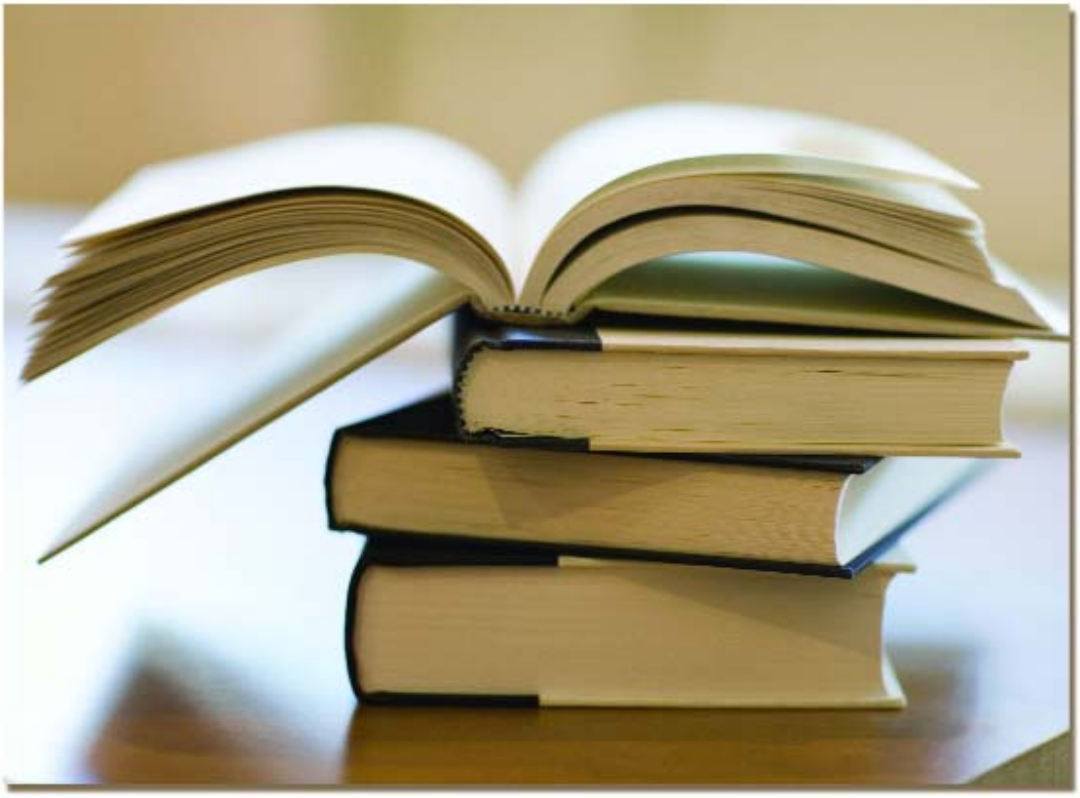
Out-of-pocket payments

In healthcare systems in the European Union



hope

European Hospital and Healthcare Federation

Out-of-pocket payments

In healthcare systems in the European Union

Contents

PREAMBLE

HOPE, the European Hospital and Healthcare Federation, is a European non-profit organisation, created in 1966, representing national public and private hospital associations and hospital owners. With 37 organisations from the 28 Member States of the European Union, Switzerland and the Republic of Serbia, HOPE covers almost the 80% of the hospital activity.

HOPE mission is to promote improvements in the health of citizens and a uniformly high standard of hospital care throughout the European Union, and fostering efficiency, effectiveness and humanity in the organisation and operations of hospital and health services.

HOPE is representing its members in the European arena, covering all policies with an impact on hospitals and health services. HOPE contributes to the legislative agenda but also to the non-legislative activities, in particular through participation in European projects.

Since its creation, HOPE has produced comparative information on the ways healthcare systems are organised and financed, which among others is achieved by workshops and conferences, and in particular by a unique annual Exchange Programme for health professionals.

CONTEXT

Hospitals are by essence a field where solidarity is of utmost importance, insuring the most costly risks. In the context of the crisis, one of the main worries is that choices would be made to reduce the coverage of such risks. HOPE already published on the influence of the crisis on healthcare systems, aiming at investigating the impact of these policies mainly in the hospital sector, but decided to focus its attention on the share collectively covered or not .

From 2000 to 2012, the total health expenditure per capita increased by 83%, from 1.831 PPP$ to 3.346 PPP$ on average in the countries of EU 28. The same variation affected the public health expenditure per capita, which rose from 1.400 PPP$ in 2000 to 2.567 PPP$. In the same period, the public sector expenditure on health as percentage of the total health expenditure slightly increased (0.13 p.p.) while the private sector one decreased (- 0.35 p.p.).

Out-of-pocket payments on health as percentage of the total health expenditure were characterised by two opposite trends from 2000 to 2012. They reduced between 2000 to 2009 from 17.38% to 15.96%, and then started to grow until 2012 when they reached 16.34%. This information is also very relevant in the context of the implementation of the Directive on patient's rights to cross-border healthcare. The scope of the present work is first to know whether it is possible to have a clear picture on what out-of-pockets payments are, and then to try to understand if and how such policies affected solidarity in the healthcare coverage.

AIM AND METHOD

This publication aims to understand to what extent healthcare systems (and more precisely hospital care) in European countries are financed by out-of-pocket payments by defining a "country profile" and by investigating which information is available on the topic. Information gathered has been organised to allow the reader to understand if out-of-pocket payments are requested for the hospital or non-hospital sector, and for which kind of healthcare services, goods or extra-services. Data has been collected by HOPE members through a survey and then integrated with contents produced by the European Observatory on Health Systems and Policies. Furthermore, the same source has been used to create country profiles for those cases where the results of the survey were missing. Quantitative and qualitative information has then been reorganised in order to respect the structure of the survey previously submitted to HOPE members.

The survey, which is annexed to this publication, contained 9 questions, divided into 4 sections.

In **section A**, the purpose was to investigate if the definition of out-of-pocket payments used in the survey, defined by WHO, reflects the definition used at national level. This definition is the following:
"Private households' out-of-pocket payment on health as % of total health expenditure are the direct outlays of households, including gratuities and payments in-kind made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. It includes household payments to public services, non-profit institutions or non-governmental organisations. It includes non-reimbursable cost sharing, deductibles, co-payments and fee-for service. It excludes payments made by enterprises which deliver medical and paramedical benefits, mandated by law or not, to their employees. It excludes payments for overseas treatment."

In **section B**, HOPE members were asked to provide qualitative and quantitative information, if available, on the out-of-pocket payment share of healthcare expenditure by *sectors* and *categories*. *Sectors* mean hospital care (both inpatients and outpatients) and non-hospital care and *Categories* refer to services, goods and extra-services (facilities). Furthermore, it was required to supply data related to the *Typologies* with the intent of understanding whether the out-of-pocket payment share of healthcare expenditure is directly funded by patients, through a voluntary insurance, or through other sources.

Most of the available data provided by HOPE members was on out-of-pocket payment divided by sectors: on hospital and non-hospital care as well as on inpatients and outpatients. Concerning the quantitative data, out-of-pocket payment share values have been provided mainly for non-hospital care, services and goods. Goods refer to pharmaceuticals and medical devices and services concern the fees for health service performed by professionals.

Section C was dedicated to analyse the trends in out-of-pocket payments between 2007 and 2012 in order to check the possible consequences of the financial crisis on the European health systems.

Section D investigated whether different policies were applied within the country concerning out-of-pocket payments.

The following HOPE members provided information: Belgium, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Netherlands, Portugal, Slovenia, Spain and Sweden.

The countries, which profiles have been only based on data from the European Observatory on Health Systems and Policies, are: Austria, Bulgaria, Croatia, Cyprus, Ireland, Italy, Latvia, Lithuania, Malta, Poland and United Kingdom.

RESULTS

The first striking conclusion emerging from the survey is that the information available is rather sparse, limited or scarce in the national databases. Furthermore, in the European Observatory on Health Systems and Policies, there are different levels of detail depending on data available at country level. In addition, qualitative information on "under the table payments" is more precise in some countries than in others.

Only some HOPE members were able to provide the percentage of coverage guaranteed by the National Health System and the fixed fees patients have to pay to get hospital care or non-hospital care.

Concerning the payments trends, the survey shows that Governments have chosen different strategies, sometimes opposite ones, to face the pressure of the financial and economic crisis on their healthcare systems.

The national definitions of out-of-pockets payment usually reflect the one provided by WHO. In Belgium, Denmark, Finland and France national definitions present some slight differences.

DEFINITIONS

The content of this publication highlights for each country different forms of out-of-pocket payments. The aim of the following list is to clarify to the reader what they consist in. The definitions used are those of the European Observatory on Health Systems and Policies.

Direct payment: a disbursement for goods or services that are not covered by any form of pre-payment or insurance.

Cost sharing: a provision of most health funding systems that requires the individual who is covered to pay part of the cost of healthcare received. Often referred to as user charges, it is comprehensive of the three different categories listed below which are co-payment, co-insurance, deductible:

- **co-payment**: a flat-rate payment for a healthcare service;
- **co-insurance**: a percentage of the total cost of the service which is paid by the patient;
- **deductible:** a ceiling up to which the patient is liable (pays out-of-pocket) and after which the insurer covers the remaining costs.

Informal payment: any unofficial expenditure for goods or services that should be fully funded from pooled revenue. Sometimes is referred to as envelope or under-the-table payments.

Table 1. Typology of out-of-pocket payments per country

(*Source: HOPE, 2015*)

COUNTRY	DIRECT PAYMENT	COST-SHARING		INFORMAL PAYMENT
		Co-payment	Co-insurance	
Austria	X	X	X	
Belgium	X	X	X	
Bulgaria	X	X		X
Croatia	X	X	X	X
Cyprus	X	X		X
Denmark	X	X	X	
Estonia	X	X	X	X
Finland	X	X		
France	X	X		
Germany	X	X	X	
Greece	X	X	X	X
Hungary	X	X	X	X
Ireland	X	X		
Italy	X	X		X
Latvia	X	X	X	X
Lithuania	X	X	X	X
Malta	X	X		
Netherlands	X	X		
Poland	X	X		X
Portugal	X	X	X	
Slovenia	X	X		
Spain	X	X		
Sweden	X	X		
United Kingdom	X	X		

COUNTRY PROFILES

AUSTRIA

In Austria, in 2010 out-of-pocket payments financed 17.7% of the total current health expenditure. 12% of the total out-of-pocket payments (770 million euro) corresponded to cost sharing payments, while 67% (4,2 billion euros) represented direct payments. 21% of spending was financed by private health insurances and non-profit organisations.

Exemptions are set for: patients with infectious diseases or dialysis; people holding a minimum pension; children covered by insurance; civil servants; people requiring social protection; people whose monthly net income did not exceed 814 euro. For individuals with a chronic illness who can demonstrate associated high costs, these income limits are raised to 937 euro. In addition, since 2008 a prescription fee cap has been set.

Out-of-pocket payment is applied to both *hospital* and *non-hospital care*.

As to *hospital care*, data from 2012 gathered by the European Observatory on Health Systems and Policies only refer to the charges applied to *inpatient* and *ambulatory care* (*outpatient* at macro level). Patients admitted to hospital usually pay a daily fee of approximately 10 euro, for a maximum of 28 days a year. A co-insurance exists for patients covered by insurances and its value amounts to 10% of the daily rate for up to a maximum of 28 days a year.

For *outpatient care*, data collected specifically refer to ambulatory care provided by physicians (contracted and not contracted). Since 2006, a general annual service fee is implemented consisting in a 10 euro e-card (the so called "electronic healthcare voucher"). Individuals insured under several funds do not pay the e-card service fee. However, they have to pay co-insurance for all physician visits.

In outpatient clinics and hospitals a co-payment of 21,20 euro is applied. Once paid, it covers all the health services received in the next four months. Services provided in outpatient allergy clinics, or by speech and language therapists, physiotherapists, occupational therapists or clinical psychologists are considered equivalent to physician services and the same user charges and exemptions are applied.

N*on-hospital care* data about out-of-pocket payments are available on: pharmaceutical products, medical rehabilitation, medical spas, therapeutic aids and psychotherapy. Data from 2012 show a fee of 5.15 euro per prescription in the so-called "Reimbursement Codex" but a ceiling has been set since 2008, limiting the total spending on prescription fees to 2% of the annual net income. In addition, exemptions exist for people with a monthly income below a certain threshold.

A co-payment exists also for medical rehabilitation and medical spas. This charge varies from 7.04 euro to 17.10 euro per day for maximum 28 days (in 2012). The general contribution for curative and rehabilitative hospital stays was harmonised in 2011 and is now applied on a means-tested basis and set annually. Patients that need therapeutic aids have to pay out-of-pocket in the form of co-insurance of 10% or 20% depending on the insurance fund they subscribed. For psychotherapy, a cost-sharing system exists. The subsidy is 21.80 euro per 1-hour session.

Table 2 shows the out-of-pocket expenditure per sub-category paid directly by patients in the form of direct payment or by cost sharing or by voluntary health insurance and/or non-profit organisations. For every sub-category, these values are expressed in both million euros and percentage.

