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Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems

Francesca Colombo,

Nicole Tapay

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PRIVATE HEALTH INSURANCE IN OECD COUNTRIES: THE BENEFITS AND COSTS FOR INDIVIDUALS AND HEALTH SYSTEMS

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English text only

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SUMMARY

1. Governments often look to private health insurance (PHI) as a possible means of addressing some health system challenges. For example, they may consider enhancing its role as an alternative source of health financing and a way to increase system capacity, or promoting it as a tool to further additional health policy goals, such as enhanced individual responsibility. In some countries policy makers regard PHI as a key element of their health coverage systems.

2. While private health insurance represents, on average, only a small share of total health funding across the OECD area, it plays a significant role in health financing in some OECD countries and it covers at least 30% of the population in a third of the OECD members. It also plays a variety of roles, ranging from primary coverage for particular population groups to a supporting role for public systems.

3. This paper assesses evidence on the effects of PHI in different national contexts and draws conclusions about its strengths and weaknesses. Private health insurance presents both opportunities and risks for the attainment of health system performance goals. For example, in countries where PHI plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive. However, it has also given rise to considerable equity challenges in many cases and has added to health care expenditure (total, and in some cases, public) in most of those same countries.

4. PHI also raises certain challenges that cut across its different roles. Policy-makers will need to intervene to address market failures in order to assure PHI access for high-risk groups. In doing so, they can choose from a range of tools. They need to balance the sometimes competing goals of access and the maintenance of a broad and diverse pool of covered lives, particularly in voluntary markets.

RESUME

5. Certains gouvernements voient dans l'assurance maladie privée un moyen de relever quelques-uns des défis liés aux systèmes de santé. Par exemple, certains envisagent de promouvoir son rôle de source de financement de substitution, de l'utiliser pour accroître les capacités du système, ou encore de la faire contribuer à la réalisation d'autres objectifs de la politique de santé, tels que le renforcement de la responsabilité individuelle. Dans certains pays, les décideurs considèrent l'assurance maladie privée comme un élément fondamental du système de couverture maladie.

6. Bien que l'assurance maladie privée ne représente en moyenne qu'une petite fraction du financement total des dépenses de santé dans la zone OCDE, elle constitue dans quelques pays Membres un mode de financement important des soins et couvre au moins 30 pour cent de la population dans un tiers des pays de l'OCDE. Elle joue par ailleurs des rôles multiples, allant de l'octroi d'une couverture primaire à des groupes de population particuliers à une fonction de soutien des régimes publics.

7. Ce rapport évalue les données disponibles sur les effets de l'assurance maladie privée dans différents contextes et tire quelques conclusions sur ses avantages et inconvénients. L'assurance maladie privée est porteuse à la fois d'opportunités et de risques si l'on se place dans la perspective des objectifs de performance du système de santé. Par exemple, dans les pays où elle joue un rôle prépondérant, l'assurance maladie privée a injecté des ressources dans les systèmes de santé, élargi le choix offert aux consommateurs et rendu ces systèmes plus réactifs. Cependant, dans la plupart de ces pays, elle a souvent engendré de sérieux problèmes d'équité et alourdi la facture des dépenses de santé (totales et, dans certains cas, publiques).

8. L'assurance maladie privée soulève également un certain nombre de problèmes qui sont indépendants du rôle qu'elle joue dans le système de santé. Les décideurs seront obligés d'intervenir pour corriger les défaillances du marché et garantir l'accès des groupes à haut risque à l'assurance maladie privée. Ils disposent de plusieurs instruments pour y parvenir. Il leur faudra mettre en balance les objectifs parfois contradictoires d'accès et de maintien d'un groupe de risques couverts large et diversifié, en particulier sur les marchés de l'assurance volontaire.

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1. Introduction[1]

9. Governments often look to private health insurance (PHI)[2] as a possible means of addressing some health system challenges. For example, they may consider enhancing its role as an alternative source of health financing and a way to increase system capacity, or promoting it as a tool to further additional health policy goals, such as enhanced individual responsibility. Yet private health insurance is a complex financing mechanism that affects and interacts with public systems in multiple ways. This is why, when assessing the current and potential role for private health insurance, policy makers need to consider the intricate interactions arising between public and private coverage, and the effects that PHI has upon the health system under different public-private mixes.

10. While private health insurance represents, on average, only a small share of total health funding across the OECD area, it plays a significant role in health financing in some OECD countries and it covers at least 30% of the population in a third of the OECD members. It also plays a variety of roles, ranging from primary coverage for particular population groups to a supporting role for public systems. Policy makers in some countries regard PHI as a key element of their health coverage systems, and seek to guide PHI markets towards desired health system outcomes. However, especially in countries with more limited PHI markets, the question of whether private health insurance should cover larger population segments or finance a larger portion of the costs currently funded by public health systems is often controversial.

11. Debates over the role of PHI are often clouded by strongly held beliefs on both sides and a mixture of proffered, but theoretical, gains and costs. Some have argued that the private sector has the ability to find more responsive and efficient answers to policy challenges facing health systems, and would enable governments to cut public health sector costs. Driven by the need to attract clients and sometimes also by a profit motive, it is argued, competing insurers improve customer service and efficiency in administering insurance plans and can enforce pressures on health service providers to minimise costs, while providing more and better quality care. As a result, supporters see PHI markets as more dynamic, innovative, and sensitive to individual preferences and consumer demands than public systems, which are conversely plagued by bureaucratic slowness and rigidities. Proponents also observe that PHI represents an additional funding option, providing enhanced choice to people wishing to purchase additional health care goods or services.

12. On the other hand, critics argue that the capacity of private health insurance to deliver equitable outcomes and efficiently manage health care costs is not yet demonstrated. For example, they say that coverage provided by multiple competing insurers can be administratively costly, thus taking away resources from actual health service delivery. PHI can contribute to higher cost borne by the public purse in other respects, for example by spurring demand. Furthermore, the same incentives that encourage insurers to be responsive to consumers' needs and limit costs could steer them towards enrolling more healthy individuals and away from more difficult-to-manage and costly cases – thus raising equity concerns for portions of the population who may face diminished or no access to coverage. Critics also claim that competition is less likely to develop, or may develop around undesirable activities – such as through risk selection – rather than upon service, quality and efficiency. Market failures linked to

1. This paper is a summary of key financings and policy lessons of an OECD study on private health insurance. It is based on a larger report on the role and impact of private health insurance across OECD countries (OECD, 2004a).

2. Private health insurance is coverage of a defined set of health services financed through private non-income-related payments (premiums) made to an insuring entity. This coverage guarantee is usually set forth in a contract between a private party and the insurance entity that spells out the terms and conditions for payment or reimbursement of health services. The insuring entity assumes much or all of the risk for paying for the contractually-specified services.

information asymmetries also call into question private health insurance markets' ability to deliver desired social outcomes.

13. However, the debate surrounding PHI markets in OECD countries is generally plagued by limited evidence on their functions and impact on health systems. This is particularly the case for those countries where PHI markets are small or insignificant, but is also true for some countries with more sizeable markets. This paper assesses evidence on the effects of PHI in different national contexts and draws conclusions about its strengths and weaknesses in order to contribute to this policy debate. In doing so, it identifies factors behind favourable or undesirable performances of PHI markets, and the impact of PHI on health systems broadly.

2. Analysis of PHI markets in OECD countries reveals a large heterogeneity of experiences

14. Private health insurance refers to diverse health funding arrangements in different national contexts across the OECD area. The diversity of private health insurance markets can be seen in dimensions such as market size (in terms of population covered or PHI's share in total health expenditures), functions within the health system, types of insurers and their market conduct, regulatory frameworks and fiscal environments.

Market sizes differ, are not correlated to GDP levels and are weakly related to total spending on health

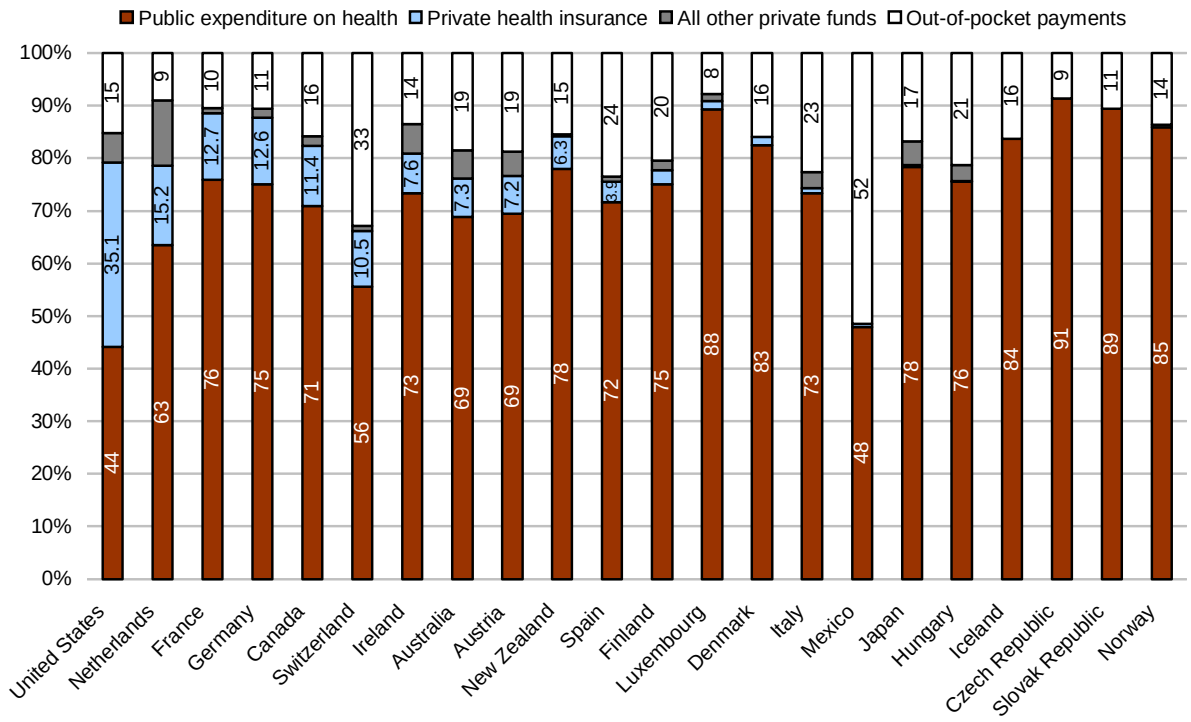
15. Although PHI accounts, on average, for 6.3%[3] of total expenditure on health (THE), its importance in funding OECD health systems varies significantly (Figure 1). The United States is the only OECD country where voluntary health insurance represents the main health financing and coverage system for most of the population, explaining why PHI accounted for 35% of THE in 2000. In France, Germany, the Netherlands and Canada, the share of financing accounted for by private health insurance ranges from 10% to 15% of THE. A similar level is found in Switzerland, where 10% of total health expenditure comes from the voluntary supplementary health insurance market.[4] Australia, Ireland, Spain, New Zealand, and Austria have levels of PHI financing between 4% and 10%. Private health insurance in all other OECD countries contributes much less than 4% to funding total health expenditures.

16. Countries with the highest shares of PHI (above 10%) show lower shares of out-of-pocket (OOP) expenditure in total health spending. However, there does not appear to be a strong inverse relationship between the importance of PHI and OOP in financing health spending for the OECD area as a whole (Figure 2). The contribution of PHI to total health financing increased only slightly between 1990 and 2000, although some of the smaller markets, such as New Zealand, have experienced the fastest growth rates.

3. Unweighted average for 22 OECD countries for which reliable data are available or estimated for 2000. It excludes the following countries: Belgium, Greece, Korea, Poland, Portugal, Sweden, Turkey and the United Kingdom.

4. The mandatory, competition-based, health insurance system in Switzerland accounts for an additional 40% of total health expenditure.

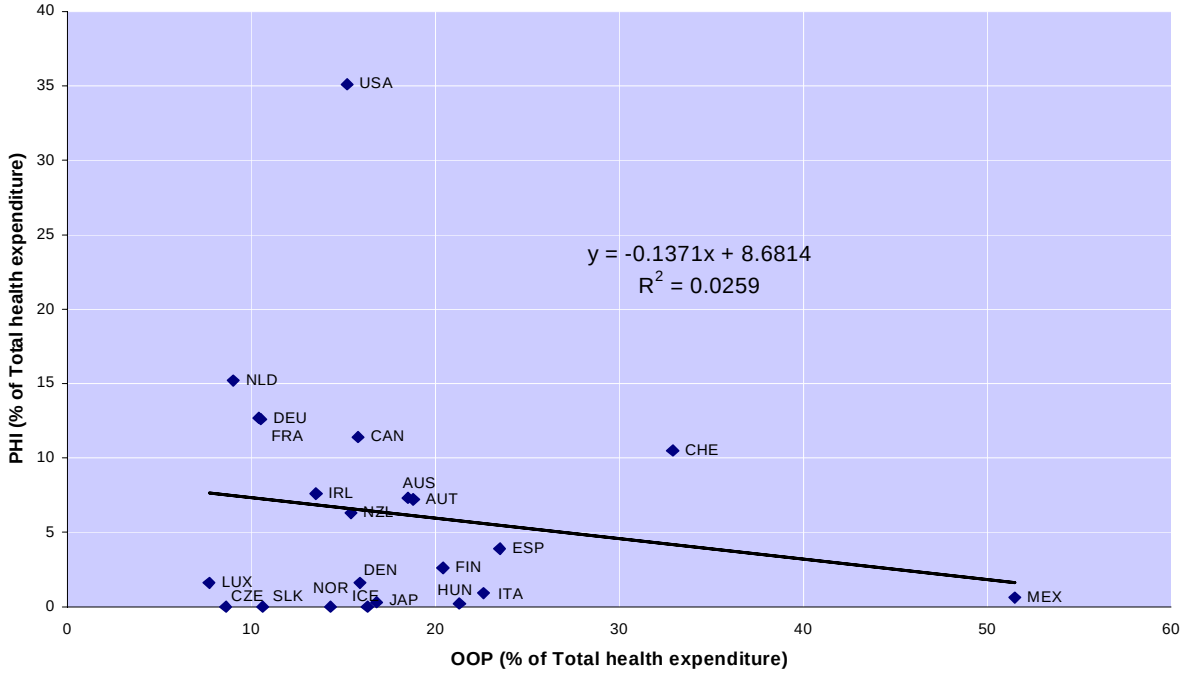
Figure 1. Health expenditure by source of health financing, 2000



Source: OECD Health Data 2003, 2nd edition.

Note. Countries are ranked by decreasing size of PHI

Figure 2. Out-of-pocket expenditure (OOP) and PHI as a share of total health expenditure (THE), 2000



Source: OECD Health Data 2003, 2nd edition.

Note: There is no relationship between out-of-pocket payments as a share of total health expenditure and PHI as a share of total health expenditure. This also applies when the United States is excluded. The equation becomes y = -0.0979x + 6.6266, with R^2 = 0.0351.

17. Countries can be grouped into different clusters by population coverage as well (Table 1). There is some, but not complete, overlap between countries with a high share of PHI financing of total health expenditure and a large privately insured population. France, Switzerland, the United States, the Netherlands[5] and Canada have population coverage above 60%. Participation in PHI markets is also high – between 30% and 60% – in Australia, Austria, Ireland, the Netherlands[6] and Belgium. It ranges between 10% and 30% in Germany, Spain, Portugal, Italy, Finland and the United Kingdom. Other OECD countries have small or negligible PHI markets. When PHI represents the sole available coverage for population groups, the level of privately insured population reflects – at least to a degree – the lack of public health coverage programmes for certain groups. Otherwise, there is no generalised link between population covered and specific functions of PHI within the health system.

18. Market size – determined by the share in total health expenditure or the share of population covered – does not appear to have a strong link to the level or growth in economic development across OECD countries (Figures 3 and 4). While the prominence of PHI in financing THE has expanded with economic growth in a few countries which have below-average GDP per capita, such as New Zealand, there is no evidence of a similar pattern at the OECD level. Similarly, strong economic growth has coincided with an expansion of population covered by PHI in Ireland but not in other fast-growing economies, such as some Eastern European countries or Luxembourg. Despite increased importance in financing total health expenditure, the percentage of the population with PHI in New Zealand has been decreasing steadily.

