Why private health insurance?

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A disproportionate impact on health system performance

Private health insurance makes a small contribution to spending on health in most countries around the world, but its effect on health system performance can be surprisingly large owing to market failures and weaknesses in public policy. Because private health insurance can have a disproportionate impact, leading to risk segmentation, inequality and inefficiency, it should be considered and monitored with care.

Proponents of private health insurance fall into two camps. Some see private health insurance as attractive in its own right: in their view, a permanently mixed system of health financing will enhance efficiency and consumer choice. Others regard private health insurance as a second-best option in the context of fiscal constraints: not as desirable as public spending on health, but preferable to out-of-pocket payments. In richer countries, it is argued, encouraging the wealthy to pay more for health care or allowing public resources to focus on essential services will relieve pressure on government budgets (Chollet & Lewis, 1997). In poorer countries, private health insurance can play a transitional role, helping to boost pre-paid revenue and paving the way for public insurance institutions (Sekhri & Savedoff, 2005). A key assumption in both contexts is that private health insurance will fill gaps in publicly financed health coverage, even though economic theory indicates that gaps may be filled for some people, but not for others. Analysts who acknowledge this tension suggest that it can be addressed through regulation (Sekhri & Savedoff, 2005).

Evidence of international interest in private health insurance first emerged in the early 1990s, in work funded by the European Commission. Studies systematically analysing private health insurance in the European Union (Schneider, 1995; Mossialos & Thomson, 2002; Thomson & Mossialos, 2009) were later extended to cover other countries in Europe (Thomson, 2010; Sagan & Thomson, 2016a, 2016b). Comparative
analysis of experience outside Europe began to appear from the late 1990s, with publications focusing on high-income countries (Jost, 2000; Maynard & Dixon, 2002; OECD, 2004; Wasem, Greß & Okma, 2004; Gechert, 2010) as well as low- and middle-income countries (Chollet & Lewis, 1997; Sekhri & Savedoff, 2005; Drechsler & Jütting, 2005; Preker, Scheffler & Bassett, 2007).

This volume adds to comparative research by offering an analysis of private health insurance in 18 high- and middle-income countries globally, which together account for one third of the world’s population. It focuses on several of the world’s largest markets, both in terms of population coverage and contribution to spending on health; covers a range of different market roles; and includes countries in which private health insurance is the only form of health coverage for some people.

The chapters that follow are mainly single-country case studies based on a standard format to enable international comparison. Each case study examines the origins of a particular market for private health insurance, considers its development in the light of stakeholder interests and discusses its impact on the performance of the health system as a whole. Country case studies reflect national developments up to 2017.

By examining national successes, failures and challenges with private health insurance, the volume aims to:

- identify contextual factors underpinning the emergence, evolution and regulation of private health insurance, including the role of internal and external stakeholders in influencing market development and public policy;
- assess the performance of private health insurance against evaluative criteria such as financial protection, equity in access and use, efficiency and quality in service delivery, and contribution to relieving fiscal and other pressures on the health system; and
- inform policy development in countries in different income groups.

The following sections of this chapter define private health insurance; outline market failures in voluntary health insurance and their consequences; summarize the history of and politics around the development of private health insurance, to understand how we got to where we are today; review data on the size of contemporary private health insurance markets; consider evidence on how well private health insurance performs; and draw policy lessons for countries seeking to introduce or
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extend the role of private health insurance or to minimize its adverse
effects on health system performance.

No two markets for private health insurance are the same

Private health insurance is often defined as insurance that is taken up
voluntarily and paid for privately, either by individuals or by employers
on behalf of employees (Mossialos & Thomson, 2002). This definition
recognizes that private health insurance may be sold by a wide range
of entities, both public and private in nature. It distinguishes voluntary
from compulsory health insurance, which is important analytically
because many of the market failures associated with health insurance
only occur, or are much more likely to occur, when coverage is voluntary
(Barr, 2004). The reference to private payment signals a further defining
characteristic: private health insurance premiums are typically linked
to a person’s risk of ill health or set as a flat rate, whereas pre-payment
for publicly financed coverage is almost always linked to income.

