Public and Private Sector Relationships in Long-term Care and Healthcare Insurance

OECD

Please cite this publication as:

OECD (2021), *Public and Private Sector Relationships in Long-term Care and Healthcare Insurance*, *www.oecd.org/finance/insurance/long-term-care-health-care-insurance-in-oecd-and-other-countries.htm*

Foreword

The take up of private insurance in long-term and health care

The importance of having access to care options and being able to finance this has been laid bare through the experience of the Covid-19 health emergency. While most countries have public options for long-term care and health care, these are not always comprehensive and may not support the needs of the community. Having long-term and health care options that are affordable are important public policy consideration, especially when ageing is affecting many OECD countries, and morbidity is impacting health outcomes.

Private insurance can extend care options, and provide additional services that may not always be available through the public sector. However, insurance is not uniformly offered across countries, especially given the differences in the public system, and the manner in which it is made available will differ as well.

This report examines select countries that have characteristics in their long-term care and/or healthcare system, which may facilitate the use of private insurance to support the provision of public health and long-term care services. 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

Figures

Boxes

1 Introduction

The OECD's Insurance and Private Pensions Committee (IPPC) launched a project on long-term care and health insurance in 2017, and published a stock-taking report on long-term care and health insurance in January 2020 (Long-term care and health insurance: a stock-taking report) based on a questionnaire which was circulated to members and non-members in June 2019.

The objective of this report is to review the differences in the take-up of private insurance coverage in different countries. Understanding the reasons for such differences may assist in recognising the main motivations of individuals for choosing private insurance to contribute to their health coverage, sometimes over public healthcare and coverage, and thus indicate the ways in which private long-term care and health insurance products can be better engaged to serve health system needs and goals. This report will examine potential correlations between the availability and quality of health services and that of private insurance. This report focuses on select countries that have characteristics in their long-term care and/or healthcare system, which may facilitate the use of private insurance to support the provision of public health and long-term care services.

There are a number of challenges to better understanding the take up of private insurance in health and long-term care became apparent:

- Data and information is not always sufficiently granular to enable a full analysis of issues, which includes publicly available data.
- Aggregate data on healthcare and long-term care at the country level may not present sufficient comparable information to understand the issues across countries.
- Data on long-term care is limited and scarce, and different definitions of long-term care make it difficult to compare between countries.

Private long-term care and health insurance do contribute to policyholders receiving better care but there are affordability and risk awareness issues in particular hamper the take up of these insurances. In addition, the affordability of such policies, while the convenience they provide, means that some policies might be better serving higher income brackets which is an unintentional consequence of such policies.

The proportion of public expenditure on health care and long-term care is expected to rise in most OECD countries. This reflects demographic changes and longevity improvements but will lead to the need for an increase in care, in particular for long-term care, strong.

One of the complications both in terms of analysing expenditure, as well as understanding of coverage by policyholders, is that long-term care is often part of health care provision in many countries. Related to this, when policyholders consider the purchase of private health insurance policies, the coverage relative to public health care is often unclear or complicated leading to a poor understanding of whether they would benefit from private health insurance. This is the case for long-term care insurance, when health care coverage may be covering some aspects of care. Or long-term care is not offered with private insurance coverage, which is likely affected by long-term care being primarily provided by family and communities.

The penetration of private health care insurance is widely diverse, with the samples presenting between 6.4 percent and 95 percent of the population having private health insurance in OECD countries. Given that all countries, with the exception of the United States, has universal health coverage, and most OECD

countries spend between 4 percent and 11 percent on health expenditure as a share of GDP in 2019 (excluding the United States which spends over 17 percent of its GDP), the take up or the manners of its take up of private health insurance being diverse.

Premiums and pricing levels are also highly relevant, with affordability being a key issue preventing higher take up of private health and long-term care insurance. This is particularly clear when private health insurance is primarily taken up by high income individuals or those belonging to organisations that provide group health policies. Related to this, the out-of-pocket for health care and long-term care and level of deductibles will affect the purchase of private insurance.

Capital requirement for insurance and regulation related to products will also impact take up of private health and long-term care insurance. For example, capital requirements of insurers may become prohibitive for insurers when mortality and morbidity rates are taken into account in long-term care insurance in some markets. On the other hand, development of a regulatory regime for long-term care insurance in Chinese Taipei, Hungary, and the United States contributed to a market becoming available for long-term care insurance.

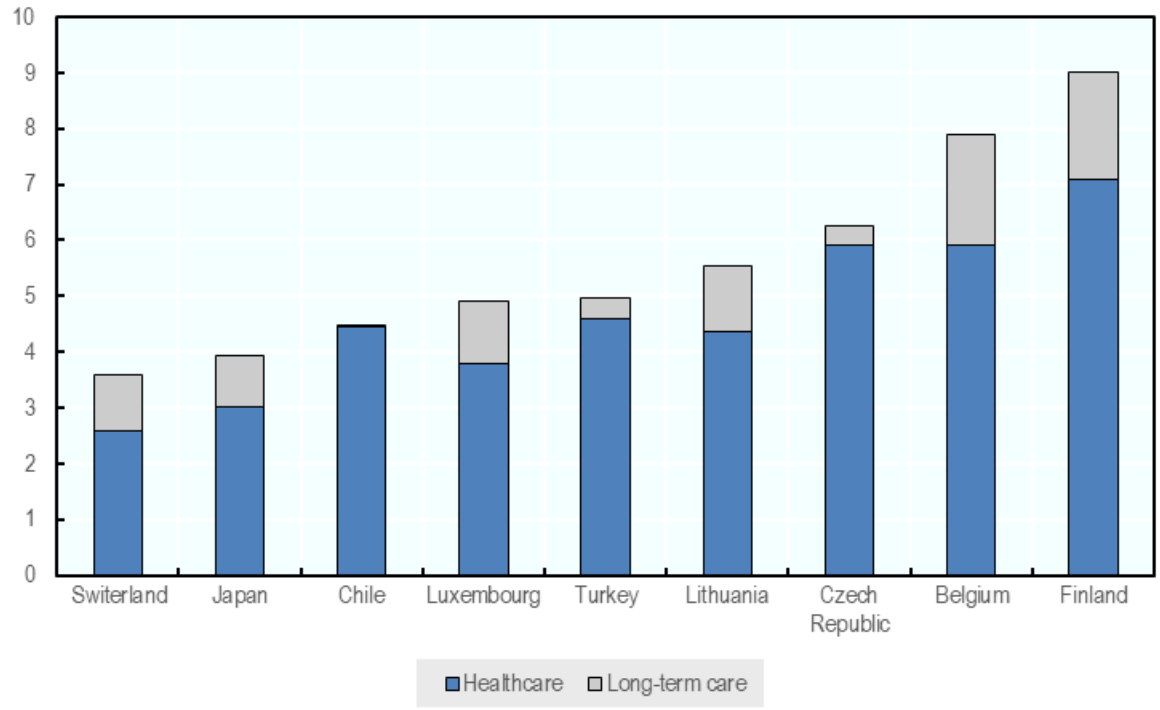
Private health insurance has a role in providing additional or better health care services relative to the public care options available. Private health and long-term care insurance may provide options in terms of elective procedures, hospitals, doctors and rooms/beds that can be accessed. There are also risk prevention and mitigation services that accompany a number of private health and long-term care insurance policies that could assist in achieving better health and well-being outcomes for policyholders. The waiting list for public health and long-term care services appears to be a major issue in a number of countries in terms of assessing the quality of care, although this is likely not the biggest obstacle to service access or quality of care. Private insurance can often overcome these roadblocks with the additional options that are made available to policyholders.

2 The growth of public expenditure on long-term care and healthcare

2.1. Public expenditure on health and long-term care

The public expenditure on long-term care and on healthcare varies between different countries, both as average expenditure per capita and as a share of GDP. Although long-term care is expensive and holds substantial costs, the total public expenditure on it is significantly lower than the expenditure on healthcare (see Figure 2.1). This is consistent with the fact that in many countries, long-term care is not a separate service from universal healthcare scheme or is not publicly, widely available (see section 4). In countries like Finland and Belgium, where the public health insurance includes coverage for long-term care related services, such as reimbursement for the expenditure on nursing homes, the expenditure on long-term care is relatively higher, but still lower than their expenditure on healthcare.

Figure 2.1. Public expenditure on health care and on long-term care, as share of GDP (%, 2016)



Source: OECD questionnaire.

