Introduction – framing the debate into its context

With the current healthcare reform debate in the United States, the question of personal coverage in health insurance systems is again being examined. Despite the existence of federal social insurance programmes Medicaid and Medicare, the US has traditionally been experiencing a problem of underinsurance. It is estimated that between 46 and 54 million Americans are without health insurance (between 20 and 27% of the American population under the age of 65). This number has steadily grown since the mid-1980s mainly because of increasing health insurance premiums. With the economic recession it is expected to grow even further by about 7 million until 2010.

Increasingly the negative effects for both health outcomes as well as the economy can not be ignored. Mortality rates, even when controlling for risk factors (age, sex, race, income), are higher among uninsured. As the uninsured are mainly to be situated among the more vulnerable and deprived groups of the population, the problem is likely to increase the health inequalities among the population. Despite the poor coverage rate the US health system is by far the most expensive accounting for 16% of GDP. The leading cause for individual bankruptcy in the US is medical debt. But also the employment-base of US health insurance is obstructing mobility among the active population. Also the problem is making health care in the US more inefficient as uninsured tend to be less involved in both health prevention and chronic disease management programmes, will forgo medical care and therefore risk to develop more serious conditions and to end up in emergency rooms where they can only be stabilised. In order to prevent this from happening Federally Qualified Health Centre (FQHC) have been set up since 1996 to provide primary and preventive healthcare services to medically underserved and (under)insured populations - including homeless, migrants and residents of public housing - regardless of their ability to pay. While they charge to patients a sliding-fee scale that is based on patients’ family income and size, the FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act. In 2006 over 15 million patients were treated in this community health centres.

The Obama administration has submitted an ambitious reform plan to Congress, which has as one of its main objectives to create universal coverage by introducing a mandate health insurance and guaranteeing low-cost insurance for those who can not find an affordable option on the private health insurance market.

In Europe the debate is framed a bit differently. The rates of uninsured are far lower in most countries compared to the US. Historically, some form of pre-paid access to healthcare services was introduced in many European countries more than a century ago. Started as voluntary systems set up to cover the working classes they have gradually been transformed into public systems organising access to health care on a compulsory basis. After World War II basically three different models were distinguished, called after the name of their founding fathers:

- **Bismarck**: systems of social insurance, funded out of income-related contributions (pay-roll taxes) and administered by (semi)-public sickness funds, ensuring financial protection against the risk of healthcare costs.
• *Beveridge*: state-run and tax-funded national health service providing free-of-charge healthcare services for the entire population through mainly publicly-owned facilities and salaried staff.

• *Semashko*: centrally-organised and state-financed health service in the former socialist countries with publicly owned healthcare facilities and different levels of state administration responsible for planning, allocation of resources and managing capital expenditures.

These models are not more than labels to type health systems with certain common characteristics, especially financial. However they cover a much more complex interaction of different mechanisms and organisational forms. Furthermore, over time all health systems have evolved into mixed systems, integrating elements from different models. Even in the most original *Bismarckian* systems state funding has come to complement financing out of social contributions. *Latvia* is an example of a social health insurance system entirely funded on taxes (since 2005). On the other hand, state-run systems which have moved to social insurance often kept the universal scope of application as well as privileged public providers to purchase services from. Today, other distinctions can be perceived more relevant to type and categorise health systems, like for instance the distinction between single and multiple payer systems.

Since coverage in both the *Beveridge* and *Semashko* models are based on residence, they are by nature universal in terms of personal scope, although also under these systems certain groups (temporary residents, non-citizens, illegal immigrants, minority groups, people living in remote areas) may experience problems of accessibility. *Ireland*, which belongs to the *Beveridge* model, traditionally only provides full coverage to residents who qualify for a Medical Card (category I) - based on income level, household size and age - is entitled to all services free of charge. For the rest of the population (category II), i.e. around 70% in 2007, are granted only free access to publicly funded secondary care services. All the rest is subject to user fees. To secure full primary coverage this group needs to purchase private health insurance.

The question of people falling outside the scope of public healthcare protection is, however, more related to the social insurance type. Historically, social health insurance was introduced to ensure cover for the social working class who could not afford to pay healthcare costs directly out-of-pocket. Later when medicine developed and became more complex and expensive, also higher income groups started to seek pre-payment for this risk either through private health insurance or via inclusion in social health insurance. Since the second World War, the personal scope of health insurance schemes was gradually extended to include more categories.

Although traditional *Bismarckian* systems have gradually become quasi-universal, the debate on universal coverage has in recent years gained a renewed interest; This has mainly to do with three different factors.

• First, healthcare reforms in certain countries have been introducing more private elements into statutory health insurance in combination with regulated market competition. This has brought about the concern of increased risk selection and thus a higher proportion of uninsured.

• Secondly, with Central and Eastern European countries after political transition moving away from the traditional state-led and tax-funded *Semashko* model and introducing *Bismarckian*-style social health insurance, the question was raised how to include and finance for non-active groups in the population and how to combine the often constitutionally-guaranteed right to free-of-charge healthcare with social health insurance based on payment of contributions.

• Thirdly, whereas remaining gaps in personal scope of statutory health insurance have been gradually closed, countries still struggle with a few pockets of uninsured groups. Besides, simultaneously cost sharing in public health protection systems has increased, mainly due to increasing public financing constraints. This raises a new dimension to the broader debate of accessibility to health care.

### Universal access: a conceptual framework

#### Universal coverage as defined by the international community

Universal health coverage can be described as a situation in which the entire population of a country has access to appropriate health care services when needed and at an affordable cost, irrespective of sex, ethnic, social or any other background nor financial or health status. Besides elements of physical and timely access, it mainly involves financial coverage by which the actual healthcare costs are funded through systems of prepayment, mainly fiscal or pay-roll tax-based.
The World Health Organisation considers universal access as integral part of its health for all strategy, which based on the 1978 Alma Ata Declaration calls upon governments, international organizations and the whole world community to take necessary measures to introduce, develop and maintain essential (primary) health care. It is considered part of the goals health systems are supposed to pursue and needs to translate in the four health system functions: governance, financing, resource generation and service delivery. It relates to the goals of equity in access, which implies that citizens should be guaranteed financial protection against the cost of health care. A derived principle is equity in financing, which supposes that households should contribute to the health system according to their capacity to pay, not according their utilisation. In its Resolution on sustainable health financing, universal coverage and social health insurance, the World Health Assembly in 2005 urged governments to ensure that health-financing systems would include a method of prepayment of financial contributions for health care with a view to sharing risk among the population and avoiding catastrophic healthcare expenditure and impoverishment of individuals as a result of seeking care. Universal and comprehensive social protection is also considered an important tool for addressing social health determinants and tackling health inequalities. The WHO Commission on Social Health Determinants in its final report advocates for publicly funded healthcare systems either through general taxation or mandatory universal insurance. It warns for the negative effects of high user fees leading to overall reduction in utilisation and worsening health outcomes. Besides appropriate financial policies it also points at the need to develop effective workforce policies to ensure adequate numbers of skilled health workers locally.

Universal access is generally considered to be a typical characteristic of health systems in the European Union. It is enshrined in several national constitutions and is also guaranteed in Article 35 of the EU Charter of Fundamental Rights, which states “Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.” It also was stated as one of the overarching values together with access to good quality care, equity, and solidarity in the Statement on common values and principles in EU health systems that the EU Health Council issued in 2006. Accepting the considerable variety among Member States in the way these values are put into practice based on their different context, the Health Ministers acknowledge the need for health systems to ensure equal access to health care for all which presupposes solidarity in the financing and equity in the provision of healthcare services. Given the increase cost pressures, especially in the light of the current economic downturn, the difficult challenge they face is to maintain and preserve these values while at the same time ensure financial sustainability of their health systems.

