

Private Health insurance in the OECD

Benefits and costs for individuals and health systems

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

Outline

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

Background

Part of OECD Health Project

Working Papers:

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






www.oecd.org/els/health/workingpapers

Final Report

- PHI in OECD Countries (autumn 2004)



Method

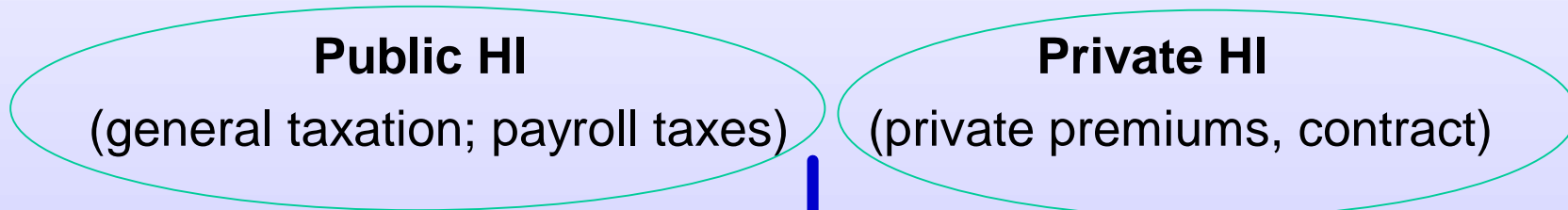
-  Taxonomy
-  Analytical framework
-  Data collection: PHI statistics and policies
-  Literature review
-  Case studies

Taxonomy - What is PHI?

INSURANCE: prepayment and pooling



on the basis of the main source of financing:



BUT: Borderline cases:

