Private Health insurance in the OECD

Benefits and costs for individuals and health systems

Francesca Colombo, OECD
AES, Madrid, 26-28 May 2004

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

- **Final Report**
  - PHI in OECD Countries (autumn 2004)

www.oecd.org/els/health/workingpapers
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:

- **Public HI**
  - (general taxation; payroll taxes)

- **Private HI**
  - (private premiums, contract)

**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

<table>
<thead>
<tr>
<th>Eligibility to public HI</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services covered by PHI</td>
<td>Duplicate (UK, EIRE, Aus, Sp, Ita)</td>
<td>Substitute/principal (USA, Ger, NL, CH, Sp)</td>
</tr>
<tr>
<td>Same services covered by public health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-payments on publicly insured services</td>
<td>Complementary (Fr, USA, Bel)</td>
<td></td>
</tr>
<tr>
<td>Additional extra services</td>
<td>Supplementary (CH, NL, Ger, Can, etc.)</td>
<td></td>
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</tbody>
</table>
PHI markets
<table>
<thead>
<tr>
<th>Country</th>
<th>PHI share of THE (2000)</th>
<th>Population covered %</th>
<th>Main PHI Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>OECD average</td>
<td>6.3</td>
<td>About 30%</td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>35.1</td>
<td>72</td>
<td>Primary</td>
</tr>
<tr>
<td>Netherlands</td>
<td>15.2</td>
<td>28/64</td>
<td>Primary/Suppl.</td>
</tr>
<tr>
<td>France</td>
<td>12.7</td>
<td>92</td>
<td>Compl.</td>
</tr>
<tr>
<td>Germany</td>
<td>12.6</td>
<td>18</td>
<td>Primary/Suppl.</td>
</tr>
<tr>
<td>Canada</td>
<td>11.4</td>
<td>65</td>
<td>Suppl.</td>
</tr>
<tr>
<td>Ireland</td>
<td>7.6</td>
<td>43.8</td>
<td>Duplic.</td>
</tr>
<tr>
<td>Australia</td>
<td>7.3</td>
<td>44.9</td>
<td>Duplic.</td>
</tr>
<tr>
<td>Spain</td>
<td>3.9</td>
<td>2.7/10.3</td>
<td>Primary/Duplic.</td>
</tr>
</tbody>
</table>

Source: OECD Health Data 2003, PHI Statistical questionnaire and other official sources.
Sources of health finances

Source: OECD Health Data 2003.
Private spending breakdown

Source: OECD Health Data 2003.
PHI not substituting for OOP

\[ y = -0.1371x + 8.6814 \]
\[ R^2 = 0.0259 \]

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

\[ y = -0.2518x + 4.685 \]

\[ R^2 = 0.014 \]

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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Then click on: Private Health Insurance

francesca.colombo@oecd.org