



PROPOSAL FOR A TAXONOMY OF HEALTH INSURANCE

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SUMMARY

1. This paper proposes a taxonomy of health insurance arrangements with the purpose of informing both policy analysis of alternative mixed systems of funding health care and data collection on such mixed funding arrangements.

2. Health insurance is a health financing mechanism that involves both pre-payment and risk pooling. This paper proposes classifying health insurance arrangements on the basis of four main criteria:

- Sources of financing public or private health insurance.
- Level of compulsion of the scheme: mandatory or voluntary health insurance.
- Group or individual schemes
- Method of premium calculation in health insurance.

3. This paper also spells out a few other important variables for analysing the structure and performance of health insurance mixes (e.g., nature of the carriers; characteristics of competition; contractual relationship with providers; regulatory framework; extent and nature of public subsidisation).

4. The criterion adopted in the taxonomy for distinguishing public from private health insurance schemes is the main source of financing. According to this criterion, public schemes are those mainly financed through the tax system, including general taxation and mandatory payroll levies, and through income-related contributions to social security schemes. All other insurance schemes that are predominantly financed through private premiums can be defined as private. The taxonomy then classifies private health insurance schemes into mandatory (by law) and voluntary, distinguishing then two subcategories: a) in relation to specific market subgroups (individual and group markets); b) in relation to requirements for risk rating (community and experience rating).

5. In sum, the following categories of health insurance can be identified by grouping the criteria:

- Public health insurance. This includes *tax-based* public health insurance and *social security* schemes.
- Private health insurance. These health insurance schemes are financed through private premiums, including:
 - *Private mandatory health insurance*. This includes health insurance that is compulsory per legal stipulation.
 - *Private employment group health insurance*. This includes health insurance that comes as part of a condition of employment.

- *Private community-rated health insurance.* This includes voluntary policies taken up by individuals or groups voluntarily, where insurers are required by regulation to apply community-rated premiums (i.e. no discrimination in premium calculations on the basis of age, health status, claims history or other factors).
- *Private risk-rated health insurance.* This includes voluntary policies taken up by individuals or groups voluntarily, where insurers apply risk-related premiums.

6. Having distinguished between what is public and what is private health insurance, this paper also proposes a classification of PHI types by function this plays within public coverage schemes. It distinguishes four functional categories of PHI: primary (including substitute and principal); complementary; duplicate; and supplementary.

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1. INTRODUCTION

7. The purpose of this paper is to propose a draft typology of health insurance schemes, with emphasis on the models of private health insurance. There are extremely heterogeneous health insurance arrangements across OECD countries, and similar schemes are often referred to with different names, or different schemes come under the same terminology. For example, while most would agree with the statement that the majority of health care systems publicly insure and pay for a range of basic health services, confusion seems to emerge on the distinction between public insurance, mandatory insurance and social insurance. These three terms are often used interchangeably, leaving the definition of private health insurance as a residual category.

8. The purpose of developing a taxonomy is two-fold. First, a taxonomy is a useful tool to guide data collection, both in terms of statistical data, and in terms of gathering policy and regulatory information on those insurance schemes that can be defined as “private”. Second, it helps policy analysis by identifying variables that may affect the performance of a private health insurance market and by distinguishing alternative roles that private schemes can play in mixed systems of funding health care.

9. The taxonomy is comprised of two distinct inputs:

- A classification of ‘models’ of health insurance clarifying, in particular, proposed distinctions between what is public and what is private health insurance (section 3).
- A classification of ‘roles’ of private health insurance clarifying the function played by private health insurance in relation to public systems as well as within private markets themselves (section 4).

Policy relevance of a typology of health insurance

10. Developing a taxonomy is a key task both to gather data on private health insurance suitable to international comparative analysis, and to inform analysis of the policy implications of alternative mixed systems of funding health care. A few examples can help understanding how key policy questions may apply differently to countries with alternative mixes of health insurance.