5. For supplementary PHI policies.

6. For primary health insurance.

Table 1. Population covered by PHI and by public coverage systems

	Public Health Expenditure as % of THE [1]	Public System Coverage[1]	Eligibility for Public Coverage [2]	PHI as % of THE [1]	Population Covered by PHI, % [3]	Types of Private Coverage
Australia	68.9	100	All permanent residents are eligible for Medicare (the tax-financed public health insurance system). Eligible persons must enrol with Medicare before benefits can be paid.	7.3	44.9 40.3[4]	Duplicate, Complementary Supplementary
Austria	69.4	99	Almost all labour force participants and retirees are covered by a compulsory statutory health insurance. Social assistance claimants and prisoners receive health benefits and services from the state authorities. 1% are without coverage.	7.2	0.1 31.8	Primary (Substitute) Complementary, Supplementary
Belgium	72.1	99	Compulsory statutory health insurance includes one scheme for salaried workers and one scheme for the self-employed people about 12%of the population in 1999). The latter excludes coverage of "minor risks" such as outpatient care, most physiotherapy, dental care and minor operations.	n.a.	57.5 (a)	Primary (Principal) Complementary, Supplementary
Canada	70.9	100	All population is eligible to public coverage financed by Federal and Provincial taxation.	11.4	65.0 (e)	Supplementary
Czech Republic	91.4	100	All permanent residents are eligible to statutory health insurance coverage	0 (e)	negligible	Supplementary
Denmark	82.5	100	All population is eligible to public coverage financed by State, County and Municipal taxation.	1.6	28 (1998)	Complementary, Supplementary
Finland	75.1	100	All population is eligible to public coverage financed by State and Municipal taxation.	2.6	10	Duplicate, Complementary, Supplementary
France	75.8	99.9	The social security system provides coverage to all legal residents. 1% of the population is covered through the Couverture Maladie Universal (CMU)	12.7	86.0 (92 including CMU)	Complementary, Supplementary
Germany	75	90.9	All employed people and their dependents are covered by statutory health insurance coverage. This does not include self-employed individuals and civil servants. Employees with an income above an income threshold can opt out of the social sickness fund system. Fulfilling certain requirements, social security insurees can choose to "stay in" the public system on a voluntary basis even if they are allowed to opt out of the system. Self-employed may also join on a voluntary basis.	12.6	18.2 of which: 9.1 9.1 (b)	Primary (Substitute) Supplementary, Complementary
Greece	56.1	100	All population is eligible to public coverage, financed by a combination of taxation and social health insurance contributions	n.a.	10 [5]	Duplicate, Supplementary
Hungary	75.5	100	All permanent residents are eligible to statutory health insurance coverage. Only 1% of the population was not covered in 1999	0.2	negligible	Supplementary
Iceland	83.7	100	All permanent residents are eligible to statutory health insurance coverage	0 (e)	negligible	Supplementary
Ireland	73.3	100	All resident population is eligible to public hospital coverage, financed by general taxation. Only about one third of the population with medical cards is eligible to GP and other outpatient coverage.	7.6	43.8	Duplicate, Complementary, Supplementary
Italy	73.4	100 (1997)	All population is covered by the National Health Service system, financed by general taxation	0.9	15.6 (1999) [5]	Duplicate, Complementary, Supplementary
Japan	78.3	100	All population is covered by a statutory social health insurance system	0.3	negligible	n.a.
Korea	44.4	100	All population is covered by a statutory social health insurance system	n.a.	n.a.	Supplementary
Luxembourg	87.8	99	All population is covered by a statutory social health insurance system, apart from civil servants & employees of international institutions (1%)	1.6	2.4	Complementary, Supplementary

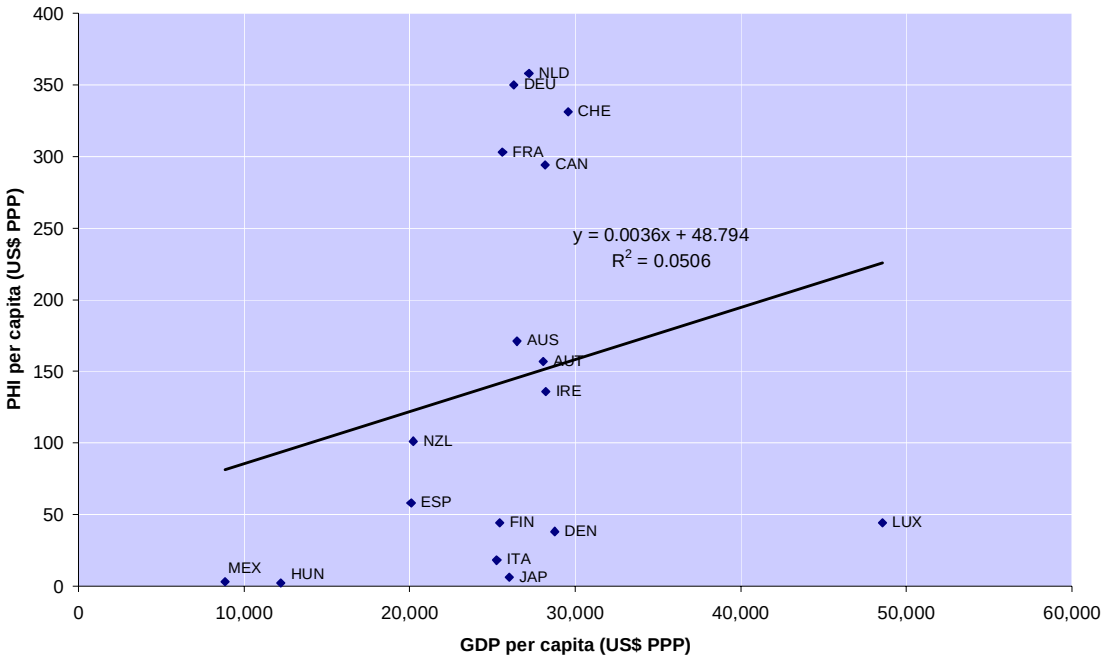
Table 1. Population covered by PHI and by public coverage systems *(cont.)*

	Public Health Expenditure as % of THE [1]	Public System Coverage[1]	Eligibility for Public coverage [2]	PHI as % of THE [1]	Population Covered by PHI, % [3]	Types of Private Coverage
Mexico	47.9	45-55 (e) (c)	Public social security schemes cover all the population working in the private formal sector and government workers, i.e. excluding independent self-employed workers, informal sector workers and unemployed people. From 2004, the System of Social Protection in Health offers a new public health insurance scheme that has been implemented to provide voluntary public health insurance to the population previously excluded from social security.	2.5 (2001)	2.8	Duplicate, Supplementary
Netherlands	63.4	75.6	Eligibility to statutory health insurance is determined by income. Individuals above a threshold are not covered (28.9% in 2000).	15.2	92 of which: 28.0 64 (e) (b)	Primary (Principal) Supplementary
New Zealand	78	100	All population is eligible to public coverage financed by general taxation.	6.3	35 [6]	Duplicate, Complementary, Supplementary
Norway	85.2	100	All population is eligible to public coverage financed by State, County and Municipal taxation.	0(e)	negligible	n.a.
Poland	70	n.a.	All eligible groups are entitled to statutory health insurance cover. People who are not specified in the eligible groups by the act of 6 February 1997 mentioned above can purchase the social health insurance voluntarily.	n.a.	negligible	Supplementary
Portugal	68.5	100	All population is covered by the National Health Service system, financed by general taxation	1.5 (1997)	14.8	Duplicate, Complementary, Supplementary
Slovak Republic	89.4	100 (1999)	All population is covered by a statutory social health insurance system	0(e)	negligible	Supplementary
Spain	71.7	99.8 (1997)	Almost all the population is covered by the National Heath System, financed by general taxation. Civil servants and their dependents are covered through a special scheme. A minor group of self-employed liberal professionals and employers are uncovered.	3.9	13 of which 2.7 [7] 10.3 [7]	Primary (Substitute, Principal) Duplicate, Supplementary
Sweden	85	100	All population is covered by a statutory social health insurance system, financed by local taxes and state grants.	n.a.	negligible	Complementary, Supplementary
Switzerland	55.6	100 (d)	All permanent residents are mandated to purchase basic health insurance.	10.5	80 (d)	Supplementary
Turkey	71.9 (1998)	66 (1997)	Population coverage through three social security schemes for private sector employees, blue collar public sector employees, self-employed persons and retired civil servants	0.7 (1994)	< 2 [8]	Complementary, Supplementary
United Kingdom	80.9	100	All UK residents are covered by the National Health Service system, financed by general taxation	3.3 (1996)	10.0	Duplicate, Supplementary
United States	44.2	24.7	Individuals eligible to public programmes include the above 65 and severely disabled (Medicare), poor or near poor (Medicaid) and poor children (SCHIP). Eligibility thresholds to Medicaid are set by states.	35.1	71.9	Primary (Principal) Supplementary, Complementary

Notes: PHI: Private Health Insurance; THE: Total Health Expenditure; Negligible indicates a proportion covered of less than 1%; n.a. indicates not available; (e) Indicates that figures are estimated; CMU stands for: "Couverture Maladie Universelle", a publicly financed programme providing complementary health insurance to eligible low-income groups. (a) For Belgium, data include voluntary PHI policies for hospital care offered by sickness funds as well as PHI policies offered by commercial companies. They exclude policies for hospital care that are compulsorily offered by several sickness funds to their members, that guarantee insurees a limited lump sum (mostly less than 12.4 euros per day: Office de Contrôle des Mutualités et des Unions Nationales de Mutualités, 2002, Rapport Annuel, p. 81) and covered about 67% of the population in 2000. (b) For the Netherlands and Germany, the data refer to supplementary PHI policies purchased by individuals who belong to the social health insurance system. Some of the individuals with primary PHI are also covered by supplementary PHI, which are sometimes packaged with primary PHI policies. (c) These coverage figures relate to social security schemes, which include workers in the private formal sector and civil servants. Important to note that public health expenditure as % of THE includes all public health spending, i.e. both social security spending and other public spending, such as resources used to finance health care provision for the uninsured population through the states' health services. Estimates vary depending on the source used; population survey data report lower figures, official administrative data report higher figures but no roster of individuals covered by the social security system is available. (d) For Switzerland, data on PHI refer only to voluntary private health insurance coverage. Mandatory health insurance covering the entire population is reported in OECD Health Data as public coverage, although it is a border line case.

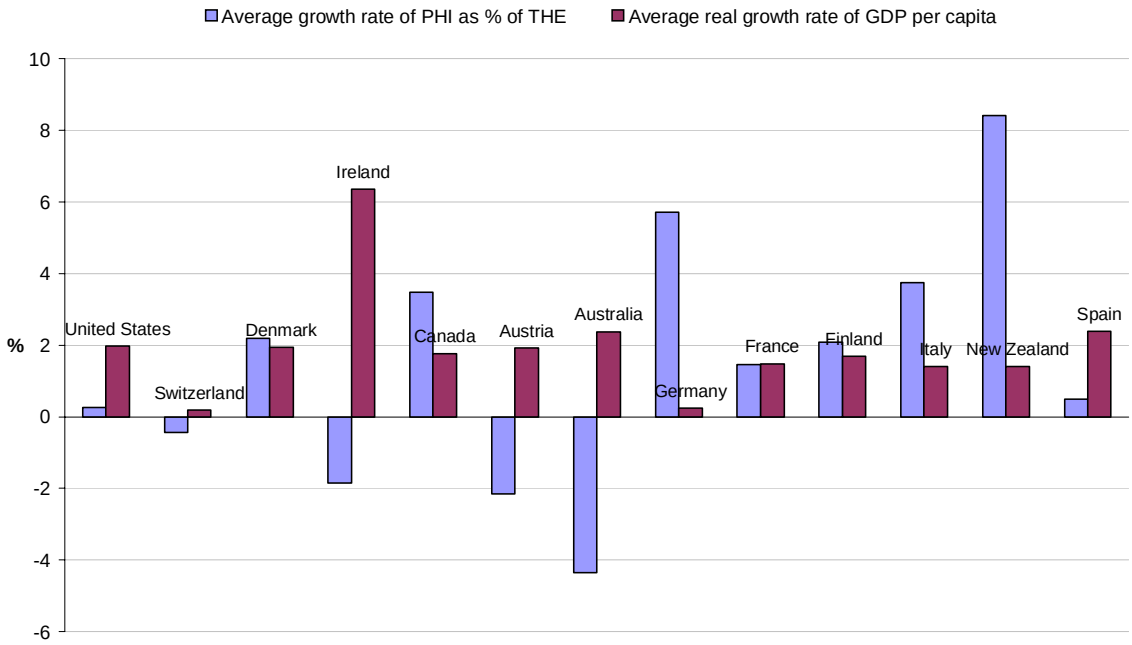
Sources: Specific data sources have been indicated below; information was also supplied by OECD member countries or obtained from official publications. (1) OECD HEALTH DATA 2003 2nd edition, 2000 data unless otherwise indicated. (2) OECD PHI Regulatory Questionnaire, 2003 and other official sources. (3) OECD PHI Statistical Questionnaire, 2000 data, unless otherwise specified. (4) PHIAC (2002), Operations of the Registered Health Benefits Organisations Annual Report 2001–02. Data refer to June 2001. (5) Mossialos and Thomson (2002). Voluntary Health Insurance in the European Union. (6) European Observatory on Health Care Systems (2001). Health Care Systems in Transition. New Zealand. (7) Ministry of Health, Spain (2003). National Health Survey 2001. According to another estimate population coverage was 16.2%in 2002 (11.3% duplicate and 4.9% substitute) (Data from UNESPA, December 2003). (8) U.K. Trade & Investment, "Health Care & Medical Market in Turkey", http://www.tradepartners.gov.uk/healthcare/turkey/profile/overview.shtml; note this figure does not distinguish between PHI alone and PHI offered as riders to life insurance policies.

Figure 3. PHI per capita and GDP per capita, 2000 (US$ PPP)



Source OECD Health Data 2003, 2nd edition.
Note: The United States is excluded. If the Unites States is included, the equation becomes y = 7.1935x + 24476, with R^2 = 0.1004

Figure 4. Average growth rate of PHI as a percentage of THE and GDP



Source: OECD Health Data 2003, 2nd edition.
Note: Countries are ranked by level of GDP per capita, US$ PPP

19. These trends have implications for the analysis of health system performance. First, the increased reliance on private financing sources for some countries,[7] including out-of-pocket expenditures and private health insurance, reduces the progressivity of the health financing mix. However, no clear conclusion can be drawn concerning how the degree of progressivity of the funding mix is evolving in the OECD area, as various sources of financing health care have become more or less progressive depending upon the country.[8]

20. Second, a growing role for private health insurance may affect incentives for health expenditure growth. Countries with the most significant PHI market size, in terms of population covered or contribution to total health expenditure, tend to be those with the highest health spending levels per capita, such as the United States, Switzerland, Germany, and France.

21. Third, levels of population coverage have implications for market stability. For example, the fluctuations in the privately insured population in Australia that occurred during the 1990s have been associated with changes in levels of participation in PHI markets of younger and healthier population groups, while Netherlands and Germany have experienced more stable PHI markets and Ireland has seen a fast growth in coverage.

PHI functions across OECD countries depend on the interaction with publicly funded systems

22. PHI markets have largely developed around public health coverage systems. The interaction between public and private coverage, along with other factors, determines what functions PHI plays (OECD, 2004b). While it represents the sole form of health coverage for significant population segments in a few countries,[9] in most OECD countries, PHI plays a supporting role to public systems. In Australia, Ireland, the United Kingdom and Spain, for example, it provides a private alternative to public coverage, furnishing insurees with access to privately financed providers, separate from public delivery systems (duplicate role). Private health insurance in France is somewhat unique within the OECD area, because its main function is to complement and "top up" reimbursements by the social security system (complementary role). The Medicare supplementary market (Medigap) has a similar role in the United States.[10]

23. Most OECD countries have some PHI policies supplementing services covered by public programmes (supplementary role). The benefits offered by supplementary PHI can be packaged together with other coverage types, as in many OECD countries, or can constitute separate policies, as in Australia (ancillary PHI), Switzerland (voluntary policies), the Netherlands, and Germany. Notably, in Canada,

7. Countries with high shares of private health financing, such as Korea, Mexico and the United States, have shown a trend towards an increasing importance of public health funding over time. The contrary is occurring in countries with high levels of public expenditure on health, where private health expenditure is increasing. These data may indicate a convergent trend in public-private financing mixes across the OECD area (OECD, 2003a), although it is unknown whether the past trend will continue.

8. See Wagstaff *et al.* (1999) for further discussion on equity of financing across several OECD countries. At least in principle, one can compensate for a lack of progressively funded health care by making the general tax system more progressive.

9. In the United States the elderly (including the vast majority of those age 65 and above), qualified disabled persons, and those with end-stage renal disease have Medicare. Certain poor populations are eligible for Medicaid or State Children's Health Insurance Program, and some of the poor elderly or disabled persons have both Medicare and Medicaid. Conversely, in the Netherlands a more limited segment of the population, the upper third of the income threshold, is responsible for buying their own private coverage. In Germany, high-income population groups are able to opt out of the sickness fund system by buying a private health insurance policy.

10. In the United States, persons eligible for Medicare can buy supplemental "Medigap" policies covering co-payments and gaps in coverage of benefits offered by Medicare.

private health insurance is only allowed to have a supplementary role and is generally prohibited from covering medically necessary hospital and doctors' services already included under the public system.[11]

24. While PHI tends to cover certain typical services, there is diversity across OECD countries in both the health services and providers accessible by privately insured individuals. Such diversity reflects the scope of public coverage, and is affected by regulation and insurers' strategies. In almost all OECD countries, private health insurance covers what could be termed as "small risks" or ancillary and supplementary services, such as dental and optical treatments, choice of provider, upgraded hospital accommodation, and luxury services not covered, or only in part reimbursed, by public systems. In most countries, private health insurance also covers hospitalisation and doctors' expenses. However, this coverage is more comprehensive where PHI provides the primary form of insurance for particular population groups. In other cases, coverage is limited to access to private hospital facilities, often focussing on elective treatments, choice of treating doctors, and hospital hotel amenities.

25. The diversity of coverage experiences seems to indicate that there is no type of service that is per se more or better "insurable" by public or private coverage. There are nonetheless some trends towards greater reliance on public or subsidised private coverage for individuals facing higher health care cost, such as the elderly and those with chronic conditions, even where PHI plays a significant or primary role. In the United States, the Medicare programme itself was created at a time when many elderly persons faced challenges finding affordable coverage within private PHI markets (Marmor and McKissick, 2000). Two schemes were established: a universal coverage programme for the elderly, funded primarily through social security contributions and general revenues (Medicare), and a means-tested programme to provide health care coverage for certain non-elderly poor populations and additional health coverage for a small group of the elderly (Medicaid).

26. A more specialised health care insurance market – private long-term care (LTC) insurance – is absent or very limited in countries with comprehensive public long-term care benefits, such as in Scandinavia, the Netherlands, Japan and Luxembourg. In Germany, LTC cover is statutory for every resident. It is obtained from sickness funds for individuals covered by social insurance, and from private insurers, for those individuals holding primary private health coverage, as well as for a small number of individuals opting voluntarily for private LTC insurance and for employees of the railway and postal services companies (Verband der Privaten Krankenversicherung, 2003). It is, however, non-existent or embryonic in most other OECD countries, even where there is no or limited public long-term care coverage. The main markets are found in France and the United States, although LTC insurance is also sold in Germany and the United Kingdom.[12] A combination of low demand[13] and limited supply[14] may explain such low rates of diffusion.

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11. The most important benefit covered by PHI in Canada is prescription drugs outside of hospitals, which are not funded through the public coverage system, although some provinces have public drug coverage programmes for the most vulnerable groups. Other benefits primarily covered by PHI include dental and optical services. Prohibitions on PHI coverage of other publicly funded hospital and physician services vary by province, and exist in the majority of provinces. See also Flood and Archibald (2001).

12. In France, private LTC insurance provides fixed benefits in the form of monthly annuity payments, while in the United States it mostly provides indemnity reimbursement of incurred expenses (Scor, 2003). In Germany, individuals with primary PHI policies are compelled to also purchase a private LTC policy, according to the principle that LTC insurance is to be provided by the same insurer offering basic health insurance (about 10% of the population has private LTC insurance in Germany). In the United Kingdom, LTC insurance policies are developing, but high premiums have hindered demand.

13. Private LTC products are complex and tend to have high premiums. Furthermore, individuals may not feel the need to buy such a policy in their young age, and the price of private LTC policy is higher, and may hence be unaffordable, in their old age. However, there may be some demand for LTC products supplementing public LTC coverage. For

27. Different PHI functions give rise to specific policy challenges. Primary PHI markets often create access-related challenges, especially for high-risk and vulnerable groups, where they represent the sole form of cover for some population groups.[15] Where public and private delivery systems are linked to different funding sources, as in systems with duplicate private health insurance, differences in access to care, choice levels and utilisation patterns occur between individuals with and without private insurance. Providers' and individuals' incentives to consume health care are particularly affected in complementary PHI markets that provide coverage for cost sharing under public programmes. The moral hazard implications of these incentives need to be weighed against the equity implications of a lack of coverage of these costs. Finally, while supplementary PHI policies insure services not provided by the public system, interactions between public and private coverage systems remain. Risk selection incentives and limited individual mobility across social insurers can also arise if the same insurers, or their affiliates, offer both types coverage.

