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Working Paper

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Working Papers in Economics and Statistics, No. 2015-05

Provided in Cooperation with:

Institute of Public Finance, University of Innsbruck

Suggested Citation: Sanwald, Alice; Theurl, Engelbert (2015) : Out-of-pocket payments in the Austrian healthcare system: A distributional analysis, Working Papers in Economics and Statistics, No. 2015-05, University of Innsbruck, Research Platform Empirical and Experimental Economics (eecon), Innsbruck

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<https://hdl.handle.net/10419/122220>

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Working Papers in Economics and Statistics

2015-05

University of Innsbruck
Working Papers in Economics and Statistics

The series is jointly edited and published by

- Department of Banking and Finance
- Department of Economics
- Department of Public Finance
- Department of Statistics

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Out-of-pocket payments in the Austrian healthcare system – a distributional analysis

Alice Sanwald[†]
Engelbert Theurl^{††*}

Abstract

Introduction: *Out-of-pocket spending is an important source of healthcare financing even in countries with established prepaid financing of healthcare. However, out-of-pocket payments (OOPP) may have undesirable effects from an equity perspective. In this study, we analyse the distributive effects of OOPP in Austria based on cross-sectional information from the Austrian Household Budget Survey 2009/10. Methods:* We combine evidence from disaggregated measures (concentration curve and Lorenz curve) and summary indices (Gini coefficient, Kakwani index, and Reynolds–Smolensky index) to demonstrate the distributive effects of total OOPP and their subcomponents. Thereby, we use different specifications of household ability to pay. We follow the Aronson–Johnson–Lampert approach and split the distributive effect into its three components: progressivity, horizontal equity, and reranking. **Results:** OOPP in Austria have regressive effects on income distribution. These regressive effects are especially pronounced for the OOPP category prescription fees and over-the-counter pharmaceuticals. Disaggregated evidence shows that the effects differ between income groups. The decomposition analysis reveals a high degree of reranking and horizontal inequity for total OOPP, and particularly, for therapeutic aids and physician services. **Conclusions:** The results – especially those for prescription fees and therapeutic aids – are of high relevance for the recent and on-going discussion on the reform of benefit catalogues and cost-sharing schemes in the public health insurance system in Austria.

JEL Classification: H22, H23, H51, I14

Keywords: out-of-pocket health expenditure, healthcare financing inequalities, Kakwani index, vertical equity, horizontal equity, reranking

Acknowledgements

The authors gratefully acknowledge financial support by the Austrian Science Fund (FWF: S10306-G16 – National Research Network Labor Economics and the Welfare State). In addition, we thank several discussants at different occasions for their helpful comments.

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1. Introduction

Out-of-pocket payments (OOPP) in the healthcare sector are substantial. Roughly 40% of the total global healthcare bill is financed from this source, and in several world regions, the OOPP share is as high as 60–70% [1]. However, even in OECD-countries – mainly countries with well-established prepaid schemes of health care financing – the share of OOPP in total healthcare spending is close to 20% (non-weighted OECD average based on the most recent information) [2]. OOPP are not only important from a fiscal perspective, they also have important consequences for economic welfare. Health expenditure is to a large extent unpredictable from an individual perspective and reduces funds to consume other necessities and amenities of life. If individuals or households were risk averse, they would demand risk-pooling mechanisms to smooth their consumption paths against the irregularities caused by bad health, in the private insurance market and/or in the political arena. Consequently, the avoidance of OOPP by pooling health expenditure risks seems to have high potential for welfare improvement. This is especially true if OOPP exceed a substantial threshold and/or push the individual or household below the poverty line [3]. In addition, it is well known from the previous empirical literature that major reliance on OOPP is likely to have a regressive impact on income distribution [4,5,6,7,8,9]. Finally, OOPP act as a barrier for healthcare use and might have negative effects on long-term health status, especially for low-income individuals or households [10]. On the other hand, if administrative costs of prepaid systems are substantial and/or moral hazard exists, OOPP might improve social welfare [10].

In this study, we focus on the effects of OOPP on income distribution. This research question is embedded in the broader context of equity and fairness in the healthcare sector [3,11,12]. Ultimately, any analysis of whether a healthcare system fulfils the benchmarks of equity and fairness has to consider healthcare payments and service utilisation simultaneously. In this study, we focus only on healthcare payments. We are aware of the necessity also to consider health care service utilisation and we argue that the separation of healthcare payments and service utilisation is especially controversial in the case of OOPP. We study the redistributive effects of OOPP for the Austrian healthcare system. Thereby, cross-sectional information on OOPP derived from the Austrian Household Budget Survey 2009/10 is used [13,14,15]. To measure the redistributive

effects of OOPP, we apply different and complementary concepts as follows: (i) disaggregated measures (concentration curve and Lorenz curve), (ii) summary indices (Gini coefficient, Kakwani index, and the Reynolds–Smolensky index) augmented by the Aronson–Johnson–Lampert approach [16], which splits redistributive effects into the following components: progressivity, horizontal equity, and reranking.

The study builds on previous research on the redistributive effects of state financing by taxes in general [16, 17,18,19] and of different financing instruments in the healthcare sector (tax, social health insurance contribution, private health insurance premium, and OOPP) [5,6,7,8,9,20,21,22,23,24]. The study contributes to the empirical research on the redistributive effects of OOPP in several ways. First, it takes the perspective of households and supplements the findings available at the individual level. Second, we use data from a healthcare system which is based on Bismarckian principals and which holds a specific two-tiered institutional architecture of healthcare service provision and financing. Empirical results for Austria are missing in previous (cross-national) studies, which focused on the distributional effects of different forms of healthcare financing [4,5,6]. Finally, we distinguish between the most important forms of OOPP and accommodate for the internal heterogeneity of this financing source. This allows us deeper insights into the distributional effects of the single components of OOPP and the overall effects.

