



# Public and private health insurance: where to mark to boundaries?

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# Outline of the presentation

- Respective roles of public and private funding for health in OECD countries
- Focus on three countries: France, Canada and Australia
- Some reflexions on political choices and opportunities for the development of PHI markets

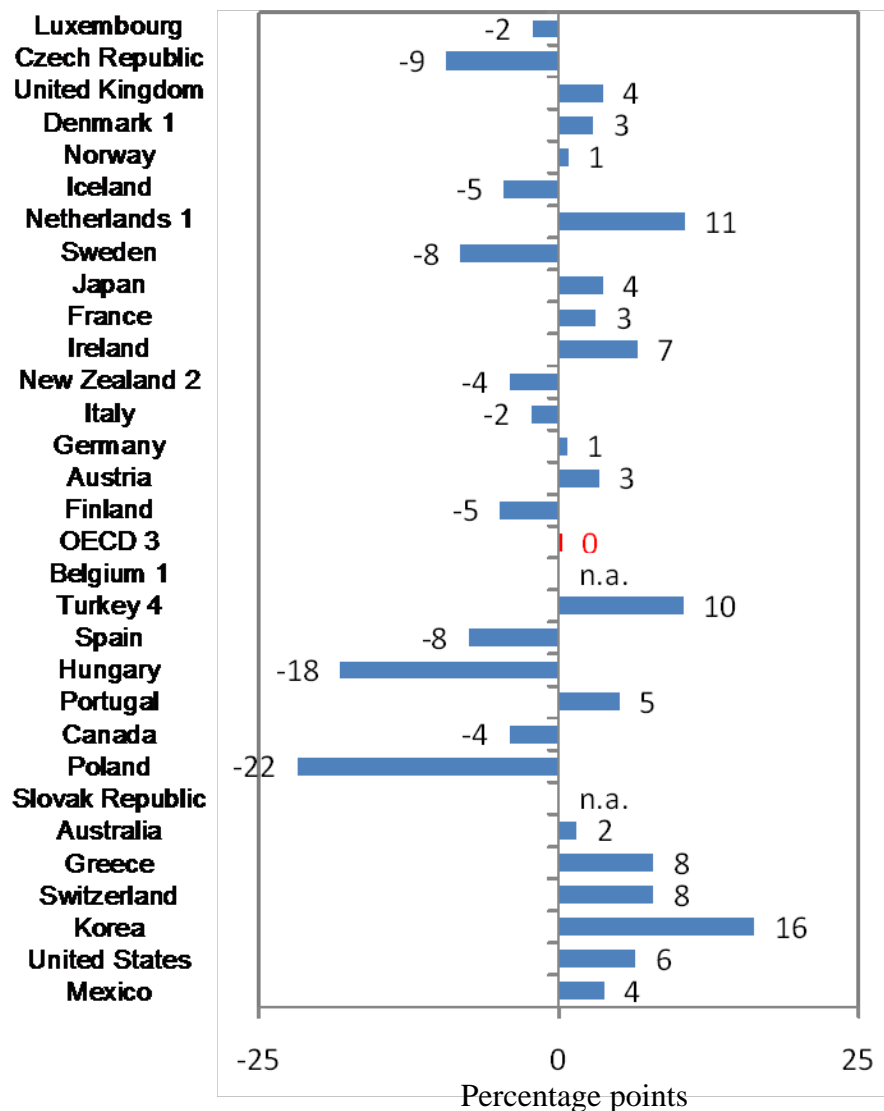
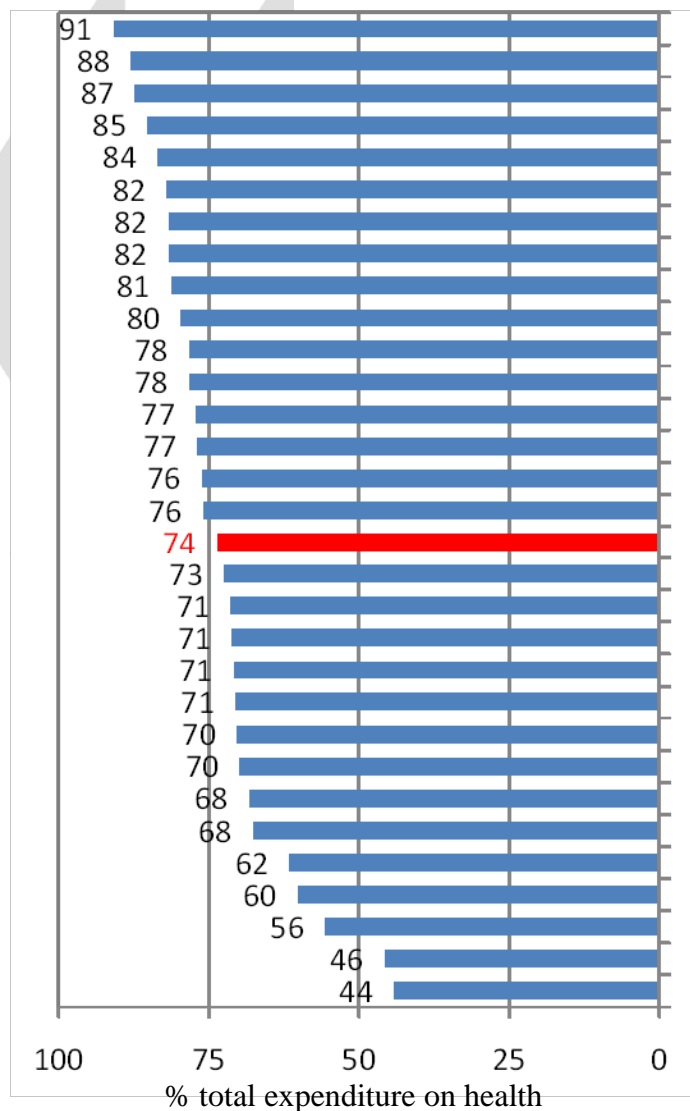
# Terminology

