE, and high numbers of both doctors (especially in Austria's case) and beds (both Germany and Austria). Slovakia primarily suffered from poor outcomes (see Table 7.9). Slovakia was among the countries with the lowest life expectancy at birth and the highest infant mortality rates, and also among the countries with above-average numbers of potential years of life lost (for both men and women) throughout the period under review. While these indicators have improved over a 20-year period, they have not matched the levels of the better performing countries.

TABLE 7.9 Data envelopment analysis of health system efficiency – ranking of countries

COUNTRY	2000		2005		2010		2015		2020	
	SCORE	RANK	SCORE	RANK	SCORE	RANK	SCORE	RANK	SCORE	RANK
AU	0.96	10	0.98	8	0.91	20	0.82	22	0.81	23
AT	0.56	29	0.61	29	0.64	30	0.57	30	0.58	30
BE	0.67	26	0.75	25	0.8	24	0.84	21	0.87	18
CA	1.00	1	1.00	1	1.00	1	1.00	1	1.00	1

COUNTRY	2000		2005		2010		2015		2020	
	SCORE	RANK	SCORE	RANK	SCORE	RANK	SCORE	RANK	SCORE	RANK
CZ	1.00	1	0.9	15	0.95	15	0.76	28	0.74	27
DK	0.85	18	0.84	19	0.81	23	0.98	13	0.92	15
EE	0.7	25	0.91	14	0.97	14	0.9	19	1.00	1
FI	0.9	14	0.8	23	0.99	11	0.96	14	1.00	1
FR	0.65	27	0.69	27	0.77	27	0.82	23	0.86	22
DE	0.6	28	0.6	30	0.65	29	0.64	29	0.64	29
GR	0.89	16	0.81	22	0.72	28	0.79	25	0.72	28
HU	0.54	30	0.62	28	0.79	25	0.79	24	0.86	21
IE	0.83	20	0.84	18	0.99	10	1.00	1	1.00	1
IL	1.00	8	1.00	1	1.00	1	1.00	1	1.00	1
IT	0.88	17	0.94	11	0.93	17	0.93	16	0.87	19
JP	1.00	1	1.00	1	1.00	1	1.00	1	1.00	1
KR	1.00	1	1.00	1	1.00	1	1.00	1	1.00	1
LU	0.92	13	1.00	1	1.00	1	1.00	1	1.00	1
NL	0.9	15	0.95	10	0.94	16	0.91	18	0.9	16
NZ	0.84	19	0.94	12	1.00	1	0.99	12	1.00	1
NO	0.94	12	0.86	17	0.92	19	0.93	17	1.00	1
PL	0.71	22	0.82	21	0.97	13	1.00	1	0.87	20
PT	0.94	11	0.83	20	0.9	21	0.84	20	0.78	25
SK	0.71	23	0.73	26	0.78	26	0.77	27	0.76	26
SI	0.83	21	0.88	16	1.00	1	1.00	1	0.95	14
ES	1.00	1	1.00	1	1.00	1	1.00	1	0.88	17
SE	1.00	1	1.00	1	1.00	1	1.00	1	1.00	1
CH	0.7	24	0.8	24	0.84	22	0.77	26	0.78	24
UK	0.97	9	0.95	9	0.97	12	1.00	1	1.00	1
US	1.00	1	0.93	13	0.92	18	0.96	15	0.98	13

Source: Pažitný et al., 2023.

8

Conclusions

The Slovak health system is based on universal coverage, compulsory health insurance and a competitive insurance model with selective contracting of health care providers and flexible pricing of services. Since the transition back to a model of social health insurance in the early 1990s, most pharmacies and outpatient physicians went into private practice, while ownership of most health care facilities was transferred to regional and local governments following reforms in 2003 (exceptions being the biggest hospitals and specialized institutions). Comprehensive health reforms followed to restructure the system in 2004. Today, health policy is formulated and implemented by MZ SR as the legislator, HICs as purchasers, public and private providers, SGRs, professional organizations and ÚDZS as supervisor.

