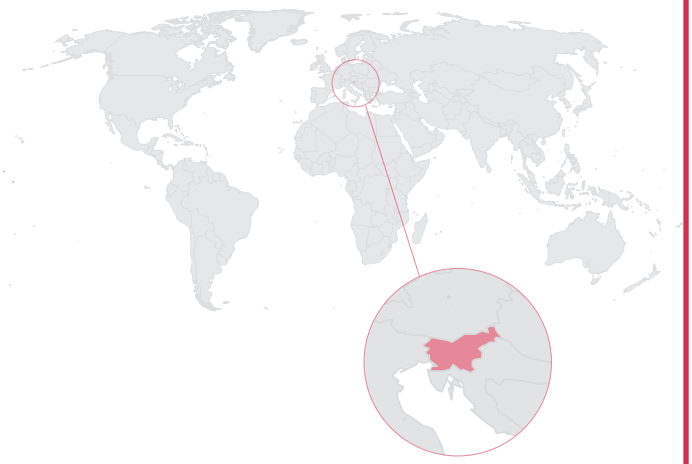
CRC 1342 | No. 54

Social Policy Country Briefs

Slovenia



Neda Milevska-Kostova

The Health Care System in Slovenia

Global Dynamics of Social Policy CRC 1342

DFG Deutsche Forschungsgemeinschaft

Neda Milevska-Kostova
The Health Care System in Slovenia
CRC 1342 Social Policy Country Briefs, 54
Edited by Achim Schmid
Bremen: CRC 1342, 2025

University of Bremen

SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term care as a new social risk

Contact: crc-countrybrief@uni-bremen.de

Postadresse / Postaddress:
Postfach 33 04 40, D - 28334 Bremen

Website:
https://www.socialpolicydynamics.de

[DOI https://doi.org/10.26092/elib/5252]
[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft
(DFG, German Research Foundation)
Projektnummer 374666841 – SFB 1342

Neda Milevska-Kostova

The Health Care System in Slovenia

CRC 1342
No. 54

The Health Care System in Slovenia

Neda Milevska-Kostova*

Content

*Neda.Kostova@radboudumc.nl

1. Country overview

Source: https://ontheworldmap.com/slovenia/ (Accessed December 17, 2025)

- Sub-Region: Southern Europe
- Capital: Ljubljana
- Official Language: Slovenian
- Population size: 2.1 million in 2024
- Share of rural population: 43.6 % in 2024
- GDP: 72.5 billion US-$ in 2024
- Income group: High Income
- Gini Index: 24.7 in 2023

Source: World Bank Open Data (https://data.worldbank.org/country/SI)

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy in 2023	79	71
Female life expectancy in 2023	85	76
Under-5 mortality rate (per 1,000 live births) in 2023	2.2	37
Maternal mortality rate (per 100,000) in 2023	3.3	197
HIV prevalence (% of population ages 15-49) in 2024	0.1	0.7
Tuberculosis incidence (per 100,000) in 2023	5	134

Source: World Bank Open Data (https://data.worldbank.org/); WHO Data, (https://data.who.int/indicators/)

