Technische Universität Berlin

Voluntary health insurance in Europe – a structured introduction into objectives and status-quo

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European Observatory on Health Systems and Policies

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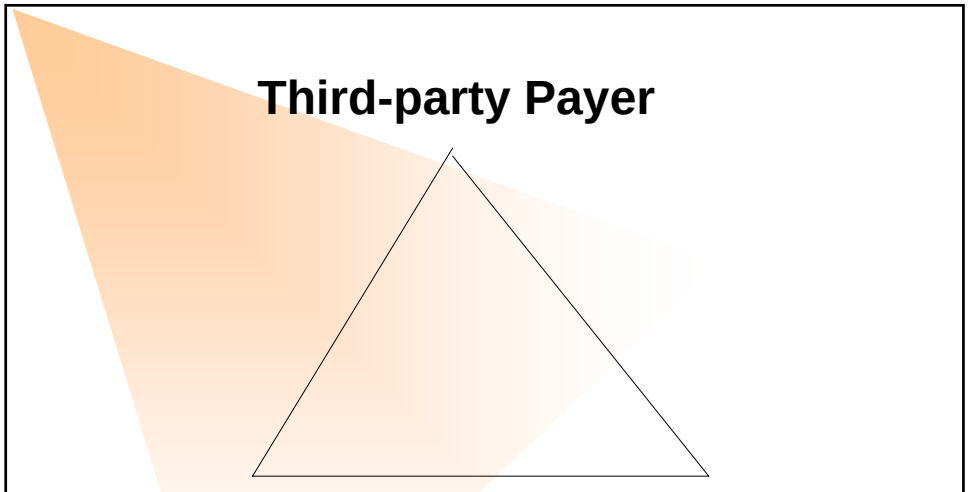

