

Long-Term Care and Health Care Insurance in OECD and Other Countries



Please cite this publication as:

OECD (2020), *Long-term Care and Health Care Insurance in OECD and Other Countries*,

www.oecd.org/fin/insurance/Long-Term-Care-Health-Care-Insurance-in-OECD-and-Other-Countries.htm

This work is published under the responsibility of the Secretary-General of the OECD. The opinions expressed and arguments employed herein do not necessarily reflect the official views of OECD member countries.

This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Foreword

Ageing is affecting many OECD countries, and as the demographic change progresses, governments will be challenged to identify financially sustainable ways to support the care of the ageing population. This is particularly important for long-term care and health care, as increasing expenditures may become financially unsustainable for many countries while compromising on care options is rarely realistic. Many countries are or will struggle with how to reform their care system to bring these costs under control, while ensuring that those in need can access the necessary care of quality.

This report carries out a stocktaking of what systems have in OECD and non-OECD countries for long-term care and health care, as well as the types of insurance products that are made available in these countries. It is part of a broader project that examines the complementarity of the social security network with the private insurance market, which examines how insurance could support the public sector long-term care and health care systems, as well as considering the financing of long-term care and health care.

Table of contents

| | |
|--|----|
| Foreword | 3 |
| 1. Introduction | 5 |
| 2. Background | 6 |
| 3. Long-term care system and insurance | 9 |
| 3.1. Macroeconomic and other factors and overview | 9 |
| 3.2. Long-term care that is publicly financed | 10 |
| 3.3. Long-term care insurance market | 16 |
| 3.4. Interaction between public care and long-term care insurance | 20 |
| 4. Health care system and insurance | 21 |
| 4.1. Macroeconomic and other factors and overview | 21 |
| 4.2. Health care that is publicly financed | 22 |
| 4.3. Health insurance market | 26 |
| 4.4. Interaction between public care and insurance market | 32 |
| References | 33 |
| Tables | |
| Table 1. How is LTC publicly financed | 12 |
| Table 2. Reimbursement method of LTC | 14 |
| Table 3. Health care financing method | 24 |
| Table 4. Method of reimbursement for health care services | 24 |
| Table 5. Health care insurance relative to public funding | 25 |
| Table 6. Institutions providing health insurance | 29 |
| Figures | |
| Figure 1. Public expenditure on long-term care (2015-2017, excluding US) (USD million) | 10 |
| Figure 2. Average per capita expenditure on Long-Term Care (USD) | 11 |
| Figure 3. Public expenditure on long-term care relative to GDP (%) | 11 |
| Figure 4. Options for provision of LTC | 15 |
| Figure 5. Gross written premiums of LTC insurance market (USD million) | 17 |
| Figure 6. Claims paid for LTC insurance (USD million) | 17 |
| Figure 7. Claims Ratio for LTC Insurance, 2013-2017 | 18 |
| Figure 8. Public expenditure on health care (USD million) | 22 |
| Figure 9. Percentage of public health expenditure relative to GDP (%) | 23 |
| Figure 10. Average per capita expenditure on health care (USD) | 23 |
| Figure 11. Gross written premiums of health insurance (excluding US) (USD million) | 27 |
| Figure 12. Claims paid for health insurance (excluding US) (USD million) | 27 |
| Figure 13. Claims Ratio for health insurance, 2013-2017 | 28 |
| Figure 14. Average out-of-pocket payment per capita for health insurance (USD) | 28 |

1. Introduction

The OECD's Insurance and Private Pensions Committee (IPPC) launched the project on long-term care and health insurance that examines the complementarity of the social security network with the private insurance market in 2018. In particular, the project examines how insurance could support the public sector long-term care and health care systems, as well as considering the financing of long-term care and health.

Ageing is affecting many OECD countries, and as the demographic change progresses, governments will be challenged to identify financially sustainable ways to support the care of the ageing population. This is particularly important for long-term care and health care, as increasing expenditures may become financially unsustainable for many countries while compromising on care options is rarely realistic. Many countries are or will struggle with how to reform their care system to bring these costs under control, while ensuring that those in need can access the necessary care of quality.

To launch the project, the OECD circulated a questionnaire to delegates of the IPPC and other non-OECD countries to gain insights into how insurance markets play a role in financing care. In addition, many insurance companies are moving toward not only financing for care but also providing for care, so greater understanding of the terms and areas in which such services are financed and provided, as well as how regulation affects the capacity of insurers to provide diverse services is necessary.

This revised report brings together a stocktaking report of the responses to the questionnaire that have been submitted to the OECD. As of early May 2019, 20 OECD¹ and 3 non-OECD² countries have responded to the questionnaire.

This report will form the first phase of this project, providing insight into areas which require further analytical research by the Committee.

¹ OECD countries that responded to the questionnaire are Austria, Belgium, Chile, Czech Republic, Denmark, Estonia, Finland, Germany, Hungary, Israel, Japan, Korea, Lithuania, Luxembourg, Mexico, Slovakia, Switzerland, Turkey, United Kingdom and the United States.

² Non-OECD countries that responded to the questionnaire are Brazil, Costa Rica and Russia.

2. Background

For the purpose of the questionnaire which formed the basis of this report, the below explanation on long-term care and long-term care insurance, and health care and private health care insurance were applied.

2.1.1. Long-term care (LTC)

Long-term care (LTC) can be broadly defined as paid care for people needing support in many facets of living over a prolonged period of time, but which are not provided by a medical doctor. LTC may be necessary as a result of disability, chronic condition, trauma, or illness, and does not aim to change health condition, but merely to make current condition more bearable. LTC includes activities of daily living (ADLs) (e.g., eating, dressing, bathing, getting in and out of bed, toileting) as well as instrumental activities of daily living (IADLs) (e.g., preparing meals, cleaning, laundry, taking medication, getting to places, shopping, managing money affairs, using telephone/internet).

Long-term care can be financed, where it is explicitly paid, through a mix of financing arrangements including government spending, compulsory social insurance (“Government/compulsory”) as well as voluntary private insurance and private funds, such as private corporations (“Voluntary”).

For the purpose of this questionnaire, the provision of long-term care could be provided by either/both private and public institutions, practitioners.

In many countries, LTC is provided by communities and families, which while providing a valuable service, would not be accounted for by the above definition. The appropriateness of this is beyond the scope of this project, so as a baseline, the above definition will be tentatively used for countries to be able to identify the services that are the scope of this questionnaire.

Long-term private care insurance comprises insurance schemes financed through private health premiums, i.e., payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person. Premiums are non-income related, although it could be purchased by a specific population or economic group (e.g., employer sponsored, group policy) or by the population at large can be subsidised by the government. The pool of financing is not channelled nor administered through the government, even when the insurer is government-owned.

Private long-term care insurance includes:

- Life and long-term care insurance schemes which include a health element, such as disease specific, lump sum, critical illness, income replacement, cash products, temporary or permanent disability, and
- long-term care insurance that could be subsidised, and cover care costs and care daily allowance.

For the purpose of this report, private long-term care insurance excludes the following schemes:

- Compulsory social insurance that is sponsored by the public sector;
- Care that is provided through the general health care system;
- Private health insurance which may include a care element.

For the purpose of the report, the private long-term care insurance could be provided by both/either a private insurer as well as a public/state-owned insurer.

2.1.2. Health care

Health care can be broadly identified as the final consumption of health care goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding spending on investments³. Health care is financed through a mix of financing arrangements including government spending and compulsory health insurance (“Government/compulsory”) as well as voluntary health insurance and private funds such as households’ out-of-pocket payments, NGOs and private corporations (“Voluntary”). It may be easier to define health care in terms of the financial coverage that is being provided. Basic (primary) health care coverage is first source of financial protection for health care users, and secondary health care coverage refers to extra coverage that can be obtained beyond basic cover through, for example, private health insurance (PHI).⁴

Private health insurance⁵ comprises insurance schemes financed through private health premiums, i.e., payments that a policyholder agrees to make for coverage under a given insurance policy, where an insurance policy generally consists of a contract that is issued by an insurer to a covered person. PHI could be provided by either life insurers or non-life insurers, depending on the jurisdiction, and thus classified as either life insurance or P&C insurance. Take up of private health insurance is often, but not always, voluntary (it may also be compulsory for employees as part of their working conditions). Premiums are non-income related, although the purchase of PHI by a specific population group or by the population at large can be subsidised by the government. The pool of financing is not channelled nor administered through the government, even when the insurer is government-owned.

Private health insurance includes:

- Employer self-insured health benefits, whereby an employer self-insures health coverage instead of purchasing cover from an insurance company. The employer acts as an insurer in that it assumes insurance risk and is thereby often subject to the same regulatory requirements as other health insurers.
- Special schemes for government employees, where the government, in its role as employers, pays part or the whole premiums of private health insurance cover subscribed for its employees.

For the purpose of this questionnaire, private health insurance excludes the following schemes:

- Travel insurance covering the risk of illness or accidents incurred abroad;
- Employers or corporation health programmes for their employees that do not imply insurance (for example, direct supply of health services or reimbursement of certain health-related costs);
- Medical savings accounts, health savings accounts or similar schemes which offer pre-payment but do not imply risk sharing or pooling across individuals;
- Life and long-term care insurance schemes which include a health element, such as disease specific, lump sum, critical illness, income replacement, cash products, temporary or permanent disability, and
- long-term care insurance.

³ Health data definition can be found at <https://data.oecd.org/healthres/health-spending.htm>.

⁴ Glossary of Health Systems Characteristics 2016 <http://www.oecd.org/els/health-systems/OECD-HSC-Survey-2016-Glossary.pdf>.

⁵ Definitions for private health insurance can be found at: <http://stats.oecd.org/wbos/fileview2.aspx?IDFile=e11b92da-6cc5-4cea-afe9-1d4cce02e5a4>.

For the purpose of the questionnaire, private health care insurance could be provided by both/either a private insurer as well as a public/state-owned insurer.

Compulsory health insurance could be provided by both/either a private insurer as well as a public/state-owned insurer.

In many countries, long-term care may be provided as part of the health care service. If so, this should be clearly noted in the responses provided, and estimates made to the expenditure that may be made towards long-term care.

3. Long-term care system and insurance

3.1. Macroeconomic and other factors and overview

One of the **main factors impacting demand for long-term care (LTC)** is the ageing population and the share of the population dependent on others (18 out of 21 respondents). Some countries project the 65+ population to triple by 2050 (Cost Rica). Estonia, Czech Republic and Chile estimate that by 2040-2050 the population of 65+ will be around 30% of the population, while Hungary estimates this to reach 24% by 2030, and Switzerland 8-10% of the population by 2030.

The Czech Republic predicts care benefits to double by 2040, and it is a similar situation in Japan. In the United Kingdom, the dependent elderly population is estimated to more than double by 2040. Other noted factors are the decrease in family provided care, greater dementia care needs, increase in the number of special needs persons, and others cite gender, having children or not as factors affecting the LTC demand. The United States notes a sharp decrease in companies selling LTC products.

Across the board, the increased share of the elderly population, prevalence of old age disability, increase of claim incidences, challenges to fiscal sustainability as the cost is increasing in all segments of LTC as well as HR problems and infrastructure insufficiency as being risks to LTC.

The **financial sustainability of the LTC system** has been a topic of discussion in all countries, with a number of studies being carried out. Topics examined include the delineation of central vs. regional/municipal competences (Belgium, Russia), the allocation of services between public and private sectors (Israel), and the integration or alignment of the health and welfare systems (Czech Republic, Lithuania). The United Kingdom is preparing a Green Paper regarding potential reforms, Costa Rica approved the Health Care Insurance Economic Sustainability Policy, and in Turkey a debate is ongoing to add LTC risk to the social security system. Germany introduced an LTC provident fund in 2015. Luxemburg reports improvements in financial sustainability in 2018 due to cost saving measures made in 2015. Korea is considering measures to block financial leakage of the system and adjusting premiums.

