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

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Third-party Payer

Population

Providers

Taxes
Social Health Insurance contributions
Voluntary insurance

prepaid
Out-of-pocket

www.observatory.dk

Developing world (e.g. India)

20% public

20%
1%
<1%
78%

http://mig.tu-berlin.de
Third-party Payer

- Taxes
- Social Health Insurance contributions
- Voluntary insurance
- Out-of-pocket

Western Europe

GDP per capita and public expenditure on health, by country income group

Source: Schieber and Maeda 1997 and OECD 2004

www.observatory.dk
### Private expenditure as a % of total

#### Out of pocket & Private health insurance (2003)

<table>
<thead>
<tr>
<th>Country</th>
<th>Out-of-pocket payment</th>
<th>Private Health Insurance</th>
<th>Total Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greece</td>
<td>47</td>
<td>2</td>
<td>49</td>
</tr>
<tr>
<td>Switzerland</td>
<td>32</td>
<td>9</td>
<td>42</td>
</tr>
<tr>
<td>Spain</td>
<td>24</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Italy</td>
<td>21</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Austria</td>
<td>19</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Finland</td>
<td>19</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Denmark</td>
<td>16</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Norway</td>
<td>16</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Ireland</td>
<td>13</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>France</td>
<td>10</td>
<td>13</td>
<td>24</td>
</tr>
<tr>
<td>Germany</td>
<td>10</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Netherlands</td>
<td>8</td>
<td>17</td>
<td>38</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>7</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Belgium</td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Portugal</td>
<td></td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>UK</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td><strong>SHI average</strong></td>
<td>16.4</td>
<td>9.3</td>
<td>26</td>
</tr>
<tr>
<td><strong>Tax average</strong></td>
<td>17.7</td>
<td>3.3</td>
<td>21</td>
</tr>
</tbody>
</table>

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 2005

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

- Austria
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Italy
- Luxembourg
- Netherlands
- Norway
- Poland
- Portugal
- Spain
- Sweden
- United Kingdom

Source: OECD Health Data, 2005
Percentage Point Change in Private Expenditure, 1990-2003 - Selected European Countries

Source: OECD Health Data, 2005

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 . . .
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**

<table>
<thead>
<tr>
<th>Country</th>
<th>Substitutive</th>
<th>Complementary/Supplementary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria (1999)</td>
<td>0.2%</td>
<td>12.9% (complementary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18.8% (complementary; hospital expenses)</td>
</tr>
<tr>
<td>Belgium (2000)</td>
<td>7.1%</td>
<td>30-50% (complementary)</td>
</tr>
<tr>
<td>Denmark (1999)</td>
<td>None</td>
<td>28% (mainly complementary; some supplementary)</td>
</tr>
<tr>
<td>Finland (1996)</td>
<td>None</td>
<td>Children aged &lt;7: 34.8% (supplementary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Children aged 7-17: 25.7% (supplementary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adults: 5.7% (supplementary)</td>
</tr>
<tr>
<td>Germany (1999)</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Greece (2000)</td>
<td>None</td>
<td>10% (supplementary)</td>
</tr>
<tr>
<td>Ireland (2000)</td>
<td>None</td>
<td>45%</td>
</tr>
<tr>
<td>Italy (1999)</td>
<td>None</td>
<td>15.6%</td>
</tr>
<tr>
<td>Luxembourg (2000)</td>
<td>None</td>
<td>70% (mainly complementary)</td>
</tr>
<tr>
<td>Netherlands (1999)</td>
<td>24.7%</td>
<td>&gt;60% (complementary)</td>
</tr>
<tr>
<td></td>
<td>(+ 4.2% WTZ)</td>
<td>Marginal (supplementary)</td>
</tr>
<tr>
<td>Portugal (1998)</td>
<td>None</td>
<td>12% (mainly supplementary)</td>
</tr>
<tr>
<td>Spain (1999)</td>
<td>0.6%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Sweden (1999)</td>
<td>None</td>
<td>1.0-1.5% (mainly supplementary)</td>
</tr>
<tr>
<td>United Kingdom (2000)</td>
<td>None</td>
<td>11.5% (mainly supplementary)</td>
</tr>
</tbody>
</table>
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?

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
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 enrollment

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).
The death spiral . . .

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

Source: CNAMTS/EPAS

www.observatory.dk

% of people % of expenses

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

20 51% 70% 90% 100% 5% 10% 20% 40% 60% 80% 98% 99%
Costs and profits (efficiency)

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

Culyer 1989

Administrative costs as % of revenue, late 1990s

Source: Mossialos and Thomson 2002
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

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

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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