Summary on Private health insurance in OECD countries

1 Health is a key component of the social and economic agenda

Health expenditures represent an ever-growing part of GDP, ranking from 8% to 10% in OECD countries today. Meanwhile, health care remains predominantly financed through public funds, which part in total health care financing is still increasing in developed countries: on average, 74% of health care are financed by public resources (be it through taxation or social insurance). In the US - the country that relies most on private health insurance- 60% of health expenditures are still financed by public sources. This overwhelming role of public finance is justified by the well-known market failures in the insurance sector aggravated in the health insurance area, in so far as it can not be considered a fully private good but rather a public good and a need for the population, at least for primary care.

However, technological progress, the new expectations of consumers, population ageing and the reluctance of governments to devote an ever-growing proportion of State budget to health care have led to the present systems coming in for scrutiny. Reform of the health sector is currently under way in the majority of Member countries. Insurers are an integral part of the prospects opened up by these reforms, and they already play a complementary role, which varies in significance, in the majority of Member countries. In some countries they even have partially taken the place of public services. However, no country has so far opted for total substitution.

Private insurance plays its role at two different levels: the financing level, where the insurer reimburses the cost of care or provides compensation, and the care providing level such as in the case of managed care. So private health insurance covers a very extensive range of services, and also brings into play a many different operators. Its characteristics, and in particular the extent of its integration in the various parts of the public systems, differ considerably from one country to another.

In this context, private health insurance now appears amongst the top priorities of the OECD insurance committee. I will therefore introduce the work carried out in this field by the Organisation. I will then present a very general overview of the development of private health insurance in OECD countries - bearing in mind that comparison is a hazardous task in an area where, alike in the pension area, each country has deeply rooted historical and social specificities. To conclude, I will illustrate this presentation with some interesting innovations on insurance products, services and institutions experimented in various OECD countries with a view to improve the private health insurance system. Future trends in the organisation of health insurance systems may well stem from some of the experience of these pilot countries.

2 OECD work on health care

Healthcare has been identified by OECD Member countries as one of the Organisation's top priorities for the years to come. The IC work in this area is therefore part of an integrated "horizontal project, " carried out in close co-operation with for instance the Working Party on Social Policy, competent with regard to public health insurance. This IC follows a two-step process. A review of the overall conditions and recent developments in the Member country markets for private health insurance from the economic, social, and regulatory standpoints, has first been conducted, which should be ready for publication in the coming weeks. Constraints and short comings of the development of private health insurance will be examined, as well as regulatory policies adopted to ensure an adequate framework for operations. Best practices will be identified to assist government in their regulatory reform in this area.

A statistical data collection has been launched to support and complement this work.

The Committee also analyses specific issues on which it wishes to pursue the work. Particular attention will for instance be paid to aspects of private health insurance that are tied in with pension systems, such as private disability and long-term care insurance schemes.

3 Recent developments of private health insurance in OECD countries

3.1 The role of private insurance in health care provision

In industrial States, health care financing has historically been inspired **by three competing "models**": the first one, implemented by Bismarck in Germany, relied on professional enrolment through compulsory contributions from employers and employees; more recently, Beveridge introduced in the after war UK a public health monopoly, ensuring universal social protection. The last form of organisation is a mix-system, which prevails in the US, where health insurance is not compulsory. Although this model is the only one not offering a right to health care to citizens, leaving 15% of the population with no health care cover, it is widely exported, notably in emerging economies.

The extend and pace of the development of private health insurance in each country has been very dependant on the original pattern of the national health care organisation, even if most countries tend to have now a rather hybrid health care system (mixing elements from the three original models). Amongst OECD member countries, **strong contrasts can now be observed in the balance between private and public health insurance**. Although, private sector is mainly *supplementary* to public coverage, in some countries it can *substitute* to public sector to cover even primary care for all or part of the population. Lastly private health insurance may provide the same level of coverage than the existing public scheme, while giving access to private providers.