The rest of this paper is organised as follows. Section 2 presents a brief overview of definitions, methods, and data used to analyse redistributive effects. Section 3 presents the main results. In Section 4 we discuss selected findings and point out the limitations of our work. Section 5 concludes.

2. Methods and Data

2.1 Definitions and Concepts

Any evaluation of the redistributive effect of OOPP needs a working definition of OOPP and a benchmark to classify redistributive effects. OOPP are expenditure on healthcare services by individuals (households) in the form of payments to healthcare providers (and sometimes to prepaid plans) net of reimbursement by prepaid plans. In contrast to financial contributions to prepaid financing schemes, OOPP are connected

directly with the actual utilisation of healthcare services. OOPP create a ‘quid pro quo’ relationship between payment and the utilisation of healthcare services. We are able to define three types of OOPP as follows:

- Type 1: an individual is not covered by a prepaid plan at all and has to pay the total healthcare bill directly in the case of healthcare service utilisation (breadth of the prepaid plan)
- Type 2: although a prepaid plan exists, parts of the healthcare services offered by healthcare providers are excluded and have to be paid out of pocket (depth of the prepaid plan)
- Type 3: healthcare services are included in the prepaid plan, but the costs are not financed completely by the prepaid plan (height of the prepaid plan).

Type 3 covers different forms of partial cost sharing (proportional and absolute cost sharing and public subsidies) while type 2 refers to a product- or service-related cost sharing of 100%. As far as the Austrian case is concerned, only the OOPP types 2 and 3 are of empirical relevance in our study. Approximately 99% of the Austrian population relies on public health insurance coverage and we do not expect that the remaining 1% of the Austrian population without public health insurance coverage to be part of our household sample. Owing to our expectation that OOPP of types 2 and 3 have to be judged differently from a distributional perspective, we discuss the affinity of the single categories of OOPP separated in the study with the OOPP types 2 and 3 later on in section 4.

Commentators on the healthcare system widely agree that every healthcare financing system has to fulfil standards of fairness [12]. In this context, the following three dimensions of fairness are important [3,12]: (i) avoiding catastrophic payments by households [3], (ii) horizontal equity, and (iii) vertical equity. Our study does not consider dimension (i)¹ [3] and concentrates on dimensions (ii) and (iii). Different forms and schedules of financial contributions may have different effects on access to healthcare services, their outcomes, and finally health status. In the following, we suppress this ‘instrumental role’ of healthcare financing as a separate issue and concentrate on the fairness of financial contributions as an intrinsic goal of the healthcare system [3]. We are aware of the fact that this approach is especially controversial in the case of

OOPP. There exists some direct relationship of exchange and equivalence between spending money and consuming healthcare services, which is not present in prepaid financing schedules. To some extent, OOPP are made voluntarily in return for benefits derived from healthcare services and it does not make sense to consider the welfare-reducing effect of OOPP while ignoring the welfare-increasing effect of healthcare consumption derived from this expenditure [3]. Thus, legitimate arguments exist to take the principle of fiscal equivalence as a benchmark for equity in out-of-pocket financing in the healthcare sector. On the other hand, there is broad agreement among health scientists, health politicians, and the general public that healthcare financing contributions should be related mainly to individuals' ability to pay (ATP) rather than the risk of illness and/or the quantity of healthcare services consumed, accompanied by the principle that healthcare services should be distributed according to need [3]. We follow this approach in our study. Thus, the rule that individuals and households should contribute to healthcare according to their ATP is the starting point of our equity analysis of OOPP. Thereby, the principle of ATP includes the two dimensions of horizontal and vertical equity. Horizontal equity means that individuals and households with an equal ATP contribute the same amount of money to the healthcare system. Horizontal equity is not just a formal principle which is easy to accomplish; it also involves the definition of equality and the identification of the 'equals'. Vertical equity defines a rule for the contribution of individuals and households with unequal ATP. In the following, the principle of vertical equity is operationalised by the rule of 'proportionality', which means that the share of ATP contributed to the healthcare sector should be the same for all ATP levels.

To exploit the informational content of the OOPP- and ATP-distributions efficiently, we combine disaggregated and aggregated measures to evaluate the redistributive effects of OOPP. Disaggregated evidence, which allows differentiated assessments across different ATP groups, is presented graphically by comparing the Lorenz curve of ATP and the concentration curves for total OOPP and different OOPP categories [20]. Aggregated evidence is based on (i) the Gini coefficient for ATP, (ii) the Kakwani index [17] for total OOPP and OOPP categories, and (iii) the Reynolds–Smolensky index [18] for the overall redistributive effect of OOPP on the ATP distribution. Thereby, the Kakwani index K is defined in the following way [20]:

$$(1) K = C_{OOPP} - G_{ATP}$$

where C_{OOPP} is the concentration index for OOPP and its different subcategories and G_{ATP} is the Gini coefficient for ATP before subtracting OOPP (pre-OOPP ATP). The Reynolds–Smolensky [19] index is defined:

$$(2) RS = \left(\frac{t}{1-t} \right) K$$

where t is the OOPP share on sample average (OOPP/pre-OOPP ATP). Thus, the size of the RS measuring the redistributive effect of OOPP depends on K of OOPP and the OOPP share. To measure ATP, we use two versions: ATP I, which represents household net income as reported by Statistik Austria, and ATP II, which adjusts for the fact that ATP should reflect free disposable household income after subtracting expenditure for the basic necessities of life (excluding OOPP). The literature [3] offers a broad discussion of adequate indicators for this expenditure. We opt to derive ATP II by subtracting the monetary value of benefits from the means-tested income maintenance program in Austria from ATP I (2010 monthly values: 744 € for a single individual; 1.108 € for a couple; 134 € for every child).² Both versions of ATP and all forms of OOPP are adjusted by an equivalence scale. We use the equivalence scale provided by Statistik Austria [13,14], in which the first adult (age >14 years) receives a value of 1, additional adults a value of 0.5, and every child (age ≤14 years) a value of 0.3.

The overall redistributive effect of OOPP on ATP – measured by the Reynolds–Smolenski index – not only depends on the vertical effect of OOPP on ATP, but also includes any horizontal inequity associated with the financing mechanism and the extent of any reranking resulting therefrom. Aronson, Johnson, and Lampert [16] worked out that we are only allowed to associate the redistributive effect of OOPP with the vertical dimension of redistribution if individuals with the same ATP pay the same contribution and the financing mechanism does not change the ordering of the ATP distribution, that is, if reranking does not exist. Aronson, Johnson, and Lampert offer a method to split redistributive effects, RE , into its three components, namely, vertical redistribution, V , horizontal inequity, H , and reranking, R . They define RE as:

$$(3) RE = V - H - R$$

with

$$V = \left(\frac{t}{1-t} \right) K$$

$$H = \sum \alpha_{ATP} G_{F(ATP)}$$

$$R = G_{ATP-OOPP} - C_{ATP-OOPP}$$

The precondition for this separation procedure is to divide the households into groups of equals in their pre-OOPP ATP. [3,25]. We group our sample into 50 groups of pre-OOPP ATP equals by using an equal bandwidth. We split *RE* into the horizontal inequality component *H*. This captures the differences resulting from OOPP for the various groups of pre-OOPP ATP equals. Inequality in the post-OOPP ATP (ATP – OOPP) is measured in each group of pre-OOPP ATP equals by the Gini coefficient $G_{F(ATP)}$. Using α_{ATP} as weights, a weighted sum of the Gini coefficients is calculated as the product of the household share and post-OOPP ATP share of households with a given pre-OOPP ATP [20,25]. *V* shows the level of ATP redistribution caused by the fact that, on average, households at different points in the ATP distribution pay different amounts of OOPP. Finally, the term *R* captures the movements of the households along the ATP distribution (reordering of the ATP distribution) in the transition from the pre-OOPP ATP distribution to the post-OOPP ATP distribution. *R* is measured by the difference between the Gini coefficient for post-OOPP ATP and the concentration index for post-OOPP ATP where, in the latter case, households are ranked by the pre-OOPP ATP [20,25].

2.2 Data

To reveal the distributional effects of OOPP in Austria, we use data from the Household Budget Survey 2009/10 conducted by the National Statistical Service Office, Statistik Austria [13,14,15]. The observation unit is the private household without institutionalised households (hospitals, long-term care, and jail). The total sample offered by Statistics Austria consists of 6,534 households with 15,540 household members. The exclusion of 510 households with undefined or unclear household structures resulted in a final sample size of 6,024 households. Information on consumer behaviour is gathered in two ways: (i) the diary approach (observation period of 2 weeks) and (ii) the recall approach (observation period of 1 year). The recall approach is used for consumer dura-

bles and irregular/seasonal expenditure within the last 12 months. Important socio-economic characteristics of the household (e.g. family structure, age, household income) are gathered from face-to-face interviews. We opt to study the redistributive effects of OOPP for total OOPP and for four important categories of OOPP. These categories are:

- *Prescription fees.* Pharmaceuticals, which are part of outpatient treatments provided by GPs/specialists who have contracts with the public health insurance system, are essentially free for the patient if they are included in the positive list of the Reimbursement Code of the public health insurance system.³ Each patient has to pay a prescription fee for every pharmaceutical prescribed. This prescription fee is an absolute amount of money (2009: 4.90 €; 2010: 5.00 €) with no link to the price of the pharmaceutical.⁴ Two schemes influence the financial burden of households and are, therefore, important for distributive considerations. There is an exemption from the prescription fee.⁵ Since 2008, this exemption is accompanied by a prescription fee cap at a 2% share of annual net household income. Prescription fees of the Austrian type belong to the type 3 OOPP. From an economic viewpoint, they amount to a specific tax per prescription, which has to be paid when consuming pharmaceuticals within a publicly provided or financed outpatient healthcare treatment.⁶
- *Over the counter (OTC) pharmaceuticals.* This type of OOPP occurs under two circumstances: (i) if patients rely on self-medication and (ii) if patients rely on the professional healthcare system, but the pharmaceuticals prescribed during medical treatments are not listed in the Reimbursement Code of the public health insurance and are not refunded by the private health insurance system.⁷ OTC pharmaceuticals belong to type 2 OOPP.
- *Therapeutic aids.* These include a heterogeneous package of medical resources (e.g. glasses, lenses, crowns, and bridges). When patients need therapeutic aids within publicly provided or financed healthcare services, they are confronted with different schedules of substantial cost sharing (proportional cost sharing, absolute cost sharing, and price subsidies). To a minor extent, OOPP for therapeutic aids result from utilising the private healthcare

sector. In summary, consumption of therapeutic aids leads to type 2 or 3 OOPP.

