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Healthcare provided during a temporary stay in another Member State to persons who do not fulfil conditions for statutory health insurance coverage

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EXECUTIVE SUMMARY

With regard to the fundamental principle of the right to healthcare in the European Union, uninsured persons should have access to healthcare during a temporary stay in another Member State.

This right could be based on Directive 2004/38, either for short (under 3 months) or longer periods of "residence". This would mean that for persons who, despite provisions in Union law and in particular Regulation 883/2004, are uninsured for healthcare, the host Member State should guarantee the same access to medical treatment or medical assistance as its legislation grants to uninsured persons having its nationality. Costs would be entirely borne by the State providing the medical treatment.
The right to healthcare could also be based on the coordination regulations. It would concern only "urgent vitally necessary treatment", which could be defined as treatment which, if it was not provided immediately, may lead to death or to the loss of a body part or a core body function. The Member State of stay would set the amount of benefits and then claim full reimbursement from the State of residence. However, another distribution of the burden of costs could be explored, with a significant financial participation of the Member State of temporary stay which could be justified by solidarity between Member States concerning access to vital care to uninsured and insolvent persons who stay temporarily in another Member State.

INTRODUCTION

Whereas Regulation 1408/71 gradually expanded its material scope through the intervention of the Court of Justice and the legislator, Regulation 883/2004 gives, at first sight, the impression that all citizens are covered by the new rules of coordination. Indeed, it shall apply "*to nationals of a Member State, stateless persons and refugees residing in a Member State who are or have been subject to the legislation of one or more Member States, as well as to the members of their families and to their survivors*" (Art. 2(1)).

However, the broad scope of Regulation 883/2004 does not imply that all European Union (EU) citizens are covered by a healthcare scheme falling within the scope of coordination rules. Since Member States retain their sovereignty to organize their own national social security schemes, it is likely that, depending on the structure and organization of each national scheme, some Union citizens may not be covered according to the definition set by Article 1(c) of Regulation 883/2004: "*insured person", in relation to the social security branches covered by Title III, Chapters 1 [sickness chapter] and 3, means any person satisfying the conditions required under the legislation of the Member State competent under Title II to have the right to benefits, taking into account the provisions of this Regulation*".

The absence of coverage may be a source of actual difficulties in the case of temporary stay in another Member State. A particular case highlights this situation: in the summer of 2008, four Romanian citizens, resident in Romania and on a temporary stay in Sweden were involved in a serious traffic accident which required substantial intensive emergency care which was given at the Uppsala University Hospital in Sweden. In view of the seriousness of the injuries, the persons required hospital care for a long period and, where their conditions were stabilized, they were assisted back to Romania by the use of ambulance air transport. Then they were hospitalized in Romania for continued care. The Romanian authorities argued that since these persons were not insured in Romania under an "883/2004 scheme" (apparently, for the reason that they had not paid their contributions), the hospital bill did not have to be reimbursed to the Swedish competent institution.

From this topical example, the objective of the Think Tank is, with regard to the fundamental principle of "right to healthcare" in the European Union (I), under the light of some key definitions (II) and after presenting a typology of the categories of mobile uninsured persons (III), to explore the current legal context as regards the provision of care (and the coverage of the costs) in case of temporary stay in a Member State other than the Member State of residence (IV).

1. THE FUNDAMENTAL PRINCIPLE OF "RIGHT TO HEALTHCARE" IN THE EUROPEAN UNION

The term '*right to health'* encapsulates legal entitlements with respect to healthcare and health protection. Human rights are said to impose three types of obligations on the holders of public power, namely obligations to respect, to protect and to fulfil. The main emphasis of such social rights consists in a claim on the public authorities for protection and assistance. The right to health may involve a positive obligation on the part of the State or other polity to protect health, and this may require taking legislative action, for instance to ensure equal access to healthcare services if they are provided by third parties, to provide healthcare to the vulnerable, to protect people from health infringements by third parties. It may involve more extensive action to fulfil the right to health by facilitating its enjoyment or by providing the means for doing so. In the context of obligations imposed on States, this right to health may require them to adopt a national health policy, to devote a sufficient proportion of national revenues to health and it may moreover require States to create the conditions where all people within the state have access to health services.

1.1 Non EU legal instruments promoting a right to healthcare

From a legal point of view, the right to healthcare is sustained by several international conventions, among which are Article 23 of the Geneva Convention of 28 July 1951, Articles 11 and 13 of the Council of Europe's revised European Social Charter ((Rev) ESC)[1] and Article 1 of the European Convention on Social Assistance[2].

If we focus on the revised European Social Charter, Article 11 covers the 'protection of health.' This is a wider notion than healthcare, as it also covers the broader determinants of good health. The Council of Europe's Member States comply with this legal provision if they provide evidence of six enumerated elements of the 'right to health'. First, there must be a healthcare system which includes 'public health arrangements making generally available medical and paramedical practitioners and adequate equipment consistent with meeting its main health problems ensuring a proper medical care for the whole population.' Secondly, special measures are required to protect the health of members of various vulnerable groups, and ensure their access to the healthcare system. Thirdly, general public health protection measures are required. Fourth, States must provide a system of health education, and, fifth, are required to follow a policy of accident prevention. Sixth, although the text is not explicit on the matter, Article 11 requires the bearing by collective bodies of the cost of health services. Both social insurance systems and national health services are recognized as valid mechanisms for fulfilling the obligations under the European Social Charter. Coverage under such systems is defined, both in terms of whether any individuals are left with inadequate access to healthcare, and in terms of which types of services are covered.

[1] Article 11 (Rev) ESC (The right to protection of health) reads as follows: *"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia: 1. to remove as far as possible the causes of ill-health ; 2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; 3. to prevent as far as possible epidemic, endemic and other diseases as well as accidents."* Not all Member States have ratified this convention.

[2] The European convention on social assistance has not been ratified by several Member States: Austria, Bulgaria, Cyprus, the Czech Republic, Finland, Hungary, Latvia, Lithuania, Poland, and Romania.

Article 13 (Rev) ESC provides the right to social and medical assistance[3]. With a view to ensuring the effective exercise of this right the parties to the European Social Charter undertake to ensure that any person who is without adequate resources and who is unable to secure such resources either by her or his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the healthcare necessitated by their condition, and to apply this provisions on an equal footing with their nationals to nationals of other parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance. This latter obligation means that social assistance must be guaranteed to those in need as of right and not dependent solely on administrative discretion. In this context, 'medical assistance' means the provision of free healthcare or of the financial assistance required to meet the costs of necessary medical treatment to those in need.

The European Social Charter binds Council of Europe's Member States in international law to comply with the obligations to which they agree therein. Whereas the details of where or how the care is given are left to the discretion of the Council of Europe's Member States, Articles 11 and 13 (Rev) ESC are a reference point in the interpretation of provisions of EU law, in particular secondary legislation because the EU Member States are also Council of Europe's Member States. It is also important to note what measures are taken to prevent healthcare costs from being an excessive burden on people with low incomes. For instance if patients' levels of co-payment to expenses have increased this should be offset by national measures that reduce the impact of cost-sharing on disadvantaged groups and thus guarantee access to healthcare, such access irrespective of the client's ability to pay being a central principle.

1.2 EU legal instruments promoting a right to healthcare

1.2.1 Right to healthcare in the Charter of Fundamental Rights of the European Union

EU legal instruments reinforce the fundamental principle of the right to healthcare. In particular, if the Charter of Fundamental Rights of the European Union (EUCFR) does not include a 'right to health' as such, several provisions can support such a right. In particular, Article 1 (protection of human dignity) and Article 3 (right to physical integrity) according to which "Everyone has the right to respect for his or her physical and mental integrity" must be emphasized. The ECHR has linked access to care and dignity in the context of access to care for prisoners[4].

Access to care is complemented by access to socialised care. Article 35 of the Charter concerns the 'right to healthcare' and provides that "*everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*." This legal provision has two elements, namely an expression of individual entitlements and a mainstreaming obligation. The individual entitlements ("*everyone has the right* …") are both to medical treatment in the case of ill-health and to preventive healthcare. In the Explanations Relating to the Charter of Fundamental Rights (2007, JO C 303/02) which are tools of interpretation intended to clarify the provisions of the Charter, it is stated that the

[3] The provision reads as follows: *"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake: 1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and in case of sickness, the care necessitated by his condition; 2. to apply the provisions referred to in paragraphs 1,2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953."*

[4] See, for instance, Case 30210/96, Kudła v. Poland 26 October 2000.

principles set out in Article 35 are based on Article 168 TFEU and on Articles 11 and 13 of the revised European Social Charter.

Furthermore, the European Union recognizes and respects *"the entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age, and in the case of loss of employment, in accordance with the rules laid down by Community law and national laws and practices"* (Article 34 (1) EUCFR), and it states that *"everyone residing and moving legally within the European Union is entitled to social security benefits and social advantages in accordance with Community law and national laws and practices"* (Article 34 (2) EUCFR).

In order to combat social exclusion and poverty, the European Union recognizes *"the right to social and housing assistance so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Community law and national laws and practices"* (Article 34 (3) EUCFR).

The principle set out in Article 34(1) is based on Articles 153 and 156 TFEU, Article 12 of the European Social Charter of the Fundamental Social Rights of Workers and point 10 of the Community Charter on the rights of workers of 1989. The Union must respect it when exercising the powers conferred on it by Articles 153 and 156 TFEU. Paragraph 2 is based on Articles 12(4) and 13(4) of the European Social Charter and point 2 of the Community Charter of the Fundamental Social Rights of Workers and reflects the rules arising from Regulation 1408/71 – now Regulation 883/2004 – and Regulation (EEC) No 1612/68. Paragraph 3 draws on Article 13 of the European Social Charter and Articles 30 and 31 of the revised Social Charter and point 10 of the Community Charter. The Union must respect it in the context of policies based on Article 153 TFEU.

Article 21 on non-discrimination is also important: any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited. The phrase *'any ground such* as' is crucial here, as it implies that other suspect grounds, for instance citizenship or nationality, might also found a complaint of discrimination. Also, according to the *common values and principles in EU health systems* adopted by the EU Health Ministers on 2 June 2006, it is the duty of the Member States to respect the overarching values of universality, access to good quality healthcare, equity and solidarity. Access for all to adequate healthcare and long-term care and tackling of inequities in access has also been proposed as a priority objective for the new streamlined Open Method of Coordination (OMC) for Social Protection and Social Inclusion.

1.2.2 Impact of the Charter on Member States' legislation

Article 51 EUCFR determines the scope of the Charter. It establishes that the Charter applies primarily to the institutions and bodies of the Union, in compliance with the principle of subsidiarity. As regards the Member States, it follows from the case-law of the Court of Justice that the requirement to respect fundamental rights defined in the context of the Union is only binding on the Member States when they act within the scope of Union law. That means that the requirements flowing from the protection of fundamental rights in the Union legal order are also binding on Member States when they implement Union law.

Paragraph 2, together with the second sentence of paragraph 1, confirms that the Charter may not have the effect of extending the competences and tasks which the Treaties confer on the Union. Explicit mention is made here of the fact that the Union only has those powers which have been conferred upon it by the Treaties. Paragraph 2 also confirms that the Charter may not have the effect

of extending the field of application of Union law beyond the powers of the Union as established in the Treaties. Article 52 EUCFR sets the scope of the rights and principles of the Charter and lays down rules for their interpretation. Paragraph 1 deals with the arrangements for the limitation of rights. It is well established in the case-law of the Court that restrictions may be imposed on the exercise of fundamental rights, provided that those restrictions in fact correspond to objectives of general interest pursued by the Union and do not constitute, with regard to the aim pursued, disproportionate and unreasonable interference undermining the very substance of those rights.

The Charter must be seen as an important expression of the values underpinning the European Union as a polity, and thus may influence legislative, administrative, and judicial activities. It may contribute alike to the construction of provisions of secondary EU law and/or national law, and this process may lead to a common understanding of the rights to health and to healthcare. It may also influence the case-law of the Court of Justice when it comes to the definition of mobile uninsured persons' rights.

However, the right to receive medical treatment does not necessarily imply the right for everybody to treatment free of charge or partly socialized. Still, concerning people with low resources, the right to care necessarily implies free access according to Article 34(3) EUCFR.

1.2.3 Right to healthcare: the TFEU inputs

Under Article 168 of the Treaty on the Functioning of the European Union (TFEU), European Union action is to complement national policies and to be directed towards improving public health. It is also meant to encourage cooperation between the Member States in the field of public health and, if necessary, to lend support to their actions, while fully respecting the responsibilities of the Member States for the organisation and delivery of healthcare services. While Article 168 (2) TFEU gives the European Union a limited right to act in the field of public health, according to Article 168 (7) Union action should fully respect the responsibilities of the Member States for the organisation and delivery of medical care and other health services. Accordingly, the competence for action in the field of health is held, on principle, by the Member States, whereas the Union has the responsibility to undertake certain actions which may complement the work done by Member States, for example in relation to cross-border health threats (e. g. Pandemics), to reducing health inequalities, and to cross-border patient mobility.

The Union has also competence for cross-border healthcare based on freedom of movement of persons under Article 48 TFEU and the freedom to provide services under Article 56 TFEU. These patients' and providers' rights have evolved through the European Courts of Justice 'Decker/KohlI et seq.'-jurisdiction on cross-border healthcare.

The question of division of competences between the Union and the Member States forms an undercurrent to the regulatory and jurisprudential activity of the EU institutions. If matters such as cross-border provision of healthcare are conceptualized as concerning the 'right to health', this may suggest that the EU institutions are competent to regulate such a right. Such a conclusion is highly contentious, because the implication that the Member States have ceded some competence in the area of securing a 'right to health' might mean that matters relating to healthcare services are no longer exclusively for national determination. The Member States are eager to limit the 'spill over' effects of EU law, particularly internal market law, into areas of national welfare provisions, such as those concerning the healthcare elements of a right to health.

Pursuant to Article 168(7) TFEU, as clarified by the case-law of the Court of Justice, EU law does not detract from the power of the Member States to organize their social security systems and to adopt, in particular, provisions to govern the organization of health services. In exercising that power,

however, Member States must comply with EU law and, in particular, with the Treaty provisions on the fundamental freedoms, since those provisions prohibit Member States from introducing or maintaining unjustified restrictions on the exercise of those freedoms in the healthcare sector (see, to that effect, *Commission v Italy;* C-531/06, paragraph 35; *Apothekerkammer des Saarlandes and others*; C-171/07 and C-171/07, paragraph 18 and most recently *Blanco Pérez* and *Chao Gómez*; C-570/07 and C-571/07). When assessing whether that obligation has been complied with, account must be taken of the fact that the health and life of humans rank foremost among the assets and interests protected by EU law and that it is for the Member States to determine the level of protection which they wish to afford to health and to the way in which that level is to be achieved. Since the level may vary from one Member State to another, Member States should be allowed a measure of discretion (see, to that effect, *Commission v Germany*; C-141/07, paragraph 51, and *Apothekerkammer des Saarlandes and others*, op. cit. paragraph 19).