3. Legal Beginning of the System

Name and type of legal act	Law on Health Insurance for Workers
Date the law was passed	1922
Date of *de jure* implementation	14 May 1922
Brief summary of content	Although historically organized health care in Slovenia has emerged during Habsburg monarchy in 18th century, the first legal document describing organized care in Slovenia dates back to the period of the Kingdom of Yugoslavia, 1918-1945 (Albreht et al. 2021). The 1922 Law on Social Insurance of Workers granted equal rights for workers' insurance and unified different types of workers' insurance into one scheme (Popic 2023). This law granted different types of health care for workers, such as medical care for a period of between six and twelve months, medicines, medical aids, medical care in spas and sanatoria, as well as income compensation for work disabilities or medical leave lasting longer than three days. It also granted compensation of funeral costs and some types of health care for workers' family members. The 1930s witnessed development of private health insurance in the form of health care cooperatives, which provided health care insurance for farmers (Vuković 2005, 2009). This also led to extension of health care insurance coverage, from 2% to 7% of the Yugoslav population, from 1922 to 1939 (Popović, Letica, and Škrbić 1981). The 1922 legal acts underpin the current social health insurance and health service delivery in Slovenia, based on the principles of solidarity and equity. These laws ensure universal health insurance, permit privatization of services and transfer some regulatory and administrative functions to professional associations (Popic 2023).
Socio-political context of introduction	During the Kingdom of Serbs, Croats and Slovenes (later renamed the Kingdom of Yugoslavia), health care insurance existed in different forms, such as municipal sickness funds covering workers from the private sector; funds covering workers from the trade, bank and insurance offices; miner's fraternity funds, and sickness funds for railway workers (Sremac and Žuža 2002). One of the first reforms of health care was introduction of common health insurance, unifying these different schemes (Popic 2023). In addition, during the 1920s, the concept of community health centres was introduced, based on the suggestion of Andrija Štampar, offering services for tuberculosis and other important health problems at the time (Svab 1995).

4. Characteristics of the System at Introduction

a. Organisational structure

Origins of an organized health care in Slovenia emerged during the Habsburg monarchy, with the first civil hospital (1784) and the establishment of the Slovenian Medical Association (1861), and the first sickness fund introduced in 1889. This period is characterized by the existence of different levels of private service providers and insurance schemes, organized at city level, suggesting a high level of decentralisation. A more structured health care with the specifics of a centralized system based on the grounds of laws and rules applicable to the whole territory dates back to the period of the Kingdom of Serbs, Croats and Slovenes, with the establishment of the Association of Health Insurance Funds (1919), the National Institute for Hygiene with its regional social hygiene institutes (1923), and the first community-based primary health care centre (1926) (Brown and Fee 2006).

b. Coverage

During the 1920s, the existing health care insurance has evolved in various forms, based on the emerging needs to address the health problems of the population, starting with the working population. This included municipality-level sickness funds covering workers from the private sector, funds insuring employees from the trade, bank, and insurance offices; miner's fraternity funds, and sickness funds for railway workers (Sremac and Žuža 2002). One of the first reforms of health care was the introduction of the common health insurance, unifying these different schemes (Popic 2023).

c. Provision

In the 1920s and 1930s, health care in the territory of present-day Slovenia – then part of the Kingdom of Serbs, Croats and Slovenes – was characterized by limited professional capacities and the uneven distribution of services. According to 1930 data for the kingdom, there were 4,545 doctors, 208 dentists, and 22,895 hospital beds in over 172 hospitals spread across the country (Helsinki Committee for Human Rights in Serbia 2017). Within that broader context, the region that corresponds to present-day Slovenia (then the Drava Banovina) appears to have had a relatively higher concentration of hospitals per capita: by 1939, it accounted for 21.2% of all hospital stays in the country (Helsinki Committee for Human Rights in Serbia 2017). However, formal nursing as a profession was still in its early phases: The first professionally trained Slovenian nurse and social-welfare nurse, Angela Boškin, was active in the 1920s. She pioneered public health nursing, maternity hygiene services and laid the groundwork for a nursing association in Ljubljana (Lovrenčič 1969). Meanwhile, much of the ancillary care – hospital attendants, charitable care, and community relief – remained provided by charitable or municipal initiatives rather than by the large, formally employed nursing corps.

The health care "service package" available during the interwar period addressed many key needs of the time, particularly for urban and more accessible areas. Public health institutions such as the Institute of Hygiene, Ljubljana (founded in 1923) oversaw growing networks of health-centres, dispensaries, and clinics for mothers, children and school health care: by 1941, in what was then the Drava Province, about twenty school outpatient clinics had been established, offering paediatric care, infectious disease prevention, basic dental and eye/ear services for children, hygiene education, and even subsidized school meals and milk programmes (Slavec and Slavec 2009). The system also included tuberculosis sanatoria and specialized clinics for infectious diseases, reflecting the public-health priorities of the time (Jaunig and Slavec 2012). However, outpatient specialist services, comprehensive dental care for adults, and broad rural coverage remained limited. Many rural populations still lacked regular access to physicians or a stable ambulatory infrastructure (Duda 2020). In summary, while the interwar service package was reasonably comprehensive for acute care, child health and infectious disease control (particularly in towns and better-connected areas), it fell short of offering uniform and continuous primary care, chronic disease management, and equitable access across rural and remote areas.

