Private health insurance in the European Union

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List of abbreviations

ABC1	upper middle class, middle class and lower middle class (demographic classifications in the UK and Ireland)
ABI	Association of British Insurers
AIM	Association Internationale de la Mutualité
CAM	complementary and alternative medicine
C2DE	skilled working class, working class, those at lowest level of subsistence (demographic classifications in the UK and Ireland)
CEA	Comité Européen des Assurances
CEE	central and eastern Europe
CFI	Court of First Instance
CMU	*Couverture Maladie Universelle*
CMU-C	*Couverture Maladie Universelle Complémentaire*
COBRA	Consolidated Omnibus Budget Reconciliation Act (US)
C(S)	complementary PHI cover of excluded services
C(UC)	complementary PHI cover of user charges
DKK	Danish *kroner*
DRG	diagnosis-related group
EC	European Community
ECJ	European Court of Justice
EHIF	Estonian Health Insurance Fund
ERISA	Employment Retiree Income Security Act (US)
EU	European Union
FFS	fee for service
FFSA	Fédération Française des Sociétés d'Assurances
FMA	Financial Market Authority (Austria)
FSA	Financial Services Authority (UK)
GDP	gross domestic product
GKV	*Gesetzliche Krankenversicherung*
GP	general practitioner
HF	Hungarian *forint*
HHS	Health and Human Services (US)
HIA	Health Insurance Authority (Ireland)
HIPAA	Health Insurance Portability and Accountability Act (US)
HMO	Health maintenance organisation
IPT	insurance premium tax
IVF	in-vitro fertilisation
MCO	managed care organisation
MISSOC	Mutual Information System on Social Protection in the Member States of the European Union
MSA	medical savings account
NHS	National Health Service (UK) or National Health System (Greece, Italy, Portugal, Spain)
NICE	National Institute for Health and Clinical Excellence (UK)
NIMES	non-insured medical expenses scheme (UK)
OECD	Organisation for Economic Co-operation and Development

OFT	The Office of Fair Trading (UK)
OOP	out of pocket
PD	*per diem*
PHI	private health insurance
PKV	Verband der privaten Krankenversicherung/German Association of Private Health Insurers
PMI	private medical insurance
POS	point of service
PPN	preferred provider network
PPO	preferred provider organisation
SCHIP	State Children's Health Insurance Program (US)
SGEI	services of general economic interest
SIC	social insurance contributions
TEH	total expenditure on health
UC	user charges
VHI	voluntary health insurance
WHO	World Health Organization

Country abbreviations

AT	Austria
BE	Belgium
BG	Bulgaria
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HU	Hungary
IE	Ireland
IS	Iceland
IT	Italy
LI	Liechtenstein
LT	Lithuania
LU	Luxembourg
LV	Latvia
MT	Malta
NL	Netherlands
PL	Poland
PT	Portugal
RO	Romania
SE	Sweden
SI	Slovenia
SK	Slovakia
UK	United Kingdom
US	United States

Executive summary

This report provides an overview and analysis of markets for private health insurance (PHI) in the European Union (EU). Part 1 reviews market role, size, structure and conduct and public policy towards PHI. Part 2 focuses on the impact of EU law on public policy towards PHI. Part 3 examines the policy implications of PHI. It looks at the impact of PHI on health policy objectives within the market and on the wider health system. It also discusses barriers to market development and public debate about the current and future role of PHI.

Every country in the European Union allows PHI to operate alongside publicly-financed (statutory) health insurance, but there is enormous diversity in the role PHI plays within the health system and in the size and functioning of different markets for PHI. It is difficult to think of PHI in isolation from statutory health coverage, particularly in the European Union, where PHI is never the only or even the main source of coverage. The dominance of statutory coverage means that markets for PHI are heavily shaped by the rules and arrangements of the publicly-financed part of the health system. It also means that PHI generally plays a modest role, although there are notable exceptions.

Market role
Many member states have a market for private health insurance that supplements public coverage (for example, Poland, Romania, Spain, the UK). A **supplementary** market usually offers access to health services that are already covered by the statutory health system, but gives subscribers greater choice of provider (often private providers) and enables them to bypass waiting lists for publicly-financed treatment. There are contexts in which PHI plays a more significant role. For example, **complementary** PHI can cover **services** that are excluded from the statutory benefits package (Denmark, Hungary, the Netherlands), or it may reimburse the costs of statutory **user charges** and extra billing by doctors (Belgium, France, Latvia, Slovenia). Complementary markets for PHI aim to improve access to health care that is either not covered or not fully covered by the statutory health system. In other member states PHI provides **substitutive** cover for people not eligible for some of all forms of statutory health coverage (the Czech Republic, Estonia) or for those who are not required to be statutorily covered and can opt into or out of the statutory scheme (Germany). Understanding these differences is important because market role is closely linked to market size, largely determines the way in which a market is regulated and may indicate the likely effect of the market on public policy goals.

PHI markets in the newer member states mainly play a supplementary role. The key exceptions are the large market for complementary cover of statutory user charges in Slovenia and the very small substitutive markets in the Czech Republic and Estonia. The most significant changes in market role have occurred in the older members states. Expansion of statutory health insurance in Belgium and the Netherlands has effectively abolished two markets for substitutive PHI, while the Irish market has developed over time from substitutive PHI to a mixture of supplementary and complementary PHI. An emerging market for supplementary PHI in Denmark has experienced rapid growth in the last five years.

Market size
PHI does not make a significant contribution to total health spending in the European Union. In 2006 it accounted for under 10% of total health expenditure in every member state except France (12.8%) and Slovenia (13.1%) and for under 5% in two-thirds of member states. The third largest market, in terms of PHI spending, is in Germany (9.3%). Between 1996 and 2006, spending via PHI experienced some growth in two-thirds of member states, but in general market size has remained relatively stable over time. The largest declines in PHI as a proportion of total spending on health care occurred in the Netherlands and the UK. PHI is also relatively low as a proportion of private spending on health care, accounting for less than 25% in 2006 in most member states.

There is large variation in the proportion of the population covered by PHI in different member states. The markets with the highest levels of coverage are those covering statutory user charges in France (92%), Luxembourg (91%), Slovenia (74%) and Belgium (73%). The Netherlands is unique in having a very high level of coverage for its mixed complementary (services) and supplementary market (92%). Ireland also has a relatively high level of coverage (51%), the exception among supplementary markets, which usually only cover up to around 10% of the population. Levels of population coverage have increased significantly in Denmark (largely due to the introduction of tax incentives for group cover in 2002), France (as a result of the introduction of CMU-C in 2000) and Ireland (due to a combination of economic growth, generous tax relief and lack of confidence in the public system). In other countries it has remained stable.

When market size is measured in terms of premium income, Germany has by far the largest market for PHI, accounting for almost half of total premium income in the European Union, followed by France, Spain and the UK.

Buyers
The extent and quality of statutory health coverage are major determinants of demand for PHI. Income is another important determinant. In many countries the typical subscriber is aged 40-50 years old, relatively well off, better educated, employed as a white collar worker (often at management level or higher), working for larger companies or self employed, living in urban areas and male. Group cover purchased (but not always paid for) by employers has maintained (and in some cases gained) a significant share of the market in many member states.

Sellers
Entities providing PHI include mutual and provident associations, commercial companies, statutory health insurance funds and employers. Mutual and provident associations have dominated the PHI market in many western and northern European countries, but their share of the PHI market has declined since the 1990s due to the entry of commercial insurers. In some countries, commercial insurers are the only source of PHI. The number of private insurers operating in each member state varies from five or fewer to around fifty to a hundred; France is the outlier with almost 1,000. The PHI market is highly concentrated in many countries: in 2006 the three largest private insurers had a market share of over 50% in most member states.

Policy conditions and premiums

Access to PHI is usually restricted to people aged under 65 and offered as a short-term (annual) contract. Private insurers offering voluntary cover are generally free to reject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums on the basis of individual health risk, set limits to benefits and impose waiting periods and cost sharing. In recent years tighter regulation has been applied to substitutive PHI in Germany and complementary PHI covering statutory user charges in Belgium, France and Slovenia. The Irish market is also tightly regulated. As a result, these markets are broadly characterised by open enrolment, lifetime cover and regulated premiums. The aim of increased regulation has been to improve access to PHI, particularly for older people, less well off people and people with chronic conditions, all of whom would otherwise find it difficult and/or expensive to obtain PHI cover. Group cover also often benefits from community-rated premiums and less stringent policy conditions.

Consumer choice

Consumers usually have some choice of private insurer, of products or plans, of level of benefits and of provider. However, it may be difficult for older or people with pre-existing conditions to move from one insurer to another, as most new policies will be priced according to current age and health status. Similarly, the lack of standardised benefits and extensive product differentiation may undermine price competition unless centralised sources of information help consumers to compare products in terms of value for money. Consumer and competition authorities have found evidence of consumer detriment due to product differentiation in several countries.

Choice is frequently circumscribed by eligibility criteria (for example, people aged 60 and over are not usually allowed to buy PHI), health status (many private insurers can reject applications if the applicant is considered to be too high risk) or ability to pay (PHI is only available to those who can afford the premium). In addition, the extent of choice available to those who are publicly covered has increased in many countries in recent years. Thus, while it is broadly true that PHI enhances consumer choice, the gap between the level of choice available to publicly and privately insured patients has narrowed over time.

Relations with providers

Some private insurers are integrated with providers. While this is the exception rather than the norm, there has been a move towards greater integration in some countries, as well as increased effort to engage in selective contracting. However, insurers have generally been cautious in attempting to strengthen purchasing as vertical integration and/or selective contracting may be unpopular with subscribers if they restrict consumer choice of provider. Most private insurers pay providers retrospectively on a fee-for-service basis and the fees they pay are usually higher than the fees paid for publicly-financed health care. Private insurers in some countries make use of private beds in public hospitals. In almost every country doctors are allowed to practise in the public and the private sector.

Insurer costs and profit

PHI is a profitable business in many countries. Although private insurers often incur administrative costs that are much higher as a proportion of total revenue than those found in the statutory health system, they are still able to maintain healthy profit margins; claims expenditure as a proportion of premium income is well under 75% in about half of all member states.

Regulation
In many countries PHI is regulated in the same way as any other financial service, particularly where commercial PHI is concerned and/or in predominantly supplementary markets. National regulation goes beyond general insurance requirements in PHI markets with a strong mutual or non-profit tradition and where the market plays a substitutive role or a complementary role covering statutory user charges. In the last 15 years the degree of regulation in these markets has increased, mainly to improve access to PHI.

The PHI market is typically regulated by some form of national financial market authority or supervision commission under the jurisdiction of the Ministry of Finance. Ministry of Health or Ministry of Social Security involvement in regulation of commercial PHI is rare; it is more common for regulation of non-profit PHI. Non-profit private insurers are often subject to a separate legal framework and overseen by a different regulatory body from commercial insurers.

In 1994 the European Union established a regulatory framework for private health insurance (the Third Non-Life Insurance Directive). This broadly precludes non-financial regulatory intervention in non-substitutive markets and has provoked controversy and national and/or European case law in Belgium, France, Germany, Ireland, the Netherlands and Slovenia.

Fiscal policy
Many countries use tax incentives to encourage the take up of PHI, although these have been abolished or lowered in several countries in the last five to ten years, without much negative effect on demand for PHI. While generous tax subsidies have succeeded in fuelling demand for PHI in a few countries (notably Hungary and Ireland), they are unlikely to be self-financing and lower equity in financing health care. The use of fiscal policy to benefit some types of insurer over others is generally outlawed by EU law.

Policy implications
The way in which PHI operates often undermines health policy objectives within the market (which may differ from policy objectives for the market), notably financial protection, equity in finance and equity of access to health care. However, this is generally only a matter of public policy concern where PHI contributes to financial protection in the wider health system – which explains the much greater degree of government intervention in substitutive markets and markets providing complementary cover of statutory user charges.

In terms of impact on health policy objectives in the wider health system, the effects of PHI are mixed. Substitutive PHI and complementary PHI covering statutory user charges clearly play an important role in providing subscribers with financial protection. At the same time, however, the existence of PHI undermines other health policy objectives, even where the market is carefully regulated. For example, allowing higher earners to choose between statutory and private coverage in Germany has led to risk segmentation and stretches the resources of the statutory scheme, which not only loses the contributions of higher earners but also covers a disproportionately high risk group of people. In countries where PHI covers statutory user charges, the depth of statutory coverage has been eroded over time and there are concerns about the fact that those who do not have PHI may face financial and other barriers to accessing health care. Where the boundaries between public and private provision are not always clearly defined there is some evidence to show that

public resources may be used to subsidise faster access to health care for those with PHI, who tend to come from higher income groups.

These problems are often a direct result of public policy rather than problems created by the way in which the PHI market operates. For example, allowing providers to charge higher fees to privately-financed patients creates strong incentives to prioritise these patients at the expense of publicly-financed patients. The use of tax relief to subsidise PHI also lowers equity by drawing resources away from publicly-financed health care. Overall, the argument that PHI will contribute to financial sustainability by relieving pressure on public budgets is not supported by evidence. Furthermore, concerns about the impact of changing demographic and labour market conditions on the financial sustainability of employment-based health care finance do not usually extend to markets for PHI, although they should, since in many member states PHI is partly financed by employers.

Market development and public debate

With one or two exceptions, there seems to be a clear divide between the newer and older member states with regard to market development and public debate about PHI. Markets in the older member states tend to be larger, show more diversity in terms of role and are or have been dominated by mutual associations. In contrast, markets in many of the newer member states have struggled to take off, mainly play a supplementary role and are sometimes exclusively commercial.

In many of the older member states public debate about PHI focuses on concerns about the potential for reductions in statutory coverage and growth in PHI to undermine equity of access to health care. In the newer member states the generosity of statutory health insurance is often blamed for slow PHI market development. Consequently, debate about PHI frequently focuses on the need for better delineation of the statutory benefits package. However, the scope and depth of statutory coverage do not seem to be greater in these countries than in the older member states. In fact, in many of them statutory cost sharing is widespread and has increased over time. This suggests that gaps in statutory coverage are not a sufficient pre-requisite for PHI market development, which may be held back by other barriers such as limited ability to pay for PHI, the presence of informal payments, lack of consumer and employer confidence, lack of private infrastructure and lack of insurance know-how.

The report highlights the diversity of markets for PHI across the European Union and notes the difficulty of generalising (frequently scarce) research evidence from one setting to another. The report also emphasises the importance of understanding each market in terms of the context in which it is situated. Nevertheless, different market roles and the way in which these roles interact with the statutory health system are associated with certain policy implications. The report attempts to outline these to raise awareness among policy-makers of the advantages and disadvantages of encouraging the growth of PHI.

Introduction

This report provides an overview and analysis of markets for private health insurance (PHI) in the European Union (EU).

Part 1 describes the different roles PHI plays in relation to statutory health insurance and outlines the size of the market in each country. It reviews the way in which PHI markets are structured and operate and discusses public policy towards PHI. This part of the report describes the status quo and discusses trends (where possible).

Part 2 focuses on the impact of EU law on public policy towards PHI. It looks at the way in which EU internal market and competition rules influence the nature and extent of government intervention in PHI markets.

Part 3 examines the policy implications of PHI. It considers the effect of PHI on public policy goals both within the PHI market and on the wider health system. It also discusses barriers to market development and public debate about the current and future role of PHI.

A note on the text: we have sometimes found it necessary to distinguish between the member states that were part of the European Union prior to 1 May 2004 and those that have joined since that date. We refer to the former as ‘older’ member states and the latter as ‘newer’ member states.

Part 1 Markets for private health insurance in the European Union

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Market role

What is private health insurance?

Every country in the European Union allows PHI to be sold alongside statutory health insurance[1], but there is enormous diversity in the role PHI plays within the health system and in the size and functioning of different markets for PHI. This diversity makes it difficult to define what we mean when we talk about PHI. PHI has been defined as insurance that is taken up voluntarily and paid for privately, either by individuals or by employers on behalf of individuals (Mossialos and Thomson 2002b). This definition recognises that PHI may be sold by a wide range of entities, both public and private in nature – including statutory 'sickness funds', non-profit mutual or provident associations and commercial for-profit insurance companies.

The distinction between voluntary and statutory coverage is important analytically, since many of the market failures associated with health insurance only occur (or are much more likely to occur) where coverage is voluntary (Barr 2004). In practice, however, it is not always useful in determining what counts as PHI. Two examples illustrate this point. In 2006 the Netherlands introduced a universal health insurance scheme that is both *statutory* (since it is compulsory for all residents and carefully regulated by the government) and *private* (since it is operated by private insurers and governed by private law). The universal scheme replaced a system in which higher-earners were excluded from statutory cover and could only obtain cover from private insurers. Conversely, higher-earning employees in Germany can join the statutory health insurance scheme on a voluntary basis – making them *voluntarily* but *publicly* insured – or choose to be covered by a private insurer.

These developments stretch standard definitions of PHI, which is one reason why it may be more constructive to focus on the *role* PHI plays in relation to statutory coverage. The remainder of this report focuses on voluntary health insurance.

What role does private health insurance play in EU health systems?

It is difficult to think of PHI in isolation from publicly-financed health coverage since there are no countries in which PHI is the *only* source of coverage and few in which it is the *main* source of coverage. This is particularly true of the European Union, where almost every country provides universal *statutory* health coverage as part of a wider system of 'social' or 'financial' protection[2]. The dominance of statutory coverage means that markets for PHI are heavily shaped by the rules and arrangements of the statutory health system in which they are located. It also means that PHI generally plays a modest role, although there are important exceptions.

[1] In this report we refer to publicly-financed health coverage as statutory health insurance or statutory coverage, regardless of whether it is organised in the form of a national health service or on the basis of membership of statutory health insurance funds (often referred to as sickness funds).

[2] Social protection aims to protect people from the impact of 'shocks' such as unemployment, the death of a breadwinner or ill health. In this report we use the terms 'social protection' and 'financial protection' interchangeably. Financial protection aims to protect people from the financial risks associated with ill health.

Many member states have a market for private health insurance that supplements public coverage. A **supplementary** market usually offers access to health services that are already provided by the statutory health system, but gives subscribers greater choice of provider – frequently, private providers – and may enable them to bypass waiting lists for publicly-financed treatment. Supplementary cover does not provide additional benefits in terms of the range of health services on offer, but may enhance some aspects of health care quality – particularly faster access to care and care provided in settings with superior amenities. It tends to be purchased by wealthier and better-educated people and, because it covers people and services already covered by the statutory health system, it rarely contributes to financial protection.

There are contexts in which PHI plays a more significant role. For example, **complementary** PHI can cover services that are excluded from the statutory benefits package, as in Ireland, where it is combined with supplementary PHI and covers about 50% of the population (The Competition Authority 2007). Or it may reimburse the costs of statutory user charges, as in Slovenia and France, where it covers over 70% and 92% of the population respectively (Albreht et al 2002; Durand-Zaleski 2008). Complementary markets for PHI aim to improve access to health care that is either not covered or not fully covered by the statutory health system. They may contribute to financial protection either by providing access to health services that are effective and valued by the population (such as dental care, physiotherapy or outpatient prescription drugs); or by lowering financial barriers to accessing publicly-financed health care.

In other member states PHI provides **substitutive** cover for people excluded from some aspects of the statutory health system. This was the case for higher-earning households in the Netherlands prior to the introduction of statutory universal coverage in 2006. The 2006 reforms effectively abolished substitutive PHI in the Netherlands (or extended it to cover the whole population, depending on your perspective)[3]. Self-employed people in Belgium were also excluded from statutory cover of outpatient care prior to 2008 and wealthier households in Ireland were not entitled to publicly-financed hospital care prior to the introduction of universal hospital cover[4]. In addition, substitutive private health insurance covers people who are not required to be statutorily covered, but can choose to opt into or out of the statutory scheme, such as higher-earning employees in Germany.

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[3] We see the Dutch health system as being mainly collectively (publicly) financed because coverage is universal; contributions are set by the government, proportionate to income and collected centrally; the benefits package is defined by the government and standardised across the country; and insurers cannot reject applications for cover. For us the two main differences between the Dutch system and, say, the French, German or Belgian systems, are as follows. First, the health insurance funds can operate on a commercial basis and they are governed under private law as opposed to social security law. This difference is an issue of governance. We do not think it fundamentally alters the collective or public nature of health care finance. For example, Medicare and Medicaid in the United States are widely regarded as public (and publicly-financed) 'programmes' or 'plans' even though they are partly operated by private insurance companies (mainly in the case of Medicaid). Second, insurers are allowed to charge a non-income-related premium in addition to the income-related contribution. This element of the Dutch system (and, from 2009, the German system) does seem to make it lean more towards a private than a public system, although the fact that the premium is subsidised by the government for people with low incomes slightly mitigates an otherwise regressive step. For the remainder of this report, when we refer to PHI in the Netherlands we are referring to its voluntary market for complementary and supplementary PHI and not to its main, compulsory, system of financing health care.

[4] Eligibility for publicly-financed accommodation in hospital was extended to the whole population in 1979 and eligibility for publicly-financed treatment by specialists in hospital in 1991. Those without medical cards still have to pay for outpatient attendance in public hospitals.

Understanding these differences in market role (summarised in Table 1) is important for three reasons. First, the role a PHI market plays is closely correlated to its size, particularly in terms of its contribution to spending on health care, as we discuss in the following section. Second, a market's role largely determines the way in which it is regulated; this has implications in terms of EU competition and internal market rules, which we discuss in Part 2. And third, as a result of its combined effect on market size and on public policy towards PHI, market role may tell us a great deal about the likely impact of PHI on health financing policy goals.

Table 1 Functional classification of PHI markets

Market role	Driver of market development	Nature of cover	EU examples
Substitutive	Public system inclusiveness (proportion of the population eligible for public cover)	Covers people excluded from or allowed to opt out of the public system	Germany
Complementary (services)	Scope of benefits covered by the public system	Covers services excluded from the public system	Denmark, Hungary, Netherlands
Complementary (user charges)	Depth of public coverage (the proportion of the benefit cost met by the public system)	Covers statutory user charges imposed in the public system	Belgium, France, Latvia, Slovenia
Supplementary	Consumer satisfaction (perceptions about the quality of publicly-financed care)	Covers faster access and enhanced consumer choice	Ireland, Poland, Romania, Spain, Sweden, UK

Source: Adapted from Mossialos and Thomson (2002b) and Foubister et al (2006)

Table 2 presents an overview of markets for PHI in the European Union.

Table 2 Overview of markets for PHI, 2008

Country	Market role(s)[e]	Eligibility[f]	Examples of benefits covered	% population covered (2006)	% TEH (2006)
Austria	Complementary (S)	Whole population	Dental and eye care, physiotherapy, home visits, psychotherapy, health resorts, rehabilitation, drugs, CAM	[g]33.0	5.3
	Supplementary		Private wards/hospitals and doctors, choice of hospital doctor, faster access (elective care), per diem cash benefits for inpatient care		
	Substitutive	Occupations opting out of the statutory scheme (some self-employed), individuals not eligible for statutory cover	Similar to statutory cover		
Belgium	Complementary (UC)	Whole population	Reimbursement of statutory user charges and extra billing for inpatient care	≈73.0	5.4
	Complementary (S)		CAM, dental and eye care, vaccines, prostheses and implants, treatment abroad, inpatient and outpatient care		
Bulgaria	Supplementary	Whole population	Superior amenities in hospital, private room, faster access to care	[h]2.0-4.6	0.4
	Complementary (S)		Dental care, medical devices, outpatient pharmaceuticals		
Cyprus	Substitutive[i]	Whole population	Inpatient care, outpatient care, diagnostic procedures, ambulance transport, psychiatry, routine maternity care, physiotherapy, cash benefits, CAM, treatment abroad	20.0	6.7
Czech Republic	Supplementary	Whole population	Private room	n/a	0.2
	Substitutive	Non-residents, self-employed migrants, children of migrant workers with residence permits, foreign students not entitled to statutory cover	Similar to statutory cover, but excludes treatment of some chronic conditions eg HIV/AIDS, drug addiction, mental health, spa treatment etc	<1.0	
Denmark	Complementary (S)	Whole population	Eye and dental care, physiotherapy, psychiatric care, chiropractic,	[j]35.7	1.5

[e] The dominant role is listed first.
[f] Reference to the whole population implies that anyone can in theory purchase this form of cover. In practice, however, many insurers limit the sale of PHI to people aged 65 years or under.
[g] 0.5% of this includes substitutive cover (ie 0.5% of 33.0%).
[h] There are two different estimates for population coverage. The Financial Supervision Commission estimates about 4.6%, a patient rights group estimates about 2.0%.
[i] Once the statutory health insurance scheme is implemented, the role of PHI is expected to be supplementary.
[j] The coverage figures cannot be aggregated as some people are covered twice; this is the case for approximately 15% of people with PHI.

	Supplementary		medical aids, chiropody Choice of doctor, private hospital and diagnostic care, faster access	22.3	
Estonia	Substitutive	Individuals not entitled to statutory cover	Similar to statutory cover, but commercial cover offers different levels of benefit[a]	<0.01	1.1
Finland	Complementary (UC) Supplementary	Whole population	Reimburses statutory user charges for outpatient prescription drugs Private care, faster access	[b](2005) ≈12.0	2.1
France	Complementary (UC) Supplementary Complementary (S)	Whole population	Reimburses statutory user charges Superior amenities in hospital, private room Eye and dental care, elective procedures (eg eye correction surgery)	≈92.0	12.8
Germany	Substitutive	Households with higher earnings, self-employed excluded from statutory cover	Similar benefits to statutory cover	≈10.0	9.3
	Complementary (UC)	Civil servants	Reimburses health care costs not fully covered by the government		
	Complementary (S)	Whole population	Dental care	≈20.0	
	Complementary (UC)		Reimburses statutory user charges for outpatient care		
	Supplementary		Private hospitals, choice of specialist, per diem cash benefits for hospitalisation		
Greece	Supplementary	Whole population	Consumer choice, better quality of services, faster access	(2002) 12.0	1.6
Hungary	Complementary (S) Supplementary	Whole population	Physiotherapy, home care, preventive care, therapeutic spa services, sports/recreation, medical devices, drugs, CAM Superior amenities in hospital	Commercial: 2.1 Mutual: 6.2	1.2
Iceland	Supplementary	Whole population	Private hospital care	Negligible	0.0
Ireland	Supplementary Complementary (UC)	Whole population	Semi-private/private rooms in public/private hospitals, faster access Reimburses statutory user charges	50.9	8.4

[a] The statutory Estonian Health Insurance Fund (EHIF) offers voluntary substitutive cover to those not eligible for statutory cover. Commercial insurers offer a range of policies with varying degrees of cover.
[b] PHI policies are mainly purchased to cover children.

	Complementary (S)		GP visits, physiotherapy, eye and dental care, CAM		
Italy	Complementary (S) Complementary (UC) Supplementary	Whole population	Eye and dental care, home care, cosmetic treatment, prostheses, rehabilitation, transplants, inpatient and outpatient care, CAM Reimburses out-of-pocket payments for drugs Private care	6.1	0.9
Latvia	Complementary (UC) Complementary (S) Supplementary	Whole population[m]	Reimburses statutory user charges Eye and dental care, physiotherapy and massage, rehabilitation, vaccines, hearing aids, prostheses, plastic surgery, IVF, CAM Direct access to specialists, access to non-contracted providers, faster access (consultations and clinical examinations)	(2003) 15.6	1.0
Liechtenstein	Complementary (S) Supplementary Substitutive	Whole population Individuals who opt out of statutory cover	Eye and dental care, ambulance transport, therapeutic spa services, medical devices, CAM Choice of doctor, superior amenities in hospital n/a	66.7	n/a
Lithuania	Supplementary	Whole population[n]	Outpatient care including surgery, consultations, diagnostics, prevention, prenatal care, home visits, physiotherapy, eye and dental care, rehabilitation, inpatient care	0.2	0.4
Luxembourg	Complementary (UC) Complementary (S) Supplementary	Whole population	Reimburses statutory user charges Eye and dental care, treatment abroad, CAM, sickness cash benefits Superior amenities in hospital, private care	Commercial: 25.0 Mutual: 66.0	1.8
Netherlands	Complementary (S) Supplementary	Whole population	Eye and dental care, physiotherapy, speech therapy, cross-border care, some preventive care, some forms of cosmetic surgery, CAM Single room in hospital	92.0	5.9
Malta	Supplementary	Whole population	Treatment abroad, inpatient and outpatient care	20.0	1.8
Norway	Supplementary	Whole population[o]	Private care, elective hospital care, faster access, cash benefits	(2007) 3.5	0.0

[m] Insurers mainly sell PHI to employers on a group basis as opposed to offering cover directly to individuals.
[n] Insurers mainly sell PHI to employers on a group basis as opposed to offering cover directly to individuals.
[o] Most PHI products include a clause saying only residents covered by the National Insurance Scheme are eligible to purchase PHI.

Poland	Supplementary	Whole population	Private care, faster access	[p]3.1-3.9	0.6
Portugal	Supplementary Complementary (S) Complementary (UC) Substitutive	Whole population Some occupational groups	Choice of provider, faster access, direct access to specialist care Dental care Reimburses statutory user charges (eg for outpatient drugs) Similar to statutory cover	15.7 Very low	2.0
Romania	Supplementary	Whole population	Superior accommodation in hospitals, choice of provider, second opinions, private care	0.1	4.0
Slovenia	Complementary (UC) Complementary (S) Supplementary Substitutive	Whole population Individuals not entitled to statutory cover (eg foreigners)	Reimburses statutory user charges CAM, superior dental care, elective care (eg cosmetic surgery), outpatient drugs Superior amenities in hospitals and health spas, superior medical devices, drugs not on positive and intermediate lists, faster access	(2005) 73.8 (2004) <1.0 n/a	13.1
Slovakia	Substitutive	Individuals not entitled to statutory cover	n/a	n/a	0.0
Spain	Supplementary Complementary (S)	Whole population	Private care, faster access Dental care for adults, chiropody, CAM	18.0	6.5
Sweden	Supplementary Complementary (UC)	Whole population[q]	Faster access, private elective care Reimburses statutory user charges for outpatient prescription drugs	(2007) 3.0-3.3	0.3
UK	Supplementary	Whole population	Acute care (ie elective surgery), screening, 'employee health management' processes	10.6	1.0

Source: Authors' estimates based on country reports; expenditure data from WHO (2009)
Note: CAM: complementary and alternative medicine; n/a = information not available; TEH: total expenditure on health.

[p] This figure refers to pre-paid subscriptions for medical benefits. Travel health insurance covers about 1.6% of the population. PHI purchased alongside life insurance covers about 76.4% of the population, but the benefits provided are likely to be marginal.
[q] Insurers mainly sell PHI to employers on a group basis as opposed to offering cover directly to individuals.

Market size

The role PHI plays in a given health system is largely determined by public policy. This in turn may reflect historical developments, political ideology, the relative power and interests of different stakeholders (particularly providers and insurers, but also different groups in the population – for example, civil servants or higher earners) and government capacity to shape and develop the market. The size of a market will also be affected by these factors, as well as by others such as people's willingness and ability to pay for private cover.

Market size can be estimated in three ways: in terms of the contribution PHI makes to levels of spending on health care, in terms of levels of population coverage (that is, the proportion of people covered by PHI in a given population) and in terms of levels of PHI premium income. We discuss each of these in turn.

Contribution to health care finance

Levels of spending on health care vary quite widely across the European Union[18]. Figure 1 shows how health care spending as a proportion of national wealth (gross domestic product; GDP) ranges from around 5% in Estonia to just over 10% in Germany and France. Although each country uses a range of public and private mechanisms to finance health care (see Figure 2), public spending on health care accounts for over two-thirds of all health care spending in most countries (see Figure 3). The last ten years have seen increases in levels of public spending as a proportion of total spending on health care, particularly in countries that have extended statutory coverage – for example, Cyprus, France and the Netherlands – but in other countries too (Austria, Finland, Italy, Latvia, Malta, Romania and Portugal). Declines in the public share of spending on health have occurred in many of the newer member states (Bulgaria, Estonia, Hungary, Poland, Slovakia and Slovenia), and in some of the older ones (notably Greece, Germany and Sweden).

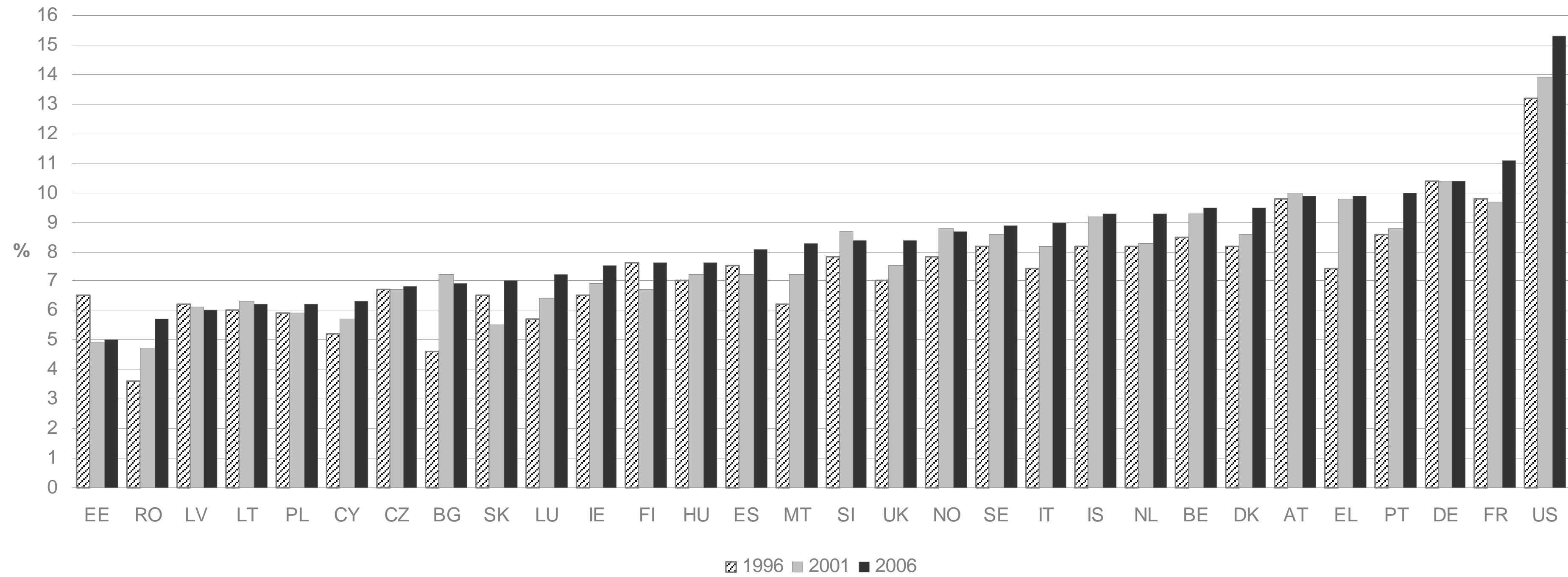
Health care spending channelled through PHI is low in most EU member states. In 2006 it accounted for under 10% of total health care spending in every member state except France (12.8%) and Slovenia (13.1%) and for under 5% in two-thirds of member states (see Figure 4). PHI plays a complementary role in France and Slovenia, reimbursing people for the cost of statutory user charges, which are widely applied. In both countries it covers a very high proportion of the population. The third largest market, in terms of PHI spending, is in Germany, where PHI plays a substitutive role for around 10% of the population. With the obvious exception of Slovenia, PHI as a proportion of total spending on health care is particularly low in the newer member states and in a handful of older member states such as Sweden, Italy and the United Kingdom. Not surprisingly, these countries tend to have supplementary markets, which are characterised by low levels of population coverage.

[18] Some of the figures in this section present data on health care expenditure in Iceland, Norway and the United States. These data are provided for comparative purposes. In the text we refer to the 27 member states of the European only.

Between 1996 and 2006, spending via PHI grew in most member states as a proportion of total spending on health care. The exceptions to this trend were Austria, Finland, Greece, Ireland, Italy, the Netherlands, Slovakia and the United Kingdom (UK). The largest declines in PHI as a proportion of total spending on health care occurred in the Netherlands and the UK. The decline in the Netherlands followed the introduction of universal coverage in 2006, leading to the de facto abolition of its market for substitutive PHI. In the UK the decline probably reflects increased levels of public spending on health care from 2000, as well as improvements in timely access to publicly-financed elective care and rises in the cost of PHI, particularly for individuals.

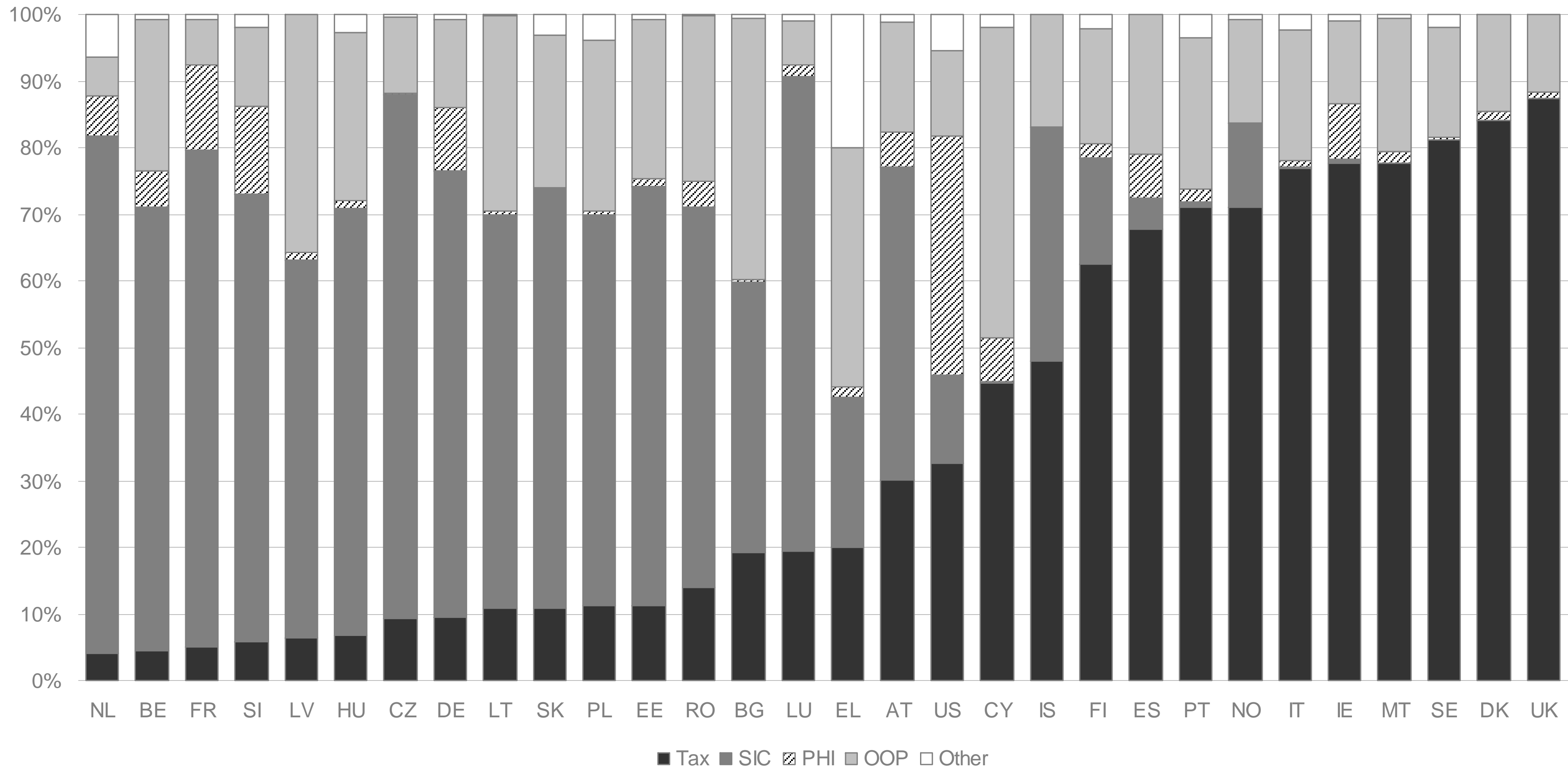
PHI is also relatively low as a proportion of private spending on health care, accounting for less than 25% in 2006 in most member states (see Figure 5). The exceptions were France (63.0%), Slovenia (48.6%), Germany (39.9%), Ireland (38.6%) and the Netherlands (32.3%). The high share of out of pocket payments in private health care may reflect the fact that public policy has relied on other methods of shifting health care costs onto consumers, such as user charges (co-payments and direct payments), rather than promoting and subsidising PHI.

Figure 1 Total spending on health as a proportion of GDP, 1996-2006 (%)



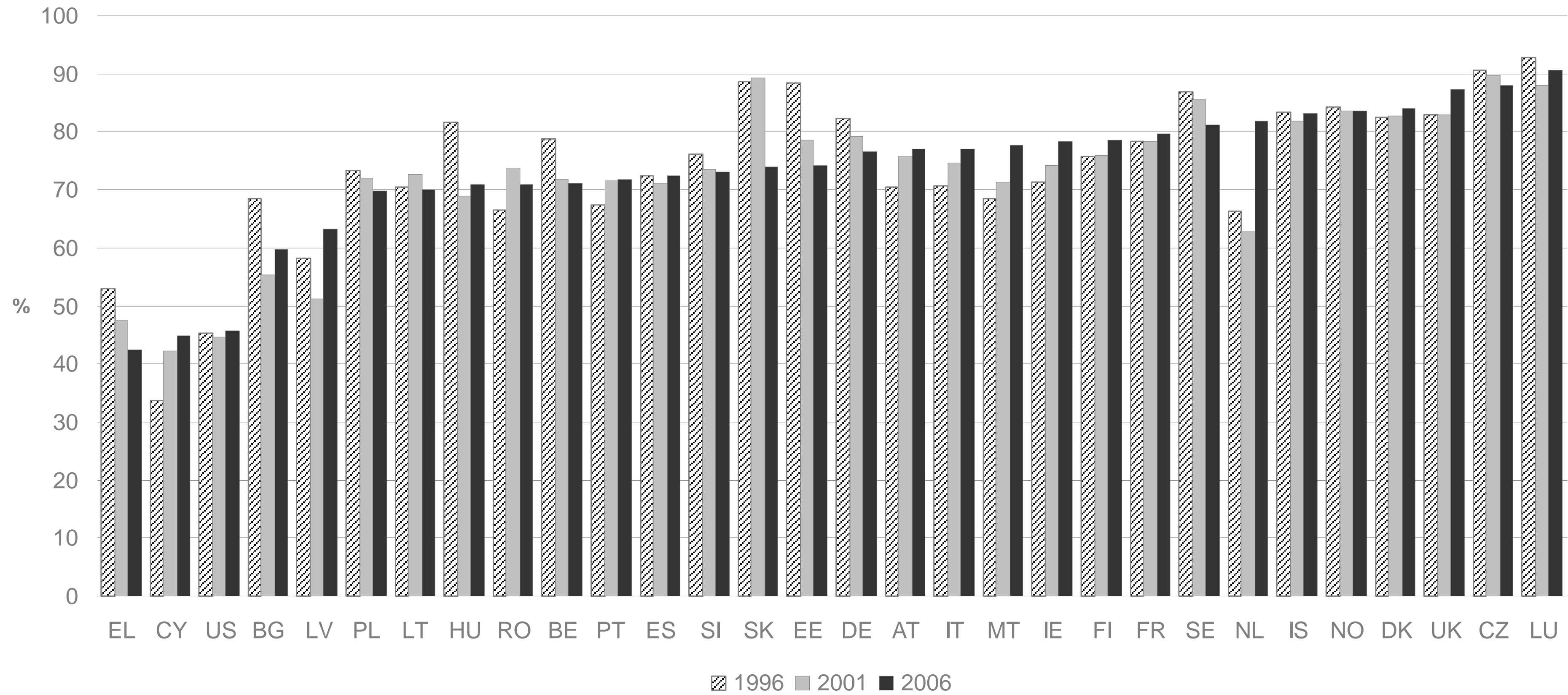
Source: WHO (2009)

Figure 2 Breakdown of the mechanisms used to finance health care by country, 2006



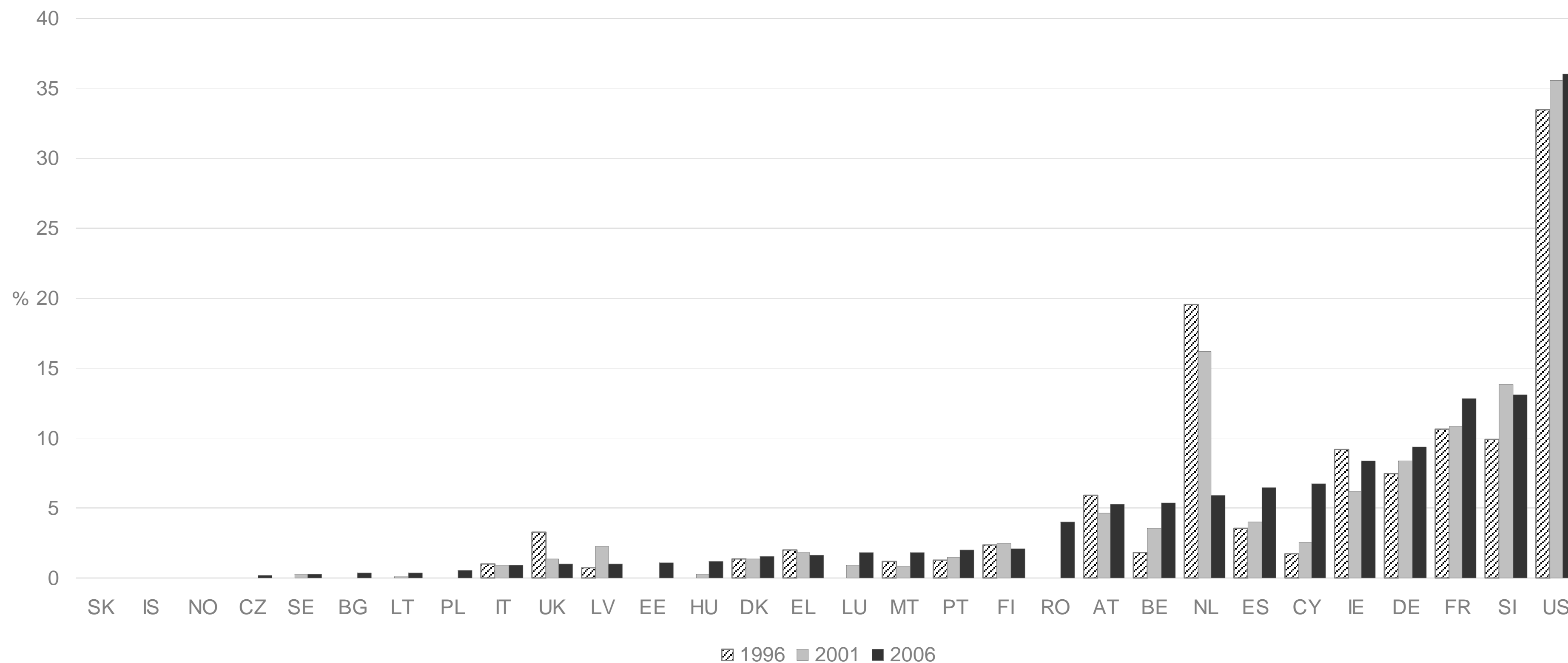
Source: WHO (2009)
Note: SIC = social insurance contribution; PHI = private health insurance; OOP = out of pocket payments. SIC refers to all funds channelled through health insurance funds, which may include substantial amounts of tax revenue.

Figure 3 Public spending on health as a proportion of total health spending, 1996-2006 (%)



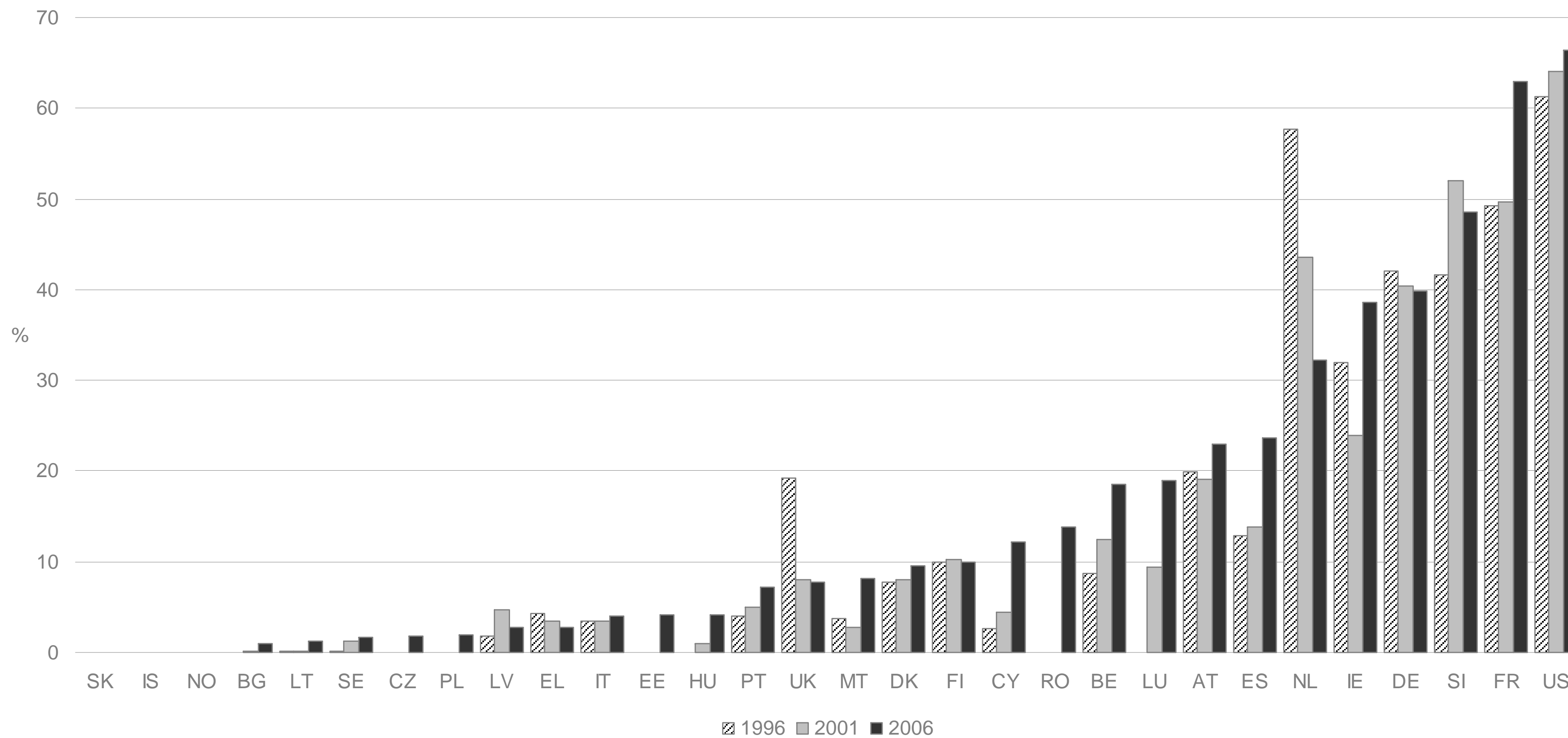
Source: WHO (2009)

Figure 4 Spending through PHI as a proportion of total health spending, 1996-2006 (%)



Source: WHO (2009)
Note: Values for Slovakia, Iceland and Norway are equal to zero in all three years.

Figure 5 Spending through PHI as a proportion of private health spending, 1996-2006 (%)



Source: WHO (2009)
Note: Values for Slovakia, Iceland and Norway are equal to zero in all three years.

Levels of population coverage

There is large variation in the proportion of the population covered by PHI in different EU member states (Figure 6)[19]. The Netherlands has a very high level of coverage for its mixed complementary (services) and supplementary market. The other markets with a high level of coverage are those covering statutory user charges (and extra billing by doctors) in Belgium, France, Luxembourg and Slovenia. Supplementary markets tend to be the smallest in terms of population coverage.

A note of caution: while these figures tell us how much of the population is covered in each country, they do not reveal the depth or quality of coverage – in other words, whether the policies people have purchased cover a narrow or a broad range of benefits. Take the French market, for example. Levels of population coverage have expanded over time, from around 30% in 1960 to around 85% in 1998, but research shows that there is a great deal of difference in the quality of coverage, with richer groups having a better quality of coverage, on average, than poorer groups (Sandier and Ulmann 2001). In 2000 concerns about the role of PHI in exacerbating inequalities in access to health care prompted the French government to provide free PHI cover to people with low incomes[20].

The high levels of coverage achieved by markets covering statutory user charges suggest that, in certain contexts, the widespread application of user charges for publicly-financed health services can encourage the development of PHI. However, this is not always the case. Some of the newer members states have increased user charges in the last five years, but complementary PHI markets have not developed. The complementary markets in Belgium, France and Luxembourg have grown over a relatively long period of time, with PHI cover traditionally provided by well-established and trusted mutual benefit associations. In these markets, cover is often associated with employment and therefore almost automatic for people in certain sectors or occupational groups.

Complementary markets covering services excluded from or only partially covered by the statutory health system are generally sensitive to changes in the statutory benefits package. For example, when some forms of dental care were removed from the statutory benefits package in the Netherlands in the early 1990s (partly re-included in the package in 1996), the Minister of Health encouraged private insurers to offer dental products. Complementary PHI coverage was at its highest in Germany in 1998 (covering 7.6 million compared to 6 million in 1996), when access to dental crowns and dentures in the statutory health system was restricted to people born after 1978; once these restrictions were reversed in 1999, the number of children with complementary PHI fell from 2.2 million in 1998 to 1.4 million in 1999 (Busse 2001).

PHI coverage remains low in many of the newer member states, even though patients in these countries may often make substantial direct payments to providers. Low levels of population coverage may reflect reluctance to pay a third party (Mossialos and Le Grand 1999). Where patients are used to paying their doctor or hospital directly, and may also make additional informal payments, the transferral of money to a third party, such as an insurer, may be seen as a measure that reduces patients' leverage over providers. The

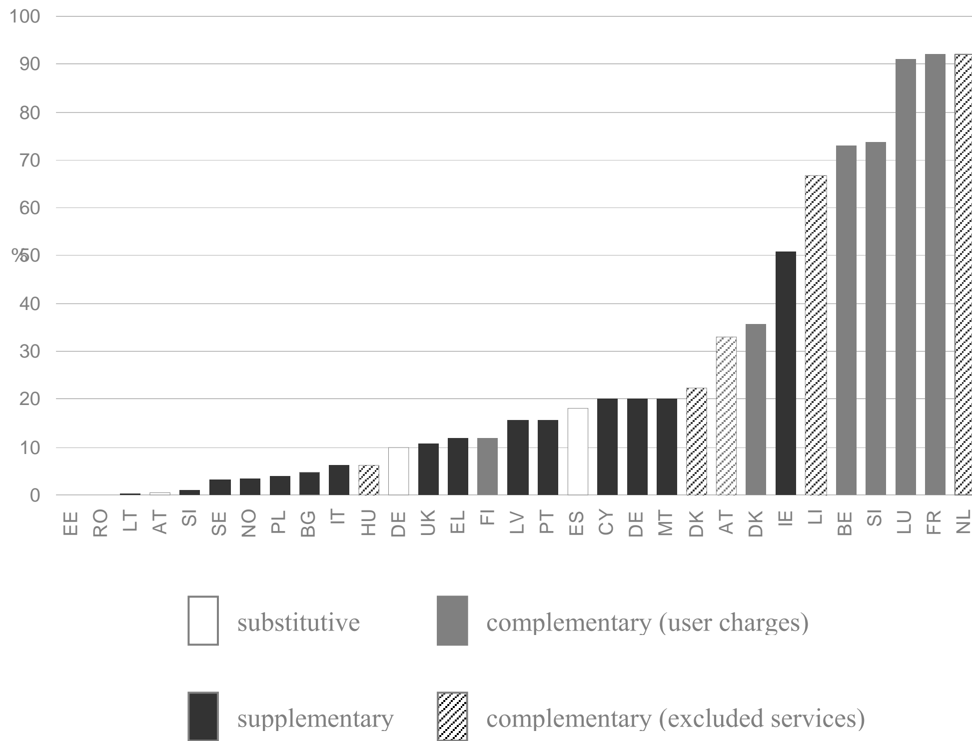
[19] It is not always possible to obtain official data on levels of complementary and supplementary PHI coverage, so some of the data shown in Figure 6 were obtained from surveys.

[20] This free PHI cover is known as *Couverture Maladie Universelle Complémentaire* – CMU-C.

implications of this cultural element for the expansion of PHI in other countries with a high level of direct or informal payments should not be underestimated (Mossialos et al 2002).

The extent of statutory coverage – and the comprehensive nature of this coverage in most countries – clearly limits the scope for PHI, leaving it to play a generally marginal role in financing health care in the European Union. However, the demand for PHI may also be affected by the high cost of premiums and restricted ability to pay in some countries.

Figure 6 Proportion of the population covered by PHI, 2008 (%)



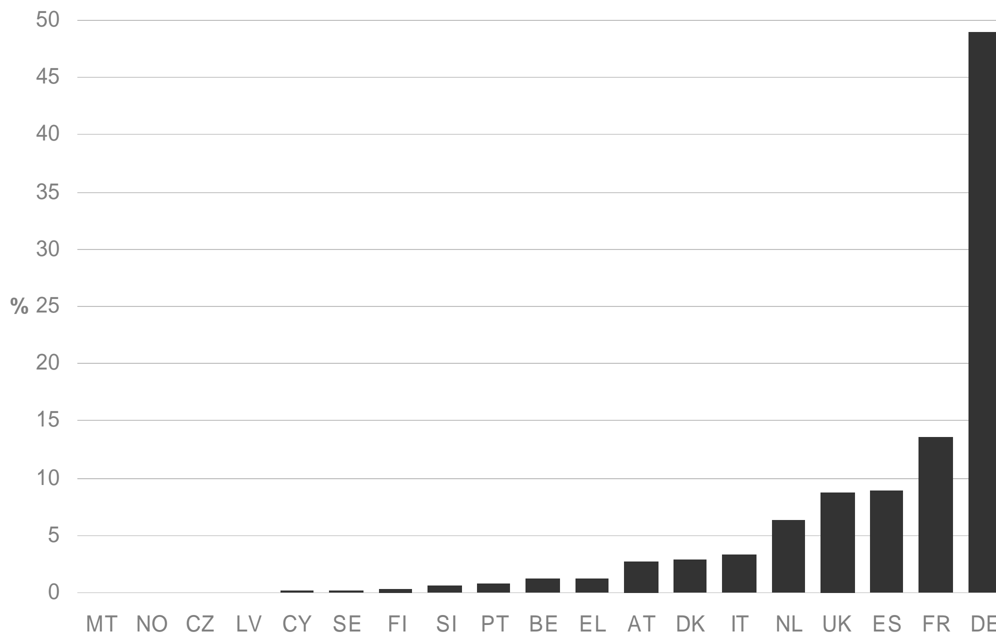
Source: Authors' estimates based on country reports
Note: The figures are for different years for Finland (2005), Greece (2002), Latvia (2003), Norway (2007), Slovenia (2005) and Sweden (2007); values for Estonia, Romania and Lithuania are greater than zero but less than 0.5%.

Levels of premium income

Market size can also be measured in terms of the level of PHI premium income. This measure gives a general indication of the relative monetary size of different markets. Figure 7 shows the size of a country's PHI market as a proportion of the total PHI market in the European Union (in selected countries only, since premium income data were not available for every EU member state). The German market for PHI is by far the largest market in the European Union, followed by France, Spain and the UK. Again, however, the role a market plays is important to bear in mind, since the substitutive PHI cover offered in Germany will obviously be more expensive than the complementary or supplementary PHI cover offered in other countries. What is interesting is that the supplementary markets in Spain and the UK, which cover between 10-20% of the population, are similar in monetary value to the complementary market in France, which covers over 90% of the population – even though the overall size of the population is

similar in the three countries[21]. This may indicate how expensive supplementary cover is relative to complementary cover of statutory user charges.

Figure 7 PHI premium income by country as a percentage of total EU PHI premium income (selected countries only), 2006 (%)



Source: CEA (2008)
Note: Values for Malta, Norway, the Czech Republic and Latvia are greater than zero but less than 1%.

Market structure

This section looks briefly at the determinants of demand for PHI. It discusses the characteristics of those who buy PHI, including the balance between individual and group policies, the nature and number of insurers and levels of market concentration.

What drives demand for private health insurance?

The existence of a market for health insurance is dependent on three conditions: there must be positive demand (that is, some individuals must be risk averse); it must be possible for insurance to be supplied at a price that the individual is prepared to pay (that is, the individual's risk aversion must be sufficient to cover the insurer's administrative costs and normal profit); and it must be technically possible to supply insurance (Barr 1992).

In addition to risk aversion, the demand for health insurance may be influenced by some or all of the following factors: the probability of an illness occurring, the magnitude of the loss incurred through illness, the price of insurance and an individual's income and education. Some factors may be harder to measure than others and the influence of each factor will vary from country to country. In the context of PHI in the European Union,

[21] Around 40 million in Spain, 60 million in the UK and 64 million in France.

factors such as price, income and education may be more important determinants of demand than the magnitude of financial loss because statutory coverage provides a high level of financial protection in most member states.

Some analysts argue that the performance of the statutory health system – notably the degree and distribution of patient satisfaction – is a key determinant of demand for PHI. Often-cited aspects of performance that may influence demand for PHI are reductions in the breadth and depth of statutory benefits, as well as the timely availability of publicly-financed health care. However, even in the United Kingdom, where the relationship between waiting times and demand for PHI has been most extensively studied, evidence of a clear relationship between the two is inconclusive.

Who buys private health insurance?

Data regarding the distribution of PHI coverage in the European Union show that most subscribers come from higher income groups. This is to be expected where substitutive PHI is concerned, as eligibility for this type of PHI usually depends on income or occupation. However, non-substitutive forms of PHI also reveal a strong bias in favour of higher income groups. In addition to income, determinants of the demand for PHI include age, gender, health status, type of employer and employment status, marital status, household composition, educational status and area of residence. Table 3 presents a summary of information about those who are more likely to be covered by PHI[22]. In addition to being richer, in many countries the typical subscriber seems to be aged 40-50 years, better educated, employed as a white collar worker (often at management level or higher), working for larger companies or self employed, living in urban areas and male.

[22] This information is mainly based on survey data.

