1 Introduction

Financial markets, actors, institutions, and technologies are increasingly determining which kinds of services and 'welfare' are available, how these are narrated, and what comes to represent the 'common sense' in the policy world and in everyday life. This volume sets out to problematise one such financial technology in middle-income countries: 'private' health insurance and the industry it inhabits.

The context of this inquiry is middle-income countries. These are home to 75 per cent of the world's population, including expanding middle classes and the majority of the world's poor. In economic terms, they represent about one-third of global gross domestic product (GDP) and are major engines of global growth (World Bank 2022b). It is not difficult to see why this group of countries is of great importance to the future of the healthcare industry and related insurance markets. Global per capita spending on health is predicted to increase by 50 per cent over this current decade, and much of this growth will be concentrated in middle-income countries (Deloitte 2019; Dieleman *et al.* 2017).

For its part, health insurance is reported to be the fastest-growing segment of the global insurance industry. It reached a value of US$1,590 billion in 2021, with excited predictions of this market reaching US$3,039 billion in 2028 at a compound annual growth rate of 5.5 per cent (Fortune Business Insights 2022). Prior to the COVID-19 epidemic, the health segment of the insurance industry made up just over one-quarter of global insurance premiums (Binder *et al.* 2021b). The segment had primarily been sustained by its operations in the United States of America, which accounted for around 70 per cent of health premiums in 2015 (Binder & Mußhoff 2017: 29). But now a shift in momentum to the emerging markets is anticipated as income levels rise, coverage widens, and more private health insurers enter regional markets.

In particular, industry sights are set on the 'underpenetrated' liberalised market economies and large populations of the Asia Pacific region, which contributed 22 per cent of the €69 billion absolute growth in total health premiums in 2019 (Binder *et al.* 2021a). The COVID-19 pandemic brought a sudden and visible increase in risks to health and life in that region, as it did around the world. It also brought a harsh awareness of the debilitatingly prohibitive costs of treatment in private hospitals. This provided new opportunities to the insurance industry, which was quick to respond. Thai insurers Dhipaya Insurance and Muangthai Insurance launched COVID-19 microinsurance products, and Dhipaya claimed it sold half a million such policies in the first quarter of 2020 (Chung *et al.* 2020). In China, health

insurance became the fastest-growing insurance category in the industry. In 2020, low-premium high-deductible 'Huiminbao' supplementary medical insurance was rolled out, led by the local government and underwritten by insurance companies in over 158 cities in 21 provinces, with over 20 million people paying more than an aggregate 1 billion yuan (US$150 million) in premiums (Shanghai Municipal People's Government 2020). By the following year, 140 million people had bought such policies (Leng 2022).

In India, the commercial health insurance sector was still small, but it was gaining traction and business was brisk there too. Only 6 per cent of the population had supplementary plans before the start of the epidemic (Thomson *et al.* 2020b: 26), but then the uptake of private health insurance plans from April to September 2020 overtook that of car insurance, the previous industry leader (Srinivas 2020). Max Bupa Health Insurance, for example, reported a 16 per cent growth in new business in May of that year alone and was confidently expecting that trend to continue (Chakrabarty 2020). When claims increased sharply in the second wave of the pandemic, the Insurance Regulatory and Development Authority of India (IRDA) came to the rescue, allowing a 5 per cent revision in premium rates to help out the insurers (Laskar 2022). Star Health, India's largest stand-alone health insurance company, was among those reporting losses, but it was still able to use the long-term growth prospects to seek new investment and attempt to be listed on the local stock exchange (ET Bureau 2021). By the end of the same year, CareEdge, the Indian analytics and credit rating agency, proclaimed health insurance to be 'a bright spot amidst the pandemic blues', and forecast continued growth at a 16–18 per cent compound annual growth rate for the period 2023–8 (CareEdge 2021).

It seems indisputable that the business opportunities abound. But what does this mean for people's access to good and timely healthcare? How and why has private health insurance become accepted and integrated into health systems in the contemporary period? And what are the implications for social relations?

