Gesundheit Österreich GmbH

Leaving no one behind

Financial burden of medicines for patients: Co-payments and protective measures in European countries

Fact sheet prepared for the European Public Health Week 2021

Universal health coverage implies access to needed health services for all people without exposure to financial hardship. Medicines can pose high financial burden for patients and their caregivers in cases of non-coverage of patients and/or non-inclusion of medicines in a benefits package scheme. Patients can also be charged co-payments for medicines that are partially funded by public payers. This fact sheet provides an overview of co-payment regulations for medicines as well as of protective mechanisms such as exemptions from or reductions of co-payments for vulnerable groups for the countries of the WHO European Region. We illustrate the actual financial burden that patients encounter when filling prescriptions for selected medicines in a few European countries.

Rationale for financial protection

According to the most recent data, 1% to 17% of households experience catastrophic health expenditure (i.e. exceeding 40% of the household income net of subsistence needs) in 24 studied high- and middle-income countries in the World Health Organization (WHO) European region (Thomson et al. 2019).

Outpatient medicines are a key driver for catastrophic out-of-pocket (OOP) payments in health care, and patients tend to forego or postpone filling prescriptions or purchasing medicines for financial reasons (Austvoll-Dahlgren et al. et al. 2008, Gemmill et al. 2008).

Universal health coverage is defined as ensuring that all people have access to needed health services […] of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship (WHO 2021).

Reducing cost-sharing and fees of patients is one dimension in making progress towards universal health coverage, as defined in the target 3.8 of the Sustainable Development Goals (SDG) (UN 2015).

This fact sheet sheds a light on co-payments for mainly outpatient medicines, which may pose a barrier in moving to universal health coverage. It also outlines principles to consider in the cases of co-payments being charged to minimize financial risks and ensure that no-one is left behind.

WHO Collaborating Centre for Pharmaceutical Pricing and Reimbursement Policies

EUROPEAN PUBLIC HEALTH WEEK

JOINING FORCES FOR HEALTHIER POPULATIONS 17-21 MAY 2021 GET INVOLVED! #EUPHW goeg.at/EUPHW_2021_e @goeg_at

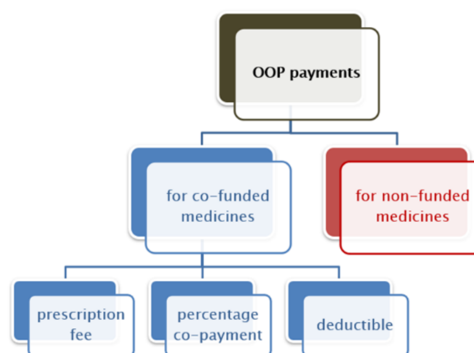
Co-payments for medicines in Europe

Taxonomy and definitions

Co-payments are out-of-pocket (OOP) payments of the patient (or their caregivers) for medicines included in a benefits package scheme. This scheme describes a formulary or catalogue of health services (in this case relating to medicines), whose expenses are, at least partially, covered by the public payer (e.g. a national health service, a social health insurance).

Co-payments for co-funded medicines can take different forms:

- **Prescription fee**: a fixed OOP payment per prescribed item,
- **Percentage co-payments**: differentiated co-payment rates for different types of medicines (e.g. no or lower co-payment percentage rates for essential medicines or medicines to treat life-threatening or serious conditions),
- **Deductible**: an initial expense up to a defined threshold.



Approaches to protect vulnerable groups from a possible high financial burden from co-payments for medicines included in a benefits package scheme include:

- **Reduction** of the co-payment amount (e.g. a lower prescription fee, a lower percentage co-payment rate),
- **Exemption** from some or all co-payments and
- **Capping** of co-payments at a certain threshold.

In addition to co-payments for medicines in the benefits package scheme, OOP payments are charged for those medicines that are not publicly funded. For those medicines, patients have to pay the price completely out-of-pocket. While this fact sheet focuses on co-payments for co-funded medicines, the non-funded medicines should also be considered since their OOP spending can be a high financial burden for patients and/or result in non-accessibility.