- Private health insurance refers to private coverage for health, by opposition to public coverage (funded by taxes or social contributions) and does not refer to the legal status of institutions.
- « Private » does not necessarily mean « for-profit ». In many countries, private health insurance is offered by private not-for-profit institutions



# Public and private coverage in OECD countries

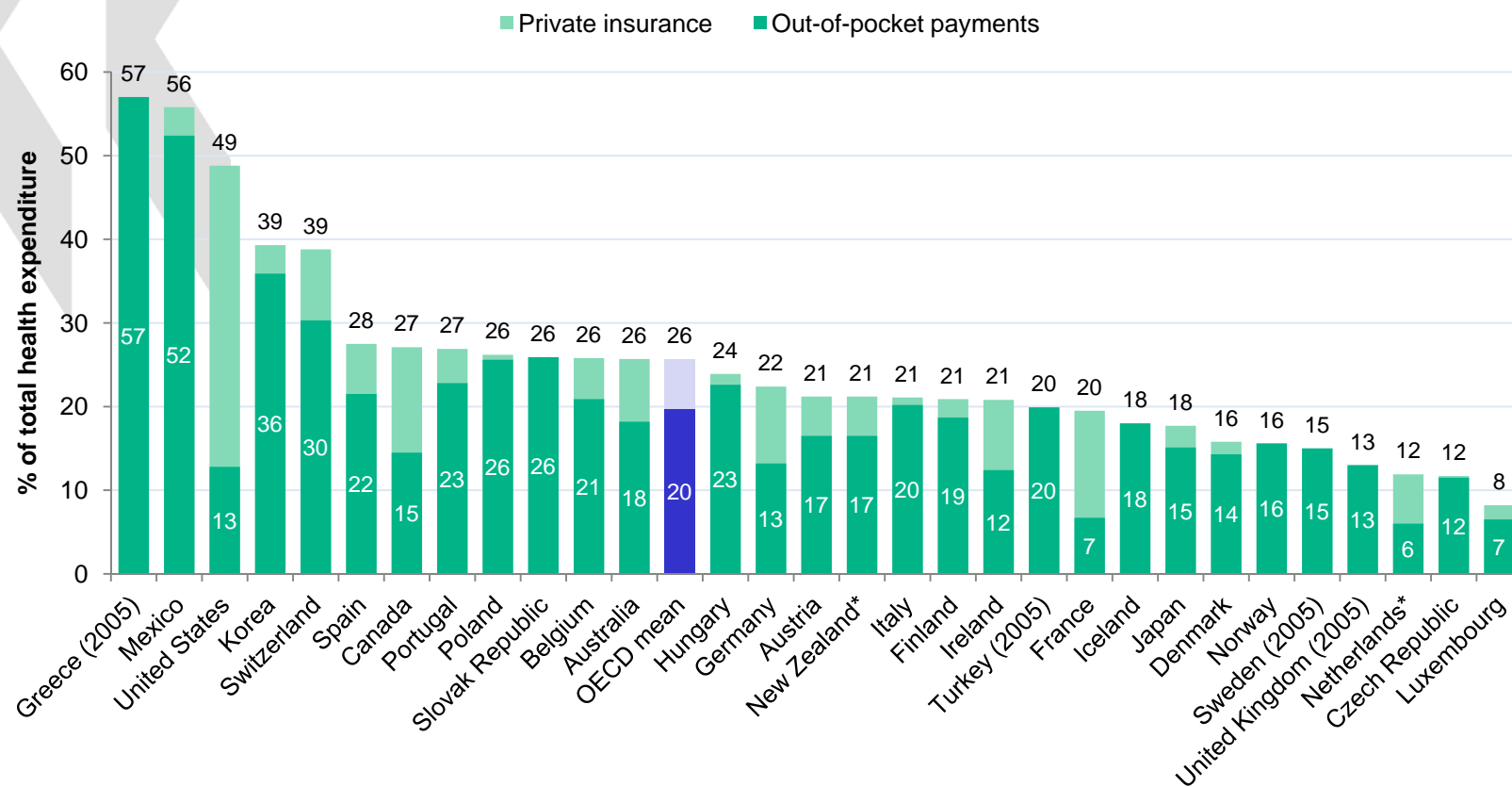
# Public sector is the main source of health financing in almost all OECD countries, with convergence since the 1990's



1. Data refer to current expenditure. 2. 2003. 3. The OECD average excludes Belgium and Slovak Republic. 4. 2005.  
 2. Source: *OECD Health Data 2008*.



