

Medlemmerne af Folketingets Europaudvalg
og deres stedfortrædere

Asiatisk Plads 2
DK-1448 København K
Telefon +45 33 92 00 00
Telefax +45 32 54 05 33
E-mail: um@um.dk
<http://www.um.dk>
Girokonto 3 00 18 06

Bilag
3

Journalnummer
400.C.2-0

Kontor
EUK

31. maj 2010

SVAR PÅ UDVALGSSPØRGSMÅL

Oversigt over egenbetaling til læge- og sygehusbehandling i EU's 27 medlemslande

Til underretning for Folketingets Europaudvalg vedlægges Indenrigs- og Sundhedsministeriets besvarelse af spørgsmål 62 ad EEU alm. del af 26. maj 2010 vedrørende regler for refusioner og egenbetalinger for læge- og hospitalsbehandling i EU's 27 medlemslande.

Lene Espersen

Folketingets Europaudvalg

Dato: 26. maj 2010
Enhed: Center for internationalt
samarbejde og retsstilling
Sagsbeh.: SUMKHV
Sags nr.: 1003412
Dok nr.: 230017

Folketingets Europaudvalg har den 26. april 2010 stillet følgende spørgsmål nr. 62 (Alm. del) til indenrigs- og sundhedsministeren, som hermed besvares. Spørgsmålet er stillet efter ønske fra Lone Dybkjær (RV) .

Spørgsmål nr. 62:

” Vil ministeren sende en oversigt over regler for refusioner og egenbetalinger for læge- og hospitalsbehandling i EU's 27 medlemslande i det omfang ministeriet ligger inde med disse oplysninger?”

Svar:

Der vedlægges 2 oversigter fra MISSOCs¹ hjemmeside:

http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do?language=en . Oversigt 1 viser patientens egenbetaling til lægebehandling mv. i de 27 medlemsstater, og oversigt 2 viser tilsvarende patientens egenbetaling ved sygehusbehandling.

I fortsættelse af min redegørelse for generaladvokatens forslag til afgørelse i sagen C-211/08, EU-Kommissionen mod Spanien, følger hermed en redegørelse for, hvorledes danske sikrede har mulighed for dækning af udgifter til sygebehandling i udlandet, samt et eksempel på mulige konsekvenser af generaladvokatens forslag til afgørelse.

Danske sikrede har i dag mulighed for at få hel eller delvis dækning af udgifter til læge- og sygehusbehandling under ophold i EU's 27 medlemsstater efter nedennævnte 3 forskellige regelsæt. Der er desuden særlige regler om planlagt sygehusbehandling, jf. Bekendtgørelse nr. 62 af 20. januar 2010 om ret til sygehusbehandling mv. Disse situationer berøres ikke af den aktuelle retssag.

1. Den offentlige rejsesygesikring – det gule kort.

Danske sikrede har under den offentlige rejsesygesikring ret til refusion af udgifter til læge-, sygehusbehandling mv. ved akut opstået sygdom inden for den første måned af en ferie- eller studierejse i et andet EU-land. Den offentlige rejsesygesikring dækker alle udgifter, inkl. hos private læger og sygehuse - på private sygehuse dog alene svarende

¹ MISSOC: Mutual Information System on Social Protection. Tabeller over medlemsstaternes sociale sikringsystemer, der udarbejdes af EU-Kommissionen efter bidrag fra medlemsstaterne. Målgruppen for MISSOCs informationer er politiske beslutningstagere og embedsmænd fra EU-lande, forskere og studerende og personer, der flytter til et andet europæisk land for at bo eller arbejde.

til udgifter på almindelig sygehusklasse (nogle EU-lande har særklasser på sygehusene).

Refusionen sker, enten ved at SOS International A/S, der administrerer den offentlige rejsesygesikring, stiller kaution over for et sygehus og efterfølgende afregner direkte med dette, eller ved at patienten betaler alle udgifterne og efterfølgende sender kvitteringerne til SOS, der derefter afregner direkte med patienten.

2. **EF-forordning 883/2004 om koordinering af sociale sikringsordninger – det blå EU-sygesikringskort**

Efter EF-forordningens regler har danske sikrede under ophold i et andet EU-land ret til den sygehjælp ”der fra et medicinsk synspunkt bliver nødvendig under opholdet”. Sygehjælpen gives på samme vilkår som til offentligt sygesikrede i det pågældende land. Hvis der er egenbetaling i opholdslandet, skal danske sikrede derfor også selv betale denne egenbetaling. Den offentlige udgift til behandlingen dækkes af den danske stat.

