

Private Health insurance in the OECD

Benefits and costs for individuals and health systems

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

Outline

- Background, method
- Overview of PHI markets in OECD countries
- Impact on health systems, useful practices

Background

Part of OECD Health Project

- **Working Papers:**

- Case studies on PHI (Aus, EIRE, Slovakia, NL)
- PHI: Benefits and costs for individuals and health systems

www.oecd.org/els/health/workingpapers

- **Final Report**

- PHI in OECD Countries (autumn 2004)



Method

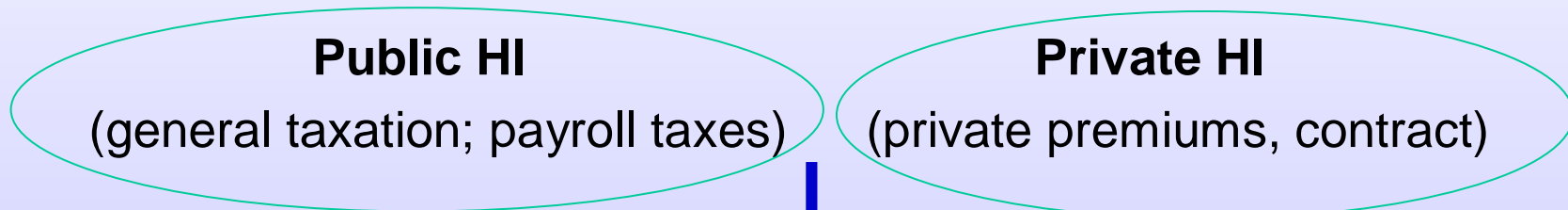
- Taxonomy
- Analytical framework
- Data collection: PHI statistics and policies
- Literature review
- Case studies

Taxonomy - What is PHI?

INSURANCE: prepayment and pooling



on the basis of the main source of financing:



BUT: Borderline cases:

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

Taxonomy - PHI role

Depend on structure of public systems

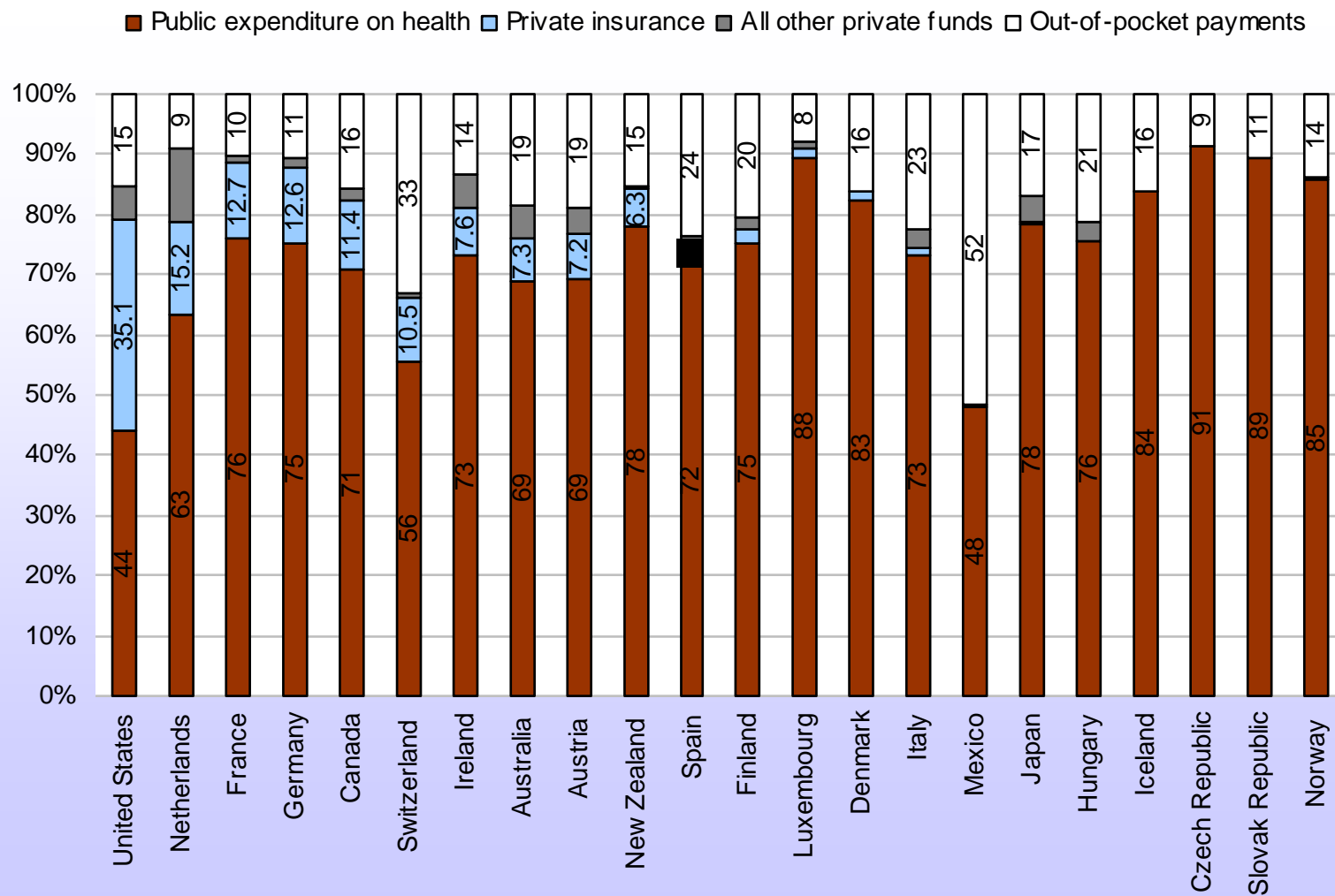
		Eligibility to public HI	
		YES	NO
Health services covered by PHI	Same services covered by public health insurance	Duplicate (UK, EIRE, Aus, Sp, Ita)	Substitute /principal (USA, Ger, NL, CH, Sp)
	Co-payments on publicly insured services	Complementary (Fr, USA, Bel)	
	Additional/extra services	Supplementary (CH, NL, Ger, Can, etc.)	

