| Country | Health care (I) | | |
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| | *i. Do patients pay co-payments when they consult a general practitioner and a specialist?* | | |
| | *Situation 1/1/2008* | *Situation 1/7/2013* | *Regulatory changes* |
| AT | The entitlement is proven towards the doctors by e-card, an electronic sickness insurance card. The annual fee is € 10 (with the exception of children, pensioners and the needy).<br><br>A contribution of 20% of the agreed fee is required for benefits provided by psychotherapists or clinic psychologists. | The entitlement is proven towards the doctors by e-card, an electronic sickness insurance card. The annual fee is € 10.30 (with the exception of relatives, pensioners and the needy).<br><br>A contribution of 20% of the agreed fee is required for benefits provided by psychotherapists or clinic psychologists. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| BE | Insured person's share must not exceed 25% for general medical care. In principle, no share borne for technical benefits. In excess of a certain annual amount paid by the insured themselves, the so-called maximum ceiling, certain categories of insured and will benefit from this point onwards from free health care services.<br><br>Basic criteria:<br>being part of a specific social category;<br>being part of a household with income under certain levels;<br><br>In concrete terms, the following incomes and ceilings of are applying: | Patient charges must not exceed 25% for general medical care. Charges are higher (40%) for certain specialist medical interventions. In principle, no charges for technical benefits. In excess of a certain annual amount paid by the insured themselves, the so-called maximum ceiling, certain categories of insured and will benefit from this point onwards from free health care services.<br><br>Basic criteria:<br>being part of a specific social category;<br>being part of a household with income under certain levels;<br><br>In concrete terms, the following ceilings | Higher charges for certain specialist medical interventions. |

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| | •up to € 15,144.56: € 450<br>•from € 15,144.57 to € 23,281.93: € 650<br>•from € 23,281.94 to € 31,419.32: € 1,000<br>•from € 31,419.33 to € 39,217.63: € 1,400<br>•from € 39,217.64: € 1,800. | are applicable according to annual income:<br>•up to € 17,523.66: € 450 (€ 350 for chronic diseases);<br>•from € 17,523.67 to € 26,939.35: € 650 (€ 550 for chronic diseases);<br>•from € 26,939.36 to € 36,355.07: € 1,000 (€ 900 for chronic diseases);<br>•from € 36,355.08 to € 45,378.45: € 1,400 (€ 1,300 for chronic diseases);<br>•from € 45,378.46: € 1,800 (€ 1,700 for chronic diseases). | Introduction of new income ceilings and of participation in case of chronic diseases. |
| BG | Any person covered under contributions funded scheme pays the physician, dentist or health-care facility (providing medical care) for each visit 1% of the national minimum (monthly) wage (minimum wage is currently BGN 220 (€ 112) per month). | Any person covered under the contribution-funded scheme pays the physician, dentist or health-care facility (providing medical care) for each visit a user fee of an amount determined by an ordinance of the Council of Ministers (Министерски съвет). This user fee currently stands at BGN 2.90 (€ 1.48). | |
| CH | •Fixed amount per calendar year (excess, deductible, “franchise”): CHF 300 (€ 181).<br>•In addition, share of costs: 10% of costs above the excess up to CHF 700 (€ 423) per year.<br>•The insurer may offer the insured person a form of insurance with a higher excess - CHF 500 (€ 302), CHF 1,000 (€ 605), CHF 1,500 (€ 907), CHF 2,000 (€ 1,210) or CHF 2,500 (€ 1,512) for adults, CHF 100 (€ 60), CHF 200 (€ 121), CHF 300 (€ 181), CHF 400 (€ 242), CHF 500 (€ 302) or CHF 600 (€ 363) for children (< 18 years) - in return for a reduction in the | •Fixed amount per calendar year (excess, deductible, “franchise”): CHF 300 (€ 243).<br>•In addition, share of costs: 10% of costs above the excess up to CHF 700 (€ 567) per year.<br>•The insurer may offer the insured person a form of insurance with a higher excess - CHF 500 (€ 405), CHF 1,000 (€ 810), CHF 1,500 (€ 1,215), CHF 2,000 (€ 1,620) or CHF 2,500 (€ 2,025) for adults, CHF 100 (€ 81), CHF 200 (€ 162), CHF 300 (€ 243), CHF 400 (€ 324), CHF 500 (€ 405) or CHF 600 (€ 486) for children (< 18 years) - in return for a | No regulatory changes over the 5-year period according to the MISSOC Tables. |

