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HEALTH CARE COVERAGE IN OECD COUNTRIES IN 2012

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ABSTRACT

This paper provides a detailed description of health coverage in OECD countries in 2012. It includes information on the organisation of health coverage (residence-based vs contributory systems), on the range of benefits covered by basic health coverage and on cost-sharing requirements. It also describes policies implemented to ensure universal health coverage –in most countries- and to limit user charges for vulnerable populations or people exposed to high health spending. The paper then describes the role played by voluntary health insurance as a secondary source of coverage. Combining qualitative information collected through a survey of OECD countries on benefits covered and cost-sharing requirements with spending data collected through the system of health accounts for 2012, this paper provides valuable information on health care coverage in OECD countries at a time universal health coverage is high on the policy agenda of many countries.

RÉSUMÉ

Ce document fournit une description détaillée de la couverture santé dans les pays de l'OCDE en 2012. Il contient des informations sur l'organisation de la couverture santé (selon que les droits sont contributifs ou accordé à tout résident), sur l'étendue des services couverts par le régime de base et sur les contributions aux frais demandés aux usagers. Il décrit également les politiques introduites pour atteindre la couverture universelle- dans la plupart des pays ou pour les limiter les dépenses pour les usagers vulnérables ou exposés à des dépenses élevées. Ce document décrit ensuite le rôle joué par l'assurance privée volontaire en tant que source « secondaire » de couverture santé. Combinant l'information qualitative recueillie sur les services couverts et dépenses laissées à la charge des usagers lors d'une enquête menée auprès des pays de l'OCDE et les données sur les dépenses recueillies à travers les comptes de la santé, ce document fournit une information précieuse sur la couverture santé dans les pays de l'OCDE à un moment où la couverture santé universelle est une priorité politique dans de nombreux pays.

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1. Introduction and context[1]

1. Across the world, many countries are moving towards providing 'universal health coverage' (UHC) for their populations. The World Health Organisation dedicated the World Health Report of 2010 to the financing of UHC (WHO, 2010), while the 2013 Report was on Research for Universal Health Coverage (WHO, 2013). "Universal health coverage" ensures that all people obtain the medical services they need, without risking a severe financial burden linked to paying for them. In practice, it could be defined as coverage for the whole population for a certain set of health services and goods, although the nature of these goods and services varies across countries.

2. The WHO and the World Bank have proposed options to measure and assess health care coverage in a given country and to measure progress towards "universal coverage" (See Box 1). They suggest that two types of measures can be used to assess progress towards universal coverage. Financial protection can be measured by looking at the proportion of people facing very high ('catastrophic') health expenditure (defined as a percentage of household spending), and by looking at the proportion of the population who fall into poverty due to health spending. Recognising the fact that it is possible that few people will fall into either category if covered health services are not supplied or are not accessible, they suggest that the availability of key health services should be tracked. The health services to be covered would vary according to the health care needs and level of development of the health system of the country in question – the proportion of trained health professionals attending birth (a current Millennium Development Goal) might be suitable in some countries; the proportion of the relevant population being screened for breast cancer might be a more useful indicator in other countries.

3. Some of these measures are of relevance to OECD countries. Although relatively few people in most OECD countries have catastrophic health spending, or fall into poverty because of such spending, this does nevertheless happen and should be monitored. Similarly, coverage of screening programmes is very relevant, and is often commented upon when included in OECD publications such as *Health at a Glance.* This paper is therefore not proposing an alternative approach to measuring health coverage. Nor does it consider these UHC measures in any detail, as these are being discussed in other fora. Instead it provides information on how basic health coverage is organised in OECD countries, details the degree of cost-sharing for different health services – an area where practices differ, sometimes dramatically, across OECD countries; and shows the role played by private health insurance as a secondary source of health care coverage.

4. This paper has been prepared at a time when there is more change in the coverage of health services than has been usual. As part of their attempts to contain health spending because of the tight fiscal situation, countries in Europe (in particular) have been adapting their health systems in a way that affects coverage (Mladovsky et al., 2012, WHO and Observatory on Health Systems and Policies, 2013).

- Only a few countries have implemented policies impacting entitlements to health care coverage or the share of the population covered. Where it happened, these policies mainly targeted the migrant population (e.g. Spain). However, in countries like Greece, where safety nets were lacking, a significant share of the population lost health insurance coverage due to long-term unemployment.

- Far more common have been changes in co-payments for health services. These have been increased in all those countries most affected by the fiscal crisis, often quite dramatically. At the

[1] Authors would like to thank OECD Member countries delegates and Mark Pearson for useful comments on earlier versions of this paper, as well as Grégoire de Lagasnerie for further comments and punctual contributions to this paper.

same time, many of these countries have also taken steps to introduce or extend exemptions for key groups, or 'safety nets' to protect the poorest and sickest. Even so, the most recent health expenditure data shows an increase in out-of-pocket payments as a percentage of total health expenditure in the majority of European countries.

- In contrast, there has been little explicit change in the package of services provided by countries. However, this statement needs qualifying, as in several countries the provision of services is determined at the local or provider level, subject to resource constraints. As budgets are tightened, in these countries, it is possible that there have been changes in coverage, but in a manner difficult to quantify.

5. Given these changes, it seems timely to review the coverage of health services in OECD countries. Section 2 of this paper defines what is considered as "health coverage" in the sections that follow. Section 3 describes institutional arrangements designed in OECD countries to supply health care coverage to their population. Section 4 provides a detailed account of cost-sharing requirements by function of care, based on country answers to the OECD Health Systems Characteristics survey 2012, and completed wherever possible, by data on health spending by function and financing agent, drawn from the System of Health Accounts. These two sets of information are complementary: in a country with high cost-sharing requirements, a low level of out-of-pocket payments indicates that a mechanism is in place that reduces these co-payments for the severely ill. By contrast, a high share of private financing in a country where people are in principle entitled to free health services suggests that people tend to turn to the private sector or accept extra-billing because of accessibility or quality issues. Section 5 lists policies in place to reduce co-payments for some population groups (typically low-income and high-risk patients, but also children and pregnant women). Section 6 summarises the role of private health insurance as a secondary source of coverage, according to information collected through the OECD Health System Characteristics Survey 2012 and regular data collection on health insurance coverage and health spending. Finally, section 7 provides a snapshot of health coverage in OECD countries in 2012.

Box 1. Measuring Universal Health Coverage

Researchers have been working for decades on the definition of indicators to measure the level of health coverage. The WHO recently proposed a list of dimensions to consider when measuring health coverage and the World Bank has made an inventory of available indicators commonly used to measure the level of coverage. The World Health Organisation proposes considering the six following elements for a measure of universal health coverage. Synthetic measures have been developed for some of these dimensions (equal access to care, financial risk protection) while information on other dimensions is less homogeneous and more difficult to synthesize in a single indicator.

Equal access to care irrespective of ability to pay: Universal health coverage ensures that all people obtain the medical services they need, without risking a severe financial burden linked to paying for them. Several studies have explored income-related inequalities in the use of health care services, adjusted by medical need (Wagstaff, 2012, Devaux and de Looper, 2012). Although inequalities do not only reflect differences in access, but also differences in preferences, lower levels of inequalities are generally considered as an indicator of good coverage.

Financial risk protection: Protection against the incidence of catastrophic expenditure, i.e. excessive out-of-pocket payments, prevents people from falling into poverty due to an unexpected illness. The share of population exposed to catastrophic health spending is commonly used to assess the level of financial protection. Results are available for some OECD countries (see below). A further risk in the absence of such a protection is that people will defer seeking medical attention, potentially worsening their condition. In some countries, population surveys ask respondents whether they have forgone or postponed the use of health care services for financial reasons. However, international comparisons of such data are difficult because people's expectations are known to differ across countries.

Availability of physicians, medicines and medical devices: Apart from appropriate health financing, elements like accessibility and availability of medicines and physicians located where they are needed, play a big role in achieving universal coverage and need to be considered together.

Timely access: Universal coverage also requires that the necessary services are available to the population. Long waiting times for covered services can severely impede access to care and worsen the health of patients requiring a procedure. Waiting times have been measured in several OECD countries, though not necessarily in a homogenous way (Siciliani et al., 2013).

Quality of Care: Good quality of health care services, well-educated physicians and safety regulations for pharmaceuticals and medical devices are a further crucial element. The quality of care has multiple dimensions and the OECD is now proposing a set of indicators in different domains which can be used by country with appropriate information systems.

Access to prevention, promotion and rehabilitation: UHC does not only concern treatment itself, but also timely and good quality access to prevention, promotion and rehabilitation.

In May 2014, the WHO and the World Bank proposed a set of indicators for **monitoring the progress towards universal health coverage** within countries and at the global level (WHO and World Bank Group, 2014). This set of indicators covers two dimensions of coverage

- The **coverage of essential services** is measured by effective access (share of the population who had access) to a set of tracer interventions, which are preventive (e.g. measles vaccination or "at least 4 antenatal care visits) or curative (hypertension or diabetes treatment);

- The **financial protection** is measured by two indicators: the fraction of the population protected from catastrophic out-of-pocket health expenditure and the fraction of the population protected against impoverishment by out-of-pocket expenditure.

For each of these dimensions, countries are encouraged to report on **equity**, i.e. to provide measures by income quintile, by place of residence (rural/urban) and by gender.

Source : Wagstaff, 2012, World Health Organisation and World Bank Group (2014)

2. Describing and measuring health care coverage

6. Health care coverage can be assessed by answering three basic questions: Who is covered? Which benefits are covered? What proportion of the costs is covered?

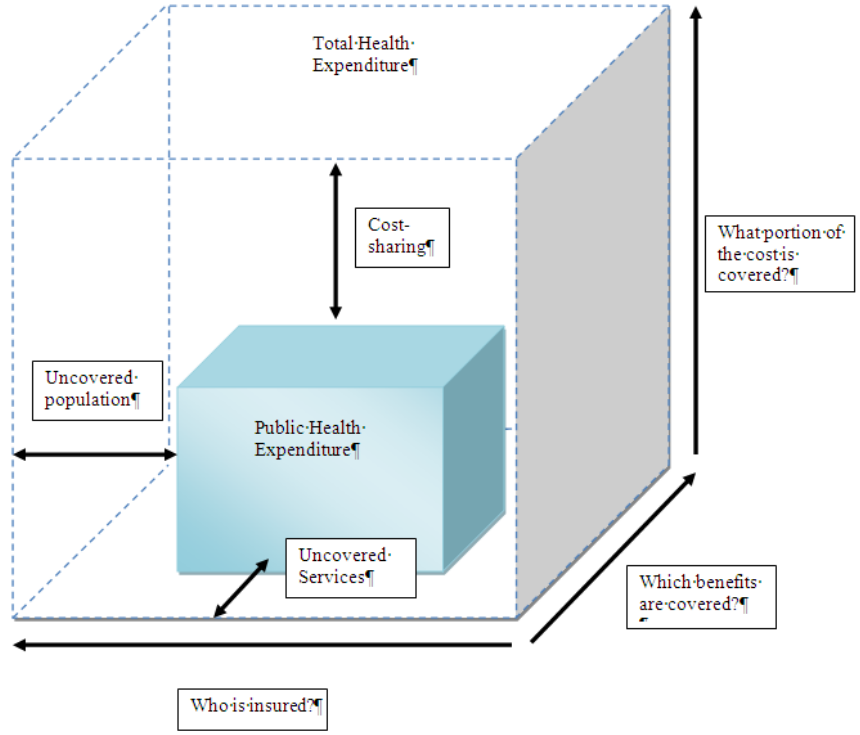
7. Busse et al. (2007) proposed a graphic presentation of these three dimensions to assess health coverage in a given country (see first figure in Box 2), which has since been adapted and widely used by the WHO (WHO, 2010). Such a presentation illustrates the importance of going beyond indicators usually used to assess the level of coverage in a given country, such as the "share of spending financed by health insurance" or "the share of household payments for health care'. In particular, focusing on the two last dimensions (range of benefits covered and level of coverage) clearly shows trade-offs that can be made between them, without affecting the global share of spending financed by government or health insurance (second Figure in Box 2).

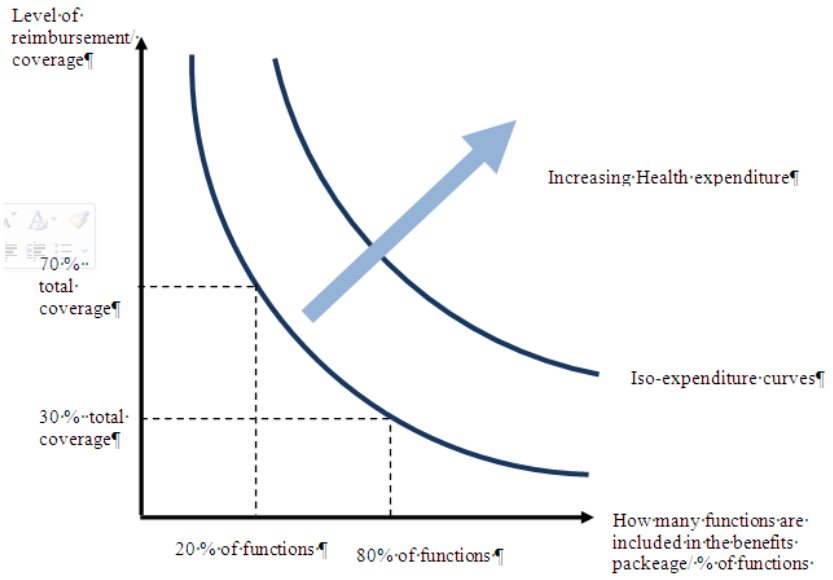
8. The great variety of institutional arrangements made to organise health coverage does not simplify attempts to measure coverage. In this paper, the term *basic (primary) health care coverage* refers to the first source of financial protection for health care users. In most - but not all - OECD countries, residents are entitled to tax-funded health coverage or covered by compulsory social health insurance. These systems can unambiguously be considered as "basic health coverage". In countries without automatic entitlement or compulsory health insurance, "basic health care coverage" is more difficult to define: it includes voluntary health insurance (VHI) which provides coverage for a basket of benefits deemed to be essential.

9. In many countries, people have the possibility to subscribe to private health insurance providing additional coverage on a voluntary basis. In this paper, this coverage is considered to be a "*secondary source of coverage*". Depending on the scope of basic health coverage, on country-specific regulations and on demand for additional coverage, VHI as a secondary source of coverage covers cost-sharing left by basic coverage and/or benefits that are not covered by basic coverage. Hence, the boundary between what is "basic" and what is "additional" is not universal and varies across countries.

10. In order to assess the level of coverage in a given country, one option is to take both types of coverage into account. However, the share of population covered by a secondary source of coverage varies from 20% to 94% across OECD countries. In countries with low take-up of voluntary secondary health insurance, it does not seem appropriate to include benefits covered by this type of insurance in the range of benefits covered for the whole population. By contrast, in countries with wide coverage by a complementary/supplementary health insurance, benefits they cover could be included in the "benefit package" covered for the whole population. Nevertheless, basic and secondary sources of coverage have different consequences in terms efficiency, cost-containment, and equity, and cannot be considered as "equivalents" (OECD, 2004b; Thomson and Mossialos, 2009). This paper mainly assesses the extent of coverage by basic primary coverage.

Box 2. Dimensions of health care coverage





Source : Adapted from Busse, Schreyögg and Gericke, 2007

3. The organisation of health coverage in OECD countries

11. Describing how basic health coverage is organised in OECD countries is not as simple as it appears. Traditional models distinguish "national health systems", in which all residents are entitled to health services mainly financed from general taxes, and "health insurance systems", in which people have to pay social contributions or premiums to get coverage for themselves and often for their dependants. However, most health insurance systems have introduced mechanisms to widen health insurance coverage to the whole population, including people who do not directly contribute to its financing through contributions. Similarly, the frontier between "public" and "private" health insurance is somewhat blurred. In countries where private health insurance funds – for-profit or not - are highly regulated in order to guarantee universal coverage, they are considered to be "public health insurance".

12. That said, basic primary health coverage is available to the vast majority of residents of OECD countries with just a few countries reporting that small or greater proportions of their populations were not covered in 2011 (Austria, Belgium, Chile, Greece, Japan, Luxembourg, Mexico, Turkey and the United States). However, countries differ in the way coverage is organised (see Table 1).

13. ***Automatic health coverage*** is provided to the entire population and mainly financed from taxes in 13 OECD countries (Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the United Kingdom). This does not mean that entitlements in a given country are uniform. In Ireland for instance, all residents are covered but entitlements to services and levels of cost sharing vary across population categories. Each resident belongs to one of two categories, depending on income level. People in Category 1 (or Medical Card Holders) are entitled to a full range of services without charge, for example general practitioner services, prescribed medicines, in-patient and ambulatory hospital care, dental and ophthalmic services, while people in Category 2 have a "limited eligibility" and must co-pay for many health services. In Italy and Spain, regions and Autonomous Communities have some latitude to adjust benefits covered or co-payments at the margins. In the United Kingdom, co-payments vary across the constituent countries: there are no co-payments on prescription drugs in Scotland, Wales or Northern Ireland, while there are in England.

14. In other countries, ***entitlement to health coverage is contributory***: coverage is linked to the payment of social contributions or health insurance premiums. These contributions are usually paid by insured people and/or employers and can be subsidised for low-income people. In seven countries (Korea, Greece, Hungary, Luxembourg, Poland, Slovenia and Turkey), a single health insurance fund provides coverage to all insured (see Table 2). In another group of four countries, several health insurance funds exist but people cannot choose their insurer and affiliation to a specific fund is determined by professional occupation and/or place of residence (Austria, Belgium, France, Japan). For example, in Japan, the self-employed are covered by the national health insurance scheme, the employed are covered by corporate-based insurance schemes and those aged 75 or older are covered by a specific scheme for elderly, but all groups have the same health coverage. In France, three separate health insurance funds exist for salaried workers, agricultural workers, and the self-employed and a number of smaller health insurance funds cover specific professions, such as people employed in the military forces, or people employed by some state-owned companies, such as the National Society of French Railways (SNCF). These schemes automatically cover family members.

15. In another group of countries with mandatory health insurance, people can choose their insurer (Czech Republic, Germany, Israel, the Netherlands, the Slovak Republic and Switzerland). In Germany, health insurance has been compulsory for all since 2009. While all residents below a certain revenue threshold must be affiliated to statutory health insurance, people beyond this threshold can choose between statutory and private health insurance and most of the civil servants are affiliated to a private insurance. As a result, 11% of the population is privately covered for basic health insurance and pays insurance

premiums instead of income-related contributions. Another 0.3% of the German population benefit from insurance that is covered by the state.

Table 1. Characterisation of basic primary health coverage in 2011 or latest available year (% of population)

Country	Automatic coverage (tax-financed)	Compulsory Insurance coverage	Voluntary coverage	Other	Not insured
Australia	100.0				
Austria		99.5			0.5
Belgium		99.0			1.0
Canada	100.0				
Chile (a)	22.5	72.2	1.9		3.5
Czech Republic		99.0	1.0		
Denmark	100.0				
Estonia	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	100.0				
France		100.0			
Germany		100.0			
Greece (b)		79.0			21.0
Hungary		100.0			
Iceland	100.0				
Ireland	100.0				
Israel		100.0			
Italy	100.0				
Japan		98.5		1.5	
Korea	3.4	96.6			
Luxembourg (c)		97.6			2.4
Mexico (d)		45.5	47.4		7.1
Netherlands		100.0			
New Zealand	100.0				
Norway	100.0				
Poland		97.7			
Portugal	100.0				
Slovak Republic		100.0			
Slovenia		100.0			
Spain	99.3	0.4	0.3		
Sweden	100.0				
Switzerland		100.0			
Turkey		99.8			0.2
United Kingdom	100.0				
United States (a,e)	34.3		64.2		13.4

Notes: (a) Coverage by government program is not always automatic, people have to enrol. (b) Data for 2013 (c) A very small proportion of the population is covered on a voluntary basis, but they are included column 2, as the exact percentage is not known. (d) A proportion of citizens are covered both by insurance related to their employment, and by the *Seguro Popular*, a voluntary public health insurance scheme open to all citizens. The main source of coverage is actually *Seguro Popular*, which is state-run but voluntary. (e) The sum of percentages is higher than 100% because some people have both public and private coverage.
Source: OECD Health system characteristics Survey 2012, Secretariat's estimates and U.S. Census Bureau Health Insurance Coverage in the United States 2013.

Table 2. Provision of basic primary coverage (for the average employed adult)

Main source of basic health care coverage		List of countries
Residence-based health coverage		Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, New Zealand, Norway, Portugal, Spain, Sweden, United Kingdom
Contributory health coverage	Single payer	Estonia, Greece(a), Hungary, Korea, Luxembourg, Poland, Slovenia, Turkey
	Multiple insurers, with automatic affiliation	Austria, Belgium, France, Japan, Mexico (b)
	Multiple insurers, with choice of insurer	Chile, Czech Republic, Germany, Israel, the Netherlands, Slovak Republic, Switzerland, United States

Note: (a) Since 2012; (b) In Mexico, employees are automatically affiliated to a health insurance fund, while other people have to enrol with *Seguro Popular* to get coverage.
Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates

16. The Czech Republic has a mandatory Social Health Insurance (SHI) arrangement whereby employees are covered by compulsory health insurance that is financed through employer and employee contributions linked to revenues. Individuals who are self-employed contribute a percentage of their income. Social health insurance (SHI) contributions are administered by multiple health insurance funds, which act as payers and purchasers of health care. In both the Czech Republic and the Slovak Republic non-working family members are not co-insured by the contributing family member, but are instead covered via lump sum transfers from the government to the health insurance companies on behalf of the beneficiaries (Bryndova et al., 2009; Hlavačka et al., 2004).

