

Private Health Insurance in OECD Countries

Health Insurance for an Expanded
Europe:
New Public-Private Options

The Prague Symposium 2004

Nicole Tapay (Novartis)*

**Based on work performed under OECD private health insurance project (2001-2004), in collaboration with Francesca Colombo, with supervision and input of several OECD delegate bodies and two OECD Directorates.*

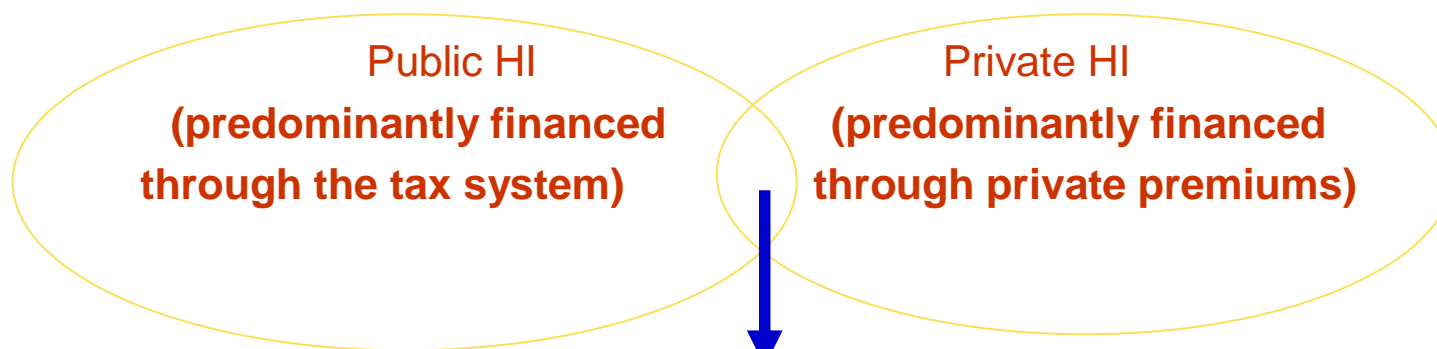
Presentation reflects views of presenter only.

What is Private Health Insurance?

INSURANCE: prepayment and pooling



on the basis of the main source of financing



BUT: Borderline cases:

- Mandatory, flat, non income-related, premiums (e.g, CH)
- Highly subsidised purchase of cover (e.g., CMU - France)
- Schemes for government employees