**Dimensions of universal access**

Universal systems, either tax-based National Health Service (NHS) or Social Health Insurance (SHI), share the following characteristics:

- They provide the principal mode of insured access to healthcare;
- Public funding dominates;
- Participation is mandatory;
- Benefit coverage is broad;
- Access (and resource allocation) is based on need.

Clearly, the concept of universal access is not limited to the issue of eligibility (horizontal dimension - breadth of protection), the question whether the entire population is falling within the personal scope of application of any system. It also relates to the material scope of application (vertical dimension - depth of protection), the question what services are covered (benefit package) and the level of coverage. The idea of universality includes two strands of principles. On the one hand the idea that everyone should be guaranteed a minimum

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1 Fifty-eight World Health Assembly, Resolution on sustainable health financing, universal coverage and social health insurance, WHA58.33, 2005
2 Sixty-second World Health Assembly, Reducing health inequities through action on the social determinants of health, 2009
3 WHO Commission on social determinants of health, Closing the gap in a generation: Health equity through action on the social determinants of health, 2008
4 Council of the EU, Charter of Fundamental Rights of the European Union, O.J. 2000, C 364
5 Council Conclusions on Common values and principles in EU Health Systems, 2733rd Employment, Social Policy, Health and Consumer Affairs Council meeting (Luxembourg, 1-2 June 2006), O.J. 2006, C 146
level of subsistence and care, on the other hand the idea of equality implying that everyone should be guaranteed an equal level and quality of care, regardless of financial or other status (Wörz et al., 2006). Heath systems can be situated in the continuum between these two principles. The often combine both principles by putting the minimum at a sufficient high level so that there is relative few remaining room for preference, choice and private market.

As a framework for analyzing access to health care, the Health ACCESS project developed a filter model identifying seven consecutive hurdles to be surmounted before realizing universal access⁶.

The filter model: seven steps of accessing healthcare services

- Population coverage
- Content of the benefit basket
- Cost-sharing arrangements
- Geographical factors
- Choice among available providers
- Organisational barriers
- Preferences

Source: Busse et al. 2006

The first step constitutes the personal scope of application. This mainly relates to public systems irrespective of their financing mode (social contributions, taxation or a mixture of both) In the European Union most statutory health systems ensure universal or nearly universal coverage for the population residing legally on the national territory.

The second hurdle constitutes the material scope of application, i.e. the extent of the benefit package covered under the system of primary coverage. Despite some variation these public systems generally guarantee coverage for a comprehensive package of benefits, including preventive and curative health services, such as primary care, ambulatory and in-patient specialist care, prescription drugs, mental health care, dental care, home care and nursing home care. Decisions to include new services to the benefit package are increasingly supported by health technology assessment (HTA).

Although these two first hurdles are fundamental and – conceptually - have priority as barriers over the other one, the material scope is also largely determined by the third hurdle of cost-sharing arrangements, as the define the level of coverage under the benefit package. Gradually all Member States have introduced cost sharing mechanisms the extent of which however varies considerably. Most commonly are user charges for prescription drugs and dental care services. Next to official user charges also informal payments occur in some Member States. Although it is more widely used there is no good evidence to indicate that cost sharing

⁶ Mapping Health Services Access: National and Cross-Border Issues (HealthACCESS), also see www.ehma.org/projects/ as well as Busse et al. 2006 and Wörz et al. 2006
is leading to more efficient use of healthcare resources or to structural long-term cost containment. Instead it clearly increases inequalities in the access to healthcare services.

The remaining four potential barriers, the importance of which will also vary according to the country, relate more to factual elements.

The geographical distribution and actual availability of health care locally can also impede on access and be a factor of unequal treatment among citizens. Especially rural areas can suffer from a lack of sufficient qualified health professionals, who are attracted to more densely populated areas where they can earn more. This can be particularly worrying for less mobile people, including elderly. Certain countries have introduced financial incentives to maintain health professionals in underserved areas as well as created special facilities to ensure basic care in underprivileged areas (e.g. walk-in centres).

Limitations in terms of healthcare providers accredited to perform under the public system as well as other organisational reimbursement conditions, such as gate-keeping and referral mechanisms, are other factors that can potentially reduce free access. Member States have made access to these services subject to different conditions and formalities. In some Member States, only services provided by public or contracted providers will be covered. Some countries guarantee benefits in-kind while others require patients to pay out-of-pocket for out-patient care and then get reimbursement from the health insurance institution. Access to secondary care services will in some countries be made subject to referral by a gatekeeper, like the general practitioner or even prior approval by the health insurance fund.

A final hurdle is represented by the personal preferences but also individual characteristics of patients. The use of health services is largely influenced by socio-economic factors but also culture and gender. Differences in health literacy, information and ability to navigate through the system are likely to disadvantage certain groups, often those who are most in need. Also direct or implicit discriminations against certain people, based on ethnic, religious or other factors can dilute entitlements to healthcare services.

Two important dimensions of universal coverage should not be forgotten and are implied by this filter model: timeliness and quality. In order to be effective, universal access needs to ensure that health care can be provided within medically justifiable time-limits and that the health care received meets the best possible quality and safety standards. Long waiting times are one of the main drivers for patients to seek healthcare outside the regular circuit or even in other countries (Rosenmoller et al. 2006). Certain countries have been successful in reducing waiting times, by introducing waiting-time targets for certain services (e.g. elective surgery), by better structuring care and organising triage of cases, by increasing capacity and introducing incentives for providers to increase their production and performance. Also concerns over quality of health care provided have become more explicit. Still, systems implemented in different EU Member States to assure and monitor quality of care exhibit a considerable degree of variation both in approach as in level of implementation (Legido Quigley et al. 2008).

Access gaps left by statutory health systems – mainly in the personal and/or material scope - can be bridged by private health insurance. In principle primary coverage of the largest share of healthcare costs can also be provided by substitutive voluntary health insurance, as is the case in Germany. More wide-spread is complementary insurance to cover for healthcare services not covered - or only partially – by statutory systems. In countries where statutory coverage is limited to public or contracted providers, supplementary insurance can provide access to an alternative circuit of private healthcare providers. As the type and extent of private health insurance depends on the scope of the statutory system, its occurrence in the different EU Member States is highly variable. In general, private health insurance will target richer, better educated and healthier groups in society. In order to make private health insurance also more accessibly for more vulnerable groups, such as lower income households, chronically ill, some Member States have imposed regulation upon private health insurers.

Overview of specific measures and policies to ensure access to care

Also based on the conceptual framework described different European studies have been analysing barriers in the access to care, especially for vulnerable groups, as well as reviewing policy initiatives to improve accessibility. The HealthQUEST study in 2008 (Quality in and equality of Access to healthcare services) identified three groups at particular risk of social exclusion: migrants (including asylum seekers and illegal immigrants), elderly people with functional limitations and people with mental disorders.
In this section we mainly focus on three dimensions of universal coverage: population coverage, service coverage and cost coverage.