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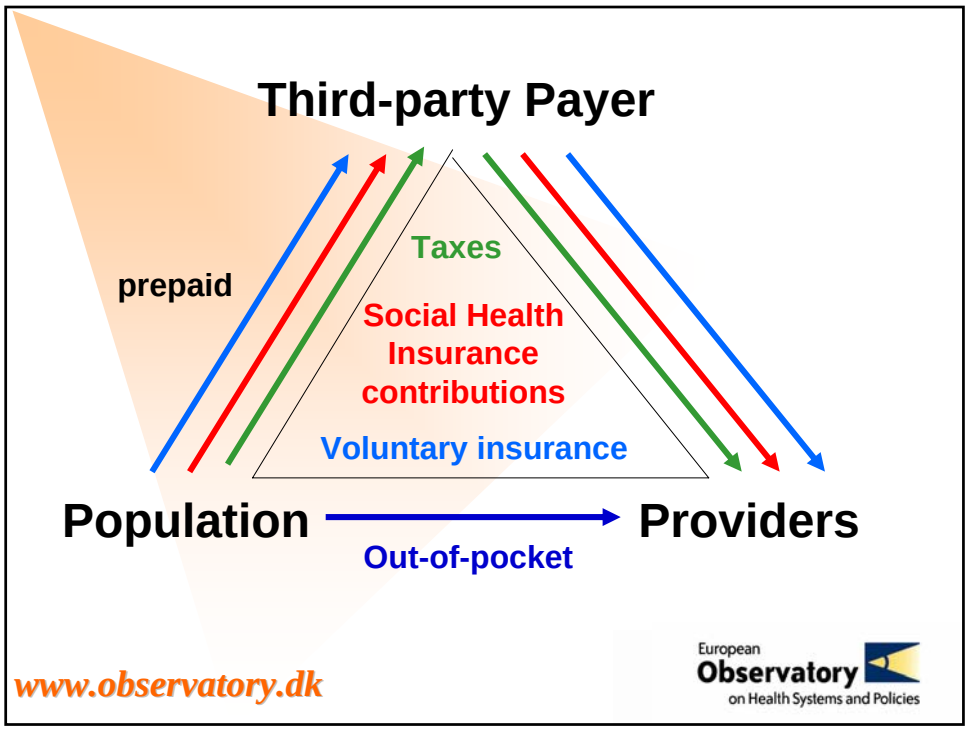
Third-party Payer
prepaid
Taxes
Social Health Insurance contributions
Voluntary insurance
Population
Providers
Out-of-pocket
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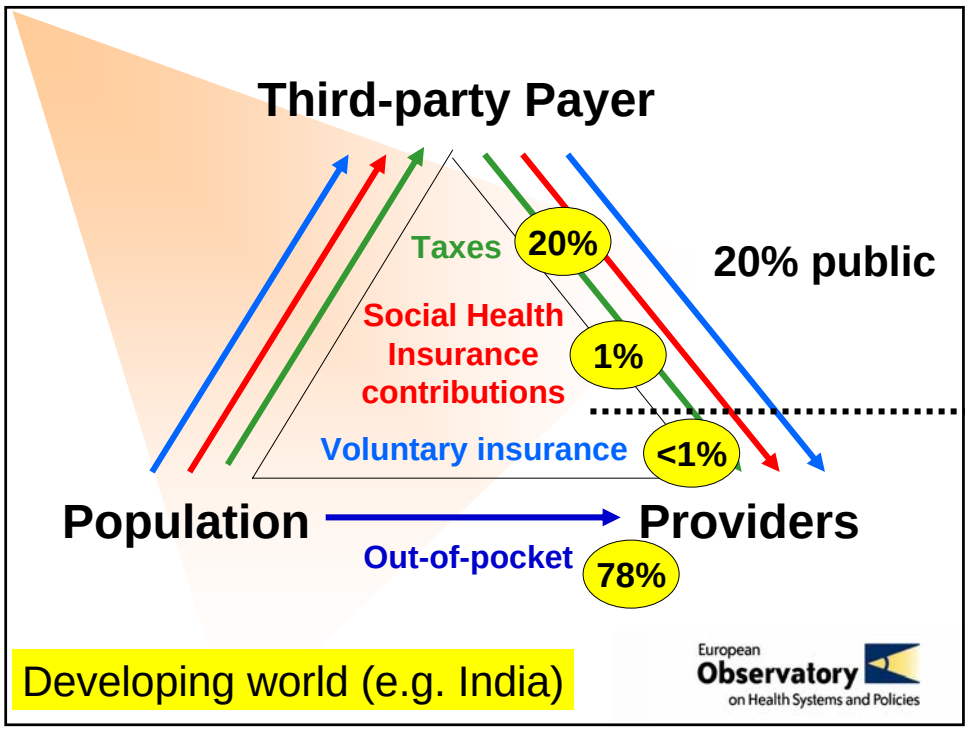
Third-party Payer
Taxes
20%
20% public
Social Health Insurance contributions
1%
Voluntary insurance
<1%
Population