# The size and composition of private funding differ considerably across countries

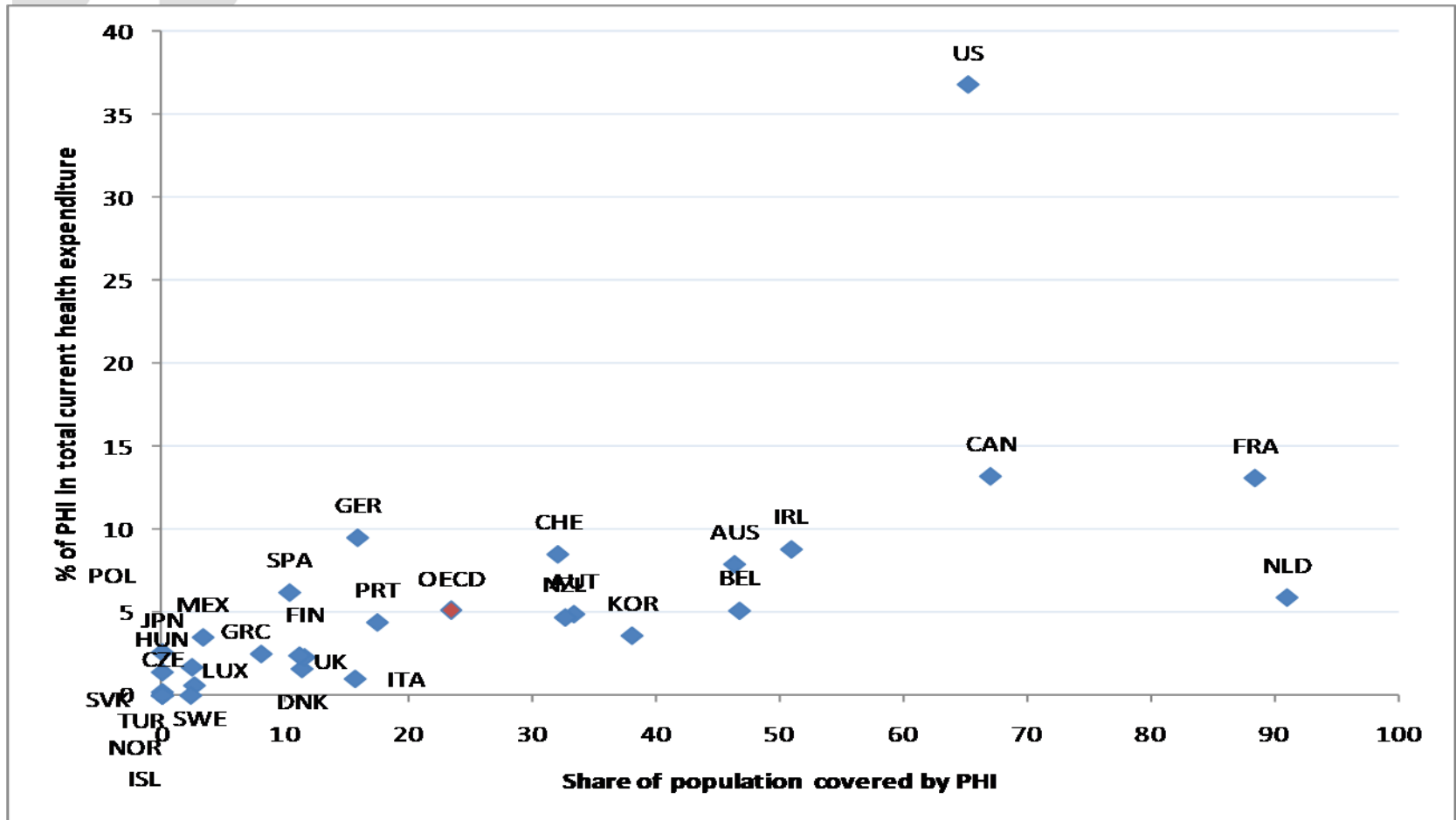


Source: OECD Health Data 2008

Note : (\*) % of total current health expenditure

Share of private insurance was not available for Greece, Iceland and UK.

# Private health insurance plays a significant role in several OECD countries - 2006



Source: OECD Health Data 2008 and OECD estimates



# The roles of PHI in OECD countries: primary, principal or substitutive

- Private health insurance acting as the **primary source of coverage**:
- **Principal** source of coverage (e.g. US)
  - Need for public intervention to ensure the coverage of high-risk people (Medicare for seniors and disabled) and low-income people with no ability to pay for health insurance (Medicaid for low-income)
- **Substitutive** source of coverage
  - For people allowed to opt out from public coverage (e.g. Germany)
- Private coverage is **not compatible with public coverage for an individual**.



# The roles of PHI in OECD countries: primary, duplicative

- Private health insurance **duplicates primary public coverage**:
  - Covers people eligible to public coverage
  - Covers the same goods and services
  - Most often with enhanced choice of provider, enhanced access
- People with duplicative insurance can choose to be treated as “private patients” or “public patients”
- Providers and facilities may be accessible to both private and public patients or dedicated to one category only
- Exists in Australia, Ireland and, to a lesser extent in the UK



# The roles of PHI in OECD countries: complementary and supplementary

- Private health insurance only intervenes on top of public primary coverage to:
- Cover copayments imposed by public coverage on goods and services covered: **complementary** (e.g. France, US for Medicare beneficiaries)
- Cover goods and services which are not covered by basic primary public health coverage: **supplementary** (e.g. Canada)
- Private health insurance often plays both roles of complementary and supplementary, with one prominent role.



