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COST SHARING FOR HEALTH AND LONG-TERM CARE BENEFITS IN KIND

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1. Introduction

1.1. Purpose and scope of the report

Good health and the ability for autonomous living are among the highest values of every individual and of society as a whole[1]. Therefore, ensuring access to health care and social support for those who are unable to live independently is not only in an individual's private interest, but is at the same time a major concern of public policy.

Social protection provided in cases of sickness or injury, be it in the form of social health insurance or a public (mostly national) health service (hereafter NHS), guarantees certain health care benefits in every MISSOC country. Nevertheless, there are differences in the organisation of such social protection systems. Social health insurance may provide benefits in kind in a so-called third party payment system (where insurance carriers conclude contracts with health care providers and pay them directly), or limit its role to the reimbursement of the cost of such benefits.[2] Also an NHS may be organised in distinct ways, i.e. in a more centralised or more decentralised manner. In the first case the central government organises health care and in the second, regional or local authorities are responsible for guaranteeing suitable health care. Some health care benefits might be entirely covered by the social protection system, making health care free at the point of delivery or reimbursed in full. This is particularly the case for certain groups or situations, such as children, women in relation to their reproductive function, persons without sufficient means, serious or chronic diseases resulting in a high cost burden for the patient and work-related illnesses.

However, many health care benefits, and in particular services such as dental care and medical goods (e.g. pharmaceuticals and medical aids), may be covered only partially by the social protection system. Patients then have to partially pay for the service or product (e.g. as a fixed amount or as a certain percentage of the total cost of the service or product or up to a certain amount) to the health care provider or bear it themselves in excess of reimbursement.

[1] Social justice and adequate social protection, high level of protection of human health, as well as solidarity (also between generations) are among the values and goals of the European Union (EU).

[2] Examples of the first might be Slovenia, Austria, Bulgaria, Croatia, Estonia, Germany (with certain exceptions) and of the second France, Belgium or Luxembourg (and other countries according to Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, OJ L88/45, 4.4.2011).

Such arrangements, which exist in different forms in all Member States, result in the sharing of costs for health and long-term care between the social protection system and an individual, hence also between public and private responsibilities for health and autonomous living.

It is argued that, albeit with some diversity, health care (together with cash sickness benefit) is guaranteed by the social protection system in every MISSOC country. However, there is much greater diversity when it comes to long-term care benefits,[3] despite the fact that they are quite often linked to health care[4] or even regarded as sickness benefits *lato sensu*.[5]

In some countries, mainly long-term care benefits in cash are being provided;[6] in others special social protection schemes have been developed, be it in the form of long-term care insurance[7] or national protection schemes.[8] In some countries long-term care benefits are provided through a system of social services, linked or not with social assistance. Some countries operate a mixed system, meaning that long-term care benefits (in kind and in cash) are provided under pension insurance (as pension supplements), under health insurance (nursing hospitals or hospital departments for non-acute care), social assistance, social services and social compensation schemes (e.g. for invalids of war). In most countries, the role of informal carers (typically spouses and other relatives) is predominant, while others rely much more on professional long-term care providers. In fact, where priority is given to informal (family) carers, two persons might be in need of social protection, the person reliant on long-term care and the person providing it.[9]

Benefits may be provided in the form of services (performed by a physician or long-term care provider) or goods (pharmaceuticals, medical and other aids) or cash payments to cover the cost of long-term care services (possibly in the form of a long-term care budget

[3] Extensively in Jorens Y., Spiegel B. (eds), Coordination of Long-term Care Benefits - current situation and future prospects, trESS Think Tank Report 2011, 145 p. (www.tress-network.org, consulted April 2014).

[4] Also in the Communication "A renewed commitment to social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion" COM/2008/0418 final.

[5] *Argumentum a contrario* from the CJEU decision in C-388/09 da Silva Martins [2011] ECR I-5737, where the Court argued that long-term care benefits are not "sickness benefits *stricto sensu*" and they may "display characteristics which in practice also resemble to a certain extent the invalidity and old-age branches … without being strictly identifiable with either of them". In the absence of more suitable provisions, they have to be coordinated as sickness benefits. Jorens Y., Spiegel B. (eds), *op. cit*., p. 14.

[6] As in Austria (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

[7] As in Germany, the Netherlands, or Flanders. (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

[8] As in Spain. Strban G. Distinctive long-term care schemes as a response to changed family structures and demographic situation, Pravnik, 3-4/2012, p. 249-278.

[9] Usually a woman. Strban G., Gender Differences in Social Protection, MISSOC Analysis 2012/2, p. 43.

with some degree of discretion regarding how the money is spent).[10] Benefits in cash to replace lost income are outside the scope of this report on cost sharing or user charges.

User charges in relation to health care provision, and partial reimbursement, are typically aimed at reducing the cost of social protection, either by reducing the share of the costs to be borne collectively, or by creating incentives for a more rational use of health systems.

The key question from a social protection perspective is whether such cost-reduction goals are being achieved without undermining the fundamental social protection goal of guaranteeing universal access to high-quality care[11]. This would require a joint examination of barriers to access and the formal cost sharing rules in force in a given country. The present report only looks at the rules applying to cost sharing arrangements for health and long-term care benefits in kind, including any hardship clauses to ensure that the burden of cost sharing does not prevent people from receiving the health care they need.

The report investigates selected international and EU documents relating to cost sharing and access to health and long-term care. It looks at various out-of-pocket payments and makes a typology of cost sharing arrangements. The question of possible alternatives to user charges is also raised, including whether the gatekeeper function of general practitioners (GPs) can be used to steer patients' behaviour in a desired direction, instead of (or alongside) cost sharing (and other) measures. It might also be the case that a non-binding gatekeeper system is applied, where patients who choose to go straight to a specialist are still entitled to social protection benefits, but have to pay a higher user charge.

The report not only looks at the current situation of user charges in MISSOC countries, but also the modifications (increase or reduction) that occurred in the last decade (and when possible also from 2008 to today), i.e. in the periods before and during the economic crisis.

1.2. Methodology

MISSOC Analysis Reports are primarily based in particular on information contained in the MISSOC Tables and Guides. However, for this report, other sources, including relevant literature and academic studies, reports and selected key documents of international organisations, including the European Union have also been taken into consideration.

The focus is on the comparative method of legal research. Additionally, the historical method was used in order to establish whether the recent economic crisis has had an

[10] As in the Dutch system (since 2014 restricted to accommodation) or in France, www.missoc.org, MISSOC Comparative Tables Database, status July 2013.

[11] See below the objectives of the Open Method of Coordination.

impact on the level and form of user charges in health and long-term care and in which MISSOC countries. This might be useful for selecting the best policy options at national and EU level.

2. User charges in selected international and EU legal documents

2.1. International legal norms

The introduction of various cost sharing arrangements in the MISSOC countries as such does not conflict with international and EU law. According to the Universal Declaration of Human Rights, everyone has the right to a standard of living adequate for the health and well-being of him/herself and of his/her family, including medical care and necessary social services.[12] Although reliance on long-term care was not recognised as a separate social risk at that time, social services may also encompass long-term care. In addition, the right to (social) security should be recognised not only in case of sickness, but also any other situation beyond the individual's control which threatens the livelihood of an individual; this could imply also reliance on long-term care.

The International Covenant on Economic, Social and Cultural Rights went further than the Declaration and enshrines the right to health. The contracting States have to create conditions which would assure to all (not just some) medical services and medical attention in the event of sickness. In the literature, it is emphasised that this implies all forms of access to high- quality health care.[13] According to the comment of the Committee on Economic, Social and Cultural Rights, among the essential elements of the right to health is economic accessibility (affordability) of health facilities, goods and services for all. Payment for health care services has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses compared to richer households.[14]

The UN Convention on the Rights of Persons with Disabilities is also relevant in this context. It is the first time in history that the EU has become a party to an international human rights treaty.[15] This convention obliges parties to recognise the enjoyment of the

[12] Article 25 of the Universal Declaration of Human Rights (UDHR). Dupas P., Global Health Systems: Pricing and User Fees, Elsevier Encyclopaedia of Health Economics, 2012, argues that under Article 25 of the UDHR access to adequate health care is a fundamental human right.

[13] Leenen H., The right to health care and its realisation in the Netherlands, in Den Exter A. Hermans H. (eds), The Right to Health Care in Several European Countries, Kluwer, 1999, p. 34.

[14] Point 12 of General Comment No. 14 (2000), The right to the highest attainable standard of health, Committee on Economic, Social and Cultural Rights (CESCR), E/C.12/2000/4.

[15] Ratified by the EU in December 2010, European Commission-IP/11/4, 05/01/2011 (http://europa.eu/rapid/press-release_IP-11-4_en.htm, consulted April 2014). All EU Member States, but not all MISSOC countries have also ratified it (more at

highest attainable standard of health without discrimination on the grounds of disability. Moreover, persons with disabilities should benefit from the same range, quality and standard of free or affordable health care and programmes as provided to other persons.[16] In addition, persons with disabilities should have access to a range of long-term care benefits in kind (in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community), equal to others in the community.[17] These obligations under the UN Convention may have implications for the degree of cost-sharing that can be imposed on persons with disabilities.

Even more specific provisions may be found in the Conventions of the International Labour Organization (ILO). It can be observed that cost sharing has been foreseen already from the first health insurance conventions (from 1927) onwards, but was later refined and restricted.

According to the so-called first generation conventions, i.e. Conventions 24 and 25 concerning Sickness Insurance in Industry and Agriculture,[18] the insured persons should be entitled to medical benefits free of charge.[19] Nonetheless, they may be required to pay part of their cost. The exact form and scope is left to the national law.[20] Similar provisions can also be found in Convention 102 concerning minimum standards of social security,[21] although a more concrete proposal of maximum one third of cost sharing was made during the preparatory process of the final text of this convention, but no consensus could be reached.[22] Nevertheless, it was recognised that overuse of cost sharing might hinder access to health care. Therefore, Convention 102 stresses that the national rules concerning such cost sharing have to be so designed as to avoid hardship. Convention 130 concerning Medical Care and Sickness Benefits went even further in regulating exceptions to cost sharing. Not only should hardship be avoided, but cost sharing (where

http://www.un.org/disabilities/countries.asp?navid=12&pid=166, consulted April 2014). For an application by the Court of Justice, see case C-312/11, Commission v. Italy [2013] not yet reported.

16 Article 25 of the UN Convention on the Rights of Persons with Disabilities.

17 Article 19 of the UN Convention on the Rights of Persons with Disabilities.

18 Although Conventions 24 and 25 have been revised by Convention 130 concerning Medical Care and Sickness Benefits, they are still in force for those MISSOC countries which have not ratified this. Convention 24 was ratified by 29 States, remaining in force in 28 (among them 16 MISSOC countries) and Convention 25 by 21 States, remaining in force in 20 (11 MISSOC countries). More at www.ilo.org, consulted April 2014.

19 Free-of-charge benefits in kind are also advocated in point 7 of Recommendation 29 concerning the General Principles of Sickness Insurance.

20 Article 4 of Conventions 24 and 25. Recommendation 69 concerning Medical Care does not seem to mention cost sharing, but entails some rules on collective financing of health insurance or NHS.

21 According to Article 10 of Convention 102, the beneficiary or his breadwinner may be required to share in the cost of the medical care the beneficiary receives in respect of a morbid condition. Convention 102 was ratified by 50 States, among them 24 MISSOC countries. More at www.ilo.org, consulted April 2014.