d. Financing

Systematically reported health-expenditure-to-GDP ratios for Slovenia in the early stages of existence of the health care system are *not* available in modern statistical compilations, but historical analyses agree that public spending on health was very low, both absolutely and relative to GDP. Interwar Yugoslavia devoted only a small fraction of state expenditure to social sectors. Health typically accounted for well under 5% of total government spending, with most public resources flowing into administration, the military, and debt servicing. A review of interwar state finances reports that the government invested "only modest sums in health and social policy," characterizing the overall social budget as chronically underfunded (Helsinki Committee for Human Rights in Serbia 2017).

Regarding financing actors and sources, health financing in the 1920s to 1930s was multi-sourced but dominated by out-of-pocket payments, with only partial state and municipal support. State budgets financed public hospitals, hygiene institutes, tuberculosis sanatoria, and vaccination programs, but chronic underfunding meant that municipalities, charities, and private households carried much of the burden. Contemporary government reports and later analyses described the interwar health system as relying heavily on municipal budgets, charitable organizations (particularly religious orders and the Red Cross), philanthropic donors, and direct household payments, while state involvement focused mainly on epidemic control and the major hospitals (Helsinki Committee for Human Rights in Serbia 2017). Social insurance mechanisms were limited and fragmented: small sickness funds existed for certain industrial and railway workers, but these covered a minority of the population and provided narrow benefits (Duda 2020). As a result, the financing mix can be described qualitatively as: household out-of-pocket payments (largest share), municipalities and charities (important share), the central state budget (modest share), and small employment-based sickness funds (minor share).

e. Regulation

In the Kingdom of Yugoslavia, the Ministry of Public Health was the main health authority regulating the provision of services. The Slovenian Medical Association played a role in representing the medical profession before the authorities, and to some extent was dealing with the professional qualifications and medical networking. The Association of Health Insurance Funds established in 1919 was responsible for the collection of funds and for covering health insurance services.

5. Subsequent historical development of public policy on health care

a. Major reform I

Name and type of legal act	Social Insurance Act
Date the law was passed	1946
Date of *de jure* implementation	1946
Brief summary of content	Post-war Slovenia, as part of Yugoslavia, needed major restructuring and build-up of the existing health care system, while ensuring equity, continuity, and sustainability. This federal law's main aim was to expand health service coverage, access and benefits, while also establishing a model of health care financing. The compulsory Social Health Insurance (SHI) was introduced which was financed through the state budget and payroll taxes, as well as through contributions from local, district, republic, and federal budgets. The health insurance system was managed on the federal level with certain republic-level autonomy. Health was considered a public good, and therefore almost all health services were provided within the state-owned system. Private practice was made illegal in 1958, however, during the health sector crisis in the 1960s, Slovenia reintroduced limited private practice, which was dropped again during the 1970s (Parmelee 1983, 1985).
Population coverage	Health insurance coverage gradually increased, initially being offered to workers, their dependents, children and retired persons, and only later expanded to farmers and the unemployed. Within two decades of its establishment, social insurance was made universally available to the entire population (Parmelee 1985).
Type of benefits	After the end of the World War II, due to limited resources, free health services were guaranteed to mothers, children, elderly and pregnant women, as well as to persons with specific, mostly communicable diseases, in the attempt to prevent epidemics. Gradually, free services at the point of delivery were made accessible to all citizens without any co-payments or additional charges (Parmelee 1983, 1985). This pertained also to pharmaceuticals, including supplements, however, there was limited availability despite right of access.
Socio-political context of introduction	World War II ended with significant resource devastation, high incidence of communicable diseases and increasing rates of maternal and infant mortality due to the lack of hygiene and health infrastructure. This law enacted under the Socialist Federative Republic of Yugoslavia (SFRY), of which Slovenia was part at the time, was aimed to establish a nation-wide system of health services and insurance. This act and other legislations formed the basis for the establishment of the modern Slovenian health care system following the country's independence from the SFRY in 1991.