MZ SR prepares budget allocations for services following consultations with HICs and providers. For inpatient care, MZ SR issues diagnosis-related group weights and has actively participated in concluding managed entry agreements with pharmaceutical registration holders since 2022. MZ SR also pays insurance contributions for the state-insured from general tax revenues, that is, economically inactive individuals (such as children, students up to the age of 26, the unemployed and pensioners; roughly 2.9 million people or 26% of social health insurance funding in 2024). SGRs oversee most health care facilities and issue almost all permits for in- and outpatient facilities (though MZ SR retains this competency for state-owned and specialized hospitals); they also approve office hours. HICs, as purchasers, are joint-stock companies and use contracting to enable their members to access health care services.

Increased consolidation in the health sector in Slovakia has resulted in there being just three HICs in 2024 (one public (VšZP, which has roughly 55% of the market), and two private (Dôvera and Union)), down from seven in 2006 after a wave of mergers.

According to national data, €9.4 billion was spent on health in 2023 in Slovakia, representing 7.7% of GDP. Per capita health spending was measured at US$ PPP 3169 in 2022. This is below what Czechia spends (US$ PPP 4617), though represents a large increase since 2000 and is higher than Poland and Hungary. Public funding has hovered around 80% of health spending since 2015, which is above the EU average. OOP payments decreased from a 27.2% share in 2010 to an estimated 18.7% in 2023, while VHI has only a marginal role in Slovakia. Expenditures for HICs accounted for 75% of health spending in 2024, of which 36% was spent on inpatient care, 20% on pharmaceuticals and 17% on outpatient specialist care. With these health expenditures, MZ SR and the Ministry of Finance work to provide a system with nearly universal health coverage in scope, breadth and depth. The basic benefits package is broad and includes inpatient and outpatient care, prescription pharmaceuticals and a certain range of dental procedures, as well as rehabilitation and spa treatments. Official cost-sharing occurs in relation to pharmaceuticals (and MDA) and dental services, while virtually all health services are free at the point of use.

Slovakia's capital stock is mostly equipped with modern devices and equipment, albeit in outdated buildings and with an increasingly lower level of intellectual assets (that is, software, databases, patents), which has been confirmed both by the RRP as well as by the Slovak National Bank. In fact, the state, as the owner of state hospitals, does not have an overview of the capital stock and equipment of its own hospitals, whereas independent think tanks publish critical findings on this topic in their publicized documents. Although the number of beds in hospitals has been declining according to internationally comparable data, the density of acute care hospital beds is still above the EU average. Regarding eHealth, some HIC-led innovations in building health information systems and interfaces for their members have led to wider adoptions of (similar) applications and tools; this has been driven by competition and the need to offer transparent information to their insured and to surveillance authorities.

At the regional level, authorities are mainly involved in the organization and provision of health services, either via direct ownership of some inpatient

providers or registering the (mostly private) outpatient providers. MZ SR also has a strategic role in public health, while the implementation of measures for health promotion and protection lies with ÚVZ SR, including during the COVID-19 pandemic. To access services, a gatekeeping system has been in place since 2013 (with exemptions for psychiatrists, dentists, gynaecologists, dermatologists and ophthalmologists), though a patient is free to choose their specialist once they have a referral. Strategic management and planning in the health sector are MZ SR's responsibility, and the Strategic Framework for Health 2014–2030 currently serves as the Ministry's guiding tool: it was the first document to determine medium- and long-term directions of Slovak health policy, and formulated goals and priority areas. However, it lacks evaluation of the overall strategies and indicators are currently under development, more than halfway into the plan's lifespan. A wider analysis done by the NKÚ of strategic health policy documents found them missing sufficient metrics on financing and monitoring of the implementation of strategies.

Recent reforms have focused on improving the efficiency of the hospital network, regulating and reimbursing pharmaceuticals, reorganizing primary care, and the introduction of population-wide screenings for cancer in the context of growing disease burden concerns. Though digital capacities have been a topic for reform efforts going back years, there has been little progress at the system level to implement new digital strategies or tools, and oftentimes the innovation has been led by HICs, first for their members and then adopted more broadly. Support from the Recovery and Resilience Fund foresees large investments (€1.5 billion) across the health system, including for specialized care and LTC, in addition to upgrading hospital facilities.

