

HEALTH CARE: USER CHARGES - INTRODUCTION

PART 1 – OVERVIEW ON HEALTH CARE

1. Background

Good insurance cover in case of illness as well as good medical care are important achievements for the citizens of Europe. Health care systems are however undergoing substantial change, in particular as a result of demographic development and technical progress. In the Commission's report „*A concerted strategy to modernise social protection*“ of 1999¹ the provision of health care which satisfies demands for high quality and can be financed in the long term is described as an important objective of the increased co-operation of member states.

The European Council of Lisbon seized this initiative in March 2000 and pointed out that major effort and reforms will be required in health care systems in order to meet the existing challenges adequately. Moreover, in June 2001 the European Council of Gothenburg requested the Council to compile a report on guidelines in the field of health care systems and care of the elderly.² The open method of co-ordination was defined as the way to proceed, which is based on co-operation as a partnership of all those involved in the health care system as part of the relevant areas of responsibility.

In the subsequent report drawn up by the Commission *The future of the health care system and care of the elderly: to ensure access, quality and long-term ability to provide finance*³ three sectors are described, which have an effect on health care expenditure. These include demographic development, the development of new technologies and therapies as well as improved prosperity and higher standards of living. In this situation, which will lead to considerably higher expenditure in the health care system without adequate measures, three long-term objectives are to be achieved in the health care system:

- General access regardless of income or wealth,
- Qualitatively high value provision of health care,
- Long-term financiability of health care systems.

The particular challenge is the fact that all three objectives, which are inter-related and therefore influence each other, are to be achieved at the same time.

¹ COM (1999) 347 final

² See COM (2001) 723 final

³ COM (2001) 723 final

The framework objectives, which have been referred to above, were approved by the European Council in Barcelona and the latter requested the Commission and the Council to examine these three topics more closely. As a result, a *Joint report by the Commission and the Council regarding support for national strategies for the future of health care provision and care of the elderly*⁴ was compiled, in which conclusions as well as proposals for future action are presented on the basis of a survey of member states.

In spring 2004 the Commission finally presented its report on *Modernisation of social protection for the development of high-value, accessible and forward-looking health care provision and long-term care: support of individual state strategies through the „open method of co-ordination”*⁵ a plan of how to proceed over the coming years. According to this report, the Commission will analyse the current situation and the targets of countries and use these to determine the common objectives of the „streamlined” social protection procedure. In 2006 this will lead to an initial range of „Strategies for Development and Reform” for health care provision and long-term care in the period from 2006 to 2009.

MISSOC-Info 2/2005 on *„Health care – user charges”* concentrates on costs being assumed by the beneficiaries within this broad framework. This aspect is incorporated within the third objective of the long-term ability to finance health care systems. Before presenting the synthesis of the reports from the member states of the EU, of the EEA and Switzerland (part 2), it is advisable to depict the current situation of health care services in Europe. Particular emphasis is placed on the expenditure for illness and health care provision as well as its development.

2. The current situation in health services

Europe is characterised by health care provision at a very high level in terms of quality. *„An important reason [...] is general insurance against the risk of illness and the risk of general disability, which covers individuals in the event of illness and has contributed substantially to the rapid and continuous progress in medicine and the treatment of illnesses.”*⁶

The social security systems assume the major part of total expenditure for illness and health care provision. How high this expenditure is – calculated in purchasing power parities (PPP) per capita – and what proportion of gross domestic product it accounts for, is shown in diagrams 1 and 2. The source of this information is EUROSTAT from February 2005 with data records from 2002. This data mainly includes all the member states of the European Union as well as the European economic area and Switzerland. However, the information is missing from some countries (Estonia, Cyprus, Latvia, Lithuania, Poland as well as Liechtenstein), so that it was not possible to give average values for the European Union or the European economic area.

