

Annex 8

HOW CAN PRIVATE HEALTH INSURANCE SERVE THE PUBLIC INTEREST?¹

What is Private Insurance?

As policy makers consider how to move towards financing mechanisms that will promote greater equity, they have a number of options to consider. All of these options combine prepayment and risk pooling, which lead to greater financing fairness, a key objective of any health system². It is this transition towards prepayment that results in “universal health coverage,”³ an important goal in ensuring affordable and equitable access to health care services for the entire population.

Analysis of high and middle income countries that have achieved some degree of universal coverage shows that all have mixed systems of financing combining both public and private sources of funding to meet different health care needs, and the needs of various segments of the population. For example, most countries use general taxation to fund or subsidise care for the poor, while those employed in the formal sector may contribute to health care costs through payroll deductions for social insurance or private insurance. In many countries, non-core services, such as eyeglasses, are funded through direct out-of pocket payments, except for the most vulnerable populations. There are three prepaid funding methods available to policy makers.

- General taxation
- Social insurance
- Private Insurance
 - Community health insurance
 - Not-for profit private insurance
 - For-profit commercial insurance

¹ Paper presented by Neelam Sekhri, HFS/PHF/WHO/Geneva, at the Regional Consultations on SHI, Bangkok, July 2003

² WHR, 2000. In addition, some countries use medical savings accounts but, with the exception of Singapore they do not play a significant role in health financing. External Aid, is also an important source of funds in developing countries, but it is not part of a sustainable financing system.

³ USanguan and Mills 'Achieving Universal coverage', 1998, p.3: "Universal coverage is defined as a situation where the whole population of a country has access to good quality services (core health services) according to needs and preferences, regardless of income level, social status or residency"

Technically, all forms of prepayment, including general taxation can be considered “insurance” because they protect against the risks of facing uncertain medical costs through pooling risks with others.⁴ In this paper, the term “insurance scheme” is used in a more limited context to include only those programs that explicitly provide a defined set of health care benefits through earmarked or direct payment to an “insurance entity”, either public or private (Figure 1.1).

Social insurance and private insurance both fall under the rubric of *insurance schemes*, though considerable confusion exists on the distinction between these two types of coverage. Many of the criteria traditionally considered unique to social insurance programs can be found in private insurance systems as well, and the boundaries between social and private insurance are increasingly blurred. There are a spectrum of arrangements that range from purely private for-profit commercial insurance to purely publicly funded and managed social insurance. Figure 1.2 shows the continuum between these two extremes based on three key dimensions:

- (1) Whether insurance is mandatory or voluntary
- (2) Whether contributions are risk rated (minimal risk transfers between members of the pool) or income related (significant transfers resulting in greater equity)
- (3) Whether management of the scheme is commercial for-profit, or public.

Although it is common to discuss private insurance and social insurance in terms of the extremes, in fact, the most common arrangements are in the centre. Generally, private insurance is financed directly through employer, employee, individual or family contributions. It is usually voluntary, but can also be mandatory and cover large segments of the population (as in Uruguay and Switzerland). Private insurance can be provided through community based health insurance schemes, through private for-profit insurers, or through private not-for-private entities (e.g. mutual aid societies, co-operatives etc). It can be risk rated, but in many countries where it plays a prominent role, it is community rated and contains varying levels of cross subsidies.

Private health insurance is used in two primary ways to provide coverage for health care services:

⁴ Cutler, p.571

- **Principal Coverage:** Private health insurance is the primary form of prepayment available to all or certain parts of the population. This can be true for large segments of the population, (as for example in the U.S, where private health insurance is the primary coverage for the non-poor who are under 65 years of age). It may also be true in countries that have social insurance systems but certain segments of the population are not entitled to participate in them or can opt-out (such as the Netherlands where those over a certain income do not participate in the sickness funds). Policies that provide principal coverage usually include a broad range of interventions often mirroring a public package of services and covering the spectrum of primary, secondary and tertiary care interventions.
- **Supplementary Coverage:** Private health insurance augments coverage provided by a publicly funded system. Policies that provide supplementary coverage usually contain a limited set of interventions which address the particular gaps in a country's public financing system. For example, policies may cover residual health care costs (such as co-payments in France), services not included in the basic publicly funded package (such as outpatient drugs or dental care in Slovenia), or allow easier access to services and payment for private providers (such as in the U.K. and Australia where private policies enable faster access to specialists and elective hospital care).

Can Private Insurance Support Universal Coverage?

Unlike social insurance which is commonly viewed as promoting equity, functioning in the general interest of society and leading to universal health coverage, private insurance often conjures up visions of unequal access to care for the poor, large segments of the population left uninsured and market forces creating elitist health care for the rich. Experience indicates that unregulated or poorly designed private insurance systems can indeed exacerbate inequalities, provide coverage only for the young and healthy, and lead to cost escalation.

History shows however, that the social insurance systems of many OECD and middle income countries evolved from voluntary, private insurance schemes based on professional guilds or communities. This evolution may be useful to inform policy discussions in developing countries as they consider private coverage. The use of private insurance as one pathway leading

towards broader coverage through publicly funded schemes, is supported by the World Health Report 2000 which recommends that *“Low income countries could encourage different forms of pre-payment- job based, community based and provider based- as part of a preparatory process of consolidating small pools into larger ones”*.⁵

Figure 1.3 illustrates that countries with high rates of private insurance coverage also have lower out-of-pocket spending, suggesting that private insurance plays a role in substituting for out of pocket expenditures and moving the health system towards more equitable financing. This may be of particular interest to developing countries with very high out of pocket payments, that have large informal sectors and limited taxation ability. In the short term, these countries will find it difficult to achieve universal coverage primarily through public spending and may consider private insurance as a method to move some segments of their population towards greater prepayment. In Asia (figure 1.4), where rates of out-of-pocket expenditures are the highest in any region in the world, moving towards prepayment through insurance is particularly attractive.