Providers
Out-of-pocket
78%
Developing world (e.g. India)
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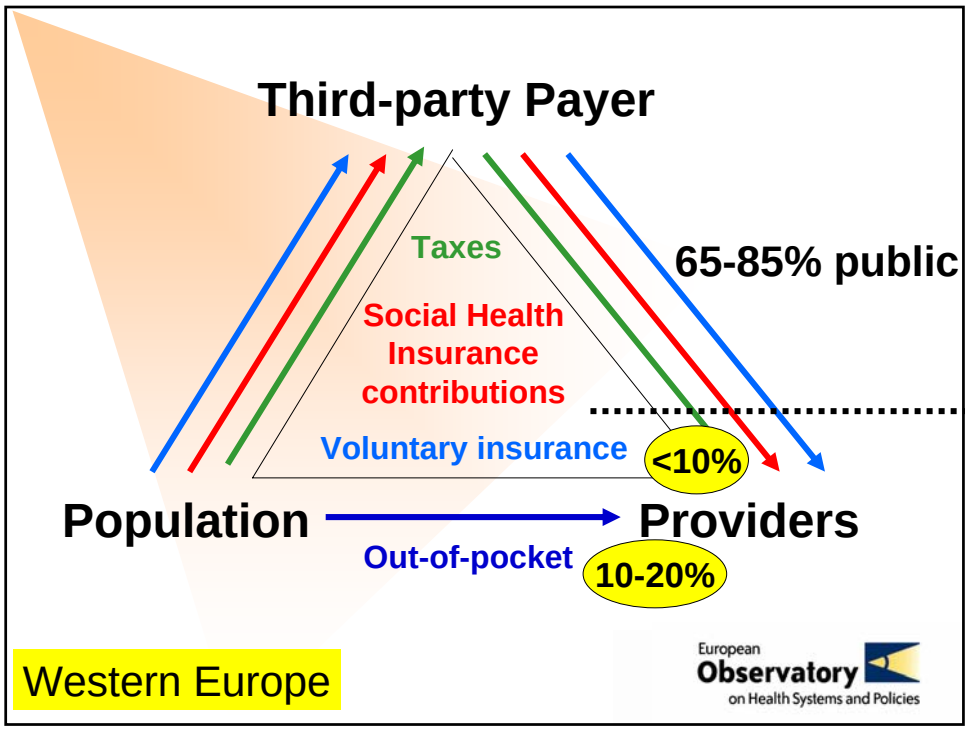
Third-party Payer
Taxes
Social Health Insurance contributions
Voluntary insurance
65-85% public
<10%
Population
Providers
Out-of-pocket
10-20%
Western Europe
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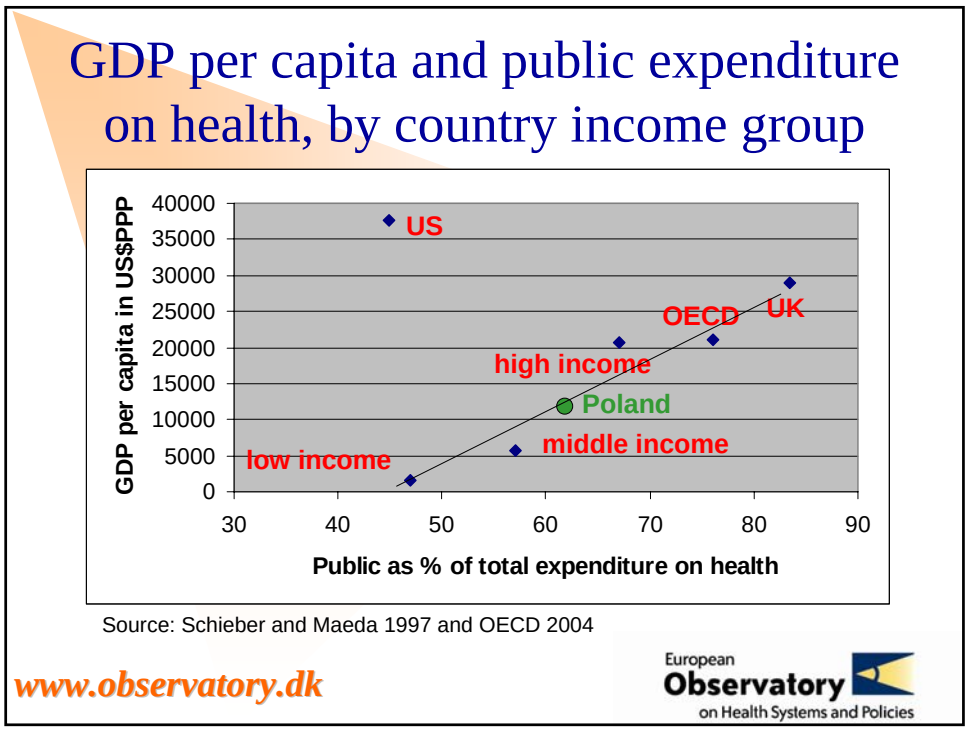