The main focus of this volume is on voluntary private health insur-
ance, defined in terms of the role it plays in relation to publicly financed
coverage. Table 1.1 highlights four distinct roles and shows the countries
in this volume in which they are present. Understanding the role private
health insurance plays in a given context matters because role often
influences the nature of public policy towards a market.

People buy supplementary private health insurance as a way of
obtaining pre-paid access to private facilities, avoiding waiting times
for publicly financed specialist treatment or benefiting from enhanced
amenities in public facilities. Complementary private health insurance
fills gaps that occur when the publicly financed benefits package is not
comprehensive in scope or involves user charges (co-payments). In
contrast to supplementary private health insurance and complementary
private health insurance covering services, which can be found in
many countries, complementary private health insurance covering user
charges is much less widespread. People buy substitutive private health
insurance because they are excluded from publicly financed coverage
on grounds of age or income, or are allowed to choose between public
and private coverage.

Three chapters in this volume focus on what the System of Health
Accounts (OECD, Eurostat, WHO, 2017) refers to as compulsory pri-
ivate health insurance in the Netherlands, Switzerland and the United
Table 1.1 Private health insurance (PHI) roles

<table>
<thead>
<tr>
<th>PHI role</th>
<th>Driver of demand for PHI</th>
<th>Main reason for having PHI</th>
<th>Country examples in this volume</th>
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<tr>
<td>Supplementary</td>
<td>Perceptions about the quality and timeliness of publicly financed health services</td>
<td>Offers faster access to services, greater choice of health care provider or enhanced amenities</td>
<td>Australia, Brazil, Egypt, India, Ireland, Israel, Japan, Kenya, Republic of Korea, South Africa, Switzerland, Taiwan, China</td>
</tr>
<tr>
<td>Complementary</td>
<td>The scope of the publicly financed benefits package</td>
<td>Cover of services excluded from the publicly financed benefits package</td>
<td>Canada, Germany, Israel, the Netherlands, Switzerland</td>
</tr>
<tr>
<td>(services)</td>
<td></td>
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<tr>
<td>Complementary</td>
<td>The existence of user charges (co-payments) for publicly financed health services</td>
<td>Cover of user charges (co-payments) for goods and services in the publicly financed benefits package</td>
<td>France</td>
</tr>
<tr>
<td>(user charges)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Substitutive</td>
<td>Rules around entitlement to publicly financed coverage</td>
<td>Covers people excluded from publicly financed coverage or allowed to choose between publicly and privately financed coverage</td>
<td>Chile; Egypt; Germany; the Netherlands before 2006; the United States</td>
</tr>
</tbody>
</table>

Source: Adapted from Foubister et al. (2006).

Note: Markets often combine elements of the first two roles; some combine elements of the first three.

States, included here as examples of the transition from voluntary to compulsory private health insurance. Parts of the private health insurance market in Chile, France and Germany are also classified as compulsory private health insurance in the System of Health Accounts. With the exception of Chile, private health insurance in these countries initially
operated on a voluntary basis, played a significant role in the health system and became compulsory as part of a drive to extend coverage to the whole population, as described in Box 1.1. Chile has allowed the whole population to choose between public and private coverage since 1981; it is compulsory to be covered and everyone must contribute the same minimum share of their income towards coverage, regardless of which option they choose. Although the decision to opt for private rather than public coverage is voluntary in Chile and for higher earners aged under 55 years in Germany, substitutive private health insurance in these countries is classified as compulsory pre-payment in the System of Health Accounts.

<table>
<thead>
<tr>
<th>Box 1.1 From voluntary to compulsory private health insurance in five countries</th>
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</table>
| Health insurance in Switzerland has always been provided by private entities. In 1996, it became compulsory for the whole population for the first time. People pay premiums related to their risk of ill health to non-profit private insurers. People with low incomes receive subsidies from local government. Publicly financed coverage became compulsory for lower earners in the Netherlands in 1941. Between 1941 and 1986, higher earners were allowed to choose between public and private coverage. In 1986, the richest third of the population was excluded from public coverage and relied on substitutive private health insurance. A national health insurance scheme was introduced in 2006. It is compulsory for all residents, operated by a mix of for-profit and non-profit private entities (former sickness funds and private insurers), governed under private law, extensively regulated by government and financed through a combination of flat-rate premiums, income-related contributions and subsidies for poor people.