The importance of the "right to healthcare objective" is confirmed by Article 168(1) TFEU and Article 35 of the Charter of Fundamental Rights of the European Union, under which, inter alia, a high level of protection for human health is to be ensured in the definition and implementation of all policies and activities of the European Union (see *Blanco Pérez* and *Chao Gómez*, op. cit. paragraph 65).

1.2.4 Conclusion: right to care and fundamental rights inputs

It follows that the objective of ensuring that the access to care ranks foremost among the interests protected both by national law of the Member States and of EU law and other international legal sources. In this respect and for matters of respect of dignity and integrity of individuals, it would not be acceptable that, for the sole reason that Union citizens are mobile within the EU, they were denied the right to have access to healthcare on the territory of the State where care is needed and, under some circumstances, to socialized healthcare.

In this report we will explore whether under EU law access to healthcare for uninsured persons can be reinforced by the principle of "no cost healthcare", at least in cases of emergency/urgent or vital care. The challenge is to define how, from a legal point of view, this right can be implemented, with the underlying question of which Member State will have to bear the costs.

2. CLARIFICATION OF KEY DEFITINIONS

It is necessary to have a good understanding of key definitions in order to define who does not fall within the scope of the coordination rules and to evaluate the potential impact of Directive 2004/38.

2.1 The concept of "insured person" (Article 1(c) of Regulation883/2004)

Article 1(c) defines "insured person" as follows: "*In relation to the social security branches covered by Title III, Chapters 1 and 3, means any person satisfying the conditions required under the legislation of the Member State competent under Title II to have the right to benefits, taking into account the provisions of this Regulation*".

This definition is new and did not exist in Regulation 1408/71. The idea of "insurance" was implicitly integrated in the definitions in Regulation 1408/71 of "employed persons" and "self-employed persons". Since the personal scope of Regulation 883/2004 was broadened to all persons who are or have been subject to the legislation of one or more Member States, without any reference any longer to their status of worker or self-employed person, the latter regulation relies in its various provisions on the notion of "insured person".

This notion refers to the legislation of the Member State which is competent under Title II. This means that first it has to determined which Member State's legislation is applicable to the person concerned. Secondly, under that legislation it has to be checked if the person satisfies the conditions required to have the right to benefits. Of course the provisions of the Regulation have to be taken into account as well.

So for the implementation of the provisions of Chapter I of Title III on sickness benefits, a person is considered to be "an insured person" if he or she fulfills the criteria for the right to sickness benefits under the legislation of the competent Member State.

Under Regulation 1408/71 the ECJ confirmed that the reference to insurance in the definition of "employed person" in this regulation does not seek to restrict the status of worker to persons who are actually insured under a scheme but is intended to define as workers all persons to which such schemes are applicable. The status of worker is acquired when the worker complies with the substantive conditions laid down objectively by the social security scheme applicable to him or her, even if the steps necessary for affiliation to that scheme have not been completed (*Mouthaan,* Case 39/76, paras 8-10). This will probably continue to be the ECJ's view under the new definition of "insured person". It is however unclear whether the payment of contributions is a *substantive condition* for being insured or just a *necessary step for affiliation* as it depends on the way national legislation defines the role of the payment of contributions.

For the implementation of the provisions of the sickness benefits chapter, the definition of "member of the family" is also relevant. Article 1 (i) of Regulation says: "*member of the family' means … with regard to benefits in kind pursuant to Title III, Chapter 1 on sickness, maternity and equivalent paternity benefits, any person defined or recognised as a member of the family or designated as a member of the household by the legislation of the Member State in which he/she resides; …. if the legislation of a Member State which is applicable under subparagraph 1 does not make a distinction between the members of the family and other persons to whom it is applicable, the spouse, minor children, and dependent children who have reached the age of majority shall be considered members of the family*"; *if, under the legislation which is applicable under subparagraphs 1 and 2, a person is considered a member of the family or member of the household only if he/she lives in the same*

household as the insured person or pensioner, this condition shall be considered satisfied if the person in question is mainly dependent on the insured person or pensioner".

This definition refers to the legislation of the Member State of residence and not to the legislation of the competent Member State.

2.2 The concepts of "stay" and "residence"

2.2.1 Concept of residence under coordination regulations

It must be stressed that residence for the purpose of social security coordination must be assessed in accordance with the relevant EU provisions (i.e. Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009). The distinction between residence and stay is of paramount importance in the sickness chapter (see in particular Articles 17 to 19).

According to the Regulation (EC) No. 883/2004 Article 1 (j), "residence" means the place where a person habitually resides, and "stay" means temporary residence. Residence for the purpose of social security coordination is therefore not assessed according to national definitions or criteria contained in other EU instruments, such as Directive 2004/38. A nationally defined residence concept could lead to a situation where a person, despite living all his/her life in the EU, is not considered to be resident by the legislation of any Member State.

However, there is not, as such, a definition of the concept of residence in the coordination regulations, but only hints which enable to define in concrete situations where the place of residence is located. Indeed, the residence of a person is decided by national social security institutions taking into account the factual situation. This assessment must be done on case by case basis. Article 11 of Regulation 987/2009 provides a number of criteria which have to be considered when assessing the centre of interest of a person, which is where residence is located. Regarding the concept of 'centre of interest', ECJ case-law (see *Di Paolo*, 76/76) has established that the main factors in deciding whether someone is habitually resident are whether they have a 'settled intention' to reside, and whether they have actually been resident here for an 'appreciable period of time'. The case-law gives some guidance on what constitutes a 'settled intention' and an 'appreciable period of time', but ultimately decisions will depend on the circumstances of each individual case.

2.2.2 Concept of residence under Directive 2004/38

Directive 2004/38 does not provide any elements of definition of the concept of residence. It seems that the concept of "residence" in Directive 2004/38 may cover the situation of "residence" as well as that of "stay" under Regulation 883/2004. Indeed, Article 6 of Directive 2004/38 grants the right of "residence" for up to three months. Presence on the territory of a Member State for less than three months would probably be considered as being a "stay" under Regulation 883/2004, for instance for the application of the provisions on sickness benefits. Even a period of "residence" of more than three months under Article 7 of Directive 2004/38 could be considered to be either "residence" or a "stay" under Regulation 883/2004. Indeed, taking into account the criteria of "residence" in Article 11 of Regulation 987/2009, there is a possibility that a person continues to be "staying", within the meaning of Regulation 883/2004, in a Member State for more than three months (for instance, the Erasmus exchange students).

2.3 The concepts of "social assistance" and "medical assistance/care"

2.3.1 Concepts of "social assistance" and "medical assistance/care" under coordination regulations

In order to define which type of cross-border healthcare uninsured persons would be eligible for under EU law, it is useful to refer to key concepts contained in Directive 2004/38 and in coordination regulations: the concepts of "social assistance" and "medical assistance/care" which may be used for the definition of rights provided to uninsured persons.

According to Article 3 of Regulation 883/2004, it « *shall not apply to social and medical assistance* ». This notion is not defined by the regulation. If we consider that this is an exception to the material scope of the regulation, the concept must be interpreted strictly, whereas the concept of "social security" must be subject to a broad interpretation. Indeed, according to the case law dealing with benefits close to social security and social assistance, "*a benefit may be regarded as a social security benefit in so far as it is granted to the recipients, without any individual and discretionary assessment of personal needs, on the basis of a legally defined position and relates to one of the risks expressly listed in Article 4(1) of Regulation No 1408/71*" (case C-419/05, *Habelt*). If we follow the case law, three elements define social assistance: need as the main criterion; the absence of requirements based on periods of work, insurance or contribution; and the individual and discretionary assessment. The broad definition of social security benefits under the coordination regulations combined with the narrow concept of social assistance lead to the conclusion that several healthcare schemes/benefits which are classified by domestic legislation as "social assistance" fall within the scope of the coordination regulations, as well as statutory healthcare schemes.

2.3.2 Concept of "social assistance" and "medical assistance/care" under Directive 2004/38

The concept of social assistance is also a key concept in Directive 2004/38, since its definition is relevant to determine the scope of the principle of equality of treatment. The concept of "medical assistance/care" is placed between "social assistance" and "sickness insurance". On one side, the interpretation of decoupling medical assistance/care and social assistance is sustained by the wording of Article 24(2) of Directive 2004/38, according to which "*the host Member State shall not be obliged to confer entitlement to social assistance during the first three months of residence or, where appropriate, the longer period provided for in Article 14(4)(b), nor shall it be obliged, prior to acquisition of the right of permanent residence, to grant maintenance aid for studies, including vocational training, consisting in student grants or student loans to persons other than workers, self-employed persons, persons who retain such status and members of their families".* It remains unclear, however, whether this paragraph only deals with the transfer of money, or whether it also includes some to medical assistance in kind. These definitions will have a decisive impact on what health care residents are entitled to (see 3.1).

Article 7(1) (b) of Directive 2004/38 makes a clear distinction between "social assistance" and "sickness insurance". Article 24 (2) of the Directive only refers to "social assistance". According to the same provision, by way of derogation from paragraph 1 (equal treatment) , the host Member State shall not be obliged to confer entitlement to social assistance during the first three months of residence or, where appropriate, for the longer period provided for in Article 14(4)(b), nor shall it be obliged, prior to acquisition of the right of permanent residence, to grant maintenance aid for studies, including vocational training, consisting in student grants or student loans to persons other than workers, self-employed persons, persons who retain such status and members of their families. In *Vatsouras* and *Koupatanze*, the ECJ seems to have given a narrow interpretation of the concept of "social assistance" within the meaning of Article 24 (2) of Directive 2004/38. Moreover, in its

Communication of 2 July 2009 (COM(2009)313) on Directive 2004/38 the Commission observes that "only receipt of social assistance benefits can be considered relevant to determining whether the person concerned is a burden on the social assistance system" (p. 9).

3. TYPOLOGY OF PERSONS WHO ARE NOT COVERED BY A SCHEME SUBJECT TO REGULATION 883/2004 (see chart, Annex II)

The point of this chapter is not to draw a line between persons who are insured and persons who are not insured, but to define which categories of persons are not insured under a scheme subject to Regulation 883/2004, irrespective of the fact that they may be covered under another scheme. A simple criterion, which applies to insured persons and members of their family, is whether an EHIC (allowing the coverage of healthcare costs in case of temporary stay abroad) can be delivered or not.
A questionnaire (*see in Annex I*) was sent by the Think Tank team to TRESS national experts in order to evaluate more precisely the situation of uninsured persons under an "883 healthcare scheme".

Even if responses provided by TRESS national experts do not provide an exhaustive presentation of national legislations[5], they clearly indicate the existence of significant coverage gaps. Indeed, only some national healthcare schemes aim at covering the entire resident population (for instance, in Bulgaria, Denmark, Finland and Sweden.. However, even universal schemes are not without gaps, since the status of (lawful) residence can be subject to doubt. For other healthcare schemes, there are also gaps in coverage. The extent of the gaps varies as it depends on the internal structure of the healthcare schemes. It is difficult to quantify the proportion of people without coverage under Regulation 883/2004. It is very likely that the figures are low[6]. For instance, about 1 to 1,5% of the population of Austria is estimated not to be covered by a health insurance scheme. In Belgium, around 104,000 persons would not be covered. In Slovenia, 97% of inhabitants are mandatorily insured for healthcare. In France, virtually all the resident population is covered.

If we look more closely at all national healthcare schemes, there are two main categories of persons who may not be subject to a scheme under Regulation 883/2004.

3.1 Persons covered by a healthcare scheme which does not fall within the scope of Regulation 883/2004

There are several types of situations where a person is covered by a healthcare scheme which does not fall within the scope of Regulation 883/2004. As a result of our research, we identified the following sub-categories, although these are probably not exhaustive:

- persons who are subject to a scheme which should fall within the scope of Regulation 883/2004 but which does not by virtue of the Regulation itself. Indeed, Annex II of Regulation 987/2009 provides that the German and Spanish special schemes for public servants are not covered by Title III, Chapter 1 of Regulation 883/2004 concerning benefits in kind;
- persons who are insured by the scheme of an international organization, including EU civil servants;
- persons who are covered by a scheme of a third State;
- persons who are covered by a conventional scheme, either organized at company level or at sectoral level, such as persons who have retired early, are only entitled to a non-statutory occupational pension;
- persons who are provided with healthcare insurance through individual initiatives: it may include persons who are covered by private individual insurance contracts (for instance, in Cyprus, persons whose income is above a ceiling -circa 37000 euros for a couple- are not entitled to free medical services or to services at reduced costs: they must make use of the

[5] See responses in Annex III.

[6] By comparison, the OECD's estimate is that about one per cent of the inhabitants are not covered by any health care scheme in the EU. Those persons must be added to those who are not covered by any scheme falling within the scope of Regulation 883/2004. Therefore, although the figures are low, they are significant.

private medical sector and pay the fees out-of-pocket). In Austria as well, some schemes provide that insurance is provided only if income reaches a certain amount. The same mechanism applies in Cyprus;

- persons who are covered abroad through travel insurance and/or repatriation insurance;
- persons who are subject to schemes for victims of war and military actions or their consequences, or other schemes which fall out of the scope of Regulation 883/2004 pursuant to Article 3(5) of Regulation 883/2004 as amended by Regulation 988/2009.

These situations are very diverse. In some cases, the coverage provided includes cross-border treatment. In some other cases, however, it does not. It is only when the absence of coverage is established that the question of access to medical assistance/care can be raised. The State where the healthcare is provided will have to verify if such coverage exists. It may even be the case that persons covered by schemes falling outside the scope of Regulation 883/2004 are simultaneously covered by a scheme which falls within this scope. For instance, a person may be covered by a conventional scheme offering additional coverage above that of the statutory schemes to which they are subject.

3.2 Persons not covered by any scheme

Various reasons explain the lack of entitlement (and therefore the absence of the right to an EHIC):

- **the conditions of insurance, of professional activity, of prior residence, of status of "member of family", of income level, of administrative duties are not fulfilled** by the person[7]. There are many illustrations. In Austria, inactive persons and students are not insured through the compulsory scheme. For family members who do not pursue any economic activity, the loss of this status (e.g. after divorce), may also lead to exclusion from healthcare insurance. In Belgium, a condition of prior residence of 3 or 6 months applies for entitlement. In Luxemburg, losing a job implies that the loss of healthcare insurance. In Poland, it concerns unemployed persons which are not registered in unemployment offices. In some Member States, persons who are entitled to an early retirement benefit may also fall outside coverage because they have ceased their professional activity and are not yet entitled to a statutory old age pension.

