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Private Health Insurance in OECD Countries
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Chapter 2

The Role of Private Health Insurance in Mixed Systems of Health Care Funding

This chapter describes the heterogeneity of experiences with private health insurance across OECD countries, and identifies clusters of countries where PHI presents common features and factors explaining differences in PHI markets across OECD countries.

In particular, this chapter addresses the following questions:

What is private health insurance? What roles does PHI play within the health financing systems of OECD countries? What are the characteristics of PHI markets in different OECD countries: What is the size of PHI markets? How are health risks insured by public or private insurance systems? Who buys PHI and what drives demand for PHI? Who supplies PHI, and how are PHI markets structured? How is the relationship between insurers and providers? What recent trends can be observed in PHI markets? What factors explain differences in development of PHI markets and roles?

1. Introduction

Private health insurance (PHI) refers to diverse health care funding arrangements in different national contexts. There is a large heterogeneity of experiences with private health insurance across OECD countries, not only for levels of population coverage and prominence in financing health systems, but also in terms of characteristics of demand and supply of private health insurance.

This chapter provides an overview of PHI markets in OECD countries. It explains the role that PHI plays in the health economy of member countries, and describes recent or significant trends. While recognising that drawing a line between different coverage types may at times not be clear-cut, this chapter sets forth a conceptual framework for distinguishing public from private health insurance, and for analysing the interaction between PHI and public health coverage systems. It then describes key characteristics and trends in PHI markets, such as levels of population and types of risk covered, the demand for PHI, and the structure of the market. Explanatory factors behind differences in market developments – ranging from historical developments to the degree of comprehensiveness of public coverage and intensity of policy support towards PHI markets – are then outlined.

2. A taxonomy of health insurance types[1]

2.1. *What is health insurance*

Health systems are financed through a variety of mechanisms, of which health insurance is one. Health insurance can be defined as a way to distribute the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time (pre-payment) and over different individuals (pooling) (Table 2.1). It differs from out-of-pocket payments which do not pool risks nor pre-pay for health care costs. Medical savings accounts, conversely, provide only for pre-payment, although they are often coupled with an insurance scheme.

Table 2.1. **Alternative options for financing health care**

		Prepayment	
		NO	YES
Pooling	NO	Out-of-pocket payments	Medical Savings Accounts
	YES	Spontaneous charity	Health Insurance

Notes: Pre-payment: Collection and management of revenues so that contributions for the health care system are collected from individuals prior to (and independently from) the utilisation by individuals of health services. *Pooling*: Collection and management of revenues in such a way to ensure that the risk of having to pay for health care is borne by all members of the pool and not by each contributor individually (WHO, 2000).

Source: OECD (2004a).

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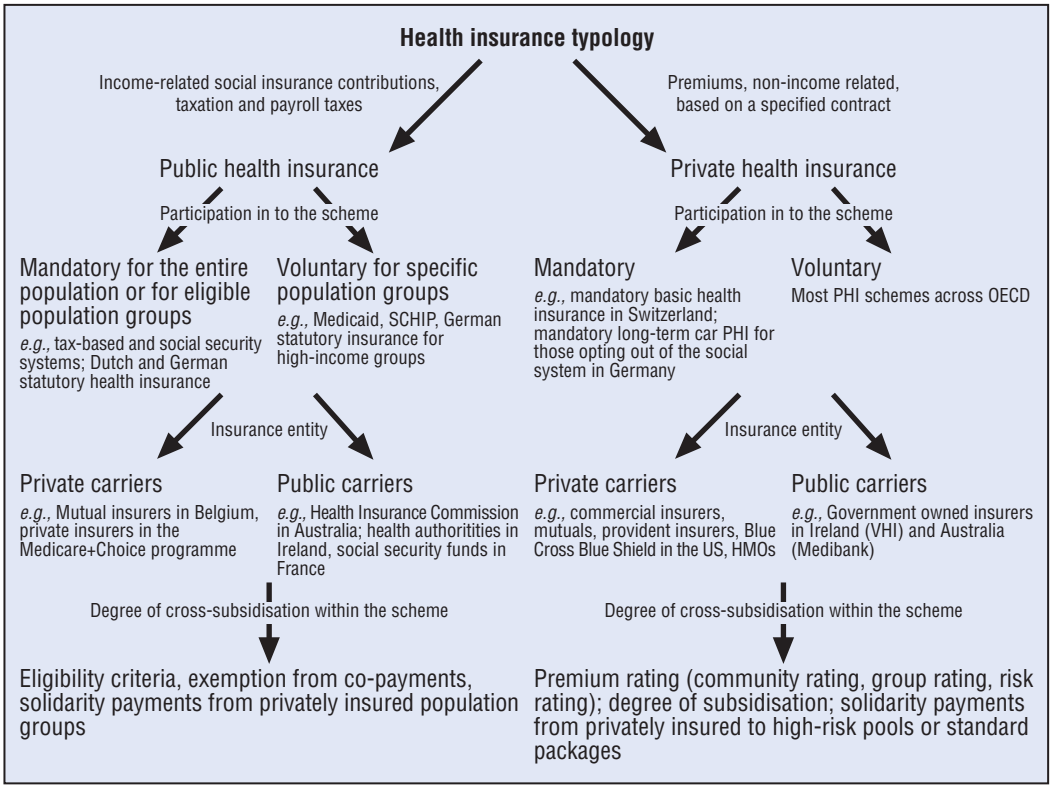
2.2. Public and private health insurance

Health insurance arrangements differ in the degree of cross-subsidisation (across time, risks and income groups) inherent in the scheme, the ownership and management of the scheme, the level of compulsion in participation, and the sources of funding (OECD, 2004a). In this report, the main method of financing health care coverage serves as the primary distinction between public and private health insurance (Figure 2.1). *Public health insurance* includes health coverage mainly financed through taxation or income-related payroll taxes including social security contributions.[2] *Private health insurance*, by contrast, is coverage of a defined set of health services financed mainly through private non-income related payments (premiums) made to an insuring entity or mutual pool.[3] This insurance guarantee is usually set forth in a contract between a private party and the insurance entity that spells 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.

Figure 2.1. **Typology of health insurance arrangements**



Source: OECD.

PHI arrangements can differ along several variables (OECD, 2004a). It is generally, but not always, of a voluntary nature, although participation may be set forth by the conditions of employment. It includes group schemes, usually covering employees of a company, as well as individual contracts. PHI can be supplied by a variety of insurance entities, usually private, which sometimes establish a direct relationship with providers. Premiums are typically risk-rated; however, as a result of regulation or voluntary insurers' practices, they

may be adjusted for the average risk of a group or a community (the latter is often termed "community-rating"). Varying government polices impact upon the way PHI is regulated, and the levels of subsidies directed towards these schemes (see Chapter 3).

Certain health-sector reforms have blurred the boundaries between private and public health insurance, for example by regulating and subsidising PHI extensively.[4] Furthermore, some financing schemes may not be easily classified as public or private on the basis of the criteria chosen for this report. Other ways to distinguish public from private health insurance can be proposed and are indeed used in the literature and by governments. These distinctions can be based, for example, on the public or private nature of the entity administering cover; the existence of a profit motive driving insurers offering it; the voluntary or statutory nature of cover;[5] the extent to which an insurance entity actually bears risk; insurers' flexibility to base their decisions upon business practices, which depends on the intensity of regulation; and whether coverage falls under general insurance law or laws specific to health insurance.[6] A few of these factors are discussed in Box 2.1 below.

2.3. Private health insurance interacts with public coverage systems in different ways

PHI can have different roles in mixed systems of funding health care. Such roles are either the result of specific regulation requiring or prohibiting certain types of private health cover (see Table 2.2, p. 35), or the effect of strategic insurer behaviours. The role of private health insurance *vis-à-vis* public health insurance depends upon two primary variables: whether *individuals* buying PHI are also eligible for part of public health insurance systems; and whether PHI offers cover for *health care services* that are already covered by public health insurance or, for individuals without public health insurance, by a PHI policy representing their primary form of cover (Figure 2.2). The four different functional categories under which PHI can be divided are defined in Box 2.2.

PHI plays a leading role in financing health care in a few OECD countries and a supporting role in many others. In a few countries, it is a main pillar of financing basic health care for large or significant sections of the population, who are either not eligible for public health insurance or have chosen to opt out of such cover (principal/substitute function). In a number of countries with universal public insurance for basic health care, PHI provides duplicate cover that parallels some or all of the cover guaranteed by public insurance systems (duplicate function). In many countries with universal health cover for basic care, PHI offers supplementary insurance for risks outside the basic or publicly insured package (supplementary function). Finally, in a number of countries with public insurance, PHI offers complementary cover for the cost sharing required by the public system (complementary function). In most OECD countries, PHI has more than one function, although usually one prominent or main role can be identified in all countries.

3. Characteristics of private health coverage in OECD countries

3.1. Different functions of PHI across public-private financing mixes in OECD countries

OECD governments have adopted three different approaches to ensure broad population coverage. A first group of countries has achieved universal or near-universal cover through a national public health system (*e.g.*, the Nordic, Mediterranean and Eastern European countries, Canada, Australia, New Zealand, Korea, Japan). A second group of countries has promoted basic public coverage only for specific population groups, leaving

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Box 2.1. **Examples of complexity in classifying health insurance as public or private**

Nature of carriers of health insurance coverage

There is a distinction between the (public or private) nature of the provider of insurance, and the health financing method used to fund a health insurance arrangement. Sometimes public programmes contract with private insurers to offer coverage to the publicly insured, such as in the case of the US Medicare + Choice programme.[1] In this case, private insurers relieve the public sector of some of the burdens of administration, in such areas as claims processing. Social security schemes can be administered and provided by private institutions, such as mutual companies in Belgium or sickness funds in the Netherlands. Conversely, government-owned insurers can also provide private health insurance. VHI Healthcare (formerly the Voluntary Health Insurance Board) is a state-backed organisation that until 1996 operated as monopoly provider of PHI in Ireland. Medibank Private, the largest not-for-profit health fund in Australia, was established by the Federal Government in 1976 and has become an autonomous Federal Government Business Enterprise since 1998. In some cases, the same insurance entity may offer different types of cover, for example sickness funds or their affiliates in the Netherlands, Belgium and Switzerland offer both statutory health insurance and voluntary private health insurance. The control over the way resources are collected (income tax or social security contributions through payroll premiums), rather than the public or private nature of the insurer, is more important in determining whether insurance is public or private for the purpose of this study. The nature or legal status of the insuring entity may nonetheless be more relevant for supervisory purposes, especially when the identity of the supervising governmental body varies by type of insurer.

Government financing of private or voluntary health insurance

Private health insurance, or segments within the PHI market, may receive public subsidies. In some cases, the purchase of health insurance policies is financed predominantly by public sources, either because of large tax-incentives or because the premiums of certain low-income individuals are greatly subsidised. The schemes nonetheless share several other features of private health insurance, particularly the main method for collecting funds (premiums), or administration by private insurance entities, applicable regulatory regime, role of the insurance arrangement in relation to public insurance systems, and so forth. In France, a government universal health insurance programme (CMU) provides eligible low-income individuals with publicly funded complementary health insurance coverage.[2] The premiums for such complementary cover are entirely subsidised through government resources. The insurance scheme is administered by the social security insurers as well as complementary insurance entities ("mutuelles", private insurance companies or provident institutions). Its benefits and conditions of cover are regulated.

Government regulation of PHI markets and similarity to public health insurance

Private insurance schemes, or segments within the PHI market, may be extensively regulated in a manner not dissimilar from public health insurance. In the Netherlands, some high-risk individuals who are not eligible to social health insurance coverage can buy standardised PHI policies (so-called WTZ) where benefits, premium levels, and enrolment conditions are regulated by the government (see Chapter 3 for more details of the WTZ scheme). Insurers' exposure to risk is minimal. In Switzerland, individuals are mandated to purchase basic health insurance from private sickness funds applying non-income related, flat rate premiums. The provision of basic insurance is regulated in a manner similar to social security schemes in other OECD countries, *e.g.,* the benefit package is standardised, premiums are community-rated, and enrolment is open (Colombo, 2001).

Box 2.1. **Examples of complexity in classifying health insurance as public or private** *(cont.)*

Government employees' schemes

The government funds health coverage of civil servants through private insurers in some countries. These schemes share many traits with private employer-sponsored coverage, despite them being largely financed through public sources. In Germany, public employees are reimbursed by the government for most of their health care bills and receive PHI coverage for the remainder (European Observatory, Germany, 2000). Civil servants and their dependents in Spain receive health coverage from private mutual funds. They can opt to receive such coverage from private commercial insurers, with the state continuing to act as a third payer (European Observatory, Spain, 2000).

Is all private health insurance voluntary?

In most OECD countries, PHI has a voluntary nature, while public systems are mandatory for at least some sections of the population. However, there can be cases of private health insurance for which participation is mandated. Switzerland, for example, had relied on voluntary PHI as principal source of health coverage until the 1996 Federal Health Insurance Law (LAMal) mandated basic coverage for the entire population. Similar proposals for extending primary health insurance to all in the Netherlands would establish a mandatory private health insurance system (Dutch Ministry of Health, Welfare and Sport, 2002). In Korea, the purchase of insurance to cover health-related expenditure in case of car accident is mandatory. Finally, individuals that opted out of the sickness fund system in Germany (as described later in this chapter) are obliged to purchase long-term care insurance from private insurers. Even when participation in private health insurance arrangements is not mandatory by law, it can be imposed by the conditions of employment, for example by general agreements or employer-specific conditions.

1. Under the Medicare+Choice programme, private health plans participate in the US public health programme for the elderly, Medicare, on a risk or cost-reimbursement basis.
2. The "Couverture Maladie Universelle" (CMU) can also be seen as an example of a public health insurance programme administered by private entities. It provides basic coverage to limited population groups that were uninsured until the introduction of the CMU in 2000, as well as subsidised complementary coverage.

Figure 2.2. **Functions of private health insurance in relation to public coverage schemes**

		Eligibility to public health insurance	
		Individuals have public cover	Individuals do not have public cover
Health services covered by PHI	PHI covers medically necessary curative services typically covered under the public system	Duplicate PHI	Primary PHI: – Substitute – Principal
	PHI covers cost sharing applicable to public coverage systems	Complementary	
	PHI covers top-up health services not included in public systems or primary PHI	Supplementary	

Note: Insurance policies may bundle differ types of cover together.

Source: OECD (2004a).

Box 2.2. **Definition of functions of private health insurance**

Primary private health insurance: private insurance that represents the only available access to basic health cover because individuals do not have public health insurance. This could be because there is no public health insurance, individuals are not eligible to cover under public health insurance (principal cover), or they are entitled for public coverage but have chosen to opt out of such coverage (substitute cover):

- **Principal:** private insurance for health costs, which for the insured individual represents the *only available access* to cover where a social security scheme does not apply. This includes employer's compulsory schemes if cover is privately insured or self-insured.
- **Substitute:** private insurance for health costs, which *substitutes for cover which would otherwise be available* from a social insurance or publicly financed insurance or employer's scheme.*

Duplicate cover: private insurance that offers cover for *health services* already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service. It does not exempt individuals from contributing to public health insurance.

Complementary cover: private insurance that complements coverage of publicly insured services or services within principal/substitute health insurance, which is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed (*e.g.*, co-payments).

Supplementary cover: private health insurance that provides cover for additional health services not covered by the public scheme. Depending on the country, it may include services that are uncovered by the public system such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service (*i.e.* medical component) are covered by the public system).

* Other institutions, researchers and laws (such as the EU Directives) adopt different definitions of functions of private health insurance than those adopted in this report.

Source: OECD (2004a).

other groups the option to buy private health insurance, self-insure or be uninsured (*e.g.*, the Netherlands, Germany, and the United States). A third approach, represented by Switzerland, is to ensure universal coverage by compelling the entire population to buy basic health insurance. Only three OECD countries have not attained universal health insurance: the United States, Mexico and Turkey.

While PHI plays one main role in each OECD country, it often has one or more additional functions. Moreover, even where PHI plays a similar function, there can be large differences in terms of benefits and population covered, or, more generally, market structures.

Primary role of PHI

In the United States, the Netherlands, Germany, and for minor population groups in Belgium, Spain and Austria (Box 2.3), PHI plays a primary role in providing basic health insurance for individuals lacking public health cover, either because they are not entitled to publicly financed coverage (principal PHI) or because they have chosen to opt out of it

Box 2.3. **Primary PHI in Belgium, Spain and Austria**

Other examples of primary PHI policies can be found in Belgium, Spain and Austria; in these countries, these types of policies play a minor role.

In **Belgium**, self-employed individuals are covered by the social security system only for so-called "major risks" such as hospitalisation, while "minor risks" (ambulatory care, dental care, drugs) can be covered through PHI offered by mutuals (which provide social health insurance) or by commercial insurers. About 12% of the Belgian population were self-employed in 1999, and about 85% of them bought PHI for minor risks (European Observatory, Belgium, 2000).

In **Spain**, civil servants and their dependents (4.6% in 1997[1] are covered under a special system by mutual funds, within which they are given the option to choose care provided by the National Health System or coverage through private health insurance. According to estimates, between 50% and 85% of this population group opts for PHI. In addition, the statutory system does not cover a minority of the population (about 1%, including certain employment categories such as independent lawyers), 60% of which buys primary insurance (Mossialos and Thomson, 2002). According to two different estimates, 3.9% had substitute PHI in Spain in 2000 (Ministry of Health, Spain, 2003) and 4.9% in 2002 (data from UNESPA, December 2003).

In **Austria**, some self-employed persons can opt out of the social security system, provided their relevant professional categories purchase substitute PHI for them, and about 0.1% of the population is insured under such arrangements.

1. European Observatory, Spain (2000), citing data from the 1997 National Health Survey.

(substitute PHI). There are differences in the population groups that buy primary PHI in each of these countries.

Both the United States and the Netherlands provide publicly financed health coverage for eligible population groups, while leaving others responsible for buying private health insurance themselves. In both countries, PHI also plays a supplementary and a complementary role.

In the United States, Medicare furnishes social insurance to qualified elderly and disabled persons (including the vast majority of those age 65 and above) or about 13.4%[7] of the population. Medicare entitles beneficiaries to hospital care, physician services, and other services (subject to co-payments and deductibles).[8] In addition, two tax-financed public programmes, Medicaid and the States Children's Health Insurance Programme (SCHIP), provide insurance to eligible low-income families with children, disabled and low-income elderly and covers 10.4% of the population, while military schemes cover 3% of the population. Individuals can also buy PHI from competing insurers. About 72.4% of the population has some form of PHI cover, most of which (64.1% of the population) is obtained through employer-sponsored plans. Overall, 86% of the US population has some coverage against health care cost, while about 14% of the population did not have any form of cover in 2001. In the Netherlands, about a third of the population – 31% in 2001 (Ministry of Health, Welfare and Sport, 2002) – relied on private health insurance for principal coverage. This population segment is, by statutory rules, not eligible for the public sickness-fund insurance. Access to PHI for high-risk individuals within this group has been facilitated by

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the creation of the WTZ scheme, a regulated niche of the Dutch primary PHI market that provides standardised PHI policies at regulated prices to eligible high-risk individuals. Unlike the United States, there is virtually no portion of the population uninsured in the Netherlands.[9]

While the Dutch primary PHI system is often compared to the German one, there is one important difference in the way individuals choose to buy such cover. Germany is the sole OECD country that allows large population groups, corresponding by and large to individuals above an income threshold,[10] to opt out of social health insurance provided by sickness funds and to buy a private health policy. Individuals eligible to opt out can still choose to remain insured with a sickness fund. Once they opt out, however, there are by and large prohibited from returning to the social health insurance system. In total, an estimated 9.6% of the population has opted out in 2002 (PKV, 2003), while 14% of the population, while eligible, choose not to do so.[11]

The Swiss health insurance system is perhaps unique across OECD countries. The population is covered through basic health insurance, which has been made mandatory for the entire population since 1996.[12] The provision of mandatory coverage by private insurers (virtually all of which are not-for-profit sickness funds) is heavily regulated: enrolment is open, premiums are community rated at the level of each insurer, the benefit package is standardised, and movement across insurers is free (Colombo, 2001). Insurers providing mandatory coverage can also furnish supplementary voluntary policies, like sickness funds in the Netherlands, through affiliated insurers. Offerings of supplementary PHI were conversely prohibited to social insurers in Germany until recently.

Primary PHI creates some unique policy challenges. First, unregulated primary markets create access challenges as they represent the sole form of cover for certain population groups. High-risk groups may face risk selection by insurers, while insurers are concerned that people, who are not obliged to purchase PHI, will buy insurance only when they need care. When eligibility to public health insurance is linked to income or group thresholds, targeting errors and rules around movements in and out of public versus private coverage may be complex to optimise. Primary PHI markets tend to be more heavily regulated. For example, there are often special regulations or governmental programmes providing access to coverage for high-risk individuals, as in many US states, the Netherlands and Germany. Within primary markets, insurers have high exposure to risk and health costs. It is therefore in some of these markets that they have both the incentives and, sometimes, the opportunity to restrict the coverage they offer to higher-risk persons in order to reduce cost. Analysis of differences in utilisation between public and primary PHI are also relevant to understand the impact of PHI on access to care and cost.[13]

Duplicate role of PHI

The main characteristic of duplicate PHI is that it provides people already covered by public health systems with a private alternative coverage for the same sets of services, most often furnished by different providers. Duplicate PHI is therefore common in OECD countries where there is a separation between publicly funded providers, such as public hospitals and doctors in public practice, and privately funded providers, such as private hospitals and doctors operating in private practice.[14] Typically, duplicate PHI exists in countries where eligibility to public coverage is based upon residency rather than affiliation by employment categories. These are the so-called Beveridge-style or tax-

funded health systems – such as the United Kingdom, Nordic countries, Australia, New Zealand and the Mediterranean countries.

Australia and Ireland are the most significant cases of duplicate insurance in OECD countries. Large population segments (over 40%) have PHI, which also accounts for a similar share of total health expenditure. Private health insurance allows individuals to insure treatments received in private hospitals and treatments provided in public hospitals to individuals electing to be "private patients".[15] Doctors in both countries often have appointments both in the public and private sectors, representing different revenue streams. People buy private health insurance primarily because it provides increased choice over providers and timely care. Both countries regulate and subsidise the provision of private health insurance. Other countries with duplicate PHI feature lower population shares (*e.g.,* 35% in New Zealand, 15% in Portugal, 10% in the United Kingdom). Duplicate insurance is offered by insurers who have no or limited involvement with the public systems' insurers or purchasing entities.

For the most part, OECD countries either entirely allow or prohibit duplication of public coverage systems (Table 2.2). In Canada, most provinces forbid private health insurers from covering any medically necessary hospital, inpatient and outpatient physician services which are provided by the publicly financed system. The rationale for such prohibition is to avoid the creation of a two-tiered system with differentiated access to services based upon insurance status and to prevent the public sector from subsidising the private sector (Flood and Archibald, 2001). On the other hand, other OECD countries have no prohibition on duplication, although hospital coverage in tax-funded systems seems to be the predominant context where duplicate insurance develops. The Australian approach to duplicate private health insurance presents some unique elements. Australia prohibits private health funds from duplicating coverage for out-of-hospital services for which public health insurance (Medicare) pays a benefit. In addition, PHI covers only a share of private in-hospital medical costs, the so-called "gap" between the actual fee charged by the doctor and the share reimbursed by Medicare (which is based on a government schedule). This reveals a desire to avoid differentiated access to care based on insurance status for outpatient coverage and to promote some sort of universality of access to private coverage and private hospital care (Colombo and Tapay, 2003).

