World Health Organization

European Region

Using income-based caps to protect people from user charges for health care

Lessons from Austria, Belgium, Germany and Spain

Improving affordable access to health care

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

A key part of the work of the Office is to assess country and regional progress towards UHC by monitoring affordable access to health care (financial protection). Financial protection is a core dimension of health system performance, an indicator for the Sustainable Development Goals, part of the European Pillar of Social Rights and central to the European Programme of Work, WHO European Region's strategic framework. The Office supports countries to strengthen financial protection through tailored technical assistance, including analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience.

The Office disseminates country-specific and internationally comparable data and policy analysis through UHC watch, a digital platform tracking progress on affordable access to health care in Europe and central Asia.

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Abstract

A small number of countries in Europe protect people from user charges for health care by setting a limit – a cap – on co-payments. Some of these countries go a step further and link the cap to income, so that it gives greater protection to people with lower incomes. Linking caps to income enhances equity and efficiency in the use of public funds and softens the impact of the cap on the health budget. This brief summarizes the use and impact of income-based caps in Austria, Belgium, Germany and Spain and draws lessons for the four countries and for other countries concerned about the negative effects of user charges on affordable access to health care.

Keywords

AFFORDABLE ACCESS
AUSTRIA
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GERMANY
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
SPAIN
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

UHC watch

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A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

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#3

Country pages with data, policy options and resources

#4

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About the series

This series of briefs provides policy-makers with information on steps they can take to improve affordable access to health care (financial protection).

Each brief:

- focuses on policy changes introduced in one or more health systems in Europe and central Asia;
- considers the implications of the policy change for out-of-pocket payments, financial hardship and unmet need for health care, particularly in people with low incomes; and
- identifies the lessons learned from this experience, both for the countries involved and for other countries.

The series covers a range of health system issues but always aims to highlight the role of health financing policy in improving affordable access to health care.

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Abbreviations

IT	information technology
MAF	maximumfactuur-maximum à facturer [maximum billing]
REGO	rezeptgebührenobergrenze [prescription fee cap]
SHI	social health insurance

Country codes

ALB: Albania; ARM: Armenia; AUT: Austria; BEL: Belgium; BIH: Bosnia and Herzegovina; BUL: Bulgaria; CRO: Croatia; CYP: Cyprus; CZH: Czechia; DEN: Denmark; DEU: Germany; EST: Estonia; FIN: Finland; FRA: France; GEO: Georgia; GRE: Greece; HUN: Hungary; IRE: Ireland; ISR: Israel; ITA: Italy; LTU: Lithuania; LUX: Luxembourg; LVA: Latvia; MAT: Malta; MDA: Republic of Moldova; MKD: North Macedonia; MNE: Montenegro; NET: Netherlands (Kingdom of the); POL: Poland; POR: Portugal; ROM: Romania; SRB: Serbia; SVK: Slovakia; SVN: Slovenia; SPA: Spain; SWE: Sweden; SWI: Switzerland; TJK: Tajikistan; TUR: Türkiye; UKR: Ukraine; UNK: United Kingdom.

Summary

User charges (co-payments) are widely applied in European health systems, posing a challenge for universal health coverage and health system performance. Policy-makers can overcome some of these challenges by paying attention to the design of user charges. Relatively simple changes in design can have a significant impact on affordable access to health care (financial protection).

A small number of countries in Europe protect people from user charges by setting a limit – a cap – on co-payments. Some of these countries go a step further and link the cap to income, so that it gives greater protection to people with lower incomes. Linking caps to income enhances equity and efficiency in the use of public funds and softens the impact of the cap on the health budget.

Austria, Belgium, Germany and Spain have income-based caps on co-payments. Their experience shows how important it is for caps to be applied to all people and all co-payments; applied automatically, using digital solutions to remove administrative barriers to entitlements; adjusted for household size; applied on a monthly rather than annual basis, in line with people's income flows; monitored regularly; and adapted as needed.

This brief summarizes the use and impact of income-based caps in Austria, Belgium, Germany and Spain and draws lessons for the four countries and for other countries concerned about the negative effects of user charges on affordable access to health care.

The policy challenge

User charges (co-payments) are widely applied in European health systems, posing a challenge for universal health coverage and health system performance (Box 1). Policy-makers can overcome some of these challenges by paying careful attention to the design of user charges. Relatively simple changes in design can have a significant impact on affordable access to health care (financial protection) (Box 2).

Studies have shown that countries can reduce the financial hardship and unmet need associated with out-of-pocket payments by introducing or improving mechanisms to protect people from co-payments – for example, through exemptions from co-payments and caps on co-payments (WHO Regional Office for Europe, 2023; Cylus et al., 2024; Thomson et al., 2024).

Exemptions effectively abolish co-payments for selected groups of people or types of health care and are most likely to improve financial protection if they target people with low incomes or chronic conditions (WHO Regional Office for Europe, 2023). All health systems in Europe have some exemptions from co-payments, indicating widespread recognition of the harm user charges can do, but only a minority explicitly exempt people with low incomes or chronic conditions (UHC watch, 2025).