17. In the Netherlands, health insurance is compulsory for all and partly financed by income-related employer contributions deducted from the payroll (Schäfer et al., 2010). The other part is financed through a flat-rate nominal premium to competing health insurance funds. In Switzerland, individuals purchase health insurance from competing funds, with means-tested subsidies for lower-income households. In both countries there are strong restrictions on health insurers in order to address market failures: health insurance funds cannot deny an insurance policy to an applicant and are not allowed to charge different nominal premiums adjusted for the person's individual health risk profile. Risk-adjustment schemes redistribute part of the resources among health insurance companies (Leu et al., 2009).

18. In Chile, Mexico, Turkey and the United States (until 2014), health insurance coverage is voluntary at least for a part of the population.

19. In Chile, employees in the formal sector must enrol in a health insurance plan and pay 7% of their monthly income or pension for coverage. They can choose to enrol with the public insurance fund, called Fonasa, which covers around 76% of the population or with one of the thirteen private health insurance funds (Isapres). Seven private funds are competing in an open market, while others are associated with public enterprises and their employees. Individuals who do not work in the formal sector, can choose to enrol, but are not required to do so. The Fonasa public insurance scheme is generally required to insure every applicant, regardless of health and income and also provides free coverage to the indigent and unemployed parts of the population, which account for 22.5%. The remaining 3.5 % of Chileans are uninsured.

20. In Mexico, the healthcare system is highly fragmented but has undergone significant progress towards broader coverage of the population in recent years. 45.5% of the population is covered under Social Security, which applies to employees in the formal sector and their dependents. Workers and their families in the private sector are covered through the Mexican Institute for Social Security (IMSS), whereas public servants and workers in the public sector are covered by the ISSTE subsystem (Institute for

Social Security Service for State Employees). Self-employed people can be insured under the *Seguro de Salud para la Familia* scheme. People who are not entitled to social security, i.e., the unemployed, rural workers and workers in the informal sector, can obtain voluntary health coverage through the *Seguro Popular*. This scheme covers 47.4% of the population, a proportion that has grown significantly since the Health Reform in 2003. In 2012, 7.1% of the population remained uninsured, and a small proportion (3%) of the population are individually privately insured. The uninsured population can still have access to health care services at below full-cost prices, publicly financed by the Ministry of Health.

21. In Turkey, health care coverage has increased since the implementation of the Health Transformation Programme (HTP) in 2003. Recently, the reform consolidated the five main social security funds into a unified social security system, the General Health Insurance Scheme (GHIS - *Genel Sağlık Sigortası*), which now covers the majority of the population for services provided by a mix of public and private sector facilities (Tatar *et al.*, 2011). The Social Security Institution (SSI - *Sosyal Güvenlik Kurumu*) has become the single-purchaser of health care services. It is funded by contributions from employers and employees, and by government contributions, which finance coverage for low-income people (former Green Card holders) and civil servants.

22. In the United States, health coverage was voluntary until 2014. The majority of Americans (64.2% in 2012) are privately insured, either through privately purchased insurance or through insurance provided by their employer or an employer of one of their family members. The government provides various public insurance schemes for low-income groups, older citizens and high-risk groups: Medicare (which covers 15.6% of the population) provides health insurance to residents over 65, people with disabilities and people with end-stage renal disease. In addition, Tricare and the Veteran Health Administration provide health coverage for military personnel, veterans and their families (4.5%). States' Medicaid programmes cover low-income people (17.3% of the population[2]). These population-specific programmes are financed by tax but eligible individuals are not automatically covered and need to enrol for the programme and pay premiums in certain cases. A large proportion of the population, estimated at 13.4 %, is uninsured (US Census Bureau, 2013). The Affordable Care Act, adopted in 2010, aims to progressively expand health insurance coverage, which became mandatory for all United States citizens and legal residents from January 2014. From this date, individuals who do not purchase health insurance will have to pay a penalty[3].

23. As a consequence of the economic crisis and the need for fiscal consolidation, a few countries have reduced entitlement to basic health care coverage: the Czech Republic and Spain have removed health coverage entitlement for people without permanent legal residency status (WHO, 2013). England has recently introduced an additional residency test for the allocation of health services and benefits to migrants.

Complementary interventions by the public sector to provide health coverage

24. Countries with tax-funded health systems covering all residents do not need complementary interventions from the government to guarantee basic health coverage for economically disadvantaged groups or for people with poor health risk profiles (though they may have schemes to reduce co-payments, as covered later in this paper). By contrast, in nearly all countries with social health insurance, governments have introduced policies to help low-income groups obtaining coverage. Countries where health insurance coverage is not determined by occupational status (active, pensioner, unemployed) have also implemented policies to avoid exclusion of "high-risk individuals" from health insurance.

2 The sum of percentages is higher than 100% since people can be covered by more than one public programme.

3 http://kff.org/interactive/implementation-timeline/

25. Fifteen countries – amongst those countries that do not provide tax-funded (automatic) health care coverage - reported that the government intervenes to ensure the provision of basic health coverage or health care services for low income or economically disadvantaged groups (see Table 3). Only one county (Austria) - reported no such intervention.

26. Most of these countries provide means-tested public subsidies: governments pay a part or the full costs of health insurance premiums or social contributions on behalf of low-income individuals. The share of the population who is entitled to such subsidies and actually takes up health insurance is however very variable: it ranges from 2 to 3% of population in countries like France or Luxembourg to half of the population in Estonia, Mexico and the Netherlands. In Chile, 22% of the population benefit from subsidies to get insured by public health insurance. In the United States, Medicaid (which covers 15.95% of the population) is a means-tested health programme for individuals and families on low incomes; the States Children's' Health Insurance Fund provides a health insurance for children in low-income families that do not qualify for Medicaid. These population-specific programmes are tax financed but eligible individuals are not automatically covered, and need to enrol for the programme and pay premiums in certain cases.

27. Wide variations in the shares of population covered by the policies described in Table 3 reflect differences in the policy objectives of these measures. In countries with occupation-related health insurance, social contributions are proportional to income (sometimes up to an income threshold) and based on earnings, pensions and (often) unemployment benefits. For these countries, additional interventions to ensure universal coverage only concern a small share of the total population. In countries where health insurance premiums are not or are only partially related to income, policies described in Table 3 aim to reduce the burden of contribution for households with lower revenues and ensure some "redistribution" between richer and poorer households. Therefore, they affect larger shares of population (for instance in Switzerland and the Netherlands).

28. In countries where health coverage is mainly linked to occupation, policies ensuring universal access to health coverage are all the more important in times of crisis. Countries have to make sure that people who lose their job do not lose health coverage at the same time. In many European countries, unemployed people and people who benefit from social assistance are most often covered for health care through "safety nets" (see table 3). In Greece, many people lost health insurance coverage during the economic crisis. In the United States, in 2009, the government introduced in the Recovery Act a subsidy to help individuals losing their jobs to purchase health insurance but Medicaid acts as a safety net for the poorest part of the population and, as already noted, a significant share of population remains uninsured. Thanks to the Affordable Care Act, the share of population without health insurance coverage has been declining.

Table 3. Public interventions in health insurance systems to ensure the provision of basic health coverage or health care services for low-income or economically disadvantaged groups, 2012 or nearest year

Countries where health insurance is mainly linked to occupation	
Austria	None
Belgium	The costs of healthcare for people with no normal insurance (<1%), for example illegal migrants, are covered through welfare centres ('Public Centres of Social Welfare'). Therefore, this is a financial support system, and not free provision of services.
Czech Republic	The State pays Social Health Insurance contributions for economically inactive persons.
Estonia	People are entitled to health care coverage through dedicated public programmes that subsidise public or private provision (50.3% of the population).
France	Residents not covered through health insurance related to employment, pensions, unemployment or social benefits are entitled to means-tested subsidies to purchase basic health insurance (*Couverture Maladie Universelle*). 2.2 million people were insured by CMU in 2011 (3.3% of population), of which 98% with subsidy.
Germany	Municipalities pay (flat) health insurance contributions for low-income, long-term unemployed people.
Hungary	The State pays Social Health Insurance contributions for the people qualified as 'socially needy'.
Japan	People receiving public assistance (1.5% of population) can receive health care services in medical institutions without any charges.
Korea	People are entitled to health coverage through dedicated public programmes that subsidise public or private provision (3.4%); and the public sector directly provides health care services to the poorest part of the population.
Luxembourg	People are entitled to health coverage through dedicated public programmes that subsidise public or private provision (2.3%); the public sector directly provides health care services to the poorest part of the population.
Poland	Means-tested public subsidies for the purchase of basic health insurance.
Slovenia	Means-tested public subsidies for the purchase of basic health insurance, to which 6.2% of the population are entitled and take up.
Countries where health insurance coverage is an individual mandate	
Netherlands	Means-tested public subsidies for the purchase of basic health insurance, to which 50% of the population are entitled, and take-up. This takes the form of an allowance that reimburses part of health insurance premium (and deductibles).
Switzerland	The Government pays means-tested subsidies for the purchase of health insurance for about 30% of the population.
Countries with voluntary health insurance coverage for a share of the population	
Chile	The public health insurance scheme Fonasa covers, upon application, low-income and unemployed people who do not contribute to the system (22% of the population).

Mexico	The public sector provides means-tested subsidies to people not entitled to coverage by social security (linked to occupation), who voluntary subscribe to the public coverage scheme *Seguro Popular* (47.4% of the population).
Turkey	The government pays social contributions to social health insurance on behalf of low-income people.
United States (before 2014)	Medicaid (which covers 17.3% of the population in 2013) is a means-tested health programme for individuals and families on low incomes; the States Childrens' Health Insurance Program provides a health insurance for children in low-income families that do not qualify for Medicaid. From January 2014, • States will be required to provide coverage to all individuals not eligible for Medicare with income up to 133% of the federal poverty level (FPL); • Premium subsidies will be available for families with income from 133% to 400% of FPL to purchase health insurance through the exchanges.

Source: OECD Health system characteristics Survey 2012, Secretariat's estimates and U.S. Census Bureau Health Insurance Coverage in the United States, 2013.

29. When health coverage is linked to residency or occupation and financed through income-related taxes or contributions: there is no need for government interventions to ensure the provision of basic health coverage for "bad risks". By contrast, where health insurance is financed through individual premium, mandatory or not, interventions are needed to make sure that people with high risks find an insurer and are not exposed to unaffordable premiums.

30. In the Netherlands and in Switzerland, health insurers are required to enrol any applicant, and health insurance premiums are community rated, which means that they cannot be adjusted by an insurer to take into account the health status of an applicant (Table 4).

31. In the United States, where health insurers were allowed to refuse applicants and set premiums according to individual risk profiles, a federal program (Medicare) supplies basic health insurance coverage to all residents over 65 years and to residents with disabilities. The 2010 Affordable Care Act introduced several measures to offset the effect of adverse selection in the private health insurance sector: the government introduced a temporary programme providing coverage for individuals with pre-existing conditions who have been uninsured for at least 6 months. From 2014, all health insurers are obliged to guarantee issue and renewability of health insurance, regardless of health status. Health insurance premiums will only be allowed to vary according to age (in a 3-to-1 ratio), geographic area, family composition and tobacco use in individual and small groups market, as well as in the insurance exchange that is being implemented.

4. Cost-sharing requirements for benefits covered, by function of care

32. The previous section of this paper showed that most OECD countries now provide basic health coverage to (almost) the entire population. This section considers the range of services covered, and the financing arrangements for these services, which vary quite significantly. With growing pressures on budgets, the levels of cost-sharing requirements for patients have been increasing in many countries. The following sections describe the level of coverage for different functions of care. Since many countries have different cost-sharing requirements for different population sub-groups (e.g. children, disabled, people with chronic diseases, seniors, low-income...), this section and accompanying tables describe the situation faced by *an adult not entitled to any specific exemption of cost-sharing*. The subsequent section considers special arrangements for population sub-groups.

33. Users' contributions to the cost of care come in the form of co-insurance rates, fixed co-payments or deductibles (see Box 3). Generally, inpatient acute and outpatient primary care, as well as costly laboratory tests and diagnostic imagining are covered or reimbursed at a higher level than pharmaceuticals and dental care or eye-care.

Box 3. Definitions of different mechanisms for cost-sharing

Co-insurance: cost-sharing requirement whereby the insured person pays a share of the cost of the medical service (e.g. 10%).

Co-payment: fixed sum (e.g. USD 15) paid by an insured individual for the consumption of itemized health care services (e.g. per hospital day, per prescription item). **User fee, prescription fee** are sometimes used as synonymous.

Deductible: lump sum threshold below which an insured person must pay out-of-pocket for health care before insurance coverage begins. It is defined for a specific period of time: one year, one quarter or one month. Deductibles can apply to a specific category of care (e.g. physicians' visits, pharmaceutical spending) or to all health expenditures (general deductible).

Extra-billing: refers to any difference between the price charged and the price used as a basis for reimbursement purpose. In the pharmaceutical sector, where "reference prices" are often used, a fixed reimbursement amount is determined for a cluster of products, while sellers remain free to set a higher price. The patient pays out-of-pocket any difference between the price of a medicine and the reference price.

34. Private household out-of-pocket payments (OOP) are direct payments for health services from primary household income or savings. OOP payments include both cost-sharing for services covered by a third-party payer and payments for services that are not covered by any type of health insurance (basic or additional), either because they are not part of the benefit basket or because they have been purchased without prescription (self-medication). OOP payments also include informal payments to health care providers (see Table 4 and box 4). They do not include health insurance premiums, contributions or taxes paid in order to get coverage.

Table 4. Out-of-pocket payments are more than cost-sharing

Out-of-pocket payments (as recorded in the System of Health Accounts)	Spending by people without coverage
	Spending for health care services which are not covered
	Cost-sharing and user charges for services that are partially covered, including extra-billing
	Informal payments to health care providers

35. The framework of the System of Health Accounts allows the reporting of data on cost-sharing and other OOP payments separately. However, only a few countries report this information. As a consequence, total out-of-pocket payments are often used as a proxy to assess the level of coverage for health care. This option raises a number of problems.

36. First, some out-of-pocket payments correspond to services and goods that countries have deliberately chosen to not cover because they consider they do not deserve collective funding and solidarity or because they cannot be considered as priorities in the development of health insurance coverage. Some of them are genuine health services (such as dental conservative care or eye products); others are more related to comfort or aesthetic considerations when getting care (e.g. private rooms in hospitals, expensive frames for glasses).

37. Second, in some countries, there is a discrepancy between what is theoretically covered by basic health coverage and constraints faced as individuals actually access care. For instance, people may be entitled to health services "free at the point of care" but nevertheless be obliged or tempted to turn to private providers with co-payments or make informal payments for different reasons (lack of supply, long waiting times). In such situations, it makes sense to consider high OOP payments as a marker for impaired access to care. However, it is important to keep in mind that high OOP payments can only exist where there is a supply of non-covered activities and where consumers have the willingness and the ability to pay for them. Thus, a low share of out-of-pocket payments cannot always be interpreted as an indication of good coverage and access to care.

38. In a few OECD countries, out-of-pocket payments are significantly impacted by informal payments to providers. Informal payments are a phenomenon frequently observed in middle and low income countries with relatively low shares of public funding for health care. They are a widespread source of financing health care services particularly in Central and Eastern European Countries, where 'under-the table' payments can be traced back to Communists regimes, due to scarcity of resources and long-waiting queues for technically free-of-charge services. Exact figures on informal out-of-pocket expenditures are difficult to obtain and many studies use projections and estimations as a proxy. In Hungary and Poland, informal payments play a role in out-patient physician care and hospital admissions. For example, average informal payments for hospital admissions are EUR 44.11 (USD 97.89) in Hungary and EUR 37.88 (USD 84.80) in Poland and total informal payments make up 2.10% and 0.6% of total health care expenditure in Hungary and Poland, respectively, following ASSPRO projections in 2012 (European Health Policy Brief, 2013). In Turkey, informal payments accounted to 25% of all out-of-pocket payments –or 5.75% of total health spending- in 2002 (Tatar et al. 2007). In Greece, out-of-pocket payments are notable in public hospitals where, according to a survey, 36% of patients paid informal cash or in-kind benefits to nurses or physicians (Liaropolous et. al, 2008; Kaitelidou, 2013).

Table 5. Expenditure by financing agent as % of current expenditure, 2012 or nearest year

Country	General government	Social security funds	Private insurance	Private households out-of-pocket exp.	Other	Total expenditure
Australia (2011)	68.3%	0.0%	8.8%	19.4%	3.8%	100.0%
Austria	32.6%	44.6%	4.8%	16.7%	1.3%	100.0%
Belgium	10.9%	64.3%	4.2%	20.4%	0.2%	100.0%
Canada	68.3%	1.4%	12.9%	15.8%	1.7%	100.0%
Chile	40.7%	6.8%	19.4%	33.1%	0.0%	100.0%
Czech Republic	4.5%	79.2%	0.2%	15.3%	0.7%	100.0%
Denmark	85.2%	0.0%	1.8%	12.9%	0.1%	100.0%
Estonia	10.5%	69.1%	0.3%	18.4%	1.4%	100.0%
Finland	59.7%	15.1%	2.2%	19.6%	3.5%	100.0%
France	3.9%	73.8%	13.8%	7.8%	0.7%	100.0%
Germany	6.8%	70.4%	9.6%	12.2%	1.0%	100.0%
Greece	28.7%	39.3%	3.0%	28.8%	0.2%	100.0%
Hungary	8.1%	53.8%	2.7%	29.1%	6.3%	100.0%
Iceland	51.7%	28.8%	0.0%	18.1%	1.4%	100.0%
Ireland[1]	67.4%	0.1%	13.4%	16.9%	2.1%	100.0%
Israel[1]	16.9%	42.9%	10.6%	25.9%	2.1%	100.0%
Italy[1]	77.0%	0.3%	1.0%	18.8%	2.9%	100.0%
Japan (2011)	9.6%	72.8%	2.4%	14.1%	1.0%	100.0%
Korea	11.4%	44.4%	5.8%	37.6%	0.7%	100.0%
Luxembourg	8.6%	74.0%	4.6%	11.6%	1.2%	100.0%
Mexico[1]	22.3%	28.3%	4.1%	45.2%	0.0%	100.0%
Netherlands[2]	7.5%	78.3%	5.5%	6.0%	2.8%	100.0%
New Zealand	74.9%	7.8%	4.8%	10.9%	1.6%	100.0%
Norway (2011)	73.3%	11.5%	..	15.0%	0.2%	100.0%
Poland	6.4%	63.6%	0.8%	24.3%	4.9%	100.0%
Portugal	61.3%	1.4%	5.1%	31.7%	0.6%	100.0%
Slovak Republic	6.8%	65.4%	0.0%	23.2%	4.6%	100.0%

Slovenia	3.2%	68.6%	14.6%	12.5%	1.1%	100.0%
Spain	67.0%	4.7%	5.8%	22.1%	0.4%	100.0%
Sweden	81.2%	0.0%	0.3%	17.4%	1.0%	100.0%
Switzerland	20.3%	45.5%	7.2%	26.0%	1.0%	100.0%
Turkey (2010)[1]	26.7%	46.0%	..	19.2%	0.1%	100.0%
United Kingdom [1]	84.0%	..	2.7%	9.0%	3.8%	100.0%
United States	5.3%	43.3%	34.8%	12.5%	4.1%	100.0%

1. Using total expenditure on health instead of current expenditure 2: In the Netherlands, out-of-pocket spending is under-reported.
Source: OECD Health Statistics, 2014

39. In OECD countries, the share of OOP payments in total spending varies from 7.8% in France to 49% in Mexico. OOP payments are rather low in in France, New Zealand and the United Kingdom and particularly high (higher than 30%) in Chile, Korea, Portugal and Mexico (see Table 5). For this reason, the analysis of entitlements presented in sections 4.1 to 4.8 is completed, in so far as is possible, by an analysis of financing by function of care.

4.1 Cost-sharing requirements: general deductibles

40. In a few countries, patients have to pay a deductible before being reimbursed by health insurance for spending related to health care. In the Netherlands, in 2013, people had to pay EUR 350 (USD 420) before claiming any reimbursement from health insurance. In Switzerland, there is an annual deductible of CHF 300 (USD 211) for all services. However, consumers can choose insurance contracts with lower premiums and higher deductibles (up to CHF 2500 or USD 1756 per year).

41. In the United States, many health insurance plans have general deductibles. For instance, 78% of workers faced deductibles in employer-sponsored health insurance plans in 2011. The average general annual deductible for all covered workers is USD 1 135. However, deductibles vary across insurance plans. The average deductible for individual plans amounts to USD 729 for health maintenance organisations (HMOs), USD 799 for preferred provider organisations (PPOs), and USD 1 314 for point-of-service plans (POS). For family coverage, the average deductible is USD 1 743 for HMOs, USD 1 854 for PPOs and USD 2,821 for POS (Kaiser Family Foundation and Health Research and Education Trust, 2013).

42. Other countries impose deductibles for some categories of services only (e.g. for pharmaceuticals). These deductibles are described in following sections.

4.2 Cost-sharing for inpatient care

43. In OECD countries, acute inpatient care is most often fully covered or subject only to small co-payments, usually justified on the grounds of covering a share of accommodation costs. Table 6 summarises information on the extent of coverage for inpatient acute care in OECD countries for average adult patients who are not entitled to any co-payment reduction or exemption. In many OECD countries patients also have the option of paying supplements for additional comforts (e.g. a private room, access to TV, telephone, etc.). These costs are not considered to be required cost-sharing.