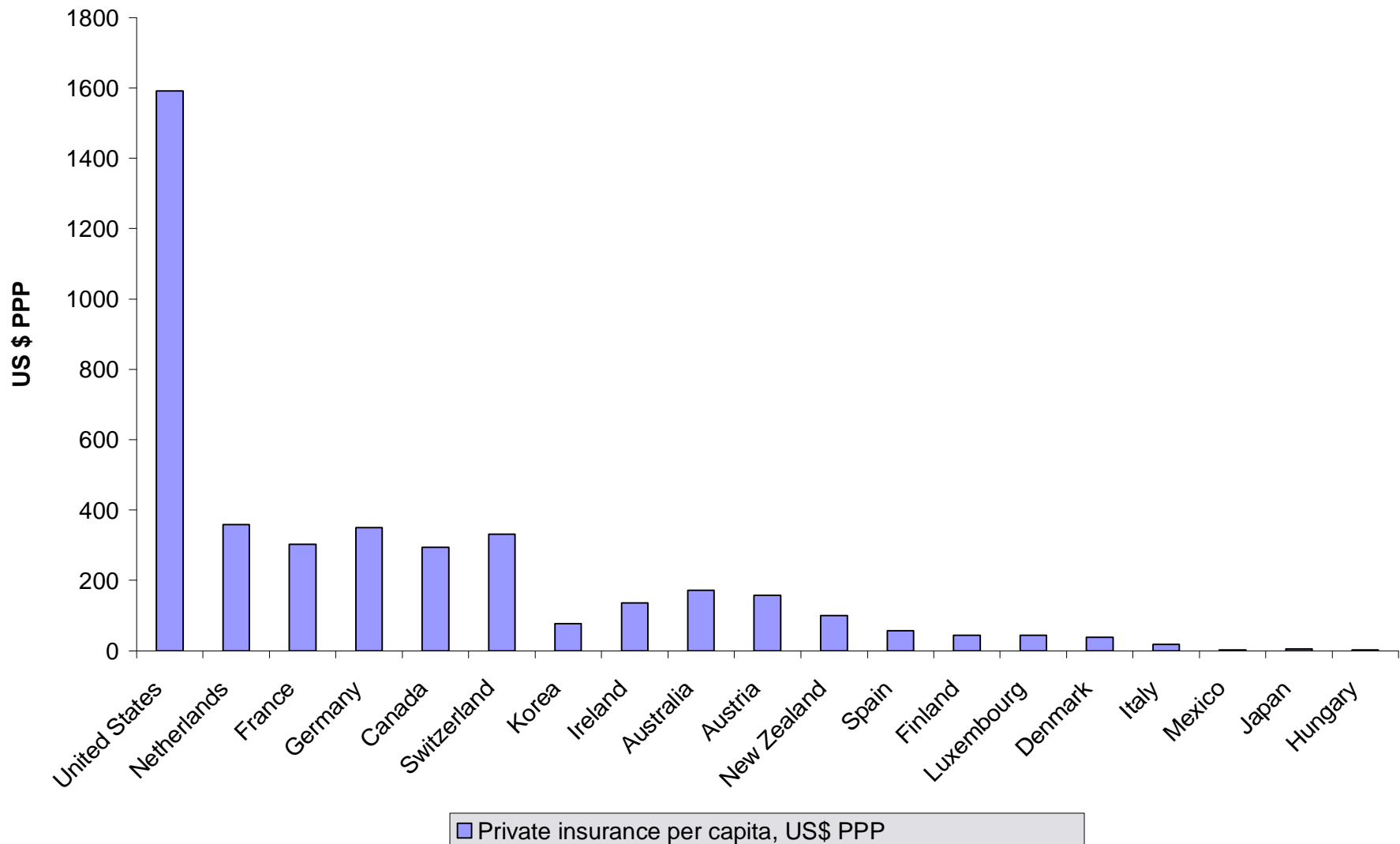
| (2000) | PHI share of THE | Population covered | Main PHI Function |
|-------------------------|---------------------|-----------------------|------------------------------------|
| OECD average | 6.4% | About 30% | |
| USA | 35.6% | 71.9% | Primary |
| Netherlands | 15.5% | 28/90% | Primary/Suppl. |
| France | 12.7% | 86% | Compl. (cost- sharing coverage) |
| Germany | 12.6% | 18% | Primary/Suppl |
| Canada | 11.4% | 65% | Suppl. |
| Ireland | 7.6% | 43.8% | Duplic. |
| Australia | 7.3% | 44.9% | Duplic. |
| New Zealand | 6.2% | 35% | Duplic. |

Source: OECD Health Data, PHI Statistical questionnaire and other official sources.