22 Dijkhoff T., International Social Security Standards in the EU, the cases of the Czech Republic and Estonia, Intersentia, 2011, p. 232.

regulated) has to be designed so as not to prejudice the effectiveness of medical and social protection.[23]

The same reasoning applied with respect to diseases which need prolonged care. Therefore, ILO Recommendation 134, accompanying Convention 130, provides that the beneficiary should not be required to share in the cost of medical care, not only if his/her means do not exceed the prescribed amount but also in respect of diseases recognised as entailing prolonged care.[24]

The most specific regulation of cost sharing may be found in European documents, more specifically in the European Code of Social Security of the Council of Europe and its Protocol. Whereas according to the Code[25] cost sharing has to be designed so as to avoid hardship, the Protocol to the Code prescribes more precisely that the part of the cost paid by the beneficiary (or breadwinner) may not exceed 25 per cent for medical care (outpatient and hospital care) and pharmaceuticals, or 33 per cent for dental care. Since the Code is a minimum harmonisation instrument, it sets a maximum percentage of the cost of a given health care product.[26] States may apply more favourable provisions (less cost sharing) in their national legislation, which was not the case in all countries.[27] Additionally, a total cost limit should be set for each type of care in a given time period.[28] It is argued that this approach, working with general health categories (and without a precise list of the medical services to be covered) may have a perverse effect. Indeed, it is better for a state to have a specific treatment not covered at all than to have it covered only partially. In the latter case, it risks to come into conflict with the Code, as the relatively high costs charged to patients might be considered to push them into hardship.[29] If the service is not covered at all, there is no conflict with minimum standards, as long as other general or specialist health care is foreseen.[30]

23 Article 17 of Convention 130. This convention has been ratified by 15 States among which there are only nine MISSOC countries. More at www.ilo.org, consulted April 2014.

24 Point 7 of Recommendation 134.

25 Article 10 of the Code.

26 Schoukens P., The Right to Access Health Care: Health Care according to International and European Social Security Law Instruments, in: Den Exter A. (ed.), International Health Law, Solidarity and Justice in Health Care, Maklu, Antwerp – Apeldoorn, 2008, p. 34.

27 For instance, there were some issues in the Czech Republic concerning cost sharing by pregnant women and in Estonia for dental care. Dijkhoff T. *op. cit.*, pp. 139 and 232. Problems with cost sharing were also reported for Belgium for visits and consultations by general practitioners and specialists (in 1993 this was between 30 and 40 per cent, more than in the Protocol. Measures have subsequently been undertaken by the Belgian government. In the Netherlands problems were detected with cost sharing for care during confinement in a hospital or special maternity home. Gomez Heredero A., Objectives and interpretation methods of the Conventions of the Council of Europe, in Penning F. (ed), International Social Security Standards, Current Views and Interpretation Matters, Intersentia, 2007, p. 61.

28 The Protocol to the initial Code was ratified by seven States (all of them MISSOC countries). More at www.conventions.coe.int, consulted April 2014.

29 Schoukens P., *op. cit.*, p. 39.

30 *Ibid*, p. 36.

The Revised Code abandoned such detailed numbers and returned to the general rule that cost sharing should not impose hardship or render medical and social protection less effective. The impact of the revised Code is limited though, since it has not (yet) entered into force.[31]

International texts reflect a compromise where, on the one hand, the principle of introducing cost sharing arrangements remains optional, but on the other hand, if national legislation adopts this principle, this must not imply too heavy charges for the patient concerned, which would prejudice the medical and social protection objectives.[32]

These objectives are making health and long-term care universally accessible, as also underlined in one of the latest Conventions, i.e. the Convention on Human Rights and Biomedicine.[33] Contracting states[34] have to take appropriate measures in order provide equitable access to health care of appropriate quality.[35] Such fair or just access would be hindered if cost sharing would cause hardship or social protection ineffective.

Thus, in international law, cost sharing arrangements might become questionable if their extent would limit access to health and long-term care and present a serious hindrance in the realisation of internationally recognised rights to social security and health. Furthermore, broader access to health care is foreseen in case of maternity, where no cost sharing is allowed.[36]

2.2. EU (hard) law and open method of coordination

The endeavours of international law to set limits for cost sharing and provide universal access to health care are also reflected in EU legal and policy documents. According to the Treaty on the functioning of the EU[37] (TFEU), a high level of human health protection has to be ensured in all EU policies and activities.[38] However, the EU has to respect the responsibilities of the Member States for the organisation and delivery of health services and medical care, which includes cost sharing arrangements. Similar provision may be found in the Charter of Fundamental Rights of the EU.[39]

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31 At least two ratifications are required for the revised Code from 1990 to come into force. So far it has only one. More at www.conventions.coe.int, consulted April 2014.

32 Engel H., Jorens Y., MISSOC Info 2/2005 Health Care: User Charges-Introduction, p. 8.

33 Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine. This was adopted in 1997 and entered in force at the end of 1999.

34 There are 29 ratifying States (20 MISSOC countries). More at www.conventions.coe.int, consulted April 2014.

35 Article 3 of the Convention on Human Rights and Biomedicine.

36 *C.f.* Part VIII of ILO Convention 102 and the European Code of Social Security. Conversely, cost sharing even in case of maternity is foreseen in the Revised Code.

37 OJ 83/47, 30.3.2010 (consolidated version).

38 Article 168 TFEU.

39 Article 35 of the Charter, OJ 364/1, 18.12.2000.

More provisions relating to cost sharing can be found in non-legally binding documents. For instance, in the context of the open method of coordination, accessible, high-quality and sustainable health and long-term care have been defined as (non-binding) common objectives. The need for care should not lead to poverty and financial dependency. Moreover, inequities in access to care and in health outcomes have to be addressed.[40] Better access to health care as well as ensuring equitable access and affordable health care and social services is also mentioned in some other policy documents.[41] High cost of care presents barriers to such access.[42] It is recognised that in times of crisis affordable access comes under strain. Lack of affordability is the most common reason for unmet medical needs. The situation in this regard has worsened, or improvements have stalled, in several countries and among various population groups. This can be due to decreased income, reduced public support, and increased private contributions including under-the-table payments.[43]

3. Cost sharing (user charges) for health and long-term care benefits in kind

The above-mentioned international and EU documents are concerned with cost sharing and access to health and long-term care in rather general terms. Nothing is said about specific forms of cost sharing, and only exceptionally are minimum standards of cost sharing set. Hence, it is important to investigate possible forms of cost sharing in a more detailed manner.

3.1. Diversity of out-of-pocket-payments

Cost sharing arrangements can take different forms and are referred to using different terms.

'Out-of-pocket payments' is an expression often used in the broadest sense to include direct payments, informal payments and formal cost sharing.[44] It is recognised that as far as the private share of spending is concerned, the poorer the country the larger the share that is typically paid out of pocket. Figures in low- and middle-income countries are

[40] Communication "A renewed commitment to social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion" COM/2008/0418 final.

[41] Communication "Annual Growth Survey 2014, COM(2013) 800 final, pp. 11-12. Communication EUROPE 2020, A strategy for smart, sustainable and inclusive growth, COM(2010) 2020 final, p. 19.

[42] Communication "Solidarity In Health: Reducing Health Inequalities in the EU", COM(2009)567 final, p. 3.

[43] Social Europe, Many ways, one objective, Annual Report of the Social Protection Committee on the social situation in the European Union (2013), EU 2014. p. 57.

[44] Mossialos E., Dixon A., Funding health care: an Introduction, in: Mossialos E. et al. (eds), Funding health care options for Europe, WHO 2002, p. 22. Schokkaert E., van de Voorde C.: User Charges, in: Glied S., Smith P.C. (eds.), The Oxford Handbook of Health Economics, Oxford University Press, 2011, p. 330.

troublesome because they imply that out-of-pocket expenditure, the most inequitable source of health care financing, prevails.[45] Out-of-pocket payments are less significant (although not negligible) in high income countries, where health care financing is based on taxes and/or social insurance[46].

a) *Direct payments* are payments for services not covered by any form of social protection system (health insurance, social assistance or NHS). They are used for the purely private purchase of uncovered services. These payments are usually made to private sector dentists, pharmacists for over-the-counter or de-listed drugs, physicians for private appointments or hospitals for private treatment, and laboratories or clinics for tests. Private expenditure on health care is may be tax-deductible in some countries, thus reducing the burden somewhat on those households that pay taxes. In practice, such subsidies can be significant.[47] In a number of MISSOC countries long-term care benefits are means tested[48], implying that households are supposed to pay for their own needs. As a result, direct payments are often significantly higher for long-term care than for health care services.[49]

b) *Informal payments* occur for services that should be fully funded from the social protection system, but where additional payment nevertheless occur[50]. Such informal out-of-pocket payments are made in the public health care sector in some countries despite not being officially endorsed.[51] These may range from ex-post gifts to thank staff for care (for patients with chronic ailments, these may also have the nature of ex-ante payments) to large payments given to the physician before treatment to secure their services. As

45 Out-of-pocket payments amount to approximately 93 per cent in low-income countries (more than 60 per cent of the total), some 85 per cent in middle-income countries (40 per cent of the total), and only 56 per cent in high-income countries (20 per cent of the total). Gottret P., Schieber G.: Health Financing Revisited, A Practitioner's Guide, The World Bank 2006, p. 4. On out-of-pocket payments in Croatia Mastilica M., Božikov J., Out-of-Pocket Payments for Health Care in Croatia: Implications for Equity, Croatian Medical Journal, Vol. 40, 1999, Nr. 2. For Hungary Baji P., Pavlova M., Gulácsi L. and Groot W., Changes in Equity in Out-of-pocket Payments during the Period of Health Care Reforms: Evidence from Hungary, International Journal for Equity in Health 2012, 11:36.

46 For instance, over 20 per cent in Belgium (a social insurance–type country), Italy and Spain (as NHS-type countries) and even over 30 per cent in Switzerland (as a private insurance country). Schokkaert E., van de Voorde C., *op. cit*., p. 331.

47 Elias Mossialos, Anna Dixon, *op. cit*., p. 22.

48 For instance, in Belgium (where the integration allowance is granted only if income does not exceed certain ceilings), Croatia (for the allowance for assistance and care), Cyprus, Hungary, Italy (invalidity and incapacity insurance), Latvia (social services), Malta (part of the benefits), Romania (for qualified personal assistance) the Slovak Republic, Spain, Switzerland (reimbursement of special costs, according to ELG/LPC), the UK (for residential social care, as well as social assistance-based long-term care benefits in some countries (e.g. in Germany and Portugal), www.missoc.org, MISSOC Comparative Tables Database, status July 2013.

49 Mossialos E., Dixon A., *op. cit*., p. 22.

50 Schokkaert E., van de Voorde C., *op. cit*., p. 346.

51 Conversely, in some countries (as in Denmark) no informal payments are reported. Olejaz M., *et al*., European Observatory on Health Systems and Policies, Out-of-pocket payments, Denmark, 2012, p. 16.

these payments are covert, much of the evidence is anecdotal. However, experts acknowledge that such payments exist in some countries.[52]

They may exist due to a lack of financial resources in the social protection system (patients cannot obtain basic supplies, staff supplement their low salaries),[53] lack of private services, desire to exercise consumer control over providers (no third party is involved in the transaction, which makes the provider accountable to the patient), or cultural tradition (in some countries this is usual and there is a long tradition of informal payments, despite attempts to abolish them).[54]

Information on the extent and size of informal payments is limited because they are hidden and illegal in many MISSOC countries (they may be regarded as an act of corruption).[55] Lack of transparency may affect patients, legislators and researchers. It adds to the uncertainty and vulnerability of patients in accessing health and long-term care. Converting informal payments into formalised cost-sharing arrangements requires compliance from the providers, who may lose substantial income,[56] and public support, which is not an easy task in every country.

c) *Formal cost sharing* consists of payments for services included in the benefit package of the social protection system, but not fully covered by it. They may take various forms.

52 For instance, in Greece, in some Eastern European countries, to a lesser extent in France and some other countries. Mossialos E., Dixon A., *op. cit.*, p. 23.

53 For instance, in Hungary, informal payments were not just tolerated, but included in the calculation of salaries of physicians and taxed (or at least subject to tax requirements). Gaál P., *et al*., European Observatory on Health Systems and Policies, Out-of-pocket payments, Hungary, 2011, p. 48.