Some countries have carried out surveys or analysis on the satisfaction with the LTC and/or its insurance. Austria reports high level of quality feedback following home visits for home cared persons. In Chile, a 2017 World Bank report observes the satisfaction of household following the introduction of the national system of support and care. Japan has a 60% approval rating of their LTC system.

Many countries report on plans to reform or change social security or insurance sector related to the provision of LTC. Austria and the United Kingdom are working on comprehensive LTC concept proposals, and in Chile the pension reform is at the Parliament level. The Czech Republic is streamlining the provision of services across health and welfare systems. Lithuanians are discussing to restore the reimbursement levels to 100%. The Japanese government is planning to publish a blueprint on the social security reform. Korea introduced a community care program for the elderly to receive care at home from the local community. In Israel, an amendment of the regulation on LTC insurance is planned.

In terms of definitions for LTC, a number of countries do not have a legal definition of LTC. Costa Rica defines it as activities carried out by others so that those with significant and permanent loss of capacity can maintain a level of functional capacity by provision of help for ADL and custodial and specialised care.

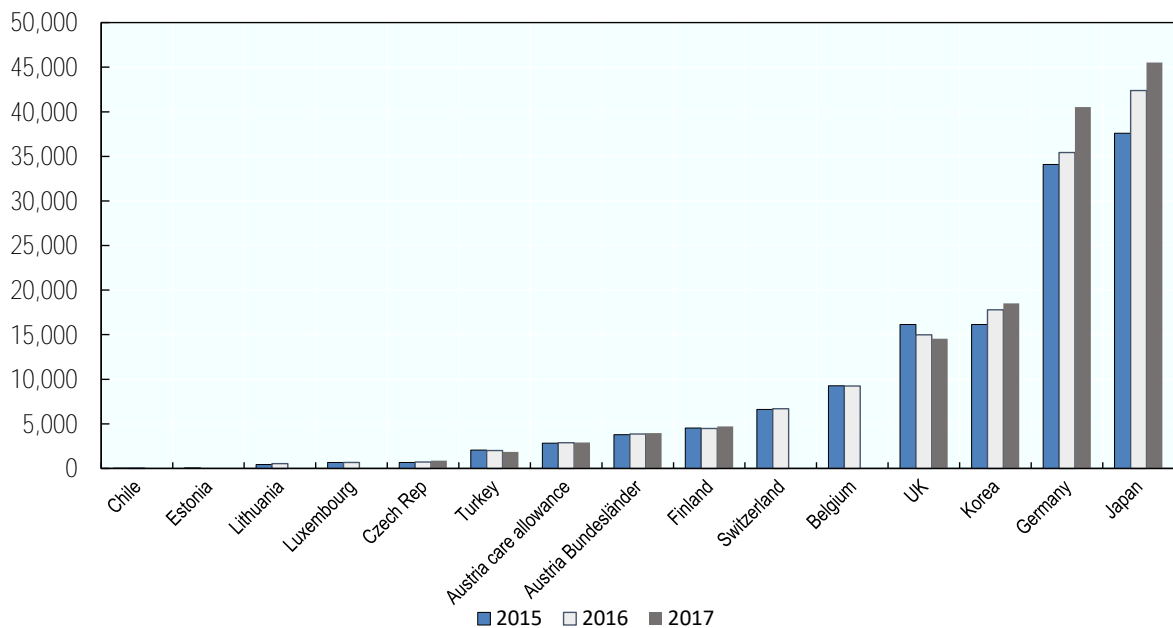
In Israel, an LTC patient is defined as a person whose medical condition prevents them from performing ADLs. Luxembourg is more specific specifying that the support for the execution of ADL of a person in need due to illness has to amount to at least 3.5 hrs per week, in the duration of 6 months or the condition has to be irreversible. Turkey and Russia seem to limit it to the services provided in the home environment or, in case of Turkey, to provision of constant care. Germany and Russia have cited a legal provision. Hungary understood the question as relating to the LTC products and as such provided definitions of three LTC products on the market - pension savings account, voluntary pension and pension insurance.

3.2. Long-term care that is publicly financed

For the **total public expenditure for long-term care annually from 2015 to 2017 and what percentage of GDP is related to long-term care**, the United States has by far the largest market, with USD 369 million expenditure in 2017, which was 2.04% of GDP. Given it is an outlier relative to other countries, it has not been included in the below diagram.

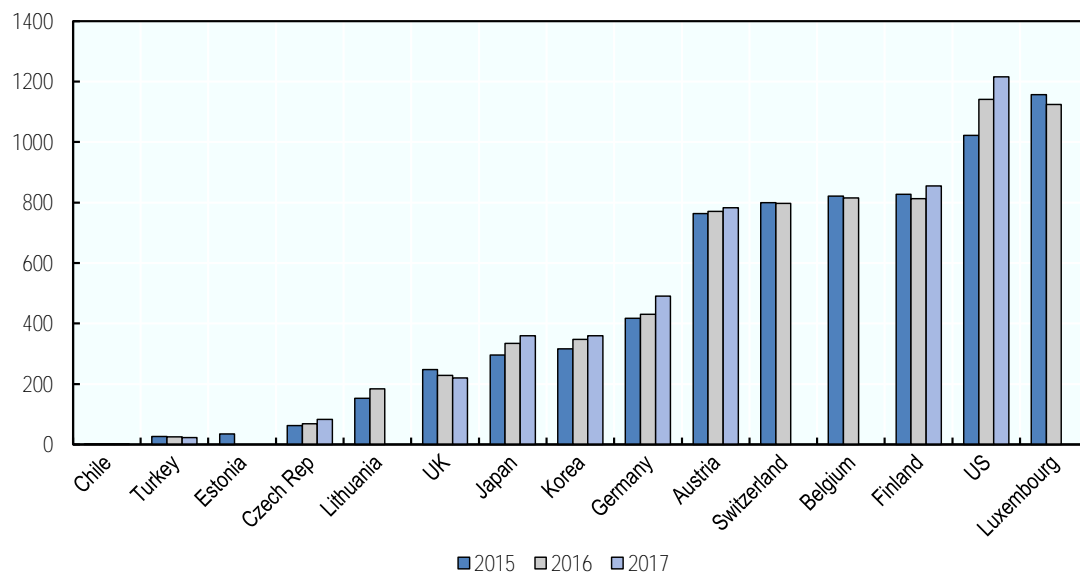
Japan and Germany have high spending figures in terms of total expenditure on long-term care, which has been rising during the period of 2015-2017 (see figure 1). In Germany, this rise is attributed to some major LTC reforms. Relative to population size, the United States and Luxemburg have the highest expenditure per capita (see figure 2).

Figure 1. Public expenditure on long-term care (2015-2017, excluding US) (USD million)



Source: OECD questionnaire.

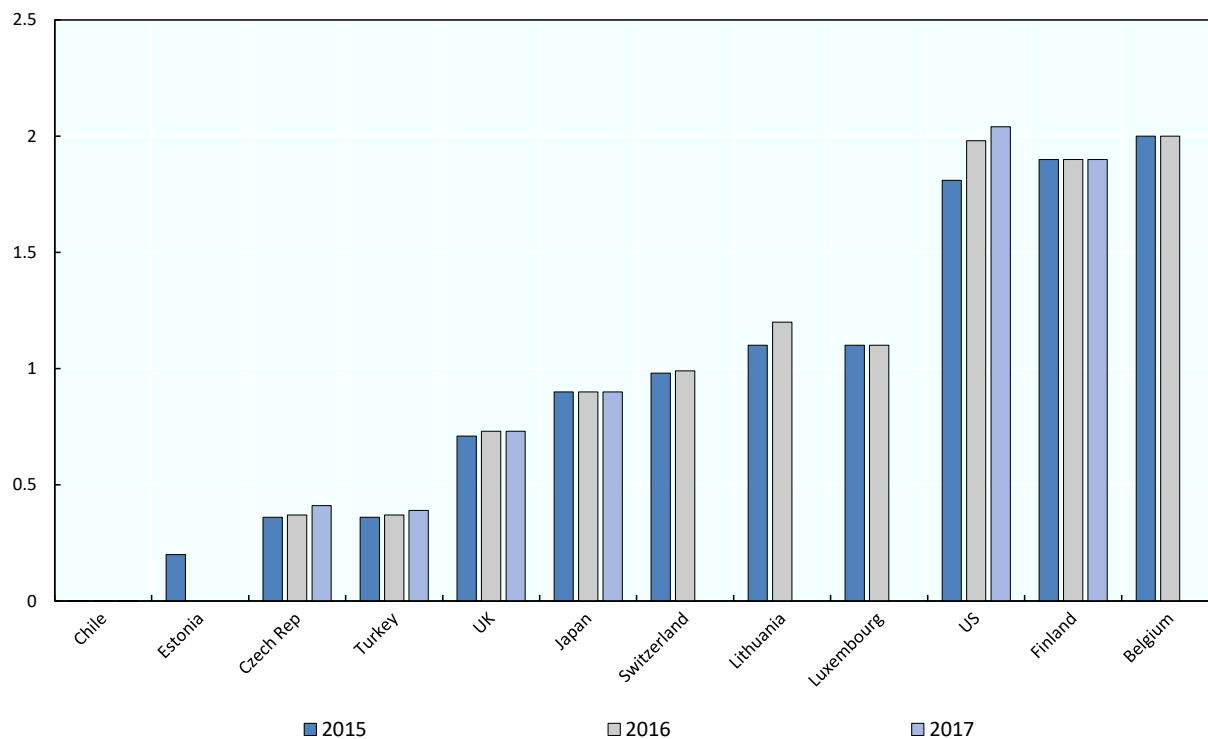
Figure 2. Average per capita expenditure on Long-Term Care (USD)



Source: OECD Questionnaire and OECD.Stat data >

In 2017, the US had the highest public expenditure relative to GDP on long-term care at 2.04%. Belgium has the consistently highest percentage of LTC expenditure at 2% in the years 2015-2016 (see figure 3).

Figure 3. Public expenditure on long-term care relative to GDP (%)



Source: OECD questionnaire.

On the method of public finance for LTC, state budget allocation was the most used source, with six countries reporting multiple sources of financing and 11 a single source. Most important is that many countries use diverse sources to publicly fund LTC. For example, the Czech Republic and Lithuania indicate that both central and municipal government funding is being used. In addition to these sources, Estonia and Lithuania use EU funds, and foreign private sector funding for LTC.

Table 1. How is LTC publicly financed

| Taxation | State budget allocation | Income-based contribution | Other |
|------------|-------------------------|---------------------------|-----------|
| Belgium | Austria | Chile | Czech Rep |
| Czech Rep | Czech Rep | Costa Rica | Estonia |
| Estonia | Costa Rica | Czech Rep | Lithuania |
| Israel | Estonia | Estonia | |
| Japan | Hungary | Germany | |
| Luxembourg | Israel | Japan | |
| US | Japan | Korea | |
| | Luxembourg | Luxembourg | |
| | Russia | US | |
| | Turkey | | |
| | US | | |

Note: In Austria there is no specific taxation for the financing of LTC. In Czech Republic, it is financed by state, regional and municipal governments. Lithuania uses central government budget, municipal budgets, EU structural funds, foreign foundations, sponsorship, social services organisation and family.

Source: OECD Questionnaire.

The countries were asked if **estimates have been made on the future expected expenditure on long-term care**. Most countries disclosed the estimates on future expected expenditure on LTC (some relying on EU reports) based on different scenarios.

Austria estimates public costs for nursing and care services financed by regions and municipalities to increase by 360% by 2050. The expenditure in 2015 which is EUR 2 billion, is expected to reach EUR 9 billion by 2050. The long-term average growth rate per annum of expenditure is 4%. Moreover, from 2050 the cost increase is expected to accelerate. The report also points to the economic effect and total public and private expenditures for care services, amounting to EUR 3.4 billion in 2015 which led to a gross value added of EUR 5.9 billion due to economic links, job creation and tax revenue.