44. In many OECD countries, patients can *access free acute inpatient care*. In Canada, Denmark, Iceland, Israel, Hungary, New Zealand, Norway, Poland, Portugal, Spain and the United Kingdom, acute inpatient care is free at the point care. In the Netherlands, inpatient services are also free of charge once the annual general deductible has been met.

45. In three countries, access to free inpatient care is possible under certain circumstances:

- In Australia, patients receive care with no cost-sharing if they are treated as public patients in public hospitals. When treated as a private patient in a public or a private hospital, Medicare covers a reduced proportion of costs and the remaining cost is often paid by private health insurance, or otherwise out of pocket. In 2011-2012, public patients accounted for 51% of hospital admissions and patients covered by private health insurance 39%4 (Australian Institute of Health and Welfare, 2013). Access to public hospitals usually involves longer waiting times than in private hospitals - a reason patients may chose additional private insurance. For example in New South Wales in 2005, the waiting time for a knee replacement in a public hospital was on average 358 days, whilst the corresponding waiting time for private patients was only half as long (Siciliani et al, 2013).

- A similar rule applies in Italy, where inpatient care is free of charge for patients treated as public patients. Though 68% of hospitals are publicly owned (the remaining being private not-for-profit (3.7%) or for-profit (28%), patients using public hospitals may be exposed to extended waiting times. Reported waiting times for inpatient services are 27 days, on average in privately accredited hospitals, compared to 57 days for public facilities (Siciliani et al, 2013).

- In Mexico, patients do not have to pay if they are treated by a provider approved by their insurer.

46. In seven countries, patients only *pay a fixed co-payment per day*, to contribute to "accommodation costs" (Austria, Belgium, the Czech Republic, Finland, Germany, Luxembourg, and Sweden). Most often, patients are exempted from these charges beyond 28 or 30 days. In Belgium, patients' out-of pocket payments generally are a flat-rate per-day fee for hospitalisation, the costs of some non-reimbursable medical products or pharmaceuticals, and flat-rate charges for pharmaceuticals, biological tests, radiology and technical acts.

47. In a few countries, patients pay *a share of the total cost* (Chile, France, Greece, Japan, Korea, Slovenia and Switzerland). In Chile, co-insurance rates vary across health insurance plans. Patients publicly insured by Fonasa under the "free choice of provider plan" (MLE) can face up to 50% cost-sharing when they receive care from private inpatient facilities. Patients insured by Fonasa under the "public provider plan" cannot face cost-sharing higher than 20%. Depending on income level, patients may be entitled to lower co-payments or exempted from co-payments (see section 5). Cost-sharing for patients insured by private insurance funds varies across plans. The average cost-sharing rate for acute inpatient care in the Isapres system was 28% in 2010. In France, patients pay 20% of the cost of care unless the hospital stay includes a diagnostic or surgical procedure whose cost exceeds EUR 120. In other cases, patients pay EUR 18 per day in acute care facilities. In France and in Slovenia, complementary private health insurance often covers co-payments.

[4] Other admissions were financed by other sources (patients themselves, employers, car insurance or Veteran coverage).

Table 6. Types and level of cost-sharing requirements from basic health insurance coverage for acute inpatient care for an adult not entitled to any co-payment exemptions, 2012 or nearest year

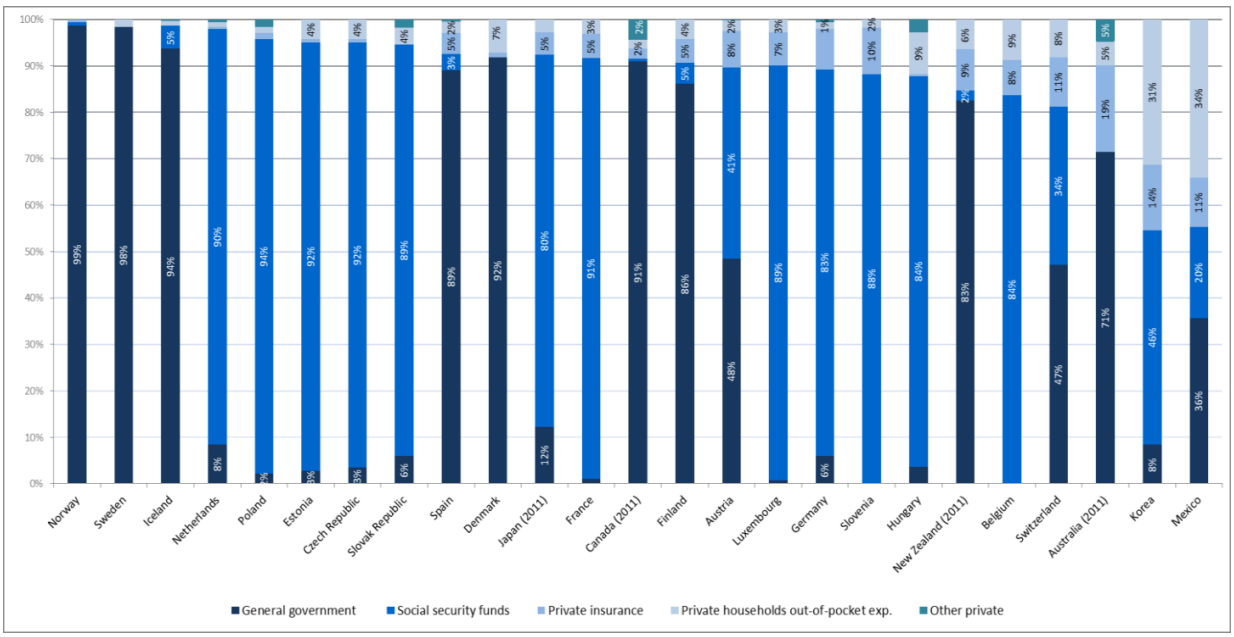
Countries	Acute inpatient care
Australia	Free at the point of care for patients treated as public patients in public hospital. Patients treated as private patients in public or private hospitals have to pay a share of the cost, often paid by their private health insurance (with some services being partly funded via the Medicare system).
Austria	Co-payment of approx. EUR 10 (USD 11.80) per day (with regional variations), up to 28 days a year.
Belgium	Co-payment per day, plus the costs of some non-reimbursable medical products or pharmaceuticals.
Canada	Free at the point of care.
Chile	Cost sharing ranges from 10% to 50%, depending on health insurer and chosen coverage plan.
Czech Republic	Co-payment of EUR 4 (USD 7.49) per day.
Denmark	Free at the point of care.
Estonia	Co-payment of EUR 1.60 per day, up to 10 days per episode. Co-payments charged for above-standard accommodation.
Finland	Co-payment of EUR 32.60 (USD 34.71) per day in somatic care; EUR 15.10 (USD 16.08) per day in psychiatric care, up to the annual cap. For same-day (outpatient) surgery there is a co-payment up to a maximum of EUR 90.30 (USD 96.12) per procedure. The annual municipal health care co-payment cap applies.
France	Cost-sharing of 20%, not applicable for diagnostic or surgical procedures whose cost exceeds a certain threshold (EUR 120). Co- payment of EUR 18/day (USD 20.85) for acute in-patient care and. EUR 13.50/day (USD 15.64) in psychiatric facilities.
Germany	Co-payment of EUR 10 /day (USD 12.51), limited to 28 days/year.
Greece	Cost-sharing of less than 10% of total bill for patients treated in public hospitals. Higher level of cost-sharing and potential extra-billing for patients in private hospitals.
Hungary	Free at the point of care.
Iceland	Free at the point of care.
Ireland	Free at the point of care for medical card holders and certain other categories. Co-payment of EUR 75 (USD 89.71) per day for public patients, capped at EUR 750 (USD 897.10) in any period of 12 consecutive months.
Israel	Free at the point of care.
Italy	Free at the point of care for patients treated as “public” patients in public and private hospitals.
Japan	Co-insurance of 30% of costs.
Korea	Co-insurance of 5-10% for medical services provided for severe diseases, 20% for other medical services; and 50% on meals.
Luxembourg	Co-payment of EUR 19.92/(USD 21.06)day for the first 30 days of hospitalization.
Mexico	Free at the point of care for patients when the provider is contracted with their own insurer. Potential extra-billing in other circumstances.
Netherlands	Free at the point of care after general deductible.
New Zealand	Free at the point of care.
Norway	Free at the point of care.
Poland	Free at the point of care.
Portugal	Free at the point of care.
Slovak Republic	Free at the point of care.

Slovenia	Co-insurance of 20% of costs.
Spain	Free at the point of care.
Sweden	Co-payment determined by each county council, approx. SEK 80 (USD 9.02) per day, up to an annual threshold and then free of charge.
Switzerland	Co-insurance of 10% after deductible, subject to annual cap.
Turkey	Free of charge in public hospitals, possibility of extra-billing in private hospitals, up to 30% of the social security payment rate. Emergency and intensive care are free of charge in public and private facilities.
United Kingdom	Free at the point of care.
United States	Varies across coverage schemes. In employer-sponsored health insurance plans, most workers face user charges when hospitalised (sometimes in addition to the general deductible): 61% pay co-insurance (18% on average); 16% pay fixed co-payments (USD 278 per hospital admission on average) and 7% per diem co-payments (USD 264 on average). 17% of insured have no additional cost-sharing after the general deductible has been met. In Medicare Part A, enrolees face a deductible of USD 1 216 for each hospital admission and then no cost-sharing up to 60 days. Then, a co- payment of USD 304 per day applies up to the 90th day. Once in lifetime, patients can benefit from a per diem co-payment of USD 608 for an additional 60 days. After this, patients have to pay the full costs of inpatient care.

Source: OECD Health system characteristics Survey 2012, Smidova (2011), Szalay et al. (2011), Anell et al. (2012), Kaiser Family Foundation and Health Research and Education Trust (2013) and Secretariat's estimates.

48. According to SHA data, basic primary coverage finances nearly the full costs of inpatient care in a number of countries, including Norway, Sweden, Iceland, the Netherlands, and Poland. Private health insurance accounts for a significant share of spending for inpatient care in Australia, Switzerland and Korea (see Figure 1). Patients' out-of-pocket payments are particularly high in Korea where they make up 31% of spending.

Figure 1. Spending for in-patient curative care by financing agent in 2012 (or nearest year)



Note: In the Netherlands, out-of-pocket spending is under-reported.
Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

4.3 Cost-sharing for outpatient primary and outpatient specialist contacts

49. Outpatient primary and outpatient specialist care is *free at the point of care* in a number of countries (see Tables 7 and 8). This is the case in Canada, Denmark, Poland, Spain, the United Kingdom, and in most cases in Germany. In Italy, primary care is free at the point of care, but specialised care is not. In the Netherlands, outpatient care is free after the annual general deductible has been met.

50. In a few countries, patients can access primary care *free of charge under certain circumstances* pertaining to the status of the provider, the status of the patient or the health insurance plan:

- In Australia, general practitioner (GP) services are free at the point of care when doctors accept direct payments from Medicare and the set Medicare tariff, i.e. in nearly 80% of cases. Outpatient specialist contacts can be free at the point of care when provided in public hospitals, or with a co-payment when provided outside of hospitals and covered by Medicare (typically when a patient has been referred by a GP to specialist care).

- In Chile, public primary care is free of charge. For outpatient specialist care, cost-sharing requirements vary across health insurance plans. People with public insurance (Fonasa) can choose to access public providers only (MAI) or use the "free choice of provider modality" (MLE) to access private providers. Low-income people using MAI receive services free of charge while people with free choice of providers have to pay a share of the costs (up to 50% for private providers). Patients choosing one of the private insurance funds of Isapres receive coverage according to their chosen plan.

- In Greece, outpatient physician consultations are free at the point of care when provided by public providers.

- In Mexico, patients insured by IMSS or ISSTE have free outpatient primary and specialist care if they use the services of a physician who is contracted with their insurer, whilst co-payments may arise for patients insured by another insurer or without public insurance. Patients under *Seguro Popular* only face co-payments if the procedure is not included in the set of covered services.

- In Ireland, medical card holders and non-medical card holders whose income is below a certain threshold, are entitled to GP services free of charge (approximately 40% of the population). The remainder of the population pays the full cost of a GP consultation as a private arrangement with their GP. In emergency departments, patients are subject to a EUR 100 (USD 144) charge, with a number of patient groups exempted from this charge.

- In Israel, many patients have free access to primary care services, but patients pay a quarterly deductible for outpatient specialist attendance.

- In Austria, patients pay a yearly fee of EUR 10 (USD 11.80) for the administration of an e-Health Card, acting as a patient record. Outpatient care consultations with physicians, who are contracted by the patient's respective health insurance company, are free at the point of care. Patients choosing a non-contracted physician are reimbursed 80% of the cost by their social insurance.

51. Belgium, Czech Republic, Finland, Iceland, Norway, Portugal and Sweden all impose *per-visit co-payments* for outpatient care, while in Japan, Korea, Luxembourg, New Zealand and Slovenia, patients have to *pay a share of the costs*. The same applies in Switzerland once the annual deductible has been met.

In Iceland, patients pay a *per-visit co-payment* for outpatient primary care provided in primary care centres; while for outpatient specialist care patients are required to *pay a share of the costs* (see Table 7).

52. Belgium and France have introduced *differentiated co-payments in order to encourage "virtuous" patient pathways*. In Belgium, patients pay a fixed co-payment per visit, which depends on two parameters: the patient status (entitled or not to "preferential reimbursement") and their registration with a GP who is responsible for managing the patient's medical record (*Dossier Médical Global/Het Globaal Medisch).* [5] In France, patients pay EUR 1.00 (USD 1.16) per visit plus a share of the reimbursement price, which varies according to the pathway to care. Patients are encouraged to register with a "treating" physician (*médecin traitant*), and obtain referral from this doctor before accessing specialist care. If patients follow this pathway, the co-insurance rate is 30% of the official tariff for both primary care and specialised care and patients can face extra-billing if they consult doctors allowed to charge higher prices than the official tariff. When patients do not register with a treating physician or consult a specialist without referral, the co-insurance rate is 70% and all physicians are allowed to charge extra-billing.

53. Similarly, in Korea, certain patterns of health care use are encouraged through financial incentives, for example the Chronic Disease Management Programme run from doctors' clinics. The Chronic Disease Management Programme reduces out-of-pocket payments for the examination fee from 30% to 20% when patients with chronic illnesses consistently use the same doctor's clinic.

54. New Zealand uses exemptions from co-payments as a means to support access to primary health care and reducing health inequalities. Very-Low-Cost-Access (VLCA) practices, which receive subsidies to serve high-need communities, accept in exchange to forgo some revenue from patient fees. As a consequence, the average co-payment per visit payable in "ordinary" practices (NZD 36.58 or USD 24.73) is reduced to NZD 14.77 (USD 9.99) in VLCA practices.

[5] A registration fee is demanded, and in return patients can choose a main general practitioner who keeps their central record as well as being entitled to a larger proportion of reimbursement.

Table 7. Types and level of cost-sharing requirements from basic health insurance coverage for outpatient primary care for an adult not entitled to any co-payment exemptions, 2012 or nearest year

Countries	Cost-sharing requirements for outpatient primary care physician contacts
Australia	Free at the point of care when doctors accept direct payments from Medicare (about 80% of GP services 2010-11). Otherwise, patients may be exposed to costs.
Austria	Deductible of EUR 10 (USD 11.80) per year and then free of charge. Certain professional groups (e.g. civil servants, self-employed, railway workers) have co-insurance (14-20%) instead of this deductible.
Belgium	Co-payment of EUR 6.50 (USD 7.48) or EUR 4.00 (USD 4.60) with GMD, reduced to EUR 1.50 (USD 1.73) or EUR 1.00 (USD 1.15) for patients with preferential reimbursement. Patients pay the full price and are reimbursed afterwards.
Canada	Free at the point of care.
Chile	Depending on health insurer, visits are either free of charge, or cost sharing is around 39% (average in 2010).
Czech Republic	Co-payment of EUR 1.20 (USD 2.24) per visit.
Denmark	Free at the point of care.
Estonia	Free at the point of care for consultation, co-payment of EUR 3.20 for home visits.
Finland	Co-payment of EUR 13.80 (USD 14.74) per visit up to the annual co-payment cap. A single primary care center cannot collect this co-payment more than three times a year.
France	Co-payment of EUR 1 (USD 1.16) per consultation and 30% cost-sharing for patients registered with a treating physician, 70% in other cases. Patients pay the full price and are reimbursed afterwards.
Germany	Free at the point of care for patients with statutory health insurance and patient with selected PHI contracts.
Greece	Free at the point of care for public providers.
Hungary	Free at the point of care.
Iceland	Co-payment of ISK 1000 (USD 7.0) per visit to primary care health centers. For services provided in outpatient specialist care settings patients are required to share a proportion of costs.
Ireland	Free at the point of care for approximately 40% of the population; while the remainder of the population (60%) pays the full cost of a GP consultation as a private arrangement with their GP.
Israel	Free at the point of care.
Italy	Free at the point of care.
Japan	Co-insurance of 30% of costs*.
Korea	30% of cost of service.
Luxembourg	Cost-sharing of 20% for physician consultation. Cost-sharing of 12% for medical acts and services.
Mexico	Free at the point of care for patients within that same subsystem but potential extra-billing for patients from different subsystems or without public insurance.

Netherlands	General deductible of EUR 350 (USD 420) and then free of charge.
New Zealand	Average cost-sharing is estimated at 30%, with a range of co-payments depending on practice type and patient status.
Norway	Co-payment of NOK 136 (USD 15.03) per visit up to an annual ceiling for all user charges of NOK 2040 (USD 225) in 2013.
Poland	Free at the point of care.
Portugal	Co-payment of EUR 5 (USD 8.06) per visit (more that 60% of the population does not pay co-payments).
Slovak Republic	Free at the point of care.
Slovenia	20% cost-sharing.
Spain	Free at the point of care.
Sweden	Co-payment determined by each county council, between SEK 100 (USD 11.36) and SEK 200 (USD 22.73), with an annual cap on cost-sharing for outpatient care of SEK 1 100 (USD 125). Consultations with a nurse are free of charge.
Switzerland	10% cost-sharing after general deductible, with an annual cap.
Turkey	Free at the point of care.
United Kingdom	Free at the point of care.
United States	Varies across coverage schemes. In employer-sponsored health insurance plans, 74% covered workers have a copayment for primary care office visits (USD 23 on average) and 20% have co-insurance (18% on average). In Medicare Part B, enrollees face a USD 147 deductible and then, 20% of Medicare-approved fees (plus 15% extra-billing if the provider does not accept Medicare rates).

Note: In Japan, there is no clear division between primary care physicians and specialists.
Source: OECD Health system characteristics Survey 2012, OECD (2013a) for Israel, Smidova (2011), Szalay et al. (2011), Anell et al. (2012) , Kaiser Family Foundation and Health Research and Education Trust (2013), and Secretariat's estimates

Table 8. Types and level of cost-sharing requirements from basic health insurance coverage for outpatient specialist care for an adult not entitled to any co-payment exemptions, 2012 or nearest year

Countries	Outpatient specialist contacts
Australia	Outpatient specialist contacts are fully covered when provided in public hospitals, and generally covered with a co-payment when provided outside hospitals and financed by Medicare.
Austria	Mostly free at the point of use for contracted physicians, with a EUR 10 (USD 11.80) annual payment. Certain professional groups have co-insurance rates (14-20%) instead of the service fee.
Belgium	Co-payments between EUR 2.50 (USD 2.88) and EUR 24.25 (27.94) depending on service type and patient status (GMD/preferential reimbursement). Patients pay the full price and are reimbursed afterwards.
Canada	Free at the point of care.
Chile	Depending on health insurer and chosen coverage plan, cost sharing ranges from 10% to 50%.
Czech Republic	User fee of EUR 1.20 (USD 2.24) per visit.
Denmark	Free at the point of care.