- *Physician services.* This category includes physician services in the inpatient and outpatient sectors, including dental services. OOPP for physician services are either type 2 or 3. Farmers, employers, and public workers (including their relatives, this amounts to approximately 20% of the Austrian population) face proportional cost sharing of 20% for physician services (type 2 OOPP). If patients consume services in the private healthcare sector, they have to pay the full price. If the services are covered by public or private prepaid plans, they receive a share of the money back (type 2 or 3 OOPP).

3. Main Results

3.1 Descriptive Statistics

We demonstrate the significance of OOPP in Austria by using two indicators: (i) OOPP per capita (in PPP/US\$) and (ii) OOPP as a share of total healthcare expenditure. In an international comparison, both indicators show a high degree of heterogeneity between OECD-countries [2]. The unweighted OECD average in 2012 is 560 US\$ on indicator (i) and 18.5% on indicator (ii). The values for Austria are slightly higher than the average for indicator (i) and slightly lower than the average for indicator (ii). In a time-series perspective covering the period since 1995, the share of OOPP on total healthcare expenditure in Austria is remarkably stable. OOPP account for approximately 75% of all private health expenditure, leaving 25% accounted for by private health insurance. In addition, we observe high stability for the share of total private consumption spend for health purposes. Based on the ESVG-1995 classification, Austrian households currently spend on average 3.5% of total private consumption expenditure on healthcare goods and services [14].

Table 1 shows the total amount of OOPP and the OOPP for different categories based on information from the Austrian Household Budget Survey 2009/10. The first two columns show the average expenditure per month and the expenditure structure for the total sample of households. Column 3 reveals the average expenditure for households with OOPP > 0. Column 4 shows the number of households with OOPP > 0 in each expenditure category. The last column shows the expenditure structure for total

health expenditure (including all sources of healthcare financing). Table 1 reveals the very specific expenditure structure of OOPP. The most important OOPP category is therapeutic aids, with 44% of total OOPP. On the other hand, 17% of OOPP are spent on pharmaceuticals, either directly (OTC pharmaceuticals) or indirectly, via payment of the prescription fee in the public health insurance system. Physician services (including inpatient, outpatient, and dental services) account for 26% of OOPP. The expenditure structure of OOPP differs sharply from the structure of total health expenditure. This is especially obvious for physician services (26.55% vs. 71%) and therapeutic aids (44.28% vs. 5%). In addition, Table 1 shows the number of households with $OOPP > 0$ in the observed period and the average expenditure per household. As expected, we observe that the share of households without OOPP for physician services is comparably high within the observation period of 2 weeks. The comparison of the average values in columns 1 and 3 reveals the specific characteristics of the OOPP data: skewness, excess zeros, and heavy right tails.

[INSERT TABLE 1 ABOUT HERE]

3.2 Results of Disaggregated Measures

Figure 1 provides disaggregated information on the redistributive effect of total OOPP and OOPP categories by comparing the Lorenz curve of pre-OOPP ATP and the concentration curves of total OOPP and of several OOPP categories.⁸ The basis of the figures are grouped data of the households: 20 groups of equal size (each group covers 301 or 302 households) ordered by the ATP level. Every household is included with identical weight independently of its size.⁹ The left-hand side of Figure 1 shows the Lorenz curve for ATP I, and the right-hand side shows the Lorenz curve for ATP II. We have to be aware that the two concepts of ATP do not only affect the Lorenz curve of ATP, but also the concentration curves of OOPP as they might change the ATP ranking of the households.

Related to ATP I, we observe a regressive effect of total OOPP in all ATP brackets. This regressive effect is very pronounced for prescription fees, especially in the upper ATP brackets. However, in the lower ATP parts, prescription fees also display pro-rich effects. This contrasts to the fact that there are income-related exclusions and limitations for the prescription fees. The concentration curve for OTC pharmaceuticals seems to dominate the concentration curve for prescription fees, at least in the upper parts of the ATP brackets. The regressive effects of OOPP for physician services and therapeutic aids are lower compared to OOPP for

pharmaceuticals. If we relate the OOPP to ATP II, the redistributive effects are even more pronounced, especially for total OOPP and the components of physician services and therapeutic aids.

3.3 Results of Aggregated Measures

Table 2 presents the distributive effects by using aggregated measures. In the upper part of the table, we present the results for ATP I, and in the lower part, we present the results for ATP II. The Gini coefficient for ATP I is 0.245. This result is in line with those of comparable studies on income distribution in Austria, including income tax and the transfer system [27]. The concentration index for all OOPP categories is substantially lower compared to the Gini coefficient. This results in a regressive effect of OOPP. The negative sign of the Kakwani index confirms this statement. It is remarkable that the negative redistributive effect of the prescription fees is higher compared to OTC pharmaceuticals. Because total OOPP and its components depict only a modest share of ATP I, the overall regressive effect on ATP I measured by the Reynold–Smolensky index is moderate. The results for ATP II confirm the empirical picture for ATP I, but the regressive effect is even more pronounced, which is indicated by the remarkable increase in the Kakwani index. This is generated mainly by the doubling of the Gini coefficient. As a result, the regressive effect on ATP II measured by the Reynold–Smolensky index also increases substantially.