1.1 Concepts, Methods, and Sources

This volume aims to offer a multidimensional critique of private health insurance. To do this, it draws on a range of literatures and perspectives from the economic and social sciences. Private insurance practice and its regulation in middle-income countries are the subjects of a growing body of health economics,

public administration, and policy literature (e.g. Drechsler & Jütting 2005a, 2005b, 2007; Ettelt & Roman-Urrestarazu 2020; McIntyre & McLeod 2020; McLeod & McIntyre 2020; Preker *et al.* 2007, 2010; Sekhri & Savedoff 2005, 2006; Thomas 2016; Thomson *et al.* 2020a; Wu *et al.* 2020). These employ varied degrees of enthusiasm or caution and critique within their disciplinary and technical parameters. The edited volume 'Private Health Insurance: History, Politics and Performance' (Thomson *et al.* 2020a) offers one of the most substantial recent analyses of the impact of private health insurance using multiple comparative high- and middle-income country case studies. The authors consider its influence on health system performance, financial protection, access to health services, and efficiency and quality in health service organisation and delivery. Their findings will be returned to in Section 5.

Critical social policy analysis has also been important in this field. It has informed the analysis in this volume by highlighting a number of interrelated processes taking place within 'health system reform' across the world. These include the sale or transfer of state-owned assets into private hands (privatisation), and also increasingly commercial behaviour by publicly owned bodies. Mackintosh and Koivusalo were among the first to distinguish 'commercialisation' as an important analytical descriptor of what has been taking place in parts of the health sector (Mackintosh & Koivusalo 2005). While the term is sometimes used rather loosely in the literature, their influential framing recognised two aspects: the provision of healthcare services through market relationships to those able to pay, and the investment in, and production of, those services (and of inputs to them) for cash income or profit.

This conceptualisation was taken forward by Tritter *et al.* (2009), writing on European health systems. Here the term commercialisation is used to describe both the engagement of commercial providers in the provision of publicly funded services, as well as the regulatory framework and priorities that shape the provision of services by both public and private providers. Subsequent contributions include Koivusalo and Sexton (2016) writing on gender and commercialisation in healthcare, Murray (2016) on the growth of commercialisation in maternity care, and Baru and Nundy (2020) on China's shift to 'market socialism' and the resultant fragmentation of the health service system.

The related term 'commodification' refers to when activities for health financing and provision are given a monetary value and start being negotiated according to market logic, with different agents buying and selling health goods and services (Cordilha 2022). Scholars in different fields have highlighted that health is being converted from being a right and entitlement to being a privately purchased commodity (Prince 2017). This is accompanied by a redefinition of

individuals as healthcare consumers, whose consumption of particular health-related goods and services is shaped not simply by perceived health benefits but also by their associations with particular images, lifestyles, and tastes (Henderson & Petersen 2002; Tritter *et al.* 2009).

An important element of the literature on medical travel highlights its relationship to commodification of healthcare (Ormond 2013) and the role of states and other brokers in developing these markets. For example, Chee (2007) describes the Malaysian state's intimate and direct involvement in the commodification of healthcare by promoting medical tourism via tax incentives, institutional infrastructure for upholding standards and quality, and by leading in the marketing through trade missions and other promotional activities. Connell (2013) similarly argues that contemporary medical tourism is a function of the growing privatisation and commodification of healthcare, where the ability to pay has become the key to obtaining medical care. It is for this reason that Lunt *et al.* (2011) favour the term 'medical tourism' rather than its alternatives, arguing that it draws due attention to the commodification and commercialisation of health travel. Writing on marketisation as the entangling of state and markets, Birch and Siemiatycki highlight that private financing and monetisation of public goods necessarily entails, on the one hand, the commodification of public services, their provision, and their delivery, and, on the other hand, the regulation of these commodification practices by bringing them within the purview of 'the state as market-maker' (Birch & Siemiatycki 2016: 193).