Table 2. Out-of-pocket payment typologies divided per different sub-categories, in million euros and in percentage, 2010

(*Source: European Observatory on Health Systems and Policies, 2013*)

SUB-CATEGORIES	OUT-OF-POCKET PAYMENT TYPOLOGIES					
	Paid by the patient				Paid by voluntary insurance	
	Direct payment		*Cost sharing*			
	Million euros	%	Million euros	%	Million euros	%
Long-term care	47	52%	0	0%	44	48%
Day clinic	1	100%	0	0%	0	0%
Ambulatory services	1,797	85%	148	7%	177	8%
Inpatient services	791	42%	252	13%	847	45%
Pharmaceuticals	855	69%	371	30%	19	1%
Medical devices	610	91%	0	0%	61	9%
Services for the patients' families	107	37%	0	0%	178	63%
Total spending	**4,208**	**67%**	**770**	**12%**	**1,327**	**21%**

In 2010, some form of private health insurance covered 34% of the Austrian population. Private health insurance financed 5.5% of the total current health expenditure corresponding approximately to 1.4 billion euro. 8% of the total private insurance funds expenditure (corresponding to 112 million euro) was spent for ambulatory, curative and rehabilitative services. Approximately 6% was spent in pharmaceuticals.

In 2007, out-of-pocket payment as percentage of total health expenditure accounted for 15.34%. In 2008, the figure slightly increases until 2009. Starting from that year, it decreased and in 2012 it returned to 15.34%.

BELGIUM

In Belgium, the definition of out-of-pocket payment roughly corresponds to the WHO one with the only difference that it includes premiums for supplementary sickness (such as for hospital) insurance.

There are two systems for out-of-pocket payment: a direct payment and a third-party payer system. In the first case, the patient pays the full fee for the healthcare service received and then asks for a reimbursement to his/her sickness fund. In the second case, the sickness fund pays the healthcare services provider and the patient is responsible for co-payments, supplements and non-reimbursed services.

The out-of-pocket system includes co-payments. These are the same for everyone except for people with the so called "*preferential reimbursement status*". Since 2009, in order to obtain this status, the patient annual taxable income must not exceed 14.339 euro. Moreover, from January 2014 this is automatically applied to the orphans. Out-of-pocket payment is used for *hospital care*, both for *inpatients* and *outpatients*, and *non-hospital* care. Out-of-pocket payment as percentage of total health expenditure was around 20% in the last years (2010, 2011 and 2012). On average, the share of out-of-pocket payment is 9% for *hospital care* and 25% for *non-hospital* care.

Table 3. Percentage of out-of-pocket expenditure over the total healthcare expenditure in the year 2009

(*Source: European Observatory on Health Systems and Policies, 2010*)

SECTORS	%
Hospital care	9%
Non-hospital care	25%

Patients with low income can benefit from the "omnio-statute", a sort of reimbursement system whose percentage of coverage is not available in the national databases. However, a system called "maximumfactuur" has been introduced in order to define the maximum threshold low income patients and their families have to pay for the "share" of healthcare expenditure not covered by the insurance.

Table 4. Means-tested annual out-of-pocket maximums, 2009

(*Source: NIHDI, 2009*)

Net family income	Out-of-pocket maximum
Up to € 16.114,10	€ 450,00
€ 16.114,11 - € 24.772,41	€ 650,00
€ 24.772,41 - € 33.430,75	€ 1.000,00
€ 33.430,76 - € 41.728,30	€ 1.400,00
Above € 41.728,31	€ 1.800,00

For what regards *hospital care*, *inpatient care* and *pharmaceuticals* purchased in pharmacies patients only pay user charges. *Outpatients* are, in principle, required to pay in advance the full fee for the service and then claim for reimbursement to their sickness fund. For *inpatient care*, out-of-pocket payment is applied to: a flat daily fee for hospitalisation; supplements for double or single room; fees for doctors who have agreed or not with general health insurance convention (in the first case, doctors can ask for this fee supplement only if the patient requested a single room) and cost of specific non-refundable products or pharmaceuticals. Additionally, a flat rate charges per each inpatient stay is adopted for biological tests (7.44 euro), for radiology (6.20 euro) and for technical acts (16.40 euro). According to the qualitative information gathered from the survey, the out-of-pocket payment in hospitals is mainly for comfort and facilities (room, refrigerator, TV, telephone, etc.), services (specialist, technical, urgency, biology examinations), doctors and pharmaceuticals (depending on the use) or para-pharmaceuticals (creams, for example).

Also in the case of *non-hospital care*, out-of-pocket payment concerns the fee paid for consultations made by doctors who have not agreed with the general health insurance convention. Co-payment rates vary between different services and they are set as follow: 25% for GPs' consultations; 35% for GPs' home visits; 40% for specialist consultations, physiotherapy, speech therapy, podology and dietetics. For patients belonging to a socioeconomically vulnerable group, under the "*preferential reimbursement status*", the rates are: 10% for GPs, 15% for specialists and about 20% for the remaining services mentioned above. Since1 December 2011, co-payment for patients *without preferential reimbursement status* asking for consultations to GPs office, doctor office and dental sciences is limited to 4 or 6 euro, depending if they have or not a global medical file. Also for patients with *preferential reimbursement status*, the co-payment varies from 1 to 1.5 euro depending if they have a global medical file or not.

In Belgium, the so-called *sickness funds* provide the voluntary and the complementary health insurance. Voluntary health insurance covers approximately 5% of the total health expenditure, according to the last data available. In 2008, expenditures covered by voluntary health insurance have reached 609 million euro. The annual growth rate of voluntary health insurance between 2001 and 2008 was 4.6% and in 2008 there were 5.3 million of affiliated people and a turnover of 826.2 million euro. For what regards the complementary insurance, in 2007 the market has reached 774 million euro with an annual increase of 3.6% since 1995.

Table 5 lists the last data available (year 2009) on out-of-pocket payment paid directly by the patients. Table 6 summarises the yearly share of total out-of-pocket payment for inpatients and outpatients. Information is listed per sub-categories.

Table 5. Out-of-pocket payment paid directly by patients divided per sub-categories, year 2009

(*Source: Institut national d'assurance maladie-invalidité – INAMI, 2011*)

SUB-CATEGORIES	Out-of-pocket payment typologies Paid directly by patient (%)
Fees for practitioners	38,4%
Fees for nurses	0,4%
Fees for dentists	6,0%
Fees for physiotherapists	7,5%
Fees for paramedicals	6,7%
Pharmacy	28,9%
Hospitalisation	10,5%
Other kind of stay	0,7%
Other	1,0%

Table 6. Yearly share of out-of-pocket payments for inpatients and outpatients referring to the years 2005-2010

(*Source: Institut national d'assurance maladie-invalidité – INAMI, 2011*)

SUB-CATEGORIES	INPATIENTS		OUTPATIENTS	
	2005	2010	2005	2010
Fees for practitioners	37,0%	34,0%	63,0%	66,0%
Fees for nurses	0,0%	0,0%	100,0%	100,0%
Fees for dentists	0,3%	0,3%	99,7%	99,7%
Fees for physiotherapists	10,1%	8,4%	89,9%	91,6%
Fees for paramedicals	62,7%	56,8%	37,3%	43,2%
Pharmacy	17,7%	13,5%	82,3%	86,5%
Hospitalisation	95,2%	94,4%	4,8%	5,6%
Other kind of stay	4,8%	4,4%	95,2%	95,6%
Other	5,3%	3,3%	94,7%	96,7%
Total	**39,5%**	**36,6%**	**60,5%**	**63,4%**

From 2007 to 2012, the political priority in Belgium was to try lowering out-of-pocket payment and cutting costs through the implementation of a different strategy. Accordingly, data from the WHO – European Health for All database showed a decreasing trend of out-of-pocket payments as percentage of total health expenditure in the same years (from 21.36% to 19.68%).

BULGARIA

In Bulgaria there are different typologies of out-of-pocket payment. These are co-payment and direct payment. The level of informal payments seems very high according to the most recent study (2006), a substantial part of out-of-pocket payments (47.1%) were informal.

The out-of-pocket payments amounted to BGN 1.789 million (917 million euro) in 2008, accounting for 36.5% of total health expenditure. These data include direct payments and cost-sharing but exclude informal payments. There are no official statistics about the share of each form of out-of-pocket payment. Therefore, it can be assumed that out-of-pocket payments are much higher than official data suggests.

Exemptions to pay user charges for GP's visits, outpatient specialist visits and inpatient stay are for children, chronically sick patients and unemployed people. Furthermore, children pay smaller co-payments in dental care.

According to the European Observatory on Health Systems and Policies, patients usually pay informally to have shorter waiting times for services, to access a specialist without referral or to secure better conditions and service quality in hospitals. Results gathered from a nationally representative survey conducted in 2006, show that: 22.4% of the patients in hospitals indicated that they paid for medical activities in an unregulated way (for surgical operations, consultations, etc.); 11.4% paid hospital attendants and 7.3% paid nurses. In 2006, informal payments in the hospitals amounted to 11.7% of all out-of-pocket payments for *inpatient care*.

The percentage of informal payments in *outpatient* care is higher. They are mostly related to the non-issuing of a receipt. According to the quoted Open Society Institute's research, in 2006, the informal payments in GPs' practices and in specialised outpatient practices were respectively 61.1% and 53.7% of the overall out-of-pocket payments.

Co-payments are a barrier and financial burden for low-income and retired individuals who visit healthcare providers more often than any other group. However, since the beginning of 2014, retirees pay reduced user fees for visits to physicians, dentists, and laboratory tests (Instead of BGN 2.90 - €1.50, pensioners currently pay 1 BGN - €0.51). The difference between the full and the reduced fee is covered by the Ministry of Health.

In the Bulgarian healthcare system, *direct payments* occur in three cases.

- Patients pay for *services* or *goods* that are *not included in the National Health Insurance Fund* basic package at prices set by the provider. This includes, for example, many of the *dental services* as well as *elective plastic surgery services*, some *laboratory tests*, *implants*, *glasses* and various *pharmaceuticals*.
- Patients pay for *services* or *goods covered by the National Health Insurance Fund* basic package but received outside the standard patient pathway in the Social Health Insurance system. Hence, when patients do not have a GP referral for any healthcare service (in hospital care and non-hospital care) or go to another GP they pay the full fee for the healthcare services received.
- *Uninsured individuals* also have to pay directly for medical services or goods, unless they visit an emergency centre in a life-threatening situation.

Concerning *hospital care*, *inpatients* pay BGN 5.40 (2.80 euro) per hospital day since 2012. Another indirect form of cost sharing exists in hospitals when patients pay for luxury hotel services such as single room, television or choice of a physician/team. The extra billing is based on the hospital's price list and can differ from one hospital to another. Since 2011, hospitals can charge a patient who wishes to choose his/her doctor up to BGN 700 (357 euro) and a patient who wishes to choose a team up to BGN 950 (485 euro). In most private hospitals, all patients pay additional fees for luxury conditions since the hospitals do not have "regular" rooms. These extra services are an integral part of the overall hospital stay of the patient and cannot be used separately and independently from the medical services. Voluntary health insurance may cover the co-payments related to inpatient care.

In *outpatient care*, the user fee for each visit to an outpatient physician was set at BGN 2.90 (1.50 euro).

Co-payments are also applied to *non-hospital care* for dental care. The amount paid by the patient varies according to the service received and voluntary health insurance may cover the fees charged to patients.

Pharmaceuticals not reimbursed by the national health insurance fund are paid by the patient in the form of co-payment (this amount depends on the kind of pharmaceuticals). No exceptions to this rule are foreseen.

Table 7. Out-of-pocket payment paid directly by patients divided per sub-categories

(*Source: European Observatory on Health Systems and Policies, 2012*)

SUB-CATEGORIES	INPATIENTS	OUTPATIENTS
Fees for hospital day	€ 2.80	-
Fees for doctors chosen by patients	€ 375.00	-
Fees for team chosen by the patient	€ 485.00	-
Fees for doctors	NA	€ 1.50

Out-of-pocket payment as a percentage of the total health expenditure has increased between 2007 and 2012. In 2007, the figure was 40.60% and it slightly decreased one year later. From 2009, it started increasing again and in 2012 accounted for 42.30% of the total health expenditure.

CROATIA

Out-of-pocket payments on healthcare services account for the majority of all private health expenditure in Croatia. They include payments for healthcare services offered by private providers (not contracted by the Croatian Health Insurance Fund) and payments from patients receiving services that are not fully covered by compulsory health insurance (provided by contracted providers).

There are two kinds of out-of-pocket payments in this country: cost-sharing and direct payment. Cost sharing includes co-insurance and co-payments and it is applied to primary care services and prescriptions. No data are available on the extent of direct payments for goods and services that are not covered by the Mandatory Health Insurance scheme or by the supplemental scheme of the Croatian Health Insurance Fund. However, complementary health insurance plans usually cover all patient co-payments.

Although informal payments are illegal, according to a recent European Bank for Reconstruction and Development study of 2011, corruption in healthcare remains relatively high: 15% of the respondents reported that they made irregular payments to get a necessary service.

No detailed information is available from the source about the out-of-pocket payments for *hospital* and *non-hospital care*. At hospital care level, for *inpatients*, it is known that supplementary health insurance may cover better standard of hospitalisation. For *outpatients* instead, the supplementary health insurance may cover preventive systematic and cardiovascular examinations, direct access to specialists, diagnostic imaging, laboratory tests and physiotherapy.

There are two types of voluntary health insurance scheme in Croatia, provided by "Croatian Health Insurance Fund" or by private insurers. Complementary health insurance covers user charges in the "Medical Health Insurance" scheme. Supplementary health insurance, instead, covers a higher standard of care. Voluntary health insurance plays a small role in financing healthcare in Croatia, accounting for less than 4% of total health expenditure in 2012.

In the period 2007-2012, out-of-pocket payments as percentage of the total health expenditure varied from 12.46% to 13.90%. This percentage increased between 2008 and 2010 of approximately 2% then decreased of 1% in 2011.

CYPRUS

Out-of-pocket payments represent over 83% of the private healthcare expenditure or nearly half of the total health expenditure.