54 Mossialos E., Dixon A., *op. cit*., p. 22.

55 For instance, in Bulgaria, informal payments used to be widespread (in a survey from 1994, 43 per cent of respondents had paid cash for officially free services). Dimova A., *et. al*., European Observatory on Health Systems and Policies, Out-of-pocket payments, Bulgaria, 2012, p. 13. However, at the beginning of 2013, the Ministry of Health proposed amendments to the Ordinance on access to medical care, aimed at reducing informal payments for hospital care. The Ordinance regulates all additional services, provided by hospitals, which may be paid for directly by the patients. It determines the circumstances under which patients can choose a physician or a team for treatment and pay for such choice. All the rest is treated as corruption. Rohova M., New measures against informal payments, Health Systems in Transition, http://www.hspm.org/countries/bulgaria22042013/countrypage.aspx, consulted April 2014. Also, in Latvia, since 2009, accepting informal payments has been a criminal offence but only very few cases have been brought. Mitenbergs U. *et al*., Latvia: Health system review. Health Systems in Transition, 2012; 14(8): p. 74. In Poland, in 1998, informal payments amounted to 100 per cent of hospital physicians' official salaries. Anti-corruption initiatives were undertaken in 2005 and informal payments reduced. Sagan A., et al., European Observatory on Health Systems and Policies, Out–of-pocket payments, Poland, 2011, p. 23.

56 In addition, informal payments have an impact on the behaviour of physicians, since money is not equally distributed among them. For some it is higher (e.g. certain specialists and in the inpatient sector) and some hardly participate (out-patient primary care). Gaál P. *et al., op. cit*., p. 48. Also, in Lithuania, informal payments seem to be widespread particularly in inpatient care. Murauskiene L., et al. European Observatory on Health Systems and Policies, Out–of-pocket payments, Lithuania, 2013, p. 13.

3.2. Typology of formal cost-sharing arrangements (user charges)

The notion of *cost sharing* is usually applied to formal arrangements, in order to indicate that (formal) costs of health and long-term care are shared between public and private actors, i.e. the social protection system (social health insurance, providing benefits in kind or reimbursing their cost, or a NHS) and the patient (or long-term care beneficiary).[57] This is essentially a division between public and private financing[58] and delineation between individual and social responsibility.[59] The notion of cost sharing is also used in international documents.[60]

Nevertheless, sometimes cost sharing is used also for direct payments (as a full user charge, where costs are completely met by out-of-pocket payment, conversely, zero cost sharing would be when the full amount is paid by the social protection system)[61] and informal payments (as informal cost sharing).[62] However, (full) direct payments and zero cost sharing as such are of no interest to the present research. The same goes for informal cost sharing, since it is nearly impossible to obtain reliable official (including MISSOC) data. Therefore we shall concentrate on various forms of formal cost-sharing measures.

They represent the share of costs a patient pays for medical and hospital services (and medical goods) partially covered by social protection system. They can take the form of *user charges*[63] (or *user fees* or *service charges* or *patient charges*[64] or *prescription charges* for pharmaceuticals or *participation*). The question of what user charges are was already raised in MISSOC Info 2/2005. A broad definition of user charges was then retained, comprising any financial contribution for which patients are asked when they make use of the health care provision. This charge does not cover all the costs and is not reimbursed by a statutory health insurance.[65]

Such a broad definition encompasses different types of cost burdens on health care users:

a) *Co-insurance* is the simplest form of user charge. Under this system, the patient is required to pay a fixed percentage (say five per cent) of the cost of services received. The

57 The patient (beneficiary) may pay it him/herself directly or take out private insurance.
58 OECD, Health at a Glance: Europe 2012, OECD Publishing 2012, p. 128
59 Schokkaert E., van de Voorde C., *op. cit*., p. 349.
60 E.g. ILO Convention 102 explicitly mentions (Article 10) that the beneficiary may be required to "share in the cost" of the medical care. Moreover, the rules concerning such "cost-sharing" shall be so designed as to avoid hardship. Both notions, i.e. "share in the cost" and "cost sharing" are also mentioned by the ILO Convention 130 (Article 17) as well as by the initial European Code of Social Security (and its Protocol) and the Revised Code (both in Article 10).
61 Engel H., Jorens Y., *op. cit*., p. 7.
62 Mossialos E., Dixon A., *op. cit*., p. 24.
63 Used also in MISSOC Table XII. Long-term care.
64 Patient charges is the notion used in MISSOC Table II. Health care.
65 Engel H., Jorens Y., *op. cit*., p. 7.

higher the cost of the service, the higher the fee. Those requiring more expensive health care could be disadvantaged, as they must contribute a higher amount than other patients.

b) *Co-payment* is an alternative to co-insurance. Under this system, instead of having to pay a share of costs, the patient is required to pay a flat fee per service (for example, five euros) which does not necessarily bear any relation to the cost of the service. The same amount is charged regardless of the actual cost of the health care provided. More intensive use (more services) naturally leads to a higher total payment.

c) *Extra-billing* or supplementary fees (or balance billing in US terminology)[66] may also be considered a type of user charge. In this instance, however, the patient's private contribution does not cover part of the costs of insured services, but rather costs not covered by the social protection system. In such a system, the doctor providing the service can bill the patient for an extra fee over and above the established social protection rate. All patients requiring medical services are affected regardless of their financial situation.

These three types of user charges have been described as "*sickness taxes*," because only health care recipients (patients) are required to pay them. User charges are frequently viewed as a regressive tax which hurts those least able to afford it.[67]

d) A system of *deductible amounts* requires the patient to pay the total cost of services received over a given period up to a certain ceiling, which is the deductible amount. Above this ceiling, the cost of services to the patient is covered by the social protection system. All users must pay a standard minimum deductible amount, which is independent of the quantity of services received. This type of cost sharing (known for instance in the Netherlands) places heavy users of the health care system at less of a disadvantage than the other forms.

In the literature, the notion of *de-insurance* can also be found. This is an extreme form of user charge whereby the social policy decision is taken to reduce the range or the extent of services covered by the social protection system. De-insurance may apply to a particular service, such as non-urgent ambulance transport, or may affect only certain groups of individuals, for example those in a high-income bracket, who become

66 Schokkaert E., van de Voorde C., *op. cit*., p. 347.

67 In the case of an *income tax on services*, the patient does not pay a share of the cost of insured services received directly; rather, the contribution is paid through the income tax system. An income tax on services takes both income and use of services into account. The tax rate applies to the sum of taxable income and the cost of services used. This is a progressive tax in that, for equal use of services, a patient with a higher income pays relatively more than one with a lower income. Furthermore, an income tax on services does not apply to those who do not pay income tax. Madore O., Health Care Financing: User Participation, BP-340E, 1993, p. 2. Robinson R., User Charges for Health Care, in: Mossialos E. *et al*. (eds), Funding health care options for Europe, WHO 2002, p. 163. Schokkaert E., van de Voorde C., *op. cit*., p. 330.

excluded.[68] Patients no longer protected, or using the services no longer covered by the social protection system, are obliged to pay the entire cost. It could be argued that in this case the user charge changes its nature to a direct payment.

Different forms of cost-sharing arrangements may exist in relation to any social protection system, i.e. NHS or social health insurance (providing benefits in kind or reimbursing the costs).

For instance, in Belgian social health insurance (as a rule based on the principle of reimbursement) cost-sharing arrangements not only include co-insurance and co-payments (for both the notion of co-payments is occasionally used),[69] but also supplements which are mostly paid on top of the co-payments (a kind of extra billing). For instance, if an insured person can afford a single room in a hospital, physicians are allowed to charge more for the health care that they provide to this person.

While the distinction between co-payments and supplements is clear in principle (co-payments are the difference between the officially set or agreed tariff and the reimbursed amount, supplements are what comes on top of such tariff), it is not always straightforward in actual applications. Within the compulsory system, the maximum billing (MaB) regulation puts a ceiling on the total amount of co-payments. The rules are different for different groups of individuals and not all co-payments are included. In fact, from the perspective of the patients, the distinction "included in the MaB" versus "not included in the MaB" is probably more important than the distinction "co-payments" versus "supplements".

Interestingly, some argue that user charges for health care (such as official payments charged by providers to patients at the point of delivery) are mainly (but not exclusively) used in tax-financed systems. To denote cost sharing by patients in systems of (private or social) health insurance, we talk of co-payments and deductibles (here the notion of co-payments is also used for both). However, user charges is also used as a broader term, encompassing formal cost-sharing arrangements in a tax-financed NHS and contribution-based social health insurance systems.[70]

Furthermore, in some countries (such as Belgium or France), people take out supplementary insurance to defray the cost of charges arising from cost sharing. In such cases, direct costs are met by third-party payments (see also point 3.5., below).

[68] Persons with a high-level income may be excluded as, for instance, in German statutory health insurance.

[69] Eigen betalingen in de Belgische gezondheidszorg, De impact van supplementen, KCE reports vol. 50A, Brussels 2007, p. 3 acknowledges the distinction between co-insurance and co-payment, but uses co-payment for both forms of cost-sharing arrangements.

[70] Schokkaert E., van de Voorde C., *op. cit*., p. 329.

3.3. Objectives/rationale of cost sharing

After setting out the typology of cost-sharing arrangements, it seems important to look beyond legal rules and discover their purpose, in order to enable informed policy decisions.

There seem to be several aims behind user charges. They should raise awareness of the cost of health care and at the same time reduce the cost for social protection systems. Proponents of user charges claim that, in increasing the cost to the patient (consumer), the aim is to limit consumption in the hope of avoiding "overuse" of benefits[71] (reduce overall demand by discouraging "unnecessary" demand). Another objective seems to be to raise revenue to expand health care provision when alternative funding (such as tax revenue) is not available.[72] In this case user charges may be intended to bridge the funding gap when public budgets are under pressure (for instance during the times of economic crisis), ensuring that more expensive and important forms of treatment are more readily available.

Whether these objectives can be fully achieved is doubtful. For instance, when patients have to pay user charges, they may be aware of the charges, but not necessarily of the full health care costs. More importantly, user charges may go against the idea of prevention in health care by deterring patients from seeking early treatment for a (minor) condition, which may develop into a more serious illness later on, possibly requiring more expensive health care.[73]

In addition, in MISSOC countries, where private supplementary insurance (insurance for user charges) is offered, insured persons are more aware of the (monthly) premium they have to pay for such insurance, rather than the cost of health care.

Whether the objectives of reducing health care costs and raising more revenue in order to expand health care provision are achieved depends on the elasticity of demand. Logically, if the first objective (reducing demand) is achieved, then the second (raising health care systems revenue) cannot be. Thus, if increasing user charges reduces the utilisation of health services, it will not increase overall revenue. The argument for raising health care revenue is based on the assumption that demand for health care is inelastic; that is, at the level of prices being charged to users, utilisation will not fall enough to offset the increased revenue from higher user charges.[74] It is argued that health care has very low price elasticity, i.e. it will be used, regardless of the price. Increasing user charges may temporarily influence the consumption of certain types of care, but the original consumption level will be resumed. Patients even tend to switch to other types of (more

71 Van Langendonck J., Health care between efficiency and quality, in: Bosco, A and Hutsebaut M (eds), Social Protection in Europe, Facing up to Changes and Challenges, ETUC-ETUI, 1997, p. 347.
72 Robinson R., *op. cit*., p. 163.
73 Van Langendonck J., *op. cit*., p. 348.
74 Mossialos E., Dixon A., *op. cit*., p. 22.

expensive) care. For instance, if higher user charges are set for outpatient care, there might be a switch to hospital care. The same might apply to home and residential long-term care. Hence, the expenditure of the social protection system might not be reduced at all. Even if it is, user charges do not reduce the total expenditure on health and long-term care. Part of the financial burden is shifted from the social protection system (be it contribution or tax financed) to patients or users (and their families).[75]

3.4. Cost sharing and access to health and long-term care

Cost sharing raises the issue of universal access to health and long-term care benefits in kind, advocated in the above-mentioned international and EU documents. It should be guaranteed that health and long-term care is affordable (economic or financial access) for all patients and equitable (equitable access). It is well recognised, that user charges often have undesirable effects on equity. The higher the proportion of user charges in the total mix of public and private health-care funding, the greater the relative share of the funding burden that falls on poor people and people in poor health. In this way, user charges reduce solidarity between healthy and unhealthy people, because affluent (and healthier) people support poor (and sicker) people to a lesser extent.[76] The empirical results suggest that user charges lead to more limited access (and non-take-up) of health care among patients with lower incomes than among those with higher incomes.[77]

It is an ethical conviction in many MISSOC countries that the financial burden should not disproportionally rest on those who suffer from illness or lack/loss of autonomy. It should rather be independent of health risks. User charges at the point of health-care delivery by definition go against this basic principle.[78]

Therefore many exceptions are required. In developed health-care systems, exemptions have been introduced to mitigate the social consequences of user charges. They may be very diverse and differentiated for distinctive categories of health care. User charges may be lowered or waived for some groups, such as the chronically ill (regardless of their wealth) or economically weaker patients, or both. Income-related ceilings, limiting the total amount of user charges, may also apply. They are designed to increase vertical (between persons with higher incomes and those with lower incomes) and horizontal solidarity (e.g. between those who are chronically ill and those who are not).