2.2. Expected growth in public expenditure on long-term care and healthcare

Most countries estimate that the public expenditure on both healthcare and long-term care will grow significantly over the next decades. For long-term care, countries estimate an average annual growth rate of 4-10 percent, reaching a total public expenditure as high as 6.9 percent of GDP (Luxembourg). Other countries, such as Belgium, Lithuania and Switzerland, predict that in the next 20-40 years their public expenditure on long-term care will consist of around 4 percent of GDP (OECD, 2020). Longer term projections made by the European Commission predict that by 2070, the average share of GDP allocated to the financing of long-term care in European Union (EU) countries will nearly double. In some EU countries, the growth in expenditure is estimated to be even higher, with a few countries, such as Ireland, Poland, Malta and Luxembourg, possibly increasing their public expenditure on long-term care by more than 150 percent by 2070 (European Commission, 2018).

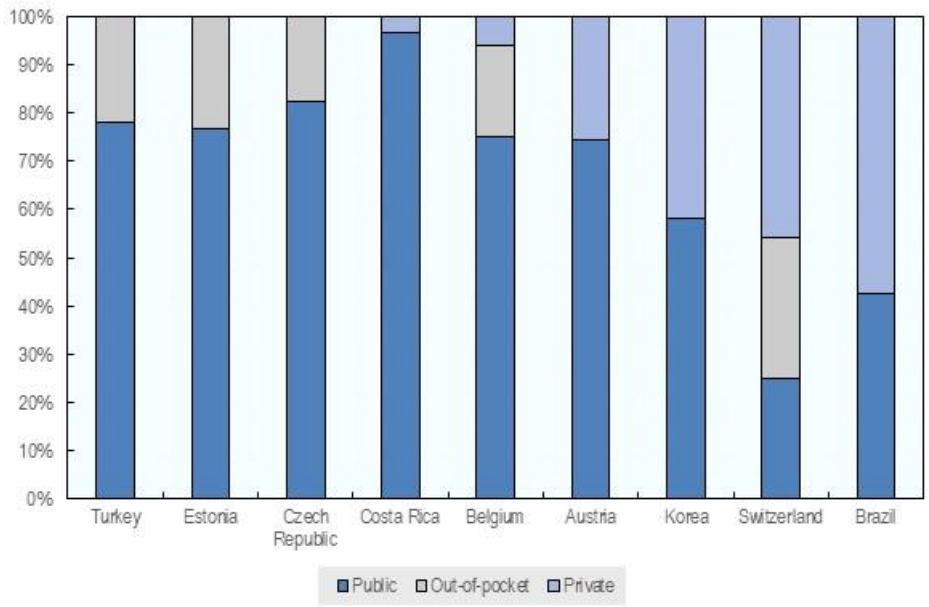
As for public expenditure on healthcare, most countries estimate that there will be some growth in terms of share of GDP, but it is expected to be more moderate than the growth in expenditure on long-term care. On average, by 2070, countries will likely increase the share of GDP spent on healthcare by about 24 percent in EU countries. Some countries, e.g. Portugal, Romania and Latvia, are likely to see a much higher increase of about 50 percent compared to their current expenditure by 2070 (European Commission, 2018).

Although lower than the expected expenditure on long-term care, the projected growth rate of health expenditure is higher than expected growth in GDP. This means that in the next years and decades, countries will face an increased fiscal burden on their budget to finance the care necessary. This is likely to lead countries to look for solutions that involve the private market, in one way or another.

3 Factors affecting demand for private health and long-term care insurance

The share of population that has private insurance coverage varies greatly between countries. In some countries, private insurance accounts for a substantial share of the total expenditure on health, while in others a private market for health insurance almost does not exist (see Figure 3.1). Understanding the reasons for the different take up of private coverage between countries may be a key to better comprehend the factors that motivate people to purchase or not to purchase private insurance, and to indicate the characteristics that could make private insurance more appealing to individuals and better contribute to spreading the financial burden.

Figure 3.1. Split of healthcare financing between public expenditure, out-of-pocket payments and private insurance

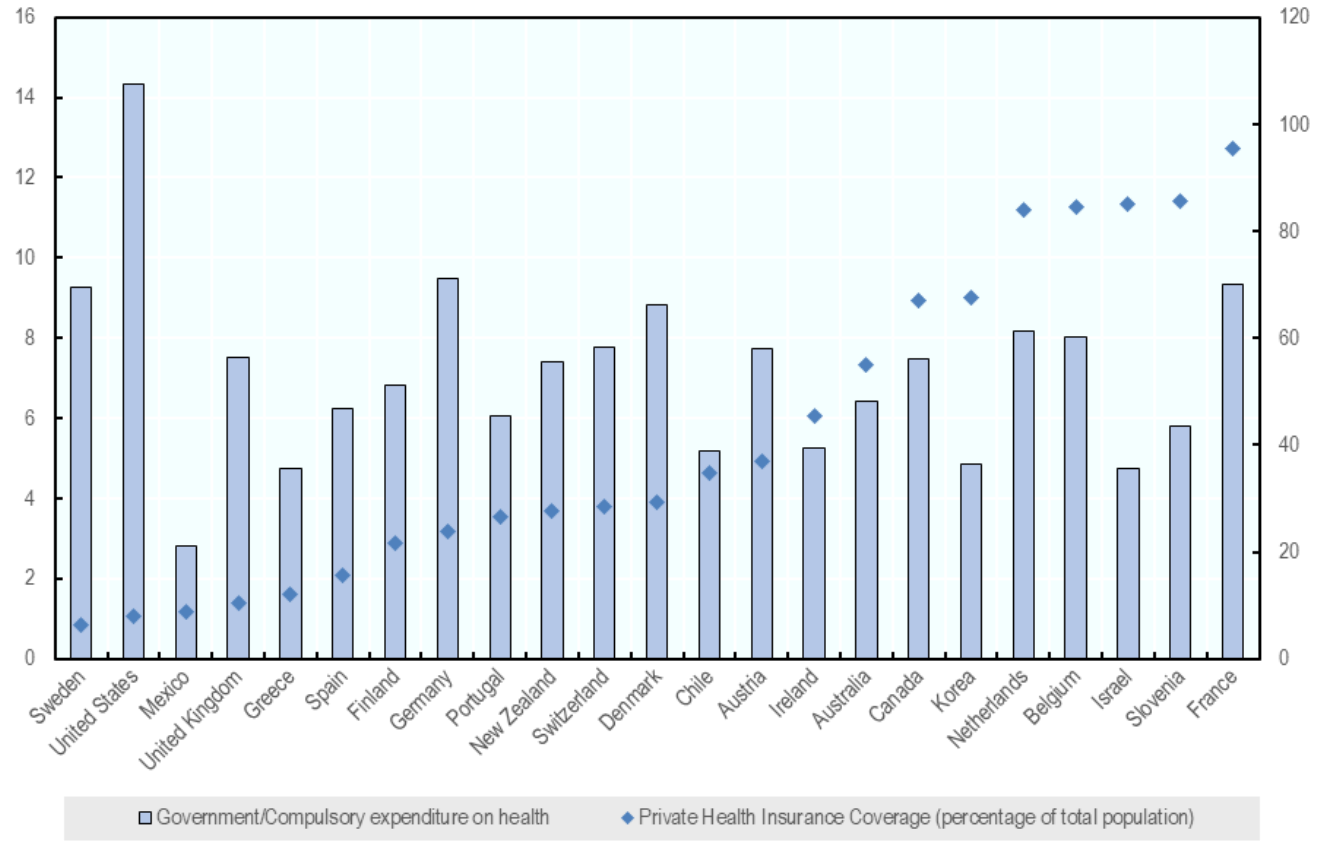


Source: OECD questionnaire.

The share of population with private insurance coverage varies between 6 and 96 percent. Countries with similar expenditure on healthcare (as a share of GDP) may significantly differ in the share of private insurance (see Figure 3.2). For example, while France and Sweden both spend 9.3 percent of GDP on health, in Sweden only 6.4 percent of the population purchased private coverage, while in France over 95

percent of the population holds private health insurance. Without more data, it is not possible to ascertain the reason for this difference, but it can be speculated that in France there is a substantial share of group health insurance policies that contribute to the proportion of the population having private health insurance (see section 3.4).

Figure 3.2. Expenditure on health as share of GDP compared to percent of population with private health insurance



Source: OECD Stats.

These differences may be explained by factors such as availability and quality of public services, the structure and mechanisms of co-payment, availability of group insurance plans, and type of private insurance products that are offered. This section will address a few of these characteristics that may contribute to the different choices of individuals in relation to the purchase of private coverage. Although the impact of each of these factors is discussed separately, it is likely that the choice in private insurance is influenced by a combination of these factors, as well as personal characteristics, preferences, awareness and understanding.

