PATIENTS’ INVOLVEMENT IN HEALTHCARE FINANCING
The OECD Perspective

Financing of healthcare: European good practice and the Czech experience

12 January 2017

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Out-of-pocket (OOP) payments and access

“User fees have punished the poor”
Margaret Chan, WHO

“Anyone who has provided health care to poor people knows that even tiny out-of-pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary”
Jim Yong Kim, World Bank

Expanded cost-sharing reforms have lowered public spending on health in the short run, but also worsened access
OECD 2015
Patients’ involvement in healthcare financing: Different types of OOP payments

Out-of-Pocket (OOP) payments

- Cost-sharing (goods & services partially covered)
- Payments for goods & services not covered
- Informal payments

- Co-insurance
- Co-payment
- Deductible
- Extra billing
Arguments for/against cost-sharing and other forms of OOP payments (in high-income countries)

- Additional revenue source
- Reduces excessive demand for healthcare (moral hazard)

- Reduces consumption of essential as well as non-essential healthcare
- Inequitable (though exemptions can help)
- Limited additional revenues and new admin costs
- Politically difficult

Design is crucial – a uniform cost-sharing approach is an unequivocally bad policy
OOP payments 10-30% of overall health spending in most OECD countries

Expenditure on health by type of financing, 2013 (or nearest year)

Source: Health-at-a-Glance 2015
Reliance on OOP payments fairly constant over time in most countries, with some notable exceptions.

Source: OECD Health Statistics
What do patients pay for? OOP medical spending by goods and services

Shares of OOP medical spending by goods and services, 2014 (or nearest year)

Source: OECD Health Statistics
Greater reliance on OOP for pharmaceutical spending than for other healthcare

Source: OECD Health Statistics
Cost-sharing policies: what do countries do?
- for basic/core health coverage schemes (Paris et al 2016)

**Inpatient**
- Typically free of charge or small daily co-payments
- In a few countries, co-insurance rates
- Sometimes free for patients in public hospitals but co-payment for private hospitals (e.g. Australia, Italy, Turkey)

**Outpatient**
- Typically free of charge or small co-payments
- In a few countries, differentiated co-payments for ‘virtuous’ patient pathways (e.g. Belgium, France, Korea)

**Pharmaceuticals**
- Medicines used during IP stays usually funded by basic health coverage
- Medicines for OP care usually have co-payments: fixed per item or prescription, uniform or varied co-insurance, deductibles, sometimes vary according to plan
- Maximum reimbursement amounts (reference prices) commonly used

**Ancillary services; other medical goods**
- Ancillary services sometimes free, sometimes with medium co-payments
- Eyewear often not covered
- Dental care more commonly covered than eyewear, but with high cost-sharing or limited pre-defined service packages
## Cost-sharing policies: what do countries do?
- for basic/core health coverage schemes

### Table: Cost-sharing policies

<table>
<thead>
<tr>
<th>Service</th>
<th>Free at point of care</th>
<th>Cost-sharing</th>
<th>Not covered</th>
<th>Varies by plan</th>
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<tbody>
<tr>
<td>Inpatient</td>
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<td>OP primary</td>
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<td>OP specialist</td>
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<td>Physio</td>
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<tr>
<td>Eyewear</td>
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<td>9</td>
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</tr>
<tr>
<td>Dental care</td>
<td>3</td>
<td>16</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>

+ 3 countries have general deductibles (Netherlands, Switzerland, USA)
+ most countries have policies to limit user charges

Source: derived from Paris et al (2016)
Policies to protect patients from high cost-sharing requirements

United Kingdom
NHS low-income scheme

Canada
Subsidised PHI

Australia
Extended Medicare Safety Net

New Zealand
VLCA practices

Most OECD countries
- Annual/monthly caps for co-payments
- Exemptions/reductions for specific population groups
Policies: if you really want to keep or introduce cost-sharing

• Protect low-income and vulnerable groups

• Make sure cost-sharing encourages appropriate behaviour
  – Incentives to use cheaper alternatives: reference prices, differentiated co-payments
  – Remove cost-sharing from cost-effective treatments where patient compliance is particularly crucial
  – Use cost-sharing to encourage virtuous patient pathways
Policies: better ways of ensuring financial sustainability of health systems (OECD 2015)

- (Diversify revenue base)
- Pharmaceuticals –policies on **generics, procurement**
- Exclude health services that are cost-ineffective or of questionable clinical benefit: critical role of **HTA**
- **Shift services** from hospitals to primary care
- Revisit how **healthcare professionals** are used
- Invest early on in **health promotion**
Concluding thoughts

1. **Cost-sharing & other OOPs**: remain a smaller source of funding than prepayment in all OECD countries.

2. **Cost-sharing design**: protect vulnerable groups; provide right incentives (but administratively complex).

3. There are better ways than cost-sharing to ensure financial **sustainability** of health systems.
Thank you

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