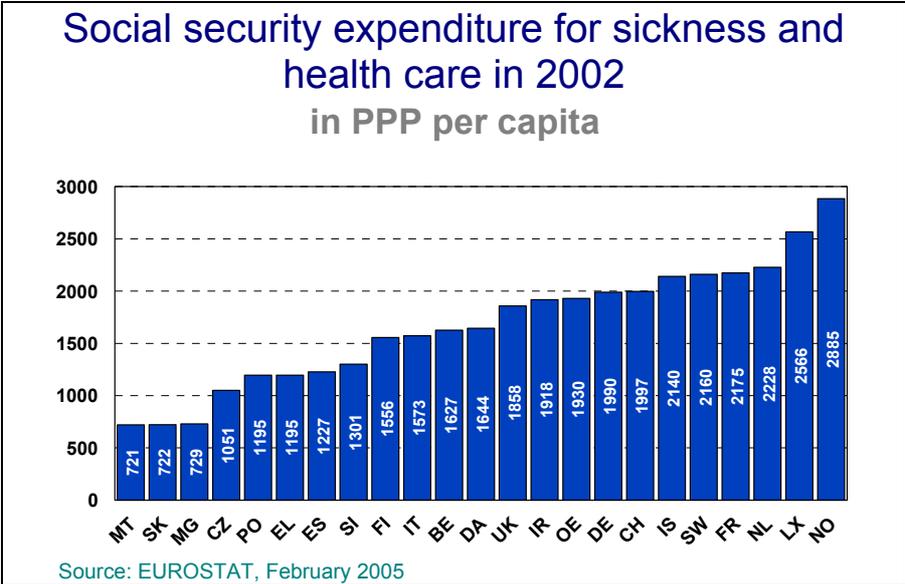
⁴ Joint report by the Commission and the Council CS 7166/03.

⁵ COM (2004) 304 final

⁶ COM (2001) 723 final

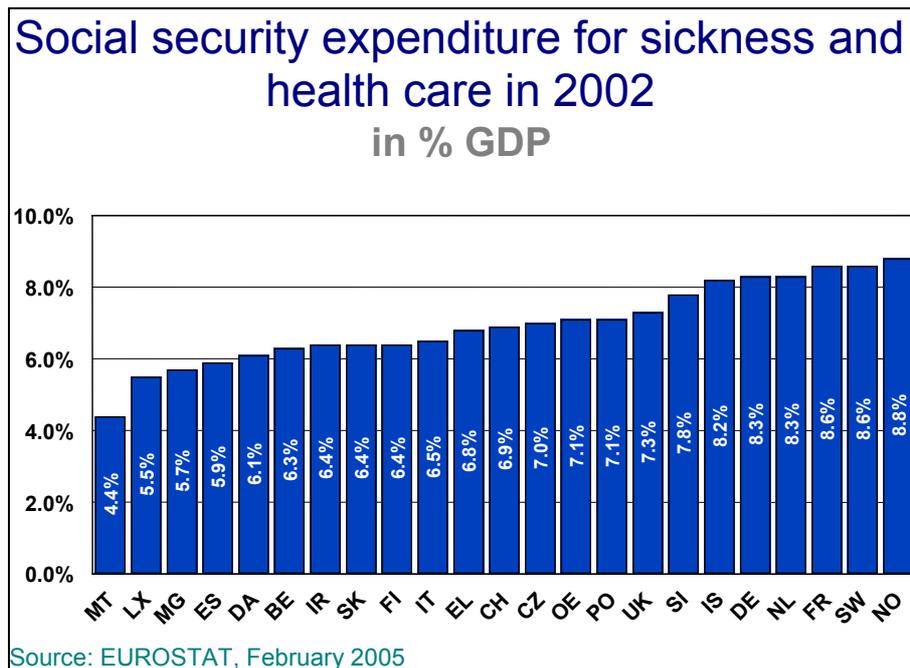
Social security expenditure for illness and health care provision in 2002 differs markedly in the countries reviewed: for instance expenditure in Norway is the highest with 2,885 PPP per capita and is four times higher than the expenditure of Malta with 721 PPP per capita. Together with Malta, Slovakia and Hungary have expenditure under 1,000 PPP per capita. Slightly higher costs between 1,000 and 1,500 PPP per capita are moreover achieved in the Czech Republic, Portugal, Greece and Spain as well as in Slovenia. These countries are followed by a broad group with expenditure between 1,500 and 2,000 PPP per capita; these include Finland, Italy, Belgium, Denmark, the United Kingdom, Ireland, Austria, Germany and Switzerland. More than 2,000 PPP per capita is spent in Iceland, Sweden, France, the Netherlands, Luxemburg and Norway, whereby the expenditure of the last two countries mentioned stands at over 2,500 PPP per capita.