Note: The information on co-payments is only one part of the picture. If a country has no or low co-payments, this does not automatically imply that patients have affordable access to essential medicines. Access may be limited because medicines are not available (not marketed in that country or subject to shortages) or not affordable (available in the private sector without state subsidy for the patient).

Co-payment regulation in European countries

Survey methodology

The country overview relates to 44 countries in the WHO European region, which includes countries that are located beyond Europe in terms of geography (e.g. Central Asian countries). In this fact sheet, data are presented for all 27 countries of the European Union (EU), Albania, Armenia, Belarus, Iceland, Israel, Kazakhstan, Kosovo, Kyrgyzstan, Moldova, North Macedonia, Norway, Republic of Serbia, Russian Federation, Switzerland, Turkey, Ukraine and United Kingdom.

Findings are presented solely for outpatient medicines because in hospitals in Europe inpatients are usually not charged any co-payments for medicines (Vogler et al. 2018, Vogler et al. 2019a).

Data were collected from the Pharmaceutical Pricing and Reimbursement Information (PPRI) networks and relate to the latest available date (the years 2021 or 2020).

Pharmaceutical Pricing and Reimbursement Information (PPRI) is a collaboration of pharmaceutical pricing and reimbursement authorities of 52 largely European countries as well as international and European institutions. One sub-group is the PPRI EECA (Eastern Europe and Central Asia) network consisting of 12 countries.

Findings for outpatient medicines

41 of the 44 analysed countries charge co-payments for outpatient medicines included in the benefits package scheme.

No co-payments are charged for outpatient medicines in the public sectors in Kazakhstan and Malta, however the scope of the medicines included in the benefits package scheme is comparably small. In Kosovo, the reason for the non-existence of co-payments is different: As a general reimbursement scheme is still being established, there are yet no publicly funded outpatient medicines, and patients have to pay OOP for all outpatient medicines.

The most frequent type of co-payment is a **differentiated** one, **with different percentage rates of the medicine price** to be paid, depending on the type of the product (i.e. medicines to treat more serious diseases tend to have lower co-payment rates). 28 countries have such a co-payment in place. Of these, 17 countries (for example Albania, Luxembourg, Romania, Spain) have it as the sole co-payment for outpatient medicines. Eight countries (e.g. France, Greece, Latvia, Turkey) apply such differentiated percentage co-payment together with a prescription fee, and two countries (Norway and Switzerland) use a combination with a deductible. Finland uses the percentage co-payment rates in combination with a deductible and a prescription fee.