GDP per capita and public expenditure on health, by country income group
GDP per capita in US$PPP
40000
35000
30000
25000
20000
15000
10000
5000
0
US
OECD
UK
high income
Poland
middle income
low income
30
40
50
60
70
80
90
Public as % of total expenditure on health
Source: Schieber and Maeda 1997 and OECD 2004
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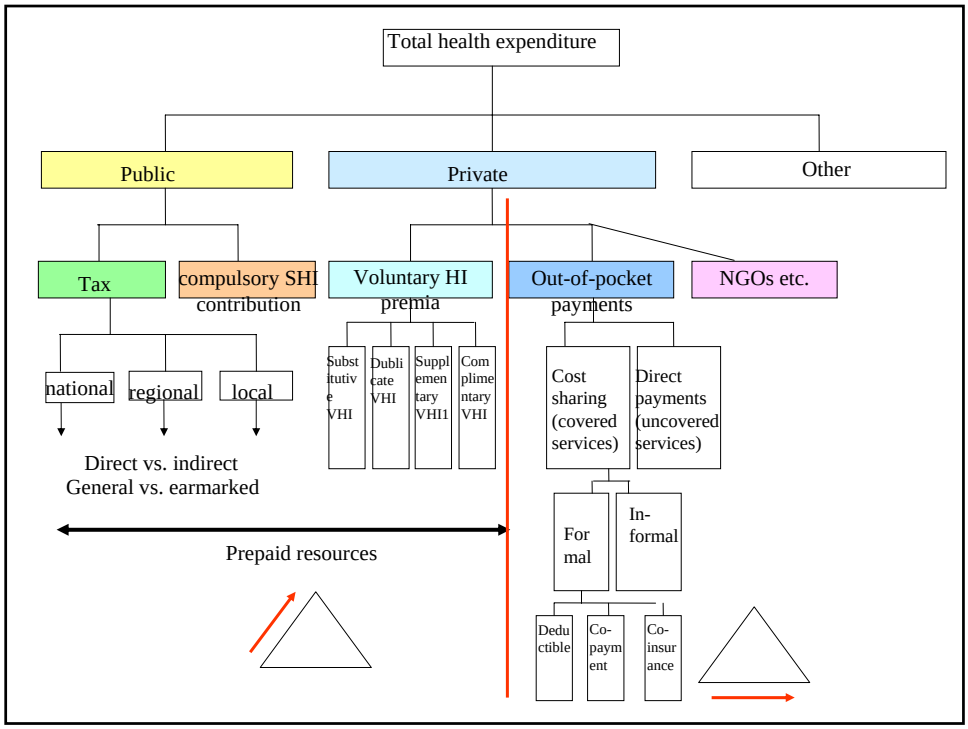
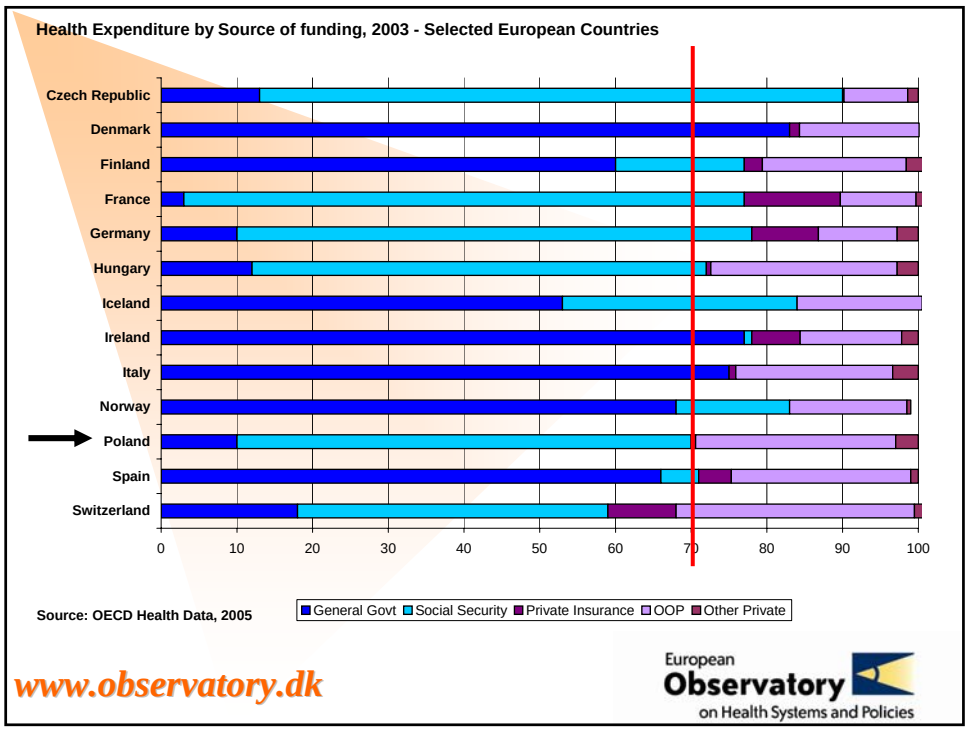