However, even sophisticated exemption mechanisms may not always be fully effective. Very poor patients would require third-party payment, since they would be unable to advance the user charges (pending subsequent reimbursement). Also, defining which

75 Van Langendonck J., *op. cit*., p. 348. In addition, wealthier users in some countries might be convinced that more expensive health and long-term care (where user charges are higher) is better, since not everyone can afford it, and increasingly ask for it. Hence the goal of discouraging overuse of care and reducing unnecessary demand might not be achieved either in this case.

76 Mossialos E., Dixon A., *op. cit*., p. 23.

77 Schokkaert E., van de Voorde C., *op. cit*., p. 349.

78 *Ibid*, p. 339.

chronic diseases give the right to an exemption might be challenged as arbitrary, and in order to verify exemptions according to a ceiling, very good information would have to be available, with very sophisticated administration to handle this properly.[79]

Not only the introduction of user charges (particularly in the form of co-insurance), but especially the many (complex) exceptions, could cause rather expensive cost-sharing arrangements. The cost of implementing and collecting user charges should be less than the revenue raised by them. The cost of implementing exemption schemes to protect the access (and incomes) of poorer people should not be underestimated. Experience from developing countries suggests that considerable administrative, informational, economic and political constraints need to be overcome.[80]

Due to all these problems with cost sharing, it is worth exploring whether there are any alternatives to user charges. Could supplementary private health insurance be the solution or are there any other possibilities to steer demand and reduce the cost of health care?

3.5. Supplementary insurance for cost sharing

One of the forms of private/voluntary health insurance is supplementary (or complementary) insurance, covering cost sharing under the social protection system. Other forms of private/voluntary health insurance may be basic, substitutive, additional and parallel health insurance.[81]

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79 This can prove to be problematic in low and middle-income countries. Ibid p. 343 some examples of African countries, where there is a recent tendency to reduce or abolish user charges, are offered.

80 Mossialos E., Dixon A., *op. cit*., p. 23.

81 *Basic* private health insurance is available to persons who are not covered at all by the social protection system and can only be privately insured.

Substitutive insurance is best known in Germany. It is for persons who are exempt from social health insurance (e.g. due to high income) and privately insured instead. In Germany, every substitutive insurance carrier is obliged to offer a so-called basic tariff (*Basistarif*). Some argue that this form of private health insurance displays some of the characteristics of social protection. Its intent is to offer necessary insurance coverage in order to provide health insurance to all inhabitants. In addition, it provides benefits in kind, similarly to mandatory health insurance. Despite its private (insurance) carriers and its content in terms of benefits it could be perceived as social security in terms of Regulation 883/2004/EC (also due to its partially mandatory character) and coordinated among the Member States. Eichenhofer E., Unterliegen die den Basistarif anbietenden Träger der privaten Krankenversicherung dem Europäischen koordinierenden Sozialrecht? MedR 28(5), 298–302 (2010).

Additional private health insurance may be taken out for benefits not covered by social protection system, such as alternative health care or beauty operations.

Parallel or *alternative* private health insurance is insurance against limitations on the supply side (waiting lists). Insured persons have direct access to specialists outside the social protection system. Since they are covered twice for the same services (in the social protection system and by private insurance) this might be beneficial for the social protection system, where no benefits are claimed. This is only true as long as such private insurance is not used to jump the queue (free riding between private insurance and the social protection system). Strban G., Temelji obveznega zdravstvenega zavarovanja (Basic concepts of mandatory health insurance), CZ, Scientia Iustitia, Ljubljana 2005, p. 53.

At least in countries of the Organisation for Economic Co-operation and Development (OECD), such markets have been found to promote risk pooling of resources that are often otherwise paid out of pocket, to enhance access to services when public or mandatory financing is incomplete, and in some cases to increase service capacity and promote innovation.

Private health insurance markets have been somewhat controversial, partly because they often reach wealthier populations and have been the subject of market failures, such as adverse selection by covered individuals and "cream skimming" of better health risks by insurers.

Hence, private health insurance has its limits. A study of OECD countries found financial barriers to access because of affordability and premium volatility. Such insurance can contribute to inequalities in access to health-care services in some countries. It has done little to reduce cost pressures on social protection systems. Nor has it made significant contributions to quality improvements, except in a few countries.[82] In addition, where supplementary private insurance for user charges is in place, patients are more aware of the (monthly) premium they have to pay for such insurance, rather than the cost of health care and they have few incentives to reduce the demand for health care.

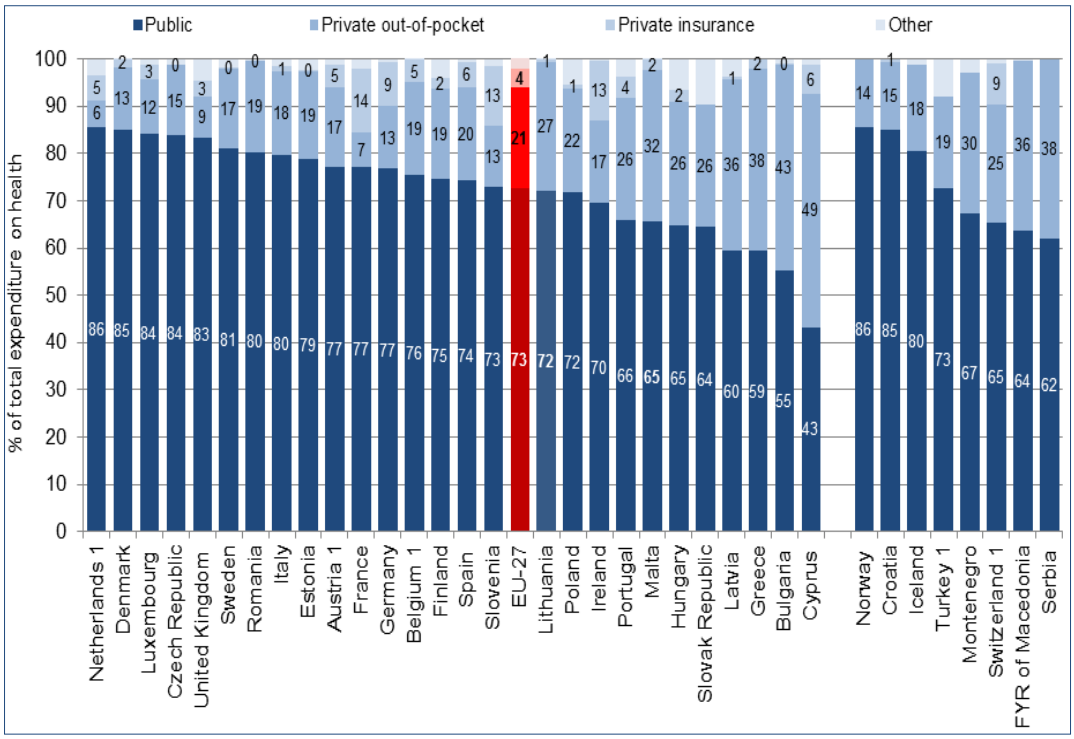

Table 1: Expenditure on health by type of financing, 2010 (or nearest year)
Source: OECD Health Data 2012; WHO Global Health Expenditure Database.[83]

82 Gottret P., Schieber G., *op. cit.*, p. 11.
83 OECD Health at a glance Europe 2012, *op. cit.*, p. 129.

It can be deduced from Table 1 that the social protection system is the main source of health-care financing in all MISSOC countries, except Cyprus (where it amounts to less than half of all costs). In 2010, on average in the EU, 73 per cent of health care was publicly financed. The highest share was in the Netherlands, the Nordic countries (except Finland), Luxembourg, the Czech Republic, the UK and Romania. The share was lowest in Cyprus, Bulgaria, Greece and Latvia.

After public financing, the main source of funding for health expenditure is out-of-pocket payment. In 2010, the share of out-of-pocket payments was highest in Cyprus, Bulgaria and Greece. It was lowest in the Netherlands, France and the United Kingdom.

Private (supplementary) health insurance is most widespread in France,[84] Ireland[85] and Slovenia. Supplementary hospital insurance is for instance available also in Belgium, as a second, private, protection mechanism. Patients who have supplementary hospital insurance have to bear only a small fraction of the out-of-pocket payments to be paid compared to those who do not have supplementary hospital insurance. A simple description of out-of-pocket payments billed by hospitals and providers in Belgium therefore gives a biased picture of what individuals really have to pay.[86] In some countries (like the Netherlands), the insurer is not allowed (or only partly, as in France) to extend the cost sharing (compulsory and voluntary deductible) to supplementary health insurance reimbursements.[87]

3.6. Possible alternative measures to cost sharing

It has been established that the objectives of direct cost sharing and supplementary private insurance for user charges (as a kind of indirect cost sharing) might not be fully achieved. Other measures might therefore be used to raise cost awareness, steering the demand (away from overuse and unnecessary benefits in kind), and collecting additional revenue for health-care systems.

For instance, raising awareness of health-care costs could also (or more effectively) be achieved with invoices including the actual costs of care provided, which could be

84 In France, the 20 per cent share of private expenditure explains why 88 per cent of the French population has private health insurance. Chevreul K., *et al*., European Observatory on Health Systems and Policies, Out-of-pocket payments, France, 2010, p. 28.

85 Private health insurance in Ireland acts as a complement to the public health system, providing coverage against charges levied on non-Medical Card holders for inpatient bed use together with more limited reimbursement of some out-of-pocket charges in the primary care sector. The overwhelming majority of individuals with private health insurance would otherwise have to pay these charges. A consumer survey undertaken for the HIA in 2005 found that 14 per cent of adults with either a Medical Card or a GP Visit Card also had private health insurance. McDaid D., *et al*., European Observatory on Health Systems and Policies, Out-of-pocket payments, Ireland, 2009, p. 52.

86 Federaal Kenniscentrum voor de Gezondheidszorg (KCE), *op. cit*. p. 122.

87 Schäfer W. et al., European Observatory on Health Systems and Policies, Out-of-pocket payments, Netherlands, 2010, p. 18.

handed out after receiving the treatment or pharmaceutical. It should be clearly stated how much the social protection system has had to pay for health or long-term care and the amount of any user charge (or private health insurance for this).[88]

Instead of user charges there are other instruments which may be used to limit or at least steer consumption (demand for health care). Better methods for reducing health care costs might also be found on the supply side, rather than on the demand side. Among these methods are improved care coordination and gatekeeping. Coordination between distinct levels of care, i.e. primary, secondary and tertiary care, but also between health and long-term care and other social services could be improved in many countries.

General practitioners may act as gatekeepers in order to prevent direct, more costly and uncontrolled use of specialists' services. So-called *doctor (s)hopping*, which may prove to be rather costly, should be prevented.[89] Gatekeeping may be mandatory (as in Denmark, Italy, the Netherlands, Norway, Portugal, the Slovak Republic, Spain and Slovenia) or encouraged by financial incentives (as in Belgium France, Germany and Switzerland).[90] Medical practitioners should also be discouraged from recommending excessive treatment.[91] This may ensure that patients are kept out of high-cost institutional (hospital) environments as much as possible. Hospitalisation should then be the solution of last resort (*ultimum remedium*).