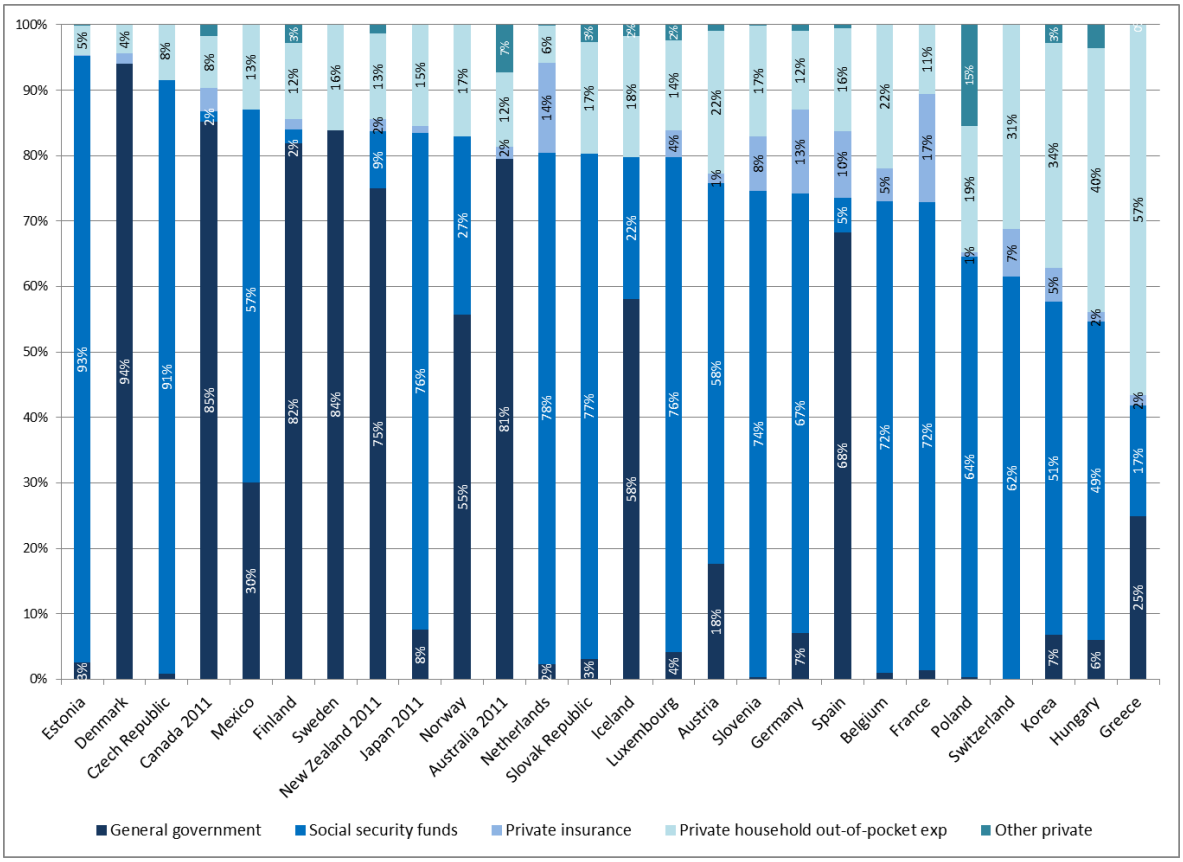
Estonia	Copayment of EUR 3.20 for visits to specialists contracted with the health insurance fund, with a GP referral. Visits without referral are not reimbursed. Specialists not contracted with health insurance determine their fees.
Finland	Co-payment of EUR 27.50 (USD 29.26) per visit to an outpatient specialist contact in a hospital.
France	Co-payment of EUR1 (USD 1.16) fee per consultation, plus cost-sharing of 30% with a GP referral, 70% otherwise. Patients may be exposed to extra-billing (allowed for 45% of private specialists). Patients pay the full price and are reimbursed afterwards.
Germany	Free at the point of care for patients with statutory health insurance and patients with selected PHI contracts.
Greece	Free at the point of care for public providers.
Hungary	Free at the point of care.
Iceland	Co-payment of ISK 4 200 (USD 30) per visit for any service exceeding ISK 4 200 + cost-sharing of 40% up to a maximum of ISK 29 500 (USD 208).
Ireland	Attendances at planned outpatient clinics in public hospitals are free at the point of care for public patients. Patients attending an emergency department are subject to a EUR 100 (USD 119.76) charge subject to a number of exemptions.
Italy	Facilities and services included in the national healthcare entitlements ("*Livelli essenziali di assistenza*"(LEA)) have a co-payment of up to EUR 36 (USD 45.57) + EUR 10 (USD 12.68) fixed cost imposed by the National legislation, which varies regionally.
Israel	Co-payment of approximately NIS 25 (USD 6.38) once every quarter.
Japan	Co-insurance of 30% of costs.
Korea	Tertiary hospitals: 60% cost-sharing (100 % for the medical examination fee); General hospitals: 50% cost-sharing (45% in case of rural area); Other Hospital: 40% cost-sharing (35% in case of rural area); Doctors' Clinic: 30% co-payment.
Luxembourg	Cost-sharing of 20% for physician consultation; cost-sharing of 12% for medical acts and services.
Mexico	Free at the point of care for patients visiting providers contracted with their own insurer. Potential user charges in other circumstances.
Netherlands	Annual deductible of EUR 350 (USD 420) and then free of charge.
New Zealand	No cost-sharing.
Norway	Co-payment of NOK 307 (USD 33.93) up to an annual ceiling for all user charges of NOK 2040 (USD 225) in 2013.
Poland	Free at the point of care.
Slovak Republic	Free at the point of care.
Slovenia	20% cost-sharing.
Spain	Free at the point of care.
Sweden	Co-payment determined by each county council, between SEK 230 (USD 26.14) and SEK 320 (USD 36.36), with an annual cap on cost-sharing for outpatient care of SEK 1 100 (USD 125).
Switzerland	10% cost-sharing after general deductible, with an annual cap.
Turkey	TRL 5 (USD 5) and 20% co-insurance in public sector secondary and tertiary care

	institutions, TRL 12 (USD 12) and 20% co-insurance in private sector secondary and tertiary care institutions.
United Kingdom	Free at point of care.
United States	Varies across coverage schemes. In employer-sponsored health insurance plans, 72% of covered workers have a copayment for a primary care office visit (USD 35 on average) and 20% have co-insurance (19% on average). In Medicare, enrollees face a USD 147 deductible and then, 20% of Medicare-approved fees (plus 15% extra-billing if the provider does not accept Medicare rates).

Source: OECD Health system characteristics Survey 2012, Smidova (2011), Szalay et al. (2011), Anell et al. (2012), Kaiser Family Foundation and Health Research and Education Trust (2013) and Secretariat's estimates

55. Public payers finance 70% or more of outpatient services in most OECD countries (see Figure 2). Private health insurance finances 17% of these services in France, where PHI pays for co-insurance and extra-billing; 13% in Germany, for people with private insurance for basic coverage; and 10% in Spain. Patients pay one third or more of the costs in Switzerland (probably because of deductibles), in Korea (because of high cost-sharing) and more than 40% of the costs in Hungary and Greece.

Figure 2. Spending for outpatient care (excluding dentists) by financing agent in 2012 (or nearest year)



Note: In Poland, occupational medicine explains most of the private financing. Belgium changed reporting practices and defined outpatient care not to include home care. In the Netherlands, out-of-pocket spending is under-reported.
Source: OECD Health Statistics, 2014, http://dx.doi.org/10.1787/health-data-en

4.4 Cost-sharing for pharmaceuticals

56. In most OECD countries, medicines used during inpatient stays are funded by basic health coverage under the same conditions as the hospital stay. Medicines used in outpatient care and funded by basic health coverage are typically subject to co-payments (with the notable exception of the Netherlands, where there is no co-payment for medicines once the general deductible has been met). Countries and health insurers have, however, adopted very different models for pharmaceutical co-payments.

57. Patients sometimes pay *a fixed co-payment per item or per prescription*[6] *(*Table 9). Australia, Austria, the Czech Republic, Ireland, Italy, New Zealand, and the United Kingdom have this type of co-payment. Australia has lower co-payments for disadvantaged groups (concession card holders) as well as a safety net to reduce overall out-of-pocket payments for high-risk patients. In England, there is a fee of GBP 7.65 (USD 11.25) per prescribed item, but more than 85% of the population is exempted from this co-payment. In the rest of the United Kingdom, there are no prescription fees. In Italy, the co-payment varies across regions.

58. In a few countries, patients pay *a co-insurance rate, which is the same for all medicines*. Germany, Japan, Norway and Switzerland use this rule. In Germany, the 10% cost-sharing applies with a minimum and a maximum amount per item.

59. In other countries, the *co-insurance rate varies* across categories of medicines with respect to their therapeutic value: co-insurance rates are higher when medicines are less effective or used in the treatment of minor diseases. This model is used in Belgium, France, Greece, Hungary, and Portugal. Spain uses different co-insurance rates but which depend on the patient's income category and status (pensioner or not).

60. France, Belgium and Finland use a *mix of models*. France recently added a fixed co-payment to its old model of different co-insurance rates. Belgium has one of the more complex systems, with different co-insurance rates and co-payments, defined according to three parameters: the therapeutic value of the medicine, the price of the medicine and the status of the patient. Finland also uses a mix of co-payments and differential co-insurance rates.

61. In two Nordic countries (Denmark and Sweden), people must *pay the full cost of medicines* up to a certain threshold (deductible) and then *pay decreasing co-insurance rates* until their annual spending reaches a second threshold (annual cap), beyond which costs are fully covered.

62. A final category is where *co-payments vary according to third-party payers*. This is the case in Chile, Canada and the United States.

- In Chile, patients covered under the public health insurance fund Fonasa with the public-provider-only option obtain medicines free of charge in primary health care facilities but must co-pay for drugs provided in other facilities, with co-payment depending on income. Formularies are defined for each level of care. In the free-choice option plan, patients have to pay the full cost of pharmaceuticals, except for medicines considered in the Payment Associated to Diagnostic Program (PAD). Patients insured in the private system Isapres pay the full costs of medicines used in ambulatory care. On average, patients in the Isapres system had co-payments of 20% in 2010 for pharmaceuticals. In addition, the GES Program (Explicit Health Guarantees) provides coverage for pharmaceuticals (depending on income) for 80 health conditions (including cancer or HIV), for patients insured by Fonasa and Isapres.

6 The co-payment is fixed and independent of the number of items.

- In Canada, two-thirds of the Canadian population obtain drug coverage through private health insurance plans, which are voluntary in all provinces but Québec. Public plans are subsidised by federal, provincial or territorial governments, providing coverage for pharmaceutical spending to about one third of the population under certain circumstances (see section 5). Each drug plan, public or private, defines its own formulary, as well as the types and levels of co-payments (often a mix of cost-sharing and prescription charges).
- In Mexico, pharmaceuticals are free at the point of care for patients choosing a provider within the same subsystem (IMSS- employees in private sector and their beneficiaries, ISSTE- Social Security for Public Sector Employees), but patients have to pay when they are insured by a different subsystem from that of their provider, or if they do not have public insurance. For those covered under the public scheme *Seguro Popular*, all medicines included in the positive list established by the Ministry of Health are fully covered; patients pay the full price of other drugs.
- In the United States, patients usually pay prescription charges, which differ across plans.

63. In addition to these co-payments, many OECD countries set maximum reimbursement amounts ("reference prices") for clusters of products, which are generic or therapeutic equivalents. When patients purchase a medicine with a price exceeding the reference price, they must pay the difference.

Table 9. Types and level of cost-sharing requirements from basic health insurance coverage for outpatient pharmaceuticals for an adult not entitled to any co-payment exemptions, 2012 or nearest year

Countries	Pharmaceuticals
Australia	Co-payment per item of AUD 36.10 (USD 24.69), reduced to AUD 5.90 (USD 4.04) for patients with concession card, subject to a Safety Net: - Concession card holders get medicines free of charge once they have reached the annual threshold of AUD 354 (USD 242); - General patients pay the concession price per medicine after reaching their annual threshold of AUD 1 390 (USD 950.9).
Austria	EUR 5.15 (USD 6.08) per prescription, capped to 2% of annual income; with exemptions for low-income patients.
Belgium	Cost-sharing ranging from 0% and 100% according to drug category (drugs of high therapeutic value used in the treatment of severe diseases –diabetes, cancer- are free of charge but patients must pay cost-sharing for other categories); patient status (preferential or not) and ex-factory price of the drug. Cost-sharing per item is capped for important drugs (e.g. antibiotics, cardiovascular).
Canada	Varies across health insurance plans.
Chile	Varies across coverage schemes. Publicly insured patients with a plan with access restricted to public providers have no cost-sharing on medicines covered. Publicly insured with free choice of provider and privately insured have no coverage for medicines and pay the full cost unless the medicine is included in the Explicit Guarantee program, in which case cost-sharing is limited to 50%. Privately insured people can purchase coverage for pharmaceuticals beyond basic coverage and get reimbursement up to 80% of the cost.
Czech Republic	Co-payment EUR 1.20 (USD 2.24) per prescription, regardless of the number or types of pharmaceuticals prescribed. Further private co-payments depend on the type of drug, the level of reimbursement by health insurances and the retail price.
Estonia	For general prescription medicines, co-payment of EUR 3.20 per prescription, and co-insurance of at least 50%, with health insurance spending capped at EUR 12 per prescription. For prescription medicines for chronic diseases, co-payment of EUR 1.30 per prescription, and co-insurance of 0 to 25%. The co-insurance rate decreases by step when patient cumulated cost-sharing increases (50%,

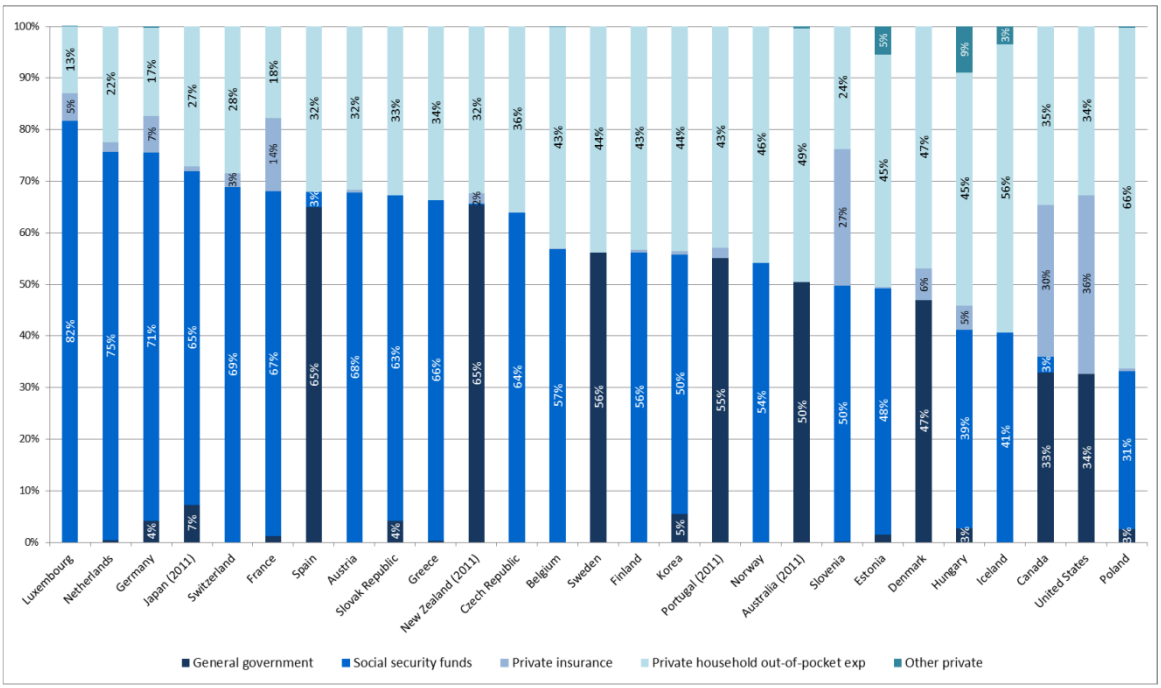
	25%). Patient cost-sharing is capped at EUR 1 278.
Denmark	Deductible of DKR 890 (USD 113) beyond which co-insurance rate applies, diminishing stepwise as spending increases (50%, 25%, 15%). Patient cost-sharing is capped to DKK 3 655 (USD 464.69).
Finland	Co-insurance rate of 58%, 28% or 0%, depending on drug category. A co-payment of EUR 3.00 (USD 3.19) per prescription applies when the medicine is fully reimbursed. Patient cost-sharing is capped to EUR 700.92 (USD 746.29). Any difference between retail price and reference price for products subject to reference pricing is paid by the patient. Changes to co-insurance rates and spending cap were expected in 2013.
France	Cost-sharing of 0%, 35%, 70%, 85%, depending on drug category, plus co-payment of EUR 0.5 per item. Any difference between retail price and "reference price" for products subject to reference pricing (about 5% of drugs dispensed) is paid by the patient.
Germany	Co-insurance of 10% of cost with a minimum of EUR 5 and a maximum of EUR 10 (USD 6.25) per item. Any difference between retail price and "reference price" for products subject to reference pricing (about 75% of drugs dispensed).
Greece	Co-insurance of 0%, 10% or 25% depending on drug category.
Hungary	Co-insurance of 50%, 30%, 10% or 0% for drugs used for life-threatening diseases or orphan drugs, with a co-payment of HUF 300 (USD 2.28) per pack for drugs which are fully covered in this category. Co-insurance of 15%, 45% and 75% of the price for drugs used in the treatment of chronic diseases. Any difference between retail price and "reference price" for products subject to reference pricing.
Iceland	Depends on reference pricing. There is a user fee plus a percentage of the price, depending on the category of the medicine, up to a maximum level (cap).
Ireland	For medical cards holders: co-payment of EUR 0.50 (USD 0.60) per item, capped to EUR 10 (USD 11.96) per family and per month [increased to EUR 2.50 up to EUR 20 in 2013]. For other groups, deductible of EUR 132 (USD 157.96) per family and per month before full reimbursement [increased to EUR 144 in 2013].
Israel	Co-insurance of generally 15% (10% for generic) of the purchase price, with a minimum payment of EUR 3 (USD 0.76) per item.
Italy	Co-payment per prescription or per package determined at regional level (EUR 1, 2 or 4) (USD 1.26, 2.53, and 5.06).
Japan	Co-insurance rate of 30% of costs.
Korea	Co-insurance of 30%.
Luxembourg	Co-insurance of 0% or 20% depending on drug category (for example 0% for drugs used for chronic diseases).
Netherlands	No-cost-sharing after general deductible. Any difference between retail price and "reference price" for products subject to reference pricing is paid by the patient.
Mexico	Free at the point of care for drug covered by the scheme: between 78% and 89% of Social Security users receive their prescriptions free of charge, whereas in Seguro Popular only 60% of users receive free prescriptions.
New Zealand	Co-payment of NZD 5 (USD 3.39) per item plus a surcharge on some items not on pharmaceutical schedule.
Norway	Co-insurance rate of 38%, capped to NOK 520 (USD 57.47) per prescription, with patient cost-sharing (for all services) capped at NOK 2040 (USD 225) in 2013.
Poland	Co-insurance rate of 0%, 30% or 50% of the reimbursable price, plus any difference between the retail price and the reimbursement price, plus a co-payment of PLN 3.20 (USD 1.70) per drug package.
Portugal(1)	Co-insurance rate, variable with therapeutic value of the medicine (10%; 31%; 95%).
Slovak Republic	User fee of EUR 0.17 (USD 0.32) per prescription, plus any difference between actual price and reimbursement amount for products subject to reference prices.

Slovenia	Co-insurance of 0% or 30%, depending on disease category.
Spain	Co-insurance rate, varying with income and status (active worker vs pensioner): - 60% of retail price for users and their dependents whose annual income is >= 100.000 €; - 50% of retail price for active insured and their dependents whose annual income is > 18.000 € and < 100.000 €; - 40% of retail price for active insured and their dependents that are not included in the two first categories; - 10% of retail price for pensioners, except when they belong to the first category. Co-insurance rate is reduced to 10% for medicines used in the treatment of severe and/or chronic diseases and capped at EUR 4.13 (USD 5.85) per package. Monthly cap on co-payment for pensioner of EUR 8, 18 or 60, depending on their income category.
Sweden	Deductible of SEK 1 100 (USD 125), beyond which co-insurance applies, diminishing stepwise (50%, 25%, and 10%). Patient annual OOP spending is capped to SEK 2 200 (USD 250).
Switzerland	Co-insurance of 10% up to an annual cap once the general deductible has been met. Co-payment is increased to 20% for off-patent drugs with cheaper (generic) alternatives.
Turkey	Co-insurance of 20% plus a prescription fee of TRL 3 (USD 3) per item for the 3 first items, reduced to TRL 1 (USD 1) for following items.
United Kingdom	England: Co-payment of GBP 7.65 (USD 11.25) per prescription item, from which many people are exempted. Scotland: no co-payment.
United States	Medicare beneficiaries can obtain coverage for medicines through Medicare Part D. Part D sponsors offer plans with either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also offer plans with enhanced benefits. The standard benefit in 2014 has a USD 310 deductible and 25% coinsurance up to an initial coverage limit of $2,850 in total drug costs, followed by a coverage gap. During the gap, enrolees are responsible for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending reaches USD 4,550. Thereafter, enrolees pay either 5% of total drug costs or USD 2.55/USD 6.35 for each generic and brand-name drug, respectively. In employer-sponsored health insurance plans, 81% of workers have plans with "tiered cost-sharing" for prescription drugs, with different average monthly co-payments across drug categories. In plans with 3 or more tiers of cost-sharing, co-payments are, on average: USD 10 for generics, USD 29 for "preferred drugs", USD 52 and USD 80 for drugs of the third and fourth tiers. In plans where cost-sharing takes the form of co-insurance, the average rates are respectively 16%, 25%, 38% and 32% for the first, second, third and fourth tiers.

Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates, OECD report on pharmaceutical pricing, Smidova (2011), Krutilova (2013), Barros et al. (2011); Wirtz et al. (2012), Szalay et al. (2011), Anell et al. (2012), Kaiser Family foundation (2013), Kaiser Family Foundation and Health Research and Education Trust (2013).

64. According to SHA, in 2012, patients paid on average 35% of outpatient pharmaceutical costs out-of-pocket (Figure 3). However, this share includes both cost-sharing requirements, which are higher than for other essential functions of care, and self-medication, which is generally not covered and more important than for other functions of care. Private health insurance plays a significant role in Canada (as a primary source of coverage for drugs) and in Slovenia and France (as a secondary source of coverage). Private out-of-pocket payments account for 40% of outpatient pharmaceutical spending or more in Poland, Iceland, Denmark, Australia, Finland, Norway, Sweden, Portugal and Estonia.