The lowest annual out-of-pocket expenditure for health services paid by people belonging to lowest income category was 436 euro in 2003 and 608 euro in 2009. The corresponding figures for people with highest incomes are 1.170 euro and 1.749 euro, respectively. Low consumption and low-income households spend a higher proportion of their annual income on health compared to richer households.

The burden of out-of-pocket payments, especially for low and middle-income households, is quite large. One possible explanation for such high out-of-pocket expenditure is that for reasons including long waiting lists, quality issues and health illiteracy, most people choose to purchase healthcare services from the private sector. This happens even in the case these patients are entitled to free access in the public sector.

Approximately 85% of the population has free or reduced rate access to public healthcare services. However, for patients who use the public sector, user charges can be substantial. Data from the Ministry of Health show that the majority of non-beneficiaries choose the private sector for healthcare.

Before 2013, there were three types of patients: beneficiaries "A" (medical card holders)[1], beneficiaries "B" and non-beneficiaries. As a rule, medical cards are issued to: Cypriots and EU citizens who reside permanently in Cyprus; patients with an annual income not exceeding 15.400 euro; members of families whose annual income does not exceed 30.750 euro; people suffering from several chronic diseases or people suffering for chronic diseases which family annual income does not exceeds 150.000 euro[2].

After August 2013, new regulations came into force regarding the public provision of healthcare services. Main changes are:

- abolition of "class B" beneficiaries;
- new criteria for the acquisition of the medical card;
- Introduction of co-payments for beneficiaries.

Theoretically, most medical services are covered and should be provided by the public sector to all beneficiaries in group "A", except for some dental services such as orthodontics, fixed prosthetics and implants. Only receivers of public assistance are excluded by charges for dentures.

There is limited evidence of informal payments, although in some cases they may occur. For example, women who want to deliver their child in a public hospital with the gynecologist or obstetrician of their choice usually offer a gift to their doctor.

Hospital care is characterised by the so called "payment ceiling" that consists on a limit expenditure beyond which the patients has to contribute through out-of-pocket payments. For the first category of patients as listed above (beneficiaries "A") the ceiling may vary from 0% for an annual income minor than 15.380 euro, to 30% for an annual income above 34.170 euro. For family members the payment ceiling is set from 0% for a family annual income up to 30.750, to a maximum of 30% for a family annual income above 42.710 euro. Civil servants and state officers which are "A" beneficiaries have to pay fixed user charges for *hospitalisation* (all the others have free-of-charge hospitalisation). Patients, which are not in the group "A", have to pay

rates for operations but there is a discount when the total amount of the expenditure exceeds a specific ceiling set.

Moreover, voluntary health insurance contracts cover *inpatient care*. In some cases inpatient coverage is received in kind, it means that the beneficiary receives care free of charge at the point of service.

Outpatients with a medical card do not pay for pharmaceuticals, x-rays, laboratory and paramedical tests. On the contrary, patients without a medical card have to pay 100% of the rate with a discount in case the total expenditure exceeds the ceiling set.

For *non-hospital care* charges are applied to GP visits, accident and emergency department visits, prescriptions for pharmaceuticals and laboratory tests. Beneficiaries "A" over 65 years, receivers of public assistance benefit, health professionals of the public sector are excluded by charges for GPs and specialists. The following table (Tab. 8) describes user charges for public healthcare services, both in *hospital care* and *non-hospital care* reported by the European Observatory on Health Systems and Policies.

Table 8. User charges for health services provided by the public sector

(Source: European Observatory on Health Systems and Policies, 2012)

SECTORS		User charges in €	
		Beneficiaries	*Non-beneficiaries*
HOSPITAL CARE	***Inpatient (per day)***		
	Intensive care unit	€20.50	€205.03
	Single-bed hospital room	€20.50	€123.02
	Two-bed hospital room	€10.25	€102.02
	Three-bed hospital room	€6.83	€71.76
	Pharmaceuticals	Free	No coverage
	Outpatient		
	GP visit	€3.00	€14.50
	Specialist visit	€6.00	€20.50
	X rays, laboratory and paramedical tests, pharmacies, etc.	Free	€100% of rate
	Dentures	€153.77	No coverage
NON- HOSPITAL CARE	Prescribed pharmaceuticals and laboratory tests	€0.50 up to €10.00	
	Accident and Emergency Department	€10.00	

In 2010, voluntary health insurance expenditure as a percentage of the total health expenditure accounted for 5.5%. It is believed that in most cases the role of voluntary health insurance is substitutive because of the absence of universal coverage in Cyprus. Gross premiums for health insurance were 71.3 euro in 2009. About 21.5% of the total Cyprus population was insured under individual or group contracts in 2009.

Between 2007 and 2012, out-of-pocket payments as the percentage of the total health expenditure, decreased. In 2007, the percentage was 47.78% and the peak was reached in 2008 with 49.70%. Then the value decreased to 48.32% and 49.38% respectively in 2010 and 2011. Finally, in 2012 out-of-pocket percentage over the total health expenditure was 49.48%.

DENMARK

In Denmark, the definition of out-of-pocket payment as a percentage of total health expenditure corresponds to the WHO one with only an exception: it does not include home-care for older people.

The only data available concerns *non-hospital care* and *pharmaceuticals*. Regarding non-hospital care, the percentages of patient co-payments as share of the total healthcare expenditure for each of the listed professionals are the following:

- dentists: 68%;
- physiotherapists: 60%;
- chiropractors: approx. 80%;
- psychologists: approx. 40%;
- chiropodists: approx. 50% - 60%.

Pharmaceuticals prescribed by GPs are subjected to co-insurance whose level depends on the pharmaceuticals cost sustained in the year. The ceiling varies from 865 DKK (116 euro) to above 3.045 DKK (408 euro). Refunds can vary from 0% to 85%. Patients affected by chronic diseases can apply for a full reimbursement of the pharmaceuticals they take permanently or frequently. Out-of-pocket payment for pharmaceuticals was 34% of the total health expenditure in 2011 but this value does not include the voluntary insurance payments.

Out-of-pocket payments paid directly from patients are for glasses, over-the-counter pharmaceuticals and cosmetic surgery. Only qualitative data exists on it. A certain percentage or *treatment level* is covered by the public healthcare insurances but at the moment no further information are available.

Concerning *hospital care* out-of-pocket payment exists if the patient decides to be treated in a private hospital, for example to avoid waiting lists of the public structures.

There are no data available in any national database concerning the payments made directly by patients or through a voluntary health insurance. However, it is possible to say that voluntary health insurance is only relevant for up to 15% of all hospital treatment and in 2007 its contribution to total health expenditure was 1.7% and provided 10.5% of the total private health expenditure.

In 2007 out-of-pocket payment as a percentage of the total health expenditure has been 14.40% and 89.40% respectively over the total and private health expenditure. In 2012 the percentage of out-of-pocket payment on the total and the private health expenditure has decreased to 12.60% and 87.20%.

ESTONIA

In Estonia, out-of-pocket payments concern *hospital-care* and *non-hospital care*. The role of informal payment is marginal. 2% of patients expressed they had paid informally for faster access care and 3% after receiving the treatment.

The National Healthcare System guarantees a certain level of coverage to some categories of patients. For example, emergency patients are covered 100%. The Government ensures free emergency care and first aid treatment for all people whether they are insured by the Estonian Health Insurance Fund or not. Children under 19 years, pregnant women, students and pensioners have the right to receive the same health services than people who pay the mandatory social tax, even if they do not pay any.

Health services provided by general practitioners are free. Patients can be charged for a maximum amount of 5 euros for GPs' home visits and for ambulatory services, offered by Estonian Health Insurance Fund contracted providers. Dental care is paid 100% out-of-pocket but pregnant women and pensioners get respectively 28 euro and 19 euro of reimbursement per year. Furthermore, pensioners receive 255 euro of reimbursement every three years for prosthesis.

For *hospital-care*, *inpatients* have to pay for hospital-care a daily fee of 2.50 euro for the first ten days of hospitalisation. If the patient stays more, the fee is covered 100% by the Estonian Health Insurance Fund. Patients pay fees only once if they receive health services in the same institution as well as if they ask for consultations to different doctors owing the same specialty.

Out-of-pocket payments are related also to *pharmaceuticals*, depending on the coverage that Health Insurance Fund ensures to patients (from 50% to 100% depending on the active principle of the pharmaceutical itself). For each prescription, the out-of-pocket payment is 1.27 euro. In 2011, the highest shares of the total out-of-pocket payments refer to pharmaceuticals and healthcare services accounting respectively for 61% and 26%. Prescribed pharmaceuticals represent themselves 41% of total out-of-pocket payments while dental care services (included in the category healthcare services) 23%. Long-term care and rehabilitation represent 5% and 6% of the total out-of-pocket payment expenditure. This data is listed in table 9.

Table 9. Share of total out-of-pocket payment in percentage, 2011

(*Source: National Health Accounts, NIHD, 2013*)

SUB-CATEGORIES	Share of total out-of-pocket payments in %
Health service	26%
Long-term care	5%
Rehabilitation	6%
Pharmaceuticals	61%
Others	2%

Further data available regards out-of-pocket payment paid directly by patients for health service, post-recovery services, outpatient specialised healthcare and pharmaceuticals. The percentages corresponding to each sub-category are listed in the table 10.

Table 10. Out-of-pocket payments paid directly by the patient

(*Source: Estonian Hospitals Association, 2013*)

SUB-CATEGORIES	Out-of-pocket payments paid directly by the patient (%)
Health service	12 %
Post-recovery services	20 %
Outpatients specialised healthcare	15 %
Pharmaceuticals	35 %

In the period between 2007 and 2012, the out-of-pocket payments as a percentage of the total health expenditure decreased: in 2007 this figure was 22.16% while in 2011 it reduced to 17.82%. In 2012 instead it had an increase of 0.40 p.p. reaching 18.42%.

FINLAND

The Social Insurance Institution (KELA) is a universal system covering all residents, which refunds for pharmaceutical prescriptions, transportation and other expenses (*private hospital care*, *private medical doctors*, *dentists*, *rehabilitation*, *laboratory tests* and *x-ray examinations*). This system is funded 1/3 by insured people and 50% by employers and the remaining part by the State. For healthcare services, pharmaceuticals prescriptions and transportation there is a limit for out-of-pocket payment: after reaching the set out ceiling, the patient has to pay only a fixed amount.

Healthcare services include: services offered by doctors in medical healthcare centres; physiotherapy and rehabilitation; serial treatments; outpatients services; day surgery; short-term inpatient care in health and social facilities and day and night costs. In 2008 exemptions from user charges were not available for patients with a low income but social assistance in the form of economic sustain exists. Individuals and families whose income is not sufficient to cover costs of living (including the ones of healthcare services) are financially helped. The payment of the benefit is stipulated by the "Act on Social Assistance" and is managed by municipalities.

Out-of-pocket payment concerns *hospital-care*, both for *inpatients* and *outpatients*, as well as *non-hospital care* (healthcare centres). The average of out-of-pocket payment for hospital-care and non-hospital care is respectively of 4.4% and 8.6%. The percentage of out-of-pocket payment for dental care, pertaining to non-hospital care sector is around 20.5%.

Data published in 2008, by European Observatory on Health Systems and Policies provide information on out-of-pocket payment for *non-hospital care*. For home-care, charges consist of a maximum of 11 euro per visit for occasional treatments received from physicians and dentists and of 7 euro for a visit done by other types of professionals. A monthly fee is set then, based on the quantity and quality of treatments and patients' income.

Fees for private services are reimbursed by the Social Insurance Institution for a maximum rate of 60% of the standard tariff calculated by the Government. Treatments and examinations ordered by a private doctor are reimbursed to the patients for a maximum amount of 13.46 euro or for 75% of the established basic tariff.

After reaching the out-of-pocket payment limit of 610 euro per year, outpatients' services are free of charge and short-term inpatients care costs 15.10 euro per day. For pharmaceuticals, the maximum ceiling per year is 670 euro and after reaching this limit, the price is of 1.50 euro. In addition to this, patients receive 42%, 72% or 100% reimbursement from the Social Insurance Institution for the majority of prescriptions. Some are not reimbursable and others are reimbursed only to certain groups of patients. Ambulance fee for the patient is 9.25 euro and the Social Insurance Institution pays the remaining part to the provider of the service. The maximum yearly fee to pay for this kind of service is 242.25 euro and additional amounts are free.

Information supplied by national database regards out-of-pocket payments, paid by *inpatients* and *outpatients* for services, goods and extra services, offered in public hospitals as well as in public healthcare centres.

Fixed fees are the following:

Inpatients

- Public hospital: 34.80 euro for hospitalisation. If the length of stay overcomes three months the fee for every additional day is 16.10 euro
- Psychiatric care: 15.10 euro per day

Outpatients

- Ambulatory services: 29.30 euro
- Day surgery: 96.40 euro
- Day or night care in hospital: 16.10 euro
- Dental care: in public oral health clinics the basic amount varies from 8 to 14.40 euro for the first three visits
- Doctor fee in public health centres: 29.30 euro per year or 14.70 per visit or 14.70 for the three first visits;
- Emergency visits in public healthcare centres from 20.00 to 8.00 during the week and whole Saturdays, Sundays or bank holydays: 20.20 euro
- Not used service fee: 36.20 euro

According to the national database, the share paid directly by patients for services is around 4.4%, including also the goods and the extra services. The amount of this kind of contribution differs between public or private hospitals. In public hospitals, it varies from 14.70 to 29.30 euros whereas in the private ones from 66 to 143 euro. Out-of-pocket payment paid directly by patients between 2007 and 2012 has been increasing for examinations, treatments, pharmaceuticals and transportation and decreasing for rehabilitation and psychotherapy.

