Private health insurance spending

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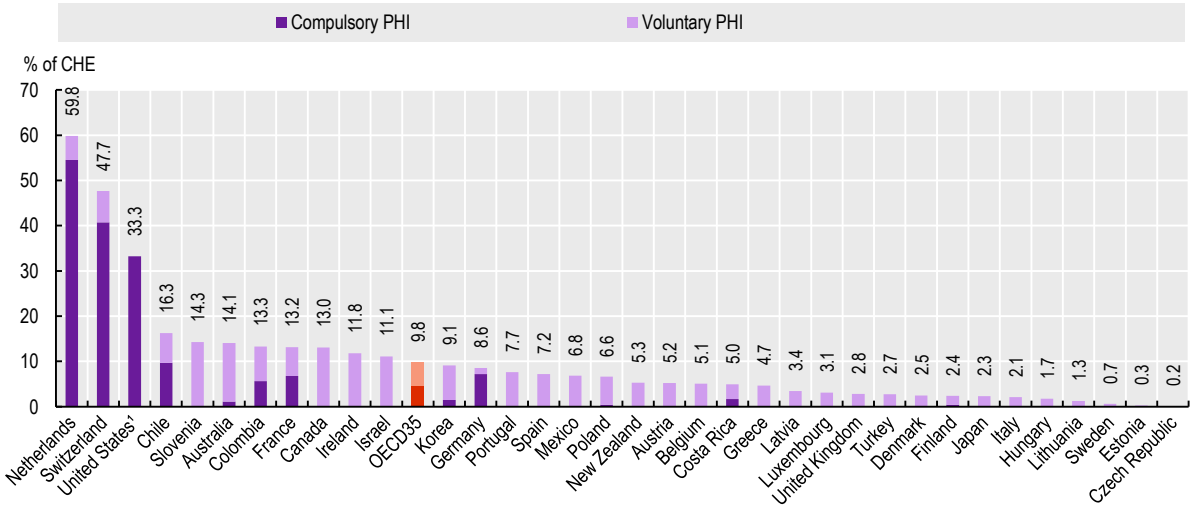
Around 10% of all health spending across OECD countries is paid by private health insurance

After government schemes, social health insurance and out-of-pocket payments, private health insurance is an important source of health financing in many OECD countries. On average, it finances one in every ten USD spent on health across the OECD, but this average masks considerable cross-country variation. Private health insurance accounts for a third of all health spending in the United States, nearly half in Switzerland and around 60% in the Netherlands (Figure 1). On the other hand, in around half of OECD countries it accounts for 5% or less of health spending and plays an almost negligible role in the Czech Republic, Estonia and Sweden.

Private health insurance plays different roles in countries depending on their health financing framework:

- In most countries, government or social health insurance schemes finance a public benefit basket covering a minimum set of health services mandated by law and accessible to people.
- In the Netherlands and Switzerland, access to this benefit package is instead provided by compulsory private health insurance. Here, private health insurance becomes the ***primary*** mechanism through which the entire population obtains health care coverage. In other countries yet, notably Chile and Germany, private health insurance fulfils a primary role for specific groups of people.
- Private health insurance can also play a secondary role by providing: ***supplementary*** coverage, for those services not included in the public benefit package (in Israel or Canada, for example); ***complementary*** coverage, covering co-payments needed to use services included in the public benefit package (e.g. France, Slovenia); or ***duplicate*** coverage, for services delivered by providers not included in the public benefit package, to obtain faster access or increase the choice of providers (e.g. Australia, Ireland).

Figure 1. Private health expenditure as share of current health spending, 2019 (or nearest year)