There are also other ways of controlling the cost of health care. Among them are regulating prices and wages, restraining prices of pharmaceuticals (for instance through negotiations, setting cost ceilings for specific drugs or therapeutic groups, promoting the use of generics), budgetary caps and constraints (which might not always be respected), modifying methods of payment (e.g., lump sum according to diagnosis-related groups or DRGs, capitation fee, modified with a fee for service), cost control in a decentralised environment, using incentives to improve supply-side performance (and cost efficiency).[92]

Moreover, it could be argued that the idea that individuals will be better off because they are paying higher prices can hardly be accepted.[93] It is the use of available resources that is important, and there is no particular reason that they should be provided by patients. User charges say absolutely nothing about the quality of service. What is most important is that only good quality health and long-term care is paid for by the social protection

88 This is already the case in some MISSOC countries (e.g. Slovenia for pharmaceuticals). However, the behaviour of individual patients might not be the same. Some would start living healthier lives after noticing the amount social protection had to pay for care, but others might be unaffected by this.

89 Doctor hopping is when there is no requirement to consult a primary care physician, but a patient can consult a specialist directly, a practice which is close to doctor shopping. Strban G., op. cit., p. 260.

90 Overview of the intensity of gatekeeping across countries in the OECD, Value for Money in Health Spending, OECD 2010, p. 73.

91 Heike Engel, Yves Jorens, *op. cit*., p. 13.

92 OECD, 2010, op. cit. p. 57 ff.

93 Schokkaert E., van de Voorde C., *op. cit*., p. 337.

system. Then every euro spent on such care would be a euro well spent and there would be hardly any need for other measures to contain expenditure. Conversely, every euro spent on bad quality care is one euro spent too much and should be eliminated.[94]

It seems more equitable to raise contributions to social health insurance (the contribution base could be broadened and/or the contribution rate modified) or taxes (if they are progressive) in a national health service, rather than to collect revenue from the patients. Reducing the need for health and long-term care through prevention and health promotion measures, as well as better communication between patients or users and care providers, could also be more effective ways of ensuring financially sustainable health care in the long run than user charges.

Removing user charges could improve service coverage and access, in particular among the poorest socio-economic groups, but quick action without prior preparation could lead to unintended effects, including deterioration in quality and excessive demands on health and long-term care workers. In order for the removal of user charges to be successful, the policy change must be preceded by careful planning, including supportive policies to address a possible increase in health care utilisation and loss of revenue. Following certain policy steps, countries wishing to move beyond cost sharing (user charges), could work towards universal access and maximise the chances for success and minimise unintended effects.[95]

4. Existing cost sharing in MISSOC countries

4.1. Cost sharing and exemptions for health care benefits in kind

Cost sharing exists in the majority of MISSOC countries, regardless of the organisation of the social protection system. We shall distinguish between user charges for consulting a physician, for hospital treatment, for dental treatment and for pharmaceuticals. In addition, cost sharing limitations, reductions, and exemptions are of paramount importance for securing equitable access to health care, called for also by international legal instruments.

4.1.1. Cost sharing when consulting a physician (GP or a specialist)

In some MISSOC countries, there is *no cost sharing* foreseen when consulting a general practitioner (GP) or medical specialist. For instance, this is the case in the Czech

[94] van Langendonck J., *op. cit.*, p. 353. See also OECD, Strengthening Health Information Infrastructure for Health Care Quality Governance: Good Practices, New Opportunities and Data Privacy Protection Challenges, OECD Publishing, 2013.

[95] More in McPake B. et al., Removing user fees: learning from international experience to support the process, Health Policy and Planning, Oxford University Press in association with the London School of Hygiene and Tropical Medicine, 2011;26: ii104–ii117.

Republic and in Denmark, where user charges are steering the behaviour of patients (no charges for Group 1, treatment by the chosen GP or a specialist to whom he/she refers the patient),[96] but also in Malta, Poland, Romania, Spain and Ireland (persons with full eligibility and those with a GP Visit Card are entitled to GP services without charge, persons with full eligibility can also avail themselves of specialist services in public hospitals free of charge). As a rule, health care is also free of charge in Lithuania[97] and the UK.

Nevertheless, in many MISSOC countries cost sharing for consulting a GP or a specialist may be prescribed in the form of co-insurance, co-payment or deductible amount. In many countries various exemptions and cost-sharing limits (caps) are regulated.

a) Co-insurance

Co-insurance exists in Austria, where user charges must amount to 20 per cent of the agreed fee for benefits provided by psychotherapists or clinical psychologists. Also in Luxembourg, co-insurance applies at a rate of 20 per cent of the ordinary tariff for visits. For other interventions and services it is 12 per cent. In Slovenia it ranges from 20 to 30 per cent. In Belgium user charges must not exceed 25 per cent for GPs, and co-insurance is higher (40 per cent) for certain specialist medical interventions. In Cyprus some insured persons have to pay 50 per cent for laboratory tests, x-rays and other diagnostics, and in Portugal cost sharing varies according to the type of visit (e.g. visit at home, normal or urgent visit, visit in a central or regional hospital, visit in a health centre).

b) Co-payment

A co-payment of EUR 10.30 per year is required for consulting physicians in Austria. In Bulgaria, Croatia, Estonia, Finland, Latvia and the Slovak Republic it is prescribed for each visit (a few euros).[98] The same applies in Cyprus, where patients entitled to free

[96] Any person who has the right to public health care benefits can choose between being covered in Group 1 or Group 2. With regard to many of the services, the person's rights will depend very much on which group s/he has chosen, For instance, Group 1 entitles to free medical treatment by a GP who has joined the collective agreement with the Public Health Service. Group 2 entitles to free choice of medical practitioner - also among GPs who have not joined the collective agreement. The Public Health Service for Group 2 only pays a part of the doctor's fee (user charges encompass the part of expenses which exceed the amount fixed by the public scheme for Group 1). The vast majority of patients (98.5% in 2007) chose Group 1. Danish Ministry of Health and Prevention, Health care in Denmark, 2008, and MISSOC tables, 2014.

[97] Patients have free access to non-emergency outpatient consultation.

[98] In Bulgaria and Croatia, the charge is approximately EUR 1.5 and in Estonia up to EUR 5 per home visit or for a visit for outpatient specialist health care. In Croatia, insured persons have to pay EUR 1.34 for health protection in primary health care (for GP visits/examinations). In Iceland, the insured person pays between EUR 6.19 and EUR 16 per visit. EUR 28 + 40 per cent of the remaining costs, but a maximum of EUR 193 per visit is charged for a visit to a specialist working under a contract with Icelandic Health Insurance. Otherwise, the insured person pays in full but can be reimbursed for the amount that would have been paid by Icelandic Health Insurance. In Latvia, an outpatient visit to the general practitioner amounts to EUR 1.42 and an outpatient visit to a specialist to EUR 4.27. For some outpatient diagnostic procedures co-payment is between EUR 1.42 and EUR 36, depending on the procedure. In the

health care have to pay EUR 2 per visit to an outpatients department. Patients entitled to medical care at reduced fees pay EUR 6.5 for visiting GPs and EUR 8.5 for specialist visits. Other groups in Cyprus have to pay EUR 14.5 or EUR 20.5 per visit to a GP and a specialist respectively.

In Finland, a maximum of EUR 13.80 is charged for the first three visits in a calendar year or an annual fee of a maximum of EUR 27.50 for 12 months depending on the municipality. In addition, EUR 18.90 may be charged for an on-call-visit to a health centre at night time and at weekends. Also, the full cost of visits to private physicians is not reimbursed. In Norway, co-payment is prescribed for consultation of doctors, psychologists, radiological treatment, laboratory tests and travel expenses. For a standard GP consultation approximately EUR 18 is charged and for a specialist consultation approximately EUR 40. Patients pay between EUR 11 and EUR 34 per visit to a doctor. A similar situation exists in Sweden, where patients pay between EUR 23 and EUR 40 for specialist care, and between EUR 23 and EUR 46 for emergency cases.

Sometimes cost sharing is introduced for special services. For instance, in the Netherlands, outpatient mental health care is divided into primary care and secondary care. Primary care deals with relatively mild mental problems that require short-term interventions. There are eight sessions included in the basic health insurance package. The co-payment for the patient is EUR 10 per session. Secondary mental care deals with mental problems that are too complex for short-term interventions. In 2008, a co-payment of EUR 15.60 per consultation was levied and there is no limit on the number of sessions.

Co-payment is also required in Italy for health services in specialist outpatient clinics. In Hungary, payments are required for certain extra services such as for a better room or specific dietary requirements. However, the exact amount of this direct payment (for extra services) is fixed by the service provider.

c) Deductibles

In the Netherlands, a compulsory deductible is applied for all insured persons aged 18 years or older at the amount of EUR 350 per year. Insured persons can opt for a voluntary deductible of EUR 100, 200, 300, 400 or 500 on top of the compulsory deductible. In return, they receive a discount on the nominal health care premium. Since 2009, health insurers may choose not to charge the deductible when patients (1) go to preferred providers, (2) use preferred pharmaceuticals or medical aids, or (3) follow preventive programmes for diabetes, depression, cardiovascular diseases, COPD (e.g. chronic bronchitis) or obesity. Certain groups of chronically ill persons are partially compensated for the deductible.

Deductibles are applied in Liechtenstein (in combination with co-insurance), where they are set at EUR 162 per year, plus a voluntary deductible of a maximum of EUR 1,215 per

Slovak Republic, EUR 1.99 is charged for each visit to the emergency department, EUR 0.17 for each prescription, and EUR 0.07 for each km of transport.

year. The situation is rather similar in Switzerland, where cost sharing takes place in the form of a deductible ("franchise"). The fixed amount per year is set at EUR 243. In addition, 10 per cent of costs above this amount are charged, up to EUR 567 per year. However, the insurer may offer the insured person a form of insurance with a higher excess.

d) Combination of cost-sharing measures

In some MISSOC countries a combination of cost-sharing arrangements can be found. For instance, in Croatia, cost sharing is also a combination of co-insurance and co-payment. Cost sharing amounts to 20 per cent of health care, but it may not be lower than a fixed amount (as a kind of minimum co-payment).[99] In Germany, the patient participation for aids (e.g. massages, baths or physiotherapy) which are part of medical treatment is 10 per cent and EUR 10 per prescription. In Liechtenstein, a combination of deductibles and co-insurance is applied.

In France, under the general scheme for employees, cost sharing by the patient is 30 per cent for ambulatory treatment (GP or specialists, in the consulting room or in hospital), with a flat-rate co-payment of EUR 1 per medical intervention (limited to EUR 50 per person and per year) and a flat-rate co-payment of EUR 18 for serious medical intervention (with a minimum rate of EUR 120). In Greece, co-insurance of 15 per cent applies for outpatient examinations, and a co-payment of EUR 5 in case of such examinations in a public hospital.

e) Exemptions and caps

Certain *exemptions* apply in many MISSOC countries, mainly relating to certain groups of persons (such as minors or social assistance recipients or disabled or older persons), certain (serious) diseases, certain services (most notably preventive care), and related to the cause of sickness (accidents at work or occupational diseases are also exempted). As part of social compensation schemes, victims of war may also be exempted from cost sharing.

For instance, there is no co-payment in Austria for family members, pensioners and those in need (i.e. lacking sufficient subsistence means). The same applies in Bulgaria for minors, prisoners and social assistance recipients[100] and similarly in Croatia.[101] In Belgium, there is no cost sharing for medical-technical benefits and in Luxembourg there is no co-insurance for haemodialysis, chemotherapy, radiotherapy treatment and

[99] The minimum co-payment in Croatia is approximately EUR 3.35 for specialist consultation, including ambulatory and surgical interventions as a day patient and rehabilitation, and approximately EUR 6.7 for specialist diagnostic procedures which are not on the level of primary health care (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

[100] Exemptions also apply to some other groups in Bulgaria.