Belgium estimates expenditure to reach 4.2% of GDP in 2070. Czech Republic's Ministry of Labor and Social Affairs projected the cost of social services in 2050 to be, with the lowest estimates, an increase of more than 500% compared to now.

In Estonia, the Ministry of Social Affairs submitted an action plan in 2018 for LTC future charges. World Bank had recommended three different policy scenarios (depending on the level of spending, changes in distribution, etc.) with LTC financing rising from 0.5% in 2013 to 0.6-0.8% of GDP (in the most modest scenario) or to 3.5-5% of GDP (in the scenario where the increase in public spending is the most significant) in 2030.

Japan estimates that by 2025, the LTC expenditure will be JPY9 trillion and JPY15.7 trillion by 2040. In Korea, the health care spending will increase from 0.3% GDP in 2016 to 0.4% in 2025 with an average annual increase of 9.3%.

Lithuania reports that the European Commission estimated an LTC increase from 0.9% of GDP to 3.8% by 2060 for Lithuania. Luxembourg projects multiple scenarios with the cost increasing from a minimum of 1.3% of GDP in 2016 to 6.9% of GDP by 2070.

Switzerland looked at different scenarios and the expenditure being 3- 3.9% of the GDP by 2040 with a nominal growth rate of 4.8% annually. Turkey submitted total LTC cost as TL 8.5 million in 2013, with that number estimated to reach TL 14.7 million in 2020 and TL 312 million by 2075. While in 2013, 930,000 people needed LTC in Turkey, this number is estimated to reach 2.7 million by 2075.

In the United Kingdom, under the current funding system, the total expenditures for adult social care is projected to rise from GBP 25 billion in 2015/6 to around GBP 63 billion in 2040, a rise of 155%.

The Congressional Budget Office in the United States estimated Medicaid expenditures to grow by an annual rate of 8% and the enrolment to grow from 71 million in 2012 to 91 million by 2023.

The **criteria or eligibility requirements for accessing public long-term care** is most often determined by the health and social services sectors, and mostly not age related. The provision of benefits and services and eligibility is most often divided between the state and local governments.

Austria defines eligibility as the permanent need for care, physical/mental disability continuing for at least 6 months, need of care of more than 65 hours per month and Austrian residence with some exceptions. Belgium's allowance to elderly requirements are being 65+, being listed in the National Registry, being resident/domiciled in Belgium, and limitations in activities in daily living (ADL) with sufficient degree of autonomy. The Flanders region offers a separate scheme in addition.

Chile has a target population of those that are 60+, disabled at any age with dependency, family caregivers and support network, and being in the most vulnerable sectors (with 60% of socioeconomic qualifications). In Costa Rica, the eligibility is based on the poverty level, absence of support networks and vulnerability.

Czech Republic's care allowance is based on long-term unfavourable health condition and dependence on another person's assistance dealing with ADL.

In Estonia, the welfare system is divided between the state and municipalities. The social security scheme is for pensions and other cash benefits to all entitled, health care and social care services relates not to age but the need of a person (ability to cope, operational capacity, health and ability to participate). The welfare for elderly is delegated to the local level where an assessment is made based on a holistic view of providing LTC services. Nursing care is provided in a hospital, at home or where the patient is cared for.

In Germany, Medical Services of the Health Insurance Funds assess the need of assistance for ADLs and IADLs according to defined legal prescriptions to determine whether a person is eligible to receive LTC benefits. In Hungary, eligibility is defined by several acts and the entitlement is defined by age, illness, previous salary, level of disability, etc. In Israel, eligibility is determined by several conditions such as residence, age, personal income, level of needed ADL help from others, and type of care (home care or not).

In Japan, residents of 65+ are eligible for LTC as well being covered with a health care plan between the ages of 40-64. In Korea, the eligibility for LTC benefits depend on the qualifications made by the LTCI Need Assessment Committee. You must be 65+ or if under 65 with cerebrovascular disease or Alzheimer.

In Lithuania, the assessment for LTC is different in health and social sectors. In the latter, services are provided irrespective of age, but many other factors such as social autonomy, mobility, ADL are taken into account. In the health sector, services are provided to all who have health insurance coverage. Nursing services at home are not guaranteed due to the lack of funding.

In Luxemburg, the LTC services are for persons who need help in ADL for more than 3.5 hrs a week, during more than 6 months. Home adaptations and technical aids are provided without any condition. Russia has a pilot project underway that would encompass the classification and the eligibility requirements.

In Switzerland, LTC is financed by public funds, mandatory health insurance, and private insurance. Mandatory health insurance contribution is based on the doctor's instructions and proven need for care. In

Turkey, the definition of disabled needing LTC are those who are not able to overcome daily routines and depend on others.

In the United Kingdom, the local authority carries out an assessment for eligibilities and financial assistance is determined based on the person's capital. In the United States, Medicaid requires mandatory eligibility groups such as low income families, qualified pregnant women and individuals receiving Supplementary Security Income. States further provide coverage options.

The **method of reimbursement** of long-term care is mostly direct payments from insurers. Main reimbursement methods are direct payment from (public) insurer to service provider (so no reimbursement), fee-for-service (the greater the amount of services provided, the higher the amount of reimbursement), or capitation (a fixed payment is made to each provider regardless of amount of services provided).

In some countries contributions from the person themselves is necessary. For example, in Austria a fee has to be paid to access mobile care services. In Estonia, out-of-pocket payment are required for LTC.

The reimbursement can depend on dependency level too. In the Czech Republic, an assessment is made on the level of care needed which determines the amount of care allowance. In the United Kingdom, direct payments can be made dependent on the eligible care and support needs. The United Kingdom also provides a safety net to those with the lowest means.

In Switzerland, the three sources of financing, inform the sources of reimbursement with public funding, contributions from the mandatory health insurance, and out of pocket.

Table 2. Reimbursement method of LTC

| Direct payment from insurer to service provider | Fee-for-service | Other |
|---|-----------------|-------------|
| Austria | Austria | Belgium |
| Belgium | Czech Rep | Chile |
| Costa Rica | Lithuania | Estonia |
| Czech Republic | Luxembourg | Korea |
| Germany | UK | Russia |
| Hungary | | Switzerland |
| Japan | | Turkey |
| Lithuania | | |
| Russia | | |
| Switzerland | | |
| UK | | |
| US | | |

Note: In Austria there is no specific taxation for the financing of LTC. Belgium uses an allowance for elderly and Flemish Social Protection. The Czech Republic and Estonia use state, regional and municipal funding.

Source: OECD questionnaire.

The receipt of (public or private) pension payments or own assets/capital will affect the financing of long-term care in all countries except in Luxembourg.

In Austria, persons placed in a publicly financed home can retain 20% of their pension (including special payments), plus 10% of care allowance of a certain level. In Belgium, such receipt affects the financing of LTC based on several criteria including familial situation. In Costa Rica, pensioners contribute 5% of the amount of their pensions. In Czech Republic, pension receipt affects the financing, with eligible persons retaining 15%.

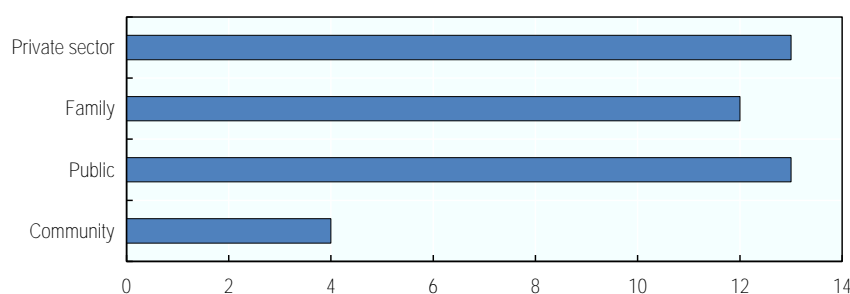
In Estonia, at the local level, financial assets and income affect the LTC and each municipality sets its own criteria. The municipality or state assess the individual's financial status cover payments if needed. In some municipalities, social care service is free of charge irrespective of the financial family situation. In Germany, there are no restrictions for LTC, but some criteria applies for social assistance. In Hungary, own assets do not affect public pension payments.

In Japan, individual financial status including pension is taken into account for the calculation of their co-payments. In Korea, after a threshold is reached, the individual pays the insurance premium. In Lithuania, the individual's contribution should not exceed 80% of income. After a threshold is reached, 1% of a person's assets are calculated for LTC contribution.

In Switzerland, LTC is financed by individuals and public institutions, and in the case a person has no funds, the public social security system will cover payments, or the remaining costs, as needed. In the United Kingdom, income and some assets affect the financing of LTC. In the United States, Medicaid will consider own assets when determining eligibility.

The **main options used for the provision of LTC** fall into four categories. Private sector, family and public have the same level of provision, with Community contributing at a lower level.

Figure 4. Options for provision of LTC



Source: OECD questionnaire.

In Austria, 80% of those cared are cared at home. In the Czech Republic, care is provided through social and health care with LTC taking place in health care facilities, social services facilities, and the home environment. In Germany, care is provided at home (cash or in-kind) or institutionally. In Japan, 70% of LTC is provided by family members, followed by companies (13%), others (1.0%) and unknown providers (15.2%).

In Luxembourg, the dependent persons living at home can choose, to get help from a provider of the private sector or informal help (normally delivered by a family member), or a combination of both. If they live in an institution, the help is provided by (private) institution.

In Switzerland, LTC is mainly provided professionally, *i.e.* by nursing homes or, if the patient lives at home, by care organisations or by self-employed nurses. Furthermore, day-care institutions also provide professional care with family care supplementing professional care.

In Turkey, the public sector has the largest role in providing both in terms of financing and in the creation of the infrastructure for the LTC system.

In the United Kingdom and Estonia, local authorities have a statutory duty to meet the eligible needs of someone requiring care and will generally provide care through contracting private sector providers, primarily in a residential care home setting or in a person's home. In Estonia in 2017, 91 general care service providers (57.6%) were owned by local governments, 60 (38.0%) by the private sector providers, 1 (0.6%) by foreign private sector provider and 6 (3.8%) by the state.

Mostly, the public long-term care provision/providers are administered and regulated by governmental bodies within the health or social welfare systems. Only in a few countries the regulation of the public LTC system is carried out by insurance regulators.

In Austria and Belgium, in kind care is provided by the regional government. In Chile, the Ministry of Social Development manages and then transfers resources to municipalities, although the inter-sectoral management of benefits and social services is not yet regulated. In Costa Rica, the Ministry of Health manages LTC and regulates service quality and money transfer made by the National Counsel for Senior Citizens.

In the Czech Republic, the Ministry of Health and seven health insurance funds as well as the Ministry of Labour and Social Affairs administer LTC. Estonia has the Estonian Social Insurance Board that supervises the quality of LTC services. Municipalities arrange the provision of services but do not decide on eligibility.

In Germany, there are registered LTC providers. In Japan, municipalities are the insurers and the government body is the Ministry of Health, Labour and Welfare. In Korea, the Health and Welfare Ministry in addition to the National Health Insurance Services which is the insurer for LTC. In Lithuania, the Ministry of Health and the Ministry of Social Security and Labour with the Department of Supervision of Social Services assesses quality and compliance. Municipalities prepare and implement municipal programs for service provisions and primary health care for disabled.

Luxembourg has the National Health Insurance which manages LTC insurance. In Switzerland, cantons establish the list of nursing homes eligible to provide co-financed services and home care is administered by municipalities. In the United Kingdom, the Department of Health and Social Care and its Care Quality Commission was established to regulate and inspect health and social services in England.

In the United States, Medicaid is a joint federal and state program providing health coverage to over 72.5 million Americans including the disabled.

Regarding the information on the **administrative costs** of the public long-term care system, administrative costs in Austria were 3.09% of total costs of care allowances in 2017, and in Costa Rica 4.27% of total costs in 2016. In Belgium, it was 0.06% of GDP. In Estonia, the estimate is around 7-10% of total costs. In Korea, administrative expenditure is 4.7% of the LTC insurance revenue for 2017.