Caps set a limit on co-payments rather than abolishing them. They are most likely to improve financial protection if they are:

- applied to all people, so that everyone benefits;
- applied to all co-payments, to enhance financial certainty;
- applied automatically, using digital solutions, so that everyone who reaches the cap benefits from it: this removes administrative barriers to accessing entitlements;
- linked to household income, so that they provide stronger protection for people with lower incomes: this enhances equity and efficiency in the use of public funds and softens the impact of the cap on the health budget;
- adjusted for household size, so that households of all sizes benefit equally;
- applied on a monthly rather than annual basis, in line with people's income flows;
- monitored regularly, so that they can be adapted as needed; and
- simple, so that people understand them.

Very few countries in Europe have caps on co-payments and only a handful link caps to income (UHC watch, 2025). This brief focuses on the experience of Austria, Belgium, Germany and Spain, four countries that introduced income-based caps on co-payments over 10 years ago, starting with Germany in 1989. It summarizes the policy change in each of the four countries, compares the design of the cap across countries, describes the impact the cap has had and draws lessons for countries concerned about the negative effects of user charges on access to health care.

The brief uses the terms "user charges" and "co-payments" interchangeably. Both terms include balance billing (a situation in which providers are allowed to charge people more than the price or tariff set by the third-party payer for covered health care).

Box 1. Despite the evidence against them, user charges are widely applied in Europe

A large body of evidence on the impact of user charges shows that they are not effective in directing people to use health care more efficiently because:

- faced with user charges, people reduce the use of essential and non-essential health care, including medicines, in equal measure (Newhouse & Insurance Experiment Group, 1993; Brook et al., 2006);
- people do not value interventions more highly when they have to pay for them out of pocket (Ashraf, Berry & Shapiro, 2010; Cohen & Dupas, 2010);
- user charges fail to address the root causes of informal payments (Gaal & McKee, 2004; WHO Regional Office for Europe, 2018);
- most decisions about health care use and costs are made by providers, not patients (Chernew et al., 2021);
- even relatively low user charges can deter people from using needed health care, reduce adherence to essential medicines and other forms of treatment, increase the use of other health services, lead to financial hardship, increase the use of social assistance and adversely affect health, particularly in people with low incomes or chronic conditions (Tamblyn et al., 2001; Goldman, Joyce & Zheng, 2007; Chernew & Newhouse, 2008; Chandra, Gruber & McKnight, 2010; Persaud et al., 2019; Madden et al., 2021; Rättö & Aaltonen, 2021; Aaltonen, Niemelä & Prix, 2022; Gross et al., 2022; Guindon et al., 2022; Fusco et al., 2023; Rättö et al., in press);
- studies have shown that user charges lead to financial hardship (catastrophic and impoverishing health spending) and unmet need for health care for many people in Europe – particularly people with low incomes (WHO Regional Office for Europe, 2023b; Cylus et al., 2024; Thomson et al., 2024); and
- user charges undermine equity in financing health care and are administratively inefficient compared to public sources of revenue (Wagstaff et al., 1999).

Despite this evidence, user charges are widely applied in European health systems, often to treatment in primary care settings. Many countries rightly avoid applying user charges to primary care visits, outpatient specialist visits and inpatient care but most impose co-payments on outpatient prescribed medicines, medical products (e.g. inhalers and hearing aids) and dental care.

Note: see UHC watch (2025) for up to date information on user charges in over 40 countries in Europe and central Asia; select the user charges filter in UHC watch's *Policy explorer*.

Source: adapted from WHO Regional Office for Europe (2023).

Box 2. User charges can be redesigned to make them less harmful

User charges are a major driver of financial hardship for households in many countries in Europe. Analysis suggests that they are most likely to undermine affordable access to health care when they are applied without multiple mechanisms to protect people (e.g. exemptions and caps) or when protection mechanisms exist but are poorly designed (Cylus et al., 2024; Thomson et al., 2024).

User charges in many countries are also complex and bureaucratic, which undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements (Salampessy et al., 2018). Percentage co-payments, balance billing (including internal reference pricing) and extra billing are particularly non-transparent; they also shift financial risk from the purchasing agency to households and expose people to out-of-pocket payments arising from health system inefficiencies.

The harm caused by user charges can be reduced if they are applied sparingly and carefully designed in the following ways:

- exemptions for people with low incomes or chronic conditions;
- an income-based cap on all user charges for everyone;
- exemptions and caps are applied automatically, using digital solutions;
- percentage co-payments are avoided or replaced by low fixed co-payments;
- balance billing and extra billing are avoided or abolished; and
- user charges are as simple as possible, aim to protect people rather than diseases and minimize administrative barriers.

When user charges are carefully designed, people know exactly how much they must pay out of pocket before they visit a doctor, undergo a diagnostic test or fill a prescription; they know that they do not have to pay more than a certain amount a year; and they automatically benefit from exemptions and caps, without having to apply for them.

Source: adapted from WHO Regional Office for Europe (2023).

The policy change

All four countries currently apply co-payments to some health care, although the design of co-payments varies substantially across the countries. Table 1 shows that co-payments are least likely to be applied in Spain and Germany; are more frequently applied in Austria, but with many exemptions; and are widely applied in Belgium, with very few exemptions (Table 1).

