OECD Health Working Papers No. 196

Incentivising patient pathways in outpatient care: A review of gatekeeping and cost-sharing policies across the OECD

Manon Hämmerli,

Ricarda Milstein,

Michael Mueller

https://dx.doi.org/10.1787/349dcf1c-en

OECD

OECD Health Working Papers No. 196

Incentivising patient pathways in outpatient care

A review of gatekeeping and cost-sharing policies across the OECD

JEL classification: I11, I13, I18, H51

Manon Hämmerli, Ricarda Milstein, Michael Mueller

OECD Health Working Papers

OECD Health Working Papers

Abstract

Improving the efficient use of scarce resources is a key priority in many OECD countries to ensure the long-term sustainability of health spending. One option is to address the demand side by incentivising patients' care-seeking behaviour. In this context, gatekeeping – a policy tool through which general practitioners (GPs) or other primary care physicians control access to specialist care, and cost-sharing - arrangements requiring patients to contribute financially to the cost of care, are two instruments frequently discussed. Both policy tools are widely applied across the OECD and may also pursue objectives beyond improving efficiency. Focusing on the outpatient sector, this Working Paper provides a stocktake of which OECD countries have these policies in place and how they are designed. It also reviews evidence on how these policies affect health care spending, efficiency and health outcomes. This is complemented by six country case studies that describe the implementation of gatekeeping and cost-sharing arrangements in detail and identify factors that can influence their impact on health system performance. These include the availability of GPs, how GPs are incentivised to deliver services, and whether patients can bypass gatekeeping pathways.

Acknowledgements

This paper was authored by Manon Hämmerli, Ricarda Milstein and Michael Mueller. All authors contributed equally to the paper. The case study on France was authored by Rym Ghouma, who also contributed to the literature review on the part on patient registration.

The authors want to express their gratitude to Jan Mainz and Janus Laust Thomsen (Denmark), Ragnhild Røhme Fjærtoft, Pia Braathen Schønfeld, Maren Skaset and Jon Hjellum Vibeto (Norway), and Madelon Kroneman (the Netherlands) for their insights informing the case studies and to all delegates of the Health Committee that provided comments on a draft version of this document.

Within the OECD Health Division, Jacek Barszczewski, Espen Hasselgreen, Chris James, Luca Lorenzoni, David Morgan, Valérie Paris, Michael van den Berg and Lisbeth Waagstein provided valuable additional input and advise. The authors are also grateful for valuable feedback from Balász Egert from the Economics Department and Camila Vammalle from the Directorate of Public Governance. The assistance of Gözde Dincer, Line Hansen, Guillaume Haquin and Isabelle Vallard of the OECD is also gratefully acknowledged. Finally, the authors would like to thank Francesca Colombo and Frederico Guanais (OECD Health Division) for their guidance.

The work presented in this document was supported with a financial contribution from the *Zentralinstitut für die Kassenärztliche Versorgung in der Bundesrepublik Deutschland* (Zi).

In Brief

Health systems are under pressure. In many OECD countries, demand for healthcare exceeds supply, leading to long waiting times and potentially unmet need. To meet these challenges, countries are exploring options to increase the efficiency in health services delivery. In addition to supply-side policies, various demand-side instruments that aim to steer patients through the health system more efficiently and incentivise them to choose optimal treatment pathways are also often considered.

This paper focuses on two of these demand-side policy tools to influence patients' care-seeking behaviour in the outpatient sector – ***gatekeeping policies***, which manage access to specialist care based on a referral from a primary care physician ***and cost-sharing arrangements***. A stocktake of how these instruments are designed and applied across the OECD and a review of the evidence on how these policies affect health care spending, efficiency and health outcomes reveal the following:

Gatekeeping is common across the OECD and its impact on health system performance mixed

- ***Over three-quarters of OECD countries (31/38) have gatekeeping in place***. For the majority (24 countries, such as Australia and the United Kingdom), these are mandatory arrangements. 7 countries have voluntary gatekeeping policies, where they use financial or other incentives to discourage patients to seek specialists directly without first consulting a general practitioner, as seen in France and Switzerland. The remaining countries (including Czechia and Japan) have generally no restrictions for patients to seek specialist care directly. In most countries, bypassing gatekeeping pathways is possible if patients are willing to cover costs themselves.
- In nearly all mandatory gatekeeping systems (21/24), patients are either legally required to officially register with a primary care physician, or this is a nearly universal practice, as in the case of Denmark or Ireland.
- A comprehensive review of the scientific evidence in OECD countries shows that the ***impact of gatekeeping on health system performance is mixed and context-specific***. Overall, gatekeeping tends to reduce specialist visits and hospitalisations while increasing primary care use, with some studies suggesting limited cost savings. Some studies link gatekeeping to better quality of care in prevention though not to improved patient experience.

Around 60% of OECD countries use cost-sharing in primary and specialist care

- On average, outpatient medical care accounts for one-sixth of total out-of-pocket costs and ***around 60% of OECD countries* (22/38) *use various types of cost-sharing arrangements*** for these services***.*** Where this is the case, cost-sharing is generally higher for specialist care than for primary healthcare (PHC) and one-quarter (including the Netherlands and Türkiye) exempt PHC services from cost-sharing altogether.
- Cost-sharing reductions and exemptions for various vulnerable population groups (such as chronic patients or those with low income) are the norm across OECD countries, and all define a cost-sharing ceiling or use other mechanisms to avoid healthcare costs becoming catastrophically high (including Colombia, Finland and Sweden).
- A comprehensive review of the scientific literature on the evidence of the impact of cost-sharing in outpatient care across OECD countries suggests that ***reducing or removing cost-sharing***

increases healthcare use by 10-20%, ***while introducing or raising it has more variable effects***. Low-income, younger, and healthier individuals are more likely to reduce utilisation, with stronger responses for non-urgent care than for urgent or chronic services.

- Most OECD studies outside the United States find no short-term deterioration in health outcomes from reduced use of outpatient services associated with the introduction of cost-sharing, although long-term effects remain understudied. This may reflect the effectiveness of most OECD healthcare systems in ensuring access to essential outpatient care for those unable to afford co-payments and that public coverage for this type of care is much more comprehensive than for pharmaceuticals and other services.

Many complementary factors should be considered when analysing gatekeeping and cost-sharing policies

A deep dive into the experience from six OECD countries after implementation of these policy tools highlights the importance of considering enabling factors when analysing their impact:

- A ***sufficient supply of GPs***, including in rural and disadvantaged areas, ***helps maintain a functioning gatekeeping system*** but this is an ongoing challenge in many countries. Denmark, for example, plans to increase the number of GPs by nearly 30% by 2035.
- The introduction of gatekeeping is associated with a higher workload for GPs. Hence, OECD countries such as France introduced additional capitation-based payments to GPs to ensure that doctors fulfil their gatekeeping role. This suggests that ***provider incentives need to be aligned with the gatekeeping objective*** to effectively redirect patient streams.
- Capacity constraints and ***long waiting times for specialist care can lead to people bypassing the designated pathway***, thus undermining the gatekeeping objective. This is a concern, for example, in Poland, and generally more likely to occur when there is strong private provider infrastructure, a viable private health insurance market and regulation that allows dual practice for public doctors.
- All OECD countries that use cost-sharing in generalist and specialist care (such as Norway) have ***mechanisms to protect vulnerable populations from excessive financial burdens***.

Overall, the reviews of policies, scientific literature and country experiences suggest that ***gatekeeping and cost-sharing can, under specific circumstances, contribute to steer patients towards more efficient patient pathways in outpatient care but their impact depends very much on policy design choices and complementary factors*** such as the alignment of primary care capacity, provider incentives, private sector regulation and financial protection for vulnerable population groups. That said, both tools have objectives that go beyond improved efficiency. Gatekeeping is considered as one measure to strengthen PHC and its impact to realise the full potential of PHC can be further discussed in this context. The generation of additional revenues can be a further objective of cost-sharing.

The descriptive groundwork laid out in this paper can be used as the basis for more analytical work, such as to investigate more causal analyses to the effects to gatekeeping or to further explore how cost-sharing signals can be used to reduce low-value care.

Table of contents

1 Introduction

1. Health systems are under pressure. Ageing populations with an associated increase in patients with chronic conditions put an upward pressure on available resources. At the same time, in the current economic and geo-political climate, a substantial increase in the resources allocated to health to meet the growing demand is unlikely. Hence, countries are looking to find efficiency gains to make health spending sustainable in the long run (OECD, 2024[1]).

2. A key component in this discussion is to improve efficiency in service delivery. Several OECD countries respond to this by addressing the *supply side*, for example, by developing integrated care models, implementing team-based primary care structures that can help reduce the workload of physicians through the delegation and substitution of tasks by other professions, or by harnessing the use of new technologies, such as digital health and artificial intelligence.

3. Another option is to address efficiency issues from the side of *demand* for healthcare. Patients do not always navigate the health system in the optimal way. Some patients seek treatment for the same condition from a multitude of doctors and feel that none of them respond to their needs. Others consult specialists directly in cases where treatment at the primary care level would be more appropriate. Finally, some patients skip the outpatient sector altogether and access care in hospital emergency departments, which already suffer from overcrowding and long waiting times.

4. In this context, countries can effectively influence demand for healthcare by nudging patients to make the right choices when seeking care and reduce low value care. This report zooms in on two out of the many options policy makers have at their disposal: (i) they can mandate or incentivise a referral system where access to specialist treatment depends on a referral from a primary care provider (typically a General Practitioner) who serves as the first point of contract and "***gatekeeper***" (and with whom patients are typically registered) and (ii) they can manage ***cost-sharing*** arrangements in which people contribute financially to the cost of the healthcare they consume.

5. However, the policies are contested. Introducing or tightening gatekeeping policies reduces patients' choice, which is generally unpopular and risks creating a duplicate structure where more affluent people seek care from the private market. The introduction of cost-sharing, on the other hand, is met with concerns that it exacerbates health inequalities, reduces access to care and drives people into catastrophic spending.

6. This paper aims to contribute to this debate focusing on the outpatient sector. Firstly, it provides a stocktake of how gatekeeping and cost-sharing policies are designed and applied across the OECD. The paper then summarises the evidence of these policies and their effect on healthcare consumption, healthcare outcomes and spending including unwanted effects based on a comprehensive review of the existing scientific literature. Finally, it compares the practical implementation of these two instruments in detail across six countries – Denmark, France, Germany, the Netherlands, Norway and Poland – also with the aim to identify some complementary factors that should be considered when analysing the impact of these tools.

2 An overview on gatekeeping and cost-sharing policies across the OECD

7. All health systems have established clear rules on how patients can access publicly financed outpatient services. In some countries, they can choose any doctor they want at any point in time; in others, this choice is restricted and patients may need a referral to access all or most specialists. Moreover, while in some countries access to outpatient care is free of charge, others require a financial participation of patients when seeking care.

8. Given the existing resource challenges in many countries, discussions are ongoing on how to make health systems more efficient. This includes questions how patients can be effectively steered through the system or incentivised to make the right choices when seeking care -with the aim to reduce inefficient patient flows and thus also reducing waiting times. In this context, policies to introduce (or not) a mandatory referral system, where a primary care physician (*"**gatekeeper**"*) controls access to specialist care, and to introduce any type of ***cost-sharing*** for patients are central instruments in the toolkit of all health ministries.

9. Policies that establish a gatekeeping scheme and introduce cost-sharing can both aim at streamlining patient pathways, improving healthcare quality and efficiency, but place different weight on the respective objectives.

- ***Gatekeeping*** describes an arrangement where access to publicly funded specialist care is accessible to patients only with a referral from a primary care physician. The gatekeeping role is frequently performed by a GP and in many countries with gatekeeping systems ***patients are required to register with a GP*** – thus gatekeeping and patient registration policies are closely linked. These policies intend to direct patients *to*, and *through* the GP they are registered with. This GP thus becomes the first point of contact, co-ordinates the care pathway and should only refer patients to a specialist when necessary. Gatekeeping is often considered as an instrument to strengthen primary healthcare (Box 2.1).
- The introduction of any type of ***cost-sharing*** arrangement is frequently motivated by raising additional revenues to cover healthcare costs, but it may also aim to make healthcare utilisation more efficient. In a situation where patients need to cover part of the service they consume, there is hope that they make more resource-conscious decisions and reduce consumption of medically unnecessary, low-value care. This could reduce the workload of doctors, who could then dedicate more time to people with more serious healthcare needs.

10. These policies are often combined. This chapter presents an overview of the current status of gatekeeping (Section 2.1) and cost-sharing polices (Section 2.2) in OECD countries. Additional details are provided in Annex A to Annex C.

Box 2.1. Gatekeeping within the Primary Healthcare framework

Primary health care is expected to be the first and main point of contact for most people with the healthcare system and encompasses a set of interrelated characteristics -including being people- and community-oriented, continuous, comprehensive, and coordinated (OECD, 2020[2]). It can be organised around multidisciplinary teams including physicians, nurses and other health professionals. There are multiple mechanisms through which primary care improves population health, including improved access, higher quality of care, stronger prevention, earlier management of health problems, and reduced unnecessary specialist use (Starfield, Shi and Macinko, 2005[3]), and there is compelling evidence that shows that stronger PHC systems are associated with improved health outcomes (OECD, 2020[2]). In this framework, gatekeeping is frequently considered an important mechanism to enforce first contact access and enable coordination.

2.1. Gatekeeping at a glance

Over three in four OECD countries have some form of gatekeeping in place

11. More than three quarters of OECD countries have some form of gatekeeping in place, but the implementation and the stringency of these schemes differ (Box 2.2). In 24 OECD countries, following a gatekeeping is pathway is mandatory for people if they want to access specialists and have their costs covered under the publicly financed system. In another 7 countries, direct access to specialists is by default possible but (some) patients are incentivised to forgo this right and opt into voluntary gatekeeping instead. These incentives may not exist on a national scale or may be limited to an individual public payer, such as a region or an individual insurance fund. In the remaining countries, patients can access specialists directly and voluntary gatekeeping schemes do not exist.

12. The role of the gatekeeper can be performed by different doctors. In most OECD countries, GPs are controlling access to specialist care but in several countries other physicians can perform this role.[1] In ***Italy***'s gatekeeping system GPs and paediatricians serve as first points of contact and gatekeepers. In ***France***, the gatekeeper is usually a GP, but in exceptional cases, other professions, such as cardiologists, rheumatologists, endocrinologists, neurologists, or psychiatrists may take on this role if they can provide regular care and coordinate treatment.

13. In many countries with gatekeeping, patients are free to choose their GP or alternative gatekeeper. Yet, this choice may be limited by certain restrictions, such as geographic boundaries or capacity constraints. In ***Italy***, for example, patients are typically assigned a GP based on their place of residence but can request a change—though this is often limited to GPs practicing within the local health authority (*Azienda Sanitaria Locale*, ASL). Rules on how often patients can switch their co-ordinating doctor vary: some OECD countries allow changes at any time, while others impose some limits to ensure continuity of care.

[1] In some countries, primary care is generally provided by specialists for family medicine. It can also be organised around multidisciplinary teams including physicians, nurses and other health professionals.

Some services are typically exempted from access limitation

14. In mandatory gatekeeping and voluntary opt-in systems, referral exemptions are often made to access some medical specialties (Table 2.1). Across OECD countries, these exemptions generally apply to emergency care, but gynaecologists are also frequently accessible without referral.

15. Table 2.1 also highlights that countries vary in how strict the gatekeeping role is interpreted. In ***Australia*** and the ***United Kingdom***, for example, GPs are generally the first point of contact and patients require a referral for almost all outpatient specialists. Gatekeeping is less strict in other countries, such as ***Estonia***, ***Hungary***, or ***Poland***, where five or more specialties are exempt from referral requirements.

Bypassing mandatory gatekeeping is possible but patients may have to pay themselves

16. Bypassing the gatekeeping systems and accessing specialists without referral is mostly possible in mandatory systems but patients typically need to cover all or part of these costs themselves. Bypassing normally implies that patients seek specialist care in the non-contracted private sector or as private patients with publicly contracted doctors. For example, while patients can see a specialist without a GP referral in ***Australia***, they are not eligible for Medicare reimbursement and must pay the full fee themselves. In some cases, the cost of bypassing can be covered by private health insurance.

Box 2.2. Gatekeeping – A closer look at its design options

Gatekeeping can be mandatory, financially incentivised, or specialists can be accessed directly

OECD countries differ in how primary care is co-ordinated with other levels of care for patients, including incentives and/or restrictions for accessing specialised levels of care. The interpretation of gatekeeping used in this report is based on whether or not primary care physicians control access to specialist care.

- **Mandatory gatekeeping**: A mandatory gatekeeping system is a healthcare model where patients are required to first consult a primary care provider – generally a general practitioner or family doctor – and are required to obtain a referral from them to access specialist services. Some specialists such as gynaecologists are frequently exempted from referral requirements and can be accessed directly. In mandatory gatekeeping systems, patients may bypass the gatekeeper and see specialists directly by choosing private care, but they are not eligible for free or subsidised healthcare in such cases.
- **Financially incentivised or voluntary gatekeeping**: Certain countries employ financial incentives to promote gatekeeping. Patients retain the option to access specialist care directly but are incentivised to sign up for a gatekeeping scheme and forgo this right. Financial incentives can include reduced co-payments (e.g., France), or reduced premium payments (e.g., Switzerland).
- **Direct access**: Direct access systems allow patients to consult specialists directly without requiring a referral from a primary care provider. However, to access some highly specialised services referral requirements may still exist.

Around one third of OECD countries allow patients to access specialists without referral, but some use policies to nudge patients into gatekeeping

17. In contrast to mandatory arrangements, around one-third of OECD countries allow patients to access specialist care directly without a GP referral. However, in seven of these countries, financial incentives have been introduced to encourage the use of gatekeeping for improved continuity or care and to reduce the number of unnecessary specialist consultations. In these countries, patients can choose to

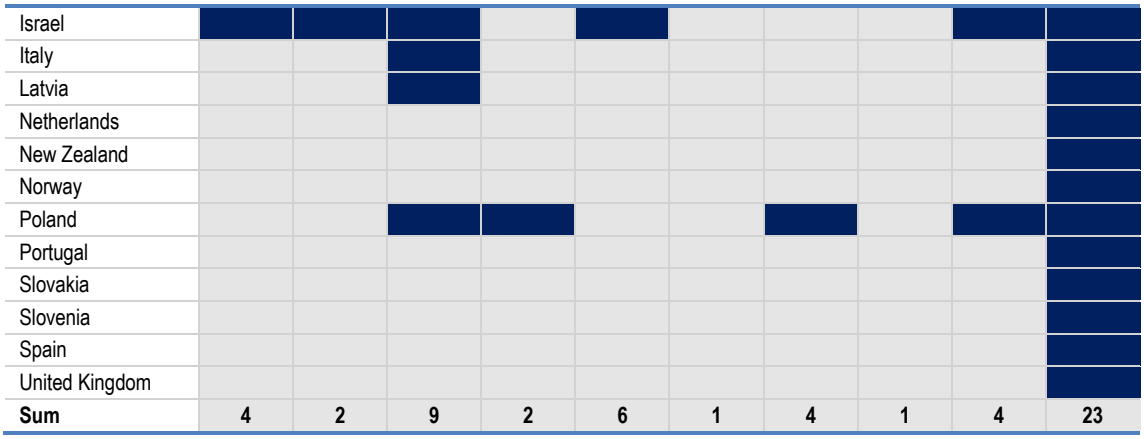
participate in a referral system or consult specialists directly. Those who opt into and adhere to a gatekeeping pathway typically receive some benefits in return – financial (e.g. reduced cost-sharing or premium/contribution payments) or otherwise (e.g. better access to primary care).

