



The effects of patient cost sharing on ambulatory utilization in South Korea

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Abstract

This study focused mainly on the effects of patient cost sharing on the demand for physician service, especially in the low-income people. Patient cost sharing is one of the policies used extensively in the health care financing in Korea, which has been adopted to control the health care cost. It has raised the argument that cost sharing inhibits low-income patients' access to affordable medical care.

Data from the National Health and Nutrition Survey conducted 1998 by the Korean Ministry of Health and Welfare was used for this analysis. Multiple regression was done with the dependent variable of the amount of ambulatory utilization and price elasticities are estimated. We obtained significant out-of-pocket price elasticities depending on patient income levels and types of care facilities in the range of -0.21 to -0.07 , -0.20 to -0.10 , respectively. We found out that low-income patients are more sensitive to cost sharing than high-income patients. Furthermore, we found out that the users of general hospitals are less sensitive to cost sharing than the users of clinics.

These results shows that the cost sharing policy in Korea does not efficiently work. Patient cost sharing in Korea induces inequitable medical service utilization and also it does not decrease moral hazard in the sense that the higher cost-sharing sector is less sensitive to cost sharing.

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1. Introduction

The effect of patient cost sharing in public health insurance is well known since the Rand Health Insur-

ance Experiment and has been the subjects of health policy research [1–11]. Sharing the cost of health care services discourages moral hazard in health care consumers, thereby over-utilization of medical services is expected to be reduced [12–14]. Other studies argue that low-income status patients may not be able to receive appropriate care when they need it due to cost sharing [15–17].

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South Korea (hereafter Korea) is a good place to study the effect of patient cost sharing in the real world. Korea has achieved universal coverage of health insurance since 1989 but the Korean government has raised coinsurance rates several times to control its health insurance expenditures. Moreover, in Korea, medical services are generally provided by the private sector and patients have the freedom to choose health care institutions because clinics do not have to provide referrals to get secondary care. The outpatient part of hospitals is larger than that of other countries and hospitals compete with each other as well as clinics. In addition, clinics as well as hospitals are reimbursed mainly based on the fee-for-service and there are a number of uninsured services because providers cannot opt out of fixed fees for insured services in Korea. As a result, the prices that patient have to pay in Korea are so high that there is no marked difference from the actual prices, particularly in the case of ambulatory utilizations.

There are few studies about the effects of patient cost sharing on the demand for the medical services [2] and any significant study showing how the magnitude of copayment effect varies by income has still not been reported in Korea. Though some studies assert that patient cost sharing in Korea is already too high and is possibly inefficient as well as inequitable, these studies only deal with the average size of out-of-pocket payment depending on referral level or types of care facilities [4]. They do not consider the influences of out-of-pocket payment on medical utilization on the individual level [2,4].

The aim of this study is to investigate the effects of patient cost sharing on the demand for the physician services in Korea. We will attempt to highlight the implications of cost sharing policies based on the empirical evidence of consumers' price sensitivities in health care in Korea. We will see in this paper how the present patient cost sharing in Korea is working in the medical utilization arena and we will focus on the potential problems of cost sharing policies, i.e. restricting medical access of low-income patients. The structure of this paper is as follows. In the next section, we will briefly describe our data from a national survey, with some important features of the Korean health care system to help understand the data. It will be followed by an explanation of the variables and the regression models used in this analysis. The fourth section will present the results, the determinants of ambulatory health services

and the difference in price elasticities of medical care among patients of different income levels and among medical institutions showing different referral levels. Finally, we will discuss whether the present cost sharing policy would work effectively in the perspective of efficiency and equity.

2. Data

The data used for this study is from the National Health and Nutrition Survey conducted in 1998 by the Korean Ministry of Health and Welfare. This is a continuous survey performed every 3 years on a representative sample of the Korean population, providing information on medical consumption and health status. In 1998, the data was collected from 39,331 individuals.

The number of observations in this study was first reduced to 26,227 because only the insured persons aged 20 and older were included. Enrollment in health insurance is compulsory in Korea and most Korean people are covered by health insurance. However, less than 5% of Korean people still cannot afford to pay the premiums of health insurance and they are covered by the Medicaid. Our data excluded these persons because they have the copayment rate different from that of the insured person. Furthermore, the analysis excluded children because their nature of demand for physician visits is different from that of adults.

Of the insured adults, 3177 subjects used ambulatory services for treatment purposes and these observations were finally used in our multiple regression model. Cases for the preventive visits were excluded because price responsiveness is different between the illness-related visits and the preventive visits [14,18].

3. Model and analysis

This study is based on the conditional-on-use analysis because our data only includes the user cases. The analytic method used in this study is partially similar to the two-part model approach that is employed by Newhouse and Phelps [19]. In the two-part model, the decision to seek care and the amount of care used by the patients who seek care are estimated separately using different equations: the former part is estimated by

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