European Commission

State of Health in the EU

SLOVENIA

Country Health Profile 2025

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS), the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that were accessible as of the first half of September 2025.

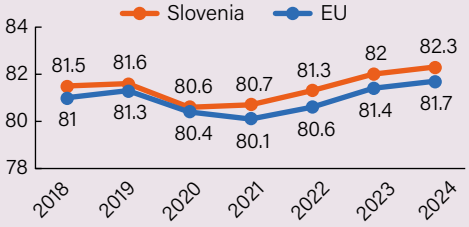
Demographic and socioeconomic context in SLOVENIA, 2024

Demographic factors	Slovenia	EU
Population size	2 123 949	449 306 184
Share of population over age 65	22 %	22 %
Fertility rate 2023[1]	1.5	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	36 089	39 675
At risk of poverty or social exclusion rate[3]	14.4 %	20.9 %

1. Number of children born per woman aged 15-49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

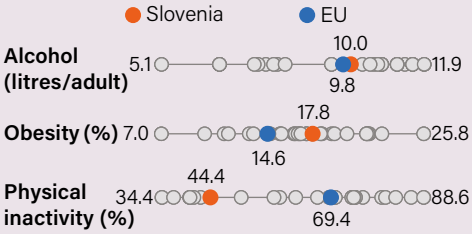
1 Highlights



Life expectancy at birth

Health Status

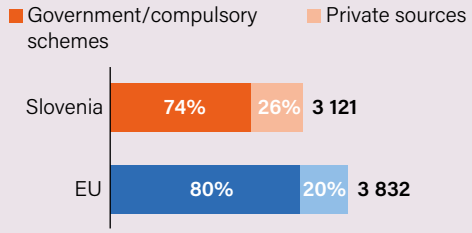
Slovenia's life expectancy at birth has been consistently above the EU average for the past decade. Following the EU average trend, life expectancy at birth declined during the COVID-19 pandemic, but rebounded and reached a new all-time high of 82.3 years in 2024. The leading causes of death in 2023 were cardiovascular diseases and cancer.



Adults, 2022 (or nearest year)

Risk Factors

Alcohol consumption among adults has remained fairly constant, and is close to the EU average. Although Slovenians are more physically active than the EU average, overweight and obesity are major public health concerns. Almost one fifth of the adult population was obese in 2022. This risk factor, along with poor diet, contributes to Slovenia's high incidence rates for cardiovascular diseases.



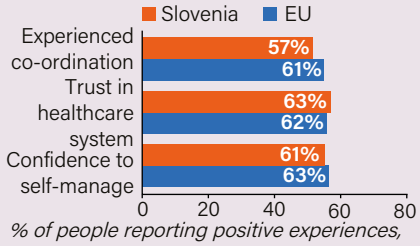
Health spending per capita (EUR PPP), 2023

The Health System

Health expenditure has increased steadily in Slovenia, reaching EUR 3 121 per capita in 2023, but has consistently remained below the EU average. Public spending accounted for 74 % of health spending, with out-of-pocket payments accounting for 12 % – below the EU average of 16 % – and voluntary health insurance accounting for the remaining 14 %. This distribution is expected to change following the abolition, in 2024, of complementary voluntary health insurance that covered copayments.

Health System Performance

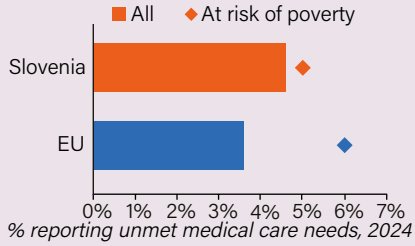
Effectiveness



% of people reporting positive experiences, 2023

Despite lower health spending per capita, most Slovenians reported positive experiences in the OECD Patient-Reported Indicator Survey – particularly for experience of quality of care and person-centred care, and trust in the primary care system. National patient experience surveys also highlight positive experiences with healthcare services among the adult and paediatric populations.

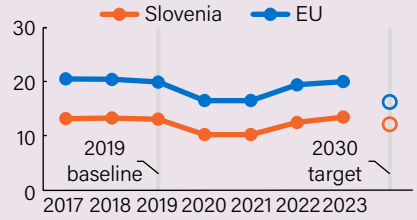
Accessibility



% reporting unmet medical care needs, 2024

Slovenia reported relatively high unmet medical needs in 2024, at 4.6 % of the population who had a healthcare need, compared to the EU average of 3.6 %. However, the gap in reported unmet needs between people at risk of poverty and the rest of the population with healthcare needs was smaller than the EU average. Unmet medical needs were mostly driven by long waiting times.

Resilience



Antibiotic consumption, defined daily doses per 1 000 pop. per day

Controlling antibiotic use and tackling antimicrobial resistance supports health system resilience. Slovenia has among the lowest consumption rates of antibiotics in the EU. Like most other EU Member States, consumption gradually climbed after a decline during the pandemic years. The One Health Strategy aims to strengthen antimicrobial resistance stewardship and support achievement of the country's 2030 antibiotic reduction targets.

Spotlight: pharmaceuticals

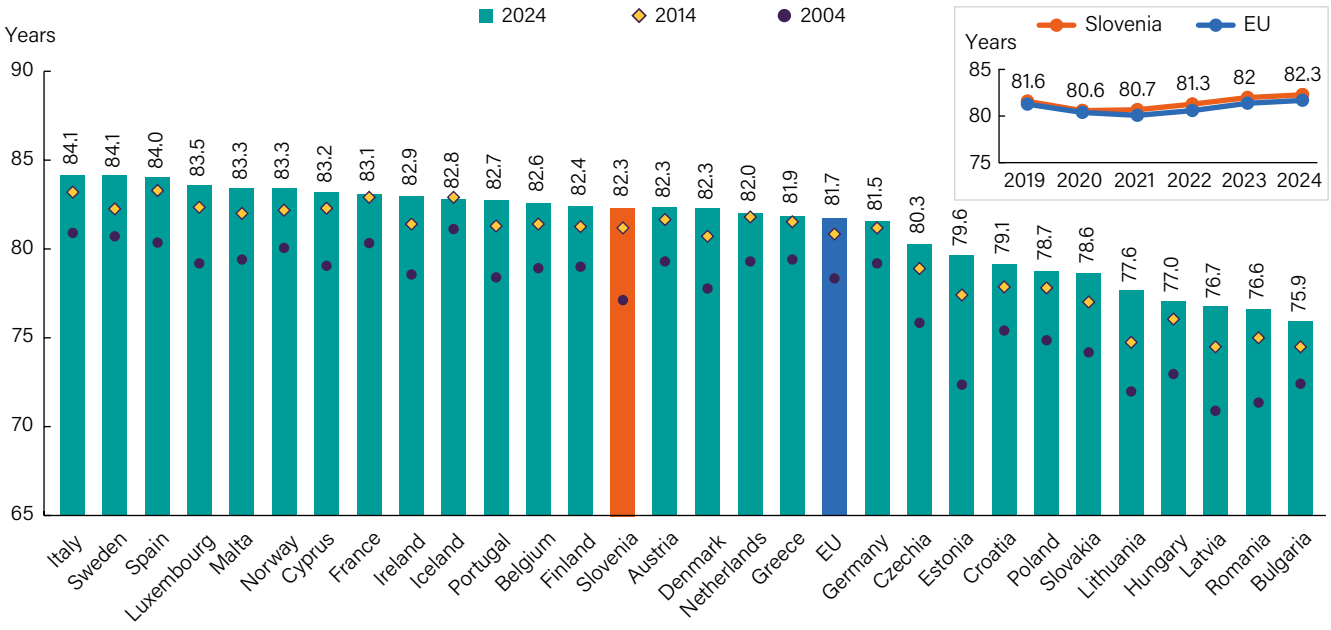
Pharmaceutical spending in Slovenia has increased steadily, especially in the retail sector. While expenditure on retail pharmaceuticals decreased after the COVID-19 pandemic in most EU countries, it increased steeply in Slovenia. Increased use of outpatient treatments and longer treatment duration, combined with the increased consumption of innovative and expensive medicines in the hospital sector, drove up expenditure on pharmaceuticals over the past decade. The new Slovenian Quality Health Care Agency aims to mitigate spending surges and to promote value-based innovations through active use of health technology assessments.

2 Health in Slovenia

Life expectancy in Slovenia has reached a new all-time high

Following a reduction caused by the COVID-19 pandemic, life expectancy at birth in Slovenia started to rebound in 2022. In 2024, it reached an all-time high of 82.3 years, which is higher than the EU average (Figure 1). As in other countries, women in Slovenia tend to live longer lives than men, and the gender gap in life expectancy (5.3 years) remained slightly higher than the EU average (5.2 years).

Figure 1. Slovenia's life expectancy is higher than the EU average



Notes: The EU average is weighted. Data for Ireland refer to 2023.
Source: Eurostat (demo_mlexpec).

Cardiovascular diseases and cancer were the two leading causes of death in 2023

In 2023, the leading causes of death in Slovenia were cardiovascular diseases (CVDs) and cancer, which together accounted for almost 70 % of all deaths (Figure 2). External causes (including suicides, falls and other accidents) also accounted for a large number of deaths, followed by respiratory and digestive diseases. Following high rates of COVID-19 mortality in 2022, COVID-19 accounted for only 3 % of all deaths in Slovenia in 2023.

Most Slovenians report being in good health, but large disparities exist by gender and income level

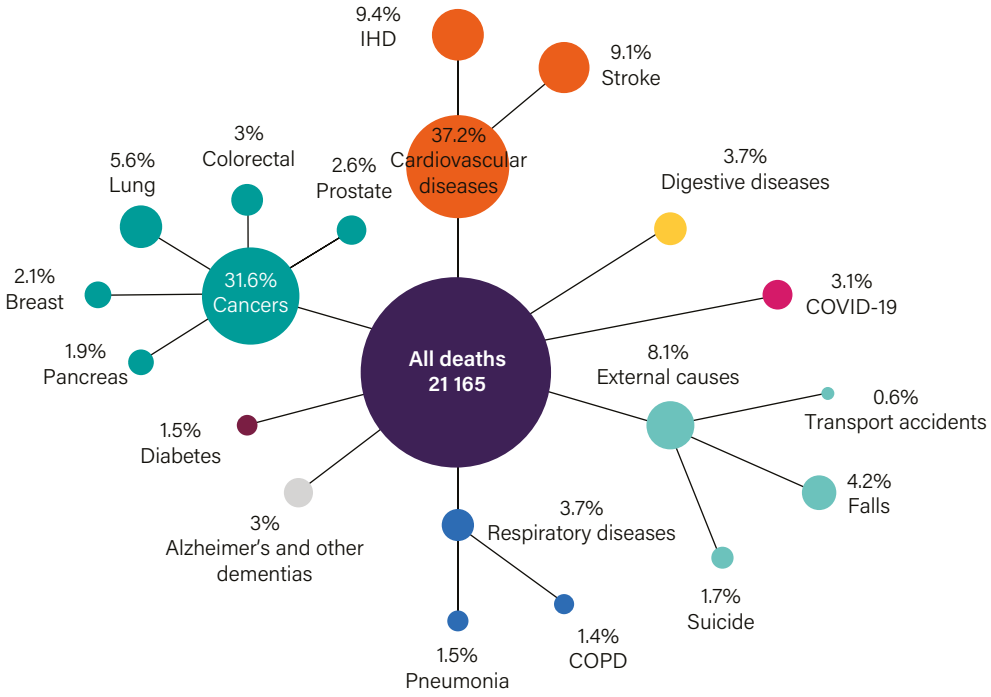
In 2024, 66 % of Slovenians reported being in good or very good health – a proportion slightly lower than the EU average (68 %). As in other countries, Slovenian women were less likely than men to report good health (63 % compared to 70 %). The gap was even more pronounced by income level: only 47 % of women in the lowest income quintile reported being in good health compared to 78 % of those in the highest quintile (Figure 3). For both genders, these income gaps are greater than the EU average gaps.

Although healthy life expectancy at age 65 is high, around one third of older people report chronic conditions and disabilities

As in most countries across the EU, the share of the Slovenian population aged 65 and over has increased over the past two decades, from 14 % in 2000 to 22 % in 2024, and is projected to reach 31 % by 2050.

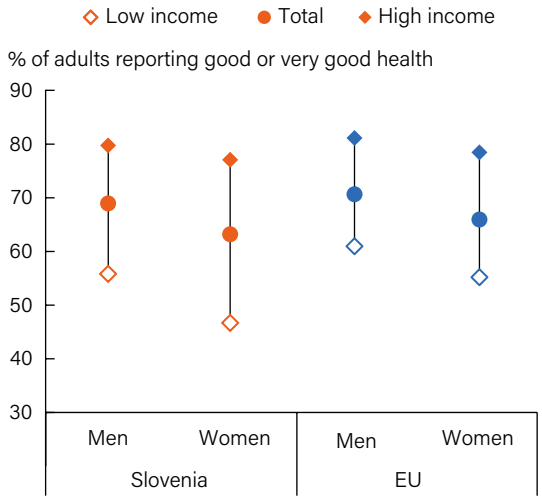
In 2022, life expectancy for men and women aged 65 was comparable to the EU average, with Slovenian men's life expectancy (17.8 years) lower than women's (21.5 years) (Figure 4). The number of healthy life years for men and women at age 65 in Slovenia was slightly higher than the EU average. This is linked to the smaller share of Slovenians over that age who report multiple chronic conditions or limitations in daily activities. Nonetheless, according to data from the SHARE survey, over a third of Slovenian men and women aged over 65 report having multiple chronic conditions, and nearly one third of Slovenian women aged over 65 report limitations in daily activities.