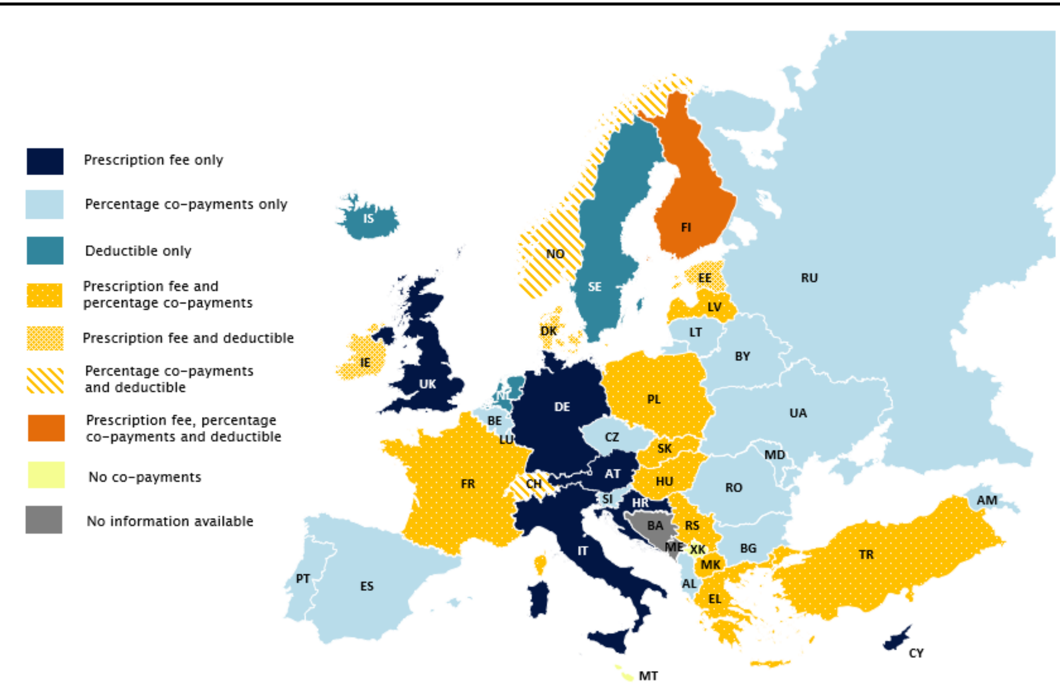
A **prescription fee** is in place in 18 of the studied countries. In six countries (Austria, Croatia, Cyprus, Germany, Italy, United Kingdom) it is the sole co-payment applied, and in 11 further countries it is used in combination with another co-payment (with a percentage co-payment in eight countries, as mentioned above, and with a deductible in Estonia, Denmark and Ireland).

A **deductible** is in place in nine of the studied countries (Estonia, Denmark, Finland, Iceland, Ireland, Netherlands, Norway, Sweden, Switzerland), of which three (Iceland, Netherlands, and Sweden) apply it as the sole co-payment policy.

This overview shows that 26 countries apply one co-payment type, whereas 14 countries use a combination of two different co-payments, and Finland uses all three types. The description relates to the common coverage scheme in a country, but some countries have different schemes for defined groups of people or medicines.

Figure 1 visualises the co-payments for outpatient medicines in the studied countries. In addition, several countries (e.g. France, Ireland, Italy, Poland) also employ a **reference price system**, in which identical or therapeutically equivalent medicines are clustered and are reimbursed at a defined amount (e.g. the price of the cheapest generic in a reference group). In countries without obligatory generic substitution, patients may ask for a higher-priced medicine of that reference group, and in such a case, patients have to pay the difference between the reimbursed amount (reference price) defined for the reference group and the actual pharmacy retail price of the requested medicine.

Figure 1: Co-payments for outpatient medicines in 44 countries of the WHO European region, 2021 or latest available year



Not in map: Israel and Kyrgyzstan – percentage co-payment only, Kazakhstan – no co-payments in the public sector
Italy: difference between regions (some with a prescription fee, others not)

Source: Pharmaceutical Pricing and Reimbursement Information (PPRI) network of competent authorities

Protective measures related to co-payments for outpatient medicines

Table 1 provides an overview on protective measures in those 41 countries that apply co-payments for outpatient medicines.

Table 1: Protection from high co-payments for outpatient medicines in 44 countries of the WHO European region, 2021 or latest available year