b. Major reform II

Name and type of legal act	Health Care and Health Insurance Act Health Service Act
Date the law was passed	1992
Date of *de jure* implementation	1992

Brief summary of content	After declaring independence in 1991, Slovenia entered into a socio-economic transition period, pertaining also to the health care system. One of the main priorities in the health sector was to ensure continuity of service provision during times of financial austerity due to reduced fiscal support from the federal government. The early independent Slovenia's health care system and social health insurance were very much based on the preceding legislation of 1922. However, the government had a vision of creating a system with wider coverage and better sustainability. Centralized health insurance was retained within the Health Insurance Institute of Slovenia (HIIS), and at the same time a third-party payer scheme was introduced, authorizing the HIIS to negotiate with and contract health care providers and purchase their services (Albreht et al. 2021). The reform also reinstated the possibility for the provision of services by private providers, enabling access for a wider scope of services for the citizens.
Population coverage	The legislation providing coverage for the majority of citizens and permanent residents in Slovenia has gradually evolved to stipulate grounds for 25 categories entitled to health insurance. Under these, in 2020 over 99% of the population in the country was insured, with the remaining being persons with temporary uninsured status, due to transitioning from employment to pension, seasonal worker status, and so forth.
Available benefits	The statutory health insurance provides coverage for a wide benefits package, including primary, secondary and tertiary care services, medicines and medical devices, as well as sick leave and health-related transportation costs. While a wide number of health services, including services related to cancer, infectious diseases and family planning, are fully covered by the insurance, for some services citizens cover a co-payment, ranging from 10% to 90% of the price, which is determined by the essentiality of the service.
Socio-political context of introduction	Following the split from SFRY, the country embarked on the process of transition from a socially planned to a market economy and pluralism. One of the main strategic goals of the government's agenda was the accession to the European Union (EU), for which the prerequisites were, the rule of law, equality, solidarity and respecting human rights. The right to health as a basic human right was embedded in the country's constitution, serving as basis for the enactment and enforcement of the main laws regulating the health care system and service provision.

6. Description of current health care system

a. Organisational structure

The health care system in Slovenia is centralized, with the Ministry of Health playing a main role in system and infrastructure planning and overseeing, and the HIIS centrally managing and administering the mandatory health insurance. Some activities are performed by local or regional branches of HIIS, however, still under supervision from the central level.

Inpatient care at secondary and tertiary level as well as public health services are also centrally managed, whereas preventive, primary and outpatient care are decentralized to the municipal level.

b. Coverage

The social insurance scheme, administered by the National health Insurance Institute of Slovenia, provides coverage for more than 99% of the population. The law defines 25 categories of insured persons, while a permanent residence status is the main basis of insurance. In 2020, around 0.14% of population were uninsured, either temporarily, such as persons awaiting recognition of the right to a pension or unemployment benefit; or individuals who do not meet the formal residency requirements, such as undocumented migrants and the homeless. In addition, at the end of 2020, approx. 0.7% had limited health insurance due to unpaid contributions, i.e. they had access only to emergency services (Albreht et al. 2021).

c. Provision

In 2020, the ratio of physicians to population was 328 per 100,000, and of that practising nurses 1,033 per 100,000 population. Major challenges with staff shortages are experienced in primary and outpatient specialist care, and in particular in rural areas, as well as for nursing professionals in hospitals across the entire country (Albreht et al. 2021).

Inpatient care in Slovenia is provided in 30 hospitals, of which 27 are state owned and the remaining three in the private domain. With regards to the hospital infrastructure, since the 1990s, acute care beds in Slovenia have decreased by 37%, reaching 413 acute care beds per 100,000 population in 2019. In terms of health technology, the country has lower rates than the EU average of MRI and CT scanners, but the needs assessment and investment in such equipment is decentralized to the health care facility level (Albreht et al. 2022).