- **required contributions have not been paid**. In Belgium, uninsured persons are mainly those who have not paid their contributions. In the Czech Republic, unemployed persons who show no evidence that they are seeking work lose their rights when the State stops paying contributions on their behalf. In Estonia, Slovakia and Poland too, the lack of payment implies the suspension of affiliation. In Slovenia, if self-employed persons do not pay their contributions, they are still insured, but they have very limited access to healthcare. This sub-category also refers to persons who either are not aware of their rights or prefer not to be covered at all or not to be covered by a compulsory scheme, for instance, because they do not want to pay the corresponding contributions. In some cases, affiliation can be optional, for instance the Spanish schemes for self-employed lawyers (in practice, it seems that many lawyers decide to opt out, preferring to find private insurance with lower premiums and lower benefits). One may wonder whether the reason why the person has not paid the contributions, leading to a lack of cover, should be taken into account in order to define the rights to healthcare. According to the *Mouthaan* case, it seems obvious that if the employer is responsible for the absence of affiliation, the person should be considered as fulfilling the substantive conditions of affiliation and, therefore, should be seen as an insured person. Therefore, normal rules of reimbursement for cross-border care should apply. If the Member State is responsible for the lack of insurance because of its inefficient administrative organization which did

[7] These national criteria must comply with the principles of the coordination regulations: equality of treatment, assimilation of facts, aggregation, export.

not claim the contributions, would we draw the same conclusion? If so, it would imply that the burden of costs would fall on the State where the person should have been insured. In our view, even if cooperation between Member States has become one of the key elements and goals of the Regulations (see Article 76 Regulation 883/2004), it would be difficult to use this argument in practice. How to prove that the absence of affiliation finds its roots in the weaknesses of the social security institutions and not in the attitude of the person? When should a Member State be deemed responsible for a situation which may be partly caused by the attitude of the person ? The proof will be very difficult. Furthermore, the principle of mutual confidence should avoid discussions on the ability to affiliate persons, except perhaps for obvious cases of dysfunction. This question could be a matter of debate within the framework of the OMC.

- **undeclared workers and undocumented residents** are uncovered by statutory schemes in most EU countries. As a matter of fact, one may suspect that these two categories of people represent the highest number of uninsured persons. When undocumented residents are third country nationals, Directive 2004/38 is in principle not applicable, but Regulation 883/2004 might be.

These categories of persons, who are uncovered by any scheme, are likely to receive medical assistance/care only. Their total lack of insurance (or alternative form of coverage) raises the problem of the coverage of healthcare abroad during a temporary stay. The solutions suggested in this report will be relevant in the first instance for these categories.

4. HOW TO ENSURE HEALTHCARE COVERAGE IN THE MEMBER STATE OF TEMPORARY STAY FOR PERSONS WHO ARE NOT INSURED UNDER 883/2004 OR BY AN ALTERNATIVE FORM OF COVERAGE?

4.1 Application of Directive 2004/38

This part of the report explores the right to medical care/assistance for migrant Union citizens and the members of their families under the Directive 2004/38[8].

The Court of Justice recently confirmed in the *Lassal* (C-162/09) of 7 October 2010 (paras 29-31) that citizenship of the Union confers on each citizen a primary and individual right to move and reside freely within the territory of the Member States, subject to the limitations and restrictions laid down by the TFEU and the measures adopted for their implementation. The ECJ underlined that the freedom of movement for persons is, moreover, one of the fundamental freedoms of the internal market, which was also reaffirmed in Article 45 of the Charter of Fundamental Rights of the European Union. Directive 2004/38 aims at facilitating the exercise of the individual right entrenched in primary law to move and reside freely within the territory of the Member States that is conferred directly on Union citizens by the FEU Treaty. The Court of Justice has also observed that, having regard to the context and objectives of Directive 2004/38, the provisions of that directive cannot be interpreted restrictively, and must not in any event be deprived of their effectiveness.

4.1.1 The right to equal treatment

Article 24 (1) of Directive 2004/38 guarantees the right to equal treatment with the nationals of the host Member State to all Union citizens residing there on the basis of that Directive for all benefits falling within the scope of the FEU Treaty. The ECJ has already confirmed in *Martinez Sala* (C-85/96) that all benefits covered by Regulation 1612/68 as well as by Regulation 1408/71 fall under the scope of the Treaty. Therefore this right to equal treatment also applies to medical care.

Moreover EU citizens residing in a Member State may also rely on other non-discrimination provisions of EU law, and in particular the Treaty provisions. Indeed, relying on Article 18 TFEU EU citizens may claim equal treatment with the citizens of the host State in order to be granted a social assistance benefit where they have been lawfully resident in the host Member State for a certain time or possesses a residence permit (see *Trojani)*.

4.1.2 What does "residing on the basis of the Directive" mean?

In order to assess the meaning and impact of this right to equal treatment for the migrant Union citizens covered by this report, it is necessary to examine the meaning of the words "residing on the basis of this Directive" in Article 24(1) of Directive 2004/38. The Union citizen is only entitled to equal treatment provided he/she resides in the host Member State "*on the basis of this Directive*". A person whose right to reside is not based on this directive would not benefit from this equal treatment provision. [9] The central question is therefore what is the meaning of the wording "*residing on the basis of this Directive"*. This report already commented above on the concept of "residence" in the Directive. We highlighted that the concept of "residence" in this directive covers the situation of

[8] It should be noted that Directive 2004/38 applies to Union citizens who move to or reside in a Member State other than that of which they are a national, and to their family members accompanying or joining them (Article 3(1)). It therefore does not apply to Union citizens residing in their own country, or third country nationals without family ties with a Union citizen (for the concept of member of the family see Article 2).

[9] It is however not excluded that such person may rely on other non-discrimination provisions in Union law, including Treaty provisions.

"residence" as well as the situation of "stay" under Regulation 883/2004, the first meaning the place where a person habitually resides, the latter meaning the place of temporary residence (see Article 1(j) and (k) of Regulation 883/2004).

4.1.2.1 "Residence" up to three months

Union citizens and their family members have the right of residence (within the meaning of this Directive) for a period of up to three months without any conditions or any formalities other than the requirement of a valid identity card or passport (Article 6). Moreover, in the first three months the right to reside is not dependent on having comprehensive sickness insurance (the condition for economically inactive persons residing for more than three months is discussed in a moment). Yet, these persons will only have the right of residence provided for in Article 6 of Directive 2004/38 as long as they do not become an unreasonable burden on the social assistance system of the host Member State (see Article 14 (1) Directive 2004/38). The concept of "social assistance" is also mentioned in Article 24(2) of Directive 2004/38. This provision derogates from the first paragraph of Article 24 by stating that the host Member State shall not be obliged to confer entitlement to social assistance during the first three months of residence. In *Vatsouras* and *Koupatanze* (C-22/08 and C-23/08) the ECJ has given a narrow interpretation of the notion of "social assistance" within the meaning of Article 24 (2) Directive 2004/38. Moreover, in its Communication of 2 July 2009 (COM(2009)313) on Directive 2004/38 the Commission observed that "*only receipt of social assistance benefits can be considered relevant to determining whether the person concerned is a burden on the social assistance system"* (p. 9). No reference is made there to receiving medical care/assistance. It remains unclear whether the term social assistance includes medical care/assistance.

However, even if medical care/assistance delivered to uninsured persons would be considered as "social assistance" it remains to be seen whether reliance on such assistance is unreasonable. The Commission's communication refers in this context to Recital 16 of Directive 2004/38 which provides three sets of criteria for this purpose, linked to the duration of the benefit, the person's situation such as the level of her or his connection with the host Member State and the amount of benefit. On the basis of these criteria the delivery of urgent medical care does not seem to fall under the definition "unreasonable".

Consequently reliance on medical care/assistance during the first three months of residence seems not to jeopardize this person's right to reside. Hence, this person is residing on the territory of the host Member State "*on the basis of this Directive*" and may therefore claim equal treatment for medical care/assistance.

4.1.2.2 "Residence" for more than three months

The right to reside for a period of longer than three months for workers or self-employed persons (and the members of their family) in the host Member State only depends on their status of worker or self-employed person, without any condition linked to income level or sickness insurance (Article 7 (1) (a) of Directive 2004/38). These persons even retain this legal status in a number of circumstances in which they become economically inactive, such as in the case of illness or accident, or in the case of unemployment (Article 7 (3) of Directive 2004/38). The concept of worker is very broad. In *Vatsouras* and *Koupatanze* (C-22/08 and C-23/08), the ECJ recalled its case law with regard to this notion saying *inter alia* that *"any person who pursues activities which are real and genuine, to the exclusion of activities on such a small scale as to be regarded as purely marginal and ancillary, must be regarded as a 'worker'"* (paras 26-30).

For a person not falling under this broad concept of economically active person, Article 7 (1) (b) of Directive 2004/38 subjects the right of residence to having sufficient resources and comprehensive sickness insurance. Comprehensive sickness insurance may be private or public and should prevent creating a burden on the public finances of the host Member State. These persons have a right to reside as long as they meet these conditions. However, an expulsion measure will not be the automatic consequence of a Union citizen's recourse to the social assistance system of the host Member State (Article 14 (2) and (3) of Directive 2004/38). By analogy this would also seem to apply in the event of recourse by such a person to medical care/assistance. Member States must act in compliance with EU law and in accordance with the principle of proportionality (see the European Commission's Communication of 2 July 2009, p. 9). If the burden on the social assistance system or the request for medical care/assistance is not unreasonable, an expulsion measure may not be taken.

This means that an economically inactive Union citizen without any healthcare coverage, either public or private, would in principle not obtain or retain a right to residence for more than three months in the host Member State, but an expulsion measure will always be subject to the proportionality test. As long as the latter test prevents the host Member State from taking an expulsion measure against this person, such a person is allowed to continue to reside in the host Member State, and therefore possibly able to rely on the principle of equal treatment with the citizens of the host State (see *Trojani*).

4.1.3 What are the consequences of the right to equal treatment for medical care?

The principle of equal treatment of Union citizens in the host Member State, either under the Directive 2004/38 or the Treaty provisions, means that these citizens must be granted the same treatment in law as that accorded to nationals of the host Member States who find themselves in the same situation (see for instance *Rüffler*, C-544/07, para 62). It is of course for the legislation of each Member State to determine the conditions for granting social security benefits, including the delivery of health services and medical care. However, when exercising that power, the Member States must comply with EU law in particular the right to free movement (see most recently *Van Delft,* C-345/09, para 84 and 99). More specifically, Member States must respect the principle of equal treatment, prohibiting direct as well as indirect discrimination on grounds of nationality.

This means that for persons who, despite provisions in EU law and in particular Regulation 883/2004, are uninsured for medical care, the host Member State should guarantee only the same access to medical treatment or medical assistance as its legislation grants to uninsured persons of its own nationality.

The provision on entitlement to equal treatment in Article 24(1) of Directive 2004/348 is clearly inspired by the ECJ's case law on European citizenship. In this case law however, the ECJ did not allow economically inactive migrants unconditional access to welfare benefits of the host State. Legal residence in the host State is the first condition to be fulfilled by the applicant (*Trojani;* C-456/02). In addition and depending on the case, s/he should "not become an unreasonable burden on the public finances *(Grzelzyck;* C-184/99) and must "have a genuine link with the employment market of the State concerned" (*Collins;* C-138/02). Thus, the ECJ accepts possible justifications, under the proportionality test, for derogations to equal treatment.

However, the proportionality test only allows a derogation when the burden on the host State's system is unreasonable. It should be tested in each individual case whether a justification exists for derogating from the equal treatment provisions, for instance for persons "residing" in a Member State, without being covered by sickness insurance of another Member State. For the assessment of "reasonableness", we could refer to the statement in the Commission's Communication of 2 July 2009 which refers in this context to Recital 16 of Directive 2004/38 which provides three sets of

criteria for this purpose, linked to the duration of the benefit, the person's situation such as the level of his or her connection with the host Member State and the amount of benefit.

When it comes to access to medical care/assistance the implementation of the proportionality test must also take into consideration the obligation that follows from the international and European fundamental rights instruments, more specifically from Article 35 of the EU Charter, which are mentioned in Part 1 of this Report. Medical care/assistance must indeed in the first place be seen within the context of the objective of a high level of human health protection (see Article 168(1) TFEU) or even the protection of life. The person's situation, including his/her state of health and the urgency of the need for medical treatment, seems to be the central criterion in assessing the reasonableness of the recourse to medical care/assistance. The duration or the amount of the cost of the healthcare urgently needed should not be predominant.

Consequently we take the view that the host Member State may not refuse urgent medical care/assistance, which is available to their own uninsured citizens, to a Union citizen and the members of his/her family residing in that Member State on the basis of Directive 2004/38, either for the first three months or for a longer period. Refusing urgent medical care/assistance would not satisfy the proportionality test. Since Directive 2004/38 does not provide any mechanism for burden sharing between the Member States involved, the cost of the medical care/assistance should be borne by the host Member State in accordance with its own legislation.

Instead of waiting for rulings by the Court of Justice based on an interpretation of the directive (and which would imply that the costs would be borne by the State of stay), the adaptation of Regulations 883/2004 and 987/2009 would be a preferable solution as it would ensure that there is an agreement between States and that a coherent system would be implemented, both as regards the medical care concerned and the distribution of costs.

4.2 Adaptation of the coordination regulations

4.2.1 Which kind of healthcare should be covered?

If the regulation is to be modified, we need to identify first for which category of medical care we would need to introduce a new provision in the Regulation. As regards the scope of healthcare which should be covered, several options can be envisaged:

- all healthcare: this option must be rejected because it would provide comprehensive sickness coverage to uninsured persons, which would be paradoxical since the same persons would not qualify for such insurance in their State of residence since they do not contribute to the financing of the existing comprehensive sickness insurance schemes. In addition, these persons would receive better treatment during a stay abroad than persons who are fully insured by a scheme falling within the scope of the Regulation. Indeed, the latter persons would need to obtain prior authorization for scheduled care and, for occasional care, would be covered only for necessary care;

- necessary healthcare: there are two meanings possible here, either "immediate necessary care" (see Article 22 of Regulation 1408/71 before it was amended by Regulation 631/2004) or, a broader interpretation, "healthcare which becomes necessary on medical grounds" (see Article 19 of Regulation 883/2004). The concept of "immediate necessary care" may prove to be difficult to implement in practice especially if there is no strict control of the situation of beneficiaries. This concept would be even more difficult to apply since it would have to take account of the expected length of stay of the person concerned. As a result, cases of scheduled care could be hiding behind the concept of immediate necessary care. The concept of "Necessary care" must also be defined in

order to ensure that access to care abroad for uninsured persons cannot be used as an alternative way of accessing medical treatment by persons who have no coverage in their State of residence;

- urgent vitally necessary treatment : this last option does already exist in Article 26(3) of Regulation 987/2009 in order to justify, in certain circumstances, a simplified and faster procedure of prior authorisation. The distinction between "urgent care" and "emergency care", and the application of the latter to cross-border care provided to uninsured persons, should be highlighted. It would allow a reduction in the number of cases that would be covered and, therefore, reduce the costs incurred by Member States. In addition, the risk of fraud would be minimized as well as the risks of disguised scheduled care. This definition would also make it possible to reduce the scope of treatment provided to uninsured persons compared to treatment provided during a temporary stay to insured persons. Indeed, by referring to "urgent vitally necessary treatment", only treatment which, if it was not provided immediately, may lead to death or to the loss of a body part or a core body function, would be covered[10].

4.2.2 How to distribute the financial burden?

The distribution of the financial burden is a key question to which the coordination regulations bring answers. But this does not prevent us from exploring alternative solutions.