A lot of statutory systems, especially those that moved after political transition to social health insurance, have defined their personal scope in terms of (permanent) residence. In Latvia for instance where almost 20% of the population is Russian who does not have Latvian nationality, all residents are equally covered under the universal coverage, enshrined in the Constitution. But also more traditional social health insurance countries have moved to covering the entire population. France in 2000 realized basic universal health coverage by creating a new category in its statutory insurance: insured person on the basis of residence (see below). Also Belgium recently closed the remaining gaps. In 1998 the principle of annual social health insurance right was introduced to create more stability in eligibility (before health insurance status was assessed per quarter). Also the waiting period, which would only entitle to reimbursement after six months of enrolment, was abolished. Since 2008, self-employed enjoy the same coverage as other categories. Before they were only statutorily covered for a reduced benefit package of so-called “major risks” (specialist and inpatient care along with rehabilitation) and they had to get private insurance to cover for the other “minor risks” (outpatient care, outpatient prescription pharmaceuticals and dental care).

The Netherlands and Germany only used to organize statutory health insurance for lower income groups. Both countries have recently reformed their health system to ensure universal coverage (see below). These competition-based models have moved from mandatory insurance towards an individual mandate to get health insurance (either publicly or privately). They provide for mechanisms to allow low-income groups to have better access to health insurance, through premium subsidies (Netherlands), via legally fixed standard policies with a basic tariff (Germany) or even to allow for free take-up of complementary health insurance (France). Sometimes practical obstacles may stand in the way of making use of certain rights. In Germany for instance the low take-up of the private standard tariff policy is explained by reluctance of private insurance companies to promote them and practitioners discouraging patients as under these legally fixed policies they earn less. Similarly in France, certain medical doctors tend to refuse CMU patients as they can not charge extra-billing upon them and are required to apply third-party payer.

One of the challenges for multiple payers systems is to balance competition with solidarity. Regulation needs to clarify on what elements health insurers can actually compete with eachother and to what extent entitlements for the insured can be different on the basis of his or her affiliation to one or another health fund. Competition on the benefit package is (still) not allowed in any of these systems. It should be noted, however, that systems which require people to operate choice (e.g. health insurer, deductibles, disease management programmes, etc.) will likely privilege groups who are capable of comparing options (e.g. insurance premiums) and are in a position to change. For instance, in the Netherlands, the active population is more likely to access collective insurance contracts and benefit from the premium reduction.

Statutory insurance systems where coverage is depending on payment of premiums or contributions are also experiencing problems with defaulters. In Hungary around 12% of eligible insured do not pay their contributions. While some countries are having difficulties to check whether contributions have been paid, others have an active enforcement policy to exclude insured defaulting payment of contributions. In Switzerland, where the number of defaulters was growing, the parliament in 2006 decided to allow health insurers to suspend coverage until outstanding premiums were settled. In stead of reducing the problem, as a result the number of defaulters grew exponentially. In 2006 alone around 119,000 insolvent insured had been suspended from coverage (1.6% of the population). Therefore, in 2008 the sanction of suspension was revoked (Crivelli 2008). Care denial to enforce payment of contribution can indeed seem a harsh measure, which is contradictory to the principle of universal protection. Alternative systems as set up in Hungary or the Netherlands (see below) of guaranteeing continuity of care while the public authority will claim the premium with an administrative fine, is to be preferred.

In many social health insurance countries certain groups are automatically insured, either without contributing or by contributions paid for by the state. These are mostly children, dependant family members, people on social security benefits (e.g. unemployed, pensioners, people on sick or maternity leave), people with no or low incomes (e.g. students, handicapped, prisoners, etc.). So either their share in expenditure is covered through general revenue from contributions or state subsidy or the state pays an individual contribution for them. In Slovakia contributions for the majority of the population are paid by the state as 65% of the population is economically non-active: pensioners, unemployed, children, informal carers, military. The contribution rate for this group was established at 4.5% of an average wage (whereas the normal contribution rate was 14%). Alternatively, contributions for recipients of social benefits (e.g. unemployment, pension) are paid by the responsible social security agency on the social benefit paid. Tax-funding of social health insurance and free membership can indeed contribute to universal coverage and
reduce the problem of uninsured. On the other hand, if only a small group of insured actually pays contributions this can undermine the collection mechanism and the willingness to pay contributions. In Romania for instance nearly 23% of the insured population was paying contributions in 2005. Therefore the government in 2006 re-introduced a contribution obligation for pensioners with a sufficiently high pension.

Despite the fact that most statutory health systems in Europe have become universal in nature, there are still certain groups who are left without coverage or experience more difficulties in getting insured. In Bulgaria, for instance, the number of uninsured is estimated at 1 million (12.9% of the population). In Estonia an estimated 5% of the population remains uninsured, essentially working age as children and pensioners are automatically covered. In 2007 the government committed itself to extend coverage for these non-insured to non-emergency primary health care. In Poland the number of uninsured/unregistered was estimated at 804,000 in 2005 (2.1% of the population). In Austria an estimated 2% in 2006 failed to register for health insurance mainly unemployed who were required to appear to a job centre to get insured. Some countries explicitly organise schemes for people not included under any protection scheme. In Slovenia urgent care is financed from the state budget for people without sufficient resources who are not covered by the statutory health insurance. In Belgium urgent care will be covered in most cases through the local office of social assistance. In France the State Medical Aid (AME) also guarantees coverage of non-urgent care for people without residence permit, except for this less than 3 months in the country (see below).

A study performed in 2005 showed that half of the EU Member States restricts access to health care for asylum seekers to emergency care (Norredam et al., 2005). Some countries have set up special schemes for them (e.g. Germany), others incorporate them into the general system (e.g. France). A group which raises special concerns are illegal immigrants, who in most countries can only get essential and emergency care. But also internal migrants, like the Roma population, suffer from the same poor access conditions. In Romania they are often excluded from coverage because they lack of citizenship or identity papers to prove their residence. As a result they are not registered with a family physician and they can not benefit from free or discounted drugs and others services included in the insurance benefit basket. (Predescu M. 2008). To tackle these kinds of inequalities, the government is taking a series of measures to ensure universal coverage of basic health services for deprived groups. Also through the use and training of Roma health mediators it intends facilitate access to care for the Roma people:

Poor and socially excluded people have a higher risk to end up without coverage, especially in systems where eligibility is not automatic, because of their more limited capacity to fulfill the administrative requirements (e.g. fixed residence, payment of contributions or premiums). Language and cultural barriers can also obstruct access to care for migrants. Evidence shows that migrants are less referring to specialist care and using more frequently emergency services. More generally, local authorities have an important role to play in monitoring and facilitating access to care for vulnerable groups.

Although statutory healthcare baskets are generally comprehensive and include most types of care, still gaps can be observed for specific types of care. Dental care and mental healthcare are among the most cited gaps in coverage. Increasing levels of cost sharing is a serious concern in certain countries as it will lead especially for more vulnerable patients, such as chronic ill and patients with low incomes, to delay care. In Latvia, despite the fact that national health insurance has reached universal protection, around 30% of the population, especially lower income groups, could not get the health care they needed, mainly due to financial reasons (Xu K. et al. 2009). In 2006, the average monthly out-of-pocket spending amounted to 4.7% of total household expenditure and 7.3% of household's capacity to pay.

