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# Issues in International Health Policy

## Primary Care and Prescription Drugs: Coverage, Cost-Sharing, and Financial Protection in Six European Countries

SARAH THOMSON, M.Sc., AND ELIAS MOSSIALOS, M.D., Ph.D.

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For more information about this study, please contact:

Sarah Thomson, M.Sc.  
Research Fellow  
LSE Health, London School of  
Economics and Political Science  
S.Thomson@lse.ac.uk

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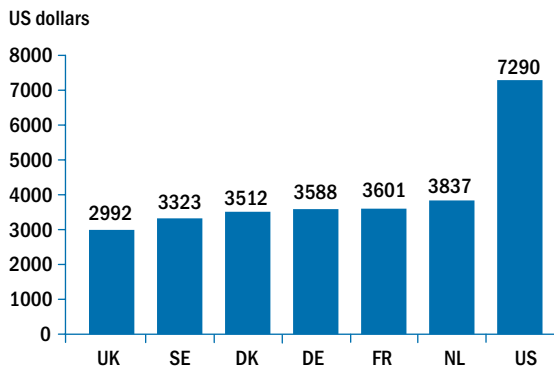
**ABSTRACT:** This issue brief describes coverage, cost-sharing, and financial protection for primary care and prescription drugs in Denmark, England, France, Germany, the Netherlands, and Sweden. Very few patients report unmet need for care or find general practitioner care unaffordable. Although none of the six countries spends more than 11 percent of gross domestic product on health care, compared with 16.2 percent in the United States, they are able to provide a level of access to and financial protection for primary care and prescription drugs that far exceeds what is available in the U.S. Several have focused recently on adapting cost-sharing design to reflect value by reducing user charges for highly effective care, preventive care, accepting referral to specialist care, adhering to clinical guidelines, and enrollment in disease management programs. These innovations, and others described in the brief, could help inform U.S. policies for national health insurance reform.



### OVERVIEW

Health insurance functions to ensure access to health care and to protect people against the high cost of illnesses and poor health. Making individuals with insurance pay something at the point of use—commonly known as cost-sharing—can undermine access and financial protection, particularly for poorer people and those with long-term chronic conditions. At the same time cost-sharing can provide incentives aligned with value. For example, a health plan or system can use cost-sharing to encourage people to select lower-cost care when choices exist between equivalent options and discourage inappropriate or less-effective treatment choices.

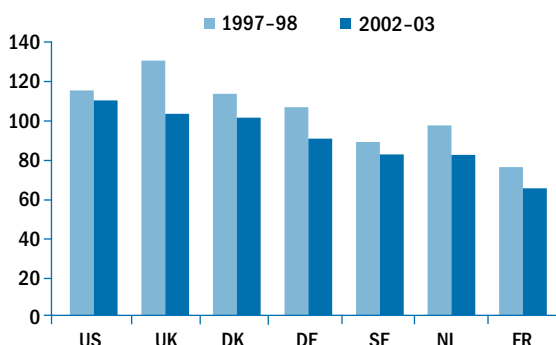
This issue brief reviews coverage and cost-sharing for primary care and prescription drugs in six European countries (Denmark, England, France, Germany, the Netherlands and Sweden) to identify insights for policy reforms and insurance design

**Exhibit 1. Total Spending on Health per Capita (in US\$ PPP), 2007**

Notes: PPP = Purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the prices of goods and services in the countries concerned. DE = Germany; DK = Denmark; FR = France; NL = The Netherlands; SE = Sweden; UK = United Kingdom; US = United States.  
Source: Organization for Economic Cooperation and Development, *Health Data 2009* (Paris: OECD, 2009).

in the United States.<sup>1</sup> The six countries were selected for review because although they spend significantly less per person on health care than the U.S. (Exhibit 1), their health system outcomes are generally similar to or often better than those in the U.S., and in recent years they have improved faster on key indicators. For example, the rate of deaths from causes that can be prevented by timely and appropriate health care has fallen markedly over time in the United Kingdom, Germany, the Netherlands, and France, but has decreased by a much smaller amount in the United States (Exhibit 2).

The European countries also were selected to demonstrate a range of approaches to insurance design, primary care organization, and cost-sharing. Denmark,

**Exhibit 2. Deaths from Causes That Can Be Prevented by Timely and Appropriate Health Care (per 100,000 people), 1997–98 and 2002–03**

Note: DE = Germany; DK = Denmark; FR = France; NL = The Netherlands; SE = Sweden; UK = United Kingdom; US = United States.  
Source: E. Nolte and M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs*, Jan./Feb. 2008 27(1):58–71.