In the Czech Republic, the salaries of administration workers amount to CZK 300-500 million. In Japan, in 2016 administrative costs amounted to JPY 200 billion. In Luxembourg, administrative costs were EUR 24 million in 2014. The United Kingdom estimates administrative costs to be GBP 1 billion for 2017-18.

3.3. Long-term care insurance market

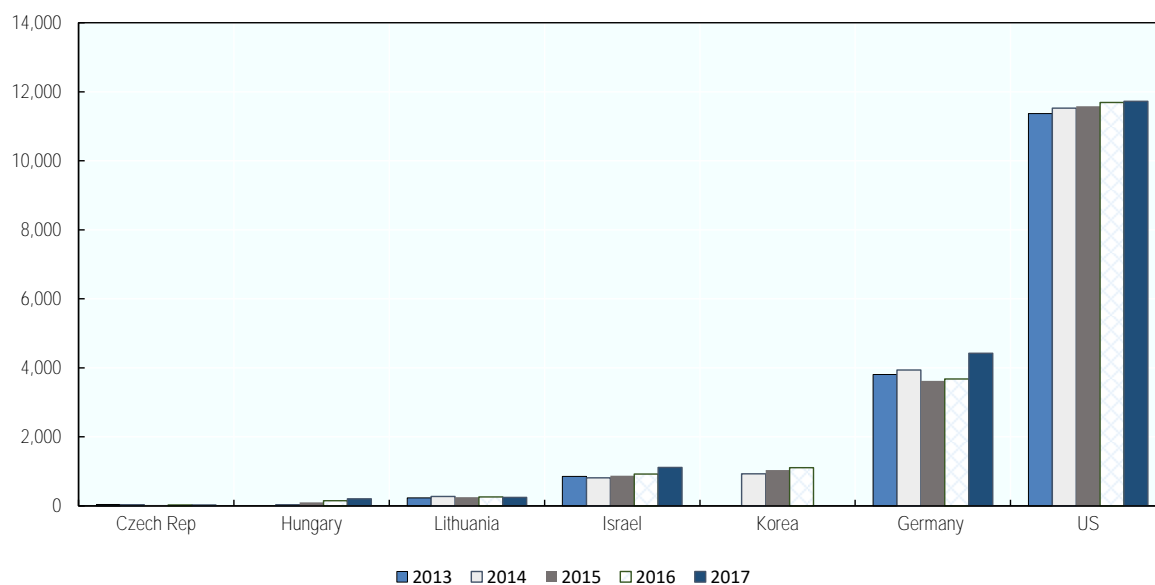
When looking at the **gross written premiums for long-term care insurance (LTCI)**, it is clear that LTC insurance market is limited in most countries, although the recognition and the need for a market is strong.⁶ The US market is by far the largest, with USD 11 billion in gross written premiums in 2017. While the market has stagnated for the last decade, the US market also presents important lessons for other markets developing LTC insurance products.

The next largest market is Germany with USD 4 billion gross written premiums in 2017. Korea's LTC insurance market currently stands at USD 1 billion in 2016. In Israel, the total amount of gross written premiums for LTCI is made up of two types of policies: collective policies (that make up around 60% of the gross written premiums), and private policies.⁷

⁶ In Belgium there is no clear distinction between LTCI and health insurance; Switzerland's estimates are based on claims under the mandatory health insurance scheme.

⁷ In Israel, collective policies are offered as groups such as employees of a certain employer, the terms and pricing of the policy are set uniformly for all policy holders, and they can change from time to time. Private policies are offered

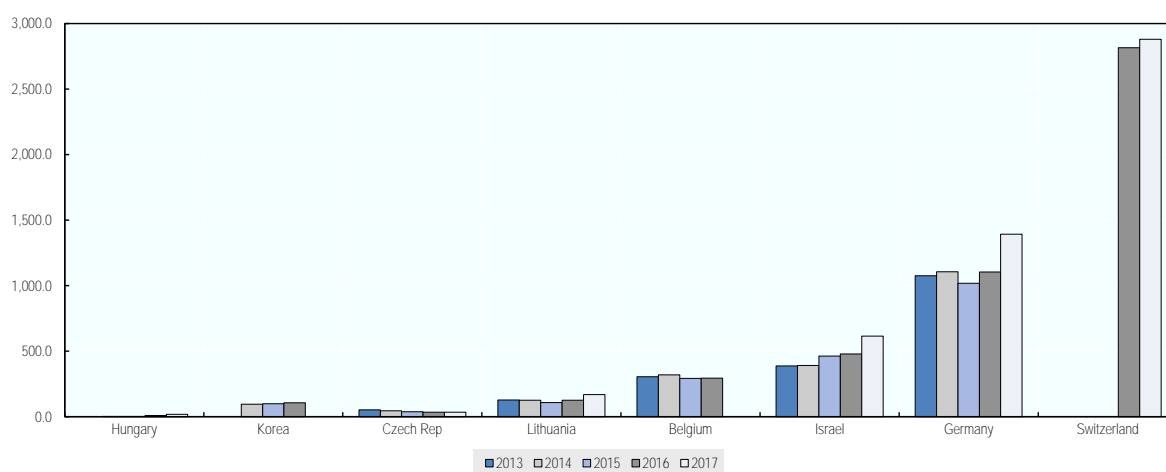
Figure 5. Gross written premiums of LTC insurance market (USD million)



Source: OECD questionnaire.

The situation is similar in terms of claims paid, although the US market demonstrates an acceleration of payment levels during the period from 2013 to 2017, with USD11 billion being paid in 2017.

Figure 6. Claims paid for LTC insurance (USD million)



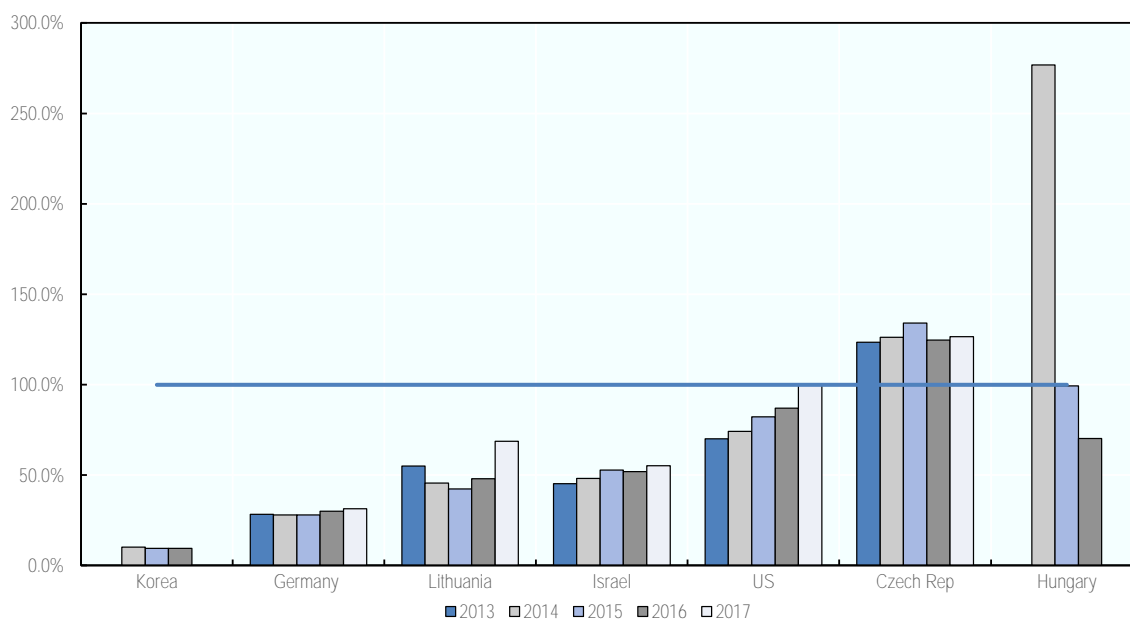
Source: OECD questionnaire.

Swiss data exists from 2016, and with a level of claims paid at USD 2 billion in 2017. Germany has a lower level of claims paid at USD 1.4 billion in 2017.

to individuals and can be purchased by anyone, the eligibility and pricing of the policy is determined according to individual underwriting of the insured person, and the terms and conditions of the policy are not subject to possible future changes.

When comparing the claims paid with written premiums of the same year, Czech Republic stands out with a ratio of over 100%, meaning written premiums did not cover claims paid in LTCI. The Czech Republic has explained that policies with LTC are from annuities related pension products, and thus short-term reconciliation would not be applicable for such products. In 2014, Hungary had a claims ratio of more than 250% compared to the written premiums, which has dropped sharply since. In Lithuania, there was a noticeable dip in claims in 2015. In the United States, the claims ratio has been growing gradually in the last 5 years, reaching almost 100% in 2017.

Figure 7. Claims Ratio for LTC Insurance, 2013-2017



Source: OECD questionnaire.

In terms of whether **long-term insurance is part of a wider product offering (products combining different insurance coverage such as with annuities) or if specific insurance catering to some LTC is being offered**, in Belgium, the private LTC health insurance is offered as a specific primary health insurance and as an ancillary part of life insurance. In Costa Rica there are no LTC products but private life insurance products cover this risk. In the Czech Republic, it is estimated that 50% of pension insurance goes to LTC. In Estonia and Russia, no LTC insurance is offered, and in Germany, it has to be combined with statutory or additional private health insurance. In Hungary, pension insurance products cover this risk.

Korea has two products, one is a stand-alone and the other hybrid with benefits of life insurance and an annuity with LTC insurance. Switzerland has LTC included in the mandatory health insurance but additional but limited coverage can be purchased as a standalone. In the United Kingdom, LTC private policies used to be available in the market but are no longer available due to low demand. There are a small number of immediate needs annuity contracts where a lump sum is provided by insured and over years received as annual payments. In the United States, both traditional LTC and a hybrid product exist in the market.

Noticeable trends in the long-term care insurance market, or signs of changing business models of products of insurers providing long-term care insurance in Belgium was that LTCI has a small share among insurance products. In Czech Republic, where the LTCI market is not very developed, there is potential for the market to grow. The main market builds in riders to life cover (critical illness, disability, etc.) in the unit-linked product which is growing.

Germany reports a trend towards digitalisation to simplify the administrative procedure. In Hungary, LTCI share in the total gross written premium has been rising and together with the product range. Korea insurers have released lapse supported products to lower insurance premium. Recently, chronic diseases LTC products for diabetes or high blood pressure have appeared.

Lithuania identified that any changes in the market are usually connected with tax incentives. In the United States, the traditional LTCI market has fallen significantly from 754,000 policies in 2002 to 89,000 in 2016. The number of companies offering policies has fallen with many facing financial problems.

In terms of the **levels of deductible, co-payment or co-insurance etc. applicable to the long-term care insurance**, in Hungary, there are no deductibles, co-payments or co-insurance. In Korea, benefits are fixed with beneficiaries responsible for 15% of the LTC home care costs and 20% of institutional care costs. Those who cannot afford this have a reduced co-payment.

In many countries, the services that long-term insurance financially cover and do not cover include ADL, and several do not include IADL. In Belgium, the insured receives an annuity and decides how to spend it including whether it is spent on nursing home, assisted care facility, at home ADL or IADL. In the Czech Republic, all listed types are covered except IADLs. Germany included nursing home and at home care and Israel covers at home ADLs. In Korea, LTC products normally pay fixed lump sums for diagnosis benefit or annuity for hospitalisation costs. In Switzerland, all types of coverage is included except toileting in ADL service and all IADL services. Contribution for basic care would be made as well as fixed contribution depending on need of medical care. In the United States, services are covered except IADLs and from ADL group, only eating is covered.

There was limited data available on the **average cost for a nursing home, at home services, and assisted living per day is concerned, and the maximum levels that long-term care insurance would cover.** The average cost in Belgium in 2016 was EUR 55 a day for a nursing home, in Germany EUR 655 a month in 2018, and in Switzerland, CHF 309 per day in 2017. In Turkey, the annual cost for public institutions is TL 30,000. The United Kingdom reports GBP 95 per day for 2017/18 and in the United States, it is USD 89,000 per year for nursing care and USD 34 a day for at-home care.