Special protection or exemption mechanisms are needed to alleviate the effects of cost sharing for certain groups. A lot of countries define categories of insured who are exempt from user charges. Exemptions can be based on age (e.g. children, elderly), social status (e.g. unemployed), income, or health status or type of illness (e.g. pregnancy, cancer, etc.). If these exemption or protection rules are defined in terms of specific categories there is always the risk that certain patients with high out-of-pocket expenses will be left out. In general it seems more equitable to apply actual out-of-pocket (OOP) spending ceilings rather than defining groups of beneficiaries (e.g. patients suffering from specific chronic diseases), although it will not always be easy to include all types of patients charges into monitoring and exemption mechanisms. For instance, in Latvia a ceiling applies for patient fees, but out-patient pharmaceuticals are not included whereas they constitute a serious financial burden (insurance cover is limited to certain medical conditions). It is even more equitable to link OOP ceilings with income. The Latvian example showed that uniform exemption threshold would disadvantage lower income groups. Around 3.2% of households (representing 45,000 individuals) still faced catastrophic health expenditure (more than 40% of household budget spent on health), with a far higher incidence in the lower income categories (7.7% in the lowest income quintile vs. 0.4% in the highest). In Belgium protection mechanisms against high out-of-pocket spending were recently revised. Traditionally,
most healthcare services have been subject to official co-insurance: statutory health insurance reimburses a percentage of conventionally agreed tariffs (e.g. 25% for a GP consultation). Certain groups are granted a higher preferential reimbursement (e.g. 10% for a GP consultation). These groups were defined in terms of their social status (pensioners, widows, orphans and invalids) and their (low) taxable income. Since 2007 the preferential reimbursement (now called OMNIO-status) has been extended to all insured below the income limit. In order to also provide better protection for chronic ill and patients accumulating user charges, a system of maximum billing (MAF) was introduced as of 2001. It currently includes three ceilings: one for households with an OMNIO-patient (450€), a specific ceiling applicable to children (650€) and a flexible ceiling according to net family income (ranging from 450€ to 1800€). The MAF system only covers for official user charges and does not include out-of-pocket costs related to extra-billing by providers (above conventional tariffs) or non-reimbursed services and drugs. France has developed a similar system (see below). Especially informal payments, which are still widely applied in several health systems, are difficult to take into account in any policy or protection mechanism.

In countries where public funded schemes do not cover the whole spectrum of people and/or services, forms of private health insurance occur to provide pre-payment of private costs. In some cases private health insurance can become an important complement of health care financing. This is the case for substitutive insurance, which provides primary protection for people excluded from public protection schemes. Given their importance governments have started to introduce regulation to ensure that subscribers would be accepted (open enrolment), could not easily be excluded (life-long insurance) and would get good protection at affordable premiums (standard tariff policies). But also for other forms the need to regulate private health insurance markets has been increasingly felt. Especially in countries where cost sharing has reached a critical level, access to complementary health insurance could become a prerequisite for access to care. Therefore, also this area is more and more subject of regulation. France in 2000 introduced a free complementary health insurance for the 10% of the population who can not afford to purchase complementary cover. Belgium in 2007 adopted new legislation to protect subscribers of complementary hospital insurance from constantly rising premiums and practices of risk selection and exclusion. Slovenia in 2005 introduced a risk equalisation scheme for complementary health insurance to impose community rating upon all insurers and to level out cost differences between insurance companies related to different risk profiles of their insured population.

Below we describe a few countries (France, Germany and Netherlands) more in depth. They recently introduced comprehensive reforms which were particularly aimed at closing gaps in coverage.

France

France may be described as a hybrid model. Although built as a Bismarkian model, from the beginning there has been a high level of state intervention. Payroll contributions by the insured have been partly replaced in 1991 by a tax based on all earnings (“cotisation sociale généralisée”). Today, over 40% of the revenue of the statutory health insurance system comes from taxes. Public financing accounts for 79.1% of all health expenditure.

Personal scope

Traditionally, social security is employment-based. Different schemes have been set up to cover various social-economic groups: employed workers in both the private and public sectors, self-employed, agricultural workers. Apart from special schemes, the three main schemes cover 95% of the population. All beneficiaries have the same coverage, irrespective of which scheme they are affiliated to or how much they contribute.

From a professional-based health insurance the French statutory system evolved to a more universal system. Despite the fact that over time in theory every person residing on French territory could adhere to one of the different schemes, still until 1999 a minority of about 150,000 remained uninsured. Therefore, in 2000 basic universal health coverage (Couverture Maladie Universelle also known as CMU de base) was introduced. This system ensures access to the general statutory health insurance scheme to all persons residing in France in a stable and regular manner for more than 3 months but does not meet any of the eligibility criteria (e.g. occupation). They are called “insured person on the basis of residence” (assuré au titre de la résidence). Also, in order to stabilise insurance entitlements, the right to reimbursement remains effective for one more year, irrespective of the change in insurance and eligibility status. (e.g. loss of employment, end of unemployment benefit payment, granting of the minimum social benefit). As soon as the traditional eligibility stops the benefits will become assistance-based (under CMU). Above a certain level of
fiscal income (9,020 €), an 8% contribution will be levied upon CMU beneficiaries. CMU beneficiaries are entitled to the same coverage as other statutorily insured. On top, they benefit from an extended third-party payment system (direct payment by the sickness fund). Providers delivering care to CMU beneficiaries are required to respect the official health insurance tariffs and cannot charge any supplementary fees.

For foreign nationals who have been in France for at least 3 months and who do not hold any residence permit, the government introduced in 2000 the State Medical Aid (Aide Médicale d'État also known as AME). To be eligible the AME beneficiary must have monthly income below of no more than €606. Dependents will be equally covered. The AME covers the cost of health care and medical prescriptions provided in hospital as well as in ambulatory care limited to statutory health insurance tariffs. People who are less than 3 months in the country can only apply for the most vital and urgent care. The Minister responsible for social action can allow exceptions. The AME replaced the former system of free medical aid which was managed decentrally by the departements. Its annual cost amounts to approximately 490 million

**Financial protection**

While the personal scope of statutory health insurance extended over time, its coverage gradually reduced. An increasing part of healthcare costs needs to be covered by the patients. Whereas the benefit basket covered by social health insurance is rather large, most healthcare services and medical goods are subject to co-insurance: physicians’ services (30%), almost all medicines (ranging from 35 to 65%), hospital care (20% plus a per-diem payment). While traditionally the French system has been characterised by the high degree of freedom of choice of provider, the 2004 health insurance reform introduced some kind of gatekeeping mechanism with an attending physician (médecin référent) who has to be consulted before any appointment to see a specialist (with some stated exceptions). Those patients who do not follow this route are subject to a higher co-insurance rate (50%), the difference of which can not be covered by complementary insurance. Certain categories are exempt from co-insurance: people on invalidity or work injury benefits, patients suffering from specific chronic illnesses and people with low income. While these user charges are covered by complementary health insurance (see below), the government in 2008 introduced non-reimbursable co-payments for consultations (1€), prescription drugs (0.50€), medical transportation (2€) and expensive treatments (18€). These co-payments are however capped up to an annual ceiling (50€). Children and people with low incomes (CMU-C beneficiaries, see below) are exempt from these deductibles.

Next to official co-payments certain physicians (sector 2) can charge extra-billing. Extra-billing is more frequent for specialists than for generalists, they exceed official fees by 17% on average for specialists, with huge variations among specialties (40% for surgeons, 30% for ophthalmologists). Similarly, prices of medical goods, such as dental prostheses and glasses, as well as some medical devices for personal use, such as wheelchairs, generally largely exceed set reimbursement prices.

While in macro-economic terms the share of public spending remains fairly stable, there is an increasing trend of cost-shifting from public to private expenditure. This is mainly explained by the increasing number of people being exempted from cost sharing as chronic ill patients to compensate for this shift.

**Private health insurance**

Given the large share of user charges in France, especially in the out-patient sector, complementary health insurance is well-developed. It accounts for up to 12.8% of health expenditure. It typically covers all or a large share of copayments, but also reimburses a share of extra-billing, often limited, for instance up to 50% or 100% of the official fee. Voluntary health insurance also acts as supplementary source of coverage for residual and “comfort” services which are not covered by social health insurance. As a source of healthcare financing complementary health insurance is more prominent in ambulatory care (20%) and pharmaceuticals (21%) compared to hospital care (only 4%).