- In ***Belgium,*** the Global Medical Dossier (*dossier medial global* / *global medisch dossier*) encourages patients to register with a GP by offering reductions in out-of-pocket costs for consultations. Through this dossier, patients benefit from an approximately 30%-reduction in fees for GP visits, with co-payments usually reduced to around EUR 1 instead of EUR 1.50 or more. For specialist consultations, the reduction applies if the patient is referred by their GP via a referral letter. In this case, the co-payment decreases by between EUR 2-5, depending on the specialty and whether the doctor is contracted with health insurance.
- In ***France***, a reform in 2004 introduced financial incentives for patients to register with a primary care physician (*médecin traitant*) and follow a coordinated care pathway, which includes seeking a referral before consulting most specialists. When patients follow this pathway, the public health insurance system (*Assurance Maladie*) reimburses 70% of the official consultation fee, minus a flat EUR 2 charge. For example, a standard GP consultation in Sector 1 costs EUR 30, of which around EUR 19 are reimbursed.[2] In contrast, if a patient has not registered with a GP or consults a specialist without referral, the reimbursement rate drops to 30% of the base fee and the specialist is allowed to charge extra-billing. This significant difference in co-payment serves as a strong financial incentive for patients to follow the coordinated care pathway. Currently, more than 90% of the population have declared a *médecin traitant*.
- ***Denmark****'s* gatekeeping system has an element of choice. More than 99% of Danes choose "Group 1"-coverage, which means patients designate a specific GP as their gatekeeper and must seek a referral to see most specialists. Less than 1% of the population choose "Group-2" coverage, allowing for direct access to specialists in exchange for higher co-payments.

Table 2.1. Exemptions of medical specialties from referrals in gatekeeping systems

	Dermatology	Ear-Nose-Throat	Gynaecology	Oncology	Ophthalmology	Paediatrics	Psychiatry (mental health)	Urology	Other	Emergency care
Australia										■
Canada	■		■				■			■
Colombia										■
Costa Rica										■
Denmark		■			■					■
Estonia	■		■		■				■	■
Finland									■	■
France			■		■		■			■
Germany			■		■	■				■
Hungary	■		■	■	■		■	■		■
Ireland										■

[2] The vast majority of French people also have complementary private health insurance that covers part of the costs not covered by the "*assurance maladie*".



Note: () = in voluntary schemes. In Canada, specialties exempt from referral differ across provinces. For additional information, please consult Annex A.

- In ***Switzerland***, health insurance funds can offer GP-centred policies ("*Hausarztmodell*") that limit the free choice of provider for patients in exchange for a lower monthly premium payment. In this model, GPs are the first point of contact and refer to specialists if needed, although direct access to gynaecologists, dentists and some other selective services is maintained. Premium reductions can vary with one insurer proposing a reduction between 7-19% compared to the standard policy (Sanitas, n.d.[4])

Gatekeeping typically goes hand in hand with patients registering with a GP

18. There is a clear relationship between implementing a mandatory referral scheme to manage access to specialist care and requiring patients to register with a primary care physician to perform the role of the gatekeeper – or assigning them to one (Table 2.2).

Table 2.2. Overview of gatekeeping and registration policies across 38 OECD countries

		Primary care physician referral required to access secondary care services		
		Required	Incentives	No
Are people registered with a primary care physician or practice?	Requirement or near universal practice	Chile, Costa Rica, Colombia, Denmark, Estonia, Finland, Hungary, Ireland, Israel*, Italy, Latvia, Lithuania, Netherlands, Norway, Poland, Portugal, Slovakia, Slovenia, Spain, some regions of Sweden, United Kingdom	Iceland, some regions of Sweden, Türkiye	Czechia, Greece, Mexico*
	Common and/or with voluntary incentives	Australia, Canada, New Zealand	Belgium, France, Germany, Switzerland*, United States*	Luxembourg
	No			Austria, Japan, Korea

Source: Authors' compilation and the OECD Health System Characteristics Survey 2023. This table reflects the situation for a standard patient, as exceptions to the rules can exist for certain groups of the population. *Reflects plan-specific rather than a territorial or national rules.

19. In the majority of OECD countries with gatekeeping, registration with a GP (or a GP practice) is a necessary requirement for people to access the public primary care system but there are differences in the implementation. In ***Denmark*** and ***Norway***, residents can choose a GP upon residence registration, within the limitations of their designated local area and based on GP availability. In ***Chile*** and ***Costa Rica***, on the other hand, people are automatically assigned to local primary healthcare units upon enrolment in the National Health Fund (*Fondo Nacional de Salud*, FONASA) or the Social Security Fund (*Caja Costarricense de Seguro Social*, CCSS), respectively.

20. While the ***Netherlands*** and ***Finland*** lack any formal mandate for patients to register with GP, it is a nevertheless a core organisational component of their systems and de-facto necessary for patients to access non-emergency care. In these countries, patients who are not registered with a GP will face difficulties accessing primary care services, especially in areas where GP shortages exist. In the ***Netherlands***, over 95% of Dutch citizens register with a GP practice of their choice, typically near where they live. Registration ensures prompt access to care, as unregistered patients risk delays in treatment.

21. Patient registration can also be mandated in the absence of gatekeeping rules. In ***Greece***, for example, registration with a GP has become mandatory in 2022. Initially, patients could choose public or publicly contracted private doctors, but shortages in public doctors and limited participation by private physicians led to a reform in 2024, broadening the range of doctors with which registration is possible. As of 1 June 2025, remaining unregistered adults were automatically enrolled.

22. There are a few countries where registration is voluntary, with or without financial incentives for patients. In Canada, New Zealand, Belgium, France and Switzerland, the lack of GP registration has financial consequences for patients in the form of higher copayments or higher premiums. However, this is not the case in Luxembourg. In ***Switzerland***, various health insurers offer cheaper plans that restrict provider choice. Similarly in the ***United States,*** Health Maintenance Organizations (HMOs) and many Point-of-Service (POS) plans require members to choose a primary care physician from the network. In ***New Zealand***, patient registration is not mandatory, but GPs and primary health organizations have voluntary patient enrolment. Enrolment is free and links patients to a Primary Health Organisation (PHO) for subsidised care, including lower doctor visit and prescription fees. Patients enrol with a GP of their choice; in smaller communities, choice is often limited.

23. Finally, a few countries do not have any official policies for GP registration in place. However, despite the lack in formal registration, continuity of care can still exist. For example, while ***Austrian*** residents can select and switch GPs freely without any official registration needed, many maintain a continuous relationship with their doctor (Hoffmann et al., 2019[5]).

Only few OECD countries have made adjustments to gatekeeping policies recently

24. Establishing a gatekeeping approach or not is a fundamental decision in any health system and any modifications to this can have far-reaching consequences. Hence, changes to this care delivery mode are relatively rare and only few reforms in recent years fully pertaining to gatekeeping could be identified. Overall, the more dominant reform trend appeared to be one of strengthening primary care capacity and expanding the scope of other health professionals rather than wholesale changes to gatekeeping policies.

- In 2025, ***Iceland*** implemented a major reform to access paediatric healthcare abolishing the referral system for children's specialist healthcare services. As a result, children under the age of 18 no longer need a referral to access specialist doctors or diagnostic services. Additionally, the 30% surcharge previously applied to non-referred visits was removed. The reform was introduced to address inequalities in the healthcare system, where children from lower-income families often faced longer wait times due to financial barriers.
- In ***Finland***, a pilot initiative was launched in 2025 to increase provider choice and access to primary care. People over the age of 65 could start seeing private GPs twice a year (three times in 2026 and 2027) for the same user fee (EUR 28.20) charged by public providers (Social Insurance Institution of Finland (Kela), 2025[6]). This pilot is scheduled to end in 2027.
- In ***Switzerland***, a referendum to establish “managed care” models that included gatekeeping as the standard option with increased premiums for those who wanted to maintain the full choice of doctors failed to get the support of the public in 2012, but these instruments have been subject to repeated discussion. For example, in 2020, the Federal Council proposed introducing referral requirements to curb cost increases in health, but this was not pursued any further. Instead, the

Federal Department of Home Affairs can now financially support pilot projects that aim to restrict free choice to achieve cost reductions (BAG, n.d.[7]).

- In ***Germany***, discussions to implement a form of gatekeeping with a central role of the GP to steer patients through the system with the intention to limit unnecessary consultations and reduce waiting times have started to take a more prominent place (SVR Gesundheit & Pflege, 2024[8]; CDU, CSU und SPD, 2025[9])

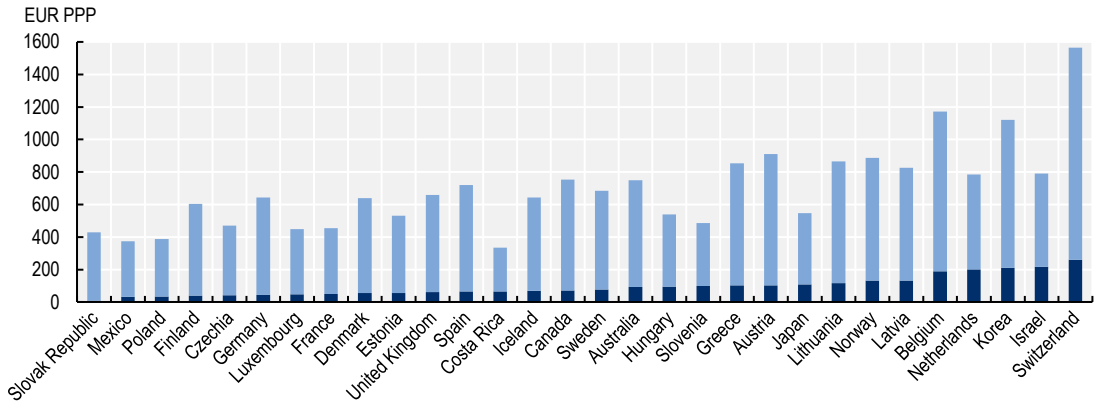
2.2. Cost-sharing in the outpatient sector at a glance

All OECD countries have some form of cost-sharing in place but not necessarily for outpatient care

25. Across all OECD countries, people contribute to the cost of healthcare provision beyond their regular tax and insurance contributions. Some services, outside of publicly funded benefit basket need to be purchased by patients directly out-of-pocket (unless private health insurance covers the costs); for others, they may need to share some of the costs with the public payer. On average, these costs account for around one-fifth of total health spending across the OECD. Beyond raising revenues, cost-sharing policies can also be an instrument to influence patient behaviour by nudging them to take a more efficient treatment pathway.

26. Cost-sharing is prominent across many different types of goods and services in the health system. Across OECD countries, patients and payers share costs for (i) outpatient services (ii) inpatient services, (iii) medical goods, and (iv) long-term care services but with wide variations between services and across countries. In this context, out-of-pocket payments (including cost-sharing) for outpatient care plays a comparatively small role. Across the OECD, it ranges from EUR 9 PPP in the Slovak Republic to EUR 259 PPP in Switzerland (Figure 2.1) and represent one-sixth of all out-of-pocket payments.

Figure 2.1: Total and outpatient out-of-pocket payments per capita, 2023 (or latest available data)



Note: Outpatient out-of-pocket payments refer to household out-of-pocket payments including cost-sharing. Outpatient refers to "outpatient curative care" without dental care. This includes services by GPs, specialists, emergency department visits and from auxiliary health providers.
Source: OECD Health Statistics 2025.

About 60% of OECD countries have cost-sharing in place for outpatient care

27. Out of 38 OECD countries, around 60%, or 22 OECD countries have some kind of cost-sharing for outpatient medical care (generalist and specialist care but excluding emergency and dental care) with

public payers or compulsory insurance systems in place (Table 2.3). Of these, six OECD countries, ***Australia, Estonia, Israel, Italy, the Netherlands*** *and* ***Türkiye***, exempt primary care from cost-sharing. In ***Austria***, ***Israel, Germany*** and **the *United States***, cost-sharing depends on the insurance arrangement enrolees have selected. Generally, cost-sharing for specialist care is higher than in primary care.

28. The design of cost-sharing arrangements differs across OECD countries (For a terminology, see Box 2.3) and there are many design features that countries consider when implementing cost-sharing arrangements (Table 2.4Table 2.5. Cost-sharing reductions and exemptions based on age, selected OECD countries). Cost-sharing in the form of *co-payments* dominate (15 OECD countries), followed by *co-insurance* arrangements (8 OECD countries). *Extra-billing* and *deductibles* are used by a smaller number of countries (however, some countries also combine various types of cost-sharing arrangements).

- The *co-payment* amounts charged to patients differs widely by country and by service. They range from EUR 2 for GP visits in ***Latvia*** to around EUR 28 for a GP visit in ***Finland***, and up EUR 100 in ***Ireland*** for a visit to the emergency department without referral.
- In ***Japan*** and ***Korea***, patients pay up to 30% of the total price as *co-insurance*, depending on the service. In ***Luxembourg***, the co-insurance generally amounts to 12%. In ***France***, the co-insurance amount is conditional of the type of physician people consult and the insurance arrangement they have chosen. It ranges from 30% to 70% for physicians that are contracted in the public sector (*conventionné Secteur 1* and *Secteur 2*) but additional private insurance can cover part of this.
- *Extra-billing* is a particular type of cost-sharing where patients have to cover the difference between the fee charged by the professional and the amount covered by the third-party payer. In ***Australia***, for 11% of GP services, doctors are charging patients beyond the fee schedule, whereas the remainder is 'bulk-billed' (i.e. directly billed to the payer). In ***Austria***, patients that consult non-contracted doctors (*Wahlärzt:innen),* who set their own fees*,* pay costs upfront and have part of it reimbursed by their health insurance. This generally covers 80% of what the insurance fund would have paid a contracted doctor. ***France*** follows a somewhat similar structure (see a detailed discussion on this arrangement in the French case study in Annex D).
- Only four countries, ***Germany***, ***Switzerland***, the ***Netherlands*** and the ***United States***, use *deductibles* for cost-sharing purposes in outpatient care. In Germany, this option is voluntary and enrollees in the SHI system can opt into this scheme in exchange for a lower contribution to their health insurance fund (*Wahltarif mit Selbstbeteiligung*), but only a very small number of SHI enrolees select these schemes.

Table 2.3. OECD countries with cost-sharing in outpatient medical care for public patients (under standard care arrangements)

Cost-sharing in primary care	Cost-sharing in specialist care	Cost-sharing for emergency department visits
Austria, Belgium, Colombia, Finland, France, Iceland, Ireland, Japan, Korea, Latvia, Luxembourg, New Zealand, Norway, Sweden, Switzerland, United States (Medicare)	Australia, Austria, Belgium, Colombia, Estonia, Finland, France, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, New Zealand, Netherlands, Norway, Sweden, Switzerland, Türkiye, United States (Medicare)	Belgium, Colombia, Czechia, Estonia, Finland, France, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Luxembourg, Netherlands, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, United States

Note: Assessment refers to public patients under standard care arrangements, excluding voluntary opt-in contracts (e.g., in Germany). Cost-sharing for emergency department visits generally applies only to patients who visited an emergency department upon self-presentation and who were not admitted for an inpatient stay. Cost-sharing is reported for public hospitals only. In some OECD countries, such as Australia, cost-sharing applies to private, but not to public hospitals. More information in Annex A to C.

Source: OECD Health System Characteristics Survey and authors' compilation.

Box 2.3. Co-payment or co-insurance? A closer look at terminologies

In all OECD countries, patients have to pay part of their healthcare expenses out-of-pocket. Out-of-pocket payments include both direct payments for healthcare goods and services which are not covered at all, as well as different types of cost-sharing or user charges for goods and services only partially covered by the main public financing schemes. The latter can be designed in four broad ways:

- **Co-payment**: A co-payment is a fixed amount, such as EUR 10 per day spent in a hospital or per GP consultation that a patient pays for a health good or service. In Sweden, for example, people pay around SEK 200 (EUR 18) for a standard consultation with a GP.
- **Co-insurance**: A co-insurance functions similar to a co-payment but is expressed as a percentage value of the fee or price. In Japan, for example, people pay up to 30% on their health visit, and the remainder is covered by their insurance.
- **Extra-billing**: Some countries allow physicians to perform extra-billing and to charge patients beyond what is reimbursed by their health insurance or national health system. This is not a fixed amount or percentage share, but depends on what patients are willing to pay, and which restrictions apply to physicians. In France, for example, several types of extra-billing co-exist.
- **Deductible**: A deductible is a fixed amount up to which patients pay for healthcare entirely at their own expenses over a defined period of time, such as one year. Above this threshold, health costs are either fully covered by the main financing scheme, or enrolees move to a different cost-sharing arrangement, such as a co-insurance. In Netherlands, for example, patients pay health services out-of-pocket up to EUR 385 if they opt for the lowest deductible

Cost-sharing differs by provider, healthcare setting and service

29. In several countries, co-payments and co-insurance rates differ by type of provider and setting healthcare is delivered in. In ***Norway***, co-payments differ by specialty. A regular consultation with a GP during office hours has a co-payment of NOK 179 (EUR 17), but of NOK 235 if performed by a GP specialising in general medicine. In ***Korea***, outpatient services can be delivered in different settings including hospitals. At 30%, the co-insurance rate is lowest in doctor's offices but increases to 50% for outpatient treatment in general hospitals (45% in rural hospitals), 40% in other types of hospitals (35% in rural areas), and to 60% in tertiary care hospitals.

30. Some services are frequently exempt from cost-sharing and co-payments and co-insurance rates often differ by type of service. Services exempt from cost-sharing typically include preventive services such as immunisation or screening as well as maternity care as seen in ***Italy***. In ***Luxembourg***, co-payments are lower for general care services, but higher for diagnostic procedures. In ***France***, the co-payment of EUR 2 for standard medical visits increases to EUR 32 for services that cost EUR 120 or more, such as certain diagnostics or surgical interventions, like a laparoscopic appendectomy.

31. There is also substantial difference in the design of deductibles. In ***Switzerland***, the minimum deductible (*Franchise*) amounts to CHF 300 (EUR 322), and enrolees contribute to costs beyond that with 10% cost-sharing, but only up to a ceiling of CHF 700. Around half of enrolees voluntarily opt for one of the five higher deductibles (*Wahlfranchisen*) of CHF 500 to CHF 2 500 against a lower premium, of up to CHF 1 540 (BAG, 2024[10]). The standard deductible in the ***Netherlands*** is set at EUR 385, but enrolees can choose higher deductibles up to EUR 885. While the number of people that choose a higher deductible represents a minority, its share has more than doubled since the introduction of deductibles in

2008 (Nederlandse Zorgautoriteit, 2025[11]). In the ***United States***, various insurance types co-exist. Medicare has different deductibles in place for each of the sectors. For Medicare Part B, which covers outpatient services, the deductible was set at USD 275 in 2025 with a co-insurance rate of 20% for all services exceeding the deductible.

32. Only few OECD countries combine various cost-sharing schemes in outpatient care. This is the case in the ***United States and Switzerland*** as seen in the complex discussion of deductibles but also in ***Austria*** and ***Colombia***, where co-payment and co-insurance exist alongside one another. In Colombia, enrolees in the *Régimen Subsidiado* of the SGSSS pay no cost-sharing at all, or a co-insurance of 10% depending on their income. Members of the *Régimen Contributivo* pay co-payments and a co-insurance that depends on income. In all cases, ceilings per service and per year are in place.

Cost-sharing models also exist in emergency care to steer patients

33. Slightly more than half of OECD countries have cost-sharing policies in place to redirect patients from emergency departments to other types of outpatient care to reduce overcrowding and long waiting times in emergency departments. Payments are charged for visits that do not translate into an inpatient stay and generally do not apply if they took place upon referral or ambulance transfer. ***Czechia*** and ***Portugal*** have abolished all types of cost-sharing in outpatient care except for emergency department visits without admission by ambulance or upon referral. In Czechia, this amounts to CZK 90 (EUR 3.70) and ranges from to EUR 14 to EUR 40 in Portugal depending on the type of department. ***Estonia*** and ***France*** operate with co-payments of EUR 20 and EUR 23, respectively, and in ***Korea***, patients are charged a co-insurance of 90% for visits that do not translate into an inpatient stay. In ***Australia*** and ***Ireland***, charges differ by hospital ownership. In Australia, patients do not pay any cost-sharing in public hospitals but can expect charges of around AUD 300-500 in private hospitals; in Ireland, public hospitals charge EUR 100, but private ones between EUR 250 and EUR 750.