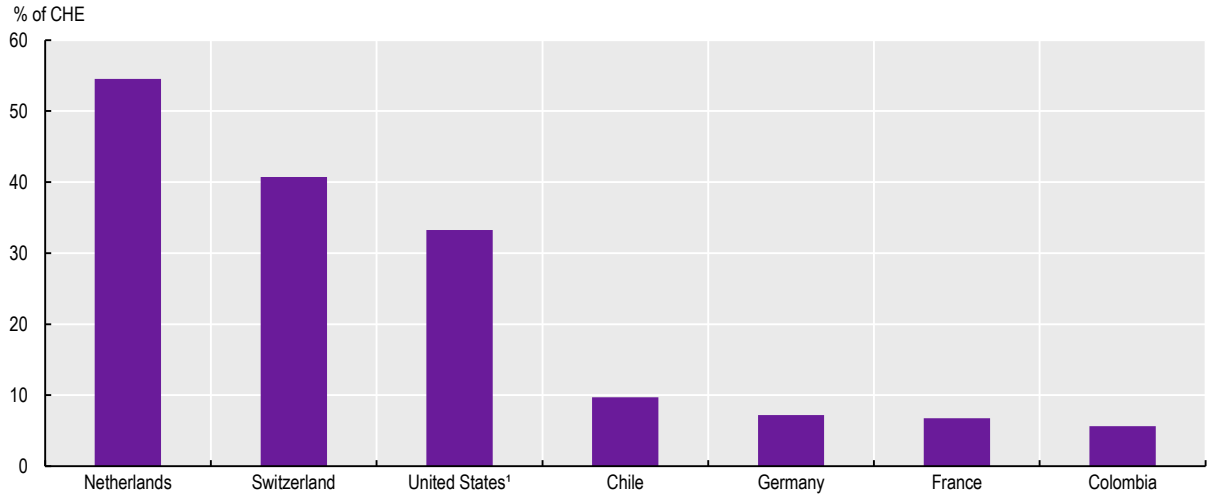


Note: Total private health insurance spending is defined as the sum of spending by compulsory private health insurance schemes and voluntary private health insurance schemes. CHE stands for current health expenditure.
1. Spending by private health insurance cannot be distinguished between compulsory and voluntary. Since the introduction of the individual mandate to purchase health insurance 2014 as part of the Affordable Care Act, the majority is considered as compulsory.
Source: OECD Health Statistics 2021, https://doi.org/10.1787/health-data-en.

In most OECD countries, voluntary affiliation is the dominant form of private health insurance

From a health financing perspective, private health insurance can be distinguished between ***compulsory*** and ***voluntary*** (Box 1). ***Compulsory private health insurance*** plays an important role in only around half a dozen OECD countries and in almost all cases refers to situations where it provides *primary* coverage for the entire or a sub-group of the population (Figure 2). In the Netherlands, spending by private insurers operating under the "Health Insurance Act" (ZVW) represents 55% of total health spending. In Switzerland, the "Federal Law on Health Insurance" (KVG) mandates the purchase of private health insurance coverage for the entire population and – together with compulsory private accident and occupational diseases insurance- accounts for 40% of total health spending. Since 2014, the Affordable Care Act in the United States requires all individuals and their families (with some exemptions) to have a minimum amount of health insurance. In Germany and Chile, people opting out of social health insurance are mandated to obtain private health insurance coverage for a minimum basket of services. Spending under these schemes, which cover around 10-18% of the population, accounts for 7-10% of all health spending in these two countries. In France, legal changes in 2016 made it *compulsory* for employers in the private sector to offer complementary insurance through mutual health insurers (e.g."*mutuelles*"), provident institutions or private insurance companies to employees (who are generally required to accept). This accounts for around 7% of total health spending. Other types of *voluntary* complementary insurance – subscribed by individuals directly – account for another 6% in France. A special case is the situation in Colombia, where compulsory private health insurance spending refers to the obligations of private insurers to cover medical costs resulting from traffic or occupational accidents.

Figure 2. Share of private compulsory health insurance spending in current health expenditure, 2019 (or nearest year)



Note: Only countries are displayed where compulsory private health insurance spending comprises 5% or more of current health expenditure.
1. Spending by private health insurance cannot be distinguished between compulsory and voluntary. Since 2014, the majority can be considered as compulsory. CHE stands for current health expenditure.
Source: OECD Health Statistics 2021, https://doi.org/10.1787/health-data-en.

Box 1. How is private health insurance spending defined?

A System of Health Accounts 2011 is the key reference framework on which international comparisons of health spending are based (OECD/Eurostat/WHO, 2017[1]). The framework defines the boundaries of health spending and proposes a system of classifications to structure health spending around the three dimensions of financing, provider of health services and types of services.

Analyses from a financing perspective are made on the level of *financing schemes* – with a scheme being defined as "the body of rules through which people can obtain health services". On the broadest level, financing schemes can be distinguished between compulsory schemes – where participation is either automatic or compulsory, and voluntary schemes – where participation either depends on the individual or is at the discretion of other actors.

