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Private Health Insurance in OECD Countries
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*Chapter 1*

# Introduction

*This chapter provides an introduction to this report. It explains why OECD has undertaken a study on private health insurance, and the policy relevance of the analysis. It also illustrates the analytical framework underpinning all chapters. This framework applies both to the review of private health insurance markets, and to the analysis of their impact on health system performance. The chapter also describes the methodology adopted, as well as the sources of information that were gathered. It finally explains how the report is structured.*

## 1. Why an OECD study on private health insurance?

Policy makers in OECD health systems face many challenges, but the question of how best to finance their health care systems remains at the forefront of their concerns with no easy answer at hand. This question is particularly complex because it involves balancing several policy goals, ranging from the equity of financing to the need to ensure adequacy and sustainability of funding.

The relative merits of private health insurance (PHI) as a health financing option have generated considerable attention among policy makers over the past few decades, although starting from diverging viewpoints. For example, proponents have lauded the potential for PHI to reduce cost pressures confronting OECD health systems and to improve their efficiency and responsiveness to individualised needs. Concurrently, critics have denounced PHI markets' tendency to price vulnerable groups out of the market and undermine governments' efforts to regulate the cost of health systems. Policy makers' goals for PHI – including its desired role within health systems – also vary tremendously, and involve considerable trade-offs.

This study explores the relative advantages and drawbacks of PHI markets, within the context of different policy goals and health system roles. It sets forth the main findings of an OECD analysis of private health insurance markets, their interactions with publicly financed health schemes, and their impact on health systems as a whole.[1]

## 2. Analytical framework and scope of this study

Figures 1.1 and 1.2 set forth the analytical framework used for this study. Government occupies a central role in shaping health insurance markets and their impact on health systems. Its influence is felt not only through its direct interventions towards private health insurers but also through broader government policies towards health and social systems, tax and benefit arrangements and insurance markets.

PHI markets do not operate in isolation. Rather, as shown in Figure 1.1, they interact with public coverage systems and sometimes overlap in the services they provide and the population they serve. Private health insurers enter into contractual arrangements with insurees, and, in some cases, with providers of services. The interaction among these structures and actors, and the financial flows and other resources across them, affect health system performance.

The impact of PHI on health systems can be measured along several key dimensions. Policy makers aim to maximise a set of policy goals, including micro efficiency (health improvement and responsiveness to consumers for any given level of health expenditure), macro efficiency (the level of health expenditure which equates the marginal benefit of services to the marginal cost), and equity (fair distributions of health, health care utilisation and health expenditure across their populations). Instrumental goals include, among others, the development of an environment conducive to innovation in health care