Table 3 Characteristics of those covered by PHI, various years

Country	Age	Education	Income	Employment	Area	Other
Austria	30-40	More educated	Higher income	>50% self-employed, 44% civil servants, 40% employed, 32% workers, 25% farmers	Urban, especially in Carinthia	n/a
Belgium	Working age	More educated	Higher income	86.5% of employers offer PHI as an employee benefit to at least some of their employees, especially large and medium companies and civil servants	Relatively more people in the Flemish region	Couples better represented than singles
Bulgaria	19-65	n/a	n/a	Employers offering corporate insurance	n/a	Slightly more males than females
Cyprus	43 (median)	n/a	Higher income	Companies with employment schemes, private sector employers, small and large enterprises	n/a	50/50
Czech Republic	n/a	n/a	n/a	n/a	n/a	n/a
Denmark (mutual)	Middle-aged over-represented	n/a	n/a	White collar workers more likely to have PHI than skilled and unskilled workers	n/a	Healthy (individuals with pre-existing conditions or chronic illnesses cannot subscribe to PHI)
Denmark (commercial)	15-29		Higher income; people earning >DKK 500,000 per year are more likely to have PHI	Private sector employers; 10% of publicly employed versus 46% privately employed have PHI	n/a	Healthy, free from pre-existing conditions or chronic illnesses
Estonia	Working age	n/a	Higher income	n/a	n/a	n/a
Finland	More common for children	n/a	Higher income	n/a	Urban, especially in larger cities	
France	30-80	n/a	Higher income	Employed people and skilled workers	n/a	n/a
Germany	All ages	More educated	Higher income	Employees with higher income, self-employed, public servants and pensioners who had been privately insured during their working lives	n/a	More males than female; fewer children (compared to population as a whole)
Greece	25-45	More educated; 43% are tertiary educated	Medium to high income; 68% are middle or upper class	Mainly employers, professionals, civil servants, white collar workers and managers working for large private companies and banks	Urban	Slightly more males than females (53% versus 47%)

Hungary (mutual) Hungary (commercial)	n/a	n/a	n/a	Large companies (industry, banking, insurance etc) with their own fund; people in paid employment	n/a	n/a
Iceland	n/a	n/a	n/a	n/a	n/a	n/a
Ireland	35-64; PHI penetration > average among 35-44 (57%), 45-54 (57%) and 55-64 (50%) age bands	n/a	Higher social classes; 73% of ABC1s versus 29% of C2DEs have PHI	In paid employment	n/a	Couples with at least one child
Italy	n/a	More educated, especially those with a university degree or more	Higher income; in 2004 only 3% of the poorest income quintile had PHI versus 22% in the top quintile	Managers and professionals, self-employed	Northern Italy; 10% of families have at least one member covered versus 7% in the centre and 2% in the south	Households with a male head, families where the head is 41-50, larger families
Latvia	40-50	More educated; 22% with the highest education versus 15% with secondary and 10% with basic education	Higher income	Middle and senior managers	Urban, especially in Riga	n/a
Liechtenstein	n/a	n/a	n/a	n/a	n/a	n/a
Lithuania	n/a	n/a	n/a	n/a	n/a	n/a
Luxembourg (mutual) Luxembourg (commercial)	n/a	n/a	n/a	Less likely for construction, domestic and service-industry workers Civil servants, EU officials, international workers, self-employed	n/a	Less likely for immigrants
Malta	n/a	n/a	Medium to high income	Employers with company-paid groups	n/a	More families than single persons
Netherlands	n/a	n/a	n/a	n/a	n/a	n/a

Norway	18-67	n/a	n/a	Profitable companies and employers with employees who are mainly under 30 years of age, highly educated and have a good risk profile; the probability of subscribing to PHI decreases with company size and for companies in the counties of Oslo, Buskerud and Vestfold	Two municipalities subscribe to PHI for their residents	n/a
Poland	n/a	n/a	n/a	In paid employment or self-employed	Urban	Couples with one child
Portugal	25-54	n/a	Medium to high income	Medium to large companies	Urban	n/a
Romania	No older than 45-50	More educated	Higher income	Multinational or large national corporations; people in paid employment or self-employed	Urban	n/a
Slovakia	n/a	n/a	n/a	n/a	n/a	n/a
Slovenia	n/a	n/a	n/a	n/a	n/a	n/a
Spain	n/a	More educated	Higher income	n/a	Urban, especially Barcelona and Madrid	n/a
Sweden	n/a	n/a	n/a	Private companies; historically top-level management and white-collar workers, although group coverage purchased today covers most or all employees	Urban (but a rural municipality, Sunne, has just purchased PHI for all employees)	n/a
UK	40-65	More educated; people with post-secondary school qualifications are >6 times more likely to have PHI than those without	Higher income; 41% in the richest income decile have PHI compared to <4% in the poorest four deciles; 51% in the top decile have employer-purchased PHI compared to 25% in the bottom four deciles	Professionals and managers are almost twice as likely to purchase individual PHI as unskilled workers or the unemployed and more than nine times more likely to have company-paid PHI; people in paid employment are twice as likely to have individual PHI	Southeast England, London and East England	Males are almost three times more likely than females to purchase individual PHI and twice as likely to be covered in the company-paid market
US	n/a	Less educated are more likely to be uninsured	Lower income are more likely to be uninsured	n/a	n/a	African Americans and Hispanics are more likely to be uninsured than Caucasians

Source: Authors' estimates based on country reports (mainly derived from national survey data)
Note: n/a = information not available.

The balance between individual and group-purchased policies

The extent to which PHI is purchased by individuals or through groups (usually employment-based groups) may influence the degree and distribution of coverage. Insurers often favour group policies because they generally have a lower unit cost and provide high volumes of business without a correspondingly large market outlay (BMI Europe 2000). Also, offering discounted premiums and favourable policy conditions to groups means that insurers automatically cover a younger, healthier, more homogenous population (Gauthier et al 1995). Insurers may regard this as important in preventing adverse selection[23].

Employers benefit from buying coverage for their employees if faster access to health care lowers absence from work due to ill health. Their enhanced purchasing power – relative to individuals – can lower the cost of coverage and this benefits employees as well; not only are group policies generally much cheaper, they are often subject to lower price increases. In addition, group policies are often group rated, which improves access to PHI for older people and people with pre-existing conditions.

However, a market dominated by group policies may increase inequalities in access to PHI and in some countries individual policies may subsidise the discounted policies offered to groups. This possibility is given credence by the fact that insurers' margins are often much tighter for group-purchased than for individually-purchased PHI. In countries like Latvia, most insurers seem reluctant to sell policies to individuals (Brigis 2009).

Figure 8 shows the proportion of group-purchased policies in 2006 in the countries for which data were available. In the last 25 years, the generally low level of individual demand for PHI in many countries has forced insurers to rely more heavily on sales to groups. The 1980s saw rapid expansion of the market for group policies. Group policies continued to gain an increasing share of the PHI market in many member states during the 1990s – a period marked by economic growth and low unemployment. In some countries, the rise of group policies has also been attributed to strategic price discounting by insurers (Ireland[24], the UK, Portugal) – often accompanied by less stringent policy conditions – and the changing attitude of employers, who increasingly recognise the potential costs of long absence from work due to accident or ill health (Lithuania, the UK) (Department of Health and Children 2001; Laing and Buisson 2001; Vhi Healthcare 2001; Instituto de Seguros de Portugal 2007). Strategic price discounting is one of the most powerful explanatory factors for the growth of group policies in the UK, which has driven much of the growth in the PHI market since the 1990s (Papworth 2000).

Group policies have continued to gain market share in several countries since the 1990s, notably Norway and Sweden – two countries in which local governments (municipalities) have recently purchased PHI cover for all their employees – but also in Spain. They are significant in some of the newer member states such as Bulgaria, Latvia, Lithuania and Poland. But the past ten years has seen a slower rate of growth and even a decline in the

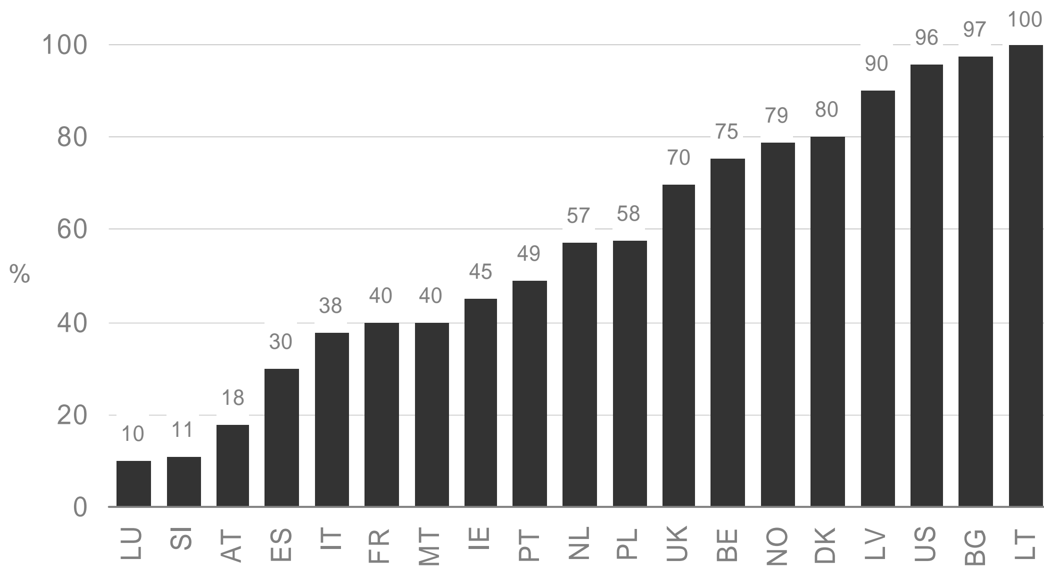
[23] Adverse selection is a form of market failure relating to information asymmetry between insurers and consumers. If consumers can hide their true risk of ill health from insurers, they may be able to obtain policies that do not accurately reflect their risk, which can jeopardise a PHI scheme's financial viability.

[24] The lack of a clear definition of a group in Ireland might also have an influence. People can be a member of an employment-based group scheme or a non-employment-based group scheme (eg credit Union, trade union, alumni association etc). Those who join online are also given the group scheme discount.

proportion of policies purchased by groups in other countries such as Belgium and Denmark. In Belgium the growth in individual coverage may be explained by rising interest in continuing to be covered after group insurance has ended (due to retirement, for example) and by the need to cover dependent family members not covered by group PHI (Palm 2009).

PHI purchased by employers may be provided as an employee benefit, in which case the employer pays the full premium, or employees may pay some or all of the premium themselves. Information about who pays for group policies is hard to find. However, in the UK the likelihood of insurance being paid for by an employer increases with income – 51% of those with PHI in the top income decile report that their policy was purchased by their employer, compared with only 25% of those with PHI in the bottom four income deciles (Emmerson et al 2001). This potential source of inequality is exacerbated where group policies benefit from tax subsidies. To mitigate this, governments in Austria and Denmark only provide tax subsidies to companies that purchase PHI for all their employees (as opposed to restricting group coverage to senior management, for example). Most group policies are voluntary, although group policies provided as a compulsory component of employees' contracts play a role in France (Sandier and Ulmann 2001).

Figure 8 Proportion of PHI policies purchased by groups, 2006 (%)



Source: Authors' estimates based on country reports
Note: The figure for Bulgaria is from the largest insurer only (with a 60% market share); the figures for Italy and Denmark are for commercial PHI only; the figure for Latvia is an estimate based on the fact that all but one insurer offers only group policies; the Irish figure is based on HIA survey data, although the actual figure may be higher – however, Quinn Healthcare no longer offers a group discount, which would lower the figure; the figure for Poland is for PHI purchased as a rider to life insurance; the figure for Slovenia is for the largest insurer (Vzajemna, a mutual).

Who sells private health insurance?

Types of insurers: legal status

There is a wide range of entities providing PHI in the European Union. These include mutual and provident associations, commercial companies, statutory health insurance funds and employers (see Table 4). Commercial companies are distinguished by for-profit legal status, while mutual and provident associations and employers organise PHI on a non-profit basis. Statutory health insurance funds usually have non-profit legal status, although this is not always the case. The distinction between non-profit and for-profit is important where an insurer's profit status influences its motivation and therefore its conduct; it sometimes has a significant bearing on its tax burden too. EU legislation prevents governments from restricting the sale of PHI to specific types of insurer or to a single insurer[25].

Mutual and provident associations have a long history of involvement in health insurance in European Union (Palm 2001). Traditionally, they have been guided by the concept of solidarity, defined by their umbrella organisation AIM[26] as a mechanism that enables everyone to 'contribute according to their financial resources and benefit from services according to their needs'. However, as there is variation in the extent to which mutual or provident associations adhere to the principle of solidarity, we cannot make assumptions about insurers' conduct on the basis of their legal status.

Mutual and provident associations have dominated the PHI market in many Western and Northern European countries, including Belgium, Denmark (99% of the PHI market), France (mutuals currently have 59% of the market and provident institutions a further 17%), Ireland (73%), Malta, Italy, Luxembourg, the Netherlands and the UK (see Table 4). They also play a significant role in newer members states such as Hungary and Slovenia (66% of the complementary market covering statutory user charges; 29% of the mixed complementary (services) and supplementary market). Nevertheless, their share of the PHI market has declined in several countries since the 1990s[27] due to the entry of commercial insurers or acquisition of mutual associations by commercial insurers – notably in Finland (where it was already insignificant), Denmark, Malta, Ireland, the UK, and, to a lesser extent, France.

In some countries, commercial insurers are the only source of PHI (Cyprus, Greece, Latvia, Lithuania, Norway, Spain and Sweden) or have a dominant share of the market (Austria, Bulgaria, the Czech Republic, Finland, Portugal and the UK).

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[25] The Third Non-Life Insurance Directive (see Part 3).

[26] Association Internationale de la Mutualité, the international grouping of autonomous health insurance and social protection bodies operating according to the principles of solidarity and non-profit making.

[27] This is equally true of the US market, where commercial insurers have gained market share and increasingly dominate the market. Over time, indemnity offerings have steadily shrunk in favour of managed care products, notably Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Point of Service plans (POS). The managed care industry is now mainly for-profit. This is largely attributable to for-profit managed care organisations (MCOs) gaining ground on their non-profit counterparts and to important insurers that were traditionally non-profit (notably Blue Cross-Blue Shield) converting to for-profit status Brown, L. (2008). Private health insurance in the United States: a study for the European Commission..

Employers organise their own health 'insurance' schemes for their employees in a handful of countries. This type of company scheme is a key feature of the Polish market and is increasingly important in the UK market, where it has proved to be a cheaper alternative[28].

Statutory health insurance funds compete with other entities to sell PHI in several of the newer member states (Bulgaria, the Czech Republic, Estonia, Romania and Slovakia). In Romania the statutory health insurance fund dominates the PHI market. In the Netherlands statutory health insurance funds had been active in the PHI market, but were required to establish separate entities for voluntary coverage. In Slovenia the voluntary coverage arm of the statutory health insurance fund is now a mutual association with the dominant share of the largest part of the PHI market.

Types of insurers: specialist vs non-specialist
A further distinction concerns an insurer's degree of specialisation in health. Some insurers offer only health products, while others may sell a range of life and non-life products. Mutuals associations generally specialise in health and are required by law to do so in Belgium, France, Hungary and Luxembourg. Some commercial insurers in Belgium and Bulgaria also specialise in health. The German government used to prevent non-specialist domestic insurers from selling PHI in order to protect PHI subscribers from insolvency arising from an insurer's other business (Bundesaufsichtsamt für das Versicherungswesen 2001). This practice was outlawed by EU internal market rules[29] and following a European Court of Justice ruling Germany was forced to change its legislation (European Court of Justice 2001).

Numbers of insurers
There is considerable variation in the number of insurers operating in each member state, although the number of insurers is not indicative of market size. Some national markets have five or fewer insurers (Estonia, Ireland, Lithuania, Slovenia), others have around 50 or more (Belgium, Finland, Germany, Greece, Hungary, Italy, Luxembourg). France is the outlier with almost 1000 insurers[30].

[28] Where it is known as a 'non-insured medical expenses scheme' (NIMES) and often administrated by a private health insurer.
[29] The Third Non-Life Insurance Directive, which came into force in 1994 (see Part 3 for further details).
[30] The US PHI market also has a high number of insurers, with estimates ranging from 800 life and health insurance companies and 150 property and casualty companies offering PHI to 2151 insurers in the group health insurance market and 643 insurers in the individual health insurance market (Brown 2008).

Table 4 Type and number of insurers selling PHI, 2007

Country	Types of insurers	Number	% specialist
Austria	Commercial insurers Mutual associations	7 1	0% 0%
Belgium	Commercial insurers Mutual associations	23 60	(one insurer only) 4% 100%
Bulgaria	Commercial insurers Statutory health insurance funds	14 1	77% 100%
Cyprus	Commercial insurers	17	(one insurer only) 6%
Czech Republic	Commercial insurers (not all offer PHI) Statutory health insurance funds	49 9	4% 100%
Denmark	Commercial insurers Mutual associations	11 1	21% 100%
Estonia	Commercial insurers Statutory health insurance funds	1 1	0% 100%
Finland	Commercial insurers Mutual associations	10 150	0% 100%
France	Commercial insurers Mutual associations Provident associations	45 848 98	0% 100% 0%
Germany	Commercial insurers Mutual associations	28 20	n/a 100%
Greece	Commercial insurers	90	Mainly non-specialist
Hungary	Commercial insurers (not all offer PHI) Mutual associations	29 40-50	0% 100%
Iceland	n/a	n/a	n/a
Ireland[31]	Commercial insurers Quasi-statutory insurance organisation	2 1	0% [32]100%
Italy	Commercial insurers Mutual associations Co-operative associations	91 3 1	5% Mainly specialist Mainly specialist
Latvia	Commercial insurers	10-12	0%
Liechtenstein	Commercial insurers Non-profit insurers	2 4	Mainly specialist
Lithuania	Commercial insurers	4	Mainly specialist
Luxembourg	Commercial insurers Mutual associations	≈11 ≈60	n/a 100%
Malta	Commercial insurers Mutual and provident associations	3 2	100%
Netherlands	Commercial insurers Non-profit insurers	33	n/a
Norway	Commercial insurers	7	(one insurer only) 14%
Poland	Subscription-based health providers Commercial insurers Statutory health insurance funds	200 15-20 1	100% 0% 100%
Portugal	Commercial insurers Mutual and provident associations	19	Mainly non-specialist
Romania	Commercial insurers	12	0%

[31] There are a small number of restricted membership undertakings (10 at the end of 2007) which limit membership to occupational groups. These accounted for approximately 4% of those covered by PHI in 2008. Restricted membership undertakings are excluded from the Irish figures and discussion unless otherwise stated.

[32] Vhi Healthcare also sells travel insurance, but this is only a small part of its business, which is dominated by health insurance.

	Statutory health insurance funds	1	100%
Slovakia	Commercial insurers Statutory health insurance funds (for-profit)	11 7	0% 100%
Slovenia	Commercial insurers Mutual association	2 1	0% 100%
Spain	Commercial insurers	22	1.5
Sweden	Commercial insurers	15	Mainly non-specialist
UK[33]	Commercial insurers Provident associations	18	38%
US[34]	Commercial insurers Non-profit insurance organizations	950-2151	n/a

Source: Authors' estimates based on country reports.
Note: n/a = information not available; commercial insurers are for-profit entities; mutual and provident associations are non-profit organisations; statutory health insurance funds are usually (but not always) non-profit organisations.

Market concentration

The PHI market is highly concentrated in many countries. Figure 9 shows that in 2006 the three largest insurers had a market share of over 50% in most EU member states. The main exceptions were France, Germany, Hungary, Italy and Spain. Economic theory generally suggests that market concentration reflects the degree of competition in the market, with a higher degree of market concentration usually associated with higher prices (to the detriment of consumers) (Tirole 1988). Nevertheless, a degree of market consolidation might lead to efficiency gains for insurers (due to lower transaction costs) and benefits for consumers if price competition is maintained.

There is little research on the effect of PHI market concentration on prices in the European Union, but some (unpublished) work suggests that higher levels of market concentration may actually be associated with lower prices for diagnostic tests. This may reflect the higher purchasing power of insurers where the market is dominated by a very small number of insurance companies – in other words, insurers may be able to 'set' prices rather than simply 'take' them. We cannot say whether this results in lower premiums for consumers, but the rise in premiums combined with healthy profit margins for insurers in many countries suggests otherwise (see below).

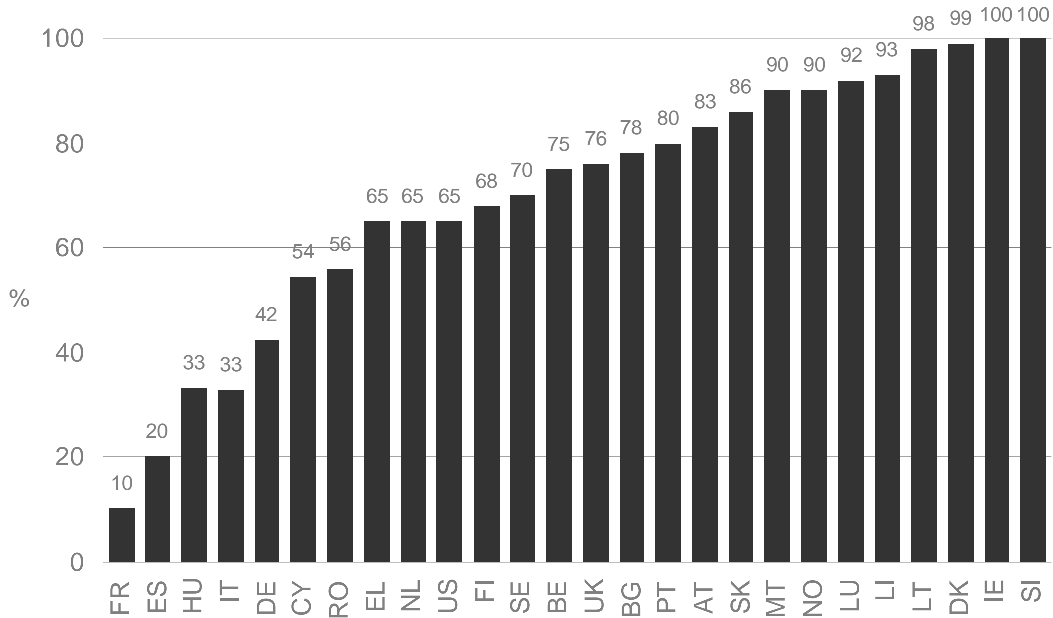
The last two decades have seen a clear trend towards increasing concentration in the PHI market in many countries mainly through mergers (Austria, France, Finland, Greece, Italy, Luxembourg, Portugal and Spain). In some countries this has reflected increased concentration in the banking and insurance sectors as a whole (Portugal). In others it reflects changes in EU legislation concerning solvency margins, which has particularly affected the mutual market in France. Between 2000 and 2006 the number of insurers in the PHI market in France fell by 40%, although the high level of competition among

[33] Commercial insurers are typically non-specialist and non-profit are generally specialist. The number of insurers excludes the 5 PHI 'carriers', who sell insurance products under their own name, but who are not insurers.
[34] Sources vary. Some estimate about 800 life and health insurance companies and 150 property and casualty companies offering health insurance. Others estimate about 2151 insurers in the group and 643 insurers in the individual health insurance market.

insurers in a saturated market was probably partly responsible for some of the mergers that took place (Chevreul and Perronin 2009).

Conversely, the PHI market has become less concentrated in some countries, as the number of insurers has increased (Bulgaria, Ireland, Malta, Slovenia and Sweden). The Irish market was opened to competition in 1994, to comply with a change in EU legislation[35], and two new insurers have entered the market (Turner 2008)[36].

Figure 9 PHI market share of the three largest insurers, 2006 (%)



Source: Authors' estimates based on country reports.
Note: Market share measured as proportion of total premium income; market shares for the Belgium and the US are for the four largest insurers; the market share for Greece is for the five largest insurers; the market shares for Italy and Luxembourg are for commercial insurers only.

[35] The Third Non-Life Insurance Directive (see Part 3).
[36] One of these (BUPA Ireland) exited the market and sold its business to Quinn Healthcare; the other (Vivas) was subsequently bought by another company, Hibernian AVIVA Health.

Market conduct

This section examines different aspects of the way in which the PHI market operates. It looks at the policy conditions associated with the sale of PHI, the methods use to set premiums, the scope and depth of benefits, the extent of consumer choice, how insurers purchase services from providers and the extent of insurer costs and profits.

Policy conditions

Age limits
Insurers in many countries set a maximum age limit for purchasing PHI, usually between 60 and 75 years of age (see Table 5)[37].

Types of contract
PHI cover can be offered as a short-term contract or as a long-term contract whereby premiums are used to finance both current year costs and to build reserves for increasing age. Short-term (usually annual) contracts are the norm for PHI in the European Union. However, many mutual associations offer lifetime cover and this is required by law for all policies in Austria, Belgium and Ireland and for substitutive policies in Germany[38]. Some insurers terminate contracts when people reach retirement age. This is particularly common among group policies. Subscribers often have the option of switching to an individual policy, sometimes for the same level of benefits and at a reasonable rate.

Open enrolment
Open enrolment entitles everyone in a given population to coverage and means that insurers cannot reject applications on the grounds of disability or ill health. It is a key regulation designed to ensure access to coverage and is therefore standard practice for statutory health insurance[39]. It is much less common for voluntary coverage in the European Union and has been prohibited for non-substitutive PHI under EU legislation since 1994 (see Part 2). Nevertheless, it is a regulatory requirement for all insurers in some countries (Ireland since 1994, Belgium since 2007[40]). In others it applies to insurers offering substitutive cover (Germany, since 2009, for the basic policy only) or complementary cover of statutory user charges markets (Slovenia). In Hungary, France and Luxembourg open enrolment is not a regulatory requirement, but has been common practice among mutual associations. In France it is incentivised through fiscal policy (see below).

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[37] EC Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation prohibits discrimination based on age, which could in future change the practice of restricting PHI cover to people aged 65 and over.
[38] Most states in the United States also require guaranteed renewal (effectively lifetime cover), although often without premium caps (Brown 2008).
[39] And, typically, for PHI in the US.
[40] Albeit a temporary regulatory measure in Belgium, and commercial insurers can still exclude or limit cover for the costs related to the chronic condition or disability.

Exclusion of pre-existing conditions
Insurers in most countries are allowed to exclude from cover pre-existing conditions that were disclosed at the time the PHI contract was signed or cover them in return for a higher premium or longer waiting periods[41]. In a few cases, however, regulation prevents insurers from excluding pre-existing conditions (Belgium for mutual associations, Slovenia for complementary PHI covering statutory user charges) and in France it is disincentivised through fiscal policy (see below).

In addition to pre-existing conditions, the list of typical exclusions from PHI policies can be very long. The UK is an extreme example[42], but in most countries insurers do not cover drug abuse[43], self-inflicted injuries, HIV/AIDS, infertility, cosmetic surgery, gender reassignment, experimental treatment and drugs, organ transplants, war risks and injuries arising from hazardous pursuits (Association of British Insurers 2001).

Premiums

Setting premiums
Contributions to statutory health insurance via tax or social insurance are usually related to income or wages. In this sense they are based on ability to pay and do not account for an individual's risk of ill health. In contrast, PHI premiums are rarely income-related[44]. They are much more likely to be rated according to individual risk or assessed on a community, experience or group basis. Risk-rated premiums take into account an individual's current health status and future risk of ill health and may vary based on risk factors such age, gender, occupation, medical history and family history of disease. Community- and group-rated premiums are based on the average risk of a defined community or firm, but community rating does not usually involve a specific assessment of risk, while group rating may. Experience rating involves adjusting premiums based on an employer's claims history; for each of these, premiums would be the same for all subscribers in a given group. The method used to set premiums (risk, community, group or experience rating) and the variables used in risk rating have implications for cost and access. PHI premiums also vary depending on the level of benefits to be provided, including the level of cost sharing involved (see below).

[41] In the United States it is also common for insurers to exclude pre-existing conditions with a few restrictions. However, the federal HIPAA law limits insurers' ability to reject people with pre-existing conditions who have had coverage and then seek to switch carriers, and it precludes differential premiums within groups. Meanwhile, the federal COBRA law lets people who lose or leave their jobs in groups of 20 or more workers keep their coverage for 18 months, but they must pay the full premium themselves, and that can be an onerous task (Brown 2008).
[42] PHI policies in the UK do not usually cover pre-existing conditions, GP services, accident and emergency admission, long-term chronic illnesses such as diabetes, multiple sclerosis and asthma, drug abuse, self-inflicted injuries, outpatient drugs and dressings, HIV/AIDS, infertility, normal pregnancy and child birth, cosmetic surgery, gender reassignment, preventive treatment, kidney dialysis, mobility aids, experimental treatment and drugs, organ transplants, war risks and injuries arising from hazardous pursuits Association of British Insurers (2001). Submission to the European Commission's study on voluntary health insurance in the European Union. London, Association of British Insurers..
[43] Under the minimum benefit regulations in Ireland, insurers must provide cover for drug- or alcohol-related treatment for up to 91 days in any continuous 5-year period.
[44] The PHI premiums charged by some mutual associations in France are income-related up to a defined ceiling (usually close to the ceiling imposed in the statutory insurance scheme) (Sandier and Ulmann 2001), but this may be the only example of income-related PHI premiums in the European Union.

Table 5 PHI policy conditions, 2008

Country	Who can buy PHI?	Open enrolment	Insurers can exclude pre-existing conditions	Type of PHI contract available (annual or lifetime)	Group cover ends at retirement
Austria	People under a defined age (typically 60-75 years)	No[ss]	Yes	Lifetime	Yes (can transfer to individual contract)
Belgium	Whole population	Yes[tt]	Mutual: No[uu] Commercial: Yes	Lifetime	Yes (can transfer to individual contract)[vv]
Bulgaria	Limited access for people aged 65+ (although they may have group cover)	No	Yes	Annual	n/a
Cyprus	Coverage typically stops at the age of 65	No	Yes	Both	Yes
Czech Republic	Whole population	No	No	Annual (varies)	n/a
Denmark[ww]	Mutual: People <60 who meet health qualifications, but coverage may stop after 60 Commercial: People <60 or not yet retired	No	Yes	Mutual: Quarterly Commercial: Annual	Commercial: Yes
Estonia	Commercial: People <63 for new contracts and <65 for continuing coverage EHIF: Whole population (if covered by the EHIF for at least 12 months in the preceding 2 years)	Commercial: No EHIF: Yes	Yes	Commercial: lifetime (65) EHIF: Annual	No
Finland	People under a defined age (typically 60-65)	No	Yes	Both (lifetime up to 60-65)	Yes (usually)
France	Whole population, but age limits for some contracts	Usually, not legally required[xx]	Yes	Annual	Yes (can transfer to individual contract)[yy]
Germany	Substitutive: those with earnings above an income threshold for three consecutive years Non-substitutive: whole population	Depends[zz]	Yes	Lifetime	No

[ss] Insurers can reject applications based on age and if the person is suffering from or has in the past suffered from some very serious illnesses (eg cancer). In practice, however, most applications are accepted.
[tt] Since 2007 commercial insurers cannot reject applications on the basis of ill health or disability although they can exclude or limit cover of the costs relating to treatment of pre-existing conditions. This rule was introduced by the Act on PHI Contracts 2007, initially for a trial period of two years.
[uu] But cover can be limited to a specific monetary amount.
[vv] Since 2007, the same level of benefits is guaranteed, although the new premium will be based on current age. However, people can pre-finance individual continuation by paying an additional premium while collectively covered, in which case the new premium is based on age at the start of the group policy.
[ww] No explicit exclusion of disabled or chronically ill people, but coverage might exclude treatment of their pre-existing disability or condition, thereby excluding them in practice.
[xx] Insurers cannot reject applicants for cover except for the small number of contracts using health questionnaires or contracts with age limits.
[yy] The individual contract is guaranteed to cover the same benefits and should not be more than 1.5 times the price of the group premium.
[zz] Insurers cannot reject applications or exclude pre-existing conditions for people eligible for the basic policy (substitutive PHI only).

Greece	People <65	No	Yes	Lifetime	Yes
Hungary	Whole population	Usually, not legally required	No	Lifetime	Yes
Iceland	n/a	n/a	n/a	n/a	n/a
Ireland	Whole population	Yes	No (may be waiting period)	Annual	Yes (employer cover, other group cover may be available)
Italy	People <75	No	Yes	Both	Mutual: Not usually Commercial: Yes
Latvia	Varies by employer	No	Yes[aaa]	Annual	Yes
Lithuania	People <60	Usually, not legally required	Yes (if diagnosed within two months of contract start)	Annual	Yes
Liechtenstein	People under a defined age (typically 62-64 years) for new contracts; existing contracts are renewed indefinitely	No	n/a	Annual	Yes (can transfer to individual contract)
Luxembourg	Mutual: Whole population Commercial: People under a defined age (typically 70)	Mutual: Yes Commercial: No	Mutual: No Commercial: Yes	Mutual: Lifetime Commercial: Annual	No
Malta	People under a defined age (typically 65-70) for new contracts; existing contracts are renewed indefinitely	No	Yes	Annual	Yes (can transfer to community-rated individual contract)
Netherlands	Whole population	Usually, not legally required	Yes	Annual	n/a
Norway	People <67[bbb]	No	Yes	Annual	Yes
Poland	Whole population; some restrict access for older people	No[ccc]	Yes	Annual	Yes
Portugal	People <60; cover may continue until 65-70, but there is no guarantee since contracts are renewed annually[ddd]	No	Yes	Annual	Varies
Romania	People <65	No	Yes	Annual	No
Slovakia	n/a	n/a	n/a	n/a	n/a
Slovenia	Complementary (UC): Whole population	C(UC): Yes	Yes	Typically bi- or tri-annual	C(UC): No

[aaa] But do not usually since most policies purchased by groups.
[bbb] No explicit exclusion of disabled or chronically ill people, but coverage might exclude treatments related to their pre-existing disability or condition, thereby excluding them in practice.
[ccc] Insurers must offer justification if they do reject an applicant, although this is easily done for individual contracts.
[ddd] No explicit exclusion of disabled or chronically ill people, but coverage might exclude treatment related to their pre-existing disability or condition, thereby excluding them in practice.

	Complementary (S) and supplementary: 6-65	C(S) and Supp: No			C(S) and Supp: No
Spain	People aged under 65 years for new contracts	No	Yes	n/a	No
Sweden	Whole population, but only people under a defined age (typically 65-70) for some products	No	Yes	Annual	Yes
UK	People under a defined age (typically 65, sometimes 74/75) for new contracts[a]	No	Yes	Annual	Yes (may be exceptions)
US	Whole population	Yes (typically, legally required in some states)	Yes	Annual	Varies

Note: n/a = information not available

EU internal market legislation introduced in 1994[57] precludes governments from specifying how PHI premiums are to be set, at least in non-substitutive markets. Insurers offering substitutive PHI are generally subject to some degree of regulation regarding the price of premiums and policy conditions, at least as it applies to specific groups of people (those eligible for the basic policy in Germany). Generally, however, risk rating is the most common method used by insurers to set PHI premiums (and it may also be used for substitutive premiums in Germany). Table 6 shows the variables used to risk-rate PHI premiums in different countries[58].

Group rating is used in Denmark (most policies), Greece (group policies) and Italy (policies sold by the largest mutual associations). Premiums may be experience-rated in Cyprus and Malta (for large group policies) and in the UK (for company-paid group policies)[59].

Community-rated premiums are less common in the European Union, particularly among commercial insurers. They are usually only available from non-profit insurers – for example, in Luxembourg (complementary cover of statutory user charges sold by mutual associations), France (compulsory employer-paid group policies and typically optional group policies as well), Malta (smaller groups), Italy (for most policies sold by non-profit insurers) and Hungary. Ireland and Slovenia are the only member states in which community rating is prescribed by law for all insurers offering PHI[60].

Information required from applicants
The information required from applicants is closely related to the rating method used to set premiums (see Table 6). Insurers that use health status as a variable for risk rating premiums will require applicants to complete a medical questionnaire, which may also include questions about family history of disease (a form of genetic information) (Mossialos and Dixon 2001). For this reason, Swedish insurers refrain from obtaining information about family history of disease (on the basis of an agreement between the Swedish government and the Swedish association of insurers), although it is required by insurers in several other countries (Greece, Luxembourg, Portugal, Poland, Romania and the UK). Medical examinations may take place in some countries (see Table 6). In some cases, insurers will not require applicants to provide any medical information, but may impose waiting periods or undertake moratorium underwriting (see below).

Waiting periods
Open enrolment is usually accompanied by mandatory waiting periods. Waiting periods range from one month to a year for most forms of health care, but may be up to ten years for cover of long-term care(see Table 6).

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[57] See Part 3 for further discussion.
[58] Following EC Directive of 13 December 2004 implementing the principle of equal treatment of men and women in access to and the supply of goods and services, some countries (including Belgium and Germany) have introduced legislation to outlaw variation in insurance premiums by gender.
[59] In the US, the Blues initially used community rating from the time they were established in the 1930s; facing competition from commercial firms that offered experience-based rates, however, they increasingly began to use experience rating as well. Experience rating is the norm for larger groups and some smaller ones today, although risk rating remains the norm for individual coverage and some small groups (Brown 2008).
[60] In the US a few states now require community rating in the small group and individual markets as well (Brown 2008).

Moratorium underwriting
Insurers in some member states may operate a 'moratorium' system of underwriting, whereby individuals do not have to make a medical declaration, fill in a medical questionnaire or undergo a medical examination, but for a specified period, any pre-existing conditions are not covered. Moratorium policies differ from policies with mandatory waiting periods in that they will only subsequently cover conditions from which the insured person remained symptom- or treatment-free during the waiting period. For example, moratorium underwritten PHI policies in the UK typically state that any relevant pre-existing condition that has been incurred in the five years before the policy was taken out will become eligible for treatment two years from the policy start date, provided that in the interim the policyholder has not consulted a doctor about that or any related condition, or otherwise sought advice about it (including related check-ups) or taken medication for it (including drugs, medicines, special diets or injections). This type of underwriting has raised concerns about the potential negative consequences of people foregoing or delaying treatment in order to qualify for full coverage (Office of Fair Trading 1996; 2000)[61]. Moratorium underwriting is not common in the European Union. It is mainly operated by some insurers in the UK and Portugal.

The price of premiums
The price of premiums within a country may vary according to the method used to set them (as noted above). Where premiums are risk rated and insurers can charge higher premiums for cover of pre-existing conditions, premiums will probably be higher for older people and people with health problems. They are usually higher for women of child-bearing age too. Employees with access to group cover will generally benefit from lower premiums than self-employed people and others who rely on individual policies. They may also benefit from group-rated premiums. In Ireland a maximum level of discounts for group policies (up to 10% lower than individual premiums) was introduced to prevent risk selection (Department of Health and Children 2001; Vhi Healthcare 2001).

The level of variation among PHI policies in different EU member states makes it difficult to compare average premium prices across countries. Furthermore, there can be substantial variation in the price of PHI premiums within a country (for the reasons given above). In most countries though, premiums appear to rise with age, and commercial policies tend to have higher premiums than PHI purchased from mutual associations.

There is also evidence to suggest that the price of PHI premiums in many EU member states has not been stable. On the contrary, PHI subscribers in some member states have been subject to premium increases above the rate of inflation in the health sector as a whole (Mossialos and Thomson 2004). It was expected that the creation of a framework for a single market for PHI in the European Union would increase competition among insurers, leading to greater choice and lower prices for consumers. However, PHI premiums have often risen faster than general health care expenditure.

[61] In 1996 the UK competition and consumer authority (the OFT) took the view that subscribers to moratorium-based PHI were more likely to suffer detriment through failing to understand what was covered and recommended that insurers abandon the practice (OFT 1996). The Association of British Insurers (ABI) suggested that improved consumer education would help to reduce consumer detriment (OFT 2000). The OFT agreed but felt that the ABI's initiative fell short of what was required. In a second report it called for tighter self-regulation than the ABI's codes and guidance provided, but this has not been forthcoming (OFT 2000).

Table 6 Setting PHI premiums, 2008

Country	Variables used for rating premiums	Medical information/ required from applicants	Waiting periods?	Dependants covered at no extra cost?
Austria	Age, gender, place of residence, health status, statutory health insurance fund	Medical history (including family medical history for some)[a]	1month to 3 years[b]	Occasionally (family packages available)
Belgium	Mutual: Age, family size Commercial: Age, sometimes place of residence	Mutual: None Commercial: Medical declaration	Mutual: Typically 6 months[c] Commercial: 3 to 6 months	No (may be discounts for dependants)
Bulgaria	Age, gender, health status (for individual contracts for older or chronically-ill people)	Medical declaration and/or certificate	n/a	No (family packages available)
Cyprus	Age, health status	Medical history[d]	Yes	No
Czech Republic	Substitutive: health status	Substitutive: Medical exam	n/a	No
Denmark	Mutual: Age, health status Commercial: Age, employment status Group: number of employees, nature of work, company sickness absence and health policies	Medical declaration (for eligibility and exclusion of pre-existing conditions)	Not usually	Mutual: Yes (children <16) Commercial: Varies (children <16)
Estonia	Commercial: Age, gender, health status EHIF: None	Commercial: Medical exam on entry and contract extension	Commercial: 1 to 9 months[e] EHIF: 1 month	No
Finland	Age, sex	Medical history	n/a	No
France	All: Age, place of residence Mutual and group cover: Level of income	Medical history[f]	No	Usually
Germany	Age, gender, health status	Medical history	Typically 3 to 8 months[g]	No
Greece	Age, gender, occupation, health status	Medical history (including family history), medical exam, x-ray[h]	Yes	No
Hungary	Mutual: None Commercial: n/a	None	n/a	No
Iceland	n/a	n/a	n/a	n/a
Ireland	None	None	6 months to 2 years[a]	No[b]

[a] Some insurers limit the period of enquiry for prior illness to 5-10 years.
[b] Group (1 month). Individual: health care / cash benefits (up to 3 months); psychotherapy, dental care (up to 8 months); childbirth (9 months); long-term care (3 years).
[c] Up to 12 months for older applicants; 9-10 months for childbirth.
[d] A medical examination can be requested above certain ages or based on questionnaire responses.
[e] Health care excluding accidents (typically up to 1month); dental care (5 months); childbirth (9 months).
[f] The medical questionnaire is rarely used since it subjects contracts to insurance premium tax (7% of Premium).
[g] Waiting periods are 8 months for deliveries, psychotherapy, dental care, dentures and orthodontia. Waiting periods do not apply for accidents, newborns and adopted children or spouses (if the other spouse is already PHI insured. Waiting periods may be waived if a new customer was previously SHI insured.
[h] Applicants are also strongly advised to provide their social insurance medical record.

Italy	Commercial: Age, gender, place of residence, health status Mutual: None	Commercial: Medical history	1 to 9 months[c]	No
Latvia	Varies	Medical exam for some	n/a	No
Liechtenstein	Age	Medical history	3 months to 3 years[d]	No
Lithuania	Age, gender, occupation	Medical history (companies <20 employees)	n/a	Varies
Luxembourg	Commercial: Age, gender, health status Mutual: None	Commercial: Medical history (including family history), medical exam (rare)	Commercial: 3 to 8 months[e] Mutual: 3 months	Commercial: No Mutual: Yes
Malta	Age	Medical exam (mainly for older people)	No	No
Netherlands	Age, health status	Medical history (increasing)	n/a	No
Norway	Age, health status	Medical history	Yes	No
Poland	Individual: Age, health status, sports Group: Age, gender	Moratorium underwriting or medical exam (plus family history)	No	Varies
Portugal	Age (primarily), health status (to a lesser extent)	Medical history (including family history), medical exam (group cover, few products)	Yes	No
Romania	Age, gender, health status	Medical history (including family history)	Yes	Varies
Slovakia	n/a	n/a	n/a	No
Slovenia	Complementary (UC): None Other PHI: Age, health status	C(UC): None Other PHI: Medical exam	C(UC): 3 months Other PHI: 2 to 24 months	No
Spain	Age and gender (primarily), health status (to a lesser extent)	Medical history	Sometimes, typically 6 months	No
Sweden	Age	Medical declaration for individuals / group cover for companies with 10-20 employees, medical exam (rare)	Yes, varies	No
UK	Age, lifestyle factors (eg smoking status), occupation, place of residence	Medical history (including family history), medical exam (rare)[f]	No	No
US	Age, health status	Medical history, medical exam (small group and individual policies)	Yes	Varies

Note: n/a = information not available.

[a] Initial period is 26 weeks (52 weeks for maternity benefits) if the applicant is <55, 52 weeks for 55-64 and 104 weeks for 65+. Pre-existing condition waiting period is 5 years for people <55, 7 years for 55-59 and 10 years for 60+. Waiting periods for cover upgrades are 2 years if the person upgrading is <65 or 5 years if 65+.

[b] The only exception to this is that insurers often cover children born to subscribers during a contract year free of charge until the next renewal date.

[c] 30 days for sickness; 180 days for new/undetected conditions; 300 days for delivery.

[d] Generally 3 months; 8 months for childbirth, psychotherapy, dental treatment/replacement and orthodontics; up to 3 years for long-term care insurance.

[e] Childbirth and psychotherapy: 8 months.

[f] For moratorium underwriting, no medical history is needed, but any condition that existed in the 3-5 years prior to the policy's commencement is excluded.

Tax subsidies
Tax incentives or disincentives to purchase PHI aimed at individuals and firms will affect the price of PHI premiums (see the section on fiscal policy below).

Benefits

The range of benefits covered by PHI
PHI in the European Union covers a wide range of health services and offers a variety of benefit options, from hospital costs to complementary and alternative treatment (see Table 2). Substitutive PHI offers the most comprehensive benefit packages, largely as a result of government intervention, typically providing benefits that match those covered by statutory health insurance. In contrast, the benefits arising from complementary and supplementary PHI are largely unregulated[76], leaving insurers free to determine the size and scope of the packages they offer. This has led to a proliferation of complementary and supplementary PHI products in many countries. Individuals may be able to choose from a wide selection of packages with differences in coverage levels, reimbursement (in kind or cash), the extent of cost sharing and benefit ceilings.

How are benefits provided?
PHI benefits can be provided in cash (either through reimbursement or direct payment of a specified sum) or in kind (through the direct provision of health services). Reimbursement requires subscribers to pay out of pocket and then claim back their expenses at a later date. It is the norm among insurers in Belgium, Denmark, Germany and the Netherlands (although Dutch insurers are increasingly paying providers directly)[77]. Reimbursement takes place to a lesser extent in Austria, France and Spain. It also occurs in Finland, Bulgaria, Finland, Estonia (EHIF), Lithuania, Luxembourg (commercial insurers), Malta and the Czech Republic.

Benefit ceilings
Insurers in some countries impost benefit ceilings in the form of maximum annual levels of PHI reimbursement (Austria, Belgium, Bulgaria, the Czech Republic, Finland, Greece, Portugal).

Cost sharing
Benefit ceilings (a form of cost sharing) and more standard forms of cost sharing (co-payments, co-insurance, deductibles, balance billing etc) may limit the financial protection provided by PHI. Cost sharing generally seeks to increase subscribers' awareness of the costs of health care and lower their level of coverage. The extent to which subscribers are subject to cost sharing varies considerably across countries (see Table 7). The trend in some countries is towards insurers increasing their reliance on cost sharing as a means of securing income (PPP Healthcare 2000). No claims bonuses are a similar form of incentive, rewarding subscribers who make few or no claims, although they are not widely applied.

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[76] Ireland is a key exception; PHI must offer a minimum range of benefits specified by the government (see below).
[77] In kind benefits are the norm in the US (Brown 2008).

Table 7 PHI cost sharing, benefit limits and protection mechanisms, 2008

Country	Cost sharing required	Upper ceiling on benefits	Protection mechanisms
Austria	Co-insurance, deductibles	Yes	Cap on co-insurance, other limits
Belgium	Deductibles (typically for private room stay)	Yes [78]	No
Bulgaria	No	Yes	n/a
Cyprus	Deductibles (typically), co-insurance	No	No
Czech Republic	No (typically)	Yes	No
Denmark	Mutual: Balance billing Commercial: Not usually, balance billing	No	
Estonia	Commercial: Not usually EHIF: Co-insurance, co-payments	No	No
Finland	Deductibles	Yes	No
France	Balance billing, reference pricing	No	No
Germany	Co-insurance (dental care), deductibles	No	Cap on deductibles for substitutive PHI
Greece	Co-insurance, co-payments, deductibles, no claims bonuses	Yes	No
Hungary	n/a	No	n/a
Iceland	n/a	No	n/a
Ireland	Balance billing, co-insurance, co-payments, deductibles[79]	No	None
Italy	Varies	No	Liability limits
Latvia	Varies	Yes	No
Lithuania	Co-insurance	No	No
Liechtenstein	Varies	No	Caps for some plans
Luxembourg	No	No	No
Malta	Co-insurance	No	Some plans
Netherlands	Deductibles	No	n/a
Norway	No	No	n/a
Poland	No	No	No
Portugal	Balance billing, co-insurance, co-payments	Yes	None
Romania	No	No	No
Slovakia	n/a	No	n/a
Slovenia	Complementary (UC): No Other PHI: Co-insurance, co-payments	No	No
Spain	Co-payments	No	No
Sweden	Not usually	No	No
UK	Deductibles	No	No
US	Co-insurance, co-payments, deductibles	Yes	Varies

Note: n/a = information not available.

[78] For mutual associations (around €12,500 per year per insured).

[79] But not to any great extent. The main hospital plans provide limited cover for ancillary services, above a deductible, with the deductible made up of allowed rather than actual expenses. For example, if an insurer were to pay €15 per GP visit and each GP visit were to cost €50 with the deductible set at €300, then the subscriber could visit the GP 20 times before reaching the deductible level. Above the deductible, the insurer usually pays a set amount per incident (eg GP visit). However, recently a number of combined hospital and ancillary plans have been launched, which provide significantly more cover for ancillary services. Some ancillary-only plans have also been launched.

Consumer choice and information

Choice of insurer
There is more than one insurer in every EU member state (see Table 4) and thus consumers are generally able to choose between at least two insurers. A couple of markets have in the past been dominated by a monopoly insurer. In Ireland prior to 1994 Vhi Healthcare was the only 'open' insurer permitted to operate in the PHI market[80], but the market was opened up to competition to comply with EU law[81] and there are now two additional insurers.

Portability
PHI subscribers in the European Union can generally switch insurer without incurring any direct costs, although most contracts require one to three months' notice prior to termination. However, the indirect costs of switching are sometimes high, particularly for older people or people with pre-existing conditions, as most new policies will be priced according to current age and health status. Also, since insurers can reject applications for cover, some people may not actually be able to take out a new policy with a different insurer. The lack of 'portability' of benefits from one contract to another is not normally considered to be problematic from a public policy perspective where complementary and supplementary PHI markets are concerned[82].

It has been an issue in Germany's substitutive market, however, largely due to the non-portability of the ageing reserve each subscriber has been required to build up to finance cover when older and to prevent premiums from rising as subscribers age[83]. This inability to transfer ageing reserves from one insurer to another prevented many PHI subscribers from changing from one company to another, which had the effect of limiting competition among private insurers to competition for new entrants to the market. In 2007 the government introduced new regulation to facilitate portability; from 2009 ageing reserves will be fully portable for all new PHI subscribers. Existing subscribers can transfer their reserves if they switch private insurer between January and June 2009, but the ageing reserve cannot be transferred if an individual switches from private to statutory cover.

Choice of plan
How much choice of PHI 'plan' or product consumers have depends to some extent on the number of insurers in the market. It may also depend on the type of contract a subscriber has. Those covered by group contracts may not have much or any choice at all if coverage decisions are made by employers. In other cases, consumers often have a wide range of choice of product and plan options (such as level of benefits, extent of cost sharing, degree of provider restriction etc).

[80] Although there were, and still are, a number of 'closed' schemes offering cover to members of specific occupational groups.
[81] The Third Non-Life Insurance Directive (see Part 3).
[82] Subscribers are free to switch insurers in the US during the annual open enrolment periods (although some policies may permit switching at less than annual intervals). Yet movement within the insurance market is restricted in practice, and portability remains a significant issue. An individual who has employer-based PHI can have substantial difficulties seeking coverage with a new employer or on the costly individual market if he/she loses his/her job. If he/she in good health, this may not be hard, but having health problems could make it very challenging to find affordable coverage with a new insurer since federal and state policies guarantee access to insurance, but not necessarily to affordable coverage (Brown 2008).
[83] The ageing reserve was financed by an additional 10% added to all premiums from 2000.

'Product differentiation' can in theory benefit consumers by increasing the range of products available to them and by providing them with products that are tailored to meet their needs. However, it can also be used to segment the market, giving insurers greater opportunity to distinguish between 'good' and 'bad' risks (because people with higher risk of ill health may be more likely to opt for generous plans covering a wider range of services and with lower levels of cost sharing). Regardless of the motives behind product differentiation, the presence of multiple insurance products may result in consumer detriment unless it is accompanied by a level of information sufficient for consumers to compare products in terms of value for money. Consumer detriment is defined as the loss to consumers incurred from making misinformed or uninformed choices (Office of Fair Trading 2000). Without the provision of sufficient information, product differentiation may lower price competition.

Consumer and competition authorities have found evidence of consumer detriment due to product differentiation in Germany, Spain, Portugal and the UK (Office of Fair Trading 1998; Datamonitor 2000; Associação Portuguesa para a Defesa do Consumidor 2001; Rodríguez 2001). Problems caused by the multiplicity, variability, and complexity of PHI products on offer can be mitigated by the use of standardised terms, the existence of a standard package of benefits, an obligation for insurers to inform potential and existing subscribers of all the options open to them and easily accessible and centralised sources of comparable information on the price, quality, and conditions of PHI products. However, under the current EU regulatory framework[84], insurers have no incentive to reduce consumer confusion and increase transparency by introducing standardised terms or standard benefit packages. Thus, while standard benefit packages may be required for substitutive PHI in some member states (Germany), they are rarely found in complementary and supplementary PHI markets.

Other approaches to addressing this problem have included a range of regulatory and voluntary measures[85]. The UK government brought general insurance sales (including the sale of PHI) under the statutory regulation of the Financial Services Authority (FSA) in 2001 (HM Treasury 2001). UK insurers have also published a guide to PHI and agreed to use some standardised terms in describing their products (Davey 1999). In countries such as the Netherlands, Italy, Ireland, Finland and France, central agencies, consumer associations or independent websites and other media provide comparative information (see Table 8), although it is not clear if these are sufficient to ensure transparency (Maarse 2009).

In order to protect substitutive PHI subscribers in Germany, the Reform Act of Social Health Insurance 2000 stipulates that insurers must inform potential subscribers of the likelihood of increasing premiums, the possibility of limiting the increase in premiums

[84] Established by the Third Non-Life Insurance Directive in 1994.

[85] In the US a myriad of insurance policies are available. For the majority of Americans receiving employer-based coverage, good-sized firms tend to offer a wide range of plans with different premiums, cost-sharing levels, breadth of provider panels etc to suit individual preference. To aid comparisons among these plans, Consumer Reports rates health plans, as do the Medicare Information Source Book website and the Consumer Health Information Source Book. As other sources of insurance plan rating proliferate though, it becomes increasingly necessary to ensure that these sources are accurate, accessible and contain the type of information consumers need and can reliably use. Concerns for consumer protection are very salient in the health insurance market, and there has been a big push in the US for more public information about the quality of providers' performance so that more objective comparisons among mortality rates, error rates etc may inform the choice of a health plan via the reputation of provider panels (Brown 2008).

with old age and the irreversibility of the decision to opt out of the statutory health insurance scheme (CEA 2000; Bundesaufsichtsamt für das Versicherungswesen 2001). Insurers are also required to inform policyholders of the possibility of switching to another tariff category when their premiums go up and to advise policyholders aged 60 or over to switch to the basic policy or another tariff category that includes the same benefits for a lower premium (Bundesaufsichtsamt für das Versicherungswesen 2001). Even so, for subscribers under the age of 60, it can be difficult to assess all the options available, both within and among insurers, which is why a market for independent consumer information (eg *Stiftung Warentest*) and independent insurance brokers has developed (Busse 2001). The former appear to provide good value for money.

The existence of a small number of comparable PHI products has enabled consumers in other member states to make appropriate choices. This is the case with complementary PHI covering statutory user charges in Slovenia (Milenkovic Kramer 2009). Similarly, consumers seem to be more easily able to compare PHI products in Bulgaria, Cyprus, Lithuania and Malta.

Group policies may also present fewer problems than individual policies in terms of comparison, as there may a reduced choice of product and/or less variation between products. For example, conditions do not vary much between group policies in France and insurers providing group policies must provide clear and accessible information about each policy (Sandier and Ulmann 2001). In Denmark the options open to employees subscribing to group policies are often limited. The information provided to employees may also be limited, but the involvement of trade union representatives in negotiating the terms on which group policies are offered may compensate for this lack of information (Vrangbaek 2001).

Choice of provider

Most supplementary PHI policies aim to widen subscribers' choice of provider, allowing them to consult doctors working in the private, as well as the public, sector. Complementary and substitutive PHI policies may also give subscribers a wider choice of provider.

The extent to which choice is restricted through the use of preferred provider networks (PPNs) or as a result of integration of insurers and providers (vertical integration) varies considerably among EU member states (see below). On the whole, PPNs and vertical integration play a minor role, but there is a tendency towards some forms of vertical integration amongst the largest insurers in member states such as Spain and the UK, where insurers have traditionally been providers as well (see Table 1). Vertical integration is also being established in Belgium, France, Greece, Ireland, Portugal and Romania. However, it is not without its problems. Efforts in Belgium and France have met with limited success (Stevens et al 1998) – in France partly due to the public's negative perception of US-style Health Maintenance Organisations (HMOs). In Ireland vertical integration does not limit consumer choice, although patients may receive discounts for using an insurer's own facilities.

In other countries insurers use networks of providers. Again, there is variation in whether or not subscribers are obliged to use these particular providers. The extent to which this would restrict consumer choice depends, of course, on the range of providers included in the network. Insurers in Greece and the UK use financial incentives to encourage

subscribers to opt for network providers. UK insurers' development of PPNs, vertical integration and negotiation of hospital charges has been monitored by the competition authorities (Office of Fair Trading 1999; Competition Commission 2000; CareHealth 2003)[86].

Restrictions

PHI subscribers in some member states are subject to a referral system or require prior authorisation for treatment[87]. Subscribers in several countries need a general practitioner's referral before their PHI policy will reimburse them for consulting a specialist or receiving inpatient treatment (Denmark, Estonia, managed care plans in Greece, Ireland, Norway, Portugal, Romania, Sweden in return for lower premiums, the UK).

Some insurers in the UK encourage subscribers to obtain permission prior to undergoing treatment, while others insist that subscribers contact them first to check that they are covered for the treatment they plan to undergo (Association of British Insurers 2000). Insurers can use this as an opportunity to guide a subscriber to their preferred network of providers. Insurers in other countries also require prior authorisation for the use of specific treatments or for all services (Austria, managed care plans in Greece, Malta, the Netherlands, Portugal, Romania). In most other member states, however, prior authorisation is only usually required for treatment abroad.

[86] During the 1990s the UK competition and consumer authority (the OFT) launched an enquiry following complaints of anti-competitive practice (primarily from private consultants and hospitals). The OFT did not uphold the complaints but said it would monitor vertical integration and demanded greater transparency in hospital selection procedures, suggesting that subscribers should be fully informed as to their rights to receive treatment from particular hospitals or consultants (OFT 1999). It repeated a 1996 recommendation for the British Medical Association and the private sector to develop a Code of Practice on charging (CareHealth 2003). In the UK today there is no strict vertical integration. The largest insurer BUPA owns hospitals but is required to keep its hospital and PHI business separate. BUPA's attempt to another hospital group in the late 1990s was halted by the Competition Commission, in part on the grounds that it was difficult to prevent exchange of information between BUPA's hospital and PHI business (Competition Commission 2000).

[87] In the US insurers feel strong incentives to lower costs, but strategies such as gate-keeping and prior authorisation have been controversial with providers and consumers. A significant 'public backlash, which was entangled in the controversy surrounding managed care, generated ameliorative laws in many states, as well as proactive market adaptations by insurers (eg attempts to attract new subscribers by guaranteeing direct access to specialists). US insurers have struggled to balance the tension between restricting access and choice to control costs and keeping providers and subscribers happy (Brown 2008).

Table 8 Central sources of comparative information about PHI products, 2008

Country	Central sources of comparative information about PHI products
Austria	No
Belgium	n/a
Bulgaria	No
Cyprus	n/a
Czech Republic	No
Denmark	No
Estonia	No
Finland	From the Consumer Insurance Office: www.vakuutusneuvonta.fi
France	No
Germany	From independent websites such as Stiftung Warentest (www.test.de) or Bund der Versicherten (www.bundderversicherten.de) and from commercial websites.
Greece	No
Hungary	n/a
Iceland	n/a
Ireland	From the Health Insurance Authority: www.hia.ie
Italy	From www.miaeconomia.it (commercial policies) and www.fimiv.it (mutual policies)
Latvia	n/a
Lithuania	No
Liechtenstein	No
Luxembourg	No
Malta	No
Netherlands	From independent websites such as www.independer.nl
Norway	No
Poland	No
Portugal	No
Romania	No
Slovakia	n/a
Slovenia	No
Spain	No
Sweden	No
UK	No
US	From: Consumer Reports, Medicare Information Source Book website, Consumer Health Information Source Book

Note: n/a = information not available.

Purchasing

Provider payment
Insurers offering PHI usually pay providers on a retrospective fee-for-service basis in the European Union, although there is deviation from this norm and insurers in some member states use more than one payment method (see Table 9). Providers are frequently allowed to charge higher fees for treating privately-insured patients. This may have equity and efficiency implications.

Selective contracting
Insurers are allowed to contract providers on a selective basis (that is, they contract with some rather than all providers) in most EU member states – France and Lithuania appear to be the only exceptions (see Table 9). While insurers in most countries take this opportunity, in others selective contracting does not occur much or at all (Cyprus, the Czech Republic, Germany, Ireland, Finland, Malta, the Netherlands)[88].

Selective contracting is more difficult to operate in countries where PHI subscribers are reimbursed and where there is free choice of provider in the statutory health system (as in Belgium, France, Germany and Luxembourg, for example). It may also be limited in some countries due to lack of capacity in the private sector.

The public-private mix in provision
Insurers in the European Union purchase services from a wide range of both public and private providers. PHI-financed care is provided by a mix of public and private providers in most countries (see Table 10). Private beds in public hospitals (beds reserved for the use of privately-financed patients) are used by insurers in Austria, Ireland, Portugal, Luxembourg, Romania and the UK. In Austria and Ireland the proportion of public beds that may be reserved for private use is capped at 25% and 20% respectively. In the UK there is full economic costing for the use of private beds in public hospitals. This is not the case in Ireland (see Part 2).

Doctors are prohibited from working in both the private and the public sector in a handful of EU member states (Greece, Cyprus, Luxembourg) but work in both sectors in most other countries (see Table 10)[89]. Some countries impose limits on the extent to which doctors can do this (Denmark, Italy, the UK).

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[88] Selective contracting also occurs in the US, as it is a fundamental component of managed care. Efforts by providers to pass 'any willing provider laws' (ie preventing selective contracting) have not often succeeded, and the POS option (using out-of-plan providers, but paying more for doing so) can be viewed as a type of compromise on this issue. It is difficult to gauge exactly how widespread selective contracting is in practice; American insurers run the gamut from Kaiser-like HMOs that use only their own employed physicians to PPOs that sign up many providers in one area. Thus, insurers are often left trying to strike a balance between having too selective a panel, which limits market appeal, and having too expansive a panel, which limits cost control (Brown 2008).

[89] Doctors in the US can work in either sector or both publicly and privately, depending on which private plans and/or public providers choose to contract with them. The public programmes Medicare and Medicaid generally pay well for hospital care, so their beneficiaries get care that is reasonably comparable to those insured by PHI. Yet doctors still grumble about 'slow, low and no' pay by Medicare and (even more so) by Medicaid for office-based services, and some consequently decline to participate in those programmes, which can create problems of access to care (Brown 2008).

