# Health Insurance Cost Sharing and Differences in Healthcare Access and Cost by Income in Eleven Countries

The level of health insurance cost sharing varies internationally and so does the importance of out-of-pocket healthcare spending. Deductibles and co-payments are two main cost sharing mechanisms. A deductible determines the amount a patient has to pay out of pocket before insurance coverage takes effect. Deductibles usually refer to annual expenditure but can also be by case. For instance, someone with a USD 1,000 annual deductible would have to pay for all healthcare accessed in that year until the USD 1,000 limit is reached. Insurance would cover any additional costs. Co-payments accrue at the point of service. For instance, in Germany, patients covered under the Statutory Health Insurance system pay EUR 10 for the first doctor visit in each quarter, EUR 10 for each of the first 28 days in hospital care, and 10 percent of the cost of prescribed medications (up to a maximum of EUR 10 per prescription). A third determinant of out-of-pocket spending is the comprehensiveness of benefit packages. While most countries tightly regulate insurance markets to ensure that a comprehensive package is offered under all insurance types, some – for example the United States – are less restrictive.

The aim of cost sharing is to increase cost awareness among patients which, ideally, limits wasteful healthcare use without incentivizing patients to forgo necessary care (Cutler und Zeckhauser 2000). The RAND Health Insurance Experiment 1974–82 empirically tested the effects of cost sharing schemes on healthcare use and health outcomes for the US (Newhouse 2004). The results showed that healthcare use declined across all income levels when cost sharing increased. At the same time, however, the healthcare use reductions negatively affected the health of the poor, putting in into question the usefulness of cost-sharing as a cost containment instrument.

In a recent empirical study, Schoen et al. (2010) examined the differences in healthcare access and cost between individuals with above and below-median incomes in 11 countries with different cost sharing provisions. The international differences in provisions are shown in Table 1. With the exception of the US, Switzerland and the Netherlands, where the standard insurance is private, none of the 11 countries has a deductible in its primary health insurance scheme. To avoid catastrophic health costs, Switzerland and the Netherlands, however, cap the deductible and require private insurers by law to offer a comprehensive benefit package. At the other end of the spectrum, the tax-financed British public health system provides healthcare free of deductibles and exempts low income households from the limited co-payments. Canada's national healthcare system also has no deductibles, but benefits are less generous than in other countries – prescription drugs and dental care are not part of the core benefit package. In France, almost all buy supplementary private insurance to cover the co-payments accruing in the public health system. Germany, Norway, Sweden and Switzerland avoid catastrophic health costs by placing annual income-related or absolute spending caps on co-payments, and Australia and New Zealand subsidize co-payment expenditure above a certain limit.

Table 2 summarizes Schoen et al.'s (2010) analysis for six measures of healthcare access and cost for respondents with below and above-median incomes. The percentages are adjusted for differences in age, health status and – for the US – whether the respondent has health insurance.

The above-median income group is more confident to receive the most effective treatment available across all countries. The difference between individuals with above and below-median incomes is smallest and not statistically significant in the UK, followed by Germany and France. In contrast, in the US the difference is 17 percentage points.

Confidence in being able to afford necessary medical treatment is also more common among individuals with higher incomes in all countries. The UK again has the smallest gap between individuals with high and low incomes. Public, tax-financed healthcare, however, does not seem to remove income differences in perceived affordability by itself as the largest difference – 28 percentage points – is found in Canada.

The third access measure is the share of respondents who did not fill a prescription or skipped a dose, had a medical problem but did not visit a doctor or had skipped a test, treatment or follow-up for cost reasons. With the exception of the UK, forgone care due

**Table 1**

**Cost sharing in 11 high-income countries, 2010**

| Country (2008 per capita spending on health care; population)[a] | Benefit package | | | | Role of private insurance | Provisions for low-income patients |
|---|---|---|---|---|---|---|
| | Deductible | Annual out-of-pocket maximum | Medication: core benefit | Cost sharing for primary care visits | | |
| France (USD 3,696; 61.8 million) | No | No | Yes | Yes | 90% buy coverage for suppl. cost sharing and some extra benefits | Supplements cost sharing; exemption for chronic disease |
| Germany (USD 3,737; 82.1 million) | No | 2% of income; 1% for patients with chronic diseases and low incomes | Yes | Yes | Approx. 20% buy coverage for suppl. cost sharing and amenities; 10% buy a substitute and opt out of social insurance | Income-related contribution for insurance; out-of-pocket maximum 1% of income |
| Netherlands (USD 4,063; 16.4 million) | EUR 165–665 (USD 219–883) | No | Yes | No | Private plans provide core benefits; 80% buy extra benefits | Income-related premium assistance (approx. 40% receive) |
| Sweden (USD 3,470; 9.2 million) | No | SEK 900 (USD 127) for health services; SEK 1,800 (USD 254) for pharmaceuticals | Yes | Yes | Fewer than 5% buy coverage for faster access and use of private providers | None |
| United Kingdom (USD 3,129; 60.5 million) | No | No | Yes | No | Approx. 10% buy coverage for benefits and private facilities | Cost-sharing exemption |
| Norway (USD 5,003; 4.8 million) | No | NOK 1,615 (USD 271) | Yes | Yes | Fewer than 5% buy coverage for faster access and use of private providers | None |
| Switzerland (USD 4,627; 7.6 million) | CHF 300–2,500 (USD 289–2,405) | CHF 700 (USD 673) maximum after deductible | Yes | Yes | Private plans provide core benefits; 70% buy extra benefits | Income-related premium assistance (30% receive); deductible exemption |
| Australia (USD 3,353 in 2007; 21.4 million) | No | 80% out-of-pocket subsidy if exceeds AUD 1,126 (USD 1,033) | Yes | Yes[b] | 50% buy coverage for suppl. cost sharing and access to private facilities | Lower cost sharing; lower out-of-pocket maximum before 80% subsidy |
| Canada (USD 4,079; 33.1 million) | No | No | No[c] | No | Approx. 67% buy coverage for extra benefits | Some cost-sharing exemptions; varies by province[c] |
| New Zealand (USD 2,683; 4.3 million) | No | Subsidies after 12 doctor visits or 20 prescriptions in previous year | Yes | Yes | Approx. 33% buy coverage for suppl. cost sharing, private facilities, and specialists; small share of total spending | Lower cost sharing |
| United States[d] (USD 7,538; 304.5 million) | Yes, no limit | No | Yes for Medicaid, Medicare w/supplement | Yes | 66% have private primary insurance; supplements and substitutes for Medicare | Medicaid separate; 2010 reforms lower premium and cost sharing starting in 2014 |