Whether **long-term care insurance is provided by a state-owned or public institution, private insurer, both or a hybrid**, in general, the providing of LTC involves private providers. Six reported it to be privately provided, and six by a mix of state and private. No country reported LTCI being provided by a hybrid institution or by the state.

Long-term care insurance products are being regulated by different regulators, and further, public LTC is regulated by again different regulators. In some cases the consumer protection authority is responsible, and in three countries the central bank for the financial stability component. The insurance regulator is responsible in Costa Rica and Japan. In Turkey, the Ministry of Treasury and Finance, in the United Kingdom the Financial Conduct Authority (for legacy LTC policies as no new ones are issued), and in Israel the Capital Market, Insurance and Savings Authority are the regulators for LTCI products. There is no designated LTC regulator, per se, indicated by any of the countries.

On **tax incentives to encourage the purchase of long-term care insurance**, in Czech Republic, Japan, Lithuania and Turkey, life insurance and/or LTCI premiums, and in the United States, tax qualified LTCI premiums and benefits can be deducted if certain conditions are met. In Germany, the contributions made to health and LTCI are generally taken into account for tax purposes.

The criteria for accessing public long-term care does not appear to be directly connected with the criteria for accessing private LTC and conditions of LTCI. In the Czech Republic, the insurers mainly follow the state criteria. In Germany, it is the same for services whether paid by social aid or privately. In Turkey, the beneficiaries of LTC can only be those who are of certain limited means or have severe disability. In the United Kingdom, the applicants for the immediate needs annuity must be assessed as needing care.

There does not appear to have been discussions on **adequacy and appropriateness of competition in the long-term care insurance market**. Only Israel reports that the LTCI market is concentrated. Korea states that insurers are not very interested in the LTC business.

The **products being offered in the market for long-term care insurance often have main features that are different to those that exist in public LTC services**. In the Czech Republic, the main feature of LTCI is financial support which can be used for any type of LTC service. In Germany, all features are legally defined for all private insurers and unlike private health insurance, the LTCI offers ADL services. In Switzerland, unlike in mandatory health insurance, non-mandatory insurance services may have different features and requirements such as waiting period. In the United States, there are features such as elimination period, maximum benefit period, daily or monthly reimbursement, inflation protection, etc.

In some countries, there are certain LTCI policies that offer additional services to accompany the insurance products. *e.g.*, in Belgium some insurance policies offer telephonic service or coordination of non-medical care. In Germany, the services offered by private LTCI correspond to those of statutory LTC and can include, for example, retrofitting for elderly care. In general, depending on the level of care required, the insurance would cover on a contractual basis the expenses needed for home or outpatient care.

The requirements and regulations related to the management of personal data towards long-term care insurers are not specific for insurance and the general data protection laws most often apply. In the EU, countries are obligated to follow the EU General Data Protection Regulation. In Germany, the disclosure of insurance data is a crime. In the United States, data protection is a matter of state law.

Short-term care insurance policies (with periods of less than a year) are available in some countries. In Switzerland, the mandatory health insurance has a period of one year. In Turkey, there are health care policies for short-term care. Such policies are also available in some US states.

The main investment strategy employed by insurers to support their long-term care insurance lines is not clear, and in most cases there are no specific regulation regarding the investments made by insurers with connection to LTC insurance lines. German insurers employ a conservative investment strategy with a long-term time horizon, which is focused mainly on interest bearing securities, a smaller share of equity investments, and a minor share of more complex investments products. One of their main investments vehicles are mutual funds.

In terms of **hedging products**, in the Czech Republic, longevity risk is covered by the product design. In Germany, derivatives are used to manage interest rate risk but not longevity risk, while in Finland the use of derivative instruments shall be possible insofar as they contribute to a reduction of risks or facilitate efficient portfolio management. In Switzerland, mandatory health insurance uses a cost splitting approach and premiums can be changed annually. In Korea, insurers have developed diverse hedging products to manage the longevity risk in stand-alone LTCI products.

Technologies are being applied to assist the coverage and claim management of long-term care insurance. For example, more precise health questionnaires due to technological progress, and the use of blockchain platforms for verification and insurance claim process.

3.4. Interaction between public care and long-term care insurance

Costa Rica notes that the perceived weakness in the public pension system may result in the search for protection for the risk of death and survival with private insurers. Czech Republic notes that the private insurers use the state definition and state service. In Korea, attempts are being made to utilise private sector resources such as LTC facilities and workforce for the provision of public LTC services. In Switzerland, some of the LTC services are provided by public institutions, such as public hospitals, and some by private providers.

4. Health care system and insurance

4.1. Macroeconomic and other factors and overview

On **macroeconomic, social or other factors that are expected to impact the provision of health care in the coming decades**, the majority of the countries listed the ageing population as a factor, along with increases in chronic diseases, including dementia and obesity, that are correlated with longevity (Crimmins and Beltrán-Sánchez, 2010). Among other factors that impact the provision of health care are the cost of pharmaceuticals, increased demand, technical and medical progress, health workforce ageing, decreased unemployment leading to more taxation positively affecting the public expenditure, growth in health care which continues to exceed the growth in GDP and regulatory framework as factors.

Risk analyses have been carried out with relation to health care and insurance systems in some, with a focus on the ageing population and its share in the overall population. Chile views the lack of regulatory compliance in health insurance as a high risk. Czech Republic considers ageing as a high risk and a stress test of the health insurance system was carried out by the Ministry of Finance which found that the system is not well prepared for any economic crisis due to the insufficiency of reserves. In Estonia, the social tax accrual is deemed as insufficient. Japan and Korea mention challenges to financial sustainability given ageing and coverage expansion. Turkey cites risks of rising cost and demographic changes. In the United States, the solvency of some insurance carriers that have written long-term care insurance is a risk, although, the majority of insurers selling this policy are well diversified and capitalised.

All countries have been discussing **the financial sustainability of the health care system**. Long term sustainability is a major topic in Czech Republic, given ageing and cyclical vulnerability stemming from dependence of revenues on wages. In Israel, the long-term financial sustainability of private insurers is evaluated during the regulatory actuarial examination of new products. In Japan, the peak in the number of senior citizens is expected be around 2040, which will presents various challenges to the health care system. Korea projects that the national health system will reach a critical state by 2023, and measures to mitigate issues are being discussed. Luxembourg organises meetings twice a year among stakeholder to analyse the financial situation of the health care system to decide if any structural measures are necessary. In Slovakia, ageing and financial issues of major public hospitals are being discussed. Switzerland has measures to address the burden of costs for people with low and middle income.

In addition to the discussions about the financial sustainability and its challenges, some counties are already taking measures to address this. In Austria, financial sustainability is a priority which resulted in the creation in 2012-13 of the health governance system to reach an agreement on financial targets to ensure sustainability of the public health system. Chile has a project to modernise its public health insurance to integrate a payment mechanism and diagnosis-related groups (DRG). In Costa Rica, a 4-year long sustainability policy was put in place to establish a roadmap for protection against health and maternity risks. Estonia has taken measures to improve adult dental care coverage and access to specialist care, increasing the state contribution into the Estonian public health fund. Lithuania has a plan for the financial sustainability of the Compulsory Health Insurance Fund.

On **surveys or analysis on the satisfaction with health care and/or its insurance**, Austria, Belgium, Korea and Turkey reported a high satisfaction with treatment and care for patient and outpatients. In the Czech Republic and Estonia, respectively 51% and 59% of the population is satisfied.

On **plans for any reforms or changes to the social security or insurance sector related to the provision of health care**, Austria is undergoing a comprehensive structural reform of social insurance agencies, and savings from this will indirectly benefit health insurance benefits. In Belgium, benchmarks to limit the growth of social benefits is likely to result in substantial savings in the public health budget with reforms on health spending including the price of pharmaceuticals and hospital financing being planned.

In Chile, reforms correcting deficiencies related to access, captivity and restriction of benefits from pre-existing conditions are being developed. A law is with congress which will move Chile towards a private health insurance market, establishing a comprehensive and single standardised benefits package to improve transparency. The Czech Republic will implement reforms dealing with hospital reimbursement, primary care overhaul and mental care. In Hungary, the Healthy Budapest program envisages large scale developments by 2025, including building a large hospital. In Japan, prevention programs and data health project is being developed.

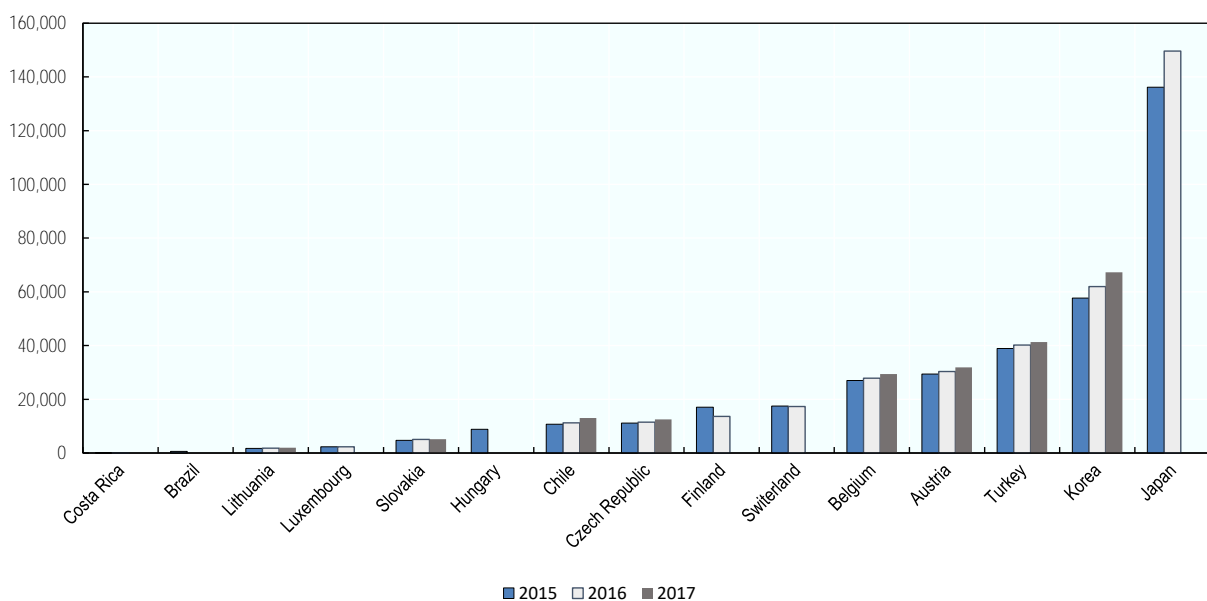
In Korea, the increase of the co-pay for services currently non-reimbursable under the National Health Insurance as well as tightening health insurance rules on foreigners are being developed. Luxembourg will introduce new services in hospitals, and modification of the sick leave period. Slovakia is considering measures around LTC such as introduction of LTCI, contribution for carers, contribution for private LTC institutions. In the United States, continuous work to control Medicaid and Medicare and make coverage affordable continues.

On **estimated costs to the health care system of the practice of defensive medicine**, Costa Rica estimates that it amounts to 3.79% of the cost of medicines acquired by the Health Public Insurance of 2017. Estonia has received complaints on procedure and malpractice but not on costs. Hungary estimates defensive medicine to cost HUF 1196 billion in 2017. Turkey notes a high reliance on scanning technology and a high number of caesarean births, which could potentially be an issue of defensive medicine.

4.2. Health care that is publicly financed

Japan had the highest public expenditure on health care at USD149 billion in 2016. This was followed by Korea with USD 67 billion in 2017.