[101] In Croatia, patients under the age of 18 are exempt from fees. The same applies to regular students, persons suffering from certain listed diseases (for those diseases only), persons with a disability needing constant assistance and organ donors (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

preventive medical tests. The same applies in Slovenia for preventive care, minors (and students), HIV/AIDS, accidents at work and occupational diseases and co-insurance for social assistance recipients is covered by the State. Regulatory charges are also not applicable in the Czech Republic for instance in case of preventive examinations, haemodialysis, laboratory or diagnostic tests, and for minors.[102] Minors are also exempt in Finland, Estonia (children under 2 years of age), France (as well as social assistance and invalidity pension recipients), Germany, Latvia,[103] Norway (under 16 years), Portugal (under 12 years), Sweden and Switzerland. In the Netherlands, care from a general practitioner and obstetric care are exempted from the compulsory deductible amount.

In some MISSOC countries there is a cap on cost sharing. This is the case for instance in Croatia (cap at approximately EUR 270 per issued health bill), France, Latvia,[104] Norway,[105] Finland[106], Iceland, Luxembourg (2.5 per cent of the annual income subject to contributions), Sweden and Liechtenstein (cap of EUR 468 per annum).

In Belgium, in excess of a certain annual amount paid by the insured, the so-called maximum ceiling (rising with income and lower for chronic diseases),[107] is applied and above it free health care is provided. This is a kind of deductible amount (not for each benefit in kind, but cumulatively) above which no cost sharing is prescribed.

f) Cost sharing when choosing a physician

It has already been mentioned that demand for health care can be steered by enabling or limiting freedom to *choose a physician*. In some countries a special (small) charge is required to register with a primary health care physician. If a patient chooses to change physician within a rather short period after registration, a further administrative charge may be applied.[108]

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102 In the Czech Republic, the regulatory fee is also applied for a visit to an emergency medical services provider or emergency dental services. However, it is not charged if the insured person is subsequently taken into inpatient care (http://www.mzcr.cz/Cizinci/obsah/basic-types-of-regulatory-fees_2662_23.html, consulted April 2014).

103 In Latvia, many other groups or services are exempted from cost sharing (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

104 In Latvia, the total annual contribution for inpatient and outpatient treatment in one calendar year should not exceed EUR 570, excluding the cost of drugs, spectacles and dental services.

105 In Norway, costs are shared up to a ceiling of approximately EUR 257 a year. A second ceiling of approximately EUR 330 applies to cost sharing for physiotherapy, reimbursable non-orthodontic dental treatment, organised health travel and stays in medical rehabilitation centres.

106 In Finland, an overall ceiling of EUR 636 per year applies to public sector fees (excluding dental care).

107 For exact amounts the MISSOC tables should be consulted.

108 For instance, in Lithuania, a small charge (EUR 0.30) is required to register with a primary health care physician. If a patient chooses to change physician within six months after registration, there is a further administrative charge of about EUR 3. Janoniene R. et al., European Observatory on Health Systems and Policies, Out-of-pocket payments, Lithuania, 2013, p. 12.

4.1.2. Cost sharing for hospitalisation

In some MISSOC countries *no cost sharing* is foreseen for hospital treatment, which may be important also for long-term care benefits (where non-acute or prolonged nursing care is possible). For instance, in Lithuania, patients have *free access* to hospital admission (secondary and tertiary health care) upon referral from a primary health care physician.[109] In this way the behaviour of patients is steered, since without a referral, the patient must pay a fee for the hospital treatment, as set by the national health insurance fund (which would make it a regulated direct payment to the health care provider). No cost sharing is required in Denmark (in public and approved or contracted hospitals, private establishments only if referred by public hospital), Iceland, Portugal and Greece (public hospitals), Ireland (persons with full eligibility), Italy, Malta, Norway, Poland, Romania, the Slovak Republic, Spain and the UK.

It should be mentioned that also in the case of *maternity*, benefits in kind (health care) are as a rule provided as part of hospital treatment. However, in many MISSOC countries no cost sharing is foreseen for childbirth (prenatal, confinement and postnatal) services. For instance, in Bulgaria, exemption from cost sharing is granted to pregnant women and young mothers up to 45 days after the birth. Similarly, no cost sharing is foreseen in Croatia (at contracted providers), the Czech Republic, Denmark, Estonia, Finland, France (full reimbursement in the last four months of pregnancy and no co-payment for medical intervention or hospitalisation), Iceland, Ireland (also for infants under six weeks), Latvia, Liechtenstein (including check-ups in the first 10 weeks after giving birth), Luxembourg, Malta, Norway, Portugal, Romania, Slovenia, Sweden and Switzerland.[110] In Greece, paraclinical examinations in case of maternity are free of charge, if carried out in public hospitals or national laboratories. However, if they are conducted in private clinics and contracted laboratories, co-insurance of 15 per cent is required. Similar provisions apply for hospitalisation. Insured women have the right to free-of-charge hospitalisation in a public hospital, whereas in a contracted private clinic the co-insurance amounts to 30 per cent, even in the case of maternity. For non-contracted clinics and hospitals, full direct payment is required.

In many MISSOC countries, cost sharing exists for hospital treatment. This may take the form of co-insurance, co-payment or a deductible. For instance, *co-insurance* exists in Austria (10 per cent for the hospitalisation of a dependant), Greece (contracted private clinics, from 10 to 30 per cent) and Slovenia (up to 30 per cent). In the Netherlands, for long-term inpatient care (and nursing care at home and social support in the form of home care), a complicated system of income-dependent cost-sharing requirements exists, in the form of co-insurance with a cost-sharing ceiling.[111]

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109 There are some exceptions to this rule; for example, no referral is required for a free visit to a dermatologist/venereologist.

110 MISSOC tables (www.missoc.org, MISSOC Comparative Tables Database, status July 2013).

111 More Schäfer W., *op. cit.*, p. 19.

Co-payment of a certain amount per day exists for instance in Austria (EUR 10 per day), and also in Germany (but with a maximum of 28 days per year), Belgium (admission fee and per day), Bulgaria and Estonia (for the first 10 days), the Czech Republic (relatively low regulatory charge), Finland (for institutional care over three months, a fee is charged based on means), Latvia (per day, and for surgical operations), Luxembourg (for a maximum of 30 days), Sweden and Switzerland.

A *combination* of cost-sharing measures is regulated for instance in Croatia (20 per cent of the cost, but not less than approximately EUR 13 per day) and Liechtenstein (co-insurance and deductible). In France, co-insurance amounts to 20 per cent (under the general scheme for employees) and a hospitalisation fee has to be paid per day (including the day of discharge). A flat-rate co-payment of EUR 18 is also required for serious medical intervention in addition to the daily hospital charge or 20 per cent co-insurance (with a minimum rate of EUR 120).[112]

A *deductible* (franchise) is applied in Liechtenstein, Switzerland and the Netherlands (mandatory and voluntary deductible).

Reduction of cost sharing occurs in Belgium (for dependent children, those benefiting from the preferential scheme and the assimilated unemployed, for hospitalisations in a psychiatric home for more than 5 years) and Sweden (income test for persons above 64 years of age).

Exemptions are regulated for social assistance recipients, minors (or children in general, including students) and some other vulnerable groups of patients (such as the disabled or chronically ill), for instance in Bulgaria, Croatia, the Czech Republic, Estonia, Finland, France, Germany (for minors, except travel costs), Ireland, Liechtenstein, Slovenia, Sweden (for children), Switzerland and the Netherlands. Exemptions are also possible for certain services, such as heart surgery in Greece.

Caps on cost sharing also exist in some MISSOC countries, including Austria, Croatia, Finland (a minimum of EUR 99 per month must be left for the patient´s personal use), Germany (no charge for patients who already exceeded the expenses limit of one or two per cent of gross income) and Latvia (combined cap for in- and outpatient care).

4.1.3. Cost sharing for dental treatment

In most MISSOC countries, dental treatment is subject to rather extensive cost-sharing measures, or even non-coverage (as in Romania from 1 April 2013).[113] For instance, *co-*

[112] More at http://www.cleiss.fr/particuliers/venir/vacances/883_en.html and MISSC tables (both 2014).

[113] For instance, in Estonia, adult dental care must be paid for directly. This is subject to partial reimbursement by the Health Insurance Fund only for certain pensioners and for insured persons aged over 63 (EUR 19.18 per year), children, emergency dental care and some other groups of persons are also

insurance may be required for orthodontic treatment and dental prostheses in Austria (between 25 and 50 per cent), Belgium (up to 25 per cent), Cyprus (for dental prostheses), France (30 per cent of a fixed amount which is far below the actual amount paid), Germany (50 per cent of the cost of fixed standard care), the Slovak Republic (35 per cent for dental prostheses), Slovenia (from 20 to 90 per cent), Luxembourg (88 per cent reimbursement in excess of an annual sum of EUR 60 which is fully covered; 80 per cent of co-insurance for dental prostheses if the patient did not regularly consult a dentist as a matter of prevention, otherwise fully covered) and Portugal (75 per cent reimbursement for dental prostheses).

Co-payment may be introduced for examination and (at a slightly higher level) for dental specialist consultation, as in Croatia, Finland (basic fee and fixed tariff for each intervention), Hungary, Italy (only paid by those whose income is above a given ceiling, otherwise free dental treatment, but full direct payment for dental prostheses).

Nevertheless in some MISSOC countries dental treatment is to a large extent free of charge, as in Poland, Luxembourg, Malta and Ireland (for persons with full eligibility).[114]

As for other health care, also for dental treatment, there are some *exceptions* from cost-sharing measures, or at least preferential provisions. As a rule this concerns children, as in Belgium (except orthodontic treatment), Bulgaria (more services covered), Denmark, Estonia, Finland, Germany, Greece (up to 13 years of age), Hungary, Iceland, Ireland (under 16 years of age), Latvia, Lithuania, Malta, Norway, Slovenia, the Netherlands and the UK. Easier (financial) access to dental treatment may apply to the elderly, as in Belgium (over 50 years of age), Denmark,[115] Estonia, Hungary, Iceland (pensioners), Lithuania (to a certain level), or those passing the means test, as in Malta and the UK.

There might be no cost sharing for dental prophylactics (preventive measures), as in the Czech Republic, Denmark, Germany (for minors), Hungary, Slovenia, and emergency dental care, as in Estonia, Hungary, and Slovenia, or if dental treatment is necessary in relation to other medical interventions (as in Switzerland and the Netherlands). Cost sharing may also be *capped* in a given year (Croatia).

covered. In Finland, no refund is provided in respect of orthodontic and prosthodontic treatment. In Iceland, dental care is covered for children (partially for pensioners), but not for the rest of the population except for treatment due to serious consequences of congenital defects, accidents or illness. Full direct payment is as a rule foreseen for dental prostheses in Latvia. In Liechtenstein, the Netherlands and Slovenia, voluntary insurance is available for dental treatment. Dental prostheses are not generally covered in Norway. More at www.missoc.org, MISSOC Comparative Tables Database, status July 2013. In Lithuania, adults must pay the cost of materials used during treatment. Murauskiene L. et al., 2013, op. cit. p. 12. As a rule, the above standard materials also have to be paid for directly in some other countries (such as the Slovak Republic).

[114] Full eligibility is e.g. enjoyed by persons over the age of 70 years whose gross incomes are below a certain threshold. A separate threshold is set for those below 70 (and increased for children or dependants). For details, please refer to the MISSOC Tables.

[115] In Denmark, for pensioners, depending on their financial situation and medical condition, municipalities can cover 85 per cent of the participation in the cost of dental prostheses by means of the Health Allowance.

4.1.4. Cost sharing for pharmaceuticals

In some MISSOC countries main cost-sharing measures apply not only to dental treatment but also to pharmaceuticals. This does not just mean that over-the-counter pharmaceuticals (including lifestyle drugs and other specific pharmaceuticals, e.g. for the treatment of common colds or travel-sickness symptoms, as in Germany) are subject to direct payment. Many MISSOC countries have introduced a number of rules on pricing and coverage in order to contain the cost of (new and expensive) pharmaceuticals. They may range from listing medicaments (applying differential co-insurance to each list, which may be lower for the list of more essential pharmaceuticals)[116] to (individual or group) reference pricing and substitution of the prescribed drugs by a pharmacist (replacing them by cheaper alternatives).

