

Patient cost-sharing for health care in Europe

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Summary

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Summary

This dissertation is devoted to the topic of patient cost-sharing, i.e. patient payments for health care services that are included in the statutory benefit package. The rising health care cost and resources constraints confront policy makers with the challenge to ensure the financial sustainability of health care systems, without jeopardizing the main health system objectives. Cost-sharing is one of the policy options to respond to this challenge. There is a twofold rationale behind cost-sharing policies. Firstly, implementing patient payments gives the opportunity to generate resources and thus, shift some of the health care cost from public budgets to patients. Secondly, making patients responsible for paying at the point of use is expected to change their behavior, i.e. reduce the utilization of unnecessary and low-value health care, so that health care resources are used more efficiently and the increase in health care cost is slowed down. Nevertheless, the introduction of patient cost-sharing might limit access to care or lead to impoverishment among the vulnerable population groups such as the low income individuals or chronically sick.

Despite the ongoing debates and concerns about the adverse equity effects, cost-sharing is broadly applied in Europe. Western European countries, following a substantial increase in their health expenditure in the 1960s and 1970s, began to implement cost-sharing as a cost-containment measure. In Central and Eastern European (CEE) countries, the role of cost-sharing became more significant after the collapse of communism. During the transition period, cost-sharing has been broadly applied to pharmaceuticals. However, the implementation of obligatory patient payments for publicly financed health care services encountered public opposition and proved to be politically difficult in many CEE countries. Nevertheless, underfunding of health care systems during the post-communist period led to spreading of non-regulated patient payments for health care services (informal and quasi-formal), which continue to exist to a greater or lesser extent in virtually all CEE countries.

Demographic trends for European countries indicate that patient cost-sharing is likely to gain relevance in the future. The need for sustainability measures is particularly evident in CEE countries, which are already struggling how to balance their health care system and in future, are likely to experience even more severe economic difficulties. To pursue cost-sharing

policy which responds to the challenges in the health care systems and remains without negative impact on equity, empirical analyses are needed to support policy makers in their decisions. However empirical evidence to strengthen cost-sharing policy is rarely available and used by policy makers, particularly in CEE countries.

To respond to the research needs, two research aims are specified in this dissertation. First, we aim to review the existing patient payment mix in European countries and identify its determinants. Along with formal cost-sharing arrangements, we study informal patient payments, as their presence has important implications for equity in health care and cost-sharing policy. To meet this aim, we rely on the analysis of available macro (country) level data for high number of European countries, including both Western European countries as well as CEE countries. Second, the dissertation is aimed to provide evidence on the potential of formal cost-sharing for health care services in CEE countries. We focus our attention on three aspects: the acceptability of cost-sharing for services, patients' financial barriers to the use of health care services, and consumers' willingness to pay for services. The analyses to meet the second research aim, draw upon primary (quantitative and qualitative) data collected between 2009 and 2010 in six CEE countries based on identical methodology. The countries included in the study are Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine. These countries share a similar communist past, however, they differ in in terms of economic development, health system characteristics, or experience with cost-sharing policy. In Bulgaria, obligatory fees have existed since 2000 when they were introduced together with the insurance system. In Hungary, the payments system was introduced in 2007 to be withdrawn only one year later as a result of a public referendum. In the other countries, obligatory formal charges for services included in the statutory benefit package have been under discussion but at the time of the study were not yet implemented.

Following the introductory chapter, this dissertation is divided into six chapters; Chapter 2 and Chapter 3 relate to first research aim, while the analyses to meet the second research aim are presented in Chapter 4-6. In Chapter 7, we summarize and discuss the main findings of the research.

In **Chapter 2**, we present the review of patients cost-sharing for health care services in 27 European Union (EU) countries (all EU countries in 2008). The review is focused on patient payment arrangements in 2007-2008, as well as the changes in cost-sharing policies since 1990. The chapter provides also evidence on the link between cost-sharing arrangements and

health care system characteristics (i.e. type of health care funding, provider payment mechanisms, presence of gate-keeping function, level of public health expenditure, presence of informal patient payments). Data are collected based on a review of international data bases, national laws and regulations, as well as scientific and policy reports. The analysis presents a combination of qualitative and quantitative research techniques.

