

Regulating Patients' Access to Healthcare Services

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ABSTRACT

Although some healthcare systems have introduced gatekeeping that forces patients to choose a general practitioner for a longer period, other systems rely on a free choice of doctors. This paper analyzes how these instruments affect differences in healthcare utilization in European countries. Using data from the first wave of the Survey of Health, Aging and Retirement, the authors investigate how access regulations affect a) the overall level of ambulatory healthcare usage, and b) disparities in utilization among groups with different educational and income levels. The data show that access regulation affects patients' decisions to see a doctor and reduces the extent of specialist healthcare used. Cost sharing could not be related to inequities among income groups; however, gatekeeping has favorable effects on reducing inequality, and the respective healthcare systems show lower levels of inequality among groups with different levels of education.

Keywords: European Countries, Gatekeeping, Healthcare Access, Inequality, Utilization

INTRODUCTION

Due to constantly increasing health expenditures, concerns about the affordability of care have motivated policy-makers to apply regulatory instruments that are expected to control expenditure levels by increased efficiency of service delivery (Thomson & Dixon, 2004). Such reforms respond to the concern that "unregulated access may involve higher costs as patients may consult several providers, resulting in wasteful duplication of services" (Ettelt, Nolte, Mays, Thomson, & McKee, 2006, p. 5). Gatekeeping and cost sharing arrangements are two major forms of healthcare organization

by which policymakers attempt to increase efficiency of healthcare consumption. While in some European countries patients' access to medical doctors is regulated by gatekeeping systems and patients have to choose a general practitioner for a longer period of time, other countries still rely on a free choice of doctors. In order to assess the regulatory effects of gatekeeping and cost sharing, it is important not only to study healthcare expenditure levels but also the consumption of healthcare services. In this article, we analyze the impact of access regulation on the level of healthcare utilization and on inequalities in utilization among social groups.

The costs and benefits of patients' choice and access regulation have been a matter of

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controversial theoretical debate. The assumption that individuals can make rational choices as defined by economic theory has received general criticism with the concept of “bounded rationality”. It has been emphasized that the rational choice mechanism is particularly unlikely to work in medical care due to special features of the healthcare market (Hanoch & Rice, 2011). Arrow argued as early as 1963 that healthcare markets are characterized by a high degree of uncertainty and informational asymmetry between patient and provider. As a result, patients find it extremely difficult to evaluate the necessity or quality of medical care. The adequacy of this theoretical proposition is supported by evidence showing that significant parts of the populations in the US and the UK lack the ability to read and understand even simple health-related information (Kutner, Greenberg, & Baer, 2005; Von Wagner, Knight, Steptoe, & Wardle, 2007). Thus, institutional regulations aiming to decrease unnecessary utilization of healthcare have to be assessed under the specific conditions of the healthcare market.

Cost sharing regulations rely on the idea that if the utilization of healthcare does not involve costs for the patient, patients will utilize care even when it is not necessary (moral hazard) (Thomson & Mossialos, 2004). Thus, by introducing costs for the patient, unnecessary care utilization should be prevented. However, this theory assumes that patients have the cognitive ability to distinguish between necessary and unnecessary use of care which is unlikely to be the case in most instances. Instead, it is reasonable to assume that patients orient their decision at a parameter which is certain – the affordability of co-payments – which varies according to one’s financial resources. As a consequence, cost-sharing regulations can be hypothesized to create inequalities in care utilization according to income. Gatekeeping systems, which regulate access to secondary care through primary care providers, are consistent with the assumption of uncertainty and informational asymmetry. In these systems, it is primarily the primary care provider who makes the decision as to whether specialist care is needed. If access to

specialists is free and often based upon patients’ choice, patients’ ability to acquire and process information becomes an important determinant of care utilization (Thomson & Dixon, 2004). Patients with higher cognitive abilities are then more likely to select and directly contact a specialist provider than are individuals with more limited abilities, and this dichotomy results in inequalities in specialist utilization.

Effects of access regulation, such as gatekeeping, on utilization have been analyzed in earlier studies. These studies were mainly conducted in the United States, and due to the fragmentation and complexity of the U.S. system, it is questionable whether the results can be transferred to European countries. In a review of 19 U.S. studies, Robinson and Steiner (1998) find that studies show decreasing, increasing, and no effect of gatekeeping on utilization. More recent literature supports the conclusion of mixed results: A study conducted by RAND reports higher numbers of total physician visits in a gatekeeper health maintenance organization (HMO) than in the less regulated point-of-service plan (PPO), and no significant differences with reference to specialist visits (Joyce, Kapur, Van Vorst, & Escarce, 2000). Schillinger et al. (2000), however, find no differences in primary care visits between people under gatekeeper arrangements and people with free access, but they find a significant reduction in specialist visits after the introduction of gatekeeping.

Whereas international studies examining the effects of access regulations on the overall level of utilization are rare, the relation between utilization differences among socio-economic groups and healthcare system features has been extensively investigated by the equity literature, especially by the work of van Doorslaer et al. (2000, 2004, 2006). In several cross-sectional analyses of the European Community Household Panel and additional national household surveys, van Doorslaer et al. (2004) investigated inequities in care utilization among income groups. One general observation in all studies is that poorer people are more frequent users of medical services. This relationship, how-

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