[INSERT FIGURE 1 ABOUT HERE]

[INSERT TABLE 2 ABOUT HERE]

Table 3 presents the decomposition of the redistributive effect RE in Austria for total OOPP and the four OOPP categories into the three components V , H , and R for ATP I (upper part of the table) and ATP II (lower part of the table). The results are based on ungrouped data.¹⁰ Thus, the coefficients and indices are slightly different compared with the grouped case (see Table 2). RE is captured by the Reynolds–Smolensky index. Table 3 shows the absolute values for RE , V , H , R , and the percentage decomposition of the components (baseline: $RE = 100\%$). The overall negative redistributive effect RE is higher in the ATP II case compared to the ATP I case. For ATP I, the negative vertical effect explains 50% of the overall redistribution of total OOPP, leaving 17% to horizontal inequality and 33% to reranking. The results for the decomposition of total OOPP mask pronounced differences between the results for the different components. Approximately 90% of the negative redistributive effect of OOPP for pharmaceuticals (prescription fees and OTC pharmaceuticals) turns out to be a distribution in

favour of households with a high ATP. The values for therapeutic aids and physician services differ substantially. Horizontal inequity and reranking is much more pronounced for these OOPP categories. The high number of households without expenditure on therapeutic aids and physician services (see Table 1) and the high degree of randomness of these expenditure categories lead to a high level of reranking and horizontal inequity. For ATP II, the results differ in size, but they confirm the direction of results for ATP I.

[INSERT TABLE 2 ABOUT HERE]

4. Discussion

Our results are in line with the empirical findings of the negative redistributive effect of OOPP in the previous literature. In a seminal cross-country study of 13 OECD countries, Wagstaff and Van Doorslaer find Kakwani indices for OOPP ranging from -0.037 (the Netherlands) to -0.387 (the US), with an unweighted average of the Kakwani index of -0.21 [7]. Owing to the specific income definition of ATP II, in our study, only the result for ATP I (-0.138) is comparable with the results of Wagstaff and Van Doorslaer. In a literature review, Yu, Whynes, and Sach [21] present a slightly fuller picture of 18 countries, including the results of the cross-national study of Wagstaff and Van Doorslaer [7]. They report regressive effects for the US, Switzerland, Colombia, France, Croatia, Denmark, Belgium, Portugal, Sweden, the UK, Finland, Spain, Australia, and Ireland (Kakwani index < -0.1), mildly regressive effects for Germany, Italy, and the Netherlands (Kakwani index between 0 and -0.1) and strongly progressive effects for Sri Lanka (Kakwani index: 0.548) [21]. Unfortunately, the statistical basis for this evidence is rather old. In a more recent study for Australia covering 1975–2003, Hajiuzabeh, Connelly, and Butler find Kakwani indices for OOPP in a similar range to Austria (between -0.0975 in 2003–2004 and -0.192 in 1988–1989) [9]. For Hungary, Baji, Pavlova, Gulácsi, and Groot estimate a Kakwani index for total OOPP of -0.22 in 2005–2008 [22]. For Ireland, Smith finds a regressive effect of OOPP of increasing size of the Kakwani index over 1987–2004 (1987–1988: -0.05; 1999–2000: -0.10; 2004–2005: -0.11) [24]. The empirical evidence on single OOPP categories is very scarce [24], while the used OOPP categories in [24] are hardly comparable with the classification categories used in our study. The same scarce picture applies to the decomposition of the redistributive effects into V , R , and H . For the Netherlands, Wagstaff and Van Doorslaer reveal components for total OOPP of the following size: $V = 61.7\%$; $H = -11.3\%$; and $R = -27.0\%$ [5].

We have already mentioned several controversial issues (section 2) in our study, which are specific to the expenditure category OOPP. The concept of “equity” in healthcare financing

used in our study follows the ATP approach widely favoured in the empirical literature. This approach has the advantage of allowing comparisons of OOPP with other forms of healthcare financing, particularly prepaid forms. However, this approach neglects the ‘quid pro quo’ relationship present in different categories of OOPP financing. It could be argued that redistributive considerations should take into account whether OOPP is the result of, on one hand, need-based medical treatment that is, in principle, publicly provided and financed, and which offers a standardised package of health care services (type 3 OOPP) or, on the other hand, part of the services of the private healthcare sector, which mainly complements the public healthcare sector (type 2 OOPP) on a voluntary basis. We would clearly favour the ATP approach in the first case and the fiscal equivalence approach in the second case. Unfortunately, there is no clear-cut separation between the public healthcare sector and the private healthcare sector in Austria, but tentative conclusions are possible. The prescription fees and therapeutic aids have a strong affinity to publicly organised medical treatment while the OTC pharmaceuticals and physician services¹¹ are strongly linked with private healthcare provision. For health policy implications, it seems to be remarkable that the OOPP category prescription fee shows the highest regressive effect and that owing to the high share of OOPP for therapeutic aids (43% of total OOPP), the negative redistributive effect – measured by the Reynold–Smolensky index – is highest. Recently, Austria’s health policy reacted to the latter case and reduced the cost sharing for therapeutic aids in dentistry.

