

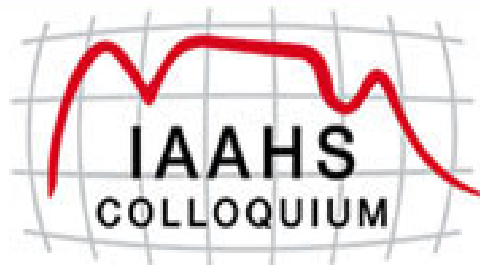


International Actuarial Association Health Section
2007 Colloquium

13th - 16th May 2007 Cape Town, South Africa

Public/Private Sector Initiatives: The OECD Health Project
IAA Health Section Colloquium

Lisa Beichl
International Health Consultant

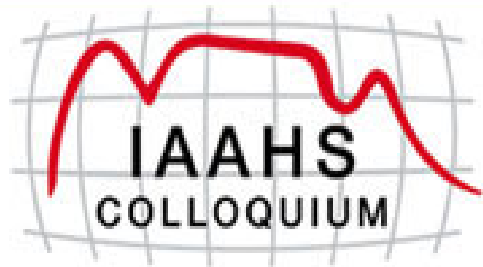


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Public/Private Sector Initiatives

- Stakeholder behavior
- OCED Health Project (Private Health Insurance)
- Complexity of "comparing what works" globally
- Building Bridges



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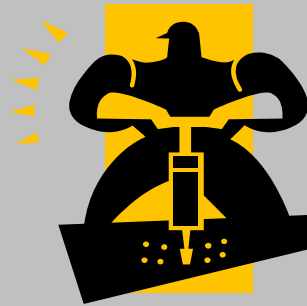
Providers



