

Private health insurance and preferences for policies in the Austrian health care system: A case of mere self-interest?

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Introduction

Introduction

- ... little is known about the nexus between the possession of private health insurance (PHI) and redistribution preferences in health care
- As Austria has statutory health insurance (SHI), yet a high degree of PHI (ca. 38%¹), it is an ideal case to study said relationship
- Primary, complementary, supplementary and/or substitutive PHI types in different healthcare systems
- In Austria PHI serves as a mainly complementary means to hedge against (future) health-related risks

Theoretical Background

Self-interest & self-regarding behaviour

- Distributive justice is sensitive to context, therein to specific social and cultural relations, exchanges, structures, and places (Deutsch 1975; Schäfer et al. 2015; Liebig and Sauer 2016; Van Hootegeem et al. 2020)
- Humans are neither fully rational nor have complete access to all relevant information in any given scenario (Sen 1990; Kahneman 2003)
- Yet they strive to maximise their so-called utility
- Social status or rank are innately tied to health, stress, and life chances (see Marmot 2004; Mitchell et al. 2020).
- Individual behaviour is most distinct when self-interest and conception of justice align

Health care & redistribution

- Public opinion on health care is shaped by welfare regime type, type of health care system, and individual characteristics (Gevers et al. 2000)
- PHI can add benefits to society (Colombo and Tapay 2004), but it also can manipulate health care systems' pursuits for equity
- PHI is not equally accessible to all social strata, minorities and exposed groups alike (e.g. King and Mossialos 2005; Kiil 2012; Jin et al. 2016)
- For Austria Cypionka et al. (2018, p. 13) note: “Although illegal to prioritize patients with VHI, empirical evidence shows that VHI policy holders can obtain faster access to elective care in public hospitals”.
- Also medical professionals follow market forces and self-interest (Light 2010; Oliver 2018)
- “... doctors and hospitals will have incentives to prioritize VHI-financed patients” (Sagan and Thomson 2016, p. 99; see also Oxholm et al. 2021).

Fairness priorities: Going beyond self-interest I

- “Few individuals in the developed world will be able to afford the health care they will need in their lifetimes” (Latham 2012, p. 130). Thus, some kind of health insurance is needed
- The fairness of possible health insurance schemes is tied to distributive justice and also relates to how health care is financed (Clark and Weale 2012)
- People have different justice attitudes within health care, when high resource scarcity is pinned against medium or low resource scarcity in health-health trade-offs (Scott and Bornstein 2009)
- Both PHI and SHI require reciprocity and some shared interest among insurants
- PHI constitutes direct reciprocal exchange as ‘risk reciprocity’, while SHI is a form of generalised indirect exchange with a long-term outlook (Molm et al. 2007; Ullrich 2002; Koos and Sachweh 2019)

Fairness priorities: Going beyond self-interest II

- Healthcare constitutes a public good in its fundamental properties (Karsten 1995; Abdalla et al. 2020; Kallhoff 2014; Sunstein and Ullmann-Margalit 2001)
- With PHI, market justice is preferred over social justice in health care (Budetti 2008)
- SHI does not discriminate on the basis of factors that can cause inability to contribute, while PHI discriminates through exclusion and by setting high risk premiums

Health insurance in Austria

SHI in Austria

- The Austrian health care system is solidaristic in the sense that people contribute on the basis of their ability (e.g. a specific percentage of people's salaries that is taken off automatically) and receive services based on their needs (Ter Meulen 2017; Spahl and Prainsack 2021)
- Bismarckian public health system and statutory health insurance (SHI). Its core funding mechanism is compulsory social security contributions that are directly or indirectly tied to employment and to occupational status
- Austria has a very high health insurance coverage rate (about 99%) and her population reports few unmet medical needs in EU comparison (Toth 2019)

PHI in Austria

Market roles	Eligibility	Examples of benefits covered	% of population covered (2006)	% of total expenditure on health (2006)
Complementary (services) Supplementary Substitutive	Whole population Occupations opting out of the statutory scheme (some self employed), individuals not eligible for statutory cover	Dental and eye care, physiotherapy, home visits, psychotherapy, health resorts, rehabilitation, drugs, CAM Private wards/hospitals and doctors, choice of hospital doctor, faster access (elective care), per diem cash benefits for inpatient care similar to statutory cover	33% ²	5.3%