While nearly 90% of the French population traditionally takes up complementary insurance, about 6 million were reported not to have any additional cover for user charges. As most people are covered through their employer, people lacking complementary insurance are mainly non-active. Since the lack of complementary health insurance has proven to impair access to health care in France, the government in 2000 introduced a system that provides free access to complementary health insurance for people with low income. This system of complementary universal medical coverage (couverture maladie universelle complémentaire or CMU-C) provides for a means-tested subsidy of health insurance premium. CMU-C beneficiaries can obtain this free complementary cover from either the traditional voluntary health insurance institutions (mutual benefit societies, provident institutions and commercial insurance companies) or the statutory health
Council of Europe

insurance fund, which receive a flat premium paid by a specific national fund. In 2006, 4.8 million people (7.5% of the population) benefited from the CMU-C system, the largest part (87%) through the statutory sickness fund. CMU contracts need to respond to specific requirements: The benefit basket is defined by law, healthcare providers are not allowed to extra-billing and third-party paying applies. Also the CMUC does not cover any costs incurred by any failure to adhere to the co-ordinated healthcare procedure.

Despite all these measures still access problems persist. According to blind testing 14% of physicians and 22% of specialists would refuse to accept CMU patients. This discrimination and care denial by health professionals is probably mainly due to the fact that physicians are not allowed to charge extra-billing and must accept direct payment by health insurance for CMU beneficiaries. Another problem has been the non take-up of the free complementary health insurance by people eligible for CMU-C as well as those groups who remain unprotected as their earnings are just above the CMU threshold. Therefore in 2004 a voucher system was introduced to complete the initial CMU scheme. These “health cheques” for the purchase of complementary insurance, which value ranges from 100€ to 400€ according to age, are provided to people with revenues exceeding CMU-C income threshold by less than 15%. Nearly 2 million people additionally benefit from this system.

Germany

The German health insurance system was founded in 1883. It was originally conceived for the working class, but was later extended to include other socio-professional groups. Still the German system is still characterized by its duality: next to statutory health insurance there is a considerable part of the population (10%) insured through individual private health insurance. Recent reforms have tried to make the health system more equitable by keeping more people within social health insurance, increasing its level of solidarity-based financing and at the same time making private health insurance more affordable irrespective of individual risk factors, thereby reducing the number of uninsured.

Whereas Germany has the highest expenditure level on health in the EU (10.6% of GDP), public financing only accounts for 77.2%. This is mainly due to the high share of private health insurance (9.1%). Next to that the share of cost sharing has increased considerably up to 13.8% in 2005.

Statutory health insurance is almost exclusively financed out of income-related contributions, the burden of which was equally divided among employer and employee (recently the employee pays a higher share). Traditionally health insurance funds have been allowed to set their own contribution rate. In 2007 the average rate nationally was 13.92%, with variation ranging from 11.30% to 15.80%. Already in 2004 a system of risk compensation was introduced to adjust for difference in both income as well as risk profile of the members of each health insurance fund (accounting for age, sex, number of members with dependants and proportion of disability pensioners). As of 2009, a single federal health fund has been established to centralize all social contribution and redistribute this revenue to individual health insurance funds on the basis of a more refined risk-adjustment system that will also compensate for morbidity on the basis of 80 diseases selected according to severity and cost. As a consequence, a unified contribution rate of 15.5% applies for all social insured. Individual sickness funds may charge an additional nominal premium if risk-adjusted capitation payments from the federal health fund would turn out to be insufficient.

With this new reform; state-funding of the German health insurance system is growing significantly. Next to social contribution revenue the federal health fund also receives a yearly federal subsidy to cover the cost of health insurance for children. This contribution, which was 2.5 billion was further increased in 2009 to 4 billion €. As of 2010 it will annually increase by 1.5 billion € to reach up to 14 billion €. This state funding should alleviate the burden on labour costs and reduce the social contribution rate.

Personal scope

Germany never had a universal health system. In 2007, 85% of the German population was covered by the statutory health insurance. An additional 4% of the population is covered by other, sector-specific governmental schemes (e.g. military, police). This also includes immigrants seeking asylum (211,000 in number in 2005) who are less than 3 years in the country. The specific governmental scheme provides limited coverage to emergency care (e.g. acute care, pain, pregnancy and birth), medically necessary preventive medical checkups and vaccinations and dentures in exceptional cases. This scheme also applies to illegal immigrants (estimated number between 450,000 and 1.5 million) although utilisation may be hampered by fear to be caught and expelled.
Sickness fund membership is mandatory for employees whose gross income does not exceed a certain threshold (€4050 per month in 2009). People with earnings above this threshold can either voluntarily join or stay in the statutory health insurance or take out substitutive health insurance with a private commercial insurance company. Although nearly 75% of those who can opt out choose to stay in statutory health insurance, the government in 2007 strengthened the conditions for opting out: only if the threshold is exceeded for three years in a row.

Dependant family members are automatically covered under the statutory health insurance through the primary beneficiary without paying any additional contribution. Compulsorily insured persons who become unemployed or retire maintain their entitlements and pay contributions levied on their benefits. Except for long-term unemployed with a flat-rate low benefit (Hartz IV recipients), the employment agency will contribute by way of a fixed per capita premium. Other people eligible to means-tested social assistance (people incapable to work, homeless, asylum seekers and refugees resident for more than three years) are also statutorily insured.

It was often assumed that in reality nearly the entire population was insured. The number of uninsured persons was estimated between 0.2% and 0.37% of the total population (official estimates: 211,000 in 2006). However, there is increasing evidence that the actual number might have been substantially higher and has been rising gradually over the years mainly due to an increase in the number of self-employed with low income. Other groups excluded from health insurance coverage are formerly social or private insured who ceased payment of contributions or premiums or divorced spouses who were previously co-insured. Most uninsured are likely to live in poverty and are not eligible to or not in reception of social assistance. Furthermore, there are no data on non-permanent residents.

In order to reverse this trend of uninsurance, the government decided in 2007 to introduce a formal obligation to take out health insurance, first in 2007 for all persons eligible to statutory health insurance, later in 2009 for the entire population. Since 1 April 2007, those without health insurance who were last insured under the statutory health insurance are reverted to their last insurance. The Ministry of Health has also actively tried to reach the different groups of uninsured through mass media and other communication channels. According to the Federal Ministry of Health, nearly 160,000 returned to the statutory health insurance as a result of these measures. With an additional estimated 24,000 people who could be recaptured by private health insurance (see below), the number of uninsured would be significantly reduced to some 50,000. On the other hand, since 2009 being without health insurance has become an administrative offence. Although uninsured can be requested to pay for outstanding premiums up to a maximum of four years (if their income allows for it), some sources report an increase in defaulters as a result of the measures taken.

At the level of municipalities or Länder low-threshold public health services are sometimes provided to socially marginalized groups, among them uninsured or people residing illegally in the country. Services are legally limited to the diagnosis, prevention and acute treatment of tuberculosis, sexually transmitted infections and other infectious diseases.

Financial protection

The statutory health insurance covers for a comprehensive range of healthcare services, including preventive services, out-patient medical treatment, hospital care, prescription drugs, medical aids, dental care, rehabilitation, mental health care. The benefit package is set by law and applies for all insured. Since 1995 long-term care is covered through a special scheme which is compulsory for the entire population.