Country	Illness & disability		Age		Socio-economic status			Further reason		
	Disease	Disability	Youth	Elderly	Low in-come	Unemployed	Retired	Pregnant	War vet-eran	Other
Albania	E/R	E	E	E/R	E/R	E/R	E/R	R	E/R	–
Armenia	E	–	–	–	E/R	E/R	–	–	–	–
Austria	E/R	–	–	–	E/R	E/R	–	–	–	–
Belarus	E	R	–	–	–	–	–	–	E	E[1]
Belgium	R	R	R	R	R	R	R	–	R	R[2]
Bulgaria	E/R	R	–	–	–	–	–	–	R	–
Croatia	E	E	E	–	–	–	E	E	E	–
Cyprus	R	–	–	–	R	–	–	–	–	–
Czech Rep.	–	–	R	R	–	–	–	–	–	–
Denmark	E	–	R	–	R	R	R	–	–	–
Estonia	E/R	R	E/R	E/R	R	R	R	–	–	–
Finland	R	–	E	–	–	–	–	–	–	–
France	E	–	E	–	E	E	–	E	–	–
Germany	R	–	E	–	R	R	–	–	–	E[3]
Greece	E/R	E	–	–	E/R	E/R	–	E	–	–
Hungary	E	E	E	–	E	E	E	–	–	–
Iceland	–	R	R	R	R	R	R	–	–	–
Ireland	E	E	–	–	–	–	–	–	–	E[4]
Israel	E	–	NA	R	R	R	R	–	E	–
Italy[5]	E/R	E/R	E/R	E/R	E/R	E/R	E/R	–	E/R	–
Kyrgyzstan	–	–	–	–	–	–	–	–	–	–
Latvia	E /R	R	E	–	E	E	–	–	–	–
Lithuania	E /R	R	–	E	E	E	R	–	–	–
Luxembourg	E /R	–	–	–	–	–	–	–	–	–
Moldova	–	–	E	–	–	–	R	–	–	–
Netherlands	–	–	E	–	–	–	–	–	–	–
North Mace-donia	E	E	–	–	–	–	–	–	–	–
Norway	E	E[6]	E	–	–	–	–	–	–	E[7]
Poland	E	–	R	E	R	R	E	E	E	E[8]
Portugal	E/R	–	–	–	–	–	–	–	–	–
Rep. Serbia	–	–	E/R	E/R	–	–	–	E/R	–	–
Romania	E	E/R	R	–	R	R	R	E	E	–
Russian Fed.	–	E	–	–	R	R	E/R	–	R	–
Slovakia	–	E	R	–	–	–	R	–	–	–
Slovenia	E	E	–	–	E	E	–	E	–	–
Spain	E/R	E	–	–	E/R	E/R	E/R	–	–	–
Sweden	E	–	E	–	–	–	–	–	–	–
Switzerland	–	–	–	–	–	–	–	E	–	–
Turkey	E	E	–	–	E	E	R	–	E	E[4,6,7]
Ukraine	E	E/R	E/R	–	–	–	E	E	E	E
UK	E	E	E	E	E	E	E	E	E	–

E = exemption from co-payment, NA = data not available, R = reduction of co-payment, Rep. = Republic

[1] Survivors of Chernobyl clean-up operation

[2] Widows

[3] In case of a price that is 30% below the reference price in a reference price system

[4] People under state protection, e.g. children in care or foster care (Ireland), orphan children (Turkey) and refugees living in emergency reception or in orientation centers (Ireland)

[5] Application of a prescription fee and possible exemptions / reductions depend on the region

[6] Work-related injuries and accidents (Norway, Spain and Turkey), work-related illnesses (Spain and Turkey)

[7] People in military service

[8] Meritorious honorary blood donors and meritorious transplant donors

Kazakhstan, Kosovo and Malta are not listed in the Table, since they apply no co-payments (Kosovo – no general reimbursement system; Kazakhstan and Malta – medicines in the private sector are fully covered by the state)

Source: Surveys with the Pharmaceutical Pricing and Reimbursement Information (PPRI) network of competent authorities in 2017 (Vogler et al. 2018) and 2018 (Vogler et al. 2019a); updated for 2020/2021

Kyrgyzstan is the sole country that has not implemented any protective measures for co-payments of outpatient medicines.

Common reasons for co-payment exemptions or reductions include defined diseases and conditions (32 countries that either offer an exemption or a reduction or both), children and youth (23 countries), low income and social-economic status (23 countries), disability (23 countries), retirement status (19 countries), status as war veteran (13 countries) and pregnancy (11 countries).