In 1970, Germany allowed higher-earning employees to choose between public, private and no coverage; previously they had been excluded from publicly financed coverage. Since 1994, those who opt for substitutive private health insurance can no longer return to public coverage after the age of 65 years, lowered to 55 years in 2000, even if their earnings fall below the income threshold. In
2009, health insurance became compulsory for all residents. Those over 55 years old who had already opted for private coverage were no longer entitled to public coverage. Substitutive private health insurance is now their only source of coverage.

The Affordable Care Act introduced in the United States in 2014 made health insurance compulsory for people under the age of 65 years for the first time. Compulsory coverage provided by private insurers in return for risk-rated premiums now operates alongside publicly financed coverage for older people (Medicare) and poor people (Medicaid) introduced in 1965.

France allows private entities to cover user charges (co-payments) for publicly financed health services. By 2015, over 90% of the population was covered by complementary private health insurance covering co-payments. In 2016, it became compulsory for employers to provide this form of private health insurance for their employees. Employees now have compulsory private health insurance covering co-payments, while those who are not employed may have voluntary private health insurance covering co-payments.

Source: Chapters in this volume.

Table 1.2 presents information on health spending in the 18 countries in 2017, the most recent year for which internationally comparable data are available.

Market failures lead to risk segmentation, inequality and inefficiency

Market failures in health insurance are well established (Barr, 1992). Economic theory posits that voluntary forms of health insurance will only result in an optimally efficient allocation of health care resources if certain assumptions hold: the probabilities of becoming ill are less than one (no pre-existing conditions), independent of each other (no endemic communicable diseases) and known or estimable (insurers are able to estimate future claims and adjust premiums for risk); and there
Table 1.2 Overview of spending on health in the countries in this volume, 2017

<table>
<thead>
<tr>
<th>Countries</th>
<th>Public spending on health as a share of GDP (%)</th>
<th>Public spending on health as a share of current spending on health (%)</th>
<th>Other compulsory spending on health as a share of current spending on health (%)</th>
<th>Voluntary PHI as a share of current spending on health (%)</th>
<th>Out-of-pocket payments as a share of current spending on health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-income countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>6.3</td>
<td>69</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>7.8</td>
<td>74</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>4.5</td>
<td>50</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>8.7</td>
<td>77</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>8.7</td>
<td>78</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>5.3</td>
<td>73</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Israel</td>
<td>4.7</td>
<td>64</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japan</td>
<td>9.2</td>
<td>84</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>6.5</td>
<td>64</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>4.4</td>
<td>57</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>3.8</td>
<td>30</td>
<td>33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States of America</td>
<td>8.6</td>
<td>50</td>
<td>34</td>
<td></td>
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</tbody>
</table>
Table 1.2 (cont.)

<table>
<thead>
<tr>
<th>Countries</th>
<th>Public spending on health as a share of GDP (%)</th>
<th>Public spending on health as a share of current spending on health (%)</th>
<th>Other compulsory spending on health as a share of current spending on health (%)</th>
<th>Voluntary PHI as a share of current spending on health (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper middle-income countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>4.0</td>
<td>42</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>South Africa</td>
<td>4.4</td>
<td>54</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Lower middle-income countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Egypt</td>
<td>1.8</td>
<td>33</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>India</td>
<td>1.0</td>
<td>27</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Kenya</td>
<td>2.4</td>
<td>49</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: WHO (2020).