The World Health Organisation (WHO) defines universal health coverage (UHC) as the ability of all individuals and communities to receive the health services that they need so that these services will be accessible to all, with regards both to costs and to other aspects of provision. UHC does not necessarily mean that the coverage is free for all services and for all residents or citizens. Compulsory public insurance for health care can be structured in a way that mandatory insurance contributions are pooled together and thus spread the financial risks across the whole population.[1]

Most OECD countries have some type of UHC, at least to some extent, although the extent of UHC varies greatly by two aspects: is it free of charge or financed by tax, and is the scope of services provided include only specific types of services (emergency, ambulatory etc.) or all services. In some countries, UHC also includes the provision of health goods such as pharmaceuticals.

3.1. Ensuring availability of care, when universal care is not accessible

Different countries have different approaches regarding the eligibility for the provision of public healthcare. Most countries run a universal healthcare system, at least to some extent, which means that health services are available to all residents. The United States is the exception as there is no UHC system, and access and eligibility to public health care is limited only to certain groups that are defined by specific criteria such as income, age and medical condition. The way that the United States tackles the question of ensuring care for those who are uninsured and do not have access to care may be relevant to other countries where UHC exists only to a limited scope.

Since the enactment of the Affordable Care Act (ACA) in 2010, public healthcare in the United States has expanded via broader eligibility to programmes like Medicaid[2] and changes to individual insurance markets by Medicare Advantage, which provides Medicare[3] benefits through a private insurer. ACA aimed to lower the costs of health insurance and thus making it affordable and within the reach of larger share of the population.

The ACA has set regulations related to the terms and conditions offered by private insurers. *Inter alia*, the ACA requires that insurance companies offer a plan to anyone who applies, and limits the differences in premiums between different insured individuals in the same policy. All insurers must offer the same plans that are divided into four tiers. Within each tier, the conditions are required to be the same between the different providers, but the price and cost-sharing amounts can differ (Gunja, Munira Z. , Collins, Sara R., Doty, 2017[1]).

Between 2010 when ACA was enacted and 2016, there has been significant growth in demand for private coverage: in 2010, 26 million people have reported they purchased or tried to purchase private insurance. In 2016, this number increased to 44 million people. The percentage of people who ended up buying an insurance product also increased – from 46 percent in 2010 to 66 percent in 2016. It seems plausible that the change in the terms and conditions of insurance products that are offered in the private market due to ACA regulation, as well as the fact that private health insurance has become more accessible and affordable has played an essential part in this increase in private coverage. Although the individual mandate (penalty), which was phased in over 2014-2016, could have played a role.

The case of the United States is an example of a country that does not offer universal coverage, and the only option to get any coverage for healthcare for many people is via the private market. The change that followed the enactment of the ACA and specifically the regulation that forced insurance companies to offer affordable, more simple and understandable insurance plans to anyone who applies emphasises how much influence regulatory measures has on the parameters that affect the choices of people for private health insurance. Policymakers who wish to encourage the purchase of private coverage by individuals in order to diversify the fiscal burden will need to formulate insurance regulation that enables plans to be accessible, affordable and simple. It also shows that even when there are no other alternatives to insure possible future catastrophes and high expenditures for health care, the purchase of private insurance coverage is not assured.

Even when UHC is available, private health insurance appears to supplement the health care options by offering diverse service options. This is further discussed in sections Quality of services provided by the public health coverage and Scope and type of services provided by private health insurance.

3.2. Structure of premiums and pricing

In countries where UHC exists, examining the characteristics of the public health system and how the private insurance market operates in the space may assist in better understanding the reasons that incentivise the purchase of private insurance coverage. Countries where the insurance market offers similar services to those available in the public health system may have specific characteristics that are relevant, such as pricing or types of services offered.

Pricing and premium structure are factors that may play a particular role in individual decisions on purchasing private health insurance, in addition or in lieu of the coverage offered by the public system. Pricing based on individual characteristics, such as age and pre-existing health conditions are likely to discourage people with those characteristics from purchasing insurance given the higher prices or unavailability of coverage from purchasing, although insurance would likely most benefit these cohorts which paying for services directly would likely be more costly in the short-term. On the other hand, if premiums are not based on personal characteristics, services that would most benefit policyholders may not be included as the pricing may not afford them.

Germany and Australia both have UHC, but have different approaches to pricing of private health insurance. In Germany, private insurance premiums are set according to the expected health risk of the insured person. The younger and healthier an insured person is, the lower the premium is.

In Australia, private health insurance is based on a system of community rating, where all people pay the same premium for the same insurance product. Insurance companies are forbidden to set different premiums or base the price on age, health status, or claims history.[4] There is some speculation that due to community rating, individuals who are healthy and/or of lower income neglect to acquire coverage. This may result in an increase in the overall premiums charged from those who choose to purchase private cover and a potential adverse selection from those with higher risk being a higher proportion of the risk pool.

Germany has a comprehensive UHC, which is mandatory for all residents, and the option to choose between public and private insurance is only available to certain groups and based on income. The services provided by private insurance correspond to those of the public system. Both the public and private insurance use the same service providers. Although private insurance offers the same coverage as public health insurance, the market share of private insurance is not negligible. As of 2017, the share of population who chose to have private coverage over the public was 10.5 percent (Vdek, 2020). Understanding the motivations for those who chose private coverage in lieu of the universal coverage may indicate which characteristics play a role in such decision.

The overlapping nature of the health system in Germany may result in adverse selection that acts against the public insurance. The main difference between the public and the private insurance is the way that premiums are structured. While in the public system premiums depends on income, private insurance premiums are calculated based on the individual's risk level. That means that private insurance is more attractive to those who pose a lower health risk, and earn higher wages. Thus, people with medical conditions who require more care are likely to stay in the public system, and as a result public expenditure on health would be subject to higher financing needs.

The example of Germany suggests that there could be a few reasons for choosing private insurance coverage in lieu of public insurance coverage. The choice to purchase private coverage can be explained by the differences in premiums structure. Young people with high income may find the private insurance more attractive and less expensive than what they will need to pay if they stay insured by public insurance. Another plausible reason may be that private insurance offers some minor benefits that are not covered by public scheme (supplementary services offered).The expectation to get a higher level of service as a private client is also a factor that may be taken into account in the decision to purchase private insurance. The (strict) regulation of switching between the two systems likely prevents adverse selection to some extent.

Box 3.1. German health care coverage: public and private health insurance

All residents are insured, by default, by the public health insurance. The option to choose private insurance, as a substitute to the public one, is only available to those whose wage is higher than a set amount, or who are self-employed. In addition, German civil servants are able to purchase private health insurance regardless of their income. These groups have the option to either stay covered by the public insurance, or opt-out and purchase a substitute private coverage. When you have private insurance, you are not covered by the public healthcare and long-term care system. Approximately 90 percent of the population is covered by a mandatory or a voluntary public health care scheme (and the corresponding long-term care scheme), while the rest are enrolled in (mandatory) private insurance. The services provided by private insurance correspond to those of the public system, with both using the same service providers, especially with regards to long-term care.

The price of public coverage is determined according to wage earned. The premiums of private insurance companies are set according to the risk level of the insured person (such as age, medical condition etc.). Thus, private insurance tends to be cheaper for those who are young and healthy relative to public health insurance, becoming more expensive as you become older or have medical condition. If an individual who has the option to purchase private coverage chooses to stay in the public scheme, he is likely to pay the maximum premium, which could be higher than the premium the same individual would to pay for private insurance coverage.

In addition to the duplicative nature of private insurance that is required to offer similar services to those offered by UHC, private insurance allows the insured person to purchase additional coverage, such as dental treatment, special treatments, travel insurance etc.

It should be noted that once a person transfers to private health insurance, it is possible only under specific circumstances to transition back to the statutory health insurance due to regulations.

There may also be instance in which premium levels are perceived to be too expensive for the purchase of long-term care insurance, or where affordable price ranges were considered important for the choice (Australia, Austria, Japan, Netherlands and United States).

Related to this, there are some suggestions that the capital requirements of insurers may become prohibitive for insurers when mortality and morbidity rates are taken into account in long-term care insurance in some markets.

Another relevant consideration is the complexity of both the public and private health care system, which may lead to poor understanding of coverage. Many countries have expressed views that the complexity of the system or misunderstanding of their coverage has influenced purchasing decisions related to private health insurance (Australia, Chile, Israel, Japan, and the United States). In Australia, due to the community rating, everyone pays the same price for the same private health insurance product, and premium increases apply equally across all members. As private health insurance is voluntary and community rated, the healthiest people with the lowest incomes (which tends to be younger generations) tend to not purchase private health insurance, which leads to higher premiums and affordability issues and the risk pooling mechanism of private health insurance may not be as widely understood.