Table 9 Private health insurers' relations with providers, 2008

Country	Purchasing from providers or reimbursement of patients?	Insurers free to contract selectively?	Vertically integrated with providers?	Provider payment?	Who sets fees?	Different from public fee-setting?
Austria	Purchasing; reimbursement for doctor visits and non-contracted hospitals[a]	Yes[b]	Some insurers part-own private facilities, but subscribers not obliged to use them	PD, FFS, lump sum	Austrian Insurance Association negotiates fees with inpatient providers, hospital doctors and regional medical associations	Yes (higher)
Belgium	Reimbursement	Yes	No	FFS	Fees are set in the context of statutory health insurance at national level by the health insurance funds and provider representatives	No, but extra billing permitted in some cases
Bulgaria	Reimbursement	Yes	Some insurers have their own facilities, but subscribers not obliged to use them	FFS	Providers; but insurers set fees for their own facilities	Varies
Cyprus	<25% purchasing	Yes, but only to a limited extent	No	FFS	Insurers and providers negotiate fees individually	No
Czech Republic	Reimbursement	Yes, but not in practice	No	FFS	Providers	n/a
Denmark	Reimbursement and purchasing	Yes, commonly occurs	Some insurers have exclusive agreements with providers	FFS	Insurers typically negotiate lower fees based on volume and type of company being insured	Yes (double for specialists)
Estonia	Commercial: Reimbursement EHIF: Purchasing	Commercial: Yes EHIF: Yes, for up to 20% of outpatient care	No	CAP, DRG, FFS, PD	Commercial: fees 20% higher EHIF: Fees government approved	Yes (20% higher)
Finland	Reimbursement	Yes, but not in practice	No	n/a	Providers[c]	Yes
France[d]	Reimbursement (usually), but some purchasing	No	No	n/a	Providers	No, but some extra billing permitted

[a] Purchasing occurs via direct billing contracts with most hospitals and framework agreements for ambulatory care, which define physician fees and treatment costs for the treatment of patients in the private ward of public hospitals or in private hospitals.
[b] The Austrian Insurance Association (on behalf of PHI companies) signs contracts with hospitals and medical associations which also define physician fees for the treatment of patients in the private ward of public hospitals or private hospitals. Direct billing contracts exist with most hospitals and ambulatory agreements with three regional medical associations.
[c] Many insurers state that they will not reimburse subscribers if the price is much more than the 'normal rate' but there is no such defined standard in Finland.
[d] The complementary market covering statutory user charges simply reimburses subscribers. Here we refer to other PHI only.

Germany	Reimbursement	Yes, but only among providers treating PHI patients only	Uncommon; insurers cannot own policlinics; some collectively own hospitals	FFS (individuals), DRGs (hospitals)	Providers are allowed to charge higher fees than statutory fees	Yes (higher)
Greece	Trend towards purchasing[a]	Yes, typically occurs	One insurer has own facilities; others encourage use of PPNs	CAP (outpatient diagnostics), FFS, salary (managed care)	Insurers negotiate fees with providers	Yes (higher)
Hungary	Mutuals: Reimbursement	Yes	Some commercial insurers use PPNs	FFS	Statutory fee schedule used for benefits covered by the statutory system; insurer-providr negotiation for other services	Yes (higher)
Iceland	n/a	n/a	n/a	n/a	n/a	n/a
Ireland	Purchasing[b]	Yes, but in practice each insurer covers most hospitals and consultants	None traditionally; Vhi Healthcare recently set up SwiftCare Clinics and Hibernian AVIVA Health an Xpress Med Urgent Care Centre	FFS (typically); trend from PD to fixed price procedures in hospital	Vhi Healthcare leads pricing negotiations with providers; the other insurers follow and most providers accept the fees	Yes (public pays salary)
Italy	Purchasing	Yes (private sector)[c]	No	FFS (typically)[d]	Accredited private providers working for the public sector regulated by fees set at regional/national level, but insurers can negotiate fees with private providers	Yes (higher)
Latvia	Reimbursement	Yes, always occurs	No	FFS	Providers, but insurers may not pay 100%	Yes (higher)
Lithuania	Reimbursement	No	Insurers offer PPNs, subscribers not obliged to use them	n/a	n/a	n/a
Liechtenstein	n/a	n/a	n/a	n/a	n/a	n/a
Luxembourg	Commercial: Reimbursement	n/a	n/a	FFS	Social security and government negotiate with providers to determines user charges	No
Malta	Reimbursement	Yes, but only to a limited extent	No	FFS	Insurers negotiate individually with hospitals, pay doctors what is reasonable	Yes (public pays salary)

[a] Not as consistent as one would expect since the market for private health care is highly concentrated and consists of two major groups (as a result of mergers).
[b] Most hospitals and consultants have fully participating agreements with the insurers. In other words, they accept the insurers' payment as full payment for the services and do not balance-bill subscribers. However, the practice of collective negotiations has come under scrutiny in recent years.
[c] They can contract tariffs paid to private facilities but not user charges/tariffs paid to the public sector. This is why many insurers offer the choice between going to public hospitals (as in Italy this is free of charge) or to PPOs free of charge vs going to public facilities or private non-PPOs with charges.
[d] Providers are mostly paid FFS if they have a direct contract with the insurer. If they operate as accredited NHS providers and operate indirectly with the company, they receive the user charges usually anticipated by the insured.

Netherlands	Reimbursement, but purchasing is in initial stages	Yes, but occurs only to a limited extent	Negligible, but one insurer is investing in primary care centres	CAP, FFS, standard hourly tariffs	n/a	n/a
Norway	Purchasing	Yes	No, but insurers use networks of providers	FFS (DRGs as price estimates)	Spare capacity in the private sector may leave room for fee negotiation	n/a
Poland	Reimbursement	Yes	No, but some insurers use networks[a]	CAP (networks), FFS	Typically, insurers set their own fee, which is accepted or not[b]	Varies
Portugal	Reimbursement (primarily), some limited purchasing	Yes, typically occurs	Some larger insurers collectively integrated; insurers offer PPNs	FFS	Providers and insurers negotiate fees; but in practice, providers are often forced to accept the prices defined by insurers	n/a
Romania	Purchasing and reimbursement	Yes, frequently occurs	Some insurers have their own hospitals	FFS, but salary if insurers own facilities	Providers and insurers negotiate fees	Yes (higher)
Slovakia	n/a	n/a	n/a	n/a	n/a	n/a
Slovenia[c]	Purchasing[d]	Yes, frequently occurs	No	FFS	Providers	Varies
Spain	Purchasing	Yes, commonly occurs	Typically insurers own hospitals, use beds in other private hospitals	FFS; some CAP	Insurers and providers implicitly negotiate fees, but insurers have monopsony power	Yes (higher public pays salary)
Sweden	Reimbursement	Yes, typically occurs	No	FFS	Price negotiations occur, but fees based on government-set fees for private providers offering care to the public sector	Yes (higher, extra pay for handling PHI claims)
UK	Purchasing[e]	Yes, common with hospitals (less common with doctors)	No (strict) vertical integration[f]	FFS	Insurers and providers negotiate hospital fees; insurers typically stipulate a limit for doctor fees up to which they will pay	Yes (higher)
US	Purchasing	Yes	Limited	n/a	Insurers and providers negotiate fees	Yes (higher)

Note: n/a = information not available; CAP = capitation; DRG = diagnosis-related groups; FFS = fee for service; PD = per diem; PPN = preferred provider networks; PPO = preferred provider organisations.

[a] Some insurers plan to purchase network providers, but it has not yet happened.
[b] The National Chamber of Physicians and some insurers, accompanied by the Union of Private Healthcare Providers, are attempting to define a common list of services/procedures which could be priced by different parties.
[c] The complementary market covering statutory user charges simply reimburses subscribers. Here we refer to other PHI only.
[d] Strategic purchasing is engaged in to the extent that the prices of different providers are compared and lower prices negotiated.
[e] Insurers do not simply reimburse. Regarding the 'facility fee', insurers usually have a list of hospitals they use. The fee is negotiated with hospitals. If the fee is not negotiated, then hospitals have set fees they charge and insurers are aware of what these fees are. Insurers may have a list of doctors with whom they have arranged set fees for particular services and these will be covered in full. For other doctors, insurers will usually pay up to a set amount, which they communicate to the insured; the insured have to meet any extra out-of-pocket.
[f] BUPA owns hospitals, but it is required to keep its hospital and PHI business separate. An attempt by BUPA to acquire another hospital group in the late 1990s was halted by the Competition Commission on grounds which related, in part, to its belief that there was indeed exchange of information taking place between BUPA's hospital business and its PHI business.

Table 10 The public-private mix in provision of health care, 2008

Country	Is PHI-financed care provided by public and private providers?	Private beds in public hospitals?	Are doctors permitted to work in the public and the private sector?
Austria	Public and private providers[104]	Yes	Yes
Belgium	Public and private providers	n/a	Yes
Bulgaria	Public and private providers	n/a	Yes
Cyprus	Private providers	n/a	No
Czech Republic	Public and private providers	n/a	Yes
Denmark	Private providers	No	No
Estonia	Commercial: Public and private providers EHIF: Public (mostly) and private providers[105]	n/a	Yes
Finland	Not relevant since insurers simply reimburse subscribers	n/a	Yes
France	Public and private providers	n/a	No
Germany	Public and private providers	Yes	Yes
Greece	Private providers [f]	n/a	No
Hungary	n/a	n/a	n/a
Iceland	n/a	n/a	n/a
Ireland	Public and private providers	Yes	Yes
Italy	Private providers (but many insurers offer subscribers the option of using publicly-financed care, for which they do not pay, although they may reimburse patient user charges)	n/a	No[106]
Latvia	Public and private providers (although no clear difference between doctors since all contract with the statutory health insurance fund)	Yes	Yes
Lithuania	Public and private providers	n/a	Yes
Liechtenstein	All doctors are private, the one major hospital is public	n/a	Yes
Luxembourg	Public providers; private beds in public hospitals	Yes	Yes (no real distinction between the sectors)
Malta	Private providers	No	Yes
Netherlands	n/a	n/a	Yes (but not common)
Norway	Private providers (but the government is trying to prohibit public hospitals from contracting with PHI)	n/a	Yes
Poland	Individual private providers (outpatient), network	n/a	Yes

[104] Public hospitals can have private wards for insurers to use in line with state regulations, but to retain non-profit status hospitals must ensure that private beds do not account for more than a quarter of the beds available. The Hospital Acts of the federal states regulate the circumstances under which a private ward may exist next to a general ward and define requirements for patient admission to private wards.

[105] About 20% of outpatient specialist care is purchased through selective contracting, where private providers can also apply for a health insurance fund contract. Most providers are publicly owned but under private regulation (as private companies or foundations).

[106] Following reforms in 1999, doctors working in the public sector were required to choose between public and private practice, but with the possibility of working privately within the hospital ('intra-moenia') both for inpatient and specialist services. Most of them have chosen to remain in the public sector and opted for intra-moenia practices.

	providers (mainly outpatient), private and public hospitals		
Portugal	Private providers; private beds in public hospitals	Yes	Yes (most doctors work in both sectors)
Romania	Public and private providers; private beds in public hospitals	Yes	Yes
Slovakia	Public and private providers	n/a	Yes
Slovenia	C(S) and Supp: Public and private providers (ie private specialists, public hospitals)	n/a	Yes
Spain	Private providers	n/a	Yes
Sweden	Private providers	No	Yes
UK	Private providers[107]	Yes	Yes
US	Public and private providers	n/a	Yes

Note: n/a = no information available.

Insurer costs and profits

Claims ratios

Average claims ratios – the ratio of benefits paid to premium income – range from 39% in Portugal to 88% in Slovenia (see Figure 10). Claims ratios were well under 75% in roughly half the EU members states for which data were available. This suggests that PHI is a relatively profitable business for insurers in many countries.

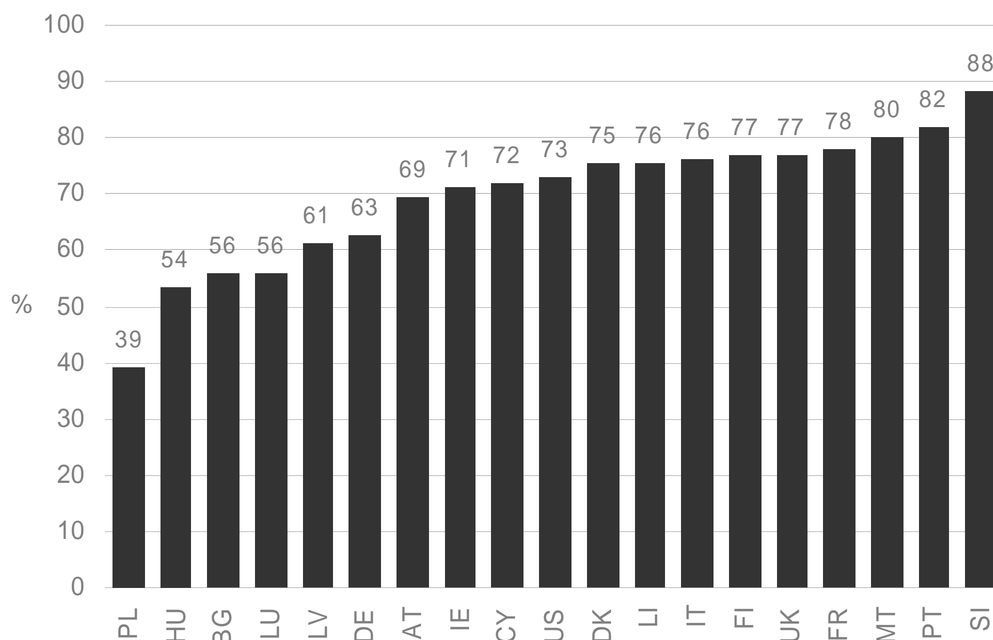
In some countries the average claims ratio varies depending on market role and insurer legal status. For example, the claims ratio for the mutual association in Denmark was 101% in 2006, which means that the average claims ratio for commercial insurers must have been as low as 50% (Vrangbaek 2009). Similar patterns can be seen in Ireland and Hungary. In Ireland the claims ratio for Vhi Healthcare (a quasi-statutory body with non-profit status) was about 97% in 2006 compared to 75% for BUPA Ireland (a branch of a UK provident association, now trading as Quinn Healthcare) and 41% for Hibernian AVIVA Health (a commercial insurer, formerly trading as Vivas Health). The significantly lower figure for Hibernian might be explained by a larger proportion of its members being newer and therefore still serving waiting periods (Turner 2008). In Hungary the mutual associations had an average claims ratio of 32% in 1998, rising to 78% in 2006, whereas the average claims ratio for commercial insurers was 27% in 1998, rising to 29% in 2006 (Boncz 2008).

In Slovenia the average claims ratio of the complementary PHI market covering statutory user charges was much higher, at 88% in 2006, than the average claims ratio for the mixed complementary (services) and supplementary PHI market in the same year (23%). Here, claims ratios in both types of market were actually lower for the mutual association than for one of the two commercial insurers (Adriatic) (Milenkovic Kramer 2009).

[107] Insurers purchase services from doctors working in a private capacity (most of whom hold part-time positions) in the public system. A small proportion of doctors work entirely privately. Insurers use private hospitals and the private wings/beds of public hospitals as well.

Average claims ratios have remained relatively stable over time in some countries (Italy, Poland, Portugal), risen in some (Slovenia; very steeply in the case of the commercial insurer Adriatic) and fallen in others (Austria, Latvia, the UK). The fall in Austria was from 77% in 2000 to 69% in 2006. Average claims ratios for private insurers here are significantly lower than those for the statutory health system, which rose from 92% in 2000 to nearly 97% in 2002 (Hofmarcher et al 2002). Average claims ratios in Latvia fell from 75% in 2002 to 60% in 2006 (Brigis 2009). In the UK they fell from 88% in 1985 to 77% in 2006 (Laing and Buisson 2007). While the claims ratio for employer-paid group policies in the UK was 85% in 2000, it was as low as 73% for PHI policies paid for by individuals and employees (Laing and Buisson 2001; The Sunday Times 2001)[108].

Figure 10 PHI average claims ratios, 2006 (%)



Notes: Slovenia: this is for the complementary market covering statutory user charges only; Ireland: this is the unweighted average calculated from the claims ratios of the major insurers (BUPA Ireland: 75%, VIVAS Health: 41%, Vhi Healthcare: 97%); Liechtenstein: the figure is for non-profit insurers only; Luxembourg: the figure is for commercial insurers only; US: the most common estimate of medical-loss ratio for US PHI is 73%; for Medicare and Medicaid, estimates say that the proportion of money in the 'pool' going to health care is 96-97%.

Administrative costs

The costs of management and administration tend to be much higher under private, rather than statutory, health insurance because of the extensive bureaucracy required to assess risk, set premiums, design benefit packages and review, pay or refuse claims . Private insurers also need to spend money on advertising, marketing, distribution (often through agents or insurance brokers) and reinsurance.

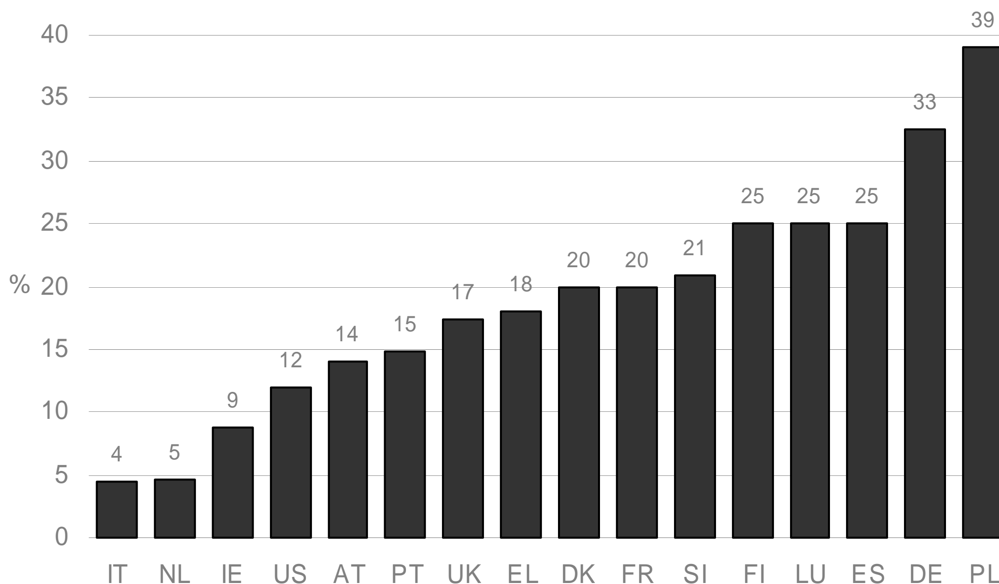
Economic theory considers high transaction costs to be inefficient if they can be avoided under an alternative system of financing and providing health care (Barr 1992). Some

[108] A media report suggested that UK insurers were "boosting profitability by increasing premiums to unprecedented levels while cutting their costs by getting tougher on claims" (The Sunday Times 2001).

commentators in the US argue that high transaction costs are justified by innovation (Danzon 1992), but this has been refuted by others (Barer and Evans 1992). For example, Danzon claims that private insurers compete ‘by devising ways to control moral hazard more effectively, including structured co-payments, utilisation review, case management, selective contracting with preferred providers and provider-targeted financial incentives such as capitation and other risk sharing forms of prospective reimbursement’ (Danzon 1992). But this argument does not seem to apply to PHI markets in the Europe Union, where the majority of insurers do not, on the whole, adopt the above-mentioned measures to contain costs.

Data on the administrative costs of insurers in different member states are limited, although the available evidence suggests that these costs are high compared to those of the statutory health system (Mossialos and Thomson 2004). Insurers’ administrative costs generally fall between 10 and 25% of total premium income (see Figure 11). In contrast, the administrative costs of statutory health systems are substantially lower at typically under 10% (OECD 2008)[109].

Figure 11 PHI administrative costs as a proportion of premium income, 2006 (%)



Notes: Denmark: data for commercial insurers; the figure for non-profit insurers is much lower, at 4.6%; Ireland: data for 2006; Luxembourg: data for commercial insurers; Netherlands: data for 2007; Poland: data for 2007; Spain: administrative costs range from 20-30%; UK: average of BUPA’s and AXA PPP’s administrative costs as a proportion of their respective premium incomes (2003); NHS data for 2003/2004; US: the most common estimates put PHI administrative costs around 12 % and Medicare’s around 3%, though PHI advocates say the Medicare number excludes various items and is more accurately pegged at 6%.

[109] In the US most estimates of public sector administrative costs are around 3%, although they may be as high as 6% (Brown 2008).

Public policy

This section focuses on national-level public policy towards PHI. It begins by outlining who is responsible for regulation in each country then briefly describes the key regulations in place, discusses fiscal policy (tax incentives and disincentives to take up PHI) and summarises recent debate about PHI. EU-level public policy towards PHI is discussed in Part 2.

Regulation

PHI in the European Union is typically regulated by a combination of general insurance legislation and more specific legislation regarding insurance contracts and products. Non-profit insurers are often subject to a separate legal framework and overseen by a different regulatory body from commercial insurers.

Who regulates?
In each member state the PHI market is typically regulated by some form of national financial market authority or supervision commission under the jurisdiction of the Ministry of Finance. Ministry of Health or Ministry of Social Security involvement in regulation of commercial PHI is rare (Finland, Spain; Italy and Slovenia for the complementary market covering statutory user charges only), although it is more common for regulation of non-profit PHI (France, Ireland, Liechtenstein and Luxembourg). Non-profit insurers are sometimes regulated by a separate body (Belgium, France, Ireland[110], Liechtenstein, Luxembourg).

What is regulated?
Regulation of PHI has three main goals (Chollet and Lewis 1997):

- maintaining market stability by setting financial and non-financial standards for insurer entry and operation, conditions for insurer exit and requirements for financial reporting, scrutiny and oversight
- protecting consumers by governing insurers' marketing practices and their relations with health care providers
- improving access to PHI through open enrolment (guaranteed issue), lifetime cover (guaranteed renewal), community rating, premium review, approval or caps, mandated (usually minimum) benefits, prohibition on exclusion of pre-existing conditions from cover

[110] This refers to prudential regulation only; all three insurers are regulated for their health insurance business by the HIA. Vhi Healthcare should come under the same prudential regulatory framework in 2009.

Table 11 Bodies responsible for regulating the PHI market, 2008

Country	Bodies
Austria	Austrian Financial Market Authority
Belgium	Commercial: Banking Financing and Insurance Commission Mutual: Control Office of Mutual Funds and national unions of mutual funds
Bulgaria	Financial Supervision Commission, Insurance Supervision Department
Cyprus	Insurance Companies Control Service (under the Ministry of Finance)
Czech Republic	Czech National Bank
Denmark	Danish Financial Supervisory Authority
Estonia	Financial Supervisory Authority
Finland	Insurance Supervisory Authority (under the Ministry of Social Affairs and Health)
France	Commercial: French Ministry of Economics and Finance, Commission of Insurers Control (linked to the French Ministry of Economics and Finance) Mutual and provident: Commission of Control of Mutuelles and Provident Institutions, Ministry of Health Department of Social Security (linked to the General Inspectorate of Social Affairs (IGAS) in the French Ministry of Health) Since 2003 all three types of insurer have been governed by a single agency: Autorité de Contrôle des Assurances et des Mutuelles (ACAM).
Germany	Federal Supervisory Office for Financial Services (BaFin), a subsidiary body of the Federal Ministry of Finance
Greece	Ministry of Development, Directorate of Insurance Companies and Actuaries
Hungary	Commercial: Hungarian Financial Supervisory Authority Mutual: Health Insurance Supervisory Authority (established in 2006)
Iceland	Iceland Financial Supervisory Authority
Ireland	Health Insurance Authority (regulator), Department of Health and Children (legislator) Prudential regulation: Vhi (Department of Health and Children)[111]; Quinn Healthcare and Hibernian AVIVA Health (the Financial Regulator)
Italy	Private Insurance Supervisory Authority (ISVAP) (primarily), Ministry of Health (complementary PHI covering statutory user charges)
Latvia	Financial and Capital Market Commission
Lithuania	Insurance Supervisory Commission of the Republic of Lithuania
Liechtenstein	Commercial: Financial Market Authority Non-profit: Office of Health
Luxembourg	Commercial: Insurance Commission Mutual: Ministry of Social Security
Malta	Malta Financial Services Authority
Netherlands	Nederlandse Bank (DNB)
Norway	Norwegian Financial Supervisory Authority
Poland	Polish Financial Supervision Authority
Portugal	Portuguese Insurance Institute (ISP), Portuguese Association for Consumer Protection (DECO), Portuguese Competition Authority (AdC)
Romania	Insurance Supervisory Commission
Slovakia	State Health Care Authority
Slovenia	Complementary (UC): Ministry of Health, Insurance Supervision Agency Complemenary (S) and Suppplementary: n/a
Spain	Bank of Spain, Department of Health (in each region)
Sweden	Swedish Financial Supervisory Authority
UK	UK Financial Services Authority
US	ERISA plans: US Department of Labor Private Medicare plans: Centers for Medicare and Medicaid Services MCOs in Medicaid: Department of Health and Human Services (in each state) PHI: state insurance commissions (along with HHS and HIPAA)

[111] Vhi Healthcare to be regulated by the Financial Regulator by the end of 2009.

The first goal falls under the category of financial or prudential regulation. The second and third goals fall under the category of material or contract regulation. Approaches to regulation of PHI vary across countries, with some governments favouring minimal financial regulation and others preferring heavier material regulation. The nature, extent and effectiveness of a regulatory framework are affected by a range of factors including the role of PHI in the health system, aspects of market structure (for example, the number and type of insurers in operation), political ideology, government capacity and legal constraints.

The European Union has a framework for financial regulation and all member states are expected to comply with minimum solvency standards. They are also expected to comply with EU rules on contracts and complaints procedures. In many countries (at least half of all member states; see Table 12) the regulations applied to PHI do not go beyond this: PHI is regulated in the same way as any other financial service and the legislative framework does not include specific mention of PHI. This is more likely to be the case where commercial PHI is concerned and/or in predominantly supplementary markets. In a further handful of countries the general insurance legislation may include sections relating exclusively to PHI (Austria, Finland, Lithuania).

National regulation goes beyond general insurance requirements in PHI markets with a strong mutual or non-profit tradition (Belgium, France, Ireland, Luxembourg); where the market plays a substitutive role (Germany) or a complementary role covering statutory user charges (Italy, Slovenia); or where regulation is not directly constrained by EU legislation (Liechtenstein)[112]. Countries that attempt to apply different rules to different types of insurer probably contravene EU law (see Part 2).

Material regulation applied to PHI in EU member states aims to improve access to the market and includes the following interventions:

- open enrolment: Belgium, Ireland, Germany (for the basic policy), Slovenia[113]
- lifetime cover: Belgium, Ireland, Germany
- community-rated premiums: the whole market in Ireland; the mutual market only in Belgium, Hungary, Italy and Luxembourg; the complementary market covering user charges in Slovenia; and EHIF substitutive policies in Estonia
- systematic prior notification of premiums and changes to premiums and/or policy conditions[114]: Austria, Germany (substitutive PHI), Liechtenstein, Luxembourg (mutuals only), Romania, Slovenia
- premium caps: Germany (for the basic policy)
- minimum or standard benefits: Ireland, Germany (for the basic policy)
- cover of pre-existing conditions: Belgium (mutuals only cannot charge higher premiums for pre-existing conditions), Ireland (subject to maximum permissible waiting periods)
- risk equalisation: Ireland[115], Slovenia

[112] In the US the advent of managed care has also led to new tasks and challenges for regulators who once focused simply on solvency (Brown 2008). However, there are some general regulations that appear to govern insurer conduct in most states, including solvency, insurer obligations, proposing and concluding contracts, privacy, reporting, reserves, consumer information, complaints protocol and supervision, among others.

[113] Open enrolment is not a legal requirement in France but is encouraged through fiscal policy.

[114] Abolished as a requirement for Vhi Healthcare in Ireland in 2008.

[115] Risk equalisation is permitted in theory in Ireland. A risk equalisation scheme was implemented in 2006 but suspended in 2008 following a Supreme Court ruling (see Part 2).

Trends in regulation

Government intervention in the market has intensified in several countries in the last 15 years, mainly in Belgium, France, Germany, Ireland and Slovenia. These regulations are overwhelmingly intended to improve access to PHI and to improve financial protection for those covered by PHI. In some cases they have been intended to enhance consumer choice and consumer protection – for example, by making ageing reserves portable in Germany and by increasing the level of information insurers are required to provide potential and existing subscribers.

Table 12 Summary of regulation specific to the PHI market, 2008

Country	Main regulations	PHI-specific legislation
Austria	Insurer obligations for each type of PHI, waiting times, cover of dependants (substitutive PHI), scope of cover, leaving group cover, changes to policy conditions and premiums (insurer must notify Financial Market Authority), services provided (tariff rules), rules for mutuals (definitions, reserves)	Insurance Contract Law (amended 1994) has PHI-specific sections; also the Law on the Supervision of Insurance Undertakings
Belgium	Mutual: open enrolment for hospital cover up to age 65 (65+ if people already covered by their previous mutual), cover of pre-existing conditions without higher premiums[lllll], prohibition of waiting periods for hospital cover if individuals were already covered by their previous mutual, restrictive conditions for changing coverage or contributions, commercial practices All insurers: lifetime cover, prohibition from changing policy conditions (premiums and benefits)[mmmmm], exclusion of pre-existing conditions only if diagnosed or should have been known at contract start contract[nnnnn], cover of chronically-ill or disabled people <65, portability (group cover portability not	Mutual Health Funds Act 1990 (amended 2007); Act on PHI Contracts 2007
Bulgaria	Health insurance reserves, use of gender as an actuarial factor[ooooo]	Health Insurance Act 1998
Cyprus	None	No PHI-specific legislation
Czech Republic	None	No PHI-specific legislation
Denmark	None	No PHI-specific legislation
Estonia	None	No PHI-specific legislation
Finland	None	Insurance Contracts Act (amended 2005) has section on PHI
France	Mutual: Governance, objectives, organisation, reimbursement[ppppp] All insurers: Advertising, penalties for anti-competitive behaviour	1986 price ordinance
Germany	Substitutive: Premium setting, pricing/reimbursement of services, benefits covered by substitutive PHI, ageing reserves, information for consumers; SGB V sets the criteria for statutory scheme membership and thus defines the boundary between SHI and PHI; regulates employer contributions to PHI premiums, eligibility criteria for the standard policy, aspects relating to civil servants; regulates the basic policy which is subject to open enrolment for eligible people (since 2007)	The Social Code Book (SGB V)
Greece	None	No PHI-specific legislation
Hungary	None	Mutual: 1993 Act XCVI on Voluntary Mutual Insurance Funds

[lllll] Pre-existing conditions that have been noted in the medical questionnaire or are diagnosed within the first two years of cover cannot be excluded but cover of these conditions can be limited to a specific monetary amount (a minimum level is legally specified).
[mmmmm] Except in explicit cases enumerated in the law and subject to the approval of the Banking Financing and Insurance Commission (BFIC).
[nnnnn] Pre-existence cannot be invoked if the diagnosis is not established within two years of the start of the contract.
[ooooo] Only allowed if reliable statistical data show gender is a determining factor in health insurance risk assessment, unrelated to pregnancy/maternity and subject to the approval of the deputy Chair of the Financial Supervision Commission.
[ppppp] The amount reimbursed to subscribers cannot exceed the price, via co-payment plus balance billing, paid by the insured.

		Commercial: No PHI-specific legislation
Iceland	None	No PHI-specific legislation
Ireland	Community rating, lifetime cover, minimum benefits, open enrolment, risk equalisation (the latter not currently in operation)	VHI Act 1957 (amended 1996, 1998,2008); Health Insurance Act 1994 (amended 2001, 2003, 2007) and associated regulations under the Health Insurance Act 1994, as amended
Italy	Complementary (UC): premiums, degree of coverage, services covered Supplementary: None	Complementary (UC): 1999 National Health System Reform Law Supplementary: No PHI-specific legislation
Latvia	None	No PHI-specific legislation
Liechtenstein	Commercial: Premiums, rate schedule, scope and type of benefits, insurers must let subscribers know four weeks in advance of a premium increase Non-profit: Notification of premium increases to the Office of Health	Sickness Insurance Act
Lithuania	Benefits covered by PHI	Health Insurance Law 1996; Insurance Law 2003 (section on PHI)
Luxembourg	Commercial: Premiums Mutual: Approval of statutes defining fees and benefits, changes in fees and benefits	n/a
Malta	The Financial Services Authority issues health insurance guidelines	No PHI-specific legislation
Netherlands	Insurers prohibited from terminating a voluntary PHI contract if a person switches to another insurer for mandatory cover.	Health Insurance Act 2006 contains only one PHI-specific regulation
Norway	None	No PHI-specific legislation
Poland	None	No PHI-specific legislation
Portugal	Consumer information (by DECO)	No PHI-specific legislation
Romania	Changes in premiums within the same risk category, insurer-subscriber and insurer-provider relationships	Law 95/2004 on health care reform; methodological norms of 22 February 2007 regarding VHI
Slovakia	None	Health Insurance Act 2004 (updated 2005, 2006, 2007)
Slovenia	Complementary (UC): Premium approval and increases, open enrolment, community rating, risk equalisation Other PHI: None	Complementary (UC): 1992 Health Care and Health Insurance Act Other PHI: No PHI-specific legislation
Spain	PHI definition	No PHI-specific legislation
Sweden	None	No PHI-specific legislation
UK	None	No PHI-specific legislation
US	Mandated benefits, premiums (some states require approval of increases), guaranteed issue (open enrolment; some states), consumer appeals, conduct of managed care plans (ie prompt payment to providers, external appeals for aggrieved consumers, financial arrangements with providers etc depending on the state), mergers, takeovers and sales of one plan by another	ERISA HIPAA

Note: n/a = information not available.

Tax policy

In this section we focus on tax policy towards PHI in the form of tax incentives (eg tax relief) and disincentives (eg premium tax) for individuals and employers. Tax relief permits the deduction of all or some of the cost of PHI premiums from taxable personal or corporate income. Disincentives usually involve: either a tax on PHI premiums (insurance premium tax; IPT) to be paid by the insurer (but often included in the price of the premium); or payment of tax on benefits in kind to be paid by the individual receiving employer-paid PHI as a benefit in kind and/or by the employer providing PHI as a benefit in kind.

Most EU member states offer some form of tax incentive for PHI (see Table 13). Tax incentives are aimed at individuals (Germany, Ireland, Luxembourg, Romania), groups (Belgium, Denmark, Finland, Latvia, Spain, Sweden) or both (Austria, Bulgaria, Greece, Italy, Portugal, Slovenia). There are no tax incentives in a handful of countries (the Czech Republic, Estonia, Norway, Poland, the UK). In Germany and Romania capped tax relief applies to all insurance premiums, not just PHI, and therefore does not create an incentive to purchase PHI. Tax disincentives are applied to individuals in some countries (Estonia, Lithuania, Poland, the UK). In Ireland and Sweden there are tax disincentives for groups (for employer-paid cover only) and individuals respectively, but the size of the disincentive is very small.

Some countries use tax policy to favour mutual associations, for example by exempting their premiums from tax. This is currently the case in Hungary and Luxembourg, although it used to occur in Belgium and France as well. In both Belgium and France it was found to contravene EU law and was subsequently abolished (see Part 2). The French government now uses tax policy to reward insurers who behave in certain ways. Insurers who refrain from asking subscribers to complete a medical questionnaire and who respect certain other social obligations are exempt from insurance premium tax (currently 7%) (Chevreul and Perronin 2009).

Tax incentives have been lowered in Italy (1992), Ireland (1995-1997), Austria (1996 and 1999) and Greece (1997). They have been expanded in Portugal (1999) and Lithuania (2007). Spain abolished them for individuals and introduced them for groups in 1999. Norway and the UK have also introduced and abolished tax incentives. Denmark abolished them in 1986 and re-introduced them (for groups) in 2002. In countries that have lowered or abolished tax incentives, there has not been any negative effect on demand.

Tax incentives can imply a major subsidy to PHI. For example, tax relief on PHI premiums cost the Irish government €321 million in 2008 – roughly equal to 2.5% of total public spending on health care (Revenue Commissioners 2009)[121].

[121] The US Treasury forgoes about $200 billion each year by allowing businesses to deduct their expenses for worker coverage from taxes and by excluding the value of employer payments for health coverage from individual taxable income. This policy began in the 1940s (when health benefits were exempt from the wage/price freeze during World War II), gained legislative sanction in the 1950s, and has been an important feature ever since. Since it so heavily favours employer-based coverage, this policy provides powerful public financial incentives for the spread of PHI, to the detriment of demand for national health insurance. For the past 50 years, economists have criticised this system as inequitable (since the value of the exclusion rises with income) and inefficient (since using pre-tax dollars encourages people to buy 'Cadillac' plans and then to use unnecessary care, which creates moral hazard and drives costs). As such, there have been calls for exclusions to be capped or eliminated, but trade unions have traditionally defended these provisions and conservatives have been wary of proposing a tax increase on millions of Americans. Conservative fears were confirmed in the 2008 presidential campaign when presidential candidate John McCain proposed exchanging the tax exclusions for a tax credit and promptly came under fire as a tax increaser (Brown 2008).

Table 13 PHI tax incentives and disincentives, 2008

Country	Tax incentives for PHI uptake	Tax disincentives for PHI uptake
Austria	Individual: 25% of premiums tax deductible (up to €2,920 per year; up to €4,380 for households with one earner; up to €7,300 for households with at least three children); this only applies to households with annual incomes lower than €36,400; beyond this amount, deductions are reduced linearly up to an income limit of €50,900 per year, after which there is no tax relief Group: Premiums up to €300 per employee per year deductible from corporate tax and exempt from being taxed as a benefit in kind for employees if all employees in the company are covered	None
Belgium	None	Employer-paid premiums (in individual and group cover) taxed as a benefit in kind
Bulgaria	Premiums tax deductible for individuals and employers	None
Cyprus	Premiums for approved health schemes will be tax deductible (but regulations establishing the criteria that the scheme must satisfy in order to be approved have not yet been issued)	None
Czech Republic	None	None
Denmark	Individual: None Group: Premiums deductible from corporate tax if all employees in a company are covered	None
Estonia	None	Non-substitutive group cover is subject to a 33% tax on benefits in kind (for employees)
Finland	Individual: None Group: PHI is not taxed as a benefit in kind for employees if all employees in a company are covered	None
France	None	Policies requiring medical questionnaires are subject to a 7% tax
Germany	All insurance premiums (not just PHI) tax deductible (up to €2400 per year for a person with substitutive PHI and €1500 civil servants with non-substitutive PHI[122]	
Greece	Individual: Premiums deductible from income tax (up to €1200 per year) Group: Premiums deductible from employee income tax (up to €1500 per year per employee)	None
Hungary	Mutual: 30% tax rebate on premiums (up to HF100,000 per year) Commercial: None	n/a
Iceland	n/a	n/a
Ireland	Premiums granted tax relief at source at the basic rate of income tax (20%)	Employer-paid premiums taxed as a benefit in kind
Italy	Individual: 19% of medical expenses can be deducted from taxable income, even if covered by PHI (subject to a deductible of €129) Group: Premiums tax deductible up to €1250 per year	None
Latvia	Individual: None Group: Premiums exempt from personal income tax and corporate tax and employee social	None

[122] A this applies to all insurance, many people reach the limit without PHI. The threshold may be raised in 2009.

	insurance contributions (if premiums do not exceed 10% of gross annual salary or LVL300 for income tax and five times the minimum wage for contributions)	
Lithuania	Individual: None Group: Employer-paid premiums exempt from personal income tax and corporate tax; employers providing PHI are exempt from corporate tax on social health insurance contributions	Premiums subject to personal income tax (at 15%)
Liechtenstein	n/a	n/a
Luxembourg	Individual: Premiums tax deductible up to €672 per person per year Group: None	n/a
Malta	n/a	n/a
Netherlands	n/a	n/a
Norway	None[123]	None
Poland	None	Premiums for individual subscribers are taxed as a benefit in kind (excepting occupational health cover)
Portugal	Premiums and out of pocket payments are tax deductible; the tax incentives are stronger for group than for individual cover	None
Romania	Individual: All insurance premiums (not just PHI) are tax deductible up to €200 per year[124] Group: None	None
Slovakia	n/a	n/a
Slovenia	Premiums tax deductible	None
Spain	Individual: None[125] Group: Granted tax relief at a rate of 38% and not taxed as a benefit in kind for employees	None
Sweden	Individual: None Group: The portion of the premium covering statutory user charges is tax deductible for employers	Individual subscribers pay tax on the portion (2-3%) of the premium that covers statutory user charges
UK	None[126]	Premiums subject to a 5% insurance premium tax; employer-paid PHI taxed as a benefit in kind; PHI provided to retirees by employers taxed as pension income
US	Individual: None Group: Employers can deduct their expenses for employee cover from taxable income; the value of employer payments for health cover are also exempt from taxable income	None

Note: n/a = no information available

[123] A tax reduction for companies who purchased PHI for their employees was introduced in 2003 and revoked in 2006.
[124] This is so low that it is not considered to be an incentive.
[125] Abolished in 1999.
[126] Tax relief on PHI premiums was introduced for those over age 60 in 1990 but it was abolished in 1997.

Part 2 EU law and public policy towards private health insurance

Sarah Thomson
Elias Mossialos

Regulation and the Third Non-Life Insurance Directive

In 1992 the legislative institutions of the European Union (EU) adopted regulatory measures in the field of health insurance[127]. The mechanism affirming the free movement of health insurance services – the Third Non-Life Insurance Directive[128] – does not apply to health insurance that forms part of a social security system (1992). But all other forms of health insurance, which we refer to as 'private health insurance', fall within the Directive's scope. This part of the report examines the implications of the Directive, and some aspects of EU competition law, for regulation of private health insurance in the European Union. The EU-level regulatory framework created by the Directive imposes restrictions on they way in which governments can intervene in markets for health insurance. However, there are areas of uncertainty in interpreting the Directive, particularly with regard to when and how governments may intervene to promote public interests. As in most spheres of EU legislation, interpretation largely rests on European Court of Justice (ECJ) case law, so clarity may come at a high cost and after considerable delay.

We also question the Directive's capacity to promote consumer and social protection in health insurance markets. In many ways the Directive reflects the health system norms of the late 1980s and early 1990s, a time when boundaries between 'social security' and 'normal economic activity' were still relatively well defined in most member states (White 1999). Today these boundaries are increasingly blurred – the new health insurance system in the Netherlands is a case in point. As governments look to private health insurance to ease pressure on public budgets or to expand consumer choice, uncertainty about the scope of the Directive and concerns about its restrictions on regulation are likely to grow.

We base our analysis on discussion of private health insurance-related ECJ rulings and cases of infringement of the Directive or other EU rules. Where actual examples are lacking, the analysis is, inevitably, more speculative. In the following sections we provide a brief introduction to private health insurance in the European Union; summarise the main changes brought about by the Directive and its initial impact on regulation of private health insurance in EU member states; examine uncertainty as to when and how governments can intervene in health insurance markets; and conclude with a summary of key points.

Health insurance attempts to alleviate some of the uncertainty around ill health. We do not usually know if or when we might fall ill; nor do we always know how severe an illness will be or how much it will cost to treat it. By pooling health risks (across groups of people) and resources (over time), health insurance provides protection from the financial risk associated with ill health. In this way it makes a valuable contribution to social welfare. However, markets for health insurance require regulation to protect consumers and insurers from the potentially negative effects of market failures such as adverse selection and risk selection (Barr 2004). Without government intervention to correct market failures, health insurance would not be easily accessible to people at high risk of ill health, people already in ill health and people with low incomes. Governments in most

[127] The authors are grateful to Rita Baeten, Tamara Hervey and Willy Palm for their comments on an earlier draft of this part of the report.
[128] Council Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (third non-life insurance Directive). From here on we refer to this as 'the Directive'. EC directives are secondary legislation, subordinate to primary legislation in the form of the EC Treaty.

high-income countries therefore ensure that health insurance is compulsory for the whole population, that contributions are based on income and that publicly-financed 'insurers' (whether sickness funds, private insurers or a national health service) cannot deny cover to any individual.

In contrast to the rules applied to statutory health insurance, the principles of which are broadly convergent across the European Union, there is considerable variation in the regulation of private health insurance. Prior to the introduction of the Directive in 1992, the extent to which EU governments intervened in markets for health insurance was largely determined by the role private cover played in the health system. Thus, substitutive private health insurance in Germany and the Netherlands tended to be relatively heavily regulated, mainly to ensure access to private cover for older people and people in poor health, but also to protect the finances of the statutory health insurance scheme, which in both cases covered a disproportionate amount of higher-risk households (Thomson and Mossialos 2006)[129]. The extent of regulation was also influenced by aspects of market structure, such as the number and mix of insurers in operation – particularly markets dominated by mutual associations – and political ideology.

Two broad approaches to regulation prevailed: minimal financial or prudential regulation focusing on solvency levels, or material regulation emphasising control of prices and products. While both approaches aimed to protect consumers from insurer insolvency[130], material regulation also endeavoured to ensure access to health care through access to health insurance. Under the subsidiarity principle – established in EU law through the European Community Treaty (Article 5 EC) – governments were free to decide on the appropriate form of regulation required in a given context. Over the last thirty years the EU legislature has restricted this freedom by introducing a series of directives aimed at creating an internal market in insurance services (European Commission 1973; European Commission 1988; European Commission 1992). Grounded in the principle of the free movement of services (enshrined in Article 43 EC, Article 49 EC and Article 50 EC), the internal market in insurance services was intended to enhance competition and consumer choice. EU competence in this area comes from the fact that insurance is considered to be an economic activity.

The Third Non-Life Insurance Directive created, for the first time, an EU-level framework for regulating health insurance. The first and second generation of insurance directives had been limited to the cover of 'large risks' of a commercial nature such as aviation or marine insurance and re-insurance (which were considered small enough, in relation to the size or status of their policy holders, not to require special protection) (Merkin and Rodger 1997). 'Mass risks' involving individuals and small businesses were excluded on the grounds that they required special protection because their policy holders would not normally have the ability to judge all the complexities of the obligation they undertook in an insurance contract (Nemeth 2001). The third generation of insurance directives extended the

[129] This is partly due to the way in which these systems are (were, in the Dutch case) designed and regulated. For example, in Germany the statutory health insurance scheme is attractive to families because it covers dependants for free, whereas private insurers charge separate premiums for all family members. It is also due to risk selection by private insurers.
[130] Financial or prudential regulation focuses on ex post scrutiny of an insurer's financial returns on business. Material or contract regulation involves ex ante scrutiny of an insurer's policy conditions and premium rates on the grounds that this eliminates the potential for insolvency.

application of internal market legislation to all types of risks, including mass risks such as health insurance.

As a result of the Directive, insurers have full freedom to provide services throughout the European Union, with or without a branch presence. The mechanisms facilitating free movement are 'home country control' (Article 9), a single system for the authorisation and financial supervision of an insurance undertaking by the member state in which the undertaking has its head office; the mutual recognition of systems of authorisation and financial supervision; and the harmonisation of minimum solvency standards (Article 17). ECJ case law confirms that insurance activities fall under the scope of the Directive (Article 2) when they are carried out by insurance undertakings at their own risk, following insurance techniques, and on the basis of contractual relationships governed by private law (European Court of Justice 1996; European Court of Justice 2000). ECJ case law more broadly (not relating to the Directive) also suggests that activities with an exclusively social purpose involving solidarity are beyond the scope of internal market and competition rules (European Court of Justice 1993; 2004).

To protect the freedoms outlined above and to prevent barriers to competition, the Directive brought about two key changes for private health insurance. First, the Directive accords primacy to the financial approach to regulation; the requirement for governments to abolish existing product and price controls (Article 6.3, Article 29 and Article 39) renders material regulation redundant and, in some cases, illegal. Second, it requires governments to open markets for private health insurance to competition at national and EU levels (Article 3).

Material regulation in the form of national rules requiring the prior approval or systematic notification of policy conditions, premium rates, proposed increases in premium rates and printed documents insurers use in their dealings with policy holders are no longer permitted (Article 6.3, Article 29, Article 39 and Recital 23). Such rules played an important regulatory function in several countries, notably France, Germany and Italy. However, most member states amended existing laws or passed new laws to comply with the Directive. Legislative changes generally involved the introduction of tighter solvency controls. Some also resulted in the loosening or outright abolition of prior approval and systematic notification[131]. France proved to be the exception in this respect, contravening the Directive by continuing to insist that insurers notify the supervisory authority when they launched a new product (European Commission 2000b). The European Court of Justice ruled against the French government in May 2000 (European Court of Justice 2000).

Although the Directive prevents governments from introducing regulatory measures that go beyond solvency requirements, member states do retain limited residual powers to protect policy holders. For example, if the home supervisory authority fails to prevent an insurer from infringing the host country's domestic law, the host supervisory authority may take action (Article 40.5). More importantly, the host supervisory authority may impose specific measures in the form of restrictions on insurance contracts, in the interest of the 'general good', where contracts covering health risks 'may serve as a partial or complete alternative to health cover provided by the statutory social security system' (Article 54.1

[131] The Irish government obtained a derogation from the Directive for Vhi Healthcare with respect to prior approval and systematic notification. However, this requirement was removed from national legislation in 2008.

and Recital 22). Where this is the case, the government can require private insurers to 'comply with the specific legal provisions adopted by that member state to protect the general good in that class of insurance' (Article 54.1 and Recital 24).

Article 54.2 and Recital 24 of the Directive list the types of legal provisions that may be introduced if private cover provides a partial or complete alternative to statutory cover: open enrolment, community rating, lifetime cover, policies standardised in line with the cover provided by the statutory health insurance scheme at a premium rate at or below a prescribed maximum, participation in risk equalisation schemes (referred to as 'loss compensation schemes') and the operation of private health insurance on a technical basis similar to life insurance. Measures taken to protect the general good must be shown to be necessary and proportional to this aim; not unduly restrict the right of establishment or the freedom to provide services; and apply in an identical manner to all insurers operating within a member state.

The German government has used Article 54.1 to justify intervention in its substitutive market, where risk selection by private insurers has prevented some older people and people with chronic illnesses from buying an adequate and affordable level of private cover (Wasem 1995). Regulatory measures include the provision of lifetime cover, the introduction of policies with mandatory pooling, standardised minimum benefits, guaranteed prices and the establishment of indirect cross subsidies from those with private to those with public coverage. The same regulatory measures were also present in the Dutch substitutive market prior to 2006. Private insurers in the German substitutive market are subject to further regulation concerning the way in which they fund cover (on a similar basis to life insurance) and the provision of information to potential and existing policy holders.

In contrast, regulation of many markets for complementary and supplementary cover has tended to focus on ex post scrutiny of financial returns on business to ensure that insurers remain solvent. Insurers are often permitted to reject applications for cover, exclude cover of, or charge higher premiums for, individuals with pre-existing conditions, rate premiums according to risk, provide non-standardised benefit packages and offer annual contracts, while benefits are usually provided in cash rather than in kind. However, there are some notable exceptions – many of them recent – particularly where complementary private health insurance is concerned. Relatively heavily regulated markets for complementary cover can be found in Belgium, France, Ireland and Slovenia. It is no coincidence that these are also the countries in which regulation of private health insurance has been most problematic from an EU law perspective (see below).

Implications for government intervention in health insurance markets

At first sight the Directive appears to give governments significant scope for regulating private health insurance under the general good principle, which broadly refers to any legislation aimed at protecting consumers (in any sector, not just the insurance sector). But on closer examination, interpretation of the principle is shown to be problematic in two areas: first, the issue of what is meant by complete or partial alternative to statutory health insurance; and second, what types of intervention are necessary and proportional. These problems arise because there is no agreed definition of the general good; interpretation

relies on ECJ case law. Following complaints about the absence of a definition, the European Commission[132] tried to clarify when and how the general good might be invoked in the insurance sector, but its interpretive communication failed to provide new information (European Commission 2000a). Calls for further clarification persist on the grounds that the lack of a definition creates legal uncertainty, while the process of testing questionable use of the general good through the courts is prohibitively lengthy and expensive (Mossialos and Thomson 2004). We discuss interpretation of the general good in relation to when and how governments can intervene in markets for private health insurance.

When can governments intervene?

There is uncertainty about when the general good can be invoked to justify material regulation, mainly because the Directive does not define what it means by partial or complete alternative to statutory health insurance. How then can we distinguish between private cover that falls into this category and private cover that does not? Circumstantial factors suggest that the distinction may hinge on whether or not private health insurance plays a substitutive role. For example, Article 54 was inserted during negotiations prior to the drafting of the Directive at the instigation of the German, Dutch and Irish governments (Association Internationale de la Mutualité 1999). Perhaps as a result of lobbying by member states with substitutive markets, the regulatory measures outlined in Article 54.2 are an exact match of those that were in place in Germany, Ireland and the Netherlands when the Directive was being negotiated. To date, the regulations applied to private insurers in these three countries have not been challenged by the Commission[133]. In addition, a summary of the Directive dating from 2006 and available on the Commission's website refers to the Directive having 'specific rules for health cover serving as a *substitute* for that provided by statutory social security systems' (our italics) (European Commission 2006b).

Recent policy developments in the Netherlands shed further light on how we might make this distinction. Dissatisfaction with the dual system of statutory cover for lower earners and voluntary private cover for higher earners had led successive Dutch governments to consider the introduction of a single, universal system of health insurance. Some governments favoured a public system, others preferred private options, in spite of concerns about the applicability of internal market rules to a private system (Maarse 2002). In 2006 a universal and compulsory privately-operated system governed under private law came into force. Regulatory measures under the new system include open enrolment, lifetime cover, government-set income-based contributions deducted at source, additional community-rated premiums set by each insurer, a package of minimum benefits in kind or cash defined by the government and a risk equalisation scheme (Hamilton 2003).

Prior to the introduction of the new system the Dutch government asked the Commission to clarify whether or not Article 54 could be relied on to justify such extensive regulation (Hoogervorst 2003). The Commission's response came in the form of a letter to the Dutch Minister of Health from the (then) Commissioner for the Internal Market Frits Bolkestein

[132] From here on we refer to the European Commission as 'the Commission'.
[133] Although, some aspects of the regulatory environment in Ireland have recently been questioned by the Commission (see below).

(Bolkestein 2003). In the letter Bolkestein states that the privately-operated system falls within the scope of the Directive, even though it is compulsory, because the insurers involved are carrying out 'an insurance activity'. However, he notes that the regulatory measures can be justified under Article 54 for two reasons: first, the system, though private, can be construed as constituting a 'complete alternative' to statutory health insurance; and second, the regulations (with some caveats, see below) 'appear necessary to ensure legitimate objectives pursued by the Dutch government' (Bolkestein 2003). The Commission supported this position in response to written questions put forward by Members of the European Parliament in 2005 (McCreevy 2005; McCreevy 2006; McCreevy 2006). It also stated that the new Dutch system was 'to be considered as a statutory sickness insurance scheme' (Špidla 2006).

Bolkestein's letter goes on to point out that it would not be proportionate to apply the proposed regulatory measures to 'any *complementary* insurance cover offered by private insurers *which goes beyond the basic social security package of cover* laid down by the legislation' (our italics) (Bolkestein 2003). The letter therefore suggests that 'partial or complete alternative' can be understood in terms of the benefits provided by a particular insurance scheme. Substitutive private health insurance constitutes an alternative to statutory cover because it replaces statutory benefits for those who are excluded from some aspects of the statutory system (for example, higher earners in the Netherlands prior to 2006 or self-employed people in Belgium prior to 2008) or those who are allowed to choose statutory or private cover (higher earners in Germany). Whether the substitutive cover is a partial or complete alternative depends, presumably, on whether the benefits it provides are 'partial' (for example, cover of outpatient care in Belgium) or 'complete' (cover of outpatient and inpatient care in Germany and the Netherlands). Conversely, complementary and supplementary cover cannot be construed as alternatives to statutory cover because they offer benefits in addition to those offered by the statutory system.

On the basis established in Bolkestein's letter, material regulation would only be permissible where private health insurance covers the same benefits as those provided by statutory health insurance. But 'partial alternative' could be interpreted in other ways. The logic behind allowing governments to intervene in substitutive markets implies that purely financial regulation of solvency levels will suffice for the purposes of consumer protection but will not be enough to ensure social protection (access to health care). Bolkestein's letter implicitly assumes that only substitutive private health insurance provides social protection. But what if other forms of private health insurance also contribute to social protection? For example, where the statutory benefits package (the 'basic social security package of cover' mentioned by Bolkestein) is relatively narrow – and/or subject to extensive co-payments – it could be argued that individuals do not have adequate protection from the financial risk associated with ill health unless they purchase complementary private health insurance covering excluded (and effective) services and/or statutory user charges. In such cases complementary cover provides a degree of social protection. Material regulation to prevent private insurers from selecting risks might therefore be justified. Under the Directive, however, rules to ensure affordable access to complementary private cover would not be permitted since a complementary market (under Bolkestein's definition) would not be covered by Article 54.1.

The implications of outlawing material regulation of complementary cover depend on various factors, not least the extent to which this form of cover does, in practice, contribute to social protection. This issue may become more serious in future if markets for

complementary cover develop and expand in light of constraints on public funding. For example, in recent years policy makers across the European Union have intensified efforts to define statutory benefits packages, often putting in place explicit criteria (including cost effectiveness) to determine whether or not certain procedures should be publicly financed (Gibis et al 2004; Schreyögg et al 2005). Such efforts may implicitly assume that statutory benefits packages can be complemented by voluntary take-up of private insurance covering less effective and/or non-cost-effective services. In practice, however, efforts to set priorities and measure cost-effectiveness tend to be limited by technical, financial and political considerations, making it easier for governments to exclude whole areas of service, such as primary care, outpatient drugs or dental care, than single interventions of low cost-effectiveness (Ham and Robert 2003). This means that complementary insurance often covers a range of necessary and cost-effective services. Similarly, in some countries governments have introduced or raised statutory user charges to supplement public resources, again under the assumption that complementary cover will bridge the funding gap. Complementary cover of statutory user charges in France has grown from covering 33% of the population in 1960 to 85% in 2000 (Sandier et al 2004). It now accounts for about 13% of total expenditure on health. Complementary cover of statutory user charges introduced in Slovenia in 1993 now covers over 90% of the population eligible to pay user charges (about 70% of the total population) and accounts for over 11% of total health expenditure (Albreht et al 2002).

However, greater reliance on complementary cover can create or exacerbate inequalities in access to health care. In France, the likelihood of having complementary cover and the quality (generosity) of that cover have been highly dependent on social class and age, employment and income levels (Blanpain and Pan Ké Shon 1997; Bocognano et al 2000). Research from France and Spain shows that those who do not have complementary cover do not consult doctors and dentists as frequently as those with cover (Breuil-Genier 2000; Rajmil et al 2000). In Slovenia there are concerns about the affordability of complementary cover and its effect on access to publicly-financed health care (Albreht et al 2002). Anecdotal evidence suggests that doctors may be reluctant to provide publicly-financed care to people without private cover in case they are unable to pay the necessary user charges (Milenkovic Kramer 2009). There are also concerns for market stability, as complementary private health insurance covers a disproportionately high number of older people.

Governments in several member states recognise that complementary cover of statutory user charges can contribute significantly to social protection. In 2000 the French government introduced free complementary cover for people with low incomes (CMU-C), raising the proportion of the population covered to over 92% (Durand-Zaleski 2008). In 2006 it extended favourable tax treatment to any private insurers offering open enrolment and community-rated premiums (see below). Since 2005 the Slovenian government has required private insurers to offer open enrolment and community-rated policies accompanied by a risk equalisation scheme (Milenkovic Kramer 2006a). In 2007 the Belgian government also introduced open enrolment and other rules to ensure access to health insurance, particularly for people in poor health and disabled people.

The lack of a definitive interpretation of partial or complete alternative creates further uncertainty when we consider what happens if a particular market for health insurance changes from playing a substitutive to a complementary role. In Ireland, for example, private health insurance developed at a time when entitlement to publicly-funded inpatient

and outpatient care was restricted to low- and middle-income households. A significant proportion of the population (15%) could only access health services by paying out of pocket or buying private cover, which may explain why, when the Irish market was liberalised in 1994, private insurers were subject to quite stringent regulation involving open enrolment, minimum benefits, community-rated premiums and a risk equalisation scheme[134] (see below). However, the level of public benefits has gradually increased so that low-income households and all those aged 70 and over have free access to all types of care, while non-elderly higher-income households have access to services that are predominantly publicly-funded but subject to co-payments[135] (McDaid and Wiley 2009 forthcoming). In 2006 the government further increased the number of people eligible for free primary care (Department of Health and Children 2006). The regulatory framework originally justified under Article 54.1 could now be questioned on the grounds of whether or not private health insurance in Ireland still constitutes a partial or complete alternative to statutory health insurance. In other words, it is debatable whether the Irish market for private health insurance continues to play a significant role in providing social protection.

In the past the Commission has avoided formally addressing what might or might not constitute a partial or complete alternative where the issue has not been absolutely clear cut. When it approved the Irish risk equalisation scheme, for example (see below), it deliberately abstained from commenting on the compatibility of the regulatory framework with the Directive. The recent *BUPA* ruling on the Irish regulatory framework did not address the issue either (see below) (European Court of Justice 2008).

Beyond its potential impact on social protection, the restriction of material regulation of non-substitutive cover may have implications for consumer protection. Examples include the possibility of conditional sale and consumer detriment arising from product differentiation. Where voluntary cover is offered by the same entities responsible for providing statutory cover, insurers can take advantage of the absence of open enrolment or lifetime cover requirements for voluntary cover to terminate a voluntary contract when an individual moves to a rival insurer for statutory cover. This 'conditional' sale is a form of risk selection that is particularly likely to deter older people or people in poor health from switching from one statutory insurer to another, for fear that a new insurer might reject their application for cover, a new voluntary contract might be too expensive (taking into account the person's current age) and/or might exclude pre-existing conditions (that had developed since the signing of the original voluntary contract and were therefore covered by that contract). Conditional sale poses a barrier to competition among statutory health insurers. If construed as abuse of dominant position, it could breach EU competition rules. However, although there is evidence to suggest that conditional sale prevents fair competition in Belgium, Germany, the Netherlands and Switzerland (Paolucci et al 2007), we are not aware of any ECJ case law in this area. We discuss the issue of product differentiation in the following section.

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[134] In effect, these were the de facto (informal) rules under which Vhi Healthcare operated prior to 1994 (with the exception of the risk equalisation scheme, which had not been necessary when Vhi Healthcare was the only insurer).

[135] Up to a maximum of €750 per year for inpatient care. There are separate co-payments for accessing emergency services without a GP referral (€100 per visit since 1 January 2009), and this category of patient also has to pay out-of-pocket for most primary care (eg GP visits) with no annual maximum ceiling.

How can governments intervene?

The second area of uncertainty concerns the types of intervention that might be considered necessary and proportional. Article 54.2 and Recital 24 of the Directive list the legal provisions governments can introduce where private cover provides a partial or complete alternative to statutory cover. But it is not clear if the list should be understood as being exhaustive, in which case unlisted interventions would contravene the Directive. And again, there is the problem of interpreting partial or complete alternatives. In this section we discuss interventions that have been disputed under internal market or competition legislation, or that may be contentious in future.