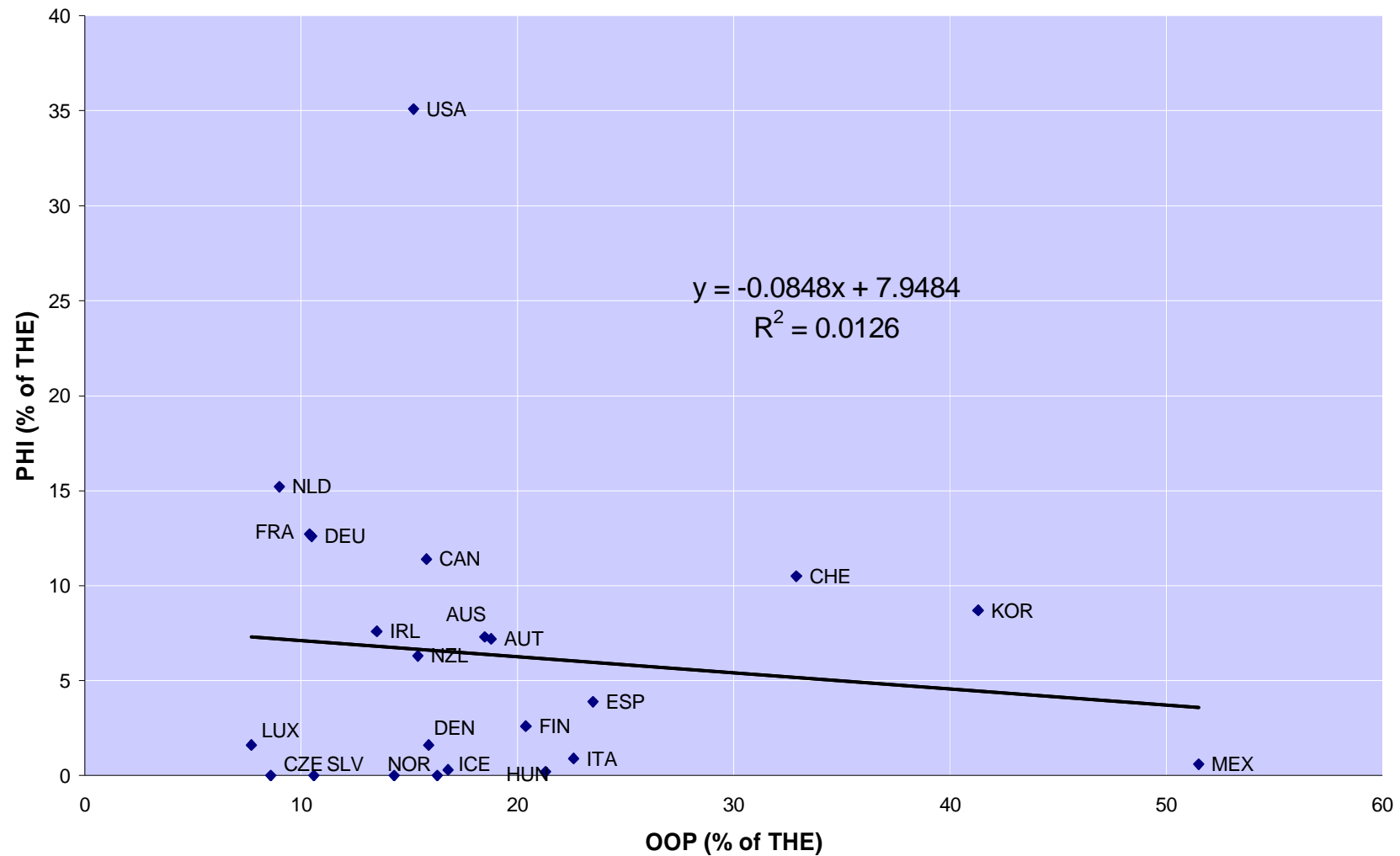
EU Accession Countries

- Currently very limited PHI market in many countries
- Primarily plays a supplemental role or is part of a specialized market (i.e. travel insurance)
- Some experience with employer-sponsored coverage that approximates insurance
- Discussions of enhanced role for PHI are linked with discussions about scope of public coverage
- Can benefit from experience of neighboring countries with longer history of PHI markets