The benefits package covered through the social health insurance is quite comprehensive and includes services at all three levels of care: primary, secondary, and tertiary, as well as medicines, medical devices, transportation costs for access to health services and sick leave coverage. Many of the services are fully covered, such as those related to cancer care, infectious diseases treatment, family planning and all services for children and the youth under the age of 26. However, for some services co-payments are defined by the HIIS in agreement with the government, mainly to avoid the overuse of services or the discouragement of using less-effective medicines. Co-payments can range from 10% to 90% depending on the essentiality of the given service or medicine. Overall, the number of services fully financially covered is gradually decreasing (Albreht et al. 2022).

d. Financing

In 2023, total health expenditures for health were 9.3% of the gross domestic product (GDP) (WHO 2024). Public spending on health was 73.2% of total current health expenditures, comprising health insurance (64.8%) and government funding (8.8%) (WHO 2024).

Private health expenditure, including voluntary health insurance and out-of-pocket payments was 26.8% of total spending (WHO 2024). Out-of-pocket payments by Slovene citizens are among the lowest in Europe. In 2023, these represented 12.4% of current health expenditures (WHO 2024).

Health insurance through HIIS is progressive (i.e. based on a percentage of income), whereas voluntary health insurance is regressive, i.e. based on a flat payment and offering exemptions for lower-income households. These measures are put in place to protect the population from catastrophic expenditures for health care. In 2015, only about 1.0% of households experienced catastrophic spending, of which more than half were for dental services not covered by the basic benefits package.

e. Regulation of dominant system

The legislative power in Slovenia is vested in the Parliament, which is responsible for the adoption of laws proposed by the government. The Ministry of Health is responsible for system and infrastructure planning and overseeing, as well as the development of health-related policies, in which the Health Council as the highest professional body plays an important role.

The Health Insurance Institute of Slovenia (HIIS) is responsible for pooling funds for health insurance and purchasing health services, through negotiations and signing agreements with providers within the public health network. Professional chambers play a role in defining professional standards, the issuance of licenses and ethical codes for regulation of the profession, while trade unions have the mandate to negotiate collective agreements for rights, responsibilities and the salaries of health care providers. The Ministry of Education and Sports holds the mandate for regulating the medical, health and health-related education in the country.

All health care providers, including medical doctors in all specializations, dentists, pharmacists and nurses are subject to licensing and re-licensing by the professional chambers based on a continuous professional development point-system.

A gatekeeping system is in place in primary care, and since 2000 the general practitioners in primary care must have a family medicine specialization in order to be able to work with patients. However, despite efforts

to improve the gatekeeping role and uptake at primary care level, long waiting lists for services especially for specialist ambulatory services, continue to be an issue in the Slovenian health care system.

The Ministry of Health is responsible for defining health policy, including the delivery of services. The benefit package is defined in coordination with the HIIS, as the sole service payer in the system. The purchasing of health services is based on a multi-step stakeholder negotiation process of service volumes and reimbursements. Negotiations involve all key actors and stakeholders, such as: MoH, HIIS, the Association of Health Institutions of Slovenia, the Medical Chamber of Slovenia, the Slovene Chamber of Pharmacy, the Association of Social Institutions of Slovenia, the Association of Slovenian Training Organizations for Persons with Special Needs and the Association of Slovenian Natural Spas (Albreht et al. 2022).

7. Co-existing systems

In 2018, to help reduce the burden of co-payments, a complementary voluntary health insurance scheme was introduced. More than three quarters of the population enrolled in the scheme, making it the dominant complementary insurance model (Rupel 2018; Baeten et al. 2018). The voluntary health insurance is regressive with a flat equal rate for all insured. To ensure financial protection for vulnerable groups and low-income households, in 2012 a change in VHI was introduced, automatically covering claims from these insured groups.

8. Role of global actors

Since joining the European Union, the country's health care system does not rely on global actors in the planning, provision or financing of health care in the country. During the transition period until mid-2000s, however, bilateral and multilateral partners, including the World Health Organisation and the World Bank have played role in supporting health care reforms with technical and financial resources.