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| | premium. | reduction in the premium. | |
| CY | Persons entitled to medical care at reduced fees pay € 6.85 and € 8.56 per visit to a general practitioner and specialist respectively plus 50% of prescribed fees for laboratory, x-ray and other examination.<br><br>Patients entitled to free of charge medical care (see "Beneficiaries: Field of application" above) make no contribution toward fees but do have to pay € 2.06 per visit at outpatients departments. | Patients entitled to free of charge medical care (see "Field of application, 1. Beneficiaries" above) make no contribution toward fees but do have to pay € 2.00 per visit at outpatients departments.<br><br>Persons entitled to medical care at reduced fees pay € 6.50 and € 8.50 per visit to a general practitioner and specialist respectively plus 50% of prescribed fees for laboratory, x-ray and other examination.<br><br>Everybody else pays € 14.50 and € 20.50 per visit to a general practitioner and specialist respectively. | |
| CZ | Ambulatory health care:<br>Co-payments only for drugs and medical requisites. | Out-patient health care:<br>Co-payments only for medicaments and medical devices. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| DE | The patient pays a practice fee of € 10 per quarter at his first visit to the doctor in the quarter (certain medical check-ups are excluded).<br><br>The patient' participation for aids (e.g. massages, baths or physio-therapy) which are part of the medical treatment is 10% and € 10 per prescription. | The patient participation for aids (e.g. massages, baths or physiotherapy) which are part of the medical treatment is 10% and € 10 per prescription. | Abolishment of the practice fee paid per quarter. |
| DK | Group 1: No charges (Treatment by the | Group 1: No charges (treatment by the | No regulatory changes over the 5-year |

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| | chosen GP or a specialist to whom he refers the patient).<br><br>Group 2: The part of expenses which exceeds the amount fixed by the public scheme for Group 1.<br>Every resident can choose once a year between two groups:<br><br>*Group 1 entitles to free medical treatment by GP who has joined collective agreement with the Public Health Service.*<br><br>*Group 2 entitles to free choice of medical practitioner - also among GPs who have not joined collective agreement. The Public Health Service in this group only pays - in principle - a part of the doctor's fee.* | chosen GP or a specialist to whom he refers the patient).<br><br>Group 2: The part of expenses which exceeds the amount fixed by the public scheme for Group 1.<br>Every resident can choose once a year between two groups:<br><br>*Group 1 entitles to free medical treatment by a GP who has joined the collective agreement with the Public Health Service.*<br><br>*Group 2 entitles to free choice of medical practitioner - also among GPs who have not joined the collective agreement. The Public Health Service in this group only pays a part of the doctor's fee.* | period according to the MISSOC Tables. |
| EE | Up to EEK 50 (€ 3.20) per home visit or for a visit for out-patient specialised medical care (set by the Board of the Hospital). | Up to € 5 per home visit or for a visit for out-patient specialised medical care (set by the Board of the Hospital). | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| EL | No charges. | Visits to doctors in EOPYY Health Units and to private doctors contracted by the National Organisation for Healthcare Services Provision (EOPYY) (ΕΝΙΑΙΟΣ ΟΡΓΑΝΙΣΜΟΣ ΠΑΡΟΧΩΝ ΥΠΗΡΕΣΙΩΝ ΥΓΕΙΑΣ - ΕΟΠΥΥ) are free of charge.<br><br>For paraclinical examinations, a co-payment of 15% applies.<br><br>Fee of € 5 in case of paraclinical | Introduction of a user charge of 15% and of a fee of € 5 in case of paraclinical examinations. |

