Co-payments for Health Care

Co-payments as an instrument for influencing the demand for health care services and thus for curbing cost expansion have played an important role in the literature on health economics ever since the famous empirical RAND Health Insurance Experiment in the mid-1980s confirmed this effect for the USA in a comprehensive way. (On the supply side, a similar cost-curbing effect is also ascribed to waiting lists for elective surgical operations as well as to the system of managed care.) This article focuses on co-payments.

Co-payments are understood as the additional payments that insured persons must remit in addition to their insurance premiums when making use of health-care services. This system involves health-care services that are reimbursed by health insurance plans but always with the deduction of a co-payment. Payments for health goods or services not covered by health insurance plans are not considered co-payments but as self-medication. In the extensive health-policy database of the OECD, the OECD Health Data, no distinction is made between actual co-payments and payments for self-medication; both are grouped together as "out-of-pocket payments".

The graph shows, firstly, that out-of-pocket payments (used in the following synonymously with co-payments) in most western industrialised countries were around 10 to 20 percent of total health-care expenditures for 2000. With co-payment rates of such a moderate order of magnitude, a demand dampening effect of 5 to10 percent can be expected (in comparison to co-payments of zero percent). If we (could) deduct spending for self-medication, the "genuine" co-payments would be even smaller. For some countries, turnover in the self-medication market is known (and in part considerable), but in most countries it is unknown.

There are, however, countries with much higher co-payment rates. Among the western industrialised countries these are Switzerland (33.3 percent), Spain (24.0 percent) and Italy (22.9 percent), in particular. Comparably high co-payment rates are also found in South Korea (41.0 percent) and Mexico (52.7 percent).

The development of co-payments over time from 1990 to 2000 is also informative. In most of the countries listed in the OECD Health Data, co-payments have increased, for example, in Norway, Canada, Australia, Austria, Italy, Finland, Spain, New Zealand, as well as in all EU accession countries. In Hungary co-payments have doubled since 1991. Small changes were recorded in Switzerland (from a very high level) and in Germany (from a comparatively low level). On the other hand, co-payments decreased in the USA (from 20.1 percent to 15.3 percent) as well as in Korea (clear decrease) and Mexico (slight decrease).

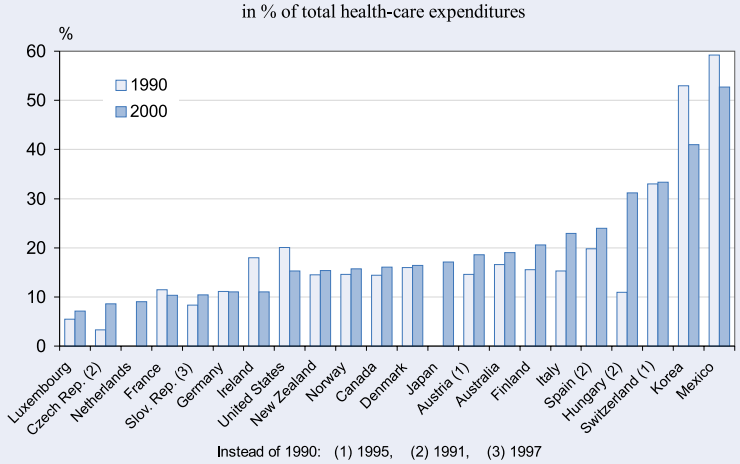
In general, co-payments – as a portion of overall health-care expenditures – are relatively low but with an increasing trend, which has been moderate in most cases, however.

Co-payments reduce the insurance premiums and tax payments for health-care services to an equal extent. Moreover, a cost-dampening effect occurs due to a reduced demand for health-care services, which leads to a further lowering in contributions or tax payments. This latter effect is probably not exhausted in most countries due to the generally still moderate levels of co-payments. However, if co-payments are increased, consideration must always be given to the redistribution effects as well as to the effects on the healing process. This can be done with an intelligent design of the co-payment system.

R.O.

Out-of-Pocket Payments for Health-Care

in % of total health-care expenditures



Instead of 1990: (1) 1995, (2) 1991, (3) 1997

Source: OECD Health Data (2003).