As in other studies on the inequality of OOPP, the information on OOPP is based on survey data and, therefore, may be subject to potential bias typical of the survey method. As reported in Subsection 2.2, information on consumer behaviour is gathered in two ways via the diary and recall approaches. The diary system covers 2 weeks and results in 1 year of bookkeeping, which allows the representation of seasonal patterns and specific consumption periods (e.g. waves of influenza). The recall approach is used for consumer durables and irregular or seasonal expenditure within the last 12 months. In addition, in general, households are asked for expenses greater than 300 € in the last year using the recall method. As far as our OOPP categories are concerned, only information on therapeutic aids in ophthalmology and dentistry is collected by the recall method. Overall, high data quality is ensured via the prevailing of the diary system and the level of instructions for the participants. Potential underreporting of the expenditure level of OOPP is reduced by the use of a disaggregated approach that asks for several OOPP categories.

On the other hand, the short observation period of 2 weeks used in the diary approach is a matter of concern. Shorrocks shows under quite general conditions that income inequality and the income accounting period are related negatively [26]. Owing to the specific character of

health expenditure, this finding also applies at a progressive rate to the relationship of inequality in expenditure and the expenditure accounting period in the healthcare sector. The results in Table 1 are a clear indication of this finding. The consequences of the observation period are mixed. First, different accounting periods apply for the different OOPP categories and the ATP, which might influence the observed degree of inequality. Second, as far as the assessment is based on grouped data (Figure 1 and Table 2), we rely on ATP bracket averages. Bias in this context occur primarily if these averages are sensitive to the length of the accounting period. Third, the problem is serious if the estimation of the distributive effects is based on ungrouped data. This is particularly relevant for the decomposition case into the components V , R , and H .

To substantiate this requires a broader discussion of the decomposition exercise for OOPP data. The decomposition method was derived first for the tax case [16]. If individual/households face the same (income) tax schedule and the tax basis exactly represents ATP, then R and H are zero. If taxation only follows ATP on average, or if taxation systematically neglects ATP, then R and H are positive, that is, violations of horizontal equity and reranking occur. This clearly means that in both the tax case and publicly prepaid schemes of healthcare financing via taxes or income-related public insurance contributions, the existence of R and H is to a high degree a matter of political design and information asymmetry between the financing institution and the payer. However, in the case of OOPP, H and R require a different interpretation. OOPP are not related systematically to ATP, and so, values of H and R that do not equal zero will be normal. They occur primarily because healthcare utilisation and, consequently, the existence and level of OOPP, are random on the individual and household level and are based on systematic risks (e.g. age, education, consumption behaviour, and family size). Only to a very limited extent are H and R for OOPP open to political design (e.g. by ATP-related limitations of cost sharing). Consequently, we would expect that H and R for OOPP are much higher compared with prepaid financing. The opposite is true for V . In the decomposition exercise for the Netherlands, Wagstaff and Van Doorslaer clearly confirm this expectation (V for direct taxation: 100.2%, V for indirect taxation: 99.7%, V for sickness fund contributions: 90.4%, V for OOPP: 61.7%) [5]. It is well documented that the decomposition results depend on the definition of the groups of pre-OOPP equals [25]. The decomposition exercise is based on ungrouped data. If the inequality of OOPP between households depends on the accounting period, the decomposition results would also depend on the accounting period. We would expect relatively lower values for H and R if the accounting period were extended.

Our analysis focuses on OOPP only. We find that the effect is clearly regressive. However, the share of OOPP on household income is low – on average, 3.5 % of ATP I – and so, the negative effect on the ATP distribution measured by the Reynolds–Smolenski index is

limited. For several reasons, our dataset is not suitable to study the redistributive effects of other financing sources (taxation, public health insurance, and private health insurance) of the Austrian healthcare system. However, we can use recent empirical evidence from other studies to complete the picture. Guger et al. analyse the redistributive effect of public financing in Austria in general [27] and find a neutral effect of taxation on the ATP distribution. Thereby, the progressive effect of direct taxation is compensated by the regressive effect of indirect taxation. The contributions to public health insurance show a clear regressive effect. The contribution rate is proportional to income and is combined with a maximum contribution basis. In addition, the contributions to the public health insurance are tax deductible and owing to the progressive scheme of the income tax, the regressive effect increases [28]. Finally the contribution basis includes only parts of the individual ATP, mainly earned income from employers and employees, excluding capital income. This also aggravates the negative distributive impact. This additional information from other financing sources clearly shows that healthcare financing in Austria is clearly regressive overall.

5. Conclusions

This study aimed to assess the redistributive effects of healthcare financing via OOPP in Austria. Disaggregated and aggregated measures were used to estimate the effect of household income distribution. The study used cross-sectional information on OOPP and income from the latest Austrian Household Budget Survey in 2009/10. The study focused on the financing side of OOPP and excluded the simultaneous consideration of financing and utilisation. Our results indicate that OOPP are regressive. This result holds for both the disaggregated and aggregated perspectives, for total OOPP, and for the different OOPP category prescription fee, OTC pharmaceuticals, therapeutic aids, and physician services. The disaggregated evidence reveals that the results differ between different income brackets. This is especially pronounced for prescription fees and physician services. The decomposition analysis reveals a high degree of reranking and horizontal inequity for total OOPP and, particularly, for therapeutic aids and physician services. However, we should be aware that the decomposition exercise has a specific meaning in the OOPP case. The results, especially those for prescription fees and therapeutic aids, are of high relevance for recent and on-going discussions in Austria on the reform of benefit catalogues and cost-sharing schemes in the public health insurance system.