Different per capita spending



Not necessarily substitute for OOP



PHI Market Traits: much variation

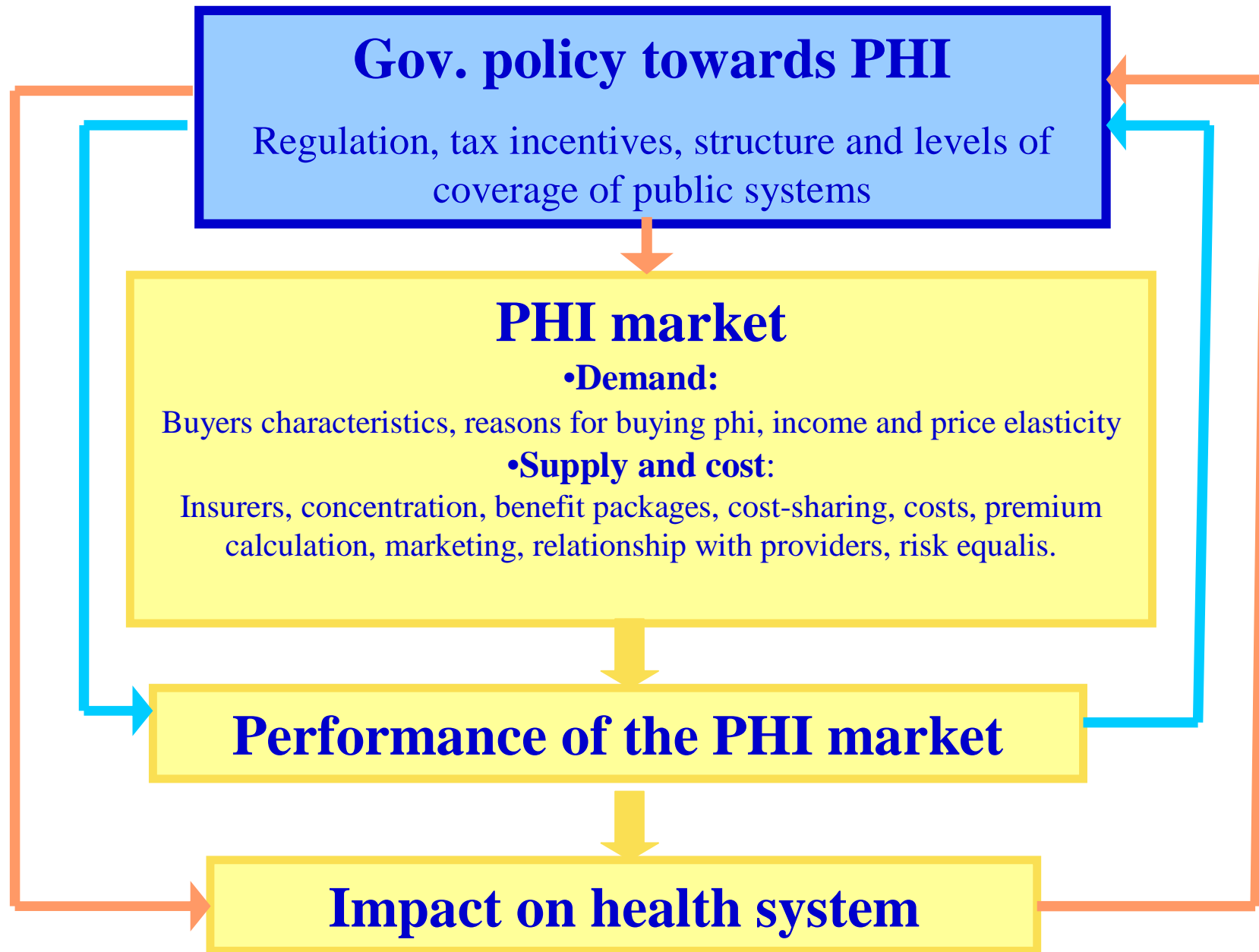
- **Concentration** (Australia: 43 insurers; Top 6 insurers: 76%; Ireland: 2 insurers)
- **Profit orientation** (Commercial ins. prevalent in the U.S., Canada; Non-profit elsewhere)
- **Specialisation** (specialised: Australia, Ireland, Germany; Non-specialised: France, Canada)
- **Relationship to providers:**
 - Indemnity (France, Canada, U.S, other)
 - Contracts (U.S., Ireland, Australia)
 - Integration (HMO in U.S, some in Spain and UK)

Reasons for different market characteristics:

- Scope of public coverage and system structure
 - Individuals; Providers; Services
- Policy choices/ government support
 - Mixed system to enhance policy outcomes
 - Individual responsibility
 - Interventions via fiscal and regulatory tools
- Historical factors
- Role of employers
- Consumer preferences

Market features have implications for performance

- PHI roles raise different policy challenges
- **Market structure and features**
 - Impact of competition not-for-profit /for-profit
 - Market concentration and effective purchasing
 - Relationship insurers/providers
 - Individual versus employer-sponsored PHI
- **Demand for PHI, Purchaser profiles and Market Size**
 - Impacts risk-pooling, potential for competition, among other aspect



Impact of PHI on Health Systems

Access to Coverage and Care

- PHI offers primary coverage when not offered publicly (e.g. U.S., Netherlands) or as a substitute (e.g. Germany, Spain civil servants)
- PHI enhances patients' timely access to hospital care in some systems (e.g. Ireland, Australia, UK) but there are tradeoffs in terms of equity and it may contribute to “2-tiered” system

Capacity and Utilisation

- PHI can **increase capacity**, such as in private hospital sector in some countries
- PHI may provide **incentives for larger treatment volumes**, such as through differential provider reimbursement levels
- PHI has shown **limited ability to constrain demand pressures**. It is not clear if this is due to latent need, moral hazard, or other reasons.