Figure 2. Cardiovascular diseases and cancer accounted for over two thirds of all deaths in 2023



Note: IHD = ischaemic heart disease; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); data refer to 2023.

Figure 3. Inequalities in self-reported health are large across gender and income groups



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10); data refer to 2024.

An estimated 28 000 new cases of cardiovascular disease were diagnosed in 2021

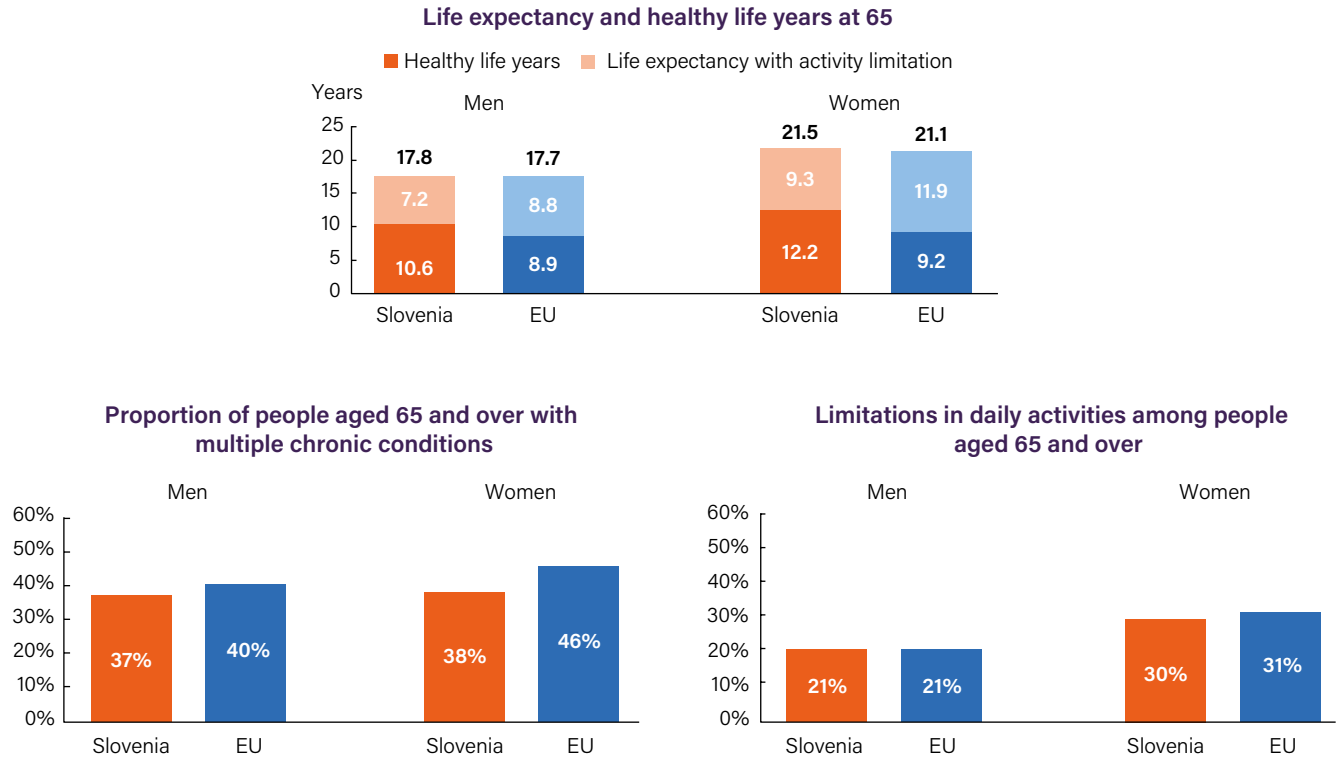
CVDs are not only one of the leading causes of death in Slovenia but also among the leading causes of morbidity and disability, mirroring patterns observed across the EU. According to estimates from the Institute for Health Metrics and Evaluation (IHME), approximately 28 000 new cases of CVDs were diagnosed in Slovenia, and 290 000 people were living with a CVD in 2021, which represents about 13 % of the Slovenian population (Figure 5). This corresponds to an age-standardised incidence rate of 1 240 cases per 100 000 population – about 7 % higher than the EU average, while the prevalence rate is identical to the EU average. CVDs also accounted for 11 % of all hospital admissions in 2022.

Ischaemic heart disease (also known as coronary artery disease) was the most frequent CVD, with an estimated 12 000 new cases each year, representing almost half of all CVDs. Launched in 2001, Slovenia's National Programme for Primary Prevention of Cardiovascular Disease began with a screening initiative to identify CVD risk factors, and has since evolved into an integrated approach to managing chronic conditions, offering structured care, lifestyle counselling and health promotion workshops within primary healthcare facilities.

In 2020, an estimated 99 000 people in Slovenia were living with cancer

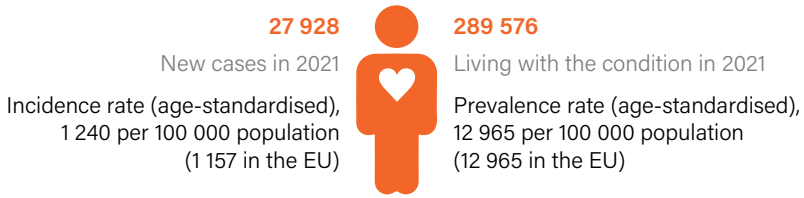
According to the European Cancer Information System (ECIS), almost 14 000 new cases of cancer were estimated to have been diagnosed in 2022 in Slovenia, and around 99 000 people were estimated to be living with cancer in 2020 (Figure 6). Compared to the EU averages, the age-standardised incidence rate of cancer in 2022 in Slovenia was 6 % higher and the 2020 prevalence rate was 5 % lower. This pattern suggests less favourable cancer survival in Slovenia – probably reflecting higher mortality after diagnosis. In 2022, the cancer incidence rate was estimated to be 18 % higher among men than among women – a gender gap slightly smaller than the EU average gap of 20 %. The most commonly newly diagnosed cancers in 2022 among men were prostate, lung and colorectal cancer; among women they were breast, lung and colorectal cancer.

Figure 4. Healthy life expectancy at age 65 is higher in Slovenia than the EU average



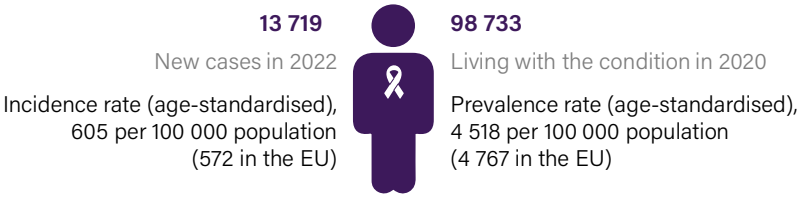
Sources: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic conditions and limitations in daily activities); data refer to 2022 and 2021-22, respectively.

Figure 5. About 13 % of people in Slovenia live with a cardiovascular disease



Source: IHME, Global Health Data Exchange; estimates refer to 2021.

Figure 6. Slovenia has higher incidence but lower prevalence of cancer than the EU averages



Notes: These are estimates that may differ from national data. Cancer incidence includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System; estimates refer to 2022 for incidence and 2020 for prevalence.

3 Risk factors

Behavioural and environmental risk factors account for over one third of all deaths

According to estimates from IHME, about 5 700 deaths in Slovenia in 2021 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Another 900 deaths can be attributed to air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone, mainly related to CVDs,

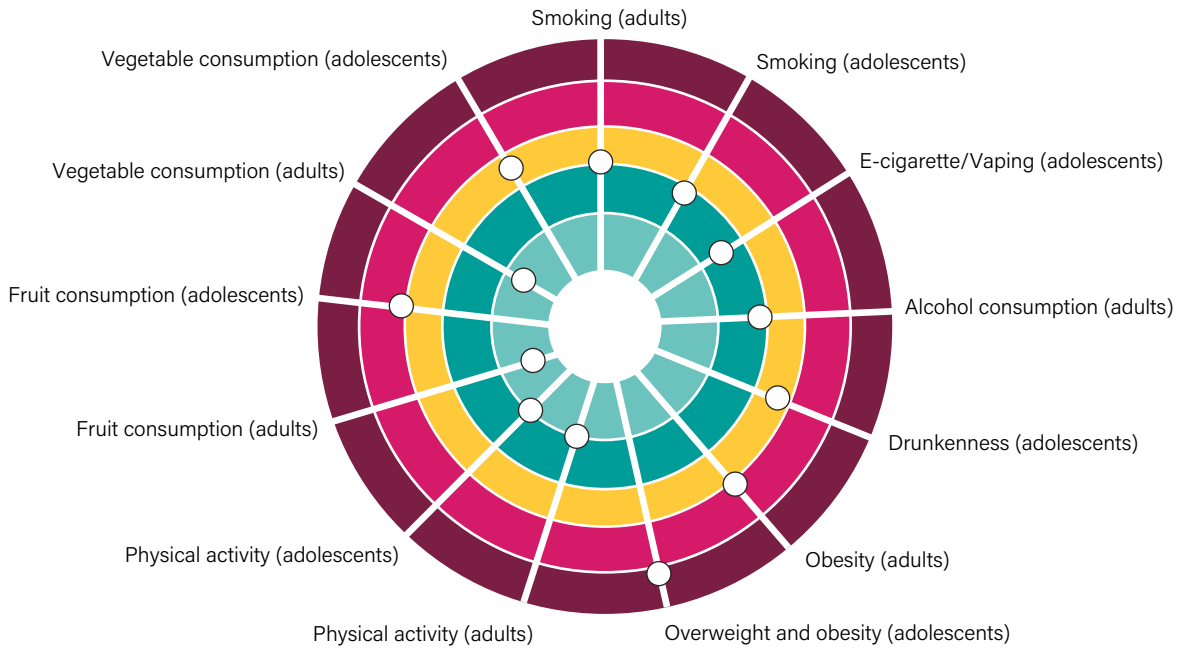
respiratory diseases and some types of cancer. Together, these behavioural and environmental risk factors accounted for 29 % of all deaths in Slovenia in 2021, which was similar to the EU average.

Overweight and obesity rates in Slovenia are higher than the EU average

In 2022, 18 % of Slovenian adults were obese – above the EU average of 15 % – with higher rates among men (22 %) than women (14 %). Among 15-year-olds, overweight and obesity rates have remained above the EU average for two decades, rising from 13 % in 2002 to 25 % in 2022. Poor diet and insufficient physical activity are key contributors. Only 44 % of Slovenian adults reported low physical activity levels (exercising fewer than three times per week), which was well below the EU average of 69 %. In parallel, 17 % of 15-year-olds reported moderate daily activity – slightly above the EU average of 15 %.

Daily fruit and vegetable consumption among adults was relatively high in 2022 (69 % for fruit, 70 % for vegetables), exceeding the EU averages. However, among 15-year-olds, daily consumption was only 29 % for fruit and 32 % for vegetables – similar to levels across the EU (see Figure 7). Slovenia's National Nutrition and Physical Activity Strategy 2015-25 remains in progress, with the Ministry of Health leading its evaluation. A new multisectoral strategy is being developed to build on this work, expanding its focus to include sleep behaviours as part of a broader healthy lifestyle approach.

Figure 7. Overweight and obesity are important public health issues, particularly among adolescents



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; Eurostat based on EU-SILC 2022 and OECD Data Explorer for adult indicators (2022 or nearest available year).