- solution of Regulations 883/2004 and 987/2009: the treatment is provided in the Member State of temporary stay with the medical resources available in that State. This means that the Member State of stay sets the amount of benefits and then claims their reimbursement from the State of residence. Indeed, in the case of treatment provided to uninsured persons, the financial burden falls on a State and not on a scheme (since there is no competent scheme). The State of residence must bear the final costs since, according to rules of reimbursement set by Regulation 987/2009, it must reimburse without delay the total costs of healthcare provided in the Member State of temporary stay. The translation of this solution to uninsured persons is essential since the Member State of temporary stay must not bear any final costs (unless there is an agreement providing for the distribution of costs). We are aware that, in some cases, the location of the State of residence could prove to be very difficult. However, since the criterion of nationality is not relevant, we cannot see at this stage which alternative criterion could be used.

Thus, the Member State of temporary stay would either be entitled to full or partial reimbursement of the costs of care if the person were insured by a scheme or an insurance contract falling outside the scope of the coordination regulations. The State of temporary stay could also claim compensation from a third party (through the principles of civil liability) or even recover the costs by application of the rules of a maintenance order, civil or succession law.

- Can another distribution of the financial burden be envisaged? Even with the application of the mechanisms of coordination regulations, the Member State of temporary stay still has to bear some residual costs, namely the administrative costs of the benefits. It must also make a cash advance until the final reimbursement by the Member State of residence. Since, the care is provided to uninsured residents who need urgent vitally necessary treatment, it makes sense to have the costs fall on the State of residence to which these expenses are connected through the expression of the principles of

[10] The limitation of the type of care to be covered could also be based on other criteria:
- limitation to unanticipated care that becomes necessary during the stay, which would avoid coverage of cases of scheduled care or of chronic diseases;
- limitation to treatment in case of a serious accident or of specified illnesses;
- limitation to treatment which is provided to uninsured persons in the State of stay.

sovereignty, social cohesion and respect of the fundamental right of the poor to access to free healthcare.

However, another distribution of the burden of costs between the State of residence and the State of temporary stay could be explored for persons who do not have sufficient resources to bear the costs, who do not have any form of cover or insurance and for whom no third party can be held financially liable. This solution has already been envisaged by some delegations at the Administrative Commission. For instance, a more significant financial participation of the Member State of temporary stay could be justified by solidarity between Member States concerning access to vital care for uninsured and insolvent persons who stay temporarily in another Member State.

Annex I
Questionnaire

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think Tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

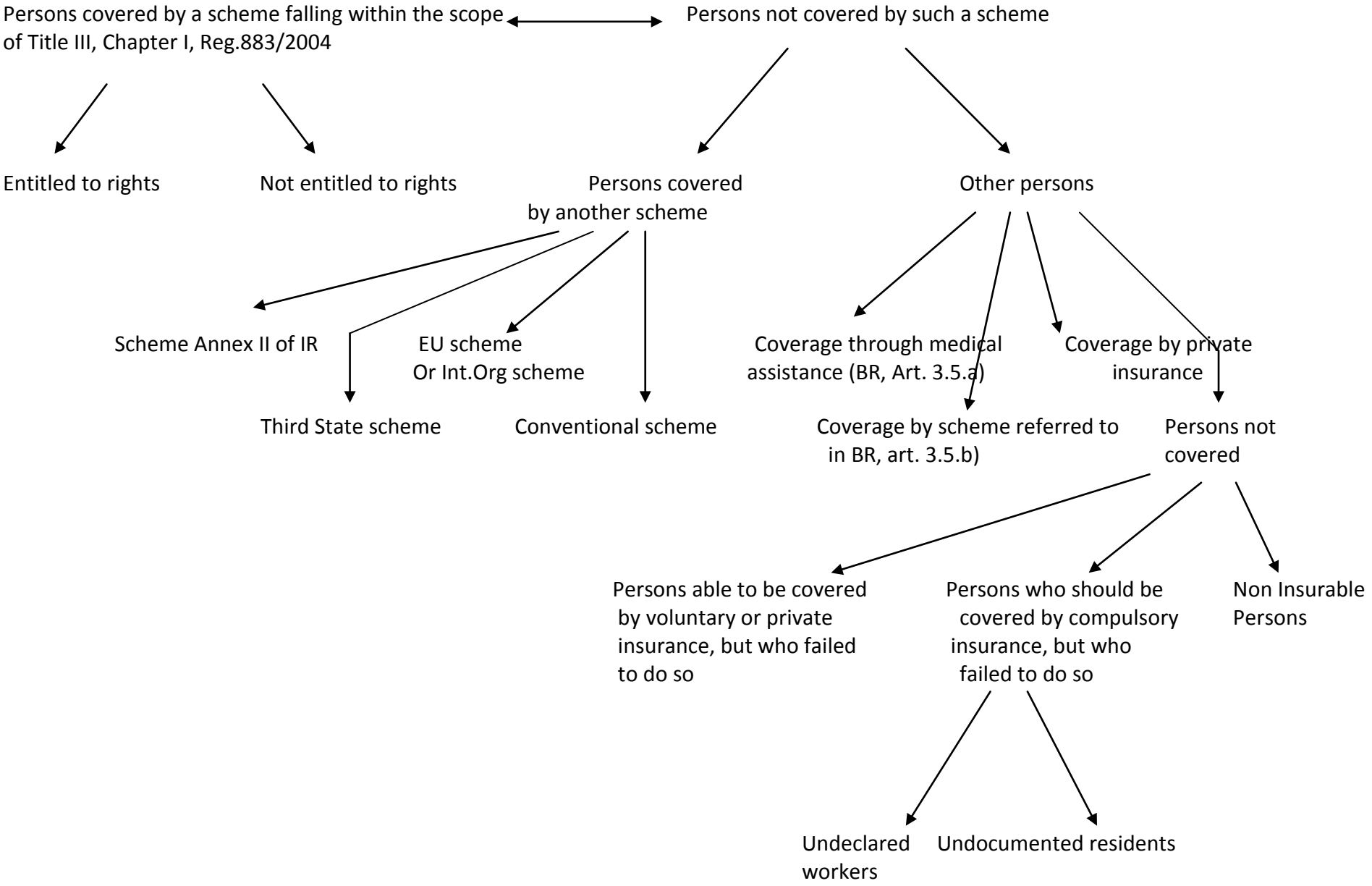
a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e. no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (i.e. the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out of national scheme(s)
h) Others

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to healthcare:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Annex II
Typology of cases



Annex III: National replies to questionnaire

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply AT

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

a) The narrow personal scope of the scheme:
The inclusion into health care insurance is subject to pursuing (self-) employed activities (§ 4 ASVG; § 2 GSVG) as long as those activities lead to a certain income: Employed persons with an income under 366,33 € (2010) are not covered by compulsory health care insurance. A similar regulation applies to self-employed persons.
So these persons have only the possibility of a voluntary insurance (§ 19a ASVG). For certain groups of inactive persons, like students, there is also the possibility of a voluntary insurance to health care (cf. § 16 ASVG).

Family members (cf. Questionnaire 2), who do not pursue any economic activity, are also covered subject to certain legally defined conditions. The loss of the status as a family member, e.g. after a divorce, may lead to an exclusion from health care insurance, if the person concerned does not pursue any economic activity at the same time.

e) The status of the person:

Illegal migrant workers, who don't meet the conditions for residence in Austria and therefore are not allowed to perform any economic activity, are not included into the social security scheme. In other words, the inclusion to health care is dependent from the permit to residence and to pursue (self-)employed activities.

The main groups of persons who are not covered by health care insurance in Austria are summarized:

- Persons with very low income (2010: 366,33 €), who do not (or are not able to) make use of the possibility of voluntary insurance.
- Inactive persons and students (which are not considered as family members any more, which applies at the latest when completing the age of 27), who do not make (or are not able to) use of the possibility of voluntary insurance.
- Inactive persons, who have lost their family member status because of a divorce.
- Illegal migrant workers.

Overall about 1 to 1,5% of the population of Austria is estimated to be not covered by health insurance schemes.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Those persons who have a residence permit but do not pursue any (self-) employed activity (e.g. students, or persons who only perform an activity of minor economic productivity) have under certain legally defined conditions the possibility to **insure** themselves **voluntarily** according to the **conventional** social security **scheme** (cf. §§ 16, 19a ASVG). All persons who do not address these requirements can only obtain protection by **private insurance**.

Those who cannot afford a private insurance rely to health care under the provincial **social assistance** schemes (medical assistance).

If the requirements for social assistance are not complied, e.g. an illegal migrant worker without permission to residence, the person concerned has only access to **charitable health care** providers (*Amber-Med*). In this case the coverage is funded by non-profit organisations like the "*Diakonie*" in cooperation with the Austrian red-cross, the federal ministry for social affairs, the health care insurance carrier of Vienna, the fund "Social Vienna", voluntary working medical practitioners and charitable donations.

A major change has to be expected with regard to persons with a legal stay in Austria when the new "*Mindestsicherung*"-scheme will be implemented: All recipients of cash benefits under that scheme (including their dependent family members) will be subsidiarily covered by the

regular health insurance scheme (such as persons drawing a pension or an unemployment benefit). Contributions will be paid by the provincial authorities. In case of a deficit for the health care institutions, the difference will be borne by the federal budget.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Persons who are covered by health care insurance due to a **voluntary insurance within the regular scheme** can draw health care benefits in other Member States as well according to the provisions of Reg 883/2004 and the Treaty.
In case of a **private health care insurance**, entitlements to health care benefits in other Member States are subject to the respective contract of insurance. Health care abroad is mostly covered under private schemes if the adequate therapy in Austria is not available.
This does not apply to persons who can draw health care benefits only under a **social assistance** scheme. Due to the fact that social assistance is under provincial legislation the access to health care provided in hospitals is basically limited to those hospitals which are financed by the respective federal state (cf. e.g. § 14 (3) *Salzburger Sozialhilfegesetz*). That means that the access to health care under social assistance schemes is actually limited to the single federal state.
The same applies to persons who are dependent of **charitable health care** providers. In this case the access to health care is limited to those practitioners and hospitals who are members of the charitable health care provider.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply BE

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The Belgian sickness insurance covers all workers and assimilated persons and the members of their families. Article 32, 15° of the Act on Compulsory Insurance for Medical Care and Allowances, coordinated on 14 July 1994, extends the scope of the sickness insurance to all residents, i.e. all persons who are included in the national register of natural persons.

In so doing, virtually the entire population is covered for sickness insurance.

Are not covered (i.e. do not have the capacity of “beneficiary/entitled person” for sickness insurance), those who are not registered in the national register of natural persons; and those who are explicitly excluded from the residents’ scheme, i.e. those who are not as of right entitled or authorised to reside in Belgium for more than 3 months or who are not authorised to establish themselves or to reside in Belgium for more than 6 months (exception to the exception: inter alia asylum seekers whose asylum request was declared admissible). There is a special regime for non-accompanied foreign minors (own right to insurability, regardless of the (il)legal character of the residence).

In order to be entitled to benefits, “beneficiaries” must be affiliated to a sickness fund. Affiliation to a sickness fund is free. This is notwithstanding the fact that, in case social security contributions are not collected at source, entitled persons must pay a “personal contribution” to the sickness fund.

The RIZIV-INAMI (National Institute for Sickness and Invalidity Insurance) has a separate category in its statistics of non-insured entitled persons, i.e. persons who are beneficiaries/entitled persons, who are affiliated to a sickness fund but who lost the right to benefits, notably because data as regards contributions were not transmitted to the sickness fund, insufficient contributions were paid, no personal contribution was paid or because the required evidence was not delivered to the sickness fund. It concerns entitled persons who are still member of a sickness fund, but are not entitled to benefits anymore (104,000 persons in 2009).

In general, being “uninsured” is often connected with lack of a legal residence and/or marginalised status (ex-prisoners, homeless persons, semi-nomadic persons).

,

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Private insurance is possible, though not very likely.

Those who cannot benefit from sickness insurance and are in need of medical care can resort to social assistance provided by the Public Centres of Social Assistance (OCMW-CPAS), provided they fulfil the conditions (means-tested). The assistance is provided in the context of the PCSA’s task to ensure the social welfare of families and individuals, and includes curative and preventive assistance of a medical nature. There are special rules for asylum seekers whose asylum application is pending, according to whether or not they are assigned to an accommodation centre.

For foreigners who are *not* legally residing in Belgium (this includes asylum seekers whose application was rejected and who received an order to leave the territory), the medical

assistance to be provided by the PCSAs is limited to “urgent medical assistance”. This concept is defined rather extensively by Royal Decree of 12 December 1996 as preventive, curative or follow-up care, which may be provided on an in- or outpatient basis. It does not cover the costs of food, clothing and accommodation.

Social assistance is ultimately paid for by the State.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Possible private insurance. Not medically assistance to my knowledge.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply BG

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The obligatory insured persons who have a right to health care in Bulgaria are explicitly enumerated in Art. 33 of the Health Insurance Code. They are: all Bulgarian nationals who are not citizens of another State as well; all Bulgarian nationals who are citizens of another State as well and reside permanently within the territory of the Republic of Bulgaria; all foreign citizens or stateless persons who have been permitted permanent residence in the Republic of Bulgaria, save as otherwise provided by an international treaty whereto the Republic of Bulgaria is a party; all persons who have been recognized refugee status or humanitarian

status or who has been afforded a right of asylum in Bulgaria; foreign students and doctoral candidates admitted for study at higher schools and research organizations in Bulgaria according to the procedure established by Council of Ministers Decree No. 103 of 1993 on Implementation of Educational Activity among Bulgarians Abroad and Council of Ministers Decree No. 228 of 1997 on Admission of Citizens of the Republic of Macedonia as Students at the Public Higher Schools of the Republic of Bulgaria; persons other than such referred to in Items 1 to 5, in respect of whom the legislation of the Republic of Bulgaria is applied according to the rules for coordination of social security schemes. The persons who, according to the rules for coordination of social security schemes, are subject to health insurance in another Member State, are not be covered by compulsory insurance provided by the National Health Insurance Fund – they receive health care under the coordination rules.
The above pointed shows that persons who are not insured for health costs are **foreigners without permanent residence** in the Republic of Bulgaria. This is due to the scope of the obligatory health insurance scheme.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Unisured persons may receive health care as all Bulgarian citizens, but they have **to pay** for it. The Health Act regulates the conditions for exercising the constitutional right to unpaid medical services. Article 82 of this Act (HA) stipulates that beyond the scope of the mandatory health insurance, medical services are provided in relation to: emergency health care; obstetric aid for all women without health insurance, regardless of the manner of birth, within the scope and by a procedure determined by an ordinance of the Minister of Health; psychiatric hospital health care; provision of blood and blood products; transplantation of organs, tissues and cells; mandatory treatment and/or mandatory isolation; expert opinions and reports on the degree of disability and long-term loss of the ability to work; payment for the treatment of diseases under terms and conditions set out by the Minister of Health; medical transport under terms and conditions set out by the Minister of Health; vaccines for mandatory immunization and re-immunization, vaccines for specific indications and in emergency situations, specific serums, immunoglobulins and other bioproducts related to the prevention of infectious diseases, as well as the technical means for their application; full range of anti-epidemic activities; access to health care activities within the framework of national, regional and municipal health programmes. These activities are financed from the Republican budjet and the municipalities' budgets independent on the health insurance status. The law recognizes these rights to Bulgarian citizens (Art. 82, para. 2 HA), as well as to foreigners residing permanent in Bulgaria (Art. 83, para. 1 HA). The same rights have the EU and the ERA citizens. Article 83, paras. 4—8 HA sets explicitly forth that all other foreigners have **to pay** for their health care. They will receive the necessary emergency health care for instance, for which the must pay after – ***personally*** or ***by private insurance company***. They may also use ***a third country scheme***.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Care provided to uninsured persons in another member-state may be covered only **by a third country scheme** or **private insurance**.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply CY

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Persons who are not insured for health costs in the frame of a temporary stay in Cyprus would fail to satisfy the personal scope of the schemes (see the above-mentioned point a), the existing statutory requirements (see the above-mentioned point d) or would sustain such a situation as a result of their status (see the above-mentioned point e in connection with undeclared workers, illegal migrant workers, etc.).