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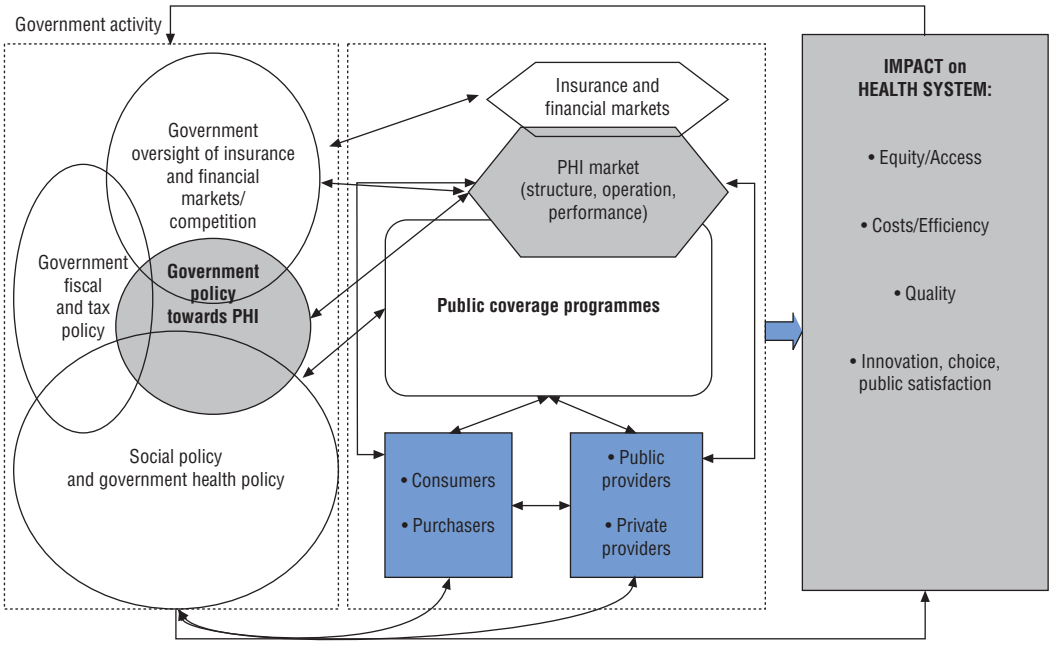
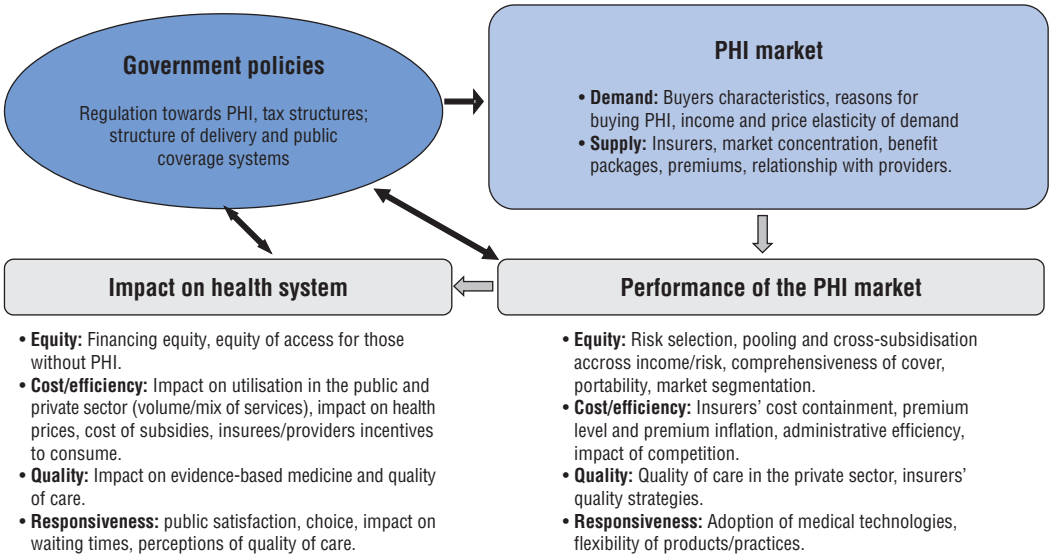
Figure 1.1. **Analytical framework for the OECD private health insurance study**




*Source:* OECD.

Figure 1.2. **Key variables for an analysis of PHI markets**




*Source:* OECD.

financing and provision, as well as the promotion of consumer choice. Judgements about the relative importance of these goals vary across countries.[2]

This study assesses the role of private health insurance as it interacts with public health insurance schemes, examining its related advantages and disadvantages and impact upon health systems. It analyses and identifies those conditions that most favour the development of an efficient and equitable health insurance market. As part of this

overall evaluation, the study examines the social, economic, financial and regulatory characteristics of different mixes of public and private health financing.

The development of PHI markets has depended on the history and culture of OECD member countries, governmental or policy maker priorities, and certain philosophical or ideological preferences. Evidence about the effects of different types of health financing institutions has also shaped policy makers' views towards the desirability of private health insurance – yet arguably to a more limited extent. Values vary sharply across OECD countries on the priority to be given to individual choice, private initiative, solidarity, and collective or public institutions in health care systems. As a result of these and other factors, there is considerable variation in the scope and role of private health insurance across OECD countries. Variations in history, values and institutions, likely limit the scope of lessons to be drawn from comparing experiences with PHI across countries. Nevertheless, certain subgroups of OECD countries display sufficient similarity in their insurance mixes to make international comparisons fruitful. In addition, there are a number of challenges which arise in most or all OECD countries with PHI markets.