Table 1. User charges (co-payments) for health care by type of care, 2025

Notes: Yes: user charges (which may include balance billing) are applied. No: user charges are not applied. Countries sorted from lower to higher application of user charges. See UHC watch (2025) for detailed information on user charges and protection from user charges (use the *Policy explorer* function).

Source: UHC watch (2025).

Country	Emergency visits	Primary care visits	Specialist visits	Diagnostic tests	Inpatient care	Dental care	Outpatient prescribed medicines	Medical products
Spain	No	No	No	No	No	No, but very limited coverage	Yes, but with exemptions for some people with very low incomes	Yes, but with exemptions for a very small group of people with very low incomes
Germany	No	No	No	No	Yes, but not for children < 18	Yes, but not for people with very low incomes	Yes, but not for children < 18	Yes, but not for children < 18
Austria	Yes, but not for employees or pensioners	Yes, but not for many employees, many pensioners and some other groups	Yes, but not for many employees, many pensioners and some other groups	Yes, but not for many employees, many pensioners and some other groups	Yes	Yes, but not for children < 18	Yes, but not for people receiving the minimum pension and some other groups	Yes, but not for children < 15, pensioners with very low incomes and some other groups
Belgium	Yes	Yes, but not for people < 25 entitled to reduced co-payments and some other groups	Yes, but not for people < 25 entitled to reduced co-payments and some other groups	Yes	Yes	Yes, but not for children < 19	Yes	Yes

Germany introduced an income-based cap on co-payments in 1989 as part of the Health Reform Act. Known as *überforderungsklause*l [overburden clause], the cap was set at 2% of a household's income. In 1997 the cap was lowered to 1% for people with chronic conditions (Siegel & Busse, 2018; UHC watch, 2025).

In 2002 Belgium introduced an income-based cap to address concerns about the rising financial burden of widespread user charges. The cap is known as *maximumfactuur-maximum à facturer* (MAF) [maximum billing] and has always been applied automatically, building on the experience of an automated cap on co-payments for groups such as pensioners and people with disabilities (Schokkaert et al., 2008). When the MAF was initially proposed by the Ministry of Social Affairs and the social health insurance (SHI) scheme (the National Institute

for Health and Disability Insurance), it had the support of most health insurance funds and patient groups but opponents worried that it would be unfair to adjust SHI benefits based on household income, and that the cap might encourage people to use more health care than necessary and add to budgetary and administrative pressure for the SHI scheme.

Austria introduced an income-based cap on co-payments for outpatient prescribed medicines in 2008 to protect people who were not exempt from co-payments (Czypionka, Röhrling & Six, 2018). The cap, known as *Rezeptgebührenobergrenze* (REGO) [prescription charge cap], was introduced without significant opposition but the SHI scheme (the Federation of Austrian Social Security Institutions) had concerns about the budgetary and administrative implications. Others expressed concern about the design of the cap, arguing that it was unfair because larger households were more likely to reach the cap than smaller households.

Before 2012, pensioners in Spain were exempt from co-payments for outpatient prescribed medicines. In response to the economic crisis, the Government used a royal decree to shift more of the cost of these medicines onto households: the decree abolished the exemption from co-payments for pensioners, increased percentage co-payments for the general population and excluded more than 400 medicines (mainly for treating minor conditions) from the National Health System benefits package (Urbanos-Garrido et al., 2021). At the same time, to protect older people, the Government introduced an income-based cap on co-payments for pensioners.

Table 2 summarizes the main strengths and weaknesses of the cap in each of the four countries.

Table 2. Main strengths and weaknesses of the design of the income-based cap

Source: authors.

The cap	Austria	Belgium	Germany	Spain
applies to all people	✓	✓	✓	✗ (pensioners only)
applies to all co-payments	✗	✓ (most, but not balance billing)	✓	✗ (most, but not co-payments for ortho-prosthetic medical products)
is applied automatically and immediately	✓	✓ (mostly; not immediately for outpatient visits)	✗	✓
is adjusted for household size	✗	✗	✗	✓
is applied on a monthly rather than annual basis	✗	✗	✗	✓
is monitored	✓	✓	✓	✗

Table 3 compares the design of the income-based cap across the four countries.

Spain's cap has many positive design features: it is automatically applied to co-payments for outpatient prescribed medicines, which account for the bulk of co-payments for National Health System benefits; it applies to individuals, so it does not disadvantage smaller households relative to larger households; and it is applied on a monthly basis. The use of a monthly rather than annual cap is more aligned with people's income flows (e.g. salaries and pensions) and may benefit people with low incomes who might otherwise struggle to pay co-payments up to an annual cap threshold.

The Spanish cap's main weakness is that it only applies to pensioners (mostly retired people over 65 years old, plus people receiving disability and other pensions). It has two other limitations. First, one of the income threshold bands is very broad, encompassing people with annual incomes ranging from €18 000 to €100 000; as a result, the cap is more protective for people with higher incomes in this band. Second, the cap is not monitored, so there are no data available on how many people it benefits.