Table 2.4. Selected cost-sharing design features in outpatient medical care

Service area	Type pf cost-sharing and amount	Differentiation by type of services	Differentiation by type of provider	Cost-sharing exemptions	Cost-sharing ceiling
• Primary care • Specialist care • ED visits	• Co-payment • Co-insurance • Extra-billing • Deductible • (combination of above)	• Same cost-sharing rules for all services in one area • Different cost-sharing rules for services in one area • Particular services exempt from cost-sharing	• Same cost-sharing rules for all providers providing the service • Different cost-sharing rules for all providers providing the service	• Identification of population groups exempted or with reduced cost-sharing (e.g. children, retired people, those with low income, chronic patient, pregnant women, others)	• Method to define ceiling • Define ceiling for each services area • Combine ceiling across all service areas

Source: Authors' assessment.

All countries offer reductions and exceptions to cost-sharing to specific population groups and overall ceilings are common

34. All 22 OECD countries with cost-sharing in outpatient medical care have reductions and exemptions in place to ensure access to urgent care for everyone in need and to avoid overburdening people of old age, people with low income and those with certain health conditions and (non-) communicable diseases. These exemptions do not only apply to cost-sharing for outpatient services but also to other health services and medical goods.

35. In those OECD countries that use co-insurance and co-payment schemes, some people benefit from lower cost-sharing or are entirely exempt from it. All OECD countries operating with these schemes in outpatient care offer exemptions and reductions based on specific medical conditions. This applies, for example, to pregnant women and most OECD countries with these schemes also exempt people with specific chronic conditions or communicable diseases from cost-sharing. In addition, almost three in four OECD countries also have reductions and exemptions in place based on age, but with some variation (See Table 2.5 and Annex C).

Table 2.5. Cost-sharing reductions and exemptions based on age, selected OECD countries

Country		Children / adolescents		Old age	
	Standard	Age (years)	Reduction	Age	Reduction
Iceland	ISK 500-3 700	<2 2-18	No cost-sharing 67% lower cost-ceiling	67 and above, or 60-66 receiving pensions	67% lower cost-ceiling
Japan	30%	<3	20%	70-74 75 and above	20% 10%-20% depending on income
Latvia	EUR 2	<18	No co-payment	65 and above	EUR 1
Luxembourg	12%	<18	No co-insurance	-	-
New Zealand	NZD 15-50	<14	Preventive care is free	-	-
Norway	NOK 64-425	<16	No co-payment	-	-
Sweden	SEK 200	<18-20	No co-payment	85 and above	No co-payment
The Netherlands	EUR 385-885	<18	Free of charge	-	-

Note: Sweden: Regional differences apply. Care is free of charge for people below age of 18 in Stockholm, Gotland, Jämtland Härjedalen, 19 years in Värmland, 20 years in all other regions.

36. Finally, all OECD countries with cost-sharing in outpatient medical care either exempt people of low income altogether, reduce their cost-sharing component or offer other forms of financial protection. For example, in ***Belgium***, the unemployed, single parents and the retired pay a lower cost-sharing amount. Similarly, in ***Estonia***, pensioners and unemployed people only make a quarter of the standard co-payment for specialist services (EUR 5 instead of EUR 20). In other OECD countries, people with low income can apply for an exemption of the standard cost-sharing arrangement. This is the case, for example, in ***Australia*** which has three schemes in place that offer reductions and exemptions to cost-sharing based on income and living situations. In ***Ireland***, people can apply for a Medical Card, and in ***New Zealand***, people below a certain income threshold can receive a Community Services Card.

37. In some OECD countries with deductibles, some services do not count towards the deductible. In the ***Netherlands***, for example, in addition to care provided by GPs, midwifery and obstetric care as well as district nursing care does not count towards the deductible. Moreover, people of low income are subject to the same deductible as people above an income threshold, but they qualify for government subsidies towards their premium.

38. 16 OECD countries have direct cost-sharing ceilings in place to limit households' financial cost-sharing burden. Beyond this ceiling, people are exempt from cost-sharing or move to a different cost-sharing arrangement. In the ***Netherlands***, ***Finland*** and ***Sweden***, for example, patients are exempt from cost-sharing beyond their deductible or co-payment ceiling. In these cases, the insurance fund (the Netherlands), the municipality (Finland) or the region (Sweden) covers the remaining healthcare expenditures. In other OECD countries, patients move towards a co-insurance beyond the cost-ceiling. This, for example, the case in ***Switzerland***, where patients pay costs between CHF 300 to CHF 2 500 at their own expenses (based on their chosen deductible) and have a co-insurance of 10% for the next CHF 700 before being exempt from cost-sharing for costs beyond this.

Cost-sharing rules are subject to frequent policy interventions

39. Changes to cost-sharing arrangements are relatively frequent in OECD countries. Compared to more fundamental health system changes like the introduction of a gatekeeping system, modifying user charges is a relatively simple administrative process. There can be different justifications for this. Increases in cost-sharing can be motivated by generating new funding sources when public budgets are tight or by incentivising patients to use resources more efficiently. Cost-sharing decreases are frequently explained by improving access to care and reducing the financial burden of households.

40. Several countries have increased the part borne by patients, either by increasing the amount that has to be paid, or raising the deductible, or by increasing the cost-ceiling up to which cost-sharing applies.

- ***Estonia*** passed a significant increase of its co-payments. From April 2025 onwards, co-payments for specialist visits and non-urgent emergency room visits have been increased from EUR 5 to EUR 20, with certain population groups being exempted from the increase (Estonian Parliament, 2025[12]).
- ***Switzerland*** is considering increasing its deductible, which has remained constant at CHF 300 for around two decades. An increase from CHF 300 to CHF 500 was estimated to generate savings of around CHF 1.16 billion for the health insurance fund *Helsana* (Felder, Meyer and Schmidheiny, 2024[13]). Previous attempts, such as the proposal of an increase from CHF 300 to CHF 350 in 2019, had been unsuccessful.

41. At the same time, several countries have removed cost-sharing policies.

- In September 2022, ***Chile*** abolished cost-sharing (*copago cero*) in its public health system (FONASA) for care provided by Public Health Networks to improve universal access to healthcare. Prior to that reform, only people receiving family allowance, and below a certain income threshold (tier A and B) were exempt from cost-sharing, which was then rolled out to the other groups (tier C and D) in 2022 (Government of Chile, n.d.[14]). People in the private health system (*Instituciones de Salud Previsional*, ISAPREs) pay a co-insurance which depends on the plan they choose. For a fixed list of 90 conditions (*Garantías Explícitas de Salu*d), the co-insurance is not allowed to exceed 20% of the basic price.
- ***Slovenia*** removed its co-insurance in 2024 as part of a fundamental overhaul of its healthcare financing system. Prior to that, patients paid a co-insurance of 20% for primary care visits and of 10-30% for specialist visits, with some population groups being exempted (Šarec and Jošar, 2025[15]).

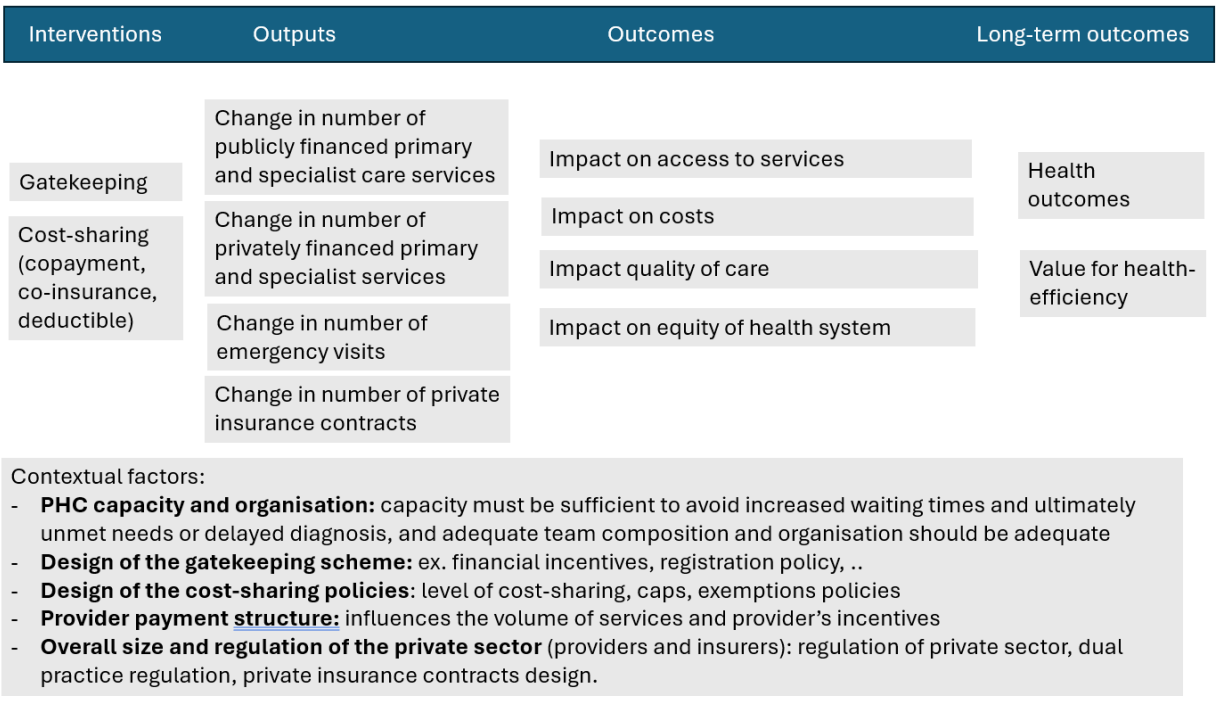
42. Other OECD countries have modulated cost-sharing arrangements.

- In 2021, ***Norway*** merged its two co-payment ceilings, the ceiling of NOK 2 460 for outpatient physicians and psychologists, hospital services and medicines, and the separate co-payment ceiling of NOK 2 176 for physiotherapy, dentistry rehabilitation and treatments in the university hospital of Oslo, to one joint scheme with a total co-payment ceiling of NOK 3 183. Estimates suggested that around 419 000 people would pay less under this policy, and around 1.03 million would see a cost-sharing increase (Helse- og omsorgsdepartementet, 2020[16]). In 2025, it increased the ceiling to NOK 3 278 (Helsedirektoratet, 2025[17]).
- ***Finland*** recently added services that count towards the cost-ceiling arrangement, indirectly translating into a reduction in cost-sharing. At the same time, co-payments, which are reviewed every two years and linked to the National Pension Index, were increased by 10% from 2023 and 2025.

3 Overview of the evidence

43. The majority of OECD countries has gatekeeping and cost-sharing in place to steer patient behaviour, but their design and how they are combined varies widely (see Chapter 2). This chapter summarises the evidence on the effect of gatekeeping and cost-sharing on utilisation, health expenditure and quality of care as well as highlighting some (undesirable) side-effects. It is based on a comprehensive literature review in OECD countries. Figure 3.1 illustrates the framework of analysis of this review. Table 3.1 and Table 3.2 summarises some key findings on the impact of gatekeeping and cost-sharing.

Figure 3.1. Framework of analysis guiding the literature review



Source: Authors compilation.

3.1 The effect of gatekeeping at a glance

Gatekeeping redirects care provision from specialists to general practitioners

44. Gatekeeping is associated with increased primary care visits in exchange for reductions in specialist consultations, hospital admissions and emergency department visits (Sripa et al., 2019[18]; Garrido, Zentner and Busse, 2010[19]), but the quality of evidence is limited. Looking into patient-behaviour of people aged 50 and above in 13 European countries, Biró (2013[20]) found that in systems where GPs

act as gatekeepers, the probability of using publicly funded outpatient specialist services was 8 percentage points lower, while the likelihood of accessing private specialist care increased by 4 percentage points – highlighting a possible important interaction between the public and private sector. The introduction of the voluntary gatekeeping system in ***France***, which offers financial incentives to patients to only consult specialists upon referral by a GP (*médecin-traitant*), led to a small reduction in specialist visits, arising from a reduction in self-referrals, consistent with the objectives of the policy. Visits fell both for specialties targeted by the policy and specialties for which self-referrals are still allowed. Additionally, the introduction of the policy reduced the tendency of patients to receive care from multiple GPs (Dumontet et al., 2017[21]). The reduction in specialist visits was particularly large for dermatologists and ear-nose-throat specialists (Le Fur, 2008[22]).

45. Nonetheless, the variation in results likely reflects both differences in study design and the broader contextual factors shaping healthcare use. For example, Garrido, Zentner and Busse (2010[19]) note that the general quality of evidence remains limited, with many studies failing to adequately control for patient characteristics. Moreover, the effectiveness of gatekeeping is likely to depend not only on formal institutional arrangements and financial incentives but also on cultural norms and established patient behaviours. A study from the ***United States*** (Ferris et al., 2001[23]) found that even after gatekeeping rules were abolished (within an HMO model), patients continued to use specialist care at similar levels—suggesting that habits and expectations may persist despite policy changes.

Table 3.1. Overview of the impact of gatekeeping on health system objectives based on the reviewed scientific literature

Outcome	Main effects	Main sources
Access to health services	• Gatekeeping is associated with increased primary care visits and with reductions in specialist consultations, hospital admissions, and emergency department visits.. • Waiting times for specialist visits appear to be longer in countries with gatekeeping but causal effect of gatekeeping unclear.	Biró, 2013 Forrest, 2003 Sripa et al, 2019
Costs	• Gatekeeping is shifting costs from specialist and inpatient care to primary care, and some studies suggest a small overall cost reduction with the introduction of gatekeeping. • Cross-country comparisons frequently fail to find significant differences in costs between gatekeeping and direct access systems.	Blöndal and Asgeirsdottir, 2019 Dourgnon and Naiditch, 2010 Sripa et al, 2019 Laux et al., 2025
Quality of care	• Gatekeeping is associated with slightly higher participation in preventive activity, but concerns exist in gatekeeping systems on timely access to quality care, in particular those that experience long waiting times and capacity constraints. • Gatekeeping can be associated with lower patient satisfaction compared to direct-access systems, but this is highly context-specific.	Greenfeld et al, 2016 Vedsted and Olesen, 2011 Sripa et al, 2019
Equity	• Gatekeeping can help moderate education-related inequalities in access to specialists.	Le Fur, 2008 Reibling and Wendt, 2009

Gatekeeping often reduces specialist demand but is not associated with shorter waiting times

46. Lower utilisation of specialist services in gatekeeping systems does not appear to be associated with reduce waiting times. An analysis from 2003 noted countries without gatekeeping averaged 8.4-day waits for specialists versus 23.2 days with it, suggesting gatekeeping responds to scarcity rather than resolving it (Forrest, 2003[24]). More recent data from the International Commonwealth Fund also suggests that in countries with mandatory gatekeeping, a higher share of patients wait more than 2 months for specialist consultations than in countries with direct access or voluntary gatekeeping schemes (Commonwealth Fund, 2023[25]).

Gatekeeping redirects spending to primary care, but has little effect on total spending

47. Two systematic reviews find that the introduction of gatekeeping is associated with a reduction in healthcare expenditures by providing similar care in a less costly setting with better continuity of care and reducing unnecessary specialist consultations in the majority of reviewed studies (Sripa et al., 2019[18]; Garrido, Zentner and Busse, 2010[19]), with limited savings in many cases but there are also examples where spending increases. Two studies from the ***United States*** suggest higher ambulatory care and outpatient spending in gatekeeping contexts (Escarce et al., 2001[26]; Kapur et al., 2000[27]). For example, when comparing total health expenditure in HMOs, Kapur et al (2000[27]) found between no differences to 7 percent higher expenditures in HMOs with gatekeeping arrangements conditional on different co-payment arrangements.

48. One explanation for the relatively modest cost savings (or the absence of any savings) shown in some studies is that in countries with free access to specialists, many patients already voluntarily follow a quasi-gatekeeping pathway by consulting a family doctor first (Dourgnon and Naiditch, 2010[28]).

49. While total spending is unlikely to decrease substantially, gatekeeping reforms can reallocate existing spending. Typically, they lead to an increase in primary care expenditure (through higher utilisation, capitation payments, or enrolment incentives) while reducing spending in other areas. The introduction of a voluntary gatekeeping system in ***Germany*** showed an increase in outpatient care spending and a reduction in spending on hospitals among those participating in the scheme, which resulted in a reduction of total spending (Hofmann and Mühlenweg, 2016[29]). This is confirmed by Laux et al. (2025[30]), who see a substantial increase in GP spending, while spending on outpatient specialists, hospitalisations, pharmaceuticals, medical goods and other care all drop – for patients in a voluntary GP scheme. In ***Switzerland***, costs of participants in a voluntary GP scheme in Aarau were around 15-19% per person lower three years after the introduction in 1997 (Schwenkglenks et al., 2005[30]). In all three cases, however, it is not clear whether specialists responded to the reduction in visits from those in the voluntary gatekeeping scheme by expanding volumes for other patients.

50. In some cases, specialists respond to reductions in volume with price increases and changes in the types of services offered and enjoyed income guarantees to get their political support of the policy reform. In ***France***, anticipated savings from the introduction of a preferred doctor-scheme failed to materialize as the remuneration adjustments the specialists won as a political concession have offset the financial savings expected from the scheme (Dourgnon and Naiditch, 2010[28]).

51. Historically, countries with gatekeeping arrangements were associated with lower total health spending. For example, in the ***United Kingdom***, gatekeeping was frequently credited with helping to maintain relatively low healthcare spending compared to other European countries (Forrest, 2003[24]). However, the author suggests that this not due to gatekeeping but the fact that gatekeeping has typically evolved in health systems with limited resources, and that supply-side controls play a more significant role in containing costs than demand management through primary care gatekeeping. Yet, a difference on an aggregate health spending level between gatekeeping and direct access countries was no longer found in a more recent analysis (Greenfield, 2016[31]). A recent study comparing total health spending between countries with gatekeeping and direct access fails to find significant cost differences betweeen the two systems after controlling for other variables when looking at data for 2002-11 (Blöndal and Ásgeirsdóttir, 2019[32]). This is similar to results from Delnoij et al.,(2000[29]) who found no significant differences in total health spending growth rates in the two sets of countries, while reduced spending growth in ambulatory care in gatekeeping countries.

Gatekeeping suggests slightly higher participation in preventive activity

52. Few studies investigate the effect of gatekeeping on quality of care, and they suggest a positive effect on the uptake of public health measures, such as vaccinations and cancer screening, and in some

instances improvements in co-ordination. In ***Germany***, people that enrolled in a voluntary gatekeeping programme had a 20% higher influenza vaccination rates among older patients, a 7% higher uptake in general health check-ups, and saw a reduction in avoidable hospitalizations by 17% (Hofmann and Mühlenweg, 2016[29]). Some evidence from the ***United States*** also points to improved screening rates: female patients enrolled in gatekeeping healthcare plans were significantly more likely to receive mammograms, clinical breast exams, and cervical cancer screenings (Sripa et al., 2019[18]).

53. It may also play a role in improving access and timely delivery of evidence-based care. In the ***United States***, one study found that patients with known coronary atherosclerotic heart disease were more likely to undergo cardiac catheterization (33% versus 19%) and received the procedure sooner under gatekeeping arrangements (Rask, 1999[33]).

54. On the other hand, there are concerns in gatekeeping systems around timely access to quality care, in particular those that experience long waiting times and capacity constraints. (Vedsted and Olesen, 2011[34]) found that cancer patients had better relative one-year survival rates in direct access systems compared to gatekeeping systems. Some studies also wonder about the diagnostic accuracy of gatekeepers. Looking at specific conditions, studies from the ***United Kingdom*** and ***United States*** found the that primary care physicians who act as gatekeepers only established accurate diagnoses in 44% and 34% of cases (Mitchell and Keenan, 2008[35]; Hartzell et al., 2013[36]). However, the studies did not include any analysis whether the diagnostic performance of non-gatekeeping GPs was better.

The effect of gatekeeping on patient experience is mixed, and findings are context-specific

55. In their systematic review, Sripa et al. (2019[18]) find that gatekeeping is generally associated with lower patient satisfaction compared to direct-access systems. Greenfeld, Foley and Majeed (2016[37]) argue that this reduced satisfaction can, in turn, contribute to poorer health outcomes and lower adherence to treatment. While Reibling and Wendt (2012[38]) suggest that most patients appreciate having a family physician as their initial contact and coordinator of care, they mention that the introduction of gatekeeping restrictions can cause dissatisfaction in countries with long-standing traditions of free choice of doctors.