Diagram 1: Social security expenditure for illness and health care provision – in PPP per capita



Social security expenditure for illness and health care provision related to gross domestic product (GDP) varies from 4.4 % in Malta to 8.8 % in Norway in 2002. Malta is followed here by Luxemburg, Hungary and Spain with shares ranging from 5.5 % to 5.9 % of GDP. A similar, slightly weaker scenario is also shown for example for Denmark, Belgium and Ireland, whose share of expenditure lies between 6 % and 7 % of GDP. The Czech Republic, Austria, Portugal, the United Kingdom and Slovenia show a share of expenditure of GDP of between 7 % and 8 % and finally there is a leading group with Iceland, Germany, the Netherlands, Sweden, France and Norway, in which the share of social security expenditure for illness and health care provision accounts for more than 8 % of GDP.

Diagram 2: Social security expenditure for illness and health care provision – in % of GDP



The level of expenditure or the level of its proportion of gross domestic product gives an indication of the expenditure situation in the countries under consideration. However, no premature conclusions can be drawn on the quality of the health care system in the relevant countries on the basis of these figures, because a system for example can also produce high costs as a result of inefficiencies, without necessarily achieving a high level of performance in terms of quality commensurate with expenditure.

Health care policy together with pension policy is therefore at the centre of the discussion regarding the stabilisation of social security systems, because costs have risen hugely in the past and will continue to rise in the future for the reasons, which have already been mentioned, of demographic development, technical progress and higher standards of living. To what extent total expenditure on health – without considering the sources of financing – has changed during the last four to five years, can be seen from the OECD data for 22 countries.⁷

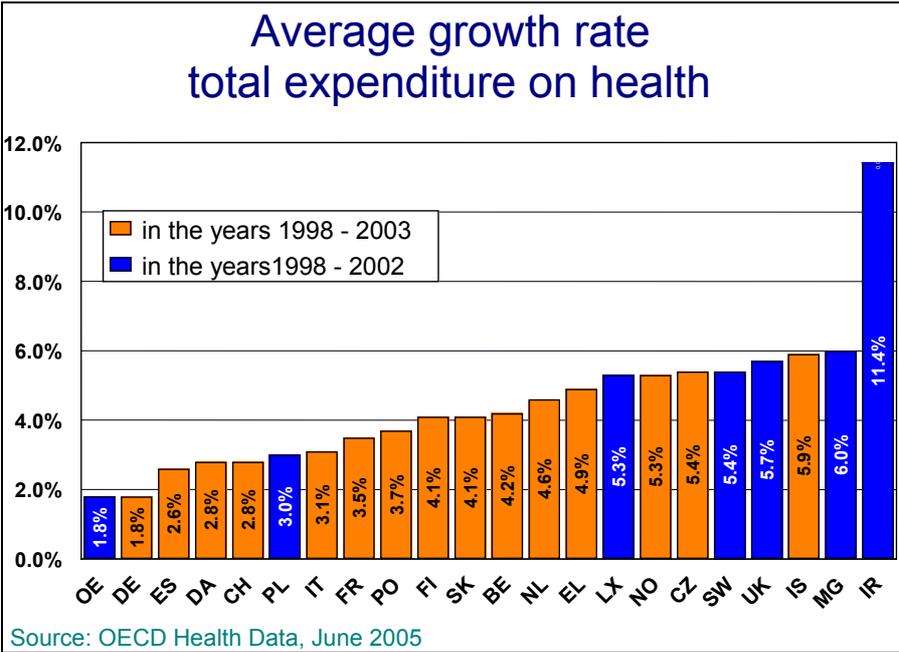
The rate of increase of health care expenditure during the last four to five years shows enormous differences from country to country and varies between almost 2 % in Germany or in Austria to over 11 % in Ireland, whereby the rate of increase in Ireland is much greater than the other countries and is nearly twice as high as that of Hungary with the second highest rate of increase amongst the countries under review.

Apart from Germany and Austria, the two countries already referred to, Spain, Denmark and Switzerland also have a very slight rate of increase of less than 3 %. The relevant rates of increase of Poland, Italy, France and Portugal stand at over 3 % and under 4 % and those of

⁷ Estonia, Latvia, Lithuania, Cyprus, Malta, Slovenia and Liechtenstein are missing from this diagram. Data from the two sources used (EUROSTAT and OECD) are obviously not mixed up for comparison in the diagrams and conclusions here presented.

Finland, Slovakia, Belgium, the Netherlands as well as Greece are below 5 %. Lastly, in addition to Hungary, rates of increase between 5 % and 6 % were recorded by Luxemburg, Norway, the Czech Republic, Sweden, the United Kingdom and Iceland. The following diagram illustrates this connection once again, whereby the rates of increase of Austria, Poland, Luxemburg, Sweden, the United Kingdom, Hungary and Ireland refer to the years 1998 to 2002, whilst the rates of increase for the remaining countries were calculated for the period from 1998 to 2003.