Analysis of the spending for prescribed medicines

Exploring the financial burden from co-payments for outpatient medicines

An analysis for five commonly used medicines was performed in nine countries of different income and regulatory frameworks in the WHO European Region (Albania / ALB, Austria / AUT, UK with a focus on England / GBR, France / FRA, Germany / DEU, Greece / GRC, Hungary / HUN, Kyrgyzstan / KGZ and Sweden / SWE) to explore the impact of co-payment regulation on the financial burden for patients and their caregivers. In this research, different scenarios (standard co-payment provisions as well as settings for low-income people, pensioners, unemployed people, patients with high spending on medicines and children, where applicable) were analysed. Possible exemptions or reductions resulting from the disease of the patient were also considered (e.g. exemption for all asthma patients in the case of an asthma medication). The studied products included two medicines for acute care and three for chronic conditions:

» the antibiotic amoxicillin / clavulanic acid (875 mg/125 mg) to treat lower respiratory tract infections,
» the analgesic ibuprofen (600 mg),
» amlodipine (5 mg) for patients with hypertension,
» salbutamol (100 µg inhalation solution/ pressurized inhalation; also for pediatric use) for asthma patients and
» metformin (500 mg) for patients with diabetes.

The financial burden for households was determined for the originator medicine (abbreviated "O" in the graphs below) and the lowest-priced generic (LPG). It was defined by patients' payments for treating an episode or a one month's therapy in case of chronic care in relation to the national minimum monthly wage (economic data such as prices and wages weighted by purchasing power parities / PPP). The research was based on data from 2017 (regulation for co-payments and protection for vulnerable groups and the economic data).