56. Yet this negative image of gatekeeping as reducing patient satisfaction may need to be more nuanced. Evidence from some of the countries with direct access to specialist and free choice of doctors shows that the majority of people already have a regular family physician and accept using that physician as their first point of contact (Dourgnon and Naiditch, 2010[28]). For example, about 75% of ***Germans*** surveyed by Himmel, Dieterich and Kochen (2000[39]) were willing to adopt a gatekeeper model if it meant lower premiums and freedom to choose their GP. Similarly, ***Denmark*** offers citizens the option to choose annually between a free-choice model with higher insurance premiums and a gatekeeping system with lower premiums. In practice, fewer than 1% of Danes opt for the free-choice model, indicating broad acceptance of gatekeeping arrangements.

57. Overall, cross-national comparisons of patient–physician communication reveal little difference between gatekeeping and open-access systems in terms of consultation length, communication styles, and patient satisfaction (Kroneman, Maarse and Zee, 2006[40]; van den Brink-Muinen et al., 2003[41]). Moreover, results from the OECD Patient-Reported Indicator Surveys (PaRIS) illustrate that high levels of patient-reported experiences in primary care can be attained in both – gatekeeping and direct access systems (OECD, 2025[42]).

Some studies point to reduced inequality in healthcare access in gatekeeping systems

58. Evidence based on 11 European countries suggests that disparities in access to care are larger in countries that allow for direct access to specialists, compared to countries with gatekeeping models,

which show a smaller gap between educational groups in the use of specialist care (Reibling and Wendt, 2009[43]). This suggests that gatekeeping can help moderate such inequalities by limiting direct access to specialists for people with higher education who normally show considerably higher specialist care utilisation rates.

59. Other evidence, however, nuances these findings. In France, prior to introduction of the *médecin traitant* in 2004 individuals with higher socio-economic status were significantly more likely to see specialists directly. After the policy change, utilisation differences between occupational status and between those with university versus secondary education became statistically insignificant. This suggests that restricting direct specialist access had a greater effect on reducing overuse among more privileged populations. However, individuals with only primary education remained less likely to access specialists than their more educated peers, and income-based inequalities persisted (Le Fur, 2008[22]).

Overall, gatekeeping needs to be assessed within a broader PHC strategy

60. Gatekeeping is one component of a wider strategy to strengthen the role of primary health care (PHC) and there is ample of evidence of the positive impact of strong PHC systems on health system performance (OECD, 2020[2]). Indeed, previous OECD analyses have found that countries that combine care continuity, strong gatekeeping, and large financial incentives for quality of care are associated with lower rates of avoidable hospital admissions (OECD/The Health Foundation, 2025[44]). However, these analyses frequently do not isolate the independent effect of gatekeeping from other PHC characteristics or wider health system features that may also shape outcomes. When they are able to consider gatekeeping in isolation, its impact appears to be small.

61. This suggests that other PHC characteristics then gatekeeping, such as care continuity or care coordination may play an important role in explaining good PHC performance and outcomes. While gatekeeping can support continuity of care in some settings by establishing a single first-contact physician for patients (Freytag et al., 2016[45]; Olm et al., 2020[46]), recent cross-country evidence finds limited causal evidence that patient registration with a gatekeeper alone improves longitudinal continuity of care (Bates et al., 2025[47]). Moreover, some countries achieve high levels of continuity and coordination without mandatory gatekeeping arrangements. In OECD's Patient-Reported Indicator Surveys for patients with multiple chronic conditions, countries without mandatory gatekeeping systems — such as Canada, Czechia, and Switzerland — reported better patient experiences of care coordination than many countries with established gatekeeping systems (OECD, 2025[42]). This suggests that factors such as the length of the patient-GP relationship and the level of trust patients place in their GP may matter more for successful care coordination than the existence of gatekeeping arrangements alone.

GP supply affects the effectiveness of gatekeeping as well as referral rates

62. Gatekeeping systems imply a strong co-ordinating role of the GPs. Hence, to be effectively implemented in a country, this policy requires sufficient GP capacity as well as a balanced geographic distribution. However, these conditions are not always met. For instance, in ***France***, low GP density in certain areas has led to increased GP workload and uneven access to care, complicating the gatekeeping role of GPs and affecting care quality (Zaytseva, Verger and Ventelou, 2025[48]). As a consequence of this high workload, some physicians decline to register new patients (Davin-Casalena et al., 2024[49]), thus limiting the option of some French people to participate in voluntary gatekeeping.

63. High workload of GPs and GP density also have an impact on referral rates. Evidence from ***England*** points to the fact that high workload of GPs drives up referral rates to specialists to be able to better manage patients (Pilvar and Watt, 2024[50]). An increase in the number of GPs can reduce referral rates but this effect depends on existing GP density. In ***England***, an increase in the number of GPs in deprived areas that experience GP shortages reduced referral rates to specialists and elective

admissions to hospitals (Innocenti, McCormick and Nicodemo, 2025[51]). On the other hand, referral rates and elective admissions were higher in affluent areas with many GPs. Results are similar in ***Norway***, where referral rates were slightly higher in areas characterised by a higher level of GP competition (Godager, Iversen and Ma, 2015[52]).

Increase in capitation payment to GPs can lead to increase in referrals

64. The different modes how GPs are paid for can impact their referral behaviour and thus affect the effectiveness of the gatekeeping system. Payment schemes that are largely based on fee-for-service payments reward physicians for high levels of activity compared to payments based on capitation or salary (Jia et al., 2021[53]). In ***Norway***, for example, the number of consultations were 21% higher and the number of services provided per consultation were 4.5% higher among physicians that were paid on a fee-for-service basis compared to those working under fixed salaries (Brekke et al., 2020[54]). While capitation payments, which are generally based on the number of patients that register with a GP, motivate them to take on the role of the gatekeeper, they also incentivise GPs to increase referral rates to specialists. In fee-for-service systems, GPs have a financial motivation to retain patients rather than refer them, leading to fewer specialist referrals (Greenfield, Foley and Majeed, 2016[37]; Jia et al., 2021[53]; Liddy et al., 2014[55]). In ***Canada*** (Ontario), for example, a change in the payment from a blended fee-for-service to a blended capitation model for GPs increased referral rates to specialists by 5-7%, increasing total costs of specialist referrals by 7-9% (Sarma et al., 2018[56]).

Private health insurance can encourage bypassing the gatekeeping system

65. Bypassing GPs and accessing specialists directly in a private capacity is a risk in gatekeeping systems which can be exacerbated if private health insurers can cover these costs. Overall, the use of specialist care is higher among people that have voluntary health insurance, as seen in ***Italy***, (Brenna and Giammanco, 2024[57]). Moreover, evidence from ***Italy***, ***Spain*** and ***Sweden*** highlights that people with PHI made less use of the public system, suggesting a redirection of care consumption to the private sector but the effect in Sweden was rather small (Cantarero-Prieto, Pascual-Sáez and Gonzalez-Prieto, 2017[58]; Kullberg, Blomqvist and Winblad, 2021[59]; Brenna, 2025[60]).

66. In that context, an increase in the uptake of private health insurance in many OECD countries is noteworthy. Constraints in the performance of the public system, long waiting times, waiting lists and gaps in coverage are among the drivers behind this trend (Besley, Hall and Preston, 1999[61]; Jofre-Bonet, 2000[62]; Bíró and Hellowell, 2016[63]; Tynkkynen et al., 2018[64]). In ***Sweden***, private health insurance was perceived as an additional safety net and used to enjoy faster access to better perceived quality (Kullberg, Blomqvist and Winblad, 2025[65]).

67. In some countries, a spill-over effect from increased private health insurance uptake to referral rates in the public sector can be observed. In ***Norway***, 42% of GPs reported that they were frequently pressured by patients to refer them without medical indication, and 28% reported doing so (Breivold et al., 2024[66]). Similarly, in ***Denmark***, 46% GPs felt under pressured by patients with supplementary insurance to refer them and 11% did so without further inspection (Andersen et al., 2017[67]). In addition, GP consultations are driven up if patients require them to access services that are covered by their private health insurance. In ***Denmark,*** private health insurance covers prescription medicine, physiotherapy and elective surgery, but only upon prescription or referral from their GP, leading to a moderate increase in GP visits to obtain them (Kiil and Arendt, 2016[68]).

3.2 The effect of cost-sharing in the outpatient sector at a glance

68. The majority of OECD countries have cost-sharing arrangements in place in the outpatient sector, and pretty much all of them have experimented with modifications at some point over the past three decades. Countries have increased or lowered the part payable by households out-of-pocket as a whole, reduced it for certain population groups (or exempted them altogether), changed conditions under which cost-sharing applies or made alterations to healthcare utilisation in other sectors that spill over into the sector that is subject to cost-sharing. This section provides a comprehensive overview of the academic literature that has studied how cost-sharing for outpatient medical care affects healthcare utilisation, expenditures and outcomes across OECD countries (Table 3.2).

69. This review shows that reducing or removing cost-sharing increases healthcare use by 10-20%, while introducing or raising it has more variable effects. Low-income, younger, and healthier individuals are more likely to reduce utilisation, with stronger responses for non-urgent care than for urgent or chronic services. Moreover, most OECD studies outside the United States find no short-term deterioration in health outcomes from reduced use of outpatient services associated with introduction of cost-sharing, although long-term effects remain understudied. This may reflect the effectiveness of most OECD countries in ensuring access to essential outpatient care for those unable to afford co-payments and that public coverage for this type of care is much more comprehensive than for pharmaceuticals and other services.

Table 3.2. Overview of selected results of effects of changes in cost-sharing on utilisation and spending

Country	Change	Effect	Source
Introduction / increase			
Czechia	In 2008, Czechia implemented user fees for healthcare use. People aged 65 and above have a 50%-lower annual cap (USD 133) than the general adult population (USD 266)	Reduction in likelihood of having any PC visit and number of visits, no reduction in probability of any hospitalisation and LOS. Likelihood significantly lower among those 65+ and the less educated, but no clear difference by income	Kalousova (2014[69])
Finland	Introduction of a co-payment for outpatient nurse visits in 2014 (abolished in 2021, see below)	Nurse visit copayment reduced primary care nurse visits by 9–10%	Haaga et al. (2024[70])
France	Introduction of co-payment of 10% in 1994	No effect on GP and specialist office visits, but reduction in GP home visits	Chiappori et al. (1998[71])
Germany	Introduction of quarterly fee of EUR 10 in 2004 (abolished in 2012, see below)	Reduction in healthcare utilization by 4-10%	Farbmacher and Winder (2013[72])
	Removal of quarterly co-payment of EUR 10 in 2012	Abolition of co-payment led to short-term increase in ambulatory care and reduction in long term, and hospitalisations	Xu and Bitschi (2022[73])
Korea	People move from co-insurance of 30% to lower co-payment at age of 65	Health utilisation after co-payment exemption due to age increases among low-income patients only	Park and Choi (2020[74])
Netherlands	Increase in deductible from EUR 150 in 2008 to EUR 375 in 2015.	Increase in deductible by EUR 100 leads to reduction in healthcare spending by 6% per year	Klein et al. (2022[75])
Sweden (*Skåne*)	Expansion of co-payment to people aged 7 and below in June 1999, exemption of people aged 19 and below in 2001	Co-payment reduces doctor utilization by 5-10%	Nilsson and Paul (2018[76])
Decrease / abolishment			
Austria	Reduction in co-insurance from 20% to 10% in Austrian sickness fund in 2016	Reduction in co-payments by EUR 0.3-6. Overall increase in healthcare utilisation (+0.8%), differs by patients that are deferrable (+1%), comparatively costly (+1.4%), or both (+1.6%).	Berger et al. (2024[77])
Ireland	In Ireland, people are in Category I (free access except for EUR2.50 per prescription) vs. Category II: inpatient services free, all other services OOP).	Introducing user fees for healthcare results in a significant decrease in GP visiting, while the removal of user fees results in a proportionately smaller, but still significant increase in GP visiting	Ma and Nolan (2016[78])

	Since 2015, GP is free for all children aged 6 and below, and adults aged 70 and above		
Ireland	Abolishment of co-payment for children below age of 6 in 2015	ED utilisation did not reduce after free GP care was rolled out to all people under 6, increase in referrals from GP to ED (2 p.p. increase), higher rate of referrals in geographically dispersed areas	Walsh et al. (2019[79])
Japan	Reduction in co-payment from 30% to 10% for people aged 70 and above in 2014	Increase in healthcare utilization and spending without positive short-term effects on health outcomes	Fukushima et al. (2016[80])

Removing a co-payment increases utilisation, but introducing one generates mixed responses

70. The reduction in cost-sharing, or the exemption of population groups from co-payments, leads to an increase in healthcare utilisation by generally around 10-20%. For example, in ***Japan***, a reduction in co-insurance was found to lead to an increase in healthcare spending and utilisation among people aged 70, and 75 and above (Shigeoka, 2014[81]; Nishi et al., 2021[82]; Fukushima et al., 2016[80]). In ***Norway***, the exemption of co-payments for children aged 12-15 increased GP visits by around 19-22% for female, and 14-16% for male patients (Olsen and Melberg, 2018[83]; Landsem and Magnussen, 2018[84]).

71. The impact of an introduction of cost-sharing on healthcare utilisation is somewhat mixed to positive. For example:

- ***Finland*** had a co-payment of EUR 10 in place for visits with a primary care nurse from 2014 to 2021, which led to a reduction in these visits by 9-10% and some suggestion of a spill-over effect on a reduction in GP visits (Haaga et al., 2024[70]).
- ***Germany*** introduced a co-payment of EUR 10 per quarter in 2004 before retiring it in 2012. While studies that were using data by the German Socio-Economic Panel (SOEP) fail to find a significant effect (Schreyögg and Grabka, 2009[85]; Augurzky, Bauer and Schaffner, 2006[86]), studies that use claims data or disentangled SOEP survey waves identified a reduction in doctor visits by up to 10% (Winkelmann, 2004[87]; Farbmacher and Winter, 2013[72]).
- In the ***United States***, the introduction of cost-sharing led to a reduction in healthcare utilisation. These findings are consistent across the RAND Health Insurance Experiment, which ran from 1971 to 1986 and co-payment introductions for children and adolescents in Utah and Alabama, where healthcare utilisation of people with cost-sharing was lower than for those where healthcare was free of charge (RAND Health, 2006[88]; Sen et al., 2012[89]).

72. There is no consensus to date on the extent to which the amount of the cost-sharing impacts differences in utilization. In Sweden, small changes in the amount of co-payments did not significantly alter utilisation (Jakobsson and Svensson, 2016[90]). In Japan, the increase in healthcare utilization was more pronounced among those whose co-insurance decreased from 30% to 10% compared to those where it decreased from 30% to 20% (Nishi et al., 2021[82]) and in Austria, a relatively small change triggered a response in healthcare utilization (Berger, Six and Czypionka, 2024[77]).

Patients tend to reduce less urgent care, but not urgent care and visits for chronic diseases

73. Whether patients respond to changes in cost-sharing, and the extent to which they respond, differs by type of service. Overall, patients display little price-sensitivity to services that they consider necessary.

- In ***Belgium***, people were most price-sensitive for GP home visits, followed by GP office visits, and less so for specialist visits, but older people and those with disabilities did not display any price-sensitivity and would not respond to increase in cost-sharing (Van De Voorde, Van Doorslaer and Schokkaert, 2001[91]).

- In ***France***, the introduction of a co-payment of EUR 10 was found not to affect office visits of GPs and specialists, but to reduce home visits (Chiappori, Durand and Geoffard, 1998[71]).
- In ***Japan***, patients with chronic conditions and without complications reduced healthcare utilisation, but not those with complications (Babazono et al., 2005[92]). They responded most to cost-sharing for orthopaedic and ophthalmologist services, but this is not the case for services by internal medicine (Fukushima et al., 2016[80]).
- In the ***United States***, co-payments for emergency visits reduced the amount of non-urgent ED visits (Sabik and Gandhi, 2015[93]).
- Vice versa, in ***Austria***, the reduction of a co-insurance from 20% to 10% saw an increase in healthcare services that could be deferred or are comparatively costly but did not identify changes in utilisation for services that were inexpensive or urgent (Berger, Six and Czypionka, 2024[77]).

Patients that are healthy and of low income respond more than other groups

74. Patients respond differently by age, gender, health status, and socio-economic status. Overall, people that are young, healthy and of lower income respond more to changes in cost-sharing arrangements than people who are older, of poorer health, and of higher income. In ***Germany***, people who delayed or avoided visits were younger, healthier and of lower income (Rückert, Böcken and Mielck, 2008[94]). Effects were also larger among young adults of lower income in ***Sweden***, with women responding more strongly than men (Johansson, Jakobsson and Svensson, 2019[95]). In 1999, the region of *Skåne* lowered exemption age for co-payments from 20 to 7 years before increasing it back to 20 years in 2001. Visits declined by 5-10% during the period during which co-payments were charged and concentrated among those of low income (Nilsson and Paul, 2018[76]). In contrast to that, in ***Norway***, responses to a reduction in cost-sharing exemption from 12 to 16 years showed greater responses by men than by women. In addition, people of low-income and those with a chronic health condition reduce their utilization more than those of high income and without a chronic health condition with cost-sharing (Bensnes, Huitfeldt and Marone, 2026[96]). In the ***Netherlands***, an increase in the deductible did not lead to different responses by age, which likely resulted from older people being in worse health, and thus having greater health needs, than younger ones (Hofland, Gaspar and Boone, 2024[97]).

Negative spill-over effects of cost-sharing on visits in other sectors are limited

75. Negative effects of cost-sharing on care consumption in other sectors, such as emergency department visits and inpatient stays, which 'offset' reductions in outpatient care, are limited and concentrated on some programmes of select OECD countries, like Chile and the United States. In ***Chile***, an increase in the co-insurance for outpatient care among patients in in the private health insurance ISAPREs was found to decrease outpatient visits in exchange for increases in hospitalisations for ambulatory-care sensitive conditions, for which cost-sharing is lower (Arrieta and García-Prado, 2015[98]). In the ***United States***, findings are mixed. Cost-sharing in the RAND experiment did not result in increases in care consumption in other sectors. Instead, care utilisation declined across the board without leading to an increase in hospitalisations (Manning et al., 1987[99]). Similarly, the introduction of cost-sharing for low-income enrolees in the Massachusetts Commonwealth Care programme did not result in increases in inpatient care (Chandra, Gruber and McKnight, 2014[100]). In contrast to that, in California, Medicare users were subjected to co-payments for physician visits and prescription drugs, leading to a modest decline in both, which was offset by an increase in hospitalisations. Effects were largely concentrated among those with chronic diseases (Chandra, Gruber and McKnight, 2010[101]).

Changes in healthcare utilisation have little effect on healthcare outcomes in the short run

76. There is little evidence that suggests an improvement in health outcomes following an increase in healthcare utilisation after a reduction or removal of cost-sharing in outpatient care. Those that respond more to cost-sharing tend to be of better health and respond in non-urgent care. Hence, there are only small marginal health gains from an increase of non-urgent services by people in somewhat good health.

- In ***Japan***, people enjoy a reduction in co-insurance after turning 70. This was found to lead to an increase in spending of USD 34 per month per person. Increases in utilisation were largely driven by healthier patients but insignificant for sicker patients, who already had higher consumption rates under higher cost-sharing rates. There was no effect of more spending on health on short-term health outcomes of blood pressure, cholesterol and blood sugar levels (Fukushima et al., 2016[80]), or on mortality, self-reported and mental health (Shigeoka, 2014[81]). An increase of free healthcare to children, which increased outpatient care consumption, increasing outpatient spending by 22-31%, but did not lead to reduced hospitalisations including avoidable hospitalisations. It also did not improve health outcomes in the short- to medium term but increased inappropriate use of antibiotics and after-hours care (Iizuka and Shigeoka, 2022[102]).
- ***Czechia*** introduced co-payments of around EUR 1.30 (CZK 30) in 2008. This implementation was associated with a reduction in primary care visits but did not lead to an increase in the probability of a hospitalisation and its length of stay (Kalousova, 2014[69]).
- In ***Sweden***, co-payments were eliminated for people aged 85 and above in 2018, leading to a delay of non-urgent visits around 2-3% visits in primary care by up to four months among those that were approaching the age threshold. The delay did not affect all-cause hospital admissions, emergency visits and mortality in the two regions Stockholm and Västra Götaland, did not impact admissions for ambulatory care-sensitive conditions, and the slight increase in ambulatory care-sensitive conditions in the region of Stockholm is difficult to attribute (Johansson et al., 2023[103]).
- An increase in co-payments for emergency departments in 2000 among people insured with commercial insurers and Medicare in the ***United States*** (California), which was found to reduce visits of emergency department visits and hospitalisations by around 4-23% depending on the amount of the co-payment and the insurance scheme without any negative consequences on adverse events (Hsu et al., 2006[104]).