Total health expenditure
Public
Private
Other
Tax
compulsory SHI contribution
Voluntary HI premia
Out-of-pocket payments
NGOs etc.
national
regional
local
Substitutive VHI
Duplicate VHI
Supplementary VHI1
Complimentary VHI
Cost sharing (covered services)
Direct payments (uncovered services)
Direct vs. indirect
General vs. earmarked
Prepaid resources
For mal
In-formal
Deductible
Co-payment
Co-insurance


Health Expenditure by Source of funding, 2003 - Selected European Countries
Czech Republic
Denmark
Finland
France
Germany
Hungary
Iceland
Ireland
Italy
Norway
Poland
Spain
Switzerland
0
10
20
30
40
50
60
70
80
90
100
General Govt
Social Security
Private Insurance
OOP
Other Private
Source: OECD Health Data, 2005
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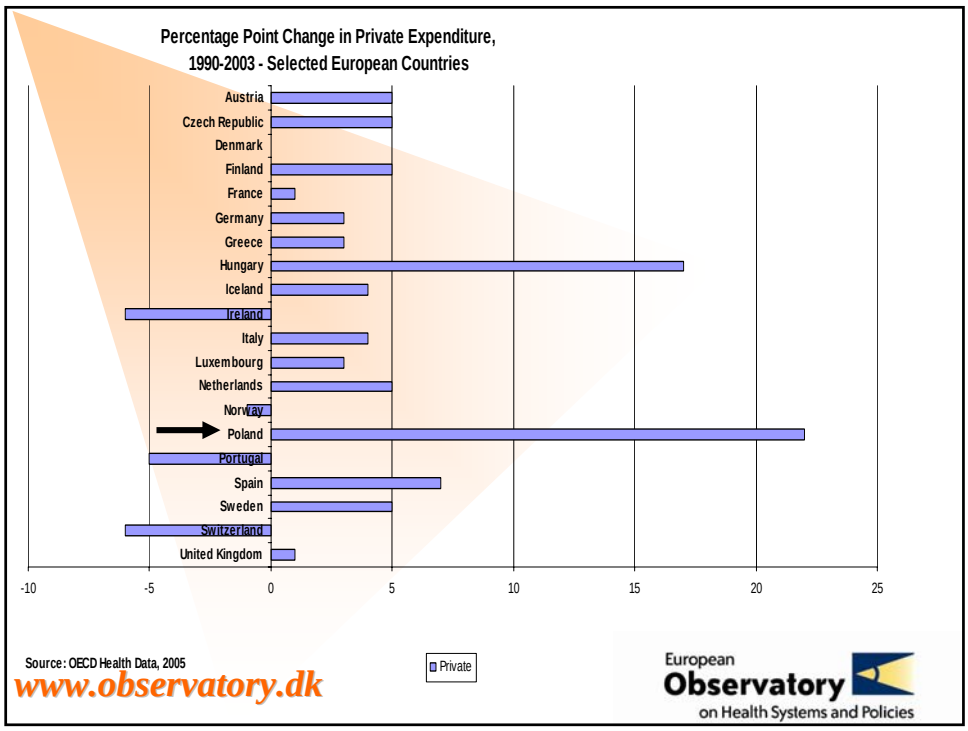
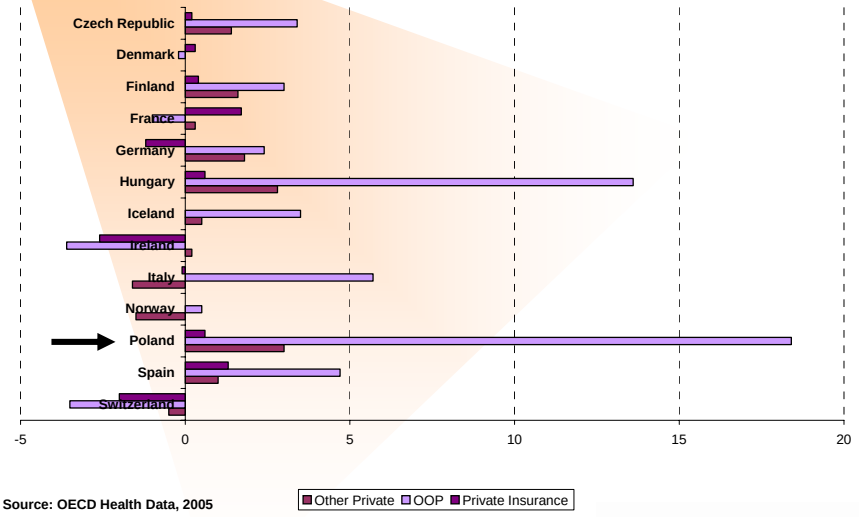
Private expenditure as a % of total
Out of pocket & Private health insurance (2003)