## 3. Methodology of the study

PHI refers to heterogeneous private health financing schemes and approaches across OECD countries. Yet the meanings attributed to "public" and "private" health insurance are not uniform. In order to carry out analysis on PHI, a typology of health insurance schemes has been developed, delineating the precise scope of the study and classifying the interaction between public and private health insurance (OECD, 2004b). The line between public and private health insurance has been drawn according to the main source and mechanisms of financing – with private health insurance being defined as health coverage derived mainly through private, non-income related payments.[3]

Data used in this study have been gathered using multiple sources and different information collection mechanisms. Primary data were collected through two survey instruments sent to national authorities of all OECD countries: a statistical questionnaire on private health insurance markets,[4] and a regulatory questionnaire on governmental interventions towards PHI.[5] An extensive literature survey was also conducted. In addition, country-specific case studies have been undertaken to examine the role and impact of PHI on health-system performance in selected OECD countries.[6]

## 4. How this report is structured

The four chapters which follow this introduction present the primary analytic results of the OECD Study on Private Health Insurance in member countries.

Chapter 2 analyses the diversity of private health insurance arrangements across OECD countries, explaining influences behind the heterogeneity of functions, sizes and structures of markets. It defines private health insurance, elaborates upon the roles it plays within the health financing systems of OECD countries, and assesses the main features of PHI markets. Chapter 2 also highlights several aspects of PHI markets and their interaction with public systems that can give rise to potential opportunities and challenges for health system performance.

Chapter 3 describes the range of government interventions and regulations towards PHI markets, highlighting their connection with identified policy goals and challenges. It includes analyses of the impact of some of these interventions, when available. It also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highlights challenges arising from the regulation of particular roles of PHI, as well as those that occur more commonly across PHI markets.

Chapter 4 assesses the impact of PHI markets on health systems and their performance. This includes an analysis of the contribution of private health insurance to access to health insurance, as well as any effect on the equity of financing and of access to health care. Private health insurance's contribution to choice, responsiveness and innovation is assessed. The chapter also analyses the impact of PHI on public and total health cost, as well as on health system efficiency. While the analysis draws mainly from evidence gathered from a selected number of OECD countries (case study countries and others with prominent PHI markets), it also highlights some of the parallel and divergent experiences of some other countries.

Chapter 5 synthesises and sets forth the key policy conclusions and lessons derived from the analyses contained in the preceding chapters. It highlights the extent to which private health insurance has contributed to, or detracted from, the attainment of health system objectives. The chapter also draws attention to those governmental interventions that have been particularly successful in addressing challenges arising from PHI markets. It closes with some forward-looking reflections on the opportunities and risks presented by PHI markets, highlighting some areas meriting further investigation.

### *Notes*

1. The study on private health insurance is one component of a larger OECD Health Project that has investigated several areas of health systems' performance. The main findings from the Project component studies are described in the Project's final report *Towards High-Performing Health Systems* (OECD, 2004a).
2. This analytical approach is consistent with a framework for assessing the performance of health systems, which was developed for the overall OECD Health Project.
3. Chapter 2 includes the definitions and typology used in this study.
4. The questionnaire collected data on premiums, claims, population coverage, share of total health expenditure covered by private health insurance and market structure.
5. Both questionnaires were distributed to relevant authorities from all OECD member countries. As multiple ministries or agencies are often involved in the oversight of PHI markets within OECD countries, responses have been co-ordinated amongst relevant ministries or agencies. Reliable estimates, or data from non-governmental sources, were included in the absence of governmental data.
6. Case studies were carried out in Australia, Ireland, and the Netherlands (Colombo and Tapay, 2003 and 2004a; Tapay and Colombo, 2004). A study on the health insurance system and prospective role for private health insurance in Slovakia was also carried out (Colombo and Tapay, 2004b). These studies include in-depth analyses of the role and impact of PHI in each system, informing the comparative analysis contained in this report. Each case study involved focused, structured interviews with main stakeholders and an extensive review of academic, policy and technical material relating to the country's health insurance mix and PHI market.