Table 1: Private health insurance in Austria. Thomson and Mossialos (2009, p. 16)

Data & Variables

The Data

- Austrian Corona Panel Project (ACPP), is an online panel survey conducted among the Austrian resident population, which started in late March 2020 (Kittel et al. 2020; Kittel et al. 2021)
- Respondents were quota sampled based on the key demographics of age, gender, region, municipality size, and educational level based on official statistics
- In this study the ACPP wave 22 (mid-April 2021) and the wave 32 (end of May 2022) are used

Outcome variables

- Eight variables that measured preferences for redistribution and policy in health care were first analysed separately
- The stated redistribution preferences were newly developed for the ACPP and responses were designed as 5-point Likert items
- A polychoric cluster-robust principal component analysis (PCA) was used to form an index of these preferences

Predictor variables

- Being insured with a PHI (binary)
- Attitudes on fairness of prioritising privately insured persons, on a 5-point Likert scale

Auxiliary variables

- Gender (binary)
- Highest attained education level (ISCED 5)
- Age (in years)
- Net household income (in deciles)
- Migration background (no parent immigrated, one/both parents immigrated or self born abroad),
- Domicile in a rural (<50,000 inhabitants) or an urban (>50,000 inhabitants) municipality
- Trust in the public healthcare system (range 0-10)
- Self-assessed health status (5-point Likert)

Methods

Methods – Analytical Strategy

- Fixed-effects graded response model (GRM) with cluster-robust covariance estimators
- Cluster-robust conditional mixed process (CMP) estimator that relies on eight ordered pooled Probit regression equations - one for each preference item
- Cluster-robust random-effects generalised least squares (RE-GLS) regressions
- Additional models to check robustness