Government



Individual



Employer

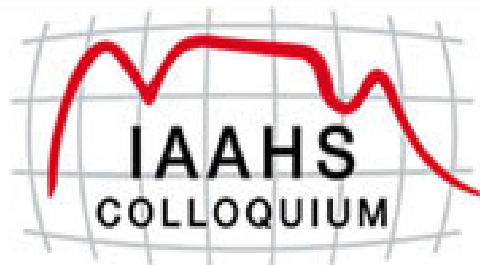


Insurer/
Reinsurer



Agent/Broker

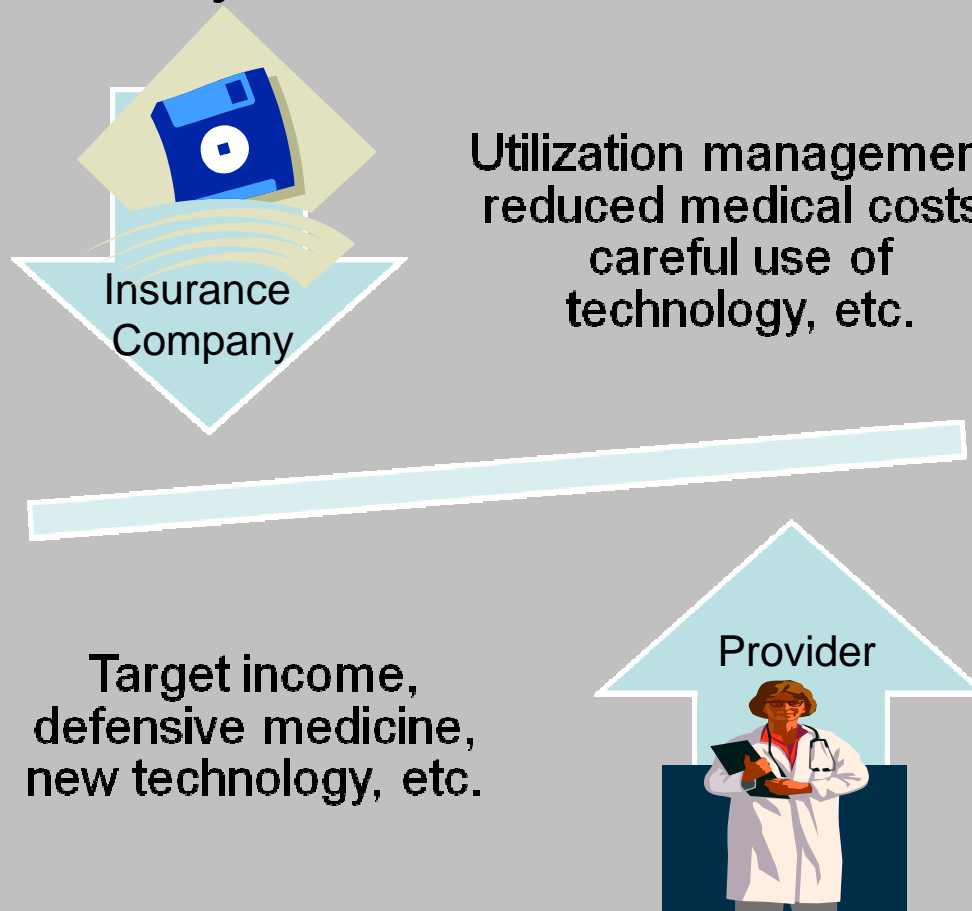


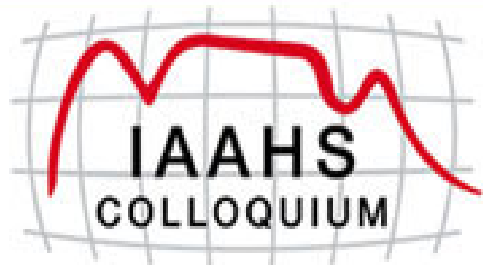


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It's easy to look at a situation in isolation





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Source the issue and impact on all stakeholders

Agent/Broker



Employer



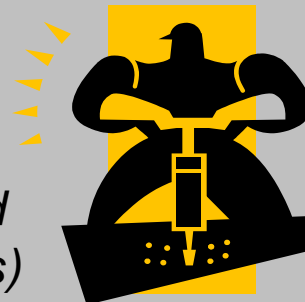
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Individual

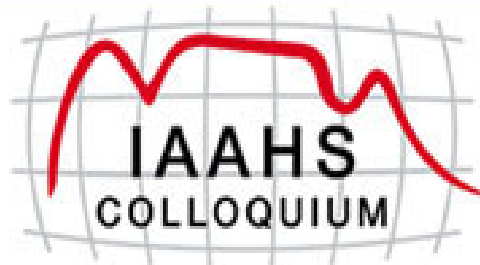


Providers



Government regulations can address:

- *Benefit Design*
- *Access*
- *Use of Evidence Based Medicine (quality metrics)*



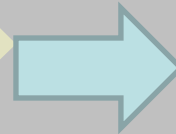
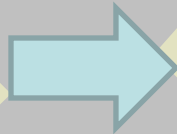
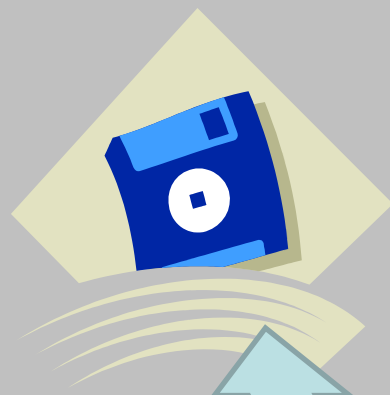
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Source the issue and impact on all stakeholders

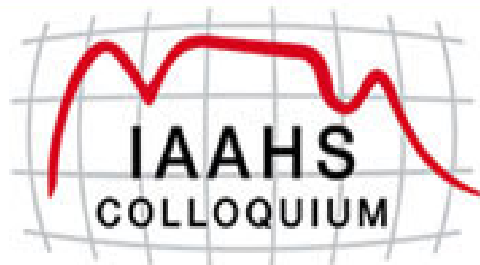
Insurer/
Reinsurer

Government



If we really seek health delivery efficiency as a top priority, unemployment will increase.