PHI markets

(2000)	PHI share of THE	Population covered %	Main PHI Function
OECD average	6.3	About 30%	
USA	35.1	72	Primary
Netherlands	15.2	28/64	Primary/Suppl.
France	12.7	92	Compl.
Germany	12.6	18	Primary/Suppl
Canada	11.4	65	Suppl.
Ireland	7.6	43.8	Duplic.
Australia	7.3	44.9	Duplic.
Spain	3.9	2.7/10.3	Primary/Duplic.

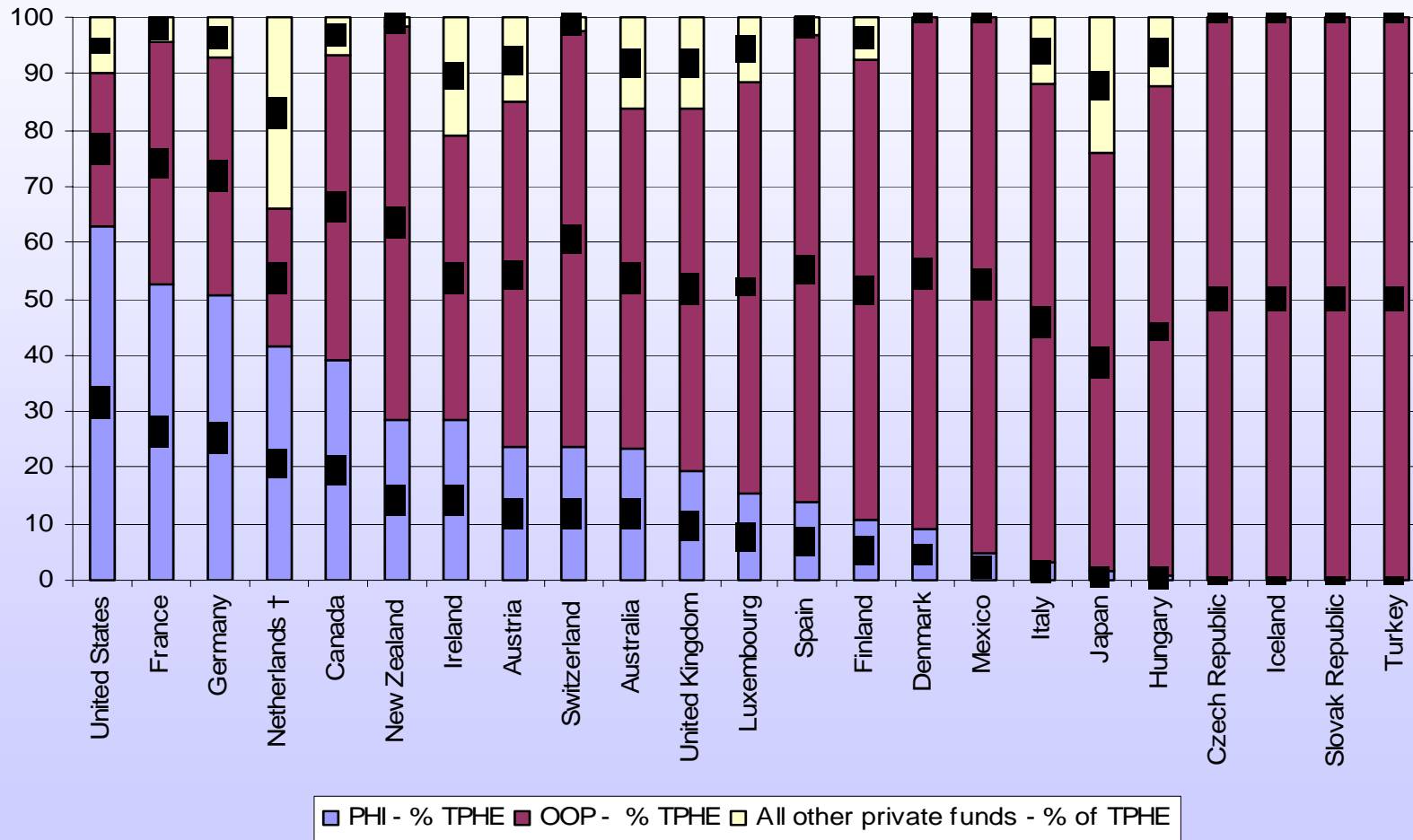
Source: OECD Health Data 2003, PHI Statistical questionnaire
and other official sources.