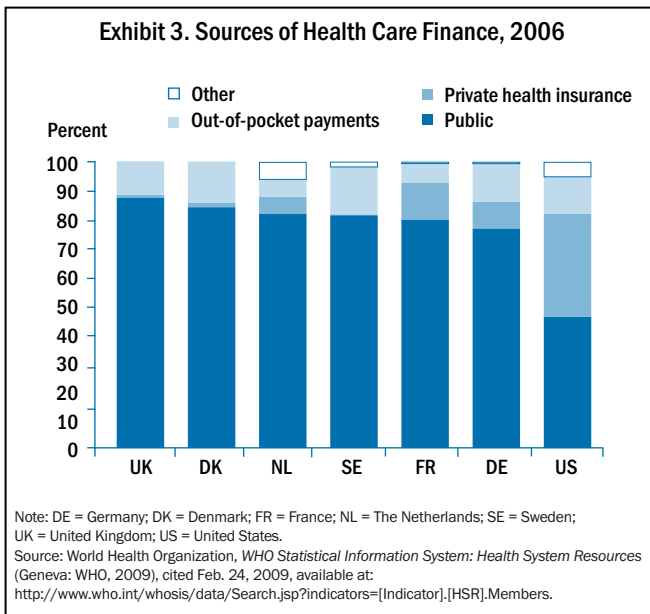
England, and the Netherlands have a long tradition of patient registration with local general practitioners (GPs) in return for free access to primary care. In contrast, France, Germany, and Sweden require patients to pay a fee to see the doctor and allow them to visit specialists without a GP's referral. In all three of these countries, cost-sharing policy is designed to encourage patients to visit a GP before seeing a specialist. The charge for specialist care is lower if patients obtain a referral from their primary care provider. The European approaches offer a valuable comparison to the U.S. system, where cost-sharing is widely applied, mainly to control health care costs, but typically with little regard to the value of services.<sup>2</sup>

## HEALTH CARE COVERAGE

The European countries illustrate different models of health care financing and organization, but public finance dominates in every country (Exhibit 3). In France, Germany, and the Netherlands, the taxes used to finance health care (often referred to as social insurance contributions) are mainly levied on employment. The health system is organized around membership in health insurance funds, using a single-payer system in France and competing payers in Germany and the Netherlands. In Denmark, England, and Sweden, taxes to finance the health system tap a broader revenue base, including non-wage sources of income. The health system is organized around local entities (single payers) responsible for a geographically defined population.

In spite of these broad differences, all the countries aim to ensure universal coverage and access to a uniform package of benefits within a regulatory framework established by the national government (Exhibit 4). In each country, there is a long tradition of commitment to principles such as solidarity and access to health care on the basis of need, rather than ability to pay. Adherence to these principles has recently been strengthened in France and Germany with a move away from employment-based access to health care, toward universal coverage based on residence.

In most of the countries, residents are automatically covered by the statutory system. Germany and the Netherlands are exceptions; residents are required



to enroll with a health insurance fund to obtain coverage, but few people (less than 3% of the population) go without coverage.<sup>3</sup> In each of these countries, primary care and prescription drugs are an essential part of the national benefit package, which covers a wide range of preventive, diagnostic, and curative services.<sup>4</sup>

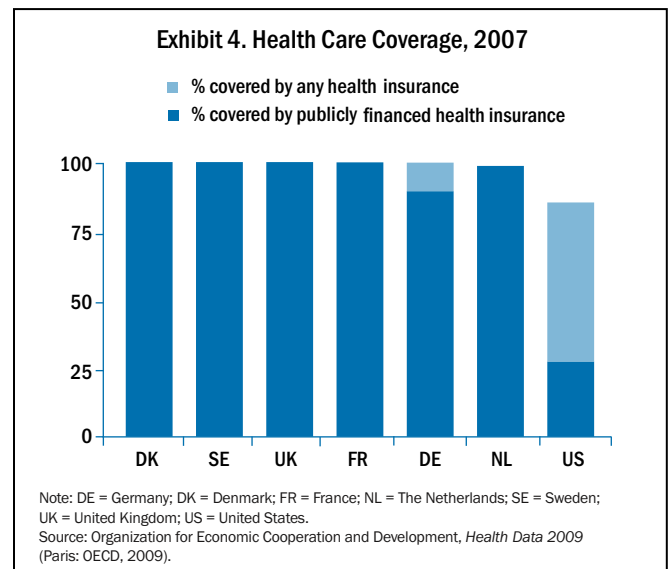
Among these six countries, Germany and France are the only ones in which both public and private insurance play a significant role, with private insurance operating either as a substitute (Germany) or complement (France) to the public insurance system.<sup>5</sup> Germany is unique among European countries in having a complex dual system of coverage, which allows people earning above a certain amount (around \$69,000 per year for three consecutive years) to choose between public and private insurance. Among higher earners, private insurance is generally cheaper than public insurance for younger people in good health with no dependents. The covered population falls into three categories: compulsorily covered by public insurance because of income (74%), voluntarily covered by public insurance (around 14%), and covered by private insurance (around 10%).<sup>6</sup>

Those who opt for private insurance in Germany can only return to the public scheme if their earnings fall below the threshold and they are under 55 years old. If they are 55 or older, they are locked into private coverage.<sup>7,8</sup> For this reason, people age 55 and older with private insurance have guaranteed access (open enrollment) to a basic policy.<sup>9</sup> In contrast to other private policies, the

basic policy provides lifetime coverage, with a benefits package similar to the public benefits package, for a premium that cannot exceed the maximum contribution for public insurance and must not reflect health risk (beyond adjustment for age and gender).