More specifically, the legislative context in Cyprus on the entitlement to health costs presents as follows:

According to Government Medical Institutions and Services (General) Regulations of 2000 to 2007 (Περί Κυβερνητικών Ιατρικών Ιδρυμάτων και Υπηρεσιών (Γενικούς) Κανονισμούς 2000-2007 (ΚΔΠ 225/2000, ΚΔΠ 660/2002, ΚΔΠ 455/2004, ΚΔΠ 364/2005, ΚΔΠ 629/2007)), both Cypriots and EU citizens who reside permanently in Cyprus and fulfill the means criteria provided by the said instrument, are entitled to healthcare cover in Public Hospitals (Κρατικά Νοσηλευτήρια).

More specifically, as far as EU citizens are concerned, they have to hold a MEU1 document, according to the Law of 2007 on the Right of Citizens of the EU and of the Members of their Family to Freely Move and Reside in the Territory of the Republic of Cyprus (Ο Περί του Δικαιώματος των Πολιτών της Ένωσης και των Μελών των Οικογενειών τους να Κυκλοφορούν και να Διαμένουν Ελεύθερα στην Επικράτεια της Δημοκρατίας Νόμος του 2007); this instrument aims at harmonizing domestic law with Directive 2004/38/EC.

According to Government Medical Institutions and Services (General) Regulations of 2000 to 2007, the persons who have an entitlement to healthcare are divided into two categories, namely:

(a) Holders of Medical Card "A" (free access), which is issued to unmarried persons whose annual income does not exceed 15.377,41 Euros and to family members whose income does not exceed 30.754,41 Euros, increased by 1.708,61 Euros for each dependent child.
(b) Holders of Medical Card "B" (reduced fees) which is issued to unmarried persons whose annual income exceed 15.377,41 Euros but not 20.503,22 Euros, and to family members whose income exceed 30.754,41 Euros but not 37.589,23 Euros, increased by 1.708,60 Euros for each dependent child.

All the above mentioned persons who are entitled to free healthcare cover pay a 2,00 Euro fee for each visit at the out-patient's department, free of any other due for services such as blood tests, X-rays, paramedic tests or medicine.
Persons entitled to healthcare aged 65 or more, recipients of public aid, active army officers, medical, paramedic, and nursing staff of public health services and some other categories of beneficiaries are exempted from the 2,00 Euro fee.

With regard to dentures, the beneficiaries pay the amount of 68,34 Euros for each denture, with the exception of those who receive a public aid.

All the persons who pay reduced fees (see the above-mentioned point b), pay a 6,50 Euro fee for each visit to a general doctor, and 8,50 Euros for each visit to a specialist. In addition to this, the beneficiaries concerned are burdened with 50% of the dues concerning blood tests, X-rays, paramedic exams and other services, as well as medicine.

The persons who are not beneficiaries pay for each visit to a general doctor the amount of 14,50 Euros, and for each visit to a specialist, 20,50 Euros. In addition to this, they pay the dues which are determined for blood tests, X-rays, paramedic exams, and other services. It should be noted that medicine is not on sale at public Pharmacies to out-patients who do not have an entitlement, subject to exceptions which have to be approved by the Ministry of Health.

The beneficiaries under "A" do not pay any other fee for stay and treatment at State Health Institutions. The beneficiaries under "B" pay 50% of the dues. The persons who are not to be considered beneficiaries pay the full amount of fees as determined by applicable Regulations.
The fees for stay, catering and nursing care are as follows:
-123,02 Euros per day for a single room
-102,52 Euros per day for a double room
-71,76 per day for a room with three or more beds

-205,03 Euros per day for a stay at the intensive care unit
For medical care of patients requiring the specialty of pathology, and for conservative treatment of patients of other specialties, 20,50 Euros per day.
Moreover, fees are to be charged for operations, medicine, blood tests, X-rays, and other services, as determined in the above-mentioned Regulations.

It is noteworthy that under Regulation 8(3) of Government Medical Institutions and Services (General) Regulations of 2000 to 2007 treatments or service required for incidents occurring at the Accidents and Emergencies Department and which are assessed as urgent incidents by the competent medical officer, are provided free of charge. This provision can be of interest to uninsured persons too.

Under Regulation 8 of Government Medical Institutions and Services (General) Regulations of 2000 to 2007 a number of services are free of charge; they mainly concern the prevention and treatment of tuberculosis, AIDS, contagious diseases, psychiatric treatment, etc.

Persons that are not holders of Medical Card A or B and are not included in the Table I of the Government Medical Institutions and Services (General) Regulations of 2000 to 2007 (this category mainly includes civil servants) are in principle not provided with medication unless the Ministry of Health decides so.

In Cyprus there is an important private health sector. Persons who are not entitled to free medical services or to services at reduced costs, make use of the private medical sector and pay the fees out-of-pocket.

It should also be recalled that in the frame of the National Health Insurance Scheme (Γενικό Σύστημα Υγείας) which is currently in the process of being elaborated but which has not been adopted yet (see www.hio.org.cy), Article 16 of the Law on the National Health Insurance Scheme 2001- 2004 (Ο περί Γενικούς Συστήματος Υγείας Νόμος του 2001 έως 2004) which is a statute that is not applicable yet, clearly states the beneficiaries of medical care, namely: (a) every citizen of the Republic of Cyprus who has his/her permanent residence in Cyprus, (b) every dependant person of a beneficiary under point a, (c) every person who is a contributor (εισφορέας) and has his/her permanent residence in Cyprus or is a contributor legally employed in Cyprus, (d) the dependants of the persons referred to under point c, provided that they are permanent residents in Cyprus for a specific period which is to be determined by means of Regulations.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:
   a) a third country scheme
   b) a conventional scheme
   c) a private insurance
   d) an occupational scheme
   e) “social assistance” and/or “medical assistance”
      - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
   f) Other

A possible option would be a private insurance.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

A private insurance would cover the services provided in another member State.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply CZ

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

One case to be mentioned is the case of children of third country nationals. According to the Czech legislation, the parents, if they are third country nationals and fulfil the conditions, they participate in the Czech health insurance system. This is not the case of their children, even if they are born in the Czech Republic. In this case, the health care provided to those children has to be paid in cash or on the basis of a private health care insurance.
This is due to the fact, that the personal scope of the health care insurance is not broad enough to take in also children of third country nationals, whereas children of own citizens are automatically covered by the system.
There are also people not covered by the system, if they do not fulfil financial requirements. They did not contribute to the system, because they lost their job and were cancelled from the evidence of the labour office, which means that the State stopped paying contributions for them. This is often a case of socially excluded people.
As the Czech health insurance system is based on declared work, if somebody works as undeclared worker or illegal migrant worker, s/he may also not be covered by the system, as there is no employer who would register such a person to the system of health care and pay contributions for her/him.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme

c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

The uninsured persons may rely especially on private insurance, some third country nationals, which are not covered by coordination, may also be covered by conventional scheme. To any person the health care has to be provided on costs of the State in the case of emergency, in order to safe the life. The Charter of Fundamental Human Rights guarantees to anybody the right to protection of own health (Art. 31).

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

This would be just the case of private insurance. Concrete conditions are defined in each agreement on private insurance. In general, private insurance companies do not guarantee the health care if the insured person travels abroad. In this case, they recommend additional travel insurance.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply DK

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The Danish health system is a non contributory system. Everyone residing or working legally in DK (and in most cases also their family members) is entitled to health insurance. During temporary stays everyone is entitled to acute treatment. If it is considered unreasonable to transfer a person to the home country for further treatment this person might get a special permission from the regional council to stay on in the Danish health care system . This possibility is not interpreted restrictively

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Not relevant see answer to question 1

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Not relevant see answer to question 1

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply EE

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

d, e

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance

d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

c. Private insurance companies offer private insurance, but it is not widespread.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

It depends on the concrete products and packages of the insurance company. Private insurance is not provided by the Estonian Health Insurance Fund.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply EL

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Answers d and e.
More specifically: The material scope of the Reg. 883/2004 (article 3 par. 5) excludes explicitly national Social Assistance scheme. Social Assistance is provided within the scope of the established by several statutes (initially be the Legislative Decree 57/1973, the Law 2082/1992 and ensuant to them by the Institutional Law 2643/1998 e.t.c.) social welfare system.
More specifically, the uninsured persons are entitled of healthcare coverage under the Ministerial Order No 139/2006 and the Presidential Decree 266/1999.

The aforementioned statutes define the categories of uninsured persons, namely certain groups of people who meet certain legal conditions that are entitled of out-patient (ambulatory) and in-patient healthcare (including pharmaceutical care) coverage.

These are the followings:

a) The persons (migrants and immigrants) who have their permanent and legal residence in Greece are not directly or indirectly insured and their annual family income is up to 6.000 Euros, increased by 20% for the wife and for each juvenile or dependant child, under the precondition that this income does not derive from the pursuit of an insurable activity. This defined income is increased to 50% in case of diagnosed disability of 67% and more. Note that in this category are also included the unemployed under certain criteria
b) Uninsured writers and their family members
c) Uninsured members of Chamber of Fine Arts and their family members and also members of relevant European Union Chambers
d) Uninsured Greek musicians, singers and other specialities activating in the field of entertainment who work occasionally
e) Uninsured ex members of the Parliament and their family members
f) Persons who are lodged by remedial centers for withdrawal or they are treated as external patients
g) Abandoned children in Centers of Social Care or other institutions
h) Soldiers of the National Resistance – injured of war and the dependant members of their families
i) Greek monks and laymen of Sina Monastery and Greek priests of the Patriarchate
j) Uninsured non-marred daughters and mothers and their children
k) Children placed with foster parents
l) Expatriates in the process of acquiring the special identity of expatriates or the Greek citizenship
m) Immigrants who have been granted a visa – stay permit for humane reasons (health reasons)
n) Third-country residents married to Greeks or to Greek expatriates or to EU citizens and their children, to the extent that the latter are not persons subject to EU Regulations
o) The recognized political refugees
p) Immigrants who have applied for a political refugee visa and the procedure for their recognition is pending on the stage of examination by the Ministry of Justice
q) Immigrants that have gained approval to stay in the country for humane reasons
r) Alien residents victims of crimes of the articles 323, 323A, 349, 351 and 351 A of the Penal Code
s) Prisoners and minors in reformatories, educational institutions for children and other places of hosting juveniles.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?

f) Other

Answer e.
More specifically: The above persons are considered to be the beneficiaries of the alternative form of healthcare coverage as provided by the Social Welfare and Assistance Authorities.
Regarding the funding of the public sector bodies that provide healthcare services of social assistance, this is based mainly by the Sate budget for the National Health System (see relevant provisions of article of the Law 2646/1998).

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

In our national legislation there are no specific provisions as to the application of the alternative healthcare coverage of social assistance, although the Council has adopted two important Recommendations in 1992, suggesting that welfare assistance policies should also be extended out of the State's borders and cover the same needs in another MS, as this applies to insured persons as well. Both the two Recommendations [No 92/441, 92/442] aim at helping the most disadvantaged by inviting the Member States to recognize **a general right to guaranteed resources** and benefits for anyone living in a Member State who has insufficient means.
More specifically, healthcare benefits of social assistance are exportable in another MS, on the grounds of an *ad hoc* evaluation of the case at hand by the competent authorities and not on the basis of a general legislative framework. Furthermore, pursuant to Ministerial Decision Z3B/Fin. 9777/23.05.1973 issued by the Ministry of Finance, an uninsured person, under the terms of a prior approval by the Ministry of Health, can be transferred to another MS with the purpose to receive proper and prompt treatment and healthcare, according to his/her health condition. The beneficiary is entitled to receive benefits in kind, equivalent to the benefits that insured persons can acquire (see pro rata art. 20 of the Reg. 883/2004). The healthcare coverage is comprehensive and includes treatment, travel expenses, accommodation and meals both for the patient and his/her attendant as well. According to the procedure, the patient undergoes medical evaluation of his condition by a competent Health Committee of the Civil Servants Sickness Insurance Fund (OPAD) and receives certification that the required medical treatment can or cannot be provided in Greece or cannot be provided within the time-limit which is medically justifiable. The final decision, though, as to the ascertainment of necessity of the patient's – applicant's transfer overseas in order to receive the appropriate plant treatment (not only in EU but also in USA if necessary) is made by the Minister of Health. Thereinafter, OPAD undertakes to cover the costs of the procedure in total, paying in advance a certain amount (front payment) to the respective Embassy at the reception country. The rest of the payment is deposited by the completion of the procedure.
We should mention, that there is no clear legal point of view as to the obligatory prior edition of an E-112 (and already S2) document by the applicant for the welfare benefits abroad patient. In fact, legal statements vary and thus the final regulation of the issue is still pending, since the legal dialogue is open.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply ES

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Spain provides health medical assistance to nationals and EU citizens and third country residents with legal residence or “authorized to stay” (“autorización de estancia”).

Illegal migrants under 18 years of age are also covered.

Illegal migrants over 18 years old will also entitled to medical assistance in case of emergency with respect to contracting serious illnesses or accidents, and in the case of pregnancy, once this state has been confirmed; and six weeks after the birth of the child.

Obviously, illegal migrants cannot invoke EU coordination rules to get medical assistance abroad.

In several cases, self-employed persons are not covered by any national coordinated scheme and therefore they are excluded from the personal scope of Regulation 883/2004.This is the situation of the "free professions", such as lawyers and doctors, who could choose between affiliation to the special scheme for self-employed persons or a complementary non-statutory scheme called mutual social insurance society (Mutualidad de Previsión Social). Apparently the second option is more advantageous because contributions paid to the Mutualidad de Previsión Social are lower than contributions paid to the special scheme for self-employed.

According Annex 2 Regulation 987, Spanish civil servants´ right to get medical abroad is limited.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Private insurance is an option available for everybody that can afford the costs. In fact, in Spain frequently people covered by the Social Security system pay simultaneously a private health insurance.
Lawyers and doctors who are not covered by the Self-Employed social security scheme are entitled to get medical assistance from their “Mutualidades”.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

In case people are covered by a private insurance, the material scope of coverage abroad depends on the stipulations of the contract.
Self-employed people protected by “Mutualidades” have their own rules:
For instance, in case of lawyers protected by the “Mutualidad de la Abogacía” they are covered abroad but the reimbursement cannot exceed from 12.000 euros.
The doctors´ “Mutual Médica” covers their affiliates abroad without a temporary limit but the reimbursement that the “Mutua” may pay is fixed in 18.000 euros.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply FI

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The Finnish health care system is universal and covers all people residing in Finland according to Finnish national legislation. The health care system is twofold. Municipalities are responsible for the public health care services and Kela (the Social Insurance Institution) is responsible for the sickness insurance system.

