Healthy Communities

Modul 4

Navigational Skills – Health Systems of the Partner Countries

Co-funded by the European Union

Partners involved:

www.bgz-berlin.de
Germany

www.eurocultura.it
Italy

www.gesundheitbb.de
Germany

www.stowarzyszeniestop.pl
Poland

www.caritas-wien.at
Austria

About the Project

With our **HEALTHY COMMUNITIES** project, we illustrate the contribution that adult education can strengthen the health skills of all citizens (including and especially groups with fewer opportunities), counteracting marginalization, and strengthening participation and commitment. One shortcoming of current health skills development programs is that they do not reach all population groups.
The project team has chosen to focus on the local community, in particular through the connection to the living environment in the community, which has so far only been elementary developed.

Health systems of the EU-project partners

Module 4 is country-specific and therefore not available as a standardized English version. Instead, we developed a comparative overview of the health systems across the partner countries, highlighting both key differences and shared characteristics.

Indicator	Germany	Austria	Italy	Poland
Health system type	Statutory insurance system (SHI), based on social insurance principles	Mandatory social insurance model. Universal access to medical care, ensuring comprehensive coverage for almost all residents.	• National Health Service (Servizio Sanitario Nazionale – SSN). • Tax-funded Beveridge model based on universal coverage. • Financed mainly through national and regional taxation. • Universal access for residents. • Essential Levels of Care (LEA) guaranteed nationwide. • Limited co-payments ("ticket") for certain services. • The system is based on solidarity: healthcare is financed according to ability to pay (taxes) and provided	Poland operates a **dual healthcare system** combining a mandatory, tax-funded public system (Narodowy Fundusz Zdrowia - NFZ) with a parallel private sector. Public healthcare, funded by a 9% income contribution, provides universal access for residents, while private providers offer faster, specialized services and are often used to supplement public care. **Key Differences:** •**Public (NFZ):** Free at the point of service, but longer waiting times. •**Private:** Paid, higher cost, but

			according to need.	faster access and more modern equipment.
System Control	Self regulated (by healthcare providers and insurance funds under state supervision). Key actors include: -Sickness funds (statutory health insurance funds) -Physicians associations -Hospitals -Federal and state governments The principle of **self-administration** allows stakeholders to negotiate fees, benefits, and service standards independently from direct government management.	Governance is decentralized, shared between the Federal Government (legislation), the nine Provinces (hospital management) and self-governing social insurance institutions that negotiate with healthcare providers.	Publicly regulated and regionally organized system. Key actors include: • Ministry of Health (defines national standards and LEA) • 20 Regional Authorities (organise, manage and finance services) • Local Health Authorities – ASL/AUSL (deliver services locally) • Public hospitals and accredited private providers Regions have significant autonomy in planning and service delivery within national standards.	Mixed, decentralized model primarily based on compulsory social health insurance, with overall oversight, regulation, and strategic management handled by the Ministry of Health. The system is built on a "gatekeeper model" where access starts with a primary care physician (POZ) **Ministry of Health (Ministerstwo Zdrowia):** The central governing body responsible for setting health policies, developing legislation, and overseeing the entire sector, including the supervision of the National Health Fund (NFZ). •**National Health Fund (Narodowy Fundusz Zdrowia - NFZ):** The primary payer and manager of public funds for health care. It handles contracting with healthcare

				providers, reimbursement of medicines, and regional management through 16 voivodeship branches. •**Territorial Self-Government:** Regional (voivodeship) and local authorities are involved in the management, financing, and supervision of public healthcare facilities within their jurisdictions, especially hospitals.
Financing of the health care system	Health fund model: Contributions are income-based. -Employers and employees share contributions. -Funds are pooled centrally and redistributed to sickness funds using a risk-adjusted mechanism.	The system is primarily financed through income-based social security contributions and tax revenues. This mix ensures financial stability and limits private out-of-pocket payments for essential medical services.	Primarily tax-based: • General national and regional taxation (e.g. IRPEF, IRAP) • Co-payments ("ticket") for specialist visits, diagnostics and some medicines • Voluntary private insurance (supplementary and increasing due to waiting times)	Primarily financed through a public, single-payer system managed by the NFZ. It relies on mandatory health insurance premiums (9% of personal income) deducted from employees, self-employed persons, and farmers. The system also includes direct state budget funding for specific services and significant out-of-pocket, private spending.

	-Additional financing comes from federal tax subsidies.		• Public healthcare provides access to most services at no or low cost.	
Number of insured people in the health care system	~83 Mio. residents: -statutory insured: 88,1% privately insured: 10,5% Most employees below a certain income threshold are mandatorily insured in the statutory system. Higher-income earners, civil servants, and self-employed individuals may opt for private insurance.	Coverage is nearly universal, with approximately **99%** of the population (about 8.9 million people) protected by statutory health insurance, including dependents and pensioners. Empolyess are automatically enrolled through their employment in one of several public funds (ÖGK, SVS or BVAEB). People who get social or unemployment benefits or pension are also enrolled to the health insurance.	Approximately 59 million residents. Nearly 100% of citizens and legally residing foreigners are covered by the SSN. Registration may be: • **Mandatory (free)** for workers, family members, asylum seekers, minors, pregnant women, etc. • **Voluntary (annual fee)** for students, au pairs and other non-mandatory categories Registration extends to dependent family members. Undocumented migrants have access to urgent and essential care.	Approximately 97% to 99%, is covered by the public healthcare system (NFZ) through mandatory, universal insurance, granting nearly universal access to services. Additionally, private health insurance is growing rapidly, with over 5.39 million people having private plans as of 2024.
basic principles of the health care system	**-Insurance obligation:** mandatory health insurance for all residents -**Contribution financing:**	**Solidarity:** Contributions are based on financial capacity (a percentage of income), while benefits remain equal for all insured persons. The	• **Universality:** All citizens and legally residing foreigners are entitled to healthcare.	**Insurance obligation:** mandatory health insurance for all residents **Contribution financing:**