The trend of out-of-pocket payments as percentage of the total health expenditure decreased from 2007 (19.34%) to 2012 (18.48%). In 2010 the figure reached the peak of 19.76% but then it stabilised at 18.6% in 2012. This data are provided by the WHO - European Health for All database.

FRANCE

In France, the definition of out-of-pocket payments includes either the expenses that are not supported by the state insurance and the ones directly supported by households. The percentage of healthcare expenditure associated to the two kinds of out-of-pocket payment is respectively 23% and 9.6%.

Out-of-pocket payments concern *hospital* and *non-hospital care* but also pharmaceuticals, other medical goods and transportation service. The percentage associated to the sectors and subsectors above is listed as follows in table 11.

Table 11. Out-of-pocket payments associated to hospital care, non-hospital care and other
(*Source: Fédération Hospitalière de France, 2013*)

SECTORS	%	SUB-SECTORS	%
Hospital care	3.2%	Inpatient Outpatient	- -
Non-hospital care	13.0%	-	-
Other	-	Pharmaceuticals Other medical goods Transportation	17.7% 20.4% 2.5%

For a defined list of long-term conditions, patients are covered 100%.

The out-of-pocket payment for *non-hospital care* concerns pharmaceuticals and its share can vary from 0 to 85%. In the case of consultations and procedures, the fee to pay depends on the status of the patient, the type of act or treatment and the nature of the risk. In any case there is a one euro participation to sum up to this kind of co-payment. An annual ceiling is set at 50 euro and a daily ceiling of 4 euro has to be paid if a patient sees the same professional several times during the same day. For the procedures costing 91 euro or more, a fixed fee of 18 euro is applied.

According to the last data available (year 2013), the out-of-pocket payment for residential care services received by households is 1.500 euro per month, a figure, which has been in constant increase. The out-of-pocket payment for residential homes for persons with disabilities (children excluded) is 18 euro per day, in 2010. Care provided in public mental health areas and in private psychiatric hospitals for adult and children is financed by Social Health Insurance.

For *hospital care* as well as for care provided in public mental health areas and private mental health hospitals the so-called "*ticket modérateur*" is applied. This form of out-of-pocket payment covers 20% of the daily hospital services, which may vary across different organisations, according to the last data available referring to year 2010. The results of the survey revealed that a daily fixed fee of 16 euro has to be paid both in public and private hospitals and 12 euro per day is the out-of-pocket payment estimated for *inpatients* in psychiatric departments. Often voluntary health insurance covers luxury services for inpatient such as private room and cost sharing for pharmaceuticals.

Other kinds of out-of-pocket fixed fee are defined for package of pharmaceutical and paramedical procedures (0.50 euro with a daily limit of 2 euro) and for transportation (2 euro with a daily limit of 4 euro).

In France, out-of-pocket payments for outpatients are higher compared to the ones for inpatients, and refer to healthcare services provided in nursing homes, public and private hospitals and private ambulatories. Moreover, French databases supply data on the different typologies of out-of-pocket payments within *hospital care* and *outpatients services*. This information is listed in table 12.

Table 12. Out-of-pocket payments typologies for hospital vare, non-hospital vare and pharmaceuticals
(*Source: Fédération Hospitalière de France, 2013*)

SECTORS	Out-of-pocket payments typologies for health in general
Hospital care	Paid by the patient: 3.2% Complementary health insurance: 5.4% Other: 1.1%
Non-hospital care	Paid by the patient: 13.2% Complementary health insurance: 22.3% Other: 1.8%
Pharmaceuticals	Paid by the patient: 17.7% Complementary health insurance: 15.1% Other: 1.2%

Aggregate data are available on the percentage of out-of-pocket payment paid by patients, voluntary insurance or other and related to fees for some professional categories (doctors, nurses and dentists), pharmaceuticals and medical devices. Further information is listed in the table 13.

Table 13. Out-of-pocket payment typologies percentage for sub-categories
(*Source: Fédération Hospitalière de France, 2013*)

SUB-CATEGORIES	Out-of-pocket payments typologies		
	Paid directly by the patient (%)	Paid by voluntary insurance (%)	Paid by other (%)
Fees for doctors	9.4%	18.3%	1.7%
Fees for nurses	9.2%	9.2%	0.8%
Fees for dentists	28.3%	34.7%	2.3%
Pharmaceuticals	17.7%	15.1%	1.2%
Medical devices	2.9%	21.3%	1.8 %

Between 2005 and 2008, the household out-of-pocket payment significantly increased from 9.0 % of the health expenditures to 9.7 %. This was due to the rise of non-refundable expenses, but also to the introduction of fixed fee for many pharmaceuticals. This growing trend has stopped since 2009 and stabilised at 9.6 %.

Table 14. Out-of-pocket payments as percentage of the total health expenditure: years 2000, 2005, 2008, 2009, 2010 and 2011

(*Source: Fédération Hospitalière de France, 2013*)

SECTORS OR SUB-CATEGORIES	Out-of-pocket payments as % of the total health expenditure					
	2000	2005	2008	2009	2010	2011
Hospital care	3.3%	2.9%	3.0%	3.0%	3.1%	3.2%
Non-hospital care	11.8%	13.0%	13.1%	13.2%	13.0%	13.0%
Pharmaceuticals	15.1%	13.0%	17.2%	16.8%	17.3%	17.7%
Other goods	38.8%	27.5%	22.8%	22.4%	21.2%	20.4%
Transportation	1.1%	2.4%	2.7%	2.6%	2.6%	2.5%
Total	**9.7%**	**9.0%**	**9.7%**	**9.6%**	**9.6%**	**9.6%**

GERMANY

Out-of-pocket payments concern *hospital care* both for *inpatients* and *outpatients* but limited data are available about the percentage of healthcare expenditure financed by co-payments as well as the distribution for different typologies of out-of-pocket paymentw for services, goods and extra services.

Inpatients have to pay 10 euro per day they spend in hospitals. This contribution is limited to 28 days per year, so the maximum amount to pay is 280 euro per year. In 2012, this kind of co-payment was 682.449.420 euro.

Table 15 shows the detailed out-of-pocket expenditure, from 2008 to 2011, related to different institutions and for different kind of services, expressed in billion euros. The total out-of-pocket expenditure in the years taken into consideration was particularly concentrated in ambulatory institutions reaching 27.6 billion of euros in 2011. As to the services area, in the same period, the majority of the out-of-pocket expenditure was related to goods (pharmaceuticals), medical aids and dental services reaching 16.2 billion euros in 2011.

Table 15. Out-of-pocket payments by institution and by type of service 2008-2011

(*Source: Statistiches Bundesamt, 2014*)

OUT-OF-POCKET PAYMENTS (€ BILLIONS)	2008	2009	2010	2011	% of increase 2008-2011
Total	**36,2**	**37,5**	**3,9**	**40,1**	**10.77%**
By institutions					
Ambulatory institutions	**24,1**	**25,5**	**26,7**	**27,6**	**14.52%**
▪ Physicians practices	3,3	3,5	3,7	3,9	18.18%
▪ Dentist practices	3,3	3,4	3,5	3,6	9.09%
▪ Other practices	1,7	1,8	1,7	2	17.65%
▪ Pharmacies	7,3	7,2	7,9	8	9.59%
▪ Health Trade professionals and retail	6,7	6,9	7,1	7,2	7.46%
▪ Ambulatory long-term care	2,1	2,1	2,1	2,1	0.00%
Other institutions	**0,6**	**0,6**	**0,7**	**0,8**	**33.33%**
Inpatient institutions	**8**	**8,5**	**8,7**	**8,9**	**11.25%**
▪ Acute hospitals	1,4	1,3	1,4	1,5	7.14%
▪ Preventive spa/rehabilitation	0,2	0,2	0,2	0,1	-50.00%
▪ Inpatient long-term care	6,5	7	7,1	7,2	10.77%
By type of services					
Medical services	**5,6**	**5,7**	**6**	**6,4**	**14.29%**
Non-physician care	**5,5**	**5,5**	**6**	**6**	**9.09%**
Room and board	**5,6**	**5,7**	**6**	**6**	**7.14%**
Goods	**14,7**	**14,9**	**1,5**	**16,2**	**10.20%**
▪ Pharmaceuticals	6,7	6,6	6,5	7,2	7.46%
▪ Medical aids	5,5	5,6	5,7	6,1	10.91%
▪ Dentures (cost of material and laboratory)	2,4	2,6	2,7	2,8	16.67%
Other medical supplies	**0,1**	**0,1**	**0,1**	**0,2**	**100.00%**

Persons covered by social health insurances that have already spent more than 2% of their annual household income as co-payments, are exempted of user charges. For patients suffering from a serious chronic illness, the threshold for being exempted by co-payment is 1%. A further requirement for the exempted patient consists in having been treated at least once every four month in the previous year. Finally, the patient should also present one of the following characteristics:

- need for long-term care;
- severe disability incapacity to work at least of 60% ;
- certificate from the treating physicians stating that the omission of continuous healthcare would cause a life-threatening aggravation, reduction of life expectancy or a long-term reduction in the quality of life.

In addition to this, a relief from income taxes is given when the percentage of out-of-pocket payment expenditure for "extraordinary" healthcare services is between 1% and 7% of the annual household income. Privately insured people have to pay directly to the provider and are then reimbursed by the insurer (*Kostenerstattungsprinzip*). People covered by social health insurance, instead, do not have to pay in advance for any service.

There is no quantitative information related to the total amount of money paid directly by patients as out-of-pocket payment. However, WHO European Health for All Database, provides data on out-of-pocket payment as percentage of total health expenditure. From 2007 to 2012, the trend of out-of-pocket payment as percentage of total health expenditure slightly varied. In particular, the lowest rate for the figure has been reached in 2008 (13.4%) while the highest one corresponds to the year 2011 (13.7%). In 2012 the value returned to 13.5% as in 2007.

GREECE

In Greece, out-of-pocket payments affect both *hospital care* and *non-hospital care*. According to the System of Health Account Definitions, outpatients are included in non-hospital care. Moreover, co-payments are estimated also for dental care, pharmaceuticals and the *ancillary services*. Healthcare services in public hospitals as well as visits to primary care physicians and diagnostic centres contracted by a social insurance fund are free of charges.

In general, out-of-pocket payments have been the dominant form of private expenditure on health in Greece and in the largest part represented direct payments and informal payments (according to Economou 2011). Under the Memorandum of Understanding, co-insurance rates have been introduced and/or increased for various type of care[3]. As a matter of fact, out-of-pocket payments in Greece represent more than half of the total health expenditure.

However, the huge amount of informal payments and black economy make difficult to estimate the exact amount of the real out-of-pocket payment expenditure for the patients. In January 2002, the Government introduced the so called "*afternoon outpatient visits*" in order to reduce informal payments and tax evasion. This initiative consists in the fact that doctors working in public hospitals (ESY) are allowed to provide private practice services.

According to the results of the survey, national databases provide quantitative information on the percentage of hospital, non-hospital and ancillary services financed by out-of-pocket payments. This information is listed in the table 16.

Table 16. Out-of-pocket payments percentage, associated to hospital care, non-hospital care and other (ancillary services and dental care)

(Source: Department of Health Economics National School of Public Health, 2013, European Observatory on Health Systems and Policies, 2009)

SECTORS	SUB-SECTORS	%
Hospital care	Inpatient	19.2%
Non-hospital care	Outpatients	61.4%
Other	Ancillary services Dental care	26.3%-39.6% 30%

Besides the quantitative data listed above, the survey results highlight some qualitative information about co-insurances rates applied for "EOPYY" beneficiaries, an entity created by merging the largest four health insurance schemes.

Concerning *inpatient care*, co-insurance rates are applied only if the patient is treated in a private structure. The reimbursement of the co-insurance varies from 30% to 50% depending on the fund chosen by the patient. Despite inpatient care in public hospitals are free of charges, out-of-pocket payments exist for extra-services not reimbursed by the health insurance, pharmaceuticals and laboratory or diagnostic tests.

The out-of-pocket payment for *outpatient departments* consists in a fixed daily fee of 5 euro. For afternoon hospital outpatient visits, patients have to pay the full fee for doctors, set between 25 euro in the rural area and 90 euro for medical professors in university-affiliated hospitals. Often, these services are not reimbursed by social insurance.

Due to the crisis, Greece had to face financial and structural problems. For this reason, national healthcare system has not always been able to answer to primary care services demand of patients. Consequently, they often had to resort to private sector. The average fee the patient has to pay for this kind of visit is 50 euro. Then, the insurance fund reimburses the patient for a fixed amount of 20 euro. *Dental care* represents the predominant field for out-of-pocket payments paid directly by patients. Cost sharing has increased compared to the past and several services. Dental prosthetics, for example, are not reimbursed anymore. In general, the 30% of the expenditure financing dental care is out-of-pocket and the co-insurance coverage ranges from 0% to 40%. For *diagnostic exams* and *tests* realised in laboratories, which do not belong to the Public Health Service, a 15% co-insurance rate that has to be paid by patients is applied. A 25% co-insurance covers *medical non-durable goods* and *therapeutic appliances*. *Pharmaceuticals* are divided into two categories. For the first one there are three levels of co-insurances: 0%, 10% and 25%; for the second one, in which over-the-counter pharmaceuticals are included, the contribution is 100%. Furthermore, an additional out-of-pocket payment is estimated to 50% of the price difference between the dispensed product and the reference price. Data from 2010 states that a 10% co-insurance rate is applied to pharmaceuticals for pensioners with low income suffering from certain diseases (Parkinson's disease, insipidus diabetes, chronic pulmonary cardiac diseases, collagens, osteoporosis, myopathy, inocystic disease, coronary heart disease tuberculosis, asthma).