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

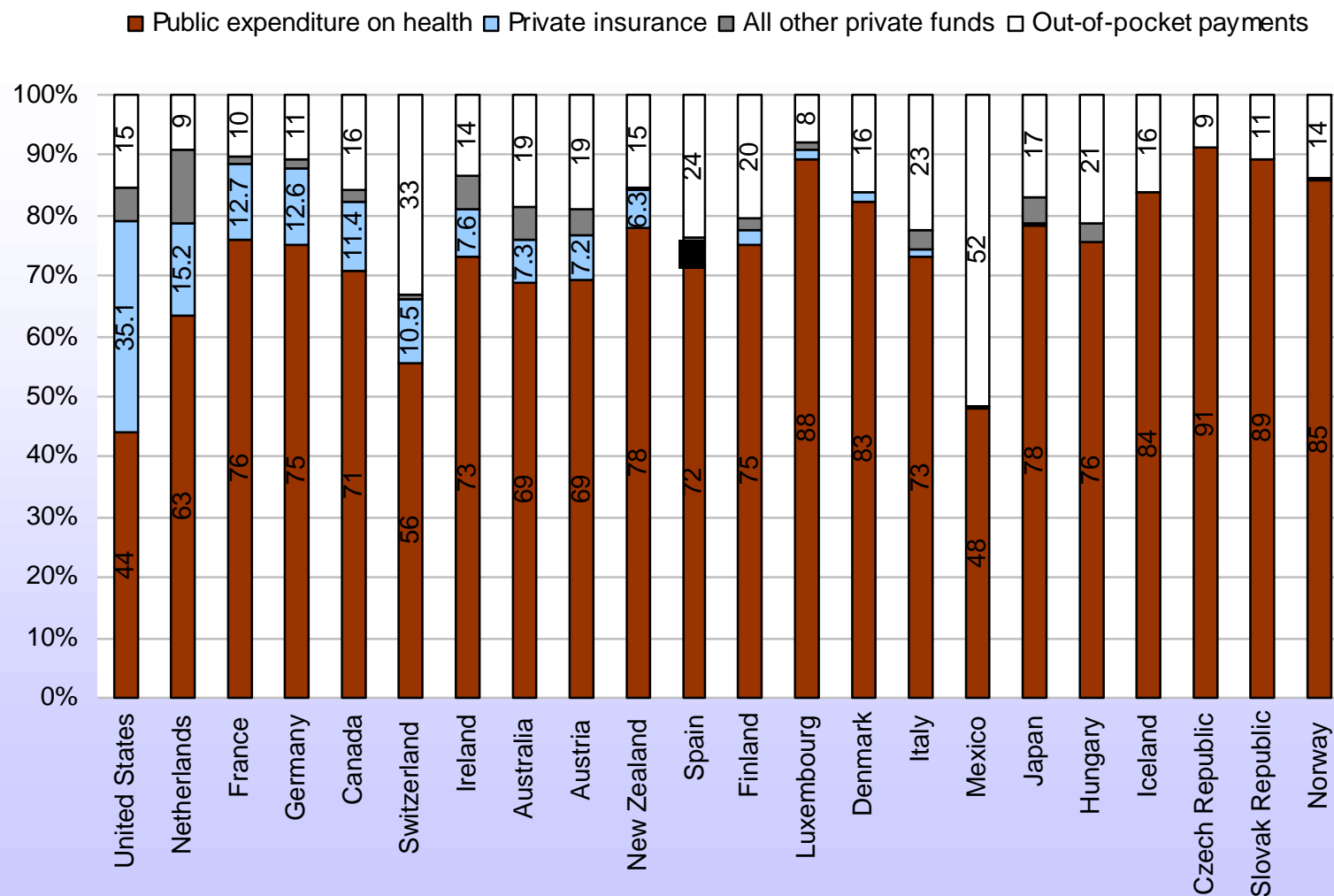
Taxonomy - PHI role

Depend on structure of public systems

		YES	NO
		Duplicate	Substitute /principal