¹ Our calculations show that owing to the comprehensive level of public healthcare coverage, the problem of catastrophic healthcare expenditure is of low priority in Austria. The percentage of households with

OOPP shares above predefined income thresholds is not related strongly to household ATP. Approximately 9% of households exceed the 2% threshold, 4.3% exceed the 5% threshold, and 1.6% exceed the 10% threshold. We expect this percentages to decrease if the accounting period is increased.

² Households which have a negative ATP II are given an ATP II of zero in the calculations.

³ Pharmaceuticals consumed within inpatient treatment are free for the patient. Their financing is included in the DRG-based hospital financing system, and there is no prescription fee.

⁴ If the price of the pharmaceutical is below the prescription fee, the patients pay the price of the pharmaceutical.

⁵ Exemptions are granted without application for (a) retired people who draw small pensions from public pension plans, (b) people with notifiable communicable diseases, (c) members of the civilian service, including their relatives, and (d) asylum seekers. On application, exemptions from the prescription fees are granted for insurance members (including co-insured household members), each with a household net income below the threshold values of the basic income maintenance system.

⁶ If patients consume outpatient medical services supplied by private physicians, pharmaceuticals are paid by the public health insurance system on request, and the system of prescription fees is applied in a similar way.

⁷ Expenditure from OTC pharmaceuticals can result from publicly or privately provided medical treatment. Private health insurance plays only a very limited role in financing pharmaceuticals.

⁸ We abstain from showing the redistributive effects of the OOPP category “other expenditure” because it includes a heterogeneous mix of different expenditure items.

⁹ Thereby, we are aware that in distributional matters, the individual rather than the household is regarded as the relevant unit and, correspondingly, individuals have to be ranked in ascending order according to their household ATP. This is analogous to weighting the household ATP by the number of household members [29,30].

¹⁰ Ungrouped data are needed for the decomposition of *RE* into *V*, *R*, and *H* [20].

¹¹ The proportional cost sharing of members of the health insurance for public workers, employers, and farmers is excluded in this assessment.

Authors' contributions

The authors contributed equally to this work. Both authors read and approved the final manuscript.

Competing interests

The authors declare that they have no competing interests.

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Table 1: Expenditure for total OOPP and OOPP components

Expenditure categories	Total HH		HH with expenditure > 0		Total health expenditure
	Average exp.	Percentage	Average exp.	Number of HH	Percentage
Prescription fee	6.79	6.59	34.59	1,183	- ²⁾
OTC pharmaceuticals	10.88	10.55	41.08	1,596	13.00
Therapeutic aids	44.28	42.96	86.04	3,100	5.00
Physician services ¹	26.55	25.76	207.42	771	71.00
Other expenditure	14.58	14.14	54.12	1,623	11.00
Total OOPP	103.08	100.00	136.68	4,543	100.00

¹ Includes inpatient and outpatient physician services as well as dental services.

² Prescription fees are not a health expenditure category in this expenditure classification. The source for the last column is [31].

Figure 1: Lorenz curve of pre-OOPP ATP and concentration curves of total OOPP and OOPP categories