For public health care services people considered as residents in Finland need to pay only a client-fee. For private health care sector's services, sickness insured people can apply for reimbursement for the fees of doctor's and dentists, costs for examination and treatment, travel costs and prescription medicines.

The criteria for residence for public heath care are set in the Act concerning municipal residence (*Kotikuntalaki 201/1994*). The criteria for residence for sickness insurance are defined in the Sickness Insurance Act (*Sairausvakuutuslaki 1224/2004*) and in the Act concerning Residence based Social Security (*Laki asumiseen perustuvan sosiaaliturvalainsäädännön soveltamisesta 1573/1993*). The criteria for residence according to these Acts are mainly similar but both authorities (the relevant municipality and Kela) make their decisions independently.

There can be situations where a person is considered to reside in Finland according to one of the mentioned Acts, but not the other. So even if a person was not covered by the Finnish sickness insurance system administered by Kela, the person may have a right to public health care on the basis of residence. Respectively, there can be situations where a person is not considered as municipal resident in Finland, the person can be covered by the Finnish sickness insurance system.

All persons considered to be covered by the Finnish legislation, according to Regulations 883/04 and 987/09, are entitled to use the Finnish public health care system. In addition, all employees who have obtained in minimum a four month work relationship (this is no waiting period) are also covered for the sickness insurance system, even if they don't fulfil the residence criteria in the Act concerning Municipal residence.

On the basis of Finnish national law, all people in need of urgent medical care are to be treated in a public health care in Finland. Nobody in need of urgent medical care is left without treatment in Finland. So, there is always an access to public health care services in Finland.

However, if the person concerned is not covered by the Finnish legislation, Regulation 883/04 or other international convention binding Finland, the Finnish public health care may charge the actual medical care costs from the person concerned.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Please see the answer in question 1.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

There is no alternative form of coverage.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply HU

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1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Personal scope: Personal scope: In brief, the personal scope of the Hungarian compulsory health insurance (social insurance) scheme is quite wide. It covers almost all Hungarian citizens and legal residents. (See below.)

The Hungarian social security (health care) system presently operates a one-insurer pattern supplemented by optional membership in not-for-profit health funds and commercially operated insurance companies.

Entitlement to health care is based mainly on the participation in the social insurance scheme (with compulsory membership, opting out is not permitted), and to a few services on citizenship. The national Health Insurance Fund (HIF) provides a virtually universal population coverage with an almost comprehensive benefit package, which applies to the whole country (i.e., there are no variations by region or by payer). Nevertheless, the HIF covers only the recurrent costs of services. The owners of health care facilities, mainly local governments, are obliged to cover the capital costs of services, which usually come from general and local taxation. Tax revenues are also used for covering the deficit of the HIF [1997 Act LXXX on Those Entitled for the Services of Social Insurance and Private Pensions and the Funding of these Services, Sect. 3(2)], certain special services (e.g., public health, catastrophe medicine, experimental medical technologies, family planning and maternal care), which are financed entirely from the central government budget [1997 Act LXXXIII on the Services of Compulsory Health Insurance, Sect. 18(5)a–d, h;

1997 Act CLIV on Health, Sects. 141(2)b, 142(2)], and the copayment for certain medicines and therapeutic devices for socially disadvantaged (1993 Act III of on Social Services). In addition to informal payments to health workers, co-payments for medicines and therapeutic devices constitute the most important private source of health care financing, which are almost exclusively out-of-pocket, as private health insurance is still insignificant in Hungary.

Eligibility for health services of domestic resident Hungarians

Essentially, the insured is eligible for in-kind health services and financial provisions. The law sets out the list of those entitled to insurance. Insured persons are entitled to all health insurance services. Some persons not listed under the insured are only entitled to in-kind health services. Such persons include, in addition to Hungarian citizens studying at day-time courses of a secondary training or education institution or a higher education institution, also foreign citizens who are in a pupil or student legal relationship based on international agreement or scholarship granted by the Ministry of Education and Culture.

People who are also entitled to health services are: recipients of sick pay; of pregnancy and confinement benefits; child-care fee; accident-related sick-pay; accident-related benefits; pension on own right; widow(er)'s pension; old-age benefit; incapacity benefit or widows'/widowers' benefit or increased-amount old-age benefit, incapacity benefit, or widows'/widowers' benefit; temporary benefits; regular social benefits; health impairment allowance; disability support; invalidity benefit; national nursing fee, war veteran's care, miner's pay supplement; child-care aid; pension from a church or a congregation; regular social aid; benefits for the elderly; nursing fee; child-raising support; income supplement of unemployed persons; persons with changed (min. 50%, certified by the competent authority) working capability, person with 40% health damage; support for persons having reached pension age and earning below 30% of the minimum wages; persons recognized as socially indigent by an official certificate issued by the mayor of a local government; persons entering into an agreement for receiving health insurance services; persons obliged to pay health service contribution; persons with a monthly earning generating a contribution base lower than 30% of the minimum wages and acting as a foster parent, provided that the persons concerned qualifies as resident Hungarian.

For the purpose of the following titles, under the law, domestic resident Hungarians are Hungarian citizens living in the territory of the Republic of Hungary; persons in immigrant or

permanent resident status or recognized as refugees; persons within the scope of the Act on the Entry and Stay of Persons With the Right of Free Movement and Residence, provided that they have a registered place of residence in accordance with the Act on Keeping records on Personal Data and Address of Citizens, or if the person concerned is stateless.

Under specific conditions, persons of minor age having a place of residence in the territory of the Hungarian Republic are likewise entitled to health services, as well as persons placed in a residential social institution providing personal care (except foreign citizens); young adult recipients aged 18-24 in follow-up care in the child protection system, and foreign minors placed temporarily by the competent Hungarian authority or put into temporary or permanent home-providing care, as well as detainees and homeless persons.

All insured persons are entitled to full accident-related care, i.e. accident-related financial provisions on top of accident-related health care. Persons eligible for some types of social security services under the applicable legislation have more restricted access. In addition to insurance policy holders, individual or collective entrepreneurs pursuing “supplementary activity” are also entitled to accident-related care. A private entrepreneurs or member of a partnership qualifies as person pursuing a supplementary business activity if he performs the activity as pensioner on own right.

Pupils in education / training / higher education institutions and schools, or trainees provided practical training outside the school system (except for foreign citizens), mental patients treated in socio-therapeutic institutions, addicts, persons apprehended, preliminary detainees, detainees, persons serving a prison sentence who suffered an accident or health damage, particularly in the course of life saving, accident and/or disaster rescue operations or blood donation, or perform public interest (voluntary) work are entitled to accident-related benefits.

Eligibility for health services of foreigners

Foreign citizens may stay in Hungary temporarily or on a permanent basis, i.e. to live their life there. In the latter case, the foreign citizen transfers his/her place of residence to Hungary to work or study there, or to live there as a pensioner, a financially dependent close relative of a Hungarian worker (policy-holder), or perhaps as a refugee, asylum seeker or stateless person. Foreign citizens with a residence permit and a permanent place of residence in Hungary are considered as domestic residents from a social security point of view, and the circle of foreigners includes, in addition to those of foreign citizenship, persons who cannot be regarded as residents, that is, also Hungarian citizens with no permanent place of residence in the country.

Residents (domestic persons) and aliens (foreigners) from a social security point of view

All the natural persons who shall not be regarded as residents shall qualify as aliens. The following shall qualify as residents (from a social security point of view):
Hungarian citizens living in the territory of the Republic of Hungary,
- Immigrants,
- persons having a settlement permit (settlers),
- persons recognized as refugee,
- persons under the effect of the Act on the entry and stay of persons with the right of free movement and residence, who exercise the right of free movement and stay in excess of three months in the territory of Hungary, and have a registered place of residence there in compliance with applicable legislation. The persons concerned include:
= EEA citizens (citizens of an EEA Member State), as long as they have an EEA residence permit, and registration certificate,

= family members accompanying an EEA citizen (as long as the have a residence card and/or registration certificate issued by the Hungarian alien control authority)
= family members of non-Hungarian citizenship accompanying a Hungarian citizen (as long as they have a residence card)
= dependants of a Hungarian citizen or a person of EEA citizenship with a Hungarian residence permit, or those having shared a household with such a person for at least one year, or those under the personal care of the Hungarian/EEA citizen for serious health reasons, if the Hungarian alien control authority given permission for the immigration and stay of that person as family member
= those enjoying the same legal status as the citizens of the EEA member countries, but are citizens of a non-EEA member country, provided that they have a residence permit,
= stateless persons.

Foreign citizens staying in Hungary temporarily, for a short period (Intergovernmental health care agreements)

Based on the principle of reciprocity and on various inter-state agreements, the parties to these agreements mutually grant various entitlements to their citizens for the period of their stay abroad. Foreign citizens arriving from countries which are party to such agreement and not insured in Hungary are entitled to health care services (covered by their health insurance policies on the basis of different accounting methods) during their stay to the extent absolutely necessary, in case of acute illnesses or emergency. The benefits concerned cover primary (basic) medical service, outpatient care, and inpatient care (hospitalization).

Foreigners undertaking work in Hungary

As a general rule, foreign citizens arriving in Hungary to undertake employment count as insured from the date of the commencement of their employment by an employer qualifying as domestic resident Hungarian and paying the relevant contributions. On that basis, the employee concerned acquires entitlement to all services provided by the health insurance system.

Close dependent relatives of the above persons

Close relatives of foreigners insured in Hungary may become entitled to health services on the basis of an agreement concluded with the county health insurance fund.

Foreign citizens studying in Hungary

The following rules are indicative for the entitlement to health benefits of persons of Hungarian or foreign citizenship studying in Hungary:
- Hungarian citizens who are full-time students in a higher education institution and foreign
- citizens who are students based on an international agreement or a grant awarded by the minister responsible for education are entitled to the in-kind benefits of the Hungarian social security system.

A foreign citizen who does not meet the above conditions (he/she has no grant provided under international agreement or awarded by the minister responsible for education) shall be entitled to health services in Hungary according to the following:

a) Entitlement to health services of EEA citizens with student legal relationship in a Hungarian higher education institution

aa) Persons arriving from a Member State of the European Economic Area (EEA), if entitled to health services in their home country, may claim the services deemed necessary in the light of their planned period of stay, and their state of health if they hold the European Health Insurance Card issued by their respective competent insurers.
ab) If an EEA citizen who is the student of a Hungarian tertiary education institution has no entitlement to health benefits in his/her home country, but has a residence permit in the EEA, then he/she will qualify as Hungarian resident from a social security point of view. Hungarian residents must pay a monthly contribution corresponding to 16% of the minimum wages following registration with the directorate of the Hungarian Tax and Financial Authority (APEH) competent by their place of residence. Through contribution payment, these persons acquire entitlement to health services, which they can claim by showing up the so-called TAJ [social security identification number] card issued upon request by the county health insurance fund geographically competent on the basis of their residence. The monthly contribution corresponds to 9% of the minimum wages after 1 April 2007.

b) Entitlement to sickness and health benefits of non-EEA (third country) citizens with student legal relationship in a Hungarian higher education institution
ba) If Hungary has a valid bilateral social policy/social security agreement with the state of which the person is a citizen, he/she may claim sickness and health benefits in Hungary in accordance with the provisions of that agreement. Given the fact that entitlement based on such agreements is acceptable as proof of the financial coverage of the health service, citizens of these states are entitled to claim emergency care in Hungary by showing up their passports.
bb) Citizens of countries, not parties to an effective agreement with Hungary, possessing a residence permit in Hungary and having established a student legal relationship at a day-time course of a Hungarian tertiary educational institution, may conclude an agreement with the county health insurance fund geographically competent by their place of residence in order to acquire entitlement to health care benefits. Since 1 July 2009 the legal permission to stay on the territory of the country is not a necessary condition to make such an agreement. Monthly contribution corresponds to 30% of the minimum wages ever. The beneficiary is entitled to emergency care in Hungary in the first six months following the conclusion of the agreement, but if he/she pays contribution due for the first six months in one sum upon concluding the agreement, he/she will acquire entitlement to the full range of social security benefits in kind from the date of concluding the agreement. Such agreement may be concluded by persons with a permanent residence permit who are citizens of a country party to a bilateral agreement with Hungary, who wish to have more extensive insurance in Hungary than just emergency care.
bc) A third-country citizen with permanent residence permit in Hungary qualifies as domestic resident from a social security point of view, and hence the obligation to pay contribution corresponding to 16% of the minimum wages ever shall apply.

A Hungarian citizen studying in a foreign higher education institution operating in Hungary, but not subject to a student legal relationship and not insured under some other title, shall pay contribution as defined under the applicable legislation.

The same applies to an EEA citizen having an EEA residence permit and studying in a foreign tertiary education institution operating in Hungary, or to a third-country citizen holding a permanent residence permit, unless they have a certificate of entitlement based on the co- ordination regulation or defined by international agreement (European Health Insurance Card, form).

A third-country citizen with Hungarian residence permit, pursuing studies in a foreign tertiary education institution operating in Hungary, may conclude an agreement with the county health insurance fund competent by his/her place of residence; in this case, the monthly contribution amount corresponds to the minimum wages.

Pensioners of foreign citizenship settling down in Hungary

Pensioners of foreign citizenship settling down in Hungary, and having a permanent residence there, and provided pension debited to the social security agencies of the Republic of Macedonia (Skopje), the Republic of Croatia, Serbia or Montenegro, and their family members entitled to benefits are provided hospital care under the same terms as pensioners of Hungarian citizenship, provided that the foreign agency disbursing their pension benefits issues a certificate to that effect.

Given the large number of Yugoslav pensioners having moved to Hungary, persons receiving pension exclusively from a Yugoslav social security agency, and having a permanent place of residence in Hungary, shall be provided health care benefits according to the relevant Hungarian regulations, to the debit of the Hungarian insurer.

Hence entitlement to free benefits in Hungary may be established if the claimant has an identity card and his/her pension is transferred to Hungary in accordance with the agreement. As the Yugoslav pension insurer does not transfer pension abroad at the moment – in spite of the provisions of the agreement –, the Hungarian party is willing to overlook the fact that the pension is not transferred to Hungary as long as an authenticated translation is presented of the pension awarding statement testifying that the person concerned receives pension in Yugoslavia.

Pensioner foreign citizens having settled down in Hungary and not within the scope of mutual agreements concluded with any of the above-mentioned countries may claim health care benefits in Hungary at a charge or they may, of course, conclude an agreement to receive health insurance services.

Title of foreigners to health services based on agreement

Foreign citizens staying for a longer period in the territory of Hungary may, if Hungary has no valid social security agreement with their country and if they are not entitled to health benefits under another legal relationship, conclude an agreement with the health insurer to provide for themselves by undertaking to pay a pre-defined contribution amount. Hungarian citizens qualifying as aliens for the purposes of the social security system (including the people who cannot have a valid Hungarian ID) shall fulfil the same conditions.
A child living in the household of a foreigner concluding such an agreement may also be provided entitlement to the health care services.