		Complementary	
		Supplementary	

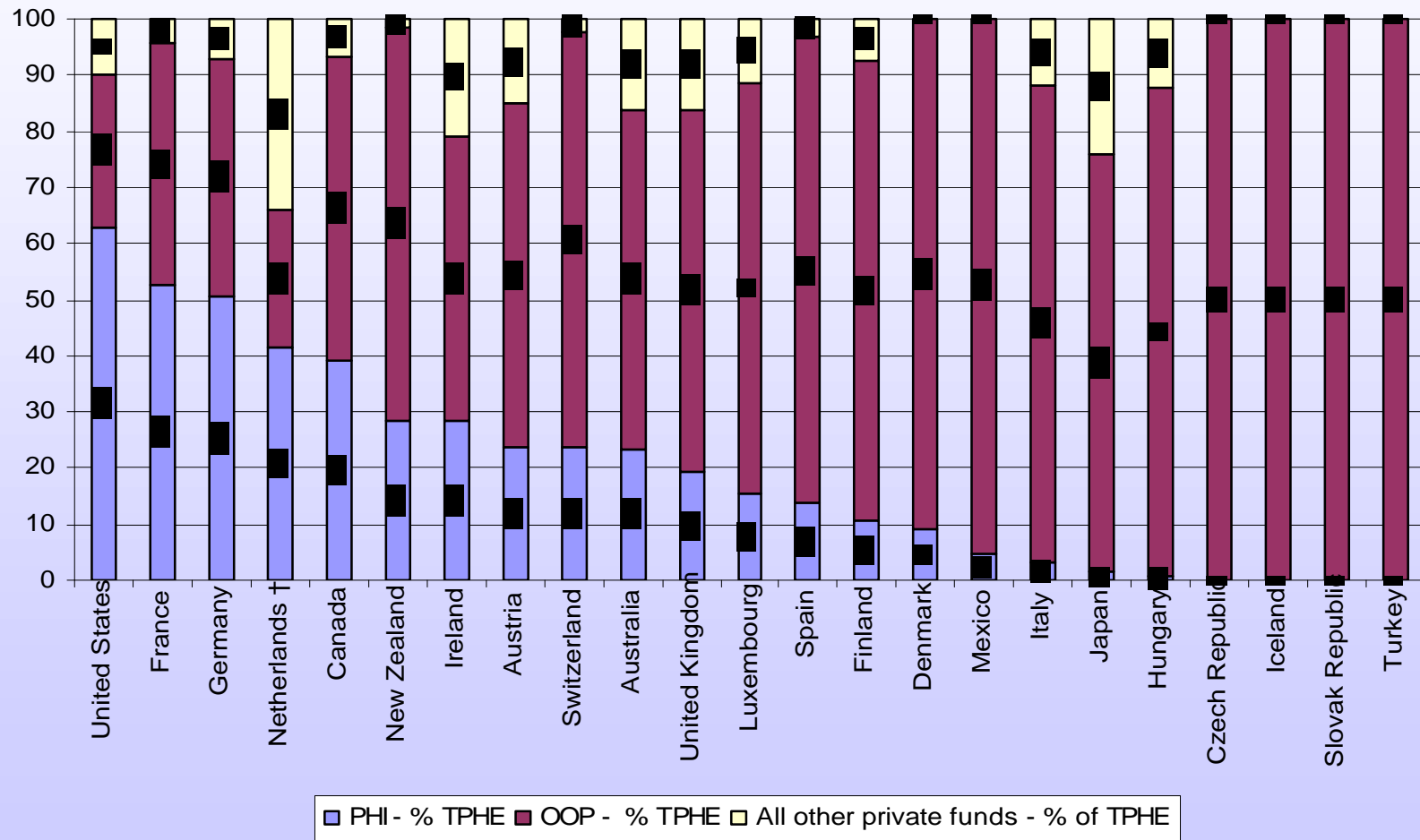
PHI markets

Sources of health finances



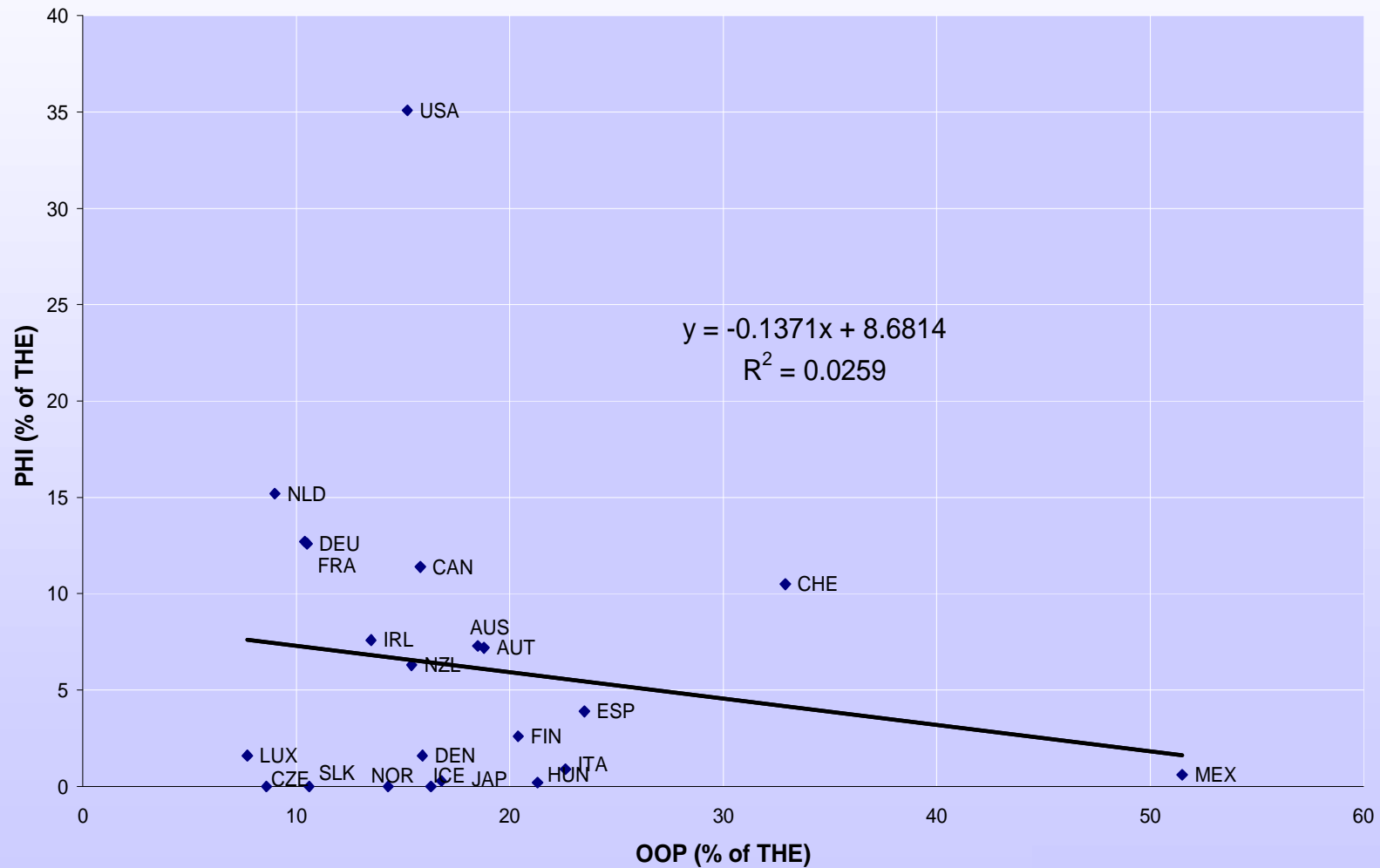
Source: OECD Health Data 2003.