Diagram 3: Average rates of increase in health expenditure



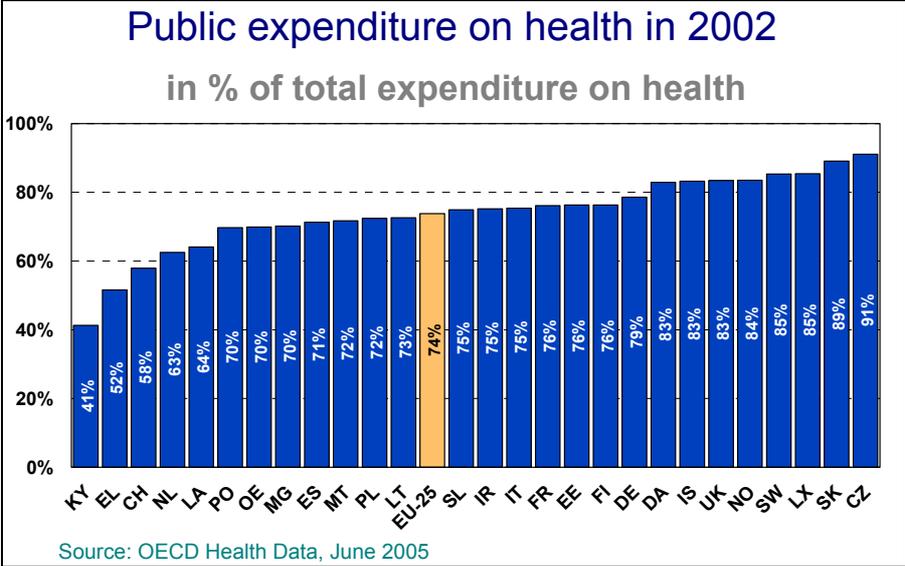
Related to the question of cost participation, it is of interest to see what proportion of public expenditure is included in total expenditure on health care provision. According to the definition of the OECD, *public health expenditure* is financed through national, regional and local authorities as well as social security systems. In addition, publicly financed investments in health care infrastructure as well as capital transfers to the private sector for hospital building and equipment are part of public health expenditure. On the other hand, private health expenditure includes private additional payments (both in the form of retentions as well as direct additional payments), expenditure by private insurance companies and by welfare associations in the health sector together with expenditure on occupational health services.⁸

The data on public health expenditure with the exception of Belgium is available for all member states of the OECD as well as for the six new member states of the EU, which are not members of the OECD (Estonia, Cyprus, Latvia, Lithuania, Malta and Slovenia) for the year 2002.

⁸ See <http://www.irdes.fr/ecosante/OCDE/411010.html>

The share of public health expenditure in total expenditure on health varies between 41 % in Cyprus and 91 % in the Czech Republic and stands at an average of 74% in the European Union. Cyprus, with clearly the lowest share of public health expenditure, is followed by Greece, Switzerland, the Netherlands and Latvia with shares between 52 % and 64 %. In 14 of the countries surveyed, the share of public health expenditure in total expenditure lies between 70 % and 80 %. Denmark, Iceland, the United Kingdom, Norway, Sweden and Luxemburg have a very high share of public expenditure in total expenditure ranging from 83 % to 85 %, which finally reaches its peak of about 90 % amongst the countries surveyed in both Slovakia and the Czech Republic.

Diagram 4: Share of public health expenditure in total expenditure



The very marked difference regarding the relevant shares of public health expenditure in relation to total expenditure can be explained on the one hand by varying social insurance models in different countries: therefore for example the share of public health expenditure in total expenditure in northern countries with universal systems of cover is higher than average. On the other hand, in other countries, which have a widespread model of self-protection, such as for example Cyprus or Switzerland with a franchise model, the share of public health expenditure is very low. Moreover, the varying level of services provided for, plays an important role in the level of health care costs borne by the public sector. Therefore in some countries statutory services for certain treatments are strictly limited, so that a large proportion of patients have to pay for their own treatment, which leads to corresponding distortions in the shares of services which are borne by the public and private sector.

After this brief overview of the situation of health care expenditure in Europe, a summarized analysis of the situation of user charges as described in the country reports follows in Part 2.