In duplicate PHI markets, public and private health financing systems run parallel to each other and are often linked by a complex set of interactions. There are real and financial flows across the two systems, particularly when doctors carry out public and private practices and when the private system receives direct or indirect public subsidies. Duplicate PHI is often seen as instrumental in reducing cost pressures on public systems by shifting demand and cost from public to private hospitals and providers. While enhanced choice is intrinsic to the nature of duplicate PHI markets, this type of cover also raises policy concerns, for example linked to differences in access to care across publicly and privately insured individuals. These issues create challenges related to the opportunity cost of maintaining duplications and the need to address trade-offs between competing policy goals.

Complementary role of PHI

Most OECD countries require co-payments or other cost sharing for services provided by public systems (Table 2.3), but most have small complementary PHI markets. For this type of cover, market size is in fact linked to the magnitude of co-payments. Limited PHI

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Table 2.2. **Permitted role of private health insurance**

	Duplicate	Complementary	Substitute/Primary	Supplementary
Australia	• PROHIBITED: coverage of out-of-hospital services for which a Medicare benefit is payable • REQUIRED: coverage of rehabilitative care; and 25% of private medical inpatient cost • ALLOWED: hospital charges	• PROHIBITED: GP/Primary care and long-term care • ALLOWED: all other services	• Not applicable	• PROHIBITED: Supplementary policies (ancillary PHI) cannot cover services for which a Medicare benefit is payable • REQUIRED: coverage of rehabilitative care • ALLOWED: all other services not included in Medicare benefit schedule (dentistry, optical, physiotherapy)
Canada[1]	• PROHIBITED: All publicly funded services (Hospital, GP/primary, specialist and dental care)	• PROHIBITED: GP/Primary and Specialist care • ALLOWED: all other non publicly funded services	• Not applicable	• ALLOWED: all services not publicly funded
Germany	• ALLOWED but there is no market	• ALLOWED: in/out patient care, dentistry, pharmaceuticals, rehabilitative care and home care	• REQUIRED: long-term care for people opting for private cover • ALLLOWED: all services covered by sickness funds for eligible individuals opting for private cover	• ALLOWED: all services not funded by sickness-funds coverage
Ireland	• REQUIRED: All PHI policies must cover minimum benefits for Hospital and specialist in-hospital care	• REQUIRED: Coverage of statutory co-payments on hospital and in-hospital specialist care non-medical-card holders	• PROHIBITED for dentistry, pharmaceuticals, long-term, rehabilitative and home care • ALLOWED: PHI can cover primary GP service for non-medical card holders	• ALLOWED: dental care, alternative medicine, home care and luxury services
Netherlands	• PROHIBITED: Long-term care and home care • ALLOWED: All other services, but there is no market	• PROHIBITED: Long-term care and home care • ALLOWED: All other services	• PROHIBITED: Long-term care and home care • REQUIRED: Hospital and specialist • ALLOWED: All other services	• ALLOWED: dental care, alternative medicine.
Poland	• ALLOWED: All services	• ALLOWED: Pharmaceuticals, long term and rehabilitative care	• Not applicable	• ALLOWED: All services not publicly covered
Portugal	• ALLOWED: All services		• Not applicable	• ALLOWED: All services not publicly covered
Spain	• ALLOWED: All services	• ALLOWED: Pharmaceuticals • PROHIBITED: All other services	• ALLOWED: All services for civil servants opting out of the public system	• ALLOWED: All services not publicly covered
Switzerland	• Not applicable	• PROHIBITED: All services under basic mandatory insurance	• REQUIRED: All services defined in a basic health insurance package	• ALLOWED: All services not insured under basic cover
United States	• Not applicable	• ALLOWED: Medicare Supplement market	• REQUIRED: minimum benefits in some States • ALLOWED: All services	• ALLOWED: All services

1. There is some variation by province in Canada.

Source: OECD Regulatory Questionnaire on Private Health Insurance and other official source.

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage**[1]

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Australia	For 25% of bills, average of USD 5. General patient reimbursed 85% of schedule fee if not bulk billed.	For 71% of bills, average of USD 8. Patient reimbursed 85% of schedule fee if referred.	Maximum AUD 23.70 (around USD 18) per prescription for general patients for drugs on the PBS Scheme.	None.	Included in specialists' bills.
Austria	20% of the population pays between 10% and 20% of doctor's fee.	Same as for GPs.	USD 4.50 per prescription.	For insured persons: USD6 per day/maximum 28 days per year. For dependents: USD 10-USD 13.50 per day/maximum 28 days per year.	Same as for GPs.
Belgium	25%, reduced to 10% for vulnerable groups.	Same as for GPs.	Flat rate plus 1/20/30/50%; 100% for drugs on negative list.	USD5-USD6 per day, USD2-USD3 for vulnerable groups. Increased after 90 days.	
Canada	None.	None.	Discretion of Provinces.	None.	None.
Czech Republic (2000)	None.	None.	Generics covered. Non-generics reimbursed if no alternative.	None.	None.
Denmark	None, except for under 3% of the population.	None, except for under 3% of the population.	Flat rate plus: 50/70/100%.	None.	None.
Finland	There is an annual maximum fee of EUR 22 for a 12-month period. If the annual fee has not been paid, the fee is EUR 11 per visit. This fee may be collected for a maximum of three visits during the calendar year. Fee for visits outside normal opening hours is EUR 15 per visit. Fees are not collected from persons under the age of 18.	Visit to the outpatient department is EUR 22 per visit, free of charge in the psychiatric outpatient treatment unit.	SII reimburses part of the cost of medicines prescribed by the physician or dentist. SII pays 50% of all medicine costs in excess of a fixed minimum per purchase (EUR 10) or, more rarely, nearly all medicine costs (scheme members with certain specified conditions qualify for a 75% or 100% refund of costs exceeding EUR 5). All non-covered medicine costs in excess of EUR 604.72 in a year are covered by SII. Drugs administered during inpatient care are included in the daily fee.	Health centre: EUR 26 per day, EUR 12 per day in the psychiatric unit. Fees may be collected from a person under the age of 18 for only seven bed-days per calendar year. Hospital: EUR 26 per day, EUR 12 per day in the psychiatric unit. Fees may be collected from a person under the age of 18 for only 7 bed-days per calendar year. Day surgery is EUR 72 per procedure. Long-term (> 3 months) institutional care in a health centre or in a hospital: Fees according to solvency. Fees may constitute a maximum of 80% of the client's income. There must remain, for the personal use of the client, a minimum of EUR 80 per month. Fees may be collected from a person under the age of 18 for only seven bed-days per calendar year.	None.
France	30%[2]	30%[2]	0% for some drugs; 35% for most drugs, 65% for "comfort" drugs or those without proven therapeutic value.	EUR 11 per day plus 20% of total cost for first 30 days up to a ceiling of EUR 200.	40%
Germany[3] (2004)	Fee of EUR 10 per quarter covers all visits during the quarter. Preventive measures are exempt from practice fees.	Patients who are referred by one doctor to another pay no additional practice fees, as long as the referral falls within the same quarter.	Co-payment amounting to 10% of the price, but no less than EUR 5 and no more than EUR 10 per medication.	Co-payment of EUR 10 per day, limited to a maximum of 28 days in a calendar year.	None.
Greece	None.	None.	0/10/25%	USD 15	–

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage**[1] *(cont.)*

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Hungary (2002)	None.	Co-payment if no referral from medical doctor (except emergency).	0/10/30/50 or 100%; some drugs based on reference price system.	Co-payment for long-term care in hospitals (may be covered, depending on income level), co-payment for above-standard "hotel services" in hospitals.	None.
Iceland[4]	USD 9	USD 17 plus 40% of the rest of the cost.	0, 12.5%, 25%	None.	USD 13
Ireland[5]	None for Category I (35% of population); those in Category II pay for GP services.	As for GPs.	No charge for Category I; reimbursement for Category II of any cost over USD 21 per month.	No charge for Category I; Category II: USD 17 per day subject to a maximum of USD 166 in any 12 month period.	None for Category I.
Italy	None.	Maximum of USD 41	Free for Category I medication; 50% for Category II; both Categories I and II are free to exempted persons; 100% for Category III medication.	None.	Up to a maximum of USD 41.
Japan[6]	30% (younger than three years, 20%).	Same as for GPs	30% (younger than 3 years, 20%).	Same as for GPs	Same as for GPs (outpatient) or inpatient care.
Korea	"Outpatient fees" as follows: 30% if seen in clinic, 40% if hospital; 55% if general hospital.	"Outpatient fees" as follows: 30% if seen in clinic, 40% if hospital; 55% if general hospital.		20% of inpatient care ("hospitalization fees").	
Luxembourg	5%	5%	0% or 20%	Flat rate between EUR 10 and EUR 15	
Mexico	No cost sharing for the members of the social security schemes (these cover around half of the population). For Ministry of Health Facilities, which are open to all the population, the Ministry of Finance sets indicative rates of cost sharing that depend on household income, but the rates applied can vary among states and hospitals.				
Netherlands	None.	None.	Prescription drugs reimbursed when judged to be of pharmaceutical value and cost-effective. Full reimbursement for those products for which no alternatives are available. Those similar to other reimbursed products are subject to reimbursement limit. Resulting co-payments are approximately 0.5% of total costs, as industry generally sets prices to avoid co-payments. Over-the-counter medicines not covered, even when prescribed.	None.	None.
New Zealand	Extra billing.	Outpatients USD 3-USD 17.	USD 2-USD 8 with stop loss.	None.	Out-patients USD 3-USD 17.
Norway	USD 11	USD 16	25% if on blue ticket, maximum USD 43 per prescription.	None.	X-ray USD 11.

Table 2.3. **Cost-sharing policies in public schemes for basic health coverage**[1] *(cont.)*

Degree of cost-sharing in per cent and in USD or EUR

	General practitioner	Specialist	Drugs	Inpatient care	X-ray and pathology
Poland (1999)	None.	None.	Basic drug list: flat fee = 0.05% of min. wage; suppl. list = 30-50% of cost of drug. Patients w/ chronic disease or war veterans fully or partially reimbursed.	None.	None.
Portugal		USD 91-USD 213	0/30/60/100% depending on drug category.	USD 30	
Slovak Republic (2000)	None.	None.	Category I: fully covered. II: Same drugs as above, different manuf. partially reimbursed. III: out of pocket.	None.	None.
Spain	None.	None.	0%, 40%. Pensioners and long-term ill largely exempt.[7]	None.	None.
Sweden	USD 13-USD 20 per visit. Maximum visiting fees per 12 months, USD 120 (including fees to GPs).	USD 26-USD 40 per visit. Maximum visiting fees per 12 months, USD 120 (including fees to GPs).	Patient pays 100% up to USD 120, after that, patient pays in three steps: 50%, 25% and 10% of the cost. Maximum patient fees for pharmaceuticals per 12 months USD 240.	Maximum USD 10 per day where some county councils have variations in costs, depending on age, income, etc. Local variations also with regard to maximum inpatient fees. Fees for inpatient care are not included in the high-cost protection system for outpatient care.	None.
Switzerland[8]	10%	10%	10%	CHF 10 per day (about USD7) if single.	10%
Turkey	None.	None	10% retired; 20% active	None.	None.
United Kingdom	None.	None.	USD 9 per prescription or free with a "season ticket" of USD 130. Many persons exempt.	None.	None.
United States (2004)[9]	20% in excess of the USD 100 deductible. Also a USD 66.60 monthly premium for coverage of physician services.	20% in excess of the USD 100 deductible. Also a USD 66.60 monthly premium for coverage of physician services.	100%	USD 876 deductible first 60 hospital days; USD 219 co-payment per day for days 61-90; USD 438 per day beyond 90 days. USD 109.50 per skilled nursing facility stay day 21-100.	Same as doctors.

1. Approximate amounts in US dollars or euros, converted at nominal exchange rates. Information refers to the most recent data available, ranging from the late 1990s to the present. Some changes arising from most recent reforms may not have been included.
2. 30% of the agreed fee schedule (doctor conventionné) and more if there is overbilling. Co-payment may be less if covered by complementary insurance which normally covers part of the co-payment including the overbilling. Complementary insurance covers over 80% of the population. Vulnerable groups and long-term ill may have zero co-payment.
3. Overall co-payment ceiling per year is 2% of gross income (1% for chronically ill patients). No co-payments for those < 18 years of age.
4. Maximum for the year in the charging scheme.
5. About 40% of the population has private health insurance that generally covers general practitioner fees above a relatively high threshold, consultant/specialist fees above a certain threshold and private and semi-private accommodation. Tax relief at the marginal rate is available on unreimbursed medical expenses above a certain threshold.
6. In Japan, there is a dedicated mandatory public health system for those aged 75 and over and those aged between 65 and 74 with severe disability. From October 2002, cost sharing is 10% (20% for those with income above certain amounts.
7. Patients with chronic illness pay 10% up to maximum of 400 pesetas (USD 2.75) per prescription.
8. Plus a yearly flat rate of CHF 300 for adults, SFR 0 for children. From 1986 higher rates can be chosen up to CHF 1 500 in exchange for a lower premium. The excess of 10% pertains to the amount exceeding the flat rate but only up to a maximum amount of CHF 700 per year for an adult of CHF 350 per year for children.
9. Applies to 13% of population (elderly and disabled) who are beneficiaries of public Medicare programme. Lower deductibles if in HMOs.

Source: Information supplied by OECD member countries or obtained from official publications.

coverage of cost sharing exists in several countries such as Ireland, Denmark, Germany, Sweden, Italy and Luxembourg, among others, where complementary cover is packaged together with other PHI types. France and the United States are the only OECD countries with significant complementary markets.

In France, PHI reimburses patients for cost sharing required by the mandatory social security system, as well as the cost of medical goods and services not included in the social benefit package or for which public reimbursement is well below market prices (Buchmueller and Couffinhal, 2004).[16] Individuals are required to pay co-payments ranging from a modest per-diem for inpatient care, to 30% of physician conventional fees and up to 65% for some drugs. The main motivation for buying complementary health insurance is therefore to limit exposure to out-of-pocket expenditures, rather than increase choice over providers or timely care. Complementary health insurance is offered by non-profit mutual associations, provident organisations, and for-profit commercial insurers. The large majority of the French population has this insurance, often through employers. With the introduction of a public programme to subsidise the purchase of PHI by low-income groups (the CMU), the percentage of the population with complementary health insurance rose from 86% in 1999 to 92% in 2002 (*ibid.*).

In the United States, persons eligible for Medicare can buy supplemental Medigap policies covering co-payments and gaps on coverage offered by Medicare. Employers often offer Medicare supplemental policies to their retired employees. The individual Medigap market is heavily regulated, for example insurers are only allowed to sell standardised policies, the renewal of policies is guaranteed, and policies must be issued to all applicants during a six-month open enrolment period at the time of eligibility. Poor Medicare beneficiaries also receive supplemental coverage through Medicaid (17% of Medicare beneficiaries). Over two-thirds of Medicare beneficiaries receive supplemental coverage through individual and/or employer purchased policies.[17] Employer supplemental coverage is often more generous than individual Medigap policies.

Complementary health insurance markets raise significant trade-offs for policy makers. The rationale for allowing or promoting coverage of cost sharing is to reduce inequity in access due to co-payments, which are large in France and under the US Medicare programme. However, as far as co-payments are used as a policy tool to moderate demand within public systems, coverage by private health insurance offsets the benefits of cost sharing. This is why governments sometimes prohibit such a role. In Switzerland, for example, coverage by voluntary health insurance of cost sharing on mandatory health insurance is not allowed.

Supplementary role of PHI

All OECD countries where PHI markets exist have some type of supplementary benefits or policies. Supplementary health insurance covers a wide range of different services across OECD countries, depending on what the public insurance system does not provide, and the insurers' definition of "health benefits". Typical services not covered by public health systems are optical, dental, physiotherapy, cosmetic surgery, luxury services and improved hotel and accommodation amenities in hospitals.

While in several cases supplementary benefits are packaged together with other types of cover, in a few countries there are "pure" supplementary policies that are sold and advertised differently from other products. This is the case of Canada, where most

provinces prohibit other coverage types; Canada is unique among OECD countries in its broad restrictions on the scope of PHI coverage. A large share of the population, estimated at 65% in 2000 is covered by supplementary PHI, which is mainly offered via employers. Benefits covered can include dentistry, long-term and rehabilitative care, home care and alternative medicine. Importantly, PHI covers outpatient prescription drugs that are not publicly covered in most Canadian provinces. In this role, PHI contributes significantly to total health expenditure. In Australia, ancillary PHI policies are sold separately from duplicate hospital policies, although most people buy both types of cover together.

Supplementary PHI markets raise a number of questions. The first is why a market develops for services that public systems do not consider necessary to insure. Supplementary PHI may well insure nonessential services, or conversely give individuals access to services that should arguably be included in the public cover because they involve significant financial risk or medical necessity. People will face different pros and cons related to choices to buy PHI or to self-insure. There are also likely to be interactions between services covered by PHI (for example dental care) and services covered by public systems (for example drugs needed after a dental treatment), which policy makers need to consider when reviewing decisions whether to include services under public coverage. If supplementary PHI is packaged with primary social insurance and is offered by the same entities or their affiliates – as in the Netherlands, Belgium and Switzerland – different regulatory regimes in these two segments may magnify insurers' incentives to select good risks from social health insurance.

3.2. Expenditure on private health insurance and public-private mix of health financing[18]

PHI is not the most prominent method of financing health expenditure across OECD countries

Public financing is the dominant form of health financing in all countries but Korea, Mexico and the United States (Table 2.4). It accounted, on average, for 72% of total health expenditure (THE) across OECD in 2000.[19] The public financing share increased during the 1970s, then stabilised and slightly decreased in the 1990s, with countries showing a convergence in the share of public spending. Private, out-of-pocket payments (OOP) accounted on average for 18.7% of total health expenditure in 2000,[20] representing about three-quarters of total private financing. Out-of-pocket payments as a share of total health expenditure have slightly increased over time.[21]

Private health insurance accounted for an average of only 6.3%[22] of total health funding in 2000 (4.9% excluding the United States). The average does not include countries for which data are not reported (nor estimated) which comprise, with a few exceptions,[23] not very significant markets. Large variation exists across countries. In the United States, private health insurance accounted for 35% of THE in 2000. Canada, France, Germany, the Netherlands and Switzerland[24] also finance a meaningful share of total health expenditure through private health insurance (10-15%). Australia, Austria, Ireland, and New Zealand belong to a third group of countries with notable levels of PHI financing (between 4% and 10%). The contribution of PHI in all other countries for which data are available remains below 4% of total health expenditure. Notably, the United States is the only OECD health system where health financing is predominantly reliant upon voluntary health insurance. Even there, however, PHI contributes less than half of total health expenditures. With the exception of Canada, the high PHI-share cluster includes countries whose health systems

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Table 2.4. **Health expenditure by source of financing, 2000**

Percentage of total health expenditure

	Public expenditure on health	Private health insurance	Out-of-pocket payments	All other private funds
Australia	68.9	7.3	18.5	5.4
Austria	69.4	7.2	18.8	4.6
Belgium	72.1	. .	. .	. .
Canada	70.9	11.4	15.8	1.9
Czech Republic	91.4	0(e)	8.6	0
Denmark	82.5	1.6	16	0
Finland	75.1	2.6	20.4	1.9
France	75.8	12.7	10.4	1
Germany	75	12.6	10.5	1.8
Greece	56.1	. .	. .	. .
Hungary	75.5	0.2	21.3	3
Iceland	83.7	0(e)	16.3	0
Ireland	73.3	7.6	13.5	5.6
Italy	75.4	0.9	22.6	3.1
Japan	78.3	0.3	16.8	4.5
Korea	44.4	. .	41.3	. .
Luxembourg	87.8	1.6	7.7	1.2
Mexico	47.9	0.6	51.5	0
Netherlands	63.4	15.2	9	12.4
New Zealand	78	6.3	15.4	0.4
Norway	85.2	0(e)	14.3	0.5
Poland	70	. .	. .	. .
Portugal	68.5	. .	. .	0.1
Slovak Republic	89.4	0(e)	10.6	0
Spain	71.7	3.9	23.5	0.9
Sweden	85	. .	. .	. .
Switzerland	55.6	10.5	32.9	1
Turkey	. .	. .	. .	. .
United Kingdom	80.9	. .	. .	. .
United States	44.2	35.1	15.2	5.6
OECD average (22)	73.5	6.3	17.7	2.5

Notes:

(e) Zeros ("0") have been estimated in cases where data were not reported but the sum of all other sources of financing amounted to 100%. While some PHI might exist in these countries, the size of the market is negligible.

. . indicates that reliable data is not available.

"All other private funds" include health expenditure incurred by corporations and private employers providing occupational health services, expenditure by non-profit institutions serving households; benefits provided for free by medical care providers and health expenditure incurred by the rest of the world.

"OECD average" includes all countries for which data are available or zeros were estimated. It excludes Belgium, Greece, Korea Poland, Portugal, Sweden, Turkey and the United Kingdom.

Some of the countries for which estimates for private health insurance for 2000 are unavailable have data available for other years: Portugal (1.5% in 1997); Turkey (0.7% in 1994); and the United Kingdom (3.3% in 1993).

Source: OECD Health Data 2003, 2nd Edition.

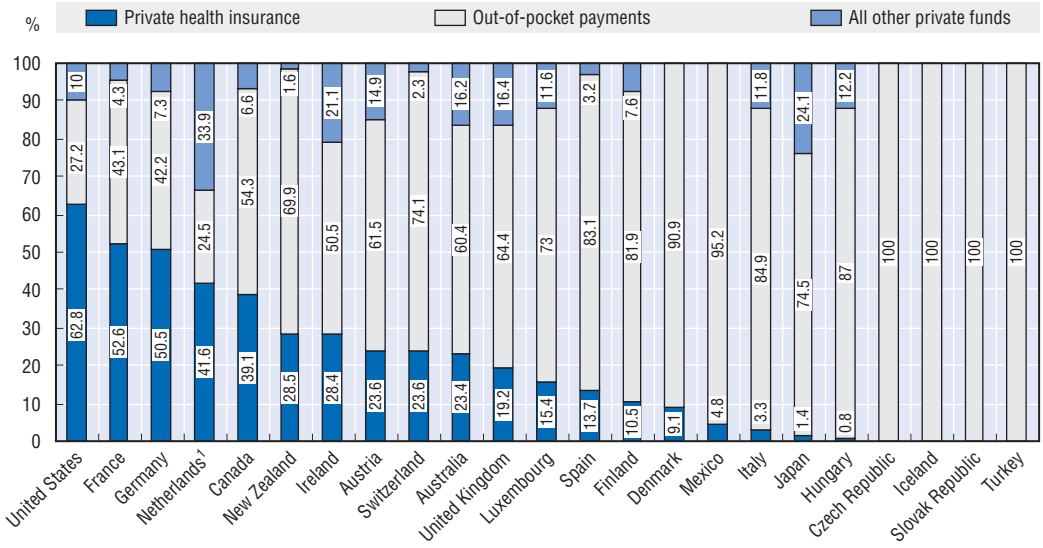
cover the entire population or large segments of it through social security or social health insurance. The third cluster of countries, with the exception of Austria, are tax-financed systems.

