

OECD Private Health Insurance Project

iHEA, 15-18 June 2003

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<http://www.oecd.org/health>

Background

- A comparative project on the role of private health insurance in OECD countries
- Preliminary results from 3 case studies (Aus, EIRE, NL); France and US to come.
- Overall comparative analysis (case studies plus other OECD countries) due in mid 2004

Objectives

- Explain differences in development of PHI markets
- Compare and contrast regulation and other government interventions (e.g., tax) and their impact
- Analyse the impact of PHI on health system
 - **Equity of access to care**
 - **Cost and cost-effectiveness of care**
 - **Individual choice and waiting times**

Method

- Taxonomy of public-private health ins. mixes
- Analysis of primary data collected through surveys administered to relevant authorities of OECD countries
 - **A survey on statistics on PHI markets**
 - **A survey on regulation of PHI**
- Focused group interviews with stakeholders in the case study countries
- Extensive literature review
- Input by senior OECD delegates

Preliminary Findings from Australia, Ireland, Netherlands

- **Differences in market size explained by:**
 - i) Roles played by PHI in the health system
 - ii) Coverage history/historical factors
 - iii) Policy support by government
- Netherlands: PHI as primary cover for those ineligible for social insurance
- Australia & Ireland: Historically large role buttressed by policy support: to enhance choice and reduce pressures on public hospitals
- Supplementary PHI for risks not publicly covered in all countries

PHI market in Australia, the Netherlands and Ireland

	PHI share of THE	Population covered	Main PHI Function
Australia	7.1%	44%	Duplicate (hospital coverage)
		41%	Supplement
Ireland	7.1%	48%	Mainly for duplicate (hospital coverage)
Netherlands	14%	28%	Primary
		Over 90%	Supplement

Source: OECD Health Data, PHI Statistical questionnaire and other sources, late 1990s.
Data are preliminary

Parallels and Differences in Regulatory Approaches

- Australia and Ireland impose some common requirements on entire PHI market:
 - Community rating (with some adjustments in AUS)
 - Guaranteed issue
 - Guaranteed renewability
 - Proposed or implemented risk equalisation
- Netherlands takes a “safety net” approach:
 - Assures access to a standard package (WTZ)
 - WTZ premiums capped and subsidised by other privately insured
 - Majority of PHI market only lightly regulated

Market Impact of Governmental Interventions on PHI's Role

- **Australia prohibits PHI coverage of out-of-hospital services; Ireland permits such coverage**
- **Australia publicly funds a share of the medical cost of services in private hospital; not in Ireland**
 - **Despite these 2 differences, overall PHI financing role nearly identical in the 2 countries (7.1% THE)**
- **Netherlands' reimbursement limits and its provider structure minimise access differences by insurance status**

Impact of PHI on Equity

- Level of care/choice may vary by insurance status in EIRE and AUS but little in NL
 - Resulting from different values/health system structures
- Payment mechanisms for public and private insurees affect application of rule of access designed to guarantee equity
 - Higher reimbursement for PHI patients
 - FFS vs. salary/capitation payments
- Fiscal incentives: mixed implications for equity
 - Tax rebate (AUS) less regressive than tax advantages (Ireland); however, there are implications for financing equity as demand for PHI is income-related

Impact on Economy and Efficiency

- More economy if cost control measures apply to the entire system (NL) rather than to public health system only (Aus, Eire)
 - Budgets, capacity controls, fee regulation
- Insurers' ability to control cost linked to insurers' bargaining power over providers
 - Bargaining power varies with PHI market concentration
- Subsidies to PHI create public cost pressures (AUS, EIRE)
 - Unclear whether tax-subsidies are self-financing
- Limited health care management by insurers
 - Desire not to restrict individual choice of provider, regulatory requirements, reimbursement practices, etc.

Impact on Responsiveness

● Choice

- Same level of choice of provider in NL; more options for privately insured in EIRE and Aus
- Limited switching of insurer in the three countries
- Too much differentiation of benefit packages may limit ease of choice (Australia)

● Waiting times

- Demand for PHI linked to waiting times (Aus, EIRE)
- PHI stimulated development of private capacity in AUS, less in EIRE, and none in NL
- PHI increases total utilisation: difficult to distinguish demand shift (from public to private hospitals) from overall demand increase

More information on the OECD Private Health Insurance Project

<http://www.oecd.org/health>

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