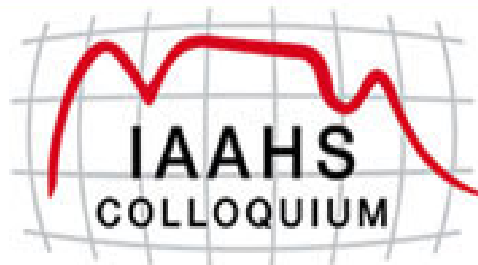


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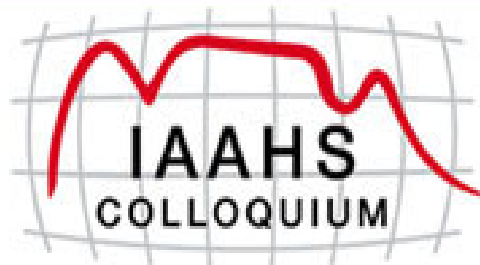
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Private Health Insurance in OECD Countries

Performance improvement means answering these questions:

- What can be done to ensure that spending on health is affordable today and sustainable tomorrow?
- What is needed to improve the quality and safety of healthcare and to ensure that health systems are responsive to the needs of patients and other stakeholders?
- How should equitable and timely access to necessary care be supported?
- What can be done to increase value for money?

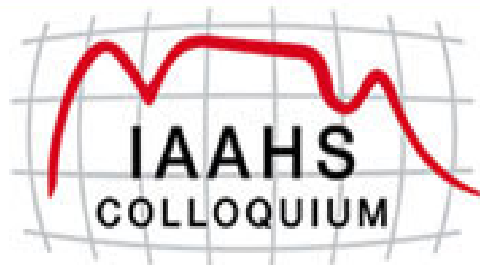


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Private Health Insurance in OECD Countries

- The role and structure of PHI markets vary across OECD countries.
- PHI is primary coverage in the US (72% of population with PHI), the Netherlands (28%), and Germany (9%).
- PHI mainly duplicates universal coverage in Australia, Ireland, New Zealand, and the United Kingdom.
 - Nearly half of the Australian and Irish populations purchase a private health policy representing the largest duplicate PHI market.

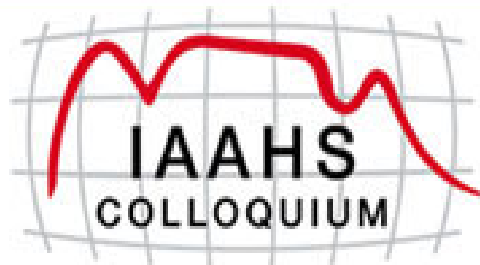


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Private Health Insurance in OECD Countries

- Supplementary PHI covers 65% of the population in Canada, 80% in Switzerland, and 90% of the socially insured in the Netherlands.
- PHI is purchased by over 30% of the population in a third of the OECD countries.



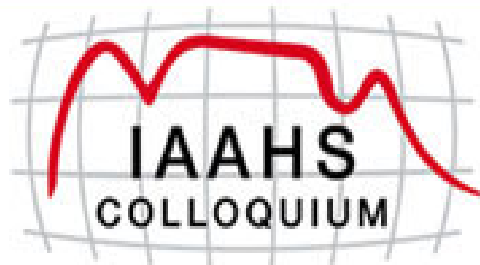
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Private Health Insurance in OECD Countries

Access to health coverage and healthcare:

- The contribution of PHI to access to health coverage varies depending on how large a PHI market has developed, how broad the pool of risks is for which it provides financial protection, and the scope of regulations of coverage and delivery systems.
- Under little or light regulation, risk selection is typical of PHI markets and higher risk individuals face access difficulties in obtaining and affording policies.
- Access is not often equitable across income-groups, largely because PHI is typically purchased by high-income groups.
 - In duplicate systems, PHI furnishes a level of care, choice and speed of access to care above what is afforded by public systems.



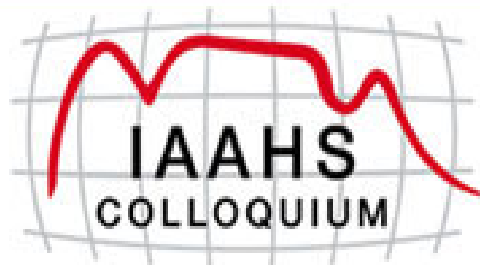
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Private Health Insurance in OECD Countries

Choice and Responsiveness:

- Ability to purchase PHI suggests choice with respect to financing certain health care services and providers on an out- of-pocket basis (primary PHI market in US, the Netherlands, and supplementary PHI in Canada.
- PHI has improved choice of health providers and timing of care in most countries with duplicate PHI markets.
- The scope of this depends on the regulation of delivery systems, the freedom of choice already existing within public systems , and insurers' contractual terms with providers.