77. Evidence on negative health effects from lower healthcare utilisation due to the introduction or increase in cost-sharing for outpatient medical care in OECD countries are limited and if so, are largely exclusive to the ***United States*** and few other countries.

- In the ***United States***, an increase in co-payments in primary and outpatient specialist care for older people in Medicare was associated with a reduction in health care utilisation but an increase in inpatient stays as well as length of stay and the effect was particularly pronounced among those with lower-income and in poorer health (Trivedi, Moloo and Mor, 2010[105]).
- In ***Colombia***, around half of the population is part of the 'contributory regime' and subject to a co-insurance rate of 11.5%, 17.3% and 23% with maximum thresholds based on income, and people can move from one rate to another on a monthly basis. People reduced their healthcare consumption across different services, including prevention, but price sensitivity was small (Serna, 2021[106]). Reductions in outpatient care were associated with increases in inpatient stays and an increase in mortality by 4 death per 10 000 people over a course of 8 years among those with high cost-sharing (Buitrago et al., 2023[107]). That said, long-term studies on the impact of cost-sharing increases on health outcomes are rare.

Patients are more incentivised by possible losses than gains

78. Countries have changed the way they design co-payments. The ***Netherlands*** moved from a no-claim refund to a deductible. Prior to 2008, patients received a refund of up to EUR 255 for low healthcare consumption at the end of the year. In 2008, the country moved to a deductible, initially set at EUR 150 that increased to EUR 375 in 2015, with possible higher voluntary deductibles. Patients responded more strongly if the cost-sharing was phrased as a loss (Remmerswaal et al., 2019[108]): The yearly spending was 8.6 percent lower with a deductible than with a no-claim refund (Hayen, Klein and Salm, 2021[109]). ***Korea*** undertook a similar change in 2007, moving from a co-payment to a co-insurance scheme. Until August 2007, people co-paid KRW 3 000 per visit until a threshold of KRW 15 000, and 30% for costs above this threshold. Following the change, people had to pay 30% irrespective of their total annual costs. This change led to a reduction in the health care utilisation and total public spending per patient (Bae, Choi and Song, 2017[110]).

Cost-sharing can successfully steer patients towards GP care

79. Some countries are strategically and successfully using cost-sharing to direct patients away from emergency departments, and from outpatient specialist care to General Practitioners. ***France*** offers financial incentives to patients who consult their GP first, which resulted in a reduction in specialist visits and self-referrals and a modest decline in 'doctor shopping' (Dumontet et al., 2017[21]). ***Korea*** introduced a 'mild disease co-insurance' for 52 disease groups for people aged 65 and above in 2011. In 2011, co-insurance was increased from 30% to 40-50% if people went to a secondary or tertiary provider but remained at 30% if they went to a primary care provider, which are providing outpatient care. Subsequently, the share of people that went to secondary or tertiary care providers declined by 3 percentage points and was particularly large among frequent users. Responses were greater among those of higher income, compared to people with lower income (Jo, Jun and Park, 2021[111]). Prior to that, the introduction of an outpatient co-payment scheme for people of low income in 2007 had led to bypassing of the outpatient in favour of the inpatient sector, which could easily be accessed without referral. The policy led to a reduction of outpatient visits and outpatient spending in exchange for an increase in inpatient stays and inpatient spending, driving up costs in total (Yoo et al., 2016[112]).

Private health insurance can counteract the intention of cost-sharing

80. Supplementary private insurance, which covers cost-sharing expenses, can drive up healthcare utilization and spending. ***Korea*** moved from a co-payment to a co-insurance scheme in 2007, which signified an increase in cost-sharing, and motivated people to opt for supplementary health insurance to cover these costs. As a result, cost-sharing for minor conditions was lower than prior to the reform, outpatient visits increased sharply and the increase in visits might have driven up public spending, as well (Kim, 2023[113]; Ko, 2020[114]). Korea responded to this by introducing minimum cost-sharing in 2009 (Choi et al., 2015[115]). In ***France***, supplementary health insurance makes people less sensitive to extra-billing (Dormont and Péron, 2016[116]).

OECD countries foresee cost-sharing exemptions to protecting people against the financial hardship of healthcare costs

81. The results presented in this section are based on comprehensive literature research on the impact of modifications in cost-sharing arrangement for *outpatient medical services in OECD countries* on service utilisation and health outcomes. One of the findings points to an only limited impact on health outcomes in the *short-term* (with analyses on long-term care consequences largely missing). This finding deviates from the evidence of cost-sharing for pharmaceuticals on treatment adherence, care consumption, and health outcomes, which identifies a negative effect of cost-sharing on these outcomes

(Guindon et al., 2022[117]). In addition, cost-sharing for pharmaceuticals represents the largest share of total cost-sharing expenditure per person and can thus have larger consequences for people of low income (Thomson et al., 2024[118]). In contrast to that, cost-sharing for outpatient medical care is rather modest. Moreover, the review presented here was limited to *cost-sharing* defined as a financial contribution to services that are covered in the public system (as defined in Chapter 2), but excluded the effect of changes in the benefit package (which may require people to fully cover services previously covered) as well as the effect of informal payments on the various outcomes of interest to this report, all of which can affect levels of unmet need and catastrophic spending.

82. This literature review was limited to OECD countries, which appear to be mostly effective in making sure that people receive healthcare when they need it. This is not necessarily the case in countries where access to Universal Health Care is still expanding, so the findings may not be directly transferable and should thus be treated with caution (Lagarde and Palmer, 2011[119]; Cohen and Dupas, 2010[120]).

83. The review did not look into the effect of cost-sharing in the outpatient sector on the incidence of catastrophic health spending, which can be a concern. Latest data suggests that across 40 European countries, around 6% of household face catastrophically high healthcare costs, ranging from 0.5% in the Netherlands to 20.3% in Armenia as a result of high user charges or limited publicly financed benefit packages, and this is typically concentrated in the poorest population group (Thomson et al., 2024[118]). However, this is mainly due to high spending for pharmaceuticals and incidence rates among OECD countries are generally lower. Moreover, patients reporting unmet need for medical care can be issue if cost-sharing is too high. Across the OECD, the share of people reporting unmet need for medical care stood at 3.1% with waiting times rather than costs being the reason for unmet need (OECD, 2025[121]).

84. That said, ensuring that everyone has access to healthcare when they need it is a key element of UHC. Hence, as seen in Chapter 2, OECD countries foresee exemptions to co-payment regimes for people who cannot afford it, chronic patients who are heavy users of the system, and selected services, such as preventative services to avoid negative implications on health.

4 How are gatekeeping and cost-sharing policies applied in practice?

85. OECD countries differ in the extent to which they use the two demand-focused policy options discussed in Chapter 2. Moreover, the actual implementation and the design of gatekeeping and cost-sharing policies vary a lot. This section compares the approaches taken in six OECD countries (Denmark, France, Germany, the Netherlands, Norway and Poland). It ranges from Germany, where people do not face any restrictions in choice and are not subject to any cost-sharing in outpatient medical care -unless they voluntarily opt into these schemes, to Norway, where almost the entire population is registered with a GP, who acts as a gatekeeper, and where people contribute to the healthcare system with co-payments. The full case studies are available in the Support Material to this report.

86. The countries selected in this comparison represent the full variety of OECD health systems. Two of the six countries (Denmark and Norway) operate a tax-financed National Health Service while the remaining four countries mainly rely on the Statutory Health Insurance to ensure access to healthcare to the population. Among them, France and Poland have a single (or predominant) health insurance fund in place. In Germany and the Netherlands, people can choose between a range of insurers, with higher levels of competition in the Netherlands than in Germany. Table 4.1 displays some relevant data related to GP and specialist care in the context of gatekeeping and Table 4.2 compares important implementation features related to gatekeeping and cost-sharing policies across the six countries.

Table 4.1. Key data related to GP and specialist care in the six case study countries

	Denmark	France	Germany	Netherlands	Norway	Poland
Number of physicians per 1 000 inhabitants	4.5	3.9	4.7	3.9	5.0	3.9
Of them, GPs (%)	15%	25%	16%	24%	18%	8%**
Average no. of patients per GP	1 715	1 621 (1 033 registered in MT scheme)	1 264	2 137	947	Limit of 2 500 patients per GP under NFZ contracts
In-person doctor consultations per patient per year	5.0*	5.4	9.7* (15.1)	10.1	3.1*	7.7
Average no. of GP visits per patient	5.0	5.4	3.0 (6.25)	5.3	3.1	4.7
Share of population who had a GP contact	85%	80%	80%	78.6%	79%	~75%
Share of people who got same day/next day appointment with doctor or nurse when needed	n.a.	33%	45%	47%	n.a.	n.a.

Share of people who waited less than 1 month for visit to specialist	n.a.	35%	54%	62%	n.a.	n.a

Note: *Likely underestimation. MT=médecin traitant. Consultation rates for Denmark excludes visits in outpatient departments in hospitals. Consultation rates in Norway are based on the billing of general consultations. This might lead to an underestimation. In Germany, consultation rates are based on the quarterly flat-fee and are likely underestimated. Consultation rates in brackets report estimates based on patient days billed. ** The share rises to 27% when all physicians working in PHC in Poland are taken into account, including specialists in internal medicine, paediatrics, or physicians without a specialty.
Sources: OECD (2025[121]), Commonwealth Fund 2023 International Policy Survey; Denmark: Praktiserende lægers organisation (2025[122]), Germany: Bifg (2025[123]), France: https://data.ameli.fr/pages/acces-aux-soins/; Norway: Statistik sentralbryå; The Netherlands: https://english.rekenkamer.nl/site/binaries/site-content/collections/documents/2025/04/02/focus-on-shortage-of-general-practitioners/Focus+on+shortage+of+general+practitioners.pdf; https://www.nivel.nl/nl/zorg-en-ziekte-in-cijfers/cijfers-zorgverleners-eerste-lijn/cijfers-zorg-die-huisarts-verleent..

Primary care is largely provided by self-employed GPs in group practices but countries differ in the number of patients per GP

87. The organisation of primary care differs across six countries but there are some communalities. In all countries, the majority of GPs is self-employed and work in group practices with other physicians and/or health workers. Yet there is a recent trend among GPs to move away from self-employment. In Denmark, Germany and Norway, around one in eight GPs work as employed GPs and earn less than their self-employed colleagues, but enjoy fewer working hours, can more easily work part-time, and have less financial risk, reflecting preferences of young doctors for a better work-life-balance over higher earnings.

88. The average number of patients per GP ranges from slightly less than 1 000 in Norway to more than 2 100 in the Netherlands. ***Denmark*** and ***Norway*** operate list-based systems. In Denmark, GPs are contracted by their region and are allowed to close their list size once it reaches 1 600 patients and have to re-open them when they drop below 1 550 patients and a closure is enforced once it reaches 2 700 patients. In Norway, GPs are contracted by the municipality and enlist between 500 and 1 500 patients but lists cannot exceed 2 500. ***Germany*** does not operate with list sizes but limits the number of GPs in areas with high GP densities. GPs who want to bill the SHI require a licence to practice from the Regional Association of SHI Physicians (*Kassenärztliche Bundesvereinigung*), which does not grant new licenses in areas where the ratio of inhabitants to GPs drops below around 1 500. In ***France***, GPs are free to practice where they want, but in practice, enlist around 1 200 patients into their *médecin traitant*-scheme. In the ***Netherlands***, GP practices decide themselves how many patients they enroll. In 2021, the average number of patients per GP was 2 137 patients, with almost one third of all practice-owning GPs having more than 2 500 patients registered due to GP shortages. In ***Poland***, facilities face capacity limits of 2 500 patients per GP under public insurance (NFZ) contracts, beyond which new declarations may be refused to ensure service quality. Purely private (non-NFZ-contracted) facilities do not participate in this registration system.

Countries follow different approaches regarding GP registration...

89. The way patients access outpatient care and the role of GPs differ widely across countries. In all six countries, patients can either voluntarily opt into a gatekeeping scheme (Germany), are financially incentivised to follow a gatekeeping pathway (France) or are required to participate in a gatekeeping system to have parts or all of their costs covered by the public payers (Denmark, Netherlands, Norway, Poland). In ***Germany***, patients are free to choose any GP they want and can decide to change their GP whenever they like, depending on availability. All SHI funds, however, are required to offer “GP-centred care” models where patients register with a GP in exchange for monetary and non-monetary incentives. An estimated one-eighth of the population participate in this care model. They can end this arrangement and move to “standard care” after a minimum of one year and cancel their participation every three

months. ***France*** operates with financial incentives to steer patients through the GP. Patients can access any GP and specialist at any point in time but benefit from reduced co-payments when choosing a designated "*médecin traitant"* and accessing specialists after referral only. Slightly more than 90% of the population are registered with such a 'preferred doctor', and they can switch to another *médecin traitant* at any time. In the ***Netherlands***, specialist care is only available upon referral from a GP but registration with a GP is not legally required. However, in practice, patients may encounter severe difficulties to schedule an appointment if they are not registered with a GP, making registration de facto mandatory.

90. In the other three OECD countries, registration with a GP is required to access the publicly financed health system. ***Denmark*** and ***Norway*** operate a list system, and patients can sign up with any GP who accepts new patients within their region, or municipality, respectively, through an online platform. They are then 'enlisted' with their GP, who becomes their first point of contact, co-ordinates their care pathway, and refers them to a specialist whenever needed. In ***Poland***, patients are required to register for primary health care by selecting a specific GP within an NFZ-contracted facility, as mandated by NFZ regulations for free access to care. This formal registration applies exclusively to NFZ-contracted public and private providers, with patients able to change their choice up to twice yearly without justification.

...and how patients are referred to specialist care

91. There is a close connection between the requirement of patients to register with a GP and whether they can freely access publicly funded specialist care.

- In ***Denmark, Norway*** and ***Poland***, where GP registration is required, a referral is needed to access most specialists under the public system. There is one exception in Denmark, where people can choose "group 2"-coverage with direct access to specialists in exchange for some cost-sharing but only around 1% of the population opt into this. However, in all three countries, bypassing the referral system is possible if patients choose specialist care outside of the public sector. However, costs for this need to be covered by patients themselves.
- The situation is different in ***France*** and ***Germany***. In both countries, the free choice of doctors extends into specialist care and most specialist can be visited without referral (with some exceptions). However, by opting into the *médecin traitant*-scheme, French patients have a strong financial incentive to only visit a specialist with a referral as it drastically reduces their cost-sharing part. In Germany, patients that choose to opt in the "GP-centred" care model forgo their right to access specialist care without referral but in exchange can enjoy exemptions from co-payments for pharmaceuticals and additional time slots for doctor appointments.
- In the ***Netherlands***, hospital and all outpatient specialist care (except emergency care and optometrists for minor eye issues) require referral from a GP. If patients go to a specialist without referral, they have to pay the full cost of the visit, as there is no reimbursement by the health insurance. Outpatient specialist doctors in the Netherlands almost never accept patients bypassing GP referral, even at insurance-equivalent rates, due to contractual obligations with health insurers. Additionally, GP care is free of charge in the Netherlands (GP consultation do not count in the mandatory deductible), creating a strong incentive for patients to visit their GP first.

92. Due to the different roles that GPs play in the various health systems, the volumes of activity in GP practices and specialist care differs across countries, although comparability of existing OECD data is limited (Table 4.1). Reported overall doctor consultations are highest in Germany and the Netherlands with around 10 patient contacts per year (but for Germany this figure is underestimated). When only considering GP visits, in most countries, patients contact them around five times per year but less often in Norway.

Table 4.2. Gatekeeping and cost-sharing policy features in the six case study countries

	Denmark	France	Germany	Netherlands	Norway	Poland
System feature	NHS system	SHI system	SHI system	SHI system	NHS system	SHI system
Gatekeeping	Mandatory	Voluntary	Voluntary	Mandatory	Mandatory	Mandatory
Patient registration	Required	Voluntary	Voluntary	Near universal	Required	Required
Bypassing of gate-keeping possible by choosing private care?	Yes	Not applicable in standard care (free choice)	Not applicable in standard care (free choice)	Unlikely	Yes	Yes
Payment scheme for GPs	~30% CAP, rest FFS.	~15-30% CAP, rest FFS.	~25% CAP, rest FFS.	~75% CAP and FFS, rest is bundled payment and PFP	~35% CAP, rest FFS.	Primarily CAP and FFS
Cost-sharing GP	No	Yes	No	No	Yes	No
Cost-sharing specialists	No	Yes	No	Yes	Yes	No

Note: CAP= capitation; FFS = fee-for-service; PFP = Pay-for-performance.
Source: Case studies and authors' assessment.

Shortages of GPs in rural areas pose challenges to gatekeeping systems

93. The number of doctors and the proportion of GPs within the medical workforce differs across the countries investigated (Table 4.1). The physician density ranges between 3.9 doctors per 1 000 inhabitants in Poland and the Netherlands to 5 in Norway. The share of GPs among all doctors is highest in France (25%) and lowest in Poland (8%).[3] Yet, all countries face difficulties recruiting and retaining GPs and specialists in rural and remote areas, which poses a serious challenge to gatekeeping systems. In ***France***, around half of GPs, who are predominantly located in rural areas, are not accepting any new patients as *médecin traitant*, thus making it de-facto impossible for inhabitants in some rural areas to adhere to the GP pathway. In ***Norway***, an estimated 100 000 people are not registered with a GP, and in ***Denmark***, around 280 000 patients are without a permanent GP. At the same time, GPs in rural areas often have higher workloads, making it unattractive for new GPs to practice in these areas. Denmark and Norway have longer list sizes and more GPs have closed their lists in rural areas than in urban ones. In ***Poland***, acute shortages of GPs seriously undermine their gatekeeping capacity, leading to high referral rates and bypassing through private care. In the ***Netherlands***, 59% of the practices surveyed in 2024 said they had stopped accepting new patients in the past year.

Bypassing of gatekeeping pathway is common in some countries facilitated by widespread dual practice of specialists which can potentially undermine gatekeeping

94. Bypassing the gatekeeping treatment pathway can be an issue if private markets exist and if specialists are allowed to engage in dual practice and see public patients also in a private capacity. Bypassing is relatively common in ***Poland***, primarily due to public-sector bottlenecks as results of a comparably low capacity and limited funding, as well as a wide availability of private alternatives. Long waiting times for specialists for public sector treatment leads patients to bypass the gatekeeper and pay out-of-pocket for quicker private access, as dual practice regulation allows doctors to devote a good amount of their time to private patients. But even in countries where gatekeeping is well enforced, persistent public-sector pressures like shortages and delays can still spur private models and bypassing. Despite its robust tax-funded system with strong GP gatekeeping, a shortage in GPs and unmet waiting time guarantees have fuelled the rise of private networks in ***Denmark***, offering quick out-of-pocket

[3] However, the share in Poland stands at 27% when all physicians working in PHC are Poland included (including specialists in internal medicine, paediatrics, and physicians without a specialty).

consultations at 750 DKK (around EUR 100). Proposals to curb dual practice by banning GPs from private payments on covered services and requiring public referrals for specialists reflect backlash against "queue-skipping," yet these models persist to meet patient demand for timely treatment. In ***Norway***, bypassing gatekeeping pathway appears to be more of an urban phenomenon as private alternatives are not widespread in rural areas. Bypassing is less of an issue in the ***Netherlands***, where provider insurance contracts and employment terms in hospitals make dual practice generally unattractive for specialists. In ***France*** and ***Germany***, the fact that specialist can see patients that participate in gatekeeping voluntarily as well as those that exercise their right to access them directly is ingrained in the health system.