According to the OECD Health database 2012, out-of-pocket payment as percentage of total health expenditure in 2007, 2008 and 2009 was 37.9%, 36.2% and 38.4% respectively. The National Statistics Agency of Greece recently published preliminary health expenditure data, according to which in 2009 the 28.4% of current expenditure on health corresponds to households' out-of-pocket payments. The percentages referred to years 2010 and 2011 are 29.2% and 30.9%.

HUNGARY

According to the European Observatory on Health Systems and Policies, the out-of-pocket payment as percentage of GDP was 1.8% in 2007. In Hungary, people pay out-of-pocket (in the form of direct payment) the fee for services received by private providers not contracted by the National Health Insurance Fund Administration.

Out-of-pocket payment concerns *hospital care* (both *in-patients* and *outpatients*) and *primary care* (GPs and Pediatricians) but no precise quantitative data is available about their average share. Qualitative information is available for hospital and non-hospital care. In particular, inpatient co-payments are established for specialised surgeries or therapies (hip replacements for example), goods (focal lens after cataract surgery for example) and extra services (single room accommodation for example). Outpatient co-payments are for additional treatments or therapies, dental care implantation and prosthetic replacement.

Informal payments are very common in Hungary and the low salaries of medical doctors and other health professionals have been major contributing factors. National databases provide information on the percentage of healthcare expenditure for services, goods and extra-services paid by the patient. On the other hand, there are no data on out-of-pocket payment paid as voluntary insurance. These values are listed in table 17.

Table 17. Out-of-pocket payment typologies percentage for sub-categories

(*Source: Hungarian Hospital Association, 2013*)

SUB-CATEGORIES	Out-of-pocket payments paid directly by the patient (%)
Surgery	10%-30%
Outpatients specialised healthcare	30%-50%
Fees for doctors	30%-50%
Fees for nurses	40%-60%
Pharmaceuticals	10%-90%
Medical devices	5%-80%
Accommodation	20%-100%

In 2007, pharmaceuticals represented 50.1% of the total out-of-pocket expenditure on health. The rest was shared between medical aids and prostheses (5.9%) and general health services (42.8%) in the same year. This data includes estimates of informal payments calculated by the Hungarian Central Statistical Office. Patients also pay out-of-pocket the full fee for certifications of health for the purpose of employment, for sport and the ones needed to obtain a driving license.

From 2007 to 2012, the general trend was that out-of-pocket payment increased in outpatient private clinics and decreased in public hospitals and outpatient public clinics. Their features change within the country: since in eastern and northern areas the general income is lower, patients have to contribute less through co -payments than patients living in the western and southern ones do.

Data from the WHO - European Health for All Database show that in Hungary, out-of-pocket payments as percentage of total health expenditure have been increasing since 2007. Their level turned from 25.4% (2007) to 27.08 (2012). Probably this increase is due to policy measures adopted to recover from the economic and financial crisis since the data was decreasing in the first half of 2000.

IRELAND

In Ireland, the definition of out-of-pocket payment reflects the WHO one. Out-of-pocket payments are set for both *hospital* (*inpatient* and *outpatient*) and *non-hospital* services. Patients may be divided in two groups: the ones who possess a medical card and the ones under the so-called "Category II".

The parameter considered to obtain a medical card is the income. Medical cards are usually granted to children in foster care and to people aged between 16 and 25 when they prove to be financially independent. If they are not, they are entitled to a medical card only if their parents have one. Income of people older than 70 years is evaluated according to a specific system.

Public hospital and non-hospital services are free of charges for patients owning a medical card. In particular, non-hospital services refer to primary care, dental and optometrist/ophthalmic care. The same rule is valid for pharmaceuticals and medical appliances. Patients under "Category II" status have instead to pay for GPs and pharmaceuticals up to 90 euro per month but they may receive some help to sustain the costs of healthcare services via the *Treatment Benefit Scheme*, a plan run by the Department of Social Protection.

Minors, women receiving maternity services, people who contracted hepatitis C through infected blood products/transfusion in Ireland, people involuntary detained under mental health legislation are exempted from charges. For those assisted on a 24 hours basis the maximum weekly charge is either 120 euro or the weekly income of the patient minus 35 euro. No charges are applied for patients under certain disadvantaged social categories. Inpatients and outpatient services are free of charges also for people owning a referral letter from their GPs.

As mentioned above, hospital care services for inpatients owning a medical card are free of charges. For the others, there is a fixed daily fee of 66 euro, covering treatments and accommodation. The maximum out-of-pocket payment per year is 660 euro, in this case. Also for patients, receiving services by Accident & Emergency hospital department, the daily fixed fee is 66 euro if they do not hold a GP's referral letter. For patients treated in private hospitals, the out-of-pocket payments could be much higher. Furthermore, patient may have a voluntary insurance covering extra-services such as private rooms. The monthly premium paid varies from 44 to 170 euro, depending on the company as well as on the level of extra service required. Some hospital care services are covered by voluntary insurance, also for pregnant women for example doctor fees up to 860 euro.

Some non-hospital care services are entirely paid out-of-pocket even if patient holds a medical card. It is the case of in-vitro fertilisation. For primary care, the fee paid by patients to GPs varies between 50 and 80 euro. Voluntary insurance refunds 20 or 30 euro of these amounts.

Table 18. Fees paid Out-of-pocket in euro for hospital, non-hospital and other types of care

(*Source: European Observatory on Health Systems and Policies, 2009*)

SECTORS	SUB-SECTORS	Fee paid out-of-pocket in euro
Hospital care	Inpatient Outpatient	€ 66 (day)
Non-hospital care	GPs visit Dental care	€ 50 – 80 -
Other	Emergency centre Long-term care Dental care insurance	€ 66 € 90 – 120 € 7 – 16

Dental care coverage by insurance costs 16 euro per month for adults and 7 euro for children. It totally covers basic services or a certain percentage (25%, 50% or 70%) of more complex services. The annual out-of-pocket payment ceiling in dental care is 500 euro per year for crown treatments and 1.000 euro per year for other services.

As reported by OECD out-of-pocket payment in percentage of the total health expenditure has increased since 2007, switching from 14.80% to 16.90% in 2012. The highest peak has been reached in 2010 with 18.20% of out-of-pocket payment over the total health expenditure. This increase has probably been set in order to recover from the financial crisis hit to the economic stability of the country. No data are available about how this out-of-pocket expenditure was subdivided among healthcare services.

ITALY

Italy has currently two main types of out-of-pocket payments. The first is a form of co-payment for diagnostic procedures, pharmaceuticals and specialist visits. The second is a direct payment to purchase private healthcare services and over-the-counter drugs.

No information exists on informal payments, although it may be common to offer non-monetary gifts to GPs making home visits as a form of gratitude.

Exemptions are established for specific categories of people: elderly people older than 65 years with gross household income less than 36.152 euro per annum; people with chronic or rare diseases or disabled people; people with HIV; spinal cord donors or organ donors; prisoners and pregnant women depending on the gestation week and specific diagnostic protocol. Furthermore, patients with specific health conditions (patients with urinary incontinence, disabled ex-servicemen, people with work-related injuries and patients already admitted to public and private accredited hospitals) who need particular medical devices can request them to their Local Health Authority (*Azienda Sanitaria Locale*). Medical devices provided free of charge are listed in the national formulary established by the law.

Co-payments for *pharmaceuticals* and *outpatient care* provided by the National Health System as well as direct payments for private healthcare receive tax benefits: these include a range of services, such as home nursing and physiotherapy. For this kind of healthcare services, a deductible sum of 129 euro is in place and only 19% of the amount that exceeds the deductible is credited. Moreover, voluntary health insurance premiums are deductible from taxable income with a maximum ceiling per year of 1.250 euro.

For what regards *hospital care*, out-of-pocket payment is set only for *outpatient care*. Indeed *inpatient care* is free at the point of use. Complementary health insurance schemes cover the potential co-payment for outpatients and hospital expenses for private rooms for inpatients.

In the field of *non-hospital care*, out-of-pocket payments are applied to pharmaceuticals and specialist visits. The budget cuts in health sector public expenditure due to the financial crisis produced an increase of co-payments in these areas. Moreover, primary care in the Italian healthcare system is free at the point of use.

For healthcare services received as hospital or non-hospital care and prescribed by a GP or a specialist, patients have to contribute with a maximum ceiling of 36.15 euro (per prescription).

Co-payment rates on pharmaceuticals vary among the different Regions of Italy. On average, from 2008 to 2010 the co-payment rates on pharmaceuticals increased while per capita pharmaceutical expenditure decreased of 12% in the same years (from 33 euro in 2007 to 29 euro in 2010)[4].

The Budget Law for 2007, which is still in place, introduced a co-payment of 25 euro on non-urgent visits to all emergency departments and the patients exempted are children younger than 14 years.

Table 19. Out-of-pocket expenditure in hospital care, non-hospital care and other sectors

(*Source: European Observatory on Health Systems and Policies, 2009*)

SECTORS	SUB-SECTORS	% or €
Hospital care	Inpatient Outpatient	Free -
Non-hospital care	Primary care	Free
Other	Emergency department	€25

The Italian National Health System is almost based on a universal coverage form, and, for this reason, voluntary health insurance plays a minor role for the healthcare system funding. Spending on voluntary health insurance (as percentage of the total health expenditure and of private expenditure) accounts less than 5%. The Italian National Healthcare System does not let patients to opt-out of the public healthcare system, seeking only for private healthcare. Therefore, the substitutive insurance does not exist. Latest available data show that 15.6% of the population was under complementary or supplementary insurance schemes, in 1999.

Finally, according to the WHO data, out-of-pocket payment expenditure as a percentage of the total health expenditure slightly decreased from 2007 to 2012, from 20.44% in 2007 to 20.24%. Between 2008 and 2010, out-of-pocket percentage of the total health expenditure was quite stable, between 19.80% and 19.92%.

In 2011, the so-called Tremonti Financial Stability Act (No.158/2011) introduced higher co-payments in outpatient care. In particular, it is applied to specialised outpatient ambulatory care, including laboratory, diagnostic and clinical tests as well as ambulatory visits. The *Agenzia Nazionale per I Servizi Sanitari* (National Agency for Health Services), using data from 11 Regional Health Systems (covering 80% of the total population) created a recent report in 2013. It shows that in 2012 there was a decrease of 8.5% in the utilisation of outpatient services, especially lab tests and services with high co-payments. During the same period, the estimated increase in revenues due to higher co-payments is approximately 500 million euro.

LATVIA

Out-of-pocket payments are the second most important source of revenue for the Latvian National Health System. Since the start of the recession in 2008, when the government cut spending and increased user charges, the share of out-of-pocket payments as a percentage of total health expenditure has been growing (reaching 38% in 2010).

In Latvia, three main categories of out-of-pocket payments exist. Firstly, patients have to pay user charges for statutorily financed care provided by National Health System contracted providers or by Ministry of Health programmes. Secondly, they have to make direct payments for non-statutorily financed care provided by National Health System contracted providers or by non-contracted providers. Thirdly, informal payments are thought to be important. In 2010 the average monthly out-of-pocket expenditure per each household member was LVL 10.40 (14.60 euro), contributing to 5.8% of total household expenditure.

According to data reported to the National Health System by contracted providers, total revenues earned from out-of-pocket payments in 2010 amounted to 80.5 million of LVL (corresponding to 113.1 million euro). 63% of this value is related to contracted care while the 37% to non-contracted care. However, these figures reflect only around 25% of all out-of-pocket payments since they do not include pharmaceuticals, direct payments to non-contracted providers, out-of-pocket payments for care provided through the Ministry of Health financed programmes and informal payments.

For all patients exempted from out-of-pocket payments, the National Health System reimburses providers for co-payments and co-insurance that would otherwise have had to be covered by patients. Children under the age of 18 are exempted by law from payment of any fees for all services included in the statutory list of services. Other exempt groups include pregnant women and women up to 42 days after childbirth, victims of political repression and participants of the national resistance movement, victims of the Chernobyl nuclear reactor accident, disabled people, tuberculosis patients and those under examination for tuberculosis, mentally ill patients under treatment and others. In addition, households with a monthly income below of LVL 120 (171 euro) per family member are exempted from user charges. Households with a monthly income below of LVL 150 (214euro) per member are eligible for 50% reduction of user charges. Patients have to pay the full price of all *over-the-counter drugs* and for a significant number of *prescription drugs*, as coverage is limited only to certain medical conditions such as diabetes, cancer and mental disorders. However, according to the degree and the severity of the patient's condition, there are different levels of exemption (100%, 75% and 50%).

Data produced by the WHO concerning *hospital care* show that all co-payments for *outpatient* and *inpatient* healthcare services per person per year capped at LVL 440 (570 euro). Inpatient co-payments refer to daily fee of LVL 9.5 (13.54 euro); hospitalisation episode fee of LVL 250 (128 euro) and surgical intervention fee of LVL 30 (42.77 euro).

In 2010, the total out-of-pocket expenditure was mainly financed by outpatients. 25% of it refers to health services while 60% to medical goods. For medical goods, it is intended mostly pharmaceuticals including over-the-counter drugs. For pharmaceuticals and medical devices there are different out-of-pocket payments systems. The first consists in a co-payment of LVL 0.5 (0.71 euro) per prescription. The second corresponds to a co-insurance of 25% or 50% over the pharmaceutical price. Outpatient co-payments are applied to diagnostic services (LVL 25, corresponding to 35.64 euro) and to specialist visits (LVL 3, corresponding to

4.28 euro). No charges exist for laboratory test with a referral letter from GP. The co-payment system regards also non-hospital care. For GPs' visits, the patient fee is set to LVL 1 (1.43 euro).

