

CO-PAYMENT MECHANISMS WITHIN VARIOUS SOCIAL HEALTH INSURANCE SYSTEMS

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1. Introduction

Under the impact of various financial constraints, population growth and demographic aging, most countries, including some well developed ones, are now facing funding shortages in their health insurance systems. Due to these facts, co-payment mechanisms were implemented under several forms¹, depending on the nature of the people who partake: premiums paid to private health insurance funds, share of the cost of services provided in the basic package offered by social health insurance and fee-for-service payments made by the uninsured.

Measures of „cost – sharing”, or, in other words, the sharing of costs between policyholders and the government, are found in each of these states, but vary in terms of the policies used to limit their effects on consumers of medical services, especially those who depend on permanent health care.

Most health care systems compel participants to the insurance funds to contribute a certain amount to the cost of medical services or goods used. However, the decision on the quota, frequency of payment and any available deductions related to co-payments is a social matter, for which the public authorities are responsible. Although cost sharing is intended to diminish usage of non-essential health care services and

upturn the cost-consciousness of consumers, it may discourage people from using necessary health care and can be discriminatory for the very sick and the low income. Furthermore, the effects were immediately felt through the extend of unjustness: individuals with a poor health status, which place reliance on constant care and those with lower levels of income have had less access to other services than those provided by the social health insurance.

In order to solve issues of equity for the chronically and acutely ill, for the low income, for other populations and health services that the guarantors of health plans may wish to stimulate, health plans around the world assimilate procedures to exempt or limit cost sharing based on such factors as a person's income, medical condition, or age. In some countries (e.g., France, Germany), individuals may purchase (or the government may purchase for them) supplementary insurance that pays the cost sharing for certain services, while in other countries (e.g., Norway) supplemental insurance is disallowed from covering the cost sharing of the national mandatory program.

Health care systems require members to subscribe some amount toward the cost of covered services or goods that they use. However, deciding what those amounts, should be, and whether and on what basis exclusions and limits to cost sharing should apply, is a demanding and often political process.

¹ Thomson S., Mossialos E., Jemai N. - Cost Sharing for Health Services in the European Union, report prepared for the European Commission Directorate General for Employment and Social Affairs, December 2003, pag 8.

2. The Role of Cost Sharing in Health Systems

Cost sharing is the financial contribution that patients are required to make when they use health care services, amounts that are not refunded by their health plan. The direct forms of cost sharing include:

- co-payments (a flat amount that the consumer must pay per service or item);
- coinsurance (a percentage of the charge that the consumer must pay);
- deductibles (an amount the consumer must pay out-of-pocket before coverage commences, usually applied for a precise time period, such as yearly).

In addition, people may expose oneself to other additional health care expenses connected to health care. Sometimes called indirect cost sharing, these indirect payments costs are conventionally not included in the definition of „cost sharing”. They apply to excess charges when patients go to health care providers not included in their health plan, charges in excess of some amount (e.g., the cost of prescription drugs in excess of a reference price), excess charges when patients go directly to a specialist when the health plan requires a primary care visit first, health care services not covered by the health plan, health plan premiums.

The arguments given for compelling cost sharing (deductibles, copayments, and coinsurance) are to discourage the use of unnecessary health care services, to provide a source of financing, and, for statutory health care systems, to make coverage or service expansions more politically palatable. The arguments against cost sharing² are that it discourages people from using

health care (which may aggravate their circumstances and lead to more expensive care later), and it is inequitable for the low income, the unemployed, and those with substantial health care costs.

3. The exceptions and limitations of co-payments

Some health structures with cost sharing include protection policies that exempt or limit patient cost sharing founded on factors such as a person's income, medical condition, or age. These barriers may address specific health care services, or the combined use of health care. The greater the cost-sharing quotas required of patients, the more significant any cost-sharing exemptions and limits become. The diverse mechanisms used to secure individual resources against cost sharing include such explicit protection mechanisms as:

- full exemption from cost sharing or decreased cost-sharing limits for certain persons (e.g., children, pregnant women, the low income, the disabled, war veterans, those in nursing homes, the unemployed, families with many dependents) or for those with certain medical conditions (e.g., pregnancy, chronic illness, rare diseases);
- out-of-pocket top points, which are typically yearly limits on the total cost-sharing amounts individuals or families are required to pay, applicable to a particular service or an aggregate of services, and can be means-tested or apply to the whole population;
- cost-sharing price reductions for selecting the services of certain providers or for choosing generics rather than more expensive brand-name drugs;
- tax deductions for cost-sharing payments or health insurance premiums (e.g., tax deductions for amounts over a deductible or for certain individuals such as the low income or the disabled).