A combination of historical and policy-related factors affects the development of PHI markets

28. The heterogeneity of experiences with private health insurance within OECD countries is the result of several factors.

29. Private non commercial arrangements, such as mutuals, go back a few hundreds of years, or more, in several OECD countries, pre-dating many public health coverage or social insurance programmes. Many of the countries where private health insurance has a prominent role – for example, the United States, Australia, Ireland, the Netherlands, France – have some tradition of private financing and private provision of health services. Public health insurance systems developed on top of, and in some cases replaced, pre-existing voluntary health insurance arrangements in Australia, Ireland and the Netherlands. The newer public entitlements then changed the role of private coverage and sometimes reduced the permitted scope of PHI. In the United States, insurance has been historically provided on a private and voluntary basis. No general government compulsion to purchase private cover accompanied the introduction of public programmes for the elderly and certain of the poor (Medicare and Medicaid) in the mid-1960's. In France, the "mutuelles", which currently provide the majority of complementary health insurance contracts, predated the development of a universal social security system. They insured two-thirds of the French population by the start of World War II.

30. Public policy is the primary determinant of the role and the size of current private health insurance arrangements in most OECD countries. Rules under public and statutory health systems shape the borders of private health insurance markets, and to a large extent determine their role.[16] Private health insurance typically focuses on coverage of eligibility gaps based on categories of individuals, health services or providers not covered by public health systems. Markets have nonetheless shown different

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example, in Spain one survey indicates that about 16% of the population would be willing to purchase insurance (Costa-Font, 2002).

14. Regulators often face challenges with LTC products, which are relatively new and fast-changing products in several markets. Rate-setting for this type of product requires a deal more sophistication than that required for most health care insurance products, along with a long-term understanding of care needs and costs. Premiums are often high, may fluctuate significantly, and may not match typical consumer perceptions of the appropriate cost for this risk. The lack of broad-based experience with this product makes regulation difficult, for example the best manner to structure premiums and ensure adequate funding of these policies is still not well established.

15. This may be a reason why nearly all OECD countries have public programmes covering elderly and poor people.

16. In some OECD countries voluntary health insurance arrangements have been crowded out by the establishment or expansion of social and public coverage programmes. For example, the establishment of a basic mandatory health insurance system with comprehensive benefits in Switzerland in 1996 resulted in a reduction in the supplementary PHI market. In Australia, the population covered by PHI declined after the introduction of universal public coverage, Medicare, in 1984.

levels of responsiveness to changes in the expansion of public system coverage. PHI stepped in to insure delisted dental benefits in the Netherlands in the 1990s. However, large levels of out-of-pocket payments in Korea have not resulted in high PHI coverage levels.[17] The structure and regulation of health delivery systems – for example price regulation in the public and private sectors, doctors' ability to practice in both sectors, public hospitals' ability to treat privately financed patients and private hospitals' financing arrangements – have also impacted upon the size and roles of PHI markets.

31. The prominence of private health insurance has been buttressed by government interventions directed at PHI markets in several OECD health systems, although the effectiveness of policies aimed at increasing market size and fostering outcome quality has differed widely. Australia, Ireland, the Netherlands, Germany, Switzerland and the United States have promoted and maintained a large and viable private health insurance market because policy makers have concluded that mixed public-private coverage systems can better deliver desired health policy and social outcomes. These governments have used regulation[18] and fiscal instruments to steer and encourage PHI markets. In Ireland and Australia, regulation has been one main factor in encouraging consumer demand for PHI products, resulting in a large and widening proportion of individuals buying private cover.[19] Fiscal subsidies and other tax advantages have been introduced to stimulate the take up of private heath insurance in many OECD countries, among which Australia, Ireland, France,[20] the United States and Canada. Their impact on coverage seems to vary, indicating different levels of price elasticity of demand for PHI by individuals and other purchasers such as employers.

32. While prominence in health policy greatly affects the size of the PHI market – in terms of population coverage, contribution to health financing or scope of government interventions – there is no necessary link between the three factors. There are sizeable PHI markets in a range of health systems with diverse mixes of public and private financing. The size of PHI markets may also result from consumer demand for better choice and more comprehensive cover, even where there is little stimulation through policy levers. Likewise, there is a large variety of institutional arrangements and different policy views towards PHI in the countries where private health cover plays a minor role. Nordic countries have comprehensive public programmes and policy makers do not appear to be as interested in private health insurance. Conversely, some Eastern European countries – such as Slovakia, Hungary and Poland – foresee and desire a role for private health insurance alongside their social health insurance system, despite the absence of a market today.[21]

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17. In the case of Korea, half of the PHI market includes disease-specific products providing the insuree with cash benefits should a certain critical illness occur, while another half is accounted for by compulsory car accident insurance providing cash benefits against the medical costs incurred after an automobile accident (OECD, 2003b).

18. Regulatory frameworks differ to large extent, although they broadly aim at protecting consumers, particularly most vulnerable groups, while encouraging insurers' competition.

19. In Australia, population coverage had decreased steadily during the 1990s. A package of government interventions including fiscal incentives and regulatory requirements intended to foster PHI purchase has been implemented since 1997. Regulatory changes in particular have been effective in stimulating a large take up of PHI from 31% in 1999 to 45% in 2001. In Ireland, the recent significant increase in PHI take-up has been supported by the strong economy and growing employer market rather than being attributed to any government interventions.

20. Mutual insurers benefited from corporate tax advantages derived from their status as mutual insurers ("mutuelles").

21. The absence of a history of private health coverage in these countries, and in some cases a relatively low degree of cultural familiarity with insurance, together with their less wealthy populations, may pose obstacles to the creation and development of a meaningful private health insurance sector. The relationship of any PHI market to public health insurance schemes, which is currently the object of legislation for example in Slovakia, will affect the impact of PHI on health system performance (Colombo and Tapay, 2004a). It will also delimit the scope of potential government intervention. In fact, the European Union requires that many regulations be justified in the interest of the "general good," as documented in the third non-life insurance directive, although it provides countries with enhanced flexibility where PHI is expected to play a more substantial coverage role

Demand for private insurance is linked to income and gaps in public systems, and is fostered by employers

33. While PHI market size is not linked to the level of economic growth of a country, high-income groups are more likely to purchase private health coverage in most countries. The uninsured in the United States are concentrated among the poor or near-poor working population.[22] In the Netherlands and Germany, primary PHI is purchased by upper income brackets, due to different entitlements to social health insurance by income level. In other countries with universal public coverage systems, the wealthier are more likely to have purchased an additional PHI policy.

34. Employers play an important and growing role in sponsoring private health cover as a work-related benefit. A large part of private health insurance policies in OECD countries with the highest levels of PHI population coverage are provided through the workplace. For example, this is the case in the United States and Canada (almost 90% of PHI policies), the Netherlands (60%), and France (50%). Despite the expansion in eligibility for public health programmes, PHI coverage in Ireland has shown an uninterrupted growth over the past decades, linked to its increasing provision by employers within a fast growing economy. Employers appear to be more powerful agents than individuals in negotiating coverage conditions with competing insurers and benefit from greater risk pooling than do purchasers of individual policies – with larger employer groups accruing particular advantage from such pooling.[23]

35. Real and perceived quality gaps in public coverage and delivery systems serve as an impetus for PHI purchases in some countries. Waiting times, increasing demand for choice, and perceptions of inadequacy of public systems are leading motivations in Ireland, Australia, Denmark, and the United Kingdom. Where public cover is not provided, primary PHI policies are purchased mainly to minimise the financial risks associated with illness. Finally, the diversity in consumer attitudes and preferences is difficult to compare across countries. Cultural factors and differences in risk aversion across national contexts may account for a higher inclination to buy private cover in some countries. For example, nearly all those ineligible to social sickness funds insurance buy a primary PHI policy in the Netherlands, and over 90% of the socially covered population buys supplementary insurance.

Diverse markets supply PHI but competition is limited

36. Different types of insurers operate in OECD private health insurance markets. European markets have been historically dominated by non-profit mutual and provident associations, although commercial insurers have entered several national markets. Private health cover can only be offered by specialised health funds in Australia and Germany, and is almost entirely sold by non-profit sickness funds in Switzerland. Non-specialised commercial insurers dominate the Canadian market, while a variety of for-profit and not-for-profit insurers operate in the United States.

37. The number and type of insurers affect intensity of competition. Several OECD markets are concentrated and dominated by few carriers, which tend to control the market with limited consumer switching. A few OECD countries include a large number of insurers – the United States, Switzerland, France, Australia and the Netherlands – although in practice enrolees' mobility is minimal in several

22. These include people with incomes between 100% and 200% of the federal poverty level. Nearly two-thirds of the uninsured (64%) US population are low-income individuals, or from low-income families. Over a third of the poor (37%) and a quarter of the near-poor (24%) are uninsured. The term "low-income," as used here refers to those making less than 200% of the federal poverty level, or US$28 696 for a family of three in 2002 (Kaiser Commission on Medicaid and the Uninsured, 2003).

23. There can, however, be downsides to employer purchase of PHI, including the potential for it to insulate individuals from the real costs of coverage and care.

among them.[24] Furthermore, several of these markets, such as the United States and Australia, remain concentrated, with a smaller number of insurers holding significant market share – although the concentration of US PHI markets varies among the states (Chollet *et al.*, 2003, p. 5). The presence of for-profit and not-for-profit entities has resulted in an evolution in insurers' practices in some markets. In the United States and France, competition between commercial and not-for-profit insurers has posed challenges to non-profit or mutual companies operating according to more solidarity-based practices. In several EU markets, insurers behave similarly regardless of their profit orientation. In countries with both group and individual coverage, employer-sponsored markets tend to be more price competitive than individual markets, because of the bargaining power exercised by employers and insurers' desire to attract large groups.

38. The ownership of insurers and the scope of their activities may also pose market challenges. While competition is arguably limited by the presence of few players, such as in the Irish insurance system, the existence of several players is not the only measure of market competitiveness. Mobility across insurers is low in many OECD countries. It is also sometimes challenging to establish incentives for "healthy" and equitable competition among PHI insurers, as they face incentives to concentrate on good risks, thereby failing to cover more vulnerable individuals. The involvement by private health insurers who are affiliates of social insurers in differently regulated statutory and voluntary health insurance compartments may pose challenges for competition and consumer mobility in both the public and private insurance systems (as in the Netherlands and Switzerland). This is because individuals find it difficult or impractical to change PHI insurers, rather than maintain the same insurer for social and private cover; for example, risk selection within the private component can present difficulties for both types of coverage.

3. PHI has contributed to health systems' performance[25]

39. The contribution of private health insurance to health system performance can be assessed from several perspectives. Access to care and financial protection, responsiveness and choice, quality, and cost are among the most prominent dimensions of performance.

Access to care and financial protection

40. Private health insurance has offered a primary source of coverage for population groups ineligible to public programmes, and contributed to provide insurance protection against other public system coverage gaps. It has helped to inject resources into health systems, enabling an expansion in capacity and services. It also enhanced access to timely care in some systems experiencing prolonged public sector waiting times. However, all of these advantages have depended upon the structure and regulation of delivery systems, insurers' strategic behaviours, the role that PHI plays, and regulation of public and private coverage. Furthermore, clear trade-offs have emerged. When resources and supply are scarce, it may be efficient to ration services on the basis of willingness to pay, for example, through voluntary purchase of PHI. However, inequities arise as well. The advantages offered by PHI in terms of access to care have actually created inherent disadvantages for those populations without private health

24. For example, there is little consumer switching in Switzerland, the Netherlands and Australia, although in Switzerland (for basic cover) and Australia, open enrolment means that consumers are entitled to switch at certain times (Switzerland) or any time (Australia). Limited switching of insurers can be explained with high transaction and informational cost. Several countries have enacted "portability" provisions to enable consumers to change insurers without certain penalising exclusions, including Australia, the United States, and Ireland.

25. Evidence in this section is mainly drawn from selected countries for which detailed analytical studies have been prepared, such as Australia, Ireland, and the Netherlands. The analysis also draws from other countries where sufficient evidence is available, for example the United States, France, Germany and the United Kingdom, among others. However, the overall country examples remain limited, reflecting a small number of OECD countries where PHI plays a significant role and for which a meaningful assessment of its impact on the health system is possible.

insurance. If PHI enrolees benefit from more timely care, policymakers must often balance trade-offs between equity concerns and a desire to promote enhanced choice and access through PHI.

PHI has served as a sole source of insurance coverage for certain populations

41. PHI provides a source of insurance in systems with targeted, non-universal access to health care coverage. It plays a particularly large role in countries with a history of private health coverage and an absence of universal coverage. For example, in the Netherlands, nearly all of the population without access to social insurance purchases PHI (about a third of the population), and the majority of the socially insured rely on PHI for coverage of services not included within social insurance. In the United States, the majority of the non-elderly population without public insurance are covered by PHI. However, unlike the case in the Netherlands, significant gaps in coverage remain in the United States, as a large population subgroup lacks either public or private cover.

42. On the other hand, PHI does not play as significant a role as might be expected in some other countries without universal public coverage or where there are significant out-of-pocket payments. For example, while the Korean National Health Insurance system pays 44% of total health cost, a significant degree of out-of-pocket expenditure remains (41%). Limited development of a private health insurance market could be explained by the lack of a history of private and voluntary coverage in Korea, where individuals have historically financed health expenditures out of their pocket, dating back to the time prior to the establishment of public health cover. Other reasons could be found in the tradition of family solidarity, manifest through self-pay of health costs as well as cultural factors that may make insurance less appealing. Similarly, in Greece and Mexico, the proportion of public spending in THE remains well below the OECD average, yet a meaningful PHI market has not developed in these countries. Turkey has experienced recent growth in its private health insurance market, although at present less than 2% of the population have such cover.

PHI has enhanced patients' access to timely hospital care in some health systems

43. The structure of health systems and PHI roles influence differences in access to health care by insurance status. In OECD countries with no observed waiting times for elective surgery – such as the United States, France, Switzerland, Japan, Belgium and Germany – all insured individuals enjoy timely access to care irrespective of whether their main form of coverage is public or private health insurance. These countries generally include insurance-based systems (public or private), where money follows the patient, specialists are paid fee-for-service rather than on the basis of salaries, and there are lower overall constraints on activity than occurs in health systems with tighter caps on activity and spending (Siciliani and Hurst, 2003). Conversely, privately insured individuals enjoy better access to more timely care in some health systems where publicly financed delivery is plagued by long waiting times, representing a clear advantage offered to those who purchase PHI. In particular, private health cover has enhanced access to timely elective care in countries where it has a duplicate function, and private delivery facilities with additional capacity have developed.[26]

44. Ireland, Australia and the United Kingdom are the most notable examples of enhanced access to timely elective care through PHI, although faster access for the privately insured occurs also in Denmark, Italy, and New Zealand among others. There is indeed a strong link between demand for private health insurance and waiting times for elective surgery in some of these countries.[27] Uncertainty over the length

26. In such systems, public health coverage is tied to public delivery structures (such as public hospitals and doctors in public practice), while a parallel private sector caters to individuals paying out-of-pocket or through their PHI policy.

27. See Hurst and Siciliani (2003), Mossialos and Thomson (2002) and case studies on Australia and Ireland (Colombo and Tapay, 2003 and 2004b).

of waiting times for publicly financed elective treatments and dissatisfaction with public health systems are among the main reasons for buying private health cover. Those who lack private insurance in these countries have a comparatively reduced choice over providers and the timing of care, unless individuals choose to self-pay for such care.

45. The ability of privately insured individuals to obtain faster access to care is significantly influenced by governmental policies and approaches. Allowing public providers to treat both private and public patients and to receive different remuneration levels for these separate activities can encourage their involvement in the private sector. This spurs the development of a market for PHI products offering access to more timely elective care in the private sector. For example the growth of privately financed facilities alongside publicly-financed hospitals has affected, and been influenced by, PHI's stepping in with products offering improved access to timely care, as in Australia. PHI can also sometimes provide quicker access to care within public facilities, as in Ireland for elective surgery.[28]

46. Having private health insurance obviously also improves access to needed care at the right time if no other form of health coverage is available and "safety-net" providers (who provide services irrespective of ability to pay) are in the minority. In the United States, there is evidence suggesting that uninsured individuals wait to receive treatment until they need emergency care – for which hospitals are under an obligation to provide services to those in need – but obtain less primary and preventative services (Docteur *et al.*, 2003). Governmental policies promoting access to health coverage for the uninsured can improve access to timely care for these population groups.

47. Individuals can benefit from enhanced peace of mind, less anxiety and less pain – and better health outcomes when waiting times are very long[29] – when provided with speedier access to care, as afforded by private health insurance in duplicate PHI markets. There are nonetheless trade-offs with other policy goals, such as equity, which have led policymakers in the Netherlands to make different policy choices. Despite the existence of a private delivery system and waiting times for elective care, purchasers of PHI do not gain better access to care compared to those without such cover in the Netherlands. The system is designed to channel patients towards the same type of care irrespective of their insurance status. This promotes equal access to services characterised by long waiting times regardless of insurance status, and thereby diminishes certain potential advantages of PHI (more timely access to care and choice of provider). The extent to which policy makers encourage (or do not prohibit) the development of PHI markets offering faster access to care reflects the different values and priorities placed on providing the option of more timely care through private health insurance versus equity of access.

PHI has increased service capacity and supply in some systems

48. Private health insurance has injected financial resources into some health systems, which has contributed to the financing of additional capacity and services.[30] On the other hand, it has also increased demand in several cases, putting pressures on health systems, and at times skewing resource allocation.

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28. In Australia, the public insurance system, Medicare, covers the cost of medical (specialists) fees for inpatient treatments in private hospitals. In Ireland, about 20% of public hospitals' acute beds are designated for treatment by private patients. These factors impact on the ability of privately insured individuals to obtain faster access to elective care.

29. Available evidence indicates that moderate waiting times for non life-threatening conditions (three to six months depending on condition) do not worsen patients' health and surgical outcomes, while longer waits can be more problematic (Hurst and Siciliani, 2003).

30. Another private insurance market – medical malpractice insurance – has recently posed challenges to the supply of medical providers in some OECD countries. Medical malpractice insurance has raised policy and cost challenges in several OECD countries and in some cases has threatened physician supply due to provider concern over its costs.