Private spending breakdown



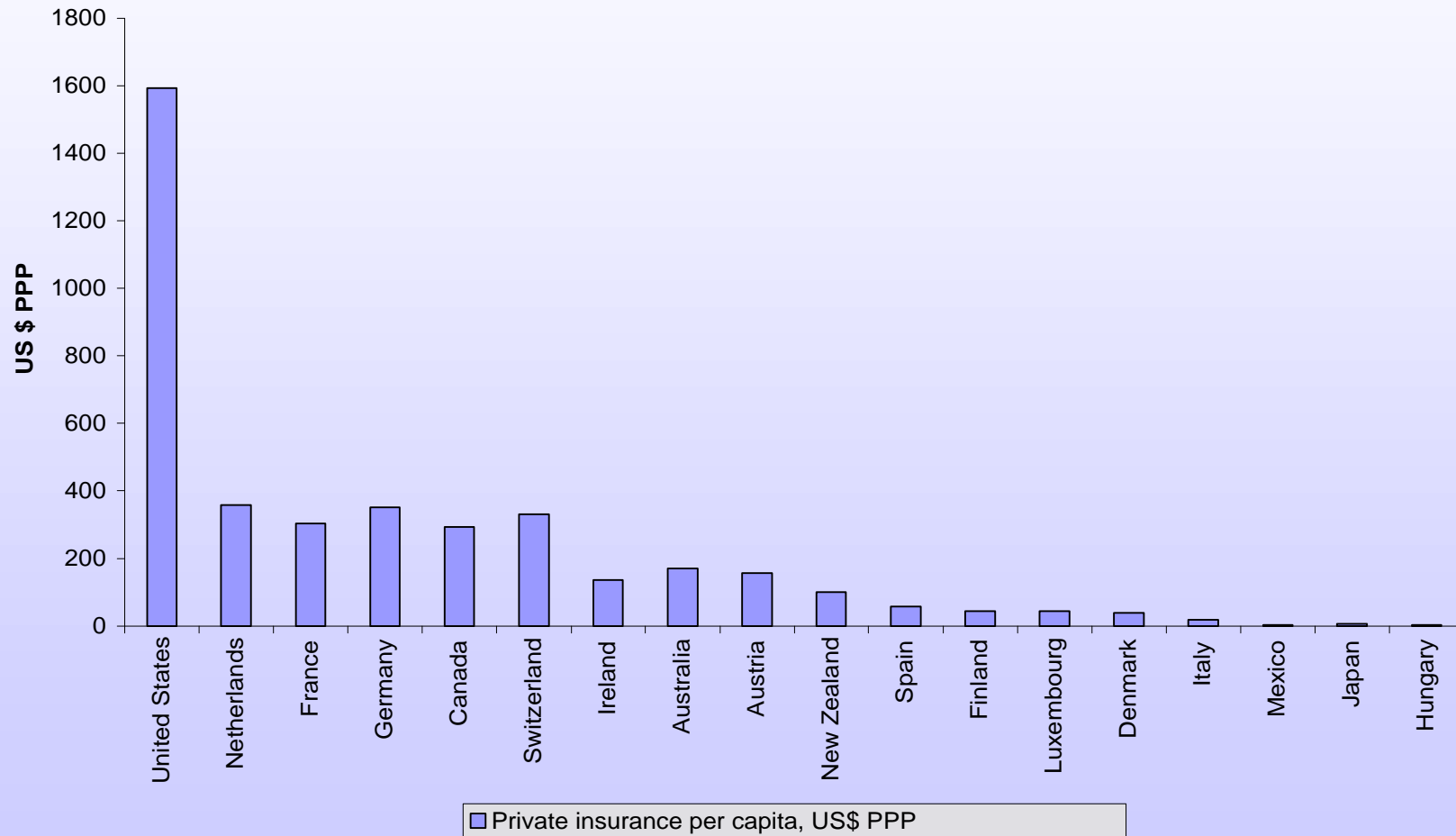
Source: OECD Health Data 2003.