Stagnant daily smoking rates among women have slowed overall reductions in adult smoking

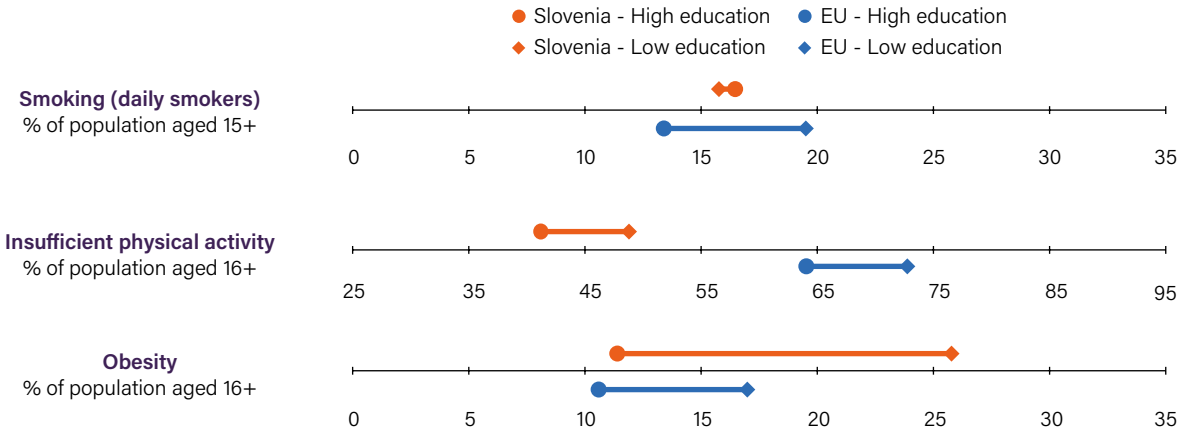
Daily smoking among Slovenian adults declined from 19 % in 2014 to 17 % in 2019, remaining below the EU average (19 %). However, progress has been uneven: while smoking rates among men fell to 19 % (below the EU average of 23 %), rates among women stagnated at 16 %, exceeding the EU average of 14 % in 2019. Among adolescents, smoking dropped from 22 % in 2014 to 14 % in 2022, which is also below the EU average (17 %). However, e-cigarette use is rising: 19 % of 15-year-olds reported using them in the past month in 2022, just under the EU average of 21 %. Nicotine-containing and nicotine-free e-cigarettes, heated tobacco products, herbal products for smoking and nicotine pouches are regulated similarly to traditional tobacco products under Slovenia's Restriction on the Use of Tobacco and Related Products Act.

Alcohol consumption among adults has remained stable at around 10 litres per capita annually, which is close to the EU average (9.8 litres). Among adolescents, 23 % of 15-year-olds reported having been drunk at least twice in their lives in 2022, aligning with the EU average (see Section 5.1).

Unlike other health risks, smoking is not more common among those with lower education levels

As in most countries, people with lower education levels in Slovenia are more likely to be obese and physically inactive than those with higher education levels. This is particularly striking for obesity, where the rate was more than twice as high among adults with lower (26 %) than higher (11 %) education levels (Figure 8). However, smoking rates show little difference by education level. In 2019, only slightly more adults with higher education levels (17 %) reported daily smoking than those with lower education levels (16 %) – a pattern that is unusual in the EU.

Figure 8. Socioeconomic inequalities in obesity are larger in Slovenia than the EU average



Notes: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8). Low physical activity is defined as people doing physical activity three times or fewer per week.
Sources: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Slovenia's social health insurance system delivers care through a mix of public and privately contracted providers

Slovenia's health system operates under statutory, employment-based, social health insurance, and offers universal health coverage. Complementary voluntary health insurance (VHI) was historically a key feature of the health system used by most of the population who were liable for copayments. However, this was abolished in 2024, along with copayments, and replaced by a fixed compulsory contribution, which is paid in addition to social health insurance contributions (see Section 5.2). Supplementary VHI remains available to cover additional specialist care or access to private providers.

The health system is relatively centralised, with the Health Insurance Institute serving as the single purchaser. Primary healthcare delivery is driven by municipal, multidisciplinary, community-based primary healthcare centres. These facilities typically employ teams that include general practitioners (GPs), nurses and other allied health professionals. GPs coordinate access to secondary and tertiary care, acting as gatekeepers. Some private providers, operating under contracts with the Health Insurance Institute, deliver care within the public system. Secondary care is largely the domain of state-owned hospitals, although some private providers also deliver inpatient services, and certain secondary-level outpatient services are delivered within primary healthcare centres and independent clinics.

The distribution of health financing is expected to change following the abolition of complementary voluntary health insurance

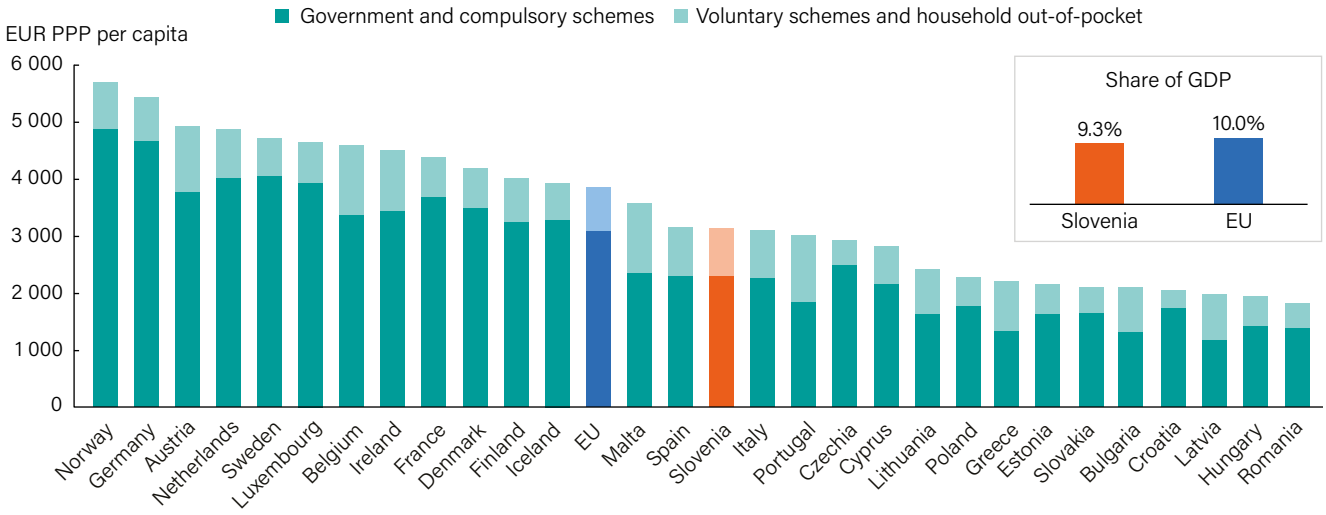
While Slovenia's total health spending has grown in recent years, particularly during the first two years of the COVID-19 pandemic, it remains below the EU average. In 2023, health expenditure reached 9.3 % of GDP – lower than the EU average of 10.0 %. On a per capita basis, Slovenia spent EUR 3 121 on health (adjusted for differences in purchasing power), compared to the EU average of EUR 3 832 (Figure 9).

Public sources accounted for 74 % of current health expenditure in 2023, which was lower than the EU average of 80 %. Private sources made up the remaining 26 %, of which VHI – historically driven by complementary VHI to cover copayments – represented 14 %. Household out-of-pocket (OOP) spending on health accounted for 12 %, well below the EU average of 16 %. These OOP payments were primarily direct outlays for services outside the statutory benefits package. The impact of moving from complementary VHI that covers copayments to a fixed compulsory contribution has not yet been reflected in the available health expenditure data, but the spending distribution is likely to change from 2024.

The highest share of health expenditure is dedicated to outpatient care

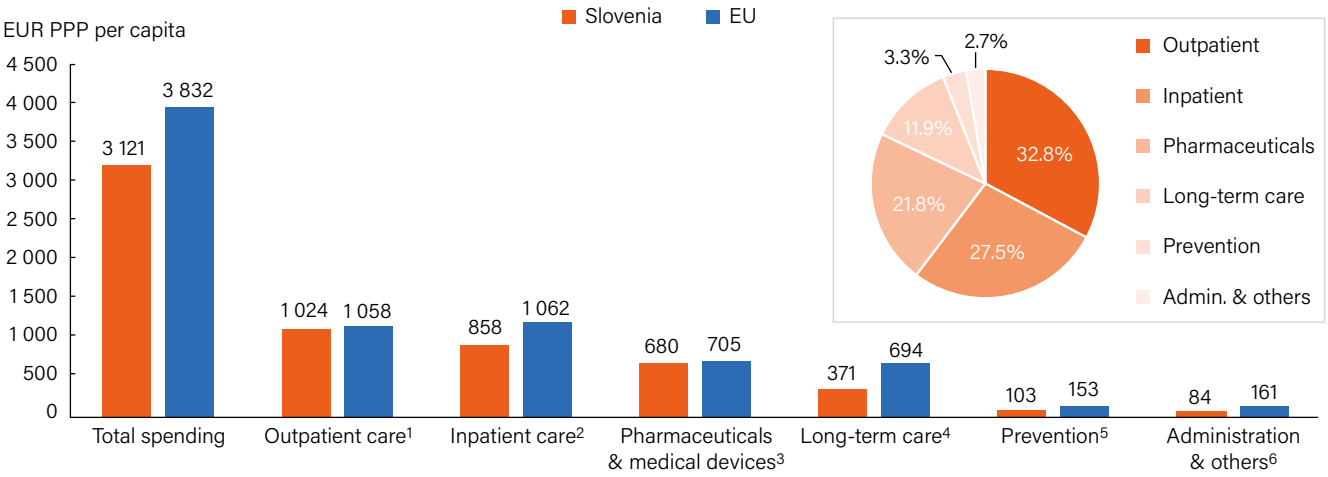
In line with overall health spending, Slovenia spent less per capita than the EU averages on all healthcare functions (Figure 10). However, in 2023, per capita spending on outpatient care was 33 % of current health expenditure – well above the EU average of 28 %. This is partly the result of reforms over the past decade that incentivised shifting patients out of hospital settings. Additionally, inpatient care

Figure 9. Slovenia spends less per capita on health than the EU average



Notes: The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat (demo_gind); data refer to 2023.

Figure 10. Slovenia currently spends approximately half the EU average on long-term care per capita



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

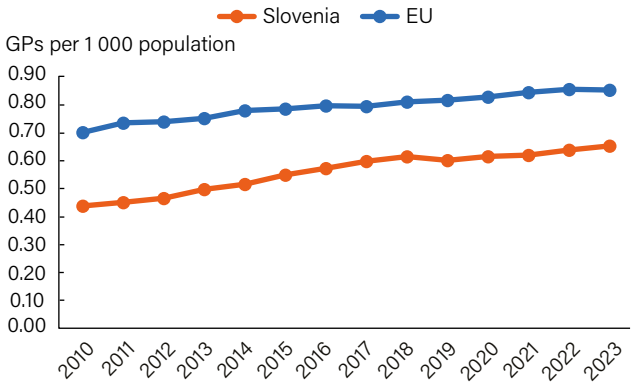
absorbed 28 % of current health spending (equal to the EU average), followed by pharmaceuticals and other medical non-durables, along with medical devices (22 %), long-term care (12 %) and prevention (3 %). While the share dedicated to long-term care was still below the EU average of 18 %, it has grown amid intensified efforts to strengthen social and healthcare support for older populations. Implementation of the latest Long-term Care Act is due to be completed by the end of 2025.

Recent policy developments aim to tackle primary care and hospital workforce shortages

The density of medical doctors in Slovenia reached 3.5 per 1 000 population in 2023 – below the EU average of 4.3 per 1 000 and among the lowest levels in the EU. GPs constituted 19 % of all practising physicians, which was close to the EU average (20 %). There has been an almost continuous increase in the density of family doctors over the last decade (Figure 11), and national data from the Institute of Public Health indicate that the number of primary care doctors in Slovenia had grown to 1 450 in 2024, reaching a density of 0.65 per 1 000 population. Further, to address persistent medical workforce shortages in primary care, recent policy developments have included a new payment model in primary care for GPs and paediatricians (introduced in February 2025), adoption of financial incentives for new graduates choosing family medicine as their specialisation, and measures to enhance task-shifting and implement new care models. Slovenia also launched public scholarships in healthcare for the 2025/26 academic year for medical doctors, nurses and pharmacy students.