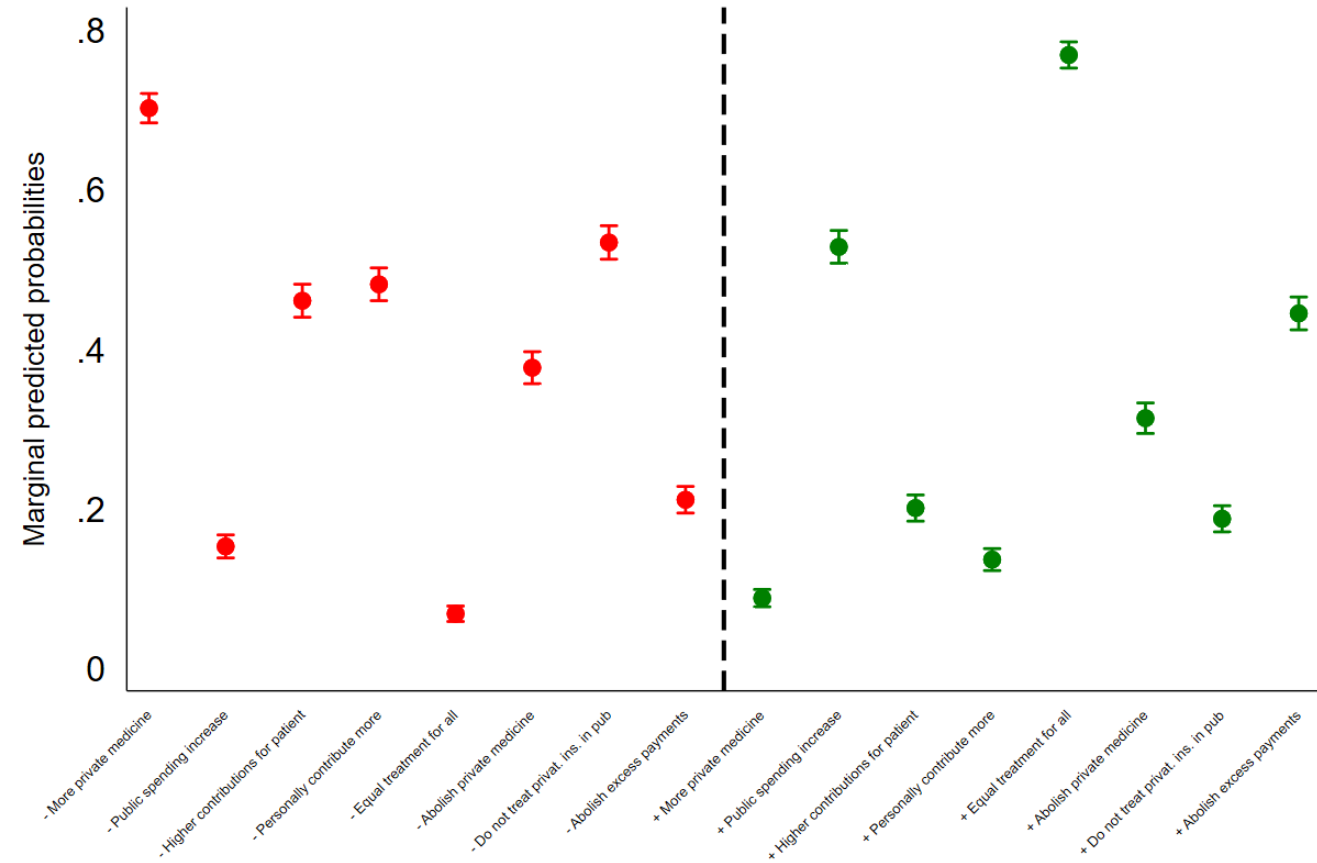
Results

Psychometrics

- **Figure 1**

- Predicted probabilities for dis/agreement with redistribution in health care
- Cluster-robust GRM with time-variant demographic weights.
- ACPP April 2021 & May 2022 (N = 1,990)