The results show that in a majority of EU countries, patients pay a fee for the use of public health care services. Patient cost-sharing arrangements are quite diverse and this diversity could be explained by some health care system characteristics. Countries most often, rely on co-payments (flat-rate fee) for broad categories of services (visit to a physician, day of hospitalization). To prevent adverse equity effects, a broad range of mechanisms that accompany patient cost-sharing is present, i.e. payments limits, exemptions/reductions for selected population groups.

The results on the dynamics of patient cost-sharing for health care services indicate that the reliance on patient cost-sharing in the EU is increasing which is motivated by the growing fiscal pressure and sustainability problems within health care systems. The limitation to the implementation of patient cost-sharing for health care services in some EU countries, appears to have its ground in a strong public opposition. A lack of public acceptance of patient cost-sharing in a country is a factor which influences cost-sharing policies and restrains policy makers from the introduction of patient cost-sharing or even contributes to its abolishment.

The analysis presented in Chapter 2 is extended in **Chapter 3** where we review the formal-informal patient payment mix in 35 European countries (including non-EU countries). We consider three indicators of patient payment mix, i.e. the scope of formal patient payments for publicly financed health care, the spread of informal patient payments, and the level of total out-of-pocket expenditure. To explain the cross-country differences in the formal-informal patient payment mix, we search for economic, governance and cultural factors. The comparative quantitative analysis is supported by a qualitative description of selected country experiences with the implementation of patient cost-sharing.

The results show that there is a great diversity in the formal-informal payment mix in European countries. In most countries, formal cost-sharing is broadly applied i.e. for both commodities and health care services. The broad scope of formal cost-sharing does not always result in high total out-of-pocket expenditure, due to the relatively small magnitude of these payments or the presence of complementary private insurance. In some CEE countries,

formal cost-sharing (for commodities and services) co-exists with widespread informal payments. This results in a high burden of out-of-pocket expenditures for patients and in barriers to health care use. Relatively high out-of-pocket spending can be also observed in some CEE countries where formal cost-sharing is not applied for services, but patients bear high costs of pharmaceuticals, or meet other payment obligations (except for informal payments also quasi-formal charges, payments for services in a private sector). Thus, the room for the extension of cost-sharing in these countries is limited.

The results of quantitative analysis indicate that a different set of factors affects total out-of-pocket expenditures, the spread of informal patient payments and the scope of formal cost-sharing in European countries. The level of out-of-pocket payment (as % of GDP) is related to the economic indicator (the share of public expenditures in total health expenditures). Informal patient payments are a multi-cause phenomenon, influenced by governance, economic and social-cultural factors. The presence of obligatory cost-sharing for health care services is associated with governance factors, i.e. the countries with cost-sharing for services are those with a greater capacity of the government to effectively formulate and implement sound policies, and countries with a more extensive system of check and balance. Nevertheless, the qualitative analysis shows that a driving force for the implementation of cost-sharing is often the economic need. The results lead to the conclusions that building a consensus on cost-sharing might contribute to more stable cost-sharing policy.

Given the results of the analysis presented in Chapter 3, in **Chapter 4** we explore the acceptability of cost-sharing for health care services among the main health care system stakeholders, i.e. health care consumers, health care providers, policy makers and insurer representatives in six CEE countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine). To outline their opinions and expectations from cost-sharing policy in their country, we analyze qualitative data collected in 2009 in focus groups discussions and in-depth interviews, as well as quantitative data gathered among the same participants.

The results show that there is a rather weak consensus among the main stakeholder groups on the presence and role of cost-sharing in the six CEE countries. Health care policy makers and insurers strongly advocate patient charges. Cost-sharing is seen as a source of funds for health care, particularly in countries where resources for health care are low. Policy makers expect also that patient payments would change consumers' behavior towards more efficient use of health care resources. Health care providers also acknowledge the importance of

reducing unnecessary use of health care services, but their approval of charges is driven by the perspective of financial profit from the payment system and a low administrative burden. Health care consumers are generally against cost-sharing for health care services. Our results indicate that the low acceptability of fees among consumers follows from the poor quality and access to health care services offered in the public health care system in these countries, combined with the low transparency and accountability. Health care consumers have no trust that the implementation of obligatory formal patient payments would benefit patients, i.e. improve health care and reduce other patient payment obligations (informal, payments for privately purchased health care). There are also concerns about patient inability to pay the fee and thus, adverse equity effects.