Some health systems have implicit protection mechanisms that can reduce cost sharing and other patient direct costs. An important mechanism is

² Wasem J., Greb S., Okma K. - The Role of Private Health Insurance in Social Health Insurance Countries in European Observatory on Health Systems and Policies Series, World Health Organization, Great Britain: Open University Press, 2004, pag 228

the availability of private health insurance. Private health insurance can function as a substitute to the national mandatory health insurance program, as in Germany, where individuals above a specific income level are permitted to choose between the public or private coverage. Private health insurance can also be supplementary to a statutory health program, either by paying for cost sharing (available in France and Germany but prohibited in Norway), or by paying directly for costs not covered or not covered in full by the statutory national plan.

4. Co-payment mechanisms in the European countries

France: The french Social Health Insurance System was established on the Bismarck model, with funds collected and managed under the direct supervision of the state. This system is based on a combination of public and private acquisitions, even in the hospital sector. Patients have free access to healthcare (freedom of choice, direct access to specialists) and an abundant supply, in terms of available medical staff. Additional voluntary insurance, although common in France, are strictly intended to supplement funds for the public system and to cover co-payments. Prior to the Health Insurance Reform Act of Aug 13, 2004, most cost sharing was in the form of coinsurance fees. Since 2006, copayments have been charged for a variety of services including examinations with health professionals, days of hospital care, prescription drugs, expensive treatments, and ambulance trips. Overall, household direct pocket payments as a rate of the total national health care expenditures have decreased over time, from 30.3% in 1960, 17.6% in 1970, 12.8% in 1980, 11.4% in 1990, 7.1% in 2000, and 6.7% in 2006 and 6,9% in 2008³.

Patient cost sharing under the French statutory health program includes⁴:

- 20% coinsurance for hospital services, plus a daily copayment of 16 Euro (12 Euro in a psychiatric unit) with a 30-day limit on the cost sharing;
- 30% coinsurance for outpatient physician services, plus a copayment of 1 Euro per consultation, limited to 50 Euro per year:
 - a copayment of 18 Euro for serious medical interventions;
 - 35% for prescription drugs, depending on the type of drug and whether it is on the national formulary,
 - 30% coinsurance for dental services;
 - 35% coinsurance for transportation, eye care, hearing aids, orthopedics;
 - 40% coinsurance for laboratory services.

In addition, French patients expose themselves to other medical costs for: goods and services not qualified for reimbursement by the insurance funds (such as a single room in a hospital), extra billing for physicians allowed to charge more than standard amount, dissimilarities between real price charged and the official reimbursement level for such items as dental prostheses, medical devices, eyeglasses, differences between the retail and the reference price for certain prescription drugs, care to patients who do not opt for a contract with a gate-keeping primary care doctor, for which the health insurance fund provides lesser reimbursement rates, down payment payments for ambulatory care - patients must pay the provider and then receive total or partial reimbursement from their health insurance fund. In spite of the fact that the patient is refunded' having to pay the

³ Couffinal A., Paris V., - Cost Sharing in France, Working Paper, CREDES, Centre de Recherche

d'Etude et de Documentation en Economie de la Sante, August 2003, pag. 6-8

⁴ Durand-Zaleski I. - The health system in France, *Eurohealth* 14, no. 1, 2008, pag. 3

full amount at first can be a financial obstacle to care⁵.

Cost sharing in France is limited by exemptions and limits under the statutory national insurance program and by supplemental insurance. About 8,5% of the population is exempted from coinsurance: 6,8% for serious illness and 1,7% for other reasons.