In France, private voluntary insurance complements public insurance, similar to Medigap policies that Medicare beneficiaries purchase in the U.S. It reimburses patients for cost-sharing in publicly financed health care and covers about 92 percent of the population. Voluntary insurance is mainly obtained through employers, but since 2000 the government has provided low-income households, around 7 percent of the population, with free private insurance through the Couverture Maladie Universelle-Complémentaire (CMU-C) scheme.<sup>10</sup> The income threshold for CMU-C ranges from \$9,887 for a single-occupant household to \$24,718 for a household with five people.

Private voluntary insurance in Denmark provides about 30 percent of the population with access to services not covered by the national benefit package, such as dental care and physiotherapy, as well as Medigap-style coverage for prescription drug cost-sharing.<sup>11</sup> In the Netherlands, about 92 percent of the population has private voluntary insurance covering dental care and physiotherapy. In England and Sweden, private voluntary insurance covers a much smaller proportion of the population (10% and 3%, respectively) and mainly facilitates faster access to elective surgery and specialist consultations.<sup>12</sup>



## PRIMARY CARE COVERAGE, BENEFITS, AND COST-SHARING

In England, Denmark, and the Netherlands, primary care is generally provided by GPs, who often work with nurses. In France, Germany, and Sweden, primary care is provided by a mixture of GPs and outpatient specialists, such as pediatricians, general internal medicine physicians, and gynecologists. Patients in Sweden also have access to nurse-led clinics. In all six countries, patients may choose their primary care provider, although in Denmark, England, the Netherlands, choice is restricted to area of residence. In France, Germany and Sweden, patients also can choose among office-based specialists and do not need referrals from their GPs. England and the Netherlands require patients to register with GPs who are responsible for referrals to specialists, while France and Germany offer patients reduced cost-sharing if they register with a regular doctor (most patients do) and obtain referrals to specialist care. The registering doctor usually holds the patient's medical records and takes responsibility for coordinating the patient's care and referrals to specialist care. This differential cost-sharing was introduced recently (in 2005 in France and in 2007 in Germany) as part of a policy reform to strengthen primary care and coordination.

The range of services to which patients have direct access (without referral) varies across countries, but patients in the six countries generally have coverage for a similar and broad basket of preventive, diagnostic, and curative care in nonhospital settings.<sup>13</sup> In all the countries, benefit design emphasizes access to primary and preventive care, with a variety of cost-sharing arrangements (Table 1). Steps to minimize financial barriers to obtaining primary care include:

- making primary care free for everyone, with no copayments or other cost-sharing (Denmark, England, the Netherlands);
- making all outpatient care free for children (including specialist visits), with no copayments or other cost-sharing (all countries except France);
- keeping cost-sharing for primary care low: a visit to a GP or specialist (without extra billing)<sup>14</sup> costs

the patient about \$9 in France, about \$13 in Germany, and between \$12 and \$36 in Sweden;

- exemptions from cost-sharing for people with chronic conditions (France);
- exemptions from cost-sharing for people who enroll in disease management programs (some health insurance funds in Germany);
- exemptions from cost-sharing for people with low incomes (France);
- annual caps on out-of-pocket spending (Germany, the Netherlands, Sweden);
- providing Medigap-style private insurance to people with low incomes (France);
- charging patients lower fees to see a GP than a specialist (Sweden); and
- charging patients lower fees for outpatient doctor visits if they register with a regular doctor and obtain referrals to specialists (Denmark, France,<sup>15</sup> Germany).

As a result of these measures, the most anyone pays out-of-pocket in a year for publicly financed primary care—including visits to office-based specialists but excluding prescription drugs—ranges from nothing in Denmark and England to \$56 in Germany (if patients accept referral requirements for seeing specialists), \$109 in Sweden, and \$199 in the Netherlands. There is no cap on out-of-pocket spending for the general population in France, but people with chronic conditions and those from poorer households do not have to pay more than about \$66 per year for health care, including prescription drugs.<sup>16</sup> Germany caps total out-of-pocket spending as a share of income, with a lower threshold for chronically ill people. Thus, financial protection for the general population is very high in five of the six countries; in the sixth country, France, there is a high level of financial protection for chronically ill people and those from poorer households.

Levels of financial protection are much lower for privately insured people in Germany and may be undermined by extra billing in France and Germany. The

privately insured in Germany are frequently subject to cost-sharing in the form of coinsurance or deductibles. In 2009, the government capped the level of deductibles for private insurance at \$6,640 per year after research showed that deductibles had increased steadily between 2001 and 2005 and older people were more likely to have higher deductibles than younger people.<sup>17,18</sup> Also, doctors in Germany can extra bill privately insured patients and are allowed to charge them more than twice as much as they charge publicly insured patients.<sup>19</sup> Some doctors in France (around 30% of specialists and 10% of GPs) are allowed to bill all patients, except those covered by CMU-C, up to 20 percent more.<sup>20</sup>

## **PRESCRIPTION DRUG COVERAGE AND COST-SHARING**

The publicly financed benefits package covers prescription drugs in each of the six countries. Drugs provided in the hospital are free for all patients. Patients usually have to pay a share of the cost of drugs provided outside the hospital, but the level of cost-sharing is generally low (Table 2). The Netherlands recently abolished cost-sharing for prescription drugs priced below the reference price.