Overall, health outcomes in terms of life expectancy, mortality and survival rates of stroke and cancer have improved over time, though there was a severe drop in life expectancy due to the impact of the COVID-19 pandemic before a rebound in 2022 and 2023 to pre-pandemic levels. As there is no comprehensive monitoring of health policies' impact on system-level goals and little stakeholder involvement, there is room for improvement on health system transparency and accountability. Financial protection is reported to be high, aided by an expansion of the system of maximum limits for co-payments for prescribed drugs to include pensioners and other groups. Slovakia still has a high level of per capita doctor visits (particularly to specialists) and high rates of avoidable mortality, indicating a greater need to focus on allocative and technical efficiency of the health system. Here, the

HSRs undertaken by MZ SR and the Ministry of Finance in recent years present a mechanism to pursue this.

A major challenge regarding health financing in recent years has been the sustainability of financial reserves, which are defined by the debt settlements of selected public hospitals and negative balance sheets of HICs. Additionally, the outdated nature of existing infrastructure (particularly in state hospitals) persists, though this is foreseen to improve in the post-COVID RRP, which provides a major opportunity and source for new (capital) investments. Furthermore, several barriers remain to integrate care and improve health information systems and eHealth offerings. Finally, regarding human resources, the ageing of the existing workforce is a concern, as many health professionals get closer to reaching retirement age, there are outflows to countries with higher wages and better conditions, and the ageing of the general population results in higher needs.

9

Appendices

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9.2 Useful websites

Ministry of Health
https://www.health.gov.sk/Index.aspx

Health insurance companies
https://www.vszp.sk/, https://www.dovera.sk, https://www.union.sk/

State Institute for Drug Control
https://www.sukl.sk/

National Public Health Institute
https://www.uvzsr.sk/web/uvz/

Health Care Surveillance Authority
https://www.udzs-sk.sk/urad/zakladne-informacie/

National Centre for Health Information
https://www.nczisk.sk/Pages/default.aspx

National Institute for Value and Technologies in Healthcare
https://niho.sk/

Supreme Audit Office
https://www.nku.gov.sk/

Statistical Office of the Slovak Republic
https://slovak.statistics.sk/

Healthy Regions
https://www.zdraveregiony.eu/

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The latest version of the template (2019) is available on the Observatory website at https://eurohealthobservatory.who.int/publications/i/health-systems-in-transition-template-for-authors.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents, to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaus and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers and health workers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care and dental care.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment of systems for monitoring health system performance, the impact of the health system on population health, access to health services, financial protection, health system efficiency, health care quality and safety, and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.

9. Appendices: includes references and useful websites.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process.
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible. One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with one another to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.4 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

9.5 About the authors

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(2002[g], 2008[g], 2012)

Romania
(2000[f], 2008, 2016)

Russian Federation
(2003[g], 2011[g])

Serbia
(2019)

Slovakia
(2000, 2004, 2011, 2016)

Slovenia
(2002, 2009, 2016, 2021)

Spain
(2000[h], 2006, 2010, 2018, 2024)

Sweden
(2001, 2005, 2012, 2023)

Switzerland
(2000, 2015)

Tajikistan
(2000, 2010[g], 2016, 2025)

Türkiye
(2002[g i], 2011[i])

Turkmenistan
(2000)

Ukraine
(2004[g], 2010[g], 2015)

United Kingdom of Great Britain and Northern Ireland
(1999[g], 2015, 2022)

United Kingdom (England)
(2011)

United Kingdom (Northern Ireland)
(2012)

United Kingdom (Scotland)
(2012)

United Kingdom (Wales)
(2012)

United States of America
(2013, 2020)

Uzbekistan
(2001[g], 2007[g], 2014[g])

Veneto Region, Italy
(2012)

All HiTs are available in English. When noted, they are also available in other languages:

- [a] Albanian
- [b] Bulgarian
- [j] Estonian
- [c] French
- [d] Georgian
- [e] German
- [k] Polish
- [f] Romanian
- [g] Russian
- [h] Spanish
- [i] Turkish

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