Germany: The German national health insurance program is based on the Otto von Bismarck model which was initially aimed at protecting low-income workers. It is composed of a social side combined with a medical purpose and it is funded through the social security system whose budget consists of contributions from employers and employees. Copayments and exemptions from copayments have typically been used in the German health care system, most traditionally for pharmaceuticals⁶. Over time, more services have been covered by cost sharing (including hospital care, rehabilitative treatment, and preventive spa treatment), and cost sharing has become more differentiated and sophisticated⁷ (e.g., copayments for pharmaceuticals have used reference pricing since 1989 and were price-related, then package-size-related; different levels of user charges for crowns and dentures are related to use of preventive annual checkups). Overall, household out-of-pocket payments as a proportion of total national health care expenditures have remained fairly steady, from 13,9% in 1970, 10,3% in 1980, 11,1% in 1990, 11,2% in 2000, 13,2% in 2006 and 14% in 2009⁸.

Patient cost sharing under the statutory health program includes:

- co-payment of 10 Euro per day for hospital care and post-hospital rehabilitation treatment, limited to 28 days per year;
- co-payment of €10 per quarter for the first visit to a physician in the quarter and for each contact with other physicians seen without referral during the same quarter;
- coinsurance of 10% of the pharmacy sales price for prescription drugs, with a minimum of 5 Euro and a maximum of 10 Euro, not to exceed the cost of the product;
- co-payment of 10 Euro per quarter for the first visit to the dentist's office;
- co-payment of 10 Euro per day for outpatient rehabilitation services;
- coinsurance of 10% for non-physician care, eye care, hearing aids, orthopedics and transportation, subject to certain limits and requirements.

In addition, German patients are responsible for direct payments for goods and services not covered by any form of insurance, including most over-the-counter pharmaceuticals, technologies and pharmaceuticals determined to have limited or unproven medical benefit, services related to sterilization, eyeglasses except for children under age 18 and the severely visually impaired, artificial insemination, and travel costs for taxis and hired cars for outpatient treatment.

The number of people fully exempt from copayments tripled between 1993 and 2000, from 10% to about 30% of the population; in 2007, 47% of the population were exempted from copayments⁹.

Norway: Overall, the Norwegian health care system is almost completely integrated. Most hospitals are owned and managed by public authorities. The most important characteristic of the healthcare system in Norway is the predominance of public funding, based on funds derived

⁵ Durand-Zaleski I. Op. cit. pag. 5

⁶ Busse R., Riesberg A - Health Care Systems in Transition: Germany, Copenhagen, WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, 2004, pag. 77-80

⁷ Busse R., Riesberg A, op. cit, pag. 81

⁸ Christian A., Matthias W., Busse R. - Cost Sharing in the German Health Care System September 2003, pag. 6

⁹ Busse R., Riesberg A, op. cit, pag. 90

from taxation. Resident population is compulsorily insured through a health insurance scheme provided by the National Health Insurance System. The system is financed by general tax revenues, with no tax levy for this purpose strictly¹⁰. The amount of co-payments as a percentage of total health expenditure has remained relatively stable over the last 20 years: 37,6% in 1985, 35, 7% in 1990, 33,0% in 1995, 31,4% in 1996, 32,9% in 2000 and 30,3% in 2009¹¹. Additional costs over compulsory health insurance, including annual amounts, coinsurance and a maximum annual fee for days of hospitalization¹², are:

- a predetermined amount, payable annually, in addition to funds provided by the state health insurance in the amount of 300 crowns (persons under 18 are exempted). Persons aged between 18 and 25 bear a lower rate, set annually;
- 10% of all medical costs up to a maximum of 700 crowns per year (350 per year for persons under 18 years);
- 20% for drugs prescribed by the physician;
- people who live alone supports a charge of 10 crowns per day for each day of hospitalization. This rule does not apply if the person is in pre-or post-natal leave.

The persons insured with the public health system have to pay, on average, a co-payment amount of 1,000 crowns per year, without those amounts being compensated by the state.

¹⁰ Johnsen J. R. - Health Systems in Transition:Norway 8, no. 1,Copenhagen: European Observatory on Health Systems and Policies, 2006, pg. 22.

¹¹ Johnsen J. R. - Health Systems in Transition:Norway 8, no. 1,Copenhagen: European Observatory on Health Systems and Policies, 2006, pg. 23.

¹² Christensen T. - Modern State Reforms, K. Heidar (ed.), Nordic Politics Comparative Perspectives, Oslo: Universitetsforlaget 2004, pag. 29.