All the countries use clinical effectiveness criteria to decide which prescription drugs should be reimbursed under statutory insurance. This seeks to ensure that the public system does not pay for clinically ineffective drugs.<sup>21</sup> Four of the countries use reference pricing schemes to give patients financial incentives to select less-expensive medications when more than one choice exists.<sup>22</sup> France goes further, adapting cost-sharing levels to match the clinical effectiveness of different categories of drugs.

The five countries that charge patients for part of the costs of outpatient prescription drugs have taken steps to exempt specific groups of people from cost-sharing, including:

- exemption for children under 18 years (Denmark, England, Germany);
- exemption for people with chronic conditions (England,<sup>23</sup> France,<sup>24</sup> some health funds in Germany);

- exemption for people with low income (England, France);
- exemption for people age 60 and older (England);
- annual caps on out-of-pocket spending (England, Germany, Sweden) and on out-of-pocket spending by chronically ill people (Denmark);
- Medigap-style private insurance (Denmark, France); and
- cost-sharing based on clinical effectiveness (France) and clinical effectiveness and price (reference pricing in France, Denmark, Germany, and the Netherlands).

As a result, almost 90 percent of outpatient prescriptions in England are exempt from cost-sharing and there is an annual cap of \$147 on out-of-pocket spending on drugs. In France, people with chronic conditions pay only \$0.65 per prescription or nothing, if they are poor or under age 18. Annual out-of-pocket caps for drugs are higher in Sweden (\$500) and Germany (1% or 2% of household income, but the cap applies to all health care spending and around 40% of drugs are free of charge) and only apply to chronically ill people in Denmark (\$678).

The Netherlands and England, therefore, provide the greatest protection against the cost of outpatient prescription drugs for the general population. France also provides a high level of financial protection for people with chronic conditions and, in Germany, many prescription drugs are free of charge. Sweden is the only country not to exempt any group from cost-sharing.

## **ACCESS TO PRIMARY CARE SERVICES AND PRESCRIPTION DRUGS**

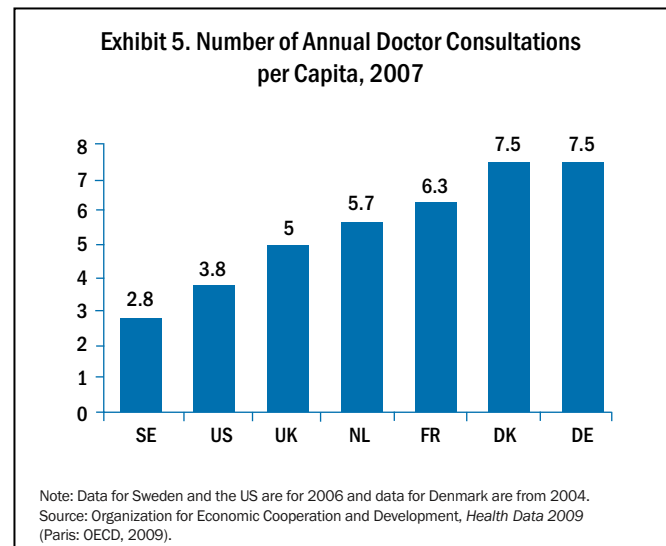
Survey data show that very few people experience financial barriers to obtaining GP care. In 2007, fewer than 5 percent of respondents in Denmark, England, and Sweden and fewer than 10 percent in France, Germany, and the Netherlands found GP care to be “not very affordable.”<sup>25</sup> No Danish or U.K. respondents found GP care to be “not at all affordable;” only 1 percent of respondents in the other four countries responded similarly.

In each country, people are more likely to have affordability problems when visiting specialists.<sup>26</sup> The percentage of respondents finding specialist visits not very affordable is quite low in Denmark and Sweden (5%) and the U.K. (10%), but much higher in the Netherlands (16%), Germany (23%), and France (39%).<sup>27</sup> Fewer than 3 percent of respondents in Denmark, Sweden and the U.K., 5 percent in Germany and the Netherlands, and 9 percent in France said specialist visits are not at all affordable.

Other survey data show that well under 5 percent of the population report having any unmet need for health care, even among relatively poor households.<sup>28</sup> The exception is Germany, where about 12 percent of the lowest-income quintile reported unmet need for health care, compared with about 4 percent for the highest-income quintile.

The affordability problems faced by some patients in France and Germany likely reflect three factors: extra billing by doctors in both countries; high deductibles for private insurance in Germany, especially among older people who are not permitted to return to the public scheme once they have opted for private coverage; and inadequate financial protection for the general population in France (that is, those without chronic conditions and nonpoor households). Although 92 percent of the French population is covered by Medigap-style private insurance, the quality of private coverage varies by socioeconomic status. For example, in 2000, over 60 percent of people earning at least \$1,620 per month had an average or high level of coverage (i.e., covering most regular cost-sharing and possibly some extra billing) compared with only 20 percent of those earning less than \$810 a month.<sup>29</sup> In addition, increases in cost-sharing have not been matched by a concomitant rise in private insurance reimbursement levels, which means that the degree of financial protection provided by private insurance has fallen over time.<sup>30</sup> Thus, the French strategy of shifting health care costs to patients and providing subsidized private insurance for poorer households has not succeeded in removing financial barriers to access, particularly for specialist care.