- PHI increases supply

49. Duplicate PHI has provided financing for capacity development in the private hospital sector in some countries, thereby helping to alleviating consumer inconvenience generated by non-price rationing in public hospitals. Only a few OECD countries have both long waiting times and high levels of population covered by PHI. Australia has especially emphasised the role private cover plays as the main mechanism for shifting demand away from overburdened public hospitals, while Ireland has instead placed more emphasis on the role of the public system in addressing waiting concerns. Cross-country comparisons of levels of waiting for elective surgery suggest longer waiting times in Ireland than in Australia, despite similar levels of private coverage (Hurst and Siciliani, 2003). This can be partly explained by the larger role played by PHI in financing treatments delivered in private hospitals in Australia, especially for elective surgery. Public subsidies to the cost of private inpatient medical treatment also contributed to the development of a larger private hospital sector (whereas in Ireland the private hospital sector is entirely privately financed). In countries where duplicate PHI covers a less significant portion of the population, but where some private insurers have purchased hospital facilities, such as the United Kingdom and Spain, PHI has boosted capacity somewhat.[31]

50. The financing contribution of private health insurance is also likely to have spurred development of overall capacity in systems without waiting times. By covering the share of cost not reimbursed by the social security system, PHI has helped to finance doctor and hospital treatments in France. In the United States, private health insurance has also furnished substantial financing to hospitals.

51. PHI has often financed the delivery of larger treatment volumes by offering higher payments to providers. Financial incentives linked to payment mechanisms exert a direct impact upon doctors' productivity.[32] This has contributed to a growth in the volumes of private hospital treatments in several countries where doctors have both public and private sector engagements, as in Australia and Ireland (Colombo and Tapay, 2003 and 2004b). Policy makers in many OECD countries allow differential doctors' payments[33] between public and private practice and permit dual appointments in order to keep the workforce motivated. Similarly, some countries – including Australia and Ireland – allow public hospitals to treat privately financed patients. This provides a mechanism to improve revenue collection because public hospitals can draw on this private financing source. It also assures better retention of doctors within the public sector due to this additional physician income stream, while providing private patients with free choice of doctor and upgraded hospital accommodation.

- But it also increases demand

52. The ability of PHI to reduce demand pressures on the public system has nonetheless proven to be constrained. Increases in the population covered by PHI in Australia and Ireland have not resulted in unambiguous signs of decline in the level of waiting (Colombo and Tapay, 2003 and 2004b). PHI membership has not only shifted demand across public and private hospitals but has also increased overall demand, thereby limiting the impact on waiting times. In some countries, incentives created by higher payment levels in PHI markets have also encouraged providers to maintain long queues in the public system or refer patients to owned private facilities in order to sustain their private practice (Hurst and Siciliani, 2003; Rodwin, 1993; DeCoster *et al*., 1998; Yates, 1995).

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31. Yet, in Spain the public sector has purchased capacity from the private sector in some regions.

32. The Human Resources for Health Care study discusses in particular the effects of different payments methods on productivity.

33. Such as allowing doctors to charge higher fees to private patients. Differences also exist when doctors are paid on a salary or capitation basis for their public practice, and on a fee-for-service basis in their private practice.

53. In sum, the extent to which PHI finances private-sector capacity is likely to be one factor explaining cross-country variations in levels of waiting.[34] Yet it has proven difficult to ascertain the precise effects of increases or decreases in the privately insured population on the length of waiting times within each country. Differential payments for doctors involved in publicly and privately financed practise stimulate higher productivity and satisfaction. However, the increase in overall volumes of care offset in part the shift of demand and utilisation between public and private hospitals. Moreover, it is unknown how much of the higher utilisation induced by private health cover is due to latent need – spurred, among others, by the ageing of the population and increased demand for better care – or to unnecessary demand resulting from moral hazard. The impact on health outcomes has also not been fully investigated.

PHI has created two-tiered accessibility to services in some countries

- Private health insurance has created differences in access to care based on insurance status

54. Private health insurance has created differences in access to care based on insurance status in some OECD countries. Evidence from a comparative study on utilisation of health services indicates that private health insurance – which is predominantly purchased by higher-income groups – encourages a pro-rich distribution of physician use in Ireland, France, the United States, and to a limited extent, Australia and the United Kingdom (Van Doorslaer *et al.*, 2004).[35] In Ireland, Italy, Portugal, Spain, and the United Kingdom, access to private health insurance has also been found to have had a positive effect on the probability of visiting a specialist (Jones *et al.*, 2002).

55. Differences in access to care by insurance status, where they occur, arise from the financial incentives created by PHI coverage. First, utilisation increases with comprehensiveness of insurance (Manning, *et al.*, 1987), hence when PHI covers benefits in addition to those covered by existing public programmes it is likely to result in higher utilisation. Second, where private health insurance gives individuals access to providers that they cannot finance through public coverage, PHI affords them an increased level of care, as in Ireland, Australia, the United Kingdom, and other duplicate PHI countries.[36] Third, different payment mechanisms for publicly and privately insured patients can encourage providers to furnish more services in the private sector.

- But the extent of government concerns over such differences in access vary

56. The extent to which policy makers are concerned about the creation of "two-tiered" access to services due to differentiated access to care or speed of access to care by insurance status varies by country, and so do their responses to this issue. The simultaneous presence of a PHI market and waiting times does not necessarily generate differences in speed of access to care by insurance status, for example, this has not been the case in the Netherlands. Instead, design characteristics of the health system, such as the link between financing sources and delivery structures, as well as government policies, affect the likelihood that such access differentials will occur.

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34. Capacity is indeed a key factor behind cross-country variations in waiting times across countries (Siciliani and Hurst, 2003).

35. In Australia and Ireland, PHI's contribution to the overall level of inequality in access to care is pro-rich for hospital utilisation, although the distribution of hospital care in Australia (in terms of probability of utilisation) favours the poor ("pro-poor" distribution).

36. In Ireland, private hospitals are not included within the publicly reimbursed health system and therefore are largely dependent on income from PHI. Irish physicians in public practice can augment their incomes through private practice, where they have increased flexibility to charge additional fees. In Australia, France, Germany, and several other OECD countries, PHI can pay for additional fees above the government fee schedule for in-hospital private treatments.

57. In Ireland and Australia, for example, policy makers have encouraged PHI as a means to offer a level of care or choice above that of the public system to those willing to pay (Colombo and Tapay, 2003 and 2004b). Inequities in access to care linked to insurance status have caused particular concern in Ireland when these have occurred in public hospitals, because access to treatment in these facilities is supposed to be provided without regard to insurance status.[37] When PHI results in significant access advantages, such as may occur in countries with long waiting lists, policy concerns grow. Yet the presence of access advantages for the privately insured does not necessarily reflect negatively on PHI; instead, it may highlight necessary improvements in public coverage.

58. Equity issues may also arise when doctors operate in both public and private hospitals. In these cases, higher physician payments on behalf of privately insured individuals may modify the elasticity of the medical supply between public and private practice, resulting in a reduction in the quantity and quality of physicians' time devoted to public patients.[38] If "under the counter" payments are common, policy makers may wish to promote private health insurance as part of a desired shift towards a more formal payment structure. This is what some countries in Eastern Europe, such as Slovakia, would like to accomplish (Colombo and Tapay, 2004a).

59. In those countries or care settings where differentiated access to care according to insurance status is not deemed acceptable, policymakers have intervened in various ways. Some have regulated prices charged for privately financed patients, or established explicit rules for access to care and requirements on doctors' engagement in public and private practice to minimise the risk of inequities.[39] In the Netherlands, the system is designed to channel individuals to the same level of care and choice, irrespective of insurance status, through uniform provider fees across insurance types and universal access to all providers (Tapay and Colombo, 2004).[40] The Irish government monitors access to publicly financed services in order to ensure continued access to medically necessary care for the entire population. In France, where low-income individuals without private complementary insurance were found to be disadvantaged relative to the privately insured (86% of the population in 2000), the government introduced a publicly-financed complementary insurance programme to minimise inequities in access to care by insurance status (CMU).[41] Yet the effectiveness of such approaches varies, requiring monitoring as well as strengthening in some cases. Notably, diverse payment systems may result in preferential treatment being

37. In both Australia and Ireland, people can elect to receive privately financed treatment in public hospitals. While they are not supposed to obtain preferential access to care compared to publicly financed patients, in Ireland, trends in utilisation of public hospital facilities by public and private patients have given rise to concerns that private patients might receive priority treatment for elective surgery. This does not seem to have been a concern in Australia.

38. While this concern has been raised in several countries, such as the United Kingdom and Ireland, evidence that this has occurred in practice is very limited. Policy makers have nonetheless in a few systems regulated the extent to which public doctors can engage in private practice. For example, doctors are prohibited from practicing in both the public and private sectors in Sweden, Luxembourg, Greece and Italy in order to limit the risk that doctors would neglect their public patients in order to engage in the remunerative treatment of private patients. The new NHS contract offered to consultants in the United KIngdom in 2003, for example, was introduced with the purpose of reducing this bias. In Ireland, the consultants' collective contract also specifies a commitment to public practice.

39. For example, prices are uniform across publicly and privately insured patients in the Netherlands. Patients are put on the same waiting list regardless of their insurance status, and access to care is according to need. In Australia, no a priori allocation of beds between public and private patients exists in public hospitals, and patients are supposed to be admitted purely on the basis of need.

40. At the same time, this reimbursement system precludes PHI from offering the advantages it provides in some countries.

41. Couverture Maladie Universelle. Evidence from Van Doorslaer *et al*. (2004) indicates that the introduction of the CMU has in part compensated for the pro-rich effect of PHI on the utilisation of doctor visits.

accorded on the basis of patients' insurance status. This may even occur where systems are designed to avoid such risk.[42]

PHI is not always affordable and accessible

60. The proportion of countries' populations covered by PHI varies greatly across OECD countries. Governmental policies encouraging or requiring PHI coverage, a strong cultural predisposition to insure, linkages between PHI and public programme comprehensiveness, and/or a high degree of employer-sponsored group coverage explain higher participation levels in PHI markets in some countries.

61. The extent to which lower or nonexistent levels of PHI coverage represents a policy concern varies depending on the role that PHI plays within health systems. On one side of the spectrum, in primary markets, uninsurance generally implies a lack of health coverage and is therefore problematic. On the other hand, in supplemental markets where PHI largely covers luxury and amenity health services, it could be argued that low levels of PHI coverage raise little concern. In public/private health financing mixes that lie between these two extremes, differential access to PHI may raise concerns, and the specific policy problems depend upon PHI's role within, and interaction with, the public coverage programme.

62. In primary PHI markets, the often voluntary nature of PHI, and its reliance on private financing, can combine to exacerbate the potential for uninsurance. In order to improve access to needed care for the entire population, Switzerland mandated the purchase of comprehensive basic coverage by its population, thus eliminating the potential for uninsurance for basic services. Where PHI purchase is not mandatory, there are surprising differences among OECD countries in the extent to which those without access to public coverage purchase PHI voluntarily. In the Netherlands, where about a third of the population, corresponding to the proportion of individuals above an income threshold, is not eligible for social insurance, the vast majority of this population group voluntarily purchases private health insurance; higher coverage costs for the high-risk privately insured are subsidised by premium surcharges imposed on the rest of the market. A combination of an ostensible cultural preference to insure, affordable PHI premiums, assured PHI access for those of high risk, together with the availability of supplementary policies from social insurers' affiliates, explains this extensive purchase of PHI.

63. In the United States, conversely, while there is a high degree of PHI purchase (72% of the population), the absence of a universal public system, combined with voluntary PHI purchase, has resulted in a significant uninsured population (14% in 2000). There is a large debate about approaches to improve access to needed coverage for this large population segment, spanning from the expansion of public programmes to tax advantages towards PHI purchase, particularly by individuals (Docteur *et al.*, 2003).

64. In many OECD countries, employers play a significant role in enhancing PHI coverage. Employer-sponsored PHI presents advantages for employees, because employers are often able to negotiate better coverage solutions. This coverage is often tax-free for employees and tax-deductible for employers, although this is not the case in all countries (*e.g.* Australia subjects such benefits to a fringe benefit tax). While employer-provided PHI may raise labour costs, it certainly plays an important "social role" by facilitating access to PHI in several OECD countries.

65. In the remainder of OECD countries, PHI coverage generally reaches less than half of the population. This often reflects the existence of more comprehensive, universal public health insurance programmes, limited consumer interest, the lack of a tradition of PHI, high premiums, and often limited

42. In Ireland, despite a 20% allocation of public acute beds to private patients, private patients have accounted for almost 30% of admissions to public hospitals in 2000, raising equity concerns (Wiley, 2001). In Australia, there is some limited evidence that the revenue potential offered by private patients for public hospitals and doctors created some incentives for preferential treatment of private patients.

policy prominence attributed to PHI. Both Australia and Ireland stimulate PHI coverage though tax incentives and other interventions, and coverage levels very nearly approach half of their respective populations.

66. Several barriers to access to PHI exist. PHI is becoming more expensive relative to general inflation, thereby limiting affordability for consumers in both primary and other PHI markets, and may thus make future PHI enrolment patterns less stable. Low-income groups are particularly less likely to purchase cover as premiums increase. In addition, PHI may be difficult to access because insurers may not accept applicants with greater anticipated health needs. The Netherlands faced such access concerns before they implemented a safety-net program for higher-risk persons ineligible for social health insurance. This remains a concern for persons seeking individual insurance in many US states as well. Most countries where PHI plays a primary role have implemented some type of programme to assure a certain degree of access to PHI by high-risk groups, yet the scope of these programmes vary. EU law generally prohibits the imposition of access-related standards for this market, except in cases where PHI plays a significant role. The consequent absence of explicit access standards or provisions in many EU countries, coupled with PHI market dynamics and insurer behaviour, has resulted in access barriers in non-primary PHI markets within the EU.[43]

PHI offers a potential source of coverage for long-term care costs but market development is low

67. PHI has the potential to cover part of individuals' long-term care costs – although consumer demand to date has been limited in most OECD countries.[44] Demographic and labour market changes, such as an ageing population and the increasing participation of women in the workforce, are likely to increase the need for formal coverage of LTC cost in the future. In some countries, policy makers have made a choice to finance such cost collectively. In others that do not have public LTC coverage, out-of-pocket payments and informal caring continue to be the dominant forms of financing long-term care cost. While the burden of long-term care cost is rising in all OECD countries, it is unlikely that private LTC markets will develop to significant extent in most OECD countries in the near future. This can partly be attributed to the complexity of the market. It is difficult for insurers, given complex and unpredictable actuarial issues surrounding premium calculations as well as difficulties in maintaining a diverse insured population over time. It is also difficult for consumers, whose understanding of this market is limited. It is finally complex for regulators, who are confronted with new or changing markets. Its development is also hampered by the typically high cost of policies (especially relative to younger groups' perceptions of their level of risk and elderly populations' often fixed incomes) and limited insurer offerings.

68. Determinations relating to whether to finance LTC expenditure through public or private sources of funding remain country-specific decisions, based on policy objectives, policy and cultural priorities, population groups or services targeted for public funding, and available resources. Nonetheless, in the absence of public coverage of LTC cost, and if private LTC markets develop in their countries, policy makers may wish to consider intervening to regulate access and benefits, and establish consumer protection mechanisms for these policies. This may increase consumer confidence in buying private LTC insurance.

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43. Mossialos and Thomson (2002) note, among other areas, the following limitations of the EU third non-life insurance directive: "While harmonisation initiatives appear to be a necessary prerequisite for the creation of a single market in insurance, *they may pose problems for member states that attempt to reach a compromise between deregulation and consumer protection*. Home country control effectively removes the right of member states to operate material regulation in the insurance sector (…). The third non-life insurance directive outlawed price and product regulation in the expectation that competition would benefit the consumer by lowering prices and increasing choice, but *to date there is no clear evidence to suggest that this expectation has been fulfilled.*" (Mossialos and Thomson, 2002, pp. 43-44, emphasis added).

44. Most private long-term care insurance markets are voluntary, except for Germany, where purchase is mandated for those with private primary (substitute) health insurance.

Given the links with policy in the areas of private pension and disability coverage, coordinating policy efforts in these areas would be important.

Ability to choose PHI over public coverage may diminish the risk pooling within public insurance

69. When persons are given the ability to choose between publicly and privately financed coverage – or between public and private carriers offering public coverage, the interaction between publicly and privately financed programmes has given raise to some problems. Countries providing this option include Germany, for higher income persons, and Spain, for civil servants.[45] "Opting out" can have an impact on the risk profile within the public system. In the case of Germany, the privately insured tend to be younger and healthier, thereby depriving the social risk pool of some of the less expensive risks. While many of the youngest workers do not meet the threshold permitting them to opt out and move therefore to statutory insurance, the number of people switching to social health insurance were only a third of those moving to private health insurance from sickness funds in 2002 (Verband der Privaten Krankenversicherung, 2003). Germany has imposed strong limits on the ability to opt back into social coverage as part of an effort to protect the risk pool within social insurance. It also has the authority to trigger a risk equalisation mechanism that would require certain privately insured to cross-subsidise some of the cost of coverage of the elderly under the standard tariff policy,[46] although to date this has not been deemed necessary.

70. Nonetheless, concerns remain regarding the impact of this "opting out" option on the breadth of the social insurance risk pool. In the United States, elderly Medicare beneficiaries may choose to receive their public coverage through private "Medicare+Choice" carriers, sometimes receiving additional benefits, such as drug coverage, through this choice. Historically, Medicare+Choice plans have enrolled healthier, lower-cost individuals than traditional fee-for-service Medicare (Dallek *et al*., 2003), leaving a larger proportion of less healthy individuals in the traditional programme. These trends must be considered in setting reimbursement levels, and in structuring public/private financing mixes, in order to prevent private health plans from profiting from their better risk profiles, to the detriment of the remainder of the public programme.

Useful practices and policy recommendations

71. When policy makers consider two-tiered accessibility to care by insurance status to be undesirable, they can choose to intervene to help minimise the risk of certain inequities. Explicit rules can be set to assure equity of access to services, for example by allocating elective care on the basis of a single waiting list for both publicly and privately insured patients, or guaranteeing that all providers treat all patients in the same care settings and are subject to the same reimbursement levels. Providers' responsibilities with respect to publicly insured patients can also be clarified and monitored. Furthermore, provider discretion to treat patients differently depending upon their insurance status can be minimised by assigning the management of waiting lists to a disinterested party.

72. Where limits in access to PHI coverage exist and raise policy concerns, certain programmes or standards can improve access to PHI coverage (see also Section 4 below). For example, programmes furnishing enhanced access to coverage, such as well-funded high-risk pools offering affordable, comprehensive coverage, or other safety net schemes providing standard PHI policies to eligible high-risk

45. In Spain, the vast majority of the civil servants opt out of public coverage (European Observatory on Health Systems, 2000). Health Care Systems in Transition. Spain, p. 38). In Germany, only those with monthly incomes above € 3 825 (in 2003) may opt out of social insurance. In 2002, individuals eligible to opt out of social insurance who remained voluntarily insured by sickness funds represented around 12% of those socially insured, or 10% of the German population (Verband der Privaten Krankenversicherung, 2003).