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| | | (outpatient) examinations in a public hospital. | |
| ES | No charges. | No charges. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| FI | *Health centre:*<br>Doctor visit maximum € 11 for the first three visits in a calendar year or an annual fee of maximum € 22 for 12 months depending on the municipality; most other services free of charge. However, € 15 may be charged for an on-call-visit to a health centre at night-time and on weekends.<br><br>*Private doctor:*<br>The patient pays doctor's basic fee which, as far as it does not exceed a fixed tariff, is refunded by 60% from the sickness insurance. For treatment costs on prescription by certain other medical staff, the patient's own liability is € 13.46 and 25% of the excess amount within a fixed tariff. | Health centre:<br>Doctor visit maximum € 13.80 for the first three visits in a calendar year or an annual fee of maximum € 27.50 for 12 months depending on the municipality; most other services free of charge. However, € 18.90 may be charged for an on-call-visit to a health centre at night-time and on weekends.<br><br>Private doctor:<br>The system allows the patient to directly know the reimbursement amount. The patient is reimbursed part of the private doctor’s fee and the examination and treatment charges according to a schedule of fixed charges. The maximum reimbursable fee is often smaller than the fee charged by the doctor. | Increase of the annual fee and of the on-call-visit fee. |
| FR | General scheme for employees *(Régime général d'assurance maladie des travailleurs salariés, RGAMTS)*:<br><br>Share borne by insured person:<br><br>•30% for ambulatory treatment (GP or specialists, in consulting room or in hospital),<br>•20% for hospital treatment,<br>•flat-rate co-payment of € 1 per medical | General scheme for employees *(Régime général d'assurance maladie des travailleurs salariés, RGAMTS)*:<br><br>Share borne by insured person:<br><br>•30% for ambulatory treatment (GP or specialists, in consulting room or in hospital),<br>•20% for hospital treatment,<br>•flat-rate co-payment of € 1 per medical | No regulatory changes over the 5-year period according to the MISSOC Tables. |

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| | intervention within a limit of € 50 per person and per year,<br>• flat-rate co-payment of € 18 for serious medical intervention (of a minimum rate of € 91). | intervention within a limit of € 50 per person and per year,<br>• flat-rate co-payment of € 18 for serious medical intervention (of a minimum rate of € 120). | |
| HR | | Participation of 20% of the health expenses. However, the participation cannot be lower than the following amounts :<br>• specialist-consultation health protection, including ambulatory and surgical interventions in daily hospital and rehabilitation – HRK 25 (€ 3.35);<br>• specialist diagnostic procedures which are not on the level of primary health care – HRK 50,00 (€ 6.71).<br><br>Insured persons are obliged to participate to the amount of HRK 10 (€ 1.34) for health protection in primary health care (for general-practitioner visits/examinations).<br><br>The cap of participation costs is HRK 2,000 (€ 269) per issued health bill. | |
| HU | Visit fee *(vizitdíj)* and hospital daily fee *(kórházi napidíj)*:<br>An amount of HUF 300 (€ 1.18) is paid, but in certain cases (unjustified emergency care, treatment without the necessary referral outside the compulsory area, using a health care provider other than referred etc.), an increased amount of HUF 600 (€ 2.37) or HUF 1,000 (€ 3.95) is to be paid. | Co-payments are charged in the following cases:<br>• unnecessarily changing the contents of prescription treatment, causing extra costs,<br>• extra services (better room, meal condition etc.),<br>• accommodation, nursing, pharmaceuticals and meal costs for those suffering from designated ailments, confirmed by primary health | Abolishment of the visit fee and hospital daily fee. |