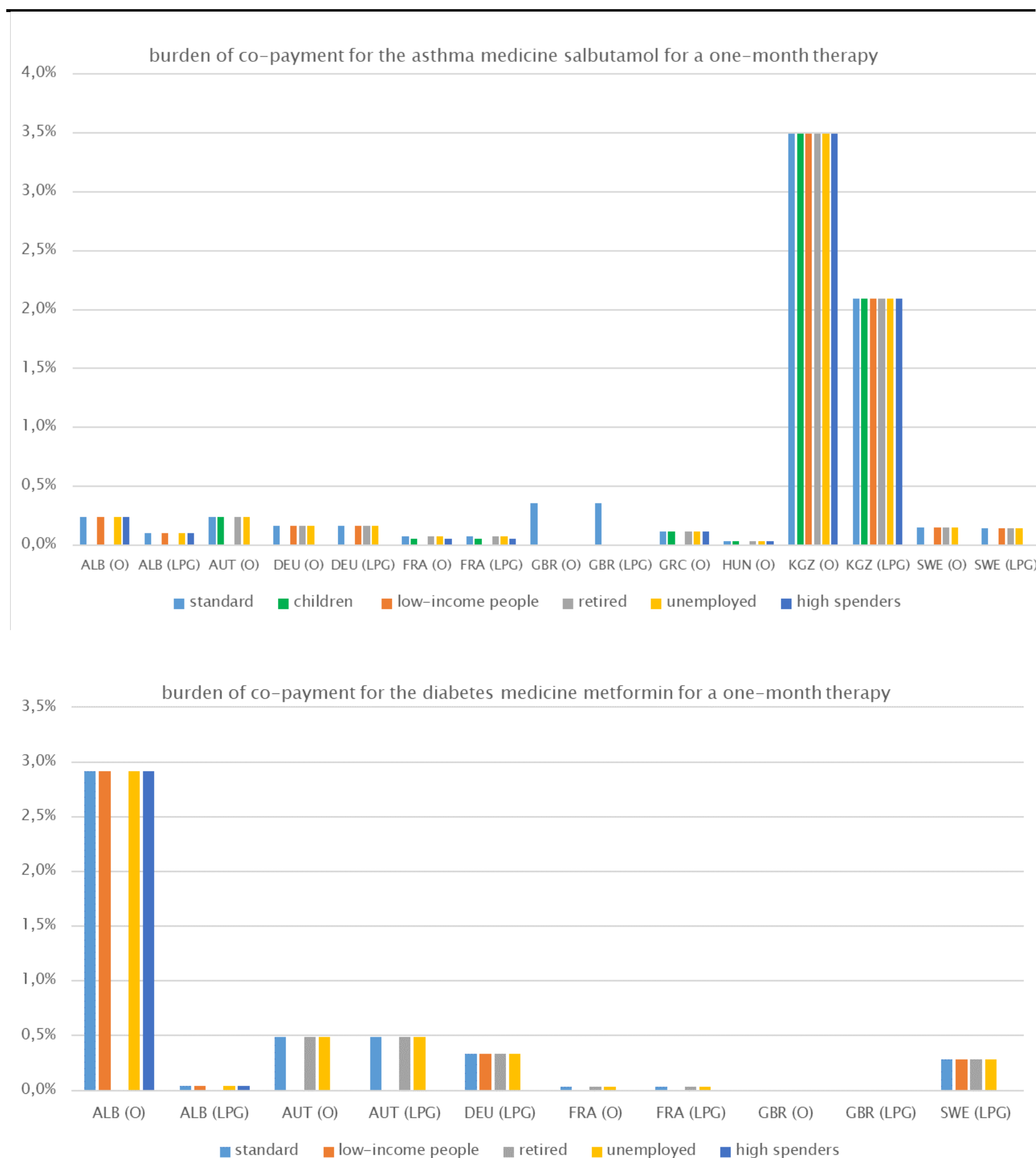
Findings from nine European countries

The financial burden resulting from co-payments differed considerably between the countries, the medicines and the patient groups, as shown in Figure 2.

Figure 2: Co-payments for an episode or a one-month treatment as a proportion of the monthly minimum wage for different patient groups

Sources: see below

Figure 2 – continued



Note: Where data of the studied medicines are not available (e.g. medicines not on the national market or not included in the reimbursement list), the medicines are not displayed in the graphs. If the combination of country and medicine (O/LPG) is included but no bar is visible (e.g. metformin in England), this means that no co-payments are charged.

Sources: regulation for co-payments -surveyed from PPRI networks, price data for EU Member States from GÖG Pharma Price Information (PPI) service and for Albania and Kyrgyzstan from country contacts, national minimum wage – Eurostat, conversion rate for PPP – OECD; for details see Vogler et al. 2018 and Vogler et al. 2019a

A worrying result concerns Kyrgyzstan where the OOP payments amounted to 9% of the minimum wage for a one-month treatment of generic amlodipine, a hypertension medicine, and to 2% to 4% for the studied asthma medicine. The co-payment was applied to all groups since Kyrgyzstan did not offer any exemptions or reductions. In the other countries surveyed, the monthly financial burden for the two medicines were mostly below 1%.

Patients needing an antibiotic in Albania and Hungary had to spend around 2% of the minimum monthly wage if they used generic amoxicillin / clavulanic acid (with a higher financial burden for the originator version).

The findings showcased implications of the different protective measures: While the share of household spending for reimbursed outpatient medicines tended to be generally higher in England than in the other countries of similar income, England provided exemptions for several groups so that co-payments were not applicable for many patients.

Except for Albania, Greece and Kyrgyzstan, patients with high spending on medicines (e.g. due to chronic diseases) were exempt from further OOP payments after having exceeded a defined threshold.

The availability of generics can significantly contribute to keep the financial burden of co-payments at a lower level. This applies especially in the cases of percentage co-payments and/or specific incentives to financially encourage patients to use generics (Germany).

Overall, with regard to lower-priced generics of the examples studied, the **financial burden** was **usually higher in the countries of lower income**. They also tended to provide **reductions of or exemptions from co-payments to fewer patient groups**.

Data were not always available; they were more often missing from countries of lower income. This was mainly because these medicines have not been included in the benefits package scheme, and in such cases, patients have to pay the full price out-of-pocket. In some cases, a few studied medicines were not launched on the national markets, which can be of concern in terms of access to essential medicines if there are no alternatives.