Since 2020 the Government of Spain has taken steps to protect some working-aged people from co-payments for outpatient prescribed medicines, for example, by extending exemptions from co-payments to people benefiting from the minimum income scheme (in 2020) and to households receiving child benefits (in 2021). At the end of 2024 the Ministry of Health proposed a draft law to apply the cap to working-aged people with annual incomes under €35 000; however, if implemented, the proposed new cap will be less protective for many working-aged people than the cap for pensioners (Ministerio de Sanidad, 2024).

The design of the cap appears to be relatively protective in Belgium: it is automatically applied to all covered people and most co-payments; it is monitored; and it has been adjusted over time to make it more protective for people with chronic conditions (in 2009) and people with low incomes (in 2022) (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023). Also, although the cap has been indexed since 2017, in 2023 it was temporarily frozen to help households cope with a rapid increase in living costs (UHC watch, 2025).

A clear strength of the caps in Austria and Germany is that they are set as a share of household income (rather than as flat amounts, as in Belgium and Spain), so that the threshold rises smoothly with income. Importantly, the share is set relatively low: 2% in both countries and 1% for people with chronic conditions in Germany.

The main weakness of the cap in Austria is that it only applies to co-payments for outpatient prescribed medicines. In Germany, the cap's main weakness is that it is not applied automatically.

Table 3. Comparison of the design of the income-based cap

Note: all values reported are as of 31 January 2025.

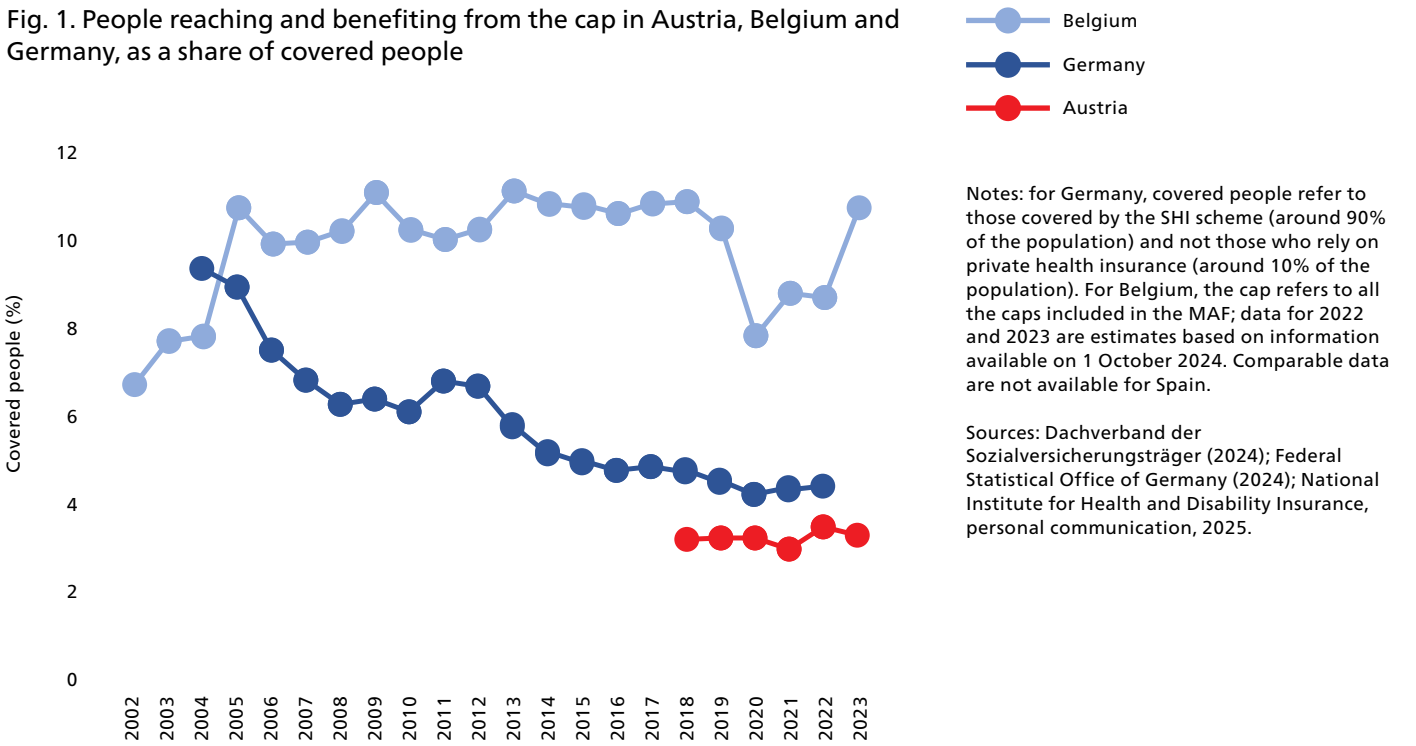
Source: UHC watch (2025) and authors.