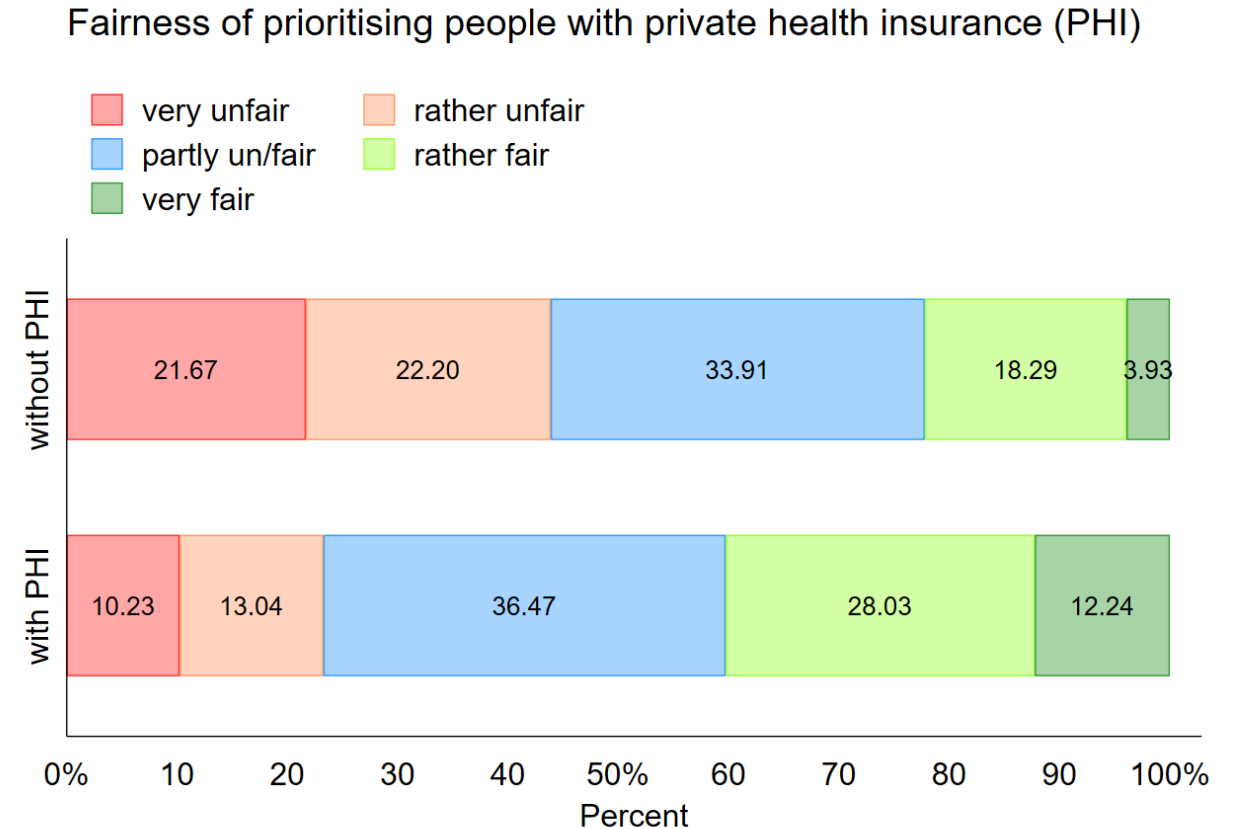
Predictive Margins with 95% CIs



Descriptive statistics

- **Figure 2**

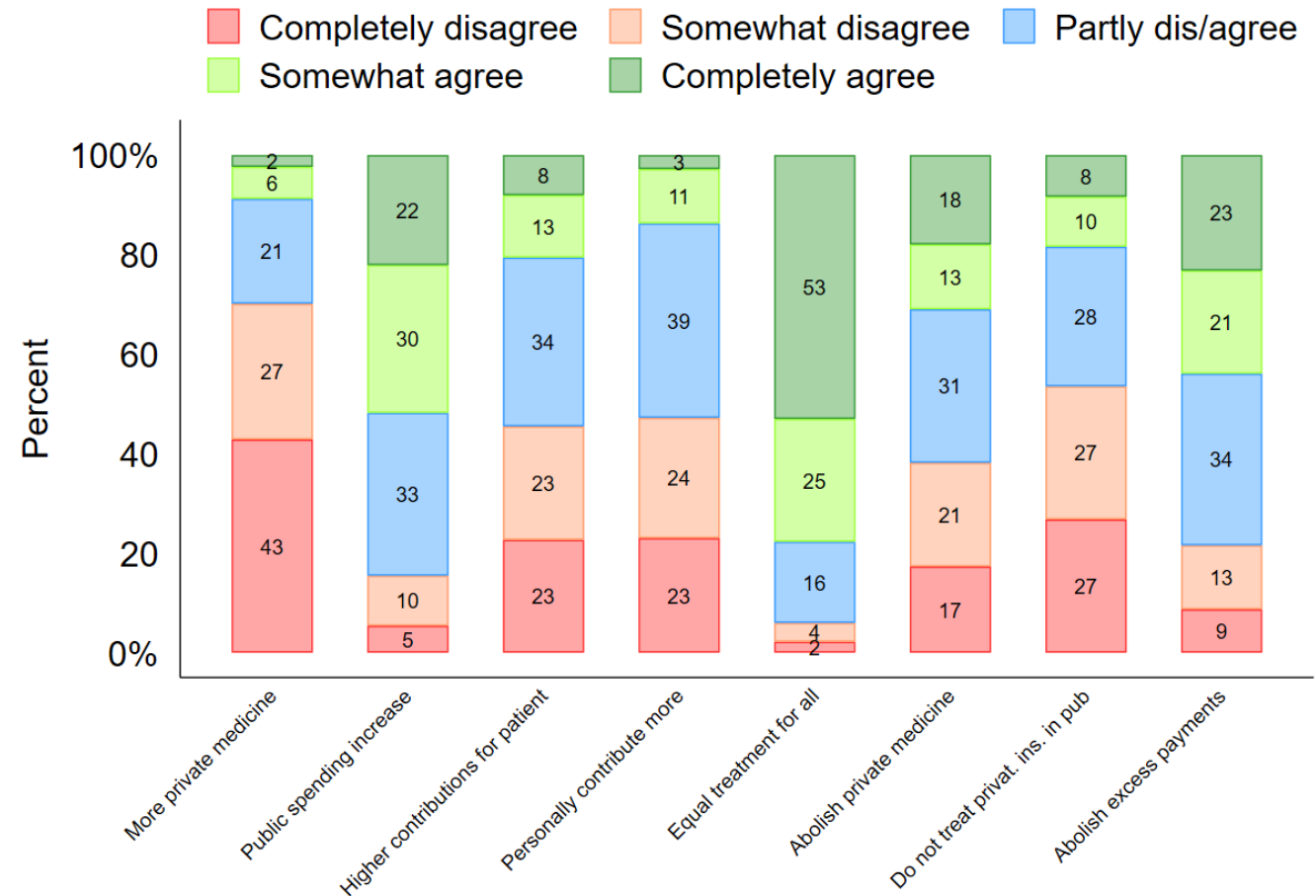
- Fairness of prioritising privately insured persons, grouped by private health insurance coverage, with time-variant demographic weights
- ACPP April 2021 & May 2022 (N = 2,414)