Private health insurance accounts on average for 24% of total private health financing[25]

There are large cross-country variations in the extent to which PHI finances private health expenditure (Figure 2.3). High PHI-share countries (with PHI over 10% of THE) tend to be those which finance THE less from out-of-pocket expenditures, both as percentage of

Figure 2.3. **Breakdown of private financing of health expenditure, 2000**

Countries ranked by contribution of PHI to total private health expenditure



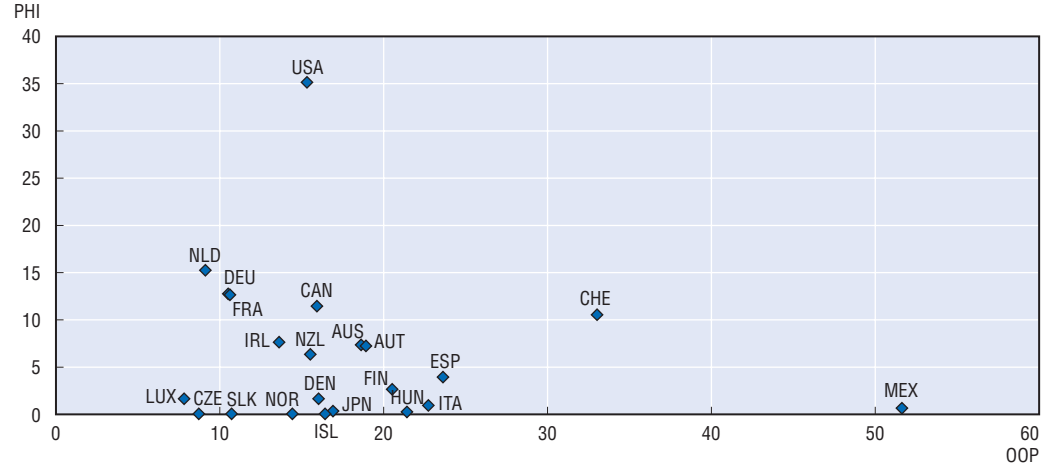
1. The relative high value for "other private funds" for the Netherlands is explained by the inclusion of administration costs of private health insurers.

Source: OECD Health Data 2003, 2nd Edition.

total private health expenditure[26] and as percentage of total health spending.[27] This does not however imply the existence of an inverse relationship between the share of PHI and out-of-pocket expenditure in financing health spending for the OECD area as a whole (Figure 2.4).[28] There is also no necessary relationship between high PHI-share and low public health spending[29] (Figure 2.5).

Figure 2.4. **Out-of-pocket payments (OOP) and private health insurance, 2000**

Percentage of total health expenditure

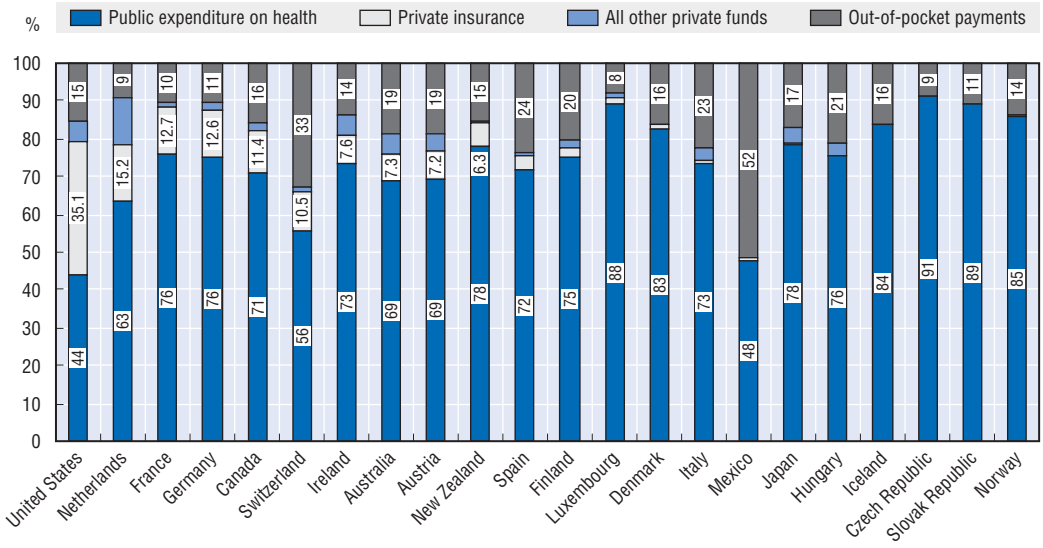


Note: The linear trendline equation is y= –0.1371x + 8.6814, with R^2 = 0.0259. There is therefore no relationship between out-of-pocket payments as a share of total health expenditure and PHI as a share of total health expenditure. This also applies when the United States is excluded. The equation becomes y = –0.0979x + 6.6266, with R^2 = 0.0351.

Source: OECD Health Data 2003, 2nd Edition.

Figure 2.5. **Health expenditure by source of funding, 2000**

Countries ranked by share of PHI in total health expenditure



Source: *OECD Health Data 2003*, 2nd Edition.

The absolute size of markets varies largely

Absolute and per capita funding through private health insurance also varies substantially in OECD countries (Table 2.5 and Figure 2.6). There is a positive but weak

Table 2.5. **Levels of PHI premiums and claims, 2000**

Million, USD PPP

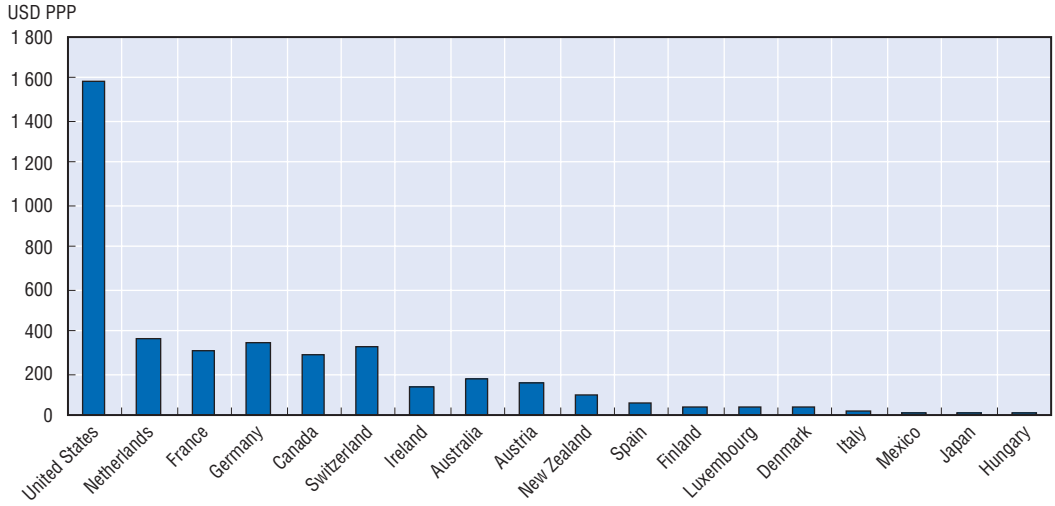
	Premiums	Claims
Australia	5 403	4 990
Austria	1 274	983
Belgium	818	681
Canada	13 528	11 699
Czech Republic	102	24
Finland	56	40
Germany	22 035	14 484
Greece	21	n.a.
Hungary[1]	23	6
Ireland	669	542
Italy	1 569	716
Japan[2]	225.4	n.a.
Luxembourg	13	n.a.
Mexico	1 409	1 014
Netherlands	5 389	4 860
New Zealand[1]	354	n.a.
Poland	311	115
Portugal	294	284
Slovak Republic	3	1
Spain	3 545	2 884
Sweden	967	n.a.
Switzerland	3 688	2 84
Turkey[1]	434	295
United Kingdom	4 048	3 228

n.a. not available.
1. Data from 1998.
2. Data from 1999.

Source: OECD Statistical Questionnaire on Private Health Insurance.

Figure 2.6. **Per capita expenditure on private health insurance, 2000**

Countries ranked by share of PHI in total health expenditure



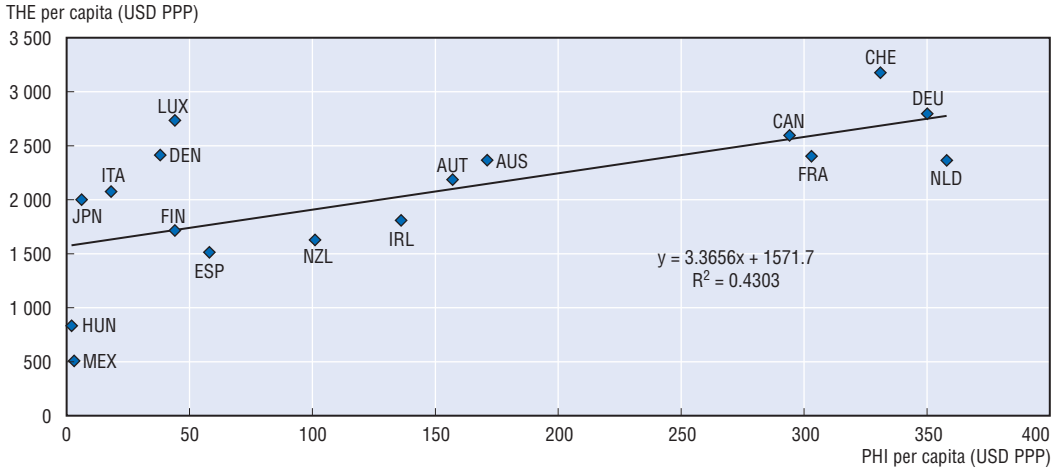
Source: *OECD Health Data 2003*, 2nd Edition.

relationship between financing through PHI and total health expenditure (Figure 2.7).[30] As shown in Figure 2.8, not all countries with high per capita spending on health have a high PHI share in total health expenditure.

The contribution of PHI to total health expenditure increased slightly between 1990 and 2000

The lack of time series data for several OECD countries hinders trend analysis of the contribution of PHI to financing health expenditure. Table 2.6 shows the evolution of PHI, out-of-pocket expenditure and public financing as a share of total health expenditure for 12 countries for which data are available for 1990 and 2000. The share of private health

Figure 2.7. **PHI and total health expenditure (THE) per capita, 2000**

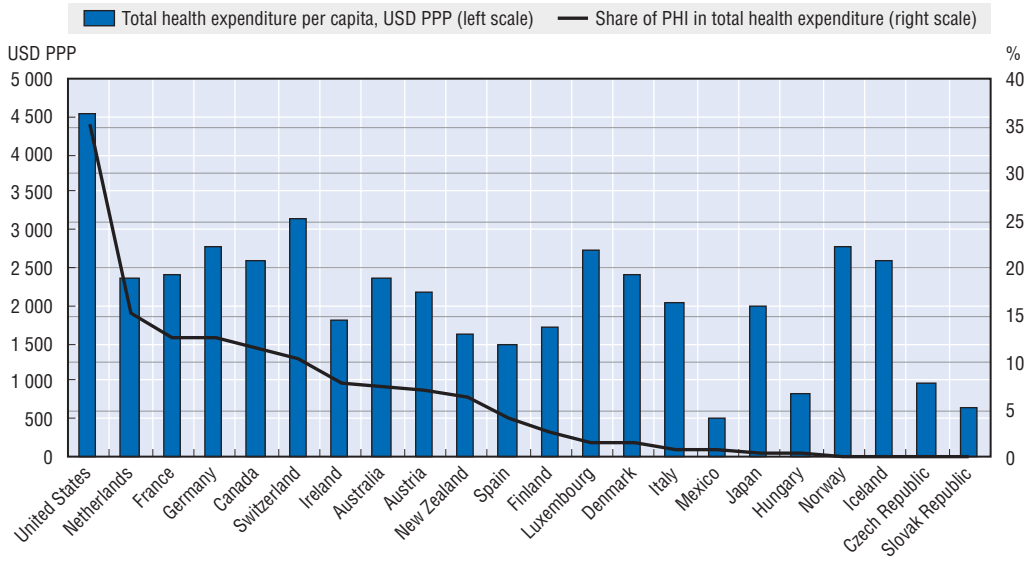


Note: The United States is excluded. If the United States is included, the equation becomes: y = 1.9258x + 1759.4 with R^2 = 0.6281.

Source: *OECD Health Data 2003*, 2nd Edition.

Figure 2.8. **Per capita spending on health and share of PHI in total health expenditure, 2000**

Countries ranked by share of PHI in total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

insurance rose on average by 1% (from 8.5% to 9.4%), while out-of-pocket expenditure increased by 0.7% (from 17.2% to 17.9%). Public health financing decreased by 1.4% (from 70.6% to 69.2%). PHI is becoming a more important source in financing THE in certain OECD countries (such as Canada, Germany and New Zealand) possibly due to cost containment measures applied to public health systems and increased coverage of services previously paid for out-of-pocket. In other countries, however, the importance of PHI in funding total and private health

Table 2.6. **Out-of-pocket payments (OOP), PHI and public health financing, 1990 and 2000**

Percentage of total health expenditure

	Private health insurance		Out-of-pocket payments		Public health spending	
	1990	2000	1990	2000	1990	2000
Australia	11.4	7.3	16.6	18.5	67.1	68.9
Canada	8.1	11.4	14.4	15.8	74.5	70.9
Denmark	1.3	1.6	16.0	15.9	82.7	82.5
Finland	2.1	2.6	15.5	20.4	80.9	75.1
France	11	12.7	11.4	10.4	76.6	75.8
Germany	7.2	12.6	11.1	10.5	76.2	75.0
Ireland	9.1	7.6	16.5	13.5	71.9	73.3
Italy	0.6	0.9	15.3	22.6	79.3	73.4
New Zealand	2.8	6.3	14.5	15.4	67.1	63.4
Spain[1]	3.7	3.9	18.7	23.5	78.7	71.7
Switzerland	11	10.5	35.7	32.9	52.4	55.6
United States	34.2	35.1	20.1	15.2	39.6	44.2
Average (12 countries)	**8.5**	**9.4**	**17.2**	**17.9**	**70.6**	**69.2**

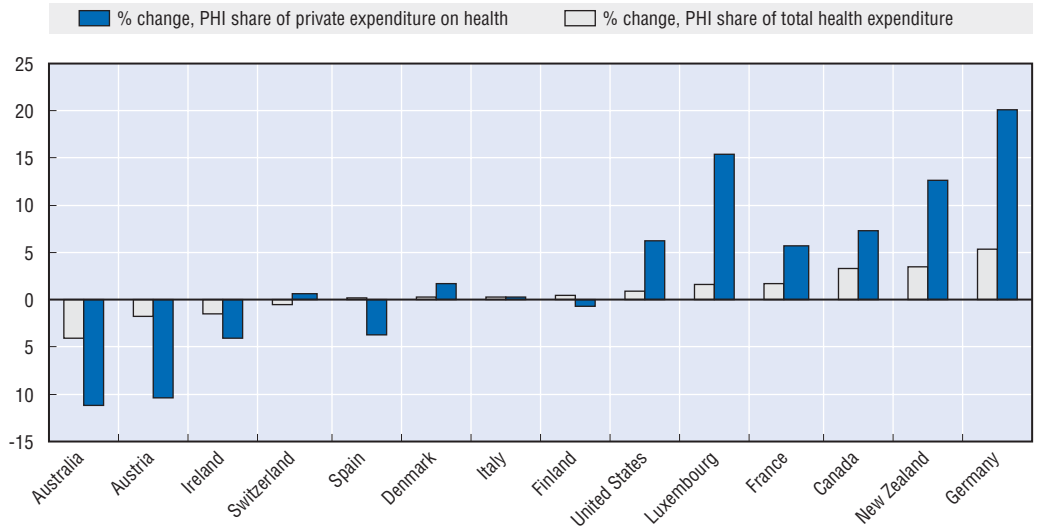
Note: This table includes only countries where reliable data on PHI, OOP and public spending where all available for 1990 and 2000.

1. For Spain, OOP payments refer to 1991 instead of 1990.

Source: OECD Health Data 2003, 2nd Edition.

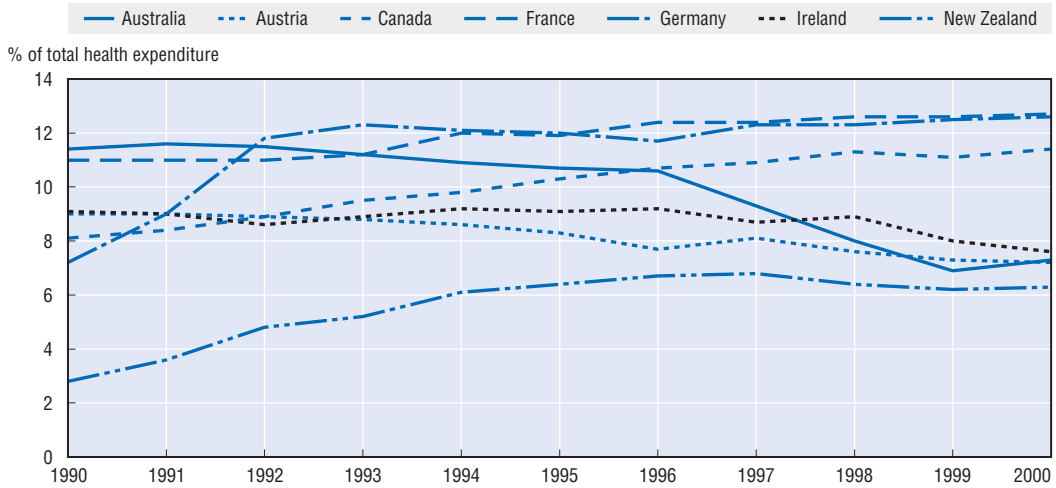
Figure 2.9. **Change in the share of total health expenditure and of private health expenditure accounted for by PHI, 1990-2000**

Countries ranked by the magnitude of the change of PHI as a share of total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

Figure 2.10. **Evolution of financing through PHI in selected OECD countries 1990-2000**



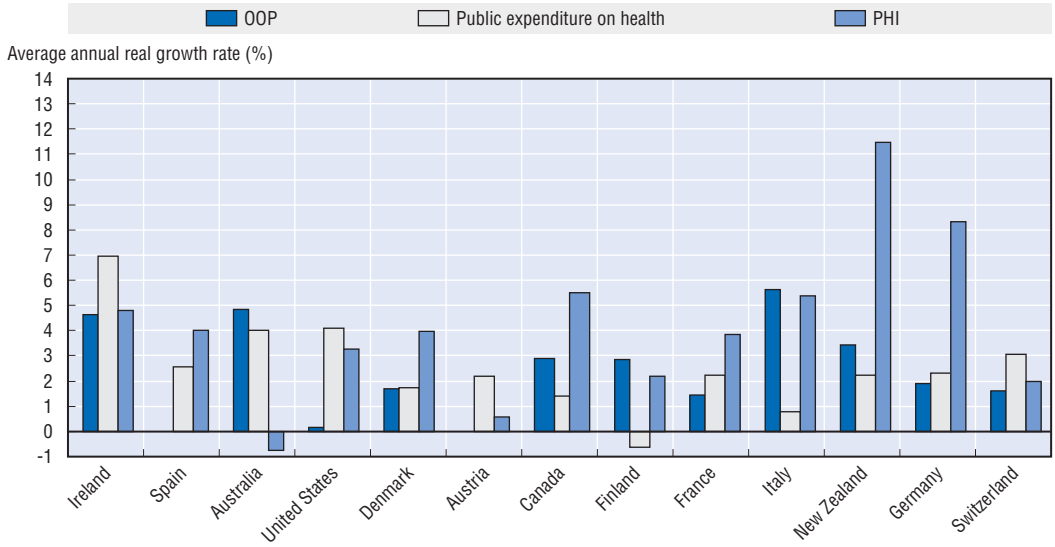
Source: OECD Health Data 2003, 2nd Edition.

expenditures has decreased over time (*e.g.*, Austria, Ireland[31] and Australia) (Figures 2.9 and 2.10). There is also no clear pattern of substitution between out-of-pocket spending and private health insurance over time, nor a convergence towards similar share of private health insurance and out-of-pocket expenditures in THE across OECD countries.

Figure 2.11 shows the average real growth rates of PHI, out-of-pocket payments and public health funding per capita over the period 1990-2000. Only about half of the countries, but most notably New Zealand, Germany and Canada, show higher PHI growth rates than public health expenditure.[32] This has not necessarily paralleled economic growth.

Figure 2.11. **Real growth of PHI, out-of-pocket payments (OOP) and public health expenditure per capita, 1990-2000**

Countries ranked from high to low average real growth rate of GDP per capita



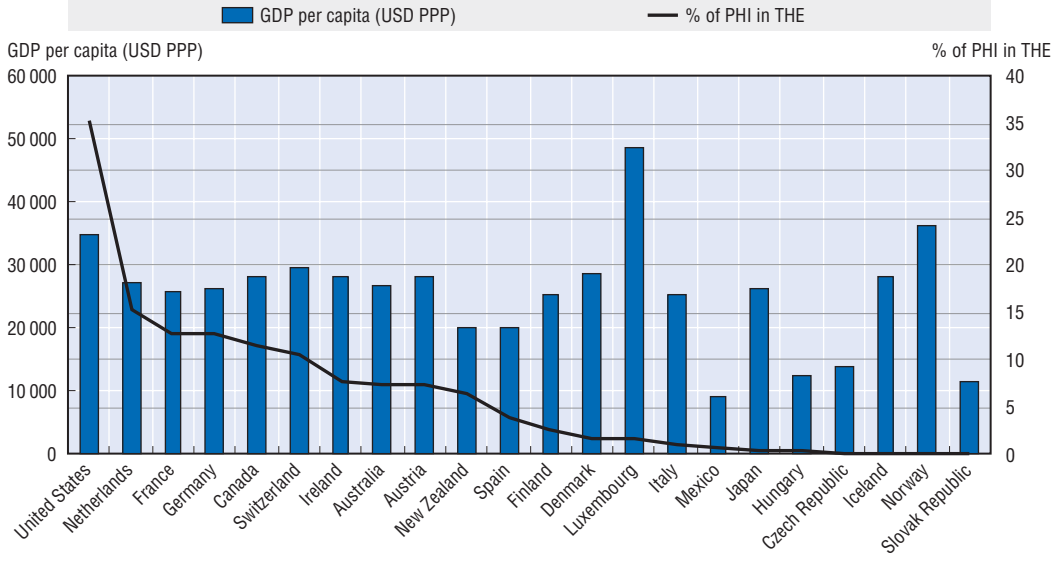
Source: OECD Health Data 2003, 2nd Edition.

Financing by PHI is not correlated to GDP

Funding through PHI does not increase with GDP, and the share of total health expenditure accounted for by PHI does not necessarily expand as economies develop. There is no evident link between level of economic development and share of total health expenditures financed by PHI (Figure 2.12), both including and excluding the main outlier, the United States (Figure 2.13). This is also true when considering trends. Economic growth

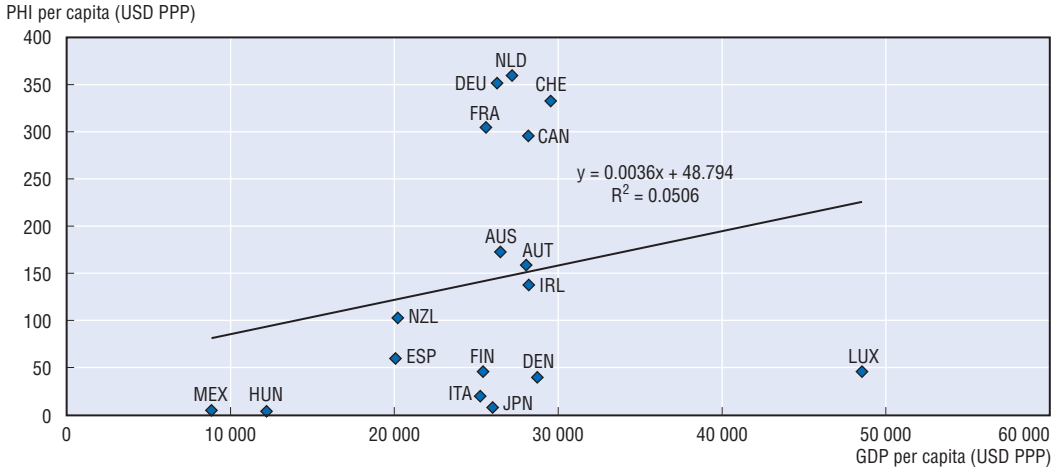
Figure 2.12. **GPD per capita and share of PHI in total health expenditure (THE), 2000**

Countries ranked by share of PHI in total health expenditure



Source: OECD Health Data 2003, 2nd Edition.