Financial transfers (risk equalisation schemes)

Risk equalisation schemes are a direct form of intervention typically involving financial transfers from insurers with low risks to insurers with high risks. They are an essential component of health insurance markets with open enrolment and community rating, where they are introduced to ensure access to health insurance and fair competition among insurers (van de Ven and van Vliet 1992; Puig-Junoy 1999). Risk equalisation measures aim to lower insurers' incentives to compete through risk selection, and to encourage insurers to compete on cost and quality. As such they are widely applied to public or quasi-public entities involved in the provision of statutory health insurance (van de Ven et al 2007). More recently, governments have applied them to private health insurers in the Netherlands (2006), Ireland (2006) and Slovenia (2005). The German government has asked private health insurers to establish a risk equalisation scheme by 2009. Internationally, risk equalisation schemes are also applied to private health insurers in Australia, Chile and South Africa. Wherever risk equalisation has been introduced in the European Union, it has been subject to legal challenge by private insurers and/or infringement proceedings[136] initiated by the Commission in response to complaints.

The legal challenges in Ireland (European Court of Justice 2008) and the Netherlands (European Court of Justice 2006) have focused on the potential for financial transfers made under a risk equalisation scheme to breach competition rules on state aid. There has been less emphasis on whether or not they breach internal market rules in the form of the Directive. An unsuccessful domestic legal challenge in Slovenia also focused on unfair competition, but did not refer either to EU competition or internal market rules (Constitutional Court of Slovenia 2006). However, the Commission's current infringement proceedings against the Slovenian government do focus on breach of the Directive. One of the issues at stake seems to be whether or not the risk equalisation scheme in Slovenia can

[136] Infringement proceedings based on the Article 226 EC procedure are triggered by complaints to the European Commission. Following an informal process (informal contacts with the Member State concerned to provide the Commission with more information) and failure to reach a settlement, the formal process involves three stages. First, the Commission writes a letter of infringement to the Member State government asking it to submit its observations on the alleged infringements. Second, if the Commission considers that the member state has not satisfactorily responded, it delivers a 'reasoned opinion', setting out the formal reasons why the member state has failed to comply with its obligations under the Treaty and asking the government to redress the breach, usually within two months. Third, if the member state does not respond satisfactorily, the Commission refers the matter to the European Court of Justice.

be justified by Article 54. In the following paragraphs we briefly outline the legal challenges in the three countries.

The Netherlands

Bolkestein's letter to the Dutch Minister of Health raised concerns that the Dutch government's risk equalisation scheme, part-financed from public funds, might contravene EU rules about state aid (Bolkestein 2003). However, in 2005 the Commission issued a decision authorising the transfer of public funds as, in its opinion, the aid did not unduly distort competition (European Commission 2005; McCreevy 2005; McCreevy 2006; McCreevy 2006). Despite further assurances from the European Commissioner for Competition (Reerink and Rosenberg 2005), Dutch analysts and politicians continued to question the legality of the risk equalisation scheme, noting that the ECJ would have the final say on whether or not the scheme was both necessary and proportionate (den Exter 2005; Meijer and Liotard 2005). In 2006 a Dutch insurer brought a case before the ECJ, challenging the Commission's 2005 authorisation of the risk equalisation scheme primarily on the grounds that the scheme breached EU rules on state aid (European Court of Justice 2006). The insurer also argued that the new Dutch health insurance system was incompatible with the Directive and Articles 43 EC and 49 EC (on freedom of establishment and free movement of services respectively). It accused the Commission of failing to provide reasons to substantiate its view that the risk equalisation scheme does not contravene either the Directive or competition rules on state aid. The case was withdrawn from the register at the request of the insurer in 2008 (Sauter 2008).

Ireland

The risk equalisation scheme in Ireland has also been challenged as breaching competition rules on state aid. In 1994 the Irish market was opened up to competition to comply with the Directive. Prior to this, private health insurance was almost exclusively provided by Vhi Healthcare, a quasi-public body under the jurisdiction of the Department of Health. By 1994 Vhi Healthcare covered about 37% of the population (Department of Health and Children 1999). After the market was opened up to competition, the Irish government relied on Article 54 to maintain the existing regulatory framework which required insurers to offer open enrolment, community-rated premiums, minimum benefits and lifetime cover. The government also passed new legislation allowing it to establish a risk equalisation scheme to be activated by the government at the request of the soon-to-be-established independent Health Insurance Authority (HIA) if it became evident that private insurers were competing through risk selection rather than on the basis of administrative efficiency and quality (Department of Health and Children 1999). In 2006 the government triggered the risk equalisation scheme on the advice of the HIA.

In 1998 BUPA Ireland, a branch of the UK insurer BUPA set up in Ireland in 1996, complained to the Commission that the risk equalisation scheme was a form of state aid that distorted competition and discouraged cost containment in the health sector (BUPA Ireland 2003). In response, the Irish government argued that the Directive allowed member states to exercise reasonable discretion with respect to the general good and that the scheme had particular regard for the need for proportionality (Department of Health and Children 2001). Five years later the Commission issued a decision[137] stating that financial transfers made under the scheme would not constitute state aid for two reasons (European

[137] Unlike Bolkestein's letter, above n.32, a Commission decision is binding and judicially reviewable at the suit of the addressee or those directly and individually concerned (Article 230 EC). Article 88(2) EC and Regulation 659/99/EC give the Commission the power to make such decisions.

Commission 2003). First, the scheme would legitimately compensate insurers for obligations they faced in carrying out a service of general economic interest (Article 86(2) EC). Second, the compensation was limited to what is necessary and proportionate to ensure stability in a community-rated market for private health insurance. The decision also noted that the scheme would not distort competition, penalise efficiency or create perverse incentives that might lead to cost inflation, nor was it likely to deter insurers from entering the market, as new entrants can exclude themselves from the scheme for up to three years. Even if financial transfers were to be considered a form of state aid, the Commission pointed out that this aid would not, by itself, amount to a violation of the Directive.

The Commission's decision is as noteworthy for what it abstains from commenting on as for what it confirms. It explicitly states that it assessed the risk equalisation scheme's compatibility with state aid rules 'without prejudice to the analysis of its compatibility with other relevant EU rules, and in particular with [the Directive]', emphasising that it was made independently of any consideration as to whether the Irish market could be regarded as a partial or complete alternative to cover provided by the statutory system (European Commission 2003: p 8). BUPA Ireland subsequently challenged the Commission's reluctance to consider whether the scheme infringed the Directive. Asking the ECJ to suspend the decision in 2003, it accused the Commission of misapplying the public service compensation test and wrongly identifying open enrolment, community rating, minimum benefits and lifetime cover as public service obligations when they actually represent rules generally applied to all insurers offering private health insurance (European Court of Justice 2008). It also accused the Commission of failing to consider whether these obligations imposed a financial burden on Vhi Healthcare and whether the risk equalisation scheme would affect the development of trade contrary to the interests of the Community, and of failing to initiate a formal investigation procedure, given the complexity of the arguments and the economic analysis required. The Dutch and Irish governments and Vhi Healthcare joined the legal proceedings in defence of the Commission. BUPA Ireland also launched a domestic challenge to the risk equalisation scheme in 2006 (see below). The following year it pulled out of the Irish market and its business was bought by Quinn Healthcare, an Irish company. Quinn Healthcare has also challenged the risk equalisation scheme (within Ireland).

In 2008 the Court of First Instance (CFI) dismissed BUPA's application, finding its claim inadmissible (European Court of Justice 2008). The Court used the criteria[138] laid down in *Altmark*, finding that the Commission had been right to conclude that the risk equalisation scheme did not contravene EU state aid rules (European Court of Justice 2003). It is worth going into the Court's decision in some detail, since the arguments involved are revealing. BUPA had argued that private health insurance in Ireland could not constitute a service of general economic interest (SGEI) as defined in Article 86(2) EC since there was no obligation of general interest imposed on insurers to provide certain services and those services were not available to the whole population. Rather, they were optional – even 'luxury' – financial services and not intended to replace the public social security system. BUPA also argued that the decision of whether or not SGEIs were being carried out was a

[138] These are as follows: 1) the recipient undertaking must have public service obligations to discharge and the obligations must be clearly defined; the service must also be of a universal and compulsory nature; 2) the parameters on the basis of which the compensation for carrying out the SGEI mission is calculated must be established in advance in an objective and transparent manner; 3) the necessity and proportionality of the compensation provided for; and 4) comparison with an efficient operator.

decision for European Community institutions and not to be delegated to national authorities. In contrast, the Irish government contended that the definition of SGEIs falls primarily within the competence and discretion of the member states and that private health insurance is 'an important instrument of the social and health policy pursued by Ireland . . . and an important *supplement* to the public health insurance system, although it does not *replace* that system' (our italics) (paragraph 164). It added that because the obligations of open enrolment and community rating ensure that private health insurance is available to all, it is not necessary that it should be universal, compulsory, free of charge, economically accessible to the whole population or constitute a substitute for the public social security system.

Responding to these claims and counterclaims, the Court confirmed that member states have a wide discretion to define what they regard as SGEIs. Moreover, the definition of such services by a member state can only be questioned by the Commission in the event of a manifest error (paragraph 165). It found that there had been an act of public authority creating and entrusting an SGEI mission in Ireland. It also found that the compulsory nature of the SGEI mission could lie in the obligation on insurers to offer certain services to every citizen requesting them (open enrolment) and was strengthened by other obligations such as community rating, lifetime cover and minimum benefits (paragraphs 188-191). According to the Court, these obligations guarantee that the Irish population has 'wide and simple access' to private health insurance, which entitles private health insurance to be characterised as universal within the meaning of Community law (paragraph 201). The Court went on to note:

> 'the criterion of universality does not require that the entire population should have or be capable of having recourse to it in practice . . . the fact that approximately 50% of the Irish population has subscribed to PMI [private medical insurance] cover indicates that, in any event, the PMI services respond to a very significant demand on the Irish PMI market and that they make a substantial contribution to the proper functioning of the social security system, in the broad sense, in Ireland' (paragraph 201).

The Court further found that the parameters used to calculate the risk equalisation payments were sufficiently clearly defined and that the scheme itself was necessary and proportionate to the costs incurred. In addition, it found that insurers operating less efficiently than their competitors would not be able to gain undue advantage from the risk equalisation scheme, because the scheme compensated insurers based on average costs. Finally, the Court concluded that the risk equalisation scheme was necessary and proportionate for the purposes of Article 86(2) EC. It noted that the Commission had been right to support the risk equalisation scheme as a measure necessary to prevent destabilisation of the community-rated Irish market caused by active risk selection on the part of Vhi Healthcare's competitors (paragraphs 285-286).

Comments by the Court on the nature of the Irish market are particularly revealing. Paragraph 204 states:

> 'In the light of the foregoing, the applicant's [BUPA's] very general argument concerning the optional, complementary and 'luxury' nature of the PMI services cannot succeed. Apart from the fact that the applicants disregard, in this context, the various levels of PMI cover available, they have not submitted a detailed challenge to the argument put forward by the defendant [the Commission] and by Ireland that Irish PMI constitutes, alongside the public health insurance system, the second pillar of the Irish health system, the existence of which fulfils a mandatory objective of social cohesion and solidarity between the generations pursued by Ireland's health

> policy. According to the explanations provided by Ireland, PMI helps to ensure the effectiveness and profitability of the public health insurance scheme by reducing pressure on the costs which it would otherwise bear, particularly as regards care provided in public hospitals. Within the framework of the restricted control that the Community institutions are authorised to exercise in that regard, those considerations cannot be called in question either by the Commission or by the Court. Accordingly, it must be accepted that the PMI services are used by Ireland, in the general interest, as an instrument indispensable to the smooth administration of the national health system and they must be recognised, owing to the PMI obligations, as being in the nature of an SGEI.'

These comments and the ruling as a whole suggest three things. First, not only do national governments have considerable discretion in deciding what is in the general interest, but the regulations in place themselves contribute to the definition of a particular service as being in the general interest. In other words, if the Irish government defines a service as being in the general interest, regulations such as open enrolment and community rating can only strengthen the government's case, although the necessity and proportionality tests would still apply. This apparently circular argument reflects the complexity of determining what is and is not an SGEI in the absence of a central definition, but it reinforces the significant scope for member state autonomy in this area. Second, the Irish government claims that even though private health insurance in Ireland plays a supplementary rather than a substitutive role, it is an important instrument of Irish social and health policy – 'the second pillar of the Irish health system' – and helps to sustain the public health insurance scheme by relieving pressure on public hospitals. The ruling notes that these claims cannot be questioned by the Commission or the Court. Consequently, if a government says that private health insurance is a key component of the national health strategy, the European Union's legislative institutions must accept it as being the case. Third, the Court makes much of the fact that private health insurance in Ireland covers about half of the Irish population and takes this as evidence that it makes a 'substantial contribution to the proper functioning of the [Irish] social security system'. Thus, the degree of population coverage might bolster arguments about the contribution of private health insurance to the 'national health strategy'.

In spite of the Court's ruling, which BUPA decided not to appeal against, the Irish regulatory framework has continued to be questioned in the domestic courts. In 2006 the Irish High Court ruled against BUPA's legal challenge of the risk equalisation scheme. BUPA appealed and in 2008 the Supreme Court upheld its appeal on procedural grounds, finding that the risk equalisation scheme was based on an incorrect interpretation of the meaning of community rating in the relevant law and would therefore have to be suspended (Supreme Court of Ireland 2008). Because the Supreme Court did not question the risk equalisation scheme on other grounds, a change in legislation may be sufficient to secure the scheme's domestic legitimacy[139].

Slovenia

The CFI ruling came after the Commission had initiated infringement proceedings against Belgium and Slovenia, but may have some bearing on both of these cases. In this section we discuss the case against Slovenia. The case against Belgium is discussed in a subsequent section. In 2005 two of the three insurance companies operating in the Slovenian complementary private health insurance market (covering statutory user charges) challenged legislation establishing a risk equalisation scheme. The largest insurer

[139] In 2008 the Minister of Health and Children noted that the interim measures would be in place for approximately three years, while work was carried out on a new risk equalisation scheme.

Vzajemna (a mutual association) argued that the scheme would favour the two other (commercial) insurers and encourage risk selection, while the larger commercial insurer Adriatic argued that the scheme would distort competition (Adriatic 2005; Vzajemna 2005). Neither challenge referred to EU law and the Slovenian High Court ruled in the government's favour (Toplak 2005). However, in 2007, following a complaint from Vzajemna, the Commission initiated infringement proceedings against the Slovenian government, arguing that the risk equalisation scheme could not be justified under Article 54.1 of the Directive because complementary private health insurance in Slovenia does not constitute a partial or complete alternative to statutory health insurance. The Commission's letter of formal notice, the contents of which have not been made publicly available, may also have noted that the requirement for insurers involved in the complementary market to inform the regulator of changes to policy conditions and premiums breaches the Directive (Article 6, Article 29, Article 39) (Rednak and Smrekar 2007). The requirement for insurers to put 50% of any profits generated back into the private health insurance scheme may also be problematic.

The Slovenian government responded by arguing (in May 2007) that the complementary market is a part of the broader social security system and has been defined in legislation as a service of general interest (Slovenia Business Week 2007). It also drew to the Commission's attention the similarities between the Irish market and the Slovenian market. Previously, the Commission had rejected the government's claim that the Slovenian market represented a partial or complete alternative to compulsory health insurance, arguing instead that the market played a supplementary role. While it seems clear that the Slovenian government will need to address potential breaches of the Directive's ban on systematic prior notification of policy conditions and premiums, it is less clear, following the *BUPA* ruling, whether the risk equalisation scheme breaches the Directive or EU state aid rules. The Court's rationale for upholding the Commission decision in favour of the risk equalisation scheme in Ireland could apply, with even greater force, in the Slovenian case. First, there is an act of public authority creating and entrusting an SGEI mission (given in the Slovenian Health Care and Health Insurance Act), which along *BUPA* lines is both compulsory and universal in nature. Second, complementary private health insurance covers an even greater proportion of the population than in Ireland (70%), strengthening the government's claim that the complementary market is part of the social security system. And, third, following *BUPA*, does the Commission have the right to question the claims of the Slovenian government? The Commission is due to respond in 2009.

In our view, both the Dutch and Slovenian cases for risk equalisation seem stronger than the Irish case, in the Netherlands because the 'private' health insurance scheme *is* the statutory health insurance scheme, and in Slovenia because the complementary market makes a more significant contribution to social protection than the predominantly supplementary market in Ireland. For example, the extent of statutory cost sharing has increased in Slovenia (Milenkovic Kramer 2006a) in recent years, whereas it has gone down in Ireland[140] (McDaid and Wiley 2009 forthcoming). Reflecting this, private health insurance in Slovenia accounts for over half of all private spending on health (the second highest proportion in the European Union after France), but only a third of private health expenditure in Ireland.

Benefits

[140] At least, eligibility for free care has been extended. The actual level of charges has increased.

Governments can regulate the benefits offered by private insurers by specifying a minimum level or standard package of benefits and/or requiring benefits to be provided in kind rather than in cash. The first intervention aims to facilitate price competition, while both aim to lower financial barriers and ensure access to a given range of health services.

Minimum or standard benefits

The question of whether or not regulators should be able to specify minimum or standard benefits – as they do in Germany, Ireland and the Netherlands (prior to 2006 and now) – has not yet been legally challenged as a form of material regulation that contravenes the Directive or as an intervention that impedes the free movement of services. Nevertheless, we raise it as an issue that has implications for consumer protection. The issue is also pertinent since a key objective underlying the introduction of the internal market in insurance was to stimulate competition among insurers, precipitating efficiency gains and bringing consumers the benefits of wider choice and lower prices (European Commission 1998). The preamble to the Directive states that it is in policyholders' interest that they should have access to 'the widest possible range of insurance products available in the Community so that [they] can choose that which is best suited to [their] needs' (Recital 19) (European Commission 1992).

In theory, product differentiation benefits consumers by providing policies tailored to meet particular needs. It benefits insurers by allowing them to distinguish between high and low risk individuals. But in practice it may be detrimental to consumers in two ways. First, it gives insurers greater opportunity to select risks, leading to access problems for high risks. Second, making consumers choose from a wide range of highly differentiated products restricts competition, which only operates effectively where consumers find it easy to make informed comparisons about price and quality.

To encourage competition based on price and quality (rather than risk selection), regulators can require insurers to offer a standard package of benefits, use standardised terms when marketing products, inform potential and existing policy holders of all the price and product options open to them and provide consumers with access to centralised sources of comparable information. However, the Directive specifically outlaws product and price controls except where private health insurance constitutes a partial or complete alternative to statutory cover, and even in these circumstances control is limited to offering benefits standardised in line with statutory benefits; that is, the primary aim is to ensure that the privately insured have access to the same services as the publicly insured rather than to facilitate price competition. For example, governments in Germany and the Netherlands have required private insurers to offer older policy holders benefits that match statutory benefits (Thomson and Mossialos 2006).

In the absence of product regulation, liberalisation of health insurance markets in some member states has been accompanied by rising levels of product differentiation, with evidence suggesting that consumers may be confused by the proliferation of products on offer (Mossialos and Thomson 2004). For example, an official investigation into information problems in the market for supplementary private health insurance in the United Kingdom found that increased product complexity did not benefit consumers; rather, consumers sometimes paid more than they should and often purchased inappropriate policies (Office of Fair Trading 1998). An OECD study noted that as the diversity of schemes in the UK market rose, consumers faced increasing difficulty in

comparing premiums and products, a concern echoed by consumer bodies in other member states (Organisation for Economic Co-operation and Development 2001).

Perhaps due to limited price competition and private insurers' limited ability to control costs, prices appear to have gone up rather than down in many member states. Research based on data from several member states shows that, during the 1990s, the compound annual growth rate of private health insurance premiums rose much faster than the average annual growth rate of total spending on health care (Mossialos and Thomson 2004).

Benefits in kind

The provision of benefits in kind enhances social protection by removing financial barriers to accessing health care. Bolkestein's letter to the Dutch Minister of Health suggests that the Dutch government's requirement for insurers to provide a basic package of benefits in kind could infringe the free movement of services by creating barriers for non-Dutch insurers entering the market and might need to be assessed for proportionality and necessity (Bolkestein 2003). This raises concerns not only for the new Dutch system, but for statutory and substitutive private health insurance in other member states. However, the issue has not yet been subject to legal challenge.

Differential treatment of insurers

Under the Directive governments can no longer influence market structure (by restricting the provision of private health insurance to a single approved insurer or to statutory health insurance funds) or discriminate against particular types of insurer. For example, Recital 25 outlaws regulation preventing non-specialist or composite insurers from providing health insurance. When the German government transposed the Directive it had to abolish its rule excluding non-specialist insurers from entering the private health insurance market, but used its social law to prohibit employers' from contributing to policies offered by composite insurers, leading the Commission to refer Germany to the European Court of Justice (European Court of Justice 2001). Germany amended its legislation and the case was removed from the register in December 2003. Other areas in which the Directive affects differential treatment of insurers concern solvency requirements and tax treatment.

Solvency requirements

National laws often distinguish between non-profit and for-profit institutions, sometimes resulting in preferential treatment of non-profit institutions. This usually favours mutual associations, which have a long history of involvement in statutory and private health insurance in many member states and traditionally operate in different areas of the market from commercial insurers (Palm 2002). The special status accorded to mutual associations has given rise to difficulties under the Directive. For example, French mutual associations operate under a special 'Code de la Mutualité', which means they were subject to less rigorous solvency rules than commercial insurers or provident associations (Palm 2002). In 1999 the European Court of Justice ruled against France for its failure completely to transpose the Directive with regard to mutual associations (European Court of Justice 1999). However, the French government failed to act and the Commission was forced to begin fresh infringement proceedings under Article 228 EC the following year, which eventually resulted in the adoption of a revised code tightening the solvency requirements for mutual associations and bringing French law in line with the Directive (European Commission 2000b; 2000c).

Solvency rules have also led to controversy in Belgium and Ireland. Mutual associations in Belgium engaged in selling a mixture of complementary and supplementary private health insurance operate under separate solvency rules from commercial insurers. Both types of insurer competed to provide cover for self-employed people, who were excluded from statutory cover of outpatient care. More recently, they also began to compete to provide complementary cover of some hospital costs. For example, the Mutualité Chretienne, which is one of several statutory health insurers, also provided its members with compulsory complementary cover of all hospital costs above a deductible per inpatient stay (Mutualité Chretienne 2008). Previously, this type of cover had been exclusively offered by commercial private insurers. In 2006 the European Commission began infringement proceedings against the Belgian government on the grounds that differential treatment might distort the market (European Commission 2006a).

The issue regarding self-employed people in Belgium has been addressed by extending statutory cover of outpatient care to them from 2008. However, the issue of complementary private health insurance has been more problematic. The Belgian government has argued that the Directive does not apply to mutual associations because the cover they provide is part of the social security system, their activity is based on solidarity rather than being economic in nature and, if the complementary cover they provide were to be viewed as an economic activity, it would be a service of general economic interest and exempt from competition rules under Article 86(2) EC. In 2008 the Commission rejected this defence and sent a reasoned opinion to Belgium, asking it to amend its national rules so that mutual associations are no longer governed by separate solvency and supervisory rules (European Commission 2008b). As shown in the discussion of France (below), the Commission is unlikely to consider this type of differential treatment of insurers necessary or proportionate to the costs incurred in carrying out SGEI activities.

In the 1970s, the Irish government had obtained a derogation from the First Non-Life Insurance Directive's solvency requirements for its quasi-state insurer Vhi Healthcare (The Competition Authority 2007). This meant that Vhi Healthcare was not subject to the same solvency requirements as its commercial competitors and was not regulated by the same regulatory body. In January 2007 the Commission began infringement proceedings against Ireland in response to a claim made by Vivas (a commercial insurer that entered the Irish market in 2004, now trading as Hibernian AVIVA Health) that Vhi Healthcare had breached the conditions of its derogation from the Directive by carrying out business in addition to its core health insurance activity (European Commission 2007b). The Irish government subsequently brought forward plans to change the status of Vhi Healthcare. It announced that by the end of 2008 (not 2012 as originally stated) Vhi Healthcare would be a conventional insurer authorised by the Financial Regulator (Department of Health and Children 2007). This was confirmed under the Voluntary Health Insurance (Amendment) Act 2008[141], which also requires Vhi Healthcare to establish subsidiaries to carry out non-health insurance business.

Some of these solvency issues may change in future, with the introduction of new economic risk-based solvency requirements in 2012 (the so-called Solvency II framework) (European Commission 2007c). The Commission is proposing to move away from a 'one-

[141] However, in late 2008 the date set for Vhi Healthcare to meet the solvency requirements that would be necessary for it to be regulated by the Financial Regulator was put back to 31 March 2009 and at the time of writing it is understood that this has been put back further to 1 September 2009.

model-fits-all' method of estimating capital requirements to more entity-specific requirements, which would be applied to all entities regardless of their legal status. However, as yet the implications of this new framework for health insurance are not clear.

Tax treatment

Tax incentives in France, Luxembourg and Belgium have traditionally favoured mutual or provident associations over commercial insurers. In Luxembourg the existence of a 'gentleman's agreement' between mutual associations and commercial insurers has prevented the latter from complaining about preferential tax treatment (Mossialos and Thomson 2004). The agreement rests on the understanding that mutual associations will not encroach on commercial insurers' dominance of the market for pensions and other types of insurance. Prior to 2008, Belgian mutual and commercial insurers competed to cover outpatient care for self-employed people. Mutual associations providing this cover benefited from state subsidies, whereas commercial insurers did not. The commercial insurers tried to challenge this in the Belgian courts, but lost their legal challenge. In 2006 the Commission began infringement proceedings against this preferential treatment, but the issue is no longer relevant as the Belgian government now extends statutory outpatient cover to all self-employed people (European Commission 2006a; 2008b).

Preferential tax treatment of mutual insurers has been most problematic in France, where mutual and provident associations have been exempt from health insurance premium tax since 1945. In 1992 the French Federation of Insurance Companies (FFSA) lodged two complaints against the French government for this discriminatory tax policy, arguing that it contravened EU rules on state aid. Their complaints were eventually upheld by a Commission decision in November 2001 and the French government was asked either to abolish the tax exemptions in question or to ensure that the aid did not exceed the costs arising from the constraints inherent in a service of general economic interest (European Commission 2001). At the same time, the Commission noted that it did not regard the provision of private health insurance by these associations to be a service of general economic interest explicitly provided for in their articles. The French government responded by removing the health insurance premium tax exemption for mutual and provident associations[142] and, instead, applying it to two types of private health insurance contract: those based on 'solidarity' (*contrats solidaires)* – in this case, contracts concluded without a prior medical examination or other reference to an individual's risk of ill health – or 'responsible' contracts (*contrats responsables*), in which private health insurers agree not to cover new co-payments intended to encourage patients to obtain a referral for specialist care and to adhere to protocols for the treatment of chronic illnesses. At first the Commission agreed that this new exemption was compatible with EU rules on state aid (European Commission 2004; 2005a). However, in 2007 it launched a formal investigation into the new *contrats*, to find out if they are indeed non-discriminatory and how much consumers really stand to benefit from the advantages granted to insurers (European Commission 2007d). The results of this investigation have not yet been published.

Some argue in favour of treating mutual associations differently on the grounds that they provide better access to health services because they generally offer open enrolment,

[142] In 2006, in response to a further decision from the Commission, the French government abolished the exemption from insurance premium tax for mutual and provident associations on non-health insurance business. See European Commission (2005b). State aid: Commission calls on France to put an end to certain tax exemptions for mutual and provident societies, IP/05/243, 2 March 2005.

lifetime cover and community-rated premiums, whereas commercial insurers usually restrict access by rejecting applications, excluding the cover of pre-existing conditions and risk rating premiums (Rocard 1999; Palm 2002). In a market where mutual associations and commercial insurers operate side by side the latter may be able to undermine the former by attracting low risks with lower premiums, leaving mutual associations to cover high risks. However, while the distinction between non-profit and for-profit insurers is important in so far as an insurer's profit status determines its motivation and influences its conduct, in practice there is considerable variation in the way in which mutual associations behave; in some member states their conduct may be indistinguishable from the conduct of commercial insurers. As it is not possible to make assumptions about an insurer's conduct on the basis of its legal status it would be more appropriate to discriminate on the basis of conduct, favouring insurers who offer greater access to health services or, where appropriate, penalising those who restrict access. This was the approach taken by the French government in 2004 and again in 2006, when it expanded the remit for exemption from insurance premium tax to any insurer agreeing to abide by specific rules intended to promote access to health care (Sécurité Sociale 2008).

Discussion

In some ways, the EU regulatory framework established by the Directive places limits on national competence in the area of private health insurance. It relies on financial regulation to protect consumers, prohibiting material regulation such as price and product controls except where private cover constitutes a complete or partial alternative to statutory health insurance and so long as any intervention is necessary, proportionate and non-discriminatory. We have argued that the Directive is not sufficiently clear about when governments can justify material regulation of private health insurance. This is mainly because there is no explicit consensus about the meaning of partial or complete alternative, leading to uncertainty and confusion among policy makers, regulators and insurers. Where the Commission and, more recently, the European Court of Justice (in *BUPA*), have had opportunity to clarify this aspect of the Directive they have tended to sidestep the issue, relying instead on rules about services of general economic interest (Article 86(2) EC) to authorise (Ireland) or prohibit (France) government intervention. Key exceptions are Bolkestein's letter, in which he argues that Article 54.1 of the Directive should not to be used to justify material regulation of complementary private health insurance, and a description of the Directive on the Commission's website, which refers to 'substitutive' private health insurance.

Bolkestein's definition of complementary cover fails to recognise that this type of private health insurance increasingly contributes to social protection for those who purchase it, operating in an unofficial partnership with statutory health insurance where it offers reimbursement of statutory user charges and/or provides access to effective health services excluded from the statutory benefits package. In particular, complementary cover of statutory user charges tends to be purchased by a relatively high proportion of the population, making it regressive in financing health care (because it is not restricted to richer groups) and creating or exacerbating inequalities in access to health care (Wagstaff et al 1999; van Doorslaer et al 2006). If, as we have argued, the logic underlying Article 54.1 is to permit material regulation where private health insurance fulfils a social protection function, then in either case obliging complementary insurers to offer open

enrolment, lifetime cover and community rating would be necessary to ensure equitable access to health care, while a risk equalisation scheme might be needed to lower incentives to select risks and to encourage competition based on price and quality. The Irish experience highlights the complexity of the issues at stake and the difficulties caused by legal uncertainty.

The Directive has been amended several times since its introduction, most recently in 2007 (European Commission 2007a). None of the amendments has had any direct bearing on private health insurance. In 2008 the Commission circulated a proposal for an amended directive that would repeal and replace the Third Non-Life Insurance Directive and several other insurance-related directives under the Solvency II framework (European Commission 2008a). Once again, there are no major changes specifically relating to private health insurance[143]. The only real change seems to be in the wording of Recital 58 (Recital 24 of the original Directive), which now excludes open enrolment, community rating and lifetime cover as possible measures that may be introduced to protect the general good (where private health insurance serves as a partial or complete alternative etc). It is not clear whether this omission has any particular significance[144].

By maintaining the same wording as the Directive ('complete or partial alternative'; Article 204), the proposed new directive has missed a key opportunity to address legal uncertainty. The Commission's reluctance to be explicit about what the phrase means, the importance of the phrase in the infringement proceedings against Slovenia (but its seeming irrelevance in the eyes of the Court of First Instance in *BUPA*), and increasing reliance on the Treaty (Article 86(2) EC) to justify intervention in private health insurance markets (in France and Ireland) suggest that the Commission would have done better to have removed the phrase from the proposed directive. As the Court confirms, whether or not private health insurance requires material regulation to protect the general good should be a matter for national governments. We have argued that the logic underlying Article 54.1 is to ensure access to private health insurance where it contributes to social protection. However, as definitions of social protection may vary from one country to another (and even within a country, over time), in our view deciding what does or does not contribute to social protection is a largely political issue. It is therefore a matter best left to the discretion of national political processes.

If, as the Court states in BUPA, governments have relative freedom to define private health insurance as being a service of general economic interest, and regulations such as open enrolment can be construed as demonstrating SGEI obligations, then there seems little need for further elaboration of this particular issue in the form of a directive, particularly given the uncertainty created by the current and proposed wording and the fact that proportionality must still be tested, regardless of which process (Treaty or Directive) applies. It remains to be seen whether the *BUPA* ruling will change the position of the Commission in its infringement proceedings against Slovenia (at least concerning the legality of the risk equalisation scheme), since the Slovenian government now has a good legal basis on which to defend the SGEI nature of its complementary private health

[143] Mainly because making any substantive changes would have involved discussion and negotiation among the members states.

[144] As before, Recital 58 of the third 'Non-life Insurance Directive states that standardised benefits offered at a premium rate at or below a prescribed maximum, participation in loss compensation (risk equalisation) schemes and private health insurance operated on a technical basis similar to life insurance may be introduced as measures to protect the general good.

insurance market. The SGEI argument is unlikely to be much help to the Belgian government, however, because hard and soft law alike consistently reject differential treatment of insurers based on legal status. A more pragmatic (and effective) approach to influencing the conduct of insurers is to favour those who adhere to specific principles. France has led the way here, with its system of tax exemptions for insurers that uphold *contrats solidaires* or *contrats responsables'*, although even this move is under investigation by the Commission.

We have also argued that there is uncertainty about what sort of government intervention in the private health insurance market might be considered to be necessary or proportionate, not just because of the Directive, but also under EU state aid rules. While it is clear that differential treatment of insurers based on legal status will not be tolerated, it is much less clear whether regulatory requirements such as open enrolment and risk equalisation schemes are compatible with the Directive – particularly (but not exclusively) where non-substitutive private health insurance is concerned. For example, the Commission's decision to authorise risk equalisation in the Netherlands has been challenged by a Dutch insurer, even though the new Dutch health insurance system is broadly accepted as being statutory in nature (European Court of Justice 2006). The Commission has contributed to this uncertainty by approving the risk equalisation scheme in Ireland (on the grounds that private health insurance in Ireland constitutes a service of general economic interest), but accusing the Slovenian risk equalisation scheme of contravening the Directive – and yet, as we have argued, the case for risk equalisation might be stronger in Slovenia than in Ireland. It is possible that the *BUPA* ruling will, in practice, remove some of this uncertainty.

Finally, we have argued that the Directive's regulatory framework may not provide sufficient protection of consumers. In markets where private health insurance does not contribute to social protection, the Directive assumes that financial regulation will protect consumers. But solvency rules alone may not be adequate if health insurance products are highly differentiated. Information asymmetry exacerbated by product differentiation appears to be a growing problem in markets across the European Union and the Commission has not yet put in place mechanisms for monitoring anti-competitive behaviour by insurers. Communications from the Commission have also raised doubts about the compatibility of certain regulatory measures with competition rules; for example, the provision of benefits in kind (Bolkestein 2003). If a requirement for insurers to provide benefits in kind were to be found to contravene competition rules, there would be implications for statutory as well as private health insurance.

The Directive reflects the regulatory norms of its time. When it was introduced in 1992 the Commission may have been convinced that it would provide ample scope for governments to protect consumers where necessary and would not jeopardise statutory arrangements. Article 54 would protect markets contributing to social protection, while in markets regarded as purely supplementary, the benefits of de-regulation (increased choice and competition resulting in lower prices) would outweigh concerns about consumer protection. These assumptions are more problematic now, partly because there is no evidence to suggest that the expected benefits of competition have, as yet, materialised. Private health insurance premiums in many member states have risen rather than fallen in recent years, often faster than inflation in the health sector as a whole, while insurers' expansion across national borders has been limited to cross-border mergers and acquisitions rather than genuinely new entrants to the market (Mossialos and Thomson

2004). The new Dutch health insurance system has not yet seen any cross-border activity and the number of insurers in operation has swiftly fallen to about five.

The assumptions are also problematic due to increased blurring of the boundaries between normal economic activity and social security. On one hand, the case law reviewed here shows governments how they might put their health insurance arrangements beyond the scope of internal market law, either by placing them firmly within the sphere of social security or by invoking the general good defence. On the other hand, as the Dutch system shows, the trend seems to be going in the opposite direction. Consequently, social security is no longer the preserve of statutory institutions or public finance, a development likely to bring new challenges for policy makers. Greater blurring of the public-private interface in health insurance gives rise to complexities that neither the existing Directive nor the proposed new directive seem equipped to address. In the light of these complexities, only some of which we have attempted to highlight here[145], we think it is time for a debate about how best to move forward. A priority for debate should be to find ways of thinking about private health insurance that go beyond 'partial or complete alternative' to statutory cover. These terms are unclear and do not reflect the often complicated relationship between public and private cover. At least in the European Union, private health insurance rarely offers a genuine 'alternative' to statutory cover (Thomson et al 2008a). We also emphasise that financial regulation may not be the only or best means of protecting consumers in health insurance markets. If it is not possible to reach a political consensus about re-examining the need for material regulation of private health insurance under some circumstances, then the Commission and the member states should consider how best to improve the way in which products are marketed and the quality of the information available to consumers.

[145] There are other issues that may also be relevant – for example, the introduction of medical savings accounts as part of either private or public coverage. Medical savings accounts (MSAs) involve compulsory or voluntary contributions by individuals to personalised savings accounts earmarked for health care. They do not involve risk pooling (except in so far as they are combined with insurance). Consequently, they do not involve any form of cross subsidy from rich to poor, healthy to unhealthy, young to old or working to non-working. The only example of MSAs in an EU context is in Hungary, where savings accounts that benefit from tax subsidies are used to cover statutory cost sharing or to cover out of pocket payments for services obtained in the private sector.

Part 3 The policy implications of private health insurance

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Framework for analysis

Theoretical arguments in favour of PHI generally take public limitations as their starting point, highlighting the inequity and inefficiency created by bureaucracy, the absence of appropriate incentives and government failure to raise sufficient revenue to finance health care. PHI, it is argued, can address these limitations in three ways. First, the profit motive and competition (Gilbert and Tang 1995) may encourage administrative efficiency, innovation (Johnson 1995) and higher quality of care (Chollet and Lewis 1997). Second, PHI may mobilise (additional) resources for health care, relieving pressure on public budgets (Chollet and Lewis 1997). Third, where out of pocket payments are a significant mechanism for financing health care, PHI may establish pre-payment and a degree of risk pooling, which paves the way for larger risk pools and public insurance institutions (Sekhri and Savedoff 2005).

PHI, it is argued, can further a range of health policy goals. However, economic theory posits that PHI will only result in an optimally efficient allocation of health care resources if certain assumptions hold (Barr 1992). Markets for health insurance – or more accurately, markets in which health insurance is *voluntary* – are characterised by a number of failures, mainly associated with information asymmetry. Consequently, they can only operate efficiently if there are no major problems with adverse selection, moral hazard and monopoly and if the probabilities of becoming ill are less than one (no pre-existing conditions), independent of each other (no endemic communicable diseases) and known or estimable (insurers are able to estimate future claims and adjust premiums for risk) (Barr 2004).

Moral hazard and monopoly issues can be problematic for both statutory and voluntary health insurance. The main problems specific to voluntary health insurance stem from the difficulty of covering people who are already ill or highly likely to incur health care costs and from insurers' attempts to avoid adverse selection (people concealing information about their risk of ill health), which leads to risk selection and market segmentation. As a result, some people will not be able to obtain any cover, or cover at a price that they are willing to pay (Evans 1984; Rice 2001), and insurers will try to maintain profit margins by selecting risks rather than through efficient purchasing and administration alone. Public policy can address these and other issues through direct intervention in the market (regulation) and indirect means involving tax policy.

The aim of this part of the report is to assess the impact of PHI[146] in the European Union on a range of public policy goals. In doing so we refer to a set of health financing policy objectives which closely mirrors the common principles underpinning EU health systems – accessibility, quality and long-term sustainability (European Commission 2005c). These objectives include: financial protection, equity in financing, equity of access, transparency and accountability, incentives for efficiency and quality in health care delivery and administrative efficiency (WHO Regional Office for Europe 2006; Mossialos et al 2007).

We acknowledge that the introduction or expansion of PHI may be motivated by other factors, among them: curbing government spending, cutting taxes, allowing richer groups to spend more on health care, enhancing consumer choice, encouraging developments in

[146] Defined in this report as voluntary health insurance (with some exceptions).

health-related technology, encouraging employers to contribute to social welfare and ensuring the viability of the PHI industry.

Taking into account arguments in favour of PHI, failures in voluntary markets for health insurance, the health financing policy objectives defined by WHO (echoed by the European Union) and a range of other potential public policy goals for PHI, our analysis addresses the following questions:

- how does PHI affect health financing policy objectives?
- does PHI enhance consumer choice?
- does PHI relieve pressure on public budgets?

These are empirical questions – that is, questions that can only be answered through observation and investigation. In many cases, however, the research necessary to answer these questions is lacking or insufficient, which makes it difficult to draw solid conclusions. In addition, the large variation in market role, size, structure, conduct and regulation outlined in Part 1 makes it difficult to generalise research results across countries. Where direct evidence is limited, the discussion that follows focuses instead on identifying incentives and their potential effect on conduct and outcomes.

A further note of caution: historical factors may also influence the policy implications of PHI. Markets for PHI often pre-date statutory health insurance. When statutory schemes were established – for example, in Germany at the end of the 19th Century or in France, the Netherlands and the UK during the Second World War – some European countries allowed PHI to play a residual role. In most of these countries, the role it plays today closely resembles the role established at that time, even though the market itself may have grown or contracted over the years. In other countries, PHI was introduced after the establishment of statutory schemes, as a direct result of public policy, with the intention of providing cover for people excluded from statutory cover (Ireland, for example). More recently, governments in central and eastern European (CEE) countries have passed legislation permitting and, in some cases, encouraging the development of PHI. Some of these countries have deliberately carved a specific role for PHI (notably Slovenia and Hungary); others have simply allowed PHI to develop alongside statutory cover, with little attempt to direct the market. These differences in market origin and raison d'être may be important to the extent that they have influenced public policy goals for PHI and, consequently, the way PHI operates and performs.

Our discussion is divided into three sections. First, we look at the impact of PHI on policy goals and objectives *within* the market itself – that is, without considering the context in which a market operates. Second, we assess the impact of the market's existence on the wider health system, which allows us to look at a broader range of issues. Third, we look at barriers to market development and public debate about the current and future role of PHI in different member states.

Implications within the PHI market

Distinguishing between policy implications within the PHI market and policy implications for the wider health system is not always easy. In many cases, the aspects of market conduct that give policy makers cause for concern are precisely those that have an impact on the policy goals of the wider health system. For this reason, as the following discussion shows, governments are much more likely both to find cause for concern and to intervene in substitutive markets and complementary markets covering statutory user charges.

Financial protection

Financial protection aims to prevent people from becoming poor as a result of using health care (WHO 2000). Health insurance makes a fundamental contribution to financial protection by spreading the financial risk of ill health across time (pre-payment) and across groups of people (pooling). In the context of health insurance, financial protection encompasses notions such as universality (or open enrolment in voluntary markets), scope of coverage (the range of benefits covered), depth of coverage (the extent of cost sharing involved) and duration of cover (annual vs lifetime).

Governments can introduce regulation to compel everyone to buy cover or to ensure that all who want to are able to buy an adequate level of cover (both in terms of scope and depth) that does not exclude treatment of pre-existing conditions and cannot be terminated by the insurer on health grounds.

Judging from the extent to which these regulations are applied to PHI in different EU member states (see Table 12), financial protection is mainly a public policy concern in substitutive and complementary markets. Substitutive PHI provides access to a range of potentially very expensive health services – cover which the subscriber might not be able to obtain from the statutory scheme. For this reason the German government has taken numerous steps to secure financial protection for substitutive PHI subscribers[147]. These include ensuring that PHI is offered on a lifetime basis, making health insurance compulsory for the whole population (from 2009), compelling subscribers to purchase inpatient and outpatient care and preventing insurers from offering deductibles higher than €5,000 per year (also from 2009). In addition, insurers providing substitutive cover must offer existing subscribers who want it open enrolment, benefits that match statutory benefits, cover of pre-existing conditions, premiums that do not reflect health risk (beyond adjustment for age and gender) and capped premiums (through the basic policy, see above).

Such extensive intervention is unique among PHI markets in the European Union and may reflect the high cost of substitutive PHI premiums, which are not linked to income, and the fact that although eligibility for substitutive cover is determined by income (now over a three-year period), the government restricts access to the statutory scheme for older people who have opted for PHI, even if their incomes fall below the threshold. In countries such as the Czech Republic, where substitutive PHI mainly covers migrant workers, there are

[147] For details see the sub-section on regulation in Part 1.

concerns about financial protection because even long-term policies offering a wider range of benefits exclude cover of childbirth, immunisation and care for chronic conditions like HIV/AIDS and mental health problems (Dlouhy 2009).

The extent to which complementary PHI causes concern to policy makers depends on which health services the statutory scheme does not cover, or only partially covers. It also depends on the degree of cost sharing imposed in the statutory scheme and whether or not there are mechanisms in place to protect poorer people and people with chronic conditions from high out of pocket spending on health care.

Germany is not the only country to impose stringent regulations on PHI aimed at ensuring financial protection. Insurers in Ireland have to offer open enrolment, lifetime cover (inclusive of pre-existing conditions), minimum benefits and community-rated premiums. The French government provides free complementary cover of statutory user charges for people with low incomes and uses tax policy to encourage insurers to offer open enrolment and premiums that do not reflect health risk (beyond age and gender). All insurers in the Belgian market must offer open enrolment and lifetime cover, while mutuals are prohibited from charging higher premiums for cover of pre-existing conditions. Slovenia requires open enrolment and community-rated premiums for the part of the market covering statutory user charges. Slovenia and Ireland have gone beyond Germany in introducing compulsory systems of risk equalisation[148] to lower incentives for risk selection heightened by open enrolment, minimum benefits (Ireland only) and community rating. In Italy and Luxembourg financial protection is secured for cover offered by mutual associations, who traditionally refrain from risk rating premiums (rather than being required to by law).

However, these are all markets that mainly provide complementary cover of statutory user charges. Markets mainly providing complementary cover of excluded services are not regulated in this way. In the Netherlands many insurers voluntarily offer both open enrolment and community-rated premiums, but this is a unique and declining trend (Maarse 2009). Limited regulation of these markets may reflect judgements about the likelihood of people incurring catastrophic costs where health services like dental care and physiotherapy are concerned.

In many PHI markets, financial protection within the market is limited by the absence of open enrolment and lifetime cover, the exclusion of pre-existing conditions, the existence of age limits for application and benefits, cost sharing and benefit ceilings (see Table 5 and Table 7). Thus, the degree of financial protection will vary depending on the extent to which individuals are able to access 'full' PHI cover as well as on their preferences and ability to pay. For example, there is evidence from France to show variation in the scope and depth of PHI cover by socio-economic status prior to the CMU-C reform introduced in 2000. Over 60% of those earning at least €1220 per month had an average or high level of cover compared to about 20% of those earning less than €610 per month (Bocognano et al 2000). This pattern has not changed significantly since the introduction of CMU-C (Chevreul and Perronin 2009). In France there are also concerns about recent rises in PHI premiums, partly reflecting higher statutory cost sharing, which have not been matched by a concomitant rise in the level of PHI benefits (Chevreul and Perronin 2009) – a trend which suggests a reduction in the degree of financial protection PHI provides.

[148] Although payments were never made under the Irish scheme, which was suspended in 2008 (see Part 2).

Equity in finance

Equity in finance aims to promote a more even distribution of the burden of financing the health system by requiring richer people to pay more for health care, as a proportion of their income, than poorer people. PHI is generally expected to breach this principle because premiums are not linked to income; the only example of income-related premiums in the European Union is for group cover provided by mutual associations in France.

Within the market, the other factors that have the potential to affect equity in finance include differences in the methods use to rate premiums, the existence of employer-paid group cover and tax incentives to encourage take up of PHI. Risk-rated premiums are more likely to be regressive than community-rated premiums due to the relationship between income and health status: on average, people in lower-income groups tend to have higher rates of morbidity and mortality than those in higher income groups. The existence of group cover, which tends to offer community- or group-rated premiums, may exacerbate this effect, particularly where group cover is paid for by employers. There is some evidence from the UK, for example, to show that employer-paid group cover is more common among higher income groups. Tax incentives can further skew equity in finance if tax relief is provided at the marginal rate of tax, which increases the size of the subsidy for those with higher pre-tax incomes. In some countries, however, only employers that provide PHI cover for all their employees benefit from tax relief, which would minimise the potential for tax relief- related inequity in finance, at least among those covered (Austria, Denmark, Finland).

There is no recent analysis of the way in which PHI affects equity in financing health care. Research published in 1999 and based on data from selected countries during the 1990s reveals that PHI is highly regressive where the majority of the population relies on it for health coverage, as in the United States and Switzerland (van Doorslaer et al 1999; Wagstaff et al 1999). Complementary PHI covering statutory user charges is also shown to be regressive, particularly where it covers a relatively large proportion of the population and is therefore purchased by middle-income groups. Where PHI plays a supplementary or substitutive role, mainly covering richer people, the effect on health care finance is found to be mildly progressive. Over the course of the 1990s, PHI became less progressive in most of the countries studied. Note, however, that this research focuses on equity in *finance* and does not look at equity in the distribution of *benefits* – in other words, it does not account for redistributive effects. It is also not clear whether the research considered the source of payment for group cover or simply assumed that all group cover was paid for by individuals with no employer contribution.

Equity of access

Equity of access to health care may be interpreted in many ways (Oliver and Mossialos 2004). The definition we use requires access to be based on need rather than ability to pay. An 'actuarially fair' PHI premium based on an assessment of an individual's risk of ill health would automatically breach this principle. So too would an insurer's ability to reject applications for cover, to set age limits for cover, to exclude or charge higher premiums for pre-existing conditions, to terminate contracts on health grounds and to impose cost

sharing, since each of these measures links access to health status and, in the case of cost sharing, to use of health services.

The potential for adverse selection in voluntary health insurance markets creates strong incentives for insurers to select risks (that is, to attract people with a lower-than-average expected risk of ill health and deter those with a higher-than-average expected risk). Adverse selection is most effectively addressed by making health insurance compulsory. In voluntary markets, however, insurers can use all of the measures outlined in the previous paragraph to select risks. If explicit risk selection is prohibited by regulations such as open enrolment, cover of pre-existing conditions, community rating and lifetime cover, insurers may engage in covert forms of risk selection – for example, advertising via the internet to attract younger people or marketing PHI alongside cut-price gym membership to attract people who enjoy keeping fit. Because open enrolment and community rating increase insurers' incentives to select risks, they are often accompanied by a risk equalisation scheme (Puig-Junoy 1999; van de Ven and Ellis 1999).

As a result of risk selection, some people may not be able to obtain an affordable level of cover or any cover at all. Those most likely to face barriers to purchasing PHI include older people, people in poor health or with disabilities and people with lower incomes. Whether or not inequalities in access to PHI are a public policy concern depends on the role PHI plays. As we have seen, barriers to accessing PHI are less likely to occur due to regulatory intervention in substitutive markets and complementary markets covering statutory user charges in Belgium, France, Germany, Ireland and Slovenia and in cover provided by mutual associations in Italy and Luxembourg.

Incentives for efficiency and quality in health care delivery

Many markets for PHI in the European Union exist to enhance consumer choice relating to the scope and depth of cover required and the range of providers to which PHI provides access. Thus insurers often have to balance their desire to contain health care costs in the interests of securing a decent surplus (which may involve efficiency-enhancing measures) with their desire to ensure a degree of consumer choice[149]. They may not bear much financial risk themselves, if they can raise premiums to meet cost inflation. At the same time, the threat of subscriber exit provoked by rising premiums or poor quality may encourage insurers to control costs and monitor the quality of health care provision – at least, those aspects of quality most readily judged by subscribers. The extent to which insurers attempt to enhance efficiency or influence quality largely depends, therefore, on the incentives they face. Incentives may be stronger where the threat of exit is higher – in more competitive markets – and where profit margins are tight.

It is difficult to measure the relative competitiveness of different PHI markets in the European Union. As we have discussed in the section on market concentration[150], the very limited evidence available suggests that assumptions about market concentration and competition do not hold where PHI is concerned. Markets that are supposedly less competitive, because more highly concentrated, are actually those in which some health

[149] This section does not apply to insurers in markets for complementary cover of statutory user charges since these insurers simple reimburse subscribers and do not actually engage in purchasing of health services.
[150] See Part 1 under 'Market structure'.

care costs (diagnostic tests) are found to be lower[151]. This may be due to greater purchasing power where the number of insurers is low. Conversely, a PHI market may be competitive even when concentrated or higher market concentration may reflect the fact that insurers that negotiate lower costs are able to drive competitors out of the market.

Insurer claims ratios – the proportion of premium income spent on claims – seem quite low across PHI markets (see Figure 10), which could indicate control of health care costs or risk selection or cost shifting (via cost sharing) or a combination of the three. Looking at the extent to which insurers actually take steps to control health care costs – for example, through vertical integration, use of preferred provider networks and negotiation of provider fees (see Table 9) – lends weight to the possibility that profit margins in some countries result from risk selection and/or cost sharing as opposed to fee negotiation and other forms of control over provider behaviour. Insurers that attempt to ensure cost-effective purchasing rather than simple reimbursement of providers are the exception rather than the norm in the European Union. This may reflect various factors: fear of restricting consumer choice or undermining aspects of quality valued by subscribers; constraints imposed by regulation of insurer relations with providers; or lack of bargaining power where markets are fragmented and providers are well-organised (Steingröver et al 2004; Spiegel online 2008)[152].

The best we can say, in the absence of strong evidence, is that insurers do not generally seem to bear significant financial risk. As a result, they probably do not have strong incentives to enhance efficiency in health care delivery.

Administrative efficiency

Insurers in markets for PHI tend to incur higher management and administrative costs than those responsible for providing statutory coverage, partly because private pools are usually much smaller than statutory pools, which results in duplication of tasks, but also due to the extensive bureaucracy required to assess risk, rate premiums, design benefit packages and review, pay or refuse claims. They also incur additional expenses through advertising, marketing, distribution, reinsurance and the need to generate a profit or surplus. Economic theory suggests that high transaction costs are inefficient if they can be avoided under an alternative system of financing and providing health care (Barr 2004).

In the European Union these additional costs cannot be justified on the grounds that private insurers are more innovative than their public counterparts in devising mechanisms to contain costs. Most attempts to contain costs operate on the demand side, through cost sharing (see Table 7), rather than through improved purchasing (see Table 9). Liberalisation of the PHI market in Ireland in 1994 resulted in higher administrative costs for the dominant insurer Vhi Healthcare, which have risen from 2% of premium income in 1996 (Light 1998) to 4.7% in 1999 (Vhi Healthcare 2000) and 8.5% in 2007 (Turner

[151] This is based on unpublished data collected by the European Commission.
[152] In Germany, for example, observers have noted that insurers face a dilemma in cases where they want to check whether services charged by a provider have been prescribed appropriately and invoiced accurately, since checking invoices is unpopular with both patients and doctors (Steingröver et al 2004; Spiegel online 2008).

2008). The increase in costs is probably due to the marked increase in advertising of PHI products following the market entry of new insurers (Department of Health and Children 2001). The very high level of administrative costs incurred by private insurers has been controversial in Poland (see Figure 11), but does not seem to be an issue elsewhere (Kozierkiewicz 2009).

Transparency and accountability

Where PHI is purchased voluntarily, insurers may be subject to much less scrutiny than their public counterparts. For example, they are not usually required to publish any business-related information beyond what is needed for financial reporting. This may mean that their operations are less transparent.

Lack of transparency in PHI markets tends to be an issue for consumers, although it can also be problematic for regulators and for insurers themselves. We have discussed the issue of consumer detriment arising from product differentiation in Part 1 (see the section 'Consumer choice and information'). Where products are highly differentiated – for example, there is choice of plan combined with varying degrees of choice of benefits at the margin, cost sharing, range of providers etc – it can be difficult for consumers to compare products in terms of money and to understand the level of benefits to which they are limited or entitled. This has been a concern for consumer associations and competition authorities in several countries. In countries like Germany the government has introduced tighter regulation of the information insurers are required to provide to potential and existing subscribers.

Regulation based on EU-wide minimum solvency standards ensures financial stability and accountability. However, insurers are not generally accountable for achieving broader social goals and in some cases efforts to impose greater control over non-financial aspects of the market are outlawed by EU legislation (see Part 2).

Implications for the wider health system

Financial protection

PHI contributes to financial protection by filling in gaps in the breadth, scope and depth of statutory coverage. It clearly enhances financial protection where it plays a substitutive role, since substitutive cover is, by definition, an individual's sole source of cover. This is true of substitutive PHI in the newer member states, which covers people who are not eligible for statutory coverage. It is less true of substitutive PHI in Austria, Germany and Portugal, which covers people who have, at some point, chosen to opt for private rather than statutory coverage. In Germany, however, not all of those who choose private cover can opt for statutory cover at a later stage, so the substitutive market will be the only source of cover for these (predominantly older) people. This may explain the lengths to which the German government has gone to ensure that those who rely on substitutive cover are guaranteed access to a minimum standard of benefits, for life, for a capped premium with capped cost sharing.

The complementary markets covering statutory user charges are similarly tightly regulated to ensure access to PHI, arguably in the interests of enhancing financial protection (Belgium, France, Ireland, Slovenia). In Belgium statutory user charges are capped, which means that patients should not have to pay more than a specified amount in user charges per year, which lowers the likelihood of catastrophic out of pocket spending on health care. In Ireland some but not all user charges are capped and in France and Slovenia, no cap exists. Statutory user charges could therefore be catastrophic for people who are not eligible for exemption – for example, those with earnings just above the threshold for exemption.

The presence of mutual associations offering open enrolment and community-rated premiums on a voluntary basis in these markets, and in Italy and Luxembourg, has in the past ensured that many of those eligible for statutory user charges have been protected by PHI. In most of these countries, levels of population coverage are very high (see Figure 6). However, in the case of France, there were serious concerns during the late 1990s about the 15% of the population that was not covered by PHI. Those who were not covered tended to be from lower social classes; for example, only 72% of unskilled workers were covered by PHI compared to 93% of those in managerial, academic and professional positions (IRDES 2000). As a result of these concerns, the government introduced CMU-C in 2000: free complementary PHI cover for people with very low incomes (Sandier et al 2004). In Slovenia government regulation requiring open enrolment and community rating across the complementary market has resulted in 98% take up among those eligible for statutory user charges (Milenkovic Kramer 2009).

The existence of a PHI market covering statutory user charges can undermine financial protection in the wider health system in more fundamental ways. Importantly, it may give the government greater freedom to introduce and increase user charges. In Slovenia, for example, the PHI market was established as a direct result of the introduction of statutory cost sharing in the early 1990s and, perhaps due to the market's provision of financial protection from user charges, the level of cost sharing rapidly increased. Table 14 shows that the cost sharing limits set out in health insurance legislation in 1992 were reached in the space of four years. In this context, the high level of statutory user charges has been a clear determinant of demand for PHI and there are concerns about PHI premiums, which have risen by almost a third since 2006 (Milenkovic Kramer 2009). In France there have also been concerns about rises in statutory cost sharing in recent years, which have not been matched by an increase in the level of benefits covered by PHI (Chevreul and Perronin 2009).

Table 14 Changes in statutory reimbursement rates in Slovenia, 1993-1996

Services	Coverage	1993	1995	1996
Health care for children, maternity care, prevention, treatment of communicable diseases, occupational illness, terminal illness, mental health care etc	100%	100%	100%	100%
Organ transplants, treatment abroad, intensive therapy, radiotherapy, dialysis and other complex interventions	At least 95%	99%	96%	95%
Fertility treatment, termination of pregnancy, specialist surgery, longer-term inpatient care, orthopaedics, orthodontics and hearing and other aids and appliances etc	At least 85%	95 or 85%	88 or 85%	85%
Drugs on the positive list and treatment of non-work-related injuries	At least 75%	80%	75%	75%
Non-emergency ambulance transport	Maximum 60%	60%	40%	40%
Eye care, adult dental care, drugs on the intermediate list	Maximum 50%	45%	38 or 25%	25%

Source: Milenkovic Kramer (2006b)
Note: the 2007 levels are the same as the 1996 levels.

Supplementary PHI does not provide financial protection since the people it covers are entitled to publicly-financed health care, the services it covers are usually already covered by statutory health insurance and the benefits it provides therefore relate to speed of access and quality of amenities.

Equity in finance

Research into equity in finance carried out by van Doorslaer and Wagstaff during the 1990s concluded that complementary PHI covering statutory user charges was regressive, particularly where it covers a relatively large proportion of the population and is therefore purchased by middle-income groups – which is the case in Belgium, France, Ireland, Luxembourg and Slovenia (van Doorslaer et al 1993; van Doorslaer et al 1999; Wagstaff et al 1999). In contrast, the same research found that supplementary and substitutive PHI contributed to the progressivity of health system financing in some countries. As we have noted, however, their results must be interpreted with caution. Wagstaff et al's 1999 study focuses on equity in finance; it does not analyse equity in the distribution of health care benefits (Wagstaff et al 1999).

Supplementary PHI appears to have a progressive effect on financing health care because those it covers continue to contribute to statutory health insurance, so their contribution to total health care finance is relatively high. However, the benefits provided by supplementary PHI accrue exclusively to those it covers, who tend to come from higher income groups. The net effect on health system equity, taking into account the distribution of benefits, is therefore regressive.

In the case of substitutive PHI, those covered no longer contribute to statutory health insurance, which lowers the statutory scheme's capacity to pool risk and makes it regressive in financing health care. Further research by Wagstaff (Wagstaff et al 1999) found that health care finance from all sources together (statutory insurance, taxes, private insurance and direct payments) was regressive in Germany and the Netherlands at the end

of the 1980s and in the Netherlands in the early 1990s. Finance through statutory health insurance alone was not only regressive, but considerably more so than financing from all sources together due to the voluntary exit or exclusion of richer people. The analysis concluded that health care financing in the Netherlands at that time was pro-rich in its redistributive effect, a factor attributed to the (then) dual system of income-related public contributions for lower earners and non-income-related private premiums for higher earners; the same conclusion can be drawn for Germany (Wagstaff and van Doorslaer 1997; Wagstaff et al 1999).

It is not clear whether this research accounted for the use of tax incentives to encourage take up of PHI. Tax relief on premiums can lower equity in finance in the wider health system because in many countries PHI mainly benefits richer people. Arguments in favour of tax incentives assume that higher take up of PHI will lower the demand for publicly-financed health care – in other words, tax relief will be self financing – or that compensating employers and employees for purchasing group cover will neutralise the effect of this cover on labour costs. We are not aware of any studies that look at this latter issue, but evidence from several EU member states shows that the removal or lowering of tax incentives does not have a negative effect on demand for PHI (Ireland, Norway, Spain, the UK). Evidence from the UK also shows that tax relief introduced during the 1990s was not self financing; its abolition in 1997 saved the government £135 million (Emmerson et al 2001).

Tax finance can be used to subsidise PHI in less obvious ways, with potentially negative consequences for equity in finance and equity of access to health care. We will discuss this in more detail below.

Equity of access

In this section we discuss two dimensions of access that might vary depending on whether or not people are covered by PHI: differences in the use of health services and differences in waiting times for treatment. These differences reflect the coverage itself – for example, people with PHI in France will face lower financial barriers to accessing health care, while people with PHI in Ireland will be able to bypass queues for publicly-financed treatment. They also reflect public policy allowing doctors to practise privately in addition to working in the public sector, allowing private beds in public hospitals and allowing the payment of higher fees for privately-financed treatment – all of which create strong incentives for providers to prioritise privately-financed patients (see Table 9 and Table 10).

Use of health services

Some countries provide good evidence to show how those with PHI enjoy preferential access to health care. Research from France and Spain reveals that those covered by PHI consult doctors and dentists more frequently than those without this type of coverage (an average of 1.5 doctor visits per month in France compared to 1.1) (Breuil-Genier 2000; Rajmil et al 2000).