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| | Further co-payments are charged in the following circumstances:<br><br>•unnecessarily changing the contents of prescription treatment, causing extra costs,<br>•extra services (better room, meal condition etc.),<br>•accommodation, nursing, pharma-ceuticals and meal costs for those suffering from designated ailments, confirmed by primary health care provider,<br>•using sanitary provisions,<br>•in case of certain dental prosthesis, orthodontic braces provided for persons under the age of 18,<br>•change of external sex organs with the exception of developmental abnormality.<br>•The amount of the co-payment is fixed by the service provider. | care provider,<br>•using sanitary provisions,<br>•certain dental prosthesis, orthodontic braces provided for persons under the age of 18,<br>•change of external sex organs with the exception of developmental abnormality.<br>The amount of the co-payment is fixed by the service provider. | |
| IE | Persons with full eligibility enjoy a full range of general practitioner services without charge (see above).<br><br>Persons with a GP Visit Card are entitled to the services of a GP without charge (see above).<br><br>Persons with limited eligibility can avail of specialist services in public hospitals free of charge. There are a number of schemes which provide assistance towards the cost of medication.<br><br>Any patient who opts for private treatment, even in a public hospital, is liable for the specialist fees and hospital charges. | Persons with full eligibility enjoy a full range of general practitioner services without charge (see above).<br><br>Persons with a GP Visit Card are entitled to the services of a GP without charge (see above).<br><br>Persons with full eligibility can avail of specialist services in public hospitals free of charge. While persons with limited eligibility are subject to nominal charges as set out below. There are a number of schemes which provide assistance towards the cost of medication.<br><br>Any patient who opts for private treatment, even in a public hospital, is | Only persons with full eligibility can avail of specialist services in public hospitals free of charge.<br><br>Persons with limited eligibility can no longer avail of specialist services in public hospitals free of charge, they are now are subject to nominal charges. |

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| | | liable for the specialist fees and hospital charges. | |
| IS | The insured person pays between ISK 1,000 (€ 11) and ISK 2,200 (€ 24) per visit to a health care centre or a general practitioner.<br><br>The insured person pays ISK 3,100 (€ 34) + 40% of the remaining costs, but max. ISK 21,000 (€ 228) per visit to a specialist. | Health care centres and general practitioners:<br>The insured person pays between ISK 1,000 (€ 6.19) and ISK 2,600 (€ 16) per visit.<br><br>Specialists:<br>The insured person pays ISK 4,500 (€ 28) + 40% of the remaining costs, but max. ISK 31,100 (€ 193) per visit to a specialist working under a contract with the Icelandic Health Insurance (Sjúkratryggingar Íslands). If that is not the case, the insured person pays in full but he/she can receive the same amount as would have been paid by the Icelandic Health Insurance as a refund. | Ex post facto reimbursement in case of resort to non-contracted providers. |
| IT | Insured persons pay up to € 36 for each test carried out or each visit to a specialist, to a physiotherapist or a water cure; by prescription there can be a maximum of 8 services rendered in the same specialised field and a maximum of 6 for sports medicine or rehabilitation benefits. | Insured persons pay up to € 36.15 per prescription (this amount can vary slightly from region to region) for health services in specialist outpatient clinics. Each prescription may include up to 8 different health treatments within the same specialty and up to 6 sports medicine or rehabilitation treatments. Reference rates are listed in the official tariff nomenclature (Annex to Ministerial Decree of 15 December 1994). An additional fixed amount of € 10.00 is requested for each prescription, to be paid to the National Health Service *(Servizio Sanitario Nazionale, S.S.N.)*. | Introduction of a fixed amount of € 10.00 for each prescription, to be paid to the National Health Service. |