- In countries that arrange principal cover for the population at large through private health insurance, failures in health insurance markets (moral hazard; adverse selection; risk selection) might hamper the achievement of policy goals of equity and efficiency. Issues of fairness in financing and access for high risk individuals or low-income groups are prominent. This calls for analysis of the role of regulation and financial incentives in preventing or reducing the potential social drawbacks of private health insurance in these cases.
- Countries with extensive public health cover might see in private health insurance a possible means to reduce cost pressures on public health systems. In many OECD countries private health insurance exists parallel to public schemes. Policy analysis may look at the impact of private health insurance on overall health expenditures and public health expenditure in particular. It could review whether private health insurance gives rise to services of different quality and/or improves individual choice and responsiveness of health systems. It may investigate how private health insurance should be regulated. Questions on whether take up

of private health insurance should be encouraged, for examples through fiscal incentives, or discouraged, also arise. Finally policy makers might be interested to review the trade-offs between regulatory measures and financial incentives to attain policy goals.

- Countries where a substantial range of services are excluded from the public system or co-payments are very high, and where private health insurance covers these relevant risks, might consider whether private health insurance might deliver equity and access for bad risks or low-income individuals. Again, issues of whether take up of private health insurance should be encouraged, its distributional impact, and whether private health insurance should be regulated arise.
- Countries where a fraction of the population cannot have access to public cover or can choose a private alternative to the public cover might be concerned about avoiding services of different quality for public and privately covered individuals. Moreover, they might consider whether people with private cover should be allowed to obtain privileged/fast access to care or should have the same conditions of access as publicly insured people. Maintaining health insurance costs within control is also a key issue.

11. Obviously, a first step to address these issues consists in identifying what is private health insurance, and what is the health insurance mix. This paper hence proposes a typology that will help analysing alternative ways of organising health insurance and its impact on health systems.

Method

12. A good typology of health insurance schemes should satisfy three main principles. First, it should be based on characteristics of the health insurance scheme that are objectively identifiable, independently from the name given to the scheme in a certain country. Second, the typology should be consistently applied to all countries so that schemes featuring similar characteristics can be grouped in the same category. Third, the typology should be relevant for policy analysis and data collection, and should be sufficiently broad to capture changes over time in the organisation and management of health insurance schemes without having to develop again new categories.

13. The method for developing a classification of health insurance schemes consists of two parts. First, some variables or criteria that can be used to distinguish across different health insurance systems are identified. Second, these variables are grouped together in order to identify meaningful categories on the basis of the principles mentioned above.

2. WHAT IS HEALTH INSURANCE AND HOW DOES IT DIFFER FROM OTHER WAYS OF COLLECTING RESOURCES FOR HEALTH

14. Health care systems pay for health care through mixed financing mechanisms. Such heterogeneous arrangements differ in the way the costs of health services and the risk linked to the variability of individual health expenditures are distributed across individuals and over time. The figure below proposes to classify financing mechanisms on the basis of two criteria:

- 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 individually¹.

Figure 1. Alternative options for financing health care systems.

		Prepayment	
		NO	YES
Pooling	NO	Out-of-pocket payments (OOP)	Medical Savings Accounts (MSA)
	YES	Spontaneous charity ⁽¹⁾	Health Insurance (HI)

Notes: (1) This case refer mainly to developing countries, where, when a situation of distress occurs, members of the community pool resources to face the immediate needs of one or some of its members.

15. Health insurance can hence 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 people (pooling). It differs from out-of-pocket payments because OOP do not provide for pooling of risks nor pre-payment, while medical savings accounts provide for pre-payment but not pooling across risks although they are often coupled with an insurance scheme.

¹ WHO (2000), p. 96.

3. A PROPOSED TAXONOMY FOR HEALTH INSURANCE MODELS AND MIXES

Criteria that can be used to classify models of health insurance

16. Three broad criteria for classifying health insurance models can be distinguished:
- Sources of financing.
 - Level of compulsion of the scheme.
 - Group or individual schemes.
 - Method of premium calculation in health insurance (i.e. the extent to which premiums may vary according to health risk or health status or health proxies such as age).

Sources of financing

17. There are three main sources of financing for health insurance schemes: tax financing, social security contributions, and private premiums.

- i. *Tax-financing include* general taxation, local government taxes and earmarked taxation.
- ii. *Social security contributions* are premiums collected to finance social security schemes, typically received as payroll tax contributed to by employers, employees or both. The level of contributions is set by a third party.
- iii. *Private-premiums* refer to private payments that a policyholder agrees to make for an insurance policy. An insurance policy consists of a written contract of insurance that is issued to a person insured by an insurer company².