In contrast, the nurse workforce stood at 10.5 practising nurses per 1 000 population in 2023, surpassing the EU average of 8.5 per 1 000 (Figure 12). However, it should be

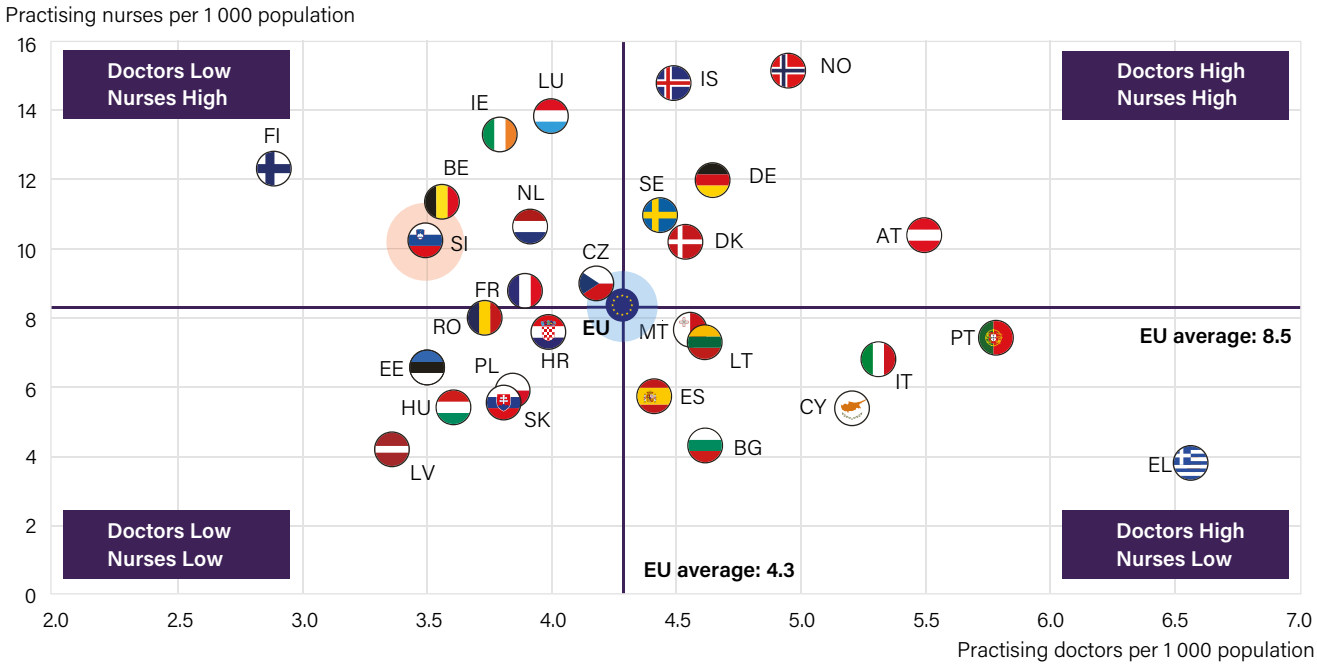
Figure 11. The density of general practitioners in Slovenia has been rising steadily, but remains below the EU average



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_PHYS_CAT).

emphasised that this graph encompasses both registered nurses and vocationally trained nursing assistants, which goes beyond the categories of nurses included in the EU Directive on the Recognition of Professional Qualifications. These assistant nurses make up over half of the nursing workforce in Slovenia. Furthermore, despite the relatively high density of nurses, hospitals still record shortages, partly attributable to salary imbalances and challenging working conditions. A new payment model for public employees, which came into effect in 2025 and applies to most healthcare workers, aims to increase the attractiveness of public sector employment for young people through increasing transparency of the wage system, salary rises and an improved system of other financial rewards (see Section 5.2). This measure is complemented by the introduction of new specialisations for registered nurses, which enhance their role and professional autonomy.

Figure 12. Slovenia has fewer medical doctors than many other EU countries



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE); data refer to 2023 or nearest available year.

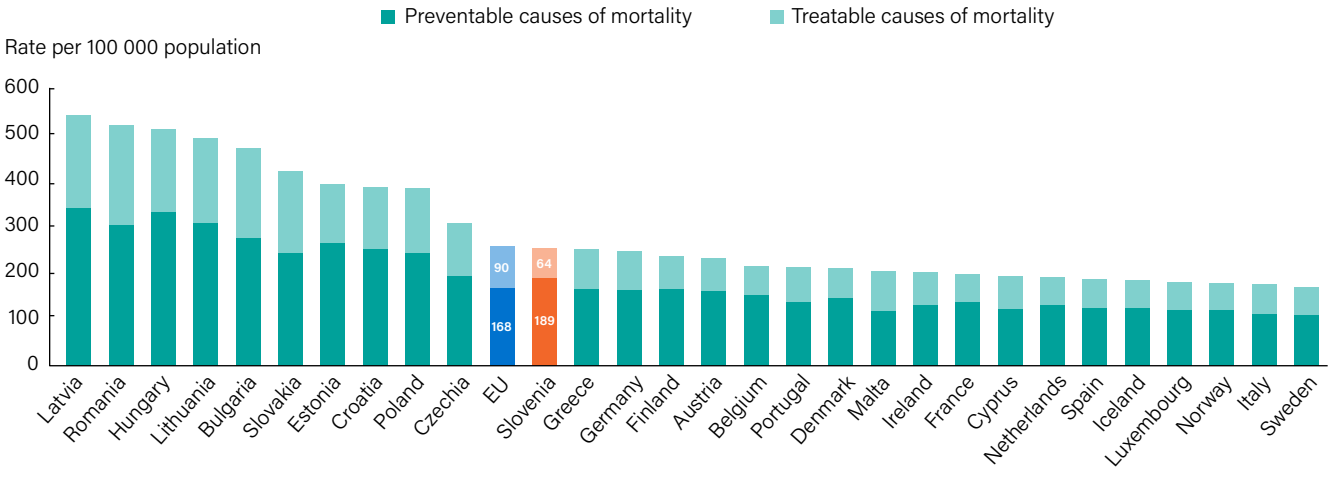
5 Performance of the health system

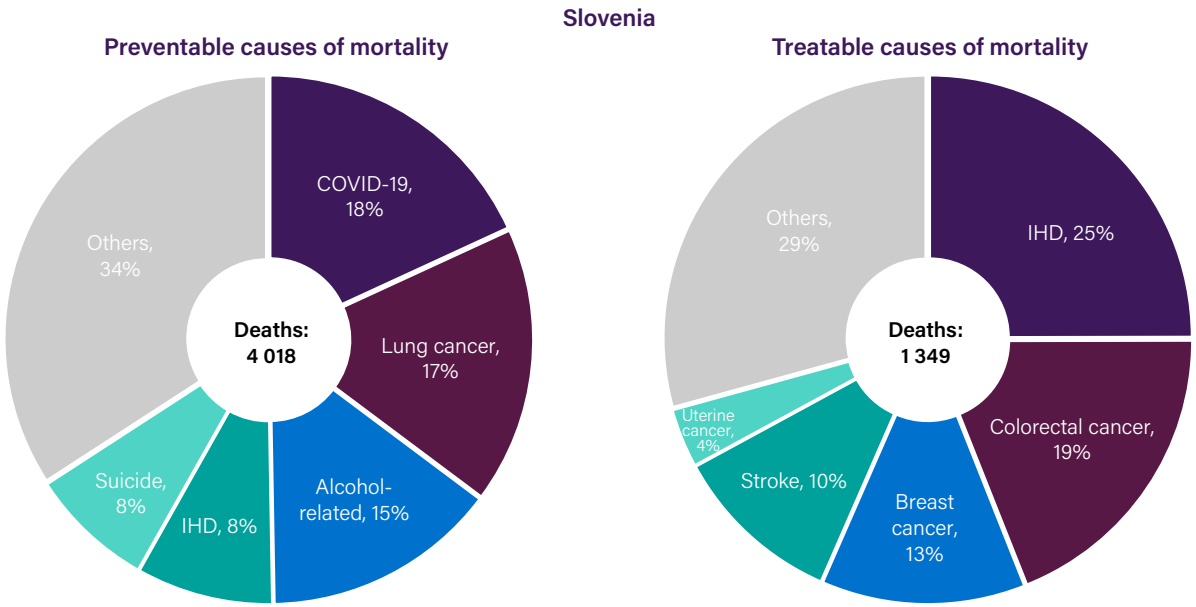
5.1 Effectiveness

Preventable mortality declined in 2022 but remained higher than pre-pandemic levels

As in most EU Member States, overall avoidable mortality in Slovenia decreased slightly in 2022, but stayed close to the EU average (Figure 13). After the pandemic-led rise that spiked to 212 deaths per 100 000 population in 2021, mortality from preventable causes declined to 189 deaths per 100 000 in 2022, remaining higher than pre-pandemic levels (173 deaths per 100 000 in 2019). COVID-19 was still the leading cause of preventable mortality, followed by lung cancer (Figure 13).

Figure 13. In 2022, the preventable mortality rate in Slovenia was higher than the EU average, while mortality from treatable causes was lower





Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease (IHD), stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat (hlth_cd_apr); data refer to 2022.

Numerous programmes for smoking prevention, exposure reduction and cessation have been systematically implemented, and smoking rates in Slovenia have been slowly declining overall. Past and ongoing measures include the enactment of the Use of Tobacco and Related Products Act in 2017 and its recent amendment in 2024, which introduces a ban on flavours in nicotine-containing and nicotine-free electronic cigarettes and their liquids, except for the taste or smell of tobacco, and a strict ban on using tobacco and related products in smoking rooms in enclosed public places and workplaces (from January 2026), as well as the adoption of the Strategy for Decreasing the Consequences of Tobacco Use for a Tobacco-Free Slovenia 2021-30 to further guide national efforts.

Alcohol-related causes were responsible for 15 % of preventable deaths. To further reduce the harmful consequences of alcohol consumption, Slovenia approved a new programme for 2025-26 (Box 1).

Suicide rates are particularly high in Slovenia, at 15 deaths per 100 000 population, making it the fifth leading cause of preventable death (8 %). In 2022, men were nearly four times more likely to die by suicide than women (23 compared to 6 per 100 000). With the implementation of the National Mental Health Programme 2018-28, community-based mental health centres were established to strengthen cross-sectoral co-operation. The number of psychiatrists has slowly increased but remains below the EU average (17 compared to 20 per 100 000 population).

Ischaemic heart disease remains the leading cause of mortality from treatable causes

For almost a decade, treatable mortality in Slovenia has been decreasing steadily – much faster than the EU average – reaching 64 deaths per 100 000 population in 2022. Ischaemic heart disease remained the leading cause of treatable deaths in 2022 (see Figure 13), followed by colorectal and breast

Box 1. Tackling alcohol harm: Slovenia's 2025-26 strategy

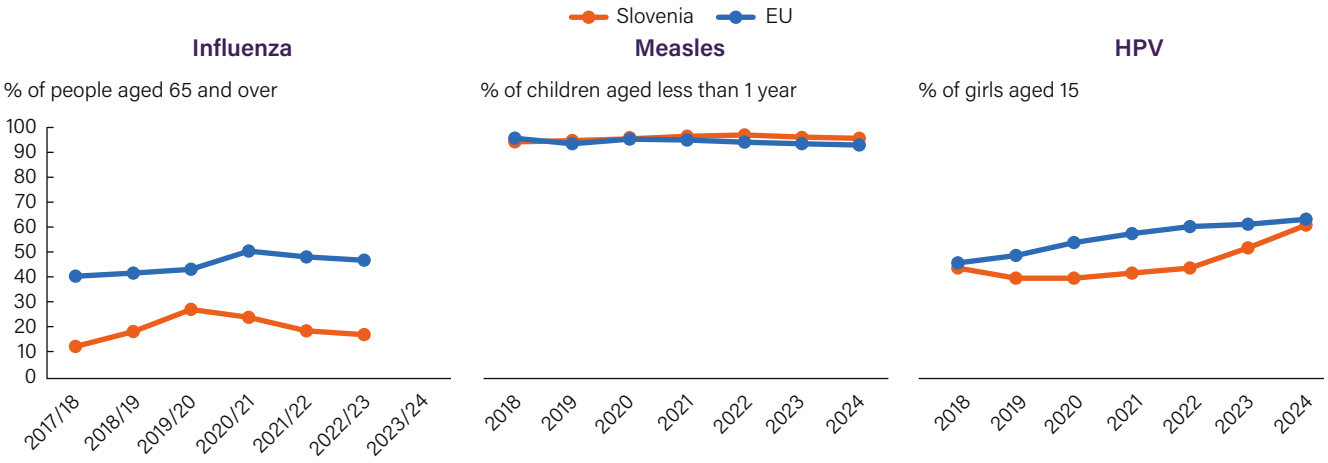
Slovenia's Programme for Limiting Alcohol Consumption and Reducing Harm (2025-26) aims to reduce the health, social and economic impacts of alcohol use, aligning with WHO and international strategies. Key measures include improving access to prevention and treatment services, enhancing early detection through alcohol screening and community interventions, and running public awareness and mass media campaigns – especially for vulnerable groups. A central focus is strengthening intersectoral co-operation across health, education, social services, local communities and non-governmental organisations. The programme also incorporates evidence-based policies on alcohol pricing, availability and labelling.

cancers, which together accounted for almost a quarter of treatable deaths. Slovenia's National Cancer Control Programme is a comprehensive, population-based strategy aimed at reducing the cancer burden through prevention, early detection, standardised treatment and equitable access to high-quality oncology care.

Influenza vaccine uptake has decreased in recent years among older people

Although the uptake of influenza vaccines among people aged 65 and over had been growing before the pandemic, the COVID-19 pandemic contributed to a subsequent decline, with only 17.6 % of people vaccinated in the winter period 2022/23 (Figure 14). However, despite growing vaccine hesitancy across Europe, vaccination rates among children remained high. Measles vaccine uptake was maintained at around 95 % of children aged under 1 year throughout the pandemic, and has been slightly above the EU average for the past five years. Human papillomavirus (HPV) vaccination uptake kept rising in 2024, reaching 61 % of 15-year-old girls, and closing the gap with the EU average (63 %).