In **Chapter 5**, we explore consumers' inability to pay for health care services in CEE countries. The analysis is based on the quantitative data collected in 2010 in nationally representative surveys in the same six CEE countries as those analyzed in Chapter 4 (i.e. Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine). Data are collected following the same methodology which allows for cross-country comparison. We present evidence on the frequency and level of patient payments for out-patient and hospital health care services and on the two indicators of inability to pay which represent different groups of strategies to cope with inability to pay: the need to borrow money and/or sell assets (representing strategies aimed at meeting health care costs) and foregoing health service utilization (a strategy to avoid costs).

The results presented in this chapter confirm that paying for health care services in CEE countries is frequent. Even when formal cost-sharing for health care services is not implemented, patients are often confronted with other forms of payments (informal, quasi-formal). However, we observe that there are significant differences in frequency, level and types of patient payments between the countries. Patient payments for health care services are very common in Bulgaria (reported by more than 70% of out-patient service users and more than 60% of hospital care users). Most of these payments are formal and comparatively small, which could be expected, as Bulgaria is the only country among the six analyzed, with a universal system of formal co-payments. Patients very often pay for health care services also in Ukraine, Romania and Lithuania. In contrast to Bulgaria, consumer expenditures on health care services in these countries include often informal payments which are relatively high. The percentage of users who report paying for health care services is lowest in Poland (where approximately 80% of users do not pay for services at all) and Hungary. Our results indicate

that Ukrainian and Romanian patients face the greatest burden of payments and difficulties to meet the costs of health care services. For example, in Ukraine more than 40% of consumers who pay for hospital services report borrowing money or selling assets to cover the payments and more than 60% of those who are in need of using health care, report foregoing at least one visit or one hospitalization due to inability to pay.

We also observe that there are significant differences in payments and in the inability to pay across socio-demographic groups of respondents. Patient payments are determined by health care needs, on one hand (i.e. paying is more frequent among those with poor self-perceived health status and with chronic condition), and the ability to pay for better quality and access to services, on the other hand (i.e. higher-income individuals pay more frequently). Further the results show that, individuals who have greater needs and those with a low ability to pay for services (i.e. those with low income) more often forego using health care services and more frequently borrow money and sell assets to cover payments, compared to healthier and wealthier groups.

Based on our results, we can also conclude that the choice of a strategy in response to payment difficulties might be affected by the ability of households to mobilize financial resources (e.g. younger respondents and those with a university education have greater ability to borrow money or sell assets), as well as the type of health problems and related costs, e.g. in case of inability to pay for out-patient services consumers more often apply strategy to avoid the cost (foregoing care) than to meet the cost (borrowing money/selling assets), while the opposite is true for hospital care.

As our study (presented in Chapter 4) reveals that consumers' opposition towards cost-sharing in CEE countries to a large extent can be explained by poor quality of health care services, in **Chapter 6** we investigate willingness to pay for publicly financed health care services which are provided with good quality and access. Just like in Chapter 5, the analysis draws upon data collected in the representative surveys conducted in 2010 in six CEE countries (Bulgaria, Hungary, Lithuania, Poland, Romania, Ukraine). We elicit information on the consumers' willingness to pay for two types of health care services, i.e. consultation with medical specialists and hospitalizations, using a stated willingness to pay technique, i.e. contingent valuation method. Stated willingness-to-pay data are compared with data on consumers' past payments reported in the same study. We also investigate the reasons for unwillingness to pay, i.e. objection to pay and inability to pay. The differences between the

countries and across socio-demographic groups of respondents are presented and discussed in the chapter.

The results confirm that consumers in CEE are willing to pay an official fee for publicly financed health care services that are of good quality and quick access. Nevertheless, our results show that the willingness to pay for services significantly differs across the six countries. The lowest shares of respondents willing to pay are in Hungary (66% for visits to specialist) and Poland (50% for hospitalizations). In the other four countries, a higher percentage of respondents express willingness to pay, reaching approximately 80% for visits to medical specialists in Romania and Lithuania and approximately 75% for hospitalizations in Ukraine and Romania. These results are in line with data on past payments reported by consumers in the six countries, i.e. Polish and Hungarian health care users report to pay less often than health care users in the other four countries. Among the respondents willing to pay for consulting medical specialists, the median amount, after correction for purchasing power parity, is the lowest in Ukraine (14 dollars) and the highest in Poland (27 dollars). The median willing-to-pay fee for hospitalization range from 192 dollars in Lithuania to 303 dollars in Bulgaria.