Afregning af udgifterne foretages i langt de fleste tilfælde ved, at opholdslandets myndigheder sender en regning til Indenrigs- og Sundhedsministeriet på en særlig blanket, hvori det oplyses, om der er tale om lægebehandling eller sygehusbehandling, og det beløb det offentlige har lagt ud.

I undtagelsestilfælde, fx hvor en dansk sikret ikke har vist det blå EU-sygesikringskort og derfor har betalt den fulde pris for sygehjælpen, kan den pågældende efterfølgende anmode sin danske bopælskommune om hjælp til at søge refusion.

Det beløb, der kan refunderes, svarer til den udgift, som opholdslandets sygesikring ville have haft for en offentligt sikret person i pågældende land.

Fra kommunen og via Indenrigs- og Sundhedsministeriet sendes de originale regninger og kvitteringer til den udenlandske sygesikring, der oplyser det beløb, der kan refunderes. Dette beløb udbetales af ministeriet til patienten, mens et eventuelt restbeløb er patientens egen andel.

Eksempel 1:

Jens Nielsen er udstationeret i 6 måneder til Luxembourg. Han kommer ud for en ulykke og bliver indlagt 1 dag og efterfølgende behandlet på skadestuen på et offentligt sygehus. Han viser sit EU-sygesikringskort. Han får en efterfølgende ambulansbehandling og lægeordnet fysioterapeutbehandling. Sygehuset og fysioterapeuten sender en regning til Indenrigs- og Sundhedsministeriet på hhv. 1.000 € og 100 € via det luxembourgske forbindelsesorgan. Regninger i dette system sendes samlet til Danmark ca. hvert halve år, men der kan gå længere tid mellem disse mellemstatslige afregninger.

Jens Nielsen betaler 12,64€ for sygehusbehandlingen, 5 € for den efterfølgende ambulante behandling og 40 € for lægeordineret genoptræning hos en fysioterapeut, svarende til 20 % af første behandling og 10 % af 2 efterfølgende behandlinger. Disse beløb på i alt 57,46€ er patientens egenandel efter reglerne i Luxembourg og kan ikke refunderes.

3. Tilskud til varer og tjenesteydelse til købes eller leveres i et andet EU-/EØS-land,²

I overensstemmelse med EF-traktatens bestemmelser om fri udveksling af varer og tjenesteydelse i det indre marked, herunder EF-domstolens afgørelser om tolkning af disse traktatbestemmelser for så vidt angår tilskud til offentlige sundhedsydelser, har danske sikrede ret til det danske tilskud til en række sundhedsydelser, også i tilfælde hvor en ydelse søges hos en yder i et andet EU-/EØS-land.

En dansk sikret, der vælger at få en behandling i et andet EU-land, har ret til at få samme beløb/tilskud udbetalt, som behandlingen ville have kostet det offentlige sundhedsvæsen i Danmark. Hvis der er tale om sygehusbehandling kan der fra dansk side stilles krav om forhåndsgodkendelse.

For at få refusion skal patienten aflevere alle regninger, kvitteringer mv. til kommunen eller regionen. Dokumentation skal gøre det muligt for kommunen / regionen at vurdere, om behandlingen svarer til en behandling, som det offentlige betaler eller giver tilskud til i Danmark. I så fald refunderer kommunen / regionen det beløb, som behandlingen ville have kostet det offentlige sundhedsvæsen, hvis behandlingen var ydet i Danmark, og betingelserne for at få tilskud i øvrigt har været opfyldt.

Eksempel 2:

Henrik Hansen har dårlige tænder. Der er ikke tilskud i Danmark til den behandling, han har brug for. Han rejser derfor til Polen og får udover den planlagte behandling fyldninger i et par tænder. Behandlingen koster i alt 3.250 kr.

Ved hjemkomsten søger han sin region om refusion. Tilskuddet til fyldningerne er 182,22 kr. Dette beløb udbetaler regionen til Henrik Hansen.

Generaladvokatens forslag til afgørelse i sag C 211-08

Generaladvokatens forslag til afgørelse indebærer, at refusion efter reglerne i EF-forordningen skal toppes op, hvis en nødvendig behandling koster mindre i opholdslandet end i patientens sikringsland.