Figure 3. Spending on pharmaceuticals by financing agent 2012 (or nearest year)



Note: In the Netherlands, out-of-pocket spending is under-reported.
Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

4.5 Cost-sharing for clinical laboratory tests and diagnostic imagining

65. Clinical laboratory tests and diagnostic imagining are *fully covered without cost-sharing* in numerous OECD countries, including Denmark, Hungary, Germany, Netherlands, New Zealand, Poland, Spain and the United Kingdom (Table 10). In Canada, these diagnostic procedures are most often fully covered, but Provinces and Territories determine the set of covered procedures.

66. In a number of countries, both diagnostic procedures are provided *free of charge only in certain circumstances*:

- In Greece, laboratory tests and diagnostic imaging are fully covered when performed by public providers, but subject to low co-insurance rates when performed by contracted private providers.
- In Ireland, patients are fully covered in public hospitals.
- In Australia, both services are free at the point of care when providers accept direct payment from Medicare, which they often do for low-income patients. In other cases, providers usually charge a price which is higher than the Medicare rate, and the patient must pay the difference between the Medicare rate and the actual cost.
- In Chile, publicly insured patients who have opted for the plan with access restricted to public providers have cost-sharing depending on their respective income group. Patients who subscribed to the free-choice-of-provider option typically pay 50% of costs of tests and imaging services. Privately insured patients (Isapres) have an average co-payment rate of 34%. Copayments are

reduced for some patient groups (see section 5) and co-payments are capped for health problems which are part of the Explicit Health Guarantees program (GES).

- In Mexico, tests and imaging are free at the point of care if the provider belongs to the same subsystem as the patient's insurance fund (IMSS and ISSTE), or if the service is listed as a covered procedure for patients under the Seguro Popular.

67. In a few countries, patients *do not pay for laboratory tests but have to contribute to the costs of imaging*. In Israel, clinical laboratory tests are free at the point of care, but quarterly deductibles apply for diagnostic imaging. The situation is similar in Finland, where a co-payment per visit is applied for diagnostic imaging.

68. *Co-payments are being used to finance both clinical laboratory tests and diagnostic imaging* in 13 OECD countries (Austria, Belgium, France, Iceland, Italy, Japan, Korea, Norway, Portugal, Slovenia, Sweden, Switzerland and the United States).

- A fixed user fee for both clinical laboratory tests and diagnostic imaging is payable in Portugal and Iceland.

- In France, patients have to pay both fixed co-payments –with a daily cap - and a share of total costs, which depends on the type of procedure; the maximum co-insurance rate is 40% for clinical laboratory tests and 30% for imaging. However, these amounts are most often covered by private complementary health insurance.

- In Slovenia, patients pay a share of diagnostic costs, which varies from 10% to 30%, depending on the type of procedure. These co-payments are mostly covered by voluntary private health insurance.

- In Austria the EUR 10 (USD 11.80) service fee per year for using the e-card is replaced by a 20% co-payment of costs for patients in certain professions like civil servants and self-employed.

Table 10. Types and level of cost-sharing requirements from basic health insurance coverage for ancillary services (clinical tests and diagnostic imaging) for an adult not entitled to any co-payment exemption or reduction, 2012 or nearest year

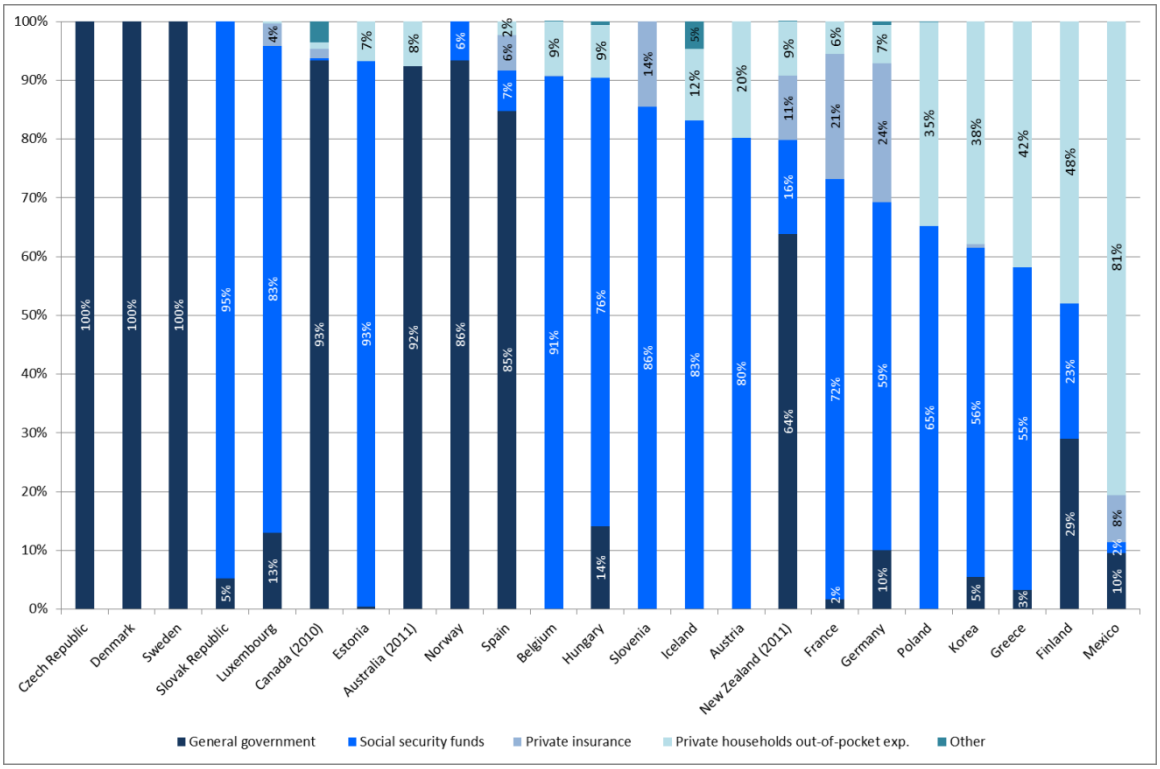
Countries	Clinical laboratory tests	Diagnostic imaging
Australia	Free at the point of care when providers accept direct payments from Medicare.	Free at the point of care when providers accept direct payments from Medicare.
Austria	EUR 10 (USD 11.80) service fee per year for using the e-card for the majority of insured people.	EUR 10 (USD 11.80) service fee per year for using the e-card for the majority of insured people.
Belgium	Co-payment, detailed information unavailable.	Co-payment, detailed information unavailable.
Canada	Free at the point of care (with benefits covered defined at provincial level).	Free at the point of care (with benefits covered defined at provincial level).
Chile	Depends on insurance plan. Patients publicly insured with a restricted access to public provides have a maximum co-insurance of 20% while patients publicly insured with free choice of provider and privately insured have a maximum co-insurance of 50%.	Depends on insurance plan. Patients publicly insured with a restricted access to public provides have a maximum co-insurance of 20% while patients publicly insured with free choice of provider and privately insured have a maximum co-insurance of 50%.
Czech Republic	Free at the point of care.	Free at the point of care.
Denmark	Free at the point of care.	Free at the point of care.
Estonia	N/A	N/A
Finland	Free at the point of care within the municipal health care system (primary and specialised care), although a co-payment may be collected if the referral is from a private sector physician.	Co-payment of EUR 27.50 (USD 29.28) per visit. If one visit to the hospital contains, for example, both a specialist's visit and diagnostic imaging, only one co-payment is charged from the patient. The annual municipal cap applies for co-payments in diagnostic imaging.
France	Co-insurance rates ranging from 40% to 0%, depending on the type of test, plus a co-payment of EUR1.00 (USD 1.16) per item, up to a maximum of EUR 4.00 (USD 4.63) per day.	Co-insurance of 30%, plus a co-payment of EUR 1.00 per item, up to a maximum of EUR 4.00; and a co-payment of EUR 18 (USD 20.86) when the procedure costs more than EUR 120 (USD 139.05) .
Germany	Free at the point of care	Free at the point of care
Greece	Typically covered without cost-sharing for public provider cost-sharing, and with low level of cost sharing in case of contracted private providers.	Typically covered without cost-sharing for public provider cost-sharing, and with low level of cost sharing in case of contracted private providers.
Hungary	Free at the point of care.	Free at the point of care.
Iceland	Co-payment of ISK1800 (USD 12.63) per visit.	Co-payment of ISK 2300 (USD 16.14) per visit for any service exceeding this amount + co-insurance of 40%, capped to ISK 29500 (USD 206.96).
Ireland	Free at the point of care in public hospitals.	Free at the point of care for public patients in public hospitals.
Israel	Free at the point of care.	Deductible of approx. NIS 25 (USD 6.13) per quarter.

Italy	Co-insurance, up to the maximum of EUR 36.15 (USD 45.57) per prescription, plus a co-payment of EUR 10 (USD 12.69) per prescription (of up to 8 tests), if included in "essential" care level.	Co-insurance, up to the maximum of EUR 36.15 (USD 45.57) per prescription, plus a co-payment of EUR10 (USD 12.69) per prescription (of up to 8 services), if included in "essential" care level.
Japan	Co-insurance of 30% of costs.	Co-insurance of 30% of costs.
Korea	Co-payment for ambulatory care: differs by the level of referral.	Co-payment for ambulatory care: differs by the level of referral.
Luxembourg	Free at the point of care.	Free at the point of care in hospitals. Co-insurance of 12% for the services of a physician.
Mexico	Depends on insurance and provider.	Depends on insurance and provider.
Netherlands	Free at the point of care after general deductible.	Free at the point of care after general deductible.
New Zealand	There are generally no user charges for people eligible for publicly funded health and disability services. Potential co-payments for tests that are not listed.	Mostly free. Occasional user charges; GPs may charge for X-rays, for example.
Norway	Variable, ex. blood tests NOK 40 (USD 4.42).	Co-payment of NOK 218 (USD 24.01), with cost-sharing (on all outpatient care) capped to NOK 2040 (USD 225) in 2013.
Poland	Free at the point of care.	Free at the point of care.
Portugal	Co-insurance capped at EUR 50 (USD 80.60), but more that 60% of the population are exempt from user fees.	Co-insurance capped at EUR 50 (USD 80.60), but more that 60% of the population are exempt from user fees.
Slovak Republic	Free at the point of care.	Free at the point of care.
Slovenia	Depends on procedure, 10-30% cost-sharing.	Depends on procedure, 10-30% cost-sharing.
Spain	Free at the point of care.	Free at the point of care.
Sweden	Free with small co-payment.	Free with small co-payment.
Switzerland	Co-insurance of 10% after general deductible and up to an annual cap.	Co-insurance of 10% after general deductible and up to an annual cap.
Turkey	N/A	N/A
United Kingdom	Free at point of care.	Free at point of care.
United States	Co-payments and deductibles vary by health insurance plan. In Medicare Part B, enrollees face a USD 147 deductible. Most Medicaid programs do have co-payments and deductibles.	Co-payments and deductibles vary health insurance plan. Most Medicare and Medicaid programs do have co-payments and deductibles.

Note: n.a. = not available
Source: OECD Health system characteristics Survey 2012, Szalay et al. (2011), and Secretariat's estimates

69. According to SHA data, costs of ancillary services are fully covered in four countries; Czech Republic, Denmark, Sweden and Slovak Republic (Figure 4). Costs are covered up to 90% or more in Luxembourg, Canada, Estonia, Australia, Norway, Spain, Belgium and Hungary. The share of direct payments from households in total spending on laboratory tests and clinical imaging is higher than 35 % in Finland, Greece and Korea. Private health insurance finances a significant share of spending in Germany, where it provides basic health coverage to 11% of the population, and in France, where it mainly covers co-payments.

Figure 4. Spending on ancillary services by financing agent 2012 (or nearest year)



Note: Data are not available for Chile, Finland, Ireland, Israel, Italy, Japan, the Netherlands, Poland, Switzerland, the United Kingdom and the United States. Norway, Mexico, Sweden and Slovak Republic have only available data on clinical laboratory tests.
Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

4.6 Cost-sharing for physiotherapist services

70. Physiotherapist services dispensed to patients in ambulatory care are most often covered with cost-sharing, when prescribed by a physician. Australia is the only country where such services are most often not covered by the basic tax-funded system Medicare (Table 11).

71. Physiotherapists' services are *free at the point of care* in a limited number of countries: the Czech Republic, Hungary, Poland, Spain and the United Kingdom. In Ireland, these services are free of charge only if obtained through public providers. In Mexico, physiotherapist services are free at the point of care if the provider belongs to the same subsystem as the patient's insurance fund (IMSS and ISSTE) and if the service is listed as a covered procedure for Seguro Popular. Danish municipalities offer physiotherapy free at the point of care after medical referral to patients with a permanent severe physical disability and to patients with disabilities as a result of a progressive disease such as multiple sclerosis.

72. Patients have to pay *a share of the costs* Belgium, Canada, Denmark, France, Germany, Greece, Iceland, Italy, Japan, Korea, New Zealand, Luxembourg, Portugal, Slovenia and Switzerland. In Chile and in the United States, co-insurance rates vary across health insurer providers and plans.

73. Some countries have *fixed per visit fees* either instead of the percentage rate (Finland, Israel) or a fixed base tariff plus the percentage rate on the cost (Austria, France, Germany, Italy).

Table 11. Types and level of cost-sharing requirements from basic health insurance coverage for physiotherapy provided in ambulatory care for an adult not entitled to any co-payment exemption or reduction, 2012 or nearest year

Countries	Physiotherapist services
Australia	Generally not covered by Medicare.
Austria	Co-payment of EUR 20 (USD 23.61) for contracted physiotherapists. Otherwise, health insurance pays a fixed reimbursement price (EUR 21.80 / USD 25.73 per hour), regardless of the price actually paid by the patient.
Belgium	Co-payment, detail not available.
Canada	Typically not fully covered. At discretion of provinces to decide if medically necessary.
Chile	Depends on insurance fund and plan: people affiliated to a public health insurance fund with the public-provider-only option pay cost-sharing scaled to their income, of 0%, 10 or 20%. Publicly-insured with the free-choice-of-provider option pay on average 50% of costs and privately insured pay on average 51% of physiotherapist costs.
Czech Republic	Free at the point of care.
Denmark	Co-insurance of 39.3 % of the fee.
Estonia	N/A
Finland	Co-payment of EUR 7.50 (USD 7.99) per visit in 2012.
France	Co-insurance rate of 40%, with an additional EUR 0.5 (USD 0.58) per service, capped to EUR 2 (USD 2.31) per day.
Germany	Co-insurance of 10% of costs plus EUR 10 (USD 12.51) per prescription (multiple sessions).
Greece	Typically covered with cost-sharing.
Hungary	Free at the point of care.
Iceland	Co-insurance of 40% and 70% after 30 visits.
Ireland	Primary care physiotherapy care is free of charge for public patients by public providers.
Israel	Deductible of approx. NIS 25 (USD 6.13) payable every quarter.
Italy	Co-insurance, up to the maximum of EUR 36.15 (USD 45.57) per prescription, plus a co-payment of EUR 10 (USD 12.69) per prescription (up to 8 session), if included in "essential" care level.
Japan	Co-insurance of 30% of costs.
Korea	Co-payment ambulatory care: differs by the level of referral.
Luxembourg	Co-insurance of 30% or free of charge, depending on the act.
Mexico	Depends on insurance and provider.
Netherlands	The first 20 sessions have to be paid by clients themselves. After these 20 sessions only clients with certain medical conditions are covered by the basic benefit package.
New Zealand	Depends on provider and injury type. Average co-payment for adults ranges from NZD 17 – 23 (USD 11.50- 15.56). Average co-payment for children ranges from NZL 16 - 23 (USD 10.38-15.56).
Norway	Deductible of about NOK 150 (USD 16.58) per half hour, up to an annual cap of NOK 2 650 (USD 293) for patients in need for long-term treatment.
Poland	Free at the point of care.
Portugal	Co-insurance capped at EUR 50 (USD 80.64), with more that 60% of the population exempted from user fees.
Slovak Republic	N/A
Slovenia	Co-insurance of 10 to 30%, depending on procedure,
Spain	Free at the point of care.
Sweden	Free with small co-payment.

Switzerland	Co-insurance of 10% once the annual deductible is met, with an annual cap on all cost-sharing.
Turkey	N/A
United Kingdom	Free at point of care.
United States	Co-payments and deductibles vary by employer and type of insurer. Most Medicare and Medicaid programs do have co-payments and deductibles.

Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates

4.7 Coverage of eyeglasses and/ or contact lenses

74. Eyeglasses and contact lenses are typically covered to a lesser extent than primary care services and important diagnostics. Nineteen countries indicate that eye glasses are not covered (Table 11), or 'generally not covered' for adults (Australia, Canada, Czech Republic, Denmark, Finland, Germany, Iceland, Israel, Italy, Japan, Korea, Mexico, the Netherlands, New Zealand, Norway, Portugal, Spain, Switzerland and the United Kingdom). For some countries, for example Germany or Italy, there are exceptions for different population groups, which are discussed below. In other countries, eye glasses are covered by basic health insurance, with cost-sharing; this is the case in Austria, Belgium, Chile, France, Greece, Poland, Slovenia and Sweden.

75. In Ireland, there is no cost-sharing at all. Extra costs only apply when patients prefer to pay for frames other than the standard frames supplied. In Luxembourg there is a flat reimbursement rate, capped at one pair of glasses every three years. In Poland, health insurance pays for one pair of eyeglasses every two years with 30% cost-sharing; eyeglasses for children up to 18 are free of charge within the reimbursement limit.

76. In some countries, coverage differs across regions or health insurance funds. This is the case in Canada, the United States or Italy, for instance. In the United States, co-payments and deductibles vary across health insurance plans; most Medicare and Medicaid programmes do have co-payments and deductible for glasses.

77. In Chile, coverage of eyeglasses depends on the type of insurance institution and the patient's income. People insured under the public health insurance fund and choosing the public-provider-only option co-pay according to their income group, contributing 0%, 10% or 20% of the costs of the eyeglasses. This insurance system does not cover contact lenses. Patients covered under the free choice modality of public providers (MLE) have to pay around 50% of the cost. In the private insurance system Isapres, the level of coverage depends on the insurance company and the chosen plan. The average co-insurance rate for glasses in the Isapres system was 80% in 2010.

Table 12. Types and level of cost-sharing requirements from basic health insurance coverage for optical products for an adult not entitled to any co-payment exemption or reduction, 2012 or nearest year

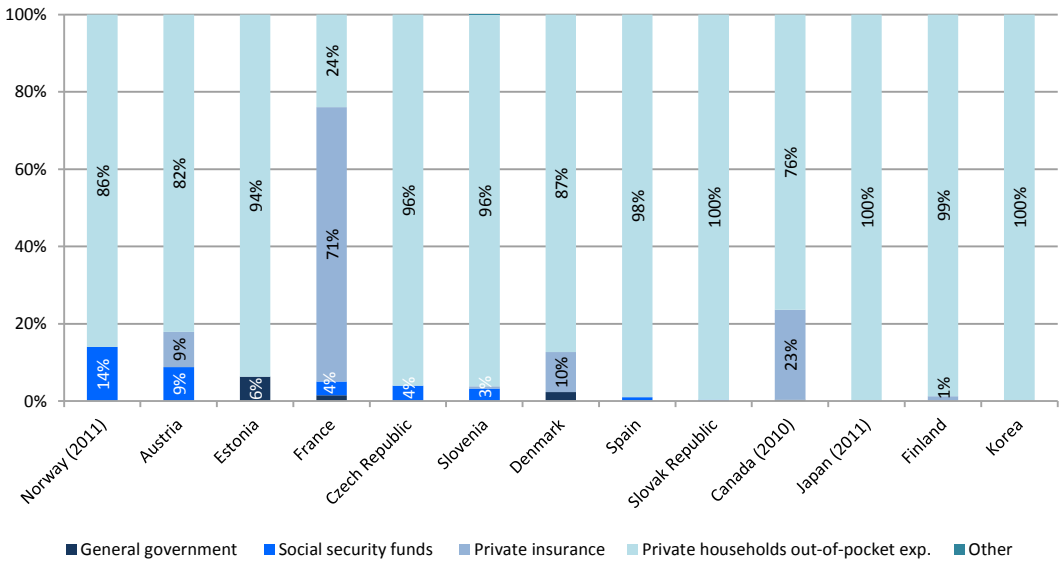
Countries	Eyeglasses and/or contact lenses
Australia	Generally not covered.
Austria	Co-insurance between 10% and 20% (depending on profession), with minimum co-pay of EUR 84 (USD 99.07).
Belgium	Typically not covered for working-age adults. Co-payments for children and seniors and people with vision above/ below a dioptre threshold (+/-).
Canada	At discretion of the provinces and territories. Typically not covered, unless deemed medically necessary.
Chile	Depends on health insurance plan and patient income.
Czech Republic	Not covered in general package.
Denmark	Not covered.
Estonia	N/A
Finland	Not covered.
France	Co-insurance of 40% of the base tariff set by the social security system, but prices are generally much higher than the tariff.
Germany	Generally not covered. Co-insurance of 10% of costs, with a minimum of EUR 5 (USD 6.25) and a cap of EUR 10 (USD 12.51).
Hungary	N/A
Greece	Covered with co-payment.
Iceland	Not covered.
Ireland	No cost sharing. Patients may choose to make an additional payment if they wish to select frames other than the standard frames supplied.
Israel	Not covered.
Italy	Generally not covered
Japan	Not covered.
Korea	Not covered.
Luxembourg	Patients are covered through a flat rate, capped to one pair of glasses every 3 years.
Mexico	Not covered.
Netherlands	Not covered.
New Zealand	N/A
Norway	Generally not covered, except for people with special conditions and disabilities.
Poland	30% cost-sharing within reimbursement limit, capped to one pair of glasses every two years. Contact lenses 30% within the reimbursement limit, only if connected to treatment of specific diseases.
Portugal	Not covered for the general population.
Slovak Republic	N/A
Slovenia	10% covered by CHI/HIIS (90% cost-sharing or covered by VHI).
Spain	Not covered.
Sweden	Free with some co-payment.
Switzerland	Not covered.
Turkey	N/A

United Kingdom	Not covered.
United States	Co-payments and deductibles vary across health insurance. Most Medicare and Medicaid programs do have co-payments and deductibles.

