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:
  1. Roles played by PHI in the health system
  2. Coverage history/historical factors
  3. 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

<table>
<thead>
<tr>
<th></th>
<th>PHI share of THE</th>
<th>Population covered</th>
<th>Main PHI Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>7.1%</td>
<td>44%</td>
<td>Duplicate (hospital coverage)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supplement</td>
</tr>
<tr>
<td>Ireland</td>
<td>7.1%</td>
<td>48%</td>
<td>Mainly for duplicate (hospital coverage)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>14%</td>
<td>28%</td>
<td>Primary Supplement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Over 90%</td>
<td></td>
</tr>
</tbody>
</table>

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
Click on: OECD Health Project
Then click on: Private Health Insurance

Francesca Colombo
Francesca.colombo@oecd.org

Nicole Tapay
Nicole.tapay@oecd.org