Figure 2.13. **PHI per capita and GDP per capita, 2000**

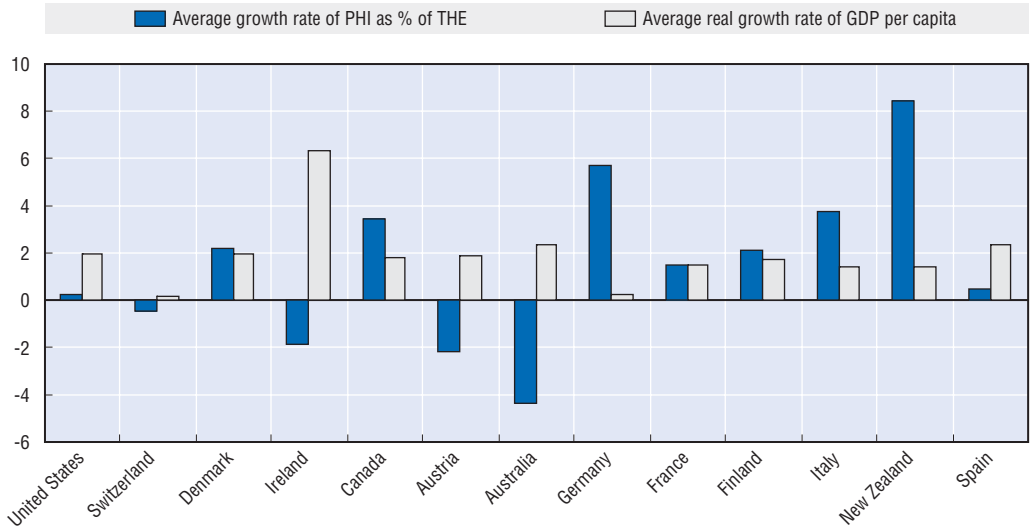


Note: The United States is excluded. If the United States is included, the equation becomes y = 7.1935x + 24476, with $R^2 = 0.1004$
Source: *OECD Health Data 2003*, 2nd Edition.

has resulted in an increase in the prominence of PHI in financing THE in some countries but not in others (Figures 2.14 and 2.15). However, one low-income and high-growth OECD country, New Zealand, experienced the highest increase in the THE share financed by PHI.

The above-mentioned trends have some implications for health systems performance. The reduction in financing through public sources arguably reduces the progressivity of health financing structures. However, the extent to which PHI is purchased by high-risk and low-income individuals, which varies considerable by countries (see Section 2.4.2.), affects the impact of current trends on financing equity. No clear trend in the degree of progressivity of the funding mix emerges in the OECD area, as various sources of financing health care may be becoming more or less progressive as a result of reforms.[33]

Figure 2.14. **Average growth rate of PHI (percentage of total health expenditure) and of GDP per capita, 1990-2000**



Note: Countries are ranked by level of GDP per capita, USD PPP.
Source: *OECD Health Data 2003*, 2nd Edition.

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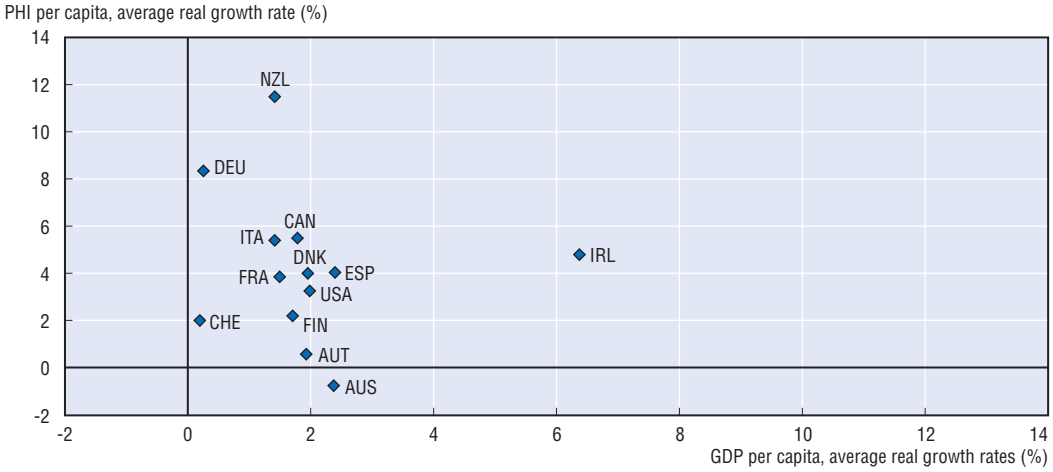
Figure 2.15. **Average real growth rates of per capita PHI and GDP, 1990-2000**



Note: The linear trendline equation is y= –0.2518x + 4.685, with R^2 = 0.014. There is therefore no relationship between average real growth rates of per capita PHI and per capita GDP.

Source: OECD Health Data 2003, 2nd Edition.

The evolution of financing sources may also impact incentives for expenditure growth. There is a negative correlation between public share of health care expenditures and the share of GDP accounted for by THE, though this correlation is weak when excluding data from the United States (Tuohy *et al.*, 2001).[34] Similarly, as shown in Figure 2.7, there is positive correlation between PHI and THE per capita, which is however weak when excluding data from the United States. Population covered by PHI – as described below – is not clearly linked to total health expenditure, although countries with either a high share of PHI in THE or high population covered by PHI tend to have high health spending. In order to better understand the impact of PHI on health spending, it is important to review incentives created by PHI market structures and by the interaction of privately and publicly financed segments of health systems, as examined in Chapter 4.

3.3. Levels of population covered by PHI

Table 2.7 shows the proportion of the population covered by private health insurance. On average, around 30% of the population has at least one type of PHI in OECD countries,[35] with great variation across countries. OECD members can be grouped along *different clusters* of population coverage. In France, Switzerland, the United States, the Netherlands and Canada, over 60% of the population has PHI. Private coverage ranges between 30% and 60% of population in Australia, Austria, Ireland, the Netherlands (for a different type of insurance), New Zealand and Belgium. PHI insures between 10% and 30% of the population in Germany, Portugal, Spain, Italy, Finland and the United Kingdom. Finally, a number of other countries have small or negligible population coverage (*e.g.*, Turkey, Mexico, Denmark).

Market sizes are not clearly linked to one particular role of PHI within the system, nor are they linked to coverage by public insurance, because private insurees often have some public cover, apart from the case of primary PHI. For example, high-coverage countries include a variety of PHI roles. While Australia and Ireland have significant levels of PHI coverage, other duplicate PHI markets tend to be smaller (*e.g.*, the United Kingdom, the

Table 2.7. **Coverage by public schemes and private health insurance in OECD countries, 2000**

	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 for public coverage financed by Federal and Provincial taxation.	11.4	65 (e)	Supplementary
Czech Republic	91.4	100	All permanent residents are eligible for statutory health insurance coverage.	0 (e)	Negligible	Supplementary
Denmark	82.5	100	All population is eligible for public coverage financed by State, County and Municipal taxation.	1.6	28 (1998)	Complementary, Supplementary
Finland	75.1	100	All population is eligible for 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 Universelle (CMU).	12.7	86 (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 for 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 for 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 for statutory health insurance coverage.	0 (e)	Negligible	Supplementary
Ireland	73.3	100	All resident population is eligible for 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

Table 2.7. **Coverage by public schemes and private health insurance in OECD countries, 2000** *(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
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 and employees of international institutions (1%).	1.6	2.4	Complementary, Supplementary
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 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 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

Table 2.7. **Coverage by public schemes and private health insurance in OECD countries, 2000** *(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
United Kingdom	80.9	100	All UK residents are covered by the National Health Service system, financed by general taxation.	3.3 (1996)	10	Duplicate, Supplementary
United States	44.2	24.7	Individuals eligible to public programmes include those older than 64 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

n.a. Indicates not available.
(e) Indicates that figures are estimated.
Negligible indicates a proportion covered of less than 1%.
PHI: Private health insurance.
THE: Total health expenditure.
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.

Source: Specific data sources have been indicated below; information was also supplied by OECD member countries or obtained from official publications.

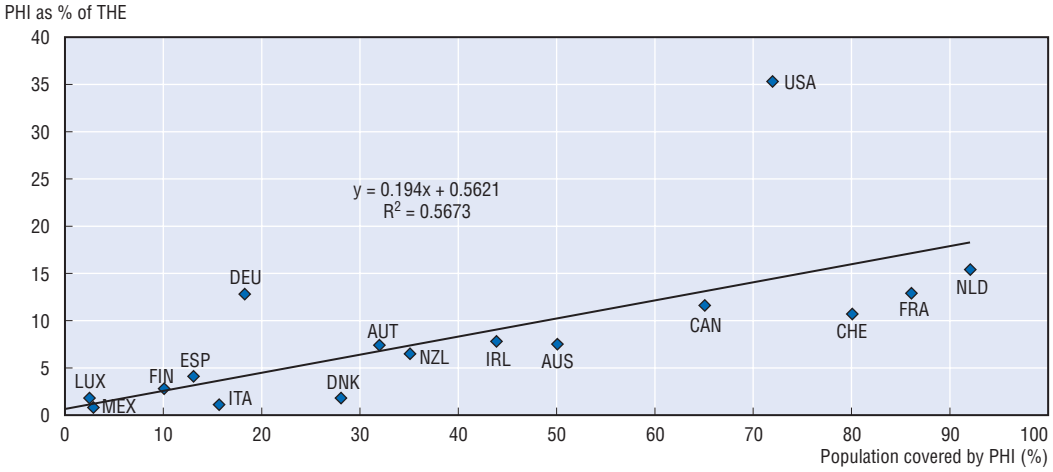
1. *OECD Health Data* 2003, 2nd Edition, 2000 data unless otherwise indicated.
2. OECD Regulatory Questionnaire on Private Health Insurance, 2003 and other official sources.
3. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.
4. PHIAC (2002), *Operations 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. UK Trade & Investment, Health Care & Medical Market in Turkey, *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.

Mediterranean and Nordic countries). Countries where individuals have PHI as primary coverage are spread across different coverage clusters.[36]

There is a positive, not very strong, correlation between the level of population covered by PHI and the share of total health spending accounted for by PHI (Figure 2.16). There is also a weak correspondence between countries with high coverage and those with high expenditure on health (Figure 2.17). On the other hand, the role played by PHI seems to be a large determinant of PHI's funding contribution. For example, the share of PHI in total health spending tends to be similar in countries where PHI plays the same role and involves a comparable population size (*e.g.,* Australia and Ireland). Also, despite similar levels of population participation in PHI markets, the share of PHI in total health spending differs substantially between countries where PHI has a primary role (*e.g.,* the United States) and countries where it has a non-primary role (*e.g.,* Canada). Countries with different roles and levels of coverage, sometimes have analogous shares of PHI in THE, as in the case of Germany and France. The high PHI spending in Germany for a smaller population covered can be explained by the substitute role of PHI. Overall, the observed patterns indicate that the link between the share of population covered by PHI and its share in THE is in part the result of the functions that private health insurance plays within the health system.

While time series on population covered by PHI are limited to a few OECD countries, no uniform trend appears. Patterns are influenced by country-specific conditions. In Australia, the level of population covered by PHI declined steadily since the mid-1980s and throughout the 1990s, due to the establishment of universal public insurance in 1984 and a process of adverse selection in the market. Government policies to support private insurance have redressed levels of population coverage to over 40% since 2000 (Colombo and Tapay, 2003). In Ireland, a booming economy and the increasing provision of PHI as a work-related benefit are responsible for an uninterrupted growth in population coverage from 22% in 1979 to 48% in 2002, despite an expansion in the generosity of public cover (Colombo and Tapay, 2004a). Fluctuations in participation in the United States PHI market

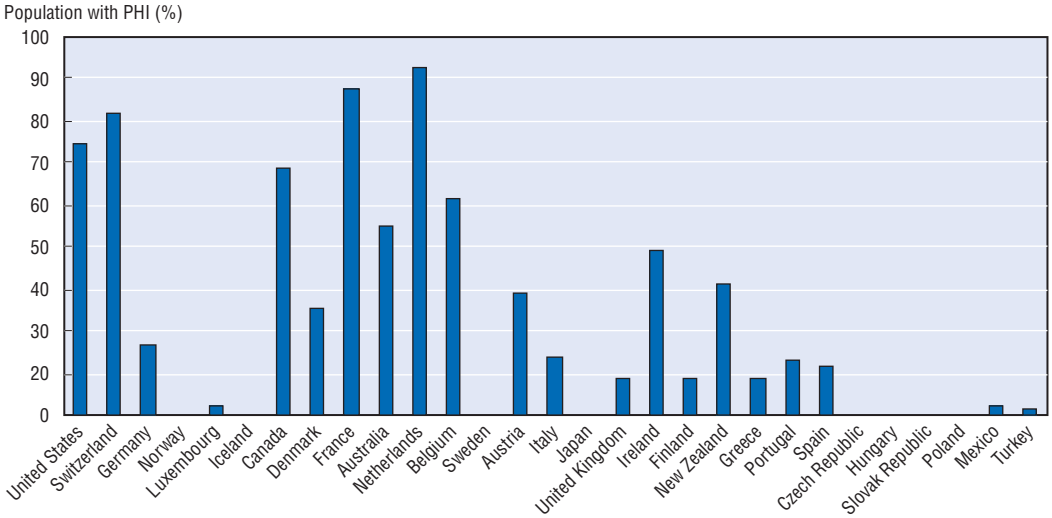
Figure 2.16. **Population covered by PHI and PHI share in total health expenditure (THE), 2000**



Note: For countries with more than one level of coverage depending on type of PHI policy, the percentage of population covered by PHI used here includes all individuals who have at least one PHI cover.
Source: OECD Health Data 2003, 2nd Edition; OECD Statistical Questionnaire on Private Health Insurance; other official data supplied to OECD.

Figure 2.17. **Population covered by PHI, 2000**

Countries ranked by total health expenditure per capita (USD PPP)



Note: Coverage data for Denmark refer to 1998. The percentage of population with PHI includes all individuals with at least one type of PHI cover. In the Netherlands, 28% of the population has primary cover, but an additional 64% has supplementary policies. Data for Switzerland refer to voluntary coverage. In Germany, 9.1% has substitute cover, and another 9.1% buys supplementary PHI. Australia includes individuals with hospital cover and a minority of individuals purchasing only ancillary PHI. Spain includes primary, duplicate and other PHI cover.

Source: OECD Health Data 2003, 2nd Edition; OECD Statistical Questionnaire on Private Health Insurance.

reflect variations in affordability by population groups and the relative stability of the labour market, as most individuals receive PHI through their employer. In France and the Netherlands, population coverage has been fairly stable and high, reflecting a certain propensity to buy insurance by the population.

Levels of population coverage have implications for market stability, particularly in countries where the profile of people buying private health insurance is spread across different risk cohorts. They also may affect insurers' drive and ability to better monitor and control cost, as well as their incentives to selectively cover different types of risks.

3.4. Benefits covered by PHI

PHI covers different benefits across OECD countries, both in terms of health services and providers. There is no typical benefit package, although there are similarities within PHI roles. Services and providers covered may or may not match those covered by public systems, reflecting health system structures, specific regulation and market strategies by insurers (Table 2.8). In particular, the scope of PHI packages is strongly influenced by the scope of public coverage and PHI's resulting role in the health system. Policies representing the primary form of coverage for population segments tend to be the most comprehensive and often resemble basic cover in public insurance programmes.[37] Those that duplicate public coverage also include similarly comprehensive benefits, but usually for a more limited range of providers, and cover additional benefits such as choice of doctor and treatments in private hospitals.[38] Supplementary and complementary policies are more limited and often varied in scope, though they are in several countries packaged and sold together with principal or duplicate PHI. 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

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Box 2.4. **Benefits covered by private health insurers**

Private health insurance covers, in almost all OECD countries, "small risks", ancillary and supplementary services such as dental and optical services, choice of provider, upgraded hospital accommodation, and luxury services. Often, these services are not provided, or only partly reimbursed, by public coverage systems. Coverage of home care, alternative medicine, long-term care and pharmaceuticals vary in relation to the generosity and structure of public health insurance.

Most, but not all, PHI policies cover **hospitalisation** expenses to some extent. All public coverage systems pay for hospitalisation, with differences in cost sharing required by individuals. Primary PHI always covers this benefit. Duplicate PHI usually covers hospital expenses for treatments received in privately financed hospital facilities. In Australia and Ireland, PHI also reimburses the hospital charges for patients electing to be treated privately within public hospitals. Duplication of hospital-related cost is often attached to other benefits such as enhanced choice of provider and, if public systems are characterised by waiting times, faster access to care. The type of hospital expenses paid for by PHI depends upon the level of development of the private delivery sector. Often, private hospitals in these countries provide predominantly elective or simple surgery. In social-insurance based health systems such as Germany, the Netherlands, Poland, Korea, Japan, Austria, France and Belgium, PHI usually pays for upgraded accommodation in hospitals but the cost of hospital treatment is usually covered by public systems, regardless of treating hospitals.

A similar differentiation emerges with respect to coverage of **GP and specialist services**. These services tend to be included in publicly financed packages. Their coverage by private insurers depends upon specific regulation, the structure of the delivery system, and other factors. Doctor's services are included in principal PHI policies. Conversely, PHI insurers are not allowed to provide medical cover in Canada, and, with the exception of so-called in-patient medical gaps,* this coverage is currently prohibited in Australia. In Ireland, while two-thirds of the population do not have public GP coverage, private insurers provide limited protection against such cost, although new primary care products are developing. This may indicate that GP benefits are sometimes perceived to be services for which insurance protection is less important. The function of pre-payment of health service cost, rather than the risk-pooling function, may be more relevant for GP than hospital benefits. PHI may subject coverage of specialists to gatekeeping by a GP, as in US managed care plans, or may allow direct referral to specialists, as in several EU countries.

Private health insurance pays for **cost sharing** applicable to public health systems in several but not all OECD countries. This coverage often depends on health system regulation. While this is the main benefit offered by complementary health insurance in France, and is also a substantial component of the US Medicare Supplemental market, it is forbidden or restricted in other counties such as Canada. In Switzerland private voluntary health insurance cannot cover statutory co-payments on the mandatory health insurance system.

Benefits can be provided in **cash or in kind**. The cost of care can be directly billed to the individual, who then claims a cash reimbursement from the insurer. This constitutes for example the practice in Belgium, Denmark, France, Germany, the Netherlands, Australia, and the United States for a segment of the market. Insurers may also have direct arrangements with providers under which individuals receive benefits in kind or invoices are settled directly. For example this is often the case when insurers have contractual arrangements with providers and in managed care settings.

Many PHI policies, including those providing treatment in kind, tend to include some out-of-pocket expenditure – such as deductibles, co-payment, reimbursement ceilings and other cost-sharing. The level of cost sharing that insurers apply can be influenced by government regulation as well as insurers' strategic choices to cost control, and vary to a large extent across OECD countries. Very limited data are available on the amount of out-of-pocket expenditures paid on PHI products across OECD countries.

* Medical gaps refer to the difference between the fee charged by a medical specialist for an in-patient treatment and the share that is reimbursed by the public system, Medicare, on the basis of scheduled fees.

Table 2.8. **Examples of benefits covered by public coverage systems and by PHI**

	Public coverage	Private coverage
Australia[1]	• Free public hospital care; GP/Primary (contribution to patient cost where GP charges more than 85% of standard Medicare fee); specialist care (where specialist provides in-hospital services to a public patient in a public hospital but only a contribution to patient cost where specialist charges more than 85% of standard Medicare fee and when the patient is treated outside a public hospital); pharmaceuticals where patients is treated as public patient in public hospital; dental care (confined to major oral trauma, and if treated in a public hospital).	• Duplicate: hospital, specialist in-hospital, and rehabilitative care; increased choice of doctor and hospital; faster access. • Complementary: co-payments for pharmaceuticals and medical gaps on in-hospital specialist care (difference between fee charged and Medicare reimbursement). • Supplementary: dentistry, pharmaceuticals, rehabilitative care, alternative medicine, home care, physiotherapy and luxury services.
Austria[3]	• Hospital care, GP/Primary care (co-payment or deductible in some cases), specialist care; pharmaceuticals (deductible in some cases); dental care (co-payment or deductible in some cases); home care; maternity; rehabilitation (co-payment or deductible in some cases).	• Increased choice of doctor; hospital care; dental care; alternative medicine; pharmaceuticals; outpatient care.
Belgium[2, 3]	• Hospital care (co-payment); GP/Primary care (varying reimbursement of patient); specialist care (co-payments and co-insurance); pharmaceutical (defined formulary); dental; self-employed covered for major risks (*i.e.* hospital care) but not minor risks (*i.e.* outpatient care, pharmacy, dental).	• Substitute: minor risks for the self-employed. • Complementary: co-payments for non-reimbursed in/outpatient costs. • Supplementary: caregiver costs (loss of independence); supplementary hospital costs; luxury services.
Canada[1]	• Hospital care; GP/Primary; specialist care; pharmaceuticals only when patient is in hospital or on welfare.	• Supplementary: dental care, pharmaceuticals, long-term care, rehabilitative care, alternative medicine and home care.
Czech Republic[3]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care.	• Supplementary: presently a very small market. This includes coverage for foreign nationals who are not eligible for the compulsory coverage and for services not provided under the state system (*e.g.,* cosmetic surgery or some categories of dental care, care abroad).
Denmark[2, 3]	• Public hospital care; GP/Primary; pharmaceuticals (only partial for primary care prescriptions); dental care (High patient co-payments over age 18).	• Duplicate: access to private hospitals in Denmark and abroad, faster access. • Complementary: co-payments for drugs, dental care, physiotherapy, spectacles, etc.
Finland[2]	• Public hospital care; GP/Primary care; pharmaceuticals; dental care (part of population).	• Duplicate: hospital care (private and public); private care for children; faster access and increased choice of provider.
France[2]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; minimal dental and optical care.	• Complementary: co-payments and cost sharing on public system (pharmaceuticals, specialist, GP, hospitals). • Supplementary: home help, luxury services (private room), dental and optical care.
Germany[1]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care.	• Substitute: hospital care; GP/Primary; pharmaceuticals; specialist; dental care. • Substitute: long-term care. • Supplementary: specialist care (doctor choice); extra dental care; alternative medicine; luxury services.
Greece[3]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care (depending on age and fund).	• Duplicate: private hospitals, physicians in private practice, private diagnostic centres. • Supplementary: services not included or partially included in the statutory system.
Hungary[3]	• Hospital care; GP/Primary; specialist care; pharmaceuticals (co-payment); dental care (co-payment).	• Complementary: drug co-payments. • Supplementary: care abroad, preventive health, dental, medical aids and rehabilitation.
Ireland[1]	• Public hospital care (free for 30% of the population who are medical card holder; statutory charges for others); GP/Primary care (medical card holders only); dental care and pharmaceuticals (only for medical card holders); specialist care (free for medical card holders and for others only if person has chosen to be treated as a public patient in public hospital).	• Duplicate: hospital care, specialist; increased choice of provider; fast access to care. • Substitute: GP/Primary care, medical diagnostics and outpatient specialist care (population without a medical card). • Supplementary: alternative medicine; luxury services; non reimbursed pharmaceuticals.
Italy[2, 3]	• Public hospital care; GP/Primary; specialist care; pharmaceuticals; some dental care.	• Duplicate: hospital care (private hospitals); increased choice of provider and fast access. • Complementary: co-payments (ticket moderateur, per diem charge in hospital). • Supplementary: non-reimbursed services; dental care.
Japan	• Hospital care; primary care; specialist care; pharmaceuticals; dental care.	