PHI not substituting for OOP



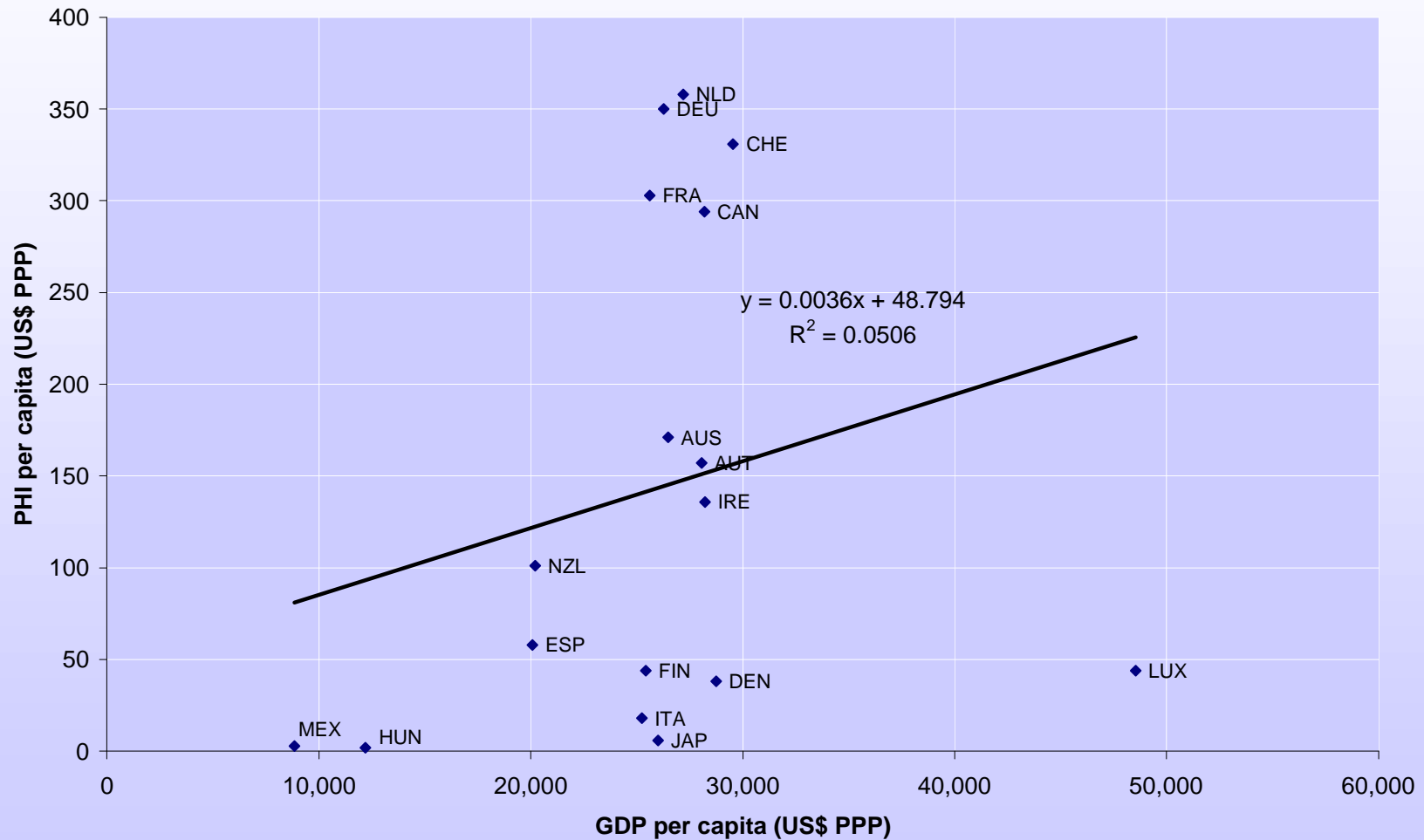
Source: OECD Health Data 2003.

Variation in PHI spending p.c.



Source: OECD Health Data 2003.