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| LI | Patients' participation in the costs for services in the form of a franchise and a percentage paid by the individual. Maximum contribution CHF 800 (€ 484) each year. Voluntary franchise of a maximum of CHF 1,500 (€ 907) each year. | Patients' participation in the costs for services in the form of a franchise and a percentage paid by the individual. The deductible (franchise) is CHF 200 (€ 162) each year. Voluntary deductible of a maximum of CHF 1,500 (€ 1,215) each year. Maximum excess is CHF 600 (€ 486) per year. | |
| LT | Basically, health care is free of charge. There is a list of health care services, which are approved as paid services that are financed entirely from the person's own resources according to a set price list. | Basically, health care is free of charge. There is a list of health care services, which are approved as paid services that are financed entirely from the person's own resources according to a set price list. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| LU | Share borne by insured person: 20% of the ordinary tariff for visits for the first medical visit in any 28 days period; 10% for other visits or consultations.<br><br>Share borne by insured person of 10% for medical outpatient treatment expenses up to a ceiling of € 5 per visit. This measure does not concern haemodialysis, chemotherapy, radiotherapy treatments nor preventive medical tests. | Co-payment for visits: 20% of the ordinary tariff for visits. For other interventions and services: co-payment of 12%.<br><br>This measure does not concern haemodialysis, chemotherapy, radiotherapy treatments nor preventive medical tests. | Simplification of the participation system. |
| LV | Patient contribution system (for adult patients):<br><br>• Out-patient visit to the general practitioner: LVL 0.50 (€ 0.72).<br>• Out-patient visit to the specialist: LVL 2 | Patient contribution system (for adult patients):<br>• Out-patient visit to the general practitioner: LVL 1.00 (€ 1.42).<br>• Out-patient visit to the specialist: LVL 3 (€ 4.27). | Increased co-payments.<br>Abolishment of the reduction of patient' participation for out-patient visit to the specialist whose pension is less than LVL 60 (€ 86). |

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| | (€ 2.86), for persons with a pension less than LVL 60 (€ 86) the contribution is LVL 1 (€ 1.43).<br>• Home visit: the doctor can set the price. For persons older than 80, disabled persons, and persons who need palliative care, the contribution is LVL 2 (€ 2.86). | • Home visits are generally not paid from the State budget (doctor can set the price), except:<br>o GP's home visits to children under 18, persons older than 80, disabled persons (only category I disability), persons who need palliative care, persons receiving permanent artificial lung ventilation in home settings (no patient contribution);<br>o GP's home visits to flu patients during flu epidemic (patient contribution is LVL 2 (€ 2.84));<br>o Specialists' home visits to persons receiving permanent artificial lung ventilation in home settings (no patient contribution) ;<br>o Psychiatrists' home visits to those with mental disorders (no patient contribution);<br>o Rehabilitation doctors' home visits to children receiving palliative care and patients who have certain cerebrovascular diseases and need health care at home (no patient contribution).<br>• Day centre board and lodging is LVL 5 (€ 7.12) per day plus allowance according to a list of contributions for various medical manipulations;<br>• For some outpatient diagnostic procedures: between LVL 1 (€ 1.42) and LVL 25 (€ 36) (depending on the procedure).<br><br>The total annual contribution for inpatient and outpatient treatment in one calendar year should not exceed LVL 400 (€ 570) (excluding the cost of drugs, spectacles and dental services). | Extension of categories of persons benefiting from reduced patients' participation in case of home visits.<br><br>Patients' participation in case of day centre board and lodging and for some outpatient diagnostic procedures.<br><br>Annual ceiling for patients' participation in case of inpatient and outpatient treatment. |

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| MT | No charges. | No patient charges. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| NL | Health Insurance Act *(Zorgverzekeringswet, Zvw)*:<br>Mandatory deductible. See Table I "Sickness and Maternity – Benefits in kind".<br><br>General Exceptional Medical Expenses Act *(Algemene wet bijzondere ziektekosten, AWBZ)*:<br>For most types of care under the Act, insured persons over 18 are required to make personal contributions towards the costs. | Health Insurance Act *(Zorgverzekeringswet, Zvw)*:<br>Compulsory deductible: all insured persons aged 18 years or older pay a maximum of € 350 per year. Care from a general practitioner, obstetric care, maternity care and dental care for children are exempted from the compulsory deductible.<br>Insured persons can opt for a voluntary deductible of € 100, € 200, € 300, € 400 or € 500 to top up the compulsory deductible. In return the insured person receives a discount on the nominal health care premium.<br><br>General Exceptional Medical Expenses Act *(Algemene wet bijzondere ziektekosten, AWBZ)*:<br>For most types of care under the Act, insured persons over 18 are required to make personal contributions towards the costs. | Introduction of a voluntary deductible, meaning that all insured can opt for a higher voluntary deductible up to 500 euro in exchange for a lower premium rate. |
| NO | • Up to a ceiling of NOK 1,740 (€ 218) a year, the patients pay cost-sharing charges for consultation of doctors, psychologists, for important medicines and nursing articles, radiological examinations/ treatment, laboratory tests and travel expenses.<br>• For a standard GP consultation NOK 130 (€ 16) is paid by the patient, for a specialist consultation NOK 280 (€ 35). | • Up to a ceiling of NOK 2,040 (€ 257) a year, the patients pay cost-sharing charges for consultation of doctors, psychologists, for important medicines and nursing articles, radiological examinations/ treatment, laboratory tests and travel expenses.<br>• For a standard GP consultation NOK 140 (€ 18) is paid by the patient, for a specialist consultation NOK 315 | No regulatory changes over the 5-year period according to the MISSOC Tables. |