Der er ikke tale om, at en patient har ret til at få dækket alle udgifter til en behandling, der er vederlagsfri i sikringslandet, men om supplerende refusion, op

² Bekendtgørelse nr. 1098 af 19. november 2008, om adgang til tilskud efter sundhedsloven til varer og tjenesteydelse, der er købt eller leveret i et andet EU-/EØS-land

til det beløb, behandlingen ville have kostet for det offentlige sundhedsvæsen i sikringslandet.

Sikringslandet skal derfor foretage følgende beregning: (Udgift for sikringslandets myndigheder til behandlingen i udlandet, jf. EF-forordningernes regler) ÷ (den potentielle udgift til behandling i sikringslandet). Hvis resultatet af denne beregning er, at sikringslandets sundhedsmyndigheder har sparet i forhold til samme behandling foretaget i sikringslandet, skal besparelsen udbetales til patienten op til beløb, han selv har betalt.

I eksempel 1 har Jens Nielsen betalt en egenandel på 57,64€ for behandlingen i Luxembourg. Hvis generaladvokatens forslag til afgørelse følges, kan han søge supplerende refusion i Danmark efter reglerne om fri udveksling af tjenesteydelser.

For at foretage den ovennævnte beregning, skal bopælsregionen have følgende oplysninger:

1. Hvilket beløb opkræver Luxembourgs sundhedsvæsen fra Indenrigs- og Sundhedsministeriet
2. Hvilke behandlinger har der været tale om
3. Svarer disse behandlinger til behandlinger, der gives i det danske sundhedsvæsen
4. I givet fald – hvad ville disse behandlinger have kostet det offentlige sundhedsvæsen

Da behandlere i nogle EU-lande betragter oplysninger om konkrete behandlinger som persondata, der er beskyttet af databeskyttelsesregler, må Jens Nielsen selv bede sygehuset og fysioterapeuten om en specifikation af den behandling, han har modtaget med angivelse af hvor meget, der er eller vil blive opkrævet de danske myndigheder efter EF-forordningernes regler.

På baggrund af den information, som Jens Nielsen indhenter - og som formentlig vil være på fransk – skal regionen afgøre om samme eller tilsvarende behandling gives i Danmark, og hvad den offentlige udgift / det offentlige tilskud ville være.

Regionen sammenligner med drg-takster for så vidt angår sygehusbehandlingen.

I eksemplet når regionen frem til, at en tilsvarende behandling i Danmark ville have kostet et skadestuebesøg svarende til 1.000 kr. Fysioterapeutens regninger omfatter dels behandlinger, der ikke er tilskud til i Danmark, dels behandlinger, der samlet ville koste det offentlige 269,66 kr. svarende til 1 første konsultation og 2 gange opfølgende træningsterapi.

Resultat af beregningen vedr. sygehusbehandlingen:

(Udgift for danske myndigheder til behandlingen i Luxembourg, jf. EF-forordningernes regler = 1.000€ = 7.500 kr.) ÷ (den potentielle udgift til behandling i Danmark) = 1.000 kr. = 6.500 kr. = det beløb sygehusbehandlingen koster mere, end den ville have kostet i Danmark.

Da sygehusbehandlingen i Danmark ville have været billigere end den, der er givet i Luxembourg, kan Jens Nielsen ikke få refusion af patientandelen på 17,64 €.

Resultat af beregningen vedr. fysioterapeutbehandlingen:

(Udgift for danske myndigheder til behandlingen i Luxembourg, jf. EF-forordningernes regler = 100€ = 750 kr.) ÷ (den potentielle udgift til behandling i Danmark) = 269,66 kr. = 480,33kr. = det beløb fysioterapibehandlingen koster mere, end den ville have kostet i Danmark.

Da fysioterapibehandlingen i Danmark ville have været billigere end den, der er givet i Luxembourg, kan Jens Nielsen ikke få refusion af patientandelen på 40 €.

Behandlingen af Jens Nielsens ansøgning i regionen, afventende evt. hans indhentelse af den nødvendige dokumentation fra de udenlandske behandlere, kan være meget langstrakt og kan som i eksemplet ende med, at der ikke er nogen refusion.