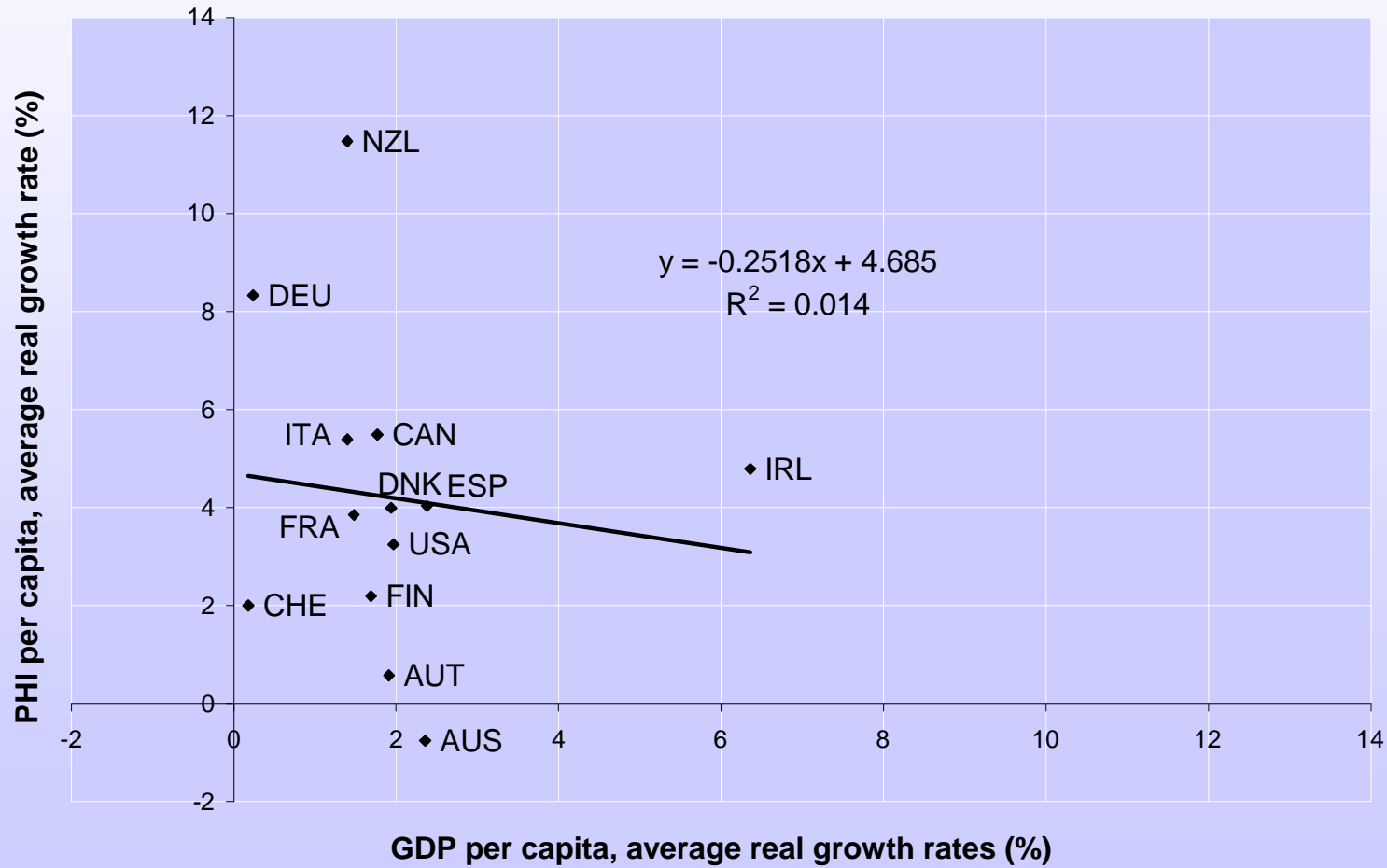
PHI not correlated with GDP



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

Source: OECD Health Data 2003.

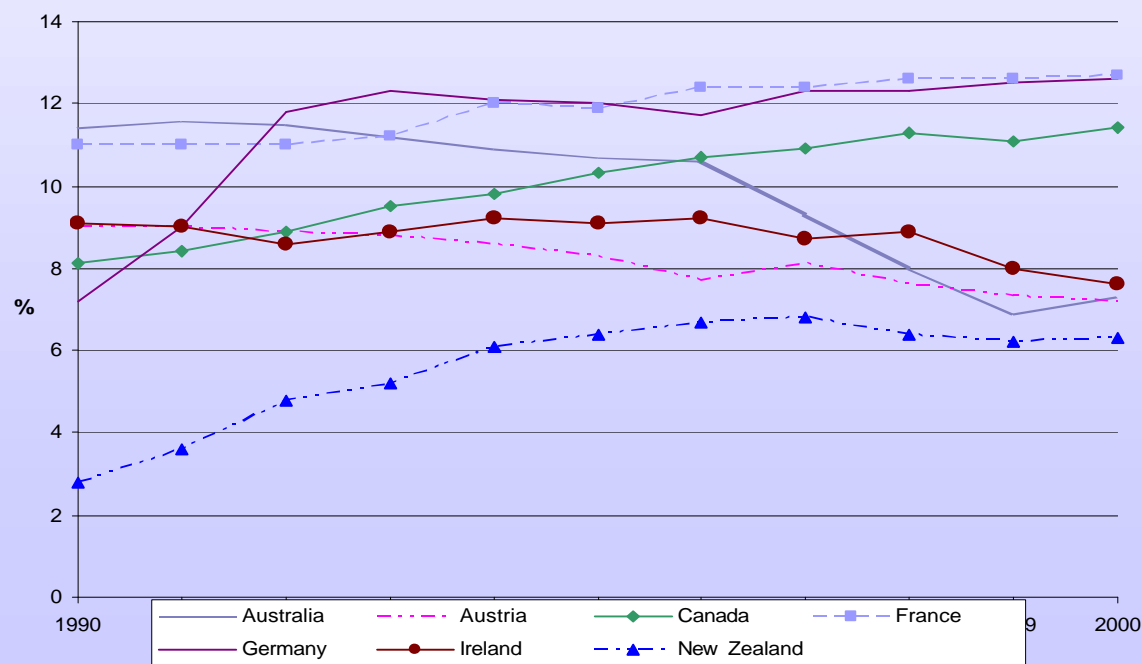
Real GDP and PHI growth 1990-2000



Source: OECD Health Data 2003.

PHI financing slightly growing 1990-2000

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



Source: OECD Health Data 2003.