Note: n.a. = not available Source: OECD Health Systems characteristics survey 2012

78. According to SHA, basic health coverage does not finance eye products (Figure 5). In most countries patients pay virtually the whole cost of eye-glasses and contact lenses, with the exception of France where private (complementary) health insurance pays 71% of the bill.

Figure 5. Spending on eyeglasses/ contact lenses by financing agent 2012 (or the nearest year)



Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

4.8 Coverage of dental care and dental prosthesis

79. Dental care is covered more commonly than eyeglasses and contact lenses, but with high levels of cost-sharing or limited pre-defined service packages. In many OECD countries, dental care and prosthesis are not covered for adults without any specific entitlement, among which are Australia, Canada, Denmark, Iceland, Israel, Italy, Mexico, New Zealand, Norway, Portugal, Spain, Switzerland and the United Kingdom (Table 13).

80. In Mexico, the Social Security does not cover dental care, while the public health insurance fund *Seguro Popular* does cover certain dental treatments. In the Netherlands, basic dental care is not generally covered, and coverage is restricted to specialist dental care in hospitals.

81. Other OECD countries have cost-sharing systems in place to finance dentist visits. These include Austria, Belgium, Czech Republic, Finland, France, Greece, and Japan, Korea and Luxembourg and all also countries, except Korea, for dental prostheses. In some countries, prices paid by patients are much higher than the price considered as the basis for reimbursement. Germany introduced an incentive: people with regular dental check-ups are entitled to reduced cost-sharing on treatment costs.

82. In Chile, co-payment for dental care depends on the insurance institution. Patients insured under Fonasa with restricted access to public providers have cost sharing of 0%, 10% or 20% for dental care and 0%, 30% and 50% for dental prostheses, depending on income group. Publicly insured patients with free choice of provider have no coverage for dental care and prostheses. Patients ensured with one of the private insurance companies of the Isapres generally do not have coverage for dental care or prostheses, but insurers often offer preferential prices for set areas following certain agreements. In addition, the GES Program (Explicit Health Guarantees) includes coverage of dental care to some populations, such as children (6 years), pregnant women and older people (60 years). Therefore, these services are covered by Isapres. The average co-payment for dental care and prostheses under Isapres in 2010 was 69%.

Table 13. Types and level of cost-sharing requirements from basic health insurance coverage for dental care and dental prosthesis for an adult not entitled to any co-payment exemption or reduction, 2012 or nearest year

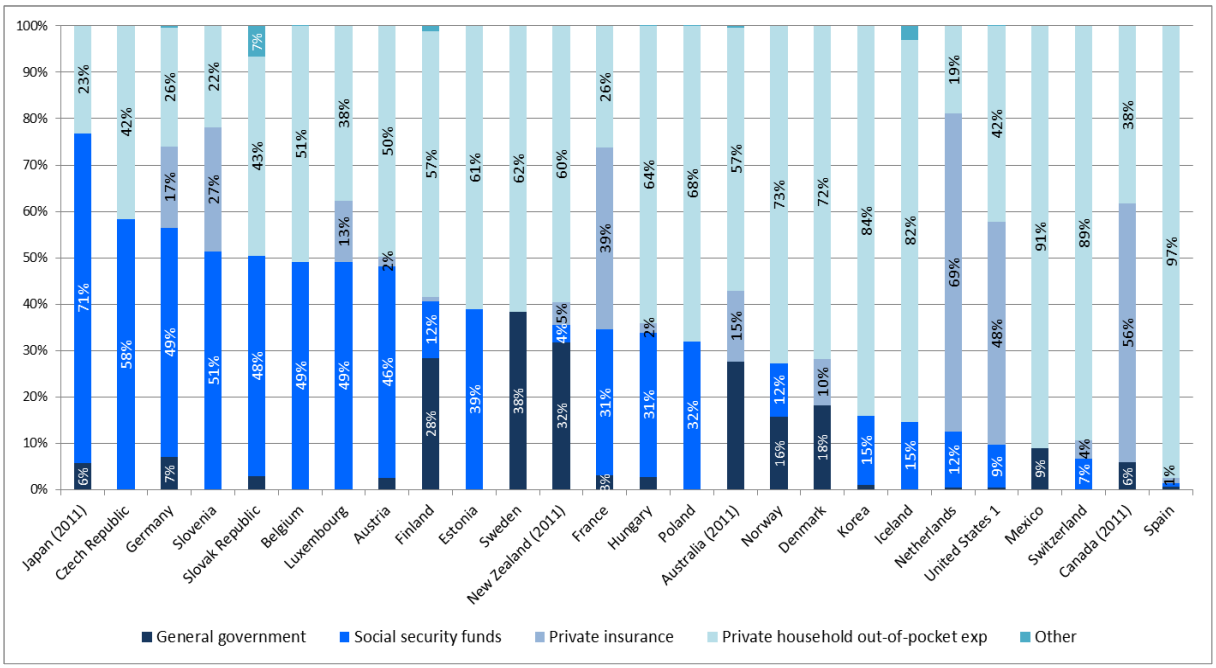
Countries	Dental care	Dental prostheses
Australia	Generally covered.	Generally not covered.
Austria	EUR 10 (USD 11.80) service fee per year for using the e-card for the majority of insured patients.	EUR 10 (USD 11.80) service fee per year for using the e-card for the majority of insured people.
Belgium	Covered with co-payments.	Covered with co-payments.
Canada	At discretion of the regions. Typically not covered, unless deemed medically necessary.	At discretion of the regions. Typically not covered, unless deemed medically necessary.
Chile	Depends on insurance fund Fonasa public/ free choice and Isapres.	Depends on insurance fund Fonasa public/ free choice and Isapres.
Czech Republic	User fee of EUR 1.20 (USD 2.24) per visit, further co-payments for using better quality materials and certain procedures which are not covered.	Co-payment depends on the type of prostheses.
Denmark	Not covered.	Not covered.
Estonia	Not covered.	Not covered.
Finland	Consultation fees: EUR 7.50 (USD 7.99) with a dental hygienist, EUR 9.60 (USD 10.22) with a dentist, EUR 14 (USD 14.91) with a specialised dentist, plus procedure-specific co-payments.	Co-payments can be up to and above EUR 100 (USD 106). Municipal dental care is not included in the annual health care co-payment cap.
France	Co-insurance of 30%.	Cost-sharing of 30% of the base tariff, which is well below prices actually paid by patients.
Germany	Covered in form of in-kind for e.g. conservative treatment, surgical treatment, x-rays.	For prostheses, crowns and bridges coverage is in the form of diagnoses-related fixed grants. Cost-sharing less than 50% of treatment costs for specified standard benefits; 0% for low income individuals.
Greece	Covered with high levels of co-payments.	Covered with co-payments.
Hungary	Most dental services are available free of charge and are divided into primary care, specialist or out-of-hours services.	Covered with co-payments.
Iceland	Not covered.	Not covered.

Ireland	No cost sharing on defined basic annual treatment package, and emergency dental treatment.	No cost sharing for denture repairs, where justified as an emergency treatment.
Israel	Not covered.	Not covered.
Italy	Generally not covered.	Generally not covered.
Japan	A fixed rate of 30% of costs.	A fixed rate of 30% of costs.
Korea	30-60% cost-sharing depending on the level of referral of the facility.	Not covered. 50% co-payment if 75 years or older.
Luxembourg	Cost-sharing for the patient: 12% of x – EUR 60 (USD 63.42) . (x = annual amount for dental care).	Cost-sharing of 0% or 20% (based on reference price) depending on prosthesis category.
Mexico	*Seguro Popular* covers some dental treatments.	Not covered.
Netherlands	Only specialist dental care in hospitals is covered; general dental care is not.	Complete dental prosthesis on implants: USD 125 (USD 149.88). Other dental prosthesis: 25% co-payment.
New Zealand	Not covered for adults aged 19 and above.	Not covered.
Norway	Generally not covered, with exceptions for specific conditions.	Generally not covered, with exceptions.
Poland	Free of charge but scope of covered dental services is limited.	Free of charge within the reimbursement limit: capped to one lower and one upper acrylic prosthesis in every five year.
Portugal	Not covered for the general population.	Not covered for the general population.
Slovak Republic	N/A	N/A
Slovenia	Co-insurance of 20%.	Co-insurance of 90%.
Spain	Not covered.	Not covered.
Sweden	Deductible of SEK 3 000 (≈ USD 340) and then 50% co-insurance up to SEK 15 000 (≈ USD 1 705) and then 15% co-insurance.	N/A
Switzerland	Not covered, except when related to serious diseases.	Not covered
Turkey	N/A	N/A
United Kingdom	England: In NHS dentistry, non-exempt patients currently pay approximately 66% of the cost of their treatment. Scotland: no cost-sharing on dental exams but 80% co-insurance on dental treatment, capped GBP 384 (USD 564.71) per course of treatment, with some exemptions.	England: In NHS dentistry, non-exempt patients currently pay approximately 66% of the cost of their treatment.
United States	Co-payments and deductibles vary across health insurance plans. Most Medicare and Medicaid programs do have co-payments and deductibles.	Co-payments and deductibles across health insurance plans. Most Medicare and Medicaid programs do have co-payments and deductibles.

Note: n.a. = not available
Source: OECD Health system characteristics Survey 2012, Smidova (2011), Krutilova (2013), Swedish TLV website consulted on July 5, 2014.

83. According to SHA, public payers finances 50% of dental care[7] or more in a limited set of countries (Japan, the Czech Republic, Germany, Austria, Slovenia and the Slovak Republic) (Figure 6). In France, private complementary health insurance finances nearly 40% of dental care and social health insurance another 31%. In the Netherlands, private supplementary health insurance covers more than two thirds of spending on dental care. In Canada it covers over half of spending.

Figure 6. Spending on outpatient dental care by financing agent 2012 (or nearest year)



Note: Data are missing for Chile, Greece, Ireland, Israel, Italy, Portugal, Turkey and the United Kingdom. In SHA, spending on dental care includes spending on dental prostheses. In the Netherlands, out-of-pocket spending might be under-reported. Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

5. Policies to protect population groups from high cost-sharing requirements

84. Most countries have introduced policies to protect patients from excessive co-payments and catastrophic expenditure for health, to guarantee access to care to some disadvantaged categories or to promote public health objectives. These policies take several forms.

85. Mechanisms to protect high consumers of health care services from high cost-sharing are: setting annual or monthly caps limiting co-payments for all or some categories of goods and services (see Table 13); reduce or remove co-payments for people affected by chronic and/or severe diseases, for the disabled or for seniors (see Table 14).

86. Many countries have introduced mechanisms to facilitate health care access for low-income patients though co-payment reductions or exemptions (see Table 15). Some countries (e.g. Australia and Belgium) grant a "preferential status" to some patients, which entitle them to reduced co-payments. Another option is to exempt low-income patients from co-payments. A third option consists of subsidising complementary or supplementary coverage for low-income categories (e.g. Canada or France). New

7 In the System of Health Accounts, spending on dental care includes dental services and prostheses billed as part of dentists services.

Zealand adopted an original mechanism to support access to primary health care and reduce health inequalities with the establishment of the VLCA scheme (see Table 13, Table 15).

87. In nearly all countries, children have no or reduced co-payments, as do pregnant women. Some countries offer such advantages to other categories (e.g. war veterans, victims of work injuries, etc.) (Table 16).

88. These mechanisms are described in following tables, according to information provided by countries in the Health Systems Characteristics Survey 2012.

Table 14. Countries with annual cap on cost-sharing

Country	Annual cap for cost-sharing
Australia	"Extended Medicare Safety Net": cap on out-of-pocket costs for outpatient services covered by Medicare (i.e. services provided by GPs, specialists, private clinics and private emergency departments). Beyond an expenditure threshold (which is indexed annually), Medicare pays 80% of the out-of-pocket costs. People on low incomes qualify for the Safety Net at a lower threshold. The pharmaceutical safety-net threshold for general patients is currently AUD 1 390.60 (USD 950) for the calendar year, while the concessional-patient threshold is AUD 345.00 (USD 242). After reaching the threshold, general patients usually pay AUD 5.90 (USD 3.93) for each prescription for the remainder of the calendar year, while concessional patients receive prescriptions free of charge.
Austria	Maximum threshold of 2% of the annual income.
Belgium	Annual cap on cost-sharing.
Chile	Annual cap on cost-sharing, plus a cap of 30% of annual household income for conditions or treatments included in the GES program.
Czech Republic	Annual cap on all cost-sharing.
Denmark	Annual cap of DKK 3 710 (USD 472 for pharmaceuticals. Other services of medical diagnostic and curative care are virtually free of charge.
Finland	Annual co-payment cap of EUR 636 (USD 677) in 2012 on cost-sharing for health services provided by municipalities.
Germany	Co-payments are capped at 2% of gross household income, reduced to 1% for the chronically ill.
Hungary	Entitlement to free pharmaceuticals for those whose medical expense exceeds 10% of the minimum pension (for households with income per capita < minimum pension = EUR 100 in 2010).
Iceland	Cap on cost-sharing for outpatient primary care, outpatient specialist contacts, clinical laboratory tests and diagnostic imaging.
Ireland	Annual cap on inpatient care, primary care and pharmaceuticals.
Israel	Annual cap on inpatient and outpatient primary care.
Japan	Monthly co-payment cap depending on age and income.
Korea	Expense limit for all cost-sharing is based on the average health insurance fee per year.
Luxembourg	Annual cap on all cost-sharing fixed at 2.5% of the annual income.
New Zealand	Annual cap for pharmaceuticals: after a family has paid for 20 items, all medicines are free of charge for patients. In addition, co-payments paid by patients enrolled at a GP practice offering the VLCA scheme are capped (to NZD 17 (USD 11.49) for an adult).
Norway	Annual cap (ceiling 1) for the combination of expenses on pharmaceuticals, consultations with physician in the primary healthcare sector, psychologists and psychiatrists, outpatient services in hospitals, physiotherapists, laboratory tests, x-rays set at NOK 2040 (USD 225) in 2013. Another annual cap (ceiling 2) includes physical therapy, some forms

	for dental treatment that are subject to reimbursement and accommodation fees at rehabilitation centres and treatment abroad, set as NOK 2560 (USD 293) in 2013.
Portugal	Annual cap on co-payments for low-income elderly people for dental prosthesis and eyeglasses.
Sweden	Annual cap for all cost-sharing requirements. Annual cap on co-payments for pharmaceuticals, set at SEK 1 800 (USD 203).
Switzerland	Patients' co-payments capped at CHF 700 (USD 492) for an adult and CHF 350 (USD 246) for a child.
United States	Most Medicare and Medicaid programs have co-payments and deductibles, with exemptions for people who have paid for health expenditure above a certain threshold. In employer-sponsored health insurance plans, nearly 88% of enrolees have cost-sharing caps. In individual plans, 29% of covered workers have a cap below USD 2 000 and 12% a cap of USD 5 000 or more. In family plans, 29% of enrolees have an aggregate cap lower than USD 4 000 and 24% have an aggregate cap of USD 8 000 or more.

Source: Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates; Baji et al, 2011.

Table 15. Exemptions or reductions of co-payments for those with certain medical conditions or disabilities or seniors

Country	Exemption
Australia	Reduction or exemptions for people with certain medical conditions and disabilities and for seniors.
Austria	Reduction or exemptions from all cost-sharing for people with communicable diseases and for seniors.
Belgium	Those with certain medical conditions are exempted from co-payments for outpatient primary and specialist care and inpatient care and seniors are exempted from the above and dental care.
Chile	People over 60 years of age insured through the public insurance fund are exempted or pay reduced rates for all cost-sharing. Publicly-insured patients with certain medical conditions and disabilities are exempted or pay reduced co-payments in outpatient primary care, outpatient specialist contacts, clinical laboratory tests, pharmaceuticals and eyeglasses and/or contact lenses.
Denmark	Reduction or exemptions of co-payments on pharmaceuticals and dental care for people with certain medical conditions and disabilities and for seniors.
Estonia	Reduced co-insurance (10%) on prescription medicines for chronic diseases for people with disability benefits or pensioners over 63.
Finland	Reduction of exemptions of co-payments on pharmaceuticals for people with certain medical conditions and disabilities.
France	Patients with chronic and severe conditions are exempted from co-payments for all treatments related to this condition. People benefitting from a disability pension are fully covered for treatment of illness and during pregnancy, except for some designated medicines and homeopathic, which are either not covered or at a lesser rate.
Germany	Chronically ill and patients with disabilities have a lower cap on co-payments at 1% of gross annual income, instead of 2%.
Greece	Chronically ill and patients with disabilities have exemptions for inpatient and pharmaceutical cost-sharing. Seniors are exempted from co-payments for pharmaceuticals.
Hungary	Reduction or exemption for people with certain medical conditions and disabilities.
Iceland	Reductions or exemption of co-payments on pharmaceuticals for patients with chronically diseases and disabilities and for seniors.
Ireland	Exemption for outpatient primary and specialist care and pharmaceuticals for patients with certain medical conditions or disabilities (eligibility for Medical Card).
Israel	Reduction or exemptions for people with certain medical conditions and disabilities.
Italy	Reduction or exemptions for people with certain medical conditions and disabilities and for seniors under designated income thresholds.
Japan	People over 65 with disabilities and all people over 75 are entitled to reduced co-payments for medical services for physical disabilities and mental disorders. For these individuals, the co-payment per month is means-tested on household income, and is limited to 10% of the costs for a medical service.

Korea	Patients with severe illness are exempted from cost-sharing when they belong to defined disease categories, e.g. chronic renal failure, haemophilia, tuberculosis, organ transplantation, psychiatric diseases, cancer, severe burn, open heart surgeries and brain surgery, and co-insurance is reduced by between 5 and 10%. In addition, Medical Care Cost Support programmes provide subsidies to the high-risk patients, including 132 disease categories, in the instance that their income is less than 300% of the established minimum cost of living, or if they are enrolled in the nation-wide Medical Aid programmes. Seniors have reductions on cost-sharing for primary care and outpatient specialists contacts. Patients over 65 have reduced cos-sharing for primary care consultations: 30% when total cost exceeds KRW 15,000 (USD 18.11) and co-payment of KRW 1,500 KRW (USD 1.81) if the total cost is lower.
Luxembourg	Exemption or reduction from pharmaceutical co-insurance for patients with certain medical conditions or disabilities.
Netherlands	Chronically ill and those with disabilities are exempted from co-payments for physiotherapist services.
Norway	Chronically ill and those with disabilities have reductions or exemptions from co-payment for outpatient primary and specialist care, diagnostic imaging, dental care and dental prostheses. Certain groups of pensioners in Norway are exempted from co-payments on prescriptions which are reimbursed by the state.
Poland	Dental care is free to those with certain medical conditions.
Portugal	Chronically ill and those with disabilities are exempted from all cost-sharing.. People living with HIV/AIDS have free access for basic dental treatments.
Slovak Republic	Compulsory health insurance pays the full (or a higher share of the) price of services including programmes of preventive care, diagnosis and treatment of infectious diseases, including HIV/AIDS, treatment and rehabilitation of occupational diseases or injuries, treatment of diseases and conditions including muscular or muscular nerve diseases, advanced diabetes, epilepsy, haemophilia, paraplegia, quadriplegia and cerebral palsy.
Slovenia	Patients with certain conditions or disabilities are exempted from all cost-sharing.
Spain	Patients with certain medical conditions or disabilities are exempted from co-payments on pharmaceuticals. Other medical diagnostic and medical services are typically free of charge.
Sweden	Those with certain medical conditions and disabilities are exempted for all cost-sharing.
Turkey	Reduced co-insurance rate (10% instead of 20%) for pensioners on a range of services.
United Kingdom	Exemption from prescription fee. Other medical diagnostic and curative services are typically free of charge.