Figure 14. Immunisation coverage shows different trends for different age groups



Note: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

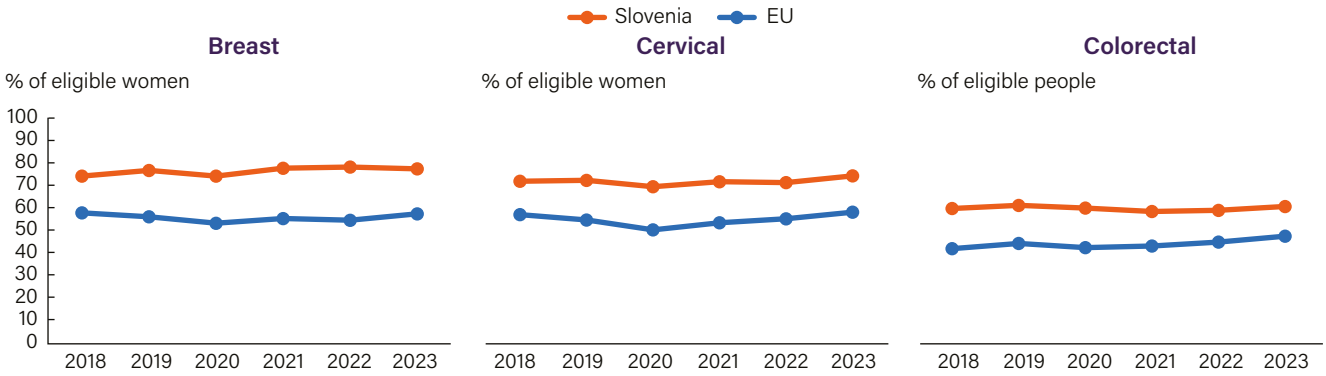
Screening programmes for breast, cervical and colorectal cancers in Slovenia are well established

In 2023, Slovenia's breast, cervical, and colorectal cancer screening rates were 15-20 percentage points above the EU averages (Figure 15). Cervical cancer screening reached 74.4 % and colorectal cancer screening 60.8 %. The breast cancer screening rate was 78 % – down slightly from previous years. Cementing the success of these programmes, Slovenia established a National Committee for Cancer Screening in 2020 to guide evidence-based early detection efforts. The possible introduction of new screening programmes, for lung and prostate cancers and for gastric cancer prevention, is currently under review (Tomšič, Ramroop & Litvinova, 2025).

Slovenia reports mixed results for quality indicators in primary care and hospital care

Avoidable hospital admission for people with chronic conditions can be used as a marker of access to, and quality of, primary care delivery, as these conditions can be successfully managed in ambulatory settings. In 2023, Slovenia reported lower avoidable hospital admission rates than the EU averages for several chronic conditions, including asthma and chronic obstructive pulmonary disease (COPD) (103 compared to 158 per 100 000 population), congestive heart failure (205 compared to 239 per 100 000), and diabetes (94 compared to 116 per 100 000). While admissions for asthma and COPD have increased slightly since the pandemic, they remain below pre-pandemic levels. In contrast, diabetes-related admissions have remained relatively stable.

Figure 15. Slovenia records significantly higher rates of breast, cervical and colorectal cancer screening than the EU averages



Notes: All data refer to programme data. Colorectal programme data are based on national programmes that may vary in terms of age group and frequency. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat (hlth_ps_prev).

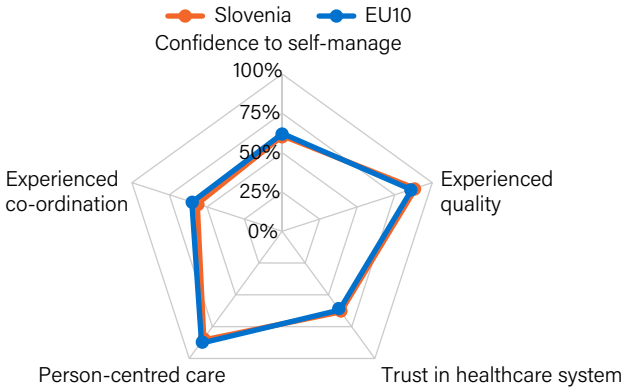
Hospital care quality indicators show mixed progress. The 30-day mortality rate for acute myocardial infarction among patients aged over 45 declined slightly over the past decade, reaching 5.7 per 100 patients in 2023 – below the EU average of 6.1 per 100. However, mortality from ischaemic stroke remained flat and above the EU average (11.7 compared to 9.5 per 100 patients).

To improve care quality, Slovenia adopted the National Strategy for Quality and Safety in Healthcare (2021-31) and passed the Healthcare Quality Assurance Act in November 2024. This legislation defined stakeholder roles and supported the creation of the Slovenian Quality Health Care Agency in March 2025 (see Section 6). Established to serve as the central institution for improved quality and safety in healthcare and evidence-based decision making, the Agency holds a wide range of responsibilities, including providing oversight on quality improvement efforts through standards and guidelines; developing digital tools for quality management; contributing to health professionals' training; overseeing and managing safety warnings and adverse events, accreditations and registries; and monitoring of performance indicators.

Slovenia scores well on patient-reported experience measures

Slovenia was among the countries that participated in the first wave of the OECD Patient-Reported Indicator Survey (PaRIS) initiative in 2023-24, collecting and reporting patient-reported experience measures (PREMs). Despite comparatively lower than average health spending per capita (see Section 4), most Slovenians reported a positive experience with quality of care (89 %) and person-centred care (85 %). Other scores were 63 % for trust in the health system, 61 % for confidence to manage own health and 57 % on experience of care coordination (Figure 16), all of which are similar to the averages among the 10 participating EU countries. In the PREMs surveys conducted by the National Institute of Public Health, patients from the paediatric and adult populations generally reported positive experiences with healthcare services, although findings also identify areas of improvement for the overall quality of care (NIJZ, 2024; 2025).

Figure 16. Slovenian patients report positive experiences with the quality of primary care and person-centred services



Note: Values refer to the percentage of people reporting positive experiences.
Source: OECD PaRIS 2024 Database; data refer to 2023-24.

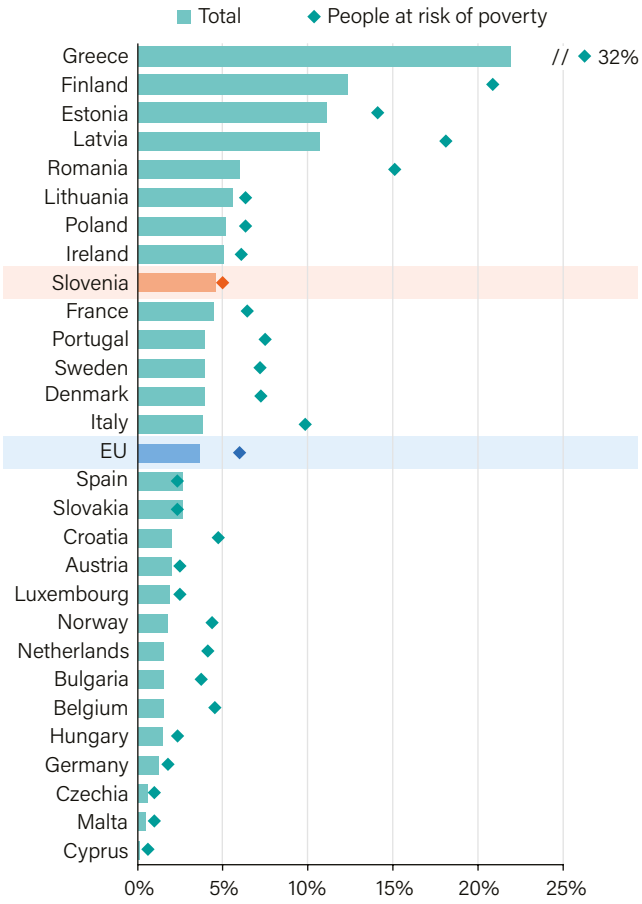
5.2 Accessibility

Slovenia has higher rates of unmet medical needs than the EU average, but the rate among those at risk of poverty is lower

According to the EU-SILC survey, among those who reported medical care needs, self-reported unmet needs due to costs, waiting times or distance to travel were higher in Slovenia in 2024 (4.6 %) than the EU average (3.6 %) (Figure 17), while self-reported unmet needs for dental examination among the population who expressed a dental health need (6.4 %) were similar to the EU average (6.3 %).

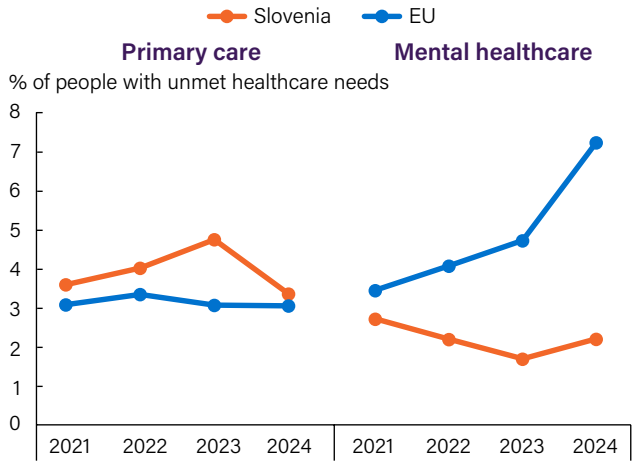
However, for both medical and dental examinations, reported unmet needs were lower among people at risk of poverty in Slovenia than the EU averages. In Slovenia, 5.0 % of people at risk of poverty reported unmet medical needs in 2024 (compared to a 6.0 % EU average) and 9.7 % reported unmet dental needs (compared to a 13.6 % EU average).

Figure 17. Self-reported unmet needs for medical care are higher in Slovenia than the EU average



Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat (hlth_silc_08b); data refer to 2024.

Figure 18. The share of adults reporting unmet needs for mental healthcare is much lower in Slovenia than across the EU



Note: Primary care includes access to a GP/family doctor or a health centre.
Source: Eurofound's Living and working in the EU survey (2025).

Survey data highlight variations in unmet needs for primary care

Higher levels of unmet needs are reported in the Eurofound Living and Working in the EU survey for more specific types of care, such as primary care and mental healthcare.[1] According to this survey, the share of adults reporting unmet needs for primary care in Slovenia spiked in 2023, reaching 5 % of respondents, to drop back to the EU average of 3 % in 2024 (Figure 18). The reasons for these variations are unclear, and may be region-dependent. Nevertheless, challenges in access to GPs were a strong public concern in the aftermath of the pandemic, which led to the establishment of additional GP offices, as well as various measures to tackle the administrative burden of primary care doctors – such as recruitment of healthcare administrators, increased digitalisation of community health centres and simplification of prescribing procedures – in addition to measures to increase the attractiveness of primary healthcare professions (see Section 4). To facilitate collaboration and coordination within primary healthcare and strengthen its accessibility, Slovenia established the Institute of Family Medicine (which supports primary healthcare professionals), upgraded the payment model of family medicine clinics and integrated model practices with family medicine clinics.

Despite high suicide rates (see Section 5.1), the share of adults reporting unmet needs for mental healthcare in 2024 was much lower in Slovenia (2 %) than across the EU (7 %) (Figure 18).

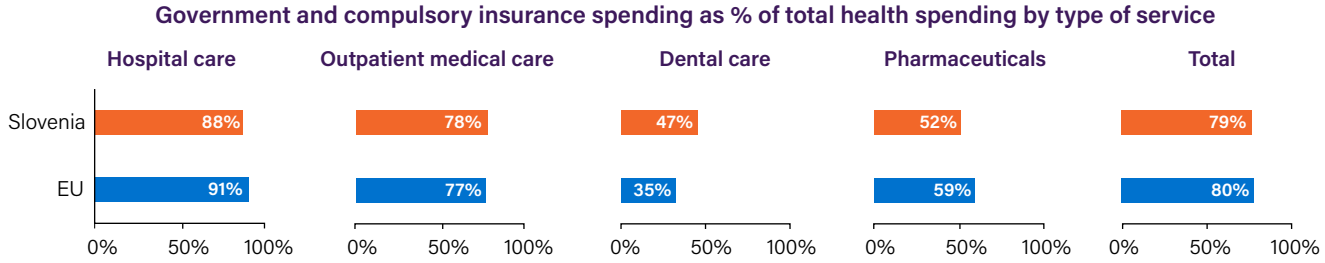
The impacts of the abolition of complementary health insurance in 2024 remain to be seen

In 2023, the share of public spending on outpatient medical care in Slovenia was similar to the EU average, but the proportion was lower for hospital care and pharmaceuticals (Figure 19), which was reflected in the high share of OOP payments for pharmaceuticals. The share of public spending on dental care was substantially higher in Slovenia (47 %) than the EU average (35 %), which may contribute to Slovenia's lower unmet dental needs among those at risk of poverty.