Notes: GDP: gross domestic product. ‘Public spending on health’ comprises government budget allocations and social insurance contributions. In Chile, this includes income-based contributions for substitutive PHI. ‘Other compulsory spending on health’ comprises the following non-income-based contributions: for substitutive PHI above the income-based contribution, PHI covering co-payments among employees, which has been compulsory for employees since 2014, but is now also compulsory for people who opt out of national health insurance since 2009 (Germany); for income-based contributions (the Netherlands); for national health insurance (Switzerland); for compulsory PHI in private insurers (United States of America). In Taiwan, China, PHI accounts for 9.5% and out-of-pocket spending on health (Kwon, Ikegami & Lee, this volume). If tax subsidies for voluntary PHI are included, voluntary PHI rises from 36% to 47% in South Africa and from 10% to 18% in Australia.
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are no major problems with adverse selection, risk selection, moral hazard and monopoly (Barr, 2004).

Moral hazard and monopoly issues can be problematic for both compulsory and voluntary health insurance and researchers have questioned whether moral hazard poses a genuine threat to efficiency in health insurance (Nyman, 2004; Einav & Finkelstein, 2018). This leaves probabilities, adverse selection and risk selection as the most likely sources of failure in markets for voluntary health insurance.

Insurance premiums are a function of the probability of illness and the expected costs of treating ill health. They are considered to be actuarially fair when they reflect the health risk of the pool of people being covered, allowing the insurer to meet its obligations to members of the pool and avoid financial losses for the firm.

Actuarial fairness is challenging to achieve for several reasons. First, it is difficult to sustain a voluntary health insurance market among people who are already ill or at high risk of becoming ill and in the context of epidemics (Barr, 2004). Second, if people conceal information and buy insurance for a premium that does not accurately reflect their health risk, the financial viability of the pool will be jeopardized: premiums will rise over time and those with a lower risk of ill health will leave to buy cheaper insurance from other firms (Akerlof, 1970). So-called adverse selection can lead to the collapse of a market. Ensuring stability is the main reason why private health insurance markets require financial regulation in the form of standards for insurer entry, operation, exit and reporting, although adverse selection is most effectively addressed by making health insurance compulsory. Third, to prevent adverse selection, insurers will engage in risk selection, attempting to attract low-risk people to the pool and deter high-risk people from enrolling.

Owing to risk selection, some people may not be able to obtain insurance if insurers reject applications for coverage; some may not be able to obtain sufficient insurance if pre-existing conditions or certain types of treatment are excluded from coverage; and some may not be able to obtain insurance at a price they can afford to pay. Private health insurance will therefore segment risk among enrollees as well as between those with and without private health insurance. This in turn limits redistribution between rich, poor, healthy and sick; violates the equity principle of access to health care based on need rather than ability to pay (Culyer, 1989); and exacerbates inequality in the
health system. Some of these consequences can be avoided through material regulation involving rules around premiums, benefits and other contractual conditions (Hsiao, 1995).

Risk selection has other unwanted side-effects. It is a pure cost from a health system perspective, because it fails to produce any social benefit, and it may lower incentives for efficiency in the organization and delivery of health insurance and health services if insurers maintain margins by selecting low-risk people rather than by streamlining operations and exerting leverage over providers (Evans, 1984; Rice, 2001; Rice, 2003).

While risk segmentation is primarily the outcome of market failures, it is sometimes compounded by public policy regarding the boundary between publicly and privately financed coverage and the nature and extent of regulation.

**How we got to where we are now: the importance of history and politics**

Economic theory clearly indicates some of the likely outcomes of fostering private health insurance. To understand how private health insurance affects health system performance also requires context-specific analysis. The diversity that makes private health insurance difficult to define means its impact will vary depending, to a large extent, on public policy. Two markets that play the same role can have divergent outcomes because of differences in public policy, which in turn may reflect the way in which public policy has been shaped by history (past events) and politics (stakeholder interests).

Each case study in this volume reviews the origins of private health insurance and developments over time. Taken together, the case studies reveal a number of patterns in how markets were established, their evolution and the role that private health insurance has played in national debates about moving towards universal health coverage.

**As the precursor to publicly financed coverage, private schemes were usually organized around employment**

Private health insurance generally predates national health insurance. In its earliest forms, before the rise of modern medicine, its primary purpose was to compensate people for earnings lost through illness. For this reason it was exclusively linked to employment. Over time, loss-of-income schemes, first established by guilds of skilled workers