18. A classification of health insurance schemes into public and private is hence proposed with reference to the *financing source*:

- Public health insurance refers to insurance schemes that are financed through taxation or payroll contributions to social security schemes:
 - *Tax-funded health insurance*. In tax-funded schemes financing is collected by a central authority³ that either pays directly health care providers, or allocates these resources to third payers.

² Vaughan and Vaughan (1996).

³ This comprises of central government, state/provincial government and local/municipal government.

- *Social security schemes.* Social security schemes are statutory programmes financed mainly through social security contributions, which are usually a share of earnings, i.e. income-related. Social security schemes are mandatory for defined categories of workers and their employers and protect insured persons and their dependants against, among others, loss arising from sickness/illness. The government is the ultimate guarantor of benefits, and usually directly participates in the financing of the scheme.
- Private health insurance refers to insurance schemes that are financed through private health premiums, which are often (but not always) voluntary. Although the government often regulates these type of insurance, the pool of financing is not usually channelled through the general government.

19. It is important to note that there might be out-of-pocket payments such as co-payments, deductibles and co-insurance in both public health insurance and private health insurance schemes. For example, public health insurance members might be required to make co-payments. In Korea, co-payments in public health insurance represent a share of up to 50% for outpatient services and 20% for in-patient care.

20. Private health insurance might also be publicly financed through subsidies or state contributions. While private health insurance schemes might receive public finances and public health insurance schemes can draw on private resources, this does not change the nature of public or private health insurance. It might however present important policy implications because it may alter the degree of redistribution implicit in these health insurance schemes.

Level of compulsion on participation to the scheme

21. Health insurance schemes differ in the degree of obligation on individuals to participate in the scheme. Broadly speaking, four levels of compulsion can be identified:

1. *Mandatory participation in a single insurance scheme.* Individuals are compelled by legal stipulation to take up insurance cover in a specified insurance scheme, for example the Dutch catastrophic medical expense scheme for long-term care and mental health (AWBZ).
2. *Mandatory participation in a health insurance scheme, but freedom to choose across alternative schemes or carriers.* This is the case of multiple payer systems. For example, the 1996 Swiss Health Insurance Law mandated basic health insurance for all Swiss residents leaving them free to choose among insurers that differ for premium levels, administrative services and in part for types of cover offered. Free choice of sickness funds for the population mandated to take up insurance was made possible in Germany in 1996 and in the Netherlands in 1992. Sickness funds differ for the contribution charged to insurees. In all three cases, insurers and sickness funds compete for attracting insurees.
3. *Participation by the conditions of employment.* This includes health insurance schemes that are not mandatory by law, but that are included in general agreements or employer-specific conditions. Employers are free to choose whether or not to offer health insurance. Individuals who join the company either are automatically insured, or can choose to enrol into the scheme (as in the case of employer-based health insurance in the USA).
4. *Participation entirely voluntary.* No level of compulsion exists in participating to the scheme. Even if participation is encouraged, for example through tax breaks or other fiscal incentives,

it remains entirely voluntary. These schemes are usually provided by private insurers, although in less frequent cases it involves publicly-owned insurers. This is for example the case of voluntary insurance provided by Medibank private in Australia.

22. A simplified classification of health insurance schemes into mandatory and voluntary is proposed:

- Mandatory health insurance includes schemes where individual participation is compulsory by government through legal stipulation⁴, whether there is a unique system or a choice among scheme/insurer. The mandate can apply to the entire population or to groups within it (e.g., individuals with income lower than a threshold). When mandated health insurance covers the population at large such as all residents of a country, the scheme can be referred to as *National Health Insurance* (NHI).
- Voluntary health insurance includes insurance where insurees participate on a voluntary basis, or where employers can choose themselves whether to offer health insurance cover to their employees either voluntarily or per effect of collective agreements.

Group or personal health insurance

23. Individuals can take up insurance individually, or the cover can come as part of a group, for example as an employment provision. In the USA, the majority of insurees are covered by employer-based voluntary health insurance, while the self-employed and non-working people or those ineligible for employer-sponsored insurance can buy voluntary individual insurance. The distinction between group insurance and individual health insurance is important because the former can bring important social elements into the private cover. Premiums under group insurance are often lower because insurers bear lower administrative costs and the size of the pool is greater⁵. A simplified classification of health insurance schemes is proposed:

- Employment group health insurance includes health insurance schemes covering employees of a company. Insurers often offer group insurance as a separate category of insurance with a different pooling and pricing structure, often offering different benefit packages as well.
- Personal health insurance includes health insurance which does not apply to specific groups.