Table 2.8. **Examples of benefits covered by public coverage systems and by PHI** *(cont.)*

	Public coverage	Private coverage
Korea	• Hospital care; primary care; specialist care; pharmaceuticals; dental care.	
Luxembourg[1, 2, 3]	• Hospital care; primary care; specialist care; pharmaceuticals; dental care.	• Complementary: hospital co-payments. • Supplementary: pre, post-op and convalescence; dental prostheses; surgical treatment abroad; non-reimbursed expenses; Luxury services (private room).
Mexico[1]	• Hospital care; GP/Primary; specialist care; dental care; pharmaceuticals.	• Catastrophic expenses products only cover major hospital interventions; other health insurance products cover hospital care, GP, specialist care, dentistry, pharmaceuticals, long-term care, rehabilitative care, alternative medicine, home care and luxury services, and some preventative services.
Netherlands[2]	• Hospital care; GP/Primary; specialist care; dental care (minimal); pharmaceuticals; long-term care.	• Primary: hospital care, GP, specialist care, pharmaceuticals. • Supplementary: dental care, alternative medicine and luxury services.
New Zealand[3]	• Public hospital care; ambulatory care/primary care (with co-payments); pharmaceuticals (co-payment for out-patient Rx).	• Duplicate: elective care in private hospitals, fast access, choice of doctor. • Complementary: contributions towards GP fees. • Supplementary: luxury services.
Norway[3]	• Public hospital care; GP/Primary; specialist care; pharmaceuticals (tiered co-payment); dental care (for children).	• Duplicate: private hospital and specialist care.
Poland[1]	• Hospital care; GP/Primary; specialist care (when patient is referred); pharmaceuticals; dental care (for children under 18 and pregnant women).	• Supplementary: extra amenities.
Portugal[1, 2]	• Public hospital care; GP/Primary care; specialist care; pharmaceuticals. • Dental care.	• Duplicate: private hospital care, GP, specialist, choice of doctor and speed of acces. • Supplementary: additional dental care; ophthalmology; pharmaceuticals. • Complementary: co-payments.
Slovak Republic	• Hospital care; GP/Primary care; specialist care; pharmaceuticals. • Dental care.	• Supplementary: travel insurance.
Spain[1, 2]	• Public hospital care; GP/Primary; specialist care; pharmaceuticals (co-payments – Pensioners exempt); dental care (co-payments).	• Duplicate: private hospital care and specialist; increased provider choice; speed of access; private dental • Supplementary: additional dental care; luxury services.
Sweden[2]	• Hospital care; Primary/GP; specialist care; pharmaceuticals.	• Duplicate: private hospital care and specialist; faster access to elective outpatient care. • Complementary: co-payments. • Supplementary: dental care; non-reimbursed pharmaceuticals; alternative treatment.
Switzerland[1, a]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care.	• Supplementary: luxury services; choice of doctor; upgraded accommodation; extra amenities.
Turkey[3]	• Hospital care; GP/Primary; specialist care; pharmaceuticals; dental care (prostheses for private employees and dependents, more coverage retired civil servants).	• Complementary: coverage of co-payments on public systems. • Private hospital care.
United Kingdom[1]	• Public hospital care; GP/Primary; public specialist care; pharmaceuticals; dental care.	• Duplicate: private hospital care and specialist care, dental care. • Supplementary: long-term care and alternative medicine home care.
United States[1]	• Hospital care; GP/Primary; specialist care; some state variation exists for Medicaid and SCHIP.	• Primary: hospital care, GP, specialist care, dental care, pharmaceuticals, long-term care, rehabilitative care, alternative medicine and luxury services. • Complementary: co-payments on Medicare, pharmaceuticals and other gaps.

a) 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:

1. OECD Regulatory Questionnaire on Private Health Insurance, 2003.
2. Mossialos and Thomson (2002).
3. European Observatory on Health Care Systems, *Health Care Systems in Transition. Various countries.*
Information was also supplied by OECD member countries or obtained from official publications.

private coverage. There are nonetheless some trends towards a greater reliance on public or subsidised PHI for those facing higher health care cost, such as the elderly and those with chronic conditions, even where PHI plays a significant or primary role.

Both services and providers covered by private health insurance have implications for health system performance. In particular, they directly affect the ability of PHI to enhance choice over the providers, conditions and timeliness of care. They affect providers' and individuals' incentives to consume health care by providing coverage for services and cost that may otherwise have to be paid for out-of-pocket. They may also impact upon medical practice, particularly in countries where public and private delivery systems are linked to different funding sources. Doctors practising in both sectors will behave differently depending on the incentives and restrictions they face in the publicly and privately financed segments of their activities. These aspects will be analysed in more detail in Chapter 4.

4. Demand for private health insurance

4.1. *Determinants of demand for PHI*

Several factors can influence demand in a voluntary PHI market: price, perceived value of private cover, risk aversion, individuals' income and education are among the key factors. Evidence of determinants of demand for PHI is restricted to a few selected countries, usually with significant PHI markets, for which studies are available.

Demand for private health insurance appears to be relatively price inelastic in several countries, although there is large variation. Some studies on demand determinants indicate a relative price inelasticity of demand for principal PHI in the United States. This may be explained by the primary role of employers, rather than individuals, in purchasing insurance. Unemployment is indeed a more important factor affecting decisions to buy coverage, especially for more educated people (Glied and Jack, 2003). However, estimates vary to a large extent. Tax subsidies for PHI, and variation in tax regimes, affect demand for PHI by modifying the net price of insurance. The elimination of tax subsidies in the United States is estimated to have had a significant impact on the number of individuals having access to group insurance (Henderson and Taylor, 2002; Thomasson, 2003).

While price may intuitively be a more important determinant of purchasing decisions when PHI is purchased on top of public coverage, countries display variation in elasticity. Reduction in tax advantages in Quebec resulted in a decrease in employer-sponsored health insurance in Canada, especially in small firms (Stabile, 2001; Finkelstein, 2002) and in New Zealand (Bloom, 2000). Conversely, in Ireland demand for PHI has proven to be rather price inelastic despite continuous premium increases and a reduction in fiscal advantages (Department of Health and Children, 1999; Nolan and Wiley, 2000). In Australia, the responsiveness to large government fiscal incentives has been limited by low price sensitivity (Butler, 2002) although opposing views have been expressed (Harper, 2003; Access Economics, 2002). In Spain and the United Kingdom, PHI appears to be insensitive to premium variations, including withdrawal of tax subsidies (Costa and Garcia, 2000; Emmerson *et al.*, 2001).

Income is found to be a strong determinant of insurance decisions in many countries (Harmon and Nolan, 2001; Barrett and Conlon, 2001; Costa and Garcia, 2000; King and Mossialos, 2002). This may suggest that, at least where public insurance guarantees basic coverage, PHI products are purchased by individuals as luxury goods for which, *ceteris*

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paribus, demand increases as individual income increases. Where PHI represents a primary form of coverage, lower demand among less wealthy populations may be a consequence of broader eligibility to public insurance programmes for low-income groups.

The actual or perceived quality of publicly financed services affects decisions to buy PHI policies. In OECD countries where consumer surveys have been carried out, such as in Ireland and Australia, factors such as long waiting, uncertainly over receiving a publicly financed treatment, and increased provider choice are leading reasons for buying private health insurance (Watson and Williams, 2001; ABS, 1998). However, analysis of such a link is complicated by the lack of clear indicators of "quality" of public coverage. In the Netherlands, decisions to "delist" services, such as for example dental care, have not resulted in substantial change in levels of population coverage by supplementary PHI, although the PHI market responded to this delisting by adding dental services to coverage packages. Waiting lists have been found to be associated with demand for private health insurance in the United Kingdom and Spain (Besley *et al*., 1998 and 1999; Jofre-Bonet, 2000), although there may be a time lag between the time when waiting has actually arisen in public systems and the time when private insurance is purchased (King and Mossialos, 2002).

Health status can also be a determinant in decisions to buy private health insurance. For example, individuals expecting to become ill, or who already have a health condition may be more likely to purchase insurance. This is a particularly important concern because PHI markets are characterised by asymmetry of information. The stability of the market is endangered if only high-risk individuals buy private cover, particularly when insurers do not have the ability, or the tools, to protect themselves from adverse selection or to risk-rate.[39] Evidence indicates that, in some markets, (bad) health status may have influenced and encouraged decisions to purchase insurance. For example, during the 1990s, the decline in population coverage in Australia had been found to be associated with health risk, with losses of participation in PHI markets among the younger, lower-risk populations (Hopkins and Kidd, 1996; Barrett and Conlon, 2001). There is evidence that employer-sponsored HMO plans in the United States – which often impose more restrictions on utilisation of services – may experience some favourable risk selection when compared to less restrictive plans.[40] On the other hand, in other countries, such as Ireland and Germany, individuals in good health are more likely to buy cover, which can be explained by the predominant purchase of PHI by high-income groups. Similarly, the probability of buying PHI has been found to increase with good health in Ireland, Italy, Portugal, Spain and the United Kingdom, contradicting the hypothesis of adverse selection in certain PHI markets (Jones *et al*., 2002), probably as a result of the link between better education and PHI coverage.

4.2. Characteristics of subscribers of PHI

Table 2.9 illustrates the characteristics of subscribers and the distribution of PHI cover across different population groups in OECD countries.

In virtually all OECD countries, PHI is predominantly purchased by high-income individuals. This is clearly the consequence of eligibility to mandatory public or social coverage on the basis of income and/or employment category in Germany, the Netherlands, and Spain. In the United States, poor population groups and all seniors are eligible to public Medicaid or Medicare coverage, respectively, while the uninsured population is comprised largely of the working poor and near poor (Kaiser Commission on Medicaid and the Uninsured, 2003). In other PHI markets, private insurees tend to belong to higher-income groups. In several countries, PHI is offered as part of an employment

Table 2.9. **Characteristics of PHI subscribers across OECD countries**

Australia[1]	• Income: Higher-income brackets more likely to subscribe (22% of low-income individuals). • Age: Coverage increases with age peaking at 45-54 years. • Region: Coverage varies across regions (44% in Western Australia versus 22% in Victoria).
Austria[2]	• Income: Those in higher income brackets more likely to subscribe. • Employment: About half of subscribers are self-employed. Another 40% are civil servants or salaried employees. • Region: Urban residents are more likely to subscribe. (50% of Carinithia residents are insured compare to 17.5% of Burgenland residents in 2001).
Belgium[3]	• Employment: About 76% of the self-employed are covered by mutuals for small risk insurance. Other self-employed are covered by DKV Belgium.
Canada[3]	• Employment: Coverage highly linked to employment status.
Czech Republic[3]	• PHI plays a minor role covering less than 1% of inhabitants. • Purchased primarily by certain foreign nationals and people travelling abroad.
Denmark[2]	• Employment: Subscription is predominantly tied to employment. • Age: Students, children and the elderly are less likely to subscribe. • Health Status: PHI favours those without pre-existing conditions.
Finland[3]	• Age: PHI usually covers children (25% of children and 6.7% adults covered in 1996).
France[2]	• Income: PHI enrolment and quality of insurance significantly related to income. • Employment: The employed and retired more likely to be covered than the unemployed. Occupational status: 59% of unskilled workers have no or little PHI but only 24% of executives and professionals in 2000. • Age: Young adults and the elderly are less likely to be insured.
Germany[2, 4]	• Income: Those in higher income brackets more likely to subscribe. • Employment: Coverage not linked to employment. 1% of the unemployed have PHI (2001). • Age: Women, young, single or married couples more likely to buy PHI. Children account for 15.6% of membership, while women for 32.2% and men for 52.2%. • Geography: PHI purchasers are more likely to reside in the old Lander (10.1% coverage rate) compared to the new Lander (3.6%) (2000). • Gender: 52% of women and 32% of men are covered by PHI (1999).
Greece[2]	• Income: Medium to high earners more likely to subscribe. • Employment: Subscribers are predominantly employers, professionals, civil servants, white-collar workers and managers working for large private companies and banks. • Age: Most subscribers 35 to 45 years old (2001). • Region: Typically live in urban areas.
Ireland[2]	• Income: Coverage linked to household income [8% in bottom decile, 70% in top decile (2001)]. • Employment: Coverage highest for professionals and managerial social classes (70% covered) compared to semi and un-skilled workers (11%) (1995). • Region: Coverage higher in Dublin and lowest in small towns and rural areas. • Social status: Higher educational level and married status associated with coverage. • Health status: Those in poor health less likely to be privately insured.
Italy[2]	• Income: Those in higher income brackets more likely to subscribe. • Employment: Subscribers are usually managers and professionals [64% of the privately insured are high-level managers while 9% are blue collar workers (2001)]. • Age: Non-linear relationship between age and insurance status with 42 years of age being the age at which probability of coverage the highest. • Region: Most subscribers live in north-east or central Italy. • Social status: Highly educated people more likely to be covered.
Luxembourg[2]	• The 30-35% of the population without PHI are mostly foreigners residing there (2001).
Netherlands[5]	• Income: Primary coverage for 1/3 of the population who earn above a set income threshold. • Employment: Employers provide PHI for 20% of the population, or 63% of those with PHI.
New Zealand[3, 6, 7]	• PHI covers 33-37% of the population. Coverage has been declining over the past years. • Age: A disproportionate amount of young and health population dropping PHI since mid-1980s. • Income: 13% of households in the lowest income band and 63% in the top band purchase PHI.
Portugal[2]	• Income: Purchasers are mostly from high-income groups. • Employment: Coverage higher among the working population, especially professionals and the self-employed. • Age: Typical subscriber is 28-34 years old. • Region: Typical subscriber lives in urban area.
Slovak Republic[8]	• PHI insignificant. Only purchased by travelers.

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Table 2.9. **Characteristics of PHI subscribers across OECD countries** *(cont.)*

Spain[2]	• Income: Those in higher-income brackets more likely to subscribe (30% of the highest-income group and 3% of the lowest-income group covered by PHI in 2001). • Employment: Coverage is higher among the employed, with employers and the self-employed more likely to purchase insurance than employees. • Education: Higher education level is linked with higher coverage rates. • Region: Coverage rates vary by region, and is higher in urban than in rural areas.
Sweden[2, 3]	• PHI plays a minor role covering less than 1% of inhabitants. • Private companies in the service sector are the most likely to purchase PHI.
Turkey[3, 9]	• PHI plays a minor role covering 1% of the population. • Employment: Over half of the privately insured are offered this benefit by their employer.
United Kingdom[2]	• Employment: Participation varies by occupational status. (22% of professionals and 23% of employers and managers had PHI in 1995 compared to 1% of unskilled manual workers). • Age: Coverage highest among the middle-aged. • Geography: Insurees more likely to live in London and the southern region. (11% of the population covered in Greater London, 14% in the South East, 10% in South West and only 4% in Scotland in 2000).
United States[10]	• Income: Those in higher income brackets are more likely to be covered (41.2% in the lowest bracket compared to 90.1% in the highest). • Employment: 64% has employment-based PHI. Coverage rise with work experience. • Education: Coverage rates rise with education level. • Ethnicity: Blacks and Hispanics less likely to be covered by PHI than Whites and Non-Hispanics. • Age: PHI coverage peaks in the 45-65 age cohorts; lowest among the elderly and young adults. • Region: Variation by region (79% of those residing in the Midwest; 68.2% in the West).

Notes: Data unavailable for Japan, Korea, Mexico, Switzerland. PHI is very limited and breakdown of coverage is therefore not available in Hungary, Norway and Iceland.

Sources: Information was supplied by OECD member countries or obtained from official publications. Other specific data sources are:
1. Colombo and Tapay (2003).
2. Mossialos and Thomson (2002).
3. European Observatory on Health Care Systems, *Health Care Systems in Transition* (various countries and years).
4. PKV (2003).
5. Tapay and Colombo (2004).
6. Bloom (2000).
7. New Zealand Household Economic Survey 1997/1998.
8. Colombo and Tapay (2004b).
9. Kisa (2001).
10. US Census Bureau (2001).

contract, and sometimes this benefit is provided only to senior employees. Private health insurance is also more frequently purchased by individuals with higher education levels and employment conditions, which also tend to be correlated to income.

The distribution of population coverage across different age cohorts is not homogeneous, most likely as a consequence of differences in public sector coverage, regulation, varied employer offerings of PHI, diverse levels of dependent coverage by PHI policies, and other factors. In Finland, children are the most likely to be covered by PHI (Mossialos and Thomson, 2002). In several OECD countries where PHI is provided as a condition of employment, coverage is highest among middle age cohorts (*e.g.,* United States, United Kingdom, Ireland, Portugal, Sweden, and Italy). In Australia and New Zealand, throughout the 1990s, the average age of the privately insured population increased as younger and healthier individuals dropped insurance. The fact that the PHI market in Australia is essentially an individual rather than a group market may be responsible for high levels of population coverage by older age cohorts, as younger persons may have less incentive to purchase insurance. The prevalence of voluntary PHI among the elderly varies substantially across countries (Singer *et al.*, 2003). For example, almost the entire elderly population in the United States buys voluntary private

insurance (with the exception of those who receive supplemental coverage through Medicaid), mainly because of gaps in the public Medicare programme, such as the lack of a pharmaceutical benefit,[41] limits on hospital coverage, and high deductibles and cost sharing. Conversely, PHI coverage by the elderly is very low in Italy (3.2%), and fairly low in the United Kingdom (11.6%) and Germany (15.9%). Coverage levels in Germany and the United Kingdom do not differ from the overall population coverage by PHI.

4.3. Group versus individual purchasers of PHI

Employers play a prominent role in paying for or negotiating PHI in several OECD countries. The presence of an employer group market does not appear to be linked to any particular PHI role (Table 2.10). Employers are also behind much of the growth in PHI coverage in some OECD countries. In the United States, principal PHI is provided as a work-related benefit for 88% of the privately insured population (Docteur *et al.*, 2003). In Canada, supplementary PHI is almost exclusively furnished by employers.[42] In the Netherlands, Ireland, the United Kingdom and Portugal, employers' role in offering private coverage is large and has been widening over the recent years.[43] About half of all PHI contracts in France have an employment link.

In some OECD countries, most notably the United States, preferential tax treatment for employer-provided PHI has influenced employers' decisions to offer PHI for employees.[44] On the other hand, tax treatments may also discourage employer-sponsored PHI, as in the case of Australia, where the weak employment link may be partially explained by its fringe benefit tax. In Germany, the high-level of social security contributions may act as a deterrent for employers to sponsor PHI coverage for their employees (Datamonitor, 2000). Tax advantages such as those provided to employers in the United States and to insurees in Australia are also subject to debate over their opportunity cost and impact (Henderson and Taylor, 2002; Deeble, 2003).

Employer-sponsored PHI presents advantages for employees. Employers are able to negotiate better coverage solutions. For example, in the Netherlands, where regulation of private markets is limited, employers sometimes negotiate limitations on coverage exclusions. They also play an important role in fostering voluntary agreements with insurers for improving portability of private coverage when insurees lose or change their jobs (Tapay and Colombo, 2004). In France, insurance offered through employers tends to be more comprehensive than individual policies. In addition, employers are often able to negotiate cheaper premiums, which tend to be community rated within the firm, and fewer exclusions, based on the spread of risks within a large group. They may also pay for part or the entire premium on behalf of their employees and sometimes their dependents too.[45] The premiums of group policies are entirely paid for by employers in Greece, Italy, Sweden, Austria and Denmark. In Spain, this type of fringe benefit is especially offered to certain senior employees (Mossialos and Thomson, 2002), while in the United Kingdom it is more common in large companies. In the United States, employers generally pay between 84% (single) and 73% (family) of the cost of employees' medical benefits.[46]

The extent of choice offered to employees with regard to their private health insurance – for example whether participation is compulsory or voluntary and the number and types of policies offered – varies by country and employer. In Canada and France, about half of employer-sponsored contracts (which represent half of the PHI market) require employee participation (Finkelstein, 2002; Buchmueller and Couffinhal, 2004). In the United States, employers often offer workers a choice of health plans, including furnishing "cafeteria type

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Table 2.10. **Group and individual purchasers of PHI**

	Policy type (%)[1]		Additional information
	Group[a]	Individual	
Australia	0	100	Predominantly individual market due to historical reasons and disincentives of the fringe benefit tax system. Employers sometimes contribute to individual PHI.[2]
Austria	21	80	Group policies are employer-paid and gained market share between 1996-2000.[3]
Belgium	63(e)[4]	37(e)[4]	Commercial PHI policies are predominantly purchased by groups.
Canada	93(e)	7(e)	Group health, dental care and disability plans partly or wholly paid for by employers (who can deduct cost of PHI from taxable income) are increasingly popular. Group coverage is also available to professional and trade associations, students, creditors and travellers. While historically there was no market for individual PHI policies, this market has been growing. Travel PHI has more than tripled in the past decade to represent almost one-fifth of today's individual PHI market.
Czech Republic	0	100	
Denmark	…	Mainly	The main mutual insurer in the market (Sygeforsikringen Denmark, with a 96% market share) offers mainly individual insurance policies. Group policies are employer-paid and account for more than 80% of commercial policies.[3]
France	52	48	Group policies lost market share during the 1990s. 23.6% of PHI policies (about half of group policies) are a compulsory component of an employee's contract.[3] Provident institutions offer mainly group contracts (mandatory group contracts account for half of their activity). In the life and health insurance industry, PHI represents less than 5% of total revenue with group and individual contracts accounting for comparable numbers of contracts.[5]
Germany	7[3]	94	Employers can only contribute to substitute PHI policies offered by private health insurers which specialise in health.
Greece	Mainly		Between 1989-1995, individual policies increased by 64% and policies purchased by groups increased by 106%.[3] All group policies are employer-paid.
Ireland	49[6]	51[6]	During the 1990s, group policies gained an increasing share of the PHI market. The number of people having their PHI premiums entirely met by their employers has grown over time.[7] In 2000, 20%-25% of group policies are employer-paid.[3]
Italy	26 (1999)[3]		All group policies are employer-paid.[3]
Luxembourg	…	Mainly	In 2000, 95% of commercial policies and 100% of mutuals were purchased by individuals. During the 1990s, group policies gained an increasing share.[3]
Mexico	56	44	Some group PHI offered by Specialised Health Insurance Institutions (ISES) involves no insurance risk undertaken by ISES, who only perform an administrative function.
Netherlands	60(e)	40(e)	During the 1990s, group policies gained an increasing share of the PHI market and now account for over half of all policies.[3] Employers play a significant role in the offering and financing of private health insurance . The proportion of the privately insured with group coverage (not including those with WTZ coverage) has been steadily increasing from 34.4% in 1980 to 62.4% in 1998. Employers provide supplemental private coverage to those covered by sickness funds to a lesser extent. Employers often pay up to 50% of the premiums for their workers, but do not always provide their employees with a choice of benefit packages.[8]
Poland	0	100	
Portugal	76	24	During the 1990s, group policies gained an increasing share of the PHI market and now account for a large majority of the market.[3]
Slovak Republic	0	100	
Spain	15-18[3, 9]		During the 1990s, group policies gained an increasing share of the PHI market.[3]
Sweden	90	10	During the 1990s, group policies gained an increasing share of the PHI market.[3]
Switzerland	17	84	Predominantly individually-purchased PHI policies. However, voluntary daily cash-benefit insurance covering loss of income due to illness is generally taken up as group insurance and covers the obligations they have to continue paying wages in the event of illness or injury.[10]
Turkey	64	36	
United Kingdom	67(e)[11]	33(e)[11]	Estimate based on "subscriber" numbers (heads of family rather than "persons covered").[1] During the 1990s, group policies gained an increasing share of the PHI market. Approximately 59% of PHI policies are purchased by employers.[3]
United States	94	6	Employer-sponsored PHI covers 58% of the population; individual policies 5%.[12]

Table 2.10. **Group and individual purchasers of PHI** *(cont.)*

(e) Estimates based on the proportion of gross premiums accounted for by group and individual PHI, based on OECD Statistical Questionnaire on Private Health Insurance, 2000 data.

a) Employer-administrated health insurance with no employer contribution, professional of other associations' plans may or not fall within the definition of the group policy depending on the country and its legal framework.