46. Germany requires insurers to offer a policy with specified standard benefits at a capped premium ("standard tariff policy") to eligible elderly and other individuals.

individuals offer meaningful insurance to those who are unlikely to have access to affordable coverage in the PHI market. Regulatory standards on all or a portion of the PHI market can also enhance access.

Responsiveness of health systems

73. In many OECD countries, PHI enhances choice in several ways. First, the very opportunity to buy PHI often inherently offers consumers additional choice with respect to financing their health care. Secondly, PHI frequently improves individuals' choice over health providers, treatments, and timing of care – although the scope and nature of this added choice depends upon the regulation of supply in public systems, standards for insurer practices, as well as insurers' strategies. PHI markets also typically offer an array of diverse coverage plans, with different benefits and cost-sharing features. However, some of the added choice afforded by PHI carries trade-offs, and may call for government intervention, such as in the area of product disclosure.

Availability of PHI affords choice

74. The very presence of a PHI market affords consumers with increased flexibility in financing their health care in most OECD countries. In the absence of such a market, they may not have any ability to insure against health costs not covered publicly; PHI provides them with the choice to do so. Benefits of PHI can include coverage of public system co-payments (complementary PHI), insurance coverage of drug costs or providers not included in some public coverage (supplementary or duplicate PHI, respectively), as well as the ability to purchase private insurance if no public coverage is available (principal PHI) or if individuals can "opt out" of public cover (substitute PHI). In all of these cases, in the absence of PHI, consumers would have to rely on out-of-pocket payments and personal savings tools to cover these costs, which are a more regressive source of financing health care.

Privately insured individuals have more choice (provider, benefits, cost-sharing) in some OECD countries

75. Private health insurance enhances choice of health care providers and care settings in several OECD countries, although in most of the cases, it has done so for a limited population segment only. The extent to which PHI enhances provider choice depends upon the structure of the health delivery system, and, in particular, whether public and private schemes cover all or a portion of the providers within the health system – rather than intrinsic differences between public and private health insurance per se. For example, in the duplicate systems, PHI provides enrolees with a broader choice of providers because it reimburses the cost of care in private hospitals which are not, or only partly, publicly funded. As private hospitals have spare capacity and offer mainly elective care, PHI also provides quicker access to non-emergency treatments, as in Ireland, Australia, New Zealand and the United Kingdom. Doctors' ability to charge higher fees to PHI enrolees in several countries' with duplicate PHI cover has provided the privately insured with preferential access to the doctors of their choice, an advantage not offered by certain public systems.[47] In the United States, the degree of choice afforded by PHI plans and by public programmes varies by coverage type (indemnity versus managed care) and specific private plans offerings. For example, individuals enrolled in traditional Medicaid may face diminished provider choice when compared to those insured with indemnity private coverage and the traditional fee-for-service Medicare programme, because the networks of physicians and providers participating in Medicaid are not always as widespread. Individuals covered by managed care plans – whether private, Medicare or Medicaid – also

47. For example, in Australia, providers can charge fees above the government fee schedule and PHI may cover such costs if incurred in a hospital setting. Those covered by PHI may be less restricted in their choice of provider as they are able to be reimbursed for the costs of seeing a more expensive provider. However, PHI does not always provide full coverage of such gaps, and private patients may face out-of-pocket expenditures. The government requires, therefore, that doctors obtain "informed financial consent" from the patient before they proceed to deliver a treatment involving such financial gaps.

face restricted provider choice, depending on specific plan characteristics. US private insurers offer a large choice of plans featuring differing degrees of free choice of provider, ranging from health maintenance organisations (HMOs) to preferred provider organisations (PPOs) to indemnity plans.[48]

76. Conversely, in most health systems characterised by unrestricted freedom of choice of provider, PHI affords the same or very similar options. In both the primary PHI markets in the Netherlands and Germany, PHI has not resulted in much additional choice of provider for its enrolees, because neither sickness funds nor private insurers have significantly restricted individuals' choice of provider. This is surprising in the case of Germany, where private and social insurers often reimburse at different levels, unlike the situation in the Netherlands.

77. PHI insurers also often offer a considerable array of products to their consumers and therefore have the potential to promote choice of benefits and financial protection schemes and better meet individual preferences. PHI markets in Australia and the United States, for example, are characterised by an exceedingly broad choice of health care plans. However, the advantages of such wide choice are not always clear. Readily understood comparative information is often not generally available, thwarting consumers' ability to take meaningful advantage of PHI product choice.[49] Furthermore, when PHI products offer a wide range of cost-sharing arrangements, and differ in the extent to which they cover expensive services particularly needed by high-risk persons, product choice can undermine risk pooling within the market. Lower risk individuals are likely to be attracted by products with higher cost-sharing and less comprehensive benefit coverage, while higher risk persons will respond in the opposite manner, seeking to minimize their out-of-pocket exposure, as in the US individual market and Australia. In contrast, in Ireland's PHI market, where most insurer offerings generally focus on five similar packages, a high degree of consumer satisfaction is reported. This indicates that a wide selection of health care insurance products may not be necessary in order to provide consumers with meaningful and satisfactory choices.

PHI has promoted innovation

78. Insurers have responded to consumer demand by tailoring products, finding innovative and flexible coverage solutions, and quickly adopting coverage of new benefits. Following removal of dental services from the social insurance package in the Netherlands, health insurers responded by promptly covering these benefits. In the United Kingdom, as demand for PHI is linked to excess waiting times, some insurers have designed low-cost products covering only elective treatments in private hospitals. In Ireland, insurers have recently started to offer primary care products to fill gaps in eligibility to public coverage for two-thirds of the population. In several OECD countries, private insurers tailor the premiums to individual needs by varying levels of cost sharing and benefits covered on different polices.

79. The presence of multiple purchasers (both public and private) has been a factor stimulating the adoption and diffusion of medical technologies in the United States, especially across hospitals. Competition in the hospital sector encourages the early adoption and a fast rate of diffusion of

48 Within "pure," traditional HMOs, enrolees can only receive health services of the HMO's panel of medical providers. In PPOs, enrolees can access the services of a selected network of providers, and may go outside the network by paying a greater percentage of costs on an out-of pocket basis. In indemnity insurance plans, choice of provider is unrestricted and insurees generally claim reimbursement from insurers, although in some cases, providers may seek reimbursement directly from the insurer.

49. Several governments have taken initiatives to assist consumers in their selection of private health insurance plans. For example, the Australian government prepares informative brochures on several topics related to private health insurance plans. Comparative information on the features and cost of health plans is also disseminated by the government or voluntary bodies in parts of the U.S.'s primary market and in Switzerland's mandatory insurance market.

technologies, which is in part encouraged by competition between multiple insurers.[50] Both enrolees of public insurance programmes and private insurees may benefit from the higher intensity of treatments delivered by US hospitals. Private insurance markets are often credited with higher responsiveness than public insurers in making reimbursement decisions about new and emerging technologies, although there is limited evidence as to whether this has happened. The implications of rapid adoption and diffusion of technology are nonetheless not always clear, including their impact on quality and health outcomes. Investments in technology are likely to have diminishing returns, prompting the need for careful assessment of their value for money.[51]

80. While PHI has offered privately insured individuals innovative and flexible coverage approaches in many OECD countries, policy makers have sometimes intervened to limit the scope of insurers' activities, through various regulatory tools. This is because insurers face incentives to use product variation as a means of improving their risk profile. For example, the proliferation of products in Australia has resulted in risk segmentation by some funds, because insurers are able to develop benefit packages that are tailored to – or appeal to – individuals of particular risk profiles. Individuals can then select the plan best matching their risk profile and insurers' risk profiles vary as a consequence of such consumer choice (Colombo and Tapay, 2003). Policy makers may wish to consider standardisation of benefit packages – as is mandated for US Medicare supplemental ("Medigap") coverage purchased by individuals – as a way to promote consumers' ability to make informed choices and reduce confusion and the purchase of unnecessary coverage, as well as certain risk-selection activities.[52] However, the extent to which such intervention is appropriate may depend on the role of PHI coverage and the market in question. More generous standard benefit packages can be subject to adverse selection – as can also occur in PHI markets without such standardisation. If insurers are not required to offer all standard products, some may consequently drop such coverage. Moreover, if statutory or regulatory standards do not enable standardised packages to be readily updated, changes or innovation in response to market changes might be inhibited.[53] Equity concerns have also prompted policy makers in the Netherlands to discourage some insurer-supported innovations in health care provision for fear that they would create inequities in access to care between privately insured individuals and those without it.[54] Obviously, countries assess the advantages and disadvantages of PHI differently, including resulting innovations and inequities, prompting varied levels of support for diverse PHI market activities and different levels of regulation.

81. Overall, demand pressures upon insurers have led them to innovate and tailor their offerings to individuals' demands. These pressures arise from competition from other insurers, as insurers fear that they would lose clients if they do not react similarly to their competitors, as well as by the lack of a statutory obligation to purchase cover in most PHI markets. Even a monopolist insurer faces pressures to improve responsiveness to consumers' desires if take-up of insurance is on a voluntary basis, especially when PHI

50. McClellan *et al.* (2002) argue that reliance on competition among insurers and providers in the United States resulted in physicians trying to attract patients through intensity of treatment, amenities and other aspects of quality, while hospitals also attracted patients and physicians by similar mechanisms.

51. Health technology is one driver of health systems' expenditure. However, the optimal rate of adoption and diffusion of medical technology, the point at which each additional unit of technology for a given population will add less to total health improvements than before, is for most technologies not known.

52. In fact, these problems were found in the U.S. Medicare supplement market prior to the standardisation requirements enacted in 1990.

53. In order to avoid standard package to become out of date, regulators can be provided with enhanced flexibility to update such packages (such as specifying them through regulations that can be changed, rather than by statute).

54. In the Netherlands, employers have been in the forefront of trying to help address certain shortages in supply, through initiatives such as employer clinics to help speed employees' re-entry into the workforce. Insurers have promptly stepped in to cover services offered in employer clinics. However, the government was concerned that this might result in inequalities in access according to willingness to pay, and prohibited such initiatives (Tapay and Colombo, 2004).

is not a primary form of cover, and individuals may perceive coverage to be less needed. Policy makers have nonetheless sometimes limited the scope for insurers' flexibility and innovation in order to avoid limitations in access to PHI coverage for more vulnerable groups.[55] This is especially the case in countries where PHI plays a more significant role, either in terms of population covered or health financing share. PHI markets clearly raise trade-offs between innovation and access concerns, not to mention cost.

Useful practices and policy recommendations

82. In sum, while PHI has enhanced choice in several OECD countries, the extent to which this has occurred depends on several factors. Health system structure, provider reimbursement systems and the scope of provider choice afforded by public and private coverage arrangements influence whether – and to what degree – private health cover furnishes added choice of benefits, providers or other advantages. The lack of regulatory safeguards and adequate comparative information concerning PHI products has restrained individual choice in many PHI markets. Governments or voluntary bodies in some countries have disseminated comparative information on the quality, features and cost of health plans. In the absence of effective voluntary efforts, such as industry-led initiatives to improve market transparency and product comparability (*i.e.* Internet-based or broadly disseminated information services) regulations can improve PHI's ability to enhance choice of insurer and of benefit packages, while safeguarding access to care for both the privately and publicly insured. Finally, the availability of a small menu of insurance products, either due to limited insurer offerings or as a consequence of regulations limiting insurers' potential products, does not necessarily mean choice is limited in a harmful way. In fact, it can enhance individuals' understanding of PHI products and improve their confidence. Policymakers need nonetheless to weight trade-offs between improving ability of consumers to make informed choices and enabling insurers to respond to innovate in response to market changes.

Quality of care

83. Private health insurers can promote the delivery of high-quality care if they utilise tools to influence the delivery of health care, such as selective contracting based upon quality indicators, or other means. They have not done so in most OECD countries, however, with the exception of some activities to improve quality of care by managed care plans in the United States and other less extensive experiences in some OECD countries. In the United States, while evidence on outcomes is mixed, there have been some experiences of improved quality of care through managed care tools. Pressure from employers and purchasers for cost-effective care has supported the development and spread of these techniques within the PHI industry in the United States, as have regulatory requirements in some states. In other countries, however, insurers have not yet attempted to modify clinical practice patterns and influence the provision of evidence-based care. This is not entirely surprising, given the limited involvement of private health insurers in decisions around the delivery of health care in most OECD countries, either because of the way the health system is structured, or because of what role and activities insurers are permitted to have, or because of limited insurers' financial and regulatory encouragement to do so. The lack of adequate incentives that reward quality care, such as value-based provider payments, and inadequate information are among the reasons why insurers still do little in this area.

With exceptions, private insurers have not served as an impetus for quality improvement

84. Traditionally, responsibility for quality assurance rested with the medical profession and provider community, but monitoring and improving quality of care has become a priority issue for policy makers confronted with evidence of quality problems in many OECD countries. Several countries have started to

55. These include, for example, restrictions on insurers' ability to impose exclusions on pre-existing conditions, premium-related requirements, benefits standards and restrictions on insurers' the ability to selectively contract with providers.

intervene by reforming institutions of professional self-regulation or increasing regulatory oversight of the medical sector. Further instruments to influence quality of care, including a larger role of purchasers and greater involvement by the public, are also emerging (Mattke, 2004).

85. In most OECD countries, private health insurers have not engaged in significant efforts to influence the quality of the health care services they finance. Several factors are likely to contribute to this trend. First, efforts to improve quality typically require significant resource investments, which may not be warranted where PHI plays a limited role. In addition, such interventions often result in efforts to steer consumers to certain providers, an activity that may restrict choice and therefore be unwelcome in countries where consumer demand for PHI is highly linked to its provision of additional provider choice. Policy makers have seldom established quality of care standards for private insurers. Instead, policy attention with respect to quality is generally focussed upon providers as an accountable unit, rather than on insurers. Quality of care is also often self-regulated by the provider community or voluntary accreditation bodies. Significant political resistance on the part of providers is likely to accompany the introduction of an additional – and non-provider – actor into this realm.

86. One important exception to this trend, however, has been the United States, where insurers and employer-sponsored health plans, particularly "managed care" companies, have been very involved in directing and overseeing certain aspects of care delivery. By exerting better leverage over the care they purchase, insurers seek to secure a competitive advantage through products offering good "value and quality for money". These efforts have largely stemmed from a combination of market developments, voluntary accreditation efforts, and consumer and purchaser demand, such as from employers.[56] There also has been some regulatory impetus by the states. Insurer efforts have often focussed on reducing the provision of unnecessary care and promoting preventive care, where appropriate. Their activities have ranged from selective networks of approved providers, pre-approval of certain services, and the implementation of disease management programmes. Similar efforts have been active or are emerging in a small number of other countries, but involving fewer insurers and activities, as in the United Kingdom and Australia.[57]

87. Public or private insurer involvement in the delivery of care introduces an additional player into the provider-patient relationship. US managed care plans' involvement in approving the delivery of specific interventions gave rise to some of the most vehement opposition by consumers and providers, and at times raised quality concerns,[58] resulting in what is often termed the "backlash" against managed care. To the extent to which insurers have engaged in efforts to manage care that impact upon the delivery of care, it is important that such efforts aid – and do not harm – the quality of health care. In order to make sure insurer practices do not put patients at risk, many US states impose quality-related requirements on health plans. For example, there are standards relating to the timeframes and decision-maker expertise for insurers who require prior approval of certain services, such as hospitalisation, prior to its delivery.[59] There

56. See *e.g.*, efforts of the National Committee on Quality Assurance in the United States (a private, voluntary effort in which insurers widely participate) to develop Health Plan Employer Data and Information Set "HEDIS" report cards assessing plan performance in several key areas.

57. In the United Kingdom, one insurer has set up partnership agreements with some providers. Doctors agreeing to charge up to the maximum benefits paid by the insurer and to fulfil a range of personal quality criteria receive from the insurer an annual 10% supplement for all their qualifying charges to insured patients. In Australia, some large funds organise diabetes educational programmes to encourage patients to purse preventative care and less costly outpatient treatments.

58. For example, there was concern that pre-authorisation requirements might take too long and therefore compromise the provision of care, or that appropriate exceptions to such standards need to be made in the case of emergency room treatment.

59. While parts of these standards seek to assure insurance coverage of certain care, they also seek to assure that insurer decision making processes are timely and performed by persons with the appropriate expertise, thereby not compromising the provision of timely and quality care.

is also a significant, successful effort to prepare report cards comparing plan performance, through the privately developed Health Plan Employer Data and Information Set (HEDIS) which enables purchasers in the United States to compare plan performance according to numerous standardised measures.[60] These efforts, however, are still not systematically applied.

88. While managed care PHI markets in the United States have demonstrated some effectiveness in promoting quality of care, the overall evidence of the impact of managed care, when compared to indemnity insurance is mixed: managed care has not yet fundamentally changed clinical processes or uniformly improved quality of care (Miller and Luft, 1997 and 2002). Plan characteristics, arrangements with providers, and quality controls are heterogeneous across plans and continue to evolve, while prevention and disease management programmes are not used by all plans. Perverse payment incentives that do not reward plans' efforts to improve quality, providers' own success in improving quality of care and still inadequate quality-measurement and reporting systems explain the still limited impact of PHI on quality improvements, even where insurers have sought to implement activities in this area.

89. Given its limitations, PHI may actually not be the best lever to improve health care quality, particularly where its role in a health system is small. The question of whether insurers are the appropriate entities to engage in quality improvement efforts depends upon the countries' health systems structure and policy makers' choices. In many OECD countries, insurers have had neither the levers nor the incentives to invest significant resources in this area. Policy makers wishing to include or enhance private insurers' role in the promotion of quality health care must understand that such efforts involve a significant investment of resources on the part of insurers and that enrolees may bristle at limitations on provider choice, which thereby limit insurers' ability to selectively contract based upon quality-related criteria. Policy makers will need to furnish insurers with adequate incentives to invest in quality-improvement initiatives and foster value-based competition. They may also need to provide consumers with assurances that restrictions on provider choice will enable them to access high-quality providers.

Useful practices and policy recommendations

90. There is not one unique path to improve quality of care, and much is still unknown about what works best (Mattke, 2004). Efforts to improve quality could well occur through value-based competition in health insurance markets, as well as consolidated and cooperative efforts by governments, as suitable given countries' health system structures and policy makers choices. Where quality-related activities have been promoted by private insurers, they have not been accompanied by the right incentive framework, stimulating inconsistent changes in clinical patterns and medical practices. Sometimes these activities have been accompanied by unpopular restrictions on provider choice or access to care, and in some cases have led to undesirable outcomes, meriting regulatory oversight to ensure the delivery of medically necessary and appropriate care.

91. Regulatory oversight is in fact needed to guarantee that minimum quality standards are maintained and ensure the delivery of medically necessary and appropriate care. Adequate financial of fiscal incentives might also be necessary to entice insurers to implement quality initiatives. Policy makers can also provide leadership by reforming payment systems to reward quality of care within public programmes. Quality-reporting systems need strengthening, which could require direct supply or subsidisation by the public sector. Finally, policy makers need to consider how best to promote and coordinate public and private sector quality improvement efforts.