9. List of additional relevant legal acts

- Communicable Diseases Act, 1995
- Medical Services Act, 1999
- Healthcare Databases Act, 2000
- Act Regulating the Sanitary Suitability of Foodstuff, Products and Materials Coming into Contact with Foodstuffs, 2000
- Restrictions on the use of Alcohol Act, 2003
- Complementary and Alternative Medicine Act, 2007
- Patients' Rights Act, 2008
- Mental Health Act, 2008
- Criminal Code, 2008 (related to illicit drug use)
- Health and Safety at Work Act, 2011
- Medicinal Products Act, 2014
- Act Regulating the Obtaining and Transplantation of Human Body Parts for the Purposes of Medical Treatment, 2015
- Restriction on the Use of Tobacco and Related Products Act, 2017

References

Albreht, Tit, Katherine Polin, Radivoje P Brinovec, Marjeta Kuhar, Mircha Poldrugovac, Petra O Rehberger, Valentina P Rupel, and Pia Vracko. 2021. "Slovenia: Health system review."

Albreht, Tit, Katherine Polin, Radivoje Pribakovic Brinovec, Marjeta Kuhar, Mircha Poldrugovac, Petra Ogrin Rehberger, Valentina Prevolnik Rupel, and Pia Vracko. 2022. "Slovenia: health system summary."

Baeten, Rita, Slavina Spasova, Bart Vanhercke, and Stéphanie Coster. 2018. "Inequalities in access to healthcare." *European Commission*.

Brown, Theodore M, and Elizabeth Fee. 2006. "Andrija Stampar: charismatic leader of social medicine and international health." *American journal of public health* 96 (8):1383-1383.

Duda, Igor. 2020. "Everyday Life in Both Yugoslavias: Catching up with Europe." *YU Historija*.

Helsinki Committee for Human Rights in Serbia. 2017. *Yugoslavia From A Historical Perspective*.

Jaunig, Senta, and Zvonka Zupanic Slavec. 2012. „Tuberkuloza, nasa ljudska, delavska in kmetska bolezen." *Zgodovinski Casopis* 2012 (3/4):362.

Lovrenčič, Bole. 1969. "Naša prva medicinska sestra Angela Boškinova [Our first medical nurse Angela Boshnikova]." *Obzornik zdravstvene nege* 3:123-130.

Parmelee, Donna E. 1983. "Medicine under Yugoslav self-managing socialism." *(No Title)*.

Parmelee, Donna E. 1985. "Whither the state in Yugoslav health care?" *Social Science & Medicine* 21 (7):719-728.

Popic, Tamara. 2023. "Slovenia." In *Health Reforms in Post-Communist Eastern Europe: The Politics of Policy Learning*, 59-104. Springer.

Popović, B, S Letica, and M Škrbić. 1981. *Zdravstvo u Socijalističkoj Republici Hrvatskoj, Razvoj–Stanje–Perspektive. Zdravlje i zdravstvena zaštita.[Health Care System in the Republic of Croatia. Development–Current situation–Perspectives. Health and Health Protection]. Zagreb: Jugoslavenska medicinska naklada*.

Rupel, Valentina P. 2018. "ESPN Thematic Report on Inequalities in access to healthcare: Slovenia."

Slavec, Zvonka Zupanic, and Ksenija Slavec. 2009. "School Healthcare in Slovenia during the Interwar Period (1918-1941) The 100th Anniversary of School Healthcare in Slovenia (1909-2009)." *Zdravniski Vestnik* 78 (12).

Sremac, Đuro, and Branko Žuža. 2002. *Hrvatsko zdravstveno zakonodavstvo: 1830-1941*: Školska Knjiga.

Svab, Igor. 1995. "Primary health care reform in Slovenia: first results." *Social Science & Medicine* 41 (1):141-144.

Vuković, Drenka. 2005. *Socijalna sigurnost i socijalna prava*: Fakultet političkih nauka.

Vuković, Drenka. 2009. "Readmisija i upravljanje migracijama." *Godišnjak FPN* (03):569-583.

WHO. 2024. "Global Health Expenditure Database." accessed 30 November 2025. https://apps.who.int/nha/database/Select/Indicators/en.