Sources: Information was supplied by OECD member countries or obtained from official publications. In addition, specific data sources include:

1. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.
2. Colombo and Tapay (2003).
3. Mossialos and Thomson (2002).
4. Data refer only to commercial companies. European Observatory on Health Care Systems (2000,. *Belgium*.
5. Buchmueller and Couffinhal (2004).
6. Health Insurance Authority (2003).
7. Colombo and Tapay (2004a).
8. Tapay and Colombo (2004).
9. OECD Statistical Questionnaire on Private Health Insurance, 1998 data.
10. Colombo (2001).
11. OECD Statistical Questionnaire on Private Health Insurance, 1999 data.
12. Kaiser Family Foundation, 1999 and 1998 *www.statehealthfacts.kff.org*.

plans".[47] The extent of choice often varies by employer size in the United States, with most of the largest employers (with 5 000 or more employees) offering a choice of plan (80%) but most small employers (3-199 workers) offering only one plan (69%) (The Kaiser Family Foundation and Health Research and Educational Trust, 2003, p. 3). While employers' offering of plan choice has the advantage of allowing individuals to better tailor their coverage and cost preferences, it may create risk segmentation within employment-based purchasing.[48] Consumer-driven models of employer-sponsored health insurance – such as defined contribution plans (see Chapter 4) – also represent ways for employers to limit their liability over choice of plans (Henderson and Taylor, 2002).

Group policies such as those with an employment link also have advantages for insurers. Employer groups – especially those of larger employers – tend to be healthier and younger than the average population. Administrative costs are lower both because of economies of scale in administering group insurance and because of the more contained advertising and often distribution costs. This is reflected in lower prices of group policies, for a given set of benefits covered, compared to individual contracts. Lower pricing may also reflect a strategic behaviour by insurers, who face more competitive pressures within group markets.

Unlike most other OECD countries,[49] the US employer-based PHI market is generally divided into a small and a large group market, with different characteristics and different regulations (Box 2.5).

Group policies sponsored by non-employer groups also exist. Group policies may be purchased through associations, purchasing pools, trade unions, or other non-employer-based groups. Typically, individuals buying these policies have to pay the premium themselves, although they benefit from discounts offered on group policies. For example these types of policies accounted for 10% in the UK market in 2002, and for about half of all group policies in Ireland (Mossialos and Thomson, 2002).

Some OECD countries have predominantly individual PHI markets, such as Korea, Australia, Poland, Luxembourg, the Czech Republic, Spain, Austria, and Germany. Individual markets across OECD countries tend to have somewhat higher administrative costs and, in countries where risk-rating is permitted, high-risk individuals may face

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Box 2.5. **Small and large group markets in the United States**

Under federal law, the small employer market is defined as employers with 2-50 employees, and states also have the option of including self-employed individuals within their small group markets. The small group market has historically suffered from greater access and accessibility problems. Their smaller risk pools made them more vulnerable to changes in employee health status and insurers often engaged in fairly aggressive rating and risk selection practices.

In an effort to address these challenges, beginning in the 1980s and culminating in a federal law enacted in 1996, a series of state-level and federal reforms imposed more stringent issuance and rating-related requirements on this market. Currently, under federal law, insurers must offer all their products to all small employer applicants. Rating practices, however, vary by state.

A federal law enacted in 1974 (ERISA) also contributed to a more segmented US employer health plan market. The law permitted employers to self-fund their employee health coverage and thereby be exempt from state laws applicable to health insurers. This option was particularly attractive for employers that were large enough to have a meaningful risk pool and assume the risk of their own coverage (although there is no size requirement in the law). It was also appealing to those operating across state lines who wanted to offer uniform health benefit packages to their employees. As a consequence of the different risk characteristics and regulations of these markets, the employer group market became increasingly diverse. It was composed of many large self-funded employer plans and diverse state-regulated insured plans (including managed care plans) offered to small employers and to those large employers wishing to purchase insured products.

expensive premiums on inception, or on renewal. Voluntary community-rated individual markets face a higher risk of premium "death spirals" if the younger and healthier people do not join or pull out of coverage, spurring further premium increases as higher health risks are left in the pool. As individuals have lower bargaining power over insurers, insurers' may recoup discounts on group markets through their individual contracts. Crowding out of individual health insurance markets by group polices may be taking place in the Netherlands (Schut and van Vliet, 2001).

5. Supply of PHI and market characteristics

5.1. *Insurers and market structures*

A variety of insurance entities operate in PHI markets. These include commercial for-profit insurers, not-for-profit funds, mutual and provident associations, or other types of entities permitted to offer insurance under applicable law (Table 2.11). While these entities tend to be "private", PHI can also be sold by public entities, such as in the case of state-owned insurers as Medibank in Australia and VHI in Ireland. Most European markets have historically been dominated by non-profit provident and mutual association insurers, although commercial entities are gaining market shares, for example in France, the United Kingdom, Denmark and Ireland (Mossialos and Thomson, 2002). The United States also has a history of insurance by not-for-profit carriers.

PHI is sold entirely by specialist insurers in Australia as well as in Ireland and Germany, and almost entirely in Switzerland. In Australia, there is a legal requirement that insurers selling PHI be specialised. Such a requirement has historically existed also in

Table 2.11. **Characteristics of insurers offering private health coverage**

	Types of health insurance organisations[1]	Additional comments[2]
Australia	Indemnity insurers; non-profit and for-profit plans; mutual associations (most health funds are incorporated not-for-profit mutual associations).	3 insurers: 57% of market. 44 health funds in the market (2000). 100% of insurers specialise in health.
Austria	Indemnity insurers, non-profit and for-profit plans. Mutual companies are not active in the private health insurance business.	8 insurers: 100% of market. 49.7% by one insurer. Trend toward insurer concentration during the 1990s.[3] About 5% of insurers specialise in health.
Belgium	Mutual associations (sickness funds) or commercial insurers. All sickness funds (but one entity that does not offer PHI) are private, legally independent, non-profit. Substitute PHI is only provided by sickness funds (mutuals) and DKV Belgium.	7 insurers : 81.5 % of market. 14% of commercial insurers specialise in health. 36 insurers undertaking and 77 sickness funds (2002).
Canada	Indemnity insurers. Non-profit vs. for-profit plans.	No insurer has more than 15% of the market. 100% of insurers do not specialise in health.
Czech Republic		4 insurers: 73% of market. 2 with > 15%, 1 > 40%. Three-quarters of insurers do not specialise in health.
Denmark[4]	The PHI market is dominated by the mutual (non profit) association (*Sygeforsikringen Danmark*).	*Sygeforsikringen Danmark* has a 96% share of the market (1.5 million people).
Finland		3 Insurers: 62% of market[3] (PHI is insignificant).
France	Mutual associations, commercial insurers and provident associations account for < 60%, > 20% and 15-20% of market respectively.[4]	118 private (mutual and commercial) insurance companies operate in the French PHI market. 56% of insurers specialise in health.[3]
Germany	Indemnity insurers, including joint-stock companies and mutual societies. All substitutive PHI is sold by specialist health insurers.	No insurer with > 14%. 14 insurers: 82% market by premium income; 50 private health insurers offer substitute and supplementary insurance, covering 99.9% of the market. In addition, there are around 45 other very small and usually regional private health insurers.[5]
Greece		5 insurers: 70.4% of market. A trend toward insurer concentration during the 1990s.[3]
Hungary	Mutual funds.[6]	4 insurers: 89% of market (1999).
Iceland	Non specialist life insurance companies.	In 2002, 4 domestic life insurance companies were offering private health and life insurances.
Ireland	Indemnity insurers, non-profit plans and mutual associations.	2 insurers: 94.9% of market. 100% of insurers are specialist.
Italy	Commercial insurers, mutual associations. Mutual associations generally have lower premiums and their markets are low-middle income people. Commercial insurers usually sell their individual policies to mid to high-income earners.[6] 0.8% of insurers are specialised.Health insurance companies are 60% for-profit and 40% not-for-profit.[3]	6 insurers: 50% of market.[3] Trends toward insurer concentration during the 1990s. The private for-profit insurance market has grown rapidly since the early. 1980s. Mutual insurance funds cover about 300 000 people. Corporate and collective funds are organized by employers or professional categories for their employees or members.[6] 100% of insurers are non specialist.[1]
Korea[1]	81% of insurers are non specialist.	3 insurers: 81.2% of market.
Luxembourg		4 insurers: 77% of market.[1] Trend toward insurer concentration during the 1990s.[3]
Mexico	Mutual associations or insurers. Specialised Health Insurance Institutions (ISESs) similar to managed care organisations offer comprehensive health coverage, while non-specialist insurers offer catastrophic health cover products.	4 insurers: 73.2% of market. 28 companies with the authorisation from the Ministry of Finance to offer insurance products. Insurers are both non specialist and specialised institutions (ISES), selling different product.
The Netherlands	Mutual associations or insurers. 75% of insurers are non specialist in health.	5 insurers: 50% of market. 47 insurers who offer principal cover.No insurer with more than 15% of the market. 27 sickness funds also offer supplementary PHI.
New Zealand	Mutuals, friendly societies, not-for profit and for profit companies.[7]	5 insurers: 64.08% of market. Southern Cross has an estimated 75% of market share.[6]
Poland	Indemnity insurers, and mutual associations or insurers.	29 non-life insurance companies were licensed in the scope of sickness insurance and 18 of them operated on the market. 31 life insurance companies conducted accident and sickness insurance supplemental to the other classes of life branch (out of 34 licensed).
Portugal	Indemnity insurers, managed care plans (operated by non-life multi-branch insurers) and mutual associations or insurers.	21 insurers, with 5 insurers: 64% of market. 1 insurer 47.4% of market. 100% of insurers are non specialist.[1] Trend towards insurer concentration during the 1990s.[3]

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Table 2.11. **Characteristics of insurers offering private health coverage** *(cont.)*

	Types of health insurance organisations[1]	Additional comments[2]
Slovak Republic	Indemnity insurers	Some non specialist insurance companies provide supplementary health insurance. One company provides private health insurance on commercial basis to persons who are not cover by social security scheme. Its share on non-life insurance market was less than 0.2 %.
Spain	Indemnity insurance and "benefits in kind" insurance (public limited companies, mutual companies and cooperatives). 87% of insurers are health specialist.	10 Insurers: 83% of market. Trend toward insurer concentration during the 1990s.[3]
Sweden		5 insurers: 85 % of market. 80% of insurers are non specialist
Switzerland	Indemnity insurers, non-profit vs. for-profit plans and mutual associations or insurers.[1] Sickness funds (non-profit) offer basic health insurance (109 in 1998) and voluntary cash benefits insurance. About half offered voluntary PHI in 1998. Other commercial insurers operate solely in the voluntary PHI market.[8]	10 insurers: 70% of PHI market.
Turkey	Indemnity insurers	10 insurers: 89 % of market. All insurers are non specialist.
United Kingdom	Indemnity insurers, including non-profit and for-profit plans run by mutual association and shareholders companies respectively. Non-indemnity insurers, typically for-profit, offer cash plans.	4 insurers: 80% of market. 36% of insurers specialise in health.[3]
United States	Indemnity insurers, managed care plans, non-profit vs. for-profit plans, mutual associations or insurers.The insuring entity can be a commercial (stock or mutual) insurer, a non-profit Blue Cross-Blue Shield plan (BCBS) (in States that still have them), a fraternal benefit society, a prepaid plan offered by health care providers, an employer-funded plan (single-employer or multiple-employer), or arrangements where more than one entity participates in the risk.	Group market: HMOs 42% of premiums, BCBS 39%, commercial insures 19%. Individual market: HMOs 20% of premiums, BCBS 57%, commercial insurers 23%. Almost every health insurance organisation can offer either managed care benefits, indemnity benefits, or "preferred provider" or "point of service."

Sources: Specific data sources have been indicated below; information was also supplied by OECD member countries or obtained from official publications.
1. OECD Regulatory Questionnaire on Private Health Insurance.
2. OECD Statistical Questionnaire on Private Health Insurance, 2000 data, unless otherwise specified.
3. Mossialos and Thomson (2002).
4. Buchmueller and Couffinhal (2004).
5. PKV (2003).
6. European Observatory on Health Care Systems.
7. Health Funds Association of New Zealand.
8. Colombo (2001).

Germany, although it was lifted for foreign EU companies following the adoption of EU directives into German Law (Mossialos and Thomson, 2002). Insurers wishing to benefit from 50% employer contribution for substitute insurance are still required to be specialised in Germany. In Ireland, besides the VHI, one other specialist company and three smaller vocational undertakings operate in the market. In Switzerland, voluntary PHI is predominantly sold by specialised sickness funds who also offer mandatory health insurance, while commercial insurers cover a minority of the market (Colombo, 2001). In all other OECD countries, PHI is predominantly or entirely sold by non-specialist insurers. Requirements that insurers be specialised, such as in the case of Australia, are meant to guarantee the separation of PHI from other types of insurance and protect the interests of purchasers of PHI products in case of insurer insolvency. Within the EU, insurers are required to account for and operate "health and accident" and other "classes" of insurance as separate business lines.

While PHI is offered by multiple insurers in all OECD countries, there are significant differences in their number and market concentration. Arguably, these may impact upon

the level of competition existing within the market. Only in a few OECD countries do a large number of insurers operate in a rather dispersed PHI market, such as in the case of the United States, Switzerland, France and Spain. While there is a relatively large number of insurers in Australia and the Netherlands, a few of them capture the majority of the insured population. One insurer dominates the Irish market. A second insurer – still occupying today a minority position – entered the market following its opening to competition in 1994. In other OECD countries, the PHI market tends to be concentrated in the hands of a small number of large insurers.

Theoretically, for-profit and not-for-profit insurers could be expected to maintain different market conducts as they respond to different financial and social incentives. Thus, for example, not-for-profit insurers would tend to apply community-rated premiums and open enrolment for applicants even in the absence of regulation compelling them to do so. Conversely, for-profit insurers would be expected to be more conscious of return-on-investment, profit and dividend policy and to use risk assessment and market segmentation more intensively. Different legal requirements for different types of plans can mandate different behaviour by non-profit insurers, as was often the case in the United States. While there is a dearth of evidence from several OECD countries concerning the extent to which these market segments behave differently, there are some interesting examples from selected countries.

In France, the entry of commercial insurers into the complementary PHI market in the 1980s prompted many mutual associations ("mutuelles") – especially those operating in the individual market – to adopt similar practices to those of commercial insurers in order to minimise risks of being adversely selected against. Both commercial insurers and mutuelles now vary non-group prices according to subscriber age (Buchmueller and Couffinhal, 2004), although, differently from many for-profit insurers, mutuelles in France do not select risks and operate more according to the logic of non-profit organisations. In the United States, non-profit Blue Cross and Blue Shield plans generally practiced community rating as a product of their charter or applicable law. Facing increasing competition from for-profit insurers, a few plans experienced financial difficulty. Some state policy makers responded by imposing similar requirements upon non-profit and for-profit plans, at times loosening the standards applicable to the non-profit plans, and at times making all plans subject to more stringent requirements. In the Netherlands, on the other hand, the co-existence of commercial and non-profit insurers seems to have had a different effect, *i.e.*, commercial insurers apply seemingly less stringent risk rating requirements than they are legally permitted to do. In several EU markets, insurers, whether for-profit or not-for-profit show similar market conduct.[50] EU law generally requires countries to subject all health insurers to uniform treatment unless differences are justified in the public interest.

In some OECD countries the market structure and ownership of insurers may pose some challenges to the functioning of the market. For example, competition in the Irish insurance system is arguably limited by the presence of only two players. Yet, even in markets with many players, it can be challenging to establish "healthy" competition on the basis of efficiency and quality levels as insurers may find risk selection a profitable ground for competition. The dominant market position and corporate status of the state-owned insurers in Ireland and Australia (VHI and Medibank) raise questions about what links, if any, these insurers should maintain with the government, and the consequences of any such association for competition.[51] In the Netherlands and Switzerland, the involvement

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by affiliated insurers in differently regulated social and private health insurance compartments may pose challenges for competition and consumer mobility in both the social and private insurance systems.

5.2. Relationship between PHI insurance carriers and health care providers

The relationships between insurers offering PHI and providers of care can be broken down into three main categories across OECD countries: an indemnity/reimbursement model, contractual arrangements between providers and insurers (with no integration), and more integrated health delivery systems. These models may simultaneously exist in the same country, for examples in the United States all types of relationship with providers can be found on the market (Box 2.6). Methods of paying doctors and hospitals, degree of selectivity in reimbursing providers, and contents of contracts vary across countries and insurers. They are influenced by regulation and insurers' strategic practices.

Indemnity insurance

Within several OECD countries, particularly those where markets are very small or insignificant, insurers have a contractual relationship with insurees but not directly with providers. In this case, by necessity, reimbursements take place between insurers and individuals who claim reimbursement of cost after treatment. Insurers may impose ceilings on the amounts reimbursed to insurees, either on single claims or through annual reimbursement limits. They may also set a schedule with maximum fees they will reimburse for different treatments. Typically, individuals are reimbursed on a per-service, treatment, or case basis, reflecting the way providers within the private sector are paid. Any cost in excess of insurers' reimbursement is the responsibility of the individual, and insurers actually leverage this as a way to limit their cost exposure. Most insurers operate on an indemnity basis in Belgium, France, Germany, Luxembourg, and Canada. In the United States, traditional indemnity insurance now represents a small portion of the PHI market as there has been a blurring of the division between indemnity and managed care plans. In the Netherlands, where insurers also tend to operate on an indemnity basis but can theoretically contract with other providers on an individual basis, they are obliged to pay for care provided by all hospitals.

Contractual arrangements between providers and insurers (with no integration)

Insurers engage in contractual relationships or stipulate agreements with providers in some PHI markets. With the exception of the United States, where provider payment arrangements are more varied, insurers typically pay providers on a fee-for-service basis and prices are the main negotiation item.[52] Other delivery conditions such as volumes, type and quality of care are less the subject of contractual agreements or negotiations. Insurers can contract with all providers or may enter into selective contracts with a more limited subset of them. In this latter case, insurers may still reimburse patients if they choose to use a non-contracting provider, but the patients generally receive a lower reimbursement or face higher cost sharing in this case. This occurs in the United States under "preferred provider organisations" (PPOs) or under the "point-of service" options of health maintenance organisations (HMOs). Negotiations with providers can take place on an individual basis or on a collective basis (between associations or group of insurers and providers). They may involve only private providers, or also extend to public hospitals in some countries (Table 2.12).

Box 2.6. **Indemnity insurance and managed care in the United States**

One major distinction in health insurance products, particularly relevant to the US market, is the difference between traditional fee-for-service indemnity insurance and managed care. Under the former, the insuree chooses freely treating providers, claiming a reimbursement from their plan for the cost of treatment received. Insurers may carry out reviews to check whether a service is part of covered benefits, but no other efforts to manage care are made. Conversely, under managed care plans, insurers select and monitor providers and the service they render though a variety of tools such as selective contracting, utilisation management, clinical guidelines, restrictions on treatments, incentives and information directed to consumers to promote the use of cost-effective providers or services. Individuals tend to have more restricted choice of provider under these arrangements, especially if they wish to receive the maximum level of reimbursement under their contract. The term managed care was originally linked to more tightly controlled integrated models such as health maintenance organisations (HMOs), but has evolved to include less stringent arrangements.

Until the early 1990s, traditional indemnity fee-for-service insurance was dominant in the US market, however, it experienced a rapid decline during the 1990s and only 7% of workers had such coverage in 2001 (Gabel *et al*., 2001). Managed care plans became the dominant form of health coverage, and insurers and employers increasingly relied on these plans' more stringent controls as a means of containing cost. Yet providers and consumers resisted managed care's restrictive practices, and, together with employers, demanded more flexibility from these coverage arrangements (often referred to as the "managed care backlash"). Health plans responded by modifying their practices, for example, by loosening controls over provider choice and access to care. As a consequence, the difference between traditional indemnity and managed care plans became increasingly blurred, and plans combined characteristics and tools of both coverage types (Docteur *et al*., 2003).

Preferred-provider-organisations (PPO) contract with providers who generally participate in more than one network, and now enrol 48% of workers (Gabel *et al*., 2001). Physicians are usually paid on a discounted fee-for-service basis under these arrangements. A variety of new insurance schemes have emerged with larger networks of participating providers and more coverage of out-of-network providers. For example, under so-called "point-of-service" (POS) plans (often offered in combination with HMO coverage), insurers also cover the cost of care supplied by providers outside the network, although at a higher cost for insurees. Their market share has increased from 14 to 22% (Gabel *et al.,* 2001). Finally, provider service organisations (PSOs) represent coalitions of providers carrying out the functions of a health plan, and can be seen as providers' response to control over their practices (Docteur *et al*., 2003). Some states require these plans to be licensed under the same or similar laws as HMOs.

Definition of different types of managed care in the United States:*

Managed care is a term originally used to refer to the prepaid health care sector (*e.g., HMOs)* where care is provided under a fixed budget and costs are therein capable of being "managed." Increasingly, the term is being used to include *preferred provider organizations (PPOs)* and even forms of indemnity insurance (or fee-for-service insurance) that incorporate preadmission certification and other utilisation controls.

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Box 2.6. **Indemnity insurance and managed care in the United States** *(cont.)*

Integrated models: HMOs. An HMO is a health care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee. Pure HMO enrolees use only the prepaid capitated health services of the HMO panel of medical care providers. Open-ended HMO enrolees use the prepaid HMO health services but, in addition may receive medical care from providers who are not part of the HMO panel. There is usually a substantial deductible, co-payment, or coinsurance associated with use of non-panel providers.

- *Group model HMO*. An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated per capita rate, which the group distributes among its physicians, usually on a salaried basis.
- *Staff model HMO*. A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The providers see members in the HMO's own facilities.
- *Network HMO*. An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups.
- *Individual Practice Association* (IPA). A type of healthcare provider organisation composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs, PPOs, and insurance companies. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Point-of-service plan. A health plan that allows members to choose to receive services from a participating or non-participating network provider, usually with a financial disincentive for going outside the network. More of a product than an organization, POS plans can be offered by HMOs, PPOs, or self-insured employers.

Preferred provider organisation. A PPO is a type of medical plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrolees may go outside the network, but then pay a greater percentage of the cost of coverage than within the network.

* *Source:* National Center For Health Statistics: *www.cdc.gov/nchs/datawh/nchsdefs/list.htm*.

In the Netherlands, Australia and Ireland, private insurers reimburse insurees for health services delivered by virtually all providers. This occurs either because they have established contracts with all providers, as in Ireland, or because, in the absence of a contract, they act as indemnity insurers (in the Netherlands) or pay a default payment to non-contracted providers (as in Australia). Only some private insurers enter into individual contracts with providers in the Netherlands. Instead, provider fees are the object of collective negotiations between provider associations and insurers, in which both sickness funds and private insurers participate. These negotiations are subject to significant government-determined parameters as negotiated fees cannot exceed national tariff limits. In Ireland and Australia, prices are agreed in individual negotiations with providers (although physician contracts are often standardised). In Ireland, the state-owned VHI exerts a strong bargaining power over reimbursement levels and other insurers follow prices set by VHI. In Australia, smaller

insurers have formed a common organisation to increase their bargaining power in contractual arrangements with providers. In both Australia and Ireland, pro-competitive regulation prohibits providers from negotiating collectively with insurers. Selective contractual arrangements between insurers and providers also exist in other OECD countries, for example some insurers do so in Austria, Portugal and the United Kingdom, among others (Mossialos and Thomson, 2002). In the United Kingdom, insurers generally directly pay providers, with whom they may also have negotiated agreements.