	Austria: REGO, introduced in 2008	Belgium: MAF, introduced in 2002	Germany: overburden clause, introduced in 1989	Spain: introduced in 2012
Does the cap apply to all covered people?	Yes	Yes	Yes	No; only to pensioners (mostly people aged > 65)
Does the cap apply to all user charges?	No; only to co-payments for outpatient prescribed medicines	No; it applies to nearly all types of health care but it does not apply to balance billing	Yes	No; it does not apply to co-payments for ortho-prosthetic medical products
Is the cap applied automatically?	Yes	Sometimes; automatically for outpatient medicines and inpatient care but not for outpatient visits (for which people are retrospectively reimbursed at the end of the month)	No	Yes
Is the cap set as a share (%) of income or as fixed amounts?	Share (2%) of annual individual net income (e.g. €240 for an annual income of €12 000)	Fixed amount; varies depending on the household's annual income: • ≤ €13 079: €260 • €13 079–€23 399: €527 • €23 399–€35 972: €762 • €35 972–€48 545: €1172 • €48 545–€60 594: €1640 • ≥ €60 594: €2109	Share (2%) of annual household income (e.g. €240 for an annual income of €12 000)	Fixed amount; varies depending on annual individual income: • < €18 000: €8.23 (€99 a year) • €18 000–€100 000: €18.52 (€222 a year) • > €100 000: €61.75 (€742 a year)
How is income status determined?	Automatically; the SHI scheme can access information about the amount of income on which SHI contributions are levied	Automatically; health insurance funds can access information on income in the tax year two years prior to the current year from the National Institute for Health and Disability Insurance, which obtains this information from the tax agency	People need to submit proof of household income to their health insurance fund	Automatically; the tax agency sends information on income in the previous tax year to the National Health System
In addition to being linked to income, is the cap more protective for some groups of people?	No	Yes; the cap is reduced by €117 for people with chronic conditions; the cap for people who benefit from reduced co-payments (households with low incomes, children with disabilities and orphans) is set at €527; an individual cap for all children < 19 is set at €762; people benefit from the most protective cap they are eligible for, so children in households with low incomes benefit from a more protective cap	Yes; the cap is reduced to 1% of annual income for people with chronic conditions	No
Is the cap applied to individuals or households?	Households	Households	Households	Individuals
Is the cap applied on a monthly or annual basis?	Annual	Annual	Annual	Monthly
Is the cap monitored and by whom?	Yes, by the Federation of Austrian Social Security Institutions	Yes, by the health insurance funds	Yes, by the health insurance funds, who send data to the Federal Ministry of Health	No, the cap is not monitored

Impact

Fig. 1 shows the impact of the cap, measured in terms of the share of covered people who benefit from the cap in Austria, Belgium and Germany. Because the cap is not monitored in Spain, comparable data are not available for Spain.

Fig. 1. People reaching and benefiting from the cap in Austria, Belgium and Germany, as a share of covered people



Notes: for Germany, covered people refer to those covered by the SHI scheme (around 90% of the population) and not those who rely on private health insurance (around 10% of the population). For Belgium, the cap refers to all the caps included in the MAF; data for 2022 and 2023 are estimates based on information available on 1 October 2024. Comparable data are not available for Spain.

Sources: Dachverband der Sozialversicherungsträger (2024); Federal Statistical Office of Germany (2024); National Institute for Health and Disability Insurance, personal communication, 2025.

The share of covered people benefiting from the cap is highest in Belgium (around 11% in 2023), possibly due to the heavy use of co-payments in the SHI scheme (see Table 1). Co-payments are applied to all types of health care and although some groups of people benefit from reduced co-payments, very few people are exempt and no one is exempt on the basis of income (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023). The share of covered people benefiting from the cap fell sharply in 2020, reflecting a fall in health care use (and co-payments) in response to coronavirus disease lockdowns (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023).

Austria's relatively low share of beneficiaries may reflect two factors: the cap only applies to co-payments for outpatient prescribed medicines and other protective mechanisms are in place, reducing the pool of people needing protection through a cap – for example, people receiving a minimum pension, people who opt for civilian rather than military mandatory service and people with specific communicable diseases are automatically exempt from these co-payments, while people with low incomes can apply for exemption (UHC watch, 2025).

The cap covers a wider range of user charges in Germany than in Austria and is lowered from 2% to 1% of household income for people with chronic conditions. This suggests that the German cap should benefit a larger share of covered people than the Austrian cap, but in practice the share is very similar in the two countries. This may be because the German cap is not applied automatically, as it is in the other three countries (see the section on user experience, below). Instead, people in Germany have to keep their co-payment receipts and apply to their health insurance fund for refunds and an exemption once they think they have reached the cap threshold.

It is not known how many people in Germany actually reach the cap's threshold because there is no data sharing between the health insurance funds and the tax agency. However, international experience suggests that the lack of automation is likely to have a significantly negative impact on take up. For example, survey data from Belgium show that when people with low incomes have to apply for reduced co-payments, only 30% of eligible people of working age and 60% of eligible people over 65 do so (Goedemé, Bolland & Janssens, 2022). Similarly, analysis from Estonia shows that applying reduced co-payments automatically in the pharmacy, using the pharmacy information technology (IT) system, increased take-up from 38% to 100% (Kasekamp & Habicht, 2025).