Method of premium calculation in health insurance

24. Insurers can calculate health insurance premiums based on different conditions. One important dimension is risk. Premiums can be calculated in three main ways:

- Income-related premiums. This is typically the case of social security schemes, where contributions are calculated as a share of earned income.

⁴ Adema (1998), page 8.

⁵ The advantage of group insurance partly explains why the U.S. federal government chose to facilitate access to group coverage for certain individuals who would otherwise have lost employer-sponsored coverage. The federal "COBRA" law enables certain individuals to continue as members of their employers' scheme for a specified time period, if they pay the full cost of the premiums, including the share previously paid by the employer.

- Community rated premiums. In community rating, premiums are adjusted for the average risk of a group, so that all insureds participating to the pool pay the same premium. There may be instances of modified community rating where certain factors are permitted to affect the premium to a specified degree, for example premium loading for late entry into a health insurance scheme. While insurers can choose to apply community rated premiums as a product strategy, in some cases government regulation mandate community rating (e.g., voluntary health insurance in Australia and Ireland; mandatory health insurance in Switzerland).
- Risk-related premiums. Premiums are related to individual risks and calculated from actuarial principles on the basis of expected medical claims.

Classification of health insurance models

25. The following main categories of health insurance schemes can be identified by grouping the criteria described above:

26. **Public health insurance:**

- i. Tax-based public health insurance.
- ii. Social security schemes.

27. **Private health insurance:**

- iii. Private mandatory health insurance.
- iv. Private employment group health insurance.
- v. Private community-rated health insurance.
- vi. Private risk-rated health insurance.

Some examples

28. Public health insurance includes for examples the Canadian Medicare instituted by the Canada Health Act⁶ (i) and the French 'Sécurité Sociale' (ii). Public health insurance is *usually mandatory*. The mandate can apply to the entire population (universal/national public health insurance) or to groups within it (e.g., individuals with income below a threshold). Possible exceptions are portions of Medicare coverage and Medicaid in the USA, where eligible individuals need to apply to public insurance agencies to receive health cover.

29. An example of private mandatory health insurance is: iii) Basic social health insurance in Switzerland, which has been mandated for the Swiss population with the 1996 Health Insurance Law.

⁶ The Act ensures that all residents of Canada have access to medically necessary hospital and physician services based on need, not on ability to pay, by setting the criteria and conditions that provinces and territories must satisfy to qualify for their full cash transfers.

30. An example of private employer group health insurance is: iv) employer-based health insurance in the United States.

31. Examples of private community-rated individual health insurance include: v) Voluntary health insurance in Ireland and Australia, and voluntary health insurance in the Netherlands provided under the WTZ Act, which is open to above-65 individuals not eligible to the sickness fund scheme for curative services (ZFW).

32. An examples of private risk-related individual health insurance is: vi) Individual health insurance in the UK.

Health insurance mix

33. OECD countries include heterogeneous mixes of public and private health insurance, which the OECD PHI Study intends to investigate. However, the proposed taxonomy of health insurance models shows that there various ways to look at the health insurance mix beyond the public/private mix based on financing source.

34. For some countries, it might be important to analyse other mixes than the public-private distinction. For example, if public health insurance does not exist in a country because basic cover for the entire population is provided through mandatory private health insurance, it might be important to analyse the mix of mandatory private health insurance and voluntary private health insurance. Furthermore, the issue of whether certain private health insurance arrangements can be considered social health insurance is important for the purpose of analysing the continuum of cross-subsidisation in premiums between income groups and in benefits between risk groups across health insurance schemes⁷.

35. The existence of alternative health insurance mixes raises important policy issues (Figure 2) which will be further developed within this project. For example, if fiscal pressures on public systems are a concern, than it might be more important to focus the attention on the public/private share. But if a policy concern is universality of population coverage and people's access to at least basic health cover, then the mandatory/voluntary mix could be relevant.

⁷ The OECD Health database collects data on private 'social' health insurance as well as other private health insurance. Private 'social' health insurance is defined as including "expenditures from private social health insurance funds". Data on private social benefits are also collected within work on Net social expenditures (Adema, 2001), whereby 'what is social and what is not social is determined by the purpose of the benefit and the prevalence of redistribution in the provision of protection'. As definitions of 'private social health insurance' are not clear cut, more understanding of how health insurance schemes differ with respect to the extend of cross-subsidisation is needed.