PART 2 – OVERVIEW ON USER CHARGES

1. Background

As we have noticed, the total share of health care expenditures in the GDP is increasing in all Member States. Not only because of the high cost resulting from technical innovation, but also because of a constantly growing use of medical provisions by patients; Member States were encouraged to introduce cost control measures. From the different methods used in this respect, user charges have become without any doubt an increasingly popular instrument. The present Missoc-Info investigates this measure and gives an overview of the extent to which user charges are used in the different health care systems of the Member States of the European Union, of the EEA and Switzerland.

What are user-charges? Under user charges we understand the financial contribution which is asked from the patients when they make use of the health care provision, which charge does not cover all the costs and is not compensated by health care insurance. These can go from zero cost sharing, when the full amount is paid by a third party, up to full user charges, where costs are completely met by out-of-pocket payments. Sometimes a difference is made between direct cost sharing and indirect cost sharing. Direct cost sharing includes measures as co-payment (a flat fee or charge per service) or co-insurance (a percentage of the total charge). Indirect cost sharing involves policies that can result in out-of-pocket expenditure, even though charges are not directly imposed. Examples are policies with a coverage exclusion or pharmaceutical regulatory mechanisms, such as generic substitution.

Many arguments are put forward in favour or against the introduction of user-charges.

Arguments against user-charges are e.g. the fact that there is a danger that the necessary medical care is not asked for, which could even result in a worsening of the health situation of the population. Participation of the beneficiaries in the costs of medical care will also lead to injustices and put sick insured people into disadvantages. In addition, participation can be perceived differently according to the financial situation of the beneficiary (rich or poor).

As argument in favour of user-charges it is sometimes believed that some governments would have perhaps even not introduced a system of medical care without them. To what extent then a smaller user charge exactly installed with the intention to avoid injustices, should be a sanction for the beneficiary? Some reports point out that user charges contribute to finance the health care sector and to maximise profits (Belgium, Greece, Austria), while other countries point out that user charges hardly had any financial influence on a reduction of the health care costs (Denmark, Luxembourg – at least for most of the benefits). The main argument however lays presumably not as such in financial reasons as user charges can hardly be considered in the different Member States as a source for financing health care and therefore providing additional revenue. It is rather believed that the absence of user charges would encourage excessive demands for health services and therefore expenditures would escalate. This is the so-called "problem of moral hazard". User charges have as main objective to strengthen the awareness of the cost of health care and as such to give more responsibility to the patient with the incentive to change his medical behaviour and to make

clear that medical services have a price (Germany, Italy, Luxembourg). A more careful and efficient use of health care is looked for (Austria, the Netherlands). On the other hand in Austria it is mentioned that user charges mostly only resulted in a temporarily change of behaviour.

This increasing tendency in Member States to introduce national user charges-regulations is perfectly in line with the international and European Regulations, which acknowledge the possibility of introducing user charges. As well, the European code of social security of 1964 and the Revised Code of Social Security of 1990 of the Council of Europe as ILO conventions 102 and 130, know comparable provisions. The "beneficiary" or his bread winner may be required to share in the costs of medical care. However, the rules concerning such cost sharing shall be so designed as to avoid hardship. These international texts reflect a compromise, where on the one hand the principle of introducing user charges remains a facultative one, but on the other hand, if national legislation adopts this principle, it may not imply too heavy charges for the patient concerned, which would prejudice the medical and social protection objectives.

An own contribution could indeed have huge consequences for the economic weak parts of the population and those categories of people who hardly possess any economic means. Hardship should be avoided, but this is a general term, as no clear precise numbers of user charges have been noted in these international conventions, in particular as the user charges differ according to the fact whether the basis for calculation is proportional or flat rate. Where the protocol to the European code of 1964 explicitly provided limits to user charges with a maximum of 25% for medical provisions and 33% for dental care, the Revised Code abandoned these detailed numbers and returned to the general rule that cost sharing will not impose hardship or render medical and social protection less effective.

It is then also not surprising that even those members who were in favour of introducing the principle of user charges, accepted that in certain circumstances (in particular for economically vulnerable people), exceptions should be made. The same reason applied with respect to diseases, which need prolonged care. Therefore, ILO Recommendation 134 concerning medical care foresees that the beneficiary should not be required to share in the cost of medical care, if his means do not exceed the prescribed amount or in respect of diseases recognise as entailing prolonged care.

The national reports reflect these international rules.

2. The Current situation

The high cost of health care, but in particular the uncertain demand implied that user charges in general only comprised a small proportion of the total health care cost. Whatever the arrangement, public or private, individuals are protected from paying the full financial costs of the services they were looking for.