Although the majority of respondents is willing to pay for better and more accessible health care services, willingness to pay is limited by financial ability and to lesser extent by objection to pay. Inability to pay as the reason for their unwillingness is frequently reported in Bulgaria (by more than 70% of those unwilling to pay), Ukraine, Romania and Lithuania. The opposition towards paying for services is more frequently reported in Hungary and Poland. Inability to pay affects particularly those with lower income, no university education, worse health status or older age. These groups are more likely to be unwilling to pay due to their inability to pay or are willing and able to pay significantly lower amounts. On the other hand, the objection to pay is related to respondents' gender and place of residence, i.e. men and residence of urban areas are more likely to declare to be against paying for publicly financed health care services.

Based on the analysis presented in Chapter 6, we also discuss the usefulness of the contingent valuation method for cost-sharing policy making. We underline that the study is based on hypothetical statements that are sensitive to the information provided to the respondents and the results can be subject to various forms of bias, e.g. strategic bias when consumers misrepresent (understate) their true willingness to pay due to the concerns about the

introduction of fees. Moreover, given the various factors affecting consumers' willingness to pay (types of services, consumers' socio-demographic characteristics), it is challenging to use willingness-to-pay data to set up fee levels that reduce excess demand without preventing those in need from using necessary health care services.

In **Chapter 7** of this dissertation, the main findings are summarized and discussed from the perspective of policy and research. We draw conclusions on how to strengthen cost-sharing policy in European countries.

Based on the results of the review of patient payment arrangements in European countries, we discuss the potential of cost-sharing to contribute to the sustainability of the health care systems. We argue that patient cost-sharing in European countries does not allow for generating substantial resources for the health care systems. To limit the adverse equity effects, countries introduce relatively low fees and apply various exemptions and reductions for vulnerable population groups. Cost-sharing has also little potential to improve efficiency in the health care system, i.e. reduce the utilization of unnecessary services without affecting the use of essential services. Most countries apply uniform fees for broad categories of services which do not adequately moderate the utilization of services and are likely to reduce both, essential and non-essential services. Thus, the benefits from the cost-sharing implementation might be outweighed by the negative consequences for equity and consumers' financial protection. Cost-sharing arrangements in European countries should be reconsidered and new approaches should be applied, such as value-based cost-sharing which might more effectively moderate demand for health care services. Given the crucial role of health care providers in shaping the demand for health care services, cost-sharing should be aligned with supply-side measures to affect the behaviors of health care providers.

In this chapter, we also focus much of our discussion on the findings which are relevant for CEE countries. We argue that cost-sharing policies in these countries should be based on a broader consensus among health care system stakeholders to ensure its acceptability and stability. In this dissertation, we provide some evidence which can facilitate building the consensus on cost-sharing policy in CEE countries. Namely, we observe that the acceptability of cost-sharing policy among health care consumers is condition upon the improvement in quality and access to health care services. Hence, CEE governments need to develop adequate cost-sharing systems which will contribute to better health care for patients. The use of resources from cost-sharing should follow the investment plans worked out taking into

consideration the expectations of health care consumers for better quality and access as well as the interests of health care providers. To be successful, the strategy needs to be supported by a system of quality control to monitor and maintain quality levels.

When implementing cost-sharing for health care services, policy makers in CEE countries need to take account of the presence of different types of patient payments (formal for pharmaceuticals, informal and quasi-formal for services) which limit consumers' ability to spend more on health care. Our results show that the introduction of formal payments for services will not reduce informal patient payments if reasons for paying informally are not addressed. Not only quality of care should be improved but there is a need for a greater government commitment to fight unregulated payments, to improve transparency and accountability in health care system and to change public attitudes towards these payments. Moreover, policy makers face the challenge how to design effective mechanisms which need to accompany the cost-sharing obligations to protect equity in health care. These mechanisms should be well-targeted at those who need protection and also transparent for patients and providers.