60. For example: National Committee on Quality Assurance (NCQA), "NCQA's Health Plan Report Card", Interactive Tool, http://hprc.ncqa.org.

Cost

92. The review of the experience of OECD countries with PHI markets highlights an overall limited contribution of PHI to total or public cost-containment efforts. Private health insurance has not shifted significant cost from the public to the private sector. Some cost shifting occurs in systems with duplicate PHI markets, although this impact is limited because insurees often continue to utilise the public system for the most expensive services. It also has had less impact in systems with small PHI markets and has been offset by public subsidies in others. Most delisted services have been ancillary or marginal benefits, hence this has had limited impact on public sector cost. Private health insurance has also resulted in higher public and total health cost in most countries where it has a prominent role, as a result of higher health prices (including elevated reimbursement levels that may also spill over into public programmes), increased utilisation, or both. Obviously, the desirability or acceptability of cost increases depends upon what benefits result from this higher health care expenditure.

PHI has removed little cost pressure from public health financing systems

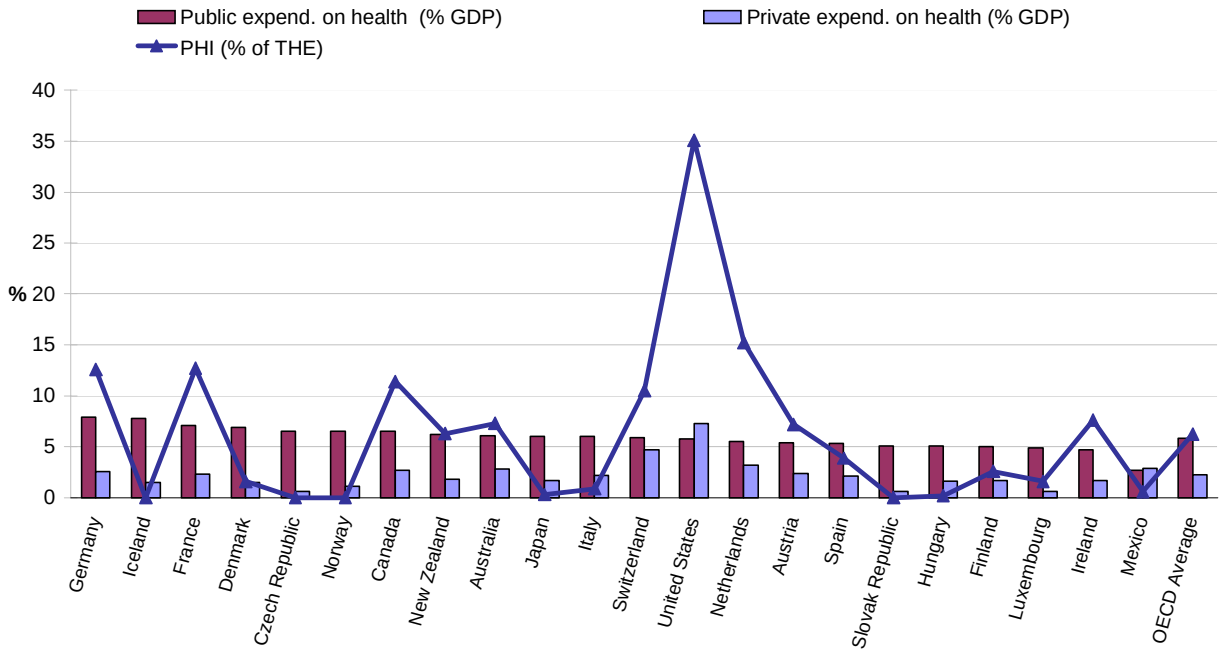
93. Several OECD countries encourage the development of private health insurance markets in order to shift cost pressures from public health systems to the private sector. Policymakers have done so in three main ways. In Australia, Ireland, and the United Kingdom, among others, PHI is allowed to duplicate coverage offered by universal public programmes. In some of these countries this reflects a primary policy goal of diverting some demand and cost pressures from publicly funded to privately funded hospitals. Germany, the Netherlands and the United States have chosen to set income or population-based eligibility criteria for public health insurance, or permitted certain populations to opt out of public coverage. In other countries, there has been a delisting of coverage for some services – thereby creating a potential niche for PHI coverage (for example, dental care in the Netherlands and Australia).

94. While in principle PHI can help shift cost from the public sector, a review of the evidence indicates that this has only occurred to a small extent. The cost-shifting potential of private health insurance is limited because the privately insured often continue to use publicly financed health services in duplicate systems, even when these same services are covered by private health insurance. This stems in part from differences between public and private providers. Private hospitals concentrate on treating minor risks and elective care, while the cost of more expensive care, such as complex cases and emergency services, rests with the public system in several countries with duplicate PHI. Furthermore, PHI has resulted in overall increases in utilisation, which only partly represent a shift of demand from publicly financed activity, as in Australia.[61]

95. Despite limited eligibility to public coverage programmes in the United States, Netherlands and Germany, public spending as a share of GDP is fairly high in those countries, although the public cost would be even higher if all population groups were covered by the public system (Figure 5). PHI in these markets often covers healthier and younger population groups, while higher risks and/or older cohorts, representing the large majority of total health spending, are enrolled in public programmes. The US health care system features higher health care prices than any other OECD country (Docteur *et al.*, 2003). This can be partly explained by the presence of multiple competing payers, who drive the higher rates of diffusion of technologically advanced services (McClellan *et al*., 2002).

61. Some of the PHI-induced utilisation derives from individuals that would, in the absence of PHI, self-finance private care, thereby not using the public system altogether (Vaithianathan, 2000). In Ireland and Australia, public funding as a share of total health spending has increased between 1990 and 2000, while the proportional contribution of PHI to THE has conversely diminished, despite increases in the privately covered population in both countries

Figure 5. Public health spending as a share of GDP and health financing by PHI, 2000



Source: OECD Health Data 2003, 2nd edition.

96. Excluding certain services from public coverage systems certainly helps to limit public sector cost. In Canada, publicly funded coverage does not cover the cost of out-patient prescription drugs[62] – and provinces provide only limited coverage – which represent almost half the cost of total claims to private insurers.[63] Yet, services that are typically candidates for delisting, such as optical and dental care, do not generally account for a large share of health systems' cost. The extent to which this cost is picked up by private insurers, as opposed to out-of-pocket financing by individuals, varies by country. In France, the Netherlands and Australia, a large segment of the population buys PHI policies offering coverage for dental care either only partly (France, Netherlands) or not at all covered publicly (Australia). At the same time, it is often politically challenging to delist more expensive services from public coverage. These attempts will likely raise concerns about the implications of the loss of cover for medically necessary care. Hence, delisting discussions have often centred on services that may be deemed alternative or less medically necessary, or which may be more readily paid for on an out-of-pocket basis by a majority of the population.

PHI has increased total health care expenditure

97. Private health insurance markets have resulted in increased overall health costs in several OECD countries. First, by bringing more financial resources into the health care system, it raises total health expenditure. Second, cost-control measures – such as global budgets, price regulation and capacity controls – have been applied to the public sector in virtually all OECD countries. Conversely, the private

62. Outpatient drugs are not publicly covered unless a person is either admitted to a hospital or eligible under a special programme for targeted groups such as seniors. PHI coverage for prescription drugs outside of hospitals represents almost half of the cost of total claims to private insurers.

63. In Canada, PHI accounts for 11.4% of total health expenditure (THE) in 2000. *Source*: *OECD Health Data* (2003).

financing sector in virtually all OECD countries, except the Netherlands, has not been subject to such centralised, governmental cost controls. This has resulted in less tight control over activities and prices in the private sector. Third, private insurers in most OECD countries do not have the same bargaining powers over the price and quantity of care provided to insurees as public systems do, although within concentrated PHI markets insurers can exert stronger pressure, as in the case of Ireland.[64] Payment options such as global budgets that have helped public systems to contain costs in several countries (Mossialos and Le Grand, 1999) are hard for private insurers to negotiate—or may not be options at all. PHI carriers have generally exerted little leverage over costs---as they might if they engaged in more selective contracting.

98. In the United States, private insurance has been less effective than the public Medicare programme in controlling costs. Growth in per enrolee payments for a comparable set of services in private health insurance outweighed Medicare over the period 1970-2000, reflecting the higher payment rates to providers paid by private insurers (Boccuti and Moon, 2003). While "managed care" delivered some cost control in the 1990s, PHI premiums have resumed double-digit growth since 2001 (Levit *et al*., 2004).

99. Cost control is also more problematic to achieve in systems with multiple competing payers, including most PHI markets. Not only their purchasing position relative to providers is weaker, but also shifting cost onto other purchasers, whether public systems or other private insurers, is a more attractive strategy for insurers than restraining cost. This is despite opportunities offered by multiple payer systems for a "spill-over" effect, disseminating innovative practices. Cost-containment initiatives implemented in PHI markets may be adopted by public programmes and private insurer may conversely turn to cost-containment strategies following public programmes.[65]

100. PHI also risks increasing public expenditure on health. This is because, while PHI may serve as an independent source of health funding, its effects are rarely entirely disconnected from the publicly funded system.

101. Subsidies to private health cover, as in Ireland, Australia and the United States, increase public sector expenditure and have an opportunity cost, sometimes increasing overall utilisation levels as well. Even in the absence of direct or indirect subsidies, PHI has given rise to higher public cost in several countries with a significant PHI market because of the way it interacts with the public system.

102. This is especially the case in complementary PHI markets, though it has also occurred within systems with duplicate and supplementary PHI. While both duplicate and complementary PHI are prohibited in Canada for publicly covered hospital and physician services, even with this more "segregated" role, there may still be an impact on the public system. In this country, the privately covered see doctors more often in order to get a prescription because PHI covers prescription drugs outside of hospitals (Stabile, 2001).[66] Private health insurance coverage of cost sharing on publicly financed health services, as in the French complementary insurance system and US Medicare supplementary system, removes price signals and incentives to consume care parsimoniously, resulting in an overall increase in demand and public system utilisation (Imai *et al*., 2000; Christensen and Shinogle, 1997). In addition, when PHI is offered by employers and its cost is in part or entirely invisible to insurees, as in the case of

64. In Ireland, there are two main large insurers operating on the market, while the private hospital industry is rather fragmented and comprised of relatively small hospitals. This has resulted in monopsonistic insurers exercising relatively strong bargaining powers over providers.

65. The private health insurance industry may seek to mimic effective public cost-containment efforts. Conversely, successful cost-control mechanisms used by private health insurers may be adopted by the public sector.

66. In the case of services where there is less of a link with publicly funded services (*i.e*. no need for a related doctor visit such as is needed for a prescription), as is the case with dental care, no utilisation impact on the public sector was found.

about half the PHI contracts in France, insurees' lack of awareness of PHI cost also increases incentives to consume.

103. There is also evidence of PHI-induced utilisation increases in duplicate systems. In New Zealand, privately treated patients generate some costs that are in fact met by the public systems, such as laboratory tests and prescriptions drugs. In Australia, allowing private insurers to cover the difference between inpatient fees charged by doctors on privately financed patients and the regulated share reimbursed by Medicare (so called "gap") seems to have had an initial inflationary effect. While it is too early to assess the longer-term impact of this measure, which was introduced in 2000, coverage of the gaps risks removing price signals and increasing moral hazard incentives. This can raise both public and total cost because Medicare finances a large share of the cost of private hospital treatments (Colombo and Tapay, 2003).

104. Finally, governments in countries with significant PHI markets, including the U.S., do not spend less on public health systems as a share of GDP than do other countries (Figure 5), while they tend to have higher private health spending. For example, in Germany, France, Australia and Switzerland both public spending on health and private spending on health are higher, as a share of GDP, than the OECD averages. In the United States, public spending is around the OECD average, although private spending is much higher. In the Netherlands, the public share is slightly lower than the OECD average, although total and private spending is higher.

105. Obviously, not all increased utilisation is bad, if it furnishes individuals with access to needed services they may otherwise not have been able to afford.[67] In countries where there is evidence of adverse selection in private health insurance, as is the case in the US Medicare supplement market, higher utilisation rates may also be partly or largely attributed to the less favourable health status of PHI enrolees (Ettner, 1997; Atherly, 2001). Certainly, if cost-sharing is high, as in the US Medicare programme, complementary coverage by PHI promotes access to care.[68] Yet some modest cost-sharing likely could remain without having significant access implications, particularly if low-income persons were exempted.

Useful practices and policy recommendations

106. Multiple factors influence the extent to which private health insurance impacts upon the cost pressures on health systems. Cost shifting will be more effective if people buying PHI do not rely on public health systems for services covered by PHI. The savings arising from cost shifting also needs to be weighed against the cost of any subsidy directed towards PHI markets. The role that PHI plays in the system, particularly the nature of the interaction between public and private health coverage, also affects cost within the health system overall. Prohibiting PHI from covering all or some cost-sharing imposed by public systems helps to contain cost because it maintains individual cost-awareness. However, it may compromise goals relating to access to care in the absence of adequate exemptions from cost-sharing for low-income groups. Finally, the way private health insurance is regulated, and particularly the structure of any cost controls, affects overall health systems' cost. Cost-control measures implemented within the overall health system may improve the ability to control cost within private health insurance markets.

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67. In the case of the US Medicare programme, assessment of the desirability of this impact is complicated by the fact that co-payments can be substantial (20% of permitted charges) and may otherwise impede access for certain populations. In addition, there is evidence of adverse selection into PHI, indicating that those with this type of PHI coverage may have more health needs. In France, PHI covers co-payments that are minimal in nature for inpatient care while public reimbursement is lower (65% and 72%) for medicines and physician services (Buchmueller and Couffinhal, 2004). Co-payments were initially imposed to reduce unnecessary utilisation. This type of coverage – now held by over 85% of the population – has removed this control.

68. In fact, evidence confirms that Medicare complementary coverage enhances beneficiaries' access to medically necessary care (Neuman and Rice, 2003).

Efficiency

107. While private health insurance is often viewed as a tool to enhance efficiency, the evidence reviewed has revealed that PHI has not contributed much to health system performance in this area. This has occurred for several reasons. First, insurers incur higher transaction and administrative costs in order to attract and retain insurees, and provide them with a diversity of insurance plans. Multiple contractual negotiations with providers have also added to insurers' administrative burdens. Second, insurers' desire not to restrict individual choice, requirements to reimburse all providers in some countries, and the cost of engaging in serious activities to manage care cost-effectively have deterred insurers from engaging in significant efforts to influence the cost-effectiveness of care in most OECD countries. Conversely, where managed care has operated for several years, as in the United States in the 1990s, providers and consumers have opposed many of the most restrictive practices – some of which contributed to the plans' earlier success in controlling cost. Difficulties in extracting efficiency improvements from PHI markets are in part due to incentives created by competition across insurers. In the absence of regulation, and sometimes even despite regulation, insurers often compete through cost-shifting and selection of risks.

Achieving value-based competition has proven difficult

108. Policymakers in several OECD countries promote competition in insurance markets as a tool to extract better efficiency and responsiveness from their health systems. Competition is viewed as the mechanism to stimulate performance improvements because private insurers seek to attract and retain insurees and, often, to maximise profits. Germany, the Netherlands and Switzerland have also encouraged regulated competition in their social and basic health insurance systems, with the aim of improving patients' choice and encouraging insurers to reduce cost.

109. However, competition in PHI markets has been limited by several factors. Individual switching across insurers has been limited by high transaction costs, and complicated in some countries by the lack of portability of private cover and the absence of comparative information on insurers' performance.[69] The size of PHI markets, particularly where this is not the main source of coverage for the population, may limit opportunities for insurers to enter the market profitably, thereby limiting the extent of competition[70]. For historical reasons, some PHI markets are dominated by insurers that draw membership from given regions, employment groups, or other groups.[71]

110. Furthermore, competition, where it has actually occurred, has not automatically delivered performance improvements in PHI markets. This is because insurers have often appeared to compete by selectively good risks or shifting the cost of certain risks onto other payers (public payers and other insurers), particularly in markets where PHI is the only or main form of coverage for population groups. In the United States, pressure from rising health care cost has recently driven insurers and employers to increasingly shift cost onto insurees by raising cost-sharing and reducing the comprehensiveness of PHI

69. In Ireland, Australia and the Netherlands, switching across insurers is extremely limited. This has also been the case in social health insurance systems that tried to introduce competition across sickness funds, such as Germany and the Netherlands (Gress *et al*., 2002). The reforms in these two countries share similar features to the reform mandating basic health insurance coverage in Switzerland (Colombo, 2001). Transaction cost, low consumer sensitivity to insurers' performance and lack of adequate comparative information on insurers seem to have hampered mobility across insurers.

70. In Ireland, only two main insurers operate in the market. Markets are very concentrated in some other OECD countries as well.

71. This is the case, for example, of social insurers offering PHI coverage in Belgium and the Netherlands. In many European countries, insurers operating on the market are predominantly provident or mutual associations, who historically have offered PHI following solidarity principles, without risk assessment on inception, although this is no longer always the case.

policies (Tollen and Crane, 2002). In Ireland, a new recent entry into the PHI market has attracted a significant portion of the younger and healthier enrolees, while competitive pressures have not encouraged either of the two main insurers to enhance care and cost management to date (Colombo and Tapay, 2004b). In France, despite large consumer mobility in PHI markets, insurers do not engage in efforts to improve cost-efficiency of care. In fact, competitive pressures deriving from the entry of commercial insurers into the market seem to have induced non-profit mutual insurers to apply stricter actuarial assessments (such as risk-rating). This pressure is similar to that experienced by some of the US non-profit Blue Cross/Blue Shield plans, which are only sometimes permitted to risk-select (Buchmueller and Couffinhal, 2004). Such insurer actions have sought to avoid adverse selection by enrolees, which occurs when insurers attract a disproportionate share of higher-risk individuals compared to their competitors.

111. Many countries with social health insurance and private supplementary systems have prohibited social insurers from offering private coverage as part of an effort to avoid unfair competition, given social funds' relationships with consumers. However, in countries such as the Netherlands and Switzerland, PHI is offered by affiliates of social insurers who, while legally separate, share administrative efficiencies and sometimes offer combined social and private insurance packages whose separation is either invisible to consumers or impractical for them. This can impact the potential for competition among social insurers because it limits insurees' mobility and because information gathered through social coverage can be used by insurers to identify bad risks. For example, individuals with combined packages of private and social benefits may be unable to change social insurer if they are unable to obtain the same private supplementary benefits from another social insurer (or their affiliate), due to their health status or other factors, as can occur in the Netherlands (Tapay and Colombo, 2004) and Switzerland (Colombo, 2001).