Sources of health finances



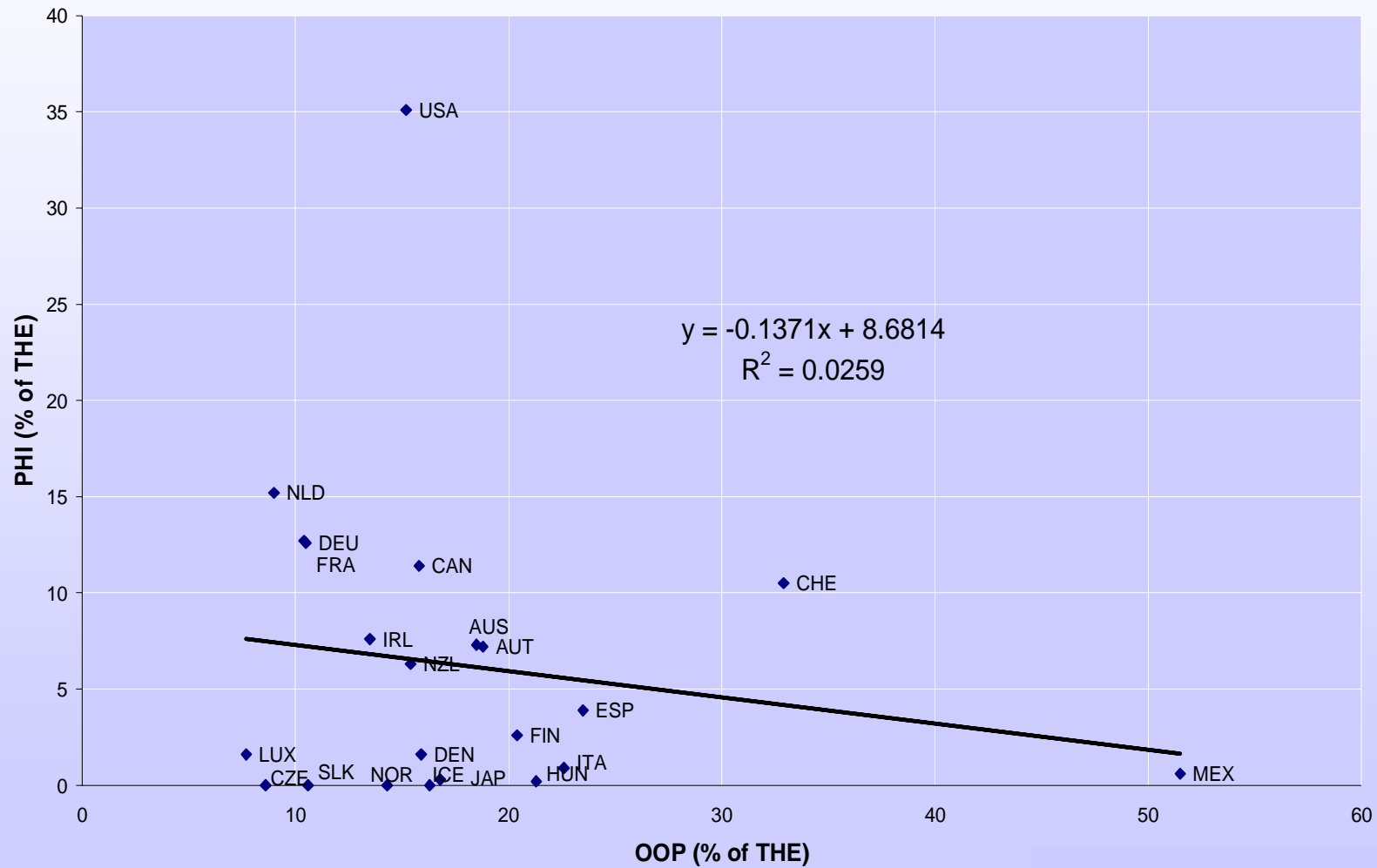
Source: OECD Health Data 2003.