Source: OECD Health system characteristics Survey 2012, Smidova (2011), and Secretariat's estimates

Table 16. Exemptions or reductions of co-payments for low-income or economically disadvantaged populations

Country	Exemption for low income and economically disadvantaged patients
Australia	People on low incomes qualify for the Safety Net at a lower threshold and for reduced co-payments on pharmaceuticals under this threshold.
Austria	Low-income patients are generally exempted from prescription fees.
Belgium	Since 2011, social health insurance has been paying user fees and co-payments for vulnerable populations (subject to conditions) visiting GPs, with the exception of home visits. Low-income Patients can also be exempted from “up-front” payments, which is the common rule in Belgium.
Canada	Most provincial and territorial governments fund a range of supplementary benefits for certain groups (incl. low-income residents), for hearing, vision and dental care, medical equipment and appliances (prostheses, wheelchairs, etc.), independent living and the services of other health professionals (such as podiatrists and chiropractors) that are not covered under the Canada Health Act. Outpatient-pharmaceuticals are covered in some provinces for all residents, while others focus on particular groups, incl. those on social assistance.
Chile	People publicly insured under Fonasa are divided in four groups based on income level and employer status. People insured under the Fonasa “public provider”-plan and in the lowest income group are exempted from all co-payments, while the second lowest income group is entitled to reduced co-payments for all categories of health services.
Czech Republic	Exemptions for patients on social benefits for inpatient primary care and some dental services.
France	Lower-income people are not protected from excessive co-payments through basic primary coverage but through means-tested subsidies for the purchase of a specific type of complementary health insurance (CMU-C). CMU-C covers cost-sharing and protects patients from potential extra-billing. In addition, with CMU-C patients do not have to pay ““up-front”, which is the common rule in France.
Greece	Exemptions from co-payments for GP visits and inpatient care.
Hungary	Information not available.
Ireland	40% of the population is entitled to the preferential status with no or lower co-payments for health services (Eligibility for Medical Card; Low-income, elderly, students, foster-care children etc).
Israel	Reduction or exemptions for low-income patients and recipients of social benefits.
Italy	Reduction or exemptions for low-income patients and patients receiving social benefits.
Japan	Exemptions from or reduction of all co-payments for patients covered by the social assistance program and under a certain income threshold.
Korea	Exemptions or reduction on all cost-sharing for patients under a certain income threshold.
Luxembourg	Reduction or exemption from all cost-sharing.
Mexico	In Mexico, the population in the first four deciles of the income distribution is exempt from co-payments. Low-income patients and recipients of social benefits have reduced co-payments on pharmaceuticals.

New-Zealand	Reduced co-payments in Very-Low-Cost-Access practices. The government subsidises so-called Very-Low-Cost-Access (VLCA) practices, which typically serve disadvantaged areas under the condition that they forgo revenue from patient fees. As a consequence, the average payable for services is lower in VCLA practices than in other practices. For instance, the average co-payment for primary services is NZD 14.77 (USD 10.00) for an adult patient instead of NZD 36.58 (USD24.73). In addition, co-payments paid by patients enrolled at a GP practice offering the VLCA scheme are capped (to NZD 17 (USD 11.49) for an adult) Overall, 30% of all New Zealanders benefit from reduced co-payments.
Portugal	Exemptions for all cost-sharing requirements for low-income patients. Coverage of dental care (usually not covered) for low-income seniors.
Slovenia	Low-income patients and those receiving social benefits are exempted from co-payments.
Spain	People receiving social benefits and non-contributory pensioners are exempted for co-payments for pharmaceuticals. Other medical diagnostic and curative services are virtually free of charge.
Sweden	Hospital copayments reduced for low-income population in some counties.
United Kingdom	England: Exemptions from prescription fee. Other medical diagnostic and curative services are typically free of charge. Low income groups receive further assistance via NHS Low Income Scheme (Scheme covers prescriptions, dental costs, eye care costs, wigs and fabrics and healthcare related travel costs).
United States	In the United States, most Medicaid programs do have co-payments and deductibles as well as exemptions for those on low incomes.

Source: Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates

Table 17. Exemptions or reductions of co-payments for children and pregnant women

Country	Exemption
Australia	Reduction or exemption from cost-sharing for children and pregnant women (on services related to pregnancy). Australian war veterans may be eligible for a broad range of health care and support services, depending on eligibility. Some veterans are entitled to all health care services at Australian Government expense, including medical, dental, optical care and subsidised pharmaceuticals. Some veterans are only entitled to be treated at Australian Government expense, including subsidised pharmaceuticals, for their accepted service related disabilities or illnesses. Eligible Aboriginal and Torres Strait Islander patients, pay reduced rates for pharmaceuticals. Pharmaceuticals (on the PBS) are provided to patients of Aboriginal Health Services at the time of consultations and at no cost to the patient, by a suitably qualified and approved health professional, in accordance with state law.
Austria	People rendering community service and asylum seekers are exempted from cost-sharing.
Belgium	Children are exempted for co-payments for acute inpatient care and out-patient primary and specialist care as well as for Dental care and Eyeglasses. Pregnant women are exempted for inpatient and outpatient care related to the pregnancy.
Czech Republic	Children are exempt from all cost-sharing. Pregnant women are exempted from co-payment on pharmaceuticals related to their pregnancy.
Denmark	Children are covered for dental care and prosthesis, which are not covered for adults.
Estonia	Children under 2 and pregnant women exempted from co-payments for GP home visits, from co-payments in inpatient care. Children under 4 only pay EUR 1.30 per prescription medicine and no co-insurance.
Finland	Children are exempted from co-payments for outpatient primary and dental care and prostheses. In addition, visits to maternity and child health clinics are free of charge.
France	Pregnant women are exempted from co-payments for care related to pregnancy and delivery. They may be exposed to extra-billing if they consult physicians allowed to charge extra-billing.
Germany	Children are exempt from all co-payments.
Greece	Children are exempt from cost-sharing on dental care and prosthesis. Children and pregnant women are exempted from co-payments on pharmaceuticals.
Iceland	Children have reductions or exemptions for all co-payments and are covered for some dental and dental prosthesis services.
Ireland	Children and Students up to 25 are exempt from co-payments for acute inpatient care, outpatient specialist contacts and pharmaceuticals. Pregnant women are exempt for acute inpatient care and outpatient specialist contacts.
Israel	Pregnant women are exempt from co-payments in acute inpatient care and dental care. Holocaust survivors and those with disabilities due to active resistance to the Nazi regime, as well as victims of traffic accidents, are exempt from co-payments.
Italy	Reductions or exemptions for children under a certain income threshold and for pregnant women for pregnancy related tests and diagnostics.
Japan	Reductions on cost-sharing for children. Normal delivery is not covered by health insurance as it is not considered as sickness but subsidies are given to pregnant women to cover the cost related to prenatal care and delivery.
Korea	Children are exempt from co-payment for acute inpatient care, outpatient primary care and specialists, clinical laboratory tests, diagnostic imaging, physiotherapist services, pharmaceuticals and dental care. Pregnant women are exempt from copayment for normal delivery services.
Luxembourg	Inpatient primary care is free for children and pregnant women in case of delivery. Pregnant women are also exempted from co-payments in outpatient care.
Mexico	Information not available
Netherlands	Children are exempt from all cost-sharing.

New Zealand	Cost-sharing is reduced for children. The average co-payment for primary care provided in "ordinary practices" is NZD 28.20 (USD 19.06) for children aged six to seventeen years old and NZD 2.60 for children aged less than six. For primary care provided in VLCA practices, these co-payments are respectively of NZD 7.65 (USD 5.17) and NZD 0. The co-payment is also zero for children under 6 enrolled in a practice offering the "Zero Fees for Under 6s" scheme. As a result, 93% of children aged less than six years old are exempted from co-payments. Free dental care for patients aged 0 to 18.
Norway	Children are exempted from all cost-sharing. Pregnant women are exempted for co-payments on outpatient care when the contact is regarding the pregnancy.Victims of occupational injuries or diseases are exempted from co-payments. Norway offers free basic dental care for children up to 18 and a reduced co-payment rate for 18-20 year olds. Orthodontic treatment can be paid for fully or partially according to the gravity of the condition.
Poland	Dental services other than the standard ones are provided free for children up to 18 years old, pregnant women and children with specific psychiatric disorders. Children up to 18 are also exempted from cost-sharing on eyeglasses and dental prosthesis.
Portugal	Children, pregnant women are exempted from all co-payments. Fire-fighter and blood-donour do not pay co-payments for outpatient primary care.
Slovenia	Children and pregnant women are exempted from co-payments.
Sweden	Children are exempted from all cost-sharing.
Switzerland	Children have no or a reduced deductible (depending on plan chosen). Pregnant women are exempt from all cost-sharing.
United Kingdom	Children and pregnant women are exempted from prescription fees for pharmaceuticals, the only cost-sharing requirement in England. They are also exempted from payments of dental charges. Children under 16 (or under 19 years of age and in full-time education) can further receive assistance for purchasing of the eyeglasses.

Source: OECD Health system characteristics Survey 2012, Smidova (2011), and Secretariat's estimates

Catastrophic health expenditure

89. The share of population facing catastrophic health spending is a good indicator with which to assess the protection against health-related financial risks. A household is considered to be exposed to catastrophic out-of-pocket health expenditures when it spends 40% or more of its non-subsistence income[8] on health. Such spending can have severe consequences for a patient, leading to potential impoverishment and indebtedness. The share of the population exposed to catastrophic health spending is an interesting indicator to measure the protection against health-related financial risks. Many OECD countries do not collect such data because they consider such a scenario unlikely to happen under the design of their health system. Where the basic benefit package is inclusive enough and co-payments limited or capped, patients are in principle protected against such catastrophic spending. Several countries indicated that this share is "0". Four countries that collect data on catastrophic spending indicate a share greater than 1.5%, Estonia, Ireland, Korea and Mexico.

90. The share of out-of pocket payments in total health expenditure is correlated with the incidence of catastrophic expenditures. Korea for example has a 3.7% share of population experiencing catastrophic health expenditure- matching its high cost-sharing requirements of 30% for all health services (Table 18).

[8] Non-subsistence income is the income available after basic needs, other than healthcare, are covered.

Table 18. Share of population exposed to catastrophic health expenditures in 2010 or the last available year

Country	% of households
Belgium	0.0%
Chile (2012)	2.1%
Czech Republic	0.0%
Denmark	0.0%
Estonia (2007)	3.3%
Finland (2001)	0.1%
Hungary	0.5%
Ireland	1.6%
Korea	3.7%
Luxembourg	0.0%
Mexico	2.2%
New Zealand	0.0%
Norway	0.0%
Slovenia (2009)	0.1%
Sweden	0.0%
United Kingdom	0.0%
United States	2.0%

Note: Information is not available in other OECD countries,
Source: OECD Health system characteristics Survey 2012, Cid and Prieto (2012) and Secretariat's estimates

6. Secondary sources of coverage

91. In a few OECD countries, private health insurance (hereafter PHI) supplies basic primary coverage to a significant share of the population. This is the case in the United States, Chile, and to a lesser extent Germany[9]. A small proportion of the population in Turkey (2.5%) also obtains basic coverage with private health insurance.

92. In other OECD countries, private health insurers supply different types of "secondary coverage" for health spending (see Box 4 for definitions).

Box 4. Definition of functions of (secondary) private health insurance

Supplementary cover: private health insurance that provides cover for additional health services not included in the basic benefit package. Depending on the country, it may include services that are uncovered by the public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service (*i.e.* medical component) are covered by the public system).

Complementary cover: private insurance that complements coverage of goods and services covered by basic primary coverage scheme(s), by covering all or part of the residual costs (cost-sharing) not otherwise reimbursed (*e.g.,* co-payments).

Duplicate cover: private insurance that offers cover for *health services* already included under public health insurance. Typically, duplicate cover does not exempt individuals from contributing to public health insurance.

[9] Other countries like Switzerland or the Netherlands rely heavily on private companies to provide basic primary coverage to the population, but given the regulatory environment in which these companies operate, they are considered as "social insurance".

Duplicate health insurance can be used in two ways:

- Covering access to providers whose services are not eligible for funding by basic primary coverage;
- Covering goods and services that are provided by providers whose services are eligible for funding by basic health coverage (e.g. to 'jump the queue' or to choose treating physician).

Source: OECD (2004a); OECD Health Systems Characteristics survey (2012).

93. In the HSC Survey, only five countries - the Czech Republic, Estonia, Iceland, Norway and Turkey - reported that private health insurance does not provide a secondary source of coverage for health and the share of private health insurance in total health spending is null or almost null.

94. In other countries, the range of services actually covered by secondary coverage depends both on the scope of the basic benefit package, on effective access to covered care, and on government regulations on possible roles for private health insurance. In several countries for instance, PHI is not allowed to cover cost-sharing left by the public system (see Table 19). This is the case in Australia, Canada, and Switzerland. PHI is not allowed to offer "duplicate coverage" in Canada, Chile and Korea. Such coverage is allowed in Finland, but only for health care services dispensed by providers that are not eligible for funding by public health coverage.

Table 19. Role played by private health insurance as secondary source of coverage, 2012 or nearest year

Country	Supplementary (i.e. coverage of services nor covered by primary source of coverage)	Complementary (i.e. coverage of cost-sharing left by basic health insurance)	Duplicate cover	
			Only when provided by providers whose services are not eligible for funding by basic primary coverage.	Including when provided by providers whose services are eligible for funding by basic health coverage (e.g. to jump the queue or choose your doctor).
Australia[1]	Significant	Not allowed	Significant	Significant
Austria	n.a.	n.a.	n.a.	n.a.
Belgium	Marginal	Significant	Not generally	Not generally
Canada	Significant	Not allowed	Not allowed	Not allowed
Chile	Significant	Significant	Not allowed	Not allowed
Denmark	n.a.	n.a.	n.a.	n.a.
Finland	Not generally	Marginal	Significant	Not allowed
France	Marginal	Significant		
Germany	n.a.	n.a.	n.a.	n.a.
Greece	Not generally	Not generally	Significant	Significant
Hungary	Marginal	Marginal	Not generally	Not generally
Ireland	Marginal	Not generally	Significant	
Israel	Significant	Marginal	Significant	Significant
Italy	Significant	Marginal	Significant	Significant
Japan	n.a.	n.a.	n.a.	n.a.

Korea	Marginal	Marginal	Not allowed	Not allowed
Luxembourg	Marginal	Significant	Significant	Not allowed
Mexico	Marginal	Not generally	Marginal	Not generally
Netherlands	Significant	Significant	n.a.	n.a.
New Zealand	Marginal	Marginal	Significant	Significant
Poland	Not generally	Not generally	Significant	Significant
Portugal	n.a.	n.a.	n.a.	n.a.
Slovak Republic	n.a.	n.a.	n.a.	n.a.
Slovenia	Marginal	Significant	Not generally	Not generally
Spain	Marginal	Not generally	Significant	Significant
Sweden		Marginal	Significant	Significant
Switzerland	Marginal	Not allowed	n.a.	n.a.
United Kingdom	Not generally	Not generally	Significant	Significant
United States	Significant	Significant	n.a.	n.a.

Note: 'Not generally' indicates that PHI is allowed to cover this but generally does not. [1]In Australia, 'significant' refers to coverage in hospitals.

Source: OECD Health Systems Characteristics Survey 2012

95. In countries where private health insurance covers high shares of the population, it most often supplies complementary or supplementary coverage, on top of basic health care coverage.

96. For instance, in France, in 2012, 95% of the population were covered by complementary insurance, which mainly covers cost-sharing in the social security system (see Figure 7).

97. In the Netherlands and New Zealand, PHI covers supplemental benefits, such as dental care and eyeglasses. In the Netherlands PHI also covers physiotherapists, contact lenses, and alternative care, as well as cost-sharing by basic health insurance on dental care. In Switzerland supplementary PHI covers dental care and alternative medicine, as well as additional costs in hospitals related to private or semi-private accommodation or choice of doctor. In Canada, PHI provides coverage for pharmaceuticals for two-thirds of the population. In Israel, PHI covers 80.3% of the populationfor services that are not included in the basic benefit package; the most significant medical service covered by this private insurance (complementary and duplicate) is the choice of physician for surgical procedures.

98. Duplicate PHI cover, where it exists, generally provides patients advantages over the "basic" system in terms of choice and access (see Table 20). In Australia, for instance, PHI duplicates the public funding for hospital care by financing access to private hospitals or the private facilities in a public hospital. These generally have more luxurious facilities, more private rooms and shorter waiting times when compared to public hospitals. PHI can also *supplement* public funding by covering services such as dental and optical treatments. In Denmark, duplicative PHI offers a means to access the private sector and to obtain faster access to treatment for which there are long waiting times in the public sector. In 2002, the government sought to encourage PHI through favourable tax advantages for group-based policies in an effort to increase choice and allow faster access to treatment, especially given concerns around long waiting times for elective surgery, which led to an increase in uptake of PHI providing duplicative coverage. However, preferential tax incentives around private health insurance were abolished in 2012 to improve financing equity (OECD, 2013b). In Italy, duplicative PHI covers diagnostic tests, specialist consultations, hospitalizations, medical oncology and pharmaceuticals.

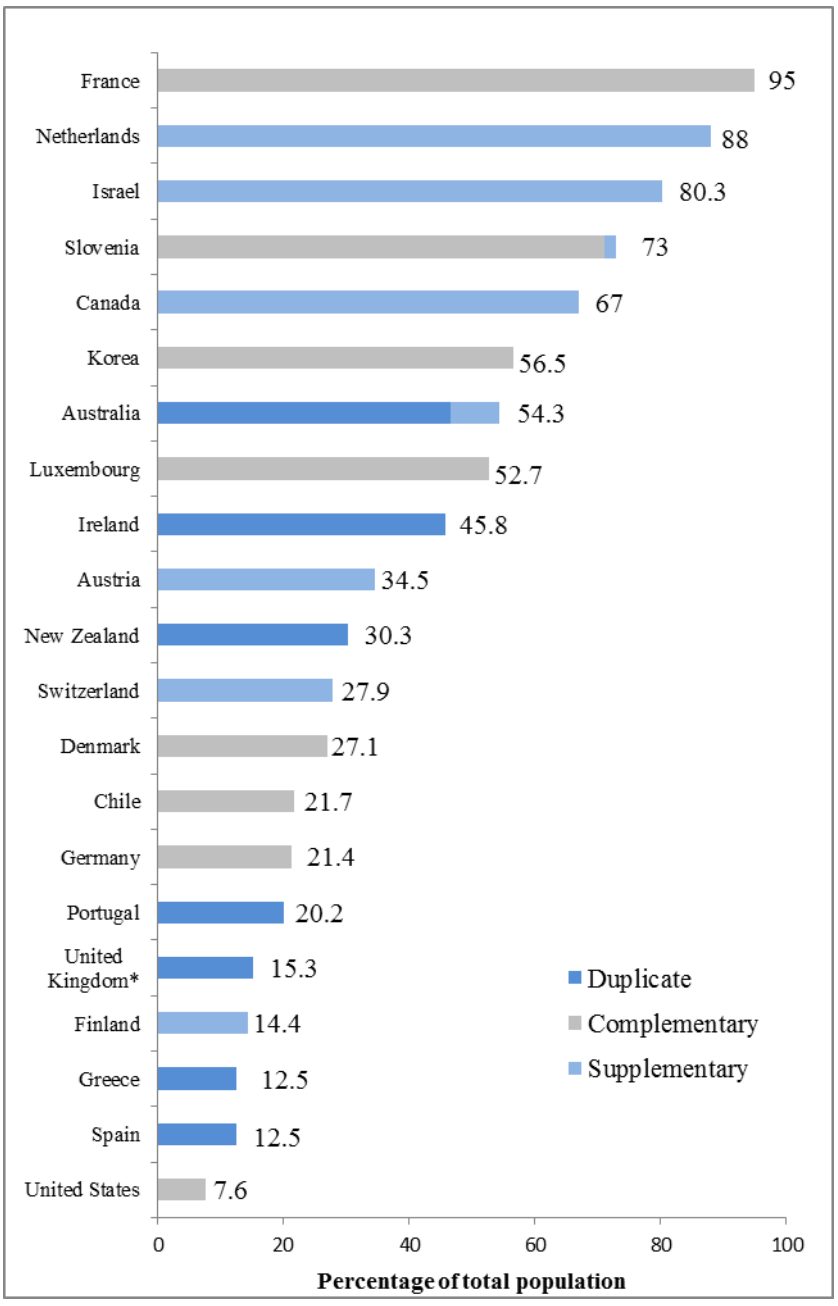
Table 20. Services covered in countries where duplicative coverage plays a significant role in PHI

Country	Expanded choice	Quicker access	Choice of doctor	Lower OOP payments
Australia[1]	✓	✓	✓	✓
Denmark		✓		✓
Finland	✓[2]	✓[2]	✓	✓
Greece	✓	✓	✓	
Ireland	✓	✓	✓	
Israel		✓	✓	
Italy		✓	✓	
New Zealand	✓	✓	✓	
Poland	✓	✓	✓	
United Kingdom		✓	✓	

Note: [1]In Australia, 'significant' refers to coverage in hospitals. 2In Finland, PHI does not provide quicker access or choice of doctor in public system, but facilitates access to private providers, which results in quicker access and wider choice.

Source: OECD Health Systems Characteristics Survey 2012

Figure 7. Private health insurance coverage in a sample of OECD country, by type of coverage, 2012 or nearest year



Note: Private health insurance can fulfil several roles. For instance, it can be both duplicate and supplementary in Australia and Israel; and both complementary and supplementary in Denmark, Ireland and New Zealand.
Source: OECD Heath Statistics, 2014 http://dx.doi.org/10.1787/health-data-en; for the UK data for 2010, OFT (2012), Private Healthcare Market Study and for Spain data for 2012, Encuesta Nacional de Salud 2011-2012.

7. Snapshot of health coverage in OECD countries

99. The paragraphs and figures below propose a synthesis of the information analysed in the previous sections of this report on cost-sharing requirements and spending by financing agents and *by function of care.*

100. Figure 8 summarises information on basic coverage and cost-sharing requirements for each function of care, for a typical working-age adult. It also includes synthetic information on the existence of caps, reductions and exemption for user charges.

- Primary care is accessible free of charge in about half OECD countries while specialist outpatient care and inpatient acute care are accessible free of charge in about one third of them;

- Pharmaceuticals are always covered with co-payments, the only exception being the Netherlands where prescribed pharmaceuticals are free of charge once the annual deductible has been reached.