Private health insurance is classified under both categories, compulsory and voluntary. ***Compulsory private health insurance*** exists in a number of countries mainly as the primary mechanism through which people obtain coverage for health care services or as a substitute for social health insurance in countries where some population groups can opt out of public health insurance if they obtain private coverage instead. However, in some countries complementary coverage can also be compulsory. The key criteria to distinguish between social health insurance and compulsory private health insurance is that the latter refers to the purchase of an individual or group insurance policy based on private law.

Voluntary private health insurance exists in nearly all countries and generally complements, supplements or duplicates existing health coverage from a publicly financed benefit package. These insurance policies are frequently taken out by individuals but can also be part of a group contract or offered by employers. Together with out-of-pocket spending, voluntary private health insurance spending forms part of "private spending on health" but the two categories differ as with out-of-pocket payments there is no prepayment involved and funds are not pooled across the population.

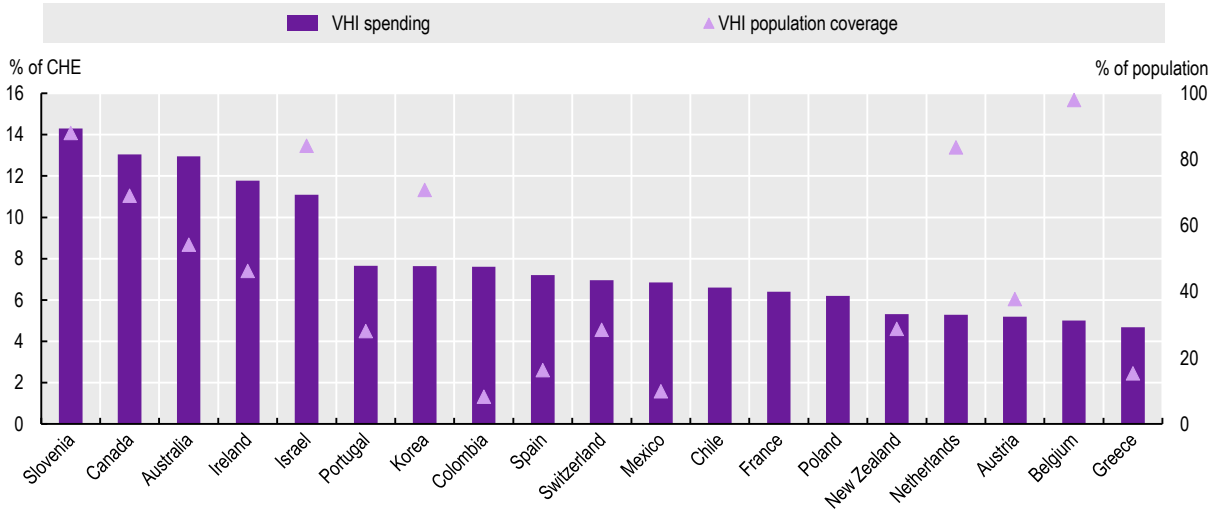
The nature of financing schemes can change over time and in some instances, schemes that used to be voluntary can be become compulsory when a legal mandate to purchase coverage is introduced.

Private health insurance is mainly financed via compulsory/voluntary premium payments by individuals or employers but in some countries the government subsidises these payments.

The role played by ***voluntary private health insurance*** is different, and the scope of services covered is generally more limited than with compulsory health insurance. From a financing perspective, it can be nevertheless important. In Slovenia, Canada, Australia, Ireland and Israel, spending by voluntary private health insurance represents 11%-14% of overall health spending (Figure 3), and a significant proportion of the population have this type of coverage -almost nine in ten people in Slovenia and close to seven in ten in Canada. Population coverage for voluntary private health insurance is also very high in Israel, the Netherlands and Belgium.

In Slovenia, voluntary private health insurance mainly finances the co-payments to social health insurance. In Canada, voluntary private health insurance provides supplementary coverage, with a particular focus on pharmaceuticals. In Australia and Ireland, voluntary insurance is mainly duplicate and used to obtain quicker access to treatment or diagnostics in public or private hospitals. While most private health insurance spending in Switzerland and the Netherlands is linked to compulsory primary insurance contracts, voluntary health insurance remains non-negligible and finances around 5-7% of overall health spending in those countries.

Figure 3. Share of private voluntary health insurance (VHI) spending in current health expenditure and share of population with VHI coverage in 2019 (or nearest year)



Note: Only countries are displayed where voluntary private health insurance spending comprises 5% or more of current health expenditure. Data on population coverage is not available for all countries. Share of VHI spending is displayed on left axis. Share of population coverage is displayed on right axis.
Source: OECD Health Statistics 2021, https://doi.org/10.1787/health-data-en.