Foreigners may initiate the conclusion of the agreement giving them entitlement to the services concerned at the county health insurance fund competent by their place of residence, and the foreigner is provided a form certifying entitlement to health services at the same place. Entitlement is certified at the place of payment or at the MEP (county health fund).

Contribution payable by foreigners based on agreement:

Foreign citizens of major age may acquire entitlement to health services by paying the 50% minimum wages in effect on the day of the conclusion of the agreement, a child younger than 18 years of age and foreigners studying at a day-time course of a Hungarian institution of education by paying an amount corresponding to 30% of the minimum wages.

Contribution due for the first month must be paid upon concluding the agreement, and later on it is payable monthly, in advance, no later than the 12 th day of the month preceding the month of entitlement.

The agreement is valid from the first day of the month following the first payment (i.e. the conclusion of the agreement), but in the first six months, it provides title to limited services only.

The beneficiary of the agreement becomes entitled to health services supported by social security as of the first day of the sixth month following the conclusion of the agreement, with the provision that he/she shall be entitled to emergency care only from the first day of the month following the conclusion of the agreement until the sixth month.

It is likewise possible to pay the contribution due for six months in one sum in retrospect upon concluding the contract, in which case all the health services provided with social security funding shall be available to the insured from the first day following the month in which the agreement was concluded.

It is possible to conclude an agreement whereby the contribution is paid by another person or organization to the benefit of the person as specified in the agreement (the beneficiary).
Persons entitled to health care based on contribution payment undertaken by agreement shall not acquire entitlement for another 45 days, i.e. entitlement on so-called passive right, after the termination of the contribution payment.

Persons who fail to meet their obligation by the specified payment deadline shall lose their entitlement from the following month and that is also the end of the agreement. The form certifying entitlement shall be submitted to the MEP within 3 days of the termination of the entitlement.

The scope of agreement-based health care benefits

The scope of health care benefits based on agreement is narrower than that of health insurance benefits based on other legal relationship. A person entitled to health care benefits by agreement shall be entitled only to emergency dental care from the dental care services provided with social security funding. Furthermore, he/she shall not be entitled to reimbursement up to the extent of the corresponding domestic expenses of service expenses incurred to avert a grave hazard to his/her life/physical integrity in a non-EU third country or of care claimed in an EEA Member State under a form that does not conform to the community legislation.

A person entitled to agreement-based health benefits may not be provided with therapy, which is not available in Hungary, abroad to the charge of his/her Hungarian health insurance.

Health services provided to refugees

Refugees enjoy the same rights and have the same obligations as Hungarian citizens; thus they can prove their entitlement to health services by showing a TAJ card issued by the health insurance fund, and they have the same health insurance contribution obligations as Hungarian citizens.

Persons excluded from insurance

Insurance does not extend to a diplomatic representative of another country, a mission member of foreign citizenship, a representative (staff member) of an international organization enjoying diplomatic immunity; an employee of an international organization enjoying diplomatic immunity; and employees of foreign citizenship of the above staying in Hungary or their spouse and children of foreign citizenship staying in Hungary and living with them.

The insurance similarly does not extend to persons employed in Hungary by a foreign employer and qualifying as foreigners. The insurance does not cover foreign persons employed in the Republic of Hungary by an employer not registered in accordance with Hungarian legislation if such person is under the effect of Regulation on 1408/71/EEC on the application of social security schemes to employed persons, self-employed persons and members of their families moving within the Community, or perform work in Hungary in the framework of posting, secondment or labour-hiring arrangements.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:
   a) a third country scheme
   b) a conventional scheme
   c) a private insurance
   d) an occupational scheme
   e) “social assistance” and/or “medical assistance”
   if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
   f)Other

Private insurance:

There is a legislation on private health insurance. It is a non-profit, voluntary and supplementary private insurance. Basically, it supplement the statutory scheme. There is no option for private health insurance scheme.

Occupational scheme

Basically, the occupational health scheme doesn’t exit in Hungary.

Medical assistance

According to the Act CLIV on Health Section 142: Unless declared an exception by law, the central budget shall cover the related costs of the following types of service and tasks for all persons (including persons without health insurance coverage) who are resident in the territory of Hungary:
a) ambulance and emergency services,
b) disaster health services,
c) services related to organizing the blood supply and making blood available,
d) the public health tasks,
f) mandatory public health and epidemiological tasks,
g) within the framework of public health activities aimed at primary prevention, tasks involving health promotion and improvement, the organization of health education, and family planning counseling,
h) prenatal care and care for mothers post partum,
i) state support for professional education and mandatory continuing education in health,
j) payment of damages that are incumbent on the State based on this Act,

k) tasks set forth under separate statute or by government decree authorized by statute.
All Hungarian citizens permanently or temporarily resident in Hungary and all non-citizens qualifying as equivalent in terms of insurance coverage, furthermore non-citizens entitled to services on the basis of international contracts shall be entitled to the services at the expense of the central budget.

The health treatment which isn't covered either the Health Act (Financing from Central Budget) or Health Insurance Act (financing from Health Insurance Fund) can be provided for legally set fee, which is paid by the patient.

Social assistance

There are two types of benefits under the Act III of 1993 on Social services: 1) Relieve the cost of high health care for needy persons (közgyógyellátás) and 2) right to heralth insurance (egészségügyi szolgáltatásra való jog).
The first one is a regular (ususally discretionality-based) for needy persons (households) who cannot afford to buy all of the necessary [For example the wage (72.500 HUF/2010) medical equipents and medicine.

The second one is designed for persons who cannot „buy" for him/herself health insurance contributions and his/her monthly income doesn't exceed the 120% of the minimum old-age pension and he/she doesn' have any assets/savings.
If every above mentioned conditions are met the entitled person will be covered by health insurance fund and will be entitled for basic health care (in-kind) benefits.
In such case, instead of the individual, the State Budget will cover the health insuance cost.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

The possible options were discussed in above.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply IE

Persons not insured for health costs within the meaning of Reg.883/2004.

1 All persons ordinarily resident in Ireland are eligible for health treatment under the State scheme. Eligibility, therefore, is not based on insurance, but on residence. All persons are eligible for health treatment in public hospitals, subject to small charges. The degree of entitlement, free of charge, to services in public hospitals and to GP services, outpatient services and drugs and medicines are related to the levels of household income or to insurance status in another EU/EEA Member State (see below). Persons who are eligible for the full range of health treatment free of charge are granted a 'medical card'.
However, legislation is currently being introduced to impose small prescription charges for all medicines under this free scheme. Charges incurred by non-medical card holders are tax deductible above certain limits.

Persons living in Ireland and intending to reside here for at least a year are considered to be "ordinarily resident". This applies regardless of nationality. However, third country nationals must also provide evidence that they are legally entitled to reside in Ireland
(work permit or visa). Persons from other EU/EEA States, who are considered to be 'ordinarily resident', in Ireland are granted entitlement to 'medical cards', (see above), if they provide evidence of being insured in other Member States (E form). If they have no E form, the income limits are applied as in the case of other residents.

The same rules apply to persons on temporary stays, except that access to hospitalization, is confined to the provision of urgent treatment. Tax deductibility would normally not arise, as people on temporary stays would not be subject to income taxation in Ireland.

2. The full range of health services in Ireland – hospital, out patients, GP services and drugs and medicines are available on a private basis to persons on temporary stays who are in effect "uninsured" under the scheme of an EU State. Treatment can be purchased under the schemes listed in a) to d) of this question, but the arrangements for so doing would be subject to the rules of these schemes. The most straightforward arrangement is having the treatment paid for at the point of purchase, with the patients being reimbursed in accordance with the rules of their scheme.

Where urgent treatment is provided to persons on temporary stays who do not have coverage under any scheme for that treatment and do not have the resources to pay for it, the cost is met under the State scheme in the same way as for residents on low incomes who are eligible for treatment free of charge. Any person resident in Ireland can purchase private health insurance

irrespective of whether insured or not. The extent of coverage and funding is totally dependent on the rules governing the private insurance policy

3. Virtually all people resident in Ireland are covered for health care and this cover is maintained if they go on temporary stays to other Member States by having an EHIC. Provision may be made by occupational and private insurance schemes to meet additional costs incurred over and above those met by the country of temporary stay. But this is totally dependent on terms and conditions of the occupational scheme or private insurance policy.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply IT

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1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The full health care benefit is due only in cases of payment of contributions and of participation of the worker to a specific pension scheme. The sum is usually paid from the employer, and then reimbursed (through compensation) by the Public Authority. When no contribution has been paid, the worker can only receive the payment of a minor sum, only in case of hospitalization. The authorization to receive health care in another member State

must, in any case, be duly certified by a doctor who recognizes the necessity to receive health care abroad.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

The uninsured person can only rely on a small cash benefit, in case of hospitalization. In case of unemployment, the unemployed can, in any case, receive a cash benefit (which, in this case, is directly paid by the National Authority for social security [INPS]).

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

This is not clearly stated in Italian social security legislation and there not seem to be reported case law. In any case, the exclusion of these persons from any kind of assistance, in case they receive it abroad, might be considered unlawful for infringement of the principle of equality and non discrimination, and could then be derogated from by the Constitutional Court.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply LT

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Persons who temporary stay in Lithuania, but do not work (or are not self-employed) have no way to enter the scheme of health insurance as well as their children. The only way for them is private health insurance, hence outside of the scope of Regulations. The reason (e) probably is the most relevant in this situation.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

(c) Only private insurance is possible for persons outside the scope of general scheme of health insurance (see question 1)

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

As alternative form of coverage is private insurance, coverage of care in other MS depends on the nature of contract. The biggest Lithuanian insurance companies “Lietuvos draudimas" and "PZU Lietuva” Informed, that health insurance is usually used by foreign pensioners who come to reside in Lithuania and by country nationals going for vacations abroad.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply LU

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? YES

If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

1. Most of the persons, who are not/no more compulsory insured for health costs in Luxembourg, lost their last job and their health coverage as an insured person or lost the right to sickness benefits as a family member and did nothing to be covered by the sickness insurance That means that they realize that they are no more insured, when they ask for a reimbursement of medical treatment costs.

In Luxembourg, it is possible to ask for the maintaining of the health insurance, if you lose the right to sickness benefits as an insured person or as a family member, under the condition that you are residing in Luxembourg (art. 2 CAS *assurance maintenue*).
It is also possible for a person, who cannot otherwise be compulsory insured, to ask for a voluntary insurance under the condition that he/she is residing in Luxembourg. But the voluntary insured person has to wait for a period of 3 months from the demand sent to the affiliation institution, called *Centre commun de la sécurité sociale*, on before getting sickness benefits (art. 2 CAS *assurance volontaire*).
It would be very simple for Luxembourg authorities to inform people that they are no more affiliated to the compulsory insurance and that they have the possibility to ask for a maintained insurance or a voluntary insurance (art. 2 CAS).

2. Illegal workers are not compulsory insured.

3. There is a special case concerning British citizens, who are residing in Luxembourg. They set up their permanent residence in Luxembourg by registering at the municipality of their residence. Then they ask to be compulsory insured in Luxembourg. Luxembourg asks them to produce a certificate from the British authorities proving that they are no more registered in Great Britain. But British authorities refuse to deliver this certificate. In order to avoid two permanent residences - one in Great Britain and one in Luxembourg - Luxembourg asks them to stop their residence in Luxembourg and to declare at the municipality that they are no more residing permanently in Luxembourg. As a consequence, they are no more insured in Luxembourg, where they are nevertheless living.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

To my knowledge - NO

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply LV

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Under national legislation Latvian citizens, Latvian non-citizens, foreigners who have permanent residence permit, nationals of EU member states, countries of EEA and Switzerland who are working or are self-employed in Latvia and their family members, refugees or persons who have acquired the alternative status, persons detained, arrested and sentenced with deprivation of liberty, as well as children of the above mentioned persons are entitled to health care services financed by the state.

The spouses of Latvian citizens and Latvian non-citizens who have a temporary residence permit in Latvia have the right to receive free of charge the care for pregnant women and birth assistance paid from the State basic budget.
All other persons, for example foreigners who have a temporary residence permit are not covered by the state financed health care system and have to pay for medical services.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

According to the Immigration Law foreigners are entitled to enter and reside in Latvia provided they have a valid health insurance policy, which guarantees the covering of expenses related to health care in Latvia, including the conveying of the foreigner back to the country of residence in the case of his or her serious illness. Only in exceptional cases a foreigner may enter and reside in Latvia without a health insurance policy.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply MT

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

D, E

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance

d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

C. In Malta, the State also offers essential treatment on humanitarian grounds in emergency situations.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Care provided in another Member State is not covered.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply NL

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Answer: e. Aliens without a residence permit (that is aliens that have applied for a residence permit and are waiting for the decision) and illegal migrants do not have a right to health care (coverage) under the social health insurances.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme

b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Aliens without a residence permit (that is aliens that have applied for a regular residence permit and are waiting for the decision) can take out a private health insurance and if they are accepted they are entitled to the care covered by the insurance. Illegal migrants also depend on private health insurance but it is not likely that illegal migrants will be accepted for a private health insurance by a private health insurer. Nevertheless, in the Netherlands everyone is entitled to medically necessary treatment. Every health care provider has the professional responsibility to provide medically necessary treatment. Uninsured persons must meet the costs of provided care themselves. Health care providers who are unable to collect (full) payment for medically necessary treatment given to aliens with no legal right of abode in the Netherlands, can apply for reimbursement under The Act that came into force on 1 January 2009. (The Act of 30 October 2008 concerning the amendment of the Health Insurance Act concerning the reimbursement to care providers who lose income as a result of given medically necessary treatment to certain groups of aliens and of the Exceptional Medical Expenses Act with a view to insurance of certain groups of minor aliens [Bulletin of New Laws 2008, 526])

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

As mentioned in the answer under 2. illegal migrants do not have an alternative form of coverage.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply PL

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

D, E

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme

c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

E It is provided by the state

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

This persons do not have the access to alternative forms of coverage. So this care is not covering help in other Member States. In Poland almost all persons have access to health care. The largest group which don't have it, are unemployed persons which are not registered in unemployment offices and which spouse is also not insured (members of the family are insured).

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply PT

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

The Portuguese Constitution establishes in article 64 that:
1 – Everybody is entitled to health care and the duty to defend and promote this right;
2 - The right to health care is fulfilled through a general and universal National Health Service, taking in account the economic and social conditions of the citizens, and tending to be free of charges.

Taking in consideration this precept of the fundamental Law, legislator adopted the Act 84/90, according to which are covered by National Health Service (NHS), regardless of contributions for social security:

- Portuguese nationals;
- Nationals of the EC Member States according to EU rules;
- Persons covered by bilateral instruments where Portugal is part, when such instruments include health care in the material scope;
- Asylum seekers as from the date of asylum demand until the final decision of the authorities;
- Refugees, stateless persons and foreigners legally residing in Portugal, under the same conditions as the Portuguese citizens;
- Beneficiaries of the temporary coverage in cases of massive flows of people from third countries.