Survey data also demonstrate clear differences in the availability of specialists and GPs.<sup>31</sup> In each of the six countries, patients are much more likely to report access difficulties with regard to specialists than with GPs. This may be due to longer waiting times to see specialists and because specialists tend to be concentrated in urban centers and not evenly distributed across the country. A higher proportion of patients reports problems with the availability of GPs in Sweden than in the other countries, perhaps because of shortages in GP supply. This shortage may be reflected in the low number of doctor visits per year in Sweden, compared with the other European countries and the U.S. (Exhibit 5).<sup>32</sup>



Differences in the affordability and availability of GP care, compared with specialist care, have equity implications. More poor people than rich people use GPs in Denmark, the Netherlands, and the United Kingdom—all countries in which GP care is free at the point of use. GPs are equally accessible for both rich and poor in France and Germany.<sup>33</sup> However, in every country except the U.K., higher-income groups use specialists at higher rates, which may reflect both higher cost-sharing for specialist visits and an uneven distribution of specialists.<sup>34,35</sup> Nevertheless, research also shows that income inequality in terms of access to doctors is less pronounced in the European countries than in the U.S.<sup>36</sup>

Recent analyses of need-adjusted use of medications among people age 50 and older found little or no

evidence of socioeconomic differences in Europe.<sup>37</sup> This reflects widespread efforts to remove financial barriers for poorer households and people with chronic conditions through exemptions and caps on out-of-pocket spending. Comparative survey data found access issues to be much less prevalent in the European countries than in the U.S.<sup>38</sup>

## **CONCLUSIONS AND POLICY IMPLICATIONS FOR THE UNITED STATES**

In the European countries reviewed in this paper, cost-sharing is much less likely to be applied across the board than it is in the United States. Three of six countries do not charge for GP visits (Denmark, England, and the Netherlands) and two do not charge for outpatient specialist visits (Denmark and England). None of the countries charges for drugs provided in hospitals and the Netherlands does not charge for outpatient prescription drugs below the reference price. All the countries exempt certain groups from cost-sharing. This most often includes children (Denmark, England, Germany, and the Netherlands), people with chronic conditions (Denmark, England, France), and low-income households (England and France). In addition, most countries place caps on out-of-pocket spending on health care.

As a result of widespread exemptions and caps on patient spending, levels of financial protection for publicly financed primary care, including visits to office-based specialists, are very high for the general population in every country except France, which does provide a high level of financial protection for patients with chronic conditions. Levels of financial protection for prescription drugs are very high in the Netherlands and England, high in France for patients with chronic conditions, and high in Germany for the general population. Denmark, France and Sweden do not provide such a high level of financial protection for the general population, although cost-sharing for drugs is capped at \$500 per year in Sweden. In Denmark, cost-sharing is capped at \$678 per year for people with chronic conditions.

Very few people report unmet need for care in any of the six countries or face financial barriers when visiting GPs. Nevertheless, a significant proportion face

financial barriers accessing specialist care in France and Germany, probably because of extra billing by doctors in both countries, high levels of cost-sharing among the privately insured in Germany, and inadequate financial protection for the general population in France. Even though Medigap-style private insurance is near-universal in France and subsidized by the government for poorer households, it does not provide full protection from cost-sharing because reimbursement levels have not matched increases in cost-sharing over time. In addition, poorer people are likely to have lower-quality private coverage.

These findings lead to several conclusions and observations worth highlighting. First, the higher number of doctor visits per person in the European countries compared with the U.S. may reflect relatively low levels of cost-sharing for doctor visits (and prescription drugs) in Europe, where there is growing emphasis on access, continuity, and primary and preventive care.

Second, the European countries generally follow the principle of providing the most financial protection to those with the greatest health needs. While the purpose for doing so is to provide equity among the population, it may also have secondary effects in terms of efficiency—those with the greatest capacity to benefit do not face financial barriers to access.

Third, several countries explicitly consider value when designing their cost-sharing policies. Value-based cost-sharing draws on evidence that shows that cost-sharing requirements can discourage patients from using high-value health care.<sup>39</sup> The European countries use value-based design to steer patients toward more-efficient patterns of health care use. This may include encouraging referrals to specialist care, enrollment in disease management programs, or generic substitution for prescription drugs. This approach is more frequently applied in countries where alternative policy levers to enhance efficiency—such as GP gatekeeping or compulsory generic prescribing—are politically less feasible.

Fourth, the affordability problems experienced by patients in France and Germany have less to do with cost-sharing policy for publicly financed care (particularly in Germany) and more to do with provider pay-

ment rules and the presence of private insurance that substitutes for or complements public insurance.