Private health insurance markets can impact bypassing behaviour

95. In the context of bypassing, the role of private health insurance (PHI) also needs to be considered -in particular whether duplicate insurance is available to cover the private costs for alternative treatments in parallel to the gatekeeping pathway. In many countries, the share of people with private insurance coverage has increased in recent years, also responding to patients' preferences for faster treatment outside of the public sector. In ***Denmark*** and ***Norway***, for example, rates of people enrolled in PHI have increased at a steep rate over the past decade. Complementary PHI in ***France*** upholds financial incentives of the gatekeeping scheme, but allows for increasing extra-billing of specialists, who compensate for reductions in specialist visits through extra-billing and efforts to reign it in have been of limited success.

Payment methods for GP care are roughly aligned in the six countries

96. The mode in which doctors are paid for the services they provide can incentivise specific behaviour and has the potential to reinforce or undermine any incentives targeted at patients to choose the best treatment pathways. Across all six countries, GPs are predominantly paid for fee-for-service, but some countries are slowly expanding the capitation part.[4] In ***Denmark*** and ***Norway***, capitation represents around 35% of the total GP income. ***France*** just reformed capitation payments as well, which now amounts to 25-35% in total. The increase in capitation payments aims at improving continuity of care and at reducing the incentive for unnecessary appointments but has raised concerns that it might lead to a reduction in GP activity and increases in referrals. In all countries, registering patients triggers capitation payments. In Denmark and Norway, doctors receive a capitation payment that is adjusted by patient characteristics per patient on their list. In France and Germany, physicians who offer care within the GP-centred care scheme receive flat-rate payments per patient enlisted with them in this scheme.

Only three countries actively apply cost-sharing in outpatient medical care

97. In addition to steering patients through the health system via patient registration and gatekeeping policies, countries can also incentivise patients to elect particular care pathways with their cost-sharing policies for services included in the publicly financed benefit package, and the benefit package at large.

98. In ***Poland***, all services provided by GPs, specialists and emergency care are fully covered by the statutory health insurance fund(s). In ***Germany*** and ***Denmark***, people covered by the public system do not have any cost-sharing for outpatient medical care but can opt into voluntary cost-sharing systems. Yet, these options are not overly popular. In Germany, patients covered by the SHI have the possibility to sign up to various voluntary cost-sharing schemes (deductibles) in exchange for financial incentives. However, very few people use this option, and the purpose of this instrument is rather to keep younger

[4] In a fee-for-service payment model, doctors receive a payment for each medical act performed according to a defined fee schedule. In a capitation payment model, doctors receive a fixed amount per month/quarter/year per registered patient.

and healthier population groups within the Social Health Insurance System than to incentivise public patients to make more efficient care-seeking decisions. In ***Denmark***, only around 10 000 people have opted into 'Group 2' and enjoy free choice against a small co-payment, for example around DKK 100 (EUR 13.40) for a simple consultation.

99. On the other hand, cost-sharing in outpatient medical care is commonplace in ***Norway*** and ***France***. In Norway, it exists for both GP and specialist care and varies by type of service -with children being exempted. For example, co-payments for a standard GP consultation stand at NOK 179 (EUR 16) and for a specialist visit at NOK 443 (EUR 39.50), with an overall ceiling of NOK 3 278 (EUR 292) in 2026. In France, the amount patients pay depends on (i) whether or not the patient adheres to the gatekeeping pathway, (ii) whether the physician has opted into an extra-billing contract or not, and (iii) which PHI package the patient has chosen. Patients always pay a co-payment of EUR 2 for a GP consultation. If they adhere to the gatekeeping pathway, the SHI covers 70% of the treatment cost and the PHI the remainder. For those who do not, the SHI covers only 30% and the PHI is not allowed to cover the rest under the *contract résponsable*-scheme. For specialist care, extra-billing is common, especially in urban areas. Here, the share patients have to pay depends on the PHI contract they have chosen. The ***Netherlands*** use deductibles before public cost-coverage sets in. In 2026, the standard deductible stood at EUR 385 – referring to health care costs to be paid by the patients themselves before health insurance coverage covers the costs. This deductible can be increased by patients themselves in exchange for lower monthly premium payments. Importantly, while some services including GP visits and maternity are excluded from the deductible (and thus fully covered) this is not the case for outpatient specialist visits and emergency visits to the hospital.

Experiences with gatekeeping and cost-sharing depend on the country-specific context

100. Denmark, Norway, Poland and the Netherlands have successfully rolled out mandatory gatekeeping systems. In ***Denmark***, ***Norway*** and the ***Netherlands*** registration and gatekeeping is either required or near universal, and GPs cover a wide range of services and are well-accepted care co-ordinators with overall trust in the system being high. ***Poland*** also operates a well-established, formal gatekeeping system within the centralised National Health Fund framework, but its effectiveness in practice is limited due to capacity constraints with long waiting times, leading to frequent bypassing of patients via the private system. ***France*** and ***Germany*** offer gatekeeping as a voluntary opt-in, but the scheme is much more popular in France than in Germany. In Germany, incentives are limited for patients and GPs. GPs receive some form of capitation payment per patient already (under standard care) and are confronted with a myriad of different contracting schemes, where payments, contracting obligations and interactions with other care programmes can differ across the roughly 100 SHI funds and regions. In contrast, French patients pay a lower co-insurance for every consultation and GPs receive an additional capitation payment per patient who signed up with them, resulting in more than 90% of patients having signed up with this scheme.

101. However, all six countries are facing challenges with increasing capacity constraints for both GPs and specialists which can seriously impact access to doctors and the effectiveness of a gatekeeping system, in particular in rural and socially disadvantaged areas. Resulting long waiting in the public sector and increasing availability of alternative private pathways are additional risks that can undermine this arrangement. Countries are trying to address these challenges, for example, by making the position of GP more attractive and reducing their workload through the delegation of tasks to nurses.

102. Cost-sharing in outpatient medical care is commonplace in ***France***, ***Norway*** and the ***Netherlands*** to generate additional revenue and to reduce unnecessary visits. In France, it is used strategically to incentivise patients to adhere to the gatekeeping system, which has contributed to high opt-in rates into this scheme. ***Germany*** envisioned using financial incentives to increase the uptake of its voluntary GP-scheme, by exempting patients from a co-payment of EUR 10 per quarter, but the co-

payment scheme was retired before the exemption could take effect. In the Netherlands, GP care does not count into the deductible, offering an incentive to seek care from GPs where possible. Norway has slightly lower cost-sharing for some services, or completely forgoes it for, e.g., digital services, which can reduce the workload for GPs from direct consultations, but displays further room to use cost-sharing more strategically to help patients use services more efficiently.

GP capacity, alignment of provider incentives and financial protection mechanism are among the contextual factors that influence the impact of gatekeeping and cost-sharing policies

103. The analysis of the six case studies but also the review of the evidence presented in Chapter 3 suggest that the actual impact of the introduction of gatekeeping and cost-sharing depends on their practical implementation with many country-specific factors that can potentially reinforce or undermine the desired effects. In this context, the following questions seem relevant:

- ***Are there sufficient primary care physicians available*** throughout the country to deal with the expected increase in consultations associated with gatekeeping and are they willing to take on this additional co-ordination role (which may have financial consequences) and do they have the necessary skills?
- ***Do provider incentives align with patient incentives***? For example, are fee-for-service and capitation payments balanced to ensure high levels of activity while supporting continuity of care?
- ***Could mandatory gatekeeping lead to dissatisfaction*** among patients who may consider ***bypassing the public referral system*** and turn towards the private sector for quicker access? In this context, trust in the public health system is crucial, especially for policies that restrict the choices of patients.
- Related to this is ***how dual practice among specialist physicians is regulated***. If specialists can see private patients in addition to public patients, they may consider extending their work in the private sector thereby reducing their capacity to treat public patients – potentially leading to longer waiting times and unequal access to care. This will be more likely if gatekeeping leads to reduced income from the treatment of public patients as a consequence of a reduction in consultations. In this context, the role and regulation of ***private health insurance markets*** can be important. Could gatekeeping lead to an increased insurance uptake that promotes alternative access to specialist care thus undermining the initial intention of the introduction of a referral system?
- Finally, regarding cost-sharing, a key question is ***how countries identify areas in outpatient care where they want to apply cost-sharing with compromising access to services for all people who need it***. This is related to the question how safeguards are implemented to avoid that in particular vulnerable and disadvantaged population groups face undue financial burden when seeking care or unmet need.

5 Conclusion

104. This report describes two demand-side instruments to steer patients through the outpatient sector more efficiently and incentivise them to choose optimal treatment pathways – ***gatekeeping*** and ***cost-sharing***. It takes stock how these instruments are designed and applied across the OECD.

105. The reviews of policies, scientific literature and country experiences suggest that gatekeeping and cost-sharing can, under specific circumstances, contribute to steer patients towards more efficient patient pathways in outpatient care but their impact depends very much on policy design choices and complementary and country-specific factors, such as the alignment of primary care capacity, provider incentives, private sector regulation and financial protection for vulnerable population groups. That said, both tools have objectives that go beyond improved efficiency, and gatekeeping is frequently considered as an important element in a strategy to strengthen primary care.

106. While this report exclusively focuses on two demand-side tools, there are of course many supply-side instruments that can be used to improve efficiency in care delivery in the outpatient care sector. This can include intensifying the use of various digital health applications, investing in more co-operative, team-based and integrated care delivery models with an increased scope of practice for nurses or rethinking the way health providers are paid for. Countries consider both options and an alignment of demand and supply-side instruments to make health systems more efficient appears to be desirable.

107. The descriptive groundwork laid out in this paper can be used as the basis for more analytical work, such as a causal analysis of the effects to gatekeeping on health system objectives. Gatekeeping is considered as one of many components that strengthen primary care and improve care continuity, but the actual mechanism remains poorly understood. Analyses are limited in number, outdated and conflicted by confounding factors. Gatekeeping is often introduced as a set of policies, making it difficult to isolate its effect. This paper could also be used in broader analysis that looks into the full range of demand-side and supply-side options to identify combinations of policies that have the most impact on health care utilisation, cost and quality of care.

108. In terms of cost-sharing in outpatient care, all OECD countries have some form of reductions and exemptions in place to ensure that people do not forgo essential care and have to choose between catastrophic spending and unmet care. However, there is little investigation yet in how these are best combined to ensure the optimal balance between reducing low-value care while ensuring everyone who needs access to care receives it. In addition, there is potential to better understand how cost-sharing can be used more effectively to steer patients towards the best provider.

References

Andersen, M. et al. (2017), "General practitioners' attitudes towards and experiences with referrals due to supplemental health insurance", *Family Practice*, Vol. 34/5, pp. 581-586, https://doi.org/10.1093/fampra/cmx035. [67]

Arrieta, A. and A. García-Prado (2015), "Cost sharing and hospitalizations for ambulatory care sensitive conditions", *Social Science & Medicine*, Vol. 124, pp. 115-120, https://doi.org/10.1016/j.socscimed.2014.11.026. [98]

Augurzky, B., T. Bauer and S. Schaffner (2006), *Copayments in the German Health System: Does It Work? IZA DP No. 2290*, Forschungsinstitut zur Zukunft der Arbeit (IZA). [86]

Babazono, A. et al. (2005), "Effects of the increase in co-payments from 20 to 30 percent on the compliance rate of patients with hypertension or diabetes mellitus in the Employed Health Insurance System", *International Journal of Technology Assessment in Health Care*, Vol. 21/2, pp. 228-233, https://doi.org/10.1017/s0266462305050300. [92]

Bae, B., B. Choi and I. Song (2017), "The impact of change from copayment to coinsurance on medical care usage and expenditure in outpatient setting in older Koreans", *The International Journal of Health Planning and Management*, Vol. 33/1, pp. 235-245, https://doi.org/10.1002/hpm.2416. [110]

BAG (2024), *Individualdaten Krankenversicherung: Statistik*, Bundesamt für Gesundheit, https://www.bag.admin.ch/de/individualdaten-krankenversicherung-statistik. [10]

BAG (n.d.), "Krankenversicherung: Pilotprojekte zur Eindämmung der Kostenentwicklung (Experimentierartikel)", https://www.bag.admin.ch/de/krankenversicherung-pilotprojekte-zur-eindaemmung-der-kostenentwicklung-experimentierartikel. [7]

Bates, S. et al. (2025), "The impact of patient enrolment in primary care on continuity and quality of care around the world, 2014–2024, and lessons for Australia: a scoping review", *Medical Journal of Australia*, Vol. 222/9, pp. 462-471, https://doi.org/10.5694/mja2.52648. [47]

Bensnes, S., I. Huitfeldt and V. Marone (2026), *The Distributional Effects of Cost-Sharing in a Universal Healthcare System*, National Bureau of Economic Research, Cambridge, MA, https://doi.org/10.3386/w34700. [96]

Berger, M., E. Six and T. Czypionka (2024), "Policy implications of heterogeneous demand reactions to changes in cost-sharing: Patient-level evidence from Austria", *Social Science & Medicine*, Vol. 340, p. 116488, https://doi.org/10.1016/j.socscimed.2023.116488. [77]

Besley, T., J. Hall and I. Preston (1999), "The demand for private health insurance: do waiting lists matter?", *Journal of Public Economics*, Vol. 72/2, pp. 155-181, https://doi.org/10.1016/s0047-2727(98)00108-x. [61]

Bifg (2025), *Arztreport: Inanspruchnahme ambulante ärztliche Versorgung*, BARMER Institut für Gesundheitssystemforschung, https://www.bifg.de/publikationen/reporte/arztreport/arztreport-inanspruchnahme-ambulante-aerztliche-versorgung. [123]

Bíró, A. (2013), "Copayments, gatekeeping, and the utilization of outpatient public and private care at age 50 and above in Europe", *Health Policy*, Vol. 111/1, pp. 24-33, https://doi.org/10.1016/j.healthpol.2013.03.009. [20]

Bíró, A. and M. Hellowell (2016), "Public–private sector interactions and the demand for supplementary health insurance in the United Kingdom", *Health Policy*, Vol. 120/7, pp. 840-847, https://doi.org/10.1016/j.healthpol.2016.05.002. [63]

Blöndal, B. and T. Ásgeirsdóttir (2019), "Costs and efficiency of gatekeeping under varying numbers of general practitioners", *The International Journal of Health Planning and Management*, Vol. 34/1, pp. 140-156, https://doi.org/10.1002/hpm.2601. [32]

Breivold, J. et al. (2024), "Gatekeeping and referral of patients holding private health insurance: a survey among general practitioners in Norway", *Scandinavian Journal of Primary Health Care*, Vol. 42/4, pp. 695-703, https://doi.org/10.1080/02813432.2024.2380923. [66]

Brekke, K. et al. (2020), "How Does The Type of Remuneration Affect Physician Behavior?", *American Journal of Health Economics*, Vol. 6/1, pp. 104-138, https://doi.org/10.1086/706624. [54]

Brenna, E. (2025), "Public versus private access in the Italian NHS - The use of propensity score matching to provide more insight on the increasing adoption of voluntary health insurance", *Health Policy*, Vol. 154, p. 105271, https://doi.org/10.1016/j.healthpol.2025.105271. [60]

Brenna, E. and M. Giammanco (2024), "The use of voluntary health insurance in the access to specialist care: Evidence from the Italian NHS", *Socio-Economic Planning Sciences*, Vol. 93, p. 101906, https://doi.org/10.1016/j.seps.2024.101906. [57]

Buitrago, G. et al. (2023), "Cost-sharing in medical care can increase adult mortality: Evidence from Colombia", *NBER Working Paper 31908*. [107]

Cantarero-Prieto, D., M. Pascual-Sáez and N. Gonzalez-Prieto (2017), "Effect of having private health insurance on the use of health care services: the case of Spain", *BMC Health Services Research*, Vol. 17/1, https://doi.org/10.1186/s12913-017-2667-4. [58]

CDU, CSU und SPD (2025), *Verantwortung für Deutschland. Koalitionsvertrag zwischen CDU, CSI und SPD. 21. Legislaturperiode*. [9]

Chandra, A., J. Gruber and R. McKnight (2014), "The impact of patient cost-sharing on low-income populations: Evidence from Massachusetts", *Journal of Health Economics*, Vol. 33, pp. 57-66, https://doi.org/10.1016/j.jhealeco.2013.10.008. [100]

Chandra, A., J. Gruber and R. McKnight (2010), "Patient Cost-Sharing and Hospitalization Offsets in the Elderly", *American Economic Review*, Vol. 100/1, pp. 193-213, https://doi.org/10.1257/aer.100.1.193. [101]

Chiappori, P., F. Durand and P. Geoffard (1998), "Moral hazard and the demand for physician services: First lessons from a French natural experiment", *European Economic Review*, Vol. 42/3-5, pp. 499-511, https://doi.org/10.1016/s0014-2921(98)00015-4. [71]

Choi, Y. et al. (2015), "The effect of cost-sharing in private health insurance on the utilization of health care services between private insurance purchasers and non-purchasers: a study of the Korean health panel survey (2008–2012)", *BMC Health Services Research*, Vol. 15/1, https://doi.org/10.1186/s12913-015-1153-0. [115]

Cohen, J. and P. Dupas (2010), "Free Distribution or Cost-Sharing? Evidence from a Randomized Malaria Prevention Experiment[*]", *Quarterly Journal of Economics*, Vol. 125/1, pp. 1-45, https://doi.org/10.1162/qjec.2010.125.1.1. [120]

Commonwealth Fund (2023), *International Health Policy Survey*, https://www.cihi.ca/en/commonwealth-fund-survey-2023. [25]

Davin-Casalena, B. et al. (2024), "How general practitioners in France are coping with increased healthcare demand and physician shortages. A panel data survey and hierarchical clustering", *Health Policy*, Vol. 149, p. 105175, https://doi.org/10.1016/j.healthpol.2024.105175. [49]

Dormont, B. and M. Péron (2016), "Does Health Insurance Encourage the Rise in Medical Prices? A Test on Balance Billing in France", *Health Economics*, Vol. 25/9, pp. 1073-1089, https://doi.org/10.1002/hec.3347. [116]

Dourgnon, P. and M. Naiditch (2010), "The preferred doctor scheme: A political reading of a French experiment of Gate-keeping", *Health Policy*, Vol. 94/2, pp. 129-134, https://doi.org/10.1016/j.healthpol.2009.09.001. [28]

Dumontet, M. et al. (2017), "Gatekeeping and the utilization of physician services in France: Evidence on the Médecin traitant reform", *Health Policy*, Vol. 121/6, pp. 675-682, https://doi.org/10.1016/j.healthpol.2017.04.006. [21]

Escarce, J. et al. (2001), "Medical care expenditures under gatekeeper and point-of-service arrangements", *Health Service Research*, Vol. 36/6, pp. 1037-57, https://pmc.ncbi.nlm.nih.gov/articles/PMC1089277/. [26]

Estonian Parliament (2025), *Ravikindlustuse seadus (lühend - RaKS)*. [12]

Farbmacher, H. and J. Winter (2013), "PER-PERIOD CO-PAYMENTS AND THE DEMAND FOR HEALTH CARE: EVIDENCE FROM SURVEY AND CLAIMS DATA", *Health Economics*, Vol. 22/9, pp. 1111-1123, https://doi.org/10.1002/hec.2955. [72]

Felder, S., S. Meyer and K. Schmidheiny (2024), *Helsana-Report: Einkommen, Vertragswahl und Prämienbelastung in der OKP*, Basel Center for Health Economics. [13]

Ferris, T. et al. (2001), "Leaving Gatekeeping Behind — Effects of Opening Access to Specialists for Adults in a Health Maintenance Organization", *New England Journal of Medicine*, Vol. 345/18, pp. 1312-1317, https://doi.org/10.1056/nejmsa010097. [23]

Forrest, C. (2003), "Primary care in the United States: Primary care gatekeeping and referrals: effective filter or failed experiment?", *BMJ*, Vol. 326/7391, pp. 692-695, https://doi.org/10.1136/bmj.326.7391.692. [24]