Nevertheless, the percentages of user charges differ to a big extent. While in certain countries the percentage of user charges is extremely low with percentages between 0% and 5% (e.g. 0% in Malta or in Spain for most of the benefits with the exception of pharmaceutical benefits or in the Czech Republic or in Denmark or less than 1% in the

Netherlands, and between 3 and 5% in Latvia and Liechtenstein), the user charges are considerably higher in other countries and go up from 10 to 12% in France and Luxembourg, from 15 to 20% in Finland and Norway and even up to almost 30% in Poland. The reports clearly show that the way the health care system is organised in the country concerned, has no implication for the question whether user charges have to be paid or not. User charges can be found in systems which apply a reimbursement principle as well as in benefits-in-kind-systems or systems with a national health service.

Even systems that provide health care in the framework of the national health service, ask some – although rather minor – user charges. In general benefits are free of charge for users in Spain and Hungary, with the exception of pharmaceutical benefits and some ortho-prostatic benefits that require a contribution from the beneficiaries. Also the United Kingdom knows some exceptions to the principle of free treatment for hospital travel costs. In Portugal for ambulatory treatment a fixed user charge has to be paid. Mostly, user charges can be applied for pharmaceutical products. Active workers in Spain must pay 40% for pharmaceutical products if they are not hospitalised. In Portugal the user charges for pharmaceutical products differ between 0 and 80%. In Malta we notice an exception to the principle of no payment for pharmaceutical products, where these products are only for free for certain people after a means test. Also the Polish legislation foresees certain limited user charges for some pharmaceutical products.

User charges can take several different forms. The most common forms of user charges are on the one hand co-payment, where every beneficiary pays a flat fee or charge per service and on the basis of which the same price is paid by each beneficiary (Norway, Sweden, Austria, Finland, Hungary for medical and dental treatment; Iceland, Latvia, Portugal, Slovakia). On the other hand, in some countries the own contribution depends on a percentage of the real costs (Norway, Sweden, Belgium, France, Greece, Luxembourg, Portugal). Most of the time, both methods are used.

Sometimes user charges form a percentage of the real costs, however with a minimum and maximum fixed amount, like for pharmaceutical products and auxiliary products in Germany, where beneficiaries pay 10% of the costs of pharmaceutical products however with a minimum of 5, and a maximum of 10 euro.

In Liechtenstein and in Switzerland beneficiaries have to pay a fixed amount per year and a certain percentage of the costs above a fixed amount up to a certain maximum. In Poland a flat fee has to be paid for pharmaceuticals with an exception for the supplementary drugs.

User charges are present in all sectors of medical care.

For in-patient care usually a flat rate co-payment per day is asked for (Germany, Finland, France, Belgium, Estonia, Sweden, Luxembourg, Poland, Switzerland) with a ceiling placed on the number of paid days for which the patient is liable (Estonia, Germany, Luxembourg).

Dental services in general present the highest user charges, basically as they are only seen as marginal to the public health system (they are almost completely excluded in the Netherlands, in Norway (for adults), in Liechtenstein, in Spain or in Portugal) and persons are mostly referred in that respect to private insurances, which obviously for these benefits also present high user charges. Basic preventive services (Czech Republic, Denmark, Greece,

Hungary, Austria, Finland) or dental services for children (Denmark, Estonia, Iceland, Malta, Hungary, Norway, Finland, Sweden and the United Kingdom) are frequently provided free of charge.

However, pharmaceuticals are a major area of cost sharing. In particular for pharmaceutical products, methods of indirect cost sharing can be found. The percentage of user charges is not based on an actual price, but rather on a reference price, or reimbursement is based on generic substitution.

Most of the time a percentage of the costs is asked for, depending on the type and category of medicine. Drugs used to treat life-threatening diseases or drugs with major therapeutic effects, are typically subject to lower rates of cost sharing than those offering only more marginal improvements in quality of life.

3. General policy of Participation: Exemptions and other measures

In line with the international obligations, many countries foresee exemptions to the payment of user charges; in some countries, certain people are exempted from paying user charges, where other people, depending on their annual income, have to pay reduced fees. This is the case in Cyprus, where certain categories of persons like members of parliament, students of the University of Cyprus, active and retired civil servants do not have to pay any charges. Also other countries know this system where certain categories of people depending on their income are entitled to medical care without any payment of user charges (for example the medical card holders in Ireland, the pink card holders in Malta). In France, persons who do not have sufficient means of subsistence to take a complementary insurance, will benefit from a universal complementary medical coverage, with as main objective to limit financial participation by the beneficiaries.