An international study based on data from the mid-1990s found that the degree and distribution of PHI lowered equity in the use of doctors, although in most countries the effect was fairly small (van Doorslaer et al 2002). However, the negative effect of PHI on equity in the use of specialists was very high in Ireland and the United Kingdom and

evident, to a lesser extent, in Spain, Belgium, Denmark, Austria, Canada and Italy. A subsequent study based on data from 2000 found that specialist visits favoured richer groups in every country included in the analysis and were particularly pro-rich in Portugal, Finland, Ireland and Italy, all countries in which supplementary PHI and direct out of pocket payments play a role in providing access to specialists (van Doorslaer et al 2006)[153].

Inequalities in access to health care created or exacerbated by PHI may manifest themselves in subtle ways. Anecdotal evidence from Slovenia suggests that people without PHI may sometimes have limited access to publicly-financed care due to fears on the part of providers that patients may not be able to pay the statutory user charges involved (Milenkovic Kramer 2009). Survey data from France show that people covered by CMU-C – government-financed complementary PHI cover for people with very low incomes – are treated differently by doctors permitted to extra bill patients. Statutory health insurance and CMU-C do not reimburse patients the difference between collectively-negotiated fees and extra billing, but normal PHI does. For this reason some doctors appear to refuse to treat patients covered by CMU-C (Chevreul and Perronin 2009). Thus, while tighter regulation of the PHI market in both countries has improved access to PHI it does not seem to have fully removed all barriers to accessing health care. In the French case, there is also the issue of the small proportion of the population without complementary PHI cover (around 6%). Not all those eligible for CMU-C have received it, perhaps due to the difficulty of extending this cover to homeless people (Durand-Zaleski 2008).

Waiting times

Evidence from several countries suggests that people with PHI enjoy faster access to health care than those covered by the statutory scheme, giving rise to concerns about 'two-tier' health care. This is not surprising in countries where doctors work in both sectors, sometimes within the same hospital, and are paid higher fees for PHI-financed care, and where avoiding long waiting times for treatment is one of the reasons for buying PHI in the first place (Austria, Ireland, Portugal, the UK). For example, surveys carried out by Statistics Austria in 2006-07 show that waiting times for cataract surgery are four times longer for publicly-financed than PHI-financed patients, three and a half times longer for knee operations and twice as long for intracardiac catheterisation (Statistik Austria 2007). Given that average waiting times for these procedures are 100 days, 97 days and 28 days respectively, these differences may be substantial. It is also reported that private patients sometimes receive too much care, being subject to multiple laboratory tests or being kept in hospital for longer than is medically necessary (Url 2006).

In Ireland, publicly- and PHI-financed care is often provided by the same staff, using the same facilities, but with fee-for-service payment for private work and salaries for public work. This mixed system is part of an explicit national strategy to allow both sectors to share resources, skills and technology (Department of Health and Children 2001 cited in Turner and Smith 2009). As a result, however, those with PHI enjoy faster access to health care, particularly inpatient care, for which there are long waiting times in the public sector. Better access to hospital care and other non-financial factors are cited as key reasons for

[153] The later analysis found that pro-rich inequity in the use of specialists had fallen in the UK. This might reflect a strong shift in the nature of demand for supplementary PHI. Since 1996 the share of individuals buying PHI has fallen (from 4.4% of the population in 1996 to 3.3 in 2003), while the share of employer-based groups buying PHI has risen (from 7.1% in 1996 to 7.9% in 2003). As groups tend to cover healthier individuals, it is possible that this has contributed to lower private demand for specialist care. It may also reflect the success of government initiatives to lower waiting times for NHS treatment.

purchasing PHI in Ireland (Nolan 2006). A special system in which 20% of non-emergency public beds are designated for use by public patients is intended to safeguard access to inpatient care for publicly-financed patients. Research shows that this system is breached, since private patients account for close to 30% of all public hospital discharges (Wiley 2001). Survey data for 2001 show that 35% of adult patients with PHI waited less than one month for inpatient care, compared to 14% of patients eligible for free care. Conversely, only 13% of privately-insured patients waited more than one year for treatment compared to 25% of those eligible for free care (Tussing and Wren 2006). Similar differences were observed for outpatient consultations and day case procedures. There are also concerns about differences in the quality of care available to public and private patients, with anecdotal evidence suggesting that the latter are more likely to receive care directly from a specialist rather than from more junior doctors (Turner 2009).

Doctors in Germany also have incentives to prioritise privately-financed patients. A 2007 study found no significant difference in waiting times for appointments with general practitioners among GKV members and the privately insured, although the former spent slightly longer in the waiting room than the latter (32 vs 21 minutes) (Schellhorn 2007). However, waiting times for an outpatient specialist appointment differed by several days, with GKV members waiting on average 10.5 days compared to only 4.5 days for the privately insured. The study found no differences in patient outcomes or satisfaction (Schellhorn 2007). A separate study found differences in waiting times as well as higher levels of satisfaction among the privately insured (Mielck and Helmert 2006). Further research also shows significant differences in waiting times for outpatient specialist appointments in five specialties, with GKV members waiting on average about three times longer for an appointment than privately insured patients (Lüngen et al 2008). Differences in waiting time between the two groups of patients ranged from 24.8 working days for a gastroscopy to 17.6 working days for an allergy test (including pulmonary function test) and 4.6 days for a hearing test (Lüngen et al 2008). Finally, two studies show that the privately insured have faster access to patented and innovative drugs than GKV members (Krobot et al 2004; Ziegenhagen et al 2004).

Concerns about two-tier access to health care caused or exacerbated by PHI feature in other countries (Denmark, Finland, Italy, Norway, Portugal, Spain, the UK). The Irish and German experience in particular illustrates the extent to which public policy towards provider payment and other aspects of health care delivery combine with PHI to create inequalities in access to health care. In countries like the Czech Republic, where substitutive PHI mainly covers relatively low-paid migrant workers, the concern is that the additional administration required for providers to be reimbursed by private insurers may be a disincentive for treating these patients (Dlouhy 2009). As we discuss below, however, the root cause of two-tier access does not lie in the PHI market so much as in government reluctance to address apparently perverse incentives in the wider health system and, in some cases, government willingness to facilitate these incentives through tax subsidies for PHI.

Incentives for efficiency and quality in health care delivery

Providers are often paid differently depending on whether they are treating publicly- or privately-financed patients. In recent years governments in many EU members states have improved the way in which health services are purchased, moving away from retrospective

reimbursement of providers towards greater use of prospective payment, often through blended systems intended to link payment to performance – for example, combining capitation with an element of fee for service to reward specific outcomes (Thomson et al 2008a). On the whole this contrasts with the way in which most private insurers in most EU member states pay providers (see Table 9); the most common payment mechanism is retrospective fee-for-service-based reimbursement and in many cases the fees paid for treatment of PHI-financed patients are higher than the fees providers are paid in the public sector.

This is mainly an issue in substitutive and supplementary PHI markets, although a key feature of complementary PHI cover of statutory user charges in France is to reimburse patients for extra billing by some doctors. The policy implications of differential payment methods on efficiency and quality may be mixed. On one hand, allowing providers to practise in both sectors and to generate higher fees for treatment of private patients may prevent doctors from leaving the public sector and focusing on purely private practice and may limit salary inflation in the public sector. For example, insurers in Germany argue that the privately insured indirectly subsidise the costs of outpatient care for GKV members (Niehaus and Weber 2005).

On the other hand, differential payment methods create strong incentives for providers to prioritise private patients, which might distort efforts to improve public resource allocation. It could also undermine the quality of care provided to public and private patients, mainly by compromising the timeliness of publicly-financed treatment, but also in terms of differences in skill levels (a concern in Ireland) and, perhaps, through over-supply of treatment to private patients (a concern in Austria). In the German case, it is not clear whether the additional funds providers receive for treating private patients are used to benefit GKV members and discrepancies in waiting times for public and private patients are particularly marked where specialist outpatient care is concerned.

In some countries public payers do not charge private insurers the full economic cost of using private beds in public hospitals, which has clear implications for efficiency in public resource allocation. If private beds in public hospitals are cheaper than beds in private hospitals, insurers will have an incentive to encourage PHI subscribers to use the former rather than the latter. In Ireland, for example, half of all PHI-financed care takes place in public hospitals (Turner and Smith 2009 forthcoming). Although charges for private beds in public hospitals have increased in recent years, they still do not cover the full economic cost, which results in a substantial public subsidy of PHI-financed care (Turner and Smith 2009 forthcoming). In 1989 the UK introduced economic pricing for private beds in NHS hospitals. As a result of NHS reforms, the newly formed NHS trusts began to charge commercial rates for PHI-financed use of NHS beds, leading to financial problems for many insurers. The largest UK insurer was eventually forced to exclude cover of private beds in NHS hospitals (Buck et al 1997).

PHI may be encouraged in some countries specifically to boost health system capacity through the establishment of new facilities. This seems to have been a public policy goal for the market in several of the newer member states, although the limited ability of many patients in these countries to pay for PHI has probably restricted success of such a strategy (Thomson 2009 forthcoming).

Administrative efficiency

It is difficult to compare the relative administrative efficiency of statutory and private health coverage due to the absence of reliable data on administrative costs in the statutory scheme. Where these data are available, they suggest that private insurers have much higher costs as a proportion of revenue than statutory insurers (Mossialos and Thomson 2002a). The extent of the difference in administrative costs probably indicates superior administrative efficiency in the statutory health system relative to PHI, although it does not necessarily imply that the statutory health system is administratively efficient.

Transparency and accountability

The process of creating a role for PHI may contribute to transparency in the wider health system to the extent that it encourages policy-makers to define the range of publicly-financed benefits more explicitly and to the extent that people are made aware of their public entitlements. It may also improve transparency in health systems characterised by informal payments (although there is no evidence of this), but again, only to the extent that private insurers attempt to restrict this type of payment.

Where there are problems with waiting times for publicly-financed treatment, the concern generated by the role of supplementary PHI in facilitating two-tier access to health care can prompt governments to take action to address long waits in the public sector. This has been the case in Denmark, Sweden and the UK. In the last ten years governments in all three countries have made concerted efforts to lower waiting times for public treatment – largely successful in Denmark and the UK, less so in Sweden (Thomson et al 2008b). These strategies have improved accountability for timely access to publicly-financed health care.

In other contexts the existence of PHI has not had such a salutary effect. In Germany, competition between statutory and private insurers – in particular, the threat of exit from the GKV of younger and healthier members – may have encouraged quality improvements in the GKV but has also encouraged the GKV to introduce measures that have the potential to undermine transparency and accountability. For example, from 2009 statutory insurers are permitted to charge their members a non-income related premium. This can take the form of a deductible with or without a no-claims bonus. Both have the potential to lower financial protection and giving people choice of different levels of deductible and/or a no-claims bonus has the potential to lower transparency[154]. Some argue that such measures would not have been introduced in the absence of competition from PHI (Busse 2008).

Governments in countries with complementary PHI markets covering statutory user charges have at once relied on the existence of PHI to enable them to raise the level of charges and then had to intervene in the market to ensure equitable access to PHI. Tighter regulation of PHI has improved access to PHI in Belgium, France and Slovenia but has not fully addressed all issues of access either to PHI or to publicly-financed health care.

[154] No-claims bonuses introduced in the Netherlands in 2006 were subsequently abolished in 2008 and replaced with a standard deductible that applies to the whole population. One reason for abolishing them was that insurers found it very expensive to reimburse the high proportion of people who do not make any or much use of health services in a given year.

Enhancing choice

Markets for PHI in the European Union can enhance choice for consumers in various ways. Supplementary markets give consumers choice of public or private provision, complementary cover of excluded services may give consumers greater choice of treatment and substitutive cover in Germany gives higher-earning consumers the choice of public or private coverage. In almost every case, however, this choice is circumscribed by eligibility criteria (income in Germany and age in most countries – for example, older people may not be eligible to purchase private cover); by health status (many private insurers can reject applications if the applicant is considered too high risk); or more simply by ability to pay. It is an obvious point, but one worth stating nevertheless: the enhanced consumer choice PHI offers is usually only available to those who can afford to pay the premium.

The extent of choice within the market has changed over time. In older markets, where mutual associations have played a key role, PHI originally offered a single product. As commercial insurers entered the market and competitive pressure grew, insurers were forced to offer a greater number of products, either to keep up with the products offered by rivals or to undercut them by using product differentiation to select risks. Product differentiation often suggests a degree of competition among insurers and enhanced choice for consumers. But closer scrutiny reveals that it is also likely to confuse consumers and make it difficult to compare products in terms of value for money. For this reason, greater choice of products does not always benefit consumers. Competitive pressures may also have forced some private insurers to restrict consumer choice to contain costs – for example, through vertical integration or the use of preferred provider networks. In Germany, the negative effects of choice of public or private cover have led the government to restrict this choice for older individuals – so those who opt out of the statutory scheme cannot return to it once they are aged 55 and over.

Finally, the extent of choice available to those who are publicly covered has in many countries also changed over time. German or Dutch residents who had no choice of statutory insurer 15 years ago now benefit from this choice. People in Ireland, the UK and Nordic countries, who did not previously have access to the private sector, now receive public finance for care in private hospitals as well as having free choice of public hospital. Thus, while it is broadly true that PHI enhances consumer choice, the gap between the level of choice available to publicly and privately insured patients has narrowed. Conditional sale may be used by insurers in some countries to select risks for statutory coverage (Paolucci et al 2007). This also has the effect of undermining the ability of some consumers to exercise choice of statutory insurer (see below).

Labour market issues

In countries that use employment as the basis for financing health care (for example, through payroll taxes) there are concerns about the impact of changing demographic and labour market conditions on financial sustainability (Thomson et al 2008a). A growing informal economy (Schneider 2002b; 2002a), rising levels of self employment and unemployment and shifting dependency ratios are all likely to shrink this particular revenue base. These concerns do not usually extend to markets for PHI, although they should, since in many member states PHI is partly financed by employers. Figure 8 shows that a high share of PHI policies is purchased by groups in many countries and that PHI is

almost exclusively purchased by groups in a handful of countries. Almost all of these groups are employment-based. Table 13 also shows the extent to which group-purchased PHI is encouraged through tax policy. In some cases it is possible that tax relief for group-purchased cover is directly intended to prevent upward pressure on labour costs. Group-purchased cover might also be seen as a means of lowering the time spent away from work due to ill health, particularly in countries with long waiting times for publicly-financed treatment. For example, the Norwegian government introduced tax relief for group-purchased PHI in 2003 to ensure a swifter return to work for employees, which it hoped would lower government payment of sickness benefits and enhance worker productivity (Johnsen 2008). However, the tax relief was abolished in 2006, without any negative effect on demand for PHI.

Relieving pressure on public budgets

One of the arguments in favour of PHI – an argument likely to gain support in the current economic climate – is that it may relieve pressure on public budgets by shifting financial risk for some health services on to private insurers. This could be achieved by lowering the breadth, scope and depth of statutory coverage or, at the very least, by not increasing the scope of statutory coverage to keep pace with technological development.

Figure 4 showing levels of spending on health through PHI as a proportion of total spending on health suggests a limited potential for PHI to relieve pressure on public budgets, since in two thirds of EU member states PHI accounts for less than 5% of total health expenditure and only exceeds 10% in France and Slovenia. The relatively high figures for France and Slovenia reflect the very high proportion of the population covered by complementary PHI covering statutory user charges in both countries (over 90% and over 70% respectively). They may also reflect high levels of statutory cost sharing resulting in relatively expensive PHI premiums. For example, the annual premium for a 50-year old man varies from between €19 and €517 in Belgium (another mainly complementary market, covering around 73% of the population), to €272 in Slovenia and €482 in France.

Nevertheless, the question of whether and how PHI might relieve pressure on public budgets is an interesting one that warrants further attention. In the following paragraphs we consider the question for each of the four roles that PHI plays in the European Union. We are not suggesting that the experience of particular countries is automatically generalisable to other settings. But it may highlight useful implications for policy.

Substitutive PHI

Allowing people to opt out of statutory health coverage or simply excluding them from statutory cover can result in demand for substitutive PHI. In the context of universal coverage, there are two main reasons for wanting to create a substitutive market: first, to ensure that limited public funds for health are spent mainly on poorer people, leaving richer households to look after their own health care needs; and second, to give people more freedom in choosing the type of health cover – public or private – that suits them best. Where financial and other constraints have prevented countries from achieving universal coverage – for example, in low-income countries – the first reason seems most compelling. The 'targeting' argument reflects both equity and efficiency principles: poorer people will benefit most from the financial protection and risk pooling provided by

publicly-financed health coverage and public funds will be spent on those most in need of health care (Chollet and Lewis 1997). The choice argument reflects a libertarian approach in which forcing people to join a statutory scheme is seen as an unnecessary constraint on personal freedom. It may also be put forward on the grounds that competition between statutory and private coverage will lead to administrative efficiency, innovation and higher quality of care (Gilbert and Tang 1995; Johnson 1995; Chollet and Lewis 1997).

A handful of European countries – notably Portugal and Italy – have considered permitting people to opt out of statutory health coverage, but proposals put forward in the early 1990s failed to gain sufficient political and popular support (Mossialos and Thomson 2004). If they were to be pursued now, they would seem out of step with the current trend to expand rather than restrict statutory health coverage. More importantly, there are good reasons why policy makers have moved away from substitutive PHI (in the Netherlands, for example). The German experience illustrates the sort of problems governments have faced in sustaining a substitutive market – not least the extensive and complex regulation required to address risk segmentation, to ensure access to PHI (particularly where it is a household's only source of financial protection) and to facilitate consumer choice[155].

Risk segmentation in the German health system is caused by two main factors: the rules governing eligibility for substitutive PHI on one hand and a regulatory framework that gives private insurers incentives to attract certain types of people on the other. For example, private insurers can reject applications for cover, risk-rate premiums, exclude cover of pre-existing conditions, charge extra for dependants and offer discounted premiums in exchange for high deductibles. As a result, the substitutive market enjoys a high concentration of 'low risks', while the GKV covers a disproportionate number of 'high risks' – notably women and children, older people and people with larger families. On average, those with substitutive cover are younger, healthier, have higher earnings and use fewer health services than GKV members. For example, people aged 65 and over account for only 11% of the privately insured, compared to 22% of GKV members (Schneider 2003).

[155] For an in depth analysis of the problems created by allowing choice of public or private health insurance see Thomson and Mossialos (2006).

Table 15 indicates differences in health status and health care use. In addition, the average earnings of the privately insured are about 60% higher than those of contributing GKV members (€38,109 compared to €22,658) (Leinert 2006a) and this income differential is reflected in data on those who report difficulties in paying for outpatient prescription drugs: 26% of GKV members versus 7% of the privately insured (Mielck and Helmert 2006)[156].

[156] Statistically significant after controlling for differences in age, gender and income.

Table 15 Comparison of health status and health care use among the publicly and privately insured in Germany, 2006

Health status and health care use	Mandatory GKV	Voluntary GKV	Mandatory PHI[157]	Voluntary PHI
Been ill during the last three months	46%	42%	47%	28%
Chronically ill	47%	33%	45%	23%
Regularly take medication	50%	35%	54%	21%
Number of visits to a doctor in a year	6.6	4.4	6.2	3.2

Source: Leinert (2006b)

The problem of risk segmentation became acute soon after the 1989 law extended choice of statutory or private coverage to all higher earners. During the early 1990s premiums rose sharply for older people with substitutive PHI, partly due to mismanagement and partly due to exploitation of loopholes in the regulatory framework. Private insurers had based premium calculations on average life expectancy, failing to account for the longer life expectancy enjoyed by substitutive subscribers, who come from higher socio-economic groups. This unforeseen discrepancy between premiums and benefit costs allowed them to raise premiums. Some private insurers also barred new subscribers from joining existing risk pools, which meant that existing subscribers were unable to benefit from lower premiums arising from the entry of younger people (Riemer-Hommel et al 2003). The GKV subsequently faced an influx of older people who had previously chosen private cover but could no longer afford the premiums (Wasem 1995).

Risk segmentation has had serious financial consequences for the GKV, contributing (with other factors) to its deficits and prompting steady rises in contribution rates. This in turn has created even stronger incentives for younger people to opt for substitutive cover (Busse and Riesberg 2004; Busse and Wörz 2004). Using panel survey data for 2000 to 2004, researchers have calculated that the GKV loses about €750 million a year as a result of people changing from GKV to private cover or from private to GKV cover (Albrecht et al 2007). The same study showed that more than half of those leaving the GKV were low risks in terms of age, family status and income, while most of those joining the GKV were high risks.

In the last 15 years the German government has taken a number of steps to address the problem of risk segmentation leading to financial imbalance for the GKV. These have involved making it more difficult for people to leave the GKV by raising the opting out income threshold by a higher than usual amount (11% in 2003) and by requiring people to earn above the threshold for three consecutive years before they can opt out (from 2007). It is estimated that the latter reform has lowered the financial loss to the GKV by 15-20% a year (Albrecht et al 2007). The government has also introduced tighter rules about when it is possible to return to the GKV for those who have previously opted out – so, for example, in 1995 people aged 65 and over lost the right to return to the GKV, even if their earnings fell below the income threshold, and in 2000 the age limit was extended to people aged 55 and over. Although these changes have stemmed the flow of older people back to the GKV and prevented them benefiting from 'free' cover (at least, cover to which they have not previously contributed), they have not fully tackled the problem of risk segmentation. High

[157] Those who are not permitted to return to the GKV.

risks and those who are risk averse are now much less likely to leave the GKV, to the advantage of private insurers, who have been swift to highlight the fact that private cover is best value for the young, single and healthy (PKV 2002).

Reforms to address risk segmentation have created a separate set of issues concerning access to substitutive cover – not just for those who no longer have the option of returning to the GKV, but also for those who find it hard to pay private premiums (perhaps because they are older or in poor health) and those who cannot obtain cover of pre-existing conditions. Research based on 2005 survey data estimates that 5% of those with substitutive cover (about 350,000 people) pay premiums that are higher than the maximum GKV contribution (Grabka 2006). The same research shows that, between 2001 and 2005 the proportion of substitutive PHI subscribers with deductibles increased continuously, with older people having contracts with higher deductibles than younger people. In 2009 the government introduced a new basic policy designed to guarantee access to substitutive cover and to a level of cover that is equivalent to the scope and depth of GKV cover at a price that cannot exceed the maximum average GKV contribution. It also capped the level of deductibles at €5,000 per year.

The high costs involved in switching from one private insurer to another in Germany (mainly due to the non-transferability of ageing reserves[158] but also due to risk rating of premiums and exclusion of pre-existing conditions) has meant that there has been almost no competition among insurers for those already part of the substitutive market. Instead, competitive efforts have focused on attracting new entrants to the market. However, from 2009 ageing reserves must be portable for all new customers (existing customers can transfer their reserves within a period of six months), which the government hopes will improve competition and consumer choice within the market.

Substitutive PHI has been a source of controversy in Germany since the 1990s. Public debate about its future intensified in 2003, with the publication of a report by the Rürup Commission[159], which included a proposal to abolish opting out and introduce a universal system of 'citizens' insurance'. The proposal was supported by the social democrats but did not obtain further political support and was abandoned. Further debate took place in 2007, culminating in a decision to make health coverage universally compulsory but maintaining the current system of opting out for higher earners. In the period preceding the 2007 reform some had suggested allowing private insurers to compete with the GKV for provision of GKV benefits, with all insurers – sickness funds and private – being part of a national system of risk adjustment. The idea of 'citizens' insurance' was revived in 2008 by a PKV working group – 'Social Security 2020 – mainly consisting of larger (commercial) insurers. However, the working group's proposal was fiercely opposed by other insurers (mostly mutual associations) and eventually dropped from the working group's report (Fromme 2008).

A succession of reforms has led to increasingly stringent regulation of the substitutive market, which is not uncontested. The PKV (the Association of Private Insurers) are opposed to several aspects of the changes introduced in the 2007 Act, notably the rules around the basic policy, the portability of ageing reserves, restricting eligibility to those with earnings above the threshold for three consecutive years and allowing the sickness

[158] Introduced to address the problem of premium increases for older subscribers.
[159] Kommission für die Nachhaltigkeit in der Finanzierung der sozialen Sicherungssysteme.

funds to offer additional cover. Several private insurers have submitted a joint appeal to the Federal Constitutional Court to review the 2007 Act on the grounds that it disadvantages PHI subscribers and infringes the entrepreneurial freedom of insurers (PKV 2008). The court's decision is pending. There is also the possibility of legal challenges at EU level.

The Netherlands faced similar issues with its market for substitutive PHI (Thomson and Mossialos 2006). In 1986 it prevented people from opting out of the statutory scheme and instead excluded higher earners and their dependants (37% of the population) from statutory cover. Eventually, however, the levels of regulation required to ensure access to substitutive cover and to compensate the statutory scheme for covering a disproportionate number of high risks were found to be too unwieldy. Some of the regulations had also generated controversy in terms of EU internal market and competition rules (see Part 2). In 2006 the government abolished the need for substitutive PHI by extending statutory coverage to the whole population.

The German experience with substitutive PHI shows that while allowing higher earners to opt into the statutory scheme and vice versa lowers the public budget in the sense that the government is no longer responsible for financing health care for those covered by substitutive PHI, it does not necessarily relieve pressure on the public budget. In fact, it increases this pressure. As a result of risk segmentation and the loss of contributions from higher earners, the average per capita amount available to spend on GKV members is lower – and the average health risk of GKV members is higher – than would be the case if the whole population were covered. In other words, the public budget must be stretched to meet the needs of a disproportionately high risk group.

Complementary PHI covering excluded services
PHI can in theory relieve pressure on public budgets by enabling the publicly-financed system to pay for a minimum level of benefits focusing on 'necessary' and cost-effective services, which creates a role for complementary cover of services excluded from the publicly-financed benefits package. This form of complementary private cover is attractive in theory. Ideally, the publicly-financed benefits package would be systematically streamlined using explicit criteria and health technology assessment, leaving private insurers to cover less (cost)-effective services. If private cover is restricted to 'unnecessary' or non-cost-effective health services, there are unlikely to be serious concerns for equity of access to health care or, ultimately, for people's health.

The reality, however, is less straightforward and this sort of market can be hard to establish. First, governments often find it politically difficult to determine a minimum benefits package, particularly if it involves a reduction in population entitlement to health care. Second, it can be both technically and politically difficult to base a benefits package on effectiveness and – even more so – on cost-effectiveness criteria, and efforts to do so frequently face both public and provider opposition (Ham and Robert 2003; Jost 2005; Sorenson, Drummond et al. 2008). In the absence of sufficient political will, technical expertise or financial resources to exclude only ineffective or non-cost-effective health services from publicly-financed cover, governments tend to resort to excluding whole areas of service rather than systematically de-listing single interventions of low value.

What this means in practice is that it is usually services that are less politically visible that are excluded (for example, some forms of eye care, dental care or physiotherapy)[160].

A further issue relates to the supply of complementary cover of excluded services. If, for example, the government were to exclude outpatient prescription drugs from the publicly-financed benefits package, a voluntary market to cover this might not develop automatically. Private insurers might be reluctant to cover something like outpatient prescription drugs due to fears about 'adverse selection' – the possibility that only high risks will want to buy cover. For this reason, private insurers might only develop products covering outpatient prescription drugs if they could be sure of high levels of population coverage, with a good mix of high and low risks.

Internationally, Canada provides probably the most 'successful' example of this sort of PHI market. The publicly-financed benefits package in most Canadian provinces does not cover outpatient prescription drugs, fuelling demand for a private market which accounts for a relatively high proportion of total spending on health – about 12% in 2005 (Marchildon 2005). Insurers have not been put off by fears about adverse selection because private cover is mainly purchased by groups (over 90%), which spreads risk, and covers two thirds of the population (67%), again spreading risk. In fact, since private cover is widely associated with employment and offered as a tax-exempt benefit it is 'voluntary' more in name than practice. Despite its apparent success, the Canadian market for complementary cover has generated serious concerns for equity. Richer households are much more likely to be covered than poorer households, which is reflected in greater use of outpatient prescription drugs among richer households with private cover, and tax subsidies for private health insurance are highly regressive (Hurley and Guindon 2009).

Complementary cover of excluded services in the European Union usually provides access to a range of both necessary and cost-effective services – mainly eye care, dental care and physiotherapy. It tends to be sold alongside supplementary products providing faster access to health care or access to care in the private sector and it is not always easy to distinguish the two markets. The Dutch market for voluntary complementary cover is unique in achieving almost universal coverage and making a modest but significant contribution to total spending on health. Such high levels of willingness (and ability) to purchase this form of complementary cover may reflect various factors: voluntary cover is sold alongside statutory cover, often by the same entities (even if they may be separate for accounting purposes); the market has been in place for many years, so people are familiar with it and understand its purpose; it covers services that are valued by a well-educated and relatively affluent society (for example, dental care for adults); private insurers have so far voluntarily followed a policy of open enrolment, which makes the market easily accessible, even to older people and people with poor health; and cover is increasingly purchased on a group basis and paid for by employers, as in Canada (Mossialos and Thomson 2004). Factors like these may be difficult to replicate in other settings.

Hungary has a much smaller private market for complementary cover of excluded services. Established in 1993, this part of the market is restricted to mutual associations (about 45 in total) who are not allowed to engage in other insurance activity. Individuals make

[160] Although governments have not always found it easy to exclude these services either. Governments in several member states have tried to exclude some of these services and then re-introduced them following adverse media coverage – for example, dental care in Germany in the 1990s and cover of spectacles in France in 2008 (Busse 2001; Chevreul and Perronin 2009).

contributions to a savings account, which can then be used to pay for health services like complementary and alternative medicine and physiotherapy, to cover the cost of some statutory user charges and to pay for other things, such as sporting equipment. The Hungarian market has grown slowly over time. In 2005 PHI accounted for just over 1% of total spending on health and covered about 6% of the population (Boncz 2008). Reasons for the slow development of this market include the broad coverage provided by the publicly-financed benefits package and the presence of informal payments. Complementary cover is mainly purchased by people in employment, covering 20% of the employed population, and is more likely to be purchased by those working for larger companies. Most (90%) of the contributions towards this cover come from employers rather than employees. Substantial tax subsidies (30% of the 'premium' or contribution) explain a large part of the demand for complementary cover.

The Dutch experience gives cause for caution on three counts. First, while the statutory benefits package is generous at present, governments may be tempted, over time, to shift services from statutory to voluntary cover; although this is likely to be politically unpopular, it remains a possibility. Such a move might undermine financial protection. Second, the open enrolment policy voluntarily followed by private insurers now may change in the near future as cost pressures intensify (Maarse 2008). If this were to happen, complementary cover would become less accessible. Third, due to the competitive environment for both statutory and voluntary cover in the Netherlands, there is concern that voluntary cover might be used by insurers as a means of selecting favourable risks for statutory cover (Paolucci et al 2007). Individuals might find it easier to purchase both types of cover from the same entity, and because insurers can in theory reject applications for voluntary cover, as well as risk rate premiums and exclude cover of pre-existing conditions (although they do not currently seem to do so), it may be difficult for some people to change to another insurer for statutory cover, undermining competition in this part of the market. There is no evidence to suggest that private insurers use voluntary cover to select risks for statutory cover, but again, this might change as the level of financial risk borne by insurers providing statutory cover increases, giving them much stronger incentives to engage in risk selecting activity, to the detriment of competition and equity of access to health care.

Complementary cover in Hungary may give cause for concern for slightly different reasons. Even though it is at present very small, policy makers should be aware of its equity implications: most of those covered and benefiting from generous tax subsidies are in employment and therefore least likely to be in need of financial protection. Given the extent of cost pressures the statutory system already faces, the government might question the wisdom of using public finances to subsidise additional cover for a relatively well off group of people.

In contrast to substitutive PHI, complementary cover seems reasonably attractive in theory – at least if the benefits it provides are genuinely marginal in the sense that they are ineffective or not medically necessary. Unfortunately, this is rarely the case and it tends to cover a range of necessary and effective services such as dental care and physiotherapy. At present, there is little evidence to suggest that complementary cover is able to relieve the government of significant financial pressure. Even where it may do so, there are likely to be important trade-offs with equity and efficiency. The same is true of consumer choice. Where complementary cover is sold alongside statutory cover, choice of both voluntary and statutory cover may be constrained in the longer term as the burden of financial risk

borne by insurers encourages them to select risks. And, as always with voluntary cover, consumer choice tends to be a luxury enjoyed by those who can afford to pay for it.

Complementary PHI covering statutory user charges

Encouraging complementary PHI covering user charges may be an appealing option for policy makers who want to limit public expenditure by expanding statutory cost sharing. The experience of France and Slovenia, the two largest markets for this type of private cover, is positive in this respect. In both countries, complementary PHI is more or less universal, which means that the burden of statutory cost sharing is distributed across a large proportion of the population. This may counteract the regressive nature of any out of pocket expenditure. Nevertheless, as we have shown, problems remain in ensuring access to PHI in France and Slovenia (although these are relatively small) and access to PHI does not remove all barriers to accessing publicly-financed care. There are also issues relating to EU internal market and competition rules (see Part 2).

A further issue is that complementary cover of statutory cost sharing may undermine government efforts to improve efficiency in the use of health services. In France, for example, co-insurance rates for prescription drugs vary based on the effectiveness and nature of pharmaceutical products. The intention here is to encourage people to use highly effective drugs rather than less effective or ineffective ones. More generally, user charges in the French health system are also intended to moderate demand for health care. However, both of these aims are potentially undermined by the availability of complementary cover which negates – fully or partially – the demand-moderating effect of user charges (for those with PHI).

Supplementary PHI

In the absence of government efforts to encourage a specific role for private health insurance, the type of market most likely to emerge is a supplementary market offering faster access to care, often through private providers. This has been the experience of many of the newer member states, where governments have introduced regulation permitting private health insurance, but markets have either not developed or play a small supplementary role. Advocates of supplementary PHI generally argue in favour of its ability to enhance consumer choice. Less frequently, some suggest it can contribute to relieving pressure on public budgets, particularly where there are waiting times for publicly-financed treatment.

For example, the Irish government claims that the PHI market in Ireland 'helps to ensure the effectiveness and profitability of the public health insurance scheme by reducing pressure on the costs which it would otherwise bear, particularly as regards care provided in public hospitals' (European Court of Justice 2008). However, there is no evidence to support such a claim. Rather, the evidence suggests that the public budget provides a substantial subsidy to the PHI market in addition to the funding it already contributes in the form of tax relief. Since about 50% of privately-insured care is delivered in public hospitals and public hospital charges for privately-insured care do not cover the full economic cost of that care, research estimates that the total public subsidy to privately-insured inpatients in public hospitals amounts to over 60% (Smith 2008 cited in Turner and Smith 2009 forthcoming).

The finding that the public budget contributes such a large subsidy to PHI-financed treatment in Ireland has equity implications. First, people in higher social classes are more

likely to have PHI than people in lower social classes. This means that the public subsidy largely benefits people who are wealthier and better educated. Second, as we have discussed, those with PHI have faster access to inpatient care, for which there are long waiting times in the public sector. Concerns about this issue have led to recommendations for a common waiting list for publicly and privately financed patients. The government has also set up a National Treatment Purchase Fund to purchase private care in Ireland and abroad on behalf of public patients waiting for extended periods of time – ironically, a further source of public subsidy to the private sector.

Neither of these initiatives really addresses the incentives inherent in the way in which providers are paid, which seem to be the main cause of two-tier access. It is possible that allowing doctors to practise privately in public hospitals both keeps those doctors available for public patients and prevents the government from having to pay them higher salaries, saving the government money in the long term. Although the research needed to answer this specific question is lacking, other research suggests that the magnitude of the public subsidy to privately insured patients is much larger than is necessary to compensate for this apparent saving (Turner and Smith 2009 forthcoming).

The Irish experience with a predominantly supplementary PHI market is clearly at odds with the government's explicit commitment to equity in the health system as a whole. Some of the negative equity effects are particularly evident because the Irish market is so large (in terms of the population it covers). In most other EU countries supplementary markets cover less than 5% of the population, rising to just over 10% in the United Kingdom. Here, the equity effects would be more muted and the overall implications of having such a market would be more mixed. A supplementary market may satisfy the demands of more affluent groups for faster access to health care and a greater degree of consumer choice. It may also satisfy those doctors who are able to boost their incomes by practising privately. Ultimately, the extent to which the government is willing to trade-off these gains for generally richer groups of people against the possibility of two-tier access to health care and distortion of public resource allocation is a matter of political choice.

Market development and public debate

Barriers to market development[161]

At the beginning of this report we emphasised the importance of the rules and arrangements of the statutory health system in influencing the role PHI plays and the size of the PHI market. It is clear that the extent and the quality of statutory health coverage are major determinants of demand for PHI. (In one or two countries substantial tax subsidies for PHI may be an equally significant determinant[162], although elsewhere the abolition of tax incentives has not lowered demand.) Nevertheless, there are countries in which some aspects of statutory health system performance are weak and yet the market for PHI remains marginal. For example, out of pocket spending on health accounts for over a third of total health expenditure in countries like Bulgaria, Cyprus, Greece and Latvia, but the

[161] This section draws on Thomson et al (2009 forthcoming).
[162] Notably Hungary and, to a lesser extent, Ireland.

market for PHI in each of these countries is very small, barely contributing to private spending (see Figure 5).

This suggests that gaps in statutory health coverage are necessary but not in themselves sufficient to encourage the growth of PHI, which has implications for the development of PHI in some of the newer member states (Thomson 2009 forthcoming). The comprehensiveness of the publicly-financed benefits package is commonly cited as the main reason for the small size of PHI markets in these countries. However, there must be other factors involved since, for example, there are no systematic differences in statutory user charges in older vs newer member states or in the range of publicly-financed services – and yet the older member states tend to have larger markets for PHI. Barriers to PHI may lie elsewhere: in limited ability to pay for PHI on the part of most of the population, lack of confidence in private markets, informal payments, lack of information, lack of private infrastructure and so on.

Limited ability to pay for PHI (on top of mandatory contributions and out of pocket payments) may be a major barrier to purchasing PHI for many people in the newer member states. In some countries this is compounded by the absence of employer or government interest in subsidising PHI premiums, leading some to call for greater use of tax incentives. However, internationally there is little evidence to suggest that tax subsidies encourage take up and the associated costs may be substantial. In practice, individuals' and employers' confidence in the market are more important factors in triggering market development (Colombo and Tapay 2003). Suspicion of insurance markets is particularly prevalent in countries which have experienced pyramid schemes, but also reflects a wider distrust of private markets in general (due to fears about high costs and corruption) and lack of experience in buying any type of insurance product. Public attitudes to PHI may be further complicated by a strong belief in the role of the state in ensuring universally 'free' access to health care, leading to a preference for public financing and provision.

The persistence of informal payments in place of other more transparent payment mechanisms in the public and private sectors (Kornai and Eggleston 2001; Balabanova and McKee 2002; Ensor and Duran-Moreno 2002; Ensor 2004; Allin et al 2006) may prevent the development of PHI in three ways. First, PHI is not always able to protect against informal payments so people may fear having to pay twice to access a particular service (PHI premiums and informal payments). Second, those who do purchase PHI must be certain that paying providers via a third party will not jeopardise the speed or quality of service they would expect to receive in return for informal payments. Third, if individuals can afford PHI premiums then it may be cheaper (in the short term) to pay out of pocket. The lack of informal payments may have contributed (among other things) to the large size of the Slovenian PHI market.

Quality and information are further issues affecting demand for PHI. If insurers are unable to ensure clinical quality (for example, where they have limited leverage over providers), people may not perceive any additional benefit in paying for PHI. Subscribers may also be inconvenienced if PHI-covered services are not integrated with public service delivery, leading to duplication. Poor information about the costs of and waiting times for publicly-financed services may prevent some people from recognising a need for PHI.

People may want to purchase voluntary cover but be prevented from doing so due to a range of constraints related to supply-side factors. In some countries markets have not

developed because there has been no government interest in PHI or legislation introducing PHI has not been accompanied by sufficiently clear administrative and regulatory frameworks, leading to uncertainty and inertia among insurers. Lack of regulatory capacity to enforce data collection and the provision of information for consumers can obstruct competition.

At the same time, insurers have not always shown interest in pooling risks for certain services due to fears about adverse selection, particularly in the case of drugs, dental care and cover of statutory user charges. In Romania, for example, insurers have been reluctant to cover statutory user charges for outpatient prescription drugs because they fear both adverse selection problems and fraud on the part of subscribers (Olsavszky 2009). Generally, insurers seem to prefer to provide supplementary rather than complementary or substitutive benefits. Insurers may themselves be held back by lack of operational capacity such as insurance know-how, particularly with regard to medical underwriting, which may prevent them from developing appropriate products, but also regarding human resources, administration and management practices. These problems can be compounded by limited private infrastructure and uncertainty surrounding public entitlements. Insurers relying on the services of private sector providers may struggle if private providers face high entry costs or if private facilities are poorly developed (usually the case outside large urban centres). Where the public benefits package is not adequately defined or changes from year to year insurers may find it hard to design products and people may not know how much additional cover they need.

A recent report identifies the following factors as enabling PHI market development: a substantial middle class; capacity for regulatory oversight and management; viable financial markets to invest reserves; and the availability of other sources of health care funding (Gottret and Schieber 2006). To this list we might add: public trust in insurance institutions and health care providers; employer interest in providing benefits for employees; and political will to foster and support a market for PHI.

Public debate about PHI

With one or two exceptions, there seems to be a clear divide between public debate about PHI in the newer and older member states (see Table 16). Public debate about PHI in the older member states often focuses on concerns about the potential for reductions in statutory coverage and growth in PHI to undermine equity of access to health care. Conversely, in the newer member states public debate is more likely to focus on better delineation of the statutory benefits package in order to encourage the development of PHI. There also seems to be more debate (mainly but not exclusively stimulated by private insurers themselves) about involving private insurers in the provision of statutory health insurance.

Table 16 Market development and public debate about PHI, 2008

Country	Market development and public debate about PHI
Austria	▪ Since 2000, some occupational groups have been entitled to opt out of statutory coverage and rely on substitutive PHI instead. ▪ Private insurers are concerned about rising costs and are taking steps to control costs and improve efficiency and quality; they also focus more on prevention, health promotion and disease management; some experiments with pay for performance.
Belgium	▪ Statutory cover of outpatient care (‘minor risks’) extended to self-employed people in

	2007, abolishing the substitutive PHI market. ▪ Additional statutory reimbursement for specific groups extended in 2007 to cover all those falling below the income threshold; a gradual extension of statutory user charges has been accompanied by the introduction of caps to protect chronically-ill and other people. ▪ PHI losses have pushed many insurers to increase their premiums in recent years. To prevent further sharp increases, a new law on PHI contracts was introduced in 2007 to specify parameters for premium increases but implementation has been problematic. ▪ The 2007 law also introduced regulatory measures to improve access to PHI.
Bulgaria	▪ Plans to stimulate competition between statutory and private coverage are being debated, but without clear policies about how this might be achieved. ▪ There are also debates about the scope of the publicly-financed benefits package and the possibility of introducing a mandatory system of complementary PHI.
Cyprus	▪ PHI currently plays a substitutive role; once the proposed General Health Scheme is implemented, PHI is expected to play a supplementary role
Czech Republic	▪ Small statutory user charges (co-payments) were introduced in 2008, but it is too early to assess their effect on PHI. ▪ The government plans to introduce more competition in the statutory scheme, perhaps by offering a range of statutory plans with different cost sharing levels; there is also debate about allowing private insurers to offer statutory coverage.
Denmark	▪ Since PHI premiums became tax deductible for employers in 2002, offering PHI has been used to attract employees, leading to a tenfold increase in PHI. ▪ In 2002 a two-month waiting time guarantee in the statutory health system was introduced, which allows patients who cannot be treated publicly within two months to be opt for treatment in a private hospital in Denmark or abroad. The reduced one-month waiting time guarantee introduced in 2007 may also affect the PHI market, although the market grew even after the 2002 guarantee. ▪ Public debate about whether PHI growth creates inequality in the supply of health care and inequality in access to health care (particularly specialist care, since specialists can almost double their earnings by treating PHI-financed patients). There are specific concerns about how this will affect people's willingness to finance the statutory health system through taxes in the longer term. ▪ Further debate centres on whether the government should support PHI via tax relief for employers or if this money would be better spent on the statutory health system.
Estonia	▪ The government sees PHI as a means of increasing spending on health care and providing additional insurance options. The most widely discussed measure to increase the role of PHI is the introduction of tax subsidies for premiums. ▪ The second option being considered is the introduction of medical savings accounts, which would allow taxpayers to save a share of the health insurance tax in a personal savings account.
Finland	▪ Municipalities defined maximum waiting times in 2005, which may have slightly lowered use of the private sector. ▪ There is some debate about the potential for PHI to create two-tier access to health care, but on the whole public discussion of PHI is rare due to its marginal role in the health system.
France	▪ The depth of statutory coverage has declined since the mid-1980s, particularly for outpatient care (drugs and doctor visits), which may have increased demand for PHI. ▪ Concerns about inequalities in access to health care due to some people not being covered by PHI led to the introduction of CMU-C in 2000 (free PHI cover for people with very low incomes). ▪ At the same time there have been concerns about the role of PHI in undermining the effectiveness of the 'ticket modérateur' and concerns about inefficient use of services. In 2004 the Health Insurance Act introduced a small deductible (€1) for individuals who do not consult their GP before visiting a specialist or who visit a GP with whom they are not registered. To discourage PHI from covering this, the government provides exemptions from insurance premium tax to insurers who do not reimburse the deductible (the 'contrat responsable'). ▪ There is public concern about whether the deductible will create financial barriers to

	access. There is also concern about the shift in costs from statutory to private cover, particularly since PHI is considered to be more regressive (except among mutual cover for civil servants).
Germany	▪ Significant public debate about the role of PHI and its effect on the financial sustainability of the statutory scheme in recent years. ▪ The 2007 reform made health insurance compulsory for the whole population; those not eligible for statutory coverage must purchase substitutive PHI. ▪ The 2007 reform also made it harder for individuals to qualify for substitutive cover and introduced a basic policy to guarantee access to substitutive PHI and to a level of benefits equivalent to statutory benefits for a premium that cannot exceed the average maximum statutory contribution (and capped deductibles). Other measures were introduced to enhance the portability of ageing reserves to encourage competition within the PHI market. ▪ Finally, the 2007 reform introduced changes to the statutory scheme, including a centrally-set contribution rate and allowing sickness funds to give people a choice of cost sharing levels as well as allowing them to offer additional benefits.
Greece	▪ Some experts believe that an expansion of PHI will contribute to further increases in private spending. Others see PHI taking on a different role, in which it can contribute to better quality of services and reduce informal payments. ▪ Although people take out PHI as a way of dealing with the problems of the NHS, politicians are not strongly inclined to strengthen the role of PHI.
Hungary	▪ Some forms of dental care were excluded from statutory coverage in 1996 and re-introduced in 2001. ▪ Statutory cost sharing for drugs was significantly increased in 2007. ▪ Legislation proposed by the Hungarian Liberal Party to replace the statutory health care financing agency with a system of regulated competition among commercial insurers was passed but not signed by the President of the Republic in 2007. However, the law was withdrawn by parliament in 2008 following the defeat of a referendum on the introduction of a statutory user charge for doctor visits.
Iceland	n/a
Ireland	▪ Universal entitlement to public hospital accommodation and to treatment by public hospital consultants was introduced in 1979 and 1991, respectively, but the penetration rate of PHI increased, rather than decreased. ▪ Tax relief for PHI lowered to the standard rate of tax (from the marginal rate) in 1995-96 and 1996-97 and has been deducted at source since 2001. The standard rate of tax has fallen over time from 27% in 1998 to 20% in 2001, but these quite large reductions in the value of tax relief have not affected demand for PHI. ▪ Politicians and consumer/patient groups are debating the degree to which PHI creates a two-tier health system and increases inequalities. ▪ A further debate among insurers within the PHI market has focused on two issues: the differential regulatory requirements applying to Vhi Healthcare (largely addressed by the Voluntary Health Insurance (Amendment) Act 2008 and the risk equalisation scheme (set aside by the Supreme Court in July 2008; a new debate has been raised regarding the interim measures put in place after this judgement, while work is carried out on a new risk equalisation scheme).
Italy	▪ Since 2007 regions have won greater autonomy in the health sector and there has been a reduction in waiting times for treatment of serious conditions. ▪ The government plans to launch complementary health funds.
Latvia	▪ The introduction of statutory user charges has driven the development of PHI and rising user charges, increasing waiting times for publicly-financed care and provider complaints about under-financing also drive demand for PHI. ▪ Some political parties advocate the use of PHI to cover the whole population instead of a publicly-financed system.
Liechtenstein	▪ Articles 8 and 9 of the Sickness Act only apply to the two commercial insurers regulated by the Financial Market Authority. This has led to questions of whether PHI the Act should be amended to permit uniform regulation of all private insurers.
Lithuania	▪ There is public debate about tax relief, defining a clearer role for PHI (which would involve clear definition of the publicly-financed benefits package) and the

	introduction of medical savings accounts.
Luxembourg	▪ n/a
Malta	▪ The new Minister for Social Policy has suggested re-examining the role of PHI and has not ruled out the possibility that PHI could become linked to the statutory system and contribute to statutory health care financing.
Netherlands	▪ The introduction of universal coverage in 2006 effectively abolished the market for substitutive PHI. ▪ The 2006 Health Insurance Act also introduced a section prohibiting insurers offering voluntary cover from engaging in 'conditional sale' (terminating a contract for statutory cover when a subscriber switches to another insurer for voluntary cover).
Norway	▪ Tax relief for employer-purchased PHI was introduced in 2003 and abolished in 2006 (without causing a fall in demand). ▪ There is debate about whether waiting times for publicly-financed care lower worker productivity. Between 1999-2005 there was a scheme offering faster access to health care for employees, but this was considered to breach equity principles.
Poland	▪ There are plans to define the statutory benefits package more explicitly, which could lead to the exclusion of some benefits. However, the plans are controversial and consensus cannot be reached. ▪ Private insurers would like to be allowed to compete with the National Health Fund to provide statutory coverage. ▪ There are concerns about the impact of PHI on equity and the very high administrative costs of insurers.
Portugal	▪ Steady growth in PHI over the last decade has been set against a backdrop of increasing co-payments in the NHS and rising dissatisfaction with waiting times and the quality of NHS care. ▪ Since the 1990s some groups have been able to transfer their health contribution to a private insurer instead of the NHS. Because the level of contribution (set by the Ministry of Health) to private insurers is low, insurers have not promoted substitutive cover.
Romania	▪ There is public debate about how best to define the statutory benefits package, which is considered to be one of the main barriers to the development of PHI. ▪ Insurers have called for less restrictive PHI legislation.
Slovakia	▪ There is public debate about health insurance, including the specific issue of PHI.
Slovenia	▪ The depth of statutory coverage has declined over time (including by shifting several drugs from positive to intermediate or negative lists), which has shifted costs to PHI and, ultimately, patients. ▪ In spite of this trend in declining statutory coverage, there is still debate about whether the statutory benefits package is too generous and therefore not financially sustainable. ▪ Further reductions in statutory cover may stimulate the development of new PHI products.
Spain	▪ No public debate about PHI. ▪ In future the market may develop more in the direction of providing complementary cover of excluded services, since the quality of the NHS seems to be as good or better than the quality of PHI-financed services, which limits the potential for supplementary PHI.
Sweden	▪ The former Social Democratic government passed a law forbidding the private sector to treat public or PHI-financed patients, but this legislation was withdrawn by the current Conservative/Liberal government in 2006. ▪ There is debate about whether faster access to health care for PHI patients is in accordance equity principles. Critics argue that the growing PHI market creates a two-tier health system, which might lower the willingness of wealthier groups to pay taxes for publicly-financed health care. Supporters counter that each patient financed by PHI contributes to shorter waiting times in the public sector.
UK	▪ Efforts to reduce waiting times in the NHS in recent years may have contributed to reduced uptake of PHI. ▪ There is debate about allowing NHS patients to use PHI to 'top up' their publicly

	financed and provided care, with particular reference to pharmaceuticals. Specifically, supporters are advocating allowing NHS patients to use PHI (and other private spending) to pay for drugs not available through the NHS, but which can be used within the course of NHS treatment.
US	▪ The market is likely to undergo significant changes in the coming years. The present pattern of incremental erosion of the depth of PHI coverage by private insurers (especially in the small group market) plus the incremental expansion of public coverage (especially via Medicaid and SCHIP) will probably continue. Under the current administration, however, the expansion of public programmes (Medicare, Medicaid, SCHIP) may be more than incremental (Brown 2008).

Note: n/a = information not available.

Conclusion

PHI often undermines health policy objectives within the market (which may be different from policy objectives for the market), notably financial protection, equity in finance and equity of access to health care. However, this is generally only a matter of public policy concern where PHI contributes to financial protection in the wider health system. This explains the much greater degree of government intervention in substitutive markets and markets providing complementary cover of statutory user charges.

In terms of impact on health policy objectives in the wider health system, the effects of PHI are mixed. Substitutive PHI and complementary PHI covering statutory user charges clearly play an important role in providing subscribers with financial protection. At the same time, however, the existence of PHI undermines other health policy objectives, even where the market is carefully regulated. For example, allowing higher earners to choose between statutory and private coverage in Germany has led to risk segmentation and stretches the resources of the statutory scheme, which not only loses the contributions of higher earners but also covers a disproportionately high risk group of people. In countries where PHI covers statutory user charges, the depth of statutory coverage has been eroded over time and there are concerns about the fact that those who do not have PHI may face financial and other barriers to accessing health care. Where the boundaries between public and private provision are not always clearly defined there is some evidence to show that public resources may be used to subsidise faster access to health care for those with PHI, who tend to come from higher income groups.

These problems are often a direct result of public policy rather than problems created by the way in which the PHI market operates. For example, allowing providers to charge higher fees to privately-financed patients creates strong incentives to prioritise these patients at the expense of publicly-financed patients. The use of tax relief to subsidise PHI also lowers equity by drawing resources away from publicly-financed health care. Overall, the argument that PHI will contribute to financial sustainability by relieving pressure on public budgets is not supported by evidence. Furthermore, concerns about the impact of changing demographic and labour market conditions on the financial sustainability of employment-based health care finance do not usually extend to markets for PHI, although they should, since in many member states PHI is partly financed by employers.

The report has highlighted the diversity of markets for PHI across the European Union and noted the difficulty of generalising (frequently scarce) research evidence from one setting

to another. The report has also emphasised the importance of understanding each market in terms of the context in which it is situated. Nevertheless, different market roles and the way in which these roles interact with the statutory health system seem to be associated with certain policy implications. The report has outlined these to raise awareness among policy-makers of the advantages and disadvantages of encouraging the growth of PHI.

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Appendix A Note on methods

Data collection

This report is based on data collected in the following ways:
- review of the literature
- detailed questionnaires completed by experts in 29 countries
- study visits to Liechtenstein and Luxembourg

Review of the literature

The review drew on statistical and non-statistical data.

Relevant sources of statistical data included:
- OECD Health Data
- WHO World Health Statistics
- CEA reports on health insurance (the latest CEA statistical report covers the following countries: Austria, Belgium, Denmark, Cyprus, Finland, France, Germany, Italy, Latvia, Malta, Netherlands, Norway, Portugal, Slovakia, Slovenia, Spain, Sweden, United Kingdom)
- national private health insurance associations (eg PKV in Germany)
- national associations collecting data on private health insurance (eg Vektis in the Netherlands and Laing & Buisson in the UK)
- national regulatory or competition bodies (eg the Health Insurance Authority and the Competition Authority in Ireland or the Office of Fair Trading in the United Kingdom)
- private insurance companies (non-profit and commercial)

Relevant non-statistical data was identified using the following databases and sources of information:
- International Bibliography of the Social Sciences (IBSS)
- PubMed
- EconLit
- Google Scholar
- SCADPlus
- Health System in Transition (HiT) reports produced by the European Observatory on Health Systems and Policies
- Health Policy Monitor (the international network for health policy and reform, a 20-country-project initiated and sponsored by the Bertelsmann Stiftung since 2002, associated with the European Observatory on Health Systems and Policies)
- International Association of Mutual Benefit Societies (AIM)
- MISSOC (Mutual Information System on Social Protection in the Member States of the European Union)

We also undertook Internet searches for published and grey literature, including reports prepared by governments, non-governmental organisations, regulatory bodies, trade associations and research institutes.

Country experts

We selected experts in 28 countries who agreed to participate in the study and provide us with detailed information on PHI markets in their country (see Appendix B for details). The experts are all native speakers of the language of the relevant country and almost all (27 out of 28) are based in the country of interest. All have expertise in health policy and many have expertise in health economics. The composition of the country experts reflects a concern for gender balance.

The research team drafted a questionnaire to circulate to all the experts. The questionnaire covered descriptive information on market role, size, structure, conduct and public policy as required for Part 1. It also covered the impact of EU competition rules and the EU regulatory framework for non-life insurance on private health insurance and the impact of PHI on public policy goals, to provide some of the information required for Parts 2 and 3.

Study visits

A member of the project team made study visits to Liechtenstein and Luxembourg, the two countries in which it was difficult to locate national experts. The aim of the study visits was to obtain information that could not be found through the literature review.

The study visits involved interviews with stakeholders. In each country we identified relevant stakeholders by contacting the Ministry of Health, the national insurance association (Liechtensteinischer Versicherungsverband e.V and Association des Compagnies d'Assurances du Grand-Duché de Luxembourg) and individual private health insurance companies.

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Appendix C Country reports

Belgium

Willy Palm

Introduction

Private health insurance (PHI) in Belgium is mainly complementary insurance, covering healthcare services that are excluded or only partially covered by statutory health insurance. The private complementary health insurance market mainly developed over the last two decades in line with increasing out-of-pocket payments. Products essentially focus on hospital stays, where patients typically face high user charges. The market is divided between insurance companies offering PHI on a commercial basis and mutual health funds organising complementary services as a way to extend solidarity beyond the scope of statutory health insurance (which they also administer). Because of the increased competition from the latter—coupled to the financial difficulties insurance companies face in trying to break even, the unlevel playing field has become the centre of political debate. At the same time, sharp and sudden increases in premiums have pushed towards more regulation in order to better protect the insured against risk selection and exclusion.

Market role and context

Complementary insurance coverage accounts for nearly 5.37% of total health expenditure. It represents nearly 22% of private expenditure. More than 75% is directly borne by the households. However, the share of complementary coverage is growing more rapidly than other parts.

Table BE1 Coverage of healthcare expenses by source (2007)

	2007	Share	Evolution 2001/2007
State	**24127.47**	**75.61%**	**+41.8%**
Social security	20228.19	63.39%	+36.5%
Federal authorities	2694.8	8.44%	+94.1%
Regional authorities	562.4	1.76%	+111.8%
Local authorities	642.1	2.01%	+18.1%
Patients	**5968.29**	**18.70%**	**+38.4%**
Out-of-pocket	4537.56	14.22%	+49.2%
User charges	1430.55	4.48%	+12.6%
Employer	**102.53**	**0.32%**	**+2.5%**
Complementary cover	**1713.91**	**5.37%**	**+61.9%**
Insurance companies	804.61	2.52%	+77.5%
Mutual health funds	909.3	2.85%	50.2%

Total	**31912.2**	**100.00%**	**+41.9%**

Source: Assuralia (2009)

PHI in Belgium combines both coverage for services not covered by statutory health insurance and coverage for user charges. On one hand, these out-of-pocket payments include official co-payments that are legally fixed patient contributions (percentage or flat rate) for statutorily reimbursed services. On the other hand, the payments can also include extra billing, which are extra payments charged by providers on top of normal user charges for special requirements relating to a stay in a (semi) private room or the use of special materials in medical interventions. Doctors are also entitled to charge fee supplements if they do not abide by the official tariffs agreed to collectively at the level of the statutory health insurance or if they treat patients in a private room. Fee supplements in hospitals can range from 100% to 300% of the agreed-upon tariff (especially in Brussels). These supplements are generally seen as a way to compensate for the alleged structural underfunding of hospital care, even if not all hospitals refer to this in the same way. Some hospitals even tend to check on admission whether patients have private cover in order to charge supplements.

Over the last ten years, several measures were taken to limit the practice of extra billing, to sustain public spending and to protect vulnerable groups (lower income groups, single-parent families, the unemployed, chronic patients, psychiatric patients, etc.) against high cost-sharing (i.e. increased reimbursement levels, maximum billing ceiling). Despite these measures, official user charges further increased by 9.3% between 2002 and 2007. More importantly, out-of-pocket spending (non-reimbursed health care services and extra billing) increased by 49.2% between 2001 and 2007 (Assuralia 2009). The use of (not-covered) special materials in (surgical) interventions, stays in private rooms and especially the use of extra billing (supplements) for the fees of providers are considered the main cost drivers. Even if in the past the possibility of hospitals charging both room and fee supplements was legally limited in common and semi-private rooms, the personal cost for patients has further increased. In 2007, the average cost for a patient in a private room ranged from €1,186 to €1,234 and from €257 to €312 in a common or semi-private room. Differences between individual hospitals are considerable.

A recent study (Schokkaert 2008) has shown that 10% of households in Belgium spend more than 5% of their income on user charges for health care. One important question is to what extent this group of patients with high user charges is actually covered by complementary insurance. A health survey conducted in 2001 demonstrated that higher income earners and more highly educated people have a greater probability of having such insurance (Berghman and Meerbergen 2005). For group contracts, workers with a long-term contracts and employees working in bigger companies and in stronger economic sectors (including the civil service) are best represented. Also, relatively more people living in the Flemish region have complementary health insurance compared to the Walloon and Brussels region. The non-insured population is mainly over aged 70, has severe medical conditions (for which they did not have insurance before developing), and/or is part of a socially vulnerable group. Young people also are often uninsured (people tend to take up insurance once they raise a family though).

Market overview

Around 73.3% of the Belgian population (10.5 million) has complementary insurance to cover the medical costs linked to a hospital stay that would typically be uncovered in the statutory system. The market for coverage of health-related costs in Belgium is fundamentally divided into two parts. PHI is offered by both sickness funds (mutual/non-profit) and insurance companies (mutual or cooperative insurers/non-profit and joint-stock companies/for-profit). For the mutual health fund sector, 60 mutual health funds are operating, which are–as legally prescribed–affiliated to one of the five national unions of mutual health funds (i.e. Christian, socialist, liberal, independent, and neutral). On the commercial insurance side, 23 different companies offer PHI, of which 3 companies cover 60% of the market: DKV (ERGO) (30.8%), Fortis (18.1%), and Ethias (11.5%) (Avalosse 2008).

Mutual health funds and commercial insurers essentially compete in the field of hospitalisation insurance, where they offer similar products. Private insurance companies in 2005 covered nearly 4.9 million people through both individual and collective policies. Around 75% of these individuals are covered in group contracts offered by employers as a legal extra benefit for their employees. Voluntary complementary hospitalisation insurance offered by mutual health funds covers around 2.8 million members. Because of their nature, mutual health funds cannot be active in the second pillar (group PHI contracts).

Mutual health funds

Historically, mutual health funds were the first to provide voluntary cover for health care. As provident associations, they offered protection and assistance to their members against the risk of illness, incapacity and death. Therefore, mutual health funds took on the task of administering compulsory health and disability insurance, which was institutionalised in 1944. At the same time, they maintained the possibility of developing complementary activities and services. The complementary activities are considered to be essential to the social role of mutual health funds, as they extend solidarity beyond social security by providing protection for needs that are excluded or insufficiently covered by statutory health insurance. On some occasions, services that have initially been covered by mutual health funds have later been integrated into the compulsory package (e.g. 'minor risks' for self-employed[164]; meningitis vaccine).