This has led to private health insurance becoming a perk that is often available to those with a higher income or a limited proportion of the population, which is also reflected in service options that are available through private health insurance (Australia, Colombia, Estonia) (see section Quality of services provided by the public health coverage).

3.3. Quality of services provided by the public health coverage

The quality and range of services that the public healthcare system offers may play a role in the decision to purchase private health insurance. This may be the main difference between public coverage vis-à-vis the coverage offered by private health insurance. In countries where the public health system is universal and accessible to all residents, and/or where the private insurance offered is duplicative – offering the same or similar services as those that are already provided by the public system - the quality of services offered by public health system may be a key reason why private insurance is purchased. If the types of service offered by public and private systems are similar, private insurers can market their products by offering services of better quality or a wider range.

Quality of public healthcare services is extremely difficult to measure, but the OECD's Health Care Quality and Outcomes programme compiles a Health Care Quality Indicator (HCQI).[5] The HCQI was revised in 2015, and covers primary care, prescribing, acute care, mental health care, cancer care, patient safety, and patient experience. While HCQI provides insight into specific aspects of care, it may not provide comprehensive understanding of a health system's quality of care.

Individuals tend to base their decisions on data that is available and transparent as a proxy for quality of their care. There are several indicators that are often referred to evaluate the quality of the services health service provided:

- Avoidable hospital admission indicators (e.g., asthma hospital admission, chronic obstructive pulmonary disease hospital admission, diabetes hospital admission);
- Indicators on prescribing of different drugs and treatments in primary care;
- Indicators on acute care (e.g., mortality within 30 days of the date of admission to the hospital);
- Indicators for quality of mental health care (e.g., deaths from suicide and excess mortality from several mental disorders);
- Indicators on patients safety (e.g., retained surgical device following a procedure, mortality after discharge);
- Indicators in connection with cancer care (five year net survival); and
- Indicators that are based on patients' experiences questionnaire.

However, the availability of data on the above are limited or not standardised, and none alone are a sufficient indicator on the quality of care too.

One indicators that is often used/referred to as a proxy for the quality of public health service is the length of waiting lists for an appointment with a specialist. These indicators often related to public health care systems which have care centrally managed or have limited capacity in terms of care providers. It should be noted that shorter waiting lists do not necessarily indicate better quality of service, and long waiting lists may not be the primary reason individuals purchase private insurance, although there could still be a mutual influence between these two factors.

In the United Kingdom, health care service is universal and free, and private health insurance offered is duplicative. Although the public health system offers full coverage, about 10 percent of the population choose to purchase private health insurance, not relying solely on the public services (OECD stats, 2017). A possible explanation is the inflexibilities of the public system, to which the length of waiting lists for non-urgent medical care could be a proper proxy. This assumption is supported by some empirical evidence that finds a correlation between long waiting lists for treatment provided by the National Health System (NHS) and the probability of purchasing private insurance (Besley, Hall and Preston, 1999[2]).

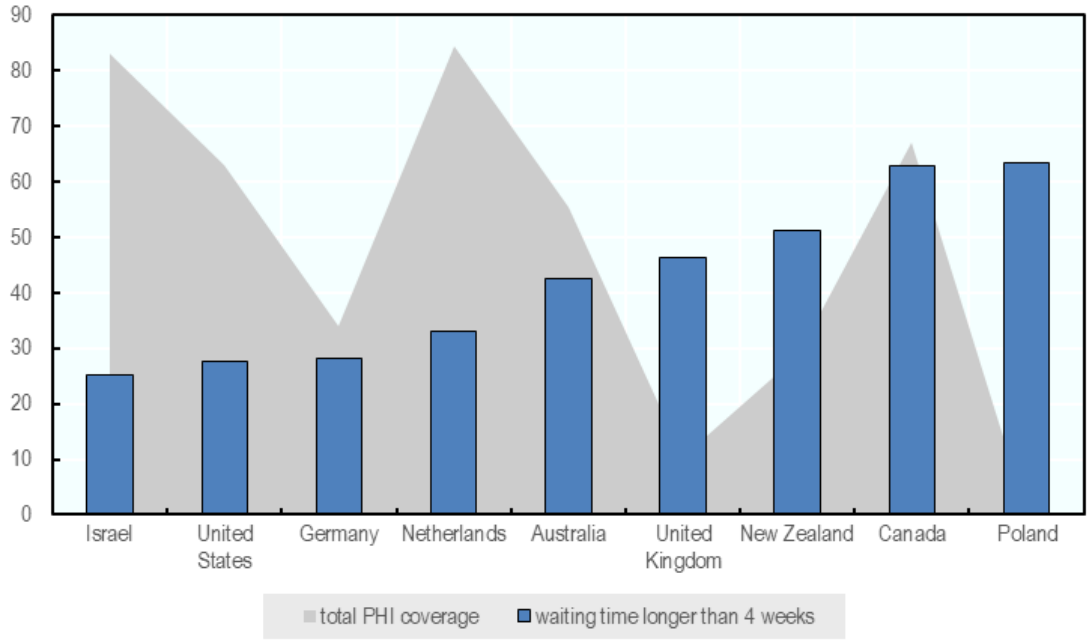
Private coverage may not only be a solution for those who wish to opt out from the public system due to the low quality of its services, but could also assist to improve the quality of public care available for the uninsured population. Service capacity could be divested from those with private insurance, and thus lower

the financial and capacity burden on the public system. If this is true, the higher the share of those purchasing private insurance, the shorter waiting time and lines would be expected to get in the public system.

Such correlation, if exists, may be explained in a different way: In countries where public healthcare is not easily accessible for all, or provided only to specific groups who are eligible to it, or has high co-payment costs, many people may choose not to get treatment and the demand for public care services is lower from the start, which could contribute to the shorter waiting lists. In such cases, the length of waiting lists does not necessarily indicate a better quality of service, and rather it may be an indicator for the inaccessibility of care.

Looking at the length of waiting lists as a single proxy for quality of care, more recent cross-country data does not present a clear relation between the share of reported long waiting times (longer than 4 weeks for an appointment with a specialist) and the percentage of population that has any type of private insurance (see Figure 3.3). Israel, the Netherlands and Australia do see relatively short waiting lists and have relatively high percent of private coverage, as expected, and the short waiting time in the United States, which does not have UHC, can be explained by the fact that the public system is not available to most people. New Zealand and Poland that have low share of private coverage see higher share of reports on long waiting lists. However, not all countries see such correlation – Canada, where more than 60 percent of the population has private insurance, see waiting lists as long as Poland. Waiting lists could be more closely related to the overall health care capacity of the country, rather than any financing aspect.

Figure 3.3. Waiting times for medical care and percentage of private coverage, 2016



Source: OECD Stats.

There is some anecdotal indication that waiting times may be a key factor for purchasing private health insurance in some countries (Australia, Chile, Colombia, Czech Republic, Estonia, Israel). In addition, the quality of hospital beds or availability of double hospital room (Austria and Japan), or wider choices of physician and hospitals may lead to the purchase of private health insurance (Australia, Austria, Colombia and Estonia). There are also situations in which some drugs or elective procedures are only available