	Out-of-pocket payment	Private Health Insurance	Total Private
Greece	47	2	49
Switzerland	32	9	42
Spain	24	4	29
Italy	21	1	25
Austria	19	8	32
Finland	19	2	24
Denmark	16	1	17
Norway	16	0	16
Ireland	13	6	22
France	10	13	24
Germany	10	9	22
Netherlands	8	Not anymore! 17	38
Luxembourg	7	1	10
Belgium			26
Portugal			30
Sweden			15
UK			17
SHI average	**16.4**	**9.3**	**26**
Tax average	**17.7**	**3.3**	**21**

Notes: Sum of private and OOP may not equal total private due to other private funds
Germany (2000) data; Spain (1991) data Source: OECD Health Data 200



Percentage Point Change in Private Expenditure, 1990-2003 - Selected European Countries



Source: OECD Health Data, 2005

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What is private health insurance?

- **offered by public / quasi-public bodies and for-profit / non-profit private organisations**
- **taken up and paid for at the discretion of individuals / employers on behalf of individuals**
- **the voluntary nature of PHI is the source of major problems . . .**

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What role does PHI play?

- substitutive: **for people excluded or exempt from statutory coverage**
- complementary: **for services excluded / not fully publicly covered, e.g. statutory user charges, drugs, dental care**
- supplementary: **for faster access, increased choice of provider**

But which services are (1) not necessary but (2) demanded?

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Table 5. Levels of VHI coverage as a percentage of the total population

Country	Substitutive	Complementary/supplementary
Austria (1999)	0.2%	18.8% (complementary) 12.9% (supplementary; hospital expenses)
Belgium (2000)	7.1%	30–50% (complementary)
Denmark (1999)	None	28% (mainly complementary; some supplementary)
Finland (1996)	None	Children aged <7: 34.8% (supplementary) Children aged 7–17: 25.7% (supplementary) Adults: 6.7% (supplementary)
France (2000)	Marginal (frontier workers)	85% (1998) (complementary) 94% (2000 estimate) (complementary)
Germany (1999)	9%	9%
Greece (2000)	None	10% (supplementary)
Ireland (2000)	None	45%
Italy (1999)	None	15.6%
Luxembourg (2000)	None	70% (mainly complementary)
Netherlands (1999)	24.7% (+ 4.2% WTZ)	>60% (complementary) Marginal (supplementary)
Portugal (1998)	None	12% (mainly supplementary)
Spain (1999)	0.6%	11.4%
Sweden (1999)	None	1.0–1.5% (mainly supplementary)
United Kingdom (2000)	None	11.5% (mainly supplementary)

Market structure: drivers of PHI market development

Nature of public system

- **scope of coverage: what is covered?**
- **depth of coverage: cost sharing?**
- **system inclusiveness: who is covered?**
- **consumer satisfaction: quality? willingness to pay privately?**

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Why private health insurance?

In theory

- libertarian thought
- allocative efficiency
- technical efficiency
- choice
- innovation
- extra resources
- public funds for poor

In practice

- history: institutions already existed
- covers user charges
- covers excluded services e.g. dental
- faster access
- access to private providers

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Fair but unfair?

- **PHI premiums try to be actuarially fair (ie payment based on risk status)**
- **rationing by price**
- **ill / old / poor cannot afford PHI**
- **gaps in coverage**
- **policy responses: public insurance or market regulation?**
- **community rating and open enrolment**

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Market conduct: price / information

- **actuarially fair premium = expected "loss" plus administration, profit etc.buyers may conceal info about their 'true' risk**
- **high costs for insurers of checking this**
- **adverse selection**
- death spiral

A situation in which individuals are able to purchase insurance at rates which are below actuarially fair rates, because information known to them is not available to insurers (asymmetric information).