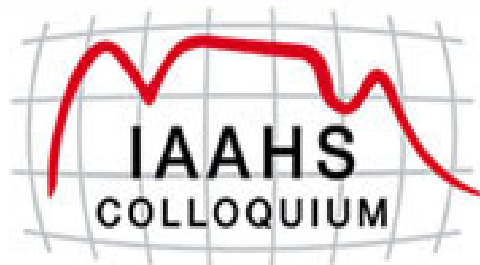
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Private Health Insurance in OECD Countries

Quality of Care:

- There is only weak evidence that PHI has promoted the delivery of high-quality care in the OECD area.
- This is due to: lack of regulatory and financial incentives for insurers, resistance by consumers to restraints on individual choice, and providers' resistance to the introduction of a new source of influence on decisions over appropriateness of care.
- The US has been the only OECD country where private insurers have been substantially involved in directing and overseeing certain aspects of care delivery (pressure from Employers and purchasers)



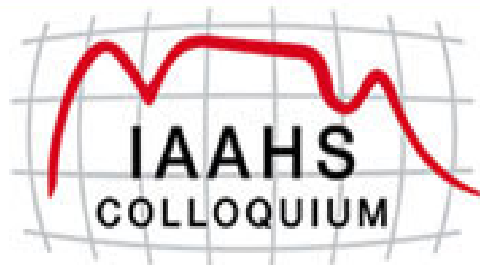
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Private Health Insurance in OECD Countries

Health Expenditure:

- PHI has not significantly assumed financing burdens from the public sector.
- PHI has injected financial resources into health systems, encouraging an expansion in capacity and services.
 - Example: PHI has provided additional revenue streams for hospitals and physicians, particularly in cases where public system activity is subject to price and reimbursement limits and providers engaged in privately financed practice enjoy greater rate flexibility (as in Germany, Ireland, Australia, the United Kingdom, etc.)
- PHI has often added to total health expenditure.



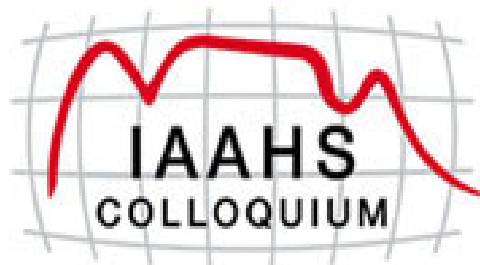
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Private Health Insurance in OECD Countries

Efficiency:

- Although PHI is often viewed as a tool to enhance efficiency, the evidence in this study showed only small contribution.



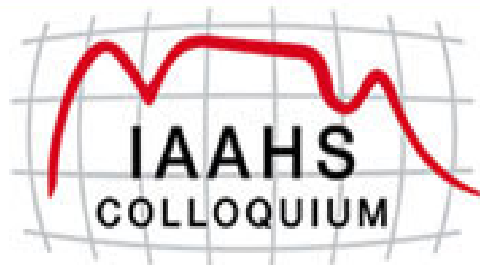
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Private Health Insurance in OECD Countries

Some useful PHI practices:

- Combination of insurance and rating rules can alleviate access-related PHI challenges.
- When PHI creates access disparities between those with and without it, policy makers can intervene by regulating the role that PHI can have.
- Policy makers can maximize effective choice by fostering readily understood comparative information and product disclosure requirements.
- Incentives or regulatory requirements might encourage PHI markets to improve cost effectiveness of care by removing insurers' obligations to contract with all providers (for example).