# To sum up:

		Eligibility to public HI	
		YES	NO
Health services covered by PHI	Same services covered by public health insurance	<b>Duplicate</b> (UK, EIRE, Aus, Sp, Ita)	<b>Substitute /principal</b> (USA, Ger, NL, CH, Sp)
	Co-payments on publicly insured services	<b>Complementary</b> (Fr, USA, Bel)	
	Additional/extra services	<b>Supplementary</b> (CH, NL, Ger, Can, etc.)	



## Focus on three experiences

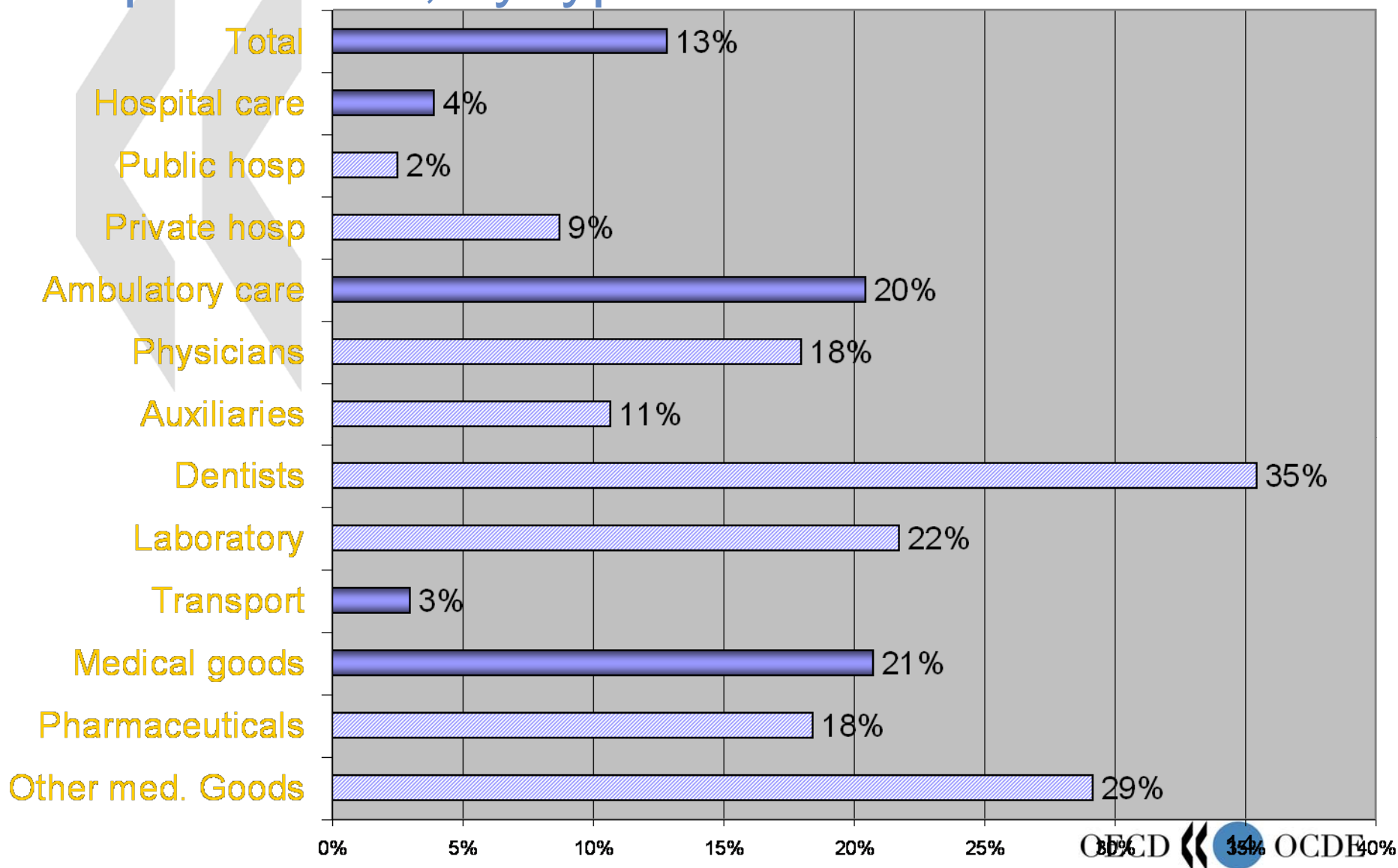
- Three countries with:
  - Dominant public coverage
  - High shares of population covered by PHI
  - Significant shares of PHI in total health expenditures
  - Different roles for PHI
  
