

Patient cost-sharing for health care in Europe

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exemption or reduction in majority of European countries, not all individuals with low income can be identified. Patients might not exercise their right for exemption due to low transparency in the system, e.g. complexity of the French patient payment system (described in Chapter 3) is seen as one of the reasons for its inequitable nature.

In pursuing an effective protection policy, the role of health care providers is also crucial. The results of our qualitative study among health care providers (Chapter 4) show that this group is against a broad exemption policy as exemptions or reductions limit revenues from fees and increase bureaucracy. Hence, there is a risk that health care providers might be unwilling to grant exemptions or might treat patients who do not provide them with revenues unequally (e.g. one of the examples is an adverse patient selection in France, Chapter 3). For this reason, protection mechanisms should rather remain without the adverse impact of health care professionals financial benefits from cost-sharing system, e.g. providers could be compensated for lower revenues, like in the mentioned earlier Latvian system.

Suggestions for further research:

To present a comprehensive picture of health care consumers' ability to pay for health care, our study on past payments could be extended by including other costs of illness (e.g. cost of pharmaceutical) as well as other strategies which households might employ to deal with payment difficulties (e.g. use of savings). A relevant issue which also requires attention is the effectiveness of different mechanisms (exemptions, limits) in protecting equity in health care when cost-sharing is implemented. For example, the reasons for the failure of mechanism or the examples of good practices could help to design better protection system.

7.3. Final words and valorization

Most European countries have well developed social institutions for pooling the financial risks associated with sickness and rely predominantly on solidarity-based public funding. The growth in a countries' wealth brings an increase of government resources for health care. Thus, more prosperous countries in Europe tend to rely more strongly on public financing. However, demographic changes and increasing health care cost challenge health care systems and solidarity within societies. Countries reach the point when a further extension of welfare state is difficult or even undesirable. In the face of "growth to limits" (Flora, 1986) of

people's willingness to share their wealth and the government capacity to spend on health, the individual responsibility for financing health care increases.

In this dissertation, we outline that in the course of the last few decades, the vast majority of Western European countries has applied cost-sharing for health care commodities and services. Despite the policy expectations for enhancing the sustainability of health care financing, there is scarce evidence on the positive effects of cost-sharing policy in European countries. The analyses presented in this dissertation indicate that the cost-sharing solutions applied by European countries have limited potential for efficiency improvements or resource generation. The benefits from the cost-sharing implementation might be outweighed by the negative consequences for equity and consumers' financial protection. Hence, European countries need to revise their cost-sharing systems and move towards payments schemes well-targeted based on the values of services and consumers' ability to pay.

A significant part of this dissertation was devoted to CEE countries. The topic of cost-sharing is equally relevant for these countries, although the context of cost-sharing policy is different than in wealthier countries of Europe. The relatively low expenditure on health, significant problems with quality and accessibility of care or shortcomings in governance, make to see cost-sharing in a different light and assign different role to these payments. Thus, although CEE countries can learn from the experiences of Western European countries, applying other countries' solutions cannot be seen as a straightforward process. Also, within the CEE countries, we observe a certain diversity, though some common features, which should find reflection in cost-sharing policy. Acknowledging these differences, we draw some conclusions from our results for cost-sharing policy in CEE countries.

A relevant conclusion which follows from this dissertation is that the implementation of patient cost-sharing for health care services, which has been considered in many CEE countries, should not be seen as the goal itself but only as a widely acceptable response to health care problem and an adequate tool for dealing with the problem. Policy makers in CEE countries too often focus their actions on the instrument rather than on the problem, letting ideology drive their decisions. So it was with the introduction of social health insurance model in these countries, which was to emulate the German health care system and believed to be superior over a tax-based system. Such approach to policy making, makes the countries likely to fall into a "trap of unfulfilled hopes" (Sowada, 2013) increasing citizens' distrust in public policy and institutions. Cost-sharing should be thus, considered in the context of

challenges and problems in the health care systems of CEE countries and the ability to implement the system, which could allow for the improvements.

Having this in mind, one might consider the introduction of cost-sharing to deal with the inefficiencies in the health care systems of CEE countries, which have not experienced significant improvements though various reforms undertaken since the collapse of communism. However, as we discussed in this dissertation, for a cost-sharing policy to be able to enhance efficiency without deteriorating equity, highly targeted payment mechanisms are required. While such systems should be increasingly applied, it is unlikely that CEE countries have the technical capacity for designing and implementing sophisticated cost-sharing systems. Moreover, when looking closer at the problem of excess demand in health care in CEE countries, the greatest losses are likely to be due to too high utilization of hospital care. The use of in-patient care is largely induced by health care providers and might result from inappropriate provider payment mechanisms, underdevelopment of primary care or poor resource planning. Thus, CEE countries should increase their efforts to implement effective supply-side measures to encourage provision of high-value services and increase the coordination of care.

A more plausible role for cost-sharing in CEE countries is enhancing quality and access of health care services. The results presented in this dissertation show that if cost-sharing leads to better care for patients might get greater acceptability. Health care consumers in CEE countries are overall willing to pay for high quality and accessible services. While there is a fair consensus on the role of cost-sharing in CEE countries, the question on how to design an adequate cost-sharing system which will contribute to services' improvement, remains partly unanswered. The experiences of CEE countries indicate that not only sufficient resources need to be generated, but there is also a need for strategies to ensure improvement in quality of services. The use of resources from cost-sharing should follow the investment plans worked out taking into consideration the expectations of health care consumers for better quality and access as well as the interest of health care providers. To be successful, the strategy needs to be supported by a system of quality control to monitor and maintain quality levels. Poorly specified and unregulated quality standards and lack of monitoring system, constitute significant obstacles for enhancing health care in CEE countries.

When implementing cost-sharing for health care services, policy makers in CEE countries need to take account of the presence of different forms of patient payments (formal for