- Traditionally, mutual health funds have offered complementary services to which all members have to subscribe based on the funds' bylaws (compulsory complementary services are also termed "generalized complementary insurance"). This is a solidarity-based package that includes a range of services for members, which are funded through a flat-rate contribution levied upon all members. This package generally includes special reimbursement for specific services not covered under the statutory insurance, e.g. orthodontic treatment, vaccination (e.g. HPV vaccine), spectacles, contraception, the organisation of certain services, medical

[164] In the past, a substitutive market existed to cover the so-called 'minor risks' of the self-employed, which were excluded from the compulsory health insurance scheme for this group. Minor risks include physician visits, dental care, minor surgery, home care and pharmaceuticals for outpatient care. Since 1 January 2008, compulsory coverage for the self-employed has been aligned with protection under the general scheme, and minor risks have been included in the compulsory insurance package (Act of 26 March 2007). As a consequence, substitutive voluntary insurance for minor risks, mainly offered by mutual health funds, has ceased to be offered. In 2006, nearly 426,000 of the self-employed took up this substitutive form of PHI. This represents around 74% of active and non-active self-employed.

transport, home care, lending material for sick and handicapped people, rehabilitation, family and elderly support, stay in rehabilitation centres, flat-rate interventions during hospital stays, cover for health care abroad and repatriation. In general, these services are not fully covered, the financial intervention is limited or a financial contribution is charged to the member making use of the service.

- Next to this global package of services, mutual health funds also offer facultative (optional) services to which members can freely adhere. These include PHI services to cover increasing personal healthcare costs, as well as additional payments in case of incapacity to work ("daily allowances"). Initially, the hospitalisation services of mutual health funds mainly guaranteed a flat-rate amount for each day spent in the hospital to partially compensate for the extra costs generated by this stay. Later in 1990, as user charges and extra billing during a hospital stay increased, they started to also fully cover the difference between statutory reimbursement and the total amount charged by the hospital. In terms of covered services, they compare with the same products offered by private insurance companies.
- Finally, mutual health funds develop a range of health-related activities, including health prevention and education, information and legal aid to patients and the social insured. In the same context, some mutual health funds have initiated and supported social movement organisations, promoting and defending the interests of certain groups in society (e.g. youth, elderly, chronically ill, and handicapped patients). They also mobilise volunteers to support these activities (e.g. home visits to sick people, youth monitors, etc.).

As non-profit private bodies active in the field of social protection, mutual health funds are governed by a specific law (MHF Act of 9 August 1990), which defines them as associations of natural persons aimed at promoting their physical, mental and social well-being in the spirit of providence, mutual help and solidarity. The relationship between a mutual health fund and its members is not based on an individual insurance contract but on bylaws, which are democratically and commonly defined by the members. These bylaws stipulate all the rights and obligations that members have. This implies that contributions and entitlements are defined by the General Assembly and that no contracts can be concluded with individual members or groups of members.

Based upon their specific legal status, mutual health funds are by law not allowed to offer any (insurance) services that are not related to health (defined according to the WHO definition). They should provide complementary coverage only for services that are excluded or partially covered by compulsory health insurance. Additional services developed by mutual health funds need to conform to the same objectives and principles as those underpinning the compulsory health insurance system, which include:

- Community-rated contributions, independent of health condition or age (for the compulsory complementary services);
- Benefits independent of the amount of contributions paid;
- Obligation to cover pre-existing conditions;
- Lifelong coverage due to the fact that mutual health funds are not allowed to exclude any member on the basis of age and health condition (art. 9 § 2 MHF Act).

In this way, how mutual health funds behave and operate in the market is part of their legal status. To ensure that mutual health funds comply with the standards linked to their specific nature, the Control Office of mutual health funds and national unions of mutual

health funds is entrusted with the task of monitoring accounting, financial and statutory transactions. It needs to give its approval of the conditions of any complementary service or any change in contributions or cover, as defined in the bylaws. It also watches for undesirable commercial practices, such as comparative or misleading publicity. Additionally, mutual health funds need to provide for reserve funds to cover the financial risks related to certain services. Especially for complementary health insurance, three types of reserve funds are required: technical provisions to cover the ongoing risks, provisions to account for the risks incurred but not yet recorded and a solvency margin in case of exceptional circumstances likely to influence the financial balance.

Insurance companies

The other part of the market is filled by typical insurers. They can be either of purely commercial nature (limited company) or take the form of a cooperative or a mutual insurance company. Insurance companies offer private health insurance as part of their broader portfolio of insurance products (only one insurer on the Belgian market offers exclusively PHI). Private health insurance represents less than 4% of the total private insurance market in Belgium.

For purely commercial, cooperative, and mutual insurers, the regulation of their activities is separated from their legal status. The Act of 25 June 1992 provides the basic legal framework for operating insurance services on the Belgian market, setting out the rights and duties of contractual parties in private insurance. As financial services, insurance activities are considered to be acts of commerce, subject to the Code of commerce. They also fall within the remit of the Act of 5 July 1975 regarding the control of insurance undertakings, which submits them to the supervision of the Banking, Financing and Insurance Commission (BFIC). The BFIC exercises prudential control over financial institutions (including insurance companies) to ensure a stable and transparent market with financially sound insurance companies.

In this context, insurers are in principle free to define cover and conditions in accordance to the risk profile of the individual subscriber. PHI premiums are generally calculated on the basis of age (mostly age at entry). Some insurance companies apply different PHI premiums according to place of residence as well. Since 2008, differentiation of premiums according to gender is no longer allowed (Act 21 December 2007 based upon EU Directive 13 December 2004, implementing the principle of equal treatment between men and women in the access to and supply of goods and services). Coverage can be excluded for certain treatments (e.g. treatment in a psychiatric institution, stay in a rest and care home, a rehabilitation centre, a spa, etc.) and for pre-existing conditions (to be reported in a medical questionnaire). Coverage can also be delayed by the application of waiting periods or front-end deductibles. In most cases, age limits are applied for joining an optional PHI policy (65 years or older). For group contracts, premiums are based on experience rating, which takes into account expenditures from the last three years. Here cover would normally stop when an employee retires or leaves his or her job.

In general, insurers offer 3-4 different individual policies, ranging from limited cover (imposing ceilings, limits to fee and room supplements) to full cover options. They also provide for a continuity contract, allowing subscribers to pre-finance premium increases when a collective contract is continued individually.

Normal insurers and mutual health funds are not allowed to work together. According to the MHF Act, mutual health funds are not allowed to promote, distribute or sell any financial services offered by banks or insurance companies (Art. 43.ter MHF Act). The Constitutional Court confirmed this in 1999 as a way to preserve the specificity of the mutual health sector and to protect the consumer and the privacy of the social insured.

Assessment of market performance

Although PHI is an interesting product to attract clients to a wider portfolio, it has proven to be a less profitable activity. The global technical results of PHI products offered by insurance companies have been negative over the last few years. Although results vary among companies, this trend was mainly the result of fierce competition on the group insurance market. Several insurance companies thus have retreated from the market. The situation for mutual health funds seems more favourable. Despite tightening reserve margins, the sector has produced overall positive results; it has done so even though the hospital services integrated into the compulsory complementary package have also been negative for some years.

Also, claims ratios for private insurers tend to be higher than for mutual health funds.

Table BE2 Technical balance and claims ratio 2002-2006

	2002	**2003**	**2004**	**2005**	**2006**
Private insurers	-18.9%	-20.5%	-19.2%	-15.2%	-8.5%
Mutual health funds (optional hospital insurance)	+10.2%	+9.72%	+5.9%	+10.7%	+9.9%
Mutual health funds (compulsory complementary hospital insurance)	-2%	-4.8%	-5.3%	-1.1%	+11.5%
Claims ratio private insurers	85,3%	91,3%	92,7%	90,0%	85,4%
Claims ration mutual health funds	79.2%	84.5%	85.5%	82.3%	79.6%

Source: Assuralia + based on Control Office

A possible explanation for the better results of mutual health funds could lie in the fact that the coverage provided by mutual funds is generally more limited than commercial products. Mutual health funds seem to apply more reimbursement ceilings (caps) on their interventions, especially on fee and room supplements. Also, their role in statutory health insurance would make them better equipped to monitor hospital performance and billing and to contain cost by negotiating limitations on supplements. PHI providers are still in many respects price-takers. Strategic purchasing is still fairly limited. Given the high value Belgian patients accord to free choice of provider, insurers are reluctant to limit reimbursement to certain hospitals.

The increasing personal cost of hospital care in general and the practice of charging supplements to patients (extra billing, especially for private rooms) in particular have placed a heavy burden on private health insurers. These practices pushed many insurers in recent years to increase their premiums. In turn, constant premium increases have generated political debate about the affordability of hospital insurance (especially for people after the age of 60) and of health care in general. In 2005, the omsbudman service of the insurance sector received 65% more complaints, mainly about premiums being

raised (Trends 2006). In 2005, a Belgian tribunal, in a case enacted by the consumer organisation 'Test-aankoop/Test achat' against DKV insurance, judged premium increases of 24% applied to the insured over the age of 60 as discriminatory and ordered DKV to review its premium policy.

To prevent for these sharp premium increases, the legislature in 2007 started regulating PHI contract conditions.

Market development, public policy and impact on the wider health system

Strengthening the social character of PHI

The Act of 20 July 2007 on PHI contracts introduced a new chapter on PHI contracts into the Insurance Act of 25 June 1992. It is aimed at strengthening the protection of the insured with respect to complementary health insurance. The urgent problem of constant and fierce premium rises is addressed within the broader context of limiting risk selection and exclusion. Since this reform only applies to private insurance companies and shifting them more in the direction of mutual health funds, additional rules were also introduced for mutual health funds almost simultaneously with the aim of further strengthening the social nature of complementary services, especially for facultative insurance for hospital costs and daily allowances organised by mutual health funds (Act of 11 May 2007 amending the MHF Act of 9 August 1990).

Table BE3 briefly presents and compares the main elements in both laws

Private insurance companies **Act of 20 July 2007 on PHI contracts, changing the Insurance Act of 25 June 1992**	**Mutual health funds** **Act of 11 May 2007 amending the MHF Act of 9 August 1990**
Lifelong cover	
Individual PHI contracts cannot be ended by the insurer (except in cases of fraud, non-payment of premium, deliberate concealment or false communication, etc.). This also means that an insurer cannot discontinue the activity unless existing contracts are taken over by another company).	Traditionally the MHF Act prohibits mutual health funds to exclude members on the basis of age or health status. As long as a member maintains his or her membership, the affiliation to one of the services provided by that mutual health fund will be for life, except if the General Assembly would decide to dissolve that particular service.
Modification of premium and cover	
As a consequence of the principle of lifelong cover, the insurer is also no longer allowed to unilaterally change the conditions (technical basis of premium and coverage) of individual PHI contracts, except in explicit cases enumerated in the law: Premium, front-end deductibles and benefits can be adapted to the normal consumption price index.	Also for mutual health funds, the conditions according to which they can change coverage or contributions have been restricted: Besides adaptations to the normal price index, contributions can only be increased in the case of a real and significant increase in the costs of guaranteed services, their evolution or in exceptional circumstances.

In the case of price fluctuations in the sector, an additional adaption can be allowed by the BFIC on the basis of objective parameters (medical index).

Premiums and coverage can be proportionally adjusted to a significant change in real costs of the benefits (e.g. due to increased frequency of hospitalisation or substantial change in risk profile) or a change in regulation with significant effect on benefits (e.g. social security legislation), subject to recognition by the BFIC.

Changes in the profession and social security status of the insured with a significant influence on the benefits can also lead to a proportional adjustment.

Also changes in coverage need to be substantiated on the basis of objective elements, which are proportional to the proposed changes.

The assessment is made by the Control Office, which must approve any amendment in the mutual health funds' bylaws.

Pre-existing conditions

Pre-existing conditions can only be excluded if they were known (diagnosed) or should have been known (symptoms occurring) at the time of concluding the contract. Pre-existence cannot be invoked if the diagnosis is not established within two years after conclusion of the contract.

Chronically ill patients and handicapped persons, younger than aged 65, cannot be refused by any PHI insurer. They have to be insured according to the same conditions as any other subscriber. The insurer can, however, exclude or limit cover for the costs related to the chronic disease or the handicap.

This is a temporary measure of two years after the introduction of the new law. This right is set to end on 1 July 2009 and will be evaluated.

The MHF Act already provided for a legal obligation for mutual health funds to accept every person, including sick and handicapped persons, for hospital insurance up to the age of 65. This obligation is now extended above the age of 65 for any person who was already affiliated to a similar service with his/her previous mutual health fund.

Pre-existing conditions that have been disclosed in the medical questionnaire or that are diagnosed within the first two years cannot be excluded, but cover for them can be limited to a flat-rate amount (minimum level is legally fixed).

Continuity

Persons covered by a group contract have the right to continue the affiliation when they loose the benefit of collective insurance if they have been collectively insured for at least two years prior to the ending.

This continuation cannot be made subject to medical formalities or waiting times. The individual contract has to provide for

As mutual health funds do not provide group contracts, this principle does not apply. However, some mutual health funds offer a continuity service, providing complementary cover on top of an employer-based group contract for which cover can be continued after termination of the latter.

In order to preserve continuity in the

similar guarantees. The premium will be calculated on the basis of age at the time of continuation. However, the employee can pre-finance individual continuation through the payment of an additional premium during the collective coverage. In that case, the premium for the individual contract will be calculated on the basis of his/her age at the start of this complementary premium.

The employer has an obligation to inform the employee of this possibility at latest 30 days after the end of group coverage. The insured has 30 more days to request for continuation. The insurer has to submit a proposal within 15 days, after which the insured has 30 days to decide.

coverage between MHF services, the new regulation also prohibits the application of a waiting period for any optional service if the person was already affiliated to a similar service with his/her previous mutual health fund. (This principle of continuity already applied for complementary services for which affiliation is automatic/compulsory).

The implementation of the 2007 PHI reform has encountered serious problems. The concept of a medical index for hospital insurance, reflecting the average increase in the real cost of hospital care based on objective parameters and setting the maximum premium increase complementary insurers can apply, needed to be established and confirmed in subsequent legislation, which to date is still not approved. Together with the Banking, Financing and Insurance Commission (BFIC), the Belgian Federal Health Care Knowledge Centre (KCE)--an independent agency established in 2002 with the task of advising policymakers about obtaining an efficient allocation of scarce healthcare resources and optimizing the quality and accessibility of health care –was tasked with establishing this medical index and monitoring compliance. Both institutions considered this beyond their legal duties.

Also due to all this delay, the new Act has had a rather counterproductive effect, encouraging insurance companies to anticipate regulation by further increasing PHI premiums. Several insurers have continued to increase premiums, ranging from 30% to 200%.

In a recent KCE report (Devolder et al. 2008) that looked into the methodology for developing such a medical price index for PHI, the researchers started from the observation that a specific index for PHI does not exist so far in any other European country. Whereas a normal consumption price index would not work since it would only take into account the increase in prices but not in consumption, a more actuarial approach based on the general evolution of costs born by insurers would also have some drawbacks. Additionally, data provided by insurers was not totally reliable. The researchers also pointed out that companies should first be given the opportunity to adapt premiums, which could again lead to a dramatic increase for certain groups, before this kind of medical index was uniformly implemented. Finally, the study noticed that this system would provide a competitive advantage to the larger PHI insurers who exercise a higher influence on the index.

Creating a level playing field for all operators

While regulation is trying to direct private insurers more towards the typical social practice of mutual health funds, there is also a call heard from the other side to align the conditions for competition between the two. Several times before private insurers have challenged the specific position of mutual health funds and the competitive advantages the mutual funds draw from it. In 1992, the Belgian insurance federation filed a complaint with the European Commission against a common service developed by all mutual health funds for cover and assistance for urgent care provided abroad (Eurocross) (Lewalle 2007). The Belgian government argued that the activities of mutual health funds are fundamentally different from those of commercial insurers since mutual funds are fulfilling a mission of general interest. This was backed by the highest Belgian Court, confirming the legitimacy and the specificity of the mutualist action and its necessity for confronting the need to ensure access to health care. Also in 2001, the Belgian Constitutional Court, ruling on a referral from the President of the Brussels commercial tribunal, classified a hospitalisation service offered by the mutual health funds as not commercial[165] since it completely fit within the mutual health funds' statutory mission to provide services in the field of health based on providence, mutual assistance and solidarity.

Whereas in 1992 the European Commission accepted the arguments of the Belgian government and discontinued the procedure, in 2006 it launched a new infringement procedure, claiming that the complementary health insurance activities developed by the mutual health funds were not in conformity with the requirements of the first and third non-life insurance directives (i.e. constitution of one of the legal forms required to organise insurances; limiting activities to insurance only; establishing minimum guarantee fund, technical reserves and solvency margins).

While not calling into question the specific function that mutual health funds serve, the Commission is addressing the different conditions under which mutual funds can compete with private insurance companies. In the Commission's opinion, the complementary insurance activities, which are not part of the statutory social security system, enter into direct competition with the products offered by commercial insurance companies. However, they are not organised according to the same rules, and thus mutual health funds are advantaged by less rigorous financial requirements, which creates unfair competition.

In an attempt to find a compromise, both sectors, at the initiative of the Belgian government, have been discussing ways to balance maintaining the specificity of the mutual health funds in terms of their legal form and social practice with establishing a more level playing field in terms of financial conditions for the commercial sector to compete in this specific market. On 11 July 2008, the federal Council of Ministers adopted a first draft compromise, the details of which were to be further elaborated upon by both sectors. This proposal for a change in the legal framework was submitted to the European Commission in October 2008, but the Commission still has to decide whether this complies with its initial requirements. Based on this assessment, it will then decide whether or not to launch a procedure with the European Court of Justice (Derieuw 2008).

[165] Cour d'Arbitrage (Constitutional Court), Ruling n° 102/2001 of 13 July 2001; see also previous Ruling n° 23/92 of 2 April 1992.

The compromise reached, which was communicated as a response to the Commission, is based on the division of complementary services provided by mutual health funds into two groups:

- Operations not falling under the scope of the 1st and 3rd insurance non-life directive, as these services would be considered "*operations of provident and mutual benefit institutions whose benefits vary according to the resources available and in which the contributions of the members are determined on a flat-rate basis*" (Article 2.2(b) First Council Directive 73/239/EEC of 24 July 1973). In order to be considered this type of operation, services would have to meet following criteria:
    - Accessibility irrespective of age, sex or health status;
    - No exclusion on the basis of age or health status;
    - Community-rated contributions (differentiation of contributions according to social status and family composition would be allowed) limited to an annual maximum globally (€250) and per class of intervention (€60);
    - Cover of pre-existing conditions;
    - Lifelong cover, even in the case of switching mutual health funds if the new fund organises a similar service;
    - Equal guarantee for each member, except if social status is taken into account. This does not exclude the possibility of focusing certain services on restricted groups (e.g. age, sex, etc.), but this would be financed by all members in a spirit of social solidarity;
    - Financial management based on repartition, with the benefit depending on the available means (no constitutions of provisions)
    - No capitalisation of the contributions;
    - Absence of profit orientation,
    - Benefits approved by the General Assembly and are registered in the bylaws.
- Insurance services falling under the scope of the mentioned directives. This encompasses insurance with optional affiliation, as well as services with mandatory affiliation that do not fulfil the conditions mentioned under operations. These insurance services will be organised under a separate entity termed a society of mutual assistance. To this end, Belgium will request the inclusion of this legal form in the material scope of the mentioned directives. Consequently, these societies of mutual assistance would have to meet the prudential requirements and other obligations contained in the directives. Even if these services fell under the scope of Belgian insurance legislation, the members' rights and obligations would continue to be registered in the bylaws without this affecting the protection guaranteed to the insured. The supervision of this specific legal form will continue to be the responsibility of the Control Office of mutual health funds and national unions of mutual health funds. Also in line with the specific nature of the societies of mutual assistance, they would only be allowed to organise insurance services relating to the health of their members.

As before, mutual health funds would limit their services–operations and insurances–to their members.

Conclusions

Whereas for a number of years a legally fixed growth rate (+4.5% annually in real terms) has kept the statutory health insurance coverage in line with the overall growth of healthcare expenditures, it is likely that the economic slowdown will change this situation and lead to a further increase in the contribution patients must pay. The challenge will be to see to what extent PHI will be capable of recovering this growing gap between statutory reimbursement and real expenditure. Even if out-of-pocket spending represents up to 28% of total expenditure, PHI has only been able to reinsure user charges to a limited degree. In fact, PHI has not shown to be really profitable. Insurance companies have been incurring losses, prompting some to leave this sector. As a result, dramatic PHI premium increases in recent years have generated public disapproval and distrust. Since for some groups complementary cover has become unaffordable, the legislature has intervened to force insurance companies to review their premium and acceptance policy. It remains to be seen whether this legal reform can bring stability to the PHI market. One risk is that commercial insurers will turn away from the individual PHI market and concentrate on group contracts, which were kept out of the 2007 reform. Also mutual health funds, which traditionally extended solidarity beyond the scope of social security and provided protection for needs that were excluded or not sufficiently covered by statutory health insurance, have entered the market for complementary hospital insurance and started to offer “full cover” products comparable to those offered by the commercial sector. However, this direct competition with commercial insurers has only fuelled the debate on the levelness of the competitive playing field and on the alleged privileges mutual health funds derive from their role as administrators of the statutory health and disability insurance.

The Czech Republic

Martin Dlouhý

Introduction

The role of private health insurance cannot be well understood without appreciating the role of public health insurance, which dominates health care financing in the Czech Republic as in other EU countries. Public health insurance is compulsory for all Czech citizens and also for all foreigners employed in the country. Health insurance funds are autonomous organizations that collect premiums from their members and purchase health services from health providers. The major public insurer is The General Health Insurance Fund of the Czech Republic (*VZP CR*), which enrols about half of the population. Nine other health insurance funds cover the rest of the population. Public insurance covers an entirely comprehensive benefit package with minimal cost-sharing. The share of private expenditures of total health expenditures was 12.0% in 2006 (Czech Statistical Office 2008). Since January 1, 2008, Czech patients have been paying newly introduced co-payments though: 30 Czech Korunas (€1.20) for outpatient visits, 30 Czech Korunas (€1.20) for drug prescriptions, 60 Czech Korunas (€2.40) per inpatient day and 90 Czech Korunas (€3.60) for emergency services. In addition, a patient pays the difference between the price of a drug and the reference price for a given group of drugs. There is a yearly maximum ceiling for co-payments of 5000 Czech Korunas (€200) that includes co-payments for drugs and outpatient visits.

Market role and context

Table 1 shows health expenditures by source of financing for the period of 2005-2006. Public health insurance is the major source of health financing in this country; the direct expenditures of the national and regional governments and those of municipalities oscillate around 10% of total expenditures. Together, sources of public financing make up almost 90% of total health expenditures. The share of private financing is relatively low, but growing slowly. From an international perspective, the share of private expenditure on total health expenditure is one of the lowest compared to OECD countries (OECD Health Data 2007). Private insurance and employer-sponsored health care made up only 0.5% of total health expenditure in 2006. Since the introduction of public health insurance in 1993, the total health expenditures have been making up steadily around 7% of gross domestic product (GDP). The economic growth has reached 4-7 % of GDP in the last years, which provided additional financial resources for the health system.

Table CZ1 Health expenditures by type of source, Czech Republic, 2005-2006

Expenditure/Year	**2005**		**2006**	
	million CZK	**%**	**million CZK**	**%**
Total Public Expenditure	191,356	88.8%	194,344	88.0%
- National and Local Budgets	21,263	9.9%	22,828	10.3%
- Public Heatlh Insurance	170,093	78.9%	171,516	77.7%
Total Private Expenditure	24,228	11.2%	26,534	12.0%
- Households	23,110	10.7%	25,346	11.5%

- Employers	606	0.3%	723	0.3%
- Private Insurance	512	0.2%	465	0.2%
Total Health Expenditure	215,584	100.0%	220,878	100.0%

Source: Czech Statistical Office (2008).

It is clear that the main barrier for the development of private health insurance in the country is a comprehensive benefit package covered by public health insurance in combination with low cost-sharing. Under such conditions, there is no space left for private health insurance. Although the role of private health insurance in the Czech health system is marginal, it used by thousands of people.

We can classify private health insurance according to whether it *substitutes* for cover that would otherwise be available from the state; provides *complementary* cover for services excluded or not fully covered by the state, including cover for co-payments imposed by the statutory health care system; or provides *supplementary* cover for faster access and increased consumer choice (Mossialos and Thomson 2004). In the Czech Republic, private health insurance plays three market roles: (a) a substitutive role for foreigners (migrants) from non-EU countries: migrants-employees are part of the public system, but their dependants (children, spouse without employment) and self-employed migrants are excluded; (b) a complementary role on the travel health insurance market; (c) a supplementary role in covering, for example, above-standard hospital rooms, above-standard dental services, etc. In addition, insurance companies offer, under the misleading name "private health insurance," policies that cover cash benefits in the case of illness or hospital admission, so it is in fact private sickness insurance.

It should be noted that sickness benefits do not form a part of health insurance; they are administered by the Czech Social Security Administration, a governmental organization under the Ministry of Labour and Social Affairs. The Czech Social Security Administration is in charge of pension insurance, unemployment insurance and sickness insurance (sickness benefits and maternity benefits). An insured person who is temporarily unable to work due to illness claims sickness benefits.

Market overview

The role of substitutive health insurance for foreigners (migrants) has increased with the growing number of migrant workers from non-EU countries, especially from the Ukraine and Vietnam (Table 2), in the Czech Republic and with stricter control of health insurance by the immigration police. Valid health insurance is required for a long-term residence permit by law. Due to the fraudulent health insurance cases covered by the mass media, the immigration police are even more strict. The total number of insured individuals is not known. *Pojistovna VZP* (2006), one of the insurers selling substitutive health insurance, had 30,960 clients in 2005 though. Still, there are many foreigners who do not have any public or private health insurance. Many of them work without a proper job contract.

Table CZ2 Foreigners in the Czech Republic, 2006-2007

Year	**31.12.2006**	**31.12.2007**
Total	321,456	392,087
Males	192,803	236,813
Females	128,653	155,274
Permanent residence	139,185	158,018

Other stays longer than 90 days	182,271	234,069
Ukraine	102,594	126,526
Slovakia	58,384	67,880
Vietnam	40,779	50,955
Russia	18,564	23,303
Poland	18,894	20,607
Other	82,241	102,816

Source: The Ministry of Interior of the Czech Republic

The importance of travel health insurance lies primarily in the fact that Czech public health insurance automatically reimburses urgent health services provided abroad by domestic prices and the patient then must pay the difference. This insurance covers also repatriation of an ill person to the Czech Republic and transfer of person's remains from abroad. The total number of policies is not known though. *Pojistovna VZP* alone had 1,031,943 clients in 2005 (10% of population); however, the data on travel insurance is misleading as one person can be counted more times in cases where this person travels frequently and buys each policy separately. Plausibly, the role of travel health insurance decreased when the country joined the European Union because health care within member countries is now better covered by international agreements within the EU. It is likely though that people continue to buy travel insurance for EU countries, as they are not sure about the coverage and fear paying high co-payments in some countries.

Two types of insurers operate in the private insurance market: commercial insurance companies and public health insurance funds. There are dozens of authorised insurance companies in the country (including both Czech companies and foreign companies operating on Czech market), but not all of them are active in health insurance market. Only two companies are specialized health insurers, i.e. ones that offer health insurance and do not engage in other insurance activities: *Pojistovna VZP* and *Vitalitas*. Both these insurers are subsidiary companies of public health insurance funds. We were able to find and verify that the following insurance companies sell substitutive health insurance for foreigners (migrants): *Pojistovna VZP* (a subsidiary company of *VZP CR*), *SLAVIA* insurance company, *UNIQA* insurance company, *Victoria Volksbanken* insurance company and *MAXIMA* insurance company. The travel health insurance market is more competitive with many companies selling those policies.

There are now nine public health insurance funds in the country. The number of public insurance funds has been stable over the last five years, with the exception of a new insurance fund that obtained authorization to provide public health insurance in 2008 (but recently merged with an existing fund. The insurance funds do not provide private health insurance products directly. At their offices, the insurance funds offer their members travel health insurance, which is a product of their subsidiary private insurance company, or the insurance funds sell the products of a commercial insurer. According to our survey, eight public health insurance funds offer travel health insurance at their offices, and two funds do not (Table 3). *VZP CR*, the largest public insurance fund, is an exception because it sells both substitutive and travel health insurance at their offices.

Table CZ3 Health insurance funds and travel health insurance market

Public health insurance fund	Travel insurance sold at offices
Vseobecna zdravotni pojistovna Ceske	Pojistovna VZP, subsidiary company of

Republiky (VZP CR)	VZP CR
Hutnicka ZP	Allianz, commercial insurer
CNZP	No product is sold at offices, recommended to visit Kooperativa insurance company that offers a 10% discount for the CNZP members
OZP	Vitalitas, subsidiary company of OZP
Metal-Alliance	Vitalitas, subsidiary company of OZP
Vojenska ZP	Generali, commercial insurer
ZPS	Vitalitas, subsidiary company of OZP
Revirni bratrska pokladna ZP	CSOB Pojistovna, commercial insurer
ZP MVCR	Generali, commercial insurer
ZP Agel	No information yet available. The fund is in operation since April 2008.

The total prescribed insurance was 122 billion Czech Korunas in 2006. The prescribed insurance by members of the Czech Association of Insurance Companies (2007) was 120 billion Czech Korunas, of which private health insurance made up 836 million Czech Korunas or 0.7% of the total insurance market. This value probably includes substitutive health insurance for foreigners, travel health insurance and sickness insurance.

The Ministry of Health of the Czech Republic is responsible for the regulation of public health insurance, but the regulation of other insurers falls within the responsibility of the Czech National Bank. The main objectives of the Czech National Bank in regard to insurance market are financial stability and consumer protection. The Bank gives authorisation to enter the insurance market and monitors the solvency of insurance companies. The standard and structure of benefits or premium settings are not regulated. There is no tax incentive for private health insurance. In fact, there is no tax incentive for public insurance since from 2008, it is paid from after-tax income. On the side of insurers, tax treatment does not differ according to an insurer's corporate status. The profits from private insurance are taxed in all cases. The administrative cost of public health insurance funds is less than 5% of revenue and is regulated by law, which determines the maximum percentage of administrative costs depending on the number of members. Smaller funds can have a little higher administrative costs than larger ones. The administrative costs of private health insurance is much higher and is not regulated.

Insurance policies

Travel health insurance includes urgent medical services and repatriation. Ideally, benefits are in kind, and health services are reimbursed directly to the health provider if possible. The insurance policies make it possible to pay for the provided services out-of-pocket and then claim for reimbursement in cash after returning from abroad. The premium may depend on age, sex, visited country, travel purpose (tourism or business), individual or group insurance. Pre-existing conditions are not excluded. Table 4 shows an illustration of prices for individual policy. A typical policy does not cover any dependant, which is related to the fact that the public system is also based on individuals, not on families. Nevertheless, group insurance is a possibility in private health insurance. Travel health insurance can be combined together with casualty insurance (including death due to casualty) or baggage insurance.

Table CZ4 Example of travel health insurance policy

Age	Europe		Rest of World		USA, Canada, Australia	
	1.5 mil.	2.5 mil.	1.5 mil.	2.5 mil.	1.5 mil.	2.5 mil.
1-15	11	19	22	36	41	68
16+	17	31	34	60	64	114

Source: CSOB Pojistovna, standard policy, price per day in Czech Korunas (1 EUR = 25 CZK), maximum limit 1.5 or 2.5 million Czech Korunas (June 2008).

Substitutive health insurance for foreigners usually offers two types of polices: an urgent-care (short-term) policy and a complex (long-term) policy. Long-term policies offer relatively comprehensive health services comparable to public health insurance, but some services related to chronic conditions are specifically excluded, e.g. childbirth, HIV/AIDS, drug addiction, mental health and vaccination (*Pojistovna VZP*, 2008, *UNIQA*, 2008). The benefits are in kind, and some cost-sharing may be required depending on the policy. An initial medical examination can be required (e.g. urine test, blood test, HIV test, X-ray). The prices of policies for migrants are risk rated (Table 5), but some products are quite simple (e.g. *UNIQA* and *Victoria Volksbanken* offer insurance for urgent care for the single price of 7200 Czech Korunas per year for any age and sex.)

Table CZ5 Example of health insurance policy for foreigners, price per month in Czech Korunas

Age	Standard	Standard + Professional Sport	Standard + Acute Dental Services	Standard + Gravidity
0-17	1240	3720	1612	2480
18-29	1900	5700	2280	2850
30-32	1850	5550	2220	2775
33-35	1975	5925	2370	2963
36-38	2105	6315	2526	3158
39-41	2295	6885	2754	3443
42-44	2480	7400	2976	3720
45-47	2690	8070	3228	4035
48-50	2900	8700	3480	4350
51-53	3160	9480	3476	-
54-56	3410	10230	3751	-
57-59	3635	10905	3999	-
60-62	3945	11835	4340	-
63-34	4025	12075	4428	-
65-67	4460	13380	4906	-
68-70	4780	14340	5258	-

Source: Pojistovna VZP, Complex Long-term Policy, maximum limit 1.2 million Czech Korunas, co-payment for drug prescription 100 Czech Korunas, terms and conditions with the effect from March 1, 2008.

As has already been mentioned, insurance companies offer under the misleading title "private health insurance" products that are not truly health insurance. They cover cash benefits in case of illness or hospital admission. Such products can be combined with other insurance products, some of which are related to health services. Above-standard services (private rooms), medical aids (e.g. glasses) and newly introduced co-payments are to some extent covered as additional benefits by private sickness insurance.

Typically, both public and private health insurance cover an individual. Dependants (wife, children) may be covered in private insurance for an extra cost. Officially, there is no restriction on purchasing any type of private insurance for disabled or the elderly. However, anecdotal stories suggest that high-risk migrants and migrants over age 70 may have problems finding insurance. Consumers have no centralised information about the price and policy conditions of different products. Such information can be gained by phone or internet search or by contacting an insurance dealer though. Some dealers offer online comparisons of selected products. Travel insurance premiums are probably competitively priced. On the substitutive insurance market, the number of insurers is limited; according to available information from annual reports, some insurers reaped high profits from the health insurance market. No information about the market held by individual insurers is publicly available. Similarly, no public information is available about those who subscribe to private health insurance (health status, socio-economic status).

Assessment of market

Relations between insurers and providers

There is nothing like strategic purchasing within private health insurance. In theory, the private insurer can selectively contract with providers, but the financial margins on the private insurance market are so slim that it is not efficient to do so. In practice, insurers simply reimburse providers or cover the bill paid by subscribers. Such arrangements mean that private insurers are price-takers that pay providers on fee-for-service basis or on real cost of services. The rates used in the public system may serve as a benchmark. Information about fees enabling a comparison between public and private insurances is not available. Subscribers of private insurance can get care from any provider, private or public. There are no restrictions on the side of providers, subscribers or private insurance on getting care from anywhere. Almost all providers have contracts with the public system, which is the dominating source of financing. To date, there is no integration between insurance and provision.

It is suspected in some health systems that doctors have financial incentives (due to different fees for public and private patients) to treat private patients differently, i.e. to treat or refer them more quickly or to give them better treatment. We do not have sufficient evidence about this issue, but one may instead suggest the opposite hypothesis in the case of the Czech Republic: private health insurance patients got worse services than publicly financed patients. A typical patient with private health insurance in the Czech Republic is a low-paid migrant worker, his/ her family members are from the Ukraine or Vietnam and are thus having problems speaking Czech fluently or does not have a clear insurance policy, which requires additional administration on the side of the provider to get reimbursement.

Market development, public policy and impact on the wider health system

Private health insurance ensures financial protection for those excluded from the public system. The exclusion of children or other dependants of foreigners without employment from the public insurance system is in conflict with the equity of access goal. It is seen as a shame that in a country with universal health insurance, there is a population that has to seek financial protection through much more expensive private insurance with limited coverage or go without any coverage at all. The solution does not lie in supporting the development of private health insurance, but instead lies in including migrants in the public system. Certainly, some measures will be introduced. In a bill on public health insurance it is assumed that dependants of an employed migrant shall be included in public insurance after 90 days of stay.

Private health insurance has no effect on the health system now; its role is marginal. The main barrier to development is the generous public system. Since January 1, 2008, co-payments have been introduced. It is too early to predict whether such co-payments will open at least some limited space for private insurance or employer-sponsored benefits. The right-wing coalition government intends to introduce more competition within public health insurance and the possibility of offering different insurance policies with different cost-sharing. There is also the idea that public health insurance can be provided by private insurers. However, the latest developments indicated that such reforms will be extremely hard to implement: one coalition party forced the government to promise that children should be freed from co-payments, and other reform proposals are under attack from the opposition, trade-unions and even some representatives from the coalition parties. Even if such a plan is implemented, the system will be essentially public health insurance administered by private companies, not real private health insurance. In the future, a slow growth of complementary private insurance can be predicted. However, without any unexpected change, the role of private health insurance will remain as marginal in the near future as it is nowadays.

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Denmark

Karsten Vrangbaek

Financial structure of the Danish health care system

The public health care system is universal and financed through a national proportional income tax at 8%, a proportional income tax at the municipal level and some user payments particularly for drugs (outside hospitals), dentistry, physiotherapy, etc. The system is based on general principles of solidarity in financing and equity in coverage. Most of the 8% national tax revenue (80%) is redistributed, from the national level to the regional level via block grants based on objective criteria such as socio-demographic factors. The remaining 20% is redistributed to the municipalities and earmarked for co-financing regional hospital stays for community members. The municipalities also finance and initiate prevention programs (Standberg-Larsen et al. 2007). The regional level is responsible for delivering most health care services. It distributes the tax revenue to public hospitals via contract budgets and activity-based financing. Private hospitals are financed through user payments, private health insurance and to some extent public taxes. An extended waiting time guarantee introduced in 2002 provides access to private hospitals at the expense of the regions if treatment cannot be commenced within the specified time limit (two months until the fall of 2007, one month since then and shorter limits for life threatening diseases).

General practitioners (GP) and specialists are private, but predominantly financed by regional funds. Access to GPs is free of charge for patients, and GPs act as gatekeepers to the rest of the system. They are paid by a combination of per capita and fee for service according to a nationally negotiated agreement. Practicing specialists are paid by activity. Access is free of charge upon referral from a GP. Specialists may supplement their income by taking in privately paying patients (often reimbursed by PHI).

The level of user payments in the Danish health care system is increasing. User payment or co-payment mostly involves mostly pharmaceuticals (outside hospitals), dental care, physiotherapy, chiropractic and psychotherapy.

The organisation of the PHI market

Historically, the for-profit private health insurance (PHI) market has been very limited. Nearly all health care is free of charge, and the public system has generally been seen as providing high-level service. However, a market for PHI covering out-of-pocket payments has existed for many years. The market has been dominated by the non-profit health insurance company “Danmark,” which is complementary to the public health care system.

A for-profit PHI market, which is supplementary to the public health care system, has been developing since the 1990s. It has expanded tenfold since 2001 and is still growing (Olsen 2007). The development of the for-profit, supplementary PHI market can be explained by several factors; but a main reason is regulation from 2002, which made it possible for employers to deduct PHI insurance premiums from their tax payments when purchased on behalf of their employees (Strandberg-Larsen et al. 2007). During the same period of time,

the private hospital sector has increased. Today 2% of all hospital beds are private. This is equivalent to approximately 500 beds. Despite the relatively small proportion of private beds, moreover, private hospitals have created considerable political discussion in Denmark. Some people are concerned that public hospitals are exposed to unfair competition as private providers are paid slightly higher rates, have fewer obligations in terms of education and research, may be selecting patients and depend on the public hospitals to handle complications. It is also argued that PHI threatens the general principles of solidarity and equity in the health care system, as it provides easier access to private facilities for some parts of the population. Other think that both PHI and private providers represent a natural and positive supplement to the public system, particularly as the overall capacity is expanded; additionally, there is potential for innovation and organizational learning, as the public hospitals are exposed to competition (Strandberg-Larsen et al. 2007).

The PHI market in Denmark consists of one not-for-profit insurance company, "Danmark", and several for-profit insurance companies. The largest for-profit insurance companies are Codan, Danica, PFA, Topdanmark and Tryg (TrygVesta) (Strandberg-Larsen et al. 2007). Other companies offering PHI are Skandia, FSP, PensionDanmark, IHI, If and Mølholm Forsikring (Forsikring & Pension 2008a). Many for-profit insurance companies are not new players in the insurance market, as they have offered other insurance for several years. The majority of PHI providers also offer other insurance, such as life insurance. Some offer PHI and travel insurance, and some companies only offer health insurance.

The different types of PHI have historically been quite distinct as non-profit PHI has a complementary market role and for-profit PHI a supplementary market role in relation to the public sector. However, the non-profit PHI company "Danmark" has over the past decade developed services that are supplementary in nature, which can be purchased as an add-on to traditional complementary insurance policies. "Danmark" thus also offers insurance that provides access to private sector treatment and critical illness insurance (Danmark 2008). Complementary PHI is almost exclusively sold by the non-profit health insurance company "Danmark," but some for-profit PHI companies offer complementary insurance in combination with supplementary health insurance schemes. In 2004, "Danmark" had a 99% market share of the PHI market, and today the number of members exceeds 2 millions, which is nearly 36% of the population (Danmark 2008; Strandberg-Larsen et al. 2007).

Not-for-profit PHI

"Danmark" offers user-payment insurance that covers or partly covers services that are not reimbursed in the public health care system. In recent years, "Danmark" has started to offer supplementary PHI as well. For both complementary user-pay insurance and hospital insurance, subscribers are required to pay a part of the cost. The cost sharing is based on balance billing where "Danmark" pays a fixed amount or percentage (often with a ceiling) of the price. Subscribers then pay the remaining cost. Four different insurance schemes are offered:

- Group 1 covers expenses related to hospital care, medication (extended cover), medical aids, chiropractic, chiropody, physiotherapy, dietician treatment, dental treatment (extended cover), eye care, glasses, contact lenses, hearing aids, psychological crises therapy, funeral aid and visits to sanatoria. Approximately

7.1% of the Danish population was covered in this group in 2004 (Danmark 2008; Strandberg-Larsen et al. 2007).

- Group 2 is designed for people who have chosen an alternative coverage option in the public health system (called group 2), which provides greater choice of GP and direct access to practicing specialists for a co-payment. This PHI scheme thus partially covers the co-payment in relation to services rendered by GPs, specialists and laboratories. Furthermore, all expenses for medications are covered. All expenses covered in Group 1 are also covered in Group 2. Only 0.8% of the Danish population was covered by this scheme in 2004 (Danmark 2008; Strandberg-Larsen et al. 2007).
- The third group is called Group 5. This is the traditional complementary insurance group. It partially covers expenses for prescription drugs (outside the exemption scheme), dental treatment, glasses, contact lenses, psychological crises therapy, chiropractic and physiotherapy. Group 5 is the largest group and covered in 2004 22.6% of the population (Danmark 2008; Strandberg-Larsen et al. 2007).
- The fourth group is called Basic Insurance and is designed for people who wish to have a right to coverage in the future, but have no immediate need for medical care. As a Basic Insurance member you will not get your medical costs refunded, but you have the right to switch to another insurance group without having to re-qualify. 3.6% of the Danish population is covered in this group (Danmark 2008; Strandberg-Larsen et al. 2007).

It is also possible to purchase "critical illness," "extended hospital" insurance and travel insurance in addition to the other insurance groups. "Critical illness" insurance provides a lump sum in the event of certain specified life-threatening conditions. "Extended hospital" coverage provides access to private facilities in Denmark or abroad. Children can be insured in the same group as their parents for free until the age of 16, as long as they comply with the health qualifications. Infants can be insured in the same group as their parents without having to qualify (Danmark 2008). People can be insured as long as they want if they pay their premiums (Pedersen 2007). Most premiums cost the same for everyone; but if you expand your scheme with "extended operation" coverage, the additional price will depend on your age. To be accepted as a "Danmark" member, you have to live up to "Danmark's" health standards and be below 60 years of age. Applications for coverage may be rejected if the applicant does not fulfil the requirements set out by "Danmark." Furthermore, pre-existing conditions are excluded from coverage (Danmark 2008; Strandberg-Larsen et al. 2007).

For-profit PHI

For-profit insurance companies are supplementary in nature and offer two different kinds of insurances.

Critical illness insurance has been very popular. The insurance companies refund a lump sum of money in case of critical illness. The refunded money is tax-free and can be used for private hospital treatment or for any purpose. It varies exactly with which illnesses are covered, but policies typically include malignant cancer, benign cancer in the brain or spinal cord, apoplexy, organ transplantations, multiple sclerosis, ALS, AIDS, Parkinson disease, blindness, deafness, aorta illnesses, heart valve surgery, borrelia and cerebrospinal meningitis (Danmark 2008; Pedersen 2007).

Another insurance possibility is hospital insurance, which is typically purchased by companies for their employees. The number of people with hospital insurance is increasing rapidly. The typical minimum scheme covers private hospital care, operations, medications, ambulatory treatment, preliminary examinations such as scanning, X-ray and laboratory examination, after-care, medical aids and transportation. The treatment is offered abroad if it cannot be provided in Denmark (Petersen 2007; Strandberg-Larsen et al. 2007). In some cases it is possible to expand the coverage to include chiropractic treatment, physiotherapy, acupuncture, dietician, psychological treatment (including crises therapy) and additional medical expenses (outside the exemption scheme) (Forsikring & Pension 2008c; PFA 2008). Benefits are paid in cash, which can only be used on medical treatment or medical services. The amount of compensation varies by the different insurance companies. Some insurance companies have no limit on the price of treatment, while others have set a maximum price for hospital treatment. If the price exceeds this level, the subscriber has to pay the difference (balance billing) (Forsikring & Pension 2008c). There can also be a limit for how long a treatment will be covered. For instance, "Tryg" covers only three months of physiotherapy treatment (Tryg 2008). In some hospital insurance schemes, such as "Tryg" and "PFA", dependent children can be covered for a minor additional fee. Often, complementary insurance is also sold in combination with supplementary health insurance schemes.

Typically for-profit health insurance schemes do not cover pre-existing illnesses and chronic illnesses. Supplementary insurance can usually be purchased until the age of 60 or retirement (around 65) and provides coverage until retirement (Forsikring & Pension 2008c; Strandberg-Larsen et al. 2007). Coverage normally excludes medical expenses such as cosmetic treatment, treatment for infertility and dental care (e.g. PFA 2008). Some insurance companies use risk rating to set premiums for group-based health insurance. The variables used for risk rating are statistics for the company's sickness absence, the company's health policies such as exercise opportunities, the number of employed people and their work functions. A "healthy" company will be offered a less expensive premium for their employees (Riisberg 2007). Individually purchased health insurance premiums are based on age and employment status (Thomson & Mossialos 2004 in Strandberg-Larsen et al. 2007). Information on possible further risk rating is not available.

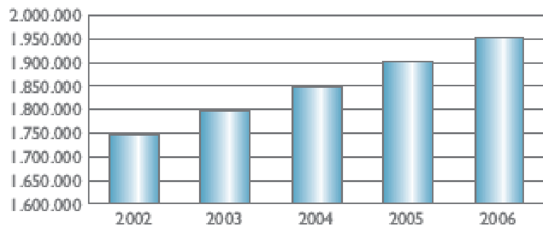
Many PHI companies offer both life and health insurance, but but it is not mandatory to buy both insurance types. The extent to which PHI is sold in combination with life insurance is not known; but according to the trade association, many critical illness insurance policies are sold in combination with life pensions (Forsikring & Pension 2008d).

Private health insurance in Denmark does not cover expenses related to illness such as loss of earnings, long-term care, etc. In case of loss of earnings, the state or your employer will refund a maximum of DKK 3515 per week for the first 8 weeks of your illness (KL & Videnskabsministeriet 2008). It is not possible to combine public and private funding (Strandberg-Larsen et al. 2007).

Coverage

The number of persons covered by complementary PHI policies has been rising despite significant growth in for-profit supplementary PHI. In the last 10 years, "Danmark" has had a mean member increase of 50,000 new members a year (Danmark 2006).

Figure DK1 'Danmark' member development



Source: Danmark (2006)

The number of people with for-profit supplementary PHI has been growing rapidly. According to the insurance companies, there has been a tenfold increase in members since 2001 (Olsen 2007). The increase has been particularly significant after 2002 when it became possible for employers to deduct the cost of health insurance for their employees from their taxes. In 2001, 45,000 people had supplementary health insurance while it was 720,000 people in 2007 (Andersen & Houe 2007).

Table DK1 Number of people with for-profit PHI

	2002	**2003**	**2004**	**2005**	**2006**
People with insurance	141.000	246.000	306.000	473.000	612.000
Gross income on premiums (million DKK)	-	-	380	590	690
Gross expenditure on compensations (million DKK)	-	-	220	360	520

Source: Forsikring & Pension (2008a)

Almost all policies sold by the non-profit PHI "Danmark" are purchased by individuals, while above 80% of the commercial policies are purchased by employers or groups as a fringe benefit for employees (Strandberg-Larsen et al. 2007). In 2006, PHI was the most widespread fringe benefit (Riisberg 2007). As many policies are tied to job contracts, PHI favours people in the workforce. In general, PHI has less significance for children, unemployed people, students, the elderly and those with pre-existing conditions or chronic illnesses (Strandberg-Larsen et al. 2007).

Table DK2 Population coverage

	Not-for-profit (Danmark)	For-profit	Total
Complementary coverage	1.953.198[A] 35.67 % of pop.[B]	n/a	1.953.198
Supplementary coverage (Critical illness)	n/a	n/a	2.200.000[E] 40.18 % of pop.
Supplementary coverage (Hospital coverage)	500.000+[C] 9.13 % of pop.	720.000[D] 13.15 % of pop.	1.220.000 22.28 % of pop.
Total	1.953.198	n/a	

A: in 2006 (Danmark 2006). **B:** The Danish population was in the 4th quarter of 2007, 5.475.791 persons (Danmarks statistik 2008a). **C:** (Forsikring & Pension 2008b). **D:** in 2007 (Pedersen 2007; Ravnsborg 2007). **E:** in 2006 (Forsikring & Pension 2008d). It should be noticed that some people are covered twice. This is the case for approximately 15% of people with a PHI (Pedersen 2007).

Characteristics of subscribers

It is a broad subset of the population who subscribes to non-profit complementary PHI; but there is an overrepresentation of middle-aged people and white-collar workers, as compared to skilled and unskilled workers, who have complementary PHI (Pedersen 2007). To buy insurance you have to qualify to certain criteria. This means that people with pre-existing conditions or chronic illnesses cannot subscribe.

Younger people (15-29 years of age), people with less education, and people that earn more than DKK 500,000 a year are more likely to obtain supplementary PHI (Strandberg-Larsen et al. 2007). The tendency is that the higher your income is, the greater the chance that you have a supplementary PHI policy. In 2007, every fourth person with a yearly income below DKK 420,000 had a supplementary PHI, yet this was the case for 3 out of 4 people with a yearly income above DKK 900,000 (Olsen 2007). People who subscribe to supplementary PHI are typically in a job, as they are insured by their employer (Strandberg-Larsen et al. 2007). They are also more likely to have supplementary PHI if their wage is high (Andersen & Houe 2007). Only one out of ten publicly employed people have supplementary insurance. The corresponding figure for private sector employees is 46 percent; for health insurance is typically offered as a fringe benefit in the private sector without direct cost to the employee (Madsen & Andersen 2008). This means that supplementary PHI has less significance for unemployed people, students, children, the elderly (aged 65+) and people suffering from pre-existing conditions or chronic illnesses (Strandberg-Larsen et al. 2007).

Market development

Since 1973, the Danish health care system has been universal and tax-financed. Only one not-for-profit complementary insurance scheme has existed for many years, but a market for commercial supplementary PHI has developed in recent years and is increasing every year. During the 1990s, critical illness insurance became popular. It is often sold in

combination with life pensions offered through job contracts. In 2001, hospital insurance was introduced, and the demand has increased rapidly since 2002. The increasing demand can be explained by several factors. First, it was not before 1989-90 that the first commercial hospital in Denmark came into existence (Pedersen 2007), and the market for private hospitals has developed ever since. Thus it was not possible to offer supplementary hospital insurance until then. Demand for more flexible services and a more critical public discourse concerning the quality of public hospital service is another factor behind the demand for commercial hospital insurance (Strandberg-Larsen et al. 2007). Furthermore, the Danish labour market has been characterized by strong competition for employees due to economic growth. At the same time, there is a high personal income tax in Denmark. Health insurance has therefore become an increasingly important way to attract and sustain employees (Madsen & Andersen 2008; Mossialos & Thomson 2002 in Strandberg-Larsen et al. 2007). In 2006, it was the most utilized fringe benefit (Riisberg 2007). One reason behind this is the regulation from 2002, which made it possible for companies to deduct the cost of the insurance premiums from their taxes (Mossialos & Thomson 2002 in Strandberg-Larsen et al. 2007). In 2006, the state "lost" DKK 405 millions in tax income because of employer-based PHI (Andersen & Houe 2007). Employers get additional benefits from insuring their employees, as they might return more quickly to work after incidences of illness.

Even though the market for complementary and supplementary PHI has increased, insurance-financed treatment constitutes a minor part of the health care system. The gross income for hospital insurance was in 2006 DKK 690 millions, and private expenditure on health constituted 20.3% of total expenditure on health (Indenrigs- og Sundhedsministeriet 2007). There are few barriers to market development, but the limited number of private providers and the shortage of medical professionals may limit the development in the short to medium term. A more general determining condition for the market will be the performance of the public health system. If waiting lists are maintained at a low level and quality is seen to be high, then there is limited reason to expect strong growth in PHI. Another underlying factor that influences the market potential is the taxation system. Possible future changes in the rules on tax deduction for employers may dampen the market.

Public policy and regulation towards PHI

As in many other countries, new public management initiatives have played a significant role in the development of the health care system during the 1990s and 2000s. There has been a political wish to create greater competition in the health care sector as a way to improve efficiency and quality in treatment. The first step was a free choice of (public) hospitals in 1993. The gradual stimulation of private hospital providers and insurance, particularly since 2002, has followed. The rules on tax deduction and the extended hospital choice with access to private facilities at the public expense when waiting times exceed one month are other instruments. It is argued that the introduction of more private providers will reduce waiting times in the public sector, as the patients who are treated in the private sector otherwise would have been treated in the public sector. The 2002 law concerning waiting time guarantees in the statutory health system provided the right to seek treatment at private facilities in Denmark or abroad if the expected waiting time from referral to treatment exceeded two months. In October 2007, the time limit was further reduced to one month (Strandberg-Larsen et al. 2007). The laws concerning waiting time guarantees have established a foundation for a private hospital sector in Denmark.

Since January 2002, it has been possible for employers to deduct the cost of premiums in tax for prevention and treatment insurance (such as hospital insurance) purchased on behalf of their employees as long as the policy is provided to all employees working more than 8 hours a week (Ligningsloven §30). Individuals purchasing PHI cannot deduct the cost of the premium in tax (Strandberg-Larsen et al. 2007).

There is no regulation of premiums for insurance companies and hence no restrictions on what insurers are permitted to cover (Strandberg-Larsen et al. 2007). This is probably because private health care has played a minor part in the Danish health care system in recent time, as public health care is universal. General market requirements such as solvency and minimum capital are regulated and supervised by the Danish Financial Supervisory Authority (Finanstilsynet).

The EU Third Non Life Insurance Directive has a general impact on regulation of the insurance market, but so far the market for PHI has been dominated by Danish insurance companies. There are no international health insurance companies operating in Denmark. But some of the Danish insurance companies (e.g. TrygVesta) sell health insurance in other Scandinavian countries. There have not been any national or EU-level court cases regarding Directive or EU competition rules.

Impact on the wider health system

PHI has been an important factor for establishing a private hospital market in Denmark (Pedersen 2007). Competition from a private hospital market may affect the public sector both positively and negatively. It provides flexibility for people who are dissatisfied with the public health care system. It may also lead to a reduction in waiting times in the public health care system since people with hospital insurance, who normally would be treated in the public system, are treated outside this system. At a more general level, there could be mutual learning effects across the public/private divide as more private actors are introduced. Finally, it is possible that the more competitive setting in and of itself might spur public providers to reconsider their service levels. An indication of this can be seen in the general reduction in waiting times in the public system over the past decade, although this was obviously made possible by a number of different factors including a general increase in funding.

On the negative side, it can be argued that a general reduction in waiting times may actually have negative effects, as the threshold for what is treated will expand with reduced waiting times. This will tend to drive up demand and overall health expenditures. This also may lead to "over treatment" of some patients. In this view, waiting times are seen as means to control demand in the public sector and, therefore, desirable to some extent. Another potentially problematic effect is increased competition for staff, which may lead to higher wages and/or problems in staffing the public hospitals. This is a valid and clear concern in the current Danish setting. In some cases, PHI has contributed to increasing the waiting times for public patients. This has been the case for privately practicing specialists where people with insurance have been prioritized over people without insurance, especially because providers earn more for consulting patients with PHI (Jessen et al. 2008). The Association of Practicing Specialists (FAPS) has reported that specialists can earn almost the double for patients covered by PHI compared to publicly covered patients (Jessen et al. 2008).

Hospital personnel are allowed to work both in the public and private sector (Strandberg-Larsen et al. 2007). Doctors working in both the public and private sector have an incentive to refer publicly financed patients who cannot be treated in the public system within a month to their own private hospital. Waiting times in the public sector may be affected by health professionals working in the public sector on ordinary days and in the private sector in their spare time. This may in part be because they are less inclined to take on overtime. On the other hand, when people are treated in the private sector, they do not burden the public waiting list.

Doctors and other health care workers earn a higher salary in the private sector. Whether this affects the way patients are treated in the different sectors is impossible to say; but it could imply that skilled health professionals are recruited from the public sector to the private sector, leaving the public health care sector with a greater proportion of less experienced and less skilled health care professionals. It also increases the problem of staffing shortages in the public health care system, and it might negatively affect the quality of treatment in the public sector and thus the overall equity in the system if the level is increased significantly (Strandberg-Larsen et al. 2007).

There is and has been significant debate in the media and among politicians about the development of private hospital insurance. Many interested parties are involved in the debate including politicians, the media, academics, the public, trade unions and health care professionals. The focus in the debate is whether growth in PHI will create inequality in the supply of treatment. People are concerned about whether the growth in the long run will affect people's willingness to finance the public health care system through taxes, which especially would affect groups that are less likely to be covered by employer-purchased insurance (students, children, unemployed, elderly etc.). Another focus of the debate is whether the state should support PHI by tax deductions for companies. Studies show that the companies get tax deductions for around DKK 400 million every year because of investment in PHI (Andersen & Houe 2007). Some argue that the money is better spent on the public health care system. A new area of interest in the public debate is whether people with PHI are favoured according to waiting times at specialists, especially because specialists treat both private and public financed patients ,and can earn almost double on patients with private health insurance (Jessen et al. 2008).

The general belief is that the PHI market will develop even further. It could though be affected by the one-month waiting time guarantee, as well as by future economic developments. In periods of recession, employers may be less inclined to purchase PHI as the need to attract employees with fringe benefits will be less relevant in periods of high unemployment.

Assessment of market performance

The next section discusses how PHI contributes to meeting the financing policy goals set out by the WHO. The evaluation will be based on personal views as evidence in the field is lacking.

In most cases, PHI is supplementary to the public health system. As everyone is covered by the public system, PHI is not relevant in promoting financial protection against financial risks associated with poor health. Furthermore, PHI does not promote a more equitable distribution of the burden of financing in the healthcare system, as insurance

premiums do not depend on your income. PHI does not tend to have an impact on equity in finance because people are not allowed to opt out of the statutory health care system. Supplementary PHI is in most cases employer-purchased as a fringe benefit for employees. Therefore, inequities of access to health care may be exacerbated, particularly for people outside the job market. Regulation ensures, however, that employer-purchased insurance is offered to everyone in the work place and not just selected employees.

The private health care and health insurance systems are not fully transparent. It can be difficult to compare insurance. The trade union 'Forsikring & Pension' collects some statistical data, but systematic and comprehensive monitoring and auditing regarding performance and quality is not taking place. Public hospitals are audited and monitored more rigorously than private hospitals. This means that the greater significance of PHI and greater use of private hospitals may reduce transparency in the wider health care system.

Private providers are in most cases paid by fee for service. However, efficiency is difficult to evaluate, as the monitoring and reporting requirements of private hospitals are less strict than in the public sector, and it is difficult to hold other factors constant. Private hospitals in principle have an incentive to provide good quality of care because they are then likely to continue their partnership with the insurance company. Furthermore, if quality in the private health care system is lower than in the public system, there is less reason to have a PHI policy because the public system is universal.

PHI ensures some level of competition on quality and efficiency in the wider health care system, which may result in better quality of treatment in general. The potential for opting out makes some public hospitals more aware of their service/quality levels. Finally, the introduction of privately managed hospitals/insurers may lead to mutual learning and sharing of innovative practices across the public private divide. However, there is limited evidence of such positive effects so far.

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France

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Context

The French public health insurance system is designed as a social security type system. It has almost reached universal coverage.[166] Historically, people have been covered on an employment basis; however, coverage moved toward a citizenship basis in 2000 when the Universal Health Coverage Act (CMU) came into effect, offering basic health insurance coverage to low-income legal residents in France regardless of their employment status.

Although the French health benefit basket can be considered generous, health goods and procedures are not 100% covered given the basket's defined exceptions on medical conditions. A share of the official statutory health insurance (SHI) healthcare tariff is left to the patient, but this will vary with the category of goods and care.

The benefit basket covers access to public and private hospitals, as well as outpatient care mainly provided by self-employed health professionals working in private practice. Actually, SHI pays hospitals directly on a DRG basis and the hospitals bill the patient for the hospital catering lump sum and for the patient's 20% co-payments when required[167].

In the outpatient sector, services are covered if they are included on one the SHI positive lists of reimbursable services and goods. Doctors and other health professionals are usually paid on a fee for service basis by the patients who secondly claim for reimbursement. An exception is made though for low-income individuals and people suffering from defined chronic conditions, as there is often direct payment of the cost by SHI to the providers for these populations.

In order to be eligible for reimbursement by the SHI, pharmaceutical products and medical devices must be prescribed by health care professionals (doctors, dentists and midwives). In this sector, the share of the official tariff covered by the SHI ranges from 70% for health care provided by doctors and dentists to 60% for medical auxiliaries and laboratory tests. Most drugs are covered at a rate of 65%, but this varies from 100% for non-substitutable or expensive drugs to 35% for drugs considered "convenience medication."

Overall, the SHI finances 75% of total healthcare expenditure. However, this varies across sectors and over time. Since the early 1990s, 92% of hospital expenditure has been financed by SHI, but its share of outpatient expenditure has become smaller and decreased over time from 77% in 1980 to 66% in 2006. This can be explained, on one hand, by the fact that in this last sector some professionals are allowed to charge patients above the official SHI tariffs (extra-billing); on the other hand, this also may be explained by the fact that since the late 1970s, most of the reforms implemented to limit the SHI chronic shortage of funds have significantly increased patients' co-payments for medical goods and overall outpatient care.

[166] In 2006, 99.9% of the population was covered.
[167] There is a large number of exemptions: after the 31st day of a hospital stay, for treatment involving of a level of surgery weighting above the appendectomy one, maternity care.

Thus, while France has a universal public health insurance system, the coverage it provides is not complete, and the 20% share of private expenditure explains why 88% of the French population has private complementary health insurance.