In 2024, complementary health insurance, which was used by a vast majority of the population to cover copayments, was abolished (see Section 4). Reimbursement of services in the statutory benefits package was extended to full coverage, and the complementary VHI was replaced by a fixed compulsory health contribution set at EUR 37.17 per month in 2025, raised on all incomes and payable in addition to already existing social health insurance contributions which are set on the basis of contribution rates (although children and students up to the age of 26 are exempted from the fixed compulsory health contribution). The compulsory health contribution is re-evaluated yearly according to the rate of average salary increase in the previous year. The state budget ensures funding for the contributions related to socially vulnerable and other designated population groups. This change had long been debated in Slovenia, and was also a response to a large increase in complementary VHI premiums in 2023, but

[1] The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

Figure 19. Slovenia provides a high share of public funding for most areas of healthcare



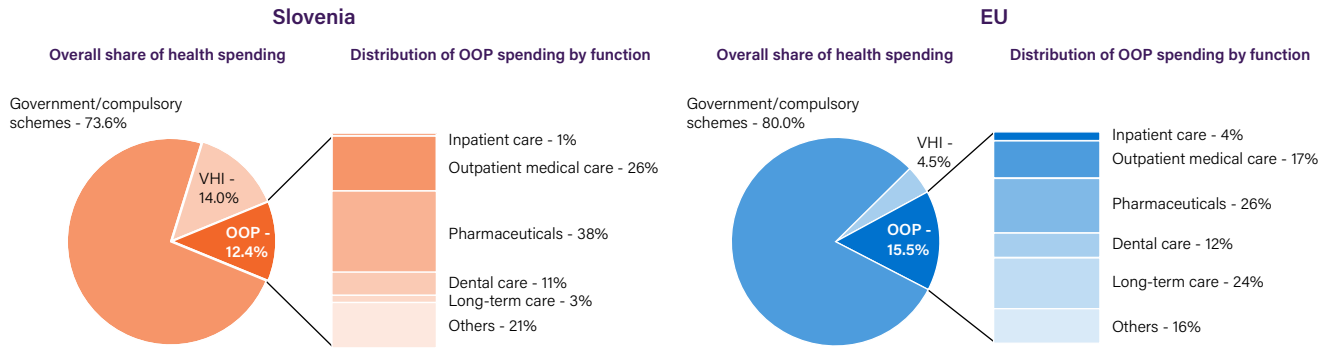
Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. N/A means data not available. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

there are still some concerns that this reform might challenge equity in the affordability and accessibility of services. The real-life impact of the change will become evident in the next few years when data from 2024 onwards become available.

Slovenia records particularly low rates of catastrophic health spending, with a relatively small gap between the poorest and the richest groups

In 2023, OOP payments represented 12 % of health spending in Slovenia, which was well below the EU average (16 %) (Figure 20). Pharmaceuticals are responsible for almost two fifths of OOP payments in Slovenia (38 %), followed by outpatient care (26 %) and dental care (11 %). In 2023, OOP payments in Slovenia included both copayments for services that are included in the benefits package and direct payments for services that are outside the benefits package. The role of OOP spending in health expenditure and for different types of services may be affected by the recent abolition of complementary VHI. Historically, the catastrophic impact of OOP payments has been very low in Slovenia: in 2022, only 0.7 % of households in the poorest income quintile faced catastrophic health spending[2] in Slovenia (compared to a 4 % EU average), which was only 0.4 percentage points higher than the share in the richest quintile.

Figure 20. Pharmaceuticals are a key driver of OOP payments in Slovenia



Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

Critical shortages among the health workforce continue to hamper service availability

Unmet needs for medical examination among the general population due to waiting times have remained high in Slovenia since 2017. Although they slightly decreased in 2022, reaching 3.6 % compared to 4.7 % in 2021, this may partly reflect the impact of the pandemic in 2021. The level in Slovenia remained far higher than the EU average (0.9 % in 2022).

In 2024, 90.6 % of patients waited more than three months for cataract surgery, and almost all patients waited over three months for hip replacement (98.6 %) and knee replacement (99.3 %) surgery.[3] Slovenia is upgrading its centralised digital waiting lists platform to enhance transparency and data accuracy. Availability gaps are partly due to personnel shortages – especially critical shortages of primary care physicians, outpatient specialists and hospital nurses. Measures that address staff shortages and strengthen the healthcare workforce (see Section 4) are expected to also improve waiting times.

The Health Insurance Institute has modified the payment model for primary care delivery. Moreover, a Renewed Health Service Act, passed in April 2025, set clearer rules on the careers of

[2] Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).
[3] Waiting times data are based on first available appointments and should be interpreted with caution as they may not reflect, for example, that necessary tests need to occur before an appointment.

health professionals, limiting the circumstances under which public employees can also work for private health providers. The objective is to strengthen the public healthcare system, where most healthcare professionals are employed, although critics point to the risk that many professionals may opt to leave the public system for the private one. This legislation also introduces performance-based payment models for public servants and the obligation for public healthcare institutions to better monitor, plan and report the workload of their healthcare staff. Finally, the National Strategy for the Management and Development of Healthcare Workers 2025-35 is in preparation; it aims to reinforce the sustainability of the healthcare workforce through measures that do not focus solely on financial incentives (see Section 4) but also support enhanced training, skills and responsibilities expansion, as well as qualification recognition.

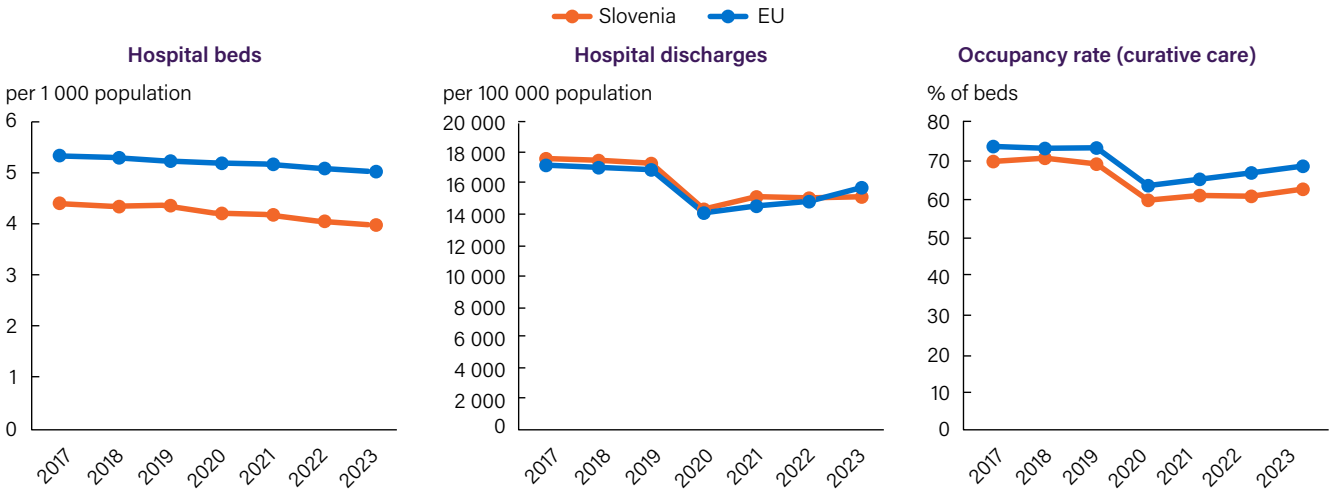
5.3 Resilience

Health system resilience – the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes – has become central to policy agendas. Key priorities include easing pressures on service delivery, strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

The density of hospital beds in Slovenia is far below the EU average

Hospital infrastructure in Slovenia has been shaped by policies favouring outpatient over inpatient care. For the past 15 years, the number of hospital beds per 1 000 population has been decreasing steadily, reaching 4.0 beds per 1 000 in 2023. This rate was below the EU average of 5.1 beds per 1 000 (Figure 21) and the rates of most of Slovenia's neighbours – including Austria (6.6 per 1 000), Hungary (6.5 per 1 000) and Croatia (5.7 per 1 000) – although it remains higher than the rate in Italy (3.0 per 1 000). The majority of hospital beds are dedicated to somatic care (85 %), while the remaining are psychiatric beds. Although the declining trend in hospital bed numbers in Slovenia was not particularly affected by the COVID-19 crisis, the pandemic had a clear impact on occupancy rates and the number of hospital discharges per 100 000 population – similar to trends in other EU countries. The number of hospital discharges declined in Slovenia from 17 000 per 100 000 population in 2019 to around 14 300 per 100 000 in 2020, increasing thereafter to 15 098 per 100 000 in 2023, which is below the EU average. The hospital occupancy rate declined from 69 % in 2019 to 60 % in 2020, increasing slightly to 62 % in 2023 – below the EU average of 68 %.

Figure 21. The number of hospital beds has been consistently below the EU average



Note: The EU averages are weighted.
Sources: Eurostat (hlth_rs_bds1) and OECD Data Explorer (DF_KEY_INDIC).

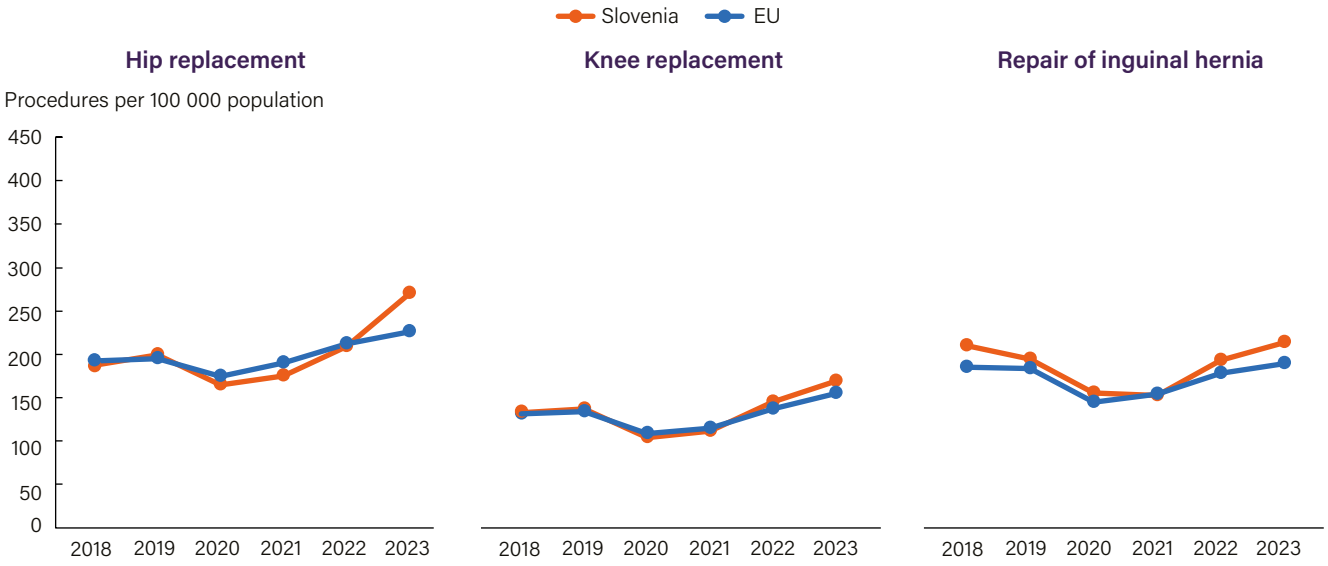
Elective surgery volumes have picked up again following the COVID-19 pandemic

Early implementation of pandemic contingency measures partly explains the drop in inpatient usage in Slovenia, as many non-urgent elective procedures were postponed. Volumes of elective hip replacement, knee replacement and repair of inguinal hernia fell between 2019 and 2020, with yearly numbers decreasing by over 35 procedures per 100 000 population for all three types of surgery (Figure 22). As in other EU countries, volumes have increased again, with repair of inguinal hernia (214 procedures per 100 000 population), hip (270 per 100 000) and knee replacement (169 per 100 000) exceeding pre-pandemic levels in Slovenia in 2023. However, waiting times remain long, and almost all patients wait more than three months for hip or knee replacement surgery (see Section 5.2).

Since the pandemic, public spending on health in Slovenia has remained high, and investments are supported by EU funds

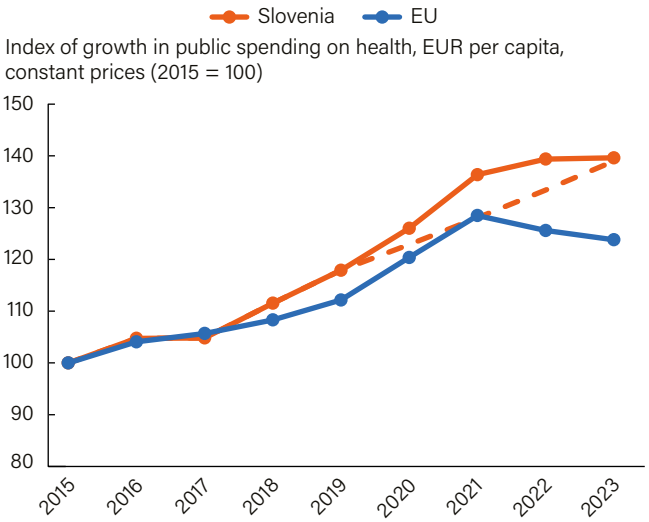
Since 2018, the growth in public spending on health per capita (based on 2015 constant prices) has been higher in Slovenia than the EU average (Figure 23). However, while the EU average has declined since 2021, Slovenia's growth

Figure 22. Volumes of elective surgeries in Slovenia are similar to volumes in the EU overall



Note: The EU average is unweighted.
Sources: Eurostat (hlth_co_proc3), OECD Data Explorer (DF_SURG_PROC).