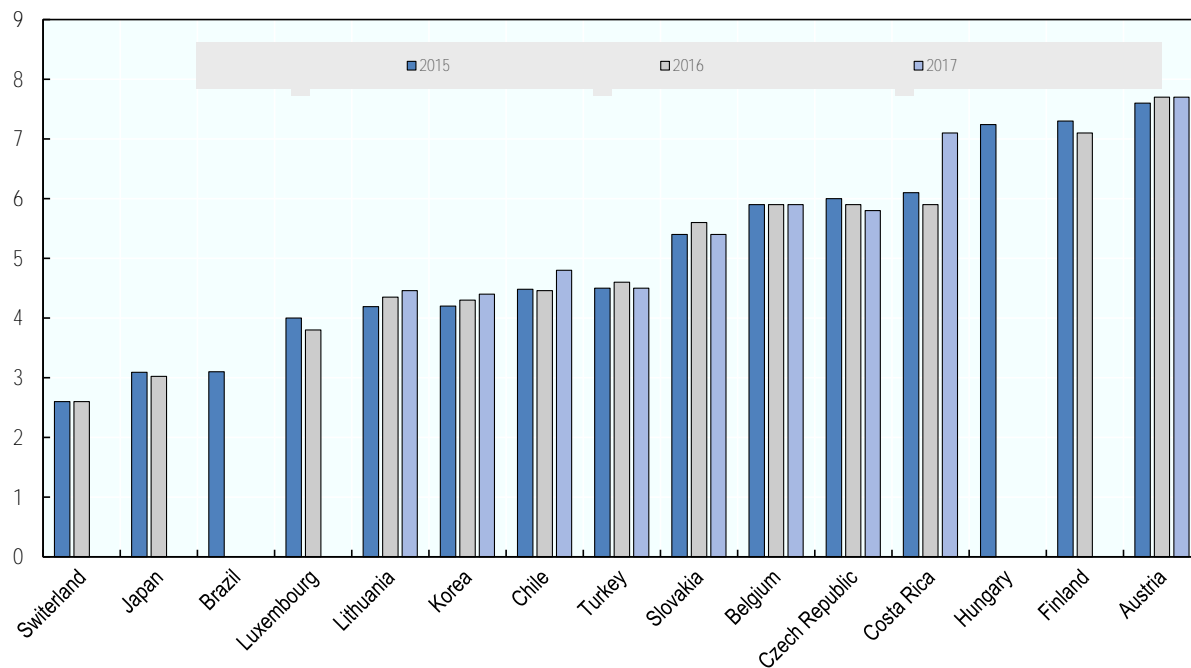
Figure 8. Public expenditure on health care (USD million)



Source: OECD questionnaire.

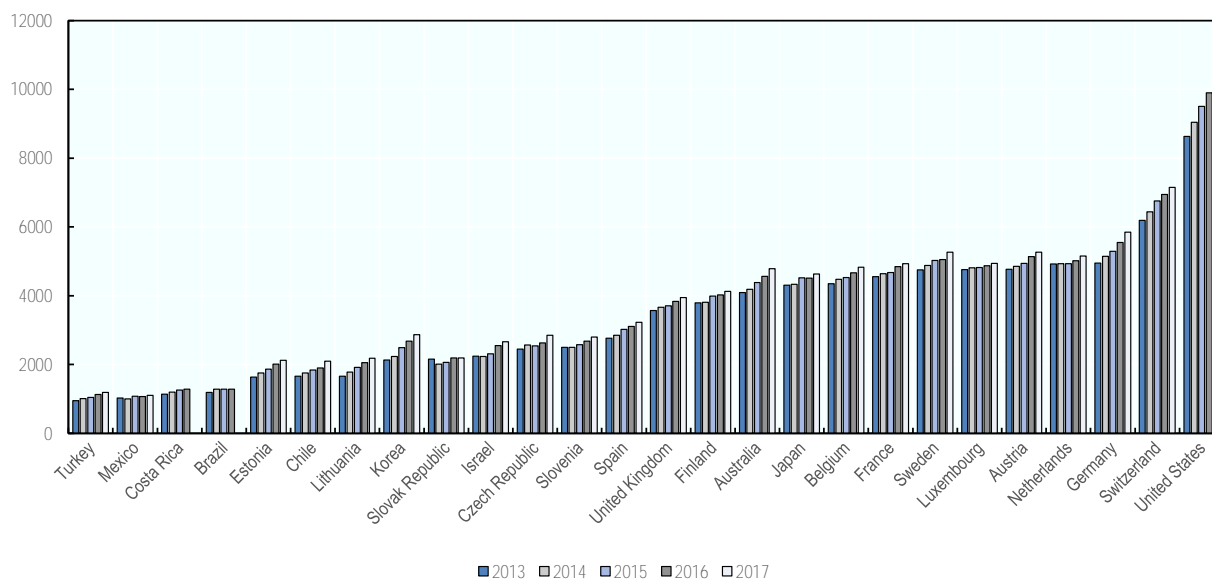
However, when viewed in the context of GDP, Austria had the highest level of public spending on health care relative to GDP at 7.7% in 2017, followed by Costa Rica at 7.1% in 2017. Many countries spend around 5% of their GDP on public health care, with Japan being on the lower end at 3.02% of GDP in 2016.

Figure 9. Percentage of public health expenditure relative to GDP (%)



Source: OECD questionnaire.

Figure 10. Average per capita expenditure on health care (USD)



Source: OECD Stats.

In terms of the average per capita expenditure on health care, the Czech Republic has the highest level at USD22,742 in 2017. The US follows at USD10,724 in 2017 and Switzerland at USD9,870 in 2016.

Austria, Finland and Luxembourg spend around the USD 4,000 mark, and otherwise most countries spend an average per capita on health care of around USD2,000.

Most countries use a diverse **source of financing for health care**, with a state-budget allocation and income-based contributions being the main source. Taxation is used to finance health care as well.

Chile specified that 32% of total expenditure is out-of-pocket. In Turkey, health care is financed by social security health insurance, out-of-pocket, and private payments.

Table 3. Health care financing method

| | Taxation | State budget allocation | Income based contribution | Other |
|----------------|----------|-------------------------|---------------------------|-------|
| Austria | X | X | X | |
| Belgium | X | X | X | |
| Brazil | X | X | X | X |
| Chile | X | X | X | X |
| Costa Rica | | | X | X |
| Czech Republic | | X | X | |
| Estonia | X | X | | |
| Finland | X | X | X | |
| Hungary | X | | | |
| Israel | X | X | | X |
| Japan | X | X | X | |
| Korea | | | X | |
| Lithuania | | | | X |
| Luxembourg | | X | X | |
| Slovakia | | X | X | |
| Switzerland | X | X | | X |
| Turkey | | | | X |
| US | X | X | X | |

Source: OECD questionnaire.

Table 4. Method of reimbursement for health care services

| Direct payment from insurer to service provider | Fee-for-service | Capitation | Other |
|---|-----------------|----------------|----------------|
| Austria | Austria | Brazil | Austria |
| Brazil | Belgium | Chile | Brazil |
| Chile | Brazil | Czech Republic | Czech Republic |
| Costa Rica | Chile | Estonia | Estonia |
| Estonia | Czech Republic | Slovakia | Hungary |
| Japan | Estonia | US | Lithuania |
| Luxembourg | Korea | | Switzerland |
| Slovakia | Luxembourg | | |
| Switzerland | Slovakia | | |
| Turkey | US | | |
| US | | | |

Source: OECD questionnaire.

In terms of the reimbursement method for health care services, the main methods are Direct payment from (public) insurer to service provider (so no reimbursement), fee-for-service (the greater the amount of services provided, the higher the amount of reimbursement) and capitation (a fixed payment is made to each provider regardless of amount of services provided), first two methods being the most prominent ones.

Most countries use a combination of reimbursement methods. Additional methods include diagnostic-related groups (DRG) used by Austria, Brazil, Czech Republic and Estonia for hospital in-patient care.

In Hungary, the state budgetary assistant is provided for capital costs and in supplementing areas of under-funding.

In Lithuania, long-term inpatient nursing health care services are reimbursed by the service provider, which is contracted with the Territorial Health Insurance Fund. Switzerland provides subsidies for low income households.

Regarding the interaction between the public health care and the insurance market, there are different types of health care insurance that function in interaction with the public care. Complementary insurance is when it complements coverage of government/social insured services by covering all or part of the residual costs not otherwise reimbursed (e.g., cost sharing, co-payments). Supplementary insurance is when it provides coverage for additional health services not at all covered by the government/social scheme.

Table 5. Health care insurance relative to public funding

| Complementary | Supplementary | Hybrid | Other |
|---------------|---------------|---------|----------------|
| Belgium | Luxembourg | Austria | Brazil |
| Estonia | Switzerland | | Chile |
| Hungary | US | | Costa Rica |
| Japan | | | Czech Republic |
| Korea | | | |
| Luxembourg | | | |
| Switzerland | | | |
| Turkey | | | |
| US | | | |

Source: OECD questionnaire.

In Brazil, health care private insurance plans provide coverage for part, all and/or additional health services in addition to services already covered by the government. In Switzerland, the mandatory base coverage is complementary, with supplementary health insurance available.

Health insurance in Chile is structured under a social security model, where public insurance (FONASA and twelve private insurance companies (ISAPRE) coexist. Workers can use their mandatory health contribution (7% of taxable income to FONASA or ISAPRE). On the other hand, private voluntary health insurance marketed by the life and general insurance companies are complementary or supplementary, depending on the insurance, to the health insurance of the social security (FONASA or ISAPRE).

On whether the **receipt of (public or private) pension payments affect the financing for health care**, it does not in Austria, Czech Republic, Hungary, Luxembourg and the United States. In Belgium, retirees have access to a top up reimbursement if their pension is less than a certain ceiling. In Chile, pensioners belonging to the solidarity pillar are exempt from mandatory health contributions. In Costa Rica, in case of the basic pension regime, pensioners contribute 5% of the amount of their pension. The Estonian Health Insurance Fund was broadened in 2018 by state contribution on behalf of non-working pensioners. In Japan, the pensioner income is taken into account when calculating the co-payment rate of the insured. In Korea, after a certain threshold of pension payments, the insured should pay the health insurance premium.

On the **definition of health care**, Belgium and Chile use general definitions connected to the social insurance systems as health care services that correspond to the health expenditures as reported in the system of health accounts.

The **criteria or eligibility requirements for accessing public health care** in Austria is access to services is regulated by social insurance law and all of the insured have a legal right to services. In Belgium, one needs to reside in Belgium and be registered in a specialised organisation/insurance. The Brazilian system is universal, free and comprehensive. In Chile, anybody in the territory can access public health care. Depending on which income bracket one belongs to, care can be free or require co-pay. In Czech Republic, access is available to permanent residents or those employed by a Czech company. In Hungary, Korea and Turkey, health care insurance is universal. In Japan, residency is required and in Slovakia, a Slovak citizen, EU citizen or asylum seeker can access health care.

In Switzerland, there is no eligibility requirement but health insurance is mandatory for all residents. In Lithuania, contributions must be paid under the compulsory insurance as per the Law on Health Insurance. In the United States, all employees/employers participate in Medicare through payroll taxes and some are eligible for Medicaid (disability, pregnancy, and children).

As far as the **administration or regulation of the public health care system** is concerned, in Austria general competence for legislation and enforcement lies with the federal government, with other responsibilities split between regional and federal bodies. In Belgium, the federal government is responsible. In Brazil, the Ministry of Health sets the policies and runs some programs as well as hospitals along the Ministry of Education although federal, state and municipal bodies are involved.

In Chile, the national health authority has the lead role, issuing rules, while the Superintendent of Health supervises and controls compliance. The Ministry of Health regulates public health insurance in the Czech Republic, which is administered by several health insurance funds. In Estonia, the Ministry of Social Affairs and Health Insurance Fund are responsible. In Hungary, the Ministry of Human Capacity is responsible and the health system is operated by the National Health Insurance Fund. In Israel, Japan, Korea, Lithuania and Slovakia, the Ministry of Health is responsible. In Switzerland, it is split between the central and regional governments. In the United States, Medicare is regulated at the federal level and Medicaid at the state level.