Cost-sharing arrangements traditionally applied to prescription drugs and dental care as well as to stay in hospital up to 28 days per year. Since 2004 a quarterly co-payment of 10€ was introduced for out-patient visits to physicians and dentists. Children under 18 are exempt from this “medical practice tax”. Cost-sharing more generally is limited to 2% of household income; for patients suffering from chronic diseases (subject to certain conditions and requirements) this is even 1%. Patients who reached the ceiling receive a certificate to prove that they are exempt from further copayments until the end of the year. In 2006 around 6.9 million social insured persons (10% of the statutorily insured population) were exempt from co-payments under these rules. Before 2004 a more general exemption for poor households existed.

Private health insurance

Nearly 10% of the German population is covered for healthcare costs through private substitutive health insurance. People eligible for private insurance are

- civil servants (5% of the population) who benefit from partly free governmental care and complementary private insurance;
• self-employed;
• employees earning an income above the legally fixed threshold who opt out of the statutory system.

Private health insurance premiums are risk-rated, although contracts are based on life insurance rules, which means that premiums are based on age at entry and need to contain a reserve for age-related cost increase (Altersrückstellung). Dependent family members are required to pay a separate premium.

In order to reduce the number of uninsured, the government has introduced further regulation to ensure access to private substitutive health insurance. As a counter-measure to the obligation to take out health insurance, which since 2009 also applies to people outside the scope of statutory health insurance, all insurers are obliged to accept all eligible persons. To allow all persons to (re-)enter private insurance irrespective of their age, sex or health condition, insurers have to offer a basic insurance contract providing cover for a benefit package as in social health insurance at a legally fixed and uniform basic premium tariff (Basistarif). This system is financed through a special risk adjustment scheme introduced in 2009. At the same time, privately insured over 55 are prohibited to return to statutory health insurance, even if their earnings fall below the income ceiling. Furthermore, to stimulate competition among private insurers, privately insured can transfer their age-related reserve to join another company at equal conditions.

While it is not allowed to re-insure user charges under the statutory health insurance, private health insurance in Germany plays a complementary role in covering for some extra benefits or payments. Around 18.4 million people have subscribed to private complementary insurance.

Netherlands

Since 2006 the Netherlands has a single privately-run statutory health insurance scheme for curative care, which is mandatory for all citizens. It replaced the previous two-tier system, which similar to the German system only provided compulsory coverage to families with incomes below an income threshold. As this threshold was lower than in Germany, the share of the population insured under social health insurance was smaller than in Germany (63% of the population in 2004).

The 2006 health insurance reform, which was based on a political debate and gradual change over a period of more than 15 years, was inspired by a growing dissatisfaction with the dual system of both a public and private coverage and all the inefficiencies and administrative burden it entailed. It is also based on a need felt to strengthen demand-driven and choice-based market competition as was way to improve performance and cost-effectiveness while at the same time preserving solidarity.

Statutory health insurance is mainly financed out of a combination of taxable income-related contributions (mostly paid by the employer) and a flat-rate insurance premium paid by the subscriber (average in 2007 was 1000€), the level of which is the same for all policy-holders of the same care insurer (community-rating). However, premium reductions can be obtained for joining a collective contract (up to 10%) or for opting for an annual front-end deductible (above 155€ up to 500€). Low income households (income under 29,069€ for singles or 47,520€ for households) can receive a premium subsidy (care-allowance) up to 40% of the premium. Premiums for children under 18 are paid out of taxes (2.2 billion € in 2009). Where contributions are centralised into a general fund, individual insurers will receive a risk-adjusted capitation payment for every insured. The level of the community-rated premium will have to compensate for the difference with the actual overall costs and act as an element of price competition.

As before, the Dutch system is composed of three horizontal compartments. Next to the curative care component, there is a statutory insurance scheme for long-term and chronic care (AWBZ) for which the whole population is covered and which is solely financed out of taxable income-related contributions. On top of the two statutory schemes there is still room left for complementary private health insurance to cover for services left out of the legally fixed basic package.

The share of public financing after the 2006 reform would account for 78%.

Personal scope

The basic health insurance is obligatory for all Dutch citizens. This means that all persons resident in the Netherlands are obliged to get health insurance and that all Dutch care insurers are obliged to accept any
candidate subscriber. Children under the age of 18 are insured free of charge under one of their parent’s policy.

For a few groups an exception was made to the obligation to get basic health insurance.

- People who reject the principle of insurance on moral or religious grounds. Healthcare costs for people who apply for this status will be financed out of a personal account, which is financed through a general income tax they will be required to pay and which equivalent to the employer contribution under the statutory health insurance. If healthcare expenditure exceeds the credit on the account, they will have to pay out-of-pocket.
- Healthcare for the military personnel is directly organised and financed by the Ministry of Defence.
- Asylum seekers are directly covered under a scheme of the Ministry of Justice for the duration of the procedure. Coverage is similar as under the basic health insurance.

Immigrants without a residence permit (illegal immigrants – estimated number between 75,000 and 185,000) are not included in the scope of basic health insurance and are only entitled to emergency and medically necessary care (defined as “care provided in a situation that does not allow for withholding or delay of medical care without jeopardising the life or health care of the person involved and/or seriously endangering public health in the Netherlands). In 2009 a new regulation was introduced to cover for care provided to this group. All providers of primary health care and emergency hospital care can claim reimbursement of unsettled bills for essential care (included in the material scope of statutory cover) delivered to illegal immigrants from the Healthcare Insurance Board (CVZ). CVZ will mostly reimburse 80% of expenses, except for pregnancy and delivery for which 100% coverage is granted. Care for which a referral or prescription is needed can only be provided by institutions which are contracted by CVZ.

Contrary to coverage under the long-term care insurance (AWBZ), which is universal and automatic, coverage under the basic health insurance requires the affiliation to an insurer and the payment of premiums. In 2008 around 171,000 people (1% of the population) were estimated to be uninsured, of which 35,000 children. Lack of insurance is more frequent among people from minority ethnic communities and persons from the new Member States. More than 4% of the immigrant population (especially first generation) was not insured against less than 1% of the Dutch native population.

In addition to the uninsured, there were 280,000 defaulters (2.2% of all insured), people who did not pay their basic health insurance premium for at least six months. Despite the fact that they can be sanctioned with a fine amounting to 130% of all unpaid premiums up to 5 years (exception mage for children), the number of defaulters has been increasing (16% between 2007 and 2008). Therefore the government introduced a whole set of measures. Since the end of 2007, they can not change insurers until they have settled the unpaid premiums. Since September 2009, defaulters will first (after two months of unpaid premiums) receive a proposal for settlement from his or her insurer, then (after four months) a warning letter. After six months the care insurer will report the defaulter to Healthcare Insurance Board (CVZ) which will charge an monthly administrative fine of 130€, which can be directly levied upon the person’s salary or social benefit. Defaulters will keep their coverage but can be cancelled by their care insurer. In order to prevent from that the government compensates care insurers after six months provided they maintain coverage. However, the political debate around defaulters and preserving their access to care is also complicated by the fact that some of them are at the same time receiving premium subsidies.

Local authorities are playing an important role in protecting in vulnerable groups against loss of insurance. In 2006 around 325 local authorities negotiated collective health insurance contracts with insurers on behalf of the recipients of social income support for whom they were responsible. Almost 80% of social income support recipients were covered through these contracts, which have the advantage of being generally cheaper, less administratively cumbersome and even more comprehensive in terms of protection.

Financial protection

The standard benefit package under statutory health insurance is legally fixed. It comprises a comprehensive range of out-patient and hospital care, prescription drugs, medical aids, patient transportation services, etc. Dental care is limited to specialist services and dentures, except for children under 18. Long-term and chronic care, including mental health care, care for the handicapped and home care, is covered under the statutory long-term care insurance (AWBZ).
Care insurers can offer two different kinds of policies: benefit in-kind contracts which provides access to care through a network of contracted providers and contracts based on reimbursement which allows more choice for patients but provides less financial protection for subscribers as providers could charge higher fees than what is covered by the insurer.