Policymakers in the U.S. could draw insights from these observations, including:

- Cost-sharing design in the European countries reflects a concern for equity of access to health care, which is likely to have positive efficiency effects. It increasingly reflects an explicit concern for enhancing value in the health system.
- The European countries generally provide the most financial protection to those with the greatest health needs—people with chronic conditions, poorer households, and children—rather than allowing those individuals to experience the highest costs. This is achieved in a variety of ways, including exemptions and caps on out-of-pocket spending.
- Various countries provide real-world examples and experience in terms of redesigning cost-sharing policy to prevent financial barriers to high-value health care and to align incentives across the health system, so that rules governing provider payment do not undermine cost-sharing policy.
- The variations among the countries also point to the importance of paying attention to financial protection for those with private insurance, as well as public insurance. The findings suggest that countries should avoid relying on Medigap-style private insurance to protect poorer households from cost-sharing because differences in access to and quality of private insurance can exacerbate inequalities in access to health care.



## NOTES

- 1 Nonfinancial barriers to access are beyond the scope of the brief and will not be considered further in any detail.
- 2 M. E. Chernew, M. R. Shah, S. N. Rosenberg et al., “Impact of Decreasing Copayments on Medication Adherence within a Disease Management Program,” *Health Affairs*, Jan./Feb. 2008 27(1):103–12.
- 3 K. Vrangbaek, I. Durand-Zaleski, R. Busse et al., *Health Care System Profiles* (New York: The Commonwealth Fund, Mar. 1, 2008). Available at [http://www.commonwealthfund.org/topics/topics\\_show.htm?doc\\_id=674975](http://www.commonwealthfund.org/topics/topics_show.htm?doc_id=674975).
- 4 Germany and the Netherlands have set up separate mechanisms to provide public coverage for long-term care.
- 5 S. Thomson and E. Mossialos, *Private Health Insurance in the European Union* (Brussels: DG Employment, Social Affairs and Equal Opportunities, 2009).
- 6 Vrangbaek, Durand-Zaleski, Busse et al., *Health Care System Profiles*, 2008.
- 7 Thomson and Mossialos, *Private Health Insurance*, 2009.
- 8 S. Thomson and E. Mossialos, “Choice of Public or Private Health Insurance: Learning from the Experience of Germany and the Netherlands,” *Journal of European Social Policy*, Nov. 2006 16(4):315–27.
- 9 Thomson and Mossialos, *Private Health Insurance*, 2009.
- 10 S. Sandier, V. Paris, and D. Polton, *Health Care Systems in Transition: France* (Copenhagen: European Observatory on Health Systems and Policies, 2004).
- 11 Thomson and Mossialos, *Private Health Insurance*, 2009.
- 12 Ibid.
- 13 M. W. Kroneman, H. Maarse, and J. van der Zee, “Direct Access in Primary Care and Patient Satisfaction: A European Study,” *Health Policy*, Mar. 2006 76(1):72–79.
- 14 Extra billing refers to allowing doctors to charge patients a higher fee than the government-negotiated fee for specific services.
- 15 In France, the financial penalty is not applied to patients with chronic conditions.
- 16 This figure is for cost-sharing only and does not include household spending on premiums for private voluntary insurance covering cost-sharing.
- 17 Thomson and Mossialos, *Private Health Insurance*, 2009.
- 18 M. M. Grabka, “Prämien in der PKV: deutlich stärkerer Anstieg als in der gesetzlichen Krankenversicherung,” *German Institute for Economic Research*, 2006 73(46):653–59.
- 19 R. Busse and A. Riesberg, *Health Care Systems in Transition: Germany* (Copenhagen: European Observatory on Health Systems and Policies, 2004); and F. Niehaus and C. Weber, *Der überproportionale Finanzierungsbeitrag privat versicherter Patienten zum Gesundheitswesen* (Cologne: Wissenschaftliches Institut der PKV, 2005).
- 20 Sandier, Paris, and Polton, *Health Care Systems in Transition*, 2004.
- 21 C. Sorenson, M. Drummond, and P. Kanavos, *Ensuring Value for Money in Health Care: The Role of Health Technology Assessment in the European Union* (Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2008).
- 22 In a reference pricing scheme, the reference price refers to the maximum price for a group of equal or similar drugs that the insurer will reimburse the user. If the user chooses a drug that costs more than the reference price, he or she must pay the difference between the cost and the reference price.
- 23 For selected chronic conditions.
- 24 In 2008, France introduced nonreimbursable copayments for health care for all patients up to an annual cap of \$66 per year.
- 25 Eurobarometer, *Health and Long-Term Care in Europe: Report Summary* (Brussels: European Commission, 2008).
- 26 This seems to be the case even in the two countries (Denmark and England) that do not impose charges for specialist visits. Here, affordability problems may reflect patients paying out-of-pocket to see specialists privately, possibly to avoid waiting to see specialists on a publicly financed basis.
- 27 Eurobarometer, *Health and Long-Term Care*, 2008.