Key Issues for Policymakers

Although no country uses private health insurance as its only mechanism to achieve universal coverage, private insurance schemes well structured and regulated, can be used to provide one source of funding towards this goal.⁶ In every country that uses private health insurance as principal coverage for a large segment of its population, vulnerable groups are provided cover through publicly funded programs. In some cases the government may “purchase” coverage on behalf of these vulnerable populations through private insurers, but this is not considered private insurance, because it is financed through the State.

Whether a country considers private insurance as a transitional mechanism that will lead to broader social insurance schemes, or whether private insurance will form the basis of a country's long term health financing strategy, depends on a variety of factors, including how the government

⁵ WHR 2000, page xviii

⁶ In Australia for instance, well-regulated private insurance is being fostered as a safety valve to the resource constrained public system. Based on a policy decision that those who can contribute to their health care costs should do so, Australia has implemented tax and early enrolment incentives to encourage the purchase of private insurance. Private insurers also contract with public hospitals, thus generating additional funds for public facilities.

chooses to define its role in financing personal health care services. In some countries, universal access and coverage for these services is considered a primary responsibility of the State. In others, the State's role is to provide access to health care for the most vulnerable groups or those that the State has a responsibility to protect. These important policy decisions should be considered prior to embarking on the creation of any type of formal insurance system.

Regardless of whether the State defines its role in health financing as limited to certain groups or more broadly, it has a critical responsibility in providing stewardship and oversight of both public and private financing mechanisms. Particularly in countries with large out-of-pocket expenditures, introducing risk rated private insurance without safeguards can lead to insurers selecting the lowest risks, leaving the most vulnerable groups out of the pool. As insurance money flows into the system, providers will raise prices and may leave the public sector. All of this will affect the publicly funded system which will be left under-resourced, and responsible for providing care to the sickest patients.

Developed countries that rely on private insurance to cover large segments of their population, or in which private insurance plays a prominent role, intervene often quite significantly, in the market to ensure adequate consumer protection and equity. Through policies, incentives and regulations they essentially "*conscript private insurance to serve the public goal of equitable access*".⁷

This is a particularly important issue for countries in the South-East Asia and Western Pacific regions, because introducing private insurers into the market will have important long-term consequences for the entire financing system. Many countries in these regions have already opened their doors to foreign insurers and are confronted by a largely unregulated private insurance market which is growing. The challenge for these policy makers is to exert influence on this market in the public interest. Table 1 summarizes the key policy issues that they might consider in regulating the private health insurance sector.

Regardless of where a country is in its development of prepaid financing, a strong but flexible regulatory framework is required to manage all types of insurance: for-profit and not-for-profit; social, public and private. In countries

⁷ Jost, p 479

that have achieved this, private insurance systems have contributed significantly to providing high quality, accessible and affordable health care for everyone.

Table 1. Key Areas for Regulating Private Insurance Markets

Regulatory Area	Key Policy Issues
Regulating who can sell insurance, rules of participation in the market and consumer protection	<ol style="list-style-type: none"> 1. What will be the importance of private insurance in health financing? 2. What role will private insurance play in the health system (principal or supplementary or both?) 3. To what extent is private insurance a mechanism to increase consumer choice? 4. How much competition should be encouraged and how many insurers should be allowed? 5. How much collaboration should be encouraged among insurers?
Regulating who should be insured	<ol style="list-style-type: none"> 1. How broadly should private coverage be extended? Will coverage be mandatory or voluntary? 2. If insurance is not mandatory, how can low risk individuals be encouraged to join the risk pool? 3. To what extent will private insurance be used to cover high-risk persons? 4. What will be the basis of affiliation in insurance plans e.g. group, individual/ family?
Regulating what should be covered	<ol style="list-style-type: none"> 1. If insurance will be principal, should a core package of interventions be mandated? 2. If insurance will be supplementary, are there particular things that should be explicitly covered or restricted from private coverage? 3. If enhanced consumer choice is a key objective, what level of customisation of benefits best serves the consumer? 4. How should mechanisms to curb unnecessary demand of services (e.g. consumer cost sharing) be balanced with providing appropriate access to those who need care?

Regulatory Area	Key Policy Issues
Regulating how prices can be set	<ol style="list-style-type: none"> 1. To what extent is private insurance intended to promote equity goals through transfers between high and low risk groups, and the rich and poor? 2. If insurance will cover high-risk groups, how can insurers be encouraged to enrol these individuals while retaining a viable market? 3. Are premiums intended to cover current costs or provide a reserve for future health expenditures?
Regulating how providers are paid and aligning incentives between providers, insurers and consumers	<ol style="list-style-type: none"> 1. What is the relationship between the public and private systems of provision and what impact do prices in one system have on the other? 2. How can the consumer and the overall system be protected from provider price inflation as a result of insurance? 3. How can provider efficiency be encouraged while maintaining access? How much risk is it appropriate to transfer to providers and how should this be governed? 4. Is consumer choice of providers an important policy objective? If so, how can costs be contained without limiting consumer choice?