For instance, in Lithuania, cost sharing involves *co-insurance* for outpatient pharmaceuticals and some medical aids for groups of patients who are exempt from direct payments.[117] Co-insurance also exists in Cyprus (for those entitled to treatment at reduced rates), the Czech Republic (from 0 to 100 per cent), Denmark (depending on the expenditure on listed medicines during the year), Estonia, France (between 0 and 85 per cent depending on the efficiency rate of the medicine), Germany, Greece, Latvia, Lithuania, Luxembourg, Poland, Portugal, the Slovak Republic and Sweden (above EUR 126).

The amount of co-insurance is a fixed proportion of the reference price of the medication or medical aid. Reference pricing (for individual drugs or for therapeutic groups of medications) should reduce the prices of pharmaceuticals (which are individually interchangeable with generics or where interchangeability exists within a certain therapeutic group) and steer the behaviour of patients (as a rule demanding cheaper drugs among equally effective products). Reference prices for therapeutic groups are applied for instance in the Czech Republic (where at least one medicament is free of charge and fully reimbursed by the health insurance fund in each group),[118] Germany, Latvia, Slovenia and Switzerland.

Hence, when the pharmaceutical price is higher than the reference price, the patient pays the difference as a *co-payment*[119] (which may be required in addition to co-insurance within the reference price).

116 This would be the case for instance in Belgium, Croatia, Romania and Slovenia.

117 Murauskiene L. *et al*., 2013, *op. cit.* p. 12.

118 It is argued that this means the cheapest effective option of all essential drugs, www.missoc.org, MISSOC Comparative Tables Database, status July 2013.

119 As in Latvia, where in 2011, co-payments for reimbursed pharmaceuticals and medical goods constituted EUR 44 million, an 8 per cent decrease compared with 2010. Murauskiene L., *et al*., 2013, *op. cit.* p. 12.

Co-payment (of a few euros) may also be required for each prescribed item (among listed drugs) in Austria, Cyprus (in private pharmacies), Estonia (depending on the level of reimbursement), France (with a limit of EUR 50 per year), Ireland, Italy, Latvia, Poland and the UK.

Again, there are some *exceptions* to cost-sharing measures, most notably for children, the elderly, the disabled, those below a certain threshold and chronically or seriously ill persons. For instance, this is the case in Austria (for notifiable infectious diseases or in case of need), Belgium (lists A and Fa), the Czech Republic (exception from regulatory charge for each prescription for some groups), Cyprus (for those entitled to free treatment), Denmark (for terminally ill patients), Estonia (for certain diseases), Greece and Italy (for accidents at work, Greece also for medication during pregnancy and chronic illnesses), Hungary (for chronic diseases, elderly or disabled persons with low income), Ireland (for specified long-term illness), Lithuania and Norway (children and pensioners), Malta (means tested and for certain diseases, otherwise direct payment), Portugal (certain pensioners and generics), Romania (children and disabled), the Slovak Republic (elderly and disabled), Spain (disabled persons, beneficiaries of non-contributory pensions, certain unemployed persons, accidents at work and occupational diseases), the UK (children, those over 60 or receiving income support).

Beside exemptions, *reductions* are also possible, as in Belgium (for those with preferential treatment), Denmark, Estonia, Germany (in all countries for children), Finland (for serious and chronic diseases), Spain (pensioners and long treatments), as are ceilings, for instance in Belgium, Finland, Germany, Iceland (reduced ceiling for the elderly, invalidity pensioners, and children), Ireland, Norway and the UK (for those requiring regular medication).

Deductibles are regulated for instance in Sweden (where the patient pays the whole cost up to EUR 126 during a period of 12 months from the first purchase) and the Netherlands (mandatory deductible up to EUR 350).

In some MISSOC countries, pharmaceuticals used for *hospital treatment* are fully covered by the social protection system or included in cost-sharing arrangements applying to hospital treatment (as in HR, EE, FI, HU, MT, PL, SI, ES). This may be explained by the complexity of the right to hospital treatment. In addition to prevailing highly-specialised diagnostics, acute medical treatment and medical rehabilitation, this also covers nursing care, accommodation, meals, pharmaceuticals and medical aids.[120] In some other MISSOC countries drugs are charged separately, as in Belgium (for each day spent in hospital).

Pharmaceuticals are usually also free of charge in case of *maternity*, with some exceptions though. For instance, in Latvia, only 25 per cent reimbursement of prescription drugs for pregnant women and women in the period following childbirth up

120 Strban G., 2005, op. cit., p. 199.

to 42 days is foreseen.[121] In Luxembourg, drugs and dietary nutrition for babies are covered by a lump sum payment.

Similar cost-sharing rules as for pharmaceuticals may apply for prostheses, spectacles and hearing aids (although at slightly different levels and with some special provisions).[122]

4.2. Cost sharing for long-term care benefits in kind

There is much less information available on cost sharing for long-term care benefits in kind than for health care. One of the reasons might be that health care is more or less similarly structured in MISSOC countries, whereas it is not always entirely clear which benefits in kind could be considered as long-term care benefits. Moreover, not all MISSOC countries regulate long-term care benefits in kind (as generally applies in Austria).[123] Nevertheless, certain cost-sharing arrangements may also be deduced from MISSOC tables.

In some MISSOC countries, long-term care (social) services have to be primarily *paid by the beneficiary* (as in BG, CY, EE, FI - for home care, LV, SI), but the payment may depend on his/her income (as in CZ, DK - for temporary care, FI - for institutional care, FR - means test, HU, IS - for social services at home, IE - nursing homes, MT - homes for elderly, PT, SI, ES, UK).

In some countries, cost sharing may be required from the beneficiary's family (a spouse, parents or children), if the person in question does not have his/her own income or his/her income would be insufficient to cover the costs (as in CZ, EE, HU, PL, SI). If they are not able do to so, the state or local communities may cover part of the costs, whereas a small amount of the pension (or other benefit) has to remain for the beneficiary (LV, SK). Hence, cost sharing may exist in cases where a social protection benefit (a pension or other cash benefit) has to be used for payment, as well as in cases in which such benefit is not sufficient and the beneficiary has to add to the costs from his/her own funds, e.g. property in Lithuania (if available).

Co-insurance might be required for certain services, as in Estonia (15 per cent of the service cost in case of nursing care), Norway (75 per cent of income above EUR 882 and up to the Basic Amount for long-term nursing at home).

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121 An exception to this rule applies when the diagnosis is eligible for other reimbursement categories (50 per cent, 75 per cent or 100 per cent), www.missoc.org, MISSOC Comparative Tables Database, status July 2013.

122 More at www.missoc.org, MISSOC Comparative Tables Database, status July 2013.

123 A good attempt at mapping long-term benefits in kind may be found in Jorens Y., Spiegel B., *op. cit.*

A small amount of *co-payment* may be required for services in day care centres (as in Iceland), or other social services (including so-called meals on wheels in Malta). Co-payment may vary according to the type of benefit and the level of invalidity (Italy), or may be officially set (Romania). In Belgium, care insurance has to be paid for by an annual contribution of EUR 25 (10 for those benefiting from the preferential sickness insurance scheme).

In the Netherlands, the system of *deductibles* also applies to certain long-term care benefits in kind. However, those living in long-term care institutions (and groups of individuals with high medicine use) may receive compensation for deductibles.[124]

In some countries, long-term care (or part of the service) is as a rule *free of charge*, as in Denmark (for personal and practical assistance), Germany, Greece, Iceland (nursing at home), Ireland (home care), Luxembourg, Norway (home nursing and personal assistance) and Poland (semi-residential and residential care).

There are some *exemptions* from cost sharing for instance for long-term care (social services) for children (BG, NL) or persons with no income (BG, HR, CY, SI - except for residential care, which has to be paid also from social assistance), or care of disabled persons (FI, IT - if totally disabled), according to the criteria of local communities (LT).

For instance, in Ireland, long-term care charges generally apply to all individuals, including Medical Card holders, although there are exemptions for people under 18, women receiving maternity services, individuals involuntarily detained under mental health legislation and people who have contracted hepatitis C as a result of infected blood products or transfusions in Ireland. Different cost sharing (charging) arrangements are applied, depending on the level of nursing care. However, there is only a limited supply of HSE-owned long-term care facilities, which means that many individuals have to find long-term care within the private sector, with a small number of private care homes also being contracted by the public sector.[125]

Caps on cost sharing for long-term care benefits in kind may be applied as well, as in Sweden (where user charges are rather small).

It may be observed that in OECD countries long-term care is predominantly funded from public sources, even when taking under-reporting of private expenditures into account. The only exception is Switzerland, although some public social-care spending items are not reported.

124 Schäfer W., *op. cit.*, p. 18.
125 McDaid D. et al., *op. cit.*, p. 56.

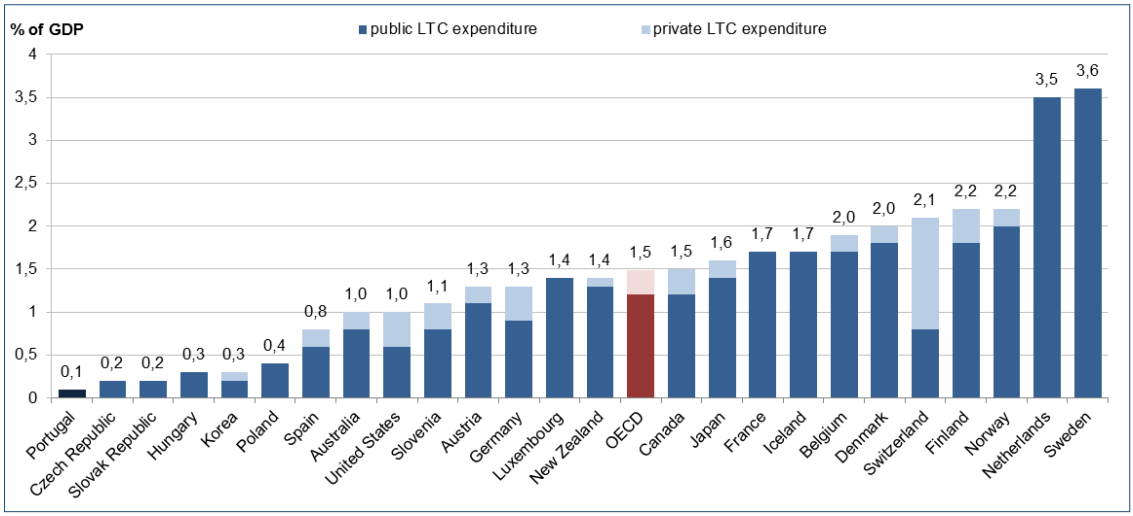

Table 2: The share of public LTC expenditure is higher than that of private LTC expenditure in OECD countries (including some MISSOC countries), Percentage of GDP, 2008
Source: OECD Health Data 2010[126].

[126] Data for Austria, Belgium, Canada, the Czech Republic, Denmark, Hungary, Iceland, Norway, Portugal, Switzerland and the United States refer only to health-related long-term care expenditure. In other cases, expenditure relates to both health-related (nursing) and social long-term care expenditure. Social expenditure on LTC in the Czech Republic is estimated at 1 per cent of GDP (Source: Czech Ministry of Health, 2009). Data for Iceland and the United States refer only to long-term nursing care in institutions. Data for the United States underestimate expenditure on fully private LTC arrangements. Data for Poland exclude infrastructure expenditure, amounting to about 0.25 per cent of GDP in 2007. Data for the Netherlands do not reflect user co-payments, estimated at 8 per cent of total AWBZ expenditure in 2007. Data for Australia refer to 2005; data for the Slovak Republic and Portugal refer to 2006; data for Denmark, Japan and Switzerland refer to 2007. Colombo, F. et al., Help Wanted? Providing and Paying for Long-Term Care, OECD 2011, p. 46.

5. Modifications of user charges during the last decade

In the previous chapter, a user charges, as currently regulated in MISSOC countries, are presented. In the present chapter, the focus shifts to the dynamics of cost-sharing measures over time, i.e. their development from pre-crisis (about ten years ago) through the crisis period (from 2008) to the present (post-crisis) situation in MISSOC countries.