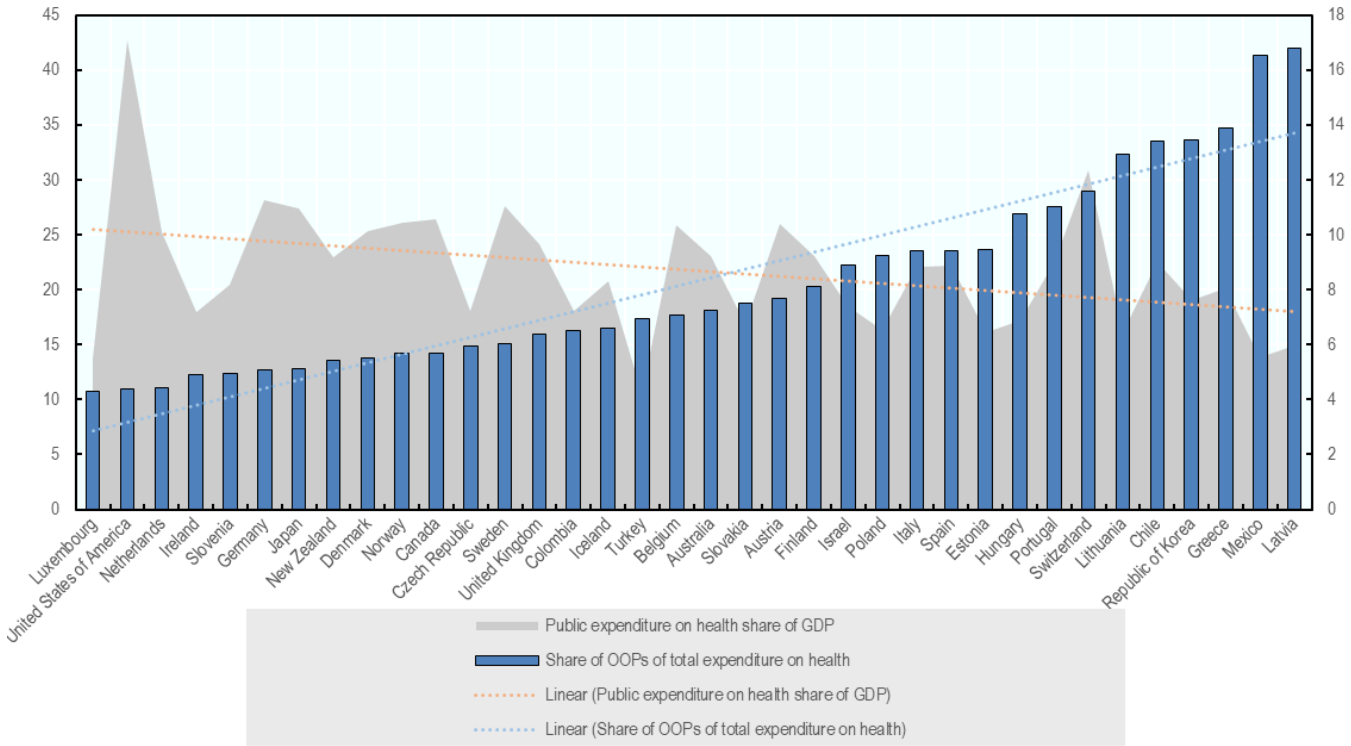
through private health insurance (Colombia, Israel). Dental care is also a common service that the public health system may not comprehensively provide (Austria, Estonia). In addition, public health coverage may have limited offering of certain services (e.g. no or low coverage for psychological/psychiatric benefits or antineoplastic treatments) which can be supplemented by private health insurance (Chile). Japanese private health insurance complements public health insurance coverage, such as out-of-pocket medical fees (30 percent of each medical bill), additional bed fees, advanced medical care fees, and income compensation for sick leave.

3.4. Level of out-of-pocket expenditure for health care services

Out-of-pocket payments (OOPs) are any payments that are made directly to the service providers at the time of service used, e.g., deductibles and co-payments, as well as any direct payment for services that are not covered. The average out-of-pocket annual payment per capita for health insurance ranges from USD 250 to 650 (OECD, 2020). OOPs are important for the reduction of moral hazard and for the rationalisation of the use of health services. On the other hand, if charges are too high, this might create a barrier to the access and provision of healthcare.

The proportion of OOPs out of the total expenditure on health care in different countries ranges from 9 percent to 42 percent. In general, the lower the share of public expenditure of GDP, the higher the level of OOPs out of total expenditure on health (see Figure 3.4). The combination of low levels of public expenditure on health care and high OOPs required may mean that some individuals are not able to receive sufficient care when needed.

Figure 3.4. Share of out-of-pocket payments of total health expenditure and share of public health expenditure of GDP (%, 2017)



Source: World Health Organization Global Health Expenditure database.

High OOP levels do appear to be affecting choices made in relation to health care expenditure. In Australia, the high OOP for private health insurance has become a focus given the increasing annual premiums that are being charged.

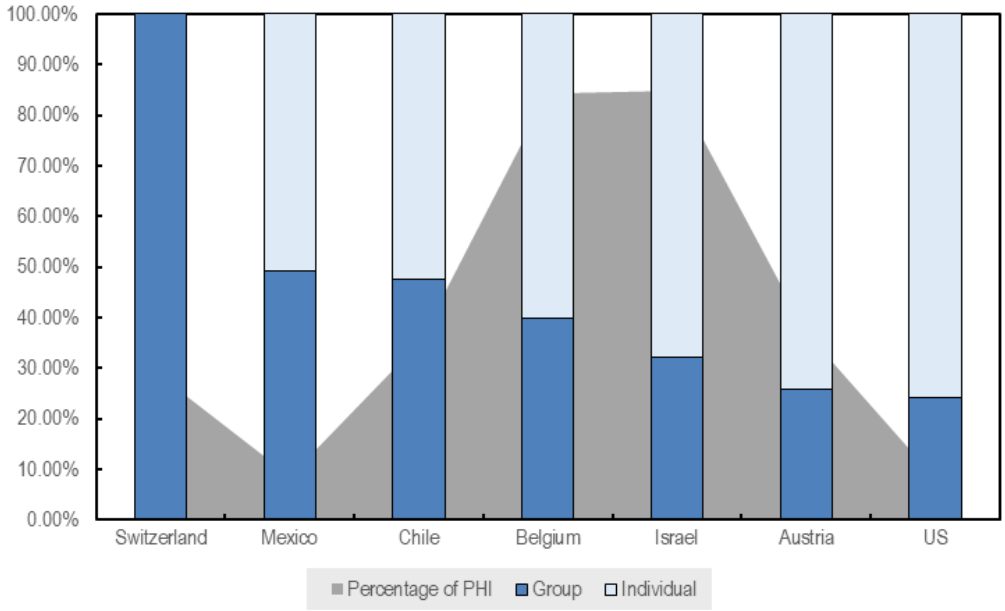
In Chile, the high OOP payment for public health insurance is influencing choices related to health care insurance too. In Israel, there appears to be a popular belief that public coverage for long-term care is insufficient to cover expenses, which has led to the purchase of private long-term care insurance in some cases.

3.5. Availability of group insurance schemes for health care

Employers or labour union often offer employees group insurance policies for health and life insurance coverage. Group insurance schemes usually offer lower premium rates, and, in general, does not require underwriting for individuals, which makes it available for individuals with former medical conditions or status, who are sometimes rejected by insurers when trying to purchase an individual health care policy. It would be expected that the availability of group insurance schemes would incentivise individuals to purchase them for private coverage.

However, when examining the data for the share of group policies out of total private insurance policies, and comparing it with the percent of population who purchased any type of private coverage, albeit a small pool of countries, there does not appear to be a correlation (see Figure 3.5). Countries with high percentage of private coverage, such as Israel and Belgium, have higher share of individual (personal) insurance rather than group insurance. In Switzerland, where all private insurance is offered via group policies, the percentage of population who chose to purchase private coverage is relatively low (28.5 percent). The availability of group insurance policies in the market does not, in itself, appear to present a sufficient reason to purchase private health insurance.

Figure 3.5. Share of group and individual insurance policies compared to percent of private coverage, 2017



Source: OECD Stats; OECD Questionnaire.

This may be due to group insurance not being widely offered as part of compensation packages or not be deemed to be sufficient incentive given the coverage and pricing of public health care.

Group policies in long-term care insurance is available in Austria, Japan and the United States. In particular, 30 percent of all long-term care insurance policies in the United States are group policies, which given that the United States is the largest market for long-term care insurance, may suggest that the availability of group policies may support the growth of the market going forward in other markets as well.

3.6. Scope and type of services provided by private health insurance

The private insurance market may fill the gaps in public coverage in a few different ways. The lack of certain services may be a reason for people to choose private insurance over public services. In countries where no public health insurance is available or accessible to individuals (notably the United States), private insurance would be the primary health insurance available. In countries with a universal public coverage, insurance schemes offered may be duplicate, complementary or supplementary. Duplicate private insurance offers coverage for the same services that are included in the public insurance scheme and the difference is usually in the available providers or in the levels of service. Complementary insurance complements the public health or insurance by covering the residual costs that are not reimbursed (cost-sharing, co-payment and so forth), while supplementary insurance offers cover for additional health services that are not covered by the public coverage.

In most countries, insurance companies offer either complementary or supplementary insurance. Several countries that responded to the OECD questionnaire (Germany, New Zealand, Denmark, Korea and Israel) have both complementary and supplementary schemes offered by insurers. In Germany, as discussed in Box 2, private health insurance can substitute the mandatory public insurance, in addition to being able to purchase non-substitutive private long-term care insurance elements as a supplement to the basic public insurance. Few countries have duplicate private insurance (Mexico, United Kingdom, Greece and Spain).