Freytag, A. et al. (2016), "The Impact of GP-Centered Healthcare", *Deutsches Ärzteblatt international*, https://doi.org/10.3238/arztebl.2016.0791. [45]

Fukushima, K. et al. (2016), "Patient cost sharing and medical expenditures for the Elderly", *Journal of Health Economics*, Vol. 45, pp. 115-130, https://doi.org/10.1016/j.jhealeco.2015.10.005. [80]

Garrido, M., A. Zentner and R. Busse (2010), "The effects of gatekeeping: A systematic review of the literature", *Scandinavian Journal of Primary Health Care*, Vol. 29/1, pp. 28-38, https://doi.org/10.3109/02813432.2010.537015. [19]

Godager, G., T. Iversen and C. Ma (2015), "Competition, gatekeeping, and health care access", *Journal of Health Economics*, Vol. 39, pp. 159-170, https://doi.org/10.1016/j.jhealeco.2014.11.005. [52]

Government of Chile (n.d.), *Copago cero. Praguntas frequentes.*, https://www.gob.cl/copagocero/preguntasfrecuentes/. [14]

Greenfield, G. (2016), "Rethinking primary care's gatekeeper role", *BMJ*, Vol. 354, https://doi.org/10.1136/bmj.i4803. [31]

Greenfield, G., K. Foley and A. Majeed (2016), "Rethinking primary care's gatekeeper role", *BMJ*, p. i4803, https://doi.org/10.1136/bmj.i4803. [37]

Guindon, G. et al. (2022), "A systematic umbrella review of the association of prescription drug insurance and cost-sharing with drug use, health services use, and health", *BMC Health Services Research*, Vol. 22/1, https://doi.org/10.1186/s12913-022-07554-w. [117]

Haaga, T. et al. (2024), "Effects of nurse visit copayment on primary care use: Do low-income households pay the price?", *Journal of Health Economics*, Vol. 94, p. 102866, https://doi.org/10.1016/j.jhealeco.2024.102866. [70]

Hartzell, T. et al. (2013), "Does the Gatekeeper Model Work in Hand Surgery?", *Plastic and Reconstructive Surgery*, Vol. 132/3, pp. 381e-386e, https://doi.org/10.1097/prs.0b013e31829acc74. [36]

Hayen, A., T. Klein and M. Salm (2021), "Does the framing of patient cost-sharing incentives matter? the effects of deductibles vs. no-claim refunds", *Journal of Health Economics*, Vol. 80, p. 102520, https://doi.org/10.1016/j.jhealeco.2021.102520. [109]

Helse- og omsorgsdepartementet (2020), *Forenkler frikortordningen: Slår sammen egenandelstak 1 og 2*, https://www.regjeringen.no/no/dokumentarkiv/regjeringen-solberg/aktuelt-regjeringen-solberg/hod/nyheter/2020ny/forenkler-frikortordningen-slar-sammen-egenandelstak-1-og-2/id2768677/?expand=factbox2769031. [16]

Helsedirektoratet (2025), *Rundskriv til folketrygdloven § 5-3 – egenandelstak*. [17]

Himmel, W., A. Dieterich and M. Kochen (2000), "Will german patients accept their family physician as a gatekeeper?", *Journal of General Internal Medicine*, Vol. 15/7, pp. 496-502, https://doi.org/10.1046/j.1525-1497.2000.10016.x. [39]

Hoffmann, K. et al. (2019), "The influence of general practitioners on access points to health care in a system without gatekeeping: a cross-sectional study in the context of the QUALICOPC project in Austria", *Croatian Medical Journal*, Vol. 60/4, pp. 316-324, https://doi.org/10.3325/cmj.2019.60.316. [5]

Hofland, M., K. Gaspar and J. Boone (2024), *Responses to cost-sharing: Do socio-demographic characteristics matter?*, CPB Netherlands Bureau for Economic Policy Analysis. [97]

Hofmann, S. and A. Mühlenweg (2016), *Gatekeeping in German Primary*. [29]

Hsu, J. et al. (2006), "Cost-Sharing for Emergency Care and Unfavorable Clinical Events: Findings from the Safety and Financial Ramifications of ED Copayments Study", *Health Services Research*, Vol. 41/5, pp. 1801-1820, https://doi.org/10.1111/j.1475-6773.2006.00562.x. [104]

Iizuka, T. and H. Shigeoka (2022), "Is Zero a Special Price? Evidence from Child Health Care", *American Economic Journal: Applied Economics*, Vol. 14/4, pp. 381-410, https://doi.org/10.1257/app.20210184. [102]

Innocenti, F., B. McCormick and C. Nicodemo (2025), "Gatekeeping in primary care: Analysing GP referral patterns and specialist consultations in the NHS", *Economic Modelling*, Vol. 142, p. 106925, https://doi.org/10.1016/j.econmod.2024.106925. [51]

Jakobsson, N. and M. Svensson (2016), "Copayments and physicians visits: A panel data study of Swedish regions 2003–2012", *Health Policy*, Vol. 120/9, pp. 1095-1099, https://doi.org/10.1016/j.healthpol.2016.07.010. [90]

Jia, L. et al. (2021), "Payment methods for healthcare providers working in outpatient healthcare settings", *Cochrane Database of Systematic Reviews*, Vol. 2021/1, https://doi.org/10.1002/14651858.cd011865.pub2. [53]

Jofre-Bonet, M. (2000), "Public health care and private insurance demand: The waiting time as a link", *Health Care Management Science*, Vol. 3/1, pp. 51-71, https://doi.org/10.1023/a:1019024903898. [62]

Johansson, N. et al. (2023), "Reductions in out-of-pocket prices and forward-looking moral hazard in health care demand", *Journal of Health Economics*, Vol. 87, p. 102710, https://doi.org/10.1016/j.jhealeco.2022.102710. [103]

Johansson, N., N. Jakobsson and M. Svensson (2019), "Effects of primary care cost-sharing among young adults: varying impact across income groups and gender", *The European Journal of Health Economics*, Vol. 20/8, pp. 1271-1280, https://doi.org/10.1007/s10198-019-01095-6. [95]

Jo, S., D. Jun and S. Park (2021), "Impact of differential copayment on patient healthcare choice: evidence from South Korean National Cohort Study", *BMJ Open*, Vol. 11/6, p. e044549, https://doi.org/10.1136/bmjopen-2020-044549. [111]

Kalousova, L. (2014), "Curing over-use by prescribing fees: an evaluation of the effect of user fees' implementation on healthcare use in the Czech Republic", *Health Policy and Planning*, Vol. 30/4, pp. 423-431, https://doi.org/10.1093/heapol/czu024. [69]

Kapur, K. et al. (2000), “Expenditures for Physician Services under Alternative Models of Managed Care”, *Medical Care Research and Review*, Vol. 57/2, pp. 161-181, https://doi.org/10.1177/107755870005700202. [27]

Kiil, A. and J. Arendt (2016), “The effect of complementary private health insurance on the use of health care services”, *International Journal of Health Economics and Management*, Vol. 17/1, pp. 1-27, https://doi.org/10.1007/s10754-016-9195-3. [68]

Kim, M. (2023), “Unintended consequences of healthcare reform in South Korea: evidence from a regression discontinuity in time design”, *Health Research Policy and Systems*, Vol. 21/1, https://doi.org/10.1186/s12961-023-00993-9. [113]

Klein, T., M. Salm and S. Upadhyay (2022), “The response to dynamic incentives in insurance contracts with a deductible: Evidence from a differences-in-regression-discontinuities design”, *Journal of Public Economics*, Vol. 210, p. 104660, https://doi.org/10.1016/j.jpubeco.2022.104660. [75]

Ko, H. (2020), “Moral hazard effects of supplemental private health insurance in Korea”, *Social Science & Medicine*, Vol. 265, p. 113325, https://doi.org/10.1016/j.socscimed.2020.113325. [114]

Kroneman, M., H. Maarse and J. Zee (2006), “Direct access in primary care and patient satisfaction: A European study”, *Health Policy*, Vol. 76/1, pp. 72-79, https://doi.org/10.1016/j.healthpol.2005.05.003. [40]

Kullberg, L., P. Blomqvist and U. Winblad (2025), “How Private Health Insurance Shapes Perceptions of Public Healthcare in Sweden”, *The International Journal of Health Planning and Management*, Vol. 40/5, pp. 1048-1057, https://doi.org/10.1002/hpm.3941. [65]

Kullberg, L., P. Blomqvist and U. Winblad (2021), “Does voluntary health insurance reduce the use of and the willingness to finance public health care in Sweden?”, *Health Economics, Policy and Law*, pp. 1-18, https://doi.org/10.1017/s1744133121000086. [59]

Lagarde, M. and N. Palmer (2011), “The impact of user fees on access to health services in low- and middle-income countries”, *Cochrane Database of Systematic Reviews*, Vol. 2011/4, https://doi.org/10.1002/14651858.cd009094. [119]

Landsem, M. and J. Magnussen (2018), “The effect of copayments on the utilization of the GP service in Norway”, *Social Science & Medicine*, Vol. 205, pp. 99-106, https://doi.org/10.1016/j.socscimed.2018.03.034. [84]

Le Fur, E. (2008), *Modes d’accès aux spécialistes en 2006 et évolution depuis la réforme de l’Assurance maladie.*. [22]

Liddy, C. et al. (2014), “What is the impact of primary care model type on specialist referral rates? A cross-sectional study”, *BMC Family Practice*, Vol. 15/1, https://doi.org/10.1186/1471-2296-15-22. [55]

Manning, W. et al. (1987), “Health insurance and the demand for medical care: Evidence from a randomized experiment”, *The American Economic Review*, Vol. 77/3, pp. 251-277. [99]

Ma, Y. and A. Nolan (2016), “Public Healthcare Entitlements and Healthcare Utilisation among the Older Population in Ireland”, *Health Economics*, Vol. 26/11, pp. 1412-1428, https://doi.org/10.1002/hec.3429. [78]

Mitchell, A. and R. Keenan (2008), “Are Grampian General Practitioners Good Gatekeepers for Access to Emergency General Surgical Care?”, *Scottish Medical Journal*, Vol. 53/3, pp. 33-35, https://doi.org/10.1258/rsmsmj.53.3.33. [35]

Nederlandse Zorgautoriteit (2025), *Informatiekaart Zorgverzekeringen 2025. Trends & ontwikkelingen*, http://file:///C:/Users/Milstein_R/Downloads/Informatiekaart%20Zorgverzekeringen%202025%20voorjaar.pdf. [11]

Nilsson, A. and A. Paul (2018), “Patient cost-sharing, socioeconomic status, and children’s health care utilization”, *Journal of Health Economics*, Vol. 59, pp. 109-124, https://doi.org/10.1016/j.jhealeco.2018.03.006. [76]

Nishi, T. et al. (2021), “Impact of the 2014 coinsurance rate revision for the elderly on healthcare resource utilization in Japan”, *Health Economics Review*, Vol. 11/1, https://doi.org/10.1186/s13561-021-00324-0. [82]

OECD (2025), *Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS)*, OECD Publishing, Paris, https://doi.org/10.1787/c8af05a5-en. [42]

OECD (2025), *Health at a Glance 2025: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/8f9e3f98-en. [121]

OECD (2024), *Fiscal Sustainability of Health Systems: How to Finance More Resilient Health Systems When Money Is Tight?*, OECD Publishing, Paris, https://doi.org/10.1787/880f3195-en. [1]

OECD (2020), *Realising the Potential of Primary Health Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/a92adee4-en. [2]

OECD/The Health Foundation (2025), *How Do Health System Features Influence Health System Performance?*, OECD Publishing, Paris, https://doi.org/10.1787/7b877762-en. [44]

Olm, M. et al. (2020), “Impact of the abolition of copayments on the GP-centred coordination of care in Bavaria, Germany: analysis of routinely collected claims data”, *BMJ Open*, Vol. 10/9, p. e035575, https://doi.org/10.1136/bmjopen-2019-035575. [46]

Olsen, C. and H. Melberg (2018), “Did adolescents in Norway respond to the elimination of copayments for general practitioner services?”, *Health Economics*, Vol. 27/7, pp. 1120-1130, https://doi.org/10.1002/hec.3660. [83]

Park, E. and S. Choi (2020), “Who Benefits from the Fixed Copayment of Medical and Pharmaceutical Expenditure among the Korean Elderly?”, *International Journal of Environmental Research and Public Health*, Vol. 17/21, p. 8118, https://doi.org/10.3390/ijerph17218118. [74]

Pilvar, H. and T. Watt (2024), “The effect of workload on primary care doctors on referral rates and prescription patterns: evidence from English NHS”, *The European Journal of Health Economics*, Vol. 26/5, pp. 817-837, https://doi.org/10.1007/s10198-024-01742-7. [50]

Praktiserende lægers organisation (2025), *PLO faktaark. Opdateret april 2025*. [122]

RAND Health (2006), *The Health Insurance Experimen*, RAND Corporation. [88]

Rask, K. (1999), "The Effect of Primary Care Gatekeepers on the Management of Patients With Chest Pain", *The American Journal of Managed Care*, Vol. 5/10. [33]

Reibling, N. and C. Wendt (2012), "Gatekeeping and provider choice in OECD healthcare systems", *Current Sociology*, Vol. 60/4, pp. 489-505, https://doi.org/10.1177/0011392112438333. [38]

Reibling, N. and C. Wendt (2009), "Bildungsniveau und Zugang zu Gesundheitsleistungen", *Das Gesundheitswesen*, Vol. 72/08/09, pp. 447-454, https://doi.org/10.1055/s-0029-1234101. [43]

Remmerswaal, M. et al. (2019), "Cost-sharing design matters: A comparison of the rebate and deductible in healthcare", *Journal of Public Economics*, Vol. 170, pp. 83-97, https://doi.org/10.1016/j.jpubeco.2019.01.008. [108]

Rückert, I., J. Böcken and A. Mielck (2008), "Are German patients burdened by the practice charge for physician visits ('Praxisgebuehr')? A cross sectional analysis of socio-economic and health related factors", *BMC Health Services Research*, Vol. 8/1, https://doi.org/10.1186/1472-6963-8-232. [94]

Sabik, L. and S. Gandhi (2015), "Copayments and Emergency Department Use Among Adult Medicaid Enrollees", *Health Economics*, Vol. 25/5, pp. 529-542, https://doi.org/10.1002/hec.3164. [93]

Sanitas (n.d.), *Grundversicherung - Hausarztmodell*, https://www.sanitas.com/de/privatkunden/versicherungen/grundversicherung/hausarztmodell.html#So-funktioniert-das-Hausarztmodell. [4]

Šarec, E. and D. Jošar (2025), *Can people afford to pay for health care? New evidence on financial protection in Slovenia*, World Health Organization. [15]

Sarma, S. et al. (2018), "Family physician remuneration schemes and specialist referrals: Quasi-experimental evidence from Ontario, Canada", *Health Economics*, Vol. 27/10, pp. 1533-1549, https://doi.org/10.1002/hec.3783. [56]

Schreyögg, J. and M. Grabka (2009), "Copayments for ambulatory care in Germany: a natural experiment using a difference-in-difference approach", *The European Journal of Health Economics*, Vol. 11/3, pp. 331-341, https://doi.org/10.1007/s10198-009-0179-9. [85]

Schwenkglenks, M. et al. (2005), "Economic efficiency of gatekeeping compared with fee for service plans: a Swiss example", *Journal of Epidemiology and Community Health*, Vol. 60/1, pp. 24-30, https://doi.org/10.1136/jech.2005.038240. [30]

Sen, B. et al. (2012), "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama", *Health Services Research*, Vol. 47/4, pp. 1603-1620, https://doi.org/10.1111/j.1475-6773.2012.01384.x. [89]

Serna, N. (2021), "Cost sharing and the demand for health services in a regulated market", *Health Economics*, Vol. 30/6, pp. 1259-1275, https://doi.org/10.1002/hec.4244. [106]

Shigeoka, H. (2014), "The Effect of Patient Cost Sharing on Utilization, Health, and Risk Protection", *American Economic Review*, Vol. 104/7, pp. 2152-2184, https://doi.org/10.1257/aer.104.7.2152. [81]

Social Insurance Institution of Finland (Kela) (2025), *A pilot study on freedom of choice in healthcare for persons aged 65 or over*, https://www.kela.fi/appointments-with-a-private-general-practitioner-for-persons-aged-65-or-over. [6]

Sripa, P. et al. (2019), "Impact of GP gatekeeping on quality of care, and health outcomes, use, and expenditure: a systematic review", *British Journal of General Practice*, Vol. 69/682, pp. e294-e303, https://doi.org/10.3399/bjgp19x702209. [18]

Starfield, B., L. Shi and J. Macinko (2005), "Contribution of Primary Care to Health Systems and Health", *The Milbank Quarterly*, Vol. 83/3, pp. 457-502, https://doi.org/10.1111/j.1468-0009.2005.00409.x. [3]

SVR Gesundheit & Pflege (2024), *Fachkräfte im Gesundheitswesen. Nachhaltiger Einsatz einer knappen Ressource. Gutachten 2024*, Sachverständigenrat Gesundheit & Pflege. [8]

Thomson, S. et al. (2024), "Monitoring progress towards universal health coverage in Europe: a descriptive analysis of financial protection in 40 countries", *The Lancet Regional Health - Europe*, Vol. 37, p. 100826, https://doi.org/10.1016/j.lanepe.2023.100826. [118]

Trivedi, A., H. Moloo and V. Mor (2010), "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly", *New England Journal of Medicine*, Vol. 362/4, pp. 320-328, https://doi.org/10.1056/nejmsa0904533. [105]

Tynkkynen, L. et al. (2018), "Development of voluntary private health insurance in Nordic countries – An exploratory study on country-specific contextual factors", *Health Policy*, Vol. 122/5, pp. 485-492, https://doi.org/10.1016/j.healthpol.2018.03.008. [64]

Van De Voorde, C., E. Van Doorslaer and E. Schokkaert (2001), "Effects of cost sharing on physician utilization under favourable conditions for supplier-induced demand", *Health Economics*, Vol. 10/5, pp. 457-471, https://doi.org/10.1002/hec.631. [91]

van den Brink-Muinen, A. et al. (2003), "Communication in general practice: differences between European countries", *Family Practice*, Vol. 20/4, pp. 478-485, https://doi.org/10.1093/fampra/cmg426. [41]

Vedsted, P. and F. Olesen (2011), "Are the serious problems in cancer survival partly rooted in gatekeeper principles? An ecologic study", *British Journal of General Practice*, Vol. 61/589, pp. e508-e512, https://doi.org/10.3399/bjgp11x588484. [34]

Walsh, B. et al. (2019), "Did the expansion of free GP care impact demand for Emergency Department attendances? A difference-in-differences analysis", *Social Science & Medicine*, Vol. 222, pp. 101-111, https://doi.org/10.1016/j.socscimed.2018.12.029. [79]

Winkelmann, R. (2004), "Co-payments for prescription drugs and the demand for doctor visits – Evidence from a natural experiment", *Health Economics*, Vol. 13/11, pp. 1081-1089, https://doi.org/10.1002/hec.868. [87]

Xu, M. and B. Bittschi (2022), "Does the abolition of copayment increase ambulatory care utilization?: a quasi-experimental study in Germany", *The European Journal of Health Economics*, Vol. 23/8, pp. 1319-1328, https://doi.org/10.1007/s10198-022-01430-4. [73]

Yoo, K. et al. (2016), "Impact of co-payment for outpatient utilization among Medical Aid beneficiaries in Korea: A 5-year time series study", *Health Policy*, Vol. 120/8, pp. 960-966, https://doi.org/10.1016/j.healthpol.2016.07.001. [112]

Zaytseva, A., P. Verger and B. Ventelou (2025), “Better Together? A Mediation Analysis of French General Practitioners’ Performance in Multi Professional Group Practice”, *Health Services Insights*, Vol. 18, https://doi.org/10.1177/11786329251331128. [48]