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| | •A second ceiling of NOK 2,500 (€ 313) applies to cost-sharing charges for physiotherapy, reimbursable non orthodontic dental treatment, organised health travels and stays in medical rehabilitation centres. | (€ 40).<br>•A second ceiling of NOK 2,620 (€ 330) applies to cost-sharing charges for physiotherapy, reimbursable non orthodontic dental treatment, organised health travels and stays in medical rehabilitation centres. | |
| PL | No participation in case of basic treatment by the chosen general practitioner or by the specialist to whom the general practitioner has referred the patient.<br><br>Scope of basic treatment is determined by Minister of Health *(Minister Zdrowia)*, all treatment outside this is left to private sector. | No patient participation. | |
| PT | The payment of the insured person's share borne varies according to the medical visit:<br><br>•visit at home,<br>•normal or urgent visit,<br>•visit in a central or regional hospital,<br>•visit in a health centre.<br><br>Or also depends on the diagnosis and therapy auxiliary elements. | The payment of the insured person's share borne varies according to the medical visit:<br><br>•visit at home,<br>•normal or urgent visit,<br>•visit in a central or regional hospital,<br>•visit in a health centre.<br><br>It also depends on the diagnosis and therapy auxiliary elements. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| RO | Prepaid by the health contributions.<br>No other direct payments. | No patient charges. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
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| SE | The insured person pays between SEK 100 (€ 11) and SEK 200 (€ 21) per visit to a doctor.<br><br>For specialist care, the patient pays between SEK 200 (€ 21) and SEK 300 (€ 32).<br><br>Emergency cases: between SEK 100 (€ 11) and SEK 300 (€ 32). | Patients pay between SEK 100 (€ 11) and SEK 300 (€ 34) per visit to a doctor.<br><br>For specialist care, patients pay between SEK 200 (€ 23) and SEK 350 (€ 40).<br><br>Emergency cases: between SEK 200 (€ 23) and SEK 400 (€ 46). | Increase of patients' participation. |
| SI | Patients make co-payments of between 5% and 75%. Voluntary supplementary insurance for co-payments is available. Medical services like cosmetic surgery and homeopathy are paid entirely by patients. | Patients make co-payments of between 10% and 90%. Voluntary supplementary insurance for co-payments is available. Medical services like cosmetic surgery and homeopathy are paid entirely by patients. | Increase of co-insurance rates. |
| SK | For services related to health care the patient's participation is:<br><br>•SKK 60 (€ 1.79) for each visit at the emergency service,<br>•SKK 5 (€ 0.15) for each prescription,<br>•SKK 2 (€ 0.06) for each km of transport. | For services related to health care the patient's participation is:<br><br>•€ 1.99 for each visit at the emergency service,<br>•€ 0.17 for each prescription,<br>•€ 0.07 for each km of transport. | No regulatory changes over the 5-year period according to the MISSOC Tables. |
| UK | No charges to patients ordinarily resident in the UK or charge-exempt overseas visitors for NHS hospital services, but see below for prescription and other charges. | No charges to patients ordinarily resident in the UK or charge-exempt overseas visitors for NHS hospital services, but see below for prescription and other charges. | No regulatory changes over the 5-year period according to the MISSOC Tables. |