- <sup>28</sup> Households with less than 20% of median income. See M. Hubert et al., *Quality in and Equality of Access to Healthcare Services* (Brussels: European Commission Directorate-General for Employment, Social Affairs and Equal Opportunities, 2008).
- <sup>29</sup> A. Bocognano, *Which Coverage for Whom? Equity of Access to Health Insurance in France* (Paris: CREDES, 2000).
- <sup>30</sup> Thomson and Mossialos, *Private Health Insurance*, 2009.
- <sup>31</sup> Eurobarometer, *Health and Long-Term Care*, 2008.
- <sup>32</sup> A. H. Glenngård, F. Hjalte, M. Svensson et al., *Health Systems in Transition: Sweden* (Brussels: World Health Organization Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005).
- <sup>33</sup> E. van Doorslaer, C. Masseria, and X. Koolman, for the OECD Health Equity Research Group, “Inequalities in Access to Medical Care by Income in Developed Countries,” *Canadian Medical Association Journal*, Jan. 17, 2006 174(2):177–83.
- <sup>34</sup> Even in Denmark, where around 2% of the population choose to have direct access to specialists in return for cost-sharing.
- <sup>35</sup> The research shows that rich people use doctors more often than do poor people in Sweden, probably because the Swedish data do not distinguish between GP and specialist visits.
- <sup>36</sup> van Doorslaer, Masseria, and Koolman, “Inequalities in Access to Medical Care,” 2006.
- <sup>37</sup> Based on survey data in 11 countries (not including England). See D. Lambrelli and O. O’Donnell, *Why Does the Utilisation of Pharmaceuticals Vary So Much Across Europe? Evidence from Micro Data on Older Europeans*, HEDG Working Paper 09/06 (York: University of York, 2009).
- <sup>38</sup> The percentage of respondents reporting access problems because of cost ranged from 7% in the Netherlands to 13% in the United Kingdom, 23% in France, 26% in Germany and 54% in the United States. See C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, “[In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008](#),” *Health Affairs Web Exclusive*, Nov. 13, 2008, w1–w16.
- <sup>39</sup> M. Chernew and J. Newhouse, *What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?* *American Journal of Managed Care*, July 2008 14(7):412–14; and J.P. Newhouse and The Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

**Table 1. Cost-sharing Arrangements and Protection Mechanisms for Outpatient and Inpatient Care in Selected Countries, 2008**

Country	GP visit	Outpatient specialist visit	Inpatient care	Exemptions	Annual cap on out-of-pocket spending	Medigap-style coverage
Denmark	None.	None.	None.	N/A	N/A	N/A
England	None.	None.	None.	N/A	N/A	N/A
France	<p><i>Coinsurance:</i> 30% with gate keeping or 50%.</p> <p><i>Nonreimbursable copayment:</i> 1 (\$1.3) per visit.</p>	<p><i>Coinsurance:</i> 30% with gate keeping or 50%.</p> <p><i>Nonreimbursable copayment:</i> 1 (\$1.3) per visit.</p>	<p><i>Coinsurance:</i> 20%.</p> <p><i>Nonreimbursable copayment:</i> 16 (\$21) per day, up to 31 days per year.</p>	<p><i>Coinsurance:</i> People receiving invalidity benefits (i.e., if they are unable to work) and work injury benefits; people with one of 30 chronic or serious conditions (for that condition only); low-income people; some surgical interventions.</p> <p><i>Nonreimbursable copayment:</i> Children under 18 and low-income people.</p>	<p><i>Nonreimbursable copayment:</i> 50 (\$66) for all health care, including prescription drugs.</p>	<p>Covers about 92% of the population.</p> <p>People with low income are entitled to free coverage (CMU-C) and free eye and dental care and cannot be extra billed by doctors.</p>
Germany	<p><i>Copayment:</i> 10 (\$13) for the first visit per quarter and subsequent visits without referral.</p>	<p><i>Copayment:</i> 10 (\$13) for the first visit per quarter and subsequent visits without referral.</p>	<p><i>Copayment:</i> 10 (\$13) per inpatient day up, to 28 days per year.</p>	<p>Children under 18 (all cost-sharing) and people who choose gatekeeping.</p> <p>Some health insurance funds provide exemptions for patients who enroll in disease management programs.</p>	<p>2% of household income (1% for people with chronic conditions). Household income is calculated as lower for dependants.</p>	No.
Netherlands	None.	<i>Deductible:</i> 165 (\$219) to 665 (\$883) per year.		Children under 18, GP services, mother and child care, preventive care, dental care for people under 22.	None.	No.
Sweden	<p><i>Copayment:</i> SEK100 to 150 (\$12 to \$18) per GP visit.</p>	<p><i>Copayment:</i> SEK200 to 300 (\$24 to \$36) per specialist or emergency department visit.</p>	<p><i>Copayment:</i> Up to SEK80 (\$10) per day in hospital.</p>	Children under 20 in most countries.	<p>Adults: SEK900 (\$109) for health services.</p>	No.

Note: Currency converted using 1 April 2009 exchange rates from [www.oanda.com](http://www.oanda.com). All dollars (\$) refer to US dollars.

Sources: K. Vrangbaek et al., *Health care system profiles*. 2008 [cited 2008 10 October]; Available from: [http://www.commonwealthfund.org/topics/topics\\_show.htm?doc\\_id=674975](http://www.commonwealthfund.org/topics/topics_show.htm?doc_id=674975); and MISSOC. *Comparative tables on social protection: situation on 1 July 2008*. 2008 [cited 2009 22 April]; Available from: [http://ec.europa.eu/employment\\_social/missoc/db/public/comparativeTables.do?lang=en](http://ec.europa.eu/employment_social/missoc/db/public/comparativeTables.do?lang=en).