Figure 23. Slovenia's public spending on health remained high in 2022 and 2023



Notes: The EU average is weighted (calculated by the OECD). The dashed line represents the projected trend based on pre-pandemic (2015-19) data.
Source: OECD Data Explorer (DF_SHA).

rate in per capita public spending on health has continued to increase slightly. This level of spending is equal to the projected growth trajectory of public spending on health based on the trend established prior to 2019. Moreover, government health spending as a percentage of total government spending returned to pre-pandemic levels in 2023 (16 %). Investment in the health system is also derived from EU funding instruments (Box 2).

Efforts to improve the digitalisation of healthcare in Slovenia are ongoing

Investments in health information and communication technologies in Slovenia have been consistently below the EU average for the past 10 years, but increased substantially following the pandemic – from EUR 1.19 million per 100 000 population in 2019 to EUR 1.96 million per 100 000 in 2024, supported by Recovery and Resilience Fund investments (see Box 2).

The number of teleconsultations per capita in Slovenia has grown strongly, and surpassed the EU averages in 2022 and 2023 (Figure 24). In 2024, the shares of people using the internet to seek health information (56.4 %) and to access health records (26.9 %) were similar to the EU averages. In particular, accessing electronic health records online surged in Slovenia during the COVID-19 pandemic, rising from just 6.2 % in 2020 to 31.0 % in 2022; this reflects not only the shift to more online activities but also the issuance of digital COVID-19 certificates through the eZvem portal, where citizens access their personal health records. After dropping to 24.7 % in 2023 following the pandemic, data from the Statistical Office of Slovenia show a steady, incremental growth in online access to health records, reaching 27.4 % in 2025. The share of people who used the internet to make an appointment in 2024 (33 %) remained below the EU average (40 %) but has more than doubled since 2018 (15 %).

As in many other EU countries, Slovenia records important gaps in use of the internet for various health-related activities between users with high or low education levels, and between age groups. People with lower education levels[4] and people aged over 64 consistently report lower use of the internet for health-related activities.

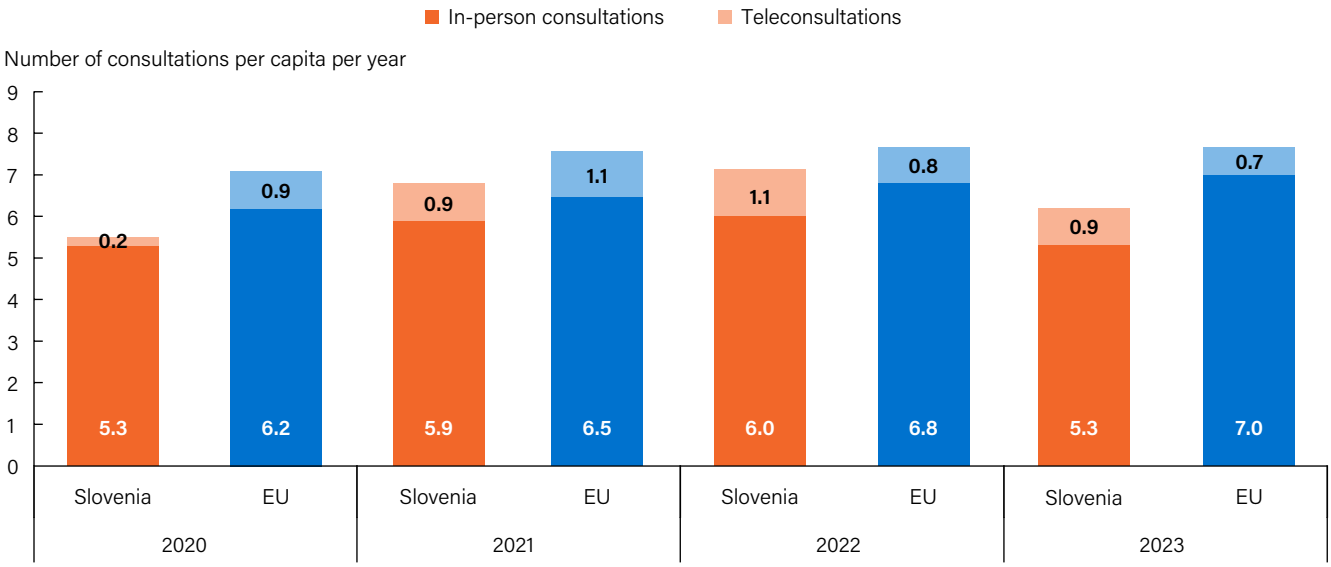
[4] Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).

Box 2. Along with other EU programmes, the Recovery and Resilience Fund and the EU's Cohesion Policy support a number of investments in Slovenia's health system

Public investment in the health sector is supported by the EU's Recovery and Resilience Fund,[5] which encompasses funding of EUR 167 million for Slovenia's health system – equivalent to 7.5 % of its total EUR 2.2 billion funding for Slovenia. Key areas of investment are for the effective treatment of communicable diseases and the digital transformation of healthcare. Complementing the Recovery and Resilience Fund, the EU Cohesion Policy (2021-27) dedicates approximately EUR 98 million (EU co-financed share) to healthcare in Slovenia, with over one third of this funding allocated to enhancing the accessibility, effectiveness and resilience of the health system, over a quarter to active and healthy ageing, another quarter to upgrading health equipment, and the remainder to digitalisation in healthcare.

Additionally, until mid-September under the EU4Health work programmes (2021-25), Slovenian beneficiaries received funding via joint actions, action grants and direct grants amounting to nearly EUR 39 million, which was dedicated to cancer initiatives (44 %), crisis preparedness (26 %), health promotion and disease prevention (13 %), health systems and health workforce measures (9 %), and digitalisation of healthcare (7 %). Finally, with a total EU budget of EUR 3.8 million, the Technical Support Instrument (TSI) (2021-27) supports closed and ongoing health reforms on patient safety and quality of care, cancer screening, healthcare digital transformation, access to EU funds for investments in primary care, health technology assessment, mental health and physical activity among young people, and long-term care.

Figure 24. The numbers of teleconsultations per capita are now higher in Slovenia than across the EU



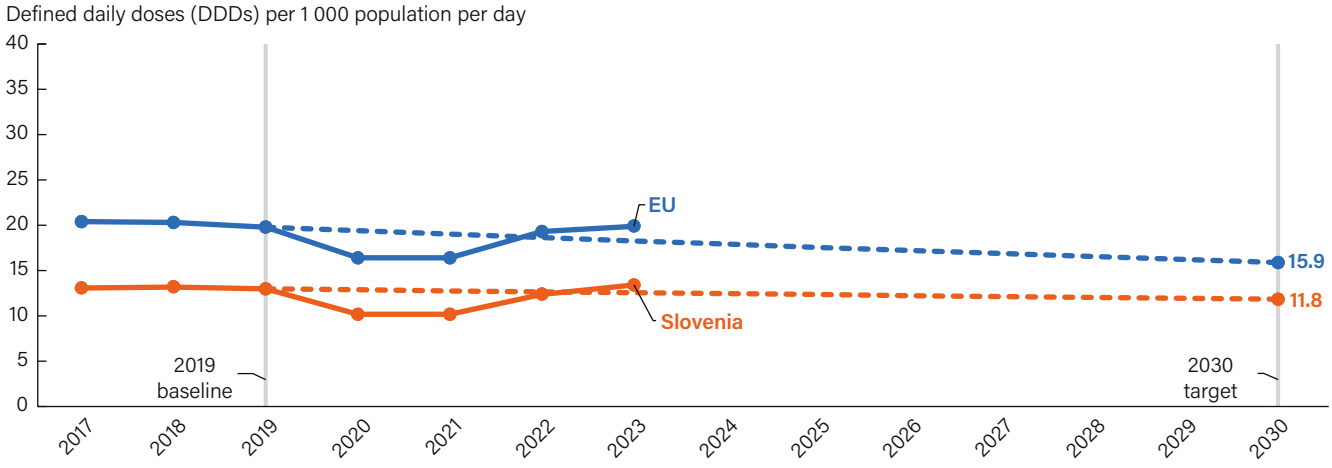
Note: The EU19 average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_CONSULT).

Slovenia's antibiotic consumption remains among the lowest across the EU, but it has increased since 2021

Curbing excessive antibiotic use is fundamental to tackling antimicrobial resistance, making it crucial to monitor consumption – particularly to track progress in meeting the EU Council's 2030 targets that were adopted in 2023.[6] Slovenia is among the EU Member States with the lowest consumption rates of antibiotics (13.4 defined daily doses per 1 000 population per day in 2023), but it has followed the trend across the EU, with antibiotic consumption that surpassed its 2019 pre-pandemic level in 2023 (Figure 25). Based on the current trend, a change in prescribing patterns will be required to return to the reduction target pathway. The 2019-24 One Health Strategy, adopted for the surveillance, detection and reporting of antimicrobial-resistant pathogens, aims to strengthen antimicrobial resistance stewardship in the country.

[5] Recovery and Resilience Fund data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.
[6] Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach, 2023/C 220/01.

Figure 25. Slovenia's antibiotic consumption in 2023 was slightly above its 2030 reduction target pathway



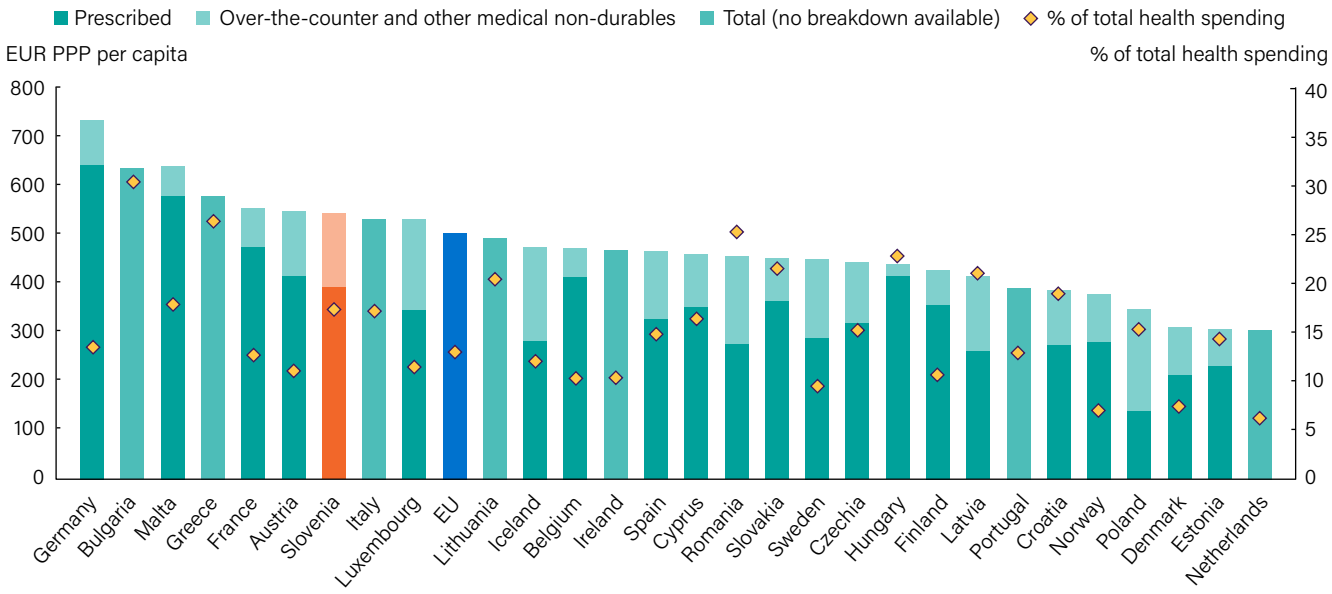
Notes: The EU average is weighted. The chart shows antibiotic consumption in hospitals and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

6 Spotlight on pharmaceuticals

Pharmaceutical spending in Slovenia is among the highest across EU countries

In 2023, expenditure on retail pharmaceuticals per capita in Slovenia (EUR 552, adjusted for differences in purchasing power) was higher than the EU average (EUR 510) and also represented a higher share of total health spending (18 % in Slovenia compared to 13 % in the EU) (Figure 26). Pharmaceutical spending in the retail sector accounted for over two thirds (65 %) of total spending on pharmaceuticals in 2023, which was slightly higher than the average of EU countries with available data (59 %).

Figure 26. Slovenia's spending on retail pharmaceuticals is among the highest across the EU



Note: This figure represents expenditure on pharmaceutical dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway (2022).

Although, in general, outpatient pharmaceuticals represent the highest share of health expenditure in Slovenia, spending on pharmaceuticals in the hospital sector is particularly high (equivalent to EUR 245 in constant prices per capita in 2022) compared to other EU countries with reported data, and has been increasing steadily since 2017. As in other EU countries, this trend can be explained by the increase in consumption of innovative and more expensive medicines in inpatient settings (ESIP & MEDEV, 2024).