- France
- Canada
- Australia



# Complementary health insurance in France

- Complementary coverage for goods and services incompletely covered by social health insurance:
  - Different kinds of copayment (co-insurance rates on out-patient services and pharmaceuticals, fixed copayment for in-patient care)
  - Extra-billings for physicians' services (on average + 17% / official fees for specialists)
  - Prices of medical goods exceeding reimbursement prices
- Supplementary coverage for goods and services which are not reimbursed at all by the statutory health insurance
  - e.g. individual room in private hospitals, alternative medicine non covered by statutory health insurance
- Covers 92.3% of the population, finances 13% of health expenditures, ... with very different share according to types of care

# France: VHI role in financing of health expenditures, by type of care - 2005



Source: National Health Accounts (DREES)



# VHI market: contracts and institutions

- Collective contracts dominate the market (57%)
  - Generally co-sponsored by employers
  - Mandatory in 50% of cases
- Individual contracts (40%)
- Inequities in coverage and quality of coverage, according to activity, sector of activity, professional status, income and age.
- Means-tested subsidy (CMU-C) introduced in 2000 to increase take-up of complementary insurance
- Complementary insurance provided by three types of institutions, subject to different types of regulation: mutual funds, provident institutions (both not for profit – 80% of PHI spending) and private health insurance.



## France: issues raised by PHI coverage

- Non take-up of private health insurance by the poorest part of the population
- Stigmatisation of CMU-C beneficiaries by health professionals, with care denials
- Gaps in continuity of PHI coverage at retirement
- Cost-shifting from SHI to PHI, though not observable at the macro-economic level
- PHI careers acting as passive payers in most cases, claiming for a more active role
- In terms of vertical equity, VHI is regressive while basic coverage is slightly progressive
- Suspected to offset efforts to influence the demand for health services and to cause price inflation for certain types of care (e.g. dental care)



# Duplicate health insurance in Australia

- Covers more than 40% of the population and accounts for 8% of total health expenditures
- Voluntary, with incentives to purchase
  - 30% rebate on PHI premium
  - 1% income-tax (Medicare levy surcharge) for people above a certain income level who do not purchase PHI
- Membership:
  - Allows to be treated in a private or public hospital as a private patient, with possibility to choose the doctor, the hospital, and a suitable time for treatment.
  - But people can choose to be treated as a public patient in public hospitals, at Medicare prices
  - Covers services not covered by Medicare such as physiotherapy, dental, optometry and podiatry services, glasses and lenses.



# Duplicate health insurance in Australia

- Physicians allowed to have dual practice, with much higher remunerations in the private sector
- Impact ?
- Little impact on waiting times with a risk of higher waiting times in the public sector
- Has provided funding for expansion of capacities in the private hospital sector
- Has increased revenues of public hospitals treating private patients
- Cost-shifting from public to private sector has been small, especially when public subsidies for the purchase of health insurance are taken into account.
- Has added to total expenditures and not reduced public spending



# Supplementary health insurance: Canada

- Context:
  - Benefits covered by Medicare (public sector) defined by the Canadian Health Act, without copayments
  - Private provision of publicly funded services authorised as long as patients do not face OOP payments (cost-sharing or extra-billing)
  - Dual practice generally prohibited. Physicians and clinics working for the private sector cannot deliver publicly funded services; patients have to pay the full cost. A few physicians have opted out, in the richest provinces.
  - Duplicate insurance prohibited in 5 provinces (among which Ontario and Québec) but no development in other provinces, because of economic disincentives
  - Gaps in public coverage: not covered care and waiting times

