7.F. Workshop: Out-of-pocket costs in Europe and their effects on health-care use

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Over the past decades, health care expenditures increased in most OECD countries and are expected to increase even more. A wide ranges of policies are implemented to try to limit this development. Several governments (e.g. of Denmark, Estonia, France, Greece, Ireland, Romania, Russian Federation, Switzerland, and Turkey) increased or introduced patient cost-sharing. Patient cost-sharing can take several direct and indirect forms such as out-of-pocket costs and coverage exclusions, ranging from full third-party payment (zero cost-sharing) to full user charges (costs met completely by out-of-pocket payments).

Macro effects of cost sharing on health care expenditures generally prove to be limited. Nevertheless, there are indications that patient cost-sharing may lead to inequalities in health status between groups and may have unintended effects on the process and outcomes of therapy.

This workshop is aimed at giving an overview of the current state of out-of-pocket costs in Europe. In particular, the workshop will go through: a) out-of-pocket costs in different European countries; b) Case study: potential effects of OOP on compliance to specialty referrals in The Netherlands. The workshop will end with a general discussion on cost sharing.

Key messages:

- The more countries spent on OOP the lower the growth rate
- In the Netherlands, noncompliance to specialty referrals increased during the years in which OOP increased.

Revisiting OOP Requirements: Trends in Spending, Burden, and Policy

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Background

While all countries rely on out-of-pocket costs (OOP) to help fund their health care systems, there is little recent, systematic information on how OOPs are changing.

Methods

This study examines trends in 10 high-income countries between 2000 and present: Australia, Canada, France, Germany, the Netherlands, Norway, Sweden, Switzerland, the UK, and the US. Most data sources are from these countries, but the study also employs aggregate longitudinal spending data from the OECD, and longitudinal data on the perceived barriers of OOP from surveys conducted by the Commonwealth Fund.

Results

Based on analysis of the data, the countries are divided into three groups: (1) historically low OOP, higher recent growth; (2) Historically moderate OOP, lower recent growth; and (3) historically high OOP cost, low to no growth in recent years. In-depth tables detailing the different types of OOP and protection mechanisms in each of the countries, and changes in policies related to OOP in the countries will be shown.

Conclusions

Generally speaking, the more countries spent on OOP the lower the growth rate. This points to a converging of spending between countries. Second, nearly all countries have tried to ensure that those who are most vulnerable, either or both in terms of income

or health, are protected from high OOP. Third, there is a movement in some countries towards rising deductibles.

Increased OOP and changes in noncompliance with specialty referrals in The Netherlands

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Background

The compulsory deductible, a form of out-of-pocket costs (OOP) in the Netherlands, has more than doubled during the past years. There are indications that as a result, refraining from medical care has increased. We studied the relation between OOP and refraining from medical care by evaluating noncompliance with referrals to medical specialists over several years.

Methods

Noncompliance with specialty referrals was assessed in the Netherlands from 2008 until 2013, using routinely recorded referrals from general practitioners to medical specialists and claims from medical specialists to health insurers. Associations with patient characteristics were estimated using multilevel logistic regression analyses.

Results

Noncompliance rates were approximately stable from 2008 to 2010 and increased from 18% in 2010 to 27% in 2013. Noncompliance was highest in adults aged 25-39 years. The increase was highest in children and patients with chronic diseases. No significantly higher increase among patients from urban deprived areas was found.

Conclusions

Noncompliance increased during the rise of the compulsory deductible. Our results do not suggest a one-to-one relationship between increased OOP and noncompliance with specialty referrals. In order to develop effective policy for reducing noncompliance, it is advisable to focus on the mechanisms for noncompliance in the groups with the highest noncompliance rates (young adults) and with the highest increase in noncompliance (children and patients with chronic diseases).