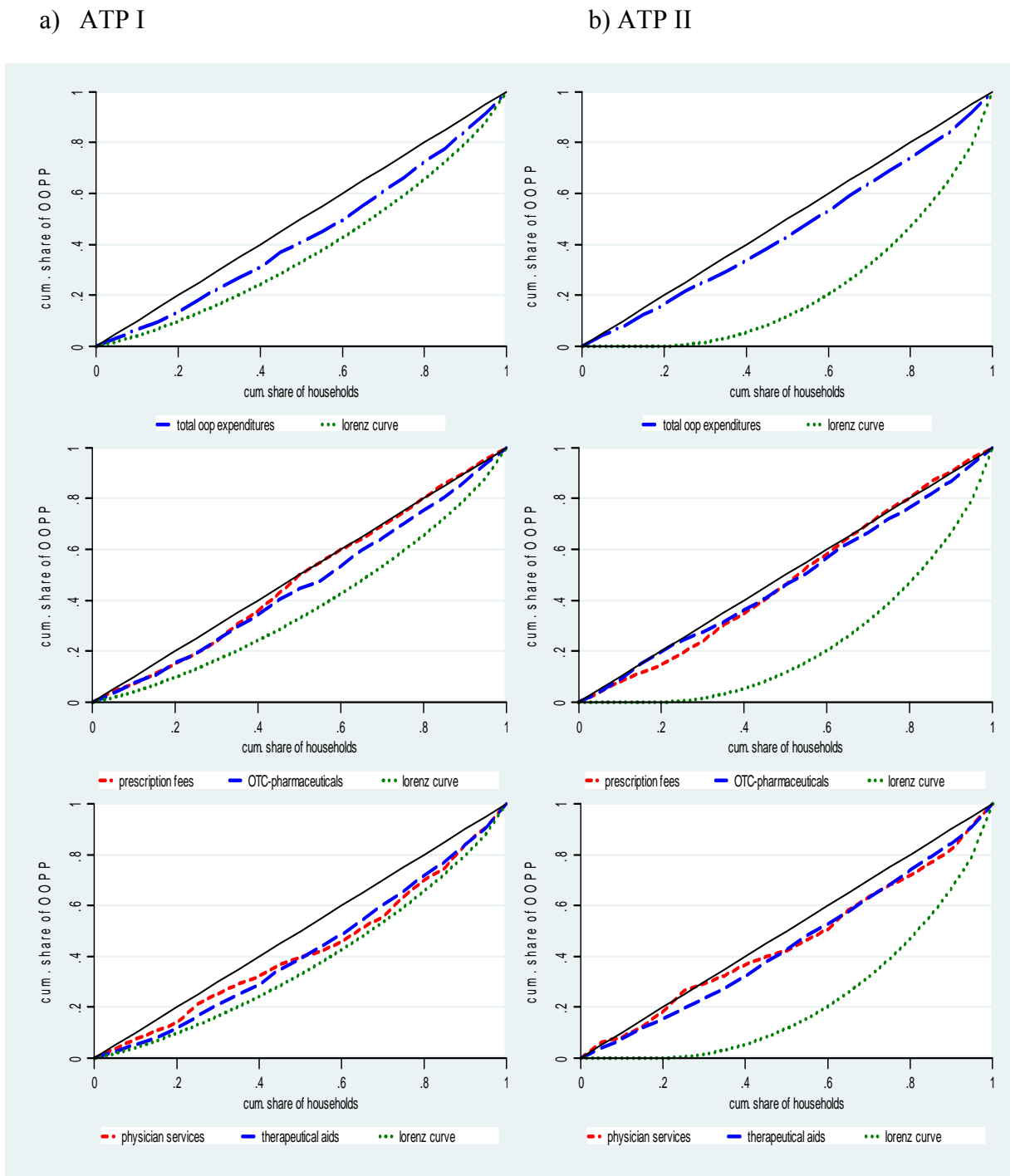


Table 2: Aggregated measures of the distributive effect of total OOPP and OOPP components.

	Total OOPP	Prescription fees	OTC phar- maceuticals	Therapeuti- cal aids	Physician services
<i>ATP I</i>					
Gini Coefficient	0.245	-	-	-	-
Concentration index	-	0.138	0.036	0.089	0.162
Kakwani index	-	-0.107	-0.209	-0.156	-0.083
t=OOPP/ATP I		0.054	0.004	0.006	0.023
Reynolds– Smolensky index	-	-0.006	-0.001	-0.001	-0.002
<i>ATP II</i>					
Gini Coefficient	0.538	-	-	-	-
Concentration index	-	0.093	0.044	0.045	0.109
Kakwani index	-	-0.445	-0.494	-0.492	-0.429
t = OOPP/ATP II	-	0.121	0.008	0.013	0.052
Reynolds– Smolensky index	-	-0.061	-0.004	-0.006	-0.024

Table 3: Decomposition of the redistributive impact of OOPP in Austria

	ATP	Total OOPP	Prescription fees	OTC pharmaceuticals	pharmaceuticals	Therapeutical aids	Physician services
<i>ATP I</i>							
Gini Coefficient	0.2469	-	-	-	-	-	-
RE		-0.0121	-0.0009		-0.0010	-0.0038	-0.0037
V		-0.0060	-0.0008		-0.0009	-0.0019	-0.0012
H		0.0021	0.0001		0.0001	0.0008	0.0008
R		0.0040	0.0000		0.0000	0.0011	0.0017
Decomposition (in %)							
RE		100.00	100.00		100.00	100.00	100.00
V		0.50	0.89		0.90	0.52	0.33
H		-0.17	-0.09		-0.08	-0.21	-0.21
R		-0.33	-0.02		-0.02	-0.28	-0.46
<i>ATP II</i>							
Gini Coefficient	0.5108	-	-		-	-	-
RE		-0.0770	-0.0042		-0.0067	-0.0278	-0.0211
V		-0.0595	-0.0039		-0.0061	-0.0227	-0.0142
H		0.0089	0.0003		0.0005	0.0024	0.0041
R		0.0086	0.0000		0.0001	0.0026	0.0029
Decomposition (in %)							
RE		100.00	100.00		100.00	100.00	100.00
V		0.77	0.93		0.91	0.82	0.67
H		-0.12	-0.07		-0.07	-0.09	-0.20
R		-0.11	-0.00		-0.02	-0.09	-0.13

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Alice Sanwald, Engelbert Theurl

Out-of-pocket payments in the Austrian healthcare system - a distributional analysis

Abstract

Introduction: Out-of-pocket spending is an important source of healthcare financing even in countries with established prepaid financing of healthcare. However, out-of-pocket payments (OOPP) may have undesirable effects from an equity perspective. In this study, we analyse the distributive effects of OOPP in Austria based on cross-sectional information from the Austrian Household Budget Survey 2009/10. Methods: We combine evidence from disaggregated measures (concentration curve and Lorenz curve) and summary indices (Gini coefficient, Kakwani index, and Reynolds-Smolensky index) to demonstrate the distributive effects of total OOPP and their subcomponents. Thereby, we use different specifications of household ability to pay. We follow the Aronson-Johnson-Lampert approach and split the distributive effect into its three components: progressivity, horizontal equity, and reranking. Results: OOPP in Austria have regressive effects on income distribution. These regressive effects are especially pronounced for the OOPP category prescription fees and over-the-counter pharmaceuticals. Dis-aggregated evidence shows that the effects differ between income groups. The decomposition analysis reveals a high degree of reranking and horizontal inequity for total OOPP, and particularly, for therapeutic aids and physician services. Conclusions: The results - especially those for prescription fees and therapeutic aids - are of high relevance for the recent and on-going discussion on the reform of benefit catalogues and cost-sharing schemes in the public health insurance system in Austria.

ISSN 1993-4378 (Print)

ISSN 1993-6885 (Online)