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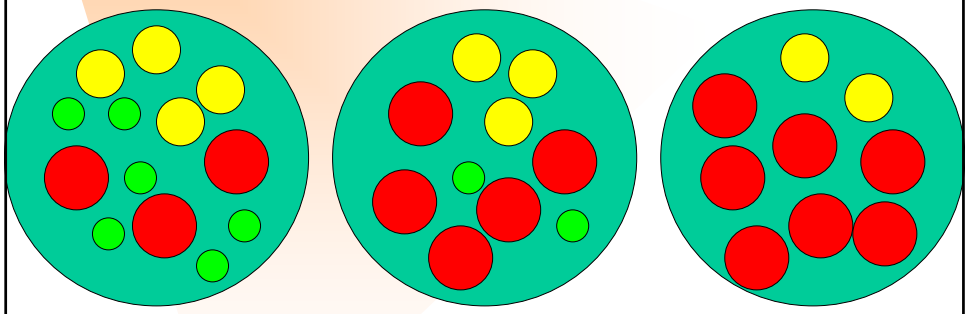
The death spiral . . .



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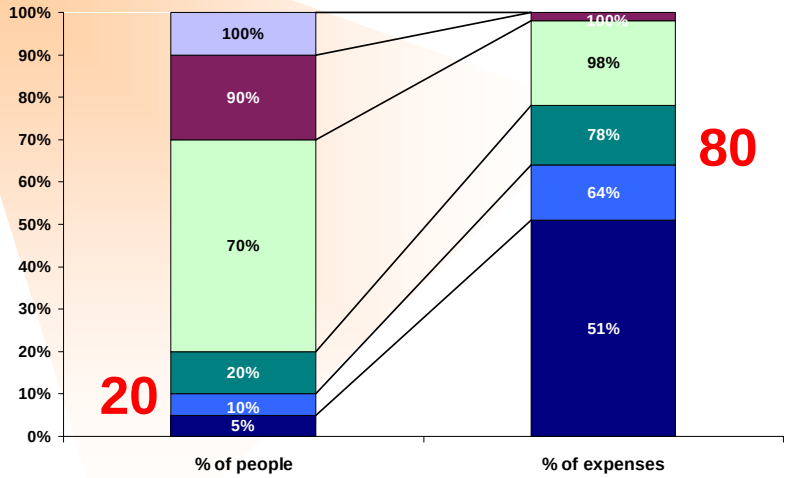
Health insurance: really necessary for relatively few: here in France 2001



Source : CNAMTS/EPAS

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Costs and profits (efficiency)

"[PHI] is bureaucratic and costly, requiring armies of accountants, actuaries, billers, checkers, fraud detectors, lawyers, managers and secretaries"

Culyer 1989

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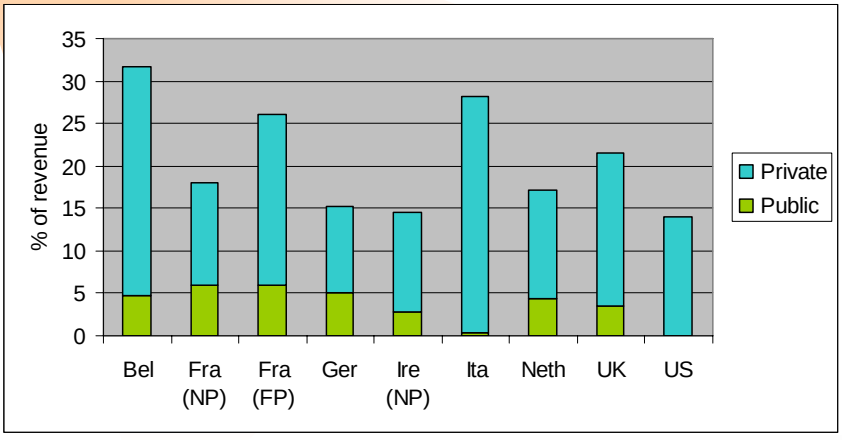
Administrative costs as % of revenue, late 1990s



Source: Mossialos and Thomson 2002

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Implications for equity

- **usually regressive in funding health care (Wagstaff et al. 1999)**
- **tax subsidies regressive / expensive**
- **lowers equity in the use of doctors (van Doorslaer et al. 2001)**
- **affordability / access: coverage gaps (but nature of regulation depends on PHI's role)**
- **potential to distort public resource allocation**

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"Breakable bones, a tendency to bleed when cut, vulnerability to germs and viruses. These are all preexisting conditions."

Voluntary health insurance
Summary

- Only limited scope
- Efficiency / administrative costs
- Equity concerns
- Necessary government regulation (access)
  - Open enrolment, risk equalization, life time cover, standardised benefit packages
  - Clarifying the boundaries
- Role of EU internal market directives

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