Annex A. Overview of gatekeeping and cost-sharing across 38 OECD countries

Country	Gatekeeping in Primary Care				Cost-sharing on physician services						
	Compulsory	Financial i.	Direct access	Registration with a GP (population share)	Co-payment	Co-insurance	Deductible	Primary Care	Outpatient specialist care	Reductions/ exemptions for patient groups	Reductions/ exemptions certain services
Australia	•			Encouraged (~50% of the pop)		•		Generally no, extra-billing in 11% of patients.	15%	Original Medicare Safety Net, Extended Medicare Safety Net (General / Concessional and Family Tax Benefit Part A) based on income; people of pension are eligible for Commonwealth Seniors Health Card.	*Not applicable.*
Austria			•	No	•	•		Up to 20% (depends)		Children, low income, disability of at least 50%	Chemo- and nuclear therapy, reduction for participation in prevention programme, organ transplant, dialysis treatment
Belgium		•		Encouraged (>50%)	•			EUR 4-6	EUR 9-12	Low income	
Canada	•			Encouraged in some regions	*No cost-sharing in place.*						
Chile	•			No	*No cost-sharing in place.*						
Costa Rica	•			Yes (~100%)	*No cost-sharing in place.*						
Colombia	•			Yes	•	•		Co-payment of COP 5 000-52 800 in Régimen Contributivo, co-insurance of 10% in Régimen Subsidiado,		Low income	Early detection programmes, maternity and childcare, communicable diseases, catastrophic and high-cost diseases

								11.50%, 17.30% or 23% in Régimen Contributivo			
Czechia			•	Yes (~50%)	*No cost-sharing in place.*						
Denmark	•			Yes (99% in public system)	*No cost-sharing in place.*						
Estonia	•			Yes (~100%)	•			*No cost-sharing*	EUR 20	Pregnant women, pensioners, unemployed, etc..: EUR 5	ED (in hospitals)
Finland	•			Yes (~100%)	•			EUR 28.20	EUR 28.20	<18, veterans, certain professional groups	Health check-ups, screening, certain diagnostics, nurse consultations, ED
France		•		Yes	•	•		EUR 2, and 70% of total consultation		30% for patients registered with GP, exemptions for, e.g., people with chronic conditions, disabilities, pregnant women, military invalidity	E.g., certain diagnostic tests and preventive measures, services related to work accidents, terrorist attacks
Germany		•		Encouraged in some plans	*No cost-sharing in place in standard care.*					Eligibility and amount income-dependent Generally EUR 200-600 for voluntary deductible schemes, eligibility and amount income-dependent	Prevention, health check-ups, maternal services, standard visits
Greece			•	Yes, mandatory for all	*No cost-sharing in place.*						
Hungary	•			Yes (~100%)	*No cost-sharing in place.*						
Iceland		•	•	Yes, although not legally compulsory	•			ISK 500-ISK 3 700		Aged <18, seniors and disabled people	Reduction for older people and individuals with disabilities, free for children
Ireland	•			Yes, compulsory	•			Fully out-of-pocket		Aged <8, >70, for GP and Medical Card holders	
Israel	•			Yes (~100%)	•			*No cost-sharing*	Depends on plan, generally around NIS25-100	Women aged 64 and above, men 67 and above with income support, people with severe illness, low-income, lower cost-thresholds for chronically ill, families (See Annex C)	Preventive care, cancer screenings.
Italy	•			Yes, mandatory	•			*No cost-sharing*	Up to EUR 36.15	Maternity, vaccination	Diagnostic tests, vaccination, HIV prevention, promotion of blood and organ donation
Japan			•	No		•		30%		Aged 70-74: 20%, aged 75 and above: 10-20% depending on income	
Korea			•	No		•		30%		Lower co-payment below ceiling for 65+ Prevention	Medical health checkups

Latvia	•			Yes (~100%)	•			EUR 2	EUR 4-35	Aged 65+: EUR 1; aged <18: EUR 0	ED, pregnancy
Lithuania	•			Yes, compulsory	*No cost-sharing in place. Specialist care is free upon GP referral.*						
Luxembourg			•	No		•		12-20%		Free <18	
Mexico			•	Yes	*No cost-sharing in place.*						
New Zealand	•			(Yes)	•			NZD 15-50		Low income, children	
Norway	•			(Yes)	•			NOK 64-425		Free for ages <16(18), soldiers, occupational injuries and abuse	Antenatal check-ups, certain communicable diseases
Poland	•			Yes, (majority)	*No cost-sharing in place.*						
Portugal	•			Yes	*No cost-sharing in place.*						
Slovenia	•			Yes	*No cost-sharing in place.*						
Slovak Republic	•			Yes (~100%)	*No cost-sharing in place.*						
Spain	•			Yes (~100%)	*No cost-sharing in place.*						
Sweden	*Depends on the region*			Yes (majority)	•			SEK 200-400	SEK 200-460	<18-20 depending on region, >85 years	Preventive and maternal services
Switzerland		•		No			•	Deductible of CHF 300-2 500		Lower for children	Preventive and maternal services
The Netherlands	•			Yes			•	*Exempt from deductible*	EUR 385-885	<18 years	
Türkiye		•		Yes	•			*No cost-sharing*	TRY 26-60	People that receive support by the social assistance and solidarity and solidarity foundations in accordance with Law No. 3294 of the Promotion of Social Assistance and Solidarity	50%-reduction if visit takes place after referral from GP
United Kingdom	•			Yes (~100%)	*No cost-sharing in place.*						
United States (Medicare)			•	No		•	•	Deductible of USD 275, 20% beyond that.		Exemptions for people with low income	Selected screening

Note: ()=registration not mandatory

Annex B. Gatekeeping policies across 38 OECD countries in detail

Country	Gatekeeping policy	Note/Exemptions	Registration with GP
Australia	Compulsory	No medical specialty allows publicly funded referral-free access for all outpatient visits, but allied health professionals and a small number of situations allow self-referral, with different rebate rules. Emergency services	About 50% of the population Patients are not obliged to register with a primary care physician or practice but are strongly encouraged to do so (incentives around care coordination)
Austria	No gatekeeping		No
Belgium	Financially encouraged	Patients who register with a GP for a Global Medical Dossier receive higher reimbursement rates for GP consultations and lower out-of-pocket costs for specialist visits if referred by their GP.	Financially encouraged via the Global Medical Dossier More than 50% of the pop
Canada	Compulsory	There are important exemptions mainly for emergencies, reproductive health, mental health services, and some specialists (dermatology and gynecology) depending on provincial policies.	Not mandatory but encouraged in some regions
Chile	Compulsory	Only in the public system (FONASA) and not strictly enforced. Emergency services	No
Costa Rica	Compulsory	Emergency services	Yes, almost the entire population
Colombia	Compulsory	Emergency services	Yes
Czechia	No gatekeeping	N/A	Yes. Although patients register with a GP for primary care, this does not restrict their ability to seek specialist care independently. About 50% of the population

Denmark	Compulsory (although a direct access scheme exists, it remains extremely marginal)	Ophthalmologists (eye specialists); Ear, nose, and throat (ENT) specialists. In emergency situations, patients can directly access hospital emergency departments or urgent care without gatekeeping.	Yes. Registering with a GP is a standard and encouraged part of the Danish healthcare system, providing continuity and coordinated care
Estonia	Compulsory	Patients can access certain specialists—such as gynaecologists, dermatologists/venereologists, psychiatrists, ophthalmologists, dentists, tuberculosis specialists, and traumatologists/surgeons for recent trauma—directly without a family doctor referral, and emergency services are also available without gatekeeping.	Yes, almost the entire population
Finland	Compulsory	Exemptions exist for occupational health, emergencies, and some public health services.	Yes, almost the entire population
France	Financially encouraged France has a voluntary gatekeeping system introduced in 2005, centered around the concept of the médecin traitant (preferred or treating doctor), usually a general practitioner (GP), whom patients over 16 are encouraged to designate and register with their health insurance.	Patients can contact gynaecologists, ophthalmologists or psychiatrists without being subjected to a financial penalty. Under 16 years-old are exempted	Patients are not obliged to register with a primary care physician (or practice) but have financial incentives to do so (e.g., reduced co-payments)
Germany	Financially encouraged (although it remains marginal) Since 2009, statutory health insurance companies are required to offer voluntary gatekeeping contracts as an alternative to standard plans. In these contracts, patients who opt in agree to use their GP as the coordinator of care and primary entry point for referrals to specialists, and participating GPs receive capitation-based remuneration for these patients.	Under gatekeeping contracts, exemptions for gynecologists, optometrists, dentists, pediatricians as well as in emergency cases	Not compulsory but financially encouraged in some insurance plans
Greece	No gatekeeping	N/A	Yes, mandatory for all
Hungary	Compulsory	No referral is needed to dermatology, gynecology, urology, psychiatry and addictology; ophthalmology, surgery and traumatology, oncology and care in case of emergency	Yes, almost the entire population
Iceland	Incentivized 'soft gatekeeping' regulations introduced in late 2024 now establish the expectation that specialist care should	Children are exempt from gatekeeping for most specialists	Yes, although not legally compulsory

	typically commence with family doctor referrals. This policy reinforces primary care's coordinating function while being supported by financial incentives that reduce patient co-payments for referred specialist services.		
Ireland	Compulsory	Emergency services	Compulsory
Israel	Gatekeeping	All health plans allow to see ENT, gynecologists, ophthalmologists, dermatologists, orthopedic surgeons, and breast surgeons directly and without prior referral.	Yes, almost the entire population
Italy	Compulsory	Mainly for emergency and some direct specialist access (especially gynecology), but the core of the system requires a GP referral for most specialist care.	Yes. Patients are required to register with a gatekeeping GP. They may choose any physician whose list has not reached the maximum number of patients allowed (1,500 for GPs and 800 for pediatricians) and may switch at any time.
Japan	No gatekeeping	The government encourages patients to choose their preferred doctors, and there are also patient disincentives for self-referral, including extra charges for initial consultations at large hospitals.	No
Korea	No gatekeeping	N/A	No
Latvia	Compulsory	Mainly for emergency and some direct specialist access (especially gynecology), but the core of the system requires a GP referral for most specialist care.	Yes, almost the entire population
Lithuania	Compulsory		Yes, compulsory
Luxembourg	No gatekeeping A voluntary “médecin référent” or Referring Doctor (RD) program was introduced in 2012, targeting mainly patients with chronic conditions to encourage care coordination by a primary care provider. However, participation is optional, and there are no financial incentives attached to it.	N/A	No
Mexico	No gatekeeping	N/A	No
Netherlands	Compulsory	Emergency care and preventative services	Yes, although not legally compulsory
New Zealand	Compulsory	Exemptions to gatekeeping in New Zealand are mainly for emergency services and specific public health or community services	Yes, although not legally compulsory
Norway	Compulsory	Emergency care	Yes, almost the entire population
Poland	Compulsory	Poland’s gatekeeping system requires GP referrals for most specialists, but allows direct access to oncologists, gynecologists, psychiatrists, venereologists, and dentists,	Yes, the majority of the population

		plus emergency care and specific patient groups without referral	
Portugal	Compulsory	Emergency services	Compulsory
Slovakia	Weakly enforced	Exceptions include emergency services and direct access to gynecologists and dentists	Yes, almost the entire population
Slovenia	Compulsory	Emergency services	Compulsory
Spain	Compulsory	Emergency services	Yes, almost the entire population
Sweden	Financially encouraged in some regions only	In most regions referral is compulsory only for minority of specific treatments. However, several regions have reduced co-payments for specialist care if the patient is referred from primary care.	Yes, the majority
Switzerland	Incentivized	Incentivized	No
Turkiye	No gatekeeping	N/A	Yes
United Kingdom	Compulsory	Emergency services	Yes, almost the entire population
United States	Depends on the plan	Depends on the plan	No

Annex C. Cost-sharing exemptions and reductions across 38 OECD countries

Country	Income	Age	Health status	Other	Cost-sharing ceiling	Cost-sharing reduction/exemption	Additional comments
Australia	•	•		•	AUD 576 to AUD 2 615.50 for Medicare Safety Net threshold	Original Medicare Safety Net, Extended Medicare Safety Net (General / Concessional and Family Tax Benefit Part A) based on income; people of pension are eligible for Commonwealth Seniors Health Card.	Australian doctors are allowed to extra-bill. The Australian government has incentives to providers in place to reduce extra-billing (bulk billing incentive payment)
Austria	•	•	•	•	Depends on income and SHI	Children, disability of at least 50%, organ donors, during certain services, low income (e.g., income-dependent caps, such as EUR 81.16 for a net income of EUR 1 800 in the BVAEB, and EUR 1 309 in the SVS for a single household)	Lower cost-sharing of 5% for people that participate in prevention programmes
Belgium	•	•	•	•	EUR 400.20 per trimester if expenditures exceeded this amount for 8 trimesters in a row and for people with chronic diseases (exemption valid for two years)	Co-payment reduction due to health-related and socio-economic conditions, e.g., for the unemployed, handicapped, invalids, single parents, older people receiving social support, retired people with annual income below EUR 28 100.75 for a single person (intervention majorée)	Additional coverage for high-cost cases, such as rare diseases and innovative treatments through 'special solidarity fund' (Fonds special de solidarité)
Canada	*Not applicable, no cost-sharing in place*						
Chile	*Not applicable, no cost-sharing in place*						
Czechia	*Not applicable, no cost-sharing in place*						
Costa Ricar	*Not applicable, no cost-sharing in place*						
Denmark	*Not applicable, no cost-sharing in place*						

Colombia	•		•		Régimen subsidiado: not more than COP 651 155 per service and COP 1 302 309 per year, regimen contributivo: co-payment of up to COP 2 995 409 per service / COP 5 990 696 per year	No co-payment and co-insurance for people of low income in régimen subisiadio I, no co-payment for people in regimen subsidiao, exemptions for people with certain chronic, high-cost and rare diseases,certain services, such as preventive and maternal care	
Denmark	*Not applicable, no cost-sharing in place*						
Estonia	•	•	•	•	-	Fees are reduced to EUR 5 for people below the age of 19 and above the age of 63, pregnant women, mothers with child below the age of 1, recipients of pension for incapacity for work or old-age pension under State Pension Insurance Act, people with parrial or no work ability under Work Ability Allowance Act, unemployed people, recipience of subsistence benefit and relatives under certain conditions. No cost-sharing for treatment related to pregnancy or childbirth, prevention, referrals to doctor within the same institution, or within the same field including other institution, and within 365 days if the doctor or specialist equivalent to a health care professional leaves the patient under their monitoring or treatment	Penalty for missed appointment of double visit fee. Full fee for private doctor.
Finland		•		•	EUR 762 in 2025, EUR 815 in 2026 (Asiakasmaksut)	Fees are free for people below 18, and for veterans and front-line workers.	Fees are indexed every two years. People of low income can apply for social assistance. Penalty for people that do not show up to doctor visit and fail to cancel
France	•		•	•	EUR 50 per year for flat-rate payments of EUR 2	Co-insurance exemption for people with chronic diseases, pregnancy, fertility treatment. Exemption of EUR 2 for people with chronic diseases, Exemption of EUR 24 for people with chronic diseases, people with work-related injuries, disability, social contribution, children and adolescents that were victims of sexual crimes	Co-payment of EUR 19.61 (EUR 8.49 for people with chronic diesases, work-related injury and certain disability level) for ED visits in hospitals that do not result in a hospital stay
Germany				•	Voluntary opt-in that can require minimum income, bonus payments can be conditional on minimum income thresholds.		
Hungary	*Not applicable, no cost-sharing in place*						
Iceland		•	•	•	ISK 5 971 per month	Ceiling of ISK 3 981 for children aged 2-18, older people, disabled people, people receiving rehabilitation pension from Social Health Insurance Administration	Unused amount can be carried over to next month. No co-payment for children below 2 years.
Israel	•	•			Depends on plan.	No cost-sharing for women aged 62 and above / men aged 67 and above receiving income support	Health funds are allowed to update their co-payments twice a year with the approval of the Ministry of Health

						allowance of who have been recognized as prisoners of Zionist activities, adults with disability or old-age benefits and dependents, services for certain conditions, e.g., cancer, HIV/AIDS, tuberculosis, children below the age of 3, in households receiving income support, people with traffic or work accidents, organ donors, children with somatic developmental disorders, children below age of 18 with disability benefits. Quarterly caps for certain households, generally around NIS218-NIS273 depending on plan, 50%-reductions for documented immigrants after first year of arrival, and for households with at least one member above retirement age	
Ireland	•	•	•		-	People can apply for a medical card and a GP visit card, which waives costs. Eligibility depends on age, health and income. Children below the age of 8 and people above the age of 70 can receive a GP visit card based on age, and those aged 8 to 69 based in income-related criteria. Medical cards are conditional on age, income and health status.	Around 40% of the population holds a Medical Card.
Italy	•		•		-	Exemption for people based on income, chronic / rare diseases, disability, pregnancy, HIV detection	
Japan	•	•	•		Dependent on income and frequency	20% for children under 3, 20% for people aged 70-74, 10-20% for people aged 75 and above and of low income	
Korea	•		•		EUR 526 (KRW 870 000) within 120 days / EUR 810 (KRW 1 340 000) for more than 120 days	General Health Checkups are free of charge, reduced co-insurance for cancer screening (0-10%). Maternal care is not exempt from co-insurance, but people can receive subsidies and additional payments.	Cost-ceiling for hospital care increases based on income, ranging from KRW 870 000 to 8 080 000 for costs within 120 days across 10 income categories.
Latvia	•	•	•	•	EUR 569.15	Children below age of 18, pregnancy and maternal care, disabled, people with tuberculosis, the mentally ill, politically repressed people, victims of Chernobyl, certain chronic and infectious diseases, ED, palliative care, people of low income, preventive screening and vaccination, people in social care and pension centres	
Lithuania	*Not applicable, no cost-sharing in place.*						

Luxembourg		•			Depends on insurance arrangement and age. E.g., EUR 30 for GPs, gynecology and dentists	Below the age of 18.	There is a limit on the number of visits, e.g., not more than one consultation with a GP within 24h except for ED, up to 2 visits within 7 days, up to 12 consultations within 6 months. Visits beyond that require pre-approval.
Mexico	*Not applicable, no cost-sharing in place*						
New Zealand	•	•	•	•	-	Free prevention services for children under 14. Lower co-payments for: holders of a High Use Health Card (more than 12 doctor visits per year and visits related to illness / ongoing health problem that was not caused by an injury); holders of a Community Services Card for people of low income (below NZD 35,997 for single living alone)	
Norway	•	•	•	•	Exemption after maximum annual limit of NOK 3 278 (exemption card - *frikort for helsetjenester*)	No copayment for individuals below 16 (18 with), patients with approved occupational injuries, soldiers serving compulsory military service, pregnant women attending antenatal checkups, initial (emergency) examination after violence in close relationship / sexual abuse, persons with certain communicable diseases, such as COVID-19, chlamydia or gonorrhea, HIV, syphilis	
Poland	*Not applicable, no cost-sharing in place*						
Portugal	*Not applicable, no cost-sharing in place*						
Slovenia	*Not applicable, no cost-sharing in place*						
Slovak Republic	*Not applicable, no cost-sharing in place*						
Spain	*Not applicable, no cost-sharing in place*						
Sweden	•	•	•		Cost-ceiling of SEK 1 450 in all regions except for Region Jämtland Härjedalen (SEK 1 300)	Preventive services generally free of charge.	
Switzerland		•	•		CHF 700 for people with deductible of CHF 300		
The Netherlands	(•)	•	•		EUR 385 per year (*eigen risico*) to EUR 885 (*vrijwillig eigen risico*) depending on premium choice.	<18 years. GP services, emergency treatments at GP after hours, district nursing care, obstetric and maternity care, care covered by supplementary insurance.	Enrollees can choose to pay deductible in monthly installments. People with low income can apply for a means-tested contribution to healthcare costs. In 2025, this amounted to up to EUR 131 per month for an income at EUR 28 000 or below for a single.
Türkiye	•			•	-	People that receive support by the social assistance and solidarity and solidarity foundations in accordance with	

						Law No. 3294 of the Promotion of Social Assistance and Solidarity	
United Kingdom	*No cost-sharing in place*						
United States (Medicaid)	•		•	•		People below income (USD 1 325 for single) and wealth thresholds (USD 9 660 for single) quality for Medicare Savings Program or Qualified Individual Program. Selected annual screenings exempt.	