Descriptive statistics

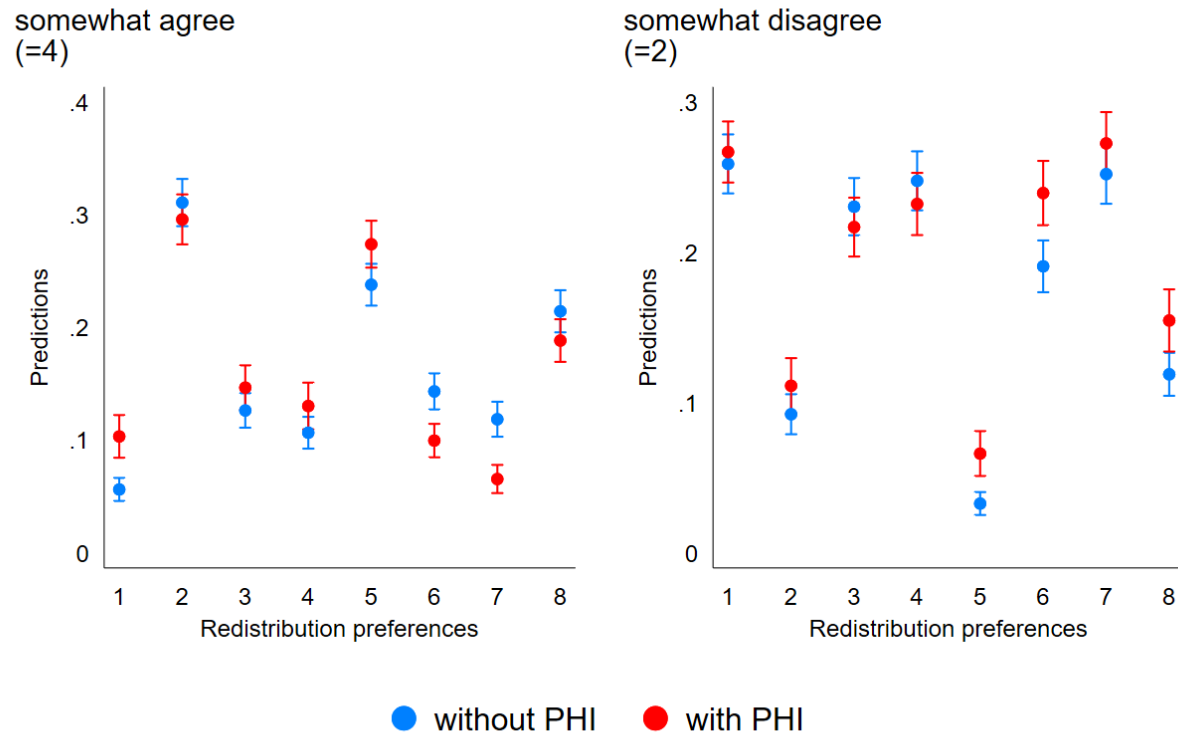
- **Figure 3**

- Redistribution preferences in health care, with time-variant demographic weights.
- ACPP April 2021 & May 2022 (N = 2,414)