Integrated health care delivery systems[53]

Within integrated health care systems, insurers often create, own or contract with a network of affiliated hospitals and providers to provide a full range of health care services to their members. These insurance schemes therefore combine health financing and delivery systems under the same entity. Integrated health delivery systems include certain types of "managed care"[54] functions in the United States and some cases of insurers linked with hospitals in France, Spain and Greece. In Mexico, specialised Health Insurance Institutions (ISES) have started to operate since regulatory reforms at the end of 1999 required all institutions offering health insurance (with the exclusion of catastrophic health coverage products) to be specialised.[55] ISES operate in much the same manner as do group-model HMOs in the United States. They own, or contract with, providers' networks, provide preventative and health promotion services, review utilisation of the health services provided, and manage the medical resources and healthcare delivery services available to their members, including referrals.

Integrated health systems often form a part of managed care plans. The original models of such integration are HMOs in the United States. HMOs manage and coordinate delivery activities by providers by employing or contracting with health care providers and subjecting them to controls over delivery patterns. Within HMOs, professionals can be paid according to methods ranging from salary, capitation, blended capitation and fee-for-service remuneration, and discounted or full fee-for service arrangements. HMOs use a mix of economic incentives, protocols and guidelines in order to influence health care delivery and contain cost.

These types of organisations were widespread in the United States in the 1990s, and at this time, managed care plans seemed to have some success in moderating health prices. Consumer backlash against more restrictive practices, together with providers' attempts to regain their primacy in medical decision-making, led insurers to back away from the more stringent managed care models and loosen their managed care arrangements and procedure approval requirements. Today, fully integrated models, such as staff-model HMOs, are only a minority of insurance arrangements in the United States (*e.g.,* Mayo, Kaiser Permanente). Practices have also evolved within the more heavily integrated systems. There is less emphasis on the use of economic leverage to control delivery patterns, and greater weight placed on quality of care, patients' safety, rewarding of performance, patient-driven care and involvement of the medical profession.[56]

Do insurers influence private provision?

The extent to which private insurers influence medical practice varies across the three models. For example, indemnity-type insurers perform primarily as reimbursement agents and generally do not, nor seek to, influence providers' practices and prices. Some indemnity insurers, as for example in the United Kingdom, have developed some pre-authorisation,

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cost containment and post-audit systems, especially where electronic claims management and direct provider-payment systems have been developed. In fully integrated models, ability to control cost and delivery conditions is at a maximum, and may have levels of control similar to public integrated models (such as the NHS in the United Kingdom). However, insurers' ability to influence medical practice depends not only upon insurers' choices and strategic behaviours, but also upon other factors. Notably, regulation can also shape the relationship between insurers and providers[57] (Table 2.12).

Policy makers may impose *restrictions on privately financed providers' practice*. For example, some countries restrict doctors' ability to charge private insurees above fixed fee levels. In the German primary PHI market, doctors are allowed to charge private insurees fees above the regulated prices charged to social insurees.[58] This also happens for some doctors in France and in the United States, among others. Conversely, in the Dutch primary PHI market, the same level of regulated fees applies to both socially insured and privately insured patients, thus limiting insurers' ability to compete upon the basis of provider payment levels. In Australia, private funds are not allowed to cover the medical cost of out-of-hospital treatments for which a Medicare benefit is payable. Insurers can however negotiate coverage of part or the entire "gap" between the private fee charged by the doctor for in-patient care and the benefit paid by Medicare (Colombo and Tapay, 2003).

Regulation also shapes providers' activities in the private sector. For example, governments may delimit public hospitals' ability to treat private patients and doctors' ability to serve both public and private patients. Private patients are admitted to public hospitals in Australia, Portugal, Ireland and the United Kingdom. In Ireland, all PHI plans are required to reimburse private treatments in public hospitals as part of minimum benefit regulations. In Australia, private hospitals arguably have large volumes of activities because the cost of inpatient medical services provided to private patients is in large part reimbursed by the public system.[59] In Ireland private hospitals do not receive direct public subsidies, although they benefit from other indirect subsidies. Doctors' are prohibited to practice in both the public and private sectors in Sweden, Luxembourg, Greece and Italy, which is conversely permissible in other EU countries (Mossialos and Thomson, 2002), as well as Australia and New Zealand.

Furthermore, governments can also impact providers' activities by restraining *insurers' ability to contract with providers*. For example, a regulatory obligation for insurers to contract with all providers exists in the basic mandatory health insurance system of Switzerland – although the removal of this obligation is being debated (Colombo, 2001). In Australia, while health funds can contract selectively with hospitals, they also face an obligation to pay a default payment to all hospitals with which they have not entered into contractual agreement (Colombo and Tapay, 2003). Some US states require managed care plans to contract with "any willing provider". While enhancing choice, these requirements have been heavily debated as they can curtail plans' ability to control costs and also may limit their ability to select providers according to quality-based criteria.

The extent to which private insurers influence medical practice has implications for health system performance, particularly cost-efficiency, quality of care and, in part, equity of access to care. Regulatory requirements relating to private health care delivery and insurers' contracts with providers also affect PHI's impact on the health system. The influence of different relationships between insurers and providers on performance, and the effect of regulation on these arrangements, is analysed in Chapter 4.

Table 2.12. **Regulated interaction between PHI insurers and health care providers**

	Main type/model	Regulation on insurers with respect to providers	Regulation on providers with respect to PHI
Australia	• All insurers have contracts with hospitals; very limited selective contracting. • Insurers mainly negotiate fee levels (usually per diems) with hospitals. Insurers negotiate "no medical gap" arrangements where doctors agree to receive a certain fee as full payment for services delivered to insurees.	• Insurers must pay a default payment to all non-contracted providers. • Insurers must cover 25% of the Medicare benefit schedule for inpatient medical treatments (75% paid by Medicare). Insurers may cover the "gap" in excess of Medicare fee schedule for inpatient treatments. • Insurers cannot cover out-of-hospital services for which a Medicare benefit is payable.	• Common in Australia for physicians to work in both public and private sector. • Doctors establish their fees freely. • Public hospitals can have private beds.
Austria	• GPs and hospitals have selective contracts with insurers.	None	• Physicians employed in public hospitals can treat private patients. • Fees vary between states. • Public hospitals can have private beds.
Belgium	• Indemnity insurers, reimburse insurees.	None	• Dual practice allowed but most physician are self-employed and private. • Public hospitals cannot have private beds.
Canada	• Indemnity insurers.	• Insurers cannot cover medical or hospital services provided by the public system.	• Doctors practicing in the private sector cannot see public patients.
Czech Republic	• Indemnity insurers.	None	• Public hospitals cannot have private beds.
Denmark	• Mainly indemnity insurers, but insurers are involved in some selective contracts with providers.	None	• Dual practice allowed.
Finland		None	• Dual practice allowed.
France	• Indemnity insurers. • Reimburse insuree on the basis of fixed fee schedule. • No contracting with providers.	None	• Dual practice allowed. • Public hospitals cannot have private beds.
Germany	• Indemnity insurers: insured individuals pay the bill and gets reimbursed by insurer. • Private health insurers usually do not contract with health care providers.	None	• Dual practice allowed. • Public hospitals may have private beds. • Doctor must follow fee scale when treating private patient but there's flexibility in calculation of charges for each medical service provided.
Greece	• Mainly indemnity insurers, but insurers are also involved in some selective contracts with providers.	None	• Dual practice allowed. • Physicians working part time in social security funds can work in the private sector. • NHS physicians are not allowed to work in the private sector (except afternoon outpatient clinics). • Public hospitals cannot have private beds.

Table 2.12. **Regulated interaction between PHI insurers and health care providers** *(cont.)*

	Main type/model	Regulation on insurers with respect to providers	Regulation on providers with respect to PHI
Ireland	• Insurers have contracts with providers.	• Insurers are obliged (under min. benefit regulations) to provide cover in respect to semi-private accommodation charges for their members within public hospitals; must also cover the statutory charge applicable to private patients who attend public hospitals with Category II eligibility.	• Dual practice allowed. • Public hospitals can have private beds.
Italy	• Mainly indemnity insurers, but insurers are also involved in some selective contracts with providers.	None	• Public hospitals cannot have private beds.
Luxembourg	• Indemnity insurers, reimburse insurees on the basis of fixed fee schedule.	None	• Dual practice not allowed. • Public hospitals cannot have private beds.
Mexico	• ISES own or contract with provider networks; general insurers offering catastrophic health cover can operate as pure indemnity insurers or contract with a network of providers.	• Professional credentials of doctors and accreditation of hospital facilities serving policy holders required for ISES.	• Dual practice allowed. • Public hospitals do not have private beds.
Netherlands	• Indemnity insurers, government determines fee schedule and fixes budgets for hospital.	• Insurers cannot contract with providers to provide preferential access to PHI insurees.	• Dual practice allowed. • Public hospitals cannot have private beds.
New Zealand	• Insurers have contracts with providers or act as indemnity insurers.	None	• Dual practice allowed.
Portugal	• Selective contracts with providers, and some managed care.	None	• Dual practice allowed. • Public hospitals can have private beds.
Spain	• Benefits in kind: integrated with providers (insurers own hospitals) and/or contract with providers (86% of premiums). • Indemnity insurance: 8% of premiums.	None	• Dual practice allowed, provided there is no work schedule conflicts. • Public hospitals cannot have private beds.
Sweden	• Insurers have some selective contracts with providers.	None	• Dual practice allowed.
Switzerland	• Insurers contract with all providers (basic health insurance). • Indemnity or contract in supplementary PHI.	• Insurers must contract with all providers in basic health insurance. • Some selective contracting is allowed in HMO-type basic insurance policies.	• Dual practice allowed. • Public hospitals can have private beds.
United Kingdom	• Indemnity insurers (insurers can set maximum benefits they will reimburse). • Selective contracts with providers (non-exclusive). • Some evidence of "provider partnership" schemes, where providers agree to charge up to the maximum benefits reimbursed by insurers' and respect other quality criteria.	None	• NHS consultants can undertake private practice up to 10% of their NHS income. If 10% limit is exceeded, they will lose 1/11th of their NHS salary. • Public hospitals can have private beds, but "pay beds" in NHS hospitals limited by Health Ministry. • Surgeons and anaesthetists time working in private sector out of from main NHS contracts is limited.
USA	• Indemnity insurers. • Contractual arrangements (PPO, POS). • Integrated models (HMOs).		• Most individuals employed by public hospitals can work in private sector on their own time.

Source: OECD Regulatory Questionnaire on Private Health Insurance, 2003. Other official data sources supplied to OECD were also used.

5.3. Product variation

In addition to traditional reimbursement or prepaid health coverage arrangements, PHI markets in OECD countries sometimes offer other insurance (or quasi-insurance) products that pay for part or all of the costs of certain health services or adverse health. Some of those are described below.

Medical Saving Accounts (MSA)[60]

The only OECD market where such products developed, though to very limited extent, is the United States. MSAs products often offer tax advantages in return for individuals or employers establishing a separate account for health expenses – a "MSA". While technically not health insurance, MSAs are typically combined with catastrophic insurance products, and can be used to cover the cost of deductibles or other non-covered health costs. Proponents of these products laud their potential to provide consumers with increased control over, and sensitivity towards, health expenses.

The US Health Insurance Portability and Accountability Act (HIPAA) established the possibility for self-employed individuals or employees of small firms to buy a voluntary, tax-exempt individual account, which has to be purchased in combination with a high-deductible health insurance plan (Jefferson, 1999). Payments into and from this account are regulated. The popularity of this product has been rather limited, despite several initial offerings by the industry.[61]

A second type of MSA product is supposed to be offered by insurance companies as one alternative plan within Medicare+Choice. It combines a high-deductible insurance plan with an individual account. The market for such products has however not yet developed, possibly because of the complex regulation, slowness in approval of high-deductible plans by Medicare (in the case of Medicare HMOs), and limited consumer interest (Hanvoravongchai, 2002; US General Accounting Office, 1998).

While several studies had predicted the advantages and drawbacks of MSAs prior to their introduction, assessment has been hampered by their low diffusion. A few studies evaluating the experience of MSA indicate that cost savings are possible, although MSA benefit the wealthy and healthy most (Hanvoravongchai, 2002; Jefferson, 1999). Critics also find that MSAs can further segment the insurance pool, taking resources out of the pool and providing individuals with tax-subsidised resources for less necessary or luxury health services.

Private long-term care (LTC) insurance[62]

Currently, private long-term care insurance markets are not much developed. This is due in part to the presence of comprehensive public LTC insurance systems in some countries (Japan, the Netherlands, and Luxembourg), and in part to a combination of low demand[63] and limited supply.[64]

Long-term care insurance entitles insurees to the payment of non-curative long-term care when it becomes medically necessary. In some countries, private LTC products are sold as part of disability and disease-specific coverage within general and life insurance (Australia, Spain). Private LTC products can be subject to the same regulatory requirements as private health insurance (Canada, Japan, and Switzerland) or separate ones (United States, Australia). Benefits can consist of reimbursement for incurred cost (United States), payment of a fixed amount (Australia, Japan, France and some US products), or regular

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payments (United Kingdom). Premiums are typically set to allow pre-funding of future costs. They are relatively high (for the actual risk) when an insuree is young, and relatively low (for the actual risk) when an insuree is old. In Canada, private LTC insurance is often purchased through employers.

The insurance markets with the longest history of offering private LTC insurance are the United States and France (Scor, 2003).[65] Even here, however, private insurance is used only little to cover the cost of long-term care. In the United States, less than 10% of total LTC costs are paid through private LTC insurance,[66] despite tax advantages for its purchase. The two markets feature some notable differences. The French market provides fixed-indemnity products that pay monthly annuities once the need for LTC has arisen. Three insurers provide over 80% of all products, and about half of purchasers are covered through group policies. In the Unites States, products mainly provide for reimbursement of expenses for care and services received at home or in a nursing home. Insurers may set daily or monthly limits to benefit payments. The reimbursement model used by insurers in the United States exposes them to larger risk of cost escalation and is the most complex to manage and administratively costly (Scor, 2003). At the same time, private LTC insurance may cover the largest proportion of costs actually incurred when reimbursement is cost-based, rather than a fixed fee unrelated to actual service costs.

In Germany, 10% of the population – corresponding by and large to those who have purchased substitute PHI – is obliged to purchase private long-term care cover equivalent to that offered by the social system. The German government established a mandatory LTC insurance system in 1995. Individuals with social health insurance receive such coverage from their sickness fund, while those privately insured must purchase it from private insurers.[67] The population covered by private LTC insurance is therefore directly related to the size of the substitute PHI market, although the former market is slightly larger.[68] Private LTC insurance is strictly regulated to make the coverage equivalent to that offered by sickness funds. The definition of "need" is the same across the two compartments, as well as the definitions of the benefits. Premiums cannot vary by gender nor exceed the maximum contribution under social compulsory LTC insurance. There is also a comprehensive system of financial equalisation of premiums, benefits and profits across private insurers.

In other countries, private LTC markets are less significant. LTC products have been sold since the 1990s in Japan, but their growth was slowed by the introduction of compulsory public LTC insurance. Existing products play a supplementary role to statutory coverage. The United Kingdom guarantees limited state coverage for LTC costs, and take-up of private LTC policies is low, despite its being offered by several insurers. Policies are generally pre-funded/saving-type products, providing regular payment of benefits upon strict medical assessment of failures to perform three activities of daily living (ADLs). Other markets starting to offer private LTC products include Italy, Spain and Belgium (Scor, 2003). Overall, evidence suggests it is unlikely that voluntary private LTC markets will develop to significant extent in most OECD countries in the near future.

Disease-specific insurance, income replacement, cash plans

Disease-specific and critical illness products provide a lump-sum to beneficiaries who have been diagnosed with a certain critical illness. The payment is often provided from the onset of the illness until the death of the insurees or the end of the illness, in a manner equivalent to a life insurance policy which pays out prior to one's death. Other types of

products include income replacement (which entitles the insuree to payments replacing part or all of their lost income in the case of events such as temporary or permanent disability). Cash plans are written on a non-"life" basis and pay the insurees a small daily or weekly cash amount in the case an insured event occurs, such as a day in any hospital. Sometimes these plans offer small fixed cash contributions for ophthalmic prescriptions, dental treatment and childbirth, for example, but the amounts are not intended to indemnify costs. Because benefits are relatively low, and are available in conjunction with public sector treatment, premiums are generally affordable. In the United Kingdom, for example, such schemes are popular among voluntary industrial groups. The benefits provided under such plans, however, are not connected with, or linked to, the overall costs of a particular episode of illness.[69]

Data on the prevalence of many of these products is poor or unavailable. In Korea, about half of the PHI market is represented by disease-specific products that provide cash benefits in case the insured person develops certain critical illnesses such as cancer (OECD, 2003b).[70] These products usually provide benefits based on the diagnosis of major illness, which do not depend upon medical utilisation. In some cases, insurees who do not develop the illness may nonetheless withdraw a cash amount. Income replacement policies are sold in several countries, including Belgium, Canada, Germany, Japan, Ireland, the United Kingdom and Switzerland. Cash schemes, usually hospital cash schemes, are also furnished in Japan, Austria, Turkey, the United Kingdom, and Ireland.[71] The United States also has a market for hospital indemnity or specified disease policies.

5.4. *Premium setting*

PHI premiums can be set based on applicants' risk profile, the average risk of a group, or the average risk of a community covered by an insurer. Premium rating is regulated in several OECD countries. For example community rating is mandated by regulation in Ireland, Australia and certain US States.[72] In the absence of regulation, insurers often rate premiums on the basis of prospective actuarial risk of an individual or group of policyholders, and, in employer-sponsored coverage, on the basis of the average risk of a group as indicated by recent "experience".

For-profit and not-for-profit insurers may follow different practices as they respond to diverse sets of incentives and aims. For example, when mutual insurance companies in Belgium apply community-rated premiums in their offerings of supplementary PHI and PHI for small risks to self-employed individuals, they do so without being required by regulation. Conversely, sickness funds, which are private entities also offering PHI, are obliged to use community rating by the Mutuality Code,[73] although they are free to limit the community to specific population groups. Not-for-profit insurers in the United States such as the Blues, used to apply community rating and some still do so. Within Europe, there is variation in the extent to which solidarity principles are applied by mutual insurers (Mossialos and Thomson, 2002). Insurers, including both commercial and not-for-profit, may take into account several factors, ranging from age and sex, to health status and area of residence, when they calculate premiums.

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6. Why does a heterogeneity of PHI market sizes and roles exist across OECD countries?

The analysis provided in this chapter has revealed a large diversity of experiences with PHI across OECD countries. Several factors explain the differences in PHI roles and in market developments, some of which are synthesised below.

6.1. Historical reasons

The varying roles of PHI stem first of all from the historical roles of private health care and coverage in OECD health systems, and the incremental fashion in which some countries attained universal or near universal coverage. Public health coverage systems have developed "on top of" or alongside pre-existing voluntary health insurance arrangements in several countries, and the role of private insurance then shifted to reflect changes in public entitlements and other regulations relating to the permitted scope of PHI. Several countries where PHI plays a prominent role today – such as the United States, Australia, Ireland, the Netherlands and France – have a tradition of private coverage and financing.

In Australia, for example, until 1974, the health system relied upon voluntary health insurance provided by private funds, subsidised by the government, and regulated under the 1953 National Health Act (Colombo and Tapay, 2003). Following a "social assistance model", entitlement to publicly financed health services was first made available only to eligible low and middle income groups in Ireland, leaving the most affluent persons responsible for financing health costs privately (Colombo and Tapay, 2004a). The state-owned VHI was established in 1957 to furnish PHI to the wealthiest 15% of the population who were not eligible to public hospital coverage. The Netherlands has a long tradition of private health financing that can be traced back to medieval guilds that offered financial protection against illness or death. Before World War II, there was no governmental role in health insurance (Tapay and Colombo, 2004).

While in the aftermath of World War I many OECD governments were moving towards state-sponsored universal coverage, the United States continued to rely upon private prepayment plans for providing health coverage. Blue Cross was born in the late 1930s, and group health insurance started to become part of collective negotiations after World War II (Henderson and Taylor, 2002). Health insurance continued to be provided on a voluntary basis, and no government mandate to purchase cover was introduced. Mutuelles have operated in France since the mid-19th century. In 1900 there were roughly 13 000 *mutuelles* and by the start of World War II, two-thirds of the population had coverage for illness through such plans. They had a role in the management of an initial Bismarkian social insurance system introduced in 1930, but not in the management of the social security system established in 1945 (Buchmueller and Couffinhal, 2004).

6.2. The central role of government policies

Perhaps the most important factor influencing the size and functions of PHI across OECD countries is public policy, in particular, public health care policy, in each country.

Decisions about comprehensiveness of public coverage and borders of PHI

Government decisions about statutory and public systems shape the borders of private financing in three main ways.

First, governments prioritise the types of risks that are to be publicly financed, leaving others to be privately insured or self-paid. Such decisions often reflect an underlying philosophy about what risks, benefits or patients are best insured by the public sector and where public resources should be allocated. Despite heterogeneity across OECD countries, the categories of risks that public systems cover break down according to *population groups,*[74] the *types of providers* and the *type of health goods or services.*[75] Comprehensiveness of public coverage has directly affected the extent to which PHI markets have developed, because PHI has focused on insuring individuals, health services or providers not publicly covered. In some OECD countries, voluntary health insurance arrangements have been crowded out by social and public programmes.[76] At the same time, universal, comprehensive public cover has not always removed the potential for a PHI market.

Second, policy makers sometimes make explicit decisions about the permitted roles of private health insurance. These decisions often reflect policy concerns about the undesirable impact of some PHI roles on health system performance, such as in the case of prohibitions on duplicate PHI in Canada and on the duplication of public coverage of out-of-hospital services in Australia. Otherwise, PHI roles are directly shaped by private initiative and PHI functions are typically carved out of the eligibility gaps in statutory insurance.

Third, the structures and regulation of health delivery systems also shape PHI roles. Notably, the structure of financing public and private providers influences the extent to which private finance may duplicate public coverage. Where public insurance finances services provided by doctors and hospitals regardless of their public or private legal status, PHI usually does not duplicate these services – although it may cover fees above the government fee schedule, as in the case of Australia for private inpatient medical treatments. Similarly, where individuals are given freedom of choice of doctor in their public system, and physicians accept the levels of public reimbursement as payment in full, there is limited scope for duplication of such services by PHI. Doctors' ability to operate both in publicly financed and privately financed practices and physician and hospitals' ability to charge different prices within the two sectors for the same set of treatments affect whether duplicate PHI markets develop, and their performance.

Policy relevance of PHI and extent of government interventions to promote its role

Some countries design explicit policies towards PHI markets because they believe that a well-designed public-private mix delivers superior social outcomes. Despite the fact that PHI plays somewhat different functions in Australia, Ireland, the Netherlands, Switzerland, and the United States, private health insurance can be described as a main pillar of the health system in each of these countries, and is recognised by the governments as such. In these countries, government policies are often based on the premise that PHI will continue to play a vital part in the overall funding of health care. PHI represents the object of explicit public policy interventions. These countries share several policy concerns, while other concerns are more particular to specific PHI roles. As a result, they have used a combination of similar and different regulations and fiscal instruments to move PHI markets towards desired social outcomes. The effectiveness of these interventions has varied.