Private spending breakdown



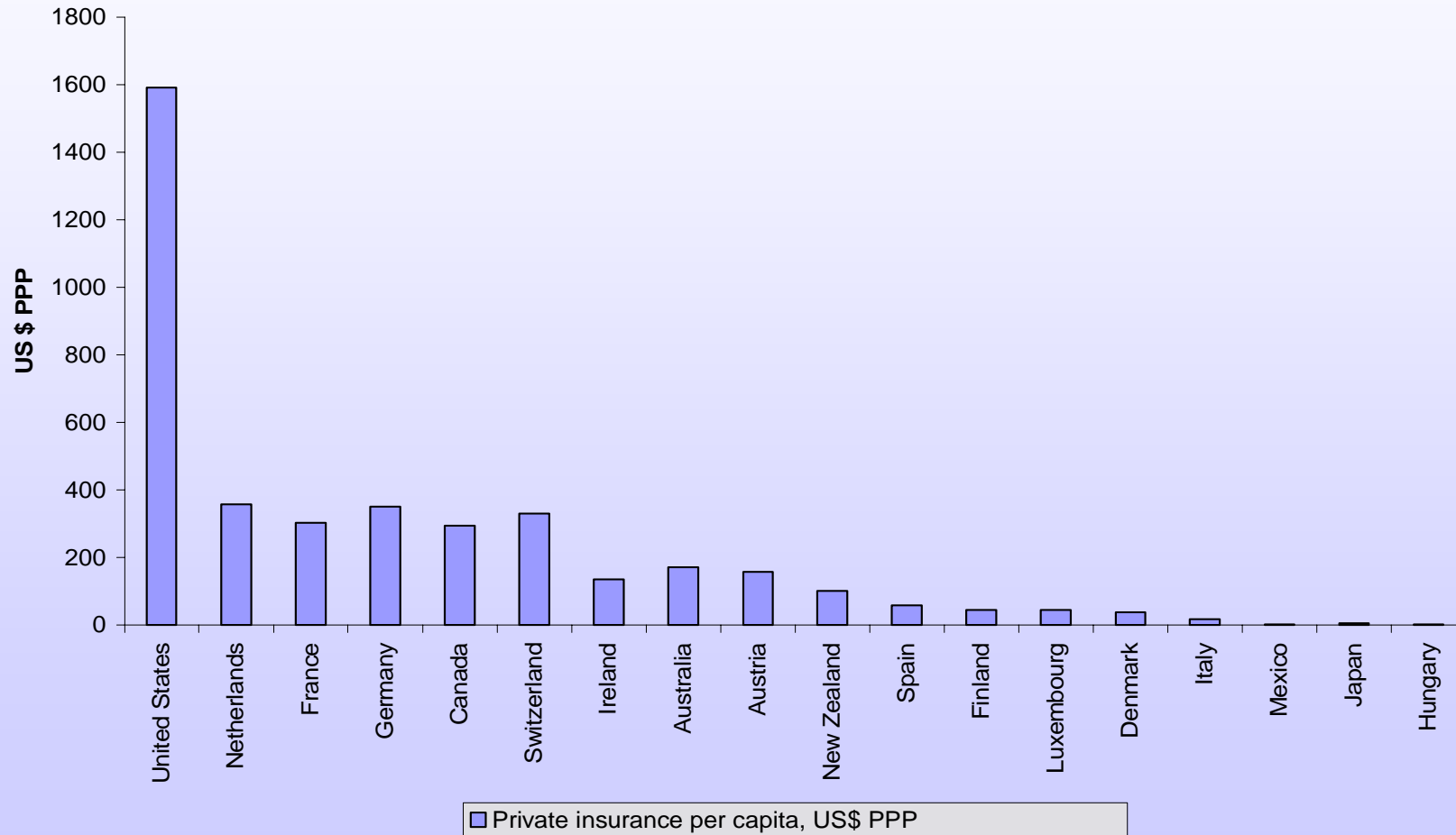
Source: OECD Health Data 2003.

PHI not substituting for OOP



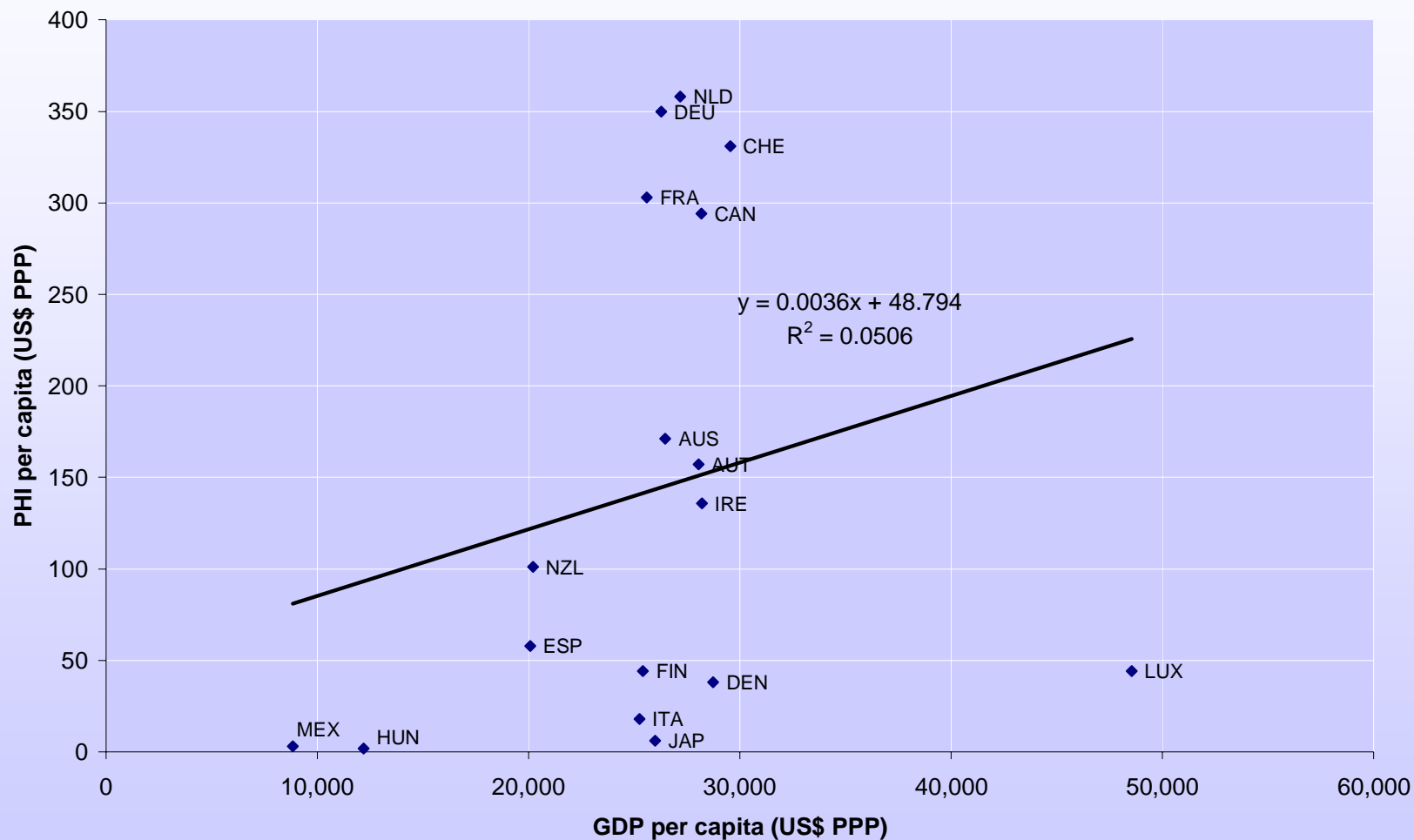
Source: OECD Health Data 2003.

