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Increased cost sharing and changes in noncompliance with specialty referrals in The Netherlands

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ABSTRACT

Introduction: The compulsory deductible, a form of patient cost-sharing 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 patient cost-sharing 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.
Discussion/conclusion: Noncompliance increased during the rise of the compulsory deductible. Our results do not suggest a one-to-one relationship between increased patient cost-sharing 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).

1. Introduction

The compulsory deductible, a form of patient cost-sharing in the Netherlands, has more than doubled during the past years. In the Netherlands, basic health insurance is obligatory for all citizens. The basic package is defined by the government and covers among others medical care provided by general practitioners (GPs), medical specialists and midwives, and pharmaceutical care. For this basic package a compulsory deductible (amount of expenses that must be paid out-of-pocket before an insurer will pay any expenses) is charged for all adult residents for all covered care, except general practice, community nursing and maternity care [1]. This compulsory deductible increased from €150 in 2008, via €220 in 2012 and €350 in 2013, to €385 yearly in 2016 (Fig. 1). For citizens with lower incomes, possibilities for compensation exist [1]. The aim of this increment is to control health-care expenditures,

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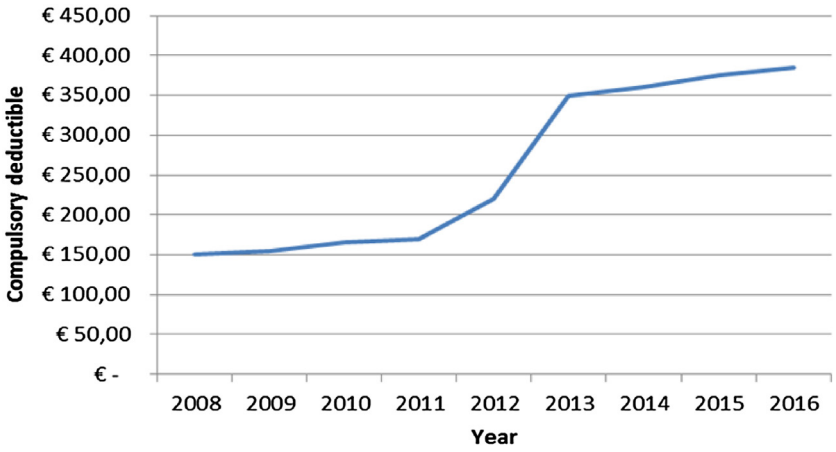

Fig. 1. Dutch compulsory deductible, 2008–2016.

both through a funding shift and by increasing patients cost awareness [2]. In response to the economic crisis, several other governments (e.g., of Denmark, Greece, Ireland, Russian Federation, Switzerland, and Turkey) increased or introduced patient cost-sharing [3].

Although patient cost-sharing reduces individual medical spending [4], it has drawbacks too. Macro effects on health care expenditures generally prove to be limited [5,6] and there are indications that patient cost-sharing leads to health inequalities between groups of patients [4,5] and delayed needed care [7]. In the Netherlands, GPs state that as a result of the increased compulsory deductible, refraining from medical care has increased [8]. Furthermore, surveys among Dutch health-care users indicate increased refraining from health care because of the costs involved [9–11]. For example, not picking up medication, not following referrals to medical specialists, or avoiding visiting GPs because of expected follow-up costs. Also in other European countries people experience unmet health-care needs because of costs [12]. Refraining from medical care may have a negative impact on the well-being of the population [13], through negative consequences for both clinical outcome and health-care costs [14]. The above-mentioned outcomes are based on self-reports. Insight in the relation between the increased compulsory deductible and refraining from medical care based on objective and comparable figures over years is not yet available. The present paper provides insight in this relation by evaluating noncompliance with referrals to medical specialists over the years.

In the Netherlands, GPs decide whether or not to refer patients to medical specialists. They function as gatekeepers, like they do in many European health-care systems and several health plans in the US [15,16]. The Dutch compulsory deductible is charged for medical specialist care, but not for GP consultation. GPs can be visited free of charge and patients decide to comply with a GP referral or not. The compulsory deductible is charged if patients follow the referral. Noncompliance with specialty referrals is therefore a form of refraining from medical care that may be affected by the increased compulsory deductible. Compliance with specialty referrals in the Netherlands is previously reported as 86.6% in 2008–2010 in a cross-sectional study [17], which is higher than compliance rates generally found in the US (63–83% [18–20]). The present paper is the first in which the development of noncompliance with specialty referrals over years, is related to the increased compulsory deductible.

The association between the increased compulsory deductible and refraining from medical care is expected to differ between patient groups. Refraining is found to be related to economic factors [21,22], and patient cost-sharing tends to be associated with reduction in health-care use especially in lower income groups [23,24]. So, we expect the influence of the increased compulsory deductible on noncompliance to be larger in patients from urban deprived areas, who generally have lower incomes [25]. Because of the nature of the Dutch compulsory deductible, its influence on noncompliance is also expected to differ with age and having chronic diseases. Noncompliance or refraining is known to be higher among younger patients [17,26]. Nevertheless, as the compulsory deductible is charged for individuals aged 18 years or older, its rise is not expected to further increase noncompliance in children. Moreover, the compulsory deductible is often easily met for patients with more chronic diseases, as a result of their high health-care costs [27–29]. Accordingly, the influence of the compulsory deductible on noncompliance can be expected to be smaller for these patients than for patients without chronic diseases. To gain further insight in the effect of the increased patient cost-sharing on refraining from medical care, we investigate the associations between patient characteristics (age, having chronic diseases, and the indicator 'living in an urban deprived area' [25]) and noncompliance with specialty referrals over years.

We aim to answer the following questions:

- Is the development of noncompliance with specialty referrals over years in the Netherlands in line with the development of the compulsory deductible?

We hypothesize that noncompliance increased throughout the years and that it increased most in 2012