The title that qualifies a person as beneficiary of National Health Service is the User's Card. Foreigners must held a stay or resident permit or a work visa.
In other situations the benefit of health care requires a document issued by the competent authorities proving that the person stayed in Portugal for, at least, 90 days. Except in cases or situations where public health can be affected, these persons may have to support the costs according to the applicable price-tables, taking in consideration the economical and social situation of the person, which can be assessed by the social security.

Illegal migrant workers, as far as they are included in the content of the first phrase of the previous paragraph, can beneficiate of NHS'protection.

Considering question g) It must be stressed that NHS is not obligatory and people covered (as referred above) is free to look for care out of the system, in private clinics, insurance companies, etc….

In another perspective, it must be said that a great part of other schemes (as referred in nr 3) celebrated agreements (protocols) with Social Security and NHS under which the respective members can beneficiate of health care in other Member States according with the Regulations.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Taking in consideration the answer to the first part of the questionnaire it seems that, practically only tourists or persons in transit to other countries, not covered by any

international instrument of social security coordination relying Portugal, could be in a situation where NHS could claim the payment of costs, according to the applicable rates.
Of course, people not covered, by any reason, can subscribe a private insurance or be addressed to health establishments that are not integrated in NHS.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Alternative forms of coverage, such as private insurances or equivalent, depend of the contractual terms between the Parts (eventually Insurance companies and the interested person). Such coverage cannot be, of course, that one relying on the EC Regulations.
It goes without saying that most part of population is covered by NHS, even in cases where people insured in special schemes, such as the case of ADSE (Health Care for Civil Servants), Militaries, Forces of Police, Banking employees and others less relevant.
In such case the costs of health care by NHS will be charged to the respective schemes.
Also, it must be stressed that in case medical emergency NHS will care anyone,and financial matters will be treated later on in cases where the persons are covered by special schemes or private insurance companies.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply RO

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

All Romanian citizens residing in Romania, as well as all foreign citizens and stateless persons who have requested and obtained the right of temporary stay or residence in Romania are compulsory insured to the health insurance system.

The general condition is that the persons are insured if they pay contributions to the health insurance system.
But there are exceptions:

- The following categories of persons covered by insurance, without paying contribution:
  - All children up to age 18, young people from 18 years until age 26 years, if they are students, including graduates from high school to start academic year but not more than three months, trainees or students and if have no income from work;
  - young people aged up to 26 years from the protection system of children and who have no income from work or are recipients of the social assistance provided under Law no.416/2001 on minimum income guaranteed, with subsequent amendments, husband, wife and parents without their own income, dependents of an insured person;
  - persons whose rights are established by laws granting rights to persons persecuted for political reasons, persecuted by the comunist regimes, war

veterans, disabled and widows, heroes and warriors in the Romanian Revolution, if they have no other other income;
- disable persosns with the disability not derive from work,
- patients with diseases included in national health programs established the Ministry of Public Health, if they have no income from employment, pension or other resources;
- pregnant women, if they have no income or have income below the minimum gross salary per country.
- For persons in one of the situations listed bellow the contributions are paid from other sources, by the responsible institutions, according to the laws:
  a) within military service (by the Ministry of Defence);
  b) is in sickness leave , due to a work accident or occupational disease (by the Accidents at Work and Occupational Diseases Insurance Fund);
  c) is in the parental leave until the age of two years and if a disabled child until the child reaches the 3 years of age (by the Ministry of Labour);
  d) executing a custodial sentence or is in custody (By the Ministry of Justice);
  e) persons receiving unemployment indemnity (by the unemployment Fund);
  f) shall be returned or expelled or are victims of trafficking and during procedures is necessary to establish identity (by the Ministry of Interior);
  g) persons who are part of a family who is entitled to social aid (by local authorities).

- EU citizens and persons proving that they are insured in an EU Member state (on the basis of the European Health Inusrance Card or other certificates privided by the EU coordination rules)
- Insured persons from countries with which Romania has signed bilateral agreements containing provisions regarding the health care service and other benefits granted in Romania, under conditions provided by these international documents.

Social health insurance is optional for:
a) members of diplomatic missions in Romania;
b) foreign citizens and stateless persons who are for a short stay in Romania, without requesting a long-stay visa;
c) Romanian citizens living abroad who are for a short stay in Romania.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

The “uninsured persons” could be insured by registering to the Health Insurance Fund, paying health insurance contributions.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

If a person is insured to the Romanian Health Insurance Fund the equal treatment principle is applied.
The other form of coverages provides in the contracts if they provides care in other MS.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply SE

1. The right to sickness benefits in kind is regulated by the (1982:763) Health and Sickness Act. Healthcare in kind is administered by the counties and – to a minor extent – by municipalities. A county has the obligation to provide healthcare for all those who are residing within the county (Sec. 3). 'The county shall also purport 'good health' in the whole of the population. The county shall also provide good healthcare for those who, despite not being Swedish residents, have a right to sickness benefits in kind according to the Coordination regulation (Sec. 3 c). The relevant county is then where the person works or is registered as a job-seeker (also family members). There is also an obligation on the county to provide immediate care for any person in need thereof despite not being a resident (Sec. 4). As regards immigrants applying for asylum there is a special Act (2008:345). If not yet 18 years of age staying in the county they are to be provided healthcare equally to residents (Sec. 5). Those 18 years of age or more are to be provided any necessary care as well as pregnancy-related care (Sec. 6). All are to be offered health control (Sec. 7). *The Swedish healthcare system is thus quite universal in its character. Everybody residing in Sweden is covered without contributions or insurance requirements. Those having a right to sickness benefits in kind according to the Coordination regulation are covered in the same manner despite residence. Anybody has the right to healthcare when needed.*
2. There are thus no 'uninsured' persons.
3. Everybody resident in Sweden or with a right to sickness benefits in kind according to the Coordination regulation also have the right to care in another MS in accordance with EU-regulation.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply SK

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

In Slovak Republic there is healthcare provided under authority of obligatory public healthcare insurance. Public healthcare insured is person:
a) with the permanent stay on the territory of Slovak Republic. Public healthcare insurance accrue from the birth and expire with death. All the Slovak citizens are obligatory healthcare insured and the state pay insurance rate for numerous groups of citizens in preproductive, postproductive age,

disabled pensioner, dependent children till the age of 26, women during maternity, parents during parental care, unemployed persons, persons during imprisonment, temporal incapacity to work

a. person without permant stay in territory of Slovak Republic if he or she is not healthcare insured in the other EU member state is employed in the Slovak Republic as:

- self-emlpoyed
- person with asylum
- student
- infant foreigner without parents
- person in the prison or during imprisonment

Public healthcare unisured persons are those who are nonpayers for several reasons.

2. Can such “uninsured persons” rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) “social assistance” and/or “medical assistance”
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

The claim for urgent healthcare have got also persons who are not obligatory healthcare insured. The claim for other as urgent healthcare uninsured persons do not have. Childbirth is the part of urgent healthcare. Healthcare insurance companies defray costs on urgent healthcare. Urgent healthcare is provided also to persons who do not have permanent stay on the territory of Slovak Republic and are not covered by healthcare insurance in Slovakia either abroad.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Urgent healthcare provided abroad to the person with permanent stay in Slovak Republic is reimburse under the same conditions as in Slovakia. All the costs of urgent healthcare are recovered by health insurance companies.
There are individual healthcare insurance in Slovakia provided within the Civil Code which provide also healthcare insurance abroad.

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply SL

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

a) The narrow personal scope of the scheme(s)
b) The non-legislative nature of the scheme
c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
e) The status of the persons (undeclared workers, illegal migrant workers, …)
f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
g) The right to opt out national scheme(s)
h) Others

Slovenian statutory health insurance covers quite a broad scope of insured persons (active, recipients of social benefits, all residents with certain income, all residents and /EU/nationals with income below certain level) and their close and broader family members. Close family members are: a spouse (also dependent ex-spouse and non-married different sex partner), and children (until the age of 26 or without limitation in unable to work). Broader family members are: dependent step-children, grandchildren, brothers, sisters, other children without parents (if conditions for children, e.g. age are met), parents, also adoptive and step-

parents (if maintained by the insured, living in the same household, without sufficient resources, totally and permanently incapable of working). In addition, everyone exercising organised activity is covered for professional risks (accident at work and occupational diseases).

The legislator's goal is that all inhabitants are covered by the mandatory health insurance. According to the yearly reports of the Health Insurance Institute of Slovenia over 97 percent of inhabitants are mandatory health insured. Those who are not either do not regulate their insurance status in due time or are not reported by other bodies, or do not want to be insured. In addition, there is no exclusion (ex lege or on the initiative) from the uniform statutory health insurance and no possibility of voluntary affiliation.

The closest to being excluded are self-employed persons (and those similar to them, e.g. farmers, top sportsmen), who have to pay contributions by themselves. They are still insured, but have very limited access to healthcare and no access to sickness cash benefit, if due contributions are not paid. They are entitled only to urgent medical treatment, until they settle the debt.

Undeclared workers and illegal labour migrants are not registered and not socially insured. However, there is a clear provision that the State has to pay for urgent medical treatment of persons whose place of residence is unknown, foreigners from the countries with which there is no bilateral social security agreement and Slovenian nationals with permanent residence abroad, who temporarily reside (stay in terms of the coordination regulations) in Slovenia or are only passing through Slovenia, and medical services could not be paid from any other source (Art. 7 of the Health Care and Health Insurance Act).

Bilateral agreements with third countries are usually open, i.e. covering all insured persons from the contracting party (although the principle of equal treatment may nevertheless be limited to nationals of the contracting party). Hence, third country nationals will be eligible for (at lest urgent) medical treatment in Slovenia (on the account of the carrier in their home country). The question of non-coverage might relate to third country nationals coming to Slovenia from the States whit which no bilateral agreement is concluded. As a rule they will have to provide proof of (public or private) health insurance coverage when entering Slovenia.

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

As already mentioned, the State has to pay for urgent medical treatment of persons whose place of residence is unknown, foreigners from the countries with which there is no bilateral social security agreement and Slovenian nationals with permanent residence abroad, who temporarily reside (stay in terms of the coordination regulations) in Slovenia or are only

passing through Slovenia, and medical services could not be paid from any other source (Art. 7 of the Health Care and Health Insurance Act). It might be argued that this is medical assistance, paid from the state budged.

As a rule, upon entry in Slovenia sufficient health care coverage will have to be presented (in a form of traveller's health insurance, or suitable health insurance if residence in Slovenia is claimed, or health insurance in the home State for posted workers). It may also be private health insurance, contracted in Slovenia or any other country. This is regulated in the Foreigners Act (officially translated as Aliens Act), i.e. *Zakon o tujcih – Ztuj-1* (Official Gazette RS, No. 61/99, last amended in 2009), applied also to EU/EEA nationals. This Act is used to implement (among others) the Directive 2004/38 (the residence directive).

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

If alternative coverage would be contracted with private health insurance company in Slovenia, it may as well cover reimbursement of healthcare costs incurred in another Member State. It depends on the product offered by the insurance company (and accepted by the insured person).

Healthcare provided during a temporary stay in another MS to persons who do not fulfill conditions for statutory health insurance coverage

Reply UK

In order to have a better understanding of the issues linked to the persons not fulfilling conditions for healthcare coverage in their MS and temporarily staying in another MS, the goals of the Think tank team are:

1° to try to identify the categories of uninsured persons within the meaning of Reg. 883/2004 (and to make a typology);

2° to propose solutions which ensure provision of care and the coverage of the costs in case of temporary stay of such uninsured persons in a MS other than the MS of residence.

In this respect, we need to have a better view of your national legislation.

Questions

1. In your MS, are there persons (residents; EU citizens or third country nationals) who are not insured for health costs within the meaning of Reg. 883/2004? If so, is it due to:

   a) The narrow personal scope of the scheme(s)
   b) The non-legislative nature of the scheme
   c) The lack of scheme (i.e.: no statutory scheme; no scheme for such or such category of workers, …)
   d) The lack of fulfillment of administrative or financial requirements (such as the payment of contributions)
   e) The status of the persons (undeclared workers, illegal migrant workers, …)
   f) The application of national rules of conflict of law (ie: the person is subject to a third country legislation through a bilateral convention)
   g) The right to opt out national scheme(s)
   h) Others

Answer

Eligibility to free treatment in the UK under the National Health Service (NHS) is based on residence. People from other countries who become 'ordinarily resident', including those who come to the UK

to work, are eligible for the full range of NHS services on the same terms as any other UK resident. Nationality, the payment of UK National Insurance contributions or taxes are not relevant. However, under regulations introduced in 1982, overseas 'visitors' are liable to pay for hospital treatment unless they are covered by a reciprocal agreement or fall into an exempted category. Amongst the exempted categories are EU 'workers'.

EU nationals who enter the UK under Treaty rights as 'non-active' persons are required to have full healthcare insurance. The UK government's view is that access to the NHS does not constitute full insurance cover and that the person concerned would need to have separate healthcare cover. However, a person who has separate healthcare cover is then entitled to access the full range of NHS services and so ironically would not need to use the additional cover.

Undocumented migrants

The position of undocumented migrants is different for access to primary (local General Practitioner (GP)) and secondary care (hospital treatment).

Under the terms of their contracts with the Department of Health (Primary Medical Services Act and Directions 2004) General Practitioners (GPs) have discretion as to who they admit onto their list as an National Health Service (NHS) patient. However, the funding position is ambiguous - under funding arrangements between the GP and the Primary Care Trust (PCT) the GP might have to argue the case for receiving funding for treating an illegal immigrant. This may contribute to variation of interpretation across the country.

The NHS (Charges to Overseas Visitors) Charging Regulations 1989 and the NHS (Charges to Overseas Visitors) Charging (Amendment) Regulations 2004 set out which persons are entitled to free hospital treatment under the NHS. The Regulations require charges to be made for NHS services provided to individuals who are not 'ordinarily resident' in the UK. Under these regulations, undocumented migrants, including failed asylum seekers, are only able to receive free healthcare from the NHS in the following circumstances:

- treatment given in an accident and emergency department or in an NHS walk-in centre that provides services similar to those of an A&E department
- treatment for certain infectious diseases, including tuberculosis (but for HIV/AIDS only the first diagnosis and counselling that follows it are free)
- compulsory psychiatric treatment
- family planning services.

There are no specific or separate arrangements for children or pregnant women. Children of undocumented migrants or failed asylum seekers are treated in the same way as their parent(s).

2. Can such "uninsured persons" rely on any alternative forms of coverage (and for whom) under which they have full or partial access to health care:

a) a third country scheme
b) a conventional scheme
c) a private insurance
d) an occupational scheme
e) "social assistance" and/or "medical assistance"
   - if so, how is the coverage funded: by the care provider, by a special fund, by the State, by the same sources as healthcare coverage provided to "insured nationals"?
f) Other

Answer

An EU ‘inactive’ person would need to have separate healthcare cover, for example, private insurance. Once a person has private healthcare cover he or she is then entitled to access the full range of NHS services and so as noted above would not need to use the additional cover.

3. If they have access to an alternative form of coverage, does it cover care provided in another MS? In which case does it not?

Answer

For a private health insurance policy it would depend on the specific conditions of the policy.