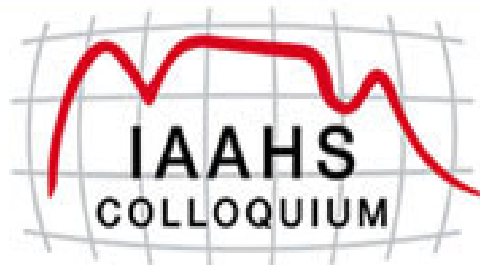


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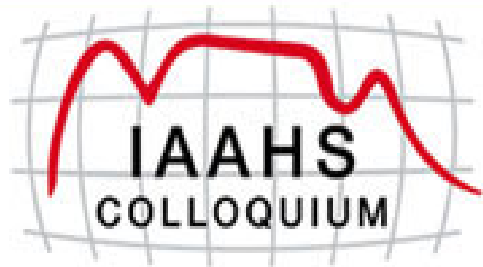
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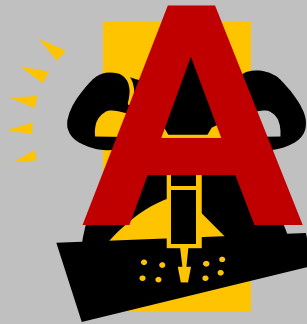
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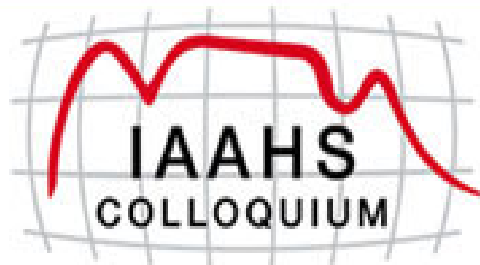
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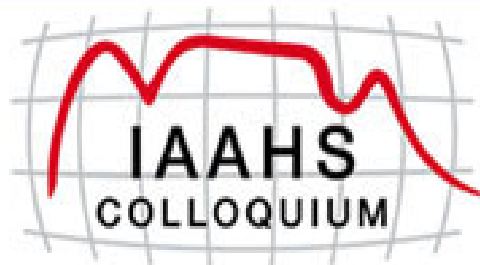


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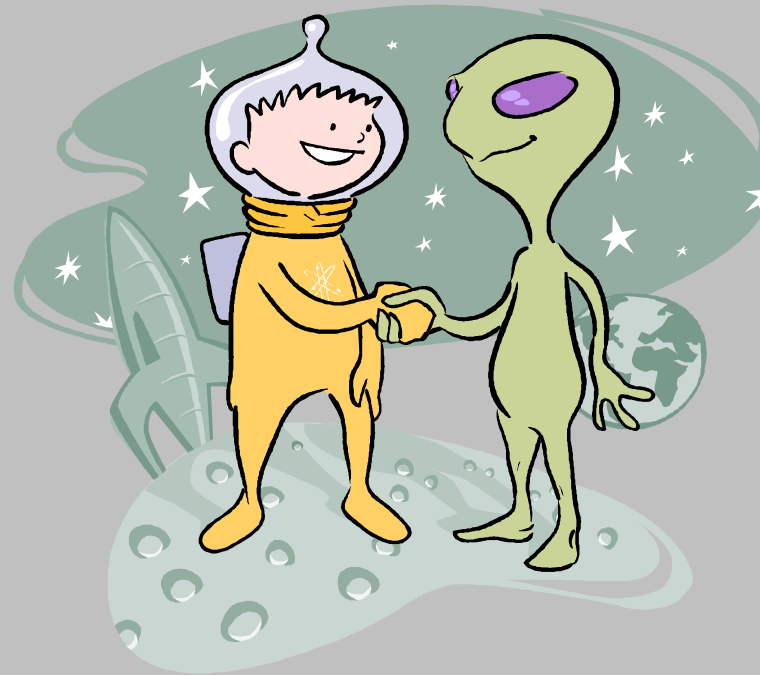
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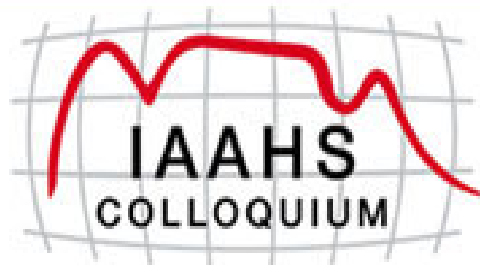
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