Med venlig hilsen

Bertel Haarder / Kirsten Hvid

	Belgium	Bulgaria	Czech Republic
II. Health care			
Benefits			
2. Hospitalisation:			
Patient's participation	Complete refund (public ward). Save for a participation of € 14.14 per day. When hospitalised within a psychiatric home for more than 5 years: € 23.57 per day. Fixed contribution by the insurance for approved homes for the aged, protected homes, nursing homes and psychiatric homes, day-care centre. Admission fee: € 41.41.	Any person covered under contributions funded scheme pays the physician, dentist or health-care facility (providing medical care) for each day of hospital treatment: 2% of the national minimum (monthly) wage, but not more than ten days annually (minimum wage is currently BGN 240 (€ 123) per month).	No co-payments. Regulatory charge CZK 60 (€ 2.33) per day of institutional care.

Denmark

Public hospitals, approved private establishments and private hospitals with agreement with the regional health authorities: No charge.
Non-approved private establishments: patients pay all costs.

Germany

Free hospitalisation in a shared room with exception of participation of € 10 per calendar day during a maximum of 28 days.

Estonia

For the services provided in standard conditions of accommodation. Not for more than 10 calendar days for one case of disease and not for more than EEK 25 (€ 1.60) for a day.

Greece

No charges.

Spain

No charges.

France

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS): 20% of costs.
Hospitalisation fee (forfait hospitalier): € 16 (€ 12 in a psychiatric unit) per day, including the day of discharge.
Flat-rate co-payment of € 18 for serious medical intervention (of a minimum rate of € 91).

Ireland

- * Persons with full eligibility: No charge.
- * Persons with limited eligibility: Charge of € 75 per night in a public ward up to a maximum of € 750 in any 12 month consecutive period.
- * A charge of € 100 applies for attendance at accident and emergency departments where the person does not have a referral note from his/her doctor.
- * For inpatient stays greater than 30 days a maximum charge of € 153.25 per week applies.
- * Private hospitals/homes: Patient is liable for all costs. A subvention is available towards the cost of maintenance in some nursing homes.
- * Infectious diseases treatment: Free of charge to all persons.

Italy

Direct assistance free (sharing a room).

Cyprus

Outpatients:

Active and retired civil servants, members of the police, members of the educational service, dependants of these groups, the dependants of the armed forces personnel and certain other groups entitled to medical care on a free base, pay € 2,00 for a visit to the outpatient department, with the exception of people over 65 years old. Persons entitled to medical care at reduced fees pay € 6.83 per visit to general practitioner, € 8.54 per visit to specialist plus 50% of prescribed fees for laboratory, x-ray and other examinations for out-patient services. For in-patient treatment the fees vary according to the income of the patient, subject to a maximum charge of 50% of the described fees. Patients not entitled to any fee reduction pay € 14.52 and € 20.50 per visit to a general practitioner and specialist respectively.

Inpatients:

Active and retired civil servants, members of the police, members of the educational service, dependants of these groups, the dependants of the armed forces personnel and certain other groups entitled with free of charge treatment. Inpatients entitled to medical care at reduced fees. Inpatients not entitled to any fee reduction pay € 14.52 and € 20.50 per visit to a general practitioner and specialist respectively.

Latvia

The amount of the patient's contribution varies according to the type of hospital and/or treatment:

* In all hospitals (except nursing hospitals, Latvian Infectology Center and State Agency for Tuberculosis and Lung Diseases): LVL 12 (€ 17) per day,

* in the Latvian Infectology Center and State Agency for Tuberculosis and Lung Diseases: LVL 5 (€ 7.12) per day, * in nursing hospitals and for treatment in hospitals' nursing units: LVL 5 (€ 7.12) per day,

* for treatment due to oncologic and oncohaematologic diseases: malignant neoplasms, in situ neoplasms, neoplasms of uncertain or unknown behaviour and other aplastic anaemias: LVL 5 (€ 7.12) per day,

* for treatment of addiction to alcohol, drugs, psychoactive and toxic substances LVL 5 per day(€ 7.12).

Maximum contribution for board and lodging is LVL 250 (€ 356) for any one period of hospitalisation in one hospital. The total annual contribution for inpatient and outpatient treatment in one calendar year should not exceed

LVL 400 (€ 569) (excluding the purchasing of drugs, spectacles and dental services). Day centre board and lod

Lithuania

No charge for insured persons.

Luxembourg

Participation in maintenance costs: € 12.64 per day of hospitalisation and for a maximum period of 30 days.