Figure 2. Health insurance mixes

HI models →	<i>Tax-based HI</i>	<i>Social security</i>	<i>Private mandatory</i>	<i>Employer-based</i>	<i>Community rated</i>	<i>Risk related</i>
H.I. Mixes ↓						
Public-private mix	Public health insurance		Private health insurance			
Mandatory-voluntary mix	Mandatory health insurance			Voluntary health insurance		
Policy relevance of the mix →	Burden for public finances, financial sustainability, impact on labour market flexibility, extent of pooling					
	Extent of pooling, coverage					
	Solidarity and progressivity, degree of cross-subsidisation in the scheme					

Boundary issues and areas of problematic classification

36. In some cases, it appears difficult to classify certain schemes that may not fit easily within the classification criteria proposed above. A few such cases, which are described below:

- *Mandatory health insurance schemes financed by individual, flat premiums.* While these schemes fall under the category of private health insurance, they are usually intensely regulated to ensure access and cross-subsidisation (e.g., community rating, open enrolment and benefit package restrictions apply). In addition, this type of insurance cover might be regulated under separate rules from those applicable to voluntary insurance schemes. In Switzerland, for example, while commercial insurers are under the supervision of the Office Fédéral des Assurances Privées, insurers are subject to separate regulation of the Office Fédéral des Assurances Sociales for any offerings of basic mandatory health insurance. Similar co-sharing of regulatory responsibilities applies to sickness funds providing both basic and supplementary health insurance.
- *Private health insurance schemes where the purchase of private health insurance is greatly subsidised.* The purchase of health insurance policies is financed, in these cases, predominantly by public sources (either because of large tax-incentives or because the premiums of certain low-income individuals are greatly subsidised). Nonetheless the scheme remains private on the basis of any other criteria, including administration (by private insurance entities), applicable regulatory regime, characteristics of the insurance market, role in relation to public insurance systems, etc. In France, for example, this applies to the system of universal health insurance (CMU), which entitles low-income individuals to large subsidies to purchase complementary private health insurance coverage.
- *Government-linked health insurance schemes for government employees.* Classification of some of such schemes might be problematic. Governments often pay directly for the health care of their employees or pay a large share of the premium for health insurance coverage for their employees. However such employees' funds in some cases don't pass through social

security organisations (e.g., Turkey), or may be used to finance the purchase of principal health insurance for civil servants from commercial insurers (Germany). Such schemes might be classified as private employer-created and sponsored schemes (the case of Germany), or as public health insurance schemes for government employees (the case of Turkey).

Other important characteristics of health insurance schemes not included in the typology

37. Although not included in the current typology, other variables represent nonetheless important descriptive characteristics of health insurance systems for the purpose of policy analysis, because they affect the performance of the insurance mix. These include, for example: i) Management/administration of the insurance scheme and nature of the carrier (public or private); ii) relationship across insurers (competition or not); iii) contractual relationship with providers; iv) fiscal advantages towards health insurance; v) other regulation affecting cross-subsidisation within health insurance.

Management/administration of the insurance scheme and nature of the carrier

38. Health insurance can be provided, managed and administered by both public and private entities:
- i. *Public* entities, such as: government units, public-sector institutions, social security branches.
 - ii. *Private* entities, such as: mutual companies, private for-profit insurers, private not-for-profit insurers, sickness funds.

39. Two criteria, management of the scheme and source of the funds, give rise to a public-private classification (figure 3). In fact, public health insurance can also be administered and provided by private institutions. Mutual companies in Belgium are part of the social security scheme that is financed through payroll contributions and other government funds. Sickness funds in the Netherlands are independent legal entities with self-appointed boards, and private insurers can take care of the administration of AWBZ insurance for their insurees. Conversely, government insurers can also provide private health insurance. The Voluntary Health Insurance board (now VHI Healthcare) in Ireland is a state-backed organisation that until the 1990s operated as monopoly provider of 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. This said, the nature of the insurer is usually more relevant for supervisory purposes.