- Two countries, the **United States** and **Switzerland** have opted for a highly privately financed system, in which private insurance intervenes even in primary care. In the US, 40% of overall health expenditures are covered by private insurance, and above 74% of the population is enrolled in a private scheme, be it a substitute or a complement to public schemes.
- **In Germany** and in **the Netherlands** the wealthiest, independent workers and most civil servants are excluded from the social health insurance. Health care insurance is left to their own initiative. In Germany, 20% of the population are insured on a voluntary basis; among these, 7 millions are entirely insured by private insurers.
- Nevertheless, in the majority of OECD countries, private health insurance is supplementary to the public scheme and provides co-payment and deductibles or covers specific services not taken into account by public financing. The majority of the population therefore contracts a co-payment insurance in **France**, **Canada, Japan**, **Austria** and **Denmark** to some extent.
- In **Ireland** and **Australia,** it is possible to "opt out" of the public scheme. In both countries, private health insurance is highly regulated in order to be accessible to the most part of the population, hence 40% have a private coverage that gives access to private providers.
- In other countries with an overwhelming public financing and providing system such as the **UK**, **Sweden**, **Norway**, **Finland** and **Portugal,** private health insurance represents a small market covering currently less than 10% of the population, and insuring mainly access to private providers.
- Regarding countries in transition, despite the recent privatisation of health care in **Poland**, health insurance markets remain narrow, due to a lack of maturity of insurance markets and to an inherited quasi-universal public coverage. Lastly, in middle income countries, like **Mexico**, **Turkey, Korea** or even **Greece**, the role of private insurance also remains marginal (5% of the population enrolled).

In absolute terms, **premiums in health insurance markets are growing** in every country. They have increased by 4% in Europe in 1997 (marked growth in group insurance policies). Market liberalisation at the European level should allow further growth in the future: even though a first attempt of harmonisation

was achieved through EU third directives on non-life insurance, this was not enough to fully liberalise the European market. Generally speaking, **international competition remains low for the time being** but could well develop in the future, especially in countries where supply is rather underdeveloped. In transition countries such as Poland, Hungary, but also Turkey, demand for better service and products is increasing, but is not so far satisfied by local providers.

3.2 A wide range of products and services

3.2.1 Characteristics of product and pricing

Health care expenditures can be financed according to three basic models: risk-based calculation of premium, community rating and funding.

- **Risk based calculation** is the most common way for private insurers to provide health products. Two different types of policies may be distinguished: **individual and group insurance**. These models involve different kind of selectivity and premium calculations.

- **Individual policies** are scarce in OECD countries (except in Italy and in Denmark). For such policies, individual contract premiums are calculated on risk-based criteria such as age or age at entry, sometimes gender (Luxembourg, Portugal, Switzerland) and often health status. Therefore premiums are higher for older and weaker persons. Moreover, private insurers are allowed in most case to deny the access to high-risked individuals or to impose waiting period (such as in the US, Luxembourg or Switzerland). This is the case in nearly all OECD countries except when policies are aimed at protecting specific categories of persons.
- **Group insurance policies** are more common. They are widespread in a number of countries such as:
  -- **The US**, with more than 70% of the population covered by this type of scheme,
  -- **France**, where two thirds of insured are covered by a global contracts through the employer,
  -- **Germany**,
  -- **The UK**, where three quarters of the population have a supplementary health insurance cover,
  -- **Canada,**
  -- And recently **Portugal**, in which 90% of contracts are group insurance policies.

  Reasons for this development certainly lie on the particular financial and access facilities of these policies. Actually, since risks are borne by more people, insured enjoy lower premiums based on an experience-rated calculation. Insurers may therefore have fewer incentives to have recourse to risk selection.

- A less widely spread model of financing private health insurance is **community-rating**. In Ireland and Australia, it has expanded on a national basis. Like in public schemes, policyholders pay according to their incomes, disregarding the risk they represent, and receive benefits according to their needs. This allows for a more equitable access to supplementary health insurance. However, an appropriate regulation is necessary, considering that this type of products requires whole-life investments, no selectivity from the part of insurers, and risk-equalisation so that risks may be shared among all insurers in the country.

A last point should be highlighted considering the length and the very financing of private health contracts. Indeed, most of the time, for group insurance and the majority of individual policies, health contracts are understood as short-term non-life insurance policies that last a year at most. These contracts are generally renewable by both parties like in England, or only by the insured like in Portugal. (Australia and Ireland, but also Greece, Austria, Germany and Switzerland to some extent, are however exceptions to this rule.

- Besides, in Austria, Germany and Switzerland, health insurance is not only provided through whole-life contracts: it also involves **funding processes** of financing. For instance in Germany, part of the premiums is accumulated in a fund that allows for no premium adjustment owing to age. Thus this specific pattern of private health insurance is better tailored to an ageing population and provides better protection for older individuals that may find it difficult otherwise to afford supplementary insurance.