Insurers incur high administration costs

112. Private insurers face high overhead costs. Marketing and underwriting represent the largest fraction of administrative expenses, but insurers also incur the cost of billing, product-innovation, and distribution, and contracting with providers. It is to no surprise, therefore, that private insurers incur larger administrative costs (per person insured and as a fraction of total cost) than do public health coverage programmes.[72] In the United States, the average administrative cost of private insurers (11.7% in 1999) exceed those of the public programmes Medicare (3.6%) and Medicaid (6.8%) (Woolhandler *et al.*, 2003). Similarly, the administrative cost of Medicare in Australia (3.7% in the year 2001-02) is well below the PHI industry average (11.1%). High administrative cost for private insurers are also found in other OECD countries, such as the Netherlands (10.4%), Canada (13.2%), Ireland (9.7%) and Germany (14%)[73] (OECD, 2004a).

113. Administration costs are larger in multiple payer systems compared to those with single payers. This is explained by duplication in functions, for example in provider contracting and claim processing, and the need to account for the high administrative costs incurred by providers. Fragmentation of coverage and financing sources, for example, create large administrative expenses for providers and insurers in the United States (Davis and Cooper, 2003). While no evidence is available on the optimal size of overhead, there is no clear indication that higher administrative costs lead to improved health care quality and outcomes (Woolhandler *et al.*, 2003).

72. Despite limited available evidence and complexity in measurement, administrative costs of private insurers have been found to be higher than those of public systems in OECD countries for which data are available (OECD, 2004a).

73. Includes both underwriting and other administrative costs. *Source*: Verband der Privaten Krankenversicherung (2003).

Insurers have implemented few measures to enhance cost-effectiveness of health care

114. Private insurers have not implemented significant measures to enhance the cost-effectiveness of care in a majority of OECD countries[74], with the notable exception of the efforts of managed care plans in the United States. Several explanations for the limited involvement of insurers in managing care[75] are plausible, including, among others, complexity and cost, resistance by the medical profession, lack of incentives, and the desire not to restrict individual choice.

115. Tools for managing care require sophistication in practices, and organisations or insurers may have limited incentives to invest in their application, especially if they do not expect significant gains, or anticipate opposition by stakeholders such as professional associations. In several OECD countries, negotiations between providers and public purchasers have also traditionally occurred on a collective basis, while there are limited traditions of selective contracting and negotiations.

116. Insurers face few incentives to manage care, especially for high-risk and high-cost cases, because their exposure to risk and cost is generally limited in countries where PHI does not have a primary role, or where it has a minor role in financing more costly care. Management of care – and its cost-effectiveness – is not a priority for insurers in many OECD countries.

117. Furthermore, incentives to manage care are challenged by some regulatory instruments. Mandatory or voluntary pooling, or "risk-equalisation" arrangements, can help spread the cost of caring for less healthy populations in primary PHI markets (as in the Netherlands) as well as other markets (*e.g.* duplicate PHI in Australia[76]). They have been introduced in order to counter any risk selection by insurers in these markets. Yet they carry trade-offs. While they promote equitable risk pooling across insurers, they do not encourage insurers to manage care efficiently if they compensate inefficient insurers for their higher costs. Some OECD countries are seeking to refine these arrangements as part of an ongoing effort to strike an improved balance between these two objectives. However, in addition to technical challenges, the development of such systems also entails policy choices about the priority to be given to the goals of promoting efficient care management versus the need to compensate insurers for their different risk profiles.

118. Insurers in the United States have actively sought to influence health care delivery patterns, volumes and costs to a much larger extent than have most other OECD countries. However, the backlash against managed care in the United States shows some of the constraints and resistance private insurance markets may face if they seek to promote improvements in the cost-efficiency of health care delivery. At the same time, it highlights private health insurers' need and ability to respond to purchaser and consumer demand, by modifying unpopular practices.

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74. For more detailed discussion on the experience of Australia, Ireland and the Netherlands, see Colombo and Tapay (2003 and 2004b), and Tapay and Colombo (2004). Where insurers negotiate with providers, as in Australia and Ireland, negotiation takes place on the basis of prices of services but do not touch upon other care delivery conditions. In other large PHI markets, such as Germany, Canada, and France, insurers are not involved in managing care, as they simply reimburse patients and have limited involvement with providers. This is more so the case in smaller PHI markets across the OECD area.

75. Managed care encompasses several tools directed at influencing the quantity, quality, and appropriateness of care provided to insurees. These include, for example, health prevention and promotion initiatives, management of chronic conditions, utilisation review, clinical guidelines, restrictions on treatments, and incentives/ information directed to consumers to promote cost-effective providers or services.

76. Australia is updating its current reinsurance arrangements with a new system that seeks to enhance incentives for improved health fund efficiency; under this scheme, reinsurance support will be based on average hospitalisation costs, rather than actual costs, and funds that successfully reduce costs of a particular age or sex cohort below the average will benefit from the difference.

Useful practices and policy recommendations

119. Incentives or regulatory requirements may be necessary in order to assure the appropriate balance between insurer cost-control efforts and the delivery of appropriate and needed health care services – a particular issue in primary markets. Regulatory interventions may also be needed if policy makers wish to use PHI markets as a lever for improving cost-effectiveness of care, for example by permitting selective contracting, removing obligations to contract with all providers, or providing incentives for insurers involved in preventative care or care management. This is because insurers may otherwise lack incentives to invest in such activities or to maintain adequate standards in this area. Policy makers designing risk equalisation systems also need to carefully assess the trade-offs between promoting equitable risk pooling and the maintenance of incentives for insurer efficiency. While striking a balance between these two goals is difficult in practice, some principles may help design effective risk equalisation systems.[77]

120. Better regulatory safeguards and improved information disclosure are also needed to enhance fair competition in a PHI market because of market imperfections such as information asymmetry and insurers' incentives to select risks. Individuals need transparent information and consumer protection regulation in order to become confident in, and knowledgeable about, the products they are buying. Improved consumer information can facilitate more meaningful competition among insurers, although it does not in and of itself remove the risk that vulnerable groups could be priced out of the market. Governments in several OECD countries, particularly those where PHI plays a primary financing role for population groups, have often intervened to protect access for vulnerable individuals, who may not be able to purchase coverage within some competitive markets.[78] Yet regulations that promote access by imposing benefit-related requirements arguably carry a price, as they may limit the scope for insurers to innovate and respond to individual preferences.

4. Policymakers' interventions in PHI markets further policy goals – but challenges remain

121. PHI's contribution to health system goals largely depends upon health system structure, insurers' strategic behaviours and governmental interventions. Rather than representing a single financing option with unchanging characteristics, private health insurance arrangements can mirror social or public insurance systems, although this depends upon their role and the level of government intervention. Some intrinsic characteristics of unregulated PHI markets, such as information failures or asymmetries and incentives for insurer risk selection present important challenges.

122. Policy makers have sought to address these issues through a variety of interventions—with mixed success (Table 2 provides a synthesis of PHI regulation in OECD countries). Countries with significant PHI markets generally regulate PHI markets more heavily. In the case of EU countries, EU law restricts the ability of most countries to impose non-financial standards on PHI markets, with the exception of private primary or substitute coverage schemes, to which it accords added flexibility. Hence, most OECD countries impose limited non-prudential standards on these markets. For those that do, regulations can address certain challenges, but may also raise their own difficulties. Furthermore, it is important to consider the interactions between interventions, and the extent to which regulations have "loopholes" that can undercut their effectiveness; these may also need to be addressed through regulation. Finally, the timing and manner of implementation can also affect their impact and success.

77. See OECD (2004a) for design principles for risk compensation mechanisms.

78. For example, by limiting the extent to which insurers can rate premiums based on risk, or can refuse access to cover and impose exclusions on cover, or by requiring provision of minimum or standard benefits.

Table 2. Key PHI-related laws and regulations

	PHI insurers must issue all or certain products	Requirements for contract renewal	Portability protections	Consideration of health risk related factors permitted in premium setting	Risk sharing or risk adjustment requirements/mechanisms
Australia	Yes- all products	Not applicable (Contracts have infinite terms)	Yes	Lifetime Health cover permits calculation based on age of entry.	Yes. Risk Equalisation Scheme funds benefits for those over 65 years of age and those experiencing over 35 days of hospitalisation per year.
Austria	No	No	No	Yes	No
Canada	No	None	No	No	In Quebec, for private drug insurance plans for high drug claims in excess of specified dollar amounts.
Germany	Yes-Access to standard tariff policy	Effectively, for substitutive cover, as it is offered on a lifetime basis. For other types of coverage, cancellation by insurer is prohibited after a certain number of years.	Yes, if moving from social to private insurance. Limits on general waiting periods and specified limits on coverage exclusions for certain conditions.	Substitutive cover must be offered on a lifetime basis; premiums determined by age of entry and gender (and benefits); health status risk surcharge may be imposed (except for civil servants switching from public cover to standard tariff). New entries may not be charged less than already insured of same age (not including ageing reserve). Premium cap: substitutive coverage.	PHI contracts include an option to impose a surcharge to pay for premium cap on standard tariff package, but this option has not been invoked. Insurers participate in a risk equalisation scheme for standard tariff policies, as the number of aged insurees varies across companies.
Ireland	Yes- all products	Yes- "Lifetime cover" requirement.	Yes	Introduction of premiums differentiated according to age at policy inception is permitted by law but regulation is required in order for it to be implemented.	Yes. Risk equalisation system being implemented.
Mexico	No	Requires insurers to specify if there is compulsory renewal, and, if so, the maximum age for renewal.	No	Limits on age-based variation established through a legally established premium range	No
The Netherlands	Yes-Standard package for elderly and high risk	Policies generally include an automatic one-year extension unless notified by the insured.	Insurer voluntary code requires ability to convert from group to individual policies on same general terms; voluntary code also promotes portability between group plans. No exclusions permitted for WTZ policies.	Premium for WTZ package subject to limitation. Limit is above average premium levels in the PHI market. No limits for supplemental coverage.	Compensation scheme between social insurance and PHI where privately insured pay a contribution to cover for social insurance covering more of the health care costs of the elderly. Pooling scheme for WTZ scheme pools costs exceeding WTZ premiums, and divides and spreads this cost through surcharge imposed on all privately insured.
Poland	No	None	No	Yes	No
Portugal	No	None	No	Yes	No

Table 2. Key PHI-related laws and regulations *(cont.)*

Slovak Republic	No	None	No	Yes	No
Spain	Yes-for civil servant substitute coverage	Yes-for civil servant coverage.	No exclusions permitted for civil servant coverage.	Yes; some entities set premiums according to age groups and others base them upon the criteria for mutuals.	No
Switzerland	Yes-for primary coverage; No for supplementary coverage	Yes for primary cover; not for supplementary cover.[1]	No exclusions permitted for primary cover; allowed for supplementary cover	No variation by health status is permitted under primary coverage; there are is some variation permitted for children and students, and for geographic area. Permitted for supplemental coverage.	Yes. A risk equalisation fund compensates insurers for cost differences in primary coverage arising from risk, based on age and gender factors. Continuation of risk equalisation scheme after 2006 is under debate.
Turkey	No	No	No	Yes	No
United Kingdom	No	No, but it is the traditional practice.	No regulatory limits.	Yes	No.
United States	Yes-Some products and markets	Yes.	Yes for group contracts; some states require it for individual contracts	Many states restrict health status-based rating ("experience rating") in small group market and some require community rating with varying degrees of permitted variation by age, gender and geography. Individual market requirements vary. Some states require community rating in the Medicare supplement market.	Many states have voluntary risk equalisation schemes in their small group markets; some are mandatory. Some states have risk equalisation in individual markets. 30 states offer high risk pools (coverage offered by separate pools, often subsidised by charges on insurers or other taxes).[2]

Source: OECD Regulatory Questionnaire responses, unless otherwise specified. [1] Colombo (2001); [2] Chollet et al. (2002)

Regulation can promote access to PHI

123. OECD countries have utilised a range of regulatory tools to promote access to PHI coverage across population groups, particularly for those with higher anticipated health costs. PHI markets without such requirements or targeted interventions often present access problems for high-risk individuals, as earlier experiences in the Netherlands and the United States have indicated. Lack of access is a particularly important concern where PHI plays a primary role, or where policy makers consider it important to afford individuals a private alternative to public coverage systems.

124. Issuance requirements are one primary tool to improve access to PHI coverage. Several countries, including Germany, the Netherlands and some US states, have required insurers to issue at least one standard package to all applicants. One disadvantage to this approach is that it tends to segment the PHI market by risk, as such policies tend to be held by higher risk persons who are unable to purchase other policies.[79] On the other hand, this segmentation reduces the impact of this higher risk population on the premiums of other PHI policyholders. Furthermore, this approach assures the offering of a meaningful, comprehensive package to all applicants. Another approach – taken in Ireland and Australia and certain states in the United States – is to require insurers to make all of their products available to all applicants. This method assures a broad choice for all applicants, but may result in overall price increases, and these may be less acceptable to those with lower health risk – a particular challenge in voluntary markets. There is no clear preferred choice between these approaches as long as meaningful coverage is available to all. In selecting the desired mechanism, policy makers will have to weigh the above-described tradeoffs and reflect cultural and political priorities. In the absence of any interventions, PHI markets are likely to suffer from some degree of risk selection. This is a greater concern in the case of primary markets or other markets where PHI's role is significant, but is arguably a policy concern in all markets – particularly if equity of access to coverage is a policy priority.

125. Requirements relating to policy issuance alone are not sufficient to promote access to coverage. For this reason, countries often couple access requirements with standards relating to PHI premiums. Again, as with the issuance requirements, approaches may fall into two broad classifications.

126. First, there are market-wide restrictions on insurers' ability to consider health status when calculating premium rates. These can range from prohibitions on the consideration of risk factors, to restrictions on their use. These standards apply broadly to PHI products and affect the rates charged to low and higher risk individuals alike. They have the advantage of spreading the risk across the entire privately insured population. However, in voluntary markets, these policies may run the risk of inducing lower risk individuals to drop coverage if overall premiums rise as a result. Allowance for some variation, such as permitting age-related variation within defined bands, or delimiting the extent to which premiums may vary based on health status, may reduce the risk of undesired coverage declines, and may in fact be preferable. It also helps maintain a broader risk pool, while still limiting risk-based premium differentials.

127. Ireland and Australia, and many US states, in their small group markets, have accompanied these rating reforms with risk-equalisation schemes which seek to compensate insurers covering a higher risk population. These schemes can also help promote fair competition among insurers. Phasing in the implementation of rating reforms over time, rather than implementation in a single step, may also help avoid market instability and dramatic shifts of covered individuals between insurers or in and out of insurance. New York and Vermont present contrasting experiences in this regard, as New York implemented its PHI community rating reforms rapidly, whereas Vermont phased in their implementation, with less resulting instability (White, 1994).

79. This package is not limited to high-risk persons in Germany, although there are requirements that insurers offer these packages to certain elderly persons, among others.

128. A second approach to PHI affordability is the imposition of caps on the premiums of coverage that must be issued to high-risk persons. Both Germany and the Netherlands limit primary PHI premiums in this way for their standard PHI packages. In both cases, premiums are well below the cost of insuring the higher risk populations and surcharges are imposed on parts or all of the rest of the PHI enrolees in order to help subsidise these lower premiums. In this way, the broader PHI market participates in the cost of these policies, which often include higher risk persons, but it does so through a mechanism that segregates these costs into a separate coverage pool. As is the case in issuance reforms, each approach carries trade-offs. The most important issue is the availability of affordable coverage for all and the limitation of cost variations based upon risk. To this end, some mechanism of cross-subsidisation is likely necessary – whether it is community rating with risk equalisation or a premium cap on coverage for those with higher anticipated health costs, with the cost differentials funded through surcharges on other insureds or other taxation. Another approach is to move outside the PHI market entirely, and offer coverage for "higher risk" individuals through public or quasi-public entities funded through industry contributions or other mechanisms (*e.g.* the "high-risk pools" in many US states). In the latter case, it is important that any such pools offer meaningful, affordable coverage and be well funded, whether by public or private sources.

129. Additional regulatory tools can bolster the effectiveness of access and premium-related requirements. For example, renewability requirements, such as exist in Ireland and the United States, among other countries, are a useful and fairly straightforward means of promoting continuity of coverage and risk pooling. Under such requirements, insurers must renew coverage contracts, as long as the insuree still wishes to do so. This type of standard prevents insurers from selectively renewing only those policies with a history of low claims or costs and thereby promotes access as well as the maintenance of a diverse risk pool. In addition, many countries have limited the length of "pre-existing condition exclusions" that insurers have imposed and prevented the re-imposition of such provisions when a person changes insurers, if they have maintained continuous coverage. These exclusions limit insurers' obligation to cover conditions existing at the time of purchase (and hence seek to minimise adverse selection against insurers). However, they can be misused if imposed for undue lengths of time or for persons who have maintained coverage. Australia, Ireland and the United States explicitly limit the length of such provisions, and other countries, such as Germany, place limits on the coverage exclusions insurers can impose. When the above-described regulatory protections are employed in combination with issuance and premium-related standards, these joint provisions help promoting the efficacy of each single measure. Otherwise, there is the potential that access or affordability requirements could be undercut by exclusions or insurer policy cancellations.

130. Access-related standards pose particular challenges as they are inextricably intertwined with affordability challenges – which are linked to broader health care cost-control concerns. They also confront one of the most difficult aspects of PHI markets – the tendency for insurers to try to select "good risks" and avoid "bad" ones and the tendency for individuals in good health to prefer less expensive, less generous coverage, or not to purchase coverage at all. These behaviours, while enabling insurers to reduce costs and premiums, and also maximise profit, respectively limit access to private coverage and deprive the insurance pool of "better risks," thus driving up the premiums of those who retain insurance.

Regulation can improve consumer confidence in PHI markets

131. Governments can shape the scope of PHI markets by imposing standards or limits on the benefits that PHI insurers can offer. Again, policymakers within OECD countries have generally adopted interventions falling into two broad categories.

132. First, they can specify required benefits through minimum benefit standards, as in Ireland, Australia, and many US states. These standards have the advantage of spreading the burden of covering certain higher cost benefits across insurers, and helping governments link PHI with health promotion goals.

At the same time, they enable insurers to retain discretion in benefit design around non-required benefits. By focussing on covered benefits, rather than the design and comparability of benefit packages, however, these standards do not address consumers' ability to compare product offerings across insurers. Some markets suffer from such challenges more than others; for example, Australia has initiated some policy initiatives to confront difficulties, while Ireland does not face the same level of challenges in this area.