Table 20. Share of overall out-of-pocket payments for healthcare, between sub-categories, in 2010

(*Source: European Observatory on Health Systems and Policies, 2012*)

SECTOR	SUB-SECTORS	%
Hospital care	Inpatients	-
	Outpatients	25% (health services) 60% (medical goods)

Table 21. User charges per different sub-categories of healthcare services

(*Source: European Observatory on Health Systems and Policies, 2012*)

SUB-CATEGORIES	Out-of-pocket payments paid directly by the patient
Inpatient services	
Daily fee	13.54 euro
Hospitalisation episode	128.00 euro
Surgical intervention	42.77 euro
Outpatients	
Diagnostic services	35.64 euro
Specialist visits	4.28 euro
Fees for doctors (GPs)	1.43 euro
Pharmaceuticals (prescription)	0.71 euro
Medical devices (prescription)	0.71 euro

Voluntary health insurance usually covers services uncovered by the National Health System, user charges and supplementary services (for example faster access to healthcare). Due to the economic crisis, population voluntary insurance coverage declined strongly, dropping to 7% in 2010.

The out-of-pocket payment as percentage of the total health expenditure was 34.90% in 2007. It decreased of 1.2 p.p. in 2008 and then increased, reaching 37.40% in 2012 (Source: WHO – European Health for All Database). Since the last years and due to the economic and financial crisis the percentage of people not obtaining care increased because of higher healthcare services cost.

LITHUANIA

One of the main characteristics of the Lithuanian National Health System is that there are no ceilings for out-of-pocket expenditure. However, the main legal cost-sharing "containment" measures consist in a co-insurance system for outpatient pharmaceuticals and the exemption from direct payments for certain patient groups.

A 2011 survey commissioned by the National Health Insurance Fund showed that 56% of respondents personally paid (as indirect payments) for healthcare services in the past 12 months (45% did it more than once) (NHIF, 2012). Most frequently, patients paid for a specialist consultation (31% of respondents), GP consultation (24%), surgery (18%) and for a diagnostic examination (14%).

Approximately 60% of the total population is insured by the State. This figure includes people eligible for any kind of pension or social assistance, children under 18 years of age, students, women on maternity leave, single parents, registered unemployed, disabled people and their carers and people suffering from certain communicable diseases. Patients have to demonstrate their eligibility for state health insurance coverage in order to receive primary care. Financial support from the local budgets is available mostly in the form of payments for institutional care or social services at home for patients in need of permanent care. The National Health Insurance Fund adopts three different levels of reimbursement for outpatient treatment prescriptions: the first is a full reimbursement applied to children younger than 18 years or elderly/disable people with a large need of specific care; the second varies from 50% to 100% and is aimed to patients diagnosed with specific diseases; the third consists of a 50% reimbursement for pensioners and disabled people. Finally, rehabilitation and spa treatments reimbursement rates are set to 80% and 50%.

Qualitative information on *hospital care* is more extensive than a quantitative one. Some facilities charge patients most often for diagnostic tests. Patients have free access to non-emergency outpatient consultations or hospital admissions upon referral from a primary health-care physician. Without a referral, the patient must pay a fee as set by the National Health Insurance Fund. Direct payments exist also for *pharmaceuticals* in outpatient *care*. In 2010, for hospital care, *outpatient services* accounted for 5% of the average annual out-of-pocket expenditure, including 3% for physician services. Out-of-pocket payments for *inpatient services*, instead, constituted approximately 2% of their total.

Concerning *non-hospital care*, the only information available on out-of-pocket payments expenditure is on pharmaceuticals, optics and medical goods. In particular, between 2000 and 2008 this value accounted for 4% for the last two categories. Total private out-of-pocket expenditure on pharmaceuticals and medical goods in 2010 amounted to 370 million euro (64% of total expenditure on pharmaceuticals and medical goods dispensed in the outpatient setting[5]). Furthermore, between 2000 and 2008, an average of 75% of out-of-pocket payments was for pharmaceuticals. When the pharmaceutical price is higher than the reference price, the patient pays the difference as a co-payment. In 2011, it constituted 44 million euro. This amount decreased of about 8% compared to the year 2010.

Table 22. Share of out-of-pocket payment for healthcare services between sub-sectors, 2000-2008

(Source: Statistics Lithuania, 2013)

SECTORS	SUB-SECTORS	%
Hospital care	Inpatients	2%
	Outpatients	5%
Non-hospital care	Optics	4%
	Medical goods	4%

The share of total health expenditure spent on voluntary health insurance represented 0.6% of the total health expenditure, in 2010. Most of people who hold voluntary health insurance receive it as an employment benefit from their companies.

During the period 2007- 2012, the level of out-of-pocket payments changed. In 2007 the out-of-pocket payments as percentage of the total health expenditure was 26.60%, it slightly varied during the year 2008 and then reached 28.54%.in 2012

MALTA

In Malta, out-of-pocket payments account for nearly all private health-care expenditures (over 90% since 2005 according to WHO, 2013) and comprise a high percentage of total spending in comparison to other European countries[6]. Out-of-pocket payments mainly consist of direct payments, which can be for *private general practice care, specialist care, pharmaceuticals and elective surgery*.

To sustain people in need of financial and healthcare aids, there are non-profit institutions that provide care to households free of charge or at reduced prices. The two most important non-profit organisations are the Malta Memorial District Nursing Association and the Hospice Malta, which are supported by NGOs.

Entitled patients, cured in public facilities, have the right to receive free of charges pharmaceuticals on the Government Formulary list. If they opt for private facilities, the full cost of pharmaceuticals has to be paid. There are two entitlement schemes that exempt individuals from out-of-pocket payments for pharmaceuticals: one is means-tested, and the other one is disease specific. Recently there was an increase in the number of formulary pharmaceuticals, which was followed by a decrease in the total amount of direct payments.

Available information on out-of-pocket payments regards mainly *non-hospital care*. *Hospital* and *non-hospital public health services* are free of charge at the point of use and primary care is readily accessible. Despite it, many people choose to pay out-of-pocket because it offers greater convenience and better continuity of care. For this reason, private primary care accounts for two thirds of the total workload on the total.

For *non-hospital care*, when it comes to long-term care, patients are expected to contribute to the costs of goods or services. In general, fees vary from 2.33 euro to 5.24 euro per week or from 2.33 euro to 5.82 euro per month depending on the patient choosing a residential or semi-residential service. Residents of homes for elderly people contribute in a range of 60% to 80% of their total income.

Dental care is provided by public and private providers but only acute emergency dental care is offered free of charge both in hospital outpatient and health centres. Most dental care is thus paid out-of-pocket by patients. Few voluntary health insurance schemes cover dental expenses.

Everyone is eligible to purchase voluntary health insurance coverage, either individually or as part of a group. In 2010, about 22% of the population has some form of private health insurance coverage and reported take-up rates remained unchanged between 2002 and 2008. In 2010, voluntary health insurance only accounted for 2.1% over the total health expenditure.

Data from the WHO – European Health for All Database – show that, in the period 2007-2012, out-of-pocket expenditure has faced an increase. The percentage shifted from 31.24% in 2007, to 32.26% in 2012. A peak was reached in 2011. In this year, the out-of-pocket payment percentage on the total health expenditure was 33.82%.

NETHERLANDS

In The Netherlands, every citizen is legally obliged to subscribe a healthcare insurance, which supplies the standard coverage of some services such as:

- medical care provided by general practitioners, medical specialists and obstetricians;
- hospital treatments;
- medications;
- dental care up to the age of 18;
- postnatal care;
- physiotherapy, exercise, speech and occupational therapy and dietary advice;
- stop smoking consultations.

Besides this, patients may opt for an additional insurance covering extensive physiotherapy or dental care for people over 18 years. Since January 1, 2013, the standard insurance package includes an increase of compulsory deductible from 220 euro to 350 euro. This means that at least the insurant pays 350 euro for healthcare services received. The voluntary deductible can be chosen in amounts of 100 to 500 euro, so it is possible to have a maximum deductible of 850 euro. The higher is the amount of the voluntary deductible the lower is the monthly premiums of insurance paid by the patient. The deductible is not applied to health costs incurred for primary care, obstetric or maternity care. Patients with a chronic illness or disability receive a financial compensation. The compulsory deductible is only applied to the standard insurance and only to people aged 18 or older. These resources represent the larger amount of out-of-pocket payment in the country. This value was around 170 euro until 2013.

Data published by the European Observatory on Health Systems and Policies, shows that out-of-pocket payment for *hospital* and *non-hospital care* depends on the level of income. There are two rates of co-insurance, which correspond respectively to 12.5% and 8.5% of the fee for the healthcare service. For each rate, there is a maximum monthly out-of-pocket payment ceiling, which is lower in the first case. There is no difference in this sense between *inpatient* and *outpatient payment systems*. There was a discussion regarding the possibility to introduce a daily fee for hospitalisation as coverage for "accommodation" cost. A further proposal regarded the possibility to introduce daily fees for not proper or unnecessary use of emergency care facilities. No measure has been adopted until 2013.

In the *non-hospital care* field (nursing care at home) the maximum tariff patients have to pay is 12.60 euro per hour but this amount may also be lower depending on the status and economic situation of the patient.

OECD Health Statistics, published in 2014, illustrate that out-of-pocket payments on *pharmaceuticals* were 8.8% of the total health expenditure[7].

The economic crisis has led to debates about increasing out-of-pocket payments in healthcare. However, their value in the Netherlands is the lowest in Europe according to the OECD report Health at a Glance, 2012. Data from the WHO show that out-of-pocket expenditure as percentage of the total health expenditure in the period 2007-2012 has decreased from 6.06% (2007) to 5.58% (2012). This percentage reached the lowest level in 2010 (5.32%) and then increased since 2011. The Dutch Healthcare Council (RVZ) has advised to introduce out-of-pocket payment for every medical treatment. The policy for healthcare payments is decided at national level so there are not substantial differences within the country.

POLAND[8]

In Poland, there are out-of-pocket payments in the form of both co-payment and direct payment. Out-of-pocket expenditure accounts for 30% of total healthcare expenditure, with the largest burden falling on private households. However, the proportion of total health expenditure paid in the form of out-of-pocket has been decreasing: it fell from 28.10% in 2004 to 22.40% in 2008.

Co-payments are used minimally, mainly in the area of *pharmaceuticals* and other *medicinal products* and to a lesser extent for room and board in long-term care institutions, rehabilitation centres and sanatoria. The law does not provide a cap on co-payments for pharmaceuticals or other health goods or services. However, the most disadvantaged people can claim social assistance that covers the costs of co-payment. Co-payment exemptions are extended to veterans with disabilities and their spouses, to servicemen and their families, and to distinguished blood and organ donors. Moreover, reimbursements for pharmaceuticals related to chronic, infectious, psychiatric diseases and disabilities are forecasted by the Ministry of Health

Informal payments are also present in Poland and they mainly concern services provided in *public hospitals.*

Regarding *hospital care*, out-of-pocket payments in the form of direct payments are foreseen by Polish law for *outpatient services offered by private healthcare providers*. In 2008 the direct payments for private services accounted for PLN 6.1 billion (1.4 billion euro) and almost 35.9% of these resources were mainly spent for specialist services in outpatient clinics and care centres. Voluntary health insurance may cover outpatient care services such as consultations provided by primary healthcare physicians and specialists, diagnostic procedures and prevention.

For *non-hospital care*, data available concern *pharmaceuticals*, *long–term care* and *transportation* expenses. Pharmaceuticals account for the largest portion of out-of-pocket expenses. There are two kinds of cost-sharing patients have to pay depending on the type of pharmaceuticals. The first consists in a fixed amount ranging from PLN 4.2 (1.0 billion euro) or PLN 12.7 (3.0 billion euro), while the second is a contribution corresponding to a percentage (30% or 50%) of the price. These rules are applied to pharmaceuticals included in the positive reimbursement list. Spending on pharmaceuticals and medical non-durables amounted to 61.7% of private health expenditure in 2008, while medical and rehabilitation services amounted to 31.1% in the same year.

Residents in nursing homes, long-term care institutions, and stationary rehabilitation centres sustain the costs for health services received. For adults these costs are set at 250% of the minimum old-age pension or 70% of the resident's monthly income. In the case of children aged 18 or younger, or full-time students under 26, the fee amounts to 200% of the lowest pension or 70% of the average monthly income of one person in the family. Moreover, patients pay travel costs to health resorts and the costs of medical transport in non-emergency situations, when patient's mobility is not impaired and permits the use of public transport. Transport costs may be covered by voluntary health insurance.

In 2008, 54.60% of out-of-pockets was spent on *dental services*. It should be noted that the share of private household expenditure in dental services financing has remained high – nearly 85% – for years. Voluntary health insurance may cover, albeit to a smaller extent, dental care.

Table 23. Shares of the total out-of-pocket payments expressed in %, in 2008

(Source: European Observatory on Health Systems and Policy, 2011)

CATEGORIES	%
Services	
Medical and rehabilitation services	31.1%
Goods	
Pharmaceuticals and medical non-durables	61.7%

Table 24. Out-of-pocket payment share among different sub-sectors in 2008

(Source: European Observatory on Health Systems and Policies, 2011)

SECTORS	SUB-SECTORS	%
Hospital care	Inpatient	-
	Outpatient	-
Non-hospital care	Dental services	54%

A strong voluntary health insurance market has not yet developed in Poland. There is no voluntary health insurance with complementary or substitutive functions, and existing voluntary health insurance forms play a supplementary role (additional to the public system). Monthly contributions are not high, ranging from PLN 12 (2.9 euro) to several hundred zloty depending on the range of services in the package.

Between 2007 and 2012, the share of out-of-pocket payment over the total healthcare expenditure, has remained quite the same. It decreased in 2010, reaching 22.24% and then increased in 2012 returning to the same level of 2007 (22.82%).