4.3. Health insurance market

The health insurance market is diverse in many countries, but the United States has the highest level of premiums at gross written premiums of USD 272 billion in 2017. The United States is the outlier in terms of gross written premiums, and so have thus been removed from the below diagram (Figure 11).

Excluding the United States, Switzerland and Germany have the highest level of gross written premiums at USD 41 billion and USD 39 billion respectively in 2017. The next market would be Korea with premiums at USD 12 billion in 2017.

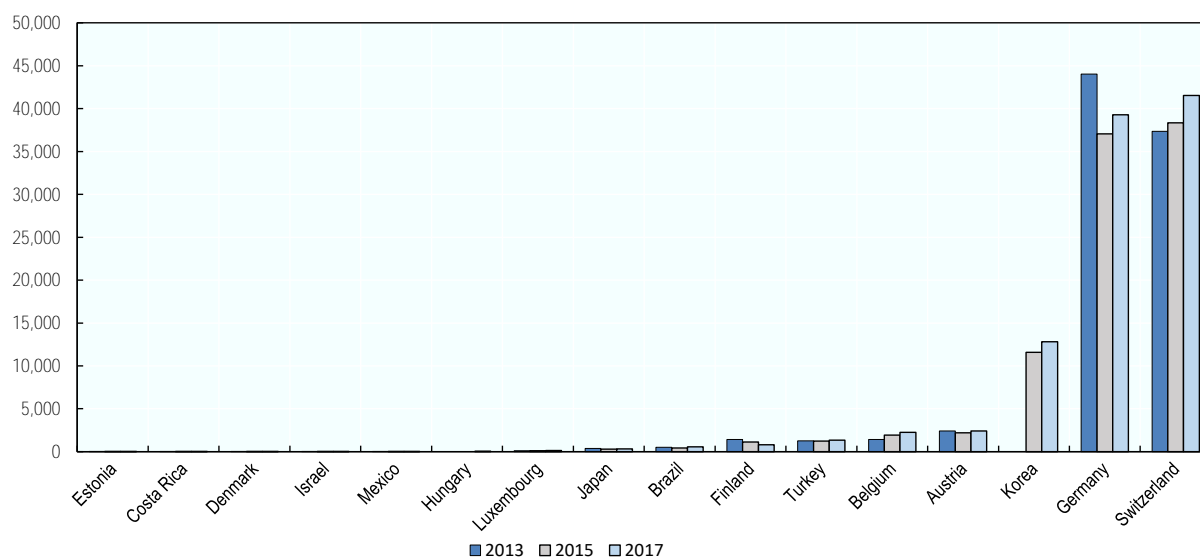
Austria, Belgium and Turkey's markets range from USD 2.4 to USD 1.3 billion. Otherwise, the health insurance markets listed are below USD 1 billion in gross written premiums.

Claims paid reflect a similar trend as gross written premiums, with US being an outlier with exceptionally high claim payments at USD 224 billion on 2017. Thus, the United States has not been included in Figure 11.

Switzerland has the highest paid claims at USD 40 billion in 2017. Germany follows with USD 27 billion in 2017, and then Chile and Korea respectively at USD 14 billion and USD 10 billion.

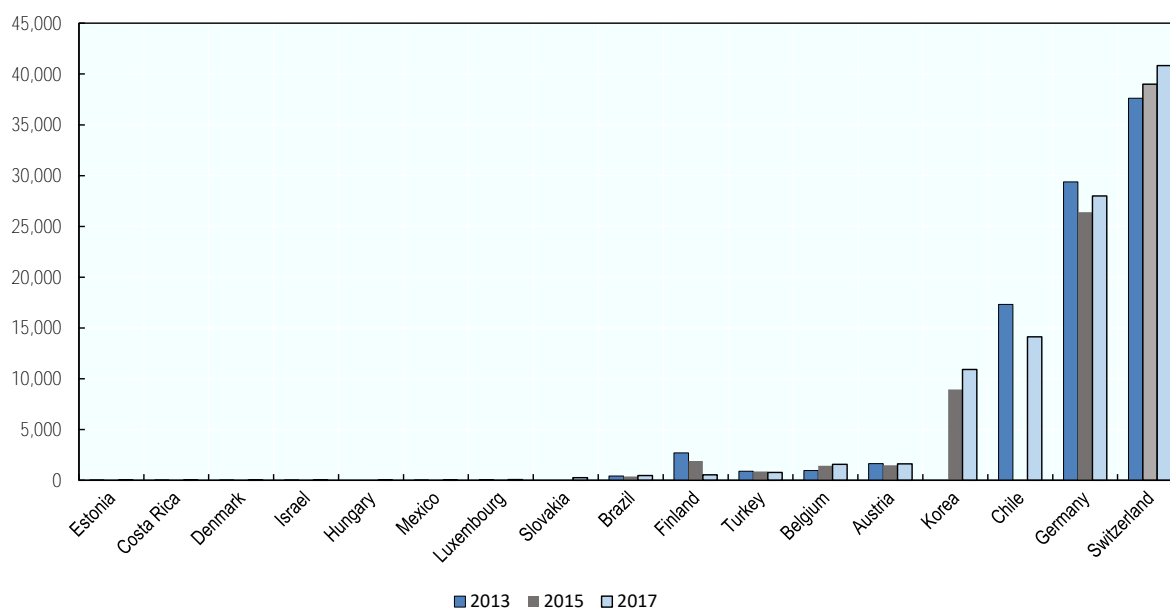
Austria and Belgium paid claims at USD 1.6 billion and USD 1.5 billion respectively, with other countries having paid less than USD 1 billion.

Figure 11. Gross written premiums of health insurance (excluding US) (USD million)



Source: OECD questionnaire.

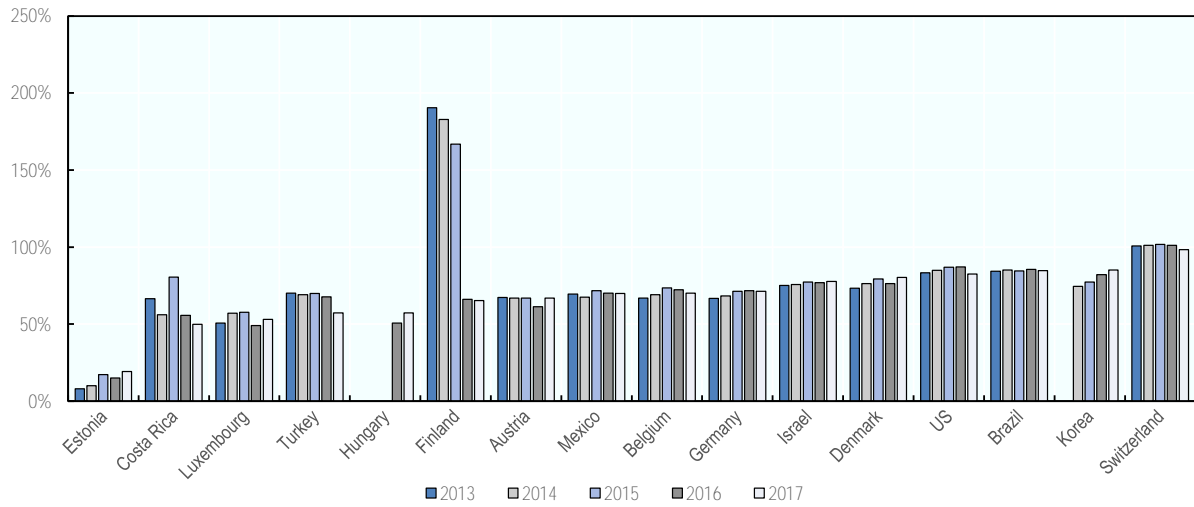
Figure 12. Claims paid for health insurance (excluding US) (USD million)



Source: OECD questionnaire.

When examining the ratio between the claims paid and the written premium for each year, in most countries this ratio is usually between 50%-85%, with two noticeable outliers as of 2017 – Estonia with a claims ratio of 19%, whereas Switzerland has a claims ratio of 88%. Finland saw particularly high claims ratio in the years 2013-2015, although this reduced from 167% to 66% in 2016 with this level maintained in 2017. The high claims in Finland could be due to a change in the statistical methodology from 2016.

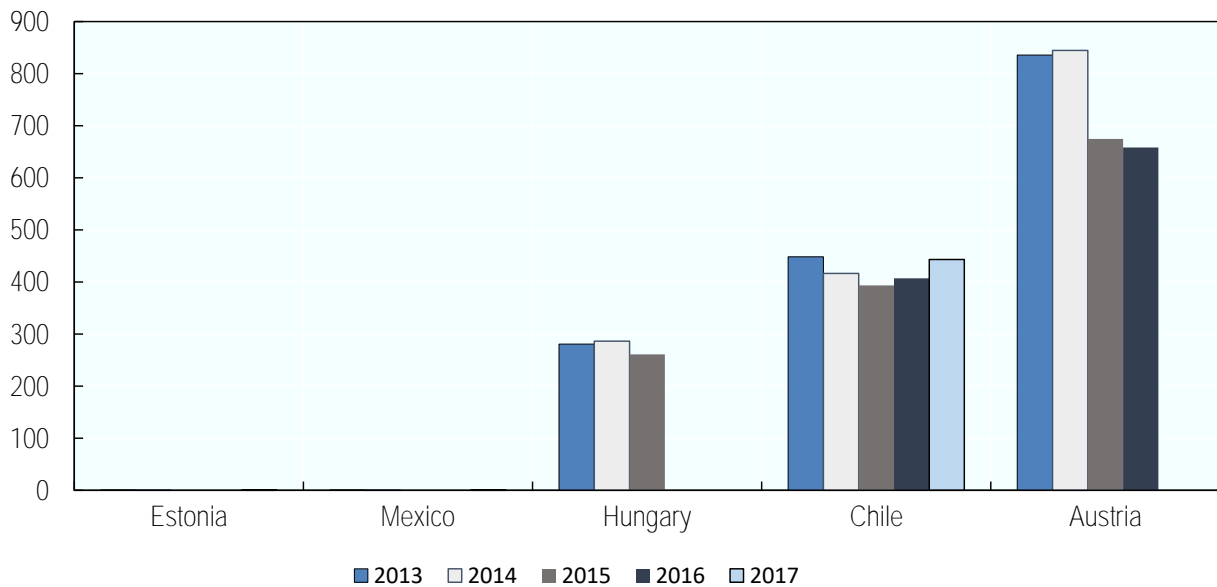
Figure 13. Claims Ratio for health insurance, 2013-2017



Source: OECD questionnaire.

In terms of the average out-of-pocket payment per capita payment for health insurance, while not all countries responded, the amounts range from USD250 to USD 650 per year.

Figure 14. Average out-of-pocket payment per capita for health insurance (USD)



Source: OECD Questionnaire.

In several countries, there is a noticeable trend of increasing demand for private health insurance, along with price increase in some of them. In Belgium tariffs were raised and more severe policy conditions were introduced. Brazil experienced an increased demand for private insurance, following the decrease in the market share of individual and family plans due to increased regulation and price control. At the same time, Brazil sees a significant trend of market concentration - from 1999 to 2018, the number of medical health care plan and medical and dental health care plan companies (excluding companies offering only dental

health care plans) has almost halved. Korea saw price increases, and also experienced increased sales in medical insurance. Luxembourg and Turkey saw more interest for the private cover.

In recent years, **changing business models or products of insurers providing health insurance have occurred due to changing markets and regulation**. Digitalisation was the biggest trend in Germany and Luxembourg. In Israel, the Capital Market Authority, that is the regulator of the private insurance market, created a uniform surgery policy. The uniform policy sets the provisions for any surgery policy and all insurers must sell policies in accordance to the uniform policy. The provisions of the inform surgery policy are being reviewed and revised by the Israeli Capital Market Authority every two years. Estonia recently introduced an option for employers to sign tax deductible contracts for employees for the amount of EUR 400 a year. In Korea, simplified insurance issuance was introduced, with insurers now offering insurance rewards for improving health. In the United States, tighter networks and higher cost-sharing, and better data analysis and care management practices were observed.