This volume builds on, and extends, this existing literature on commercialisation, commodification, and marketisation, offering a critical analysis of the phenomenon of private health insurance and its market growth in middle-income countries. Drawing on multidisciplinary viewpoints and empirical examples, it examines a range of interrelated dimensions, including the influences of global governance, constitutional rights, states as market makers, and industry interests and actions. It considers the impact on health, implications for social stratification, and the influence on societal relations and behaviours. In doing so, it argues that the influence of private health insurance extends far beyond its percentage contribution to health spending. There are important implications across the health system in terms of the allocation of resources and inequity of access. Across society, private insurance reinforces individualism and social distinctions and increasingly acts as a mode of governance of behaviour.

The overview brings together available evidence, existing experience, and conceptual thinking. The analysis relies upon a close reading of research and policy documents on health systems and their financing, as well as knowledge acquired through two decades of research on health systems in middle-income countries. Sources include a literature review, coverage in the business press

media, and primary data from qualitative interviews conducted in Chile, India, and China during a series of interrelated studies on the privatisation, commercialisation, and financialisation of healthcare.[1] These are employed to explore the expansion and operation of this industry in middle-income countries covering case examples from Chile, Brazil, and Colombia – as early adopters, and contemporary developments in emerging economies such as India, South Africa, Türkiye, and China. For the analysis presented in Section 8.1, digital business and popular press media coverage were obtained through Google Alerts over a twelve-month period. This material serves as a source of data in order to scrutinise the discursive construction of the contemporary health insurance market in India.

The intention is not to provide comparative case studies of health system performance in a series of countries, a type of analysis ably done by others (see Thomson *et al.* 2020a). Rather, examples from different countries are employed to illustrate the themes and issues that a probing examination of private health insurance raises. Put another way, the focus is to problematise private health insurance using real-world experiences and to elaborate further on practical and theoretical understanding. The trajectories in five countries (Chile, Brazil, China, India, and South Africa) are presented in some detail, and two others (Colombia and Türkiye) are referred to more briefly. Between them, these countries include several of the world's largest markets for the health insurance industry – existing and potential, countries in which private health insurance is an established element of health system financing, and those where the industry is opening up new frontiers.

Table 1 offers a snapshot of the seven countries. This indicates population size; a recent World Bank estimate of their progress toward universal health coverage (UHC) (a concept discussed further in Section 2); the spending on health in each prior to the COVID-19 epidemic, as collated in the System of Health Accounts;[2] and estimates of the percentage of the population in each

[1] Social and structural factors influencing high caesarean section rates in Chile. (1995–7). Overseas Development Agency Health and Population Division (UK): RD352.
Healthcare under Chilean neoliberalisation: Places, spaces and practices. (2015–16). Santiago.
Practices, regulation and accountability in the evolving private healthcare sector: Lessons from Maharashtra State, India. (2017–19). Co-I: I. Chakravarthi. Medical Research Council (Joint Funded Initiatives): MR/R003009/1.
Deconstructing the financialisation of healthcare. Co-I: B. Hunter.
Analysing the transnational provisioning of services in the social sector: The case of commercialisation of NHS services in China and India. (2019–22). Co-Is: R. Bisht, B. Hunter, B. Salter, Y. Zhou. Economic and Social Research Council: ES/S010920/1.

[2] An internationally agreed systematisation of information on financial flows related to healthcare in different countries.

Table 1 Characteristics of coverage and spending on health in Brazil, Chile, China, Colombia, India, South Africa, and Türkiye.

