

## **Health policy course in Europe**

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### **I. Introduction**

During the past decades, many governments have introduced patient cost-sharing in their public health-care system. This trend towards more cost-sharing by patients has affected the European Union (EU) member states as well the objective of patient cost-sharing is to increase the efficiency of health-care utilization by making consumers more cost-conscious. The introduction of patient cost-sharing is also a method to generate additional health-care revenues and/or to shift health-care costs to consumers while trying to contain the overall public expenditures on health. Although the achievement of these objectives is disputed, the current context of increased fiscal pressure and sustainability problems within the European public health-care systems brings patient cost-sharing on the policy agenda.

The policy objectives assigned to patient cost-sharing, are found to influence the design of patient payment mechanisms. However, as suggested by Ros et al. there are also relations between patient cost-sharing designs and the characteristics of the health-care sector [e.g. method of system funding, provider payment mechanisms and the role of general practitioners (GPs) as gate-keepers]. Comparative analyses between the patient cost-sharing mechanisms in Europe could help to outline their strengths and weaknesses, As well as to indicate strategies for improvements. Although comparative analyses on this issue have been done, they are limited only to Western and some Southern EU countries prior to the 2004 EU enlargement. In this article, We review the forms of patient cost-sharing for health-care services in all 27 EU countries. We extend the existing analyses by including the new EU member states of Central, Eastern and Southern Europe. Moreover, we present data not only on the current patient cost-sharing mechanisms in the EU but also data on their dynamics. After this introductory section, the article outlines the methodology that we apply. This is followed by the description of the results and their discussion.

### **II. Methods**

For the purpose of our analysis, we define patient cost-sharing as an official arrangement that is specifically aimed to involve Patients in the payment for public health-care services provided to them. by public health-care services, we mean services that are funded from general tax revenues, payroll taxes or social health insurance contributions, provided by public and/or private health-care providers. This includes: Co-payments (flat-rate fees), co-insurance (fees equal to a given percentage of the actual service cost) and deductibles (Payments of the actual service cost up to a given limit) for public health-care services (excluding patient payments in the private sector).

We focus on out-patient physician's and in-patient hospital services and we exclude additional patient payments for diagnostics, tests, pharmaceuticals and medical devices. Although these additional payments are common in the EU countries and equally relevant to policy, they are rather diverse and should be the focus of separate studies. Moreover, in case of pharmaceuticals and medical devices, a different theoretical framework is required because they are commodities and thus, distinctive from the health-care services analyses in this article.

Also, we consider only those patient cost-sharing arrangements in the EU countries that are formal and obligatory, and concern services included in the basic service package in a country. We exclude the optional patient cost-sharing in exchange, for example, for lower insurance premiums or luxury hospital accommodation, as well as provider determined patient payments, such as extra billing. Given the results of previous studies on the same topic, we expect that the existence and main elements of patient cost sharing may be related to the characteristics of the health-care systems. In particular, a tax-based funding of the health-care system implies stronger social values for equity than an insurance-based funding mechanism. Therefore, it is expected that patient cost-sharing (which implies inequity) is less often applied in tax-based health-care systems. Moreover, When patient cost-sharing is applied, exemptions of vulnerable groups of populations or essential services from patient cost-sharing are expected to be more common in tax-based than in insurance-based systems.

Patient cost-sharing is expected to help to reduce unnecessary use of health-care services, although the achievement of this objective is disputed in the literature. Unnecessary use of health-care services can be also filtered through supply-side arrangements (e.g. GPs acting as gate keepers to specialized care). The latter are

being recommended as more effective and equitable compared to the former. Nevertheless, Countries that are focused on increasing health-care efficiency and containing public expenditures, may apply During the past decades, many governments have introduced patient cost-sharing in their public health-care system. This trend towards more cost-sharing by patients has affected the European Union (EU) member states as well. The objective of patient cost-sharing is to increase the efficiency of health-care utilization by making consumers more cost-conscious. The introduction of patient cost-sharing is also a method to generate additional health-care revenues and/or to shift health-care costs to consumers while trying to contain the overall public expenditures on health. Although the achievement of these objectives is disputed, the current context of increased fiscal pressure and sustainability problems within the European public health-care systems brings patient cost-sharing on the policy agenda.

The policy objectives assigned to patient cost-sharing, are found to influence the design of patient payment mechanisms. However, as suggested by Ros et al. there are also relations between patient cost-sharing designs and the characteristics of the health-care sector [e.g. method of system funding, provider payment mechanisms and the role of general practitioners (GPs) as gate-keepers]. Comparative analyses between the patient cost-sharing mechanisms in Europe could help to outline their strengths and weaknesses, as well as to indicate strategies for improvements. Although comparative analyses on this issue have been done, they are limited only to Western and some Southern EU countries prior to the 2004 EU enlargement.

In this article, we review the forms of patient cost-sharing for health-care services in all 27 EU countries. We extend the existing analyses by including the new 12 EU member states of Central, Eastern and Southern Europe. Moreover, we present data not only on the current patient cost-sharing mechanisms in the EU but also data on their dynamics. After this introductory section, the article outlines the methodology that we apply. This is followed by the description of the results and their discussion.