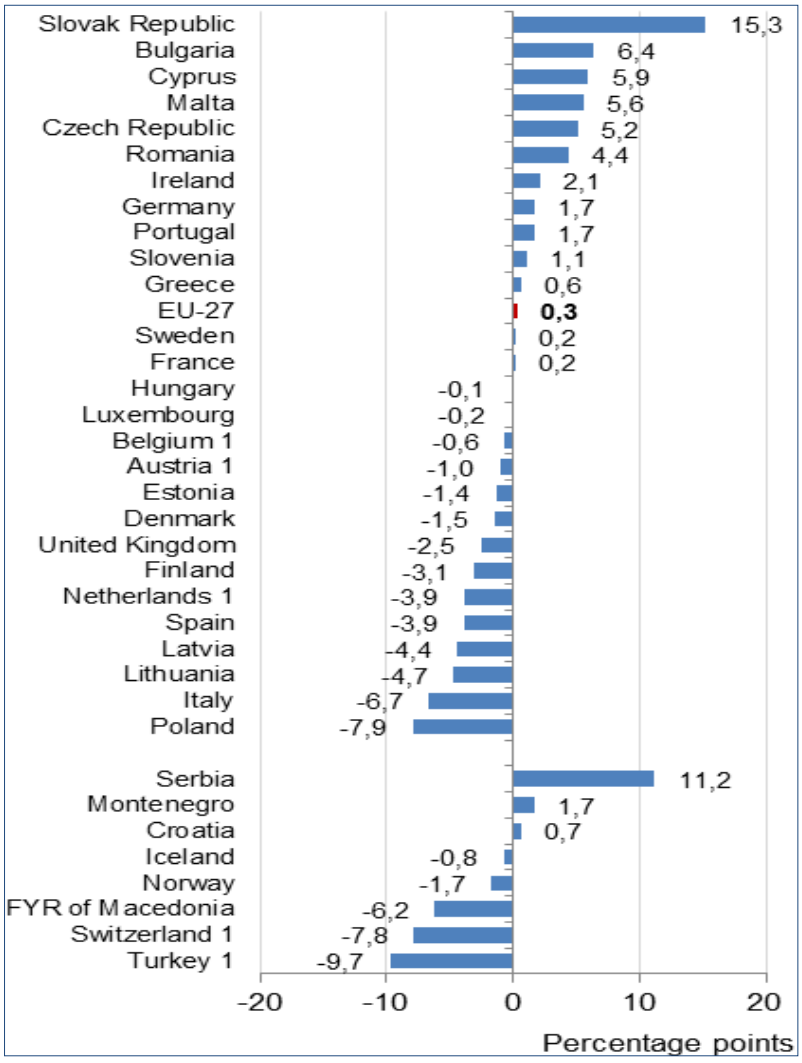

Table 3: Change in share of out-of-pocket spending in total health spending, 2000 to 2010 (or nearest year)
Source: OECD Health Data 2012; WHO Global Health Expenditure Database[127]

The economic crisis has had an effect on the mix of public and private health financing as public spending has been contained or cut in many countries severely affected by the recession. In Ireland, the share of public spending decreased by nearly 6 per cent between

[127] OECD Health at a glance Europe 2012, *op. cit.*, p. 129.

2008 and 2010 and now stands at 70 per cent. Substantial falls have also been observed in the Slovak Republic and Bulgaria.[128]

The share of out-of-pocket spending as a whole has *increased* over the past decade in about half of MISSOC countries while it has decreased in the other half. The Slovak Republic has seen the biggest increase in cost sharing paid directly by households, with a rise of over 15 per cent between 2000 and 2010. This increase is due to a rise in user charges for prescribed pharmaceuticals, higher spending by households on direct payments for non-prescribed medicines, increased use of private providers and informal payments to public providers. The share of out-of-pocket payments has also increased substantially in Bulgaria, Cyprus and Malta. In some countries hard hit by the economic crisis, public coverage for certain services has been reduced in recent years, with a growing share of payments being transferred to households. In Iceland, the share of out-of-pocket spending increased by 2.2 per cent between 2008 and 2010, although this did not totally offset the previous reduction in this share between 2000 and 2008. In Ireland, the share of out-of-pocket spending increased by 1.7 per cent between 2008 and 2010, and is 2.1 per cent greater than in 2000.[129]

Several MISSOC countries increased or instituted user charges in response to the economic crisis (among them CZ, DK, EE, FR, GR, IE, IT, LV[130], NL, PT, RO). In some countries, user charges were introduced or increased in the hospital sector (as in CZ, EE for inpatient nursing care, FR, IE, RO). Pharmaceuticals were subject to increased user charges in several countries (CZ, FR, IE, LV, PT and SI).[131] Co-insurance for pharmaceuticals was also increased in Latvia.[132] User charges were increased for ambulatory care in Greece, Italy and Romania. User charges even increased for emergency departments (in Ireland) and for services not considered urgent in Italy.

128 *Ibid*.

129 *Ibid*.

130 Since the start of the recession in 2008, when the Latvian government cut spending and increased user charges, cost sharing has experienced significant growth. User charges are an important source of revenue for contracted health care providers. In fact, their total revenue from user charges (including co-payments and co-insurance) doubled in nominal terms from 2008 to 2009 and remained at this high level in 2010 (from 5.6 per cent in 2008 to 14 per cent in 2010, although about half of this amount was reimbursed for exempted patients). Mitenbergs U., *et al*., *op. cit*., p. 68.

131 In England, a programme to expand the range of long-term conditions that benefit from free prescriptions was announced by the previous government but not implemented; this will now no longer be taken forward. Mladovsky P., et al., Policy summary 5. Health policy responses to the financial crisis in Europe, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2012, p. 17.

132 There have been several changes in co-insurance rates and eligibility under the state health insurance scheme. Major changes centred around prescriptions for outpatient medicines (in addition to 100 per cent and 80 per cent reimbursement rates, rates of 90 per cent and 50 per cent were introduced) and medical rehabilitation and spa treatment, where 80 per cent and 50 per cent reimbursement rates, respectively, replaced 100 per cent for medical rehabilitation and 90 per cent for sanatorium treatment. In 2010, cost sharing constituted about 32 per cent of the total expenditure for reimbursed medicines. Murauskiene L., *et al*., 2013, *op. cit*. p. 12.

In seems that in Switzerland the co-insurance rate will increase from 10 to 15 per cent for people who opt for traditional insurance plans (to encourage people to subscribe to a managed-care model of insurance).

Some countries have introduced or increased charges for specific services such as in vitro fertilisation (DK and NL), ambulance transport (FR, SI), physiotherapy and some mental health services (NL), some vaccines such as yellow fever, Japanese encephalitis, typhoid, meningitis and rabies tetravalent (PT), GP home visits (RO), non-acute spa treatment, dental prostheses and some ophthalmologic appliances (SI) and dental care (IE).[133]

In contrast, some other countries have *extended public coverage* for health services in recent years to improve access to care, resulting in a lower share of health spending paid directly by households.[134] The share of out-of-pocket payments has come down substantially in Poland and Switzerland, although it still remains slightly above the EU average.[135]

Some countries reported expanding benefits, targeting low-income groups in the area of pharmaceuticals (AT, FR, IE, IT), reducing cost sharing (HR for primary care and outpatient prescription drugs) or abolishing it for some services (IT, HU).[136]

Recently, in Germany, co-payment in the form of a consultation fee (*Praxisgebühr*) of EUR 10 per quarter at the first visit to the physician (excluded for certain medical check-ups) was abolished from the beginning of 2013. It was established that such co-payment did not contribute to a significant reduction in visits, but those with lower income were deterred from visiting physicians. It was a burden for patients and providers (due to bureaucratic procedures) and the revenue was rather low (one per cent of social health insurance expenditure).[137]

There have been changes in cost sharing not only for health care, but also for *long-term care* benefits in kind. For instance, in Ireland, people with an (intellectual) disability are now being asked to pay new charges and contributions if they wish to continue receiving

133 For adults with full eligibility, the range of treatments in Ireland has been limited since April 2010 due to the introduction of measures to contain expenditure on dental treatment.

134 Although not among the MISSOC countries, Turkey is the most striking example; since 2003, it has moved to extend public coverage for health services for a larger proportion of the population, with public funding now accounting for 73 per cent of total health spending, equal to the EU average. This has led to a reduction of nearly 10 per cent in the share of direct payments by households over the past decade. OECD Health at a glance Europe 2012, *op. cit*., p. 129.

135 *Ibid*.

136 Although in the case of Hungary this was not a response to the crisis but helped to promote financial protection. Mladovsky P., *et al*., *op. cit*. p. 17.

137 *Beschlussempfehlung und Bericht des Bundestagsausschusses für Gesundheit*, Bundestags-Drucksache 17/11396, 7 November 2012. More on the *Gesetz zur Regelung des Assistenzpflegebedarfs in stationären Vorsorge- oder Rehabilitationseinrichtungen* at http://www.bmg.bund.de/ministerium/presse/pressemitteilungen/2012-04/bundestag-ende-der-praxisgebuehr.html, consulted April 2014.

disability services and support. They are under intense pressure to pay these levies. Up to now, these services would have been provided at no cost to the person with a disability or their parents. The charges affect both adults and children with an (intellectual) disability.[138]

Since the beginning of 2013, cost-sharing requirements for long-term care, which is covered by the Exceptional Medical Expenses Act in the Netherlands, have been increased for patients with private assets. Eight per cent of taxable assets are now added to their income. The measure is taken to compensate for the inequity between people with low incomes and high assets, who paid lower cost sharing, and people with high income and low assets (who paid higher cost sharing).[139]

6. Findings

The present analysis shows that out-of-pocket payment for health and long-term care benefits in kind is significant and that formal cost sharing (with all exemptions and reductions) is a common feature in MISSOC countries. Cost sharing may take various forms (such as co-insurance, co-payment, extra billing or deductibles), which are intended to achieve certain policy goals. Among them are raising awareness of health and long-term care costs, reducing what is considered as unnecessary utilisation, raising additional funds for social protection systems, or steering the behaviour of users (with lower cost sharing in case of public providers, or for preventive measures).

However, cost-sharing measures increase the financial burden of users, i.e. patients and long-term care recipients (and their households) and may reduce the use of high-value (cost-effective) and low-value care equally. In particular, special attention should be paid to lower-income individuals (and their households), elderly, disabled, or chronically ill people. Cost sharing might be most likely to reduce access to and use of health and long-term care benefits in kind for these groups, even when the level of user charges is rather low. Applying or increasing cost-sharing measures should not result in worsening health outcomes for most vulnerable groups in society.

Therefore, in order to respect the provisions of internationally agreed standards, and secure not only equal, but also (financially) equitable access to health and long-term care benefits in kind, MISSOC countries have developed rather complicated (and costly) mechanisms of reductions, exemptions and caps on cost sharing.

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138 People are being threatened that services will be reduced or withdrawn if new charges or contributions for service and supports are not made. In some cases, people have been asked to contribute over EUR 100 per month to continue attending a day service. Inclusion Ireland, National Association of People with an Intellectual Disability, 2012 – 2013 Reviewed Inclusion Ireland, p. 11.

139 The measure is expected to result in a saving of EUR 200 million. Kroneman M., Higher contribution for long-term care for people with private assets, in Schäfer W., *op. cit.*, p. 19. See also https://zoek.officielebekendmakingen.nl/kst-33204-3.pdf, consulted April 2014.

To avoid undesirable outcomes, social policy alternatives to cost sharing might be considered, among them better coordination of the provision of health and long-term care benefits in kind, promotion of preventive measures and quality of care, as well as steering the behaviour of users by other (or additional) means (including issuing invoices and promoting the gatekeeper function of primary care physicians).

In a way, cost sharing is also defines the borderline between public and private responsibility for health and long-term care. Whatever the mix of public and private elements in each MISSOC country, access to health and long-term care benefits in kind should be guaranteed, in order to enable healthy and independent living of every member of the society as far as possible.

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