Variation in PHI spending p.c.



Source: OECD Health Data 2003.

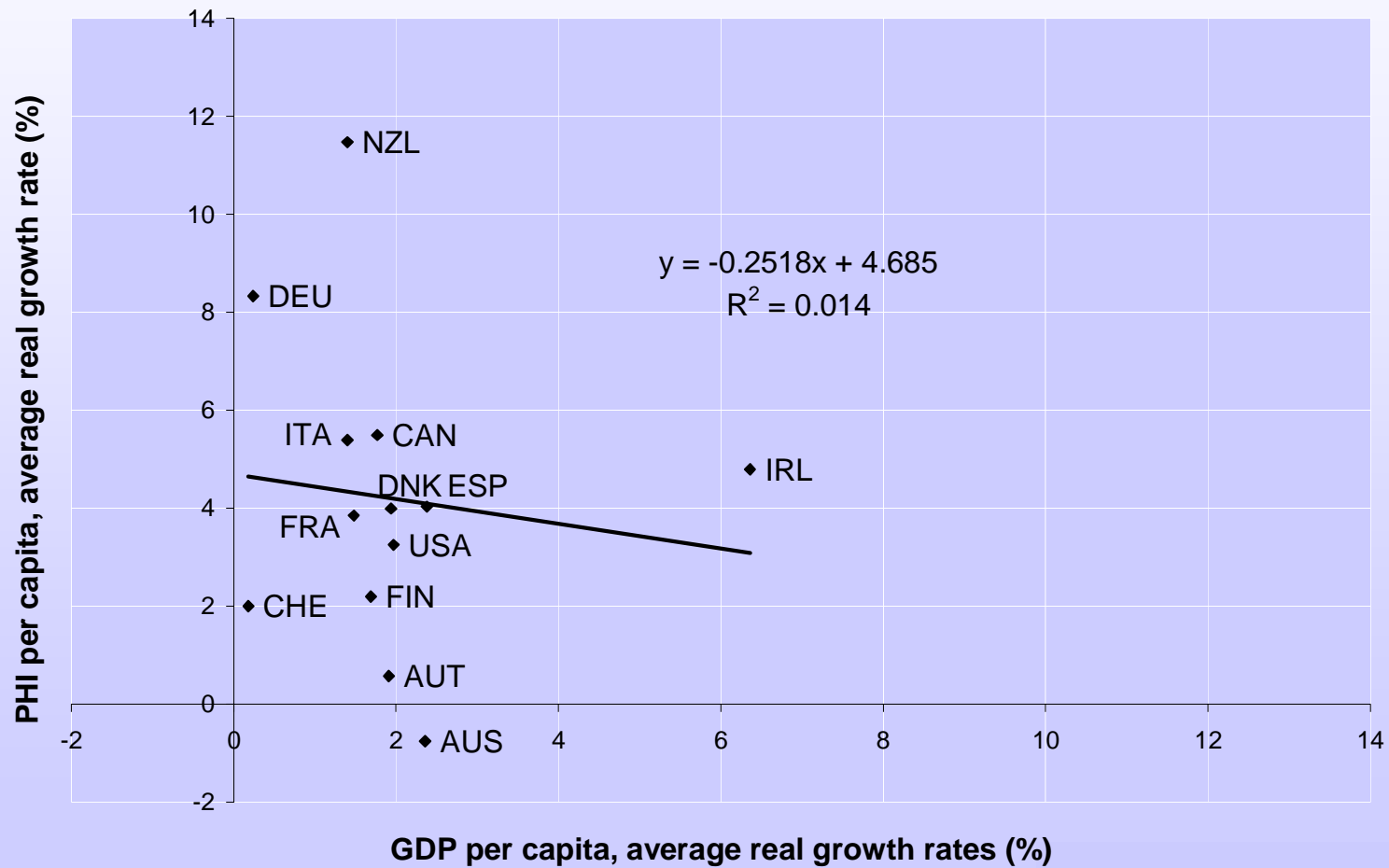
PHI not correlated with GDP



Note: If the USA is included, the equation becomes $y = 7.1935x + 24476$, with $R^2 = 0.1004$

Source: OECD Health Data 2003.