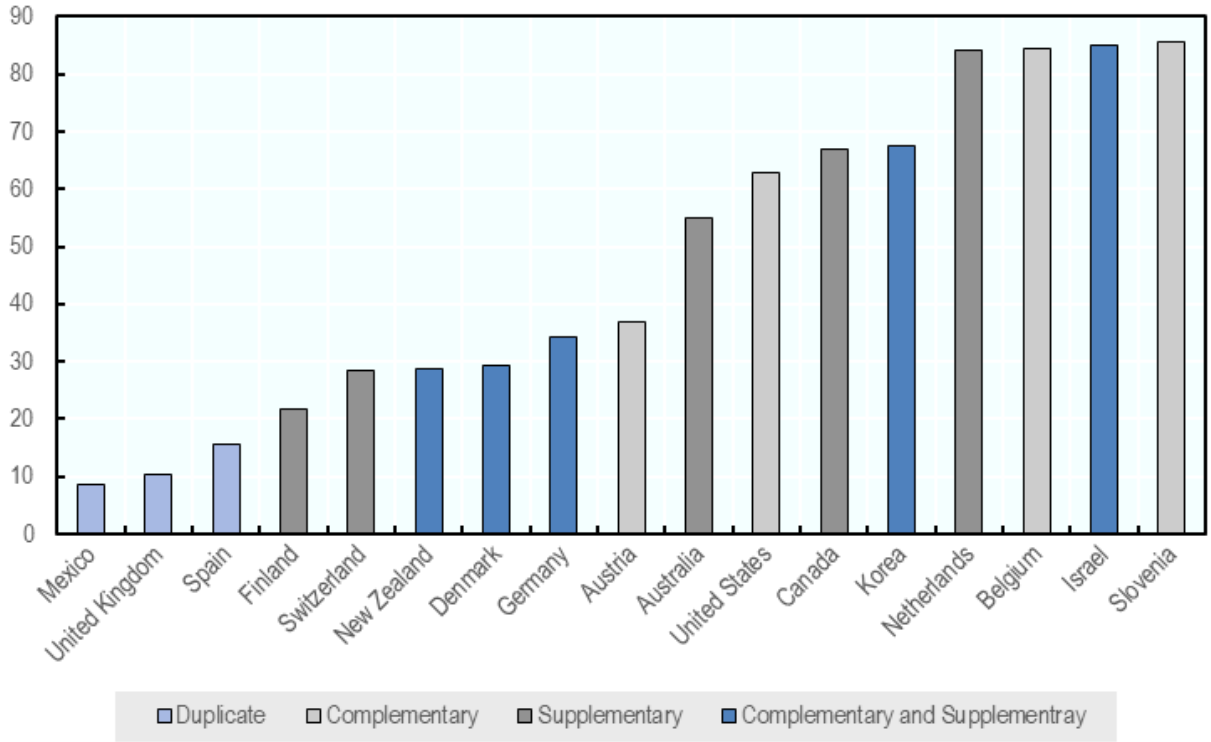
Public healthcare does not always encompass all the services that may be required for the well-being of individuals - for instance, preventative care, pharmaceuticals or advanced care may not be provided for. If indeed the lack of coverage for certain services motivates individuals to purchase private insurance, it is expected that the share of private coverage in countries with supplementary insurance would be higher than in those where the private insurance is complementary to the public system. On the other hand, if the share of private coverage in countries with complementary insurance is higher than in countries with supplementary insurance, it could imply that individuals look to minimise the excess cost of medical care, which could still be high due to level of deductibles or co-payments.

Economic assumption of rational decisions may not be fully realised in decisions related to the purchasing of private insurance. Some empirical evidence suggests that the inclusion or exclusion of certain services in the public scheme do not necessarily influence the choice to buy supplementary insurance. In Germany, dental prostheses were taken out of the compulsory benefit package of social health insurance, and two years later were included back in. According to research from the years when these reforms were executed, the exclusion of this service did not have a significant influence on the purchases of private insurance that provides this type of coverage during the two years. While it could be suggested that this coverage was not sufficiently relevant to the population group that was affected by this change, it is worth noting that the demand for private insurance contracts that offer this service is quite high in Germany. The more plausible explanation could be that most individuals may not have sufficient information and capability to make informed choices on the scope of coverage (Augurzky and Tauchmann, 2011[3]).The availability of sufficient and understandable information is important for individuals to make informed choices regarding the purchase of insurance coverage, and the question of the way such information is presented and framed is a condition for rational choices to be made.

If indeed the type coverage being offered by private insurance has an influence on the individual's choice on whether to purchase private coverage or not, a difference in private coverage percentages between countries that offer complementary and supplementary insurance would be expected. If countries that offer complementary insurance see higher percentage of private coverage in the population in comparison to countries with supplementary insurance, it may indicate that people see higher value in an insurance that pays their residual costs, implying that the high costs of health services are the main motive for purchase. On the other hand, if countries that have supplementary insurance perceive increased demand for private insurance and purchase such coverage, this may imply that the public system does not offer sufficient services and that the private market is filling the void of such services.

Comparing private coverage in different countries, there is no significant difference of coverage between countries that have complementary insurance and those that have supplementary insurance. In most countries that offer either one of these insurance types or both of them, 28-86 percent of population have private health coverage (Finland is an outliner, offering supplementary insurance and having coverage of 21.6 percent). Countries where the private insurance scheme offered is duplicate insurance see lower coverage percentage of between 8.7-15.7 percent (see Figure 3.6).

Figure 3.6. Percentage of individuals with private coverage in countries with different types of insurance schemes



Source: OECD Stats, 2017.

The proportion of people who purchase private insurance is significantly higher for countries with complementary and supplementary insurance coverage than in countries where the private insurance is duplicate. While the evidence is not strong enough to conclude which matters more to individuals – the cover for excess costs offered by complementary insurance or additional services that are not available via the public system, it does seem that both schemes offer an added value that is perceived as attractive to individuals than coverage offered by duplicate insurance schemes.

For private health and long-term care insurance, there may be particular services that are not offered by the public service but are included in private insurance that could lead to take up, such as specialised services that only private insurance offers (also see section Quality of services provided by the public health coverage for additional options that offered relevant to public health care system).

For example, life insurance products can offer benefits for long-term care such as a lump sum payment (one-time nursing care payment), pension (nursing care pension) or a combination of the two. These benefits can be acquired by adding a long-term care rider to the main life policy or purchasing long-term care insurance as the main policy. As public health care curtails certain services, these services are then often taken up by private health insurers (Netherlands).

Germany presents a similar situation in which supplementary long-term care insurance is purchased to supplement the mandatory long-term care insurance system, which does not cover all care-related costs. If long-term care retirement insurance is offered as part of life insurance, the insurance will pay a monthly benefit depending on how much assistance they need. Long-term care insurance may pay the residual costs after the mandatory social and/or private long-term care insurance has paid its share, by paying all or part of the remaining costs. Then there is long-term care insurance to pay nursing daily or monthly payments, which is needs based and the payment is made in full regardless of the actual costs of care.

An important aspect which carries across both private health and long-term care insurance is how the policies provide support for health risk prevention and management. These might be additional services relative to the public health care system (see section Quality of services provided by the public health coverage), or preventative services to improve health outcomes such as preventative medical examinations particularly for executives (Colombia), offering of gym discounts, diet programmes and healthy food (Israel). Discounts on insurance premiums and cash-back services based on health examination results and individual health promotion efforts may also be offered (Japan). In addition, advice for improving individual health based on health examinations, and encouraging the use of applications that help check cognitive functions are being offered as part of private health insurance.

4 The private long-term care insurance market

Long-term care differs from healthcare in a number of ways, and these differences need to be taken into account when trying to understand what could incentivise individuals to purchase insurance for coverage.

Provision of long-term care, both formal and informal, has significantly high costs. The cost of long-term care can be higher than the total income of the individual in need of care or their household. Insurance that covers these costs, either publicly or privately, ensures individuals from future impoverishing from long-term care expenditures. Private long-term care insurance was found as having a positive impact on the financial well-being of the insured individuals as it ensures the coverage of future high costs, and thus considered to be a rational choice (Dong, Smieliauskas and Konetzka, 2019[4]).

In some countries, the public system provides long-term care services (either mandatory or voluntary). It is likely that if public long-term care services are available and similar to those provided by private insurers, it would constitute either a full or partial substitute at a lower cost (Sloan and Norton, 1997[5]). Two prominent countries that have a comprehensive mandatory care system in which long-term care is included are Germany and the Netherlands (OECD, 2019). The German government addressed the need for a solution that would cover the high costs of long-term care back in the 1980s, as most individuals were unable to pay the high costs of ongoing long-term care and it would become a financial burden on the public system. The result is a mandatory social insurance system in which the entire population pays affordable premiums, which helps to provide the necessary coverage on a cost-sharing basis. The same institution provides both long-term care insurance and healthcare insurance, in order to prevent disputes over the definition of certain medical situations (Riedel, 2003[6]).

