Hard work for government!
Balancing public & private financing for UHC in Europe

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Private parts? CHSPR 2020 32nd annual health policy conference
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Universal health coverage (UHC) means everyone can use the quality health services they need without financial hardship.

Public spending on health.

Carefully designed coverage policy.
Where are the gaps in coverage?

Does private health insurance (PHI) fill them?

Why is this hard work for government?

Lessons from Europe
Where are the gaps in coverage?
Public spending on health dominates –

Breakdown of current spending on health by financing scheme

– but there are gaps in coverage
Gaps in coverage are largest for dental care & outpatient medicines

Breakdown of current spending on health by type of service

- Inpatient care
- Ancillary services
- Outpatient care
- Medical products
- Outpatient medicines
- Dental care

Public spending
Out-of-pocket payments
PHI

Eurostat & OECD NHA data for EU countries in 2016

– do coverage gaps matter?
Gaps in coverage lead to financial hardship

The % of households with catastrophic health spending is consistently highest in the **poorest** quintile

The poorest households are mainly spending on **outpatient medicines**
Gaps in coverage lead to unmet need for services

The % of adults reporting unmet need is consistently highest in the poorest quintile

Health care

Dental care

Unmet need (poorest)

Unmet need (average)

Catastrophic incidence (average)
What causes coverage gaps?

- Out-of-pocket payments and unmet need arise when...
  - Where are user charges
  - People are not covered

- Entitlement linked to payment of contributions
  - Migrants excluded
  - Pooled funds

- Benefits package is narrow & timely access is an issue
- All EU countries apply user charges to outpatient medicines
- Dental care
- Waiting times
- Unmet need for poor & financial hardship for rich
Does PHI fill these gaps?
PHI’s role in filling gaps varies across countries

- PHI offers choice + faster access where there are long waits
- PHI covers user charges
- PHI covers excluded services

There is almost no PHI spending on outpatient medicines or dental care

– it doesn’t do a good job in most cases

Sagan & Thomson (2016); WHO spending data for 2016
The gaps filled by PHI vary across countries

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- PHI covers excluded services

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OECD data for 2017
Why is PHI hard work for government?

CHAPTER I

All happy families resemble one another, but each unhappy family is unhappy in its own way.
Common challenges with PHI:

- Inequality
- Spillover effects
- Complexity

Undermine publicly financed coverage

Insurers are risk averse:
- Risk-rated premiums 91%
- Pre-existing conditions… 85%
- No open enrolment 68%
- Cover ends at retirement 68%
- Annual contracts 68%
- Waiting periods 62%
- Not sold to older people 56%

PHI systematically favours:
- Richer people 96%
- People living in cities 96%
- More educated people 94%
Common challenges with private (voluntary) health insurance:

- Inequality
- Spillover effects
- Complexity

Can undermine the performance of publicly financed coverage

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Sagan & Thomson (2016); survey of PHI in 34 countries
France: >90% have PHI covering heavy user charges

% population with PHI

2005: subsidies for poor people
2000: free PHI for very poor people


Current PHI coverage

No PHI
Subsidised PHI
PHI

100%
80%
60%
40%
20%
0%

Poorest Richest

2016: employers mandated to pay for PHI for employees
Many (mainly poor) people still lack PHI due to financial & administrative barriers

Couffinhal & Franc in Thomson, Sagan & Mossialos (in press); Thomson & Mossialos (2007); data on PHI status from WHO/Bricard (in press)
France: heavy regulation & subsidies for poor people have led to high take-up & low out-of-pocket payments – but inequalities persist

PHI premiums are regressive, accounting for a much higher share of income among poor people.

Catastrophic incidence in poor households is higher for those with subsidised PHI or no PHI.

6.1%
12.7%
18.5%

PHI Subsidised
PHI
No PHI

Size matters: PHI covering user charges must be affordable for everyone needing protection but it’s hard to ensure this for poorer people.

WHO/Bricard (in press)
Ireland: >45% have VHI for faster access to hospitals

1957: richer people not covered for hospital care → Tax subsidies for PHI

1994, 2013: tax subsidies for PHI reduced;

2002: public buys care from private hospitals

2015: penalties for not buying PHI when young

1991: richer people are entitled to inpatient care

2014: levy on use of private bed in public hospitals; encourages hospitals to use private beds

2003, 2007: legal challenges

Waits increase; non-rich start to buy PHI

Demand for public hospital treatment grows

Turner & Smith in Thomson, Sagan & Mossialos (in press)
Ireland: indiscriminate tax subsidies, perverse incentives & blurred boundaries skew resources away from need

I buy PHI to jump queues  PHI is a necessity not a luxury

Poor people subsidise faster access for richer people

40% of PHI-financed care takes place in public hospitals

Steady increase in the numbers waiting for inpatient care & in the length of waits

Size matters: for PHI offering people faster access, (very) small is beautiful because in larger markets it’s hard to manage powerful interests

Lessons from Europe
PHI is predictably challenging

**Economic theory**: insurer risk aversion means access & affordability problems are to be expected in a voluntary market

**International experience**: weak public policy – poor design, failure to clarify boundaries, failure to manage interests

Context matters too

Is it worth it?

Thomson, Sagan & Mossialos (in press)
Fixing PHI takes up energy and resources – don’t let the tail wag the dog

"SLOW & TEDIOUS – BUT IT’S POSSIBLE TO RESIST"

Focus on improving the publicly financed part of the health system
European Observatory on Health Systems and Policies & WHO Regional Office for Europe

Cambridge University Press.

Copenhagen: WHO Regional Office for Europe.