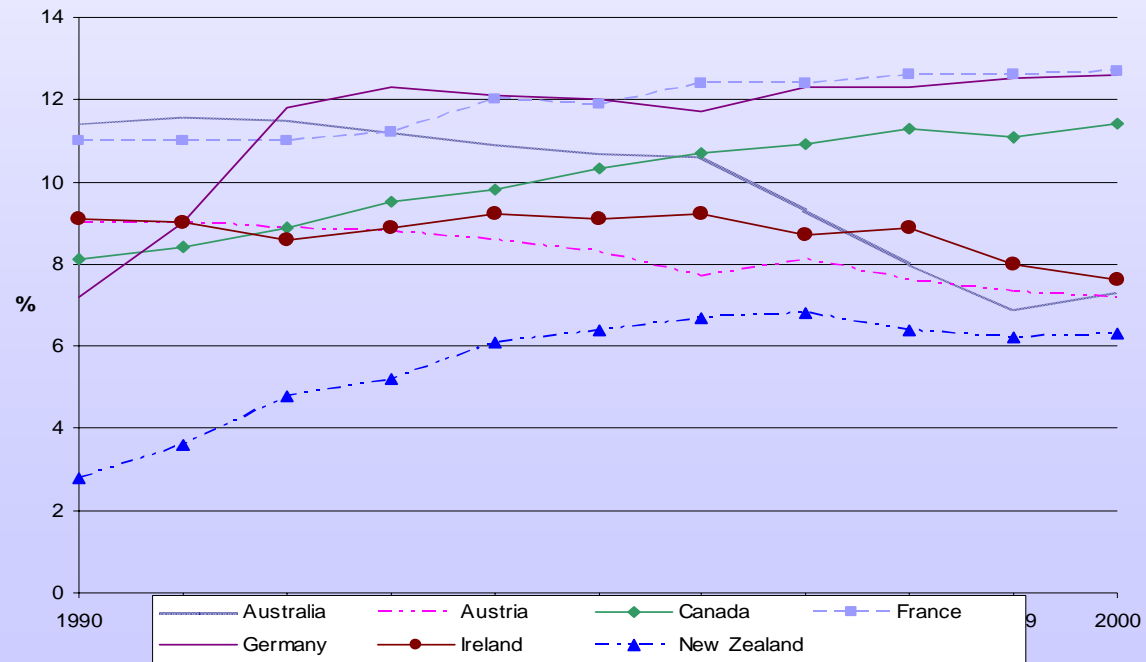
Real GDP and PHI growth 1990-2000



Source: OECD Health Data 2003.

PHI financing slightly growing 1990-2000

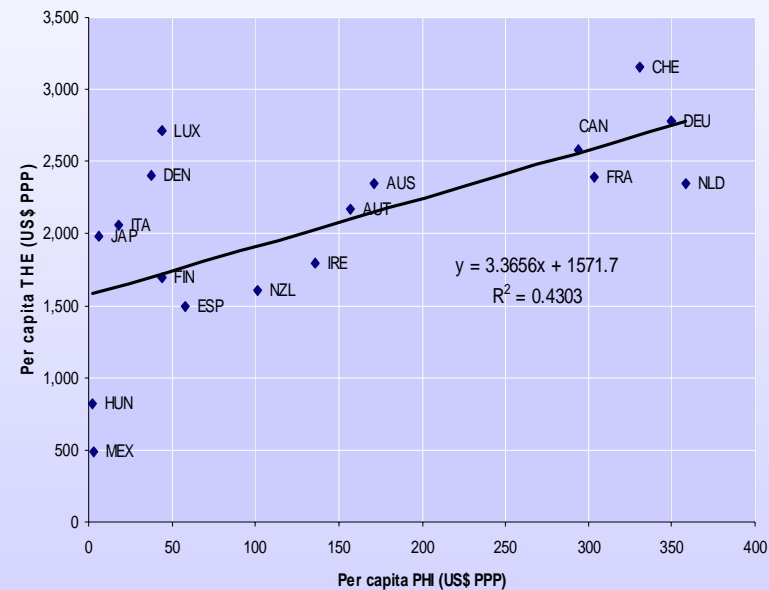
- For 12 countries, from % 8.5 to 9.4% of THE
- Increased in NZ, Germany, Canada;
- Reduced in Australia, Austria, Ireland



Source: OECD Health Data 2003.

PHI and THE

- Weak correlation, especially if U.S. is excluded
- Countries with either:
 - High PHI share in THE
 - High PHI pop. coveragetend to have high per capita health spending (U.S., CH, Germany, France)



Source: OECD Health Data 2003.

Why differences in market size?