The PHI Role

Historically, the primary role of PHI is complementary for user charges: PHI covers the discrepancy between the SHI's cost-sharing and the tariffs for care. In France, unlike in some other countries, private insurance is not used to jump public sector queues or to obtain access to elite providers. It rather provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered, most notably dental and optical care for which charging over the statutory fees is the rule.

However, PHI's role has also been of a supplementary type with regards to private amenities that are not included in the benefit basket. For instance, a good number of PHI insurance contracts cover the price of a private room up to a defined tariff per day.

With the wide extension and saturation of this market, PHI has recently extended to cover complementary type services. VHI suppliers compete on offering contracts that cover goods and services that are not covered by the SHI, such as omega 3 pills and near-sightedness surgery.

Most PHI firms offer several types of contracts. If all of them are of complementary type for user charges, they are frequently also of supplementary type and less often of a complementary type for services. Contracts differ on the level of cost coverage left to the patient after SHI reimbursement. They usually fully cover the patient's cost sharing for non-convenience drugs, as well as procedures and tests when providers do not charge above the official SHI tariff. Thus, PHI contracts will differ on the level of coverage of the costs that are charged above the official tariffs; of the costs of convenience drugs, medical devices and private amenities; and occasionally, of the costs of services not included in the SHI benefit package. An analysis of modal contracts shows that for a specialist visit priced at €60 (including extra-billing), one-third of the contracts offer coverage above the official tariff, and the overall rate of coverage is 120% (Arnould & Rattier 2008), An increasing number of PHI firms offer tailor-made contracts where people can choose the rate of coverage for each type of care.

Supply-side incentives to fit with the system rules

There is no restriction on what insurers are permitted to cover, but there are strong incentives for them to work within the system's rules and solidarity principles.

First, in 2002, a 7% taxation exemption was created for a solidarity-based contract category (*contrats solidaires*). In order to belong to this category, contracts have to offer premiums that are independent of pre-existing conditions and that do not require a health questionnaire.

Later, in 2004, the latest round of French healthcare reforms attempted to make patients more responsible for their consumption of care by introducing deductibles and what is known as a coordinated care pathway, essentially a soft gate-keeping schedule. Patients are asked to register with a preferred doctor of their choice, who they should visit before

accessing a specialist. However, patients can opt out and have direct access to specialists or other GPs if they are willing to pay additional user charges.
In order to insure the efficacy of these measures and to incite patients to follow the pathway, the concept of "responsible contracts" (*contrats responsables*) was created, making PHI firms eligible for financial rebates. With the aim of decreasing moral hazard, these contracts should not cover some of the deductibles introduced recently (€1 for GP visit, €0.5 for every drug package[168] and ancillary care and €2 for sanitary transportation) or the additional co-payments for doctor fees when patients opt out. To ensure equity of access, moreover, these contracts should cover 100% of the registered GP's fees, 100% of the specialists' fees when patients follow the pathway, at least 95% of the costs of important drugs that are covered at a 65% level by SHI and 95% of the costs of lab test covered by the SHI. Lastly, these contracts should cover two important preventive services from a list described by the national health authority (HAS). Contracts that do not follow these criteria are taxed at a 7% level. However, in 2006, almost all of the PHI contracts were "responsible contracts" (Arnould, Rattier 2008).

Individual and group contracts
PHI contracts can be purchased by individuals or by firms for their employees. In 2006, ESPS[169], a general population survey, showed that 40% of people privately insured are covered by a company group contract (Kambia-Chopin et al 2008a).

Most of PHI contracts are subscribed to on a voluntary basis. However, group contracts are most often mandatory and are strictly regulated in this case as follow:

- Contracts must be "responsible contracts."
- Companies must offer them either to the whole staff or to a well-defined category of employees (for example, executives, workers, etc.), and they must sponsor them.
- Coverage must be strictly uniform among beneficiaries.
- Premiums must be community rated for beneficiaries.
- Lastly, when beneficiaries retire, the insurer must offer them a contract with equivalent coverage for an increase in premium (taking into account employer participation) below 50% for the year that follows retirement[170].

Group contracts offer usually broader coverage than individual contracts. 85% of them are sponsored by the employer who pays on average 60% of the premium (Couffinhal et al 2004). It is important to note that this is usually not proportionate to age, but instead proportionate to wages in approximately 30% of contracts.

Premiums for individual contracts are usually more expensive and are not proportionate to revenue, but to age, in 70% of modal contracts (Arnould et al 2007). The level of coverage varies widely across contracts and insurance companies; however, it is on average inferior to that of group contracts.

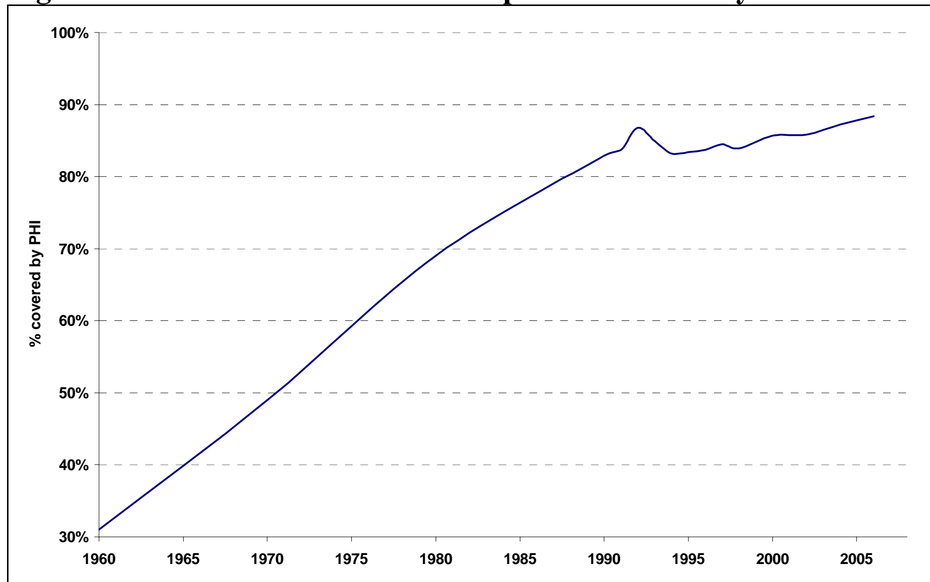
Populations covered and demand-side measures to increase coverage

[168] Goods and services provided in a prevention programme such as immunization are not concerned.

[169] ESPS: *Enquête santé protection sociale* (Health, Health Care and Insurance survey)
[170] At retirement, all financial advantages (employer participation and preferential tax treatment) are lost and premium can be adjusted to the individual risk. In this case, the meaning of equivalent benefit has been controversial, some insurer modifying the contract on their perception of retired people's requirement.

The population covered by PHI contracts increased from 50% in 1970 and 69% in 1980 to 83% in 1990 and 88% in 2006 (see Figure FR1 below). Thus, the costs of the diminishing share of SHI coverage for outpatient care were slowly transferred to PHI.

Figure FR1 Trend in the number of person covered by PHI from 1960 to 2006



Source : INSEE, ESSM survey (before 1992), IRDES, ESPS survey (till 1992)

Many factors have participated in the growth of the population covered by PHI. With the shifting of outpatient costs from SHI to households beginning in the 1970s, PHI has played a growing role in financing outpatient care and ensuring access. Moreover, the overall growth of population wealth has favoured insurance coverage, and insurance companies broadened their range of contracts in order to attract younger and healthier uninsured people. Over that period, the government developed several demand-side measures to increase the proportion of the population covered by a PHI contract.

First, tax rebates are offered to companies that provide group contracts for their employees, and employees can deduct the cost of premiums from their taxable income. In 2003, 40% of firms were offering and sponsoring a health insurance contract to at least a share of their employees. However, this figure varies greatly with the size of the firm. It ranges from 30% of the firms employing less than 10 persons to nearly 100% for firms with more than 500 employees (Couffinhal et al 2004). A recent 2008 reform limits companies' tax rebates for mandatory contracts. Following this, voluntary group contracts will probably disappear.

Second, two measures were implemented for equity concerns since lower income individuals were not able to access private complementary health insurance for economic reasons. From 2000, complementary universal health coverage (CMU-C)--a public complementary health insurance scheme--was offered on a voluntary basis to those whose monthly income fell below €621 for a single person in 2008[171]. In 2006, CMU-C covered 7% of the population. As a result, the PHI potential market size is 93% of the French population.

[171] This level increase with the number a people in the household up to a ceiling of €1800 per month for a six-people household.

The other measure implemented to help "the poorer of the less poor" access PHI was the creation of a voucher scheme called *aide complémentaire santé*. Financial help is offered to people whose income is above the CMU-C ceiling and below a ceiling equal to 120% of the CMU ceiling. The amount of what is called the 'health check" (*cheque santé*) depends on the patient's age. It ranges from €100 per year for people aged 25 and under to €400 for people above 60. In 2008, it reached €220 on average. However, only a small share of the targeted population is currently taking advantage of this. In November 2007, only 330,000 persons out of the 2.2 million people targeted[172] (Fonds-CMU 2008) actually benefited from this voucher.

Disparities in coverage
Access to PHI remains largely linked to social status. In 2006, among the 8% of the population with no complementary coverage, 53% reported that they do not access PHI because of financial matters. Among the 4% of people who have recently lost their complementary coverage, 30% reported that it was due to financial problems (Kambia Chopin et al 2008b).

The share of people with no PHI coverage is 32.1% among the 20% least well off. For instance, 36.6% of the unemployed and 24.4% of unskilled workers, compared to 12% of the general population, do not have PHI.

This can be explained by two main reasons. First, the less well off have less access to group contracts. Non-executives have a lower probability of being offered complementary health insurance coverage by their firm (Francesconi et al 2006). People who are laid off or who resign for health reasons lose group coverage. Finally, those who have never worked cannot even access this type of contract. Second, on the individual market, the poorest end up devoting the largest proportion of their financial resources to purchasing a supplementary health insurance contract since premiums are generally not linked to income, (Kambia Chopin et al 2008a).

Table FR1 Average % of income spent on PHI premiums by person of the household covered

Level of income	**Average % of income by person covered**
1rst fifth (Income < 800)	10.3%
2nd fifth (800<= Income <1100)	6.3%
3rd fifth (1100 <= Income <1400)	4.8%
4th fifth (1400 <= Income <1866)	4.0%
5th fifth (1866 <= Income)	2.9%

Source: IRDES, ESPS (2006)

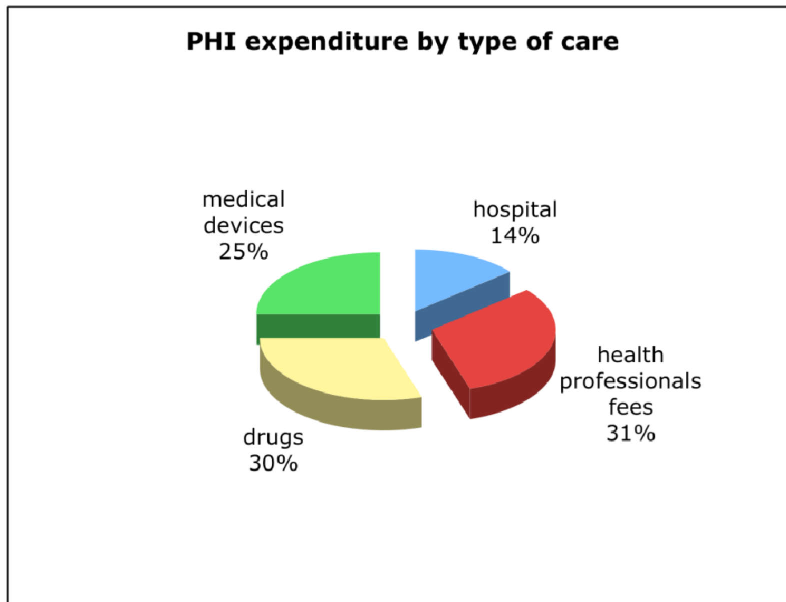
It has to be mentioned that a large share of low-income individuals are enrolled in the CMU-C scheme and thus leave the PHI market. However, it is clear that social disparities in coverage remain.

[172] 3.5% of the whole population

Access to PHI also varies by age group. The highest rate of people without PHI is observed among people who are between 20 and 29 years of age (16.4%) and among people over age 80. For the former, this may result from lower healthcare needs, lower income and lower access to group contracts. For the latter group, this may be the product of the loss of group coverage at retirement time and higher premiums due to age-rating.

The PHI growing role in financing health expenditure
In 2006, PHI expenditure was split as follows: 31% on health professionals' fees, 30% on drugs, 25% on medical devices and 14% on hospital care (see below).

Figure FR2 PHI expenditure by type of care



Source: DREES, Comptes nationaux de la santé (2006)

In 2006, the share of total health expenditure financed by PHI was 13%. SHI and PHI coverage varied inversely across sectors. Indeed, PHI financed 30% of medical goods (e.g. eye wear, dental prosthesis, etc.), 20% of overall outpatient care and only 4% of hospital expenditure.

In the mid 1980s, PHI financed less than 6% of total health expenditure. This share reached 11% in 1990. Since that time and despite decreasing SHI coverage of outpatient care, the share of health expenditure financed by PHI did not rise much. In 2006, it reached 13%. This can be explained by two opposite trends that have compensated for each other. On one hand, total health expenditure has increased, and the official level of SHI coverage of outpatient services has decreased. In theory, these trends should have increased the PHI share of expenditure. However, with the ageing population, the number of people exempted from co-payments for chronic conditions has risen, leading to a higher genuine SHI share of outpatient costs than expected (HCAAM 2008).

Table FR2 PHI expenditure as a percentage of PIB and total health expenditure

Year	% of PIB	% of THE
1960	0.2	5.7
1980	0.4	5.7
1985	0.5	5.9

1990	0.9	11
1995	1	10.3[b]
2000	1	10.8
2006	1.4	12.8[b]

[b] break in series between this year and the last year showed

Nevertheless, premiums have dramatically increased in the last ten years. In 2006, the average premium of an individual contract was €530 per capita, a marked increase from €340 in 1998. (Allonier et al 2008).

As a result, PHI is considered an overall healthy business. Its turnover reached 26 billion Euros in 2006 and has increased by 48% since 2000 (Fonds CMU 2007). Therefore, in the course of the 2008 summer, the French government implemented a new tax on PHI return. Starting from 2009, PHI must pay a €1 million amount. This will be used to finance the CMU Fund, and the revenue of the earmarked taxes on tobacco and alcohol, which are currently financing this fund, will be given to the SHI.

A growing role in the governance of the healthcare system
New measures have taken into account the growing role of PHI in funding the system by allowing it to participate in the governance of the healthcare system. The 2004 reform set up the National Union of Complementary Health Insurers (UNOCAM), a body that is consulted prior to the introduction of a new product in the public health benefit package. It can participate in the negotiation of national agreements with healthcare professionals. As a member of the pricing committee CEPS, it negotiates together with representatives of the Ministry of Health, the Ministry of Finance and the SHI funds to determine the price of drugs and medical devices. Moreover, UNOCAM issues a report on the PHI positions on the changes and trends in the healthcare sector.

In 2008, following the announcement of the €1 billion taxation of PHI revenue, the government offered "a strengthened coordination between the SHI funds and the PHI firms for the management of healthcare coverage and of healthcare financing." It said that "from now, three-party negotiations between SHI, complementary health insurers and health professionals can be planned ahead and, above all, in sectors where complementary health insurers cover a large share of the cost of care…PHI will be associated with actions that tend to diminish the price charged above the statutory official tariffs."

Market overview

The PHI market is very complex because of a great diversity in insurers and in products.

A great number of insurers
The French PHI market is characterized by a large number of insurers. In 2006, there are 991 insurers on the market (Fonds-CMU 2007). The top ten insurers make 25% of the whole turnover. Nevertheless, due to the high level of competition (the market is considered almost saturated) and to a request for higher provisions and solvency ratios, a lot of insurers merged or simply disappeared, which lead to a constant decrease in the number of insurers (40% decrease between 2000 and 2006).

Insurers belong to three families (their relative weights on the SHI market are given in Table **FR**X), which differ according to their logic and principles. These principles are translated into specific regulatory texts called "Code."

The mutual insurance companies

The main family is composed of mutual insurance companies called "mutuelles de santé." Existing since the ninteenth century, they are the historical insurers. Indeed, PHI pre-dates the creation of Social Security. By the start of World War II, mutual insurance companies--the only insurers on the market--were covering two-thirds of the population (Sandier et al 2002). The 19 October 1945 Law that set up the Social Security system redefined the role of "mutuelles" as being complementary to SHI. In 1960, hardly 31% of the population benefited from this type of coverage.

Mutual insurance companies are not-for-profit firms. The "Code de la Mutualité," which is articulated around a social doctrine, regulates them. They aim to achieve solidarity and mutual aid (art. L. 111-1 of the Code de la Mutualité) by implementing equality of treatment of their insurees (art. L. 121-2 of the Code de la Mutualité). This implies that they avoid, as much as permitted by competition, differentiation in premiums for a given level of coverage. For this reason, they make limited use of risk rating. Moreover, some "mutuelles" also adjust their premium based on income.

"Mutuelles" are highly specialized in health insurance contracts (which represent 73% of their turnover). The remaining part of their activity is devoted to providing provident cash benefits for coverage of what is considered "heavy risk" (i.e. maternity, disability, death and sick-leaves). Mutuelles mainly offer individual contracts, and the majority of their group contracts are optional.

Commercial insurance companies

The second category, in term of weight on the health insurance market, is made up of the commercial insurance companies. Unlike mutuelles, commercial insurance companies are not explicitly social in scope. They are regulated by the "Code des assurances," under which private insurance is a commercial activity. Therefore, they can use a large set of characteristics (including health status) to rate premiums. Unlike mutuelles, commercial insurance companies are allowed to cover other non-life risks (e.g. auto, housing, etc.). In 2006, health insurance represented barely 5% of their turnover (FFSA 2006). On the health insurance market, the activity of commercial insurance companies is mainly related to individual contracts (60% of their turnover), but group contracts are not negligible (40% of their turnover). Commercial insurers entered the health insurance market in the early 1980s when the other branches of the non-life insurance market were considered saturated.

Provident institutions

Provident institutions are the third family, which is also the smallest one. They have a not-for-profit aim and are specialized in providing mandatory group contracts for companies (nearly 80% of their turnover). They are regulated by the "Code de la Sécurité sociale" and the "Code des assurances" for their offer of individual contracts. Provident institutions were created at the end of World War II to manage the supplementary retiree pensions of executives. They progressively enlarged their activities to cover "heavy risk" and finally to provide complementary health insurance. In 1993, the law imposed a separation of insurance type of activities. Since then, the same provident institution cannot manage retiree pensions and "heavy risk" or health insurance. In 2006, 44% of the provident institutions' turnover came from their health insurance activity, and the remaining part

came from the “heavy risk” provident benefits coverage. From 1992 to 2006, the share of provident institutions in PHI healthcare funding significantly increased (from 29% to 22%). This reflects the successful spreading of employer-based group contracts.

Evolution of the market

In the 1980s, practices on the individual contract market were strongly modified with the entrance of commercial insurance companies (Mauroy 1996). Before, mutual insurance companies were the only type of insurers on the health insurance market. In line with their principles of solidarity and equality between clients, each insurer offered a unique level of coverage and flat premiums (i.e. independent of age and health status). Nevertheless, this policy subjected “mutuelles” to adverse selection when commercial insurance companies entered the market, offering several levels of coverage and employing risk-rating strategies.

Facing the risk of a death spiral, mutuelles progressively relaxed their principles and adopted more commercial-oriented strategies. First, an increasing number of them used risk-rating strategies. In 2001, this led them to clarify their rating practices in the “Code de la Mutualité.” Premiums can only vary with the following factors: income, the time span since the initial subscription of a contract, the insuree’s SHI funds, the location, the number of beneficiaries and their age. Thus, the use of age as a rating variable was ratified, but the use of health status remained prohibited. In 2005, community rating based on age was used in two-thirds of mutual insurance contracts (Arnould et al 2007) as compared to nearly 100% for commercial insurance contracts. Mutuelles also diversified their offerings by providing tailored contracts, which enable people to adapt their level of coverage to their healthcare consumption. The “Code de la mutualité” imposed that their benefits be in line with the “responsible contract” requirements. Nowadays, more and more mutuelles offer this type of contract. The fact that the position of mutuelles on the health insurance market has remained quite stable since the early 1990s indicates that they have, at least partially, achieved their transformation (Couffinhal, Franc 2008).

Table FR3 Weights of families of insurers on PHI market

	Mutuelles	**Provident institutions**	**Commercial insurance companies**
Number	848	45	98
% of total number	85.6%	4.5%	9.9%
% of PHI turnover	58.8%	16.8%	24.4%
% of PHI health care funding	56.7%	18.6%	24.7%
% of health insurance contract	59.7%	13.8%	26.6%
% of privately insured	59.2%	15.1%	27.4%

Sources: Fonds-CMU (turnover), DREES-Comptes de la santé (healthcare funding), Enquête santé protection sociale 2006 (% de contrats of privately insured).

Note: the sum of percentages of privately insured exceed 100% as one person may be covered by several contract provided by different families of insurers

Specificities of coverage by categories of insurers

There are specific populations covered by each type of insurer. In spite of their evolution toward more commercial practices, mutuelles still have a higher proportion of elderly people; for people over 64 years of age represent 14.8% of their clientele versus 10.9% for commercial insurance companies and 12.8% for provident institutions. Nevertheless, this difference may be explained by a cohort effect (Couffinhal, Franc 2008), as mutuelles were the only family of insurer operating on the health insurance market before the 1980s. So, despite the fact that people may switch insurers, individuals who subscribed to a contract before this time have a higher likelihood of being covered by a mutuelle.

The difference in age profiles may explain why a higher proportion of people declare a poor health status among mutuelle insurees. 19.3% report a "fair," "bad" or "very bad" general health status versus 16.1% of commercial insurance subscribers and 17.5% of provident institution enrollees.

Sharp contrasts can also be observed according to the profession of the family head. Members of farmer households are highly over-represented among commercial insurance companies, in part due to the presence of insurers like Groupama, a big insurer that is specialized in covering farmers[173]. Provident institutions are characterized by a higher proportion of executive households. As a matter of fact, this type of insurer is specialized in providing group contracts that are more frequently offered to executives than to other categories of employees (Francesconi et al 2006). Skilled workers are also significantly over-represented.

[173] As a matter of fact, Groupama is allowed to manage farmers Social health insurance (collecting premiums and distributing benefits) for

Table FR4 Complementary VHI coverage by social category, by age and reported health status (% of persons covered), 2006

	Mutual insurance companies	Provident institutions	Commercial insurance companies
Social category			
Farmers	3.7%	0.6%	10.2%
Commercial craftsmen	7.2%	8.4%	11.5%
Managerial, academic, professional	18.8%	22.5%	18.9%
Intermediate categories (teachers, administrative)	25.2%	20.3%	19.7%
Office employees, etc.	9.6%	3.5%	5.4%
Commerce employees	2.6%	2.2%	2.8%
– Skilled workers	26.0%	34.0%	24.5%
– Unskilled workers	7.0%	8.6%	7.1%
Total	100%	100%	100%
Age			
Below 16 year	18.2%	21.2%	22.7%
16 to 39 year	29.9%	28.8%	31.9%
40 to 64 year	37.1%	37.2%	34.6%
65 year and over	14.8%	12.8%	10.9%
Total	100%	100%	100%
Health Status			
Very good	29.8%	32.3%	32.6%
Good	50.8%	50.2%	51.4%
Fair	16.1%	15.1%	14.4%
Bad	2.7%	1.8%	1.4%
Very bad	0.5%	0.6%	0.3%
Total	100%	100%	100%
Chronic Health Problems or chronic disease	22.4%	20.1%	19.2%

Source : IRDES, ESPS 2006, proportions were calculated using data from Irdes report (Allonier et al 2008)

Regulation

The body responsible for regulation varies by category of insurer. The watchdog for the mutual insurances companies and the provident institutions is the Department of Social Security (Direction de la Sécurité Sociale) in the French Ministry of Health. For the commercial insurers, it is the French Ministry of Economics and Finance. Since 2003, these three types of operators have been under the control of the same authority, the ACAM (Autorité de contrôle assurance et des mutuelles). The mission of ACAM is to review the finances, management and business practices of organizations in order to verify that these elements are in line with regulation (in particular, prudential exigencies) and the interest of policyholders (i.e. to ensure that organizations will be able to provide the benefits that they promised to their policyholders).

Changes due to EU legislation
European legislation contributed to a homogenization of the rules that govern each type of provider, introducing more transparency and more equality toward competition. This homogenization was of three orders:

- *Standardization of tax treatment between the types of insurers:*

Previously, mutuelles and provident institutions were benefiting from preferential tax treatment because they were considered to be acting more in line with the concept of solidarity than commercial insurance companies, and it was thought that they were impacting public health policy through health care centers and prevention actions. In detail, mutuelles and provident institutions benefited from:

  - An exemption from the tax on convention agreement (7% of the premium);
  - An exemption from the corporate tax;
  - A preferential rate for the business tax.

In 1993, commercial insurance companies argued to the European Commission that these advantages induced a distortion in competition in violation of the EC Treaty. As a result, “contrats solidaires,” which benefit from an exemption to the tax on insurance agreements regardless of the type of provider (for no adjustment of premiums according to an individual’s characteristics or health status, in particular foregoing a health questionnaire and experience rating), were created in 2002. Thus, the tax was not based on the type of companies anymore but on the type of products. In 2006, the exemption of corporate tax and the business tax, which were benefited to “mutuelles” and provident institutions, were removed.

- *Harmonization of the financial rules related to health insurance management (e.g. provisions, composition of assets portfolio, solvency ratio, etc.) and harmonization of the control of these rules as per Directive 92/49/EEC*

These rules where integrated into the new “Code de la mutualité” in 2001. Before this time, mutuelles were submitted to much less strict norms, in particular concerning provisions and the solvency ratio. The raising of these norms led some mutuelles to merge and others to disappear, which partially explains the concentration observed among this type of insurer.

As a consequence of this harmonization, financial and management control of “mutuelles,” provident institutions and commercial insurance companies have been placed since 2003 under the supervision of a single authority, the ACAM.

- *Specialisation of all types of providers toward non-life insurance activities*

Article 8 of Directive 73/239/EEC leads to a separation of health insurance activity from other types of activity:

  - In 1993, provident institutions were asked to separate their activities that concern the mandatory complementary retirement pensions from their activities that concern health insurance and other provident benefits.
  - In 2001, the new “Code de la mutualité” introduced the principle of separation between insurance activity and the management of health centres.

All of these evolutions increased competition and contributed to the elimination (at least partially) of the specificities of each type of provider.

Market performance

Despite the fact that French SHI can be considered almost universal and generous in coverage, a share of the cost of reimbursed care is not publicly insured. Therefore, PHI, which is mainly of a complementary type, increases the financial protection of the French population.

In doing so, it also greatly increases equity of access, in particular for categories of care that are well covered through the rules of responsible contracts. Cost-sharing for GP and specialist visits (excluding extra-billing and important drugs) after PHI coverage is low for the 92% of the population with complementary coverage. This explains the government's efforts in developing access to PHI contracts for the poor (i.e. CMU-C and voucher schemes). An evaluation of the impact of public complementary insurance showing an increase in access to care in people with CMU-C confirms this (Grignon, Perronnin 2003). However, this enhancement of equity of access is almost limited to the categories of care named above.

The coverage of other services, in particular medical devices, and extra-billing varies a lot across contracts and PHI firms. For instance, SHI pays one-third of the overall medical device expenditures, PHI finances another one-third and the remaining one-third is paid by households. For spectacles and dental prostheses, overall household expenditure accounts for 44% and 40%, respectively (HCCAM 2008) and the patient out-of-pocket amount is, depending on the type of PHI and contract, between €32 to €336 and €212 to €527(Arnould, Rattier 2008) (see Table 3).

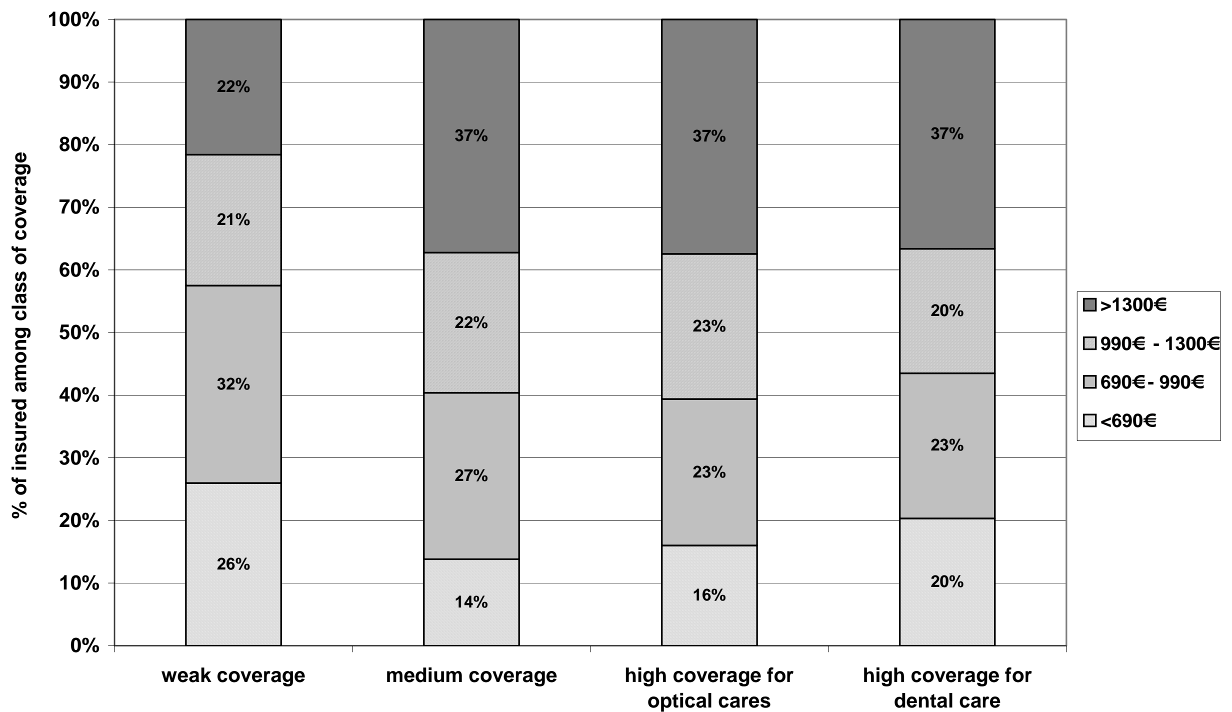
Table FR5 Median out-of-pocket expenditure by type of insurers and category of contracts 2006

	Mutual insurance companies		Provident institutions		Commercial insurance companies	
	Individual contracts	Group contracts	Individual contracts	Group contracts	Individual contracts	Group contracts
Basic spectacles Reference price: €200	€ 84.22	€ 32.16	€ 72.58	€ 21.94	€ 52.58	€ 0
Complex spectacles Reference price: €500	€ 266.42	€ 274.67	€ 349.67	€ 216.67	€ 336.42	€ 255.67
Digital Hearing helps Reference price: €3000 for 2	€ 1 990.59	€ 2 001.45	€ 2 001.45	€ 1 592.09	€ 2 480.76	€ 1 542.12
Dental prosthesis Reference price: €750	€ 444.75	€ 444.75	€ 481.25	€ 427.50	€ 527.50	€ 212.50

Source: DREES, survey among complementary health insurance providers, published in Etude et resultats n°635 (May 2008)

Moreover, wealthier people are more frequently covered and buy contracts with higher premiums. Premiums increase by 20%, when income increases by 130% (Kambia-Chopin et al 2008). This can be indirectly associated with broader coverage, as was stated in ESPS surveys in 2000 and 2002, which showed that people with higher incomes are better covered for spectacles and dental care (Couffinhal, Perronnin 2004).

Figure FR3 Quality of complementary VHI coverage according to income level



Source: IRDES, ESPS (2000-2002)

The reform trend of increasing user charges and thus PHI participation in financing the system decreases equity of finance. Indeed, SHI contributions are related to income while, with the exception of 30% of group contracts and individual contracts offered by mutual insurance companies for civil servants, PHI premiums are not. Thus, richer people participate less (as a proportion of their income) in the financing of health care than the poor. Moreover, SHI premiums are not related to age and risks, whereas PHI premiums are.

In order to preserve the solidarity principle, several incentives are in place to prevent risk selection: financial rebates for contracts that do not adjust premiums based on health status (i.e. contrat solidaire, group contracts) and a legal process to limit conditions where people can opt out of group contracts. Moreover, some of the qualifying criteria for responsible contracts favour better coverage for fragile populations.

Following from this, there is growing debate about the role of PHI in the sustainability of the current system based on social redistribution across age and wealth. Indeed, the recent

increase in user charges has led to an over 7% rise in premiums (HCCAM 2008). This is all the more a source of concern since premiums seem to have increased much more than benefits (between 2001 and 2006, PHI turnover increased by 48%, while benefits increased by 32% for a stable share of people covered) (Fonds-CMU 2007; Fenina 2006; Allonier 2008).

Moreover, a high level of competition would be needed to contain premium costs. However, the PHI market is not transparent: there are a large number of insurers and no standardized format to present contract benefits. Benefits are often presented in a way that is not clearly understandable by consumers, and people struggle to compare exactly what is covered and at what level across contracts (there is no official source of information).

To conclude, the PHI role in the healthcare system organization results from its historical role in the system and the shortage of money in public insurance. The cost of health care is shifted to PHI through the development of many measures aimed at increasing coverage for all the population. Negative effects on equity in finance lead to heavy control and incentives to reduce it, decreasing the range of possibilities for insurers to increase competition and then contain the cost of premiums.

A solution would be to genuinely separate the role of SHI and PHI. SHI would then almost fully cover a defined basket of important care, and PHI would cover other services, switching therefore to a complementary role on services (Witter 2008). However, this would affect the historical aim of the French SHI, which is to provide universal coverage for care to the whole population. The French population, which is very much attached to its SHI principle, is not ready for this change, as was shown in 2008 when the MoH suggested SHI stop covering spectacles in favour of leaving it to PHI and then did an about-face after significant media coverage.

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Germany

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Introduction

Health care in Germany is largely funded through two types of insurance: (1) social health insurance (GKV), which in 2007, covered about 88% of the population and was mandatory for about 74% of the population; and (2) substitutive private health insurance, which covers about 10.3% of the population. Until recently, there was a small number of individuals without health insurance; however, since January 2009 when health insurance became mandatory, they have joined either the statutory scheme or taken out private cover. There is also a market for complementary private health insurance that mainly reimburses health services not covered by GKV and/or co-payments. In 2006, about 18 million complementary private health insurance plans had been taken out.[174]

Health insurance is heavily regulated through legislation. Social Code Book V (SGB V) regulates all aspects of social health insurance, including, for example, criteria for eligibility and for 'opting out'—both of which indirectly also affect private health insurance. While the SGB V does not regulate private health insurance directly (perhaps with the exception of the recently introduced 'basic tariff'), changes in legislation aimed at reforming social health insurance often affect private health insurance (e.g. by lifting the threshold or changing the criteria for opting out).

In addition, private health insurance is regulated through a number of laws and ordinances applying to the insurance market in general (e.g. the insurance contract law) or to private health insurance specifically (e.g. the calculation of premiums). Financial oversight of the private health insurance companies is exercised by the Federal Supervisory Office for Financial Services (*Bundesanstalt für Finanzdienstleistungsaufsicht*, BaFin), an agency of the Ministry of Finance. Developments in the private health insurance sector are also closely observed by the Ministry of Health, despite the fact that the Ministry has little direct control over the market; for as interventions typically require changes in legislation that must be passed by parliament.

Private health insurance products are currently offered by 48 insurance companies. 28 of these are publicly-listed corporations, usually with a wider insurance portfolio. 20 are mutuals, which specialise in health care; nine of the listed corporations are subsidiaries of mutual organisations. Three insurance companies have a joint market share of 43%. There are two additional private funds for railway and postal workers, dating back to the time when both enterprises were (fully) state-owned and their employees were public servants. Additionally, there are a few small private insurers operating regionally and only in the complementary market (PKV 2007).

History

[174] Individuals may take out several complementary insurance contracts (e.g. for dental care, for improved accommodation in hospital); thus the proportion of people who have taken out complementary private health insurance cannot be exactly determined.

Universal health coverage is arguably a very recent phenomenon in Germany, as health insurance was only made compulsory in January 2009. Prior to this, the majority of the population (i.e. those with earnings below a threshold) was required to join a sickness fund, while those with higher incomes had the option of remaining uninsured if they did not want to take out private health insurance or become a voluntary member of a sickness fund.

Choice of public or private health insurance for high-income earners was introduced in 1970, when legislation to promote equity of access extended compulsory enrolment in the GKV to 'white-collar' workers with earnings below a specified threshold (Rosenberg 1986). Previously, the GKV had only covered 'blue-collar' (manual) workers. The same law also allowed white-collar workers with earnings above the threshold to enrol in the GKV on a voluntary basis, again for equity reasons. In 1989, choice of public or private cover was made available to all non-public sector workers with earnings above the threshold in order to eliminate an increasingly irrelevant distinction between blue- and white-collar workers. From 2009, anyone not enrolled in the GKV now must take up private health insurance or is entitled to re-join GKV, depending on his/her previous insurance status.[175]

Entitlement
Enrolment in the GKV is compulsory for non-public sector employees earning less than €48,150 a year (in 2008), some self-employed people (farmers, artists, journalists, etc), students, those receiving unemployment benefits, people with a disability (if they work in a recognised institution) and retired people who were member of a sickness fund prior to retirement. Employees who have earned above the threshold for three consecutive years and their dependants (about 20% of the population) currently have two options[176]: (1) they can remain in the GKV, or (2) they can opt for substitutive private health insurance, which exempts them from contributing to the GKV. About three-quarters of this group choose to remain in the GKV as voluntary members (Busse and Riesberg 2004). Legislation also specifies a range of other criteria for voluntary GKV membership. Eligible are, for example, individuals who were previously insured as dependents but who have now lost this status; persons who have opted out of GKV who wish to return; employees who were working abroad and require insurance after their return; and migrants of German ethnic origin from Eastern Europe (*Spätaussiedler*).

Self-employed people who are not eligible for GKV membership also purchase substitutive private health insurance. Civil servants can in theory join the GKV, but it is not financially attractive to them since they qualify for 'Beihilfe,' a system in which the public employer covers a significant share of their health care costs. Civil servants typically purchase private health insurance to complement this financial assistance. The level of 'Beihilfe' varies for federal and state civil servants, as states and the federal level each have developed different legislation in relation to civil servants in their jurisdiction. Several changes were made to the system of 'Beihilfe' during the 1990s, partly in response to financial pressures on public employers associated with the rising costs of health care and demographic ageing (Deutscher Bundestag 2005).

[175] For example, someone who was previously GKV insured as a dependent (e.g. a wife without a separate income) and who lost this status (e.g. through divorce) would be eligible to join a sickness fund.
[176] A third option – to abstain from buying any sort of health coverage – was abolished in 2009 with the introduction of universal coverage. In other words, from 2009 all residents must have either public or private health insurance.

Financing

Private health insurance premiums are based on an assessment of an individual's risk profile at the time of purchase and may therefore vary by age, sex and medical history. For employees, the cost of the premium is typically shared with the employer. The employer's contribution matches the employer's share in the statutory system that is calculated as a percentage of the employee's salary, up to a maximum of half the cost of the actual insurance premium (PKV 2009). Tax subsidies are available; but since they apply to all forms of insurance, they do not provide a significant financial incentive to purchase private health insurance. Dependants are not automatically covered and must pay separate premiums. Cover is for life and operates on a funded basis. Since 2001, insurers have been required to charge applicants an additional 10% of the cost of the premium to build up an 'ageing reserve' to cover the costs of health care when one gets older.

Insurers can reject applications and exclude pre-existing conditions from cover or charge a higher premium to cover pre-existing conditions. From 2009, however, they are required to accept any applicant (open enrolment) who is eligible for a 'basic' policy (previously known as a 'standard' policy) and cannot exclude cover of pre-existing conditions for this category of person. The basic tariff covers the same set of services as the GKV for a premium that varies based on age and sex only (not medical history) and is capped at the level of the maximum contribution paid by those who are voluntary GKV members (€533 in 2008) (BMF 2008). It is open to anyone from January to June 2009, after which it will only be open to people who already have private cover or people aged 55 and over who are excluded from the GKV and eligible for private cover but cannot afford a regular private premium.

Some insurers offer group-purchased contracts, which can be purchased through employers. Group contracts may offer financial and other advantages, such as lower premiums and waiver of risk assessments and waiting times (DKV 2008).

Benefits

Substitutive contracts typically cover the same range of benefits as the GKV. Some specific services may be excluded though, such as treatment in a health resort, and others may be added. From 2009, substitutive contracts must cover both outpatient and non-long-term inpatient care.[177] Insurers usually impose a waiting period of three months before benefits apply (or eight months for childbirth, psychotherapy and dental care), but this may be waived if a new customer was previously covered by the GKV (DKV 2008).[178] Benefits are mainly provided in cash i.e. the individual pays for treatment first and is subsequently reimbursed by the insurer. Substitutive contracts may involve cost sharing. For example, co-insurance is common in dental care, where patients pay a proportion of the total costs. Insurers also impose deductibles (excesses). The deductible amount is capped at €5,000 per year though (PKV 2009).

The private health insurance market offers a wide range of complementary insurance plans--covering additional services fully or partially excluded from GKV reimbursement, such as spectacles, hearing aids, some health checks and diagnostic services, co-payments

[177] Separate arrangements apply to long-term care cover, which is universally compulsory and provided by public insurers for GKV members and by private insures for those with private health coverage.

[178] Waiting periods do not apply for newborns and adopted children if one parent is already privately insured, in case of accidents and for spouses if the other spouse is already privately insured.

for dental services and pharmaceuticals as well as service ‘top ups’ in hospital including accommodation in single or two-bed wards and treatment by the chief consultant. Despite the enormous variety of plans available, these mostly cover combinations of the same services.

Choice

Substitutive policies offer people a wide range of options regarding level of cost sharing and choice of provider. A number of web-based initiatives, some of them commercial, exist to compare private health insurance premiums and products. However, the multitude of options available can make it hard for consumers to compare products in terms of value for money. The ‘model policy conditions’ developed by the private insurers’ association (PKV) stipulate that subscribers should be offered free choice of any physician and hospital in the country (as does social health insurance). Recently, however, some insurers have begun to establish ‘preferred provider networks’–for example, for dental care–which offer restricted choice in return for a reduction in or exemption from cost sharing. While there are currently only a few of these networks, they may become more relevant in the future as a strategy to control costs.

Substitutive subscribers are in theory free to change from one insurer to another at any time. In practice, changing insurers may not be financially feasible for everyone since new subscribers will undergo a new risk assessment, and the new premium will be based on their current age. Until recently, savings towards an ‘ageing reserve’ were not portable, which meant that joining a new insurer involved building up a new reserve.
This effectively prevented many people from changing insurers and meant there was little movement within the substitutive market. Instead, private insurers focused on competing for new entrants to the market–that is, on attracting those who were voluntary GKV members. However, existing subscribers have until the end of June 2009 to transfer their ageing reserve to a new insurer; meanwhile all new subscribers, subscribers aged 55 and over and basic tariff subscribers will have fully portable ageing reserves.

Relations with providers

Private insurers are largely bound by collective agreements on provider payment formed by the associations of sickness funds and provider associations, although they can agree to prices with providers that only treat privately insured patients. Vertical integration with providers is rare and not permitted in some cases–for example, insurers cannot own policlinics.

In general, private insurers have little leverage over providers, many of whom are allowed to charge higher fees for privately-insured patients. Additionally, private insurers’ incentives to control costs are constrained by their need to attract subscribers, as one of their unique selling points is the generosity of their cover (compared to GKV).

Insurance companies only form contractual relationships with clients/patients, not with doctors, hospitals or other providers. While insurers routinely check all medical bills submitted by patients, these procedures mainly aim to uncover exaggerated accounts of delivered services or services not covered by the patient’s plan (such as those associated with a pre-existing condition). In practice, insurers have little control over providers’ billing practice or the quality of the services they deliver.

Public policy

Strict regulations apply to the substitutive market, and these have become more stringent over time, particularly in the last 15 years. Some of the key regulations in place are set out in Tables 2.1 and 2.2. Developments in public policy towards substitutive private health insurance have had been motivated by two key concerns: first, to prevent those who opt for private cover from falling back on the GKV when they get older and/or are in poor health; and second, to ensure that those who rely on private cover have sufficient and affordable access to health care. More recently, the regulatory framework has been amended to enhance choice and competition within the substitutive market by making it easier for subscribers to change from one private insurer to another.

A major reform took place in 2007 with some of the key changes becoming effective only in 2009. The 2007 Reform Act (GKV-WSG) followed a period of intense public debate about the role of substitutive cover in the German health system and about the future sustainability of health insurance more broadly. One of the problems addressed in the reform was the growing number of people without any health insurance--either because they had opted out of the GKV and were no longer eligible to return to it or because they had previously been covered by the GKV as a dependant, had lost this status (perhaps due to divorce) and could not then afford to buy substitutive cover. From 2009, anyone who has lost health cover is permitted to return to his/her previous source of cover (whether the GKV or a private insurer). The Act also makes it harder for people to leave the GKV (by restricting eligibility for substitutive cover for those with earnings above the threshold for three consecutive years instead of one and by lifting the income threshold); requires private insurers to offer open enrolment and capped premiums to select groups of people; and facilitates choice of private insurer (by making ageing reserves fully portable), as noted above.

Risk segmentation

Risk segmentation in the German health system is caused by two main factors: (1) the rules governing eligibility for substitutive private health insurance and (2) a regulatory framework that gives private insurers incentives to attract certain types of people. For example, private insurers can reject applications for cover, risk rate premiums, exclude cover of pre-existing conditions, charge extra for dependants and offer discounted premiums in exchange for high deductibles. As a result, the substitutive market enjoys a high concentration of 'low risks', while the GKV covers a disproportionate number of 'high risks'–notably women and children, older people and individuals with larger families. On average, those with substitutive cover are younger, healthier, have higher earnings and use fewer health services than GKV members. For example, people aged 65 and over account for only 11% of the privately insured, compared to 22% of GKV members (Schneider 2003). Table 3 highlights differences in health status and health care use. In addition, the average earnings of the privately insured are about 60% higher than those of contributing GKV members (€38,109 compared to €22,658) (Leinert 2006a), and this income differential is reflected in data on those who report difficulties in paying for outpatient prescription drugs: 26% of GKV members versus 7% of the privately insured (Mielck and Helmert 2006)[179].

[179] Statistically significant after controlling for differences in age, gender and income.

Table DE1 Comparison of health status and health care use among publicly insured and privately insured people in Germany, 2006

	Mandatorily GKV insured	Voluntarily GKV insured	Mandatorily privately insured	Voluntarily privately insured
Been ill during the last three months	46%	42%	47%	28%
Chronically ill	47%	33%	45%	23%
Regularly take medication	50%	35%	54%	21%
Number of visits to a doctor in a year	6.6	4.4	6.2	3.2

Source: Leinert (2006b)

NB: Voluntarily insured (public and private) are employees with earnings above the threshold or self-employed. Mandatorily publicly insured are largely employees with earning below the threshold and their dependents. Public servants and pensioners (who had taken out private insurance during their employment) constitute the mandatorily privately insured group.

The problem of risk segmentation became acute soon after the 1989 law extended choice of public or private health insurance to all higher earners. During the early 1990s, private premiums rose sharply for older people with substitutive private health insurance, partly due to mismanagement and partly due to exploitation of loopholes in the regulatory framework. Private insurers had based premium calculations on average life expectancy, failing to account for the longer life expectancy enjoyed by substitutive subscribers who tend to come from higher socio-economic groups. This 'unexpected' discrepancy between premiums and benefit costs allowed them to raise premiums. Some private insurers also barred new subscribers from joining existing risk pools, which meant that existing subscribers were unable to benefit from lower premiums arising from the entry of younger people (Riemer-Hommel et al 2003). The GKV subsequently faced an influx of older people who had previously chosen private cover, but could no longer afford the premiums (Wasem 1995).

Risk segmentation has had serious financial consequences for the GKV, contributing (with other factors) to its deficits and prompting steady rises in contribution rates. This in turn has created even stronger incentives for younger people to opt for substitutive cover (Busse and Riesberg 2004; Busse and Wörz 2004). Using panel survey data for 2000 to 2004, researchers have calculated that the GKV loses about €750 million a year as a result of people changing from GKV to private cover or from private to GKV cover (Albrecht et al 2007). The same study showed that more than half of those leaving the GKV were low risks in terms of age, family status and income, while most of those joining the GKV were high risks.

Equity

Critics of Germany's dual insurance system argue that substitutive private health insurance undermines equity in the health system as a whole; for high income earners, especially when they are young and healthy, are allowed to take out private health insurance at a premium lower than their contribution to GKV if they would remain voluntarily insured. In contrast, the association of private insurers (PKV) claims that the privately insured indirectly subsidise the costs of outpatient care for GKV members because outpatient doctors can and do charge higher fees to private patients (Niehaus and Weber 2005). However, it is not clear whether these additional funds are used by providers to benefit GKV members, and there is evidence to suggest that provider incentives to prioritise private patients over GKV members undermines equity of access to health care,

particularly where outpatient specialist care is concerned. It also contributes to cost inflation in the health sector (Busse and Riesberg 2004).

Substitutive private health insurance largely covers the same health services as GKV with a few additional services that are excluded from GKV. The additional services typically refer to interventions where there is insufficient evidence of their effectiveness (e.g. alternative treatment, additional diagnostic procedures).

A 2007 study found no significant difference in waiting times for appointments with general practitioners among GKV members and the privately insured, although the former spent slightly longer in the waiting room than the latter (32 vs 21 minutes) (Schellhorn 2007). However, waiting times for an outpatient specialist appointment differed by several days, with GKV members waiting 10.5 days compared to only 4.5 days for the privately insured. The study found no differences in patient outcomes or satisfaction (Schellhorn 2007). A separate study found differences in waiting times, as well as higher levels of satisfaction among the privately insured (Mielck and Helmert 2006). Further research also shows significant differences in waiting times for outpatient specialist appointments in five specialties, with GKV members waiting about three times longer for an appointment than the privately insured patients (Lüngen et al 2008). Differences in waiting time between the two groups of patients ranged from 24.8 working days for a gastroscopy to 17.6 working days for an allergy test (including pulmonary function test) and 4.6 days for a hearing test (Lüngen et al 2008). Finally, two studies show that the privately insured have faster access to patented and innovative drugs than GKV members (Krobot et al 2004; Ziegenhagen et al 2004).

In the last 15 years, the German government has taken a number of steps to address the problem of risk segmentation that had led to financial imbalance for the GKV. These steps have involved making it more difficult for people to leave the GKV by raising the income threshold above which individuals are allowed to opt out by a higher than usual amount (11% in 2003) and by requiring people to earn above the threshold for three consecutive years before they can opt out (since 2009). It is estimated that the latter reform has lowered the financial loss to the GKV by 15-20% a year (Albrecht et al 2007). The government has also introduced tighter rules about when it is possible to return to the GKV for those who have previously opted out. For example, in 1995 people aged 65 and over lost the right to return to the GKV even if their earnings fell below the income threshold, and in 2000 the age limit was lowered to people aged 55 and over. Although these changes have stemmed the flow of older people back to the GKV and prevented them from benefiting from cover to which they did not previously contribute, they have not fully tackled the problem of risk segmentation. High risks and those who are risk averse are now much less likely to leave the GKV, to the advantage of private insurers, who have been swift to highlight the fact that private cover is the best value for the young, single and healthy (PKV 2002).

Access and financial protection

Reforms to address risk segmentation have created a separate set of issues concerning access to substitutive cover–not just for those who no longer have the option of returning to the GKV, but also for those who find it hard to pay private premiums, perhaps because they are older or in poor health, and for those who cannot obtain cover of pre-existing conditions. During the 1990s, substitutive premiums rose sharply for many older people, in part due to miscalculation by insurers. To prevent this from happening again, the government (since 2001) requires insurers to charge new subscribers an additional 10% of

the premium (2% a year for 5 years for existing subscribers) to build up sufficient ageing reserves (Bundesaufsichtsamt für das Versicherungswesen 2001). Based on survey data from 2005, research has estimated that about 350,000 people with substitutive cover (about 5% of all those with substitutive cover) pay premiums that are higher than the maximum GKV contribution (Grabka 2006).

The government also requires insurers to offer open enrolment, cover of pre-existing conditions and capped premiums for select groups of people–first through the 'standard' policy introduced in 2000 and now through the extended 'basic' policy introduced in 2009. Finally, the government requires insurers to inform subscribers of the irreversibility of the decision to opt out of the GKV, the likelihood of premiums rising with old age and the possibility of changing to a standard policy (Bundesaufsichtsamt für das Versicherungswesen 2001). In 2007, the government debated including private health insurers in the system of risk adjustment that currently only involves sickness funds in order to lower their incentives to select risks, but this option was politically not feasible.

Competition

The high costs involved in changing from one private insurer to another–mainly due to the non-transferability of ageing reserves, the risk rating of premiums and exclusion of pre-existing conditions–has meant that there has been almost no competition among insurers for those already part of the substitutive market. Instead, competitive efforts have focused on attracting new entrants. However, from 2009 ageing reserves must be portable, which the government hopes will improve competition and choice.

Since 2004, policymakers have also sought to increase competition between private insurers and GKV by allowing sickness funds to offer additional tariffs (Wahltarife) – a privilege previously only enjoyed by private insurers. Sickness funds are now allowed, and in some cases mandated, to offer their members deductibles, no claim refunds and additional coverage for services excluded from the GKV benefits package. These tariffs aim to make GKV more attractive to voluntary members who otherwise could be tempted to take out private insurance. This change was strongly opposed by private insurers (Schulze Ehring and Weber 2007).

Policy developments

Substitutive private health insurance has been a source of controversy in Germany since the 1990s. Public debate about its future intensified in 2003, following the publication of a report by the Rürup Commission.[180] The report discussed options for securing the financial sustainability of health care funding in the future, and it included a proposal to abolish substitutive private health insurance and introduce a universal system of 'citizens' insurance.' An alternative suggestion was to include PKV premiums into the national system of risk adjustment, which so far only involves sickness funds. Both proposals were supported by the majority of Social Democrats and the Green Party (then forming the federal government), but they did not obtain sufficient political support to pass both chambers of Parliament and were eventually abandoned.

Further sustained debate took place following the election of a new coalition government formed by the (conservative) Christian Democrats and the Social Democrats in September 2005. In turn, this led to an agreement on a number of reform proposals in February 2007.

[180] Kommission für die Nachhaltigkeit in der Finanzierung der sozialen Sicherungssysteme.

While most changes--such as the introduction of cost-benefit analysis for pharmaceuticals, the creation of a 'health fund' to virtually pool resources across all sickness funds and the merger of GKV associations at the federal level–were directed at the GKV, the reform also had substantial implications for private health insurance. As mentioned above, health insurance, public or private, was made mandatory for all residents, and private insurers are now required to offer a basic tariff to eligible individuals.

Arguably, the outcome of the 2007 reform exemplifies two dynamics in contemporary German health policy. Although the existence of substitutive private health insurance was repeatedly discussed, there was no political majority that would have supported the abolition of the dual insurance system. Despite its problems (e.g. the increase in premiums and the lack of cost control) private health insurance still is the favoured model in large parts of the conservative and liberal (pro-private/pro-corporate) establishment. The dual insurance system [often dubbed '*Zweikassenmedizin*' (two-class medicine) by its critics] is also fiercely defended by the medical profession. Thus the political costs of change are high, creating a propensity to maintain the status quo.

However, policymakers have to strike a fine balance between responding to the challenges faced by GKV, which mainly but not exclusively revolve around cost containment, and the challenges facing private health insurance that are also associated with increasing costs and premiums. The challenge for policymakers is to address these issues within the dual insurance system by finding different solutions appropriate for each part of the system. As change introduced to either part of the system tends to affect the other one, this balance seems to become increasingly difficult to maintain.
The succession of recent reforms has led to increasingly stringent regulation of the substitutive market, which is not uncontested. The PKV opposed several aspects of the 2007 and earlier reforms, most notably the rules around the 'basic' tariff, the transferability of ageing reserves, restricting eligibility to those with earnings above the threshold for three consecutive years and allowing the sickness funds to offer additional cover. Several private insurers have submitted a joint appeal to the Federal Constitutional Court to review the 2007 Act on the grounds that it disadvantages private health insurance subscribers and infringes on the entrepreneurial freedom of insurers (PKV 2008). The court's decision is pending. There is also the possibility of legal challenges at the EU level.

Concerns about future viability were also voiced by a PKV working group in 2008 – 'Social Security 2020.' In an internal discussion paper (leaked to the press), the group proposed to consider the option to introduce compulsory health insurance, private or public, based on fixed premiums and independent from age and individual risk. The concern was that demographic ageing, in conjunction with regulation, could undermine the private insurers' ability to attract a sufficient number of young and healthy customers to be able to keep premiums stable. This proposal, which was mainly supported by larger (commercial) insurers, was fiercely opposed by other insurers (mostly mutual associations) (Fromme 2008).

More recent debates mainly revolve around issues related to the latest instalment of the 2007 reform, which became effective in January 2009. This included the introduction of the GKV 'health fund' and the implementation of the new reimbursement system for ambulatory physicians. Further reform, agreed to in February 2009, involved a change in hospital funding, with the federal government taking a larger role in funding investments and facility maintenance.

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Hungary

Imre Boncz

Market role and context

The current Hungarian health care system is a solidarity based, compulsory health insurance system with a single payer. After the political changes of 1990, responsibility for providing health care services was transferred to local governments . Only a few exceptions were made such as university clinics and national medical institutes, which represent the highest level of health care services (tertiary care). This decision has had a lasting effect on the Hungarian health system.

Responsibility for financing health care services was given to the National Health Insurance Fund Administration (NIHFA), the only health insurance fund in Hungary (Országos Egészségbiztosítási Pénztár) and performance-related financing was introduced. As a general rule, the NIHFA finances the running costs from its separate budget (Health Insurance Fund), whereas capital costs is the responsibility of the owner of the given health care institution, mainly local governments. The Health Insurance Fund consists of more than 15 sub-budgets for different types of services (primary care, out-patient care, acute and chronic in-patient care etc), capped with a national budget ceiling.

The principal methods of health care financing vary by type of health care service. General practitioners (GPs) are reimbursed by a combination of capitation fee (related to patients number), fixed fee (related to fixed cost, e.g. maintenance cost), supplementary fee (related to practice location), and duty fee (related to duty obligation) [Boncz et al 2004].

In Hungarian outpatient care, an activity based point payment system (called 'German fee-for-service point system') is used for financing. Acute inpatient care is financed through the implementation of a system similar to the American Diagnosis Related Groups (DRG): Homogén Betegségcsoportok, further referred to as HBCS. In 2004, in addition to the activity based fee-for-service payment system in out-patient care and to the DRG-type financing technique in acute hospital care, the so-called Performance Volume Limit (PVL) (Teljesítmény Volumen Korlát) was introduced forming an artificial financial cap for the activity based financing of the Hungarian hospitals. [Boncz et al 2008]

Market role

The Hungarian PHI market can be described as a combination of supplementary and complementary (services) insurance. Coverage includes:

- services excluded from the public system (e.g. Holistic medicine, recreation)
- statutory cost sharing (e.g. drug co-payment).

The Hungarian PHI market is a voluntary scheme. There are two major types of PHI in Hungary:

A) Egészségpénztárak (Voluntary Mutual Insurance Funds)
This type of PHI is similar to the mutual associations in France. These organizations are non-profit, self-governing bodies providing complementary health insurance, and they are not allowed to carry out other insurance activity. The larger part of contributions goes to individual accounts and can be used by the account holder only – effectively, a medical savings account-type scheme. They have been on the market since 1993 and traditionally provide the following services listed in Table HU1 and Table HU2.

Table HU1 Types of services provided by the Hungarian Voluntary Mutual Insurance Funds (2005 and 2006)

	Description	2005	2006
1.	Health care services	2.761,65	4.867,12
2.	Home care	5,02	5,94
3.	Homeopathic services	45,76	69,77
4.	Therapeutic exercise, massage and physiotherapy	57,60	80,46
5.	Balneotherapy, walk-in hospitals for persons with impaired mobility, spa-hospitals, sanatoria, rehabilitation centres and climatic health care centres, curative drinking halls and therapeutic caves	60,89	95,29
6.	Recreational holiday, rehabilitation and therapeutic holiday services	1.453,10	1.532,19
7.	Medical treatment provided by therapeutic sections of public baths	7,29	9,43
8.	Expenditures directly related to sport activities (e.g. passes entitling participation in exercises held in sports facilities, tracks, courses, swimming pools, gym halls, etc.)	637,33	804,53
9.	Subsidized purchase of sports equipment for active exercise	2.624,51	3.150,06
10.	Subsidy of books and magazines printed in Braille	0,03	0,01
11.	Subsidy for special equipment facilitating the normal way of life of persons with impaired mobility or in weak health condition and for equipment for the adaptation of their living environment to their special needs	0,26	1,67
12.	Subsidy for keeping guide dogs for the blind	0,05	0,18
13.	Cures offered by health-care provider or homeopaths for 1. addiction related treatment 2. detoxification 3. liquid diet 4. preventive cure	5,75	5,58
14.	Subsidy for pharmaceuticals	7.002,84	11.296,36
15.	Subsidy for medical aids	4.468,71	5.042,82
16.	Supplementing part or whole of income lost due to illness-related inability to work, on a case-by-case basis	362,62	263,81
17.	Supplementing part or whole of income lost due to illness-related inability to work, on a regular basis (allowance type)	0,01	22,39
18.	Case-by-case aid granted to survivors of a fund-member or of the fund-member's close relative	55,74	72,75
19.	Regular (allowance type) aid granted to survivors of the fund member or of the fund member's close relative	3,23	0
	Total	19.552,38	27.320,37

Source: Hungarian Financial Supervisory Authority, 2007

Due to the fact that the Hungarian Financial Supervisory Authority changed its statistical data collection and reporting system, we can provide data for 2007 and 2008 on a different manner:

Table HU2 Types of services provided by the Hungarian Voluntary Mutual Insurance Funds (2007 and 2008)

	Description	2007	2008
1.	**Auxiliary health insurance services**	17.678,68	38.510,36
1.1.	Social security supplementary health services benefit	2.699,02	6.085,64
1.2.	Home care support	0,98	3,06
1.3.	Therapeutic treatments and health services aeexercise, massage and physiotherapy	120,07	292,74
1.4.	Therapeutic treatments in public bath	36,13	92,28
1.5.	Sevices for the blind	0,02	0,20
1.5.1.	Subsidy for the purchase of special books for the blind	0,01	0,03
1.5.2	Subsidy for the keeping costs of guide dogs for the blind	0,01	0,17
1.6.	Aid for persons with changed health status for buying special tools and for adapting their home environment to their needs	0,00	0,77
1.7.	Support in connection with the costs of sport activities	430,01	1.218,56
1.8.	Treatment for quitting pathological addictions	3,89	2,70
1.9.	Mutual aid services provided by health funds	13.966,14	30.132,17
1.9.1.	Support for the purchase of medicines within supplementary mutual aid services	9.381,20	19.879,36
1.9.2.	Support for the purchase of medical aids within mutual aid services	4.316,75	9.789,47
1.9.3.	Supplementing part or whole of income lost due illness-related inability to work	171,71	329,14
1.9.4.	Granting aid to survivors in case of death of a fund member	12,86	10,44
1.9.5.	Visit fee	76,80	107,14
1.9.6.	Hospitalization fee	6,83	16,62
1.10	Therapeutic holiday, curative holiday	422,43	682,25
2.	**Health fund services for the improvement of quality of life**	1.022,63	1.241,66
2.1.	Alternative medical services	11,03	9,38
2.2.	Recreational holiday	61,02	60,11
2.3.	Support for purchasing sports equipment	662,35	1.060,96
2.4.	Cures facilitating the improvement of quality of life	11,63	12,45
2.5.	Subsidy for the purchase price of pharmaceuticals within the mutual aid services aimed at improving quality of life	86,62	79,71
2.6.	Subsidy for the purchase price of medical aids within the mutual aid services aimed at improving quality of life	189,97	19,06
	Total	**18.701,31**	**39.752,02**

Source: Hungarian Financial Supervisory Authority, 2009

B) Betegségbiztosítás (sickness insurance)

This type of PHI is provided by large, for-profit, multi-national insurance companies as a part of their non-life insurance branch. Private for-profit health insurance is even more limited. Some companies offer insurance at the upper end of the market, but these are mainly income replacement cash-benefit policies for certain illnesses and not real indemnification insurance. There are new attempts to extend the private health insurance market by offering in-kind benefits in the form of above-standard hotel services, but the outcome of these projects is not yet known.