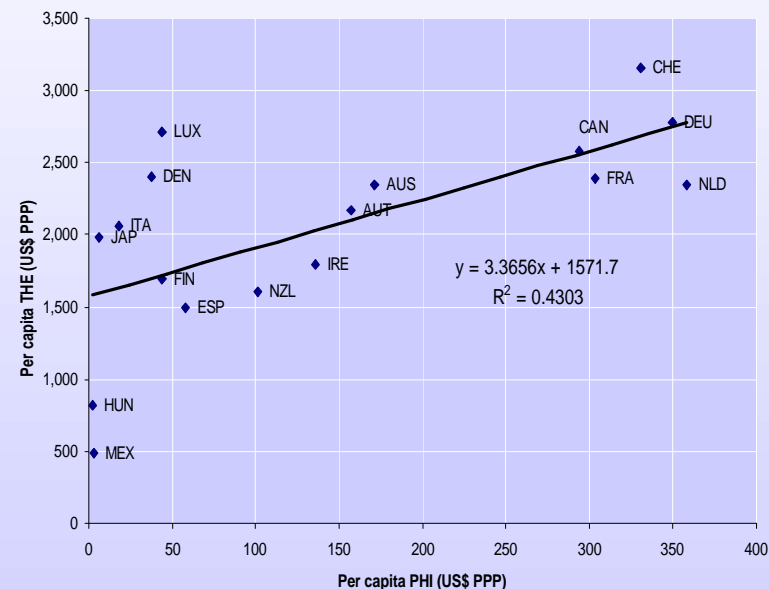
PHI and THE

Weak correlation, especially if U.S. is excluded

Countries with either:

- High PHI share in THE
- High PHI pop. coverage

tend to have high per capita health spending (U.S., CH, Germany, France)



Source: OECD Health Data 2003.

Why differences in market size?

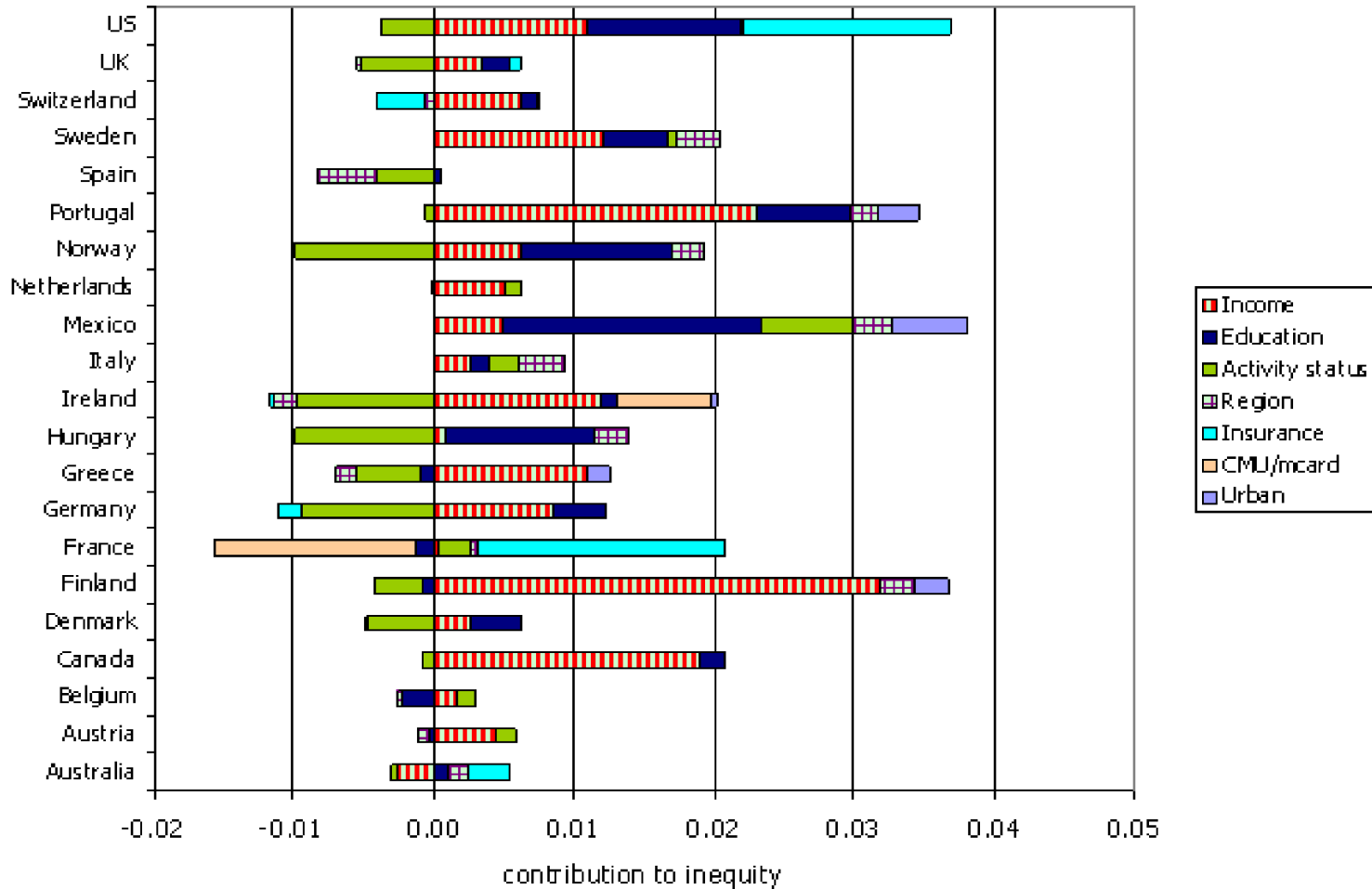
- 📦 Historical factors
- 📦 Public policy
 - Entitlement to public coverage
 - Degree of policy support to PHI (individual responsibility; fiscal/regulatory interventions)
- 📦 Role of employers: growing
- 📦 Perception of public sector quality (waiting times)