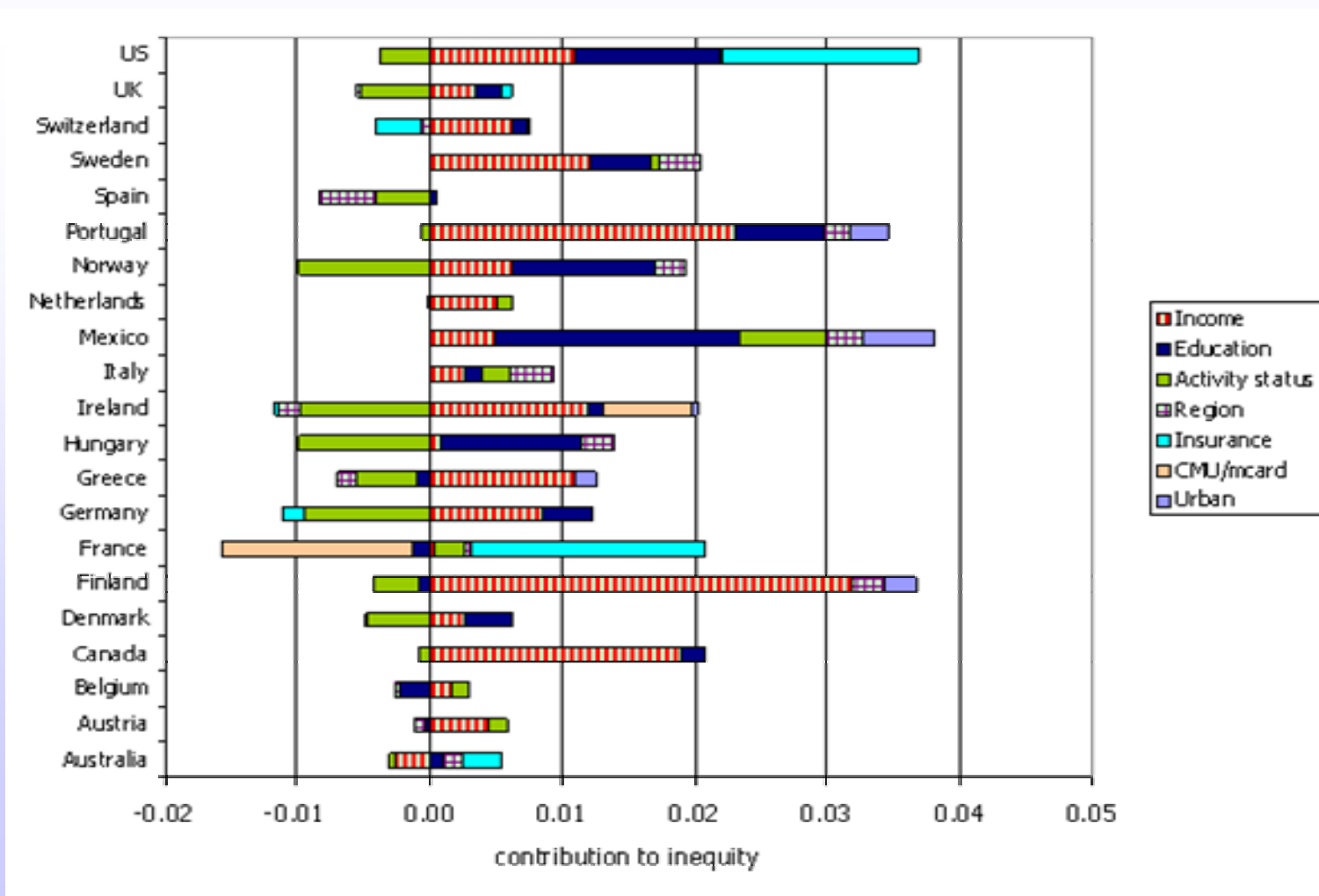
- Historical factors
- Public policy
 - Entitlement to public coverage
 - Degree of policy support to PHI (individual responsibility; fiscal/regulatory interventions)
- Role of employers: growing
- Perception of public sector quality (waiting times)

Impact of PHI, useful practices

Access to Care

- Enhanced access to care when public coverage has large gaps (e.g., USA, France)
- Enhanced insurees' timely access to hospital care in duplicate systems (e.g., Eire, Aus)
- Contributed to higher service volumes and development of private capacity (e.g., Aus)
- *Trade-offs in terms of equity:* distribution of service utilisation; providers incentives

Decomposition: prob. of doctor visits



Source: Van Doorslaer *et al.* (2004), for OECD.

Note: A negative contribution means that the effect is to lower inequality in visits favouring the rich (a positive contribution has the opposite interpretation).

Useful practices: equity

- Rules of access to care for public and private patients (e.g., Aus public hospitals)
- Unique waiting lists (e.g., NL)
- Specifying/monitoring providers' commitment to public patients (e.g., UK, Eire)
- Regulation of public-private sector prices (e.g., NL)

Access to PHI coverage

- PHI has not developed much in some OECD countries with large OOP (e.g., Mex, Kor, Turk)
- Not accessible/affordable to low-income/high-risks without interventions (e.g., USA; NL; Fra)
- Insurers or employers shift cost onto insurees (e.g., U.S. less comprehensive/defined contribution PHI)

Useful practices: PHI coverage

- Regulatory standards for all PHI market: combine issuance and rating reforms (e.g., community rating; guaranteed issue): Australia, Ireland, few US States)
- Safety net approach: well-funded high-risk pools and standard PHI policies for high-risks (e.g., NL, Germany, many US States)
- Impact of subsidies: mixed evidence (less targeted, cost: e.g., U.S. tax credit, Aus)

Responsiveness

- Generally PHI enhances choice, but:
 - Provider choice depends on choice in public systems and insurers networks (e.g, US managed care)
 - Barriers to switching of insurers
 - Too much product diversity limits ease of choice and creates selection by product (e.g., Aus)
- Generally insurers more prone to innovate, adopt new technologies, but:
 - Cost effectiveness?
 - Government regulation to protect equity reduces incentives to innovate