Figure 3. Examples of public-private mix of sources and management of scheme

Source of funds	Ownership/Management of the scheme/carriers	
	Public	Private
Public health insurance (taxation, social security contributions)	UK NHS	Sickness funds in the Netherlands and mutualités in Belgium.
Private health insurance (private premiums)	VHI (Ireland)	US employer-based insurance, HMOs.

Relationship across insurers (competitive or not)

40. Another important characteristic is whether the relationship among carriers is *competitive or not*. Thus, for example, the Dutch catastrophic medical expense scheme for long-term care and mental health (AWBZ) and the sickness fund scheme for curative services (ZFW) are both public, social insurance schemes. The former is administered by Regional social health insurance funds, which are not competing. The latter is provided by social health insurance funds that seek to attract fund membership: the flat-rate part of the premium, which is applied on top of income-dependent capitated payments received by a central fund, is established competitively across funds. In the case of private health insurance, insurers typically compete for customers. However, if different regulatory frameworks apply to different types of insurers, this may affect the nature of the competition.

Contractual relationship with providers

41. Health insurance schemes differ widely on the basis of the contractual relationship between the insurer and the providers. Three main categories emerge:

- i. *Indemnity insurance*. No contractual arrangements exist between insurers and providers under “pure” indemnity insurance models. Indemnity insurance pays compensation to an individual for his/her specified loss according to the terms of the contract, which often may seek to restore the initial financial position of the person prior to the loss (subject to cost sharing or deductibles). Indemnity insurance offers choice of doctors (including specialists), hospitals, and other health care providers. Indemnity health insurance pays its share of the costs after receiving a bill. Bills are usually paid on a fee-for-service basis.
- ii. *Selective contracting*. Insurers negotiate agreements with certain doctors, hospitals, and health care providers to supply a range of services to insurees at reduced cost. Selective contracting can free the patient from the need to pay for health care up-front. It also facilitates cost containment by giving the insurers direct purchasing power in relation to providers. Selective contracting is widely applied in managed care options, and has recently replaced obligatory contracting of all providers in the social health insurance scheme for curative services in the Netherlands.
- iii. *Integration with providers*. Insurers and providers are vertically integrated. Providers are not independent, but are rather salaried workers of the insurer, or may be otherwise integrated under certain contractual arrangements. One example is staff-model Health Maintenance Organisations.

Tax funded subsidies for health insurance

42. Finally, another important characteristic of health insurance systems is the possibility for tax subsidisation, for example:

- i. *General tax-breaks*. Governments can award tax breaks on individuals taking up health insurance and/or employers sponsoring health insurance among employees. An example is the 30% rebate on voluntary health insurance in Australia.
- ii. *Selective tax breaks*. Subsidies may be provided for low-income groups to reduce the burden of taking up health insurance. An example is means-tested subsidies for mandatory health insurance available to poor insurees in Switzerland.

Other legal stipulations affecting cross-subsidisation in the scheme

43. Governments may also promote cross-subsidisation in premiums between income groups and in benefits between risk groups through *legal stipulations and regulation*. One important measure that has been identified includes legal enforcement of community-rated premiums. Other important measures include, for example:

- i. Open enrolment and limits on cream-skimming and risk selection. In some countries, insurers are compelled to accept all individuals who demand private health insurance coverage and cannot select among applicants, as in the case of voluntary health insurance in Australia and in Ireland for individuals below 65.
- ii. Minimum benefit or standard benefit regulation. Insurers cannot provide health insurance below a minimum level and may be compelled to provide a standard package of benefits.
- iii. Lifetime cover. Insurers are required to provide insurance cover to insurees for their lifetime, i.e. they cannot deny individuals to renew cover from one year to the next apart from exceptional circumstances such as dishonest behaviour and fraud.

4. A PROPOSED TAXONOMY OF FUNCTIONS OF PRIVATE HEALTH INSURANCE

44. The role of private health insurance in relation to public health insurance differs widely in OECD countries. In order to analyse the interaction between public and private health insurance, the impact on health systems arising from such interaction, and the characteristics of private health insurance markets themselves, private health insurance schemes can be classified according to the function they perform within the public-private mix, depending on two primary variables:

- Eligibility to public health insurance. Certain population groups might not be eligible to public health insurance. Individuals are left with the alternative to insure themselves privately. At an extreme, if there is no public health insurance, cover will only come through PHI.
- Health services covered. Private health insurance might offer cover for health care services that are (or are not) part of a publicly defined basic package (usually covered in public health insurance).