User charges until recently were only scarcely applied in the Dutch health system. Under the new statutory health insurance, a compulsory annual deductible of 150€ applies (103 euro for persons with chronic illnesses). Insured can opt for a higher voluntary deductible up to 500€ in exchange for a premium reduction. Certain healthcare services are exempt from the deductible, such as primary and maternity care. Co-payments for residence and home care under the statutory long-term care insurance are income-related with a maximum ceiling. Out-of-pocket expenses account for about 8% of total expenditure on health.

Insured persons under 18 are exempt from any cost-sharing, including the front-end deductible. As of 2009 care insurers can exempt insured persons from the basic deductible if they get treatment from preferred providers who have special selective contracts with the insurer on the basis of price and quality standards.

**Private health insurance**

Under the former system around 35% of the population was excluded from social health insurance and required to seek coverage with substitutive private health insurance. Already in 1986 the possibility of remaining voluntarily in statutory health insurance – similar to Germany - was abolished. Therefore, guarantee access to private health insurance irrespective of age, health status and other risk factors, the government started to regulate this sector. A standard package policy was introduced under the Medical Insurance Access Act (WTZ), a publicly designed private substitutive insurance with a legally defined scope of benefits (comparable to statutory cover) and a legally fixed maximum premium. All Dutch health insurers were obliged to provide this policy to any candidate meeting the legal criteria. Some 14% of all private insured opted for this standard package policy. The financial risk for these standard package policy subscribers was however shared among all insurers through a risk pooling system financed out of a special contribution paid by all private policyholders.

With the integration of social and private health insurance into one single statutory system, based on a mandate to take up health insurance, private health insurance is now predominantly complementary in nature. It is provided by the same insurers administering the statutory health insurance.

**Concluding remarks**

Although health systems in Europe are mostly or almost universal in terms of their person scope, this does not mean that universal access is guaranteed. Ensuring access to health care for all parts of the population requires a broader action, including securing a comprehensive benefit basket, monitoring the out-of-pocket spending, as well as other potential barriers. It is not sufficient to guarantee inclusion in the personal scope of application without also looking at what kind of protection is provided under the statutory health insurance. The issue of personal coverage can not be looked at in isolation. It needs to be situated in the broader scope of the entire health system, including its underpinning values and objectives, its different functions as well as its performance and its support by the population.

Despite comprehensive health protection systems based on need rather than capacity to pay, Europe is facing important inequalities in the distribution of health. The European Commission has only recently issued a new Communication on “Solidarity in health; reducing health inequalities in the EU” in which it sets out a series of actions to support EU Member States in better tackling health gaps, especially since the current economic situation may exacerbate these gaps. Vulnerable and socially excluded groups (immigrants, ethnic minorities, homeless, handicapped, elderly) are particularly at risk. For example, Roma people have on average a 10 years lower life expectancy. Poor health status is to a large extent determined by socio-economic elements. It often relates to a variety of factors: housing, nutrition, education, living and working conditions, health related behavior, access to health and social services. Therefore, addressing health inequalities requires a broad and integrative approach. Improving access to health care is definitely an important objective to address these health inequalities.

Social health insurance has gradually closed the gaps in the personal scope and include all people residing on the territory. By extending the revenue-base to taxes, groups who can not afford to pay contributions can be included in the scope. However, if the contribution-base gets too small willingness to contribute may
suffer from it and financial sustainability of the system can be endangered. Even though small in size, it is important to also pay sufficient attention to the remaining pockets of uninsured. They represent mostly very vulnerable and excluded groups who are most in need of access to care.

The huge differences in the level of public expenditure on health in relation to total health spending is an indication that even if universal in scope, European health system do not necessarily guarantee universal access to health care. Public funding in Latvia is for instance one of the lowest in the EU. In order to ensure confidence in the health system, public financing needs to be secured and user charges have to be carefully designed and monitored. Also the existence of informal payments needs to be acknowledged and its effects need to be properly monitored and addressed.

Of course, differences in access to care among countries can be largely explained by structural and financial limitations that countries face. However, it is also a matter of political choice how much and how to invest in health systems. Furthermore, governments have an obligation to make sure that their statutory systems are equitable and efficient.

Willy Palm
Dissemination development Officer
European Observatory on Health Systems and Policies
# Overview of social insurance systems