Romania: The introduction of the co-payment mechanism through the Moderator Tag for Health Care is one of the main terms of financial arrangement between the Government and the International Monetary Fund and the World Bank. The new measure is expected that to lead to a better addressing of the population's primary health care, to the improve of health system financing and to the achievement of better control in terms of services, thus ensuring an appropriate quality of healthcare. Co-payment, which is expected to be introduced with the second half of the year 2011, will be the personal, on spot contribution to medical services, medicines and appliances.

Benefits from the introduction of vouchers are aim to be:

- A. increases access to healthcare at an appropriate level;
- B. increased efficiency in the healthcare;
- C. an appropriate nonitoring and transparency of all health related expenditures;
- D. competition in the system for the revenue from tickets;
- E. options for reducing the financial burden on the taxpayer;
- F. creating the conditions for the development of private health insurance.

For one's personal contribution to health care, the patient will be issued a document called Moderator Tag for Health Care, which is to be proof of the completion of the medical evidence of payment. Tickets are set to be affordable in means of costs health and some certain categories of persons are to be are exempt from paying, with their share of costs covered from public funds.

The costs of co-payment introducing are expected to be differentiated as follows:

- *primary medical services* - coupler for GP consultations and other related services not included in the reimbursements provided by the National Insurance House, and certain medical

services which are paid separately (e.g. immunizations) will be 5 lei and 15 lei for home visits outside working hours;

- *Outpatient Services:* Outpatient consultation from a specialist will be 10 lei and a specialist consultation outside working hours - 20 lei; consultation carried out by the ambulance service, with no hospitalization necessary- 20 lei; outpatient rehabilitation services for physical therapy procedures, physiotherapy, massage, etc. is 50 lei per course, up to 100 lei per year (taking into account an average of 10 days per diet, 2 courses / year);

- *Hospital services:* coupler for hospitalization will be 10 lei, and 50 lei for continued hospitalization.

Some *laboratory services* will also be taxed: laboratory – 1 leu per test; radiology and functional exploration - 5 lei; cat-scan without the substance of contrast - 25 lei, and cat-scan with the substance of contrast - 50 lei; MRI without the substance of contrast - 100 lei, and MRI with the substance of contrast - 200 lei; angiography - 150 lei; scintigraphy- 100 lei.

When prices for health vouchers had been set, values from countries with a similar mechanism, were taken into account such as Estonia, Croatia. Also, when defining the system the example of Western European countries was followed, since they have substantial experience in managing additional contributions. Those exempt from the additional payment are defined as it follows: persons with no income and those who are part of a family who is entitled to social assistance, according to Law no. 416/2001; pensioners with an income below 700 lei per month; children up to the age 18; young people aged from 18 to 26, if they are students, including high school graduates until the start of the academic year but not more than three months afterwards, apprentices and students; the unemployed and other categories of persons who receive gratuities by virtue

of specific laws (revolutionaries, political persecution, war veterans, disabled, etc..) if they do not have an additional other than the one from financial rights granted by law, such as those from pension; pregnant women and pregnancy related services only.

Under this measure, one of the major problems highlighted refers to the effect of the reform on disadvantaged populations, such as the poor, chronically ill and elderly. Generating a direct impact on people, the aim and scope of this measure could be influenced by the reaction of the masses.

5. Conclusions

Romania's accession to the European Union has made health policies and health services in the European Union to become the reference framework for the citizens of Romania. In this context it is not surprising that although the financial efforts of the Romanian state increased considerably, both in absolute and percentage, with almost all revenues and expenditures doubling over the past four years for most categories, the gaps in the system increased and continue to persist and worsen. If we look at the overall performance of the Romanian health system in the international context, also taking into account the concept of WHO¹³ performance (improving health, increasing responsiveness to public expectations, ensuring equity in terms of financial contribution) we note that Romania is ranked 99 in the world, behind countries such as Albania (55), Slovakia (62), Hungary (66), Turkey (70), Estonia (77).

The financing of the health system continues to be used in an inappropriate and inefficient manner. Despite an increase of total health expenditure as a share of GDP, the

¹³ The World Health Report 2000 - Health systems: Improving performance, WHO, 200

financing of the Romanian health system is yet low in the European context, especially when considering the long period of chronic underfunding and lack of investment in health care and services.

This situation, coupled with the lack of clear and consistent performance criteria make it difficult to implement effective management systems that reward efficient managers.

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