3.2.2 The range of benefits provided by private health insurance

- Except for the US, Switzerland and to some extent Germany and the Netherlands, benefits of private health insurance are mainly **co-payments of practionners' fees** and drugs and of a large range of specific treatments not covered by public schemes. These can be specific diseases such as cancer in Korea, particular or luxury services such as private room, and alternative medicines. Coverage may be comprehensive with a variety of different policies like in most western European countries and the US, or narrower like in Turkey or Korea.
- On the other hand, in Sweden, Finland, Denmark, the UK, and above all in Spain, Portugal and Mexico, private health insurance is understood as a way to avoid long-waiting lists of public providers and to gain more freedom of choice for general practitioners and in-care treatments as well as better quality services.
- **Long-term care** has recently developed on private health insurance markets. In Germany, France, Italy, the US but also Denmark, the UK and the Belgium, this benefit has lead to specific ruling allowing private sector to cover this risk. Germany even innovated by establishing an obligation to contract long- term care insurance.
- **Income replacement** in the event of sickness or disability is also currently developing in many OECD member countries including Switzerland, Japan, or the US.

4 Main issues at stake and prospect for future developments.

4.1 Issues at stake in the development of private health insurance

Assessing the performances of health care systems is not an easy task. Two main criteria could be considered to this end:
-- **Efficiency**, understood in relation to the achievement of three main goals: improving population health; responsiveness to the legitimate aspirations of consumers; and cost-minimisation, and
-- **Equity**, or the fairness of the distribution across the population of each for these three goals.

4.1.1 Advantages

So far private health insurance in OECD Member countries has proved able to achieve some of these goals. It has certainly helped in **upgrading the quality of health care provision**, even when private health insurance intervenes in primary care.
In the US, where private health insurance covers the population even for primary care, life expectancy of female at birth is close to 80 years. This is almost as much as in the United Kingdom, although the latter mainly implements a public system to finance health care. In Switzerland, life expectancy is even higher (82.5 years at birth for women). Furthermore, these countries have developed high quality treatments for serious diseases like aids or cancer.

As regards to **efficiency and satisfaction of consumers**, in a context of curtailing expenses and hence benefits in the public sector, private insurance is mainly used as a way to alleviate public burden while insuring tailored and free-choice services to patients.
Accordingly, in Sweden, Norway, but also Portugal or Mexico, there are strong incentives to promote private health insurance, in order to offset the deficiencies of the public system. Similarly, in Greece or Turkey, the high level of discontents regarding their public system has lead to regulatory changes in the 1980s, paving the way for private health insurance development.
Moreover, new medical technologies and treatments create new expectations. A growing number of very specific treatments are more consistent with private choice of financing and coverage. In this regard, high quality services and tailored prevention can be viewed as more of a private good.

These advantages of private health insurance should not mask the risks that need to be addressed if this sector is to expand.

4.1.2 Constraints and problems stemming from the growth of private health insurance

- The major objections addressed by the detractor of private health insurance relate to **equity considerations**: private health insurance often turns out to be insurance for "good risks", that is to say for the young and healthy. For instance in Switzerland, since the new Health insurance Law of 1996 has entered into force, premiums become to high for people over a certain age. These individuals however need more than any other age category of the population supplementary coverage and *a fortiori* primary care insurance. In the United States the situation is even worse, since private health insurance is not mandatory. About one fifth of the population is not covered, part–time job employees. Besides, there are great inequalities in the level of premiums and that of benefits. These discrepancies do not appear only between individual and group policies, but also impact group policies according to the size of firms. Lastly, this linkage of health insurance to professional position may generate distortions in individual labour market decisions.

- More surprisingly the goal of **cost-minimisation** is far from being achieve through the mere market. The American example is worth considering in this respect: it is at the same time the most privately financed health care system and the most expensive OECD system.13.6% of GDP is spent on health care, against only 6.7% in the United Kingdom, and 8% to 10% on average in OECD countries.

These figures could be considered as less worrying if it corresponded to a specific choice of the population to spend more on health care, or if it results in better products and services. However, the raise in costs owe more to the financing arrangement and asymmetry of information on the health market than to the improvement of services provided. Besides, the competition entails heavy specific expenditures, such as managerial and advertising costs.

Many other issues could also be mentioned among the regulator challenges. I will only name 2 of them:

-- **competition**: "Traditional" insurers are not the only actors on the private health insurance market, there also being a considerable number of mutual companies and other organisations such as managed care organisations. These various operators are in many cases subject to different prudential and tax regulations. This is raising several problems. Besides, should competition issues be analysed in the context of private health insurance or, more generally, in the broader context of health insurance (in order to take account of the blurring of the distinction between public and private)?

-- **Information access**: Private health insurance requires that risks be identified and classified. This involves having access to certain types of information and being able to segment risks on the basis of certain criteria. However, access to and divulgation of medical information as well as risk segmentation raises sensitive issues? Preventing abuses in this area is far from an easy task.