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# List of Acronyms

| | |
|---|---|
| **AARP** | American Association of Retired Persons |
| **ABI** | Association of British Insurers (United Kingdom) |
| **ACCC** | Australian Competition and Consumer Commission (Australia) |
| **AFSCME** | American Federation of State, County and Municipal Employees (United States) |
| **AHIP** | America's Health Insurance Plans (United States) |
| **ASIC** | Australian Securities and Investments Commission (Australia) |
| **ASO** | Administrative Services Only (United States) |
| **AWBZ** | De Algemene Wet Bijzondere Ziektekosten (Exceptional Medical Expenses Act, Netherlands) |
| **CLHIA** | Canadian Life and Health Insurance Association (Canada) |
| **CMS** | Centers for Medicare & Medicaid Services (United States) |
| **CMU** | Couverture Maladie Universelle (Universal Health Coverage, France) |
| **CPI** | Consumer Price Index |
| **CONDUSEF** | Comisión Nacional para la Protección y Defensa de los Usuarios de Servicios Financieros (National Commission for the Protection and Defence of Financial Service Users, Mexico) |
| **DG** | Directorate General |
| **DHHS** | Department of Health and Human Services (United States) |
| **DOHA** | Department for Health and Ageing (Australia) |
| **DOHC** | Department for Health and Children (Ireland) |
| **DOL** | Department of Labor (United States) |
| **EBSA** | Employee Benefits Security Administration (United States, Department of Labor) |
| **ERP** | External Review Programs (United States) |
| **ERISA** | Employee Retirement Income Security Act (United States, Department of Labor) |
| **EU** | European Union |
| **FMA** | Financial Market Authority |
| **FMABG** | Finanzmarktaufsichtsbehördengesetz (Financial Market Supervisory Act, Austria) |
| **FOS** | Financial Ombudsman Service (United Kingdom) |
| **FSA** | Financial Supervisory Authority (Germany) |
| **FSAs** | Flexible Spending Accounts (United States) |
| **GDP** | Gross Domestic Product |
| **GI** | Guaranteed Issurance |
| **GISC** | General Insurance Standards Council (United Kingdom) |
| **GP** | General practitioner |
| **HEDIS** | Health Plan Employer Data and Information Set (United States) |
| **HIC** | Health Insurance Commission (Australia) |
| **HMO** | Health Maintenance Organisation (United States) |
| **HIPAA** | Health Insurance Portability and Accountability Act (United States) |
| **HIPPA** | Health Insurance Privacy and Portability Act (United States) |