PORTUGAL

Out-of-pocket payments concern *hospital care* for both *inpatient* and *outpatient care*, and *non-hospital care* (primary healthcare centres and in-house services). In line with the Central Administration for Health System, the exemption from the payment of fee for service/user charges (the so called "*taxa moderadora*") regards almost the 53% of Portuguese population.

The patients who have the right to be 100% covered by the National Health System are the following: children until 12 years; unemployed properly registered at Employment Centre (spouse and children included); people with low income or disadvantaged economic conditions (attested annually); 60% or more disabled; live donors of cells, tissues and/or organs; blood donors and firemen only for primary healthcare users; militaries or former militaries with disabilities form; pregnant women and those within the 60 days period after giving birth and transplanted patients. Exemptions exist for people who suffer from chronic conditions and HIV/AIDS and oncology patients.

Concerning *hospital care* and *non-hospital care*, patients have to pay user-charges ("*taxa moderadora*") in most public healthcare services. User charges are defined by a fixed fee for consultations (primary healthcare and hospital outpatient visits), emergency visits, domestic visits, diagnostic testing and therapeutic procedures.

For complementary methods of diagnosis performed, "*taxa moderadora*" varies according to the National Health Service price defined for each diagnosis method. User charges for complementary methods of diagnosis performed vary from 0.35 euro (if diagnosis methods price is included between 0.50 euro and 1 euro) and up to 50 euro (if diagnosis methods price is above 500 euro).

According to the data published in 2010 by the European Observatory on Health Systems and Policies, the out-of-pocket payment value is very low in general and covers only a small percentage of the fee of services offered. In National Health System hospitals it represents approximately the 0.7% of the total health expenditure. Instead, the 0.28% of this value refers to primary care. User charges for *hospital care* have been implemented for *outpatient services*, in particular for *pharmaceuticals prescriptions* (patients over 65 years are exempted of 50%) and for *specialist visits* (social security beneficiaries and certain patient groups are exempted).

In *non-hospital care*, the out-of-pocket payment system is set for *primary care* (GPs visits) and *emergency visits*. For the first category, patients under a certain social or health status may receive an exemption. For out-of-pocket payment on dental care, there is no data available. It is known, anyway, that payments for dental care and most specialist consultations in private ambulatories are out-of-pocket.

Out-of-pocket payments regard also medical devices, pharmaceuticals and transportation. For pharmaceutical products covered by the National Health System and for other health insurance arrangements (such as subsystems, HIV and other chronic diseases as multiple sclerosis) there is co-insurance, which could vary depending on the therapeutic value of the drug. Moreover, the patient pays the transportation costs, except in special circumstances such as long-distance travelling. Emergency care transportation is free of charge.

Table 25. Out-of-pocket payment fixed fees for hospital and non-hospital care[9]

(*Source: Portuguese Association for Hospital Development, 2013*)

MEDICAL APPOINTMENTS	2007	2009	2011	2012	2013
Central hospitals	€ 4,30	€ 4,50	€ 4,60		
District Hospitals	€ 2,85	€ 3,00	€ 3,10		
Primary healthcare centres	€ 2,10	€ 2,20	€ 2,25		
GPs/not specialised cares				€ 5,00	€ 5,00
Health professionals appointment in primary HC				€ 4,00	€ 4,00
Health professionals appointment in hospitals				€ 5,14	€ 5,15
Specialised care appointment				€ 7,71	€ 7,75
Domiciliary care appointment				€ 10,28	€ 10,30
Medical appointments without patient attendance				€ 3,00	€ 3,10
ATTENDANCE IN EMERGENCY SERVICE					
Central hospitals	€ 8,75				
District Hospitals	€ 7,75				
Primary healthcare centres	€ 3,40	€ 3,70	€ 3,80		
Hospital admission episodes (user fees in the first 10 days)	€ 5,00	€ 5,20			
Outpatient surgery episode	€ 10,00	€ 5,20			
In house services	€ 4,50	€ 4,70	€ 4,80		
Multipurpose emergency service		€ 9,40	€ 9,60	€ 20,00	€ 20,60
		€ 8,40	€ 8,60	€ 17,50	€ 18,00
Medical/surgical and basic emergency services				€ 15,00	€ 15,45
Extended or permanent attendance service				€ 10,00	€ 10,30
Day hospital session (ambulatory care)				€ 25,00	€ 25,00

In 2010, approximately 20% of the population subscribed to a voluntary health insurance. Half of the policies are group insurance (provided by the employer to the employees) while the other half is made up of individual policies (51.7% in 2008)[10]. Patients who sustained out-of-pocket payments obtain a 30% tax credit rate for a maximum ceiling of 156 euro (for a married couple). Approximately 7% of the population use mutual funds financed through voluntary contributions. These funds provide limited coverage for consultations, pharmaceutical products and rarely to some inpatient care.

Almost 90% of the total out-of-pocket payment on the total health expenditure is represented by pharmacies (dispensing chemists), outpatient care centres, physicians' offices, hospitals, nursing and residential facilities. By 2013, the Ministry of Health announced an increase in user charges following the 2.8% inflation rate. Primary healthcare services were excluded from this update.

SLOVENIA

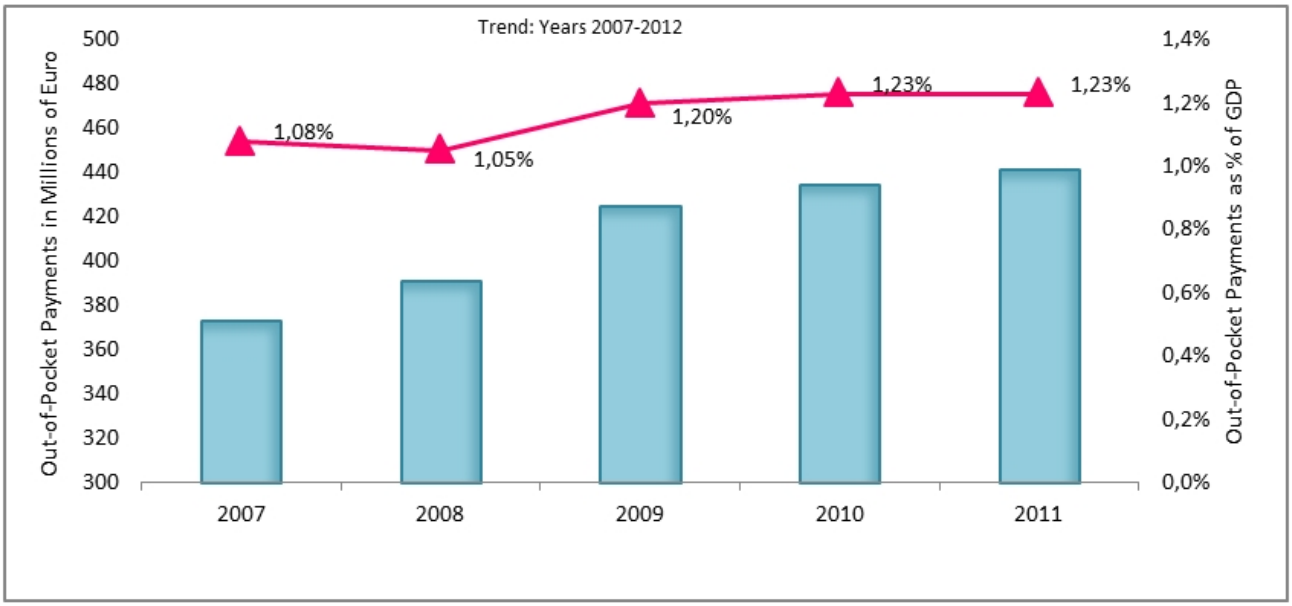
In Slovenia there are two forms of out-of-pocket payments: cost sharing and direct payment. According to the Healthcare and Health Insurance Act of 1992, cost-sharing consists in a flat rate for healthcare services which is applied to all patients except children, unemployed and low income people as well as patients suffering from chronic illness.

Co-payments concern *hospital care* (both *inpatients* and *outpatients*) and *non-hospital care*. However, the only quantitative data available is about out-of-pocket payments as percentage of GDP and total health expenditure, whose values are respectively 1.2% and 13.7%.

The share increased between 2009 and 2012 due to the financial crisis, while the public expenditure decreased.

Figure 1. Out-of-Pocket Payments as % of GDP. Trend: Years 2007-2012

(*Source: Association of Health Institutions of Slovenia, 2013*)



According to the qualitative information provided by the HOPE Member, only few hospital treatments are paid directly by patients. Out-of-pocket payments are mainly for *outpatients care*, *pharmaceuticals*, *over standard medical goods* (e.g. for dental care) and *medical devices*.

Out-of-pocket payment in the form of cost sharing is applied both to *hospital* and *non-hospital care* (fees for GPs and specialists) as well as for laboratories services and the ones covered, in general, by the *Health Insurance Institute of Slovenia*. In these cases, charges vary from 5% to 75% of services or pharmaceutical costs. The rest may be covered by voluntary insurance.

Direct payments are defined as out-of-pocket payment, which is not covered by any form of insurance. This category includes visits to primary care physicians and private providers without a contract with the Health Insurance Institute of Slovenia, specialist services without GPs referral and private dentist services.

Patients can also directly pay for covered services going to private providers to avoid waiting lists, to have special hospital services or services not included in the benefit package of the compulsory insurance.

Most of those who subscribed for a complementary health insurance have also a voluntary health insurance covering co-payments. This explains the low level of direct out-of-pocket payment from patient to provider.

Between 2007 and 2012 the level of out-of-pocket payments as percentage of the total health expenditure has dropped. In 2007 the out-of-pocket payments percentage was 13.20% and decreased to 11.80% in 2009. In 2010, out-of-pockets slightly increased of 0.30 p.p. but decreased to 11.94% in 2012.

SPAIN

Out-of-pocket payments concern *outpatient specialised care* and *non-hospital care*. There is no co-payment for inpatient care.

Outpatient specialised care includes: cardiology, traumatology, day hospital, day surgery, high-resolution units care, mental health units and home hospitalisation. In primary care (health services provided by GPs, pediatricians, nurses and midwives, psychologists and physiotherapists), out-of-pocket payments are mainly for pharmaceuticals, medical devices, special kind of nourishments, dietetic products and patient transportation. The share that patients have to pay depends on several aspects such as the level of income.

Out-of-pocket payments share related to pharmaceuticals could vary as listed in table 26 in relation to several factors: the patient economic and social security situation or the fact he/she belongs or not to the active population.

Table 26. Out-of-pocket payment typologies percentage for sub-categories

(*Source: Instituto de Gestión Sanitaria – INGESA, 2013*)

SUB-CATEGORIES	Out-of-pocket payments paid directly by the patient (%)
Pharmaceuticals Medical devices Other goods[11]	10%-40%-50%-60%
Transportation	10%-40%-50%-60%

National Health System covers 100% of the healthcare expenses for unemployed people who do not receive minimum pension and workers who had accidents or in case of occupational disease. Pharmaceuticals provided, distributed or administered to inpatients are free of charge, although this fact is being under revision. The rules described above are applied also to dietetic products. Out-of-pocket payments concerning transportation will be subjected to a reduction or abolition, as in the case of transfers between hospital and patient's home.

Annual family expenditure on health increased from 952 euro in 2007 to 1.023 euro in 2008 (+7.5%), moving from 2.9% to 3.2% of the total annual household expenditure. Total household expenditure on pharmaceutical and medical devices has grown less, from 403 euro in 2007 to 416 euro in 2008. Anyway, the biggest part of private financing is out-of-pocket payments in the form of co-payments for pharmaceutical prescriptions.

In Spain 81% of all voluntary health insurance policies is the "benefit in kind" type and the rest are employer-paid group policies. Private health insurance had an increase of 3.4% in 2014.

The level of the out-of-pocket payments as a percentage of the total health expenditure, between 2007 and 2012 has been fluctuating. From 2007 to 2009, the percentage of out-of-pocket payments decreased from 20.46% to 18.92%. However, after 2009 out-of-pockets percentage of the total health expenditure kept increasing reaching 20.26% in 2012.

SWEDEN

In 2011, the private household out-of-pocket payment share on total healthcare expenditure was 16.2%. There are out-of-pocket payments for both *inpatient* and *outpatient hospital care* and for *non-hospital care*. Patients also pay for *dental care*, *pharmaceuticals*, *medical devices* and *transport*. The average share values for these sectors are available in national databases and listed in table 27. Hospital care data concerns inpatient and outpatient curative and rehabilitative care. Non-hospital care includes dental care and the last sector is related to pharmaceuticals on prescription.

Table 27. Out-of-pocket payments percentage associated to hospital care, non-hospital care and others

(*Source: Swedish Association of Local Authorities and Regions – SALAR, 2013*)

SECTORS	SUB-SECTORS	%
Hospital care	Inpatient curative and rehabilitative care Outpatient curative and rehabilitative care	1.6% - 2.2*% (*day cases) 24.6%
Non-hospital care	Dental care	60.0%
Others	Pharmaceuticals	23.4%

Besides out-of-pocket payment, the expenditure for Swedish healthcare are covered by county council/ municipal proportional income taxes and state grants (81.6%), private insurances (0.3%), NGOs (0.2%) and private companies (occupational health services, 1.7 %).

In relation to *outpatient care*, each county council or region sets its own fees. According to the national high cost protection, no patient pays more than 125 euro (1.100 SEK) for outpatient care in one year.

Inpatients pay a maximum day fee of almost 11 euro (100 SEK). The costs for pharmaceuticals given during treatment in hospital are totally covered by county councils or regions, in contrast to outpatient care.