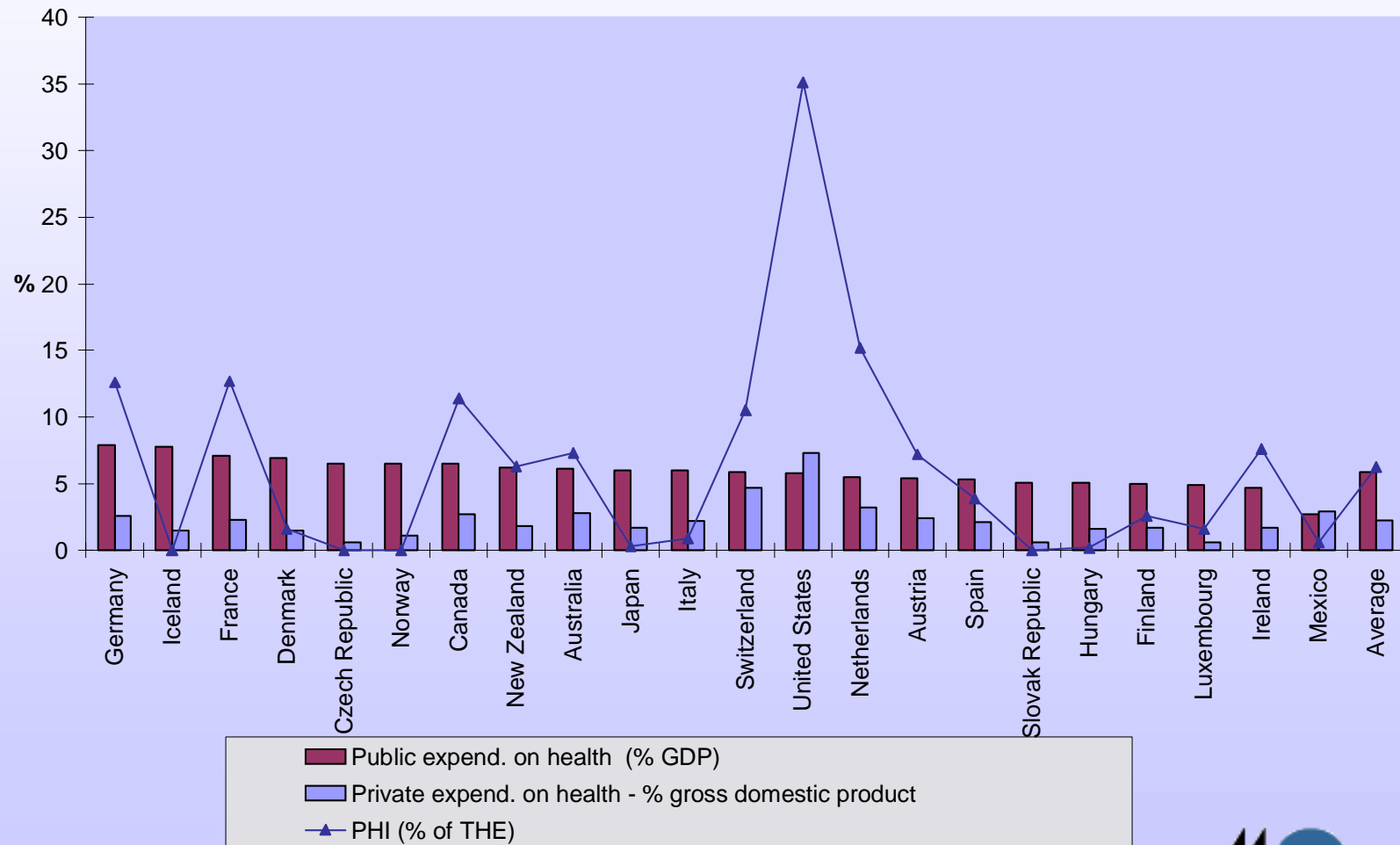
Useful practices: choice

- Comparative information on plans and benefits by governments or private sector (e.g., US HEDIS)
- Regulation of benefits and products
 - Minimum benefit (e.g., Aus, EIRE, many U.S. states)
 - Benefit standardisation (e.g, US Medicare Supplement, NL and Germany for high-risks)
- Assess trade-offs between consumer choice and insurers' incentives to innovate

Economy: little cost shifting

- Public sector bears cost of expensive risk
- Duplicate PHI (e.g., Aus, Eire)
 - Patients continue to utilise public sector
 - PHI raises total utilisation, not only shifts demand
- Supplementary PHI (e.g., NL)
 - less expensive services delisted (dental, optical)
- Primary PHI (e.g., U.S., Ger, NL)
 - Some groups not publicly covered, but spend no less on public system than OECD average

Public health spending as share of GDP and health financing by PHI



Source: OECD Health Data 2003.

Economy: add to THE

- PHI has less bargaining power over the price and quantity of care than public systems
- Pressures on public budgets:
 - To affect coverage levels, substantial subsidies required (not self financing) (e.g., Aus)
 - Complementary PHI: cost of utilisation increases fall onto public systems (e.g., France)
 - Supplementary PHI: interdependence with public system utilisation (e.g., New Zealand)

Useful practices: Economy

- Encourage private insurees to use privately financed services
- Apply same cost controls to public and private system (e.g., Netherlands)
- Weigh opportunity cost of any subsidies
- Avoid full PHI coverage of cost-sharing on statutory/public systems (e.g., CH)

Efficiency

- Little managing of care by insurers
 - Desire not to restrict choice, opposition by medical profession (e.g., backlash against managed care)
 - Regulation (e.g., limits on selective contracting)
 - Cost, lack of know-how by insurers
- High administrative costs
- Competition yet to deliver efficiency gains
 - Few demand signals (e.g., often little switching)
 - More incentives to select than to manage risks
 - Not favourable conditions in the delivery market

Useful practices: Efficiency

- Introduce policies to encourage insurers' involvement in cost-effectiveness:
 - Removing obligations to contract with all providers
 - Incentives for prevention and care management
- Regulate competition on risk selection
 - E.g., Risk equalisation: balance between retrospective/prospective; choice of risk adjusters
- Promote effective competition
 - Information disclosure, product comparability

In sum

- Pros/cons of PHI, “by and large”:
 - PHI has enhanced responsiveness
 - But less positive impact on equity and efficiency
- However, performance vary
 - PHI role
 - Government interventions
 - Market structures and insurers’ behaviours
- Interaction with public systems raise trade-offs
 - Policy makers to choose permitted PHI role and degree of interventions

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