<table>
<thead>
<tr>
<th>Country</th>
<th>Personal scope</th>
<th>Material Scope</th>
<th>Special protection mechanisms</th>
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<tbody>
<tr>
<td>Austria</td>
<td>In 2004 the statutory health insurance scheme covered 98% of the population.</td>
<td>Social insured members have a legal entitlement to a wide range of benefits, including outpatient medical treatment, dental treatment (without fixed dentures), psychotherapy, physiotherapy, ergotherapy and speech therapy, medicines and therapeutic aids, medical nursing care, rehabilitation, hospital treatment and stays at spas.</td>
<td>Low-income pensioners, children, and people with chronic illnesses are exempt from prescription charges (approximately 12% of the population). Health insurance funds can offer additional voluntary benefits or exemptions from cost sharing.</td>
</tr>
<tr>
<td>Belgium</td>
<td>The publicly financed health insurance scheme covers 99% of the population.</td>
<td>The benefits package is defined and covers a wide range of services. Cost sharing is applied to most health services.</td>
<td>Those with income below a specified threshold pay a lower rate of co-insurance. Also an annual ceiling on OOP payments applies. Private health insurance plays a mixed complementary and supplementary role, covering the cost of inpatient charges and providing access to better amenities in hospital. It covers about two thirds of the population, often as an employee fringe benefit.</td>
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<tr>
<td>Bulgaria</td>
<td>The publicly financed health insurance scheme, which was introduced in 1998, covers all residents</td>
<td>Statutory health insurance covers a broadly comprehensive, defined benefits package. Cost sharing was introduced in 1998 for outpatient prescription pharmaceuticals, with exemptions for treatment of chronic illnesses. In 2000, further cost sharing was introduced for patients with specific illnesses, children, unemployed and other low-income people are exempt from cost sharing. Private health insurance plays a very small complementary role.</td>
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<td>Country</td>
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<tr>
<td>Cyprus</td>
<td>Cyprus is in the process of implementing a National Health Insurance Scheme (NHIS), under which comprehensive coverage will be extended to all residents. Prior to the implementation of the NHIS, the Government provided free or reduced cost care to 85–90% of the population. Employer- and trade union-sponsored schemes also provided coverage for their members. OOP payments for health care are high. Individuals with chronic or severe acute illnesses may face catastrophic levels of health expenditure. The introduction of the NHIS is expected to result in abolition of user charges for publicly financed health services (with the possible exception of user charges for pharmaceuticals).</td>
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<tr>
<td>Czech Republic</td>
<td>The publicly financed health system covers all citizens, who are required to enrol with one of nine health insurance funds. The benefits package covers a broad range of services. Cost sharing has been restricted to outpatient pharmaceuticals and dental care but from 2008, it will be extended to doctor visits, inpatient stays and use of the emergency department. Pregnant women, chronically ill people and people with low incomes are exempt from cost sharing. Private health insurance plays a very limited supplementary / complementary role in the Czech health system, covering better amenities and dental care.</td>
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<tr>
<td>Estonia</td>
<td>Coverage is based on residence and membership of specific groups. The Health Insurance Fund covers 94% of the population. Prisoners are covered by the Ministry of Justice. Those without coverage are usually non-working adults. They have access to publicly financed emergency care but must pay for all other care. The EHIF provides a broad and defined package of benefits, although it does not cover optician services or adult dental care. Statutory cost sharing was introduced during the 1990s and has since increased. Co-payments now apply to home visits by doctors, outpatient prescription pharmaceuticals, specialist visits and inpatient care. Recently, some exemptions and/or reduced rates to user charges were introduced for small children, pregnant women, older people (prescription charges) and patients in intensive care (inpatient charges).</td>
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<tr>
<td>France</td>
<td>In 2000 France introduced universal coverage (CMU) and since then the publicly financed health system has covered all individuals legally resident in France. The statutory health insurance scheme covers employees and their dependants, the central Government covers those not eligible for The publicly financed benefits package is defined by the National Union of Health Insurance Funds (UNCAM) guided by advice from the National Health Authority (HAS) an independent public body. Complementary private health insurance for statutory user charges covers over 92% of the population.</td>
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<td>Country</td>
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<tr>
<td>Germany</td>
<td>From 2009 health insurance will be compulsory for the whole population. Publicly financed health insurance covers approximately 88% of the population. It is compulsory for employees earning up to approximately €48 000 per year and their dependants. Civil servants and employees with earnings above this amount are currently not obliged to be covered. They can either remain in the publicly financed scheme on a voluntary basis or choose to purchase private health insurance (or even remain uninsured). Around three quarters of those who are able to choose between public or private health insurance (less than 20% of the population) opt to remain in the publicly financed scheme, which offers free cover for dependants. In total, 10% of the population are covered by private health insurance; mainly civil servants and self-employed people. Less than 1% of the population has no insurance coverage at all. From 2009</td>
<td>Publicly financed health insurance provides a comprehensive package of benefits. Long-term care is covered by a separate insurance scheme, which has been compulsory for the whole population since 1995. Cost sharing traditionally covered outpatient prescription pharmaceuticals and dental care, but in 2004 it was introduced for doctor visits and extended in other areas. However, children are exempt from cost sharing, which is capped at an annual maximum of 2% of household income (or 1% for chronically ill people).</td>
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<tr>
<td>Hungary</td>
<td>Entitlement to statutory health benefits is based on citizenship. The statutory system covers over 99% of the population.</td>
<td>The national health insurance system offers a comprehensive range of benefits. Initially, cost sharing was limited and mainly applied to outpatient prescription pharmaceuticals, with some cost sharing for spa treatment, dental prostheses, long-term care, some hotel services in hospitals, and specialist care obtained without referral. In Patients on very low incomes are exempt from paying prescription charges.</td>
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<tr>
<td>Country</td>
<td>Description</td>
<td>Health System Description</td>
<td>Notes</td>
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<tr>
<td>Latvia</td>
<td>The publicly financed health system covers all residents.</td>
<td>The statutory system covers a wide range of health services (excluding adult dental care and surgical treatment for conditions that are not life-threatening, such as hip replacements). Cost sharing is applied to most health services and outpatient prescription pharmaceuticals in the form of co-payments. Informal payments are a problem.</td>
<td>Some maximum ceilings apply for user charges, as well as exemptions for pharmaceuticals for some diseases (such as cancer and diabetes) and reduced rates for some older people. Private health insurance plays a minor complementary and supplementary role, covering patient co-payments and providing faster access to care.</td>
</tr>
<tr>
<td>Lithuania</td>
<td>The publicly financed health system covers all residents for emergency care. Access to other services depends on payment of contributions to the statutory health insurance scheme.</td>
<td>The statutory health insurance scheme covers a fairly comprehensive range of benefits. Cost sharing applies to outpatient prescription pharmaceuticals and dental care for adults. Informal payments are an issue.</td>
<td>Children, disabled people and pensioners are exempted from prescription charges. Private health insurance plays a very minor supplementary role.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>The publicly financed health insurance scheme covers 99% of the population. The scheme does not cover civil servants and employees of international and European institutions, or unemployed people who are not receiving benefits.</td>
<td>The range of benefits covered by the scheme is broad. Cost sharing is widely applied in the form of co-insurance.</td>
<td>Antenatal and postnatal care, as well as emergency care, are exempt from user charges. Three quarters of the population purchases private health insurance to encompass services not covered by the statutory scheme. Private health insurance benefits from tax subsidies.</td>
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<tr>
<td>Netherlands</td>
<td>In 2006 the Government introduced universal coverage through the Health Insurance Act (Zorgverzekeringswet; ZVW). Coverage is statutory but provided by private health</td>
<td>Cost sharing is applied to some services but not to GP visits or antenatal and maternity care.</td>
<td>Complementary private health insurance covering services excluded by the ZVW or AWBZ is purchased by most of the population.</td>
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</tbody>
</table>
insurers and regulated under private law. Insurers must accept every resident in their coverage area (although most already operate nationally) and offer a standard benefits package defined by law. The ZVW covers primary and secondary outpatient care, inpatient care and dental care (the latter only up to the age of 18).

Prior to 2006 the statutory health insurance scheme excluded people with earnings over approximately €30,000 per year (and their dependants). These people mainly relied on substitutive private health insurance.

The Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten, AWBZ) covers the whole population for long-term and mental health care.

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<table>
<thead>
<tr>
<th>Poland</th>
<th>The publicly financed health system covers all citizens.</th>
<th>Statutory health insurance gives access to a wide range of benefits. Recently, rehabilitation, spa treatment and “nonstandard” dental and other health services (such as some cosmetic surgery) have been excluded from the benefits package. Cost sharing applies to outpatient prescription pharmaceuticals, diagnostic tests, orthopaedic devices, the costs of food and accommodation in nursing homes and rehabilitation centres, as well as some travel costs.</th>
<th>Levels of cost sharing are limited by OOP maximums linked to household income. Private health insurance is mainly organized by employers and takes the form of supplementary cover, providing faster access to outpatient care. Commercial private health insurance exists but plays a very minor role.</th>
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<tr>
<td>Romania</td>
<td>The publicly financed health system covers all citizens and residents for a broad range of health services. The voluntarily insured and the uninsured have access to a more limited package of benefits, which includes cover for emergency care, care of communicable diseases and family.</td>
<td>Services not covered by the defined benefits package include in vitro fertilization, adult cosmetic surgery and some dental care. Cost sharing applies to outpatient pharmaceuticals, long-term spa treatment and specialist visits without referral. Patients also make informal payments to</td>
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<tr>
<td>Country</td>
<td>Health Insurance Scheme</td>
<td>Comprehensive Defined Package of Benefits</td>
<td>Cost Sharing Details</td>
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<tr>
<td>Slovakia</td>
<td>The statutory health insurance scheme in Slovakia covers all residents.</td>
<td>The comprehensive defined package of benefits includes preventive, curative and rehabilitative care.</td>
<td>Cost sharing was introduced for doctor visits and inpatient care in 2003, but abolished in 2006. At the beginning of 2007, co-payments were applied to visits to an emergency department, outpatient prescription pharmaceuticals, transport to hospital, spa treatment and dental care.</td>
</tr>
<tr>
<td>Slovenia</td>
<td>The statutory health insurance scheme covers all Slovenian citizens</td>
<td>The public system covers for a wide range of benefits. However, cost sharing is extensive.</td>
<td>Complementary private health insurance covering statutory cost sharing is available and covers over 74% of the population (98% of those eligible for cost sharing).</td>
</tr>
</tbody>
</table>

Source: Thomson, Foubister and Mossialos 2009
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