- Dental care is not systematically covered for adults by basic health coverage schemes in OECD countries and eye products are generally not covered by basic coverage schemes.

- User charges are capped in two-third of OECD countries and a vast majority of countries have policies in place to reduce or wave co-payments for low-income population.

- In countries where entitlement to health coverage is defined by residency rather than contributory, the range of benefits covered tend to be narrower but services are more often free of charge.

101. Figure 9 shows, for each function of care, the share of spending financed by basic primary coverage and Figure 10 the share of spending financed by *any form* of coverage. The juxtaposition of these two figures allows the quick visualisation of well-known facts:

- Inpatient and outpatient medical services, as well as ancillary services (imaging and lab tests) are better covered by basic health coverage schemes than other types of care. Coverage for pharmaceutical spending is typically lower, due to often-higher cost-sharing and the possibility of self-consumption. Basic health coverage schemes cover about half of spending in dental care in a handful of countries (Austria, Belgium, Czech Republic, Luxembourg, Slovak Republic, and Slovenia) and three-quarter in Japan.

- VHI plays a significant role in financing medical services in only a few countries: it finances nearly 20% of hospital inpatient spending in Australia, 14% in Korea, 11% in Switzerland, 10% in Slovenia, and more than 5 % in Australia, Belgium, and France. VHI also finances a significant share of outpatient medical services in France (16%), Poland (16%), the Netherlands (14%), Spain (10%) and a significant share of pharmaceutical spending in Canada (30%), Slovenia (26%) and France (14%).

- VHI is the main primary financer of dental care in the Netherlands, where it covers 68% of spending for dental care and in Canada (56%). It also finances 39% of dental care in France and 25% Slovenia. VHI finances three-quarter of spending for eye products in only one country: France.

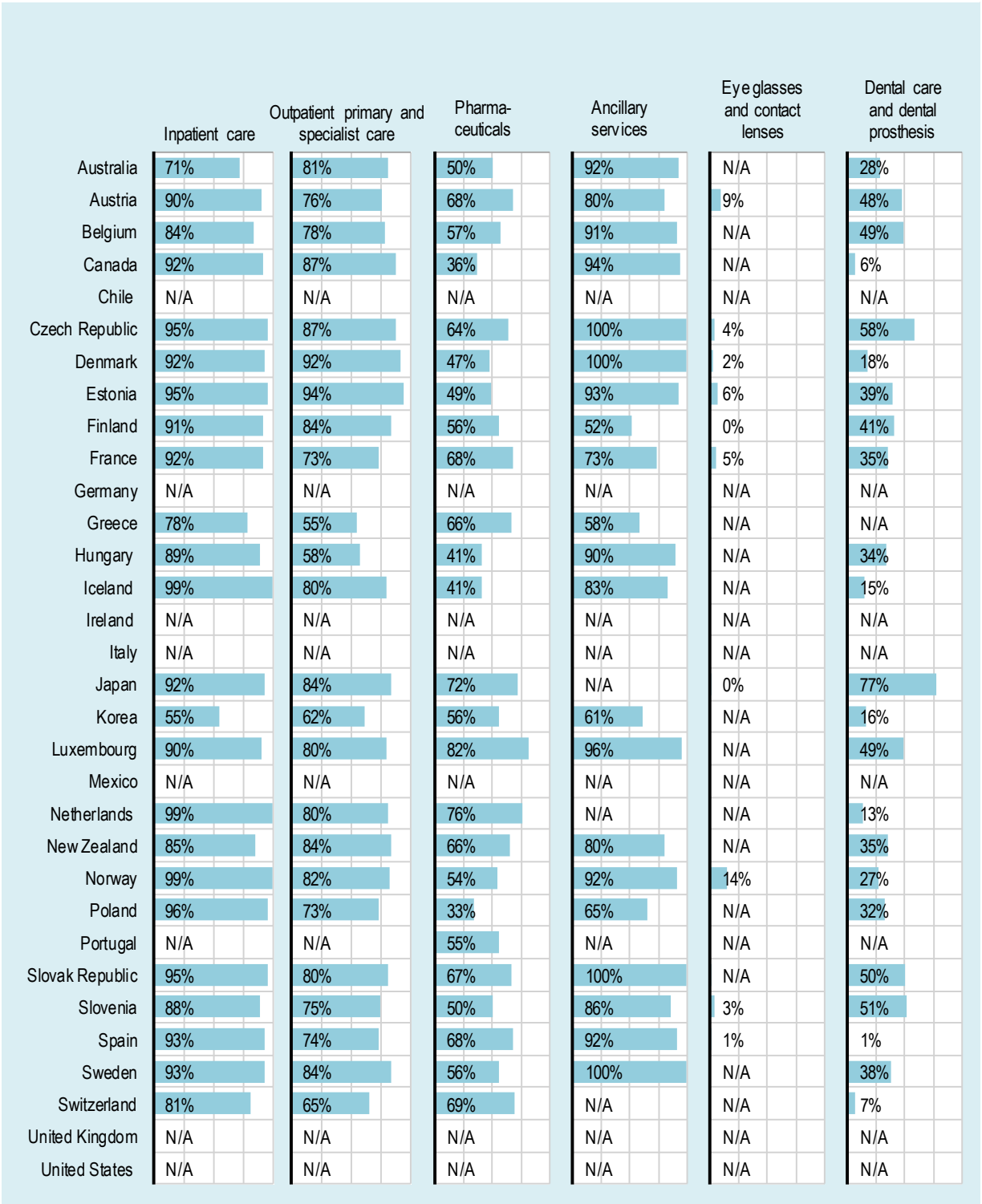
Figure 8. Health coverage and cost-sharing requirements by function of care and policies in place to limit user charges for specific groups, 2012 or nearest year

	Coverage and cost-sharing requirements								Policies to limit user charges
	Inpatient care	Outpatient care		Pharmaceuticals	Ancillary services	Physio-therapist	Eye glasses and contact lenses	Dental care and dental prosthesis	
		Primary care	Specialist care						
Australia	○	○	○	⊙	○	●	●	○	
Austria	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Belgium	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Canada	○	○	○		○	●	●	●	
Chile	⊙	⊙	⊙					○	
Czech Republic	⊙	⊙	⊙	⊙	○	○	●	⊙	
Denmark	○	○	○	⊙	○	⊙	●	●	
Estonia	⊙	○	⊙	⊙	N/A	N/A	N/A	●	
Finland	⊙	⊙	⊙	⊙	⊙	○	●	⊙	
France	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Germany	⊙	○	○	⊙	○	⊙	●	⊙	
Greece	⊙	○	○	⊙	○	⊙	⊙	⊙	
Hungary	○	○	○	⊙	○	○	N/A	⊙	
Iceland	○	⊙	⊙	⊙	⊙	⊙	●	●	
Ireland	⊙	⊙	○	⊙	⊙	○	●	●	
Israel	○	○	○	⊙	⊙	⊙	●	●	
Italy	⊙	○	⊙	⊙	⊙	⊙	●	●	
Japan	⊙	⊙	⊙	⊙	⊙	⊙	●	⊙	
Korea	⊙	⊙	⊙	⊙	⊙	⊙	●	⊙	
Luxembourg	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Mexico	○	○	○	⊙			●	⊙	N/A N/A
Netherlands [GDP]	○	○	⊙	○	○	○	●	⊙	
New Zealand	○	⊙	○	⊙	○	⊙	●	●	
Norway	○	⊙	⊙	⊙	⊙	⊙	●	●	
Poland	○	○	○	⊙	○	○	⊙	○	
Portugal	○	⊙	⊙	⊙	⊙	⊙	●	●	
Slovak Republic	○	○	○	⊙	○	N/A	N/A	N/A	
Slovenia	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Spain	○	○	○	⊙	○	○	●	●	
Sweden	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	
Switzerland [GDP]	○	⊙	⊙	⊙	⊙	⊙	●	●	
Turkey	⊙	○	⊙	⊙	N/A	N/A	N/A	N/A	
United Kingdom	○	○	○	⊙	○	○	●	⊙	
United States [GDP]									

Source: OECD Health system characteristics Survey 2012 and Secretariat's estimates

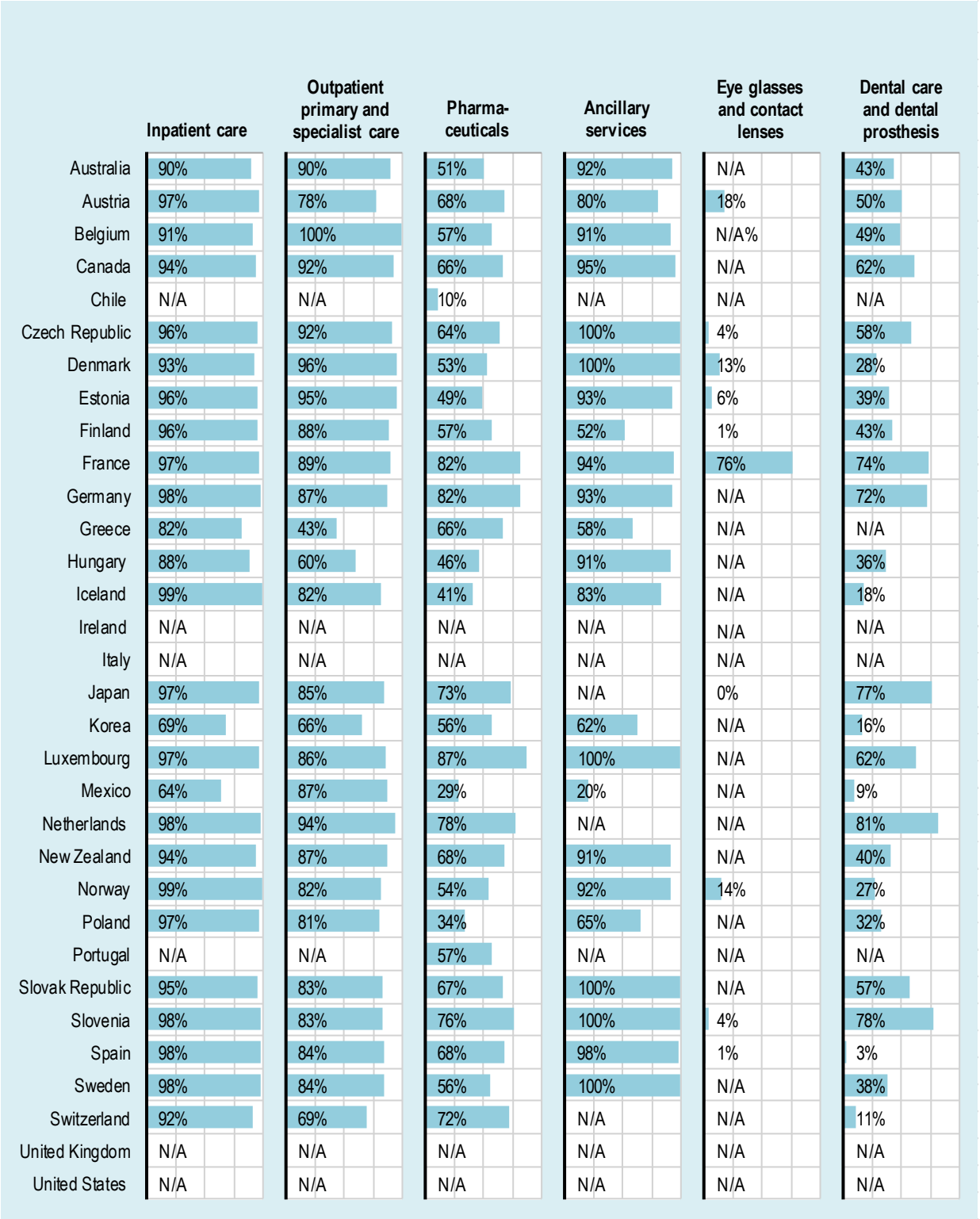
Description							
[GDP]	General deductible	⊙	Cost-sharing		Annual or monthly cap on co-payment		Exemption or reduction for low income populations or those receving social support
○	Free at point of care	●	Not covered		Varies by plan		Exemption or reduction for children
	Certain medical conditions and diagnoses		Exemption or reduction for elderly and/or disabled persons		Exemption or reduction for pregnant women		

Figure 9. Share of health spending financed by basic health coverage schemes in 2012, by function of care, in OECD countries



Note: In many OECD countries the basic health coverage is publicly provided. In Germany these estimations were not possible to produce; other countries did not provide data. Outpatient primary and specialist care data do not include dental care; transport is not included in ancillary services. Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en .

Figure 10. Share of health spending financed by all health coverage schemes in 2012, by function of care, in OECD countries



Note: Outpatient primary and specialist care data do not include dentist care; transport is not included in ancillary services. Source: OECD Health Statistics 2014, http://dx.doi.org/10.1787/health-data-en

Conclusions

102. Most OECD countries have now implemented universal health coverage for their population. Only a few countries reported in 2012 that a significant share of their population were still uninsured: Greece, Mexico and the United States. Measuring what is covered and at what level is still a challenge, though several options have been proposed to monitor the progress of universal coverage worldwide.

103. This report presents an assessment of the depth and breadth of coverage in 34 OECD countries. It draws on a country survey conducted in 2012 by the OECD among member countries. This survey collected information on coverage and on cost-sharing requirements for different categories of health care goods and services. It shows that:

- Countries have organised health care coverage in many different ways but there is no *systematic* link between the organisation of health care coverage and the overall level of coverage.

- The way coverage is organised, however, influence the design of cost-sharing requirements. Health systems in which coverage entitlement is determined by residency (instead of linked to insurance contributions) are more likely to provide full coverage for a range of basic health services, such as outpatient services provided by physicians and acute hospital care.

- Cost-sharing requirements are often waved for a significant part of the population, which varies across countries (children, vulnerable population), reduced for the very-ill or capped in absolute or relative terms.

- Dental services and optical products are less likely to be covered than other categories of care in OECD countries, or are typically subject to high cost-sharing, although a large number of countries have exemptions for these categories (children, especially). Diagnostic tests are also often subject to cost-sharing.

104. The conjoint analysis of coverage cost-sharing requirements and spending by financing agent collected through the system of health accounts *by function of care* allows a better understanding of entitlement and effective health coverage, as well as a cross-validation of these two sets of information (HSC 2012 and SHA data).

- In some cases, out-of-pocket payments are lower than expected according to coverage entitlements and cost-sharing requirements. These situations generally reflect the fact that user charges are waved or reduced in a number of situations in many OECD countries. In a few countries, they are explained by the fact that private health insurance, acting as a secondary source of coverage (e.g. France, Slovenia) covers some of these charges.

- When OOP payments are much higher than expected given the level of entitlement, this may result from one of several of the following factors:

    - The range of services covered *within* this function of care is actually restricted or opportunities to use non-covered health care services are high (e.g. for instance self-consumption of OTC pharmaceuticals);

    - The availability of covered services/providers is low and patients have to turn to other providers;

- Or the price charged to patients is not the price used as a basis for reimbursement (because of extra-billing or informal payments).

105. The System of Health Accounts framework allows in principle a separate reporting of cost-sharing on covered services and of out-of-pocket payments for not-covered care. However, only few countries are able to inform these categories, let alone at the level of health care functions. Countries should consider improving reporting of these categories by all means. As they will continue to face budget constraints and ever-increasing financing needs, policy-makers might have to operate choices concerning the range of benefits covered or the level of coverage of covered benefits. Yet, increasing cost-sharing and restricting the range of benefits covered to priority areas to be covered collectively are not equivalent choices in a society. Whatever choices countries will do, it will be wise to monitor their impact on out-of-pocket payments and their distribution across population groups.

REFERENCES

Anell A, Glenngård AH and S. Merkur (2012), Sweden: Health system review, Health Systems in Transition, Vol. 14, No. 5, pp. 1–159.

Barros P., Machado S. and J. Simões (2011), Portugal: Health system review. Health Systems in Transition, 13(4):1–156).

Buchmueller, T.C., M. Couffinhal and M. Perronnin (2004), "Access to Physician Services: Does Supplemental Insurance Matter? Evidence from France", Health Economics, Vol. 13, No. 7, pp. 669-687

Busse R. , Schreyögg J. and C. Gericke (2007), Analysing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach, Health, Nutrition, and Population (HNP) Discussion Paper

Bryndova L. et al. (2009), Czech Republic: Health system review, Health Systems in Transition, Vol 11, No.1, pp. 1-122

Cid, C. and L. Prieto (2012). El gasto de bolsillo en salud: el caso de Chile, 1997 y 2007. Revista Panamericana de Salud Publica, 31(4), 310-316

CMS -Centers for Medicare & Medicaid Services- (2015), National Health Expenditure Tables, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html (accessed 27/04/2015)

Colombo, F. and N. Tapay (2004), "Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems", OECD Health Working Papers, No. 15, OECD Publishing. http://dx.doi.org/10.1787/527211067757

Devaux M. and M de Looper (2012), Income-Related Inequalities in Health Service Utilisation in 19 OECD Countries, 2008-2009, OECD Health Working Papers, No. 58

European Policy Brief (2013), *Formal and Informal Out-of-pocket payments for Health care services in Central and Eastern European Countries- What are the actual patients contributions?*, ASSPRO CEE 2007 Project

Kaiser Family Foundation (*2013)*, The Medicare Part D Prescription Drug Benefit, *Fact Sheet*, November 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/11/7044-14-medicare-part-d-fact-sheet.pdf

Kaiser Family Foundation and Health Research and Education Trust (2013), Employer Health Benefits, Annual survey 2013 http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf

Kaitelidou D.C. et al. (2013), "Informal payments for maternity health services in public hospitals in Greece", *Health Policy*, Vol. 109, No. 1, pp. 23-30.

Kambia-Chopin, B. *et al.* (2008), "Complementary Health Insurance in France in 2008: Access is Still Unequal", *Issues in Health Economics (Questions d'economie de la santé).* Irdes, 132.

Koppel A, et al. (2008), Estonia: Health system review, *Health Systems in Transition*, Vol. 10, No. 1, pp. 1-230.

Krutilova, V (2013), *Cost sharing of patients for health care- forms, extents, impacts*, Brno: Masaryk University. Available at: http://is.muni.cz/th/76247/esf_d/disertacni_prace_Krutilova_yhrwbpmz.pdf

Leu R.E. et al. (2009), *The Swiss and Dutch health insurance systems: universal coverage and regulated competitive insurance markets*, The Commonwealth Fund.

Liaropoulous L. et al (2008), Informal payments in public hospitals in Greece, *Health Policy* , Vol. 87, No. 1, pp. 72-81

Mladovsky P, Srivastava D, Cylus J, et al. (2012), Health policy responses to the financial crisis in Europe, Policy summary 5, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2012

OECD (2004), Private Health Insurance in OECD Countries – The OECD Health Project. OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264007451-en

OECD (2012), Health Systems Characteristics Survey, http://www.oecd.org/els/health-systems/characteristics.htm

OECD (2013a), OECD Economic Surveys: Israel 2013, OECD Publishing. http://dx.doi.org/10.1787/eco_surveys-isr-2013-en

OECD (2013b), OECD Reviews of Health Care Quality: Denmark 2013: Raising Standards, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264191136-en

OECD (2014), OECD Health Statistics (database), http://dx.doi.org/10.1787/health-data-en

OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264181809-en

Schäfer W, Kroneman M, Boerma W, van den Berg M, Westert G, Devillé W and van Ginneken E. The Netherlands: Health system review. *Health Systems in Transition*, 2010; 12(1):1–229.

Siciliani, L., M. Borowitz and V. Moran (eds.) (2013),Waiting Time Policies in the Health Sector: What Works?, OECD Health Policy Studies, OECD Publishing, Paris

Smidova, Z. (2011), "Public Sector Spending Efficiency in Estonia: Healthcare and Local Government", OECD Economics Department Working Papers, No. 881, OECD Publishing. http://dx.doi.org/10.1787/5kg86qq1k2vl-en

Szalay T. et al. (2011), Slovakia: Health system review, *Health Systems in Transition*, Vol. 13, No. 2, pp. 1–200.

Tatar M, Mollahaliloğlu S, Şahin B, Aydın S, Maresso A, Hernández Quevedo C. Turkey: Health system review. *Health Systems in Transition*, 2011, 13(6):1–186.

Thomson S. and E. Mossialos (2009), Private health insurance in the European Union, Final report prepared for the European Commission, Directorate, General for Employment, Social Affairs and Equal Opportunities, London School of Economics.

The Commonwealth Fund (2012), *International Profiles of Health Care Systems 2012*).

Jessica C. Smith and Carla Medalia, U.S. Census Bureau, Current Population Reports, P60-250, *Health Insurance Coverage in the United States: 2013,* U.S. Government Printing Office, Washington DC, 2014.

Wagstaff A. (2012), *Measuring universal health coverage – plus ça change?*, blog posted on http://blogs.worldbank.org on 18/09/2012.

WHO (2010), *The world health report - Health systems financing: the path to universal coverage*, World Health Organisation, Geneva.

WHO (2013), The world health report 2013: research for universal health coverage, World Health Organisation, Geneva http://www.who.int/whr/2013/report/en/

WHO and Observatory on Health Systems and Policies (2013), Health, health systems and economic crisis in Europe, unpublished draft.

World Health Organisation and World Bank Group (2014), *Monitoring progress towards universal health coverage at country and global levels – Framework, measures and targets*, May 2014, WHO, Geneva

Wirtz V.J. et al. (2012), Heterogeneous Effects of Health Insurance on Out-of-Pocket Expenditure on Medicines in Mexico, *Value in Health*, Vol. 15, pp. 5 9 3 – 6 0 3

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