In Italy, the disabled receive complete exemption regardless their economic or family situation.

In particular children are most of the time exempted from paying user-charges, although the age, the extent and range of benefits may differ (in Norway no user charges under 7 years of age; in Sweden under 18 to 20 years of age; in Denmark youngsters under 18 years of age receive a partial exemption for pharmaceutical products; in Estonia a discount is provided for children from 4 to 16 years of age for pharmaceutical products; in Finland there are no user charges for certain treatments for children under 18 years of age; in Germany there is no payment for medical products and medical services for children; in Liechtenstein no user charges have to be paid up to 20 years old; in Portugal no user charges are asked under 12 years of age; in Slovakia no user charges are requested for children and in Switzerland there is a reduction of user charges for children). Exemptions are also foreseen for special diseases (Greece, Ireland, Norway), for other categories of people like those who receive minimum pensions (Norway, Austria, Hungary for certain medicines, Portugal, Switzerland [means tested], United Kingdom), for long term institutional care (France, Iceland, Finland) or for chronic diseases (Belgium, Liechtenstein, Portugal, Luxembourg).

However, there seems to be a tendency that even persons who are exempted from paying any user charges, have to pay at least something. People must pay in addition to the

percentage of user charges (e.g. flat rates for each medical visit or medical product). In Cyprus, persons who are entitled to free medical care should at least pay a fixed amount per visit. In France, a lump sum amount of 1 euro has to be paid for each medical consultation. In order to promote change in medical behaviour, mechanisms have been installed that should discourage the complementary insurers to cover this payment.

Many countries have however installed mechanisms through social or fiscal measures for limiting the total number of user charges someone has to pay in order to avoid hardship. Different countries foresee a maximum amount of user charges that has to be paid per year for medical costs. If the costs for patients exceed this limit, this exceeding part will be refunded in total. In Belgium e.g. there is a social and fiscal maximum invoice. From the moment the total of user charges to be paid by the beneficiary exceeds this ceiling, either the sickness fund or the fiscal administration will reimburse all further user charges. This ceiling varies between the social category someone belongs to (in that respect the social maximum invoice is only applicable for certain social categories), while the fiscal maximum invoice is also to the benefit of families who have a higher income and foresees different ceilings according to the declared income. It is the fiscal administration which will, only two years later, reimburse the user charges above the ceiling. Nevertheless, in all these systems attention should be paid to the fact that not all user charges for all medical interventions are taken into account for calculating this ceiling. In Denmark a system has been set up for continued subsidy in case of high invoices for pharmaceuticals which install a maximum amount of user charges for medical costs up to a certain limit; a similar system exists in Iceland in case the income is below a certain level. In Germany, beneficiaries only pay user charges up to an individual tax ceiling (see also Luxembourg). In Liechtenstein and Ireland a maximum ceiling for yearly payment is foreseen for user charges. Several other countries have similar systems, like e.g. Finland, Latvia and Switzerland.

More and more measures were installed in the Member States intended to change the behaviour of the insured and to avoid them to run from one doctor to another, which would lead to a reduction of the health care cost. Measures were introduced to incite patients to choose one doctor who follows up the medical file and will further coordinate the care to be received. In Belgium e.g. a patient who entrusts his global medical file to a doctor can receive a reduction from 30% in user charges. This method should avoid unnecessary examinations and double treatments. In France a similar system is set up, where patients who do not follow this coordinated way are penalised in two ways: on the one hand a minor reimbursement of costs by the sickness insurance fund and on the other hand the possibility for doctors who have been consulted directly, to claim higher tariffs than the agreed ones. In Latvia a patient needs to be sent by a primary doctor in order to receive specialist care. If the patient goes directly to the specialist, without being referred to by the primary care doctor, he must pay out of pocket or through a private health insurance. The same mechanism is applied in Lithuania.

A similar method is established for pharmaceutical products, where people are encouraged to buy generic medical products to reduce costs. All these measures should promote a good use of the financial budget by the patient concerned. In Hungary generally bio-equivalent

generic products are subsidised with a fixed amount, which is based on the price of the least expensive alternative product, included in the given group of products.