In Japan, there is a public long-term care system which requires those from 40 to 64 years of age to financially contribute which is automatically collected through the public health care system. While it is comprehensive, given that 29 percent of the population is over 65, the public long-term care system often does not have sufficient capacity to accommodate those that require institutional care. Thus, the bulk of long-term care is provided by the public system, although due to the limited space in public care, some insurance companies provide institutional care as part of their policies as well as offering preventative services.

In Austria, there are considerable differences between the various private long-term care insurance products, particularly in terms of entitlement to claims and premiums. There are two types of entitlements: The entitlement to benefits is based on the classification under the statutory long-term care system according to the Federal Care Allowance Act (BPGG) (care level) and on the selected tariff. Once the need for care has been determined, a monthly pension is paid out on top of the public pension. Or the entitlement is based on the specific needs of the person concerned. If certain everyday activities (for example dressing, eating, using the bathroom, general mobility) can no longer be carried out without outside support due to the need for care, the monthly pension is paid out.

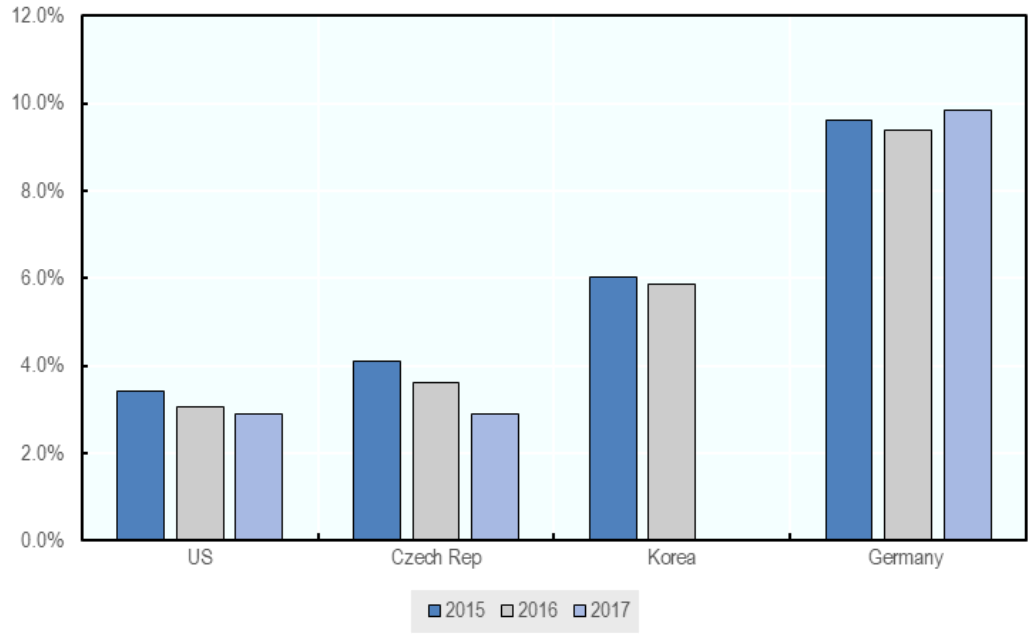
The premiums paid for private long-term care insurance in Austria are generally high, but decrease the earlier the insurance is taken out. Some insurers already offer private long-term care insurance for children, other products can only be taken out from the age of 35.

Not all countries have long-term care as part of their public health system. In countries with no public long-term care system, private long-term care coverage may be the only alternative for an individual, other than relying on community or family care. In spite of that, in most countries, the share of people who choose to purchase private long-term care insurance is relatively low. The amount of gross written premiums paid annually is not high, and when compared to the total public expenditure on long-term care it is a fraction (see Figure 4.1).

In some countries, long-term care insurance is not available (Australia, Chile, Colombia, Estonia, Netherlands, Russia, United Kingdom). In other countries, long-term care insurance is often part of other insurance products (Belgium (health), Costa Rica (life), Czech Republic (life), Finland (life), Germany (life and health), Israel (health and life), Japan (health and life), Korea (life and annuities), Switzerland (health), and United States (life and annuities), and the data cannot be easily disaggregated. On the other hand, countries that do offer stand-alone long-term care insurance products are Austria, Chinese Taipei, Czech Republic, Germany, Hungary, Japan, Korea, Lithuania and the United States.

Countries have noted that private long-term care insurance may not be offered due to the adverse competition and high claim experience in the past (US) or lack of demand (UK)(OECD, 2020).

Figure 4.1. The ratio between gross written premiums paid and public expenditure on long-term care, 2015-2017



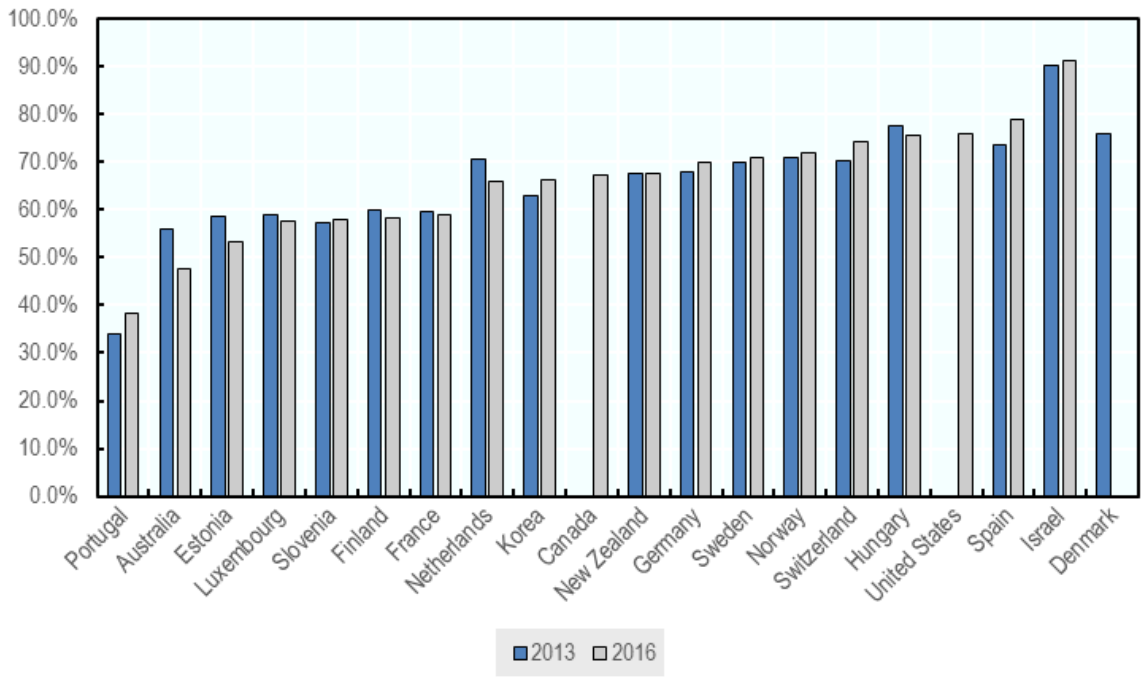
Source: OECD Questionnaire.

One possible reason for the limited size of the market for long-term care insurance may be the presence of family members who provide informal care and substitute the need for formal care. The role that family and community play in the provision of care varies, and depends on the degree of substitutability between formal and informal care, as well as the level of altruism in the society (Klimaviciute, Pestieau and Schoenmackers, 2019). In several countries, an increase in the share of aging-in-place and home care over institutional care, partially assisted by technological advances have contributed to this care situation, as well as changes in health systems. It can also be explained by personal and cultural preferences (Alders and Schut, 2019[7]).

According to available data, in most countries, the role of family and informal care still plays a significant part in the long-term care provision, and it is historically the more common method of long-term care. In Austria, for example, it has been estimated that 70-80 percent of the elderly who are in need of long-term care rely on the assistance of their family. In Japan, of those eligible for public long-term care cover, 80 percent are being cared at home.[6] Almost all countries have a higher number of long-term care (LTC) recipients who receive care at home than the number of those who receive care in formal institutions (other than hospitals). On average, the share of LTC recipients at home is around two-thirds of all LTC recipients (see Figure 4.2). Portugal is the only country in the sample where the share of LTC recipients in formal institutions is higher than those who receive informal care. In Israel, more than 90 percent of patients receive home care.

The high share of informal care by family and community may also be explained by necessity due to the lack of alternatives – if a person does not have coverage that enables access to formal care, family and community are likely to step in. The prohibitive cost of formal care, and the lack of awareness of potential benefits of having long-term care insurance products, which, with planning, could establish a better financing plan for care, could also contribute to the size of the market.

Figure 4.2. Share of LTC recipients at home out of total LTC recipients aged 65 and over



Source: OECD Stats, 2013 and 2016.