Functional classification of private health insurance schemes

45. Four main categories of private health insurance cover can be identified from the two criteria: *duplicate, principal/substitute, complementary and supplementary* (figure 4).

Figure 4. Functional classification of private health insurance arrangements

		Eligibility to public health insurance	
		Individuals have public cover	Individuals do not have public cover
Health services covered by PHI scheme	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.

46. Definitions of the roles of private health insurance are presented in Box 1. While recognising that, in the course of collection of statistical data, it might be difficult to separate between different functions, and that certain products perform more than one function, this conceptual differentiation is useful for the purpose of facilitating policy analysis.

Box 1. Definitions of functions of Private health insurance

Primary PHI: 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, or they are entitled to public coverage but have chosen to opt out of such coverage:

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 scheme⁸.

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.

Duplicate PHI: 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, such as: i) access to private health facilities that are not accessible through public insurance when the full cost of the service is paid by private insurance; ii) access to fast/privileged cover by bypassing queues in public system; iii) Access to care independent from referral and gatekeeper systems; iv) choice of doctor, hospital, or other health provider. It does not exempt individuals from contributing to public health insurance.

Complementary PHI: 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 PHI: 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).

Source: OECD (2004)

Difficulties in using a functional classification for data collection.

47. While the functions of private health insurance are all conceptually separate and relevant for policy analysis, it is however often difficult in practice to draw a clear-cut separation across these categories because private health insurance policies often bundle together cover for different medical and other non-medical services. This possible difficulty might complicate data collection efforts.

Examples of functions of PHI across OECD countries.

48. Private health insurance functions do not all apply within a given country. Two main country groups can be distinguished.

⁸ 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.

49. **Case I:** countries where eligibility criteria for public health systems are categorical for particular groups or portions of the population. PHI performs a substitution function for individuals not covered under public schemes. PHI schemes can also supplement the public scheme by covering services excluded by the public cover. This is the case, for example, of the Netherlands, Germany, Ireland (primary care and outpatient services only for about two-thirds of the upper-income population). The United States can also be included in this category (Figure 5).

Figure 5. Case I

Groups Services	Eligible to public cover	Non eligible to public cover
Medically necessary curative services covered in a publicly defined basic package	Public health insurance - Medicare, Medicaid (USA) - AWBZ, ZFW schemes (Netherlands) - Social security (Germany)	Substitute PHI - High-income people in NL (including WTZ ¹) - High-income people who choose PHI in Germany - High-income people ineligible for primary care and out-patient care services in Ireland.
Other services	Supplementary PHI (e.g. in the Netherlands: cover for dental care for adults, private rooms in hospitals, alternative care)	

Notes: (1) Voluntary health insurance in the Netherlands provided under the WTZ Act, which is open to above-65 individuals not eligible to the sickness fund scheme for curative services (ZFW).

50. **Case II:** countries with universal public health systems. PHI can have a duplicate function giving access to the same health services as public health insurance, but this obviously comes together with complementary services to make marketing of duplication possible, such: access to facilities or doctors that could not be utilised under the public cover, bypassing of queues, etc. Depending on the generosity of the public cover, PHI may also be offered for supplementary cover (services not covered under the public cover) and for separate complementary function such as co-payments (Figure 6).

Figure 6. Case II

Groups Services	Eligibility to public cover (universal)	
Medically necessary curative services covered in public health insurance	Public health insurance - National Health Service (UK) - Servizio Sanitario Nazionale (Italy) - Medicare (Australia) - Hospital services (Ireland) - National Health Insurance (Korea) - Securite Sociale (France) - Medicare (Canada)	Duplicate PHI (e.g., UK, Italy, Australia, New Zealand, Ireland) Complementary PHI (for co-payments, e.g., France)
Other services	Supplementary PHI	

CONCLUSION

51. This paper has proposed a taxonomy of health insurance with the purpose of guiding policy analysis of alternative mixed systems of funding health care. It has indicated some primary dimensions that enable to distinguish alternative health insurance schemes. It has proposed the source of financing as main distinguished criteria between public and private health insurance. It has nonetheless shown that there is a great heterogeneity of health insurance types beyond the public-private distinction. It has then classified private health insurance schemes on the basis of the way PHI interacts with public coverage systems.

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