	Contributions are income-based, not risk-based. **-Principle of solidarity:** The healthy support the sick; high earners support low earners; families are co-insured without additional contributions -**principle of benefits in kind:** Patients receive medical services directly; providers are reimbursed by insurance funds (no upfront payment in most cases). **Principle of self-administration:** Decision-making is shared between insurers and healthcare providers rather than fully state-controlled.	healthy pay for the sick, the young for the elderly, and high earners for those with lower incomes. **Benefits in kind:** Insured individuals are entitled to the medical service itself, not just the reimbursement of costs. Using the e-card, patients get direct access to doctors and hospitals without (usually) having to pay a bill upfront. **Mandatory insurance:** Anyone who starts a job is automatically insured by law with the relevant insurance carrier. This prevents people with high risks (e.g., pre-existing conditions) from being rejected or left without protection. **The Principle of Self-Governance:** While the state sets the legal framework, the actual implementation lies with the social insurance carriers. These are managed by representatives of the insured and employers (interest groups). This	• **Mandatory coverage:** Residents staying longer than three months must have health coverage (mandatory or voluntary registration). • **Equality of access:** Services are provided regardless of income or social status. • **Equity:** Healthcare is delivered according to medical need. • **Solidarity:** Funded through general taxation based on ability to pay. • **Regional decentralization:** Regions organise and manage services within national standards. • **Public responsibility:** The State guarantees the Essential Levels of Care (LEA) nationwide. • **Registration-based access:** Entitlement to full services requires registration with the Local	Contributions are income-based, not risk-based. **Coverage:** Once insured, the person and their family members (spouse, children) are entitled to free healthcare services in public facilities. **Voluntary:** People not obligated to be insured (e.g., some freelancers or non-EU citizens) can sign a voluntary agreement with the NFZ to gain access to public care. **Universal Access:** The constitution guarantees equal access to healthcare, with specific provisions for children, pregnant women, the disabled, and the elderly. **Equal Treatment:** The system is based on the principle of equal treatment, regardless of the

		ensures that administration remains close to the needs of the contributors. **Inclusion of dependents** contribution-free (or subsidized) co-insurance of children and, under certain conditions, partners. This extends protection to the entire family, even if only one family member is gainfully employed.	Health Authority (ASL) and issuance of the health card (Tessera Sanitaria). Health protection is recognized as a fundamental right.	amount of contribution paid. **Electronic System (eWUŚ):** Insurance status is verified electronically at the point of care using a PESEL number (national identification number). **E-services:** Prescriptions, referrals, and sick leave are primarily digital (e-recepta, e-skierowanie). **Universal Emergency Services:** Emergency care is provided to everyone in life-threatening situations, regardless of their insurance status. Emergency rooms are known as SOR (Szpitalny Oddział Ratunkowy) **Every child** (in legal terms, any person **under 18**) has the right to free health care, regardless of their or their parents' insurance

				status.
Patient rights	-Free choice of doctor and statutory health insurance fund -Access to medical records and treatment documentation -Clear and understandable medical information -Informed consent and autonomous decision-making -Privacy and data protection -A patient receipt -Access to benefits such as medical treatment, rehabilitation, sick pay, and long-term care -Compensation in cases of medical malpractice	Rights are codified in the "Patients' Charter," ensuring the right to informed consent, dignity, access to medical records, and the right to complain through independent Patient Advocacy offices (Patientenanwaltschaft)	• Free choice and change of General Practitioner and paediatrician. • Access to services included in the Essential Levels of Care (LEA). • Access to emergency care without discrimination. • Access to hospital care upon referral or emergency admission. • Right to informed consent before medical procedures and surgery. • Right to clear and understandable medical information. • Access to medical records and health documentation. • Privacy and data protection. • Access to maternity care and Family Planning Clinics. • Right to exemptions or reduced co-payments based on income, age, disability or chronic conditions. • Right to file complaints and seek compensation in cases of malpractice.	They are described in the Act on Patients's Rights and the Patient's Rights Ombudsman- bill. Chosen ones are: • Free choice and change of General Practitioner and paediatrician (change possible up to 3 times a year) • Access to emergency care without discrimination. • Right to immediate care • Right to second opinion • All children under 18 are granted health care regardless of their partents' employment status • Access to medical records and treatment documentation • Privacy and data protection, • Informed consent and autonomous decision-making • Access to benefits such as medical treatment, rehabilitation, sick pay, and long-term care

Medical emergency numbers	• **112** Emergency number (ambulance, fire brigade; EU-wide emergency number) • **116117** Out-of-hours medical on-call service (non-life-threatening conditions)	**144** Ambulance **141** Medical Emergency Service (GP on call) **112** European Emergency Number, and **1450** for health advice (Health Hotline).	• **112** – Single European Emergency Number (ambulance, police, fire brigade) • **118** – Medical emergency service (historical number, still active in some regions) • **116117** – Non-emergency medical on-call service (continuity of care / guardia medica)	**112** General emergency number **999**- Ambulance **998**- Fire bridage **997** - Police

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- Narodowy Fundusz Zdrowia: https://www.nfz.gov.pl/
- **National Medical Institute of the Ministry of the Interior and Administration**: https://www.gov.pl/web/cskmswia-en

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