Impact of PHI, useful practices

Access to Care

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

Decomposition: prob. of doctor visits



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

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

Useful practices: equity

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

Access to PHI coverage

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

Useful practices: PHI coverage

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

Responsiveness

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

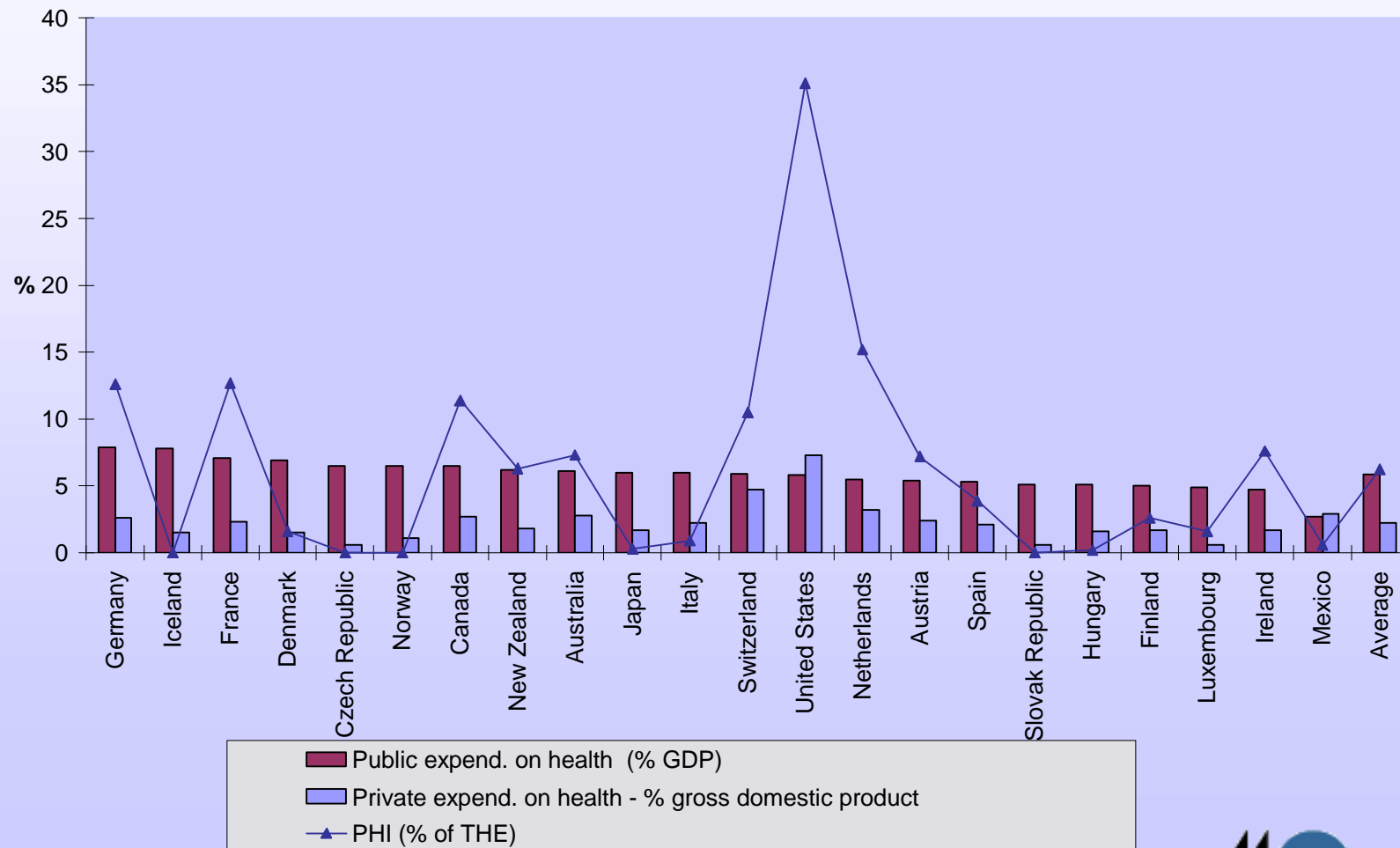
Useful practices: choice

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

Economy: little cost shifting

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

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



Source: OECD Health Data 2003.

Economy: add to THE

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

Useful practices: Economy

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

Efficiency

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

Useful practices: Efficiency

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

In sum

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

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