Conclusions

A **multi-faceted approach** is needed to ensure access **to safe, effective and high-quality essential medicines that are affordable** to patients without causing any financial hardship. One important policy is the implementation of a general **reimbursement system**. Such a system should be universal so as to cover as many patients as possible and comprise all essential medicines which meet defined criteria such as cost-effectiveness and affordability. Medicines included in a reimbursement system are funded by the public payer, at least to some extent.

Moving to universal health coverage does not imply eliminating all co-payments for publicly (co-)funded medicines. Co-payments may be needed to ensure financial sustainability. However, if policy-makers opt for the application of co-payments, it should be **ensured that co-payments neither result in financial hardship for patients** nor in under-use as patients may decide not to fill prescriptions.

The design of co-payments has an important impact on the extent of financial burden for patients. Since for some regulations (e.g. percentage co-payments) the amount of co-payment is related to the price of the medicine, pharmaceutical polices such as **price regulation** and **generic promotion** are further important tools in this context.

When designing a co-payment policy, it is of utmost importance to consider the **impact on vulnerable groups** and to tailor the regulations so that no one is left behind.

Bibliography

Publications for this fact sheet

The data presented on the financial burden from co-payments in nine countries was published in a technical report and a scientific paper:

Vogler, Sabine; Haasis, Alexander; Dedet, Guillaume; Lam, Janice and Bak Pedersen, Hanne (2018): Medicines Reimbursement Policies in Europe [Online]. World Health Organization Office for Europe. Copenhagen. http://www.euro.who.int/__data/assets/pdf_file/0011/376625/pharmaceutical-reimbursement-eng.pdf?ua=1

Vogler, Sabine; Dedet, Guillaume and Bak Pedersen, Hanne (2019b): Financial Burden of Prescribed Medicines Included in Outpatient Benefits Package Schemes: Comparative Analysis of Co-Payments for Reimbursable Medicines in European Countries. In: Applied Health Economics and Health Policy 17/6, 803-816

Further references

Austvoll-Dahlgren, Astrid; Aaserud, Morten; Vist, Gunn Elisabeth; Ramsay, Craig; Oxman, Andrew D; Sturm, Heidrun; Kosters, Jan Peter and Vernby, Åsa (2008): Pharmaceutical policies: effects of cap and co-payment on rational drug use. In: Cochrane Database of Systematic Reviews 1

Gemmill, Marin C; Thomson, Sarah and Mossialos, Elias (2008): What impact do prescription drug charges have on efficiency and equity? Evidence from high-income countries. In: International Journal for Equity in Health 7/12

Thomson, Sarah; Cylus, Jonathan and Evetovits, Tamás (2019): Can people afford to pay for health care - New evidence on financial protection in Europe [Online]. WHO Regional Office for Europe. Barcelona. https://apps.who.int/iris/bitstream/handle/10665/311654/9789289054058-eng.pdf?sequence=1&isAllowed=y

UN (2015): Sustainable Development Goals (SDG) [Online]. United Nations. Geneva. https://www.un.org/sustainabledevelopment/health

Vogler, Sabine; Zimmermann, Nina and Haasis, Manuel Alexander (2019a): PPRI Report 2018: Pharmaceutical pricing and reimbursement policies in 47 PPRI network member countries [Online]. Vienna. https://ppri.goeg.at/sites/ppri.goeg.at/files/inline-files/PPRI%20Report2018_2nd_edition_final.pdf

WHO (2021): Universal health coverage [Online]. World Health Organization. Geneva. https://www.who.int/healthsystems/universal_health_coverage/en

Please cite as: Vogler, Sabine; Haasis, Manuel Alexander; Zimmermann, Nina (2021): Financial burden of medicines for patients: Co-payments and protective measures in European countries. Factsheet prepared for the European Public Health Week 2021. Gesundheit Österreich (GÖG / Austrian National Public Health Institute), Vienna