Table 2. Cost-sharing and Protection Mechanisms for Outpatient Prescription Drugs, 2008

Country	Outpatient prescription drugs	Exemptions	Annual caps on out-of-pocket spending	Medigap-style cover
Denmark	<i>Deductible:</i> DKK520 (\$93) per 12-month period. <i>Coinsurance:</i> varies depending on 12-month drug costs above the deductible; DKK520 to 1,260 (\$225); 50%; DKK1,260 to 2,950 (\$526); 25%; > DKK2,950 (\$526): 15%.	Children under 18. Terminally ill people and those with very low incomes can apply for financial assistance. The reimbursement rate may be increased for some very expensive drugs. Reference pricing.	<i>Chronically ill people:</i> DKK 3,805 (\$678).	Covers about 30% of the population.
England	<i>Copayment:</i> £7.10 (\$10) per prescription.	Children under 16, people ages 16 to 18 in full-time education, people ages 60 or over, people with low incomes, pregnant women and women who have given birth in the past 12 months, war pensioners, people with certain medical conditions and disabilities, prescribed contraceptives, drugs administered by a GP or at a walk-in centre, drugs for treatment of sexually transmissible infections.	<i>Annual prepayment certificate:</i> £102.50 (\$147).	No.
France	<i>Coinsurance:</i> nothing for highly effective drugs; 35%, 65% and 100% for drugs of limited therapeutic value. <i>Nonreimbursable copayment:</i> 0.50 (\$0.6) per prescription.	<i>Coinsurance:</i> People receiving invalidity and work injury benefits, people with one of 30 chronic or serious conditions (for that condition only), low-income people. <i>Nonreimbursable copayment:</i> Children under 18 and low-income people. Reference pricing for generic drugs.	<i>Nonreimbursable copayment:</i> €50 (\$66) per person, per year for all health care, not just prescription drugs.	Covers about 92% of the population. People with low income are entitled to free coverage (CMU-C).
Germany	<i>Coinsurance with minimum and maximum copayment:</i> 10% of the cost of drugs priced between 50 (\$66) and 100 (\$130), with a minimum of 5 (\$6.5) and a maximum of 10 (\$13) per prescription, plus costs above a reference price (about 7% of drugs).	Children under 18. No charge for drugs that are at least 30% below the reference price (around 40% of drugs).	<i>For all cost-sharing:</i> 2% of household income (1% for chronically-ill people). Household income is calculated as lower for dependents.	No.
Netherlands	None for medications below the reference price.	Reference pricing.	N/A	N/A
Sweden	<i>Deductible:</i> SEK900 (\$105) in a 12-month period. <i>Coinsurance:</i> varies depending on 12-month drug costs above the deductible; SEK900 to 1,700 (\$198); 50%; SEK1,700 to 3,300 (\$384); 25%; SEK3,300 to 4,300 (\$500); 10%; > SEK4,300 (\$500): none.	None.	<i>12-month cap:</i> SEK4,300 (\$500).	No.

Sources: K. Vrangbaek et al., *Health care system profiles*. 2008 [cited 2008 10 October]; Available from: [http://www.commonwealthfund.org/topics/topics\\_show.htm?doc\\_id=674975](http://www.commonwealthfund.org/topics/topics_show.htm?doc_id=674975); and MISSOC. *Comparative tables on social protection: situation on 1 July 2008*. 2008 [cited 2009 22 April]; Available from: [http://ec.europa.eu/employment\\_social/missoc/db/public/compareTables.do?lang=en](http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do?lang=en); and Vogler, S. *PPRI Report, Commissioned by European Commission, Directorate-General Health and Consumer Protection and Austrian Federal Ministry of Health, Family and Youth*. 2008 [cited 2008 10 October 2008]; Available from: <http://ppri.oebig.at/index.aspx?Navigation=1210>.

#### ABOUT THE AUTHORS

**Sarah Thomson, M.Sc.**, is a research fellow and deputy director of LSE Health at the London School of Economics and Political Science, a senior research fellow at the European Observatory on Health Systems and Policies, and an associate editor of *Health Economics, Policy and Law*. Her research focuses on health systems and health care reform, with particular emphasis on health financing in high- and middle-income countries. From 2005 to 2008, she was part of a team advising the U.K. Department of Health on health care reform in 13 countries. Ms. Thomson has a master's degree in health policy, planning, and financing from the London School of Economics and Political Science and the London School of Hygiene and Tropical Medicine.

**Elias Mossialos, M.D., Ph.D.**, is Brian Abel-Smith Professor of Health Policy at the London School of Economics and Political Science, codirector of the European Observatory on Health Systems and Policies, and director of LSE Health. His research focuses on comparative health systems and policy, addressing questions related to funding health care, pharmaceutical policies, access to medicines in developing countries, private health insurance, and the impact of European Union law on health care systems. Dr. Mossialos is coeditor-in-chief of *Health Economics, Policy and Law*; editor-in-chief of the *Health Systems in Transition* reports published by World Health Organization; editor of the Cambridge University Press *Health Economics, Policy, and Management* book series; and chair of the editorial board of *Globalization and Health*. His Ph.D. in health policy is from the University of Athens.

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