The four countries provide relatively good levels of financial protection compared to many other countries in Europe, including many other European Union countries: the share of households with catastrophic health spending ranges from 2.4% in Germany and 2.9% in Spain to 4.2% in Austria and 5.2% in Belgium (Fig. 2). In all four countries, however, catastrophic health spending is heavily concentrated in the poorest fifth of households, although to a lesser extent in Belgium (Fig. 3). The incidence of catastrophic health spending is therefore much higher than average in the poorest fifth of households, ranging from 7.5% in Germany to 10.8% in Spain, 12.2% in Belgium and 14.9% in Austria (UHC watch, 2025).

The relatively high incidence of catastrophic health spending in the poorest households in Austria and Belgium could reflect the following factors: widespread application of user charges in Belgium, with some reduced rates but no exemptions for people with low incomes; the cap in Belgium does not apply to balance billing, which is quite extensive; and the cap in Austria only applies to outpatient prescribed medicines (Czypionka, Röhrling & Six, 2018; Bouckaert, Maertens de Noordhout & Van de Voorde, 2023). Although pensioners with very low pensions are automatically exempt from most co-payments in Austria, other households with low incomes may have to pay out of pocket for covered health care (UHC watch, 2025). This suggests that a cap alone is not enough to protect people with low incomes.

In contrast, user charges are applied much less frequently in Germany and Spain, with some exemptions for people with very low incomes (Siegel & Busse, 2018; Urbanos-Garrido et al., 2021; UHC watch, 2025). Although the cap has important weaknesses in both countries (it only applies to pensioners in Spain and is not applied automatically in Germany), these weaknesses may not be as damaging as they would be if co-payments were more widely applied.

Fig. 2. Share of households with catastrophic health spending and out-of-pocket payments as a share of current spending on health, latest available year

Note: data on out-of-pocket payments are for the same year as data on catastrophic health spending (2022 for Slovakia). Data on catastrophic health spending in Austria are for 2019/2020. Austria, Belgium, Germany and Spain are highlighted in red. The country codes used here can be found in the Abbreviations.

Source: data on catastrophic health spending from UHC watch (2025); and data on out-of-pocket payments from WHO (2025).

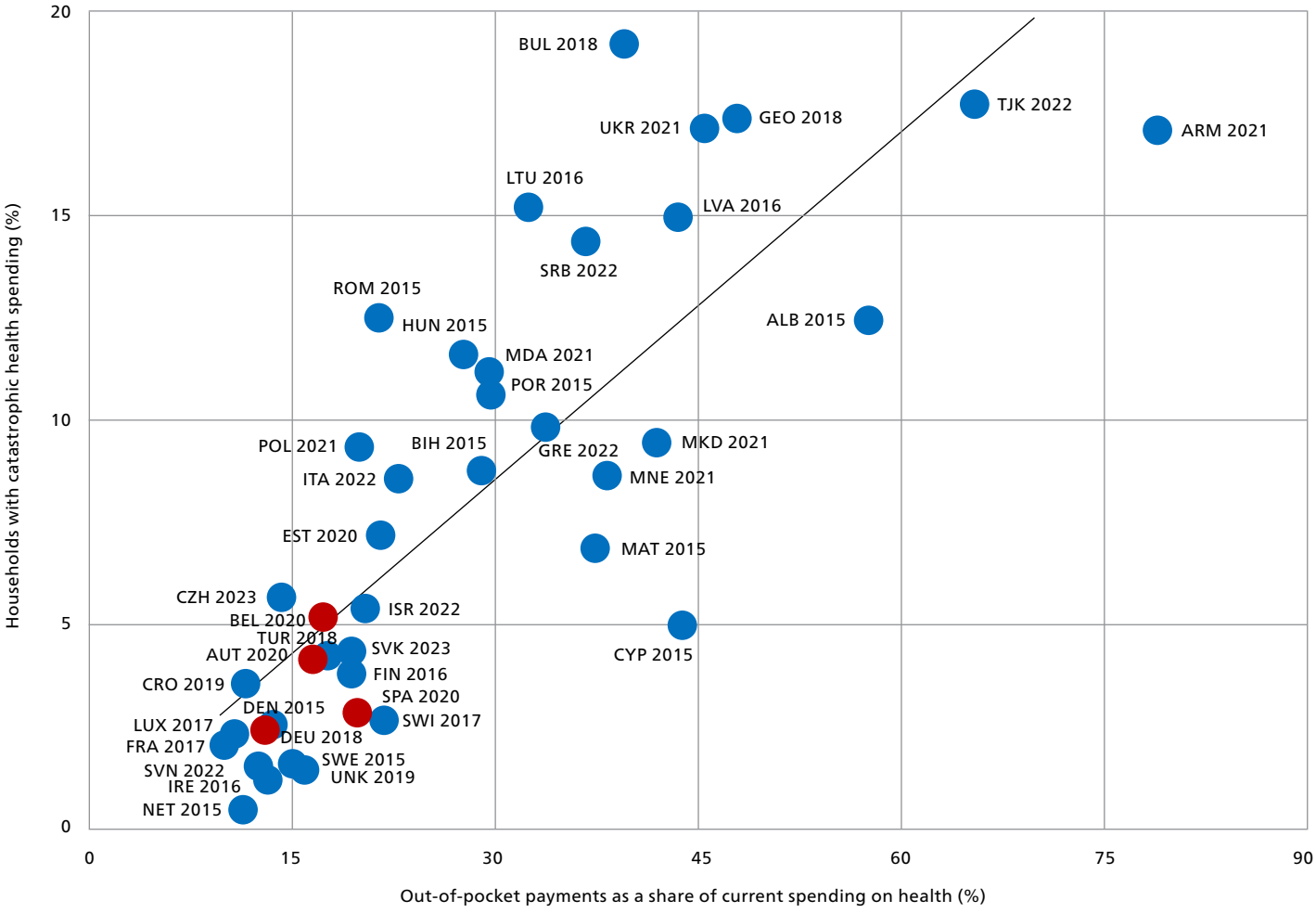
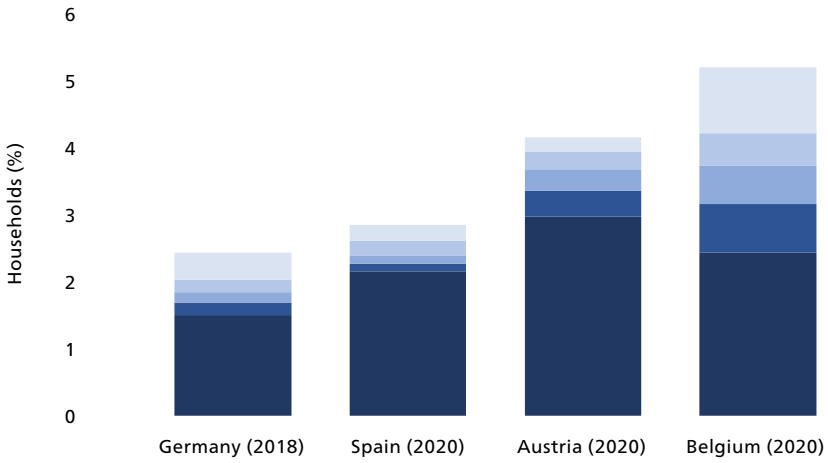