On the **main types of groups (employment based, sector based, union)** which health insurance is offered to, some countries included all groups as long as actuarial technical requirements are satisfied, including employment based, sector based, business collective plans, family, individual, foreigners, complimentary cover, individual policies and group policies. Employment based plans are predominant in all countries, and in Switzerland there are no group plans, only individual plans.

On **special health insurance schemes for those that are self-employed, disabled, unemployed or with lower incomes**, in Belgium, Chile, Israel, Switzerland and Estonia there are no special insurance schemes for these groups. Brazil's free and comprehensive health care is for all and can be insured under the collective business plan for 24 months at their own expense.

In other countries, special insurance schemes for these groups do exist. Austria, Luxembourg and Turkey have special private insurance products for the self-employed. In Korea, there is a special product for the disabled. In Mexico, there is a microinsurance product to promote access of the low-income population to insurance. In Slovakia, insurance for the disabled and unemployed is paid by the government. In Hungary, it is free for children, parents of babies, students, low income, disabled and church employees.

Table 6. Institutions providing health insurance

| State-owned or public institution | Private Insurer | Hybrid institution | Other |
|-----------------------------------|-----------------|--------------------|-------|
| Chile | Austria | Belgium | Chile |
| Costa Rica | Belgium | Brazil | |
| Czech Republic | Brazil | Slovakia | |
| Hungary | Chile | | |
| Israel | Costa Rica | | |
| Mexico | Estonia | | |
| Slovakia | Israel | | |
| Turkey | Japan | | |
| US | Korea | | |
| | Luxembourg | | |
| | Mexico | | |
| | Switzerland | | |
| | Turkey | | |
| | US | | |

Source: OECD questionnaire.

On whether **insurers providing health insurance are solely health insurers, or offer other insurance lines**, only few countries have regulations that limit the option to offer health insurance to a specific type of insurer. In Germany, substitutive [complementary] health insurers are not allowed to offer other insurance lines. In Mexico, health insurance companies can only offer health insurance, but insurers offering personal accident insurance and medical expense insurance can offer property or life, but not both. In Switzerland, mandatory coverage is offered by dedicated health insurers. Private insurers, to a small degree, operate in the market for non-mandatory supplementary coverage.

Most countries allow health insurance to be offered by different types of insurers. In Austria, health insurance companies also operate in life and non-life lines of business. In Belgium, they are mostly in the health insurance business, but some life insurers also provide health insurance. In Brazil, health plans can be sold by insurance companies, but also by medical entities. In Chile, Turkey and the United States, life and non-life insurance companies offer private health insurance.

In Costa Rica, personal insurance licensed insurers as well as composite insurers can sell health insurance products. In Estonia, there was one health insurance provider until 2017 and now there are four, both life and non-life insurers. In Japan, both life and non-life insurer can sell health products.

In Luxembourg, some insurers are solely health insurers while others offer mixed offering with non-life products. In Slovakia, it is mostly offered by health insurance companies but also by non-life insurance companies.

On **tax incentives relative to the purchase of health insurance**, Belgium, Chile, Hungary, Israel, Korea, Mexico, Slovakia, Switzerland and Turkey do not have tax incentives. In Estonia, there are no tax incentives for private persons, whereas employers have a tax deduction for employee health insurance contracts of EUR 400 a year. In Austria, the tax relief plays a minor role and is slowly being fully eliminated.

In Brazil, private health premiums are eligible for tax deduction. Japan gives a tax deduction for income up to a certain amount. In Lithuania, employer contributions are deductible for the purposes of corporate income tax as well as some tax deductions for individuals as well. Luxembourg, Turkey and the United States have tax incentives for group and personal policies. The United States grants incentives to small employers and individuals up to a certain income level.

As for the question regarding **the criteria for accessing public health care and the conditions for health insurance**, in Austria, private health care insurance generally requires a health check which may lead to additional premium or a non-offering of insurance policy by the insurer. In Belgium, private LTC insurers can use a medical questionnaire and in Hungary a risk assessment is carried out. In Brazil, if private health plan beneficiaries use the public health care system, the private insurer needs to reimburse the system.

In Korea, there is no financial eligibility requirement for private health insurance, but access is dependent on health status. In Luxembourg, Switzerland, Mexico and Turkey, access to public health does not influence access to private health. In the United States, access to health insurance is guaranteed and premiums in the small group and individual market can vary based on age, geography and smoking habits.

On **adequacy and appropriateness of competition in the health insurance market and what are the issues discussed**, in Belgium, there is an ongoing discussion on the prohibition to terminate contracts or raise premiums for non-occupational health insurance. Some insurers set low premiums initially for competition purposes, and later had to turn to the supervisor in order to have premiums increased as they claimed their entry premiums were too low, which has led to a debate of whether this practice is an unfair competition.

In the period 1999-2018 in Brazil, the number of health plans and insurers almost halved, leaving still a high number of 735 companies providing health insurance leading to questions on concentration levels. In Chile, there is a discussion on vertical integration between insurers and health care providers, but there are

no normative guidelines. In Costa Rica, concentration has been reduced by 70% from 2008 to 2017. In Germany, there are occasional discussions on the necessity of portability of the full age reserve in private health insurance. In Hungary, Luxembourg, Israel and the United States, there are discussions about the level of competition. The markets in Korea and Switzerland are competitive.

To the question of who **regulates health insurance and its products**, in Austria, private insurance is mainly for supplemental insurance and therefore the regulation on it is not very detailed. In Belgium, one article of the insurance law is dedicated to health insurance. Similarly in Costa Rica, there is limited regulation specific to health insurance. In Estonia, health insurance products are regulated under the Law of Obligations Act. In Hungary there is no specific regulation.

Israel's Capital Market Authority regulates private insurance market, as in Japan where it is the Financial Service Agency. In Brazil, ANS regulates health care plans and products pursuant to specific regulation. In Chile, the Superintendency of Health regulates a minimum list of benefits that must be covered by insurance and its minimum coverage, and complementary health insurance sold by insurance companies is regulated by the Insurance Intendancy that belongs to the Financial Market Commission. In Korea, private health insurance is supervised by the Financial Services Commission (FSC and the Financial Supervisory Service (FSS. In Switzerland, the regulation on non-mandatory supplementary health insurance is defined by the Federal Insurance Supervision Act and Insurance Supervision Ordinance.

Slovakia is the only country amongst the countries that responded to the questionnaire where the Ministry of Health regulates and supervises private health insurance, according to Act 580/2004 on Health Insurance and Act 581/2004 on Health Insurers. In Mexico and Turkey, although regulated by financial regulators (Ministry of Finance, and Ministry of Treasury and Finance, respectively both have additional regulations which are under the Ministry of Health regarding health insurance. In the United States, there are several federal agencies and state departments of insurance that regulate health insurance products, with several federal laws and many state laws

In terms of regulation on **the relationship between physicians/hospitals and insurers**, in Austria, the level of reimbursement from supplementary insurance is agreed between the insurance industry and health care providers, and so in many cases direct settlement is possible. In Chile, the physicians of public hospital have contractual relationships defined by law, whereas physicians of private clinics are regulated via private contracts. Fees can be paid directly by patients and then reimbursed or there could be a benefit program for the direct payment by the insurer. Insured is limited to the predetermined network in case ancillary services are required.

In Estonia, insurer and physicians/hospital have agreements. In Hungary and Turkey, such relationships are not regulated. In Japan, a policyholder pays the health costs and then gets reimbursed by the insurer. In Mexico, health services are provided through the network of physicians and hospitals and reimbursement done by the insurer.

On the **requirements and regulations related to the management of personal data towards health insurers and other insurers who provide health benefits**, in the EU it is regulated by the EU General Data Protection Regulation. In Luxembourg the relevant national laws are the criminal law, insurance law and EU regulation. Mexico, Costa Rica, Turkey and Switzerland have their law on data protection. In Korea, a stringent regulation package on the handling of personal data in the financial sector has been announced. In Slovakia, personal patient microdata has to be anonymised before being handled. In the United States, state cyber security laws apply as well as federal and state Health Insurance Portability and Accountability Act privacy regulations.

The **main features of the products being offered in the market for health insurance** in Austria is that private supplementary insurance provides free choice of doctors, no waiting for hospital beds, higher comfort and free hospital choice. In Belgium, products mostly cover hospitalisation and ambulatory costs, and they are lifelong in duration and cannot be terminated or have the premiums increased by the insurer.

In Brazil, ANS regulates a list of services which coverage is mandatory for health care plans, making products relatively similar. What varies is the quality and geographical spread of providers, payment mechanism and segmentation. In Chile, there is a large number and variety of complementary health plans with free choice of providers. In Estonia, there is access to family and special doctors, as well as dental care, which is only partially covered by state.

In Germany, private insurers are obliged to reimburse medically necessary treatment expenses and other allowances defined by law. In Israel, the market offers coverage for private surgery, transplants, critical illness, and medication that is not in the health basket. In Korea, Private Medical Indemnity Insurance was introduced in 2003 to complement the national health insurance. However, increasing loss rates and premiums due to the poor management of medical expenses for non-benefit medical care made it urgent to review. In Luxembourg, there are products that are supplementary and complementary to the public sector products. In Slovakia, there is only one type of general coverage. In Mexico, there is personal accident insurance, medical expenses insurance and health insurance, each covering different risks.

On the **types of services accompanying insurance products**, in Austria, there is a trend of offering health checks and spa stays, and health care is gaining importance. In Belgium, assistance abroad is popular. In Brazil, screening and preventative care is available.

In Chile, private health insurance (ISAPRE) is obliged to grant work disability allowances, as well as a series of minimum benefits, such as preventive medicine, benefits that are in connection to health during pregnancy, child benefits, catastrophic diseases benefits as well as a list of other benefits are available with additional charges. In Estonia, family and special doctors as well as dental, hospital and post trauma treatment is available. In addition to the already mentioned, Germany reports that many health insurers include the possibility of acquiring a second opinion, medical remedies, and disease management programs. Hungary also listed second opinions as well as diagnostic examinations, screening programs and one-day surgery.

In Israel, supplementary cover for medical examinations and consultations as well as alternative medicine can be purchased. In Korea, health screenings, disease consultation is available. In Mexico, ambulance service, discounts for lab, prevention are provided for. In Turkey, the cover can include the cost of treatments, diagnoses and hospital stay. In the United States, preventive services are mostly available.

Insurance policies targeting specific illnesses or injury include Japan's to cancer, stroke and myocardial infarction coverage, Israel's cancer, Estonia's critical illness, Chile's occupational accidents and diseases, and cancer insurance, and Korea's cancer coverage.

Technologies being developed to assist health insurance processes in Austria include digitalisation, health tracking devices, automated claims processing and medication delivery systems. In Germany, insurance companies already offer several technology-assisted services, such as smartphone apps for invoice submission and appointments.

4.4. Interaction between public care and insurance market

How the public health care system and health insurance relate to each other, in Austria and Luxembourg, the public health care offers a good level of performance and private health care is supplemental. Chile has, since 1990, the National Intra-hospital Infection Surveillance System. In Estonia, the demand for private health care is caused by long waiting in the public health care system. Korea reports that the Ministry of Health and the Financial Services Commission are reviewing the relationship between the national health insurance and private health insurance. In Turkey, penetration of the health insurance market is low as the national health system is generous.

References

- Crimmins, E.M., & Beltrán-Sánchez, H. (2010). Mortality and morbidity trends: is there compression of morbidity? *Journal of Gerontology: Social Sciences*, 66B(1), 75–86, doi:10.1093/geronb/gbq088.
- Glossary of Health Systems Characteristics 2016. <http://www.oecd.org/els/health-systems/OECD-HSC-Survey-2016-Glossary.pdf>.

www.oecd.org/finance/insurance