| | |
|---|---|
| **HRAs** | Health Reinbursment Arrangements (United States) |
| **HSA** | Health Savings Accounts (United States) |
| **IPA** | Individual Practice Association (United States) |
| **ISES** | Instituciones de Seguros Especializados en Salud (Specialised Health Insurance Institutions, Mexico) |
| **ISFAS** | Instituto Social de las Fuerzas Armadas (Social Institute for the Army, Spain) |
| **LAMal** | Loi Fédérale sur l'Assurance Maladie (Federal Health Insurance Law, Switzerland) |
| **LTC** | Long-term Care |
| **LSE** | London School of Economics |
| **MBS** | Medicare Benefits Schedule (Australia) |
| **MLS** | Medical Levy Surcharge (Australia) |
| **MOOZ** | Medefinanciering oververtegenwoordiging oudere ziekenfondsverzekerden (Act on Co-financing the Overrepresentation of Elderly on the Sickness Fund Scheme, Netherlands) |
| **MSA** | Medical Savings Accounts (United States) |
| **MUGEJU** | Mutualidad General Judicial (General Mutual for the Judicial System, Spain) |
| **MUFACE** | Mutualidad General de Funcionarios Civiles del Estado (General Mutual for Civil Servants, Spain) |
| **NAIC** | National Association of Insurance Commissioners (United States) |
| **NCQA** | National Committee on Quality Assurance (United States) |
| **NHA** | National Health Act (Australia) |
| **NYCRR** | New York State Codes Rules and Regulations |
| **OECD** | Organisation for Economic Co-operation and Development |
| **OHPSCA** | Office of Health Plan Standard and Compliance Assistance (United States, Department of Labor) |
| **OPAC** | Office of Participant Assistance and Communications (United States, Department of Labor) |
| **OOP** | Out-of-pocket expenditure |
| **OSFI** | Office of the Superintendent of Financial Institutions (Canada) |
| **PEA** | Pre-Existing Ailment |
| **PHI** | Private Health Insurance |
| **PHIAC** | Private Health Insurance Administration Council (Australia) |
| **PHIIS** | Private Health Insurance Incentive Scheme (Australia) |
| **PHIO** | Private Health Insurance Ombudsman (Australia) |
| **PHIQS** | Private Health Industry Quality and Safety Committee (Australia) |
| **PLC** | Public Limited Companies |
| **PPO** | Preferred Provider Organization (United States) |
| **PRSI** | Pay Related Social Insurance Contributions (Ireland) |
| **PSO** | Provider service organization (United States) |
| **RE** | Risk Equalisation (Scheme) |
| **SCHIP** | State Children's Health Insurance Program (United States) |
| **THE** | Total expenditure on health |
| **TPA** | Third Party Administrators |
| **TPHE** | Total private expenditure on health |
| **URAC** | Utilization Review Accreditation Commission (United States) |
| **VHI** | Voluntary Health Insurance (VHI Healthcare, Ireland) |
| **WTZ** | Act on Access to Insurance (Netherlands) |
| **WHO** | World Health Organisation |
| **ZFW** | Ziekenfondswet (Health Insurance Act, Netherlands) |
| **ZN** | Zorgverzekeraars Nederland (Association of Dutch health Insurers, Netherlands) |


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# *Preface*

This report is the first-ever comparative analysis of the role and performance of private health insurance (PHI) in OECD countries. It offers policy insights on the role of private markets and governments in financing health systems that are relevant for both OECD countries and non-members. The analysis focuses on a set of policy questions, such as the impact of PHI markets on access to coverage and care, their contribution to health system responsiveness, and implications for cost and efficiency of health systems. Policy makers will also find an assessment of useful governmental interventions. Regulatory mechanisms, financial incentives, and broader health policy interventions that can help deliver equity, efficiency, and responsiveness from different health insurance mixes are analysed.

The report starts with an analysis of PHI markets and identifies policy issues arising from their interdependence with public health coverage schemes. It then reviews trends and challenges arising from regulation of private health insurance markets. It continues with an assessment of the impact of PHI against health policy objectives, discussing costs and benefits related to private health insurance in different insurance mixes. The analysis identifies strengths but also areas where private health insurance might detract from health system performance. Governmental interventions that can help private health insurance markets to promote health systems' performance and useful practices for the development of an efficient and equitable health insurance market are also presented.

The report is based on multiple sources of information. Primary data were collected through a questionnaire of PHI markets statistics and a questionnaire on regulation. Information was also obtained from OECD *Health Data*, policy documents and administrative data supplied by OECD countries' authorities, and a comprehensive review of the academic literature. Several case studies were carried out to gain an in-depth understating of the PHI markets in selected OECD countries that feature a prominent role for private health insurance. Case studies involved a visit to the country where all main stakeholders were interviewed. Several issues for further research have emerged. The study highlights shortfalls in existing data and information sources that hamper efforts to assess fully the implications of PHI markets for health-system performance.

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