Country and population size (2021 rounded) [a]	World Bank Country income classification [b]	UCH achievement (%) [c]	Spending on health (2019 or nearest available year) [d]				Percentage of pop. with private (commercial) health insurance cover
			Public spending on health as a share of GDP (%)	Govt/compulsory schemes' spending on health as a share of current spending on health (%)	Voluntary private health insurance as a share of current spending on health (%)	Out-of-pocket payments as a share of current spending on health (%)	
Brazil – 214 million	Upper-middle	74.9	3.9	40.9	31.1	24.9	26 [e]
Chile – 19 million	High income[3]	83.1	5.7	60.6	6.6	32.8	>46 [f]
China – 1.4 billion	Upper-middle	71.1	3.0	56.1	8.7	35.2	4 [g]
Colombia – 51 million	Upper-middle	73.0	6.3	77.4	8.4	14.1	49 [h]
India – 1.4 billion	Lower-middle	57.4	1	33.1	11.6	54.8	6 [e]
South Africa – 60 million	Upper-middle	78.5	4.4	48.2	46.1	5.7	16 [e]
Türkiye – 85 million	Upper-middle	55.5	3.4	77.7	5.3	17.0	7.6 [i]

Sources: [a]World Bank (2022b); [b] World Bank (2022a); [c] World Bank (2020): this analysis by Wagstaff & Neelsen (2020) uses an index that captures both health service coverage and financial protection from high out-of-pocket medical spending; [d] Organisation for Economic Co-operation and Development (2022a); [e] Thomson *et al.* (2020b: 26); [f] Organisation for Economic Co-operation and Development (2022b): while 17 per cent have healthcare cover from health plans with ISAPREs and 46 per cent have complementary health insurance policies, it is not possible to determine the overlap between these groups; [g] Chen *et al.* (2022); [h] Ministerio de Salud y Protección Social (2022): this percentage represents the section of Colombia's population with mandatory membership of the 'contributory regime' run by private insurers; [I] Organisation for Economic Co-operation and Development & European Union (2018: 175).

[3] Chile moved up into the high-income classification in 2006 but was considered to be middle-income during the period described in Section 3.1 when its substitutive private insurance policy was introduced.

country with commercial health insurance cover. The presentation of this data is intended to be descriptive and to give a sense of range among the cases, rather than to offer a ranking within any category or to suggest there are simple causal relationships between the data in different columns. It should be noted that reliable estimates of the percentage of a population with private insurance cover are hard to come by and represent differing points in time, types of sources, and definition.

The data in Table 1 indicate that there are wide variations in the proportion of public spending on health, and also in the extent that so-called 'voluntary' private health insurance currently contributes to spending on health. Thomson and colleagues' analysis of global spending data shows that in 2017, voluntary private health insurance accounted for more than 10 per cent of current spending on health in only twenty-three countries, half of these being middle-income (Thomson *et al.* 2020b: 21). On average, at that time, voluntary private health insurance accounted for an average of 2.4 per cent in lower middle-income countries and 6.3 per cent in upper middle-income countries, but there was a great deal of variation at the country level, particularly in upper middle-income countries.

Does the data on the proportion of current spending on health mean that private health insurance is just not that significant? There are three rather different points that need to be made here. Firstly, the current extensive market-making activity suggests that the role of private insurance within spending on health will be changing in the future for some countries, especially those with expanding middle classes. Indeed, the 'big growth stories' for the insurance industry are forecast to be India and China, due to their economic growth and large population sizes,[4] and their respective governments' embrace of market economy approaches in the sphere of health (Binder *et al.* 2021b; Preker *et al.* 2010).

Second, the percentage contribution to health spending may be a useful indicator, but it provides a limited picture. As some of the illustrative cases in this volume will demonstrate, there are other impacts that private health insurance can have on health systems, especially over the longer term. Private health insurance is key to sustaining and expanding for-profit hospitals and diagnostics sectors, with implications for resource allocation. Furthermore, it redefines the way access to healthcare is thought about.