Hungary

See "Benefits: 1. Medical treatment, Patient's participation".

Malta

No participation.

The Netherlands

Mandatory deductible. See Table I "Sickness and Maternity – Benefits in kind".

Austria

Full coverage of expenses in the general scale of fees of a hospital funded by a Länder health fund (Landesgesundheitsfonds), with the exception of a minor participation of an amount of approximately € 10 per day (different in each federal state (Bundesland)).
For the hospitalisation of a dependant a 10%-contribution is charged.

Poland

No charges.

Portugal

No participation in charges in public ward (or in private room if recommended by the doctor).
If in private room freely chosen by beneficiaries, charges are payable in full by the beneficiaries, as well as private hospital and clinic charges.

Romania

A contribution towards the costs for patients who request better accommodation than the social health insurance system standards, and/or services stipulated on the list of non-standard services.

Finland

Public hospital:
The fee for an out-patient visit is € 22, for day surgery € 72. The fee for in-patient care is € 26 a day. Patients receiving long-term institutional care at a ward (over three months) are charged a fee in accordance with their means. Such a fee, however, may be no more than 82% of the patient's net monthly income (if a person has a spouse who has lower income, the fee may be no more than 42% of their combined net monthly income).
Irrespective of this, minimum € 90 per month must be left for patient's personal use.
Private hospital:
Part of the doctor's fee and costs for examination and care are refunded by the sickness insurance.

Slovenia

Up to 25% of costs in case of hospitalisation as a continuation of hospital treatment (services connected to asserting and treating reduced fertility, non-medical part of care).

Slovakia

No participation.

Sweden

The patient will be charged maximum SEK 80 (€ 7.46) per 24 hours.

United Kingdom

No charge to patients ordinarily resident in the UK or charge-exempt overseas visitors, except where the patient asks for special amenities or for extra treatment which is not clinically necessary.

II. Health care
Belgium
Benefits

1. Medical treatment:
Patient's participation

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. Basic criteria:

- * being part of a specific social category;
 - * being part of a household with income under certain levels;
- In concrete terms, the following incomes and ceilings of are applying:

up to € 16,114.10:
€ 450

from € 16,114.11 to € 24,772.41:
€ 650

from € 24,772.42 to
€ 33,430.75: € 1,000

Bulgaria

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 240 (€ 123) per month).

Switzerland

* Fixed amount per calendar year (excess, deductible, "franchise"): CHF 300 (€ 202).

* In addition, share of costs: 10% of costs above the excess up to CHF 700 (€ 471) per year.

* The insurer may offer the insured person a form of insurance with a higher excess - CHF 500 (€ 336), CHF 1,000 (€ 672), CHF 1,500 (€ 1,008), CHF 2,000 (€ 1,345) or CHF 2,500 (€ 1,681) for adults, CHF 100 (€ 67), CHF 200 (€ 134), CHF 300 (€ 202), CHF 400 (€ 269), CHF 500 (€ 336) or CHF 600 (€ 403) for children (< 18 years) - in return for a reduction in the premium.

Czech Republic

Out-patient health care:
Co-payments only for drugs and medical devices.

Denmark

Group 1: No charges (treatment by the chosen GP or a specialist to whom he refers the patient).
Group 2: The part of expenses which exceeds the amount fixed by the public scheme for Group 1.

Germany

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).
The patient' participation for aids (e.g. massages, baths or physiotherapy) which are part of the medical treatment is 10% and € 10 per prescription.

Estonia

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).

Greece

No charges.

Spain

No charges.

France

General scheme for employees (Régime général d'assurance maladie des travailleurs salariés, RGAMTS):
Share borne by insured person:

* 30% for ambulatory treatment (GP or specialists, in consulting room or in hospital),

* 20% for hospital treatment,

* flat-rate co-payment of € 1 per medical intervention within a limit of € 50 per person and per year,

* flat-rate co-payment of € 18 for serious medical intervention (of a minimum rate of € 91).

Iceland

The insured person pays between ISK 1,000 (€ 5.57) and ISK 2,600 (€ 15) per visit to a health care centre or a general practitioner.

The insured person pays ISK 3,600 (€ 20) and 40% of the remaining costs, but max. ISK 25,000 (€ 139) per visit to a specialist.