133. A second approach to regulating benefits, and promoting product comparability, is the requirement that insurers offer a limited number of specified benefit packages. This approach enhances consumers' understanding of product offerings and lends itself to more ready price comparisons. It can be of particular use for more vulnerable populations, such as the elderly, and indeed has been found to promote consumer understanding when required for the US Medicare supplement market (which offers complementary coverage to those 65 years of age and older). There has been less experience with these requirements than with minimum benefit standards in OECD countries, outside of the US Medicare supplement market. While some are in place in a handful of US states, they do not appear nonetheless to have been widely adopted. In contrast, requirements that certain standard policies be offered alongside other coverage options are more common, such as in Germany, the Netherlands, and many US state small employer markets.

134. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage options. In recognition of the complexity and uniqueness of certain issues arising within private health coverage markets, several OECD countries developed and impose health insurance specific disclosure standards (*e.g.* Australia, Portugal, Germany, Mexico and the United States). In another approach, in the United Kingdom, the industry requires compliance with certain voluntary standards as a condition of membership in the insurer trade association.[80] When combined with standardised packages or minimum standards, these requirements can promote purchaser familiarity with their coverage options because they assure more similarity or comparability among the products of competing insurers and make it easier for plans or governments to describe certain benefit plan characteristics. In other cases, disclosure standards apply to all insurers offering health and non-health products alike (*e.g.* Germany, the Netherlands, Poland, Portugal and Spain), and are sometimes applied in conjunction with health insurance specific standards.

135. Consumer confidence in PHI markets and their coverage can also be strengthened by mechanisms which provide policyholders with cost-free or low-cost means to appeal certain plan decisions, when insurees have not been able to resolve disputes through plan internal appeal and complaint mechanisms. "Ombudsman programmes" can help resolve disagreements without costly litigation – an avenue which many persons might not pursue due to its lengthiness and cost. In a number of countries, there are bodies focusing exclusively on health insurance related complaints (*e.g.* Australia, Germany, Switzerland and most US states), whereas in others, these entities adjudicate health insurance complaints as well as other insurance-related disputes (*e.g.* Ireland, Poland, the Netherlands and Spain) or grievances against the financial services industry (United Kingdom). Experiences with these independent bodies have generally been quite positive and they appear to be well regarded by industry and consumers alike.

Effectiveness of regulation requires constant monitoring and flexible adaptation

136. Of course, the efficacy of regulatory instruments ultimately depends upon industry compliance and governments' ability to both monitor plan conformance with standards and impose penalties for non-compliance. To this end, OECD countries invoke a range of tools, including policy review, civil monetary penalties, and requirements for corrective action, among others. Furthermore, PHI markets are commonly

80. Disclosure requirements are applied to members of the Association of British Insurers by ABI "Codes of Practice", as a condition of membership. OECD Regulatory Questionnaire, UK response.

regulated by multiple agencies, drawing from relevant government departmental expertise, and thereby maximising the input of relevant government expertise and enforcement efforts (*e.g.* Australia, Ireland, the Netherlands and many US states) For example, it is not unusual for PHI financial standards to be overseen by the relevant financial authority, while PHI health care related standards are often (but not always) overseen by the agency with jurisdiction over health care financing and/or provision. Furthermore, PHI markets are generally subject to broader competition standards as well. The division of government responsibilities can vary without compromising regulatory efficacy, as long as it permits the development of well-designed regulation and promotes government's ability to respond in a quick and flexible fashion to market developments.

Governments can use other instruments and approaches to foster desired policy goals

137. Tax incentives or advantages connected with the purchase or offering of PHI (Table 3) have encouraged and shaped the development of PHI markets in several OECD countries, although price elasticity of demand for PHI varies widely across OECD countries. For example, the presence of tax incentives favouring the offering and take-up of employer coverage is credited with the development of a significant employer-sponsored PHI market in the United States and Canada, among other countries. One significant incentive is the absence of individual taxation of employer-sponsored benefits, such as occurs in the United States, Ireland, and several other countries. Conversely, disincentives, such as the imposition of a fringe benefit tax on employers offering such coverage in Australia, have hampered the development of a group PHI market in this country, where PHI policies are largely purchased on an individual basis.[81] The impact and desirability of individual tax incentives, however, have been the objects of debate on equity and cost grounds. While such fiscal incentives can shape purchase patterns, they alone are less likely to address some of the more entrenched challenges of PHI markets – namely access challenges due to insurer underwriting practices – particularly those that restrict acceptance and increase premiums based on enrolee or applicant health status. Unless tax incentives can vastly increase the level of population coverage and result in large numbers of higher and lower risk persons – which they are less likely to do unless they are coupled with access or premium standards that assure access to higher risk persons[82] – certain challenges found in unregulated markets likely will remain.

81. However, the imposition of this tax in Australia reflects the precedence accorded to other important policy priorities – namely the integrity of the income tax system and the desire to preclude the offering of employee benefits as a means of "bypassing" this system.

82. Merlis (1999) highlights some of the complexities in implementing premium subsidies in the individual market, with or without other insurance market reforms. One question that arises is whether policymakers seek to enhance coverage levels, irrespective of risk status, or whether they seek to expand coverage for those of both high and low risk. The authors note, for example, "It is possible that subsidies without rating reforms would provide coverage to more individuals, but that subsidies with rating reform would reach most of the individuals most in need of coverage" (Merlis, 1999, p. 8).

Table 3. Tax and monetary incentives

Australia	▪ 30% premium rebate to individual purchasers of ph insurance. ▪ Medicare Levy Surcharge on taxable income of high income earners who do not take out private health insurance[1]
Austria	▪ Single people (deduction limited amount and available up to an income threshold) and sole earners (subject to limit) can deduct 25% of VHI premiums from their taxable income. ▪ Firms can deduct employer-paid premiums from tax[2]
Belgium	▪ Self-employed people can deduct premiums for substitutive PHI from taxable income ▪ Firms can deduct employer-paid premiums from tax[3]
Canada	▪ Tax credits, allowances, deductions and exclusions.
Denmark	▪ Firms can deduct employer paid premiums from tax[4]
Finland	▪ None[5]
France	▪ Employees can deduct amount PHI premiums paid by employers from taxable income[6]
Germany	▪ Premiums for PHI as well as contributions for social insurance are deductible up to a limit. Health care costs not covered by insurer may deducted up to a maximum amount (which is based on income)
Greece	▪ VHI premiums are deductible from taxable income up to a maximum deductible amount (587 euros per year).[7]
Ireland	▪ Tax allowances: Applicable to all taxpayers, deducted by insurers at the standard tax rate, limited to health insurance premiums for registered health insurance undertakings. Tax relief is also available for out-of-pocket medical expenditures not covered by PHI, at the higher, "marginal" rate. ▪ Rebates: If not claimed as a tax allowance. ▪ From 1 January 2004, employers are to pay "Employers Pay Related Social Insurance Contributions" (PRSI) on a broad range of 'benefits in kind' provided to employees, including employer-paid health insurance premiums.
Italy	▪ VHI premiums for group commercial policies and all (group and individual) mutual policies are deductible from taxable income at standard rate up to a ceiling (1250 euros)[8]
Luxembourg	▪ Individuals can deduct mutual VHI premiums from taxable income up to a ceiling (ceiling for all insurance premiums)[9]
Mexico	▪ Tax allowances: Amount of tax allowance equals the premium amount, there is no limitation or additional requirements
The Netherlands	▪ Tax Credits: Tax credit for young disabled (<65). Credit deducted from tax that persons (entitled under Wajong law) have to pay € 500 (2002) ▪ Tax allowances: Healthcare costs are income tax deductible (costs directly related to illness or invalidity). Must exceed a certain threshold (11.2% of income with a max of € 5 594 (2002) in order to become deductible. ▪ Premiums for private (industrial) disability are deductible.

Table 3. Tax and monetary incentives *(cont.)*

Portugal	▪ Tax allowances (deduction from income tax, not taxable income)[10]: 25% premium amounts, limit € 71.75 for single persons, € 143.50 for married persons for each child an extra € 35.88.
Spain	▪ No tax on insurance premiums (re: all policy subscribers). ▪ Employees/workers (Income Tax): The premiums or quotas paid by companies to insurance entities are not considered as earned in kind up to a limit: Limits: € 360,61 per year (individual); € 1 202,02 per year (if the insurance includes the spouse or dependents). The amount in excess is considered in kind income. ▪ Employers: (Corporate Tax) premiums paid are considered deductible expenses. ▪ If the taxpayer (in business activities) is the insured: (In come Tax), the amount of the premium is deductible in the direct estimation regime under the same terms of the Corporate Tax
United Kingdom	▪ None for individuals nor firms (since 1997), [11] although firms can deduct premiums from taxable profits.
United States	▪ Tax Credits: 60% of premium applicable to trade-displaced persons on Qualified Health Insurance products (Health Insurers must be licensed) ▪ Tax allowance, deductions or exclusions: 100% for employers and 85% for self-employed

Sources: OECD Regulatory Questionnaire Responses and related correspondence with delegates or additional sources specified in notes.

1. Medicare Levy Surcharge (MLS) was introduced in 1997 to encourage high income earners to purchase phi and remove some of the burden from the public hospital system. The surcharge is additional to the compulsory Medicare Levy

2-11. Mossialos and Thomson (2002), Table 16, p. 91.

138. Voluntary standards or less stringent, benchmark standards can form a useful part of regulatory approaches, although the potential effectiveness of the latter remains untested. Several ombudsman programmes and industry disclosure standards, among others, have been instituted on a voluntary basis by industry accord, or on a plan-by-plan basis. Benchmark standards are under development in Australia as part of an attempt to lighten the regulatory load on the industry and to measure their compliance with broader regulatory standards through specified outcome targets, rather than more detailed standards. This innovative approach merits further monitoring and may prove to be an interesting model for government oversight.

139. EU PHI markets provide an interesting laboratory for testing the effects of deregulation on PHI markets. With the exception of certain primary and duplicate PHI markets – which can be subject to more stringent standards under EU law – member countries have generally been prohibited from imposing requirements beyond prudential standards since the mid-1990s. EU policymakers have begun to question and explore whether these markets merit different, and perhaps more intensive, intervention than other insurance markets.[83] Given their connection to national health systems, the need to assure sales across country lines may merit less concern in this market than other insurance markets which are arguably less country-specific. At the same time, deregulation has the advantage of utilising less government resources and providing the industry with free rein to innovate. Policy makers may also be less concerned with access and equity-related issues arising from supplemental or complementary markets, and decide to leave these markets largely unregulated. As described herein, such a decision will likely result in access and risk selection challenges, in the absence of voluntary industry adherence to certain solidarity principles. However, if governments in EU countries wish to consider changed or increased roles for PHI, it may be useful for them to have enhanced flexibility regarding potential regulatory instruments.

140. The above-described regulatory approaches and government interventions have met with a good degree of success. However, challenges sometimes arise and it is therefore important for governments to continue to monitor the effects of their initiatives, to ascertain whether changes or refinements are warranted.

Useful practices and policy recommendations

141. A combination of issuance and rating reforms, such as adjusted community rating or modified experience rating combined with risk equalisation, or the imposition of premium caps along with cross-subsidies, can alleviate some challenges – such as insurers using another mechanism (*i.e.* selective premium increases) to select risks if they are subject to issuance requirements. However, challenges relating to PHI affordability and access are likely to persist as they are often the product of complex interactions within the PHI market and between the PHI market and other players in health systems. Policy makers thus need to continue to devise creative solutions to these problems. In addition, the continued presence of access-related problems may not, in and of themselves, signal a failure of certain regulations, but rather display their limitations. Regulations, particularly when carefully designed and implemented, can help stabilise markets and promote risk-spreading and fair competition. Selected regulatory mechanisms have been shown to promote purchasing of PHI by population groups that previously did not regard purchasing PHI as a good use of their disposable income or for whom premiums are unaffordable. Fiscal incentives and subsidies can also boost the purchase of insurance and shape a market (*e.g.* through promoting employer coverage) by reducing the net price of insurance take-up. However, untargeted subsidies do not favour price cross-subsidisation across individuals of different risk, while targeting of fiscal subsidies are complex to implement. Furthermore, given price elasticity of demand, eliminating, or significantly reducing, disparities in access to PHI between population groups of different incomes and

83. See European Parliament (2000), FINAL A5-0266/2000, *Report on Supplementary Health Insurance.* Committee on Employment and Social Affairs, Rapporteur: Michel Rocard.

health status, will require the investment of significant financial resources, in some cases beyond the levels of current tax or fiscal advantages. Where publicly funded systems provide meaningful and adequate access to needed health services, the need for such regulatory and fiscal interventions is debatable. Yet where PHI provides the only available coverage, such action is essential if affordable health coverage is to be available to all.

5. Conclusions

142. Private health insurance presents both opportunities and risks for the attainment of health system performance goals. For example, in countries where PHI plays a prominent role, it can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive. However, it has also given rise to considerable equity challenges in many cases and has added to health care expenditure (total, and in some cases, public) in most of those same countries.

143. The impact of PHI on OECD health systems stems in part from the incentives PHI markets create for various health system actors. However, several variables, such as PHI market characteristics and structures, the function that PHI plays within the health system, and policy interventions, have a substantial impact upon its actual performance. In many cases, the degree and types of government intervention influence whether challenges arise or are successfully addressed.

144. Private health insurance is one of many instruments that can help promote health system responsiveness, further governments' health system goals and meet consumer and societal demands. Given trade-offs that often arise in this area, however, some may decide that PHI's benefits are not worth their accompanying costs. Yet most OECD countries have, and will continue to have, some type of PHI market. For many, a key policy question is therefore how best to make use of PHI markets – what role and significance should PHI have within a given health system – rather than the question of whether any market should exist. Country responses to this question will vary, depending upon policy priorities and the historical and health system context. For example, policy makers may have explicit goals for primary PHI markets, and design and impose policies targeted to this type of coverage. At the same time, they may choose not to invest significant resources in regulating other types of PHI, concentrating instead on encouraging equity of access through public coverage. Consumer demand will also influence market developments and help shape policymakers' thinking.

145. As emphasised in this report, the advantages and disadvantages of PHI often depend upon its role within health systems and its interaction with public coverage. Key strengths and weaknesses arising from different PHI roles are:

- A system based on competing primary private insurers can improve responsiveness and consumer choice, but this will come at increased cost. Where private health insurance is primary for certain population groups, ensuring access to affordable coverage will be an important policy consideration. However, regulations to address common primary market failures and promote equity have costs, both in terms of government resources, as well as in terms of diminished insurer flexibility and ability to innovate. Furthermore, it may be particularly challenging to assure adequate access to private coverage for vulnerable populations.

- Duplicate PHI markets can serve as a policy lever to improve systems' responsiveness when policy makers consider it efficient to ration public health expenditure according to persons' willingness to pay. Yet, this type of insurance generally results in differences in access to care and coverage according to insurance status. The degree of differential access that occurs, and the extent to which these access variations are perceived to be equity challenges vary by country. In

addition, while it can help reduce some of the capacity pressures faced by public health systems, it does not significantly reduce public health expenditure.

- In the presence of significant cost-sharing within public systems, complementary health insurance helps ensure access to needed care. However, full private coverage of public sector cost-sharing encourages moral hazard-induced utilisation. Unless some cost-sharing is retained to maintain individual cost awareness, PHI coverage hinders efforts to control public systems' outlays.

- Supplementary PHI markets are less intertwined with public coverage systems, in contrast to other PHI roles. Supplemental coverage of services removed, or delisted, from public coverage can reduce public expenditure. However, insurees' utilisation of supplemental services may still be linked to publicly financed services, resulting in increased public costs as well. Also, since PHI markets generally have less universal reach than public coverage, decisions to de-list services need to balance the desire to reduce public sector cost with the equity implications of no longer covering certain services publicly.

146. PHI also raises certain challenges that cut across its different roles. For example, access to PHI coverage can be an important social objective in systems with universal coverage, where policy makers wish to offer consumers an alternative to universal publicly-financed providers, or where certain medically necessary health services and products are not covered publicly. Yet, policy-makers will need to intervene to address market failures in order to assure PHI access for high-risk groups. In doing so, they can choose from a range of tools. They need to balance the sometimes competing goals of access and the maintenance of a broad and diverse pool of covered lives, particularly in voluntary markets. In addition, governments and insurers should make further strides to ensure meaningful disclosure of policy terms and better dissemination of information in order to enable consumers to make informed decisions between competing PHI products. This would enhance consumer understanding as well as promote transparency and more meaningful competition. Even then, sometimes too great a choice may hamper purchasers' ability to make informed coverage decisions. Policy makers will need to address some of these issues or they will risk undermining their stated goals.

147. This report has provided an overview of some of the more effective instruments and system designs employed by OECD countries with diverse insurance mixes, as they seek to address challenges raised by mixed funding arrangements, encourage access to PHI and bolster consumer confidence in these products. It has highlighted the advantages and disadvantages of various approaches, including the demonstrated strengths and limits of certain fiscal and regulatory instruments, as well as the implications of using one tool in lieu of another. Problems arising from PHI markets can be ameliorated through government intervention, although several issues continue to pose challenges, including how to maximise the effectiveness of various actions. The report has also drawn attention to a number of trade-offs that policy makers must balance when deciding how to best promote their particular policy choices through a mixed public-private insurance system.

148. It is important to be realistic about the potential benefits of competitive PHI markets and what they most likely will *not* achieve. For example, cost-containment within health systems is often best achieved through means other than an expansion of private health insurance's role. Unregulated PHI markets, especially in the absence of other mechanisms to offer affordable coverage to high-risk persons, are inadequately equipped to promote access to coverage for people with chronic conditions and other high-risk persons. On the other hand, serious consideration ought to be given to the value of health system responsiveness, an area where private health insurance has contributed positively to health system performance. Whether or not it is intended or desired, PHI markets interact with health provision and delivery systems in several ways, some of which are advantageous and others less so. The role of PHI

should be structured around policy goals for health financing, as well as broader health systems' policy objectives, to ensure policy coherence. Flexible policymaking is also needed to address promptly any problems and undesirable outcomes that may emerge from the interaction of private PHI markets with public systems.

149. Some important questions also merit further investigation. For example, the impact of private health insurance on quality of care is still under-researched. The mechanisms through which competition in PHI markets can foster health system efficiency are also not well understood. There is limited information about the role of PHI markets in adopting and diffusing new and emerging medical technology, and the way this process interacts with technology assessment in public systems. The pros and cons of private long-term care insurance, as opposed to public health financing, also deserve closer investigation, as clearly do the links between private pension and disability coverage, on the one hand, and PHI markets, on the other. The public at large would benefit from enhanced and expanded efforts to educate them about health coverage options, and the implications of coverage decisions. Furthermore, improved availability of data on private health insurance markets would help to improve policy making and comparative analysis on PHI across OECD countries. Finally, there is room for further reflection regarding how best to strike a balance between the sometimes competing goals of ensuring equity, promoting flexibility, and preserving efficiency incentives within PHI markets. While the desired and permitted role for PHI remains a country-specific policy choice, answers to these and other questions would advance evidence-based policy making in this area.

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