Third, we need to interrogate the term 'private health insurance'. How does its definition set the parameters for what questions are asked? What does it

[4] India represents 17.85 per cent and China represents 17.81 per cent of the world population (World Population Review 2023).

reveal, and what does it hide? In the health financing literature, 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' (Thomson *et al.* 2020b: 3). It is treated as a technical category, but it is more than this. The emphasis on voluntary serves to reinforce the neoliberal notion that private health insurance is about the creation of choice. The emphasis on voluntary also means that compulsory health insurance managed by private health insurance companies in Chile is not categorised as private health insurance in the internationally standardised definitions for spending in health. Instead, this sits under 'government/compulsory pre-payment schemes' (column 5 of Table 1). The same applies to Colombia's mandatory health insurance, where the funds collected by the government flow on to feed managed competition between forty-five private insurers (Garcia-Ramirez & Nikoloski 2021). This obscures the actual breadth and embedded nature of the insurance industry activity within some health systems. The definitional focus on 'take up', the demand side, also de-emphasises that the insurance is economic activity conducted with the intention to make a profit, before going on to fund for-profit healthcare companies. Private health insurance is the accepted term, and for that reason it is used in this volume, but 'commercial health insurance' would be a more accurate descriptor, as indicated in the final column of Table 1.

This volume will draw on multidisciplinary perspectives to consider private health insurance and examine it from different angles. It is divided into eight main sections, starting with issues of policy and market development. Section 2 describes how and why the global policy environment has favoured health insurance industry growth in the contemporary period, and it considers the experiences of early adopters, including those now trying to disentangle themselves from its legacies. Sections 3 and 4 explore state and industry strategies in several of the world's largest potential markets. Sections 5 and 6 summarise key critiques of the effectiveness of private health insurance that have been articulated within health policy and systems debates and bring together some of the experiences of state attempts at regulating the sector. The final sections widen the analytical lens. Section 7 highlights the changing nature of the industry and its role within transnational financial services and the political economy. Then, building on contributions from sociology and social anthropology, Section 8 articulates the extent of its broader influence over institutions and everyday life through the concept of *a private health insurance regime*. This is illustrated through examples from South Africa and India exploring private health insurance's relationship to class, social differentiation, consumption, and individualism.

It also draws attention to the largely unseen role that it plays in the regulation of behaviour through technologies of surveillance and notions of consumer rights in access to healthcare.

2 Development Goals, Health Policy, and Privatism

In order to understand the place and future of private health insurance within health policy in middle-income countries, it is important to consider the way healthcare financing has come to be understood in the contemporary context. There are four main sources of funding for healthcare services that are commonly cited in the economics and health policy literature. These are general taxation, social insurance, private insurance, and direct payments by users, sometimes referred to as out-of-pocket payments. To what extent health services in a country are protected from commodification will depend, in part, upon the way the system articulates healthcare finance to access to health services (Yilmaz 2013).

Significantly, in recent policy and public discourse, private health insurance has achieved a high profile. It has been portrayed variously as the answer to overstretched public healthcare systems, as a transitional step to publicly provided UHC (Sekhri & Savedoff 2005), as the sensible response for a head of household to the risks of catastrophic private healthcare costs, and as the embodiment of 'freedom' and the right to choice. We need to examine the social and political influences that have led to this in specific countries, and to this end, the cases of Chile, Brazil, and China will be considered in Section 3. But first, this section offers a reflection on the recent history of the internationally agreed goal of UHC and how international agencies have helped to open up the markets for the health insurance industry in the majority world.

The transnational transmission and mediation of ideas and processes, as well as their spread through epistemic communities, have been important in this policy diffusion (Tritter *et al.* 2009). The Millennium Development Goals of 2000, followed by the UN Sustainable Development Goals (SDGs) of 2016, succeeded in focusing the attention of international organisations and national governments on health as a necessary contributor to development. But they did more than this. It was through the circulating concept of UHC and the call for low- and middle-income countries to 'invest in health' that health insurance became globalised. The result was, as Birn and colleagues argue in their blistering analysis of the history of UHC, 'the most remarkable contemporary co-optation of the global health equity agenda' (Birn *et al.* 2016: 745). The terminology itself was telling. As Birn and Nervi point out, more recent use of the term 'coverage' stems from the early twentieth-century US insurance industry, referring to the amount of