Both supply and demand-side measures to eliminate unnecessary use of health-care services.

The cost-related information generated by the provider payment mechanism may also influence the type of patient cost-sharing. It is expected that countries where physicians are paid by capitation or are salaried employees, rely more on co-payments than countries that apply output-based provider payment mechanisms such as fee-for-service or case-based payment systems.

In case of capitation or salaries, the introduction of co-insurance or deductibles is technically difficult. Besides, we also expect that two additional system characteristics specific for most of the new EU countries, namely the existence of informal patient payments and relatively low public expenditure on health, also affect the existence and design of patient cost-sharing.

The data for our analysis were collected in a desk research. In order to assure the validity of the data, we applied the method of triangulation, i.e. cross-checking data from various groups of sources: (i) comparative databases and reports provided by international institutions [namely EU, Organization for Economic Co-operation and Development (OECD) and World Health Organization (WHO)], (ii) national laws and regulations (when available in English), and (iii) papers published in peer-reviewed journals (using Pub Med, Medline and Scholar Google).

For each country, several sources of information were obtained and compared to confirm the validity of the data.

The objective was to outline a comprehensive description of the patient cost-sharing arrangements in the EU for 2007–08, the major changes in these arrangements since 1990, and the basic characteristic of the EU health-care systems.

In order to assure comparability of data on the existence of informal patient payments in all EU countries, we used results of the cross-European survey on informal payments reported in the Health Consumer Index 2008. Data on the level of health expenditure are from the OECD Health Data. We analyzed the data qualitatively in order to search for typical combinations of patient cost-sharing arrangements and the characteristics of the health-care systems.

### **III. Patient cost-sharing mechanisms in EU**

The review indicates that in more than half of the EU countries, there is formal patient cost-sharing for GP's, out-patient specialists' and in-patient hospital services. The most common type is co-payment (in case of all three types of services), followed by co-insurance (in case of GPs' and specialists' services), and a mixture of these two types. In some EU countries, patients meet higher payment obligations when visiting a specialist than when visiting a GP. In most EU countries, patients who visit a specialist without a referral when a referral is required, meet higher payment obligations. Only 5 out of 27 countries do not apply such regulation. It is difficult to compare the actual magnitude of patient cost-sharing because in case of co-insurance and deductibles, the size of payment depends on the actual service cost, which in turn depends on the nature of health-care services provided.

However, if we look at co-payments (when this is the only type of patient cost-sharing), the size of co-payments varies considerably within the EU ranging from about 1 up to 40 Euro for the first visit to GPs and specialists per year, and up to 75 Euro for the first day of hospitalization per year.

In virtually all EU countries where patient cost-sharing is implemented, there are some cost-sharing limits that apply to all patients. Maternity and preventive services are often excluded from patient cost-sharing. In all countries, there is some form of exemptions or fee reductions for the key vulnerable population groups, i.e. children, elderly/pensioners, Low-income individuals and those with chronic or severe illnesses.

We find that the proportion of the population to whom patient cost-sharing actually applies can vary considerably, for example, from 92% in France to 60% in Italy and 50% in Portugal. In some countries (e.g. Slovenia, France, Germany), individuals can purchase private health insurance that covers their cost-sharing obligations. The collection and use of cost-sharing payments also takes various forms. In some countries, fees paid by patients are transferred to the state or the health insurance fund (e.g. Czech Republic, Estonia), while in other countries, the fees are collected and retained locally at the point of service provision (e.g. Belgium, France, Sweden). Another source of diversity in patient cost-sharing in the EU is the content of the basic service package. Thus, a service provided in one country with a certain degree of patient cost-sharing, could require full-coverage of service costs by the patients in another country if this service is not included in the basic package.

#### **IV. Results of the statistical analysis:**

The results of the partial correlations between patient cost-sharing arrangements and the characteristics of the EU characteristic that we found to be significantly correlated with the existence of patient cost-sharing, is the presence of informal patient payments. In countries with informal patient payments, patient cost-sharing is less frequent. Patient cost-sharing that is not related to service cost (i.e. co-payments), is more common in EU health-care systems with tax-based system funding and in systems with less gate-keeping by GPs. While patient cost-sharing that is related to service cost (co-insurance and deductibles), is more frequently observed in insurance-based health-care systems where the GPs' gate-keeping function is stronger. We do not find any significant correlation between the characteristics of the EU health-care systems and the presence of equity protection mechanisms.

#### **Results:**

Patient cost-sharing arrangements in the EU have been changing considerably over the past two decades (mostly being extended) and are quite diverse at present. There is a relation between patient cost-sharing arrangements and some characteristics of the health-care system in a country. In a few EU countries, a mix of formal and informal charges exists, which creates a double financial burden for health-care consumers.

Conclusions: The adequacy of patient cost-sharing arrangements in EU countries needs to be reconsidered. Most importantly, it is essential to deal with informal patient payments (where applicable) and to assure adequate exemption mechanisms to diminish the adverse equity effects of patient cost-sharing. A close communication with the public is needed to clarify the objectives and content of a patient payment policy in a country.