Ireland

Persons with full eligibility enjoy a full range of general practitioner services without charge (see above).
Persons with a GP Visit Card are entitled to the services of a GP without charge (see above).
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.
Any patient who opts for private treatment, even in a public hospital, is liable for the specialist fees and hospital charges.

Italy

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.

Cyprus

Persons entitled to medical care at reduced fees pay € 6.83 and € 8.54 per visit to a general practitioner and specialist respectively plus 50% of prescribed fees for laboratory, x-ray and other examination.
Patients entitled to free of charge medical care (see "Beneficiaries: Field of application" above) make no contribution toward fees but do have to pay € 2.00 per visit at outpatients departments.

Latvia

Patient contribution system (for adult patients):

- * Out-patient visit to the general practitioner: LVL 1.00 (€ 1.42).
- * Out-patient visit to the specialist: LVL 5 (€ 7.12).
- * Home visit: the doctor can set the price. For persons older than 80, disabled persons, persons who need palliative care, the contribution is LVL 2 (€ 2.85).

Liechtenstein

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 (€ 131) each year. Voluntary deductible of a maximum of CHF 1,500 (€ 984) each year. Maximum excess is CHF 600 (€ 394) per year.

Lithuania

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.

Luxembourg

Co-payment 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. Co-payment by insured person of 10% for medical outpatient treatment expenses up to a maximum of € 5 per visit. This measure does not concern haemodialysis, chemotherapy, radiotherapy treatments nor preventive medical tests.

Hungary

Visit fee (vizitdíj) and hospital daily fee (kórházi napidíj) were abolished as of 1 April 2008, due to a referendum held on 9 March 2008. Co-payments are charged in the following circumstances:

- * unnecessarily changing the contents of prescription treatment, causing extra costs,
 - * extra services (better room, meal condition etc.),
 - * accommodation, nursing, pharmaceuticals and meal costs for those suffering from designated ailments, confirmed by primary health care provider,
 - * using sanitary provisions,
 - * in case of certain dental prosthesis, orthodontic braces provided for persons under the age of 18,
 - * change of external sex organs with the exception of developmental abnormality. The amount of the co-payment is fixed by the service provider.
- Control of entitlement As of 1 April 2007 service providers are obliged to control the entitlement of patients for health services. From 1 January 2008 it became more rigorous:
- * service providers have to control the entitlement of the patient before providing treatment (except emergency services),
 - * failure to control the entitlement will be
 - * if the patient is not entitled the provider
 - * in case of lack of entitlement, NHIF (Nal

Malta

No charges.

The Netherlands

Health Insurance Act (Zorgverzekeringswet, Zvw): Mandatory deductible. See Table I "Sickness and Maternity – Benefits in kind".

General Exceptional Medical Expenses Act (Algemene wet bijzondere ziektekosten, AWBZ): For most types of care under the Act, insured persons over 18 are required to make personal contributions towards the costs.

Norway

* Up to a ceiling of NOK 1,780 (€ 198) 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.

* For a standard GP consultation NOK 132 (€ 15) is paid by the patient, for a specialist consultation NOK 295 (€ 33).

* A second ceiling of NOK 2,560 (€ 285) applies to cost-sharing charges for physiotherapy, reimbursable non orthodontic dental treatment, organised health travels and stays in medical rehabilitation centres.

Austria

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). A contribution of 20% of the agreed fee is required for benefits provided by psychotherapists or clinic psychologists.

Poland

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.

Scope of basic treatment is determined by Minister of Health (Minister Zdrowia), all treatment outside this is left to private sector.

Portugal

The payment of the insured person's share borne varies according to the medical visit:

- * visit at home,
- * normal or urgent visit,
- * visit in a central or regional hospital,
- * visit in a health centre.

Or also depends on the diagnosis and therapy auxiliary elements.

Romania

No other direct payments.

Finland

Health centre:

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.

Private doctor:

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 amount exceeding a fixed tariff.

Slovenia

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.

Slovakia

For services related to health care the patient's participation is:

- * € 1.99 for each visit at the emergency service,
- * € 0.17 for each prescription,
- * € 0.07 for each km of transport.

Sweden

The insured person pays between SEK 100 (€ 9.33) and SEK 200 (€ 19) per visit to a doctor.

For specialist care, the patient pays between SEK 200 (€ 19) and SEK 300 (€ 28).

Emergency cases: between SEK 100 (€ 9.33) and SEK 300 (€ 28).

United Kingdom

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.