Notes: Currency converted to US dollars using http://oanda.com on 9 August 2010.
[a] Spending adjusted for cost of living. – [b] To make services free or low cost to patients, the majority of Australian primary care providers bill the government direct for the covered amount (referred to as "bulk billing"). – [c] Varies by province; there is no national requirement for core Canadian Medicare benefits. – [d] Before passage of the Affordable Care Act.

Source: Schoen et al. (2010).

to cost is more prevalent among individuals with below-median incomes in all countries. The relative difference is largest in Norway, where individuals with below-median incomes are more than four times more likely to forgo care. In absolute terms, the difference is largest in the US where 39 percent of below median income respondents have forgone care for cost reasons. Despite its capping of co-payments, Germany has the second largest share of individuals with both above and below-median incomes who have not used health services because of cost.

With regards to out-of-pocket healthcare spending, the United Kingdom, Sweden and France have the lowest share of respondents with annual spending above USD 1,000. The highest share is found in the US, Switzerland and Australia, where the differences between above and below-median income earners are also large. Higher out-of-pocket spending, however, only appears to translate into widespread payment problems in the US, where they are reported for 24 percent in the below-median income group. In all other countries, the percentage is below 13 percent. The lowest percentage is again found in the UK, where only 3 percent report payment issues.

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**Table 2**

**Healthcare access and cost by income-level in 11 countries, 2010**

| Country, income level (sample size) | Percent who were confident or very confident that they would receive most effective treatment | Percent who were confident or very confident that they would be able to afford needed care | Percent who experienced at least one access barrier due to cost | Percent who had out-of-pocket spending of USD 200 or less | Percent who had out-of-pocket spending of USD 1,000 or more | Percent who had serious problems paying or were unable to pay medical bills |
|---|---|---|---|---|---|---|
| France | | | | | | |
| Above average (619) | 88 | 78[a)] | 8[a)] | 41[a)] | 5 | 2[a)] |
| Below average (508) | 85 | 67 | 17 | 53 | 5 | 13 |
| Germany | | | | | | |
| Above average (289) | 82 | 77[a)] | 17[a)] | 40[a)] | 10[a)] | 1[a)] |
| Below average (223) | 78 | 62 | 27 | 52 | 5 | 7 |
| Netherlands | | | | | | |
| Above average (488) | 88[a)] | 87[a)] | 3[a)] | 37 | 11 | 2[a)] |
| Below average (224) | 81 | 65 | 13 | 42 | 7 | 11 |
| Sweden | | | | | | |
| Above average (917) | 70[a)] | 79[a)] | 5[a)] | 52 | 2 | 2[a)] |
| Below average (598) | 58 | 61 | 14 | 49 | 2 | 9 |
| United Kingdom | | | | | | |
| Above average (342) | 95 | 93[a)] | 4 | 88 | 0 | 2 |
| Below average (274) | 92 | 87 | 4 | 86 | 0 | 3 |
| Norway | | | | | | |
| Above average (638) | 72[a)] | 79[a)] | 4[a)] | 30[a)] | 16 | 1[a)] |
| Below average (201) | 63 | 57 | 21 | 39 | 15 | 10 |
| Switzerland | | | | | | |
| Above average (354) | 91[a)] | 86[a)] | 7[a)] | 19[a)] | 34[a)] | 2[a)] |
| Below average (569) | 86 | 67 | 12 | 26 | 20 | 9 |
| Australia | | | | | | |
| Above average (855) | 79[a)] | 77[a)] | 12[a)] | 23[a)] | 31[a)] | 5[a)] |
| Below average (1,649) | 73 | 56 | 22 | 44 | 16 | 10 |
| Canada | | | | | | |
| Above average (1,155) | 80[a)] | 79[a)] | 6[a)] | 48 | 17[a)] | 2[a)] |
| Below average (1,161) | 71 | 51 | 18 | 51 | 12 | 9 |
| New Zealand | | | | | | |
| Above average (296) | 87[a)] | 85[a)] | 8[a)] | 56[a)] | 11[a)] | 2[a)] |
| Below average (419) | 78 | 67 | 15 | 68 | 6 | 6 |
| United States | | | | | | |
| Above average (853) | 82[a)] | 74[a)] | 20[a)] | 24[a)] | 45[a)] | 9[a)] |
| Below average (861) | 65 | 50 | 39 | 38 | 29 | 24 |

Note: Percentages were adjusted based on logistic regression to control for health status, age, and – in the US – insurance status. Average is the median.
[a)] Indicates significant within-country differences with below-average income ($p < 0:05$).

Source: Schoen et al. (2010).

## References

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