Fig. 3. Share of households with catastrophic health spending by consumption quintile



Note: data for Austria are for 2019/2020. Quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled "poorest" and the fifth quintile "richest".

Source: UHC watch (2025).

User experience

One of the most important differences in design across countries is whether the cap is applied automatically or not.

Fig. 4 illustrates how the cap works from the perspective of a person with chronic conditions: Maria is 70 years old and receives a lower-than-average pension. She lives with hypertension and diabetes, takes medicines for her chronic conditions every day, visits her primary care doctor at least once every three months and undergoes regular laboratory tests.

In Austria, Belgium and Spain the cap is applied automatically and does not require any action on Maria's part – she might not even need to know about it. As soon as she reaches the cap's income threshold, the IT system immediately prevents her from having to pay co-payments covered by the cap.

In contrast, the cap in Germany is not applied automatically, so Maria has to:

- pay co-payments up front;
- know about the cap and how much she has to pay in co-payments to meet the income threshold;
- keep all her co-payment receipts;
- apply for a refund once she thinks she has reached the threshold, providing her health insurance fund with co-payment receipts, proof of income and medical certificates confirming her chronic conditions; and
- wait to see if her application is successful and she is re-funded for any co-payments that she has paid beyond the cap – a process that can take several weeks, depending on her health insurance fund.

Only at this point is Maria automatically exempt from paying co-payments for the rest of the year.

In Belgium Maria is disadvantaged by having to pay up front for outpatient visits and wait for a refund from her health insurance fund. This is because – unlike in most other European Union countries – retrospective reimbursement is still allowed for outpatient care providers (except for general practitioners when treating people with a low income, disabled children and orphans) (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023). Also, if Maria's outpatient or inpatient health care providers charge her higher than normal prices (balance billing), she must bear the cost of these user charges herself because the cap does not apply to balance billing.

In Austria the cap only applies to outpatient prescribed medicines, so Maria may have to pay for other types of outpatient care, depending on which health insurance fund she is covered by. However, she is likely to be exempt from most co-payments if she receives the minimum pension.

Fig. 4. User pathway showing the steps required for Maria to benefit from an income-based cap

Note: the cap only applies to pensioners in Spain.

Source: authors.

Spain

Step 1
At the doctor, Maria is given an electronic prescription; there are no co-payments for outpatient visits

Step 2
At the pharmacy, Maria shows her health insurance card; the IT system knows if she has reached the cap and she does not have to pay for medicines above the cap

Austria

Step 1
At the doctor, Maria's electronic health record informs the doctor if she has reached the cap or not; if she has, the doctor ticks a box to apply the cap to her electronic prescription

Step 2
At the doctor, Maria may have to pay the doctor for the visit (co-payments), depending on her health insurance fund and other factors

Step 3
At the pharmacy, the IT system knows when Maria has reached the cap and she does not have to pay for medicines above the cap

Belgium

Step 1
At the doctor, Maria is given an electronic prescription

Step 2
At the doctor, Maria pays the doctor for the visit (co-payments and balance billing)