Out-of-pocket payments in Swedish healthcare have been rather stable in recent years. The Swedish healthcare system covers all residents, but a small increasing percentage of the population has a voluntary additional private healthcare insurance. In about 80 % of these cases, the employer pays the additional insurance. The patient fees are not the same throughout Sweden and each county council or region sets its own fees and fee structures. However, the high-cost protection levels are national and the same for all residents as well as the maximum daily fees for inpatient care.

Between 2007 and 2012, the level of out-of-pocket payments as a percentage of the total health expenditure very slightly changed. In 2007, the percentage of out-of-pockets was 16.50% and it decreased to 16.14% in 2012.

UNITED KINGDOM[12]

In this country profile, data were mainly gathered from the European Observatory on Health Systems and Policies. This source does not really make a difference between UK and England, so it is not possible to make always a clear distinction between them.

Most revenue for the healthcare system in England is provided by public sources (general taxation, National Insurance Contributions and some local taxation). The rest comes through private sources, primarily "Private Medical Insurance", National Health System user charges and direct payments for private care. The NHS healthcare is free at the point of use, however, some services are either not covered. In this case, patients must therefore pay out-of-pocket (direct payments) or are covered by the NHS but subject to cost sharing usually in the form of co-payments. Informal payments are not a feature of the health system in England.

Since 1992, patients started to rely more and more on private healthcare services. For this reason, the market for private treatments had grown between 1992 and 1993 (13% of total private acute) and 2006 (18%). This happened, partly in response to perceptions about the quality of National Health System treatment and long waiting lists. In addition, the National health System use of the private sector also grew significantly between 2006 and 2008, from 14.5% of the total private acute market to over 23%.

Usually direct payments cover *private treatment in NHS facilities*, *over-the-counter pharmaceuticals*, *ophthalmic services* and *social care*. Co-payments cover *NHS prescriptions* and *NHS dental care*. NHS prescription charge is set at a flat fee that is not related to the amount prescribed or the actual cost of the prescribed item to the NHS. Furthermore, complementary "Private Medical Insurance" covering the cost of user charges is not generally available in the United Kingdom.

The system has set exemptions from prescription charges for about the 50% of the population. Around 94% of all prescription items were dispensed free of charge in 2009. People exempt from charges include children (i.e. younger than 16 years), full-time students aged 16–19 years, people aged 60 years and over, pregnant women and women who have given birth in the previous 12 months, people with specified medical conditions and people on the NHS low-income scheme. In April 2009, patients undergoing treatment for cancer were added to the list of exemptions. In addition, prescriptions for contraceptives are free. Free sight tests are available to children (i.e. people aged under 16 years), full-time students aged 16–19 years, people aged 60 years and over, people on low incomes, people who are diabetic, and people who have, or are at risk of having glaucoma.

Concerning *hospital care*, and more precisely for *inpatients*, few data are available. Most private health insurance packages cover surgery as an inpatient or day case, hospital accommodation and nursing care and inpatient tests. Private health insurance mainly pays for patients to attend private hospitals and to a lesser extent National Health System private patient units and pay-beds. Payments to private hospitals usually consist of two elements: the facility charge and the specialist fee. There are direct payments for private treatment, mainly for acute elective surgical procedures. Most expenditure on private acute hospital care in the United Kingdom is funded through private medical insurance (61% in 2008), although patients out-of-pocket funding accounted for 14%. Private hospitals have made their services more accessible to patients without private medical insurance, for example through fixed price packages in which the total cost of the treatment is agreed in advance, even if unexpected complications arise.

However, fixed price packages are usually applied to routine surgical procedures such as hip and knee replacements, cataract surgery and hernia operations and are much less likely to be available for medical conditions such as cancer treatment.

In *non-hospital care*, most out-of-pocket payments by individuals are direct, with some 41% devoted to over-the-counter pharmaceuticals. User charges for National Health System services are the next largest part, accounting for 13% of the total. For free over-the-counter pharmaceuticals, no eligibility criteria are applied. Prescription charge is set at a flat fee that is not related to the amount prescribed or the actual cost of the prescribed item. The charge is £7.20 (10.2 euro) per item (from 1 April 2010), which is about 72% of the average total prescription cost. Complementary private medical insurance covering the cost of user charges is not generally available in the United Kingdom.

Table 28. Share of the total out-of-pocket payments in sub-categories

(*Source: European Observatory on Health Systems and Policies, 2011*)

SECTORS	SUB-SECTORS	%
Hospital care	Inpatient	-
	Outpatient	-
Non-hospital care	Over the counter pharmaceuticals	41%

National Health System dental services are another example where co-payments are applied. The NHS general dental services are provided by independent dentists under agreements made with local health authorities. There are currently three charging bands for National Health System dental treatment, which vary according to the complexity of the healthcare services provided and are respectively: £16.50, £45.60, £198.00. (corresponding to 23.3, 64.4 and 279.5 euro).

Table 29. Out-of-pocket expenditure covered by patients, voluntary health insurance or others, in % and in £

(*Source: European Observatory on Health Systems and Policies, 2011*)

SUB-CATEGORIES	OUT-OF-POCKET PAYMENTS TYPOLOGIES		
	Paid directly by the patient	Paid by voluntary insurance	Paid by other
Health service			
Private acute hospital care	14%	61%	-
Long-term care	43%	-	57% (public resources)
Dental services	16.50 - 45.60 -198.00	-	-
Pharmaceuticals			
Prescription charge	7.20 (per item)	-	-

Universal ophthalmic services are not available under the National Health System. Most of them are now provided on a commercial basis by private opticians. This care area is covered by out-of-pocket payment (direct payment).

In the period between 2007 and 2012, out-of-pocket payment as percentage of the total health expenditure in the United Kingdom had a decreasing trend. The percentage passed from 11.48% in 2007 to 9.76% in 2011.

ANNEX: QUESTIONNAIRE

SURVEY ON OUT-OF-POCKET PAYMENTS IN HEALTHCARE SYSTEMS IN EUROPE

This questionnaire aims to understand how healthcare is financed in Europe. More precisely, it is to collect information and figures on out-of-pocket payments in healthcare systems in Europe. Since the information available is rather sparse and limited, the intention is to discover what is not available in the existing databases.

A. DEFINITION OF OUT-OF-POCKET PAYMENTS

For the purpose of this questionnaire, the WHO definition for out-of-pocket payments is applied, as agreed during the 14 March 2013 Liaison Officers' meeting:

"Private households' out-of-pocket payment on health as % of total health expenditure are the direct outlays of households, including gratuities and payments in-kind made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. It includes household payments to public services, non-profit institutions or non-governmental organisations. It includes non-reimbursable cost sharing, deductibles, co-payments and fee-for service. It excludes payments made by enterprises which deliver medical and paramedical benefits, mandated by law or not, to their employees. It excludes payments for overseas treatment."

1. Does the WHO definition reflect the definition used in your country?

- ❑ Yes
- ❑ Not

2. If not, what are the differences?

B. Definition of sectors, categories and out-of-pocket payments typologies

1. **Are there out-of-pocket payments for (please tick the box(es) concerned) :**

   - ❑ Hospital care (inpatients and outpatients)
   - ❑ Inpatient hospital care only
   - ❑ Outpatient hospital care only
   - ❑ Non-hospital care
   - ❑ Other, please precise

     .....

2. **If data is available, please provide the average share of out-of-pocket payments for the sectors/sub-sectors listed in the table below (for example: out-of-pocket represents 10% of hospital care expenditure)**

SECTORS	%	SUB-SECTORS	% (please specify if possible)
Hospital care	_____%	Inpatient Outpatient	_____% _____%
Non-hospital care	_____%	-	-
Other, please precise	_____%		

3. **If there are important extremes around the average could you provide explanation (indicating for example that some patients are covered 100%)?**

4. **Could you provide qualitative information on out-of-pocket payments on hospital care and non-hospital care (for example that patients have to pay a fixed fee per day, etc.)?**

5. Could you provide qualitative information on inpatient and outpatient out-of-pocket payments?

6. Referring to the categories listed in the table below:

A. Is there in your country a database in which are collected the information in order to fulfil the table below?

- ❑ Yes
- ❑ No

B. If data are available, could you please specify in the table the out-of-pocket payment typology(ies) (money paid directly by the patients, voluntary insurance or other) which correspond to each category?
*For example: for **services**, money paid by the patient is 20% (in average); voluntary insurance is 10% (in average) and other is 5% (in average). In the example, the total out-of-pocket payments for services are in average 35%. The same method should be used for **goods** and **extra services**, if possible.*

CATEGORIES	Out-of-pocket payments typologies for health in general	%
Services	Money paid by the patient	____%
	Voluntary insurance	____%
	Other	____%
Goods	Money paid by the patient	____%
	Voluntary insurance	____%
	Other	____%
Extra services	Money paid by the patient	____%
	Voluntary insurance	____%
	Other	____%

C. Could you please, for each category, tick in the table above which is the more common out-of-pocket payment typology in your country?

7. Referring to the sub-categories listed in the table below:

A. Is there in your country a database in which are collected the information in order to fulfil the tab above?

- ❑ Yes
- ❑ Not

B. If data are available, could you please specify in the table the out-of-pocket payment typology(ies) (money paid directly by the patients, voluntary insurance or other) which correspond to each sub-category?
For example: surgeries are paid (in average) 5% by the patient; 1% by voluntary insurance and 0% by other out-of-pocket payments. In the example, the total out-of-pocket payments for surgeries are in average 6%. The same method should be used for the other sub-categories, if possible.

SUB-CATEGORIES	Out-of-pocket payments typologies		
	Paid directly by the patient (%)	Paid by voluntary insurance (%)	Paid by other (%)
Health service	_____	_____	_____
Surgery	_____	_____	_____
Pre-recovery services	_____	_____	_____
Post-recovery services	_____	_____	_____
Outpatients specialised healthcare	_____	_____	_____
Therapeutic appliances	_____	_____	_____
Fees for doctors	_____	_____	_____
Fees for nurses	_____	_____	_____
Fees for other human resources taking care of the patient	_____	_____	_____
Pharmaceuticals	_____	_____	_____
Medical devices	_____	_____	_____
Other services	_____	_____	_____
Meals	_____	_____	_____
Accommodation	_____	_____	_____
Services for the patients' families	_____	_____	_____

C. Could you please, for each sub-category, tick in the table above which is the more common out-of-pocket payment typology in your country?

C. Out-of-pocket payments before and after the economic crisis: Trend 2007-2013

"The economic crisis has had an effect on the mix of public and private health financing. After public financing, the main source of funding for health expenditure is out-of-pocket payments. The share of out-of-pocket spending has increased over the past decade in about half of EU Member States while it has decreased in the other half. In some countries, hard hit by the economic crisis, the public coverage for certain services has been reduced in recent years, with a growing share of payments being transferred to households. On the other hand, some other countries have extended public coverage for health services in recent years to improve access to care, resulting in a lower share of health spending paid directly by households. This has led to a reduction in the share of direct payments by households over the past decade."[13]

1. **Which were the trends in out-of-pocket payments from 2007 to 2012 (please indicate the year of reference and source of the information/figures)[14]?**

D. Out-of-pocket payments features in the different regions of the EU Member States

1. **Were previous information and figures provided at country level? Are there major differences within your country? If yes, please precise**

FOOTNOTES

1. http://www.moh.gov.cy/moh/moh.nsf/All/FD0134CDED1D026243257A37002C2C47?OpenDocument
2. http://www.moh.gov.cy/moh/moh.nsf/All/FD0134CDED1D026243257A37002C2C47?OpenDocument
3. Economou C. 2011. Greece: Health system review. Health Syst. Transit. 2010;12(7):1-177, xv-xvi
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5. European Commission, 2013
6. http://www.euro.who.int/__data/assets/pdf_file/0010/241849/HiT-Malta.pdf
7. http://www.oecd.org/els/health-systems/Briefing-Note-NETHERLANDS-2014.pdf
8. To convert the national currency in Euro it was used the change rate of July 2015, according to InforEuro – European Commission official currency converter http://ec.europa.eu/budget/contracts_grants/info_contracts/inforeuro/inforeuro_en.cfm
9. Decree-Law 113/2011 of 29 November 2011; Decree-Law 128/2012 of 21 June 2012; MS.ACSS. Revisão de categorias de isenção. Administração Central do Sistema de Saúde, Ministério da Saúde, 02.10.2012. Available in http://www.acss.min-saude.pt/Portals/0/FAQ_taxas%20moderadoras_02102012__.pdf; Barros P, Machado S, Simões J. Portugal: Health system review. Health Systems in Transition, 2011, 13(4):1–156. 04/03/2013: Update on User charges updates by Pedro Pita Barros ; Ordinance n.º 395-A/2007, de 30 de March, published in DR, I Series, n.º 64, of 30-03-2007; Ordinance n.º 34/2009, de 15 de January, published in DR, I Series, n.º 10, of 15-01-2009; Ordinance n.º 1320/2010, de 28 de December, published in DR, I Series, n.º 250, of 28-12-2010 ; Mandatory circular n.º 05/2013 /DPS, 17 January 2013. Available in http://www.portaldasaude.pt/NR/rdonlyres/A555202A-3168-48C2-A861-7C838FFC1805/0/CircularNormativa5202013.pdf)
10. Instituto de Seguros de Portugal
11. Health products, special kind of nourishment, dietetic products
12. To convert the national currency in Euro it was used the change rate of July 2015, according to InforEuro – European Commission official currency converter http://ec.europa.eu/budget/contracts_grants/info_contracts/inforeuro/inforeuro_en.cfm
13. OECD (2012), "Financing of healthcare", in Health at a Glance: Europe 2012, OECD Publishing. http://dx.doi.org/10.1787/9789264183896-56-en
14. Where data for the years indicated are not available, it is possible to consider the figures referred to the nearest years but it is mandatory to indicate them.

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