For controlling pharmaceutical expenses and making rational use of medicines, many countries established a reference price system. The reference price, e.g. in Spain, affects pharmaceutical products that may be included in so-called groups. Groups are categories of pharmaceutical products that contain the same active principle and include at least one generic product with the same qualitative composition of medicinal substances. For each group a maximum funding price or reference price is established and pharmacies are not allowed to sell a product with a higher price. This shows a clear tendency in Member States to further refer patients to generic products. It is particularly clear in Belgium, third biggest consumer for pharmaceuticals in Europe, where a big discussion concerning the price of pharmaceuticals took place recently. The idea was proposed to follow the system of public calls for tenders as in force in New Zealand (the so called "Kiwi model"), where different formulas are used to set the price of a subsidized pharmaceutical product. Among the used formulas there is – when several generic alternatives to the same product are available - the system of public calls for tenders, following which the Pharmaceutical Management Agency proposes exclusive reimbursement rights for the best offer, which will often be for three years. At the end of 2004 a "soft Kiwi" model was included in the new Belgian Health Act for 2005. This Health Act makes provision for the gradual introduction of a system of calls for tenders. For a determined pathology, the least expensive pharmaceutical product will receive a greater reimbursement (+/- 25%) than its competitors. The system however only applies to non patent pharmaceuticals.

Also in Switzerland e.g. pharmacists are allowed to replace original preparations on the speciality list (list of reimbursed medicines) by generic products, unless the doctor explicitly prescribes the original speciality preparation. Similarly, in Estonia reference prices have been set up, which include that the sickness insurance fund only reimburses certain parts of the costs of pharmaceutical products up to the reference price.

In Denmark the reduction on user charges in case of pharmaceuticals is as such not always based on the actual cost price, but rather based on a subvention price, which is not necessarily the same. In principle the subvention price is the actual binding price in Denmark or in Europe. The European price is a kind of average price used for selling the pharmaceutical products in most of the EU states, which have a level of price as on the Danish market. If an European price is set up, the subvention price in Denmark for older groups of pharmaceutical products corresponds to the lowest price on the market. Pharmaceutical products are classified in groups, where products having the same pharmaceutical elements are part of the same group. A new plan has been introduced on the basis of which the subvention prices will only be based on the lowest Danish price within the certain group the pharmaceutical product belongs to.

In Slovenia e.g. important changes have been adopted in the area of drug prescription. A system of supplementary payments for more expensive drugs (the exchange of drugs with the highest acknowledged value) was established, but the introduction of this system demonstrated that insured persons were not really to make supplementary payments for

exchangeable drugs, with a dramatic fall being recorded in the use of drugs for which supplementary payments are prescribed.

4. Some concluding remarks

If user charges should be introduced and the way in which they are introduced are the result of political choices. No arguments can be given why exactly this or that method should be used.

The attitude of the public could play here an important role. According to the Polish report there is a clear position against the idea of having at all any user charges in the legislation. In some countries it is mentioned that introducing user charges would be against the solidarity principle in the health care sector. It could influence or constrain the fundamental right of a patient to health care.

Whether user charges are efficient and have an effect on equity are issues that cannot be tackled here. Although studies show that introducing user charges tend to reduce demand and utilisation of health care services, some adverse effects could be noticed, where as well appropriate and inappropriate demand was reduced. Sometimes effects upon poor people have been noticed, which raise the question of equity. Studies show that sometimes cost sharing adversely affected the health of poor, unemployed and homeless people. However judging on these issues would also imply that information would be needed on the administrative cost for implementing the system of user charges. A potential risk, as the Polish report mentions, is that after introduction of fees for treatments the number of consultations would indeed diminish and people would go less to a doctor; but on the other hand, the costs of more expensive medical support as hospital treatment would increase as certain illnesses were not earlier diagnosed and people now have to go to a specialist doctor which is more expensive. This is an important element.

Perhaps this is also the reason why it is sometimes believed that a better method for reducing health care costs should be found at the supply side, rather than at the demand side. Medical practitioners should rather be discouraged to recommend excessive treatment.

It is actually very difficult to compare user charges between countries in the health care systems. Differences between the health care systems are indeed so enormous that comparing user charges almost becomes impossible. It is clear that this element of user charges has no influence or does not say anything about the quality of benefits. It may indeed not be forgotten that perhaps in certain countries no user charges are asked for particular products or medical treatments, just because these treatments or products are excluded from the public health care system. In many systems patients would rather have to rely on the private sector and on private insurances to obtain these benefits or products, but even in these private insurance contracts sometimes user charges are applied. An additional problem relates to the fact that the concept is differently used in the various Member States and is not uniform. What exactly has to be understood under "specialist care", "auxiliary products", "pharmaceutical products", etc. should in that respect be further investigated.