In another group of "minor role" countries, government health policies focus primarily on the organisation and functioning of the public health system. The role of private health insurance is considered less critical to the achievement of health policy goals, and the PHI

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market is often neither stimulated nor regulated explicitly, apart from the area of prudential standards. Market penetration is often low, as in the case of Northern European and Mediterranean countries. These countries may nonetheless be interested in a larger involvement of private health insurance in financing health care, as may be countries where PHI is virtually non-existent, such as in some of the Eastern European countries. For example, there is very little to no PHI in Poland, although legislation provided for the possibility to establish private health insurance schemes after 2002.[77] Despite the creation of a legal framework for PHI in 1993 and the introduction of government subsidies, so far few insurers have been established in Hungary. The low demand for PHI has been attributed to comprehensive statutory health insurance coverage, and a preference to make informal payments rather than purchase PHI (European Observatory, Hungary, 1999). A similar case is offered by Slovakia (Box 2.7).

In the few countries that fall somewhere in between the categories of "major" and "minor" role regulations may be limited. This is the case of France, except in the case of mutual insurers. In Germany, the government regulates substitute coverage more heavily, and had imposed stricter controls on all PHI contracts prior to the application of the EU directives. In Canada, despite government interventions to circumscribe the scope of PHI coverage, there are significant tax advantages for employers offering PHI, and the large majority of the population has some insurance to cover permitted benefits.

6.3. The role of other actors

Employers

In several OECD countries, employers encourage the purchase of PHI and may actually represent a leading factor in the expansion of coverage. In the United States, Canada, the Netherlands and France, private health insurance is predominantly sponsored by employers, and levels of population covered by PHI are high compared to other OECD countries. Economic growth and the increased provision of PHI as a work benefit help to explain the expansion of PHI coverage in Ireland, even during a time when entitlements to publicly funded services became more generous. A larger role for employers in buying private insurance can have positive implications for equity of access and for the comprehensiveness of cover. It may, however, affect the characteristics of remaining individual policies and lead to a more fragile individual market. It can also augment competitive pressures exercised upon insurers as employers exert their purchasing power in negotiations with insurers. Employers often are also savvy purchasers, closely examining value for money in their employee-benefit decisions.

Consumers

Obviously, consumer preferences are a key determinant of demand for PHI. Propensity to buy insurance varies. Even in primary insurance markets such as the United States and the upper-third income bracket in the Netherlands, there are striking differences. About 14% of the US population is uninsured, while this is the case for less than 1% in the Netherlands. Furthermore, over 90% of those with social insurance in the Netherlands purchase some type of supplementary coverage, underscoring an apparent cultural preference and, possibly, a higher degree of risk-aversion. While uninsurance is largely a problem faced by the poor and near poor working population in the United States, some of the uninsured in the United States have incomes above 200% of the federal poverty level[78] (Kaiser Commission on Medicaid and the Uninsured, 2003). Although the absolute cost of

Box 2.7. **Potential role for PHI in Slovakia**

Since 1994, the Slovak health care system has been based upon a Bismark-style mandatory social health insurance scheme. Health insurance contributions are income-related, set at 14% of the assessment base, and shared between employers (10%) and employees (4%). The State pays for all inactive persons, including dependents, elderly, soldiers, and the disabled (approximately 60%, of the population). There are five social insurers operating nation-wide, for two of which the State guarantees solvency. One of these covers about two-thirds of the population. Public health expenditure represents the main source of health funding (89% of THE in 2001). Out-of-pocket expenditure is the only source of private financing, and includes large, unmeasured informal payments. PHI is virtually non-existent. Slovakia spent 5.7% of its GDP on health in 2000 (*OECD Health Data 2003*), one of the lowest health spending levels in OECD countries.

Over the last decade, Slovakia has been involved in reforming its health sector in order to solve its many problems (underfunding, inefficient delivery, poor management, lack of market incentives, and low accountability). The new strategy for health sector reform intends to reform the social health insurance system, reducing the benefit package covered by mandatory health insurance and permitting voluntary private health insurance. Other measures to be implemented include the privatisation of all state-owned facilities and insurers, price de-regulation, and the introduction of patient co-payments (Pazitny and Zajac, 2001).

PHI is expected to play mainly a supplementary role, covering services delisted from mandatory health insurance. Some duplication of services provided by public health insurance appears also to be envisioned, at least with respect to coverage providing improved timeliness of access to care. Insurers will also be permitted to offer PHI for co-payments in the public health insurance system and other out-of-pocket costs. They will also be able to cover the higher fees of providers outside the network(s) contracted by social health insurers for compulsory coverage. Regulation of PHI is expected to remain minimal. Both social health insurers (through private affiliates) and commercial insurers would be able to offer private health insurance.

The proposed role for PHI might offer some opportunities, but also create some challenges. It is envisioned that the development of a PHI market will help formalise informal payments and make certain hidden phenomena, such as waiting times, become visible. Under-the-table payments would be substituted by open queues, transparent fees, and open rationing as a mechanism to equilibrate demand and supply. However, the lack of history and tradition of PHI in Slovakia may deter a PHI market from developing. Individuals are not used to buying insurance policies and seem to have limited trust towards insurers as buyers of health services. They may prefer direct buying of services from doctors, through informal payments, to paying third-party payers, which act as intermediaries between patients and doctors. They may have no guarantee and little trust that paying an intermediary insurer would assure quality care (Murthy and Mossialos, 2003).

In addition, even if a market develops, PHI might accentuate inequities in access to care unless its role is clearly defined. For example, in the absence of transparent information and clear rules for prioritising access to care, there is a risk of reduced access to care for those who do not have PHI, particularly if PHI is allowed to cover the waiting times and higher fees of doctors delivering faster treatments. This may produce incentives for providers to discriminate among patients on the basis of income expected from different patients. For this reason, a strict separation of the financing of public and private health services, transparent rules for allocation of doctors' time between public and private work, and explicit access rules would be needed.

Source: Colombo and Tapay (2004b).

premiums and the greater degree of public coverage in the Netherlands may be one explanatory factor, other more difficult to explain cultural inclinations are likely to have a role. Social-political beliefs seem to be related to purchase of PHI by individuals in the United Kingdom (Mossialos and Thomson, 2002).

Consumer preferences also reflect perceptions regarding the quality of private and public health provision and financing systems. Differences in entitlements to public cover influence such perceptions. The perceived value of private cover also reflects dissatisfaction with public system performance. Waiting times in public hospitals increase population uncertainty about their ability to receive needed care in a timely fashion in several countries, such as the United Kingdom, Ireland and Australia and are a leading factor in the demand for PHI. Finally, an increasingly strong preference for individual choice appears to drive decisions to purchase PHI, especially in those countries where choice of provider is cost-free only for the privately insured.

Insurers

Finally, a PHI market will not develop unless there is private initiative behind it. Strategic behaviours by insurers affect how markets develop. Insurers may decide not to offer a product, or to enter a market, if it is not considered viable, or profitable, in the long-term. In Ireland, despite the fact that two-thirds of the population are not publicly covered for GP services, insurers have historically offered limited primary care benefits and subjected them to large deductibles, possibly reflecting the difficulties of containing moral hazard in that segment and lower cost, compared to inpatient services. Markets have also responded differently to modifications in the generosity of public system coverage. Private health insurers in the Netherlands promptly covered dental benefits in supplementary PHI products after they were delisted from sickness-fund insurance in the 1990s, but may have more difficulty doing the same if other benefits are delisted. However, large levels of out-of-pocket payments under the Korean national health insurance system have not resulted in the development of complementary health insurance. Despite somewhat limited public cover of long-term care benefits in several OECD countries, the development of such products is confined to a limited number of OECD markets, and is still in an embryonic stage in others.

Notes

1. The discussion under this section largely draws from OECD (2004a).
2. Often, the terms "public" and "social" health insurance are used interchangeably. However, there is technically speaking a distinction between the terms. While the former refers to a certain way of collecting resources and sources of funds, the latter refers to a notion of "redistribution" across different risk and income cohorts. Typically, (public) social health insurance schemes include statutory programmes, financed through income-related contributions usually collected by employers and employees, which are managed either by public, private or semi-private insurance entities. Private health insurance can also serve a "social" nature, for example when it receives public subsidies and is regulated in a manner to promote extensive cross-subsidisation across different risk-cohorts. See also Adema and Einerhand (1998), Adema (1999), and Pearson and Martin (forthcoming) for an analysis of the growing role of private social benefits across OECD countries.
3. Governments may however give individuals means-tested subsidies to the purchase of insurance, as in the case of primary insurance in Switzerland and complementary insurance in France.
4. Dror (2000) discusses how there has been a convergence between public and private health insurance arrangements. As a result of reform, the former have introduced changes that go in the

direction of reducing solidarity, for example by increasing cost sharing under public health insurance schemes. Conversely, regulation of private health insurance increases the degree of cross-subsidisation across risks and enhances the "social" nature of such schemes.

5. This is for example the approach used by Mossialos and Thomson (2002).
6. This report has chosen to adhere to a criterion based on financing method and main financing source because this seems to be more relevant from a perspective of health policy. Policy makers look at PHI as a possible way for financing health care which involves a lower tax burden than other financing methods. The criterion chosen enables to include all the health insurance arrangements that are relevant to policy discussion.
7. All data on population coverage in the United States are from: US Census Bureau, Current Population Survey, March 2001.
8. Legislation enacted at the end of 2003 enables Medicare beneficiaries to obtain prescription drug coverage, subject to premiums, coverage limitations and cost sharing (except for certain low-income persons who are exempt from premiums and subject to reduced cost sharing), beginning in 2006.
9. Less than 1% of the Dutch population does not have any health insurance at all. This group consists mostly of illegal residents and groups refusing insurance because of religious reasons (Gress *et al.*, 2002, p. 7).
10. Three main groups can be covered by primary PHI in Germany: the self-employed who are excluded from the social security system, civil servants, and employees above an income threshold (Gress *et al.*, 2002).
11. Such limited level of opting out has been explained by several factors. First, while PHI may be convenient for single and young individuals, social health insurance offers cheaper family coverage by including dependants. Second, PHI policies are rated on the basis of risk and age of entry while social health insurance contributions are income-related, thereby offering cheaper coverage for high-risk individuals. Third, once individuals have chosen to opt out of the social health insurance system, they cannot opt back into social health insurance upon becoming ill, for example in old age. This protects the social health insurance system against adverse selection, while representing an uncertainty factor than may deter people from opting out (Thomson and Mossialos, 2002; Gress *et al.*, 2002).
12. The 1994 Health Insurance Law (LAMal) took effect in 1996. It mandated primary coverage for the entire population and created a regulatory separation between this type of cover and that applicable to voluntary health insurance policies.
13. Regulatory responses to such challenges as well as the impact on performance of primary and other PHI types are reviewed in Chapters 3 and 4 respectively.
14. In several OECD countries, doctors can operate both public and private practice (see Table 2.12). Sometimes, private hospitals receive some public funding and viceversa, however these constitute only a minor proportion of overall funding.
15. In Ireland, a share of total acute care beds in public hospitals (20%) has been designated for private patients, usually treated in semi-private or private room. In Australia, there is no a priori allocation of beds to private or public patients, and individuals opting to be treated as private patients have the sole advantage of choosing their own doctor.
16. This type of coverage is referred to as "assurance complémentaire" (as opposed to statutory cover under social security arrangements).
17. McCardle *et al.* (1999, Figure 1) citing Eppig and Chulis (Fall 1997). 30% of Medicare beneficiaries have employer-sponsored supplemental coverage, 28% individual Medigap and 4% a combination of employer and individual coverage; 19% rely on Medicare alone.
18. For a more comprehensive description of data and trends on health expenditure and financing across OECD countries, see OECD (2003c). Data are drawn from OECD *Health Data 2003*.
19. Based on 27 countries. It excludes Belgium, Slovak Republic and Turkey, for which data for 1990 are not available to make meaningful comparisons with 2000 data. *Source*: OECD (2003a).
20. Based on 23 countries for which data are available. It excludes the United Kingdom, Turkey, Sweden, Portugal Poland, Greece and Belgium. *Source: OECD Health Data 2003*.

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21. For the 19 countries for which data are available, OOP as percentage of THE increased from 19.1% in 1990 to 19.8% in 2000. Conversely, their importance in total private health financing has been slightly diminishing from 75.3% to 73.2% (OECD, 2003a).
22. Unweighted average for the 22 OECD countries for which reliable data are available or estimated. Data exclude Belgium, Greece, Korea, Poland, Portugal, Sweden, Turkey and the United Kingdom.
23. Such as the United Kingdom and Belgium.
24. Data for Switzerland refer to voluntary health insurance and do not include basic mandatory health coverage.
25. Based on 22 countries for which reliable data are available or estimated for 2000.
26. For example, PHI as a share of total private health expenditure (TPHE) in 2000 was 63% in the United States, 53% in France, 51% in Germany, and 42% in the Netherlands.
27. For example OOP as a share of THE in 2000 was 15.2% in the United States, 10.4% in France, 10.5% in Germany, 9% in the Netherlands.
28. Countries with low level of OOP spending as percentage of THE do not necessarily have high levels of PHI (*e.g.,* Luxembourg, Czech Republic). Australia and Austria also have a prominent PHI market, but this does not go with low levels of OOP spending.
29. High levels of PHI financing are not necessarily accompanied by a low share of public health spending (with the exception of the United States). Countries with a low share of public health financing include an equal mix of high-PHI share countries (*e.g.*, the United States) and high-OOP share countries (*e.g.*, Mexico, Korea).
30. If data from the United States are excluded, the relationship is weaker.
31. In the case of Ireland this has risen due primarily to particularly strong growth in public expenditure in recent years.
32. The literature has examined the issue of crowding out of private finance by public health expenditure, finding that an increase in public finance crowds out private spending (*e.g.,* Cutler and Gruber, 1996). Tuohy *et al.* (2001) examine the opposite case. They find that a 10% increase in the level of private spending is associated with declines of between 1 and 3% in the level of public spending in the future. The crowd out of public spending by private spending is however not taking place in the hospital sector, suggesting that the relationship between growth in public and private financing may be different in different sectors of the health system. The analysis, however, does not enable to distinguish the relative importance and impact of PHI versus OOP. Nor does it examine the different contributions of public and private expenditure to financing THE growth.
33. See for example discussion by Wagstaff *et al.* (1999) on equity of financing across several OECD countries.
34. The analysis was carried out based on *OECD Health Data for 1997*. This suggests that countries with primarily public financing are more able to control health care costs than countries with greater private financing.
35. This average is based on population coverage data reported in Table 2.7 for 26 countries (excluding Korea, Sweden, Turkey and the United Kingdom). For countries where different types of coverage estimates exist depending on type of insurance, data included refer to the proportion of individuals with at least one type of cover.
36. 72% in the United States; 31% in the Netherlands, about 9% in Germany; 10% in Belgium (self-employed without social coverage for minor risks); about 5% in Spain.
37. In the Netherlands, there is a strong convergence between coverage by social and primary PHI: most PHI packages offer a similar scope of benefits to social insurance, though many offer additional benefits as well. However, this only occurs as a result of government interventions in the case of the standard package (which is required to largely mirror the benefits contained within the social insurance package). In several OECD countries these policies may be subject to regulatory requirements.
38. Benefit packages in duplicate PHI such as Australia and Ireland resemble public coverage systems.
39. Adverse selection refers to the phenomenon when a disproportionate number of high-risk individuals apply to join or belong to a certain insurance pool, whether that of a particular insurer or product. Under such a scenario, individuals whose premiums exceed the level of their individual risk exit insurance, thus reducing risk pooling and increasing the costs of coverage for remaining individuals.

40. Nicholson *et al.* (2003) found that those switching from a non-HMO to an HMO used 11% fewer medical services in the period prior to their switch than those who remained in non-HMO plans and this lower use persisted when they were enrolled, as compared to those already enrolled.

41. On December 8, 2003, a Medicare prescription drug benefit bill was passed into law. It provides significant prescription drug assistance to 14 million low-income Medicare beneficiaries with incomes below 150% of the federal poverty level, and catastrophic drug protection for all 40 million beneficiaries. The voluntary outpatient prescription drug benefit starts in 2006, with an estimated USD 420 annual premium and USD 250 deductible. Beneficiaries pay 25% of drug expenses up to USD 2 250, the entire bill between USD 2 250 and about USD 5 100, and 5% of any remaining drug expenses. Low-income beneficiaries get subsidies for premiums and out-of-pocket expenses (*www.cmwf.org/programs/topten_2ndpg.asp*).

42. According to Finkelstein (2002), 97% of the Canadian market is group market.

43. The growth of the Portuguese PHI market between 1996 and 1999 was mainly due to group policies. In the Netherlands, the group market grew from 34.5% of all policies in 1980 to 54% in 1998. In the United Kingdom, strong corporate performance has driven an increase in employer-sponsored PHI, from 48% of all policies in 1993 to 59% in 2002 (Mossialos and Thomson, 2002).

44. The existence of a strong link between tax treatment and offerings of PHI as a work-related benefits has been highlighted by several studies, for example: Finkelstein (2002) and Stabile (2001) for Canada; Henderson and Taylor (2002) and Gruber (2001) for the United States. In France, the cost of PHI is a tax-deductible expense for employers when enrolment by employees is mandatory (Buchmueller and Couffinhal, 2004). See also Chapter 3 for an analysis of tax advantages towards PHI.

45. For example, in Germany employers may offer access to group policies (although not directly providing insurance cover) whose premiums are cheaper than those on individual contracts.

46. See the Kaiser Family Foundation and Health Research and Educational Trust (2003, p. 3).

47. So-called cafeteria plans include work-related fringe benefits where individuals are given a choice of the area where they want to spend benefits (*e.g.,* child care, health care, etc.).

48. Bundorf (2003) examines the effects of offering choice in employment-based purchasing groups in the United States, finding that greater availability of choice increased the proportion of workers covered by the plans offered by employers but also resulted in a reduction in the generosity of the plans and premium shifting across individual and family policies.

49. In most OECD countries individual and group policies are subject to uniform requirements. This is not the case in the United States, where most states' individual markets have different characteristics and regulation from employer markets.

50. Variations by insurance type may exist nonetheless. For example, in Italy commercial insurers sell individual policies primarily to medium to high-income people, while mutual associations favour middle to low income purchasers. The application of solidarity principles across EU member states vary (Mossialos and Thomson, 2002).

51. VHI Healthcare is to be transformed into a state-owned public limited company, but its corporate status is still unclear. While Medibank Private Ltd is owned by the Australian government, it does not have a special relationship with the government, per se, as it has to comply with the same regulatory requirements as every other health fund.

52. In Australia, in an effort to better control costs, some main players are moving towards negotiating case-based payments with private hospitals.

53. "Integrated delivery system" or "integrated health care delivery system" include organised systems of health care providers to span a broad range of health care services. *See* Blakeslee, A. (2003), "Managed Care Terminology", in *Managed Care* (Cornell) at *http://trochim.human.cornell.edu/gallery/blakesle/cornell.htm* and Box 2.6.

54. Managed care plans usually involve three key components: oversight of the medical care given; contractual relationships and organisation of the providers giving care; and the covered benefits tied to managed care rules (Integrated Healthcare Association, *IHA Managed Care Fact Sheets: Overview*, Walnut Creek, CA, *www.iha.org)*.

55. 12 ISES had authorisations to operate in Mexico in 2004. ISES covered 2.9% of the privately insured population in 2002, while the rest of the PHI market is represented by catastrophic health products (GMM) offered by general insurers. GMM have large deductibles that can be waived or reduced if individuals choose to receive services from a network of providers (hospitals and doctors) with whom the general insurer has a contract. In this latter case, insurers operate in a manner similar to PPOs in the United States.

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56. See for example Lawrence (1997) and Goldsmith (2002) on the Kaiser Permanente experience.

57. More detailed discussion on regulation is included in Chapter 3, while Chapter 4 discusses the impact of some of these systems' structures on performance.

58. German doctors can charge all private insurees fees that are 1.7 to 2.3 times higher than the fee schedule for private medical services set by the Ministry of Health (Mossialos and Thomson, 2002).

59. While 75% of the Medicare component of the fee-for-service paid to medical specialists working in private hospitals or working privately in public hospitals is paid by the public system, this represents only 19% of the total cost of private hospital treatment. The Medicare payments are made to the specialists directly and do not subsidise the private hospitals themselves (PHIAC, 2002).

60. Medical Saving Accounts are individual saving accounts providing for pre-payments of health care expenditure. See Hanvoravongchai (2002) for an analysis of the international experience with MSAs.

61. Possible reasons for limited diffusion include the complexity of the product, making it of limited appeal to consumers, and generally low demand. This type of MSA+ High-deductible product was supposed to be discontinued after 2002, although current proposals include making this type of product permanent and reduce restrictions applicable to it (Hanvoravongchai, 2002).

62. An OECD project also reviews member countries' experiences with public and private long-term care insurance (OECD, 2005). Some of the information in the paragraphs below has been gathered as part of this project.

63. Private LTC products are complex and their premiums can represent a significant opportunity cost for individuals. Furthermore, individuals may not feel the need to buy such a policy when young, and the price of private LTC policy is often higher, and may hence be unaffordable, for the elderly. However, there may be some demand for LTC products supplementing public LTC coverage. For example, in Spain one survey indicates that about 16% of the population would be willing to purchase such insurance (Costa-Font, 2002).

64. Private LTC markets are 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 complex for regulators, who are confronted with new or changing markets.

65. There are over 6.5 million long-term care insurance policyholders in the United States and over 1.5 million in France (Scor, 2003).

66. OECD Questionnaire on Long Term Care.

67. People who are voluntarily insured at a sickness fund, because they have not chosen to opt out of the public system, can opt between LTC policies offered by a private insurer or by their sickness fund.

68. All the members of the two mutuals that cover the employees of public railway company and the now privatised postal services company are also obliged to take out private compulsory LTC insurance. This is why there is about 1 million people more with private LTC insurance than those with substitute PHI.

69. In many cases, this type of coverage overlaps with, and duplicates, other health insurance coverage for the same event or illness.

70. The other half of the market is comprised of compulsory insurance against car accidents, which also pays a fixed cash amount to the patients once an accident takes place.

71. *Source*: OECD Statistical Questionnaires on PHI, responses from various countries; and Colombo (2001).

72. A more comprehensive discussion of different approaches towards regulating premium rating across OECD countries is included in Chapter 3.

73. Article 2 of the Law of 6 August 1990 on mutuals and national unions of mutuals.

74. Most OECD countries have universal coverage. Otherwise, eligibility to public coverage is based on socio-economic and demographic groups (such as in the case of limited income-based eligibility to public health insurance in the Netherlands and Medicaid in the United States), or is based on age (as Medicare in the United States).

75. For example, certain products or services are not covered by public health systems, perhaps because they are regarded as non-essential or discretionary, such as non-prescription pharmaceuticals, dental and optical treatments, or alternative medicine in several countries.

76. For example, the establishment of a basic mandatory health insurance system with comprehensive benefits in Switzerland in 1996 induced a shrinking in the size of voluntary PHI market. In Australia, drops in the level of PHI membership followed the introduction of universal health insurance (Medicare) in 1984.

77. European Observatory on Health Care Systems, Poland (1999). Polish employers sometimes stipulate arrangements with providers to provide health services to their employees. These activities seem to operate similarly to HMOs in the United States, but are employer-specific and small. They also bear resemblance to efforts of US self-funded employers who contract with a network of providers and fund employee care.

78. 16% of those with incomes between 200 and 299% of the Food Poverty Line are uninsured, as are 6% of those with incomes above 300%.

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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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