# Supplementary health insurance: Canada

- PHI plays a supplementary role and typically covers:
  - Pharmaceuticals, Dentistry, Long-term and rehabilitative health care, home care and alternative therapies
  - PHI coverage mandatory for pharmaceutical in Québec
- Covers 65% of the population, accounts for 13% of total health expenditures
- Mainly provided through employer



# Supplementary health insurance: Canada

- Two types of concerns:
- Linked to supplementary coverage:
  - Not affordable for all
  - Serious gaps in pharmaceutical coverage in some provinces
  - Debates to expand medicare coverage to pharmaceuticals
  - Discontinuity in coverage (public/private) sometimes leads to inefficient use of health care resources.
- Debates on duplicative health insurance:
  - Inequal access to diagnosis and treatments between citizens able to afford private care (Ontario & Québec), already exist, would it be worse with duplicate health insurance?
  - Prohibition of duplicate health insurance criticized by some stakeholders and recently challenged by a judgement of the Supreme Court of Canada (2005)
  - Risk of critical shortages of doctors in the public sector.

Respective roles for public and private health insurance: a political choice under constraint of existing demand for PHI



# Public and private health insurance mix: a political choice

- Public health financing generally more progressive in terms of vertical equity:
- (Voluntary) Private health insurance entails risk-selection (from patients and insurers), which may be attenuated by regulation
- Public coverage or subsidies are needed at least for population groups (low-income, seniors, disabled)
- Private health insurance take-up is linked to income and other socio-economic characteristics,
- Which leads to inequalities in access to health care
- **Collective preference for (vertical and horizontal) equity leads to a preference for public funding as the primary source of coverage, based on taxes or social contributions**



# Public and private health insurance mix: a political choice

- What role for PHI if public insurance is the primary source of coverage?
  1. What is the benefit basket covered by public health insurance?
  2. What would be the objectives of PHI?
  3. What are the lessons for experiences in OECD countries?



# The benefit basket covered by public health insurance

- Definition of the benefit basket covered by public health insurance or national health service:
  - Concentrate on “essential” goods and services:
    - Indispensable for population health
    - Effective (evidence-based)
    - The most cost-effective when treatment alternatives exist
  - Design copayment mechanisms
    - With minimum levels for most essential care
    - to steer consumption towards the most cost-effective goods and services
    - With exemption mechanisms for low-income and monthly or annual caps
- Embed incentives for quality and efficiency in providers payment schemes

# Which role for PHI? PHI responds to common and to different expectations

- Private health insurance
  - Alternative source for public funding
  - Allows risk-pooling and prepayment (by opposition to out-of-pocket payment)
  - Expected to improve access to health care services
  - And to increase providers' revenues
- Complementary PHI
  - Protect people from cost-sharing requirements for covered goods and services, **suppose the existence of copayments**
- Supplementary PHI
  - Protect people from out-of-pocket payments for not-covered goods and services, **suppose “marketable” gaps in public coverage**
- Duplicative PHI
  - Increase choice of providers, responsiveness of health system, increase supply of and access to health services
  - **Suppose gaps in supply and access**



# Is there a demand for PHI? What are its determinants?

- Real and perceived quality gaps in public coverage and delivery systems
  - High levels of OOP payments (cost-sharing or not-covered care)AND/OR
  - Reduced choice of providers, waiting times
- Demand for PHI linked to income
  - No link between income and PHI market size at the macro-economic level
  - Suppose ability to pay for health insurance for at least a fraction of the population: are OOP payments a good proxy?
  - In OECD countries where PHI exists, high-income people more likely to purchase PHI
- Historical importance of PHI markets



# Contribution of PHI to health system performance in OECD countries

## Lessons from experience

- Enhanced access to care and financial protection
  - Helped to inject resources into health systems
  - Expansion in capacity and services
  - Improved timely access to health care in some systems
  - Diverted resources from the public sector in others
- But raised equity concerns
  - Equity in financing and equity in access
- Enhanced choice
  - PHI more responsive to consumer demand for choice
- Impact on quality?
- Associated with higher public and total health expenditures



● Thank you for your attention.