Private health insurance finances different health care services, depending on whether it is compulsory or not

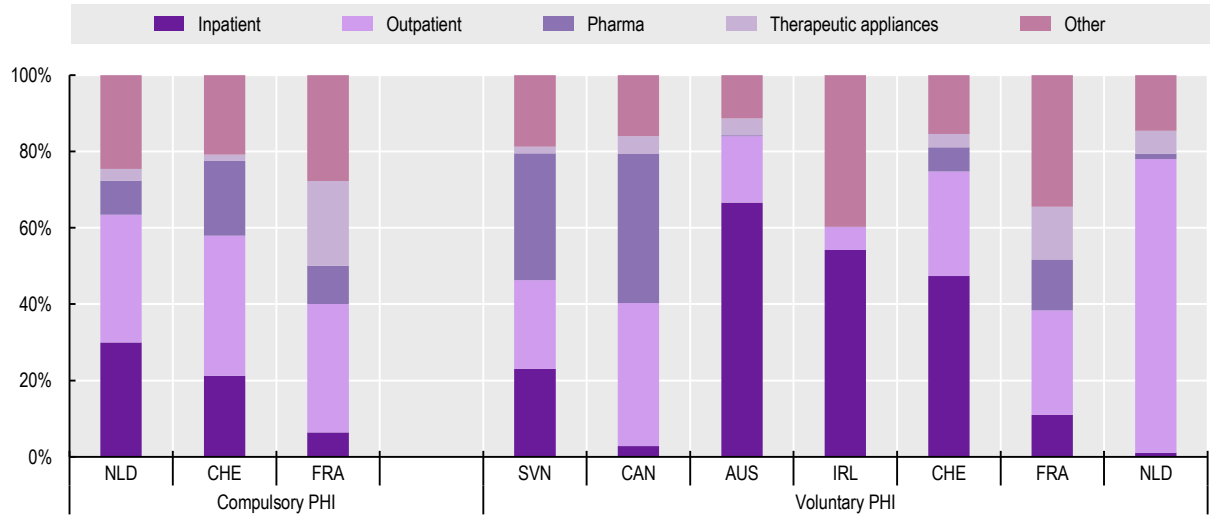
The type of health care goods and services financed by private health insurance (e.g. outpatient care, inpatient care, long-term care, pharmaceuticals, therapeutic appliances) varies across compulsory and voluntary schemes, reflecting differences in health system characteristics (Figure 4).

Looking at *compulsory* private insurance schemes in the Netherlands and Switzerland, the breakdown of spending is similar, reflecting the scope of coverage in mandated primary insurance and health care utilisation patterns. In France, on the other hand, compulsory private health insurance mainly reimburses the co-payments to social health insurance, thus mirroring public cost-sharing regulations. As a result, France shows much lower compulsory private health insurance spending on inpatient care and much higher spending on therapeutic appliances such as glasses or hearing aids than the Netherlands or Switzerland.

The spending structure of *compulsory* private health insurance in the Netherlands and Switzerland is very different compared to that of *voluntary* private health insurance in those countries. In the Netherlands, voluntary private health insurance is dominated by outpatient care spending, mainly for dental care and rehabilitative care (such as physiotherapy), while in Switzerland, inpatient care is dominant. In France, since both compulsory and voluntary private health insurance are complementary, the type of health care financed differs very little between the two types of private insurance.

Looking at countries with important *voluntary* private health insurance schemes, pharmaceutical spending makes up the most of spending in the case of Canada and Slovenia, while inpatient spending is dominant in the case of Australia and Ireland. Again, this variation reflects differences in roles played by private insurance across countries.

Figure 4. Composition of private health insurance (PHI) spending by type of service



Note: Countries ranked in descending order based on share of private health insurance in total health spending, separately for compulsory and voluntary PHI.
Source: OECD Health Statistics 2021, https://doi.org/10.1787/health-data-en.