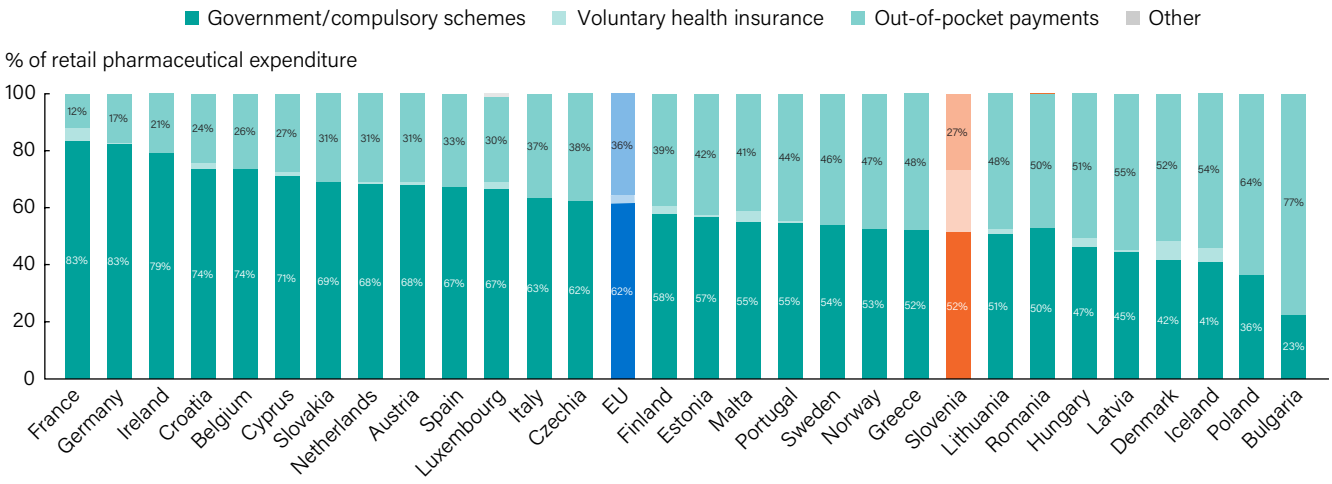
To mitigate the spending surge on innovative pharmaceuticals, Slovenia established the Slovenian Quality Health Care Agency, whose mandate includes quality-specific roles (see Section 5.1), as well as evidence-based evaluations to support pricing and reimbursement decision making through health technology assessment (HTA). Following the adoption of its statutes (Official Gazette of the Republic of Slovenia, 2025) and the nomination of an interim director in April 2025, the new Agency became operational in July 2025. HTA is expected to actively inform pricing and reimbursement decision making, as well as investment decisions in Slovenia, in line with the EU's HTA Regulation (PPRI, 2025). The Agency is actively participating in implementation of the Regulation at the EU level, taking part in joint clinical assessments. Drafting of national bylaws and HTA methodology is ongoing. The Agency is also building its capacity in HTA with the technical support of the EU through the TSI (see Box 2). To curb expenditure on off-patent medicines, a generic reference pricing system was introduced in 2003 (ESIP & MEDEV, 2024).

Historically, government funding for retail pharmaceuticals as well as out-of-pocket spending have been below the EU averages

In 2023, the share of government funding for retail pharmaceuticals in Slovenia was 51 %, which is much lower than the EU average of 62 % (Figure 27). However, OOP payments also represented a lower share of total retail pharmaceutical expenditure (27 %) than the EU average (36 %), which is explained by the substantial role of VHI (22 %).

OOP payments for pharmaceuticals represented 38 % of total OOP expenditure for health in 2023. Although this makes them a key driver of OOP spending, overall OOP spending in Slovenia is low, as is household catastrophic health spending (see Section 5.2). Nevertheless, in 2022, medicines were still linked to 18 % of catastrophic health spending in the lowest income quintile and 16 % in the second lowest quintile, while they have a much smaller effect – ranging from 3 % to 9 % – in the higher income quintiles (WHO Regional Office for Europe, 2025). This may be due in part to the role of complementary health insurance: while most people are covered, about 5 % of the population had low incomes, lacked VHI coverage and were not exempt from copayments. The recent abolition of complementary health insurance and removal of copayments (see Sections 4 and 5.2) may contribute to tackling these inequalities.

Figure 27. In 2023, only half of retail pharmaceutical expenditure in Slovenia was covered through government schemes



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway (2022).

Slovenia matches the EU average in new medicine availability, but faces longer delays

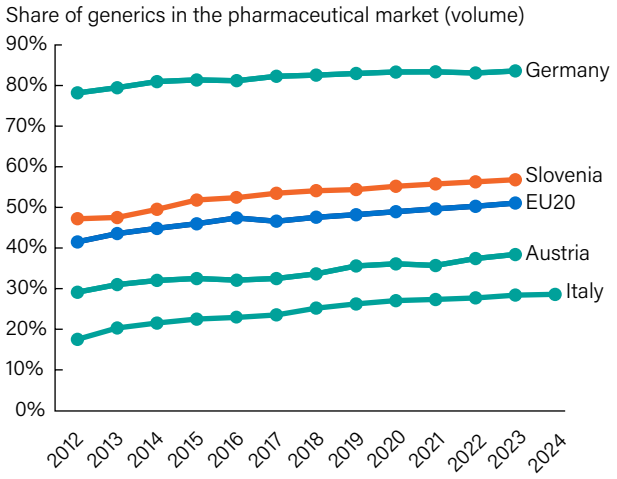
Two of the indicators most commonly used to assess the timelines and breadth of access to new medicines are the average time elapsed between EU marketing authorisation and public reimbursement, and the proportion of centrally approved medicines available nationally. Both metrics are reported in the European Federation of Pharmaceutical Industries and Associations' Patients WAIT Indicator Survey (Newton et al., 2025). While neither indicator comprehensively measures meaningful patient access to effective treatments, they provide a foundational basis for discussion. Of 173 products that received EU approval between 2020 and 2023, Slovenia had 86 available, which is slightly above the EU average (80 products). It took an average of 610 days in Slovenia for new medicines to become available – a month longer than the EU average (578 days). The upcoming integration of HTA into pricing and reimbursement decisions,

along with the new timelines set by the EU's HTA Regulation, are likely to influence both the timing and extent of access to new medicines.

Uptake of generics is slowly growing while biosimilar uptake has improved significantly

The share of generics in the total volume of medicines dispensed in community pharmacies in Slovenia has been increasing for the past decade, and is consistently above the EU average. In 2023, it reached 57 % of the pharmaceutical market, compared to 51 % on average across the EU (Figure 28). In recent years, the share of biosimilars has improved significantly. For example, in 2023, it reached 68 % of reimbursed cancer medicines in Slovenia, which was above the EU average (65 %) (OECD/European Commission, 2025). Furthermore, pricing and funding mechanisms for biological medicines ensure reasonable prices, which contribute to containing pharmaceutical expenditure.

Figure 28. The consumption of generics in Slovenia is above the EU average



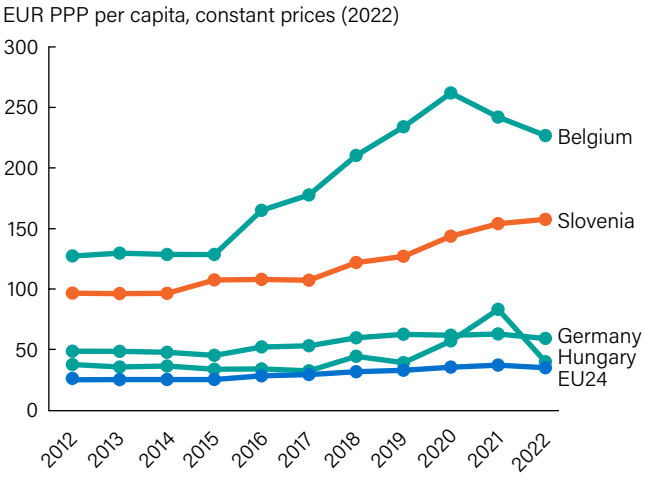
Note: The EU average is weighted.
Source: OECD Data Explorer (DF_GEN_MRKT).

Slovenia's investment per capita in pharmaceutical industry research and development is high

Slovenia is among Europe's leading drug manufacturing countries, serving as a key hub for generic pharmaceutical production, and becoming a rapidly growing export sector (EFPIA, 2023). The country's skilled workforce, strong research and development (R&D) infrastructure, and supportive regulatory environment continue to attract major investments, including for advanced biopharmaceuticals.

In 2022, Slovenia's R&D investment per capita in the pharmaceutical industry was the third highest in the EU (EUR 158 per capita, adjusted to constant 2022 prices), behind Belgium (EUR 227 per capita) and Denmark (EUR 171 per capita). This is more than four times higher than the EU average of EUR 35 per capita in 2022, but also significantly higher than the level in countries with high-performing economies such as Germany (EUR 59 per capita) and neighbouring countries such as Hungary (EUR 40 per capita) (Figure 29).

Figure 29. Slovenia's research and development investment per capita in the pharmaceutical industry is one of the highest in the EU



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

According to OECD Intellectual Property Statistics, nine patent applications filed under the Patent Co-operation Treaty (PCT) in 2022 originated from applicants based in Slovenia – equivalent to 4.2 patent applications per million people. This is on a par with the EU average and similar to pre-pandemic levels (OECD, 2025). In 2024, Slovenia conducted 18 clinical trials per million population – also close to the EU average. Only 37 % were industry sponsored, which is well below the EU average of 52 %, and this share has not exceeded that level since 2019. Slovenia also lags in early-phase (phase I and II) trials, which made up just 33 % of total trials compared to 44 % across the EU. Slovenia seems slightly better embedded in global studies: nearly half (45 %) of Slovenia's clinical trials in 2024 were multi-country, approaching the EU average of 51 %.

7 Key findings

- Life expectancy at birth and age 65 is high, and most Slovenians report being in good health. However, health disparities by gender and income are higher in Slovenia than the EU averages, with fewer women and low-income groups reporting good or very good health.
- Cardiovascular disease and cancer incidence rates are higher in Slovenia than on average across the EU. These rates are influenced by behavioural and environmental risk factors, which contribute to nearly a third of all deaths. Overweight and obesity – especially among adolescents – are major public health concerns. While overall adult smoking rates have fallen, the daily smoking rate among women has stagnated. Alcohol consumption has remained stable and is close to the EU average.
- Overall health spending in Slovenia has been increasing steadily over the past decade, but has consistently remained below the EU average. In 2023, almost three quarters of health spending was publicly funded, while complementary voluntary health insurance drove just over half of private spending. The majority of the population who were liable for copayments took out such insurance, contributing to historically low levels of out-of-pocket spending in Slovenia. The 2024 abolition of complementary voluntary health insurance covering copayments, and the shift to a fixed compulsory contribution under the public health insurance scheme to accompany the removal of copayments, will alter expenditure dynamics.
- Although mortality from preventable causes declined in 2022, it was higher than pre-pandemic levels and above the EU average. COVID-19 remained a leading cause of preventable mortality in Slovenia, along with lung cancer and alcohol-related causes. In contrast, treatable mortality rates have been decreasing steadily, and are consistently below the EU average. Along with ischaemic health disease, colorectal and breast cancers accounted for almost a quarter of treatable deaths. Screening programmes for major cancers are in place, with plans to expand to gastric, lung and prostate cancers.
- Slovenia reports mixed results on quality indicators, but scores highly on patient-reported experience measures. Although results from quality indicators for primary healthcare and hospital care are better than the EU averages, improvements have been gradual. The National Strategy for Quality and Safety in Healthcare aims to integrate quality monitoring better, supported by the new Slovenian Quality Health Care Agency, which will serve as the central institution for improved healthcare quality and safety.
- While Slovenia reports higher unmet needs for medical examinations than the EU average, mainly due to long waiting times, these needs are lower than the EU average among people at risk of poverty. The health system remains relatively centralised, with most professionals in the public sector, but workforce shortages in both primary and hospital care contribute to delays in accessing care. A comprehensive set of policies aims to improve workforce retention and sustainability, including financial and non-financial incentives for health professionals and students, new payment models for healthcare workers and primary healthcare clinics, increased funding and training opportunities, and task-shifting measures. Other policies have expanded the number of general practitioner offices and increased digitalisation of community health centres to aid accessibility.
- Pharmaceuticals accounted for over a third of household out-of-pocket payments. Until 2024, the substantial role of voluntary health insurance helped to keep these costs relatively low compared to the EU average. Medicines still contribute to a relatively significant share of catastrophic health spending for those in the lowest income quintile. The removal of copayments in 2024 for services covered under the public benefits package aims to mitigate these inequalities. Pharmaceutical spending in Slovenia has been rising steadily, especially in the retail sector, which the upcoming health technology assessment activities of the new Slovenian Quality Health Care Agency aim to tackle through evidence-based pricing and reimbursement evaluations.

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Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

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