The Netherlands is an example of a country that chose to rely on informal care and aging-in-place as a substitute for the increasing expenditure on long-term care. Before 2015, The Netherlands was characterised by a high level of public expenditure on long-term care relative to GDP. The high expenditure is partially explained by high levels of institutionalisation with 3 percent of GDP spent on residential long-term care facilities in 2014 (OECD stats). Spending on long-term care accounted for one third of the total expenditure on health at the time (Bakx, O'Donnell and van Doorslaer, 2016[8]).

Box 4.1. Dutch reform of long-term care system

Due to budget cuts in 2015, the Dutch government implemented a reform that aimed to promote and facilitate aging-in-place (remaining to live in the community with some level of independency) over care homes. One of the pillars in the reform focused on limiting access to care homes, with eligibility determined by the severity, and restricted only to those who require permanent 24 hours care (Krabbe-Alkemade et al., 2020[7]).

Assessing the impact of such reform on the quality of care is difficult, as once a substantial share of care provision is carried out at home by informal caregivers, there is no standardised monitoring of care quality. However, putting more emphasis on informal care may allow for greater flexibility and personalised care, as well as provision of care closer to home. On the other hand, the accessibility and availability of long-term care services became problematic for elderly people who have no social network that could support them (Jongen, 2017). Interestingly, and contrary to the expectations, the data shows a moderate decline in the share of patients who receive care at home from 2015 on.

Informal care or ageing-in-place options as a substitute for public long-term care has advantages and can constitute a solution for countries that see increasing budget constraints and still provide care to the population in need. However, reducing the public expenditure on long-term care may impact the accessibility of services for some.

While Japan has the highest longevity, the gap between the average life expectancy and healthy life expectancy has widened, leading to longer periods that require long-term care and medical treatment. In addition, the trend toward nuclear families has led to a shortage of long-term caregivers at home. Thus, long-term care insurance which includes early disease detection programmes, such as for dementia, are becoming increasingly important for making care available.

On the other hand, some countries have introduced regulation to support the provision of long-term care insurance. Hungary's regulator released a recommendation in 2014 on pension insurance, which include expectation of such products to ensure the highest possible standard of living for the elderly, although the product is primarily a retirement savings vehicle. The United States' NAIC has a model standard on long-term care insurance, from which most states base their regulation of long-term care insurance products. This may have contributed to the take up of long-term care insurance products.

In Chinese Taipei, the financial regulator approved model provisions for long-term care insurance policies in 2015, providing a standardised policy for long-term care policies. In addition, responding to the government's Long-term Care Policy of 2017, the life insurance industry launched in-kind payment long-term care insurance products in 2018.

As governments look to decrease their expenditure on the public provision of long-term care services, governments could examine how private market solutions could supplement the public system of long-term care.

5 Conclusion

Public expenditure on health care constitutes a large share of GDP in most OECD countries. Public expenditure on long-term care is not as high as the expenditure on health, but due to the ageing population, it is expected to significantly increase in the coming decades. The proportion of public expenditure on health care and long-term care is expected to rise in most OECD countries, reflecting demographic changes and longevity improvements which is expected to lead to the need for an increase in care, in particular for long-term care, strong.

Countries are trying to address their current and expected expenditure in these two areas in a way that would maintain proper care for their citizens and residents. Private insurance market could be part of the solution, as it can offer substitutional and additional services in accordance with demand, and thus distributing some of the burden. Private insurance also provides a pricing framework for health and long-term care services, which could make services more efficient and streamlined.

Understanding the main reasons and motivations for people to purchase private insurance is key to better leveraging the private insurance market for the needs and service of the public care system. Some of these reasons may derive from dissatisfaction with overall or particular characteristics of the public care system, while others might be in connection to the added value that certain insurance products offer. The reasons for purchasing private health insurance may be quite different from those that motivate individuals to purchase long-term care insurance, due to the different nature of these two products.

The services, or lack thereof, of the universal care system will influence the choice to purchase private coverage. It is plausible that people would turn to the private market if public services are not available or accessible, either due to ineligibility status or high costs. However, the data does not demonstrate a clear correlation between the existence or availability of the public health system and the share of people who opt for private insurance coverage.

One of the complications both in terms of analysing expenditure, as well as understanding of coverage by policyholders, is that long-term care is often part of health care provision in many countries. Related to this, when policyholders consider the purchase of private health insurance policies, the coverage relative to public health care is often unclear or complicated leading to a poor understanding of whether they would benefit from private health insurance. This is the case for long-term care insurance, when health care coverage may be covering some aspects of care. Or long-term care is not offered with private insurance coverage, which is likely affected by long-term care being primarily provided by family and communities.

Certain characteristics of the public health system may partially explain why individuals choose to purchase cover in the private insurance market. These characteristics may be the structure of costs, the level of out-of-pocket payments required in time of service provision, and/or in connection with the quality of service provided by public system. In many countries, private health insurance tends to be purchased by higher income households to supplement the services being offered by the public system.

The choice to turn to private insurance market could also be explained by the type of insurance offered, and nature of schemes available in the market (for example, group insurance plans as opposed to individual insurance policies). While there is no significant difference between the share of complementary insurance and supplementary insurance in countries, it is worth noting that countries where insurance

products offered as either complementary or supplementary (or both) see higher share of private coverage than where the insurance market offers a duplicative insurance.

Several factors will influence how individuals and households choose to purchase private coverage for health and long-term care insurance. The decision may not always be based on rational choice and could be affected by a lack of understanding of sometimes complex coverage schemes or how it interacts with the public health care system.

Private long-term care and health insurance do contribute to policyholders receiving better care but there are affordability and risk awareness issues in particular hamper the take up of these insurances. In addition, the affordability of such policies, while the convenience they provide, means that some policies might be better serving higher income brackets which is an unintentional consequence of such policies.

Premiums and pricing levels are also highly relevant, with affordability being a key issue preventing higher take up of private health and long-term care insurance. This is particularly clear when private health insurance is primarily taken up by high income individuals or those belonging to organisations that provide group health policies. Related to this, the out-of-pocket for health care and long-term care and level of deductibles will affect the purchase of private insurance.

The penetration of private health care insurance is widely diverse, with the samples presenting between 6.4 percent and 95 percent of the population having private health insurance in OECD countries. Given that all countries, with the exception of the United States, has universal health coverage, and most OECD countries spend between 2 percent and 10 percent on public health expenditure as a share of GDP (excluding the United States which spends over 14 percent of its GDP), the take up or the manners of its take up of private health insurance being diverse.

Although group insurance schemes often offer lower costs and allow easier access to private health insurance coverage, their relative share in the health insurance market of several countries is low compared to individual health insurance plans.

Capital requirement for insurance and regulation related to products will also impact take up of private health and long-term care insurance. For example, capital requirements of insurers may become prohibitive for insurers when mortality and morbidity rates are taken into account in long-term care insurance in some markets. On the other hand, development of a regulatory regime for long-term care insurance in Chinese Taipei, Hungary, and the United States contributed to a market becoming available for long-term care insurance.

Private health insurance has a role in providing additional or better health care services relative to the public care options available. Private health and long-term care insurance may provide options in terms of elective procedures, hospitals, doctors and rooms/beds that can be accessed. There are also risk prevention and mitigation services that accompany a number of private health and long-term care insurance policies that could assist in achieving better health and well-being outcomes for policyholders. The waiting list for public health and long-term care services appears to be a major issue in a number of countries in terms of assessing the quality of care, although this is likely not the biggest obstacle to service access or quality of care. Private insurance can often overcome these roadblocks with the additional options that are made available to policyholders.

Behavioural aspects may also be an important explanatory factor for individual choice to purchase or not to purchase private insurance coverage. Behavioural analysis is an area that would requires further research and examination. This could be particularly useful in trying to understand the level of awareness of private health and long-term care insurance products, as well as coverage from their public health care system.

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Notes

[1] WHO, Key facts https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

[2] Medicaid is a federal and state program that provides health coverage according to criteria such as low income and disability.

[3] Medicare provides health insurance for elderly people (65 and older), as well as younger people who have a disability and are eligible for social security disability payments.

[4] Private Healthcare Australia, Private Health Insurance Community Rating System <https://www.privatehealthcareaustralia.org.au/consumers/private-health-insurance-community-rating-system/>.

[5] Quality in health care means that the care provided is:

- Effective: achieving desirable outcomes, given the correct provision of evidence-based healthcare services to all who could benefit, but not to those who would not benefit
- Safe: reducing harm caused in the delivery of health care processes
- Patient-centred: placing the patient/user at the center of its delivery of healthcare.

[6] OECD calculations based on Ministry of Health, Labour and Welfare figures from August 2020. https://www.mhlw.go.jp/topics/0103/tp0329-1.html

www.oecd.org/finance/insurance