The share of private health insurance spending grew slightly over the last 15 years, but COVID-19 reversed this trend in 2020

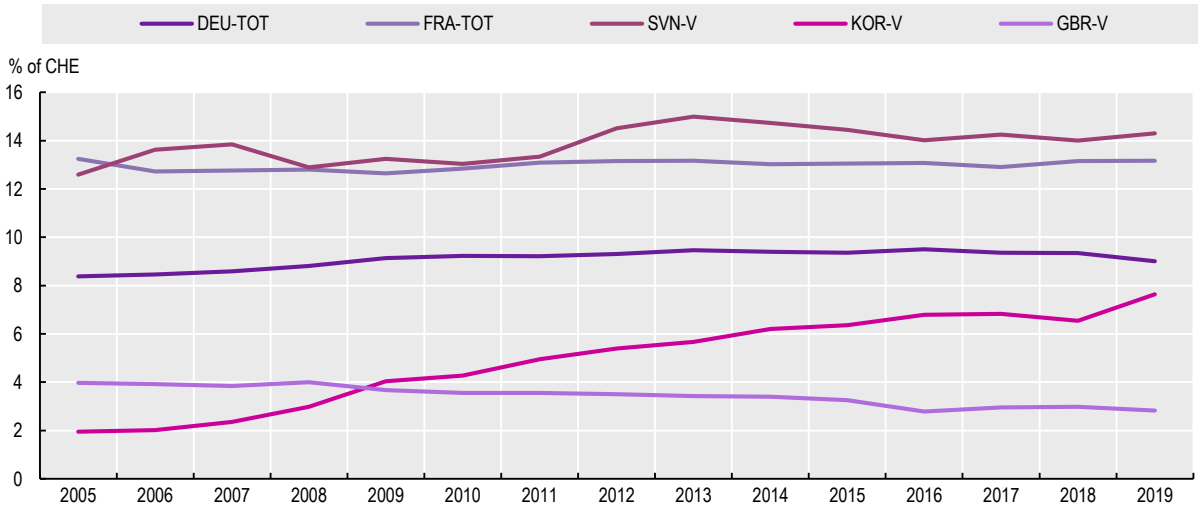
Overall, spending by private health insurance has grown at a slightly greater rate than total health spending since 2005. By 2019, the share of private health insurance in current health expenditure had risen to 9.8% on average across OECD countries, up from around 8% in 2005. Some of this development can be explained by legislation or reforms changing how health care is financed. In the Netherlands, a major health financing reform replaced the existing social health insurance system with one based on compulsory private health insurance in 2006. In other countries, while the share of total private health insurance spending has remained largely unchanged, the balance between compulsory and voluntary private insurance has altered (Figure 5). In Germany, the uptake of private health insurance coverage was made compulsory for certain population groups in 2009 (for which it was voluntary before). In France, voluntary private insurance for complementary coverage became compulsory for most employees in the private sector in 2016.

Focusing on the evolution in voluntary health insurance spending highlights several interesting trends (Figure 5). In Korea, the growing popularity of complementary and supplementary private insurance (more than seven in ten Koreans had this type of coverage in 2019) has seen its share of spending rise steadily from 1.9% in 2005 to 7.6% in 2019. Population coverage of voluntary insurance has also grown strongly in Slovenia, reaching 88% in 2019. However, the corresponding spending share only increased slightly from 12.6% in 2005 to 14.3% in 2019. In the United Kingdom, on the other hand, the proportion of health spending from private health insurance dropped, from 4% in 2005 to 2.8% in 2019, mirroring the decline in the share of the population with duplicate insurance (to around one in 10 in 2019).

Despite the gradual growth in private health insurance spending over the long-term, preliminary data for 2020 suggest a fall in private health insurance spending in a number of countries as private (elective) treatment has been postponed to secure sufficient treatment capacity for COVID-19 patients and due to other restrictions on health care delivery, or simply reflecting the fact that fewer people sought care out of fear of infection. In Chile, compulsory private health insurance spending is expected to drop by 9% in real

terms in 2020. In Slovenia, voluntary private health insurance spending stagnated in 2020, while it decreased by 8% in the Netherlands and 28% in the United Kingdom.

Figure 5. Private health insurance spending as a share of current health expenditure, 2005-19, selected OECD countries



Note: Data for France and Germany refers to the sum of compulsory and voluntary PHI (total PHI spending). Data for Korea, Slovenia and the United Kingdom to voluntary PHI only.
Source: OECD Health Statistics 2021, https://doi.org/10.1787/health-data-en.

Useful links

OECD (2021), OECD Health Statistics 2021 (database), https://doi.org/10.1787/health-data-en.

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264270985-en.

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