Step 3
At the pharmacy, the IT system knows if Maria has reached the cap and she does not have to pay for medicines above the cap

Step 4
At the end of the month, Maria's health insurance fund automatically refunds any co-payments for outpatient care that she has paid above the cap but it does not refund balance billing; the health insurance fund informs Maria of the refund by email, post or digital platform, according to her preference

Germany

Step 1
At the doctor, Maria is given an electronic prescription; there are no co-payments for outpatient visits

Step 2
At the pharmacy, Maria pays the co-payments for her medicines and obtains a receipt

Step 3
At home, Maria stores the receipt in a safe place

Step 4
Once Maria thinks she has reached the cap, she applies to her health insurance fund (by post or electronic submission) for a refund of co-payments above the cap, attaching her co-payment receipts, proof of income and medical certificates confirming her chronic conditions

Step 5
The health insurance fund checks Maria's request; this process can take several weeks, depending on the health insurance fund

Step 6
If her application is approved, the health insurance fund refunds Maria for money spent on co-payments above the cap and exempts her from paying co-payments for the rest of the year

Lessons learned

The design of income-based caps in Austria, Belgium, Germany and Spain provides important lessons for other countries in Europe. Even though user charges are widely applied in European health systems, only a few countries cap co-payments and only a handful link caps to income (UHC watch, 2025). This shows the potential for many countries to protect people from co-payments by introducing or improving caps.

Caps should apply to all people. Everyone can benefit from the financial certainty that a limit on co-payments provides. A major weakness of the cap in Spain is that it only applies to pensioners. To address this shortcoming, the Government has recently proposed extending the cap to working-aged people with low incomes. It could also consider extending the cap to the whole population, as Austria, Belgium and Germany do.

Caps should apply to all co-payments. Caps that only cover some co-payments do not provide as much financial certainty as caps that cover all co-payments and could create perverse incentives (e.g. if they steer people towards types of health care covered by the cap). Austria's cap only covers co-payments for outpatient prescribed medicines; extending it to all co-payments would improve financial protection and enhance administrative efficiency by creating a single system of protection from co-payments.

Linking caps to income helps to address concerns about financial sustainability. Countries may fear the budget impact of introducing a cap or extending an existing cap to all people and all co-payments. Flat caps are of greater benefit to people with higher incomes, which makes them more difficult to justify. In contrast, income-based caps that aim to give stronger protection to people with lower incomes are not only more likely to improve financial protection but will also ensure equity and efficiency in the use of public funds and soften the impact on the budget.

Income-based caps require health system capacity to track a person's health care spending and access to data on household income. Austria, Belgium, Germany and Spain have a system of unique user numbers, which is the minimum requirement for tracking a person's health care spending. In Austria the SHI scheme has access to data on current household income because it collects mandatory SHI contributions levied on earnings. In Belgium and Spain, the health system can access data on income from the tax agency. Germany requires people to provide their own proof of income. One disadvantage of using tax agency data is that it may not be up to date (e.g. the tax agency data used in Spain is for the previous tax year, while in Belgium it is for two years earlier). This can cause problems for people who retire, lose their jobs or experience a fall in income and have to wait for a new income assessment.

Caps should be applied automatically, using digital solutions, to remove administrative barriers to accessing entitlements. International experience shows that take up of protection mechanisms is significantly lower when people have to apply for them. Interoperable digital solutions (e-prescriptions and electronic health records linked to health care provider IT systems) play a vital role in enabling an automatic cap in Austria, Belgium and Spain. Learning from this, Germany should consider applying its cap automatically.

As a first step, it should monitor how many people actually reach the cap by linking health insurance fund data on co-payments with income data from the tax agency.

Caps should be applied on a monthly rather than annual basis, in line with people's income flows. Most people receive their salaries or pensions monthly and some of them may struggle to pay the amount needed to reach an annual cap. This is why Spain has a monthly cap. Changing to a monthly cap can be easily done once a digital solution is in place. It would be of particular benefit to people with low incomes.

Caps should be adjusted for household size, so that households of all sizes benefit equally. The cap in Spain applies to an individual person, but in the other countries it is applied at household level, which provides greater benefit to larger households.

Caps should be regularly monitored and adjusted as needed. Belgium carefully monitors its cap and has used data to adjust the cap and enhance its effectiveness. It has also adjusted the cap in response to changing circumstances (e.g. rapid increases in the cost of living). Austria and Spain can follow Belgium's lead in monitoring the cap and adjusting it in response to evidence and changing circumstances.

The public should be aware of the cap. If the cap is not applied automatically, as in Germany, it is important to make sure people are aware of the cap. Even when caps are applied automatically, it is worth investing in public awareness campaigns so that people know in advance that they may be eligible for protection from co-payments; this can help to ensure people use health care when it is needed, without fear of financial hardship.

Caps alone are unlikely to be enough to protect people from financial hardship and unmet need. Countries should also take steps to exempt people with low incomes from all co-payments (including by lowering existing caps to 0) and remove administrative barriers to accessing entitlements (WHO Regional Office for Europe, 2023; Cylus et al., 2024).

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