Access to Coverage

- PHI is not always affordable
- PHI is often not accessible to high-risk persons in the absence of government interventions
- Degree of problem depends in part of scope of public system

Choice

- PHI provides an **additional financing option** for health care costs
- PHI often provides **enhanced provider choice**
- PHI carriers often offer **an array of benefit packages**
- Presence of **multiple purchasers**, such as private and public insurers, **can stimulate adoption of new technologies**

Cost and Expenditures

- Some but **limited cost shifting**
 - Public sector bears cost of expensive services
 - Patients continue to utilise public sector
 - De-listing of less expensive services
- **Increase total expenditure** (higher prices/volumes), but
 - Bargaining power of insurer affects impact on expenditure
 - Value for money of increased expenditure not well researched

Efficiency

- Limited managing of care by insurers
- Limited impact of competition on efficiency
 - Limited switching of insurer limits competition
 - More incentives to select than to manage risks

Waiting times

- Demand for PHI linked to waiting times
- PHI contributed to higher service volumes and development of private capacity
 - In AUS more than EIRE, little in UK, none in NL
 - Less waiting in Australia than Ireland
- But: PHI also increases total utilisation:
 - This reduces demand shift potential

Main messages

- Pros/cons of PHI, “by and large”:
 - PHI has enhanced responsiveness
 - But less positive impact on equity and efficiency
- However, performance varies, often according to:
 - PHI role
 - Government interventions
 - Market structures and insurers’ behaviours
- Interactions with public systems raise trade-offs

Challenges/trade-offs by PHI role

- **Primary:** Affordability and access to cover can present challenges, especially for vulnerable populations but covered population often have greater choice of benefit packages and do not depend on public coverage
- **Duplicate:** promoting choice while reducing undesirable access inequities
- **Complementary:** minimising moral hazard-induced utilisation while promoting access to care
- **Supplementary:** decision not to cover certain services (to “de-list”) may still impact publicly financed system

But also common challenges

- Access to PHI cover: What are the right regulatory tools to promote it?
- Product comparability to encourage choice: Should governments require or facilitate?
- Premium inflation and cost: Can insurers aid in controlling cost?
- Higher health prices and volumes: What is the value for money?

Unique Challenges for EU Accession Countries

- Little if no history with PHI markets
- Effort to replace less formal payments is difficult to legislate
- Regulatory expertise and resources would need to be developed and allocated
- Questions arise at same time that public system undergoing scrutiny
- Equity issues may raise significant concern, especially where there are constitutional or other legal guarantees to health care and little history with a “two-tier” health coverage market

Policy makers need first to assess trade-offs of PHI:

- Set **clear policy objectives** for PHI
- Determine **potential benefits** of PHI market (whether it exists already or not):
 - Assess **interactions with public coverage/delivery systems**
 - Assess **value to be assigned to choice**
 - Assess **acceptability of access according to by willingness or ability to pay**
 - Assess **desired level of individual responsibility for uncovered services/providers**
 - Assess **importance of equity of access for all**

Then, choose approach

- **How much intervention?**
 - EU Directive limits regulation beyond solvency:
 - Australia, Ireland, some U.S. States intervene to a greater degree, as well as other countries with primary coverage markets
- **What type of intervention?**
 - Regulation, fiscal instruments, or both?
 - Outcome-oriented regulation (Australia)
 - Voluntary standards can be useful (Ombudsman)
- **What tools?**
 - Access standards, benefit regulation, contract limitations
 - Type of tax/fiscal advantage
 - Other subsidies

Monitor Impact of Interventions

- Establish means of monitoring impact of regulation
- Provide means for government to respond to negative or unanticipated outcomes
- Improved data on population coverage and types of coverage may help policymakers