4.2 Policy responses to new challenges: OECD countries experience

Several OECD countries have recently initiated regulatory reforms and changes in the design of their health insurance organisation in order to circumvent the major drawbacks entailed by the development of private health insurance.

4.2.1 Innovative regulatory policies to remedy to market failures

With a view to maintain an equilibrium between efficiency and competition on the one hand, and equity on the other hand, OECD member countries are experimenting various paths:

- To avoid major inequities or excessive rise in premiums, **group insurance contracts** have been favoured by the regulation in the US, as well as in Portugal or Italy more recently.
  However, as explained above, group policies have also their shortcoming in excluding part of the non-working population or less favoured people. Community rating is another way to avoid major inequalities but it may result in less competitive and rather oligopolistic market.

A second way to tackle the equity issue is to consider private health coverage as a **long- term risk**. This perspective is consistent with new products sold on the market such as long-term care and may be dealt with using various financial vehicles. In Switzerland proposed reforms concerning health insurance involve that **age at issue** be the **reference age for successive policies** taken out with the same insurer. This would prevent insurers from increasing premiums with age and oblige them to support part of the risk for ageing. Private health insurance should be accessible in the same way and at the same price for men and women. Furthermore, this reform would imply that insurers could no longer be allowed to launch a new product providing exactly the same cover, with the sole aim of creating a closed fund of selected policyholders.
The improvement of the **portability of rights** is also high on the political agenda. The US 1996 law (Health Care insurance portability and accountability act) or the Austrian legislation in this regard ensure that previous benefits can be retained after a change of employer in order to avoid job-locks. This problem can also be addressed in preventing insurers to cancel policies or to retain pre-existing conditions and waiting periods for individuals who were already covered by health insurance.
Further on this line, the **funding or partial funding** of private health insurance, as in Germany or Austria, may appear as a promising solution.

Other new developing trends could briefly be pointed out *inter alia:*

- the new regulation on compulsory long-term care insurance in Germany
- the surge of new private health insurance products, such as medical savings accounts in the United States,
- the marketing of private health care electronic cards by insurers in Portugal,
- or lastly the establishment of equalisation funds between insurers in Ireland.

4.2.2 Curbing the costs through health care?

In a several OECD countries, the unbearable increase in health expenditures has fostered the development of private carriers in charge of controlling providers' activity. This attempt can range from **formal agreements between insurers and specific providers to the so-called managed care** mainly developed in the US through Health maintenance Organisations or HMOs. Under this arrangement, the financing and delivery of health services are integrated so as to control costs by managing the recourse to health providers and the providers' payment level. In the US, more than 80% of the insured population were enrolled in Managed care organisations in 1998. Through HMOs in particular, insured receive a comprehensive benefit package available form a defined network of providers for a fixed payment.
Although, these organisations are similar to small private British National Health System, and are thus affected by the same drawbacks: restricted freedom of choice for consumers. Consumers concerns in this respect have led to the promotion of more flexible alternative models. These are the Preferred Provider organisation (PPO) - a kind of agreement contracts between insurers and providers. Both HMOs and PPOs can also be mixed. Latest research for the US suggested that HMOs are able to save 20 to 30 % of expenditures compared to traditional health insurance organisation. However, this results may be more linked to selected low-risk population than real curtailment in unnecessary consumption.

Such types of arrangement are also developing in other OECD countries (*inter alia* in 4 Austrian länders, in Greece, France, the United Kingdom or Poland), most of the time in the form of agreements between insurers and providers,

In addition, new forms of private managed care are being experimented in **Portugal**: managed care companies involve a **medically formed call centre** that operates 24 hours a day. This structure is aimed at providing a customised service to each policyholder and to direct them to the most appropriate health care service. The new organisation would then insured the follow-up of each patient while reducing administrative costs and unnecessary consumption.

Private health insurance has a crucial role to play in modern health care organisations. Its development is a great opportunity for an enhanced efficiency of health care provision. It is also a serious challenge for policy makers to design an appropriate regulatory framework in order to palliate to the drawbacks enduced by the development of private health care systems. The need for regulatory changes will be also a function of the extent to which private health insurance is substituting to public systems. The impact of recent regulatory changes remain to be scrutinized, while the performances of new private managers of health care provision are so far difficult to assess and rather controversial. It is foreseeable that a majority of OECD countries will continue to rely on dual health care systems. Comparative analysis and international information sharing on the results of many recent and promising experiences will become more and more crucial, in an area where demographic, technological and budgetary pressures entail innovative reforms. Through its new horizontal project on health care, the OECD will attempt to provide relevant tools for policy makers, both in member and non-member countries.