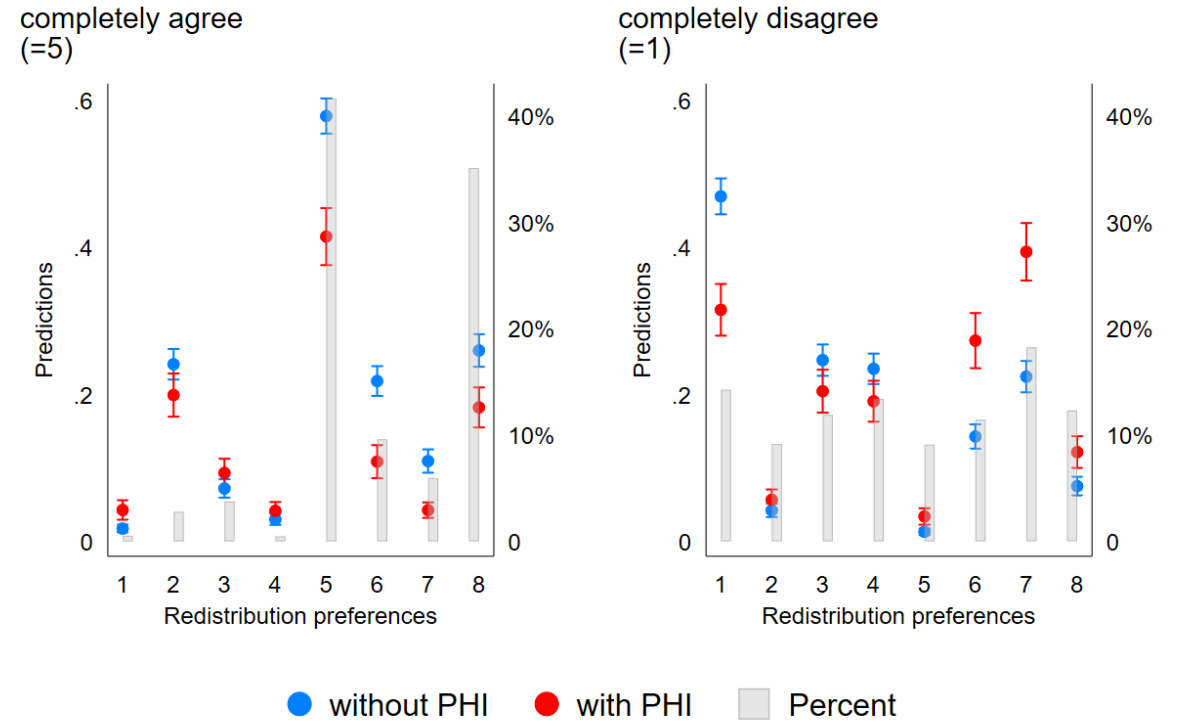
Inferential analysis

Predictive Margins with 95% CIs



based on 8 ordered Probit equations in a CMP

Predictive Margins with 95% CIs



based on 8 ordered Probit equations in a CMP

Figures 4 & 5

Discussion & Conclusions

Interpretation & implications of the findings

- Policy makers should be clear and explicit about whether they want to foster a medical two-tier system or not
- In the long term PHI might undermine solidarity in the health care system because people who possess PHI may exclude people not covered by PHI in their understanding of reciprocity, fairness and solidarity, which have to be foregrounded and reinforced especially amidst a pandemic
- Leopold et al. (2020, p. 1) show when it comes to national reimbursement decisions for health care in New Zealand and in Belgium the most relevant aspects are '1) political commitment to initiate change, 2) broad involvement of all stakeholders, and 3) commitment of all to engage in a long-term process'
- Following Miller and Horowitz (2000) it would be beneficial for patients if doctors made their financial incentives explicit and openly communicated their private practice, if existent, to patients in order to foster transparency
- Many scholars are alert when it comes to more privatisation of health care, as a strong public health care system is better equipped to manage pandemics and other health-related crises

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Thank you!