Although between 2006-2008. the Hungarian government wanted to introduce private companies in the field of statutory health insurance (Dutch 2006 or Slovakian 2004 model), and the Hungarian parliament accepted a new law regulating this huge change, this

model failed in Hungary before its practical introduction in March 2008. Later (May 2008) the Hungarian government withdrew this [Magyar Közlöny 2008].

Population coverage

Both employers and employees are eligible to purchase PHI. For more than a decade following the legal implementation of "Egészségpénztár" PHI in Hungary in 1993, most of PHI was purchased by employers on behalf of their employees. In the last couple of years there has been some increase in direct activities of employees / citizens.
"Betegségbiztosítás" usually purchased by individuals. The volume of this type of PHI much smaller than "Egészségpénztár".

In Hungary only a very small proportion of the total population buys PHI. Compared to the current population of Hungary (≈ 10 million) approximately 624,240 people (6.2 % of the Hungarian population) were covered by Voluntary Mutual Insurance Funds, while 215,676 people (2.2 % of the Hungarian population) had sickness insurance. However, we should emphasize that the number of members has shown a significant increase over the past decade. (Table HU3 and HU4)

Table HU3 Membership of "Egészségpénztárak" (Voluntary Mutual Insurance Funds)

(Members, thousands)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
New entry	23,48	20,38	26,93	36,11	33,14	75,74	153,68	166,58	158,43	193,69	148,06
Died	0,03	0,05	0,05	0,11	0,12	0,18	0,24	0,58	0,91	0,99	0,92
Left	0,63	2,69	3,00	5,12	5,25	7,05	11,59	13,65	16,69	28,51	26,32
Total	**31,49**	**48,92**	**70,94**	**128,08**	**151,22**	**219,07**	**358,46**	**490,88**	**614,72**	**733,23**	**842,12**
From total: cancelled payment	0,14	0,05	0,67	1,67	4,24	3,46	3,81	6,43	8,79	11,14	23,28

Source: Hungarian Financial Supervisory Authority, 2009

Table HU4 Membership of "Betegségbiztosítás" (commercial sickness insurance)

(Number of contracts)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Sickness insurance	45.366	81.259	71.574	63.984	57.313	54.407	73.552	83.144	129.070	215.676

Source: Hungarian Financial Supervisory Authority, 2009

Table HU5 Current assets and number of members of "Egészségpénztárak" (Voluntary Mutual Insurance Funds)

	Name of fund	Assets (market value) HUF	Number of members
1.	OTP Országos Egészségpénztár	5.785.302.000	113.038
2.	AXA Önkéntes Egészségpénztár	4.070.795.000	87.594
3.	MKB Egészségpénztár	5.015.937.000	86.064
4.	Patika Önkéntes Kölcsönös Egészségpénztár	2.268.679.000	73.659
5.	K&H Medicina Egészségpénztár	3.235.321.000	64.169
6.	TEMPO Országos Önkéntes Kiegészítő Egészségpénztár	3.539.882.000	62.389
7.	Vasutas Önkéntes Kölcsönös Kiegészítő Egészségpénztár	2.858.172.000	34.411
8.	Generali Önkéntes Kölcsönös Egészségpénztár	1.572.562.000	32.443
9.	Honvéd Önkéntes Kölcsönös Kiegészítő Egészségpénztár	3.047.625.000	29.848
10.	Wellness Országos Önkéntes Egészségpénztár	462.963.000	22.072
11.	VITAMIN Egészségpénztár	2.104.226.000	19.027
12.	Postás Egészségpénztár	643.785.000	17.534
13.	Dimenzió Önkéntes Kölcsönös Egészségpénztár	2.679.246.000	16.319
14.	Erste-Harmónia Önkéntes Kölcsönös Egészségpénztár	925.991.000	16.169
15.	ADOSZT Adó-és Pénzügyi Ellenőrzési Dolgozók Önk. Kieg. Egészségpénztára	700.146.000	14.595
16.	Allianz Hungária Önkéntes Kölcsönös Egészségpénztár	477.357.000	10.554
17.	Test-Vér Magán Biztosító Egészségpénztár	170.225.000	8.044
18.	Aranykor Országos Önkéntes Egészségpénztár	280.538.000	5.021
19.	Pro Vita Első Magyar Kiegészítő Egészségpénztár	247.285.000	3.996
20.	Danubius Gyógyüdülők Országos Egészségpénztár	394.600.000	3.366
21.	Kardirex Önkéntes Kölcsönös Kiegészítő Egészségpénztár	143.270.000	3.031
22.	Egészségért Országos Önkéntes Egészségpénztár	51.311.000	2.114
23.	Budai Egészségpénztár	124.552.000	2.042
24.	Életerő Egészségpénztár	50.682.000	1.817
25.	Herendi Porcelánmanufaktúra Zrt. Egészségpénztára	64.667.000	1.076
26.	Fitt Országos Önkéntes Kiegészítő Egészségpénztár	8.136.000	683
27.	Balzsam Egészségpénztár	39.259.000	675
28.	Extra-Fit Önkéntes Kölcsönös Kiegészítő Egészségpénztár	17.933.000	438
29.	Servus Egészségpénztár	10.930.000	393
30.	Quaestor Országos Egészségpénztár	11.570.000	197
31.	Új Pillér Önkéntes Kölcsönös Kiegészítő Egészségpénztár	18.455.000	191
32.	Első Regionális Önkéntes Egészségpénztár	5.583.000	131
33.	Életút Egészségpénztár	5.272.000	107
34.	Vitalitás közalkalmazottak, köztisztviselők és szolgálati viszonyban állók Országos Önkéntes Ep.	4.353.000	51
35.	Pro Sanitate Egészségpénztár	1.003.000	27
36.	Tradíció Önkéntes Kölcsönös Kiegészítő Egészségpénztár	681.000	26
37.	OptiPlusz Egészségpénztár	221.000	17
38.	Long Life - Hosszú Élet Egészségpénztár	712.000	13

Source: Hungarian Financial Supervisory Authority, 2007

Health care expenditure

Expenditure and revenue of voluntary mutual insurance funds (Egészségpénztárak) and commercial sickness insurance (Betegségbiztosítás) are shown in the following table. Their share from the total Hungarian health insurance fund budget – measured by comparing revenues to revenues – significantly changed over the past decade by increasing from 0,54 % in 1998 to over 2,5 % in 2007.

Table HU6 Contribution of PHI to health care expenditure in Hungary (million Hungarian Forint)

HEALTH INSURANCE FUND	1998.	1999.	2000.	2001.	2002.	2003.	2004.	2005.	2006.	2007.
Revenues	561.500	653.500	734.100	884.700	1.024.600	1.025.400	1.100.140	1.204.475	1.567.346	1.676.000
Expenditures	632.200	701.200	797.700	915.000	1.111.200	1.335.400	1.443.800	1.579.734	1.678.617	1.648.600
Voluntary Mutual Insurance Funds	**1998.**	**1999.**	**2000.**	**2001.**	**2002.**	**2003.**	**2004.**	**2005.**	**2006.**	**2007.**
Membership fee paid by members	32	125	302	652	949	1.608	2.227	3.081	3.840	5.064
Contribution of employer	379	1.199	2.080	3.730	5.310	9.801	16.701	19.215	27.865	27.650
Membership fee TOTAL	411	1.324	2.383	4.382	6.259	11.409	18.927	22.296	31.705	32.714
Others fees paid by members	6	17	75	181	282	723	1.123	1.890	2.257	1.478
Other support	383	1.092	1.473	1.460	158	182	617	852	1.058	905
Revenues total	799	2.433	3.931	6.023	6.699	12.314	20.667	25.038	35.020	35.097
Expenditures for services	257	1.100	1.737	3.333	4.516	9.220	15.005	19.579	27.433	34.049
Expenditures for operation	118	321	591	1.047	1.378	1.876	2.615	3.427	4.056	4.453
Total expenditures	375	1.421	2.328	4.381	5.894	11.096	17.620	23.007	31.489	38.503
sickness insurance	**1998.**	**1999.**	**2000.**	**2001.**	**2002.**	**2003.**	**2004.**	**2005.**	**2006.**	**2007.**
Revenues	2.205	2.358	3.175	3.720	4.164	4.672	4.906	6.170	6.497	6.979
Expenditures for sickness	601	650	1.098	1.054	1.161	1.236	1.338	1.505	1.870	1.882
SHARE (Revenues/Revenues)	**1998.**	**1999.**	**2000.**	**2001.**	**2002.**	**2003.**	**2004.**	**2005.**	**2006.**	**2007.**
Voluntary Mutual Insurance Funds	0,14%	0,37%	0,54%	0,68%	0,65%	1,20%	1,88%	2,08%	2,23%	2,09%
sickness insurance	0,39%	0,36%	0,43%	0,42%	0,41%	0,46%	0,45%	0,51%	0,41%	0,42%
Together	0,54%	0,73%	0,97%	1,10%	1,06%	1,66%	2,32%	2,59%	2,65%	2,51%

Source: Hungarian Financial Supervisory Authority, PSZÁF and National Health Insurance Fund Administration, OEP

The Hungarian PHI market can be considered as a combination of supplementary and complementary (services) insurance. Although we can see a continuous development in the past years, its role within the whole health care system is still small.

Market overview

Types of insurers

A) Egészségpénztárak (Voluntary Mutual Insurance Funds)

This type of PHI is similar to the mutualities in France. These organizations are non-profit, self-governing bodies, and they are not allowed to carry out other insurance activity. They have been on the market since 1993. The number of these organizations were ca. 40-50 at the end of the year 2006.

B) Betegségbiztosítás (commercial sickness insurance)

This type of PHI is provided by large, for-profit, multi-national insurance companies as a part of their non-life insurance branch. There were 29 insurance company of the Hungarian market at the end of the year 2006, but we do not have information on how many of them offer sickness insurance (it is estimated 9-10 companies). There have not been significant changes over time.

Subscriber characteristics
People aged 25-60 and with higher than average income are most likely to subscribe to PHI. For many years, mainly the employers decided on the contract with voluntary mutual insurance funds and they paid most of the membership fee. It can be considered as a kind of benefit in kind or part of the employee's benefit package. We have statistical data for the members of voluntary mutual insurance funds (Table HU7).

Table HU7 Distribution of voluntary mutual insurance funds' members in Hungary

	Number	Ratio	Mean age
Male	372355	51,84 %	40,65
Female	345895	48,16 %	40,77
Total	718250	100 %	40,71

Source: Hungarian Financial Supervisory Authority, PSZÁF

Regulation
Act XCVI of 1993 on Voluntary Mutual Insurance Funds (promulgated: 06/12/1993) created the legal conditions for the establishment of private non-profit health insurance, which the government encourages through tax relief to contributors.
The Act of LX of 2003 on insurers and insurance activities regulates the "Betegségbiztosítás" (commercial sickness insurance) system.

Market performance

We should emphasize again, that voluntary health insurance funds have not been allowed so far to offer benefits covered by the statutory health insurance scheme administered by the National Health Insurance Fund Administration (Országos Egészségbiztosítási Pénztár, OEP), the only health care financing agency in Hungary. Therefore the Hungarian PHI system does not have any specific health financing policy goals in general. The existence of this system is strongly dependent on tax relief, which can be considered the most important, if not the only incentive towards the voluntary health insurance funds.

In some very rare specific cases the Hungarian government tried to make a direct connection between the voluntary health insurance funds and the statutory health insurance scheme. After the introduction of visit fee and hospital daily fee in February 2007, the government changed the regulation of voluntary health insurance funds and made it possibly to pay the visit fee and hospital daily fee from voluntary health insurance funds. After the withdrawal of visit fee in Hungary in April 2008, this role of voluntary health insurance funds was cancelled.

Another example was when specific services of dental care were excluded in 1996 from the statutory health insurance scheme, but they were included again in 2001. Meanwhile people covered by voluntary health insurance funds could have reimbursement for dental care services from voluntary health insurance funds.

Market development, public policy and impact on the wider health system
The most important factor in the development of voluntary mutual insurance funds was government encouragement through tax relief to contributors. This means that a certain percent (20 %) of your contributions (with an upper ceiling) to voluntary mutual insurance funds is deductible from personal income tax. In 2007 there was an important change in

the regulation of services provided by the voluntary mutual insurance funds. The new regulation divided the services into two groups:

- Auxiliary health insurance services (tax free)
- Health fund services for the improvement of quality of life (personal income tax should be paid)

From that time (01 June 2007) a part of services provided by voluntary mutual insurance funds became taxable. In Hungary for many years and still now, informal payments (under the table money, black money, gratitude money) could have been considered as the "real private health insurance". People still prefer to pay gratitude money one a year or once every five years directly to their physician, instead of paying a regular monthly contribution to voluntary mutual insurance funds. The only public policy intervention is the tax relief to contributors which has been in place without significant changes since the establishment of the system.

The most important boundary between PHI and statutory publicly-financed health care is that PHI funds and/or companies have not been allowed thus far to offer benefits covered by the statutory health insurance scheme. The existence of PHI system did not have a significant effect on the wider health system. Its most important approach and incentive is to provide tax relief to contributors. Most of PHI expenditure goes on reimbursement of drug prices which are not reimbursed or only partially reimbursed (co-payment) by the statutory health insurance scheme.

There is a (small) preferred provider network of PHI schemes in Hungary. In some cases it is an obligatory choice for the subscribers because e.g. they have an especially equipped hospital ward in a certain hospital. In other cases preferred providers are strongly recommended by insurers, but are not compulsory.

Since the social and political changes of 1990 in Eastern Europe, from time to time, there are political debates and plans on the role of PHI on the Hungarian health insurance market. The smaller political (liberal) party of the current (2002-2008) left-wing government proposed the introduction of a multi-insurance system in Hungary replacing the current National Health Insurance Fund Administration with competing for-profit insurance companies (PHI). After political and economic debate, the Hungarian parliament accepted a new act (17 December 2007) on the introduction and regulation of private, for-profit health insurance companies into the Hungarian health insurance market replacing the single health care financing agency. However, this Act has not been signed by the President of the Republic. The Parliament put this law again its agenda on February 2008, and accepted it again on the 11 February 2008. However, this law, after the failure of referendum on the visit fee (the majority of the Hungarian population voted against the visit fee therefore it had to be cancelled) was withdrawn by the parliament on the 26th May 2008.

No doubt, the Hungarian health insurance system needs real reform on both sides: providers and payers. In my opinion, the introduction of private, for-profit health insurance companies into the Hungarian health insurance market to replace the single health care financing agency is the wrong approach. First we should review the current role of the statutory health insurance scheme and single health care financing agency (National Health Insurance Fund Administration, Országos Egészségbiztosítási Pénztár, OEP). Following the assessment of the current basic benefit package one should define the specific areas

and services to be opened for PHI schemes in a complementary role. On the other hand it is also important to strengthen the purchasing role of the National Health Insurance Fund Administration turning it from a simple payer position into an active buyer of health services. In order to develop successful PHI in Hungary, one should eliminate the so called under the table money or black money from the system. This under the table money is a barrier to the further development of PHI in Hungary.

Assessment of market performance

Due to the fact that the Hungarian PHI market is not very developed, we have only very limited information and evidences on its function. Therefore I shall answer this question based on my own view.

Table HU8 Evaluation of the Hungarian PHI system

Goal	Within the market itself	Impact on the wider health system
Financial protection	No effect	No effect
Equity in finance	Adverse effect: rich people are more likely to have PHI in Hungary and therefore they can benefit from it (e.g. tax relief to contributors)	Adverse effect: people with PHI can use more advanced facilities (e.g. single bed hospital rooms)
Equity of access	Adverse effect: people with PHI can have more access to services which are not or only partially reimbursed by the statutory health insurance scheme	Increased access and/or utilization
Transparency and accountability	Positive effect: clear connection between premiums and services	Positive effect: may (or might) reduce the role of informal payments
Quality and efficiency	I did not find any evidence for affecting the quality of care I did not find any evidence for affecting the efficiency of care	Some elements of health care system can have advanced infrastructure. I did not find any evidence for affecting the efficiency of care
Administrative efficiency	The administrative costs of PHI are much higher (3-5 %) than the statutory health insurance scheme (1.5 %)	No effect.

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Ireland

Brian Turner

Background to the market

The private health insurance (PHI) market in Ireland, in its current form, was established with the passing of the Voluntary Health Insurance Act in 1957 (the 1957 Act). Prior to this, a number of small-scale attempts at PHI had been tried, but without much success (see O'Morain 2007 for further details).

The 1957 Act established the Voluntary Health Insurance Board (VHI), which now trades as Vhi Healthcare. The aim was to provide the option of voluntary health insurance for the top 15% of earners who, at that time, were not entitled to free access to the public hospital system. Since then, however, access entitlements have been extended, with entitlements granted for public hospital accommodation in 1979 and for the services of public hospital consultants in 1991.

Currently, all Irish residents are entitled to access to public hospitals and public hospital consultant treatment. For those who qualify for a medical card, such access is free of charge, while those without a medical card must pay nominal fees (currently €66 per night in a public hospital bed subject to a maximum annual charge of €660). Entitlement to a medical card is primarily based on financial circumstances; but since 2001, all those aged 70 or over are also entitled to a medical card, irrespective of income. The proportion of the population with a medical card currently stands at 29% (HSE 2008).

The role of the PHI market in Ireland has thus changed over time. Initially, it was envisaged that the system would play a substitutive role. However, enrolment was not limited to those ineligible for free hospital treatment. For some, PHI offered the option of better accommodation or choice of consultant, while also giving the option of treatment in private hospitals to many subscribers, irrespective of their entitlements to public hospital treatment. Therefore, PHI also played a supplementary role. Since entitlements to the public healthcare system were extended, PHI in Ireland no longer plays a substitutive role though. It now plays primarily a supplementary role, with elements of a complementary system also.

Hospital plans (which account for the vast majority of PHI in Ireland) provide access to semi-private or private rooms in public hospitals and access to private hospitals (on semi-private or private basis) depending on the level of cover. There is also a perception (backed up by some evidence, which will be discussed later) of shorter waiting periods for those with PHI. Most hospital plans provide limited cover for ancillary (non-hospital) services, such as visits to general practitioners, physiotherapists, etc., which must be paid for out-of-pocket for those without medical cards. However, in recent years, an increasing number of hospital plans with significant ancillary cover have been introduced. Some ancillary plans have also been introduced--some of which may be purchased on a stand-alone basis and others of which can be combined with hospital plans. The ancillary plans would primarily be complementary, while the hospital plans (the ones with limited ancillary cover) would

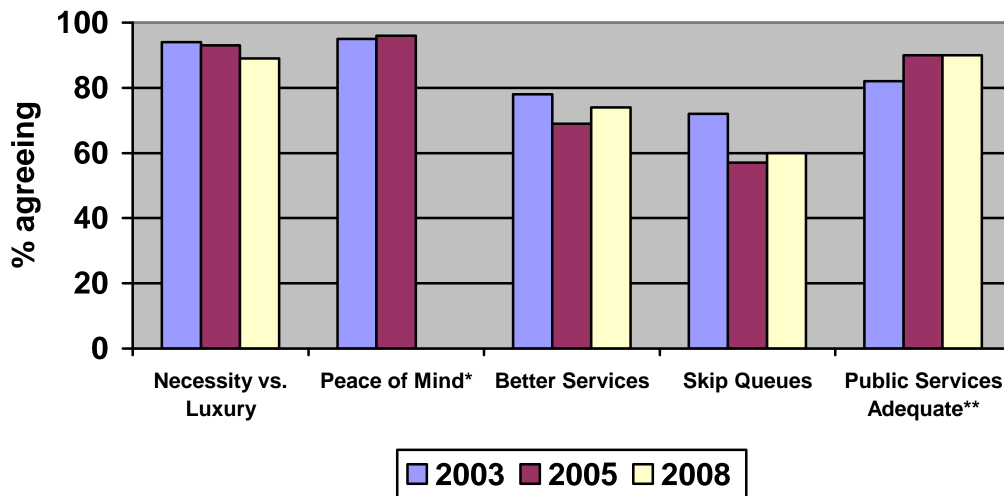
primarily be supplementary. The combined hospital and ancillary plans would be both complementary and supplementary.

Development of the market

The market has seen rapid growth since its inception in 1957. The proportion of the population covered by PHI has far exceeded the 15% originally intended and currently stands at over 50% (HIA 2007). The OECD (2004) found that Ireland, with an estimated take-up of PHI of almost 44% in 2000, and Australia, with almost 45% take-up in the same year, were the largest duplicate health insurance markets in the OECD. Duplicate insurance in this instance refers to the situation where private insurers operate in parallel to the public healthcare system.

Given the universal access entitlements to the public hospital system, it is interesting to examine the reasons for the high level of take-up of PHI in Ireland. The Health Insurance Authority (HIA)–the independent statutory regulatory body for the private health insurance industry in Ireland–has commissioned three surveys of consumers (HIA 2003, 2005, 2008). As part of the quantitative surveys, a number of statements were presented, and respondents were asked to rate their level of agreement with those statements. Figure 1 shows the level of agreement with certain statements among those surveyed who had PHI.

Figure IE1 Consumer attitudes to PHI



* Not asked in 2008
** Percentage disagreeing
Source: HIA (2003), HIA (2005), HIA (2008)

From this Figure, it can be seen that those with PHI view it as a necessity rather than a luxury. This might be strongly linked to the disagreement with the statement that there is no need for PHI in Ireland as public services are adequate. Insured respondents in the 2003 and 2005 surveys also indicated strongly that PHI provided peace of mind. In all three surveys, a majority of those insured agreed that having PHI means always getting a better level of healthcare service and being able to skip the queues for treatment (a point that will be returned to later).

These findings mirror those of an earlier study, undertaken by the Economic and Social Research Institute (ESRI) and reported in Harmon & Nolan (2001) and Nolan & Wiley (2000). The ESRI survey shows that the two most important reasons cited for having PHI were "fear of large medical or hospital bills," with 88.5% of respondents citing this as being very important, and "being sure of getting into hospital quickly when you need treatment" (86.4%). These findings reinforce the idea of PHI providing peace of mind and being seen as a way for people to skip long waiting lists for public treatment.

In terms of the characteristics of those who purchase PHI, not surprisingly there is a significant differential between social classes, while some age effects can also be seen. Table 1 shows that significant majorities of those in social classes A, B and C1 (upper middle class, middle class and lower middle class, respectively) have PHI, while those in the lower social classes (C2–skilled working class, D–other working class, and E–casual workers and those dependent on welfare) are less likely to have it. Those in the farming class have take-up rates similar to the overall average.

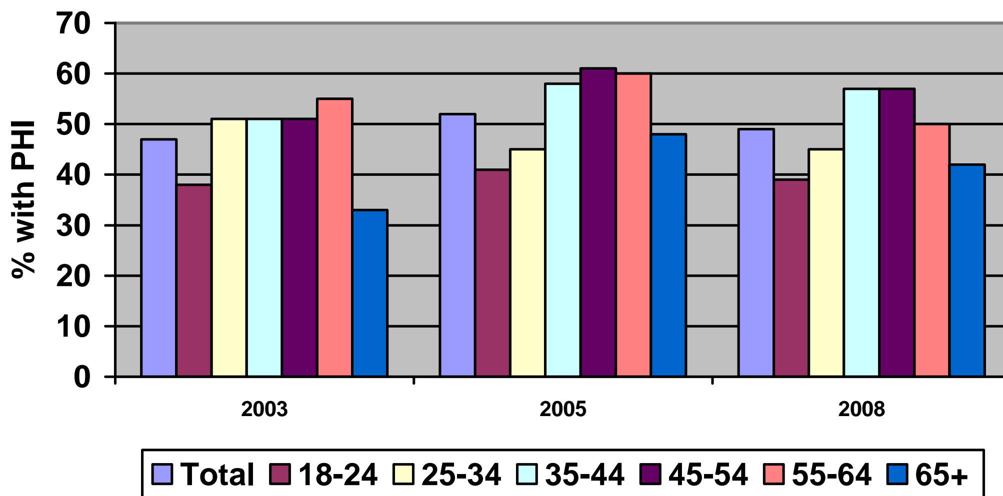
Table IE1 PHI take-up by social class

Social Class	AB	C1	C2	DE	Farming	Overall
Take-up 2003	70%		31%		39%	47%
Take-up 2005	85%	75%	46%	18%	55%	52%
Take-up 2008	89%	65%	42%	18%	49%	49%

Source: HIA (2003), HIA (2005), HIA (2008)

Figure 2, meanwhile, shows the take-up of PHI by age group. It can be seen from this Figure that those in the younger and older age groups tend to have lower take-up rates than those in the middle-age groups.

Figure IE2 PHI take-up by age



Source: HIA (2003), HIA (2005), HIA (2008)

From 1957, VHI was effectively the only private health insurer in the Irish market. A number of small, mostly vocational-based schemes existed when VHI was established, and a number of others have since been established; however, these operate on a restricted basis, with restrictions primarily based on employment with a particular organisation. Having had a 40-year headstart, VHI first faced competition in the 'unrestricted' market in 1997 when BUPA Ireland (BUPA) launched its first plans. BUPA withdrew from the market in early 2007 and its operations were taken over by Quinn Healthcare, part of Quinn Insurance Ltd., which already had a presence in the motor and home insurance markets in Ireland. A third insurer, VIVAS Health (VIVAS), entered the market in October 2004. In early 2008, it was announced that Hibernian Insurance Ltd, an AVIVA company tht already had a presence in other non-life insurance markets in Ireland, would purchase a majority stake (70%) in VIVAS. From July 2008, VIVAS has been re-branded Hibernian Health. The latest estimates suggest that VHI has a 70% share of the market, Quinn Healthcare 20%, VIVAS 6% and the restricted membership undertakings account for the remaining 4% (HIA 2008).

It is clear from these figures that, although both BUPA/Quinn and VIVAS have experienced strong growth in the time that they have been active in the market, the majority of consumers have stayed with VHI. The HIA surveys suggest that the rate of switching remains low. The surveys also show that, by the end of 2002 (when the fieldwork for the 2003 survey was carried out), only 6% of consumers had switched health insurers (HIA, 2003). By 2005, this number had increased only slightly to 10% (HIA 2005), and the figure had remained at 10% by late 2007 (when the fieldwork for the 2008 survey was carried out). Furthermore, a relatively small number of those who had not switched insurer have seriously considered doing so (ranging from 12% in the 2003 survey to 14% in the 2008 survey). Cost savings were the main reason cited by switchers for changing insurers, while the main reason for not switching was satisfaction with the current insurer.

This research also suggests that VHI has a larger proportion of older, higher-risk members[181] than its competitors. This is partly due to the fact that consumers taking out health insurance for the first time tend to be younger than the average insured population and to the fact that those who switch insurers tend to be younger than average.

In terms of the characteristics of the PHI providers in the Irish market, VHI is a non-profit organisation, with its only legislative mandate being to break even in any given year. BUPA Ireland, as part of the British United Provident Association, was a not-for-profit organisation, while Quinn Healthcare and VIVAS Health are both for-profit organisations. Despite being not-for-profit organisations, both VHI and BUPA Ireland made profits in recent years, with VHI building up its reserves in anticipation of a change in its corporate status (which is discussed further below).

Market regulation

In 1992, the European Third Non-Life Insurance Directive was passed, requiring all EU Member States to facilitate the entry of non-life insurers based in other Member States. This directive was reflected in the Health Insurance Act of 1994 in Ireland. Among other

[181] Although age is only one determinant of risk posed to a health insurer, it is widely used as a proxy for risk.

provisions, this Act defined community rating, which VHI had previously been operating on a *de facto* basis. A number of related regulations were introduced in 1996, including those relating to open enrolment, lifetime cover and minimum benefits.

Community rating in Irish legislation specifies that insurers may not vary premiums or benefits based on age, gender, current or prospective state of health or any other risk factor. The variant of community rating currently operating in Ireland is single rate community rating, whereby all insured persons--irrespective of the age at which they enter the market--are charged the same premium for a given plan. The introduction of lifetime community rating, whereby premium loadings are applied the older a person is when they first take out PHI, is anticipated.[182] Such a move was proposed in 1999 (Department of Health and Children 1999), and provision was made in the Health Insurance (Amendment) Act of 2001 for regulations governing this to be brought forward.

Open enrolment mandates that any applicant for PHI must be accepted.[183] Lifetime cover specifies that insurers may not refuse to renew coverage, unless in exceptional circumstances.[184] The three concepts of community rating, open enrolment and lifetime cover have become the 'pillars' on which the Irish PHI system is founded, and they enjoy broad, cross-party support in the Oireachtas (parliament). In addition, the Minimum Benefit Regulations (S.I. No. 83 of 1996) specified minimum levels of cover, which must be provided by any eligible plan, for hospital bed charges and a large number of prescribed procedures undertaken by consultants–the idea being to ensure that enrolees would not underinsure due to information asymmetry.

The 2001 Act made provisions for the establishment of the HIA, which was established on 1 February 2001. The HIA regulates all private health insurers in the market from the point of view of meeting their obligations under the Health Insurance Acts. It does not have functions in relation to prudential regulation, however.

Risk equalisation

The 1994 Act also provided for regulations to be drafted introducing risk equalisation (also known as risk adjustment or, as in the Australian market, reinsurance). This is a system that aims to "equitably neutralise differences in insurers' costs that arise due to variations in the health status of their members." (HIA, 2007: 11) This aim is achieved by means of transfers of money from insurers with relatively low-risk membership profiles to a risk equalisation fund, from which money is then received by insurers with relatively high-risk membership profiles.

Such regulations were introduced in 1996; however, they were later revoked in 1999 without transfers having been made, pending a review of the health insurance market in Ireland. The then government commissioned a report on risk equalisation, which was submitted in 1998 (Advisory Group to the Minister for Health on the Risk Equalisation

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[182] A similar move was effected in Australia in 2000.
[183] The original 1996 regulations (S.I. No. 81 of 1996) specified that this applied only to those aged under-65 when first applying for health insurance, but this stipulation was removed in revised regulations in 2005 (S.I. No. 332 of 2005).
[184] According to the regulations (S.I. No. 82 of 1996), the circumstances allowed for are when an insurer ceases to carry on health insurance business in the State or when an insured person has committed fraud that caused, or could have caused, financial loss to an insurer.

Scheme 1998) and formed one of the inputs into the White Paper on Private Health Insurance, which was published in 1999 (Department of Health and Children 1999). Following the publication of the 1999 White Paper, the 2001 Act allowed for the Minister for Health and Children to introduce regulations specifying a new risk equalisation scheme.

Although the original risk equalisation scheme was in place when BUPA Ireland entered the market, BUPA Ireland was strongly opposed to risk equalisation on the basis that it would be required to make payments to VHI, which it saw as having a dominant market position. Following a complaint from BUPA Ireland, the European Commission examined whether risk equalisation in the Irish market constituted illegal State Aid and ruled in 2003 that it did not, thus paving the way for the introduction of the 2003 scheme. BUPA Ireland challenged the Commission's decision in the European Court of First Instance, but the Court rejected this challenge in a judgment delivered in February 2008.

BUPA Ireland also challenged the legality of the scheme in the Irish courts, and the High Court dismissed BUPA Ireland's case in a judgment delivered in November 2006. BUPA Ireland appealed this decision to the Irish Supreme Court, which heard the case in November 2007, although judgment has been reserved. In the meantime, a stay remains on payments under the scheme. BUPA Ireland currently has two cases pending in the Irish courts, including the Supreme Court appeal, while Quinn Healthcare also has two cases pending, one challenging the risk equalisation scheme and the other challenging emergency legislation that was passed in early 2007 to close a loophole that could have allowed Quinn Healthcare to benefit from a three-year exemption for new entrants from making risk equalisation payments.

Prudential regulation

In terms of prudential regulation, VHI was exempted from the provisions of the Insurance Acts in Ireland under its founding legislation (the 1957 Act). In practice, the main implication of this is that VHI is not obliged to hold a minimum level of reserves to guarantee solvency unlike its competitors, which have to meet the reserve criteria set down by the Financial Regulator in Ireland (effectively 40% of premium income). Amending legislation to the 1957 Act also allowed for VHI to engage in other business activities with the prior consent of the Minister for Health and Children. In recent years, it has begun selling travel insurance and dental insurance and operating minor injury clinics and an online health shop.

VHI's competitors have claimed that VHI benefits from an unfair advantage arising from its statutory status, in particular relating to its reserves (although it should be noted that VHI has been accumulating reserves in recent years in anticipation of a change in its corporate status). VHI notes that its statutory status also confers it with additional requirements to which its competitors are not subject. Specifically, VHI must seek Ministerial approval if it wishes to increase premiums or launch new products.

BUPA Ireland was a tied agent of BUPA Insurance, part of the British United Provident Association, which is regulated by the Financial Services Authority in the UK. It was therefore not required to make returns to the Financial Regulator in Ireland.[185] Quinn

[185] Except as a multi-agency intermediary, in which capacity it was regulated by the Financial Regulator.

Direct Insurance Limited (trading as Quinn Healthcare) and VIVAS Insurance Limited (trading as VIVAS Health) are regulated as non-life companies by the Financial Regulator. Until BUPA's exit, the three main health insurers in the Irish market were each subject to a different prudential regulatory regime, although all health insurers are treated equally under the Health Insurance Acts and regulated equally by the HIA.

Although a change in the corporate status of VHI to bring it into line with its competitors was proposed in the White Paper in 1999 (Department of Health and Children 1999), it has taken some time for this to come about. A complaint to the European Commission about VHI's differential treatment, which led to the Commission directing that VHI's derogations be removed, may have added impetus to the process. The Voluntary Health Insurance (Amendment) Act of 2008 seeks to address these issues. This Act specifies that, by the end of 2008, VHI must meet the same solvency reserves as its competitors and establish subsidiaries to carry out business other than health insurance.

Health system financing

Despite the prevalence of PHI, the health system in Ireland remains primarily funded by general taxation. In 2006, general government expenditure on health accounted for 78.3% of total expenditure on health, with private sector expenditure accounting for only 21.7%. PHI accounted for just 38.6% of private sector expenditure on health, or 8.4% of total expenditure on health (WHO 2008). As Nolan (2006) notes, the level of resources generated by PHI in Ireland is not commensurate with the leverage within the health system enjoyed by those with PHI.

The degree of leverage referred to here includes the fact that much of the treatment of privately insured persons takes place in public hospitals. Figures from 2002 (Department of Health and Children 2002) suggest that there were approximately 12,000 acute beds in public hospitals in Ireland at that time. Approximately 20% of beds in public hospitals are designated private, in other words for use by privately insured patients. It was also estimated that the number of beds in private hospitals at the time was approximately similar to the number of private beds in public hospitals. More recent figures from a report commissioned by the Health Service Executive (HSE 2007) show that private beds accounted for just over 17% of beds in public hospitals and that the number of private beds in public hospitals exceeded the number of beds in private hospitals (although the report excluded some beds in private hospitals from its totals).

According to Vhi Healthcare (VHI 2003), approximately half of the bed capacity used by its members was in public hospitals. Insurers have a financial incentive to have their members treated in private beds in public hospitals rather than in private hospitals. This is due to the fact that insurers do not currently pay the full economic cost of private beds in public hospitals. However, the government is committed to moving to a situation where insurers do pay the full economic cost of such beds, and therefore the charges for these beds have been increased in recent years.

This is not the only way in which the State subsidises PHI. Tax relief is available on PHI subscriptions. Although this was available from the onset of the market, it was previously available at the marginal rate of tax. This was changed over two tax years ago (1995/96 and 1996/97) to the standard income tax rate (currently 20%). Since April 2001, this tax relief has been deducted at source. The White Paper in 1999 (Department of Health and

Children 1999) noted that two reports had recommended the abolition of tax relief on PHI premiums, but suggested that the equity and effectiveness concerns behind these calls were addressed by reducing the rate of the tax relief from the marginal rate to the standard rate. The White Paper also noted the argument that some incentive to purchase PHI could be justified "on the basis that those who opt for private cover effectively forgo a statutory entitlement while continuing to contribute to the funding of the public health service through taxation." (Department of Health and Children 1999: 24). The provision of this tax relief was estimated to have cost €300m in 2007.

A third way in which the State subsidises the PHI market is indirectly, via the provision of education and training for medical professionals. Since much of the treatment of privately insured individuals takes place in public hospitals and since most hospital consultants work in both public and private practice, the training of these medical professionals, which is subsidised by the State, also benefits private patients.

The intertwining of public and private health care in Ireland

The fact that the private and public healthcare systems in Ireland are so intertwined has led to some concerns, particularly over equity of access. Evidence for why such concerns might be justified comes from figures compiled by the Central Statistics Office (CSO). Its Quarterly National Household Survey module on health, carried out in 2001 (CSO 2001), shows that just over a quarter (25.9%) of the adult (over-18) population had a medical card at that point in time, while 46.3% had PHI only, a further 2.1% had both PHI and a medical card and 25.6% had neither a medical card nor PHI. Distinct trends emerge between those with and without PHI, particularly in relation to waiting periods.

In the sample as a whole, 1.6% of people were on inpatient waiting lists when the survey was carried out. However, when broken down by medical cover, the figures range from 3.2% of those with medical cards only to 1.0% of those with PHI only. The figures were 2.3% for those with both a medical card and PHI and 1.0% for those with neither form of cover. These figures suggest a difference based on possession of a medical card rather than PHI.

However, a different trend emerges in terms of the length of time people in the various categories had been on the waiting lists. Just over a quarter of those with medical cards only who were on waiting lists for inpatient treatment had been waiting over a year for treatment. By contrast, only 12.7% of those with PHI only had been waiting that long. Of those with neither form of cover, 38.5% had been waiting for over a year, while the sample size in the group with both was too small for estimation by the CSO.

At the other end of the scale, just over 60% of those with PHI only and nearly 72% of those with both PHI and medical cards had been waiting less than three months. Meanwhile, only 36.3% of those with medical cards only and just under 31% of those with neither form of cover had been waiting less than three months for treatment. It would appear from these figures that those with PHI cover (with or without a medical card) are, on average, not waiting as long for treatment as those without PHI cover (those with a medical card only or neither form of cover). Similar trends are apparent for waiting lists for day case procedures or investigations.

As O'Morain (2007) notes, a common waiting list for public and private patients has been called for, but has not been implemented. However, in 2002, the National Treatment Purchase Fund (NTPF) was established. This provides a facility for public patients who have been waiting longer than three months for an operation or procedure in a public hospital to be treated free of charge in a private hospital in Ireland or the UK. Over 100,000 patients have been treated under the NTPF so far. According to the NTPF, the median waiting times for all procedures in Ireland in October 2007 was 3.5 months (NTPF 2007). These figures also show that, as of October 2007, there were just over 15,000 adults and just over 2,000 children awaiting surgical procedures for more than three months (of whom, almost 27% of adults and just over 24% of children were waiting for 12 months or more). As noted by O'Morain (2007), the treatment of public patients in private hospitals means that the NTPF has a direct impact on the financing of private hospitals. As such, the linkages between the public and private healthcare systems in Ireland are two-way.

Another concern arising from the close interactions between the public and private healthcare systems is that hospital consultants might spend more time with their private patients than their public patients, leaving the latter to be treated by non-consultant hospital doctors. Consultants are generally paid a salary for their public work and are paid on a fee-for-service basis for their private work. It has been suggested that this gives them a financial incentive to focus on their private patients.

Wren (2003) estimates that consultants earned an average of €130,000 from private practice in 2002, and €280,000 between the public and private practices combined. She also cites anecdotal evidence that consultants prefer to spend time with their private practice, leaving NCHDs to treat many of their public patients. However, O'Morain (2007) notes that the Value for Money Audit of the Irish Health System, commissioned by the Department of Health and Children and published in 2001, found no systematic evidence of such practices, although it did acknowledge that lack of information hindered the making of informed judgments on the issue.

The concern over consultants' treatment of public versus private patients has been reflected in the negotiations between the Health Service Executive (which oversees the delivery of health care in Ireland and reports back to the Minister for Health and Children) and hospital consultants to draw up a new consultant contract.[186] The agreement reached between the HSE and the Irish Hospital Consultants Association means that new consultants (and any consultants who choose to transfer from their existing contracts to the new contracts) must agree to carry out their private practice on public hospital campuses and, except in limited cases, limit their private practice to 20% of their workload. Three new types of contracts will be available–the first (and highest paid) will be for consultants who agree to carry out only public work, the second for those who agree to limit their private work to 20% of their workload and the third (and lowest paid) for consultants appointed in exceptional circumstances who are permitted to carry out private work outside the public hospital campus.

Other recent government policies are aimed at separating public and private hospital treatment. In particular, the policy of hospital co-location, favoured by the current government, aims to have private patients treated in private hospitals built on the campuses

[186] Current contracts allow most consultants to carry out private practice, in some cases only on a public hospital campus, but in other cases off-site private practice is also permitted.

of public hospitals. The argument put forward in favour of this is that it will allow beds in public hospitals that are currently designated private to be re-designated as public beds. Tax incentives for the development of private hospitals are also available.

The future of PHI

It is clear that PHI will remain a key feature of the Irish healthcare system for the foreseeable future. This was acknowledged in the White Paper (Department of Health and Children 1999) and again in the 2001 Health Strategy (Department of Health and Children 2001). Plans have been proposed on a number of occasions to implement universal health insurance. Most recently, in April 2008, the Adelaide Hospital Group proposed a social health insurance system to replace the current tax-financed public health system (Thomas et al 2008). However, given the popularity of the current system of voluntary PHI, any change from the current system could prove to be a hard sell.

The takeover of BUPA Ireland's business by Quinn Healthcare, part of a wider insurance group that offers motor and home insurance, has seen offers increase on a bundle of insurance options (for example, an offer being promoted at the time of writing entitles customers who have motor and health insurance with the Quinn Group to free household insurance to the value of €200 and free travel insurance[187]). Although at the time of writing, Hibernian Health does not offer such incentives, it has not ruled them out in the future. With VHI set to become an authorised non-life insurer, it is quite possible that it too might offer combinations of insurance products in the future.[188] As the market for PHI is possibly close to saturation (although HIA 2008 shows that 27% of those who do not already have PHI intend to take it out at some point in the future), diversification into other insurance–and non-insurance–offerings would seem to be a logical strategy going forward.

Further increases in PHI premiums in both nominal and real terms are also likely to feature in the future. Factors impacting these increases will include the ageing population, continuing advances in medical technology, the continued move towards charging the full economic cost for private beds in public hospitals and the increased proliferation of private hospitals combined with the anticipated consequent reduction in the number of beds in public hospitals available for private use. This price effect, combined with the current slowing of economic growth, might test the elasticity of demand for PHI in Ireland in the coming years.

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[187] See http://www.quinn-healthcare.com/press_and_media/pressrelease280508.htm.

[188] There is currently some degree of product bundling between PHI and travel insurance, with VHI's travel insurance plan paying for medical care while on holiday only after the limit on the overseas cover element of the insured person's PHI plan has been exceeded.

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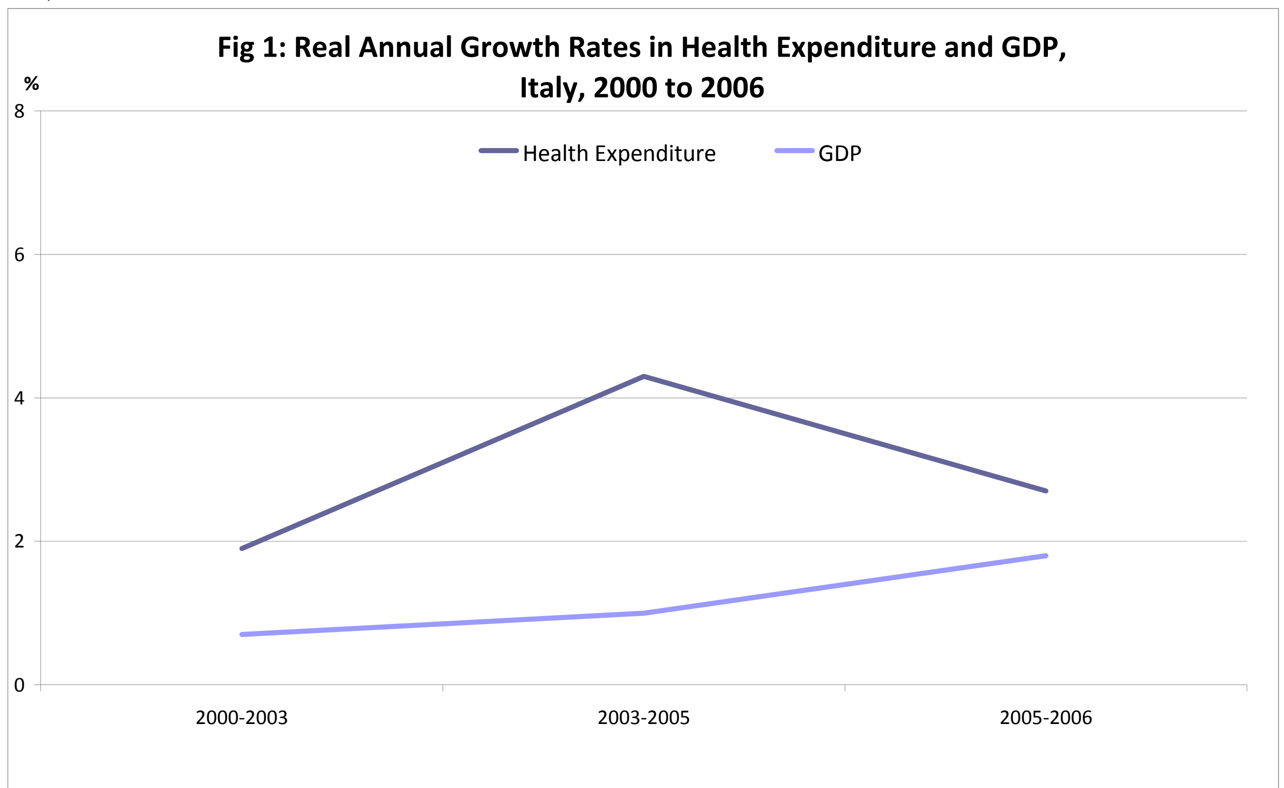
Italy

Margherita Giannoni-Mazzi

Introduction

Since 1978, in Italy there has been a universal Health Care System (Servizio Sanitario Nazionale – SSN) covering the whole population with national universal and compulsory health insurance. In Italy, therefore, it is not possible to opt-out of the SSN. Patients are free to choose between public or private providers for many health care services. Since it is possible for the public sector to outsource the delivery of medical health services, an increasingly large part of health care services are currently provided by accredited private providers. Moreover, patients are free to buy private health insurance and to receive treatment at non-contracted private hospitals or consult private outpatient specialists, at their own expense. As in other European countries, with increased personal income levels, more individuals opt to supplement their public health insurance with the purchase of private insurance and/or private services, out-of-pocket[4]. In Italy, as in most EU countries, health care expenditure has been rising over the last years at a faster rate than the GDP (Fig IT1).



In 1980, the share of private expenditure on GDP was 1.4%. This increased over time to a level of 2% in 2006. This value is slightly lower than the 2.4% average of EU countries (Oecd, 2008). The share of public expenditure over GDP was 5.6% in 1980, 6.5% in 1992, and decreased to 5.3% in 1995. But after this period it started to increase again (Oecd, 2008). Overall, the share of public expenditure on GDP has traditionally been lower than

[4] See Mossialos and Thomson, 2001; Giannoni, 2001.

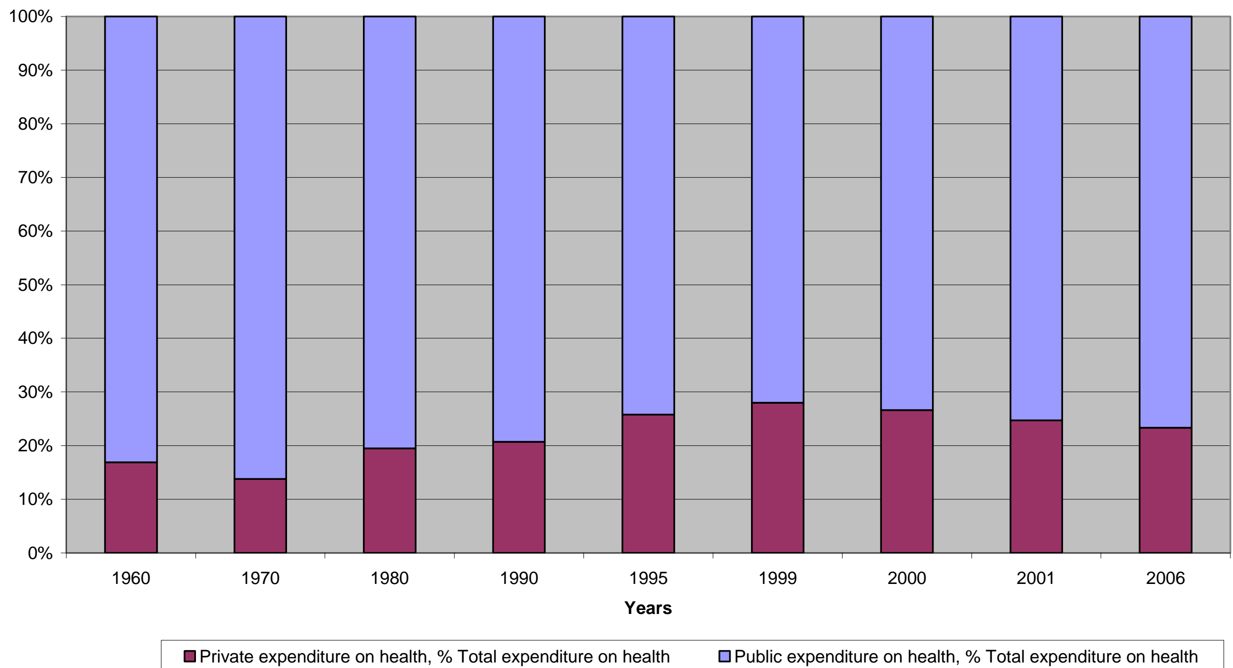
the E.U. average, and is still lower than the 1992 value. However, in these last years it has gradually risen to 6.9% in 2006 which was above the OECD average of 6.5%. However, considering the effects of the health care system regionalisation process which started after the mid-1990s, a careful analysis of both private and public health care expenditure should be performed at the regional level, as there is clear evidence of wide differences in both trends in expenditures and in policy behaviour among the twenty regions of Italy. Reviewing regional levels of expenditure there appears a continuous growth of public expenditure for health in the last ten years coupled with the persistence of annual public deficits in these last years in most regions. Looking at the period 2000-2006, it has been shown that those regions, such as e.g. Tuscany, Umbria, Emilia-Romagna, in which public provision of health care is dominant, and those regions, such as Lombardy, relying on greater regional fiscal authonomy, are those who showed better capacity to recover from past deficit levels (Fedeli, 2008).

Since the 1980s, one of the primary features of the development of health care expenditure in Italy has been the steady increase in its private share. Despite the SSN being the primary pillar, offering coverage to the entire population, health care expenditure has been characterized during the past fifteen years by the increasing importance of the private consumption. Approximately one third of total private expenditures are uncovered by the SSN (primarily drugs), while more than two thirds of these expenditures are accounted for by the free choice of the citizens or insufficient public provision.

According to OECD data (2002, 2008) the share of private expenditure in total health care expenditure increased from 19.5% in 1980 to 28.2% in 1998, and then it started to decrease from 24.7% in 2001, to 22.2% in 2006. Conversely, the public share which was 80.5% in 1980 and 79.3% in 1990 decreased during the 90's to 72% in 1999, and then in 2001, it increased to 75.3%, being 76.67% in 2006 (Figure IT2). This decreasing trend in the 90's is a reflection of a series of cost containment policies that were implemented during 1992-1995 in most EU countries aimed at containing public health care expenditure.

Prior to 1991-92, and the beginning of the cost-containment reforms, trends in total expenditure reflected those of its public components, which was growing at high rates, while at the same time the private component was almost stationary. Conversely, between 1991-1995, overall expenditure growth was contained through a reduction of public expenditure and, at the same time, the private component has more than doubled, which indicated that part of the cost-containment process had shifted towards an increased burden of total health care expenditure, on the private side.

Figure **IT2**



In 1995, as public expenditure started to grow again, the trend changed. Private expenditure continued to grow until the ratio between private and public expenditures remained almost constant, at approximately 25.6%. Since 1995, the marked increase in total expenditures has been credited to an increase in pharmaceutical sales and the renewal of salary negotiations between physicians and the government. In 2000, there was a 33% net increase in public expenditure for drugs and this was due mainly to the discontinuation of user charges on drugs (tickets). At the same time, public expenditure increased and private expenditure decreased. Following the Constitutional Reform of 2001 aimed at the devolution of central power to regional and local governments, in 2001-2003 many regions decided to raise user charges on drugs. As a consequence of this, private expenditure started to increase again both in current and real prices; public expenditure's growth decreased; the ratio between private and public expenditure started to increase again. However, in recent years in all regions public expenditure constantly increased again at faster rates than in 2001-2003.

Financing public health care expenditure

Before 1978, financing of health care was by employers and employees through health insurance funds. This system suffered for the typical problems associated with a structure managed by an extremely high number of health insurance funds: different financing methods, with high variability in contribution rates and in benefit packages offered to patients. The financing heterogeneity and the lack of horizontal equity were addressed by the 1978 reform (Law n.833) devising a national budget, the National Health Fund (*Fondo Sanitario Nazionale – FSN*), which would meet the costs of health care provision to all citizens. The global amount of the FSN would be fixed yearly by the central government and funding would derive from several sources, mainly from general taxation,

contributions by both employers and employees and a health tax levied on the self-employed[4]. The responsibility for determining regional health care resources was left to central government. However most of the revenues accrued directly to the Regions and the State transferred to the Regions only general tax revenues. As over time there has been a continuous rise in public health care expenditure, with Regions constantly running budget deficits which had to be covered by revenues from general taxation, several reforms of the NHS financing mechanisms have been introduced. The 1992/93 NHS reform (Legislative Decrees n. 502/92 and 517/93) stated that Regions incurring budget deficits could not rely on general taxation, but had to raise the extra resources either through higher co-payment levels or higher regional taxes. The 1997 fiscal reform, aimed at eliminating disparities in payroll tax contributions rates, and at introducing fiscal decentralisation. The fiscal reform affecting the financing of the NHS (Legislative Decree n.56/00) stated that, starting from 2001, FSN would be gradually abolished over time together with all national transfers to the Regions. Health care funding is increasingly under regional responsibility as regions have to rely on a growing share of regional taxes for funding both health care and other regionally funded activities.

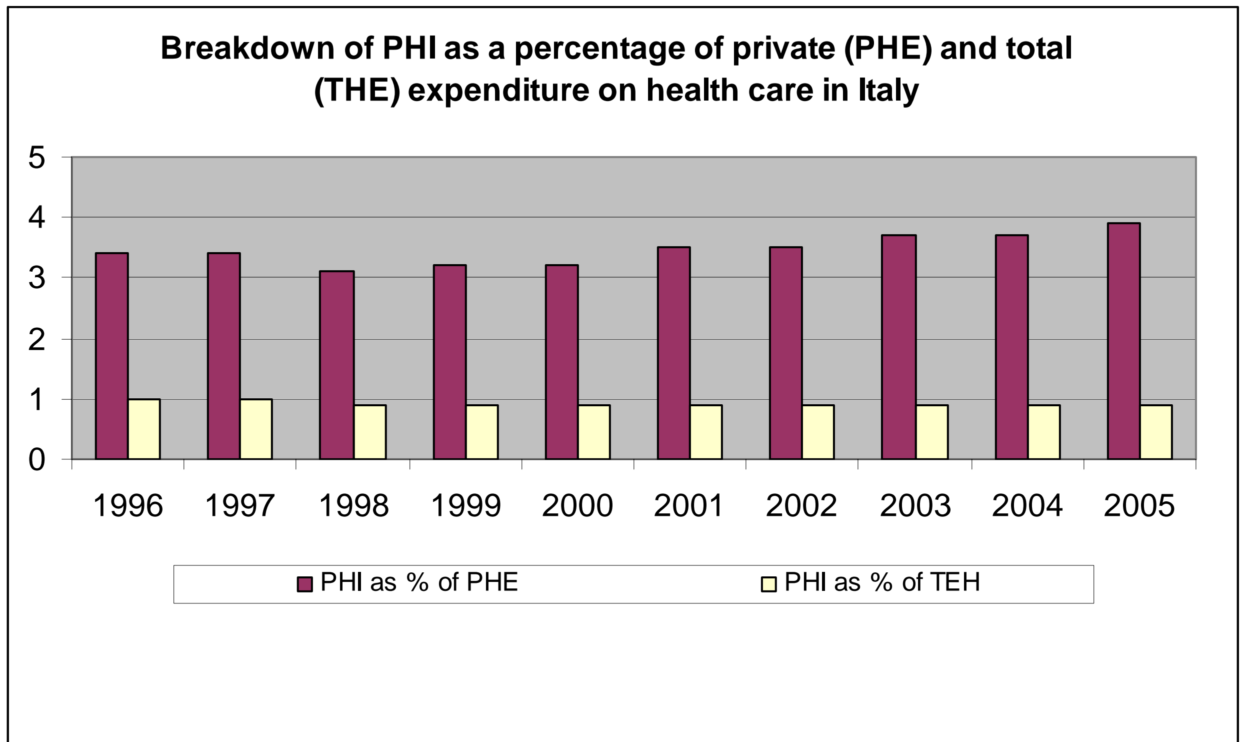
Financing private health care expenditure

The Italian system, like all other OECD countries, is based on three tiers according to which health care which is not covered by the SSN is financed by:
- private insurance companies for profit or mutual associations (generally non-profit and self-administered): in these cases the individual is buying individual policies or adhering to collective policies. Non-profit associations are firm-specific insurance funds, funds managed by organisations of categories of professional workers or mutual organisations (SMS);
- individuals pay directly to providers.

Private expenditure in Italy, as in other OECD countries, is financed by private insurance or by individuals on an out of pocket basis. In 2001, the share of out-of-pocket expenditure on total health care expenditure was over 22% - one of the highest among OECD countries - and the share of voluntary health insurance was 0.9%; both shares increased by 50% in 1990-2000.

Private health care expenditure in 2006 was 27,982 million euros (istat, national accounts), 21.80 % of total health expenditures. Only 4% of private expenditure is financed by PHI, the rest being mostly represented by out-of-pocket expenditures. In Italy, there are primarily two categories of out-of-pocket payments: the first category is cost sharing, for example, co-payments and co-insurance rates for pharmaceuticals, diagnostic procedures, and specialist visits; the second category is the direct payment by patients to medical care providers for private medical services and for over-the-counter medications (Donatini et al., 1999). The following figure, shows PHI as a proportion of private expenditure on health and total expenditure on health over the period 1996-2005.

Figure IT3- PHI as a proportion of private expenditure on health and total expenditure on health care in Italy, 1996-2005



Data source: OECD Health data 2007

It can be seen that PHI contribution to total expenditure and private expenditure on health care over time was only 0.9% and 3.9% in 2005, respectively. Moreover, PHI incidence on total health care expenditure remained quite constant during the period 1996-2005. Over time, therefore, there has not been so much space for the health insurance market to further develop.

Market role

Since 1978, in Italy there has been a universal Health Care System (Servizio Sanitario Nazionale – SSN) covering the whole population with national universal and compulsory health insurance. In Italy, therefore, it is not possible to opt-out of the SSN. Given this, there are two types of voluntary private health insurance in Italy: corporate, where companies cover their employees and sometimes also their families; and non-corporate, with individuals buying insurance for themselves or for their family. Health insurance policies, either collective or individual, are supplied by both for-profit and non-profit organisations. The market is characterized by the presence of three types of non-profit organizations. The first are voluntary mutual insurance organizations. The rest is made by corporate and collective funds organized by employers/professional categories for their employees/members. Table IT1 provides a taxonomy of PHI in Italy.

Table IT1 – Taxonomy of PHI in Italy

Types of PHI	Types in Italy
Substitutive PHI (acts as a substitute for statutory hea insurance)	Does not exist in principle in the Italian context, where it is not possible to opt out of the Statutory Health Insurance. There is a type of individual insurance, offered by for-profit insurance companies, which provides insured "full coverage" of all expenditutures. In this case insured are free to go private and buy services that are substitutes for those provided by the public sector. However, also in this case the insured continue to be covered by SSN, and only if they go private are they reimbursed by insurance companies. Moreover, there are several limitations in terms of benefits excluded and eligibility restrictions that impede this type of VHI to act in practice as a substitute of statutory health insurance.
Complementary PHI (provides cover for servi excluded or not fully covered by the state, including payments)	Can be either: 1)corporate 2)non-corporate 1)corporate (companies offer coverage to their employees and often also to their families with a collective insurance scheme). Can be supplied by : 1A) for-profit organisations. 1B) non-profit organisations, that are named: 1B1)-"Fondi Aziendali" (corporate, firm-specific, Insurance Funds (as e.g. FIAT, IBM etc.) can be managed internally by the firm itself or outsourced to an insurance company. Corporate policies are seen in Italy as a fringe-benefit for employees. In 1994 only 24% of firms did not offer any coverage (Piperno, 1997). 1B2)- "Casse di Categoria" (funds managed by organisations of categories of professionals workers as, e.g., lawyers, journalists etc, or by associations of categories of workers 2)non-corporate (individuals buy insurance for themselves and for their family) Can be offered by : 2A) for-profit organisations. 2B) non-profit mutual organisations, that are named "Società di Mutuo Soccorso" (SMS),

Both types of VHI are often provided by the same policy. What differs from policy to policy is the degree of complementarity/supplementarity of the policy with respect to the NHS. For-profit insurance companies tend to encourage people to use public services, many policies have no-claim bonuses when using public free-of-charge facilities and daily reimbursements for inpatient stay in public hospitals.

Tax regulation aims at increasing the presence of complementary VHI, setting a higher tax exemption regime for funds providing only complementary VHI (see below on taxation). Eligibility criteria are different according to different types of PHI (Table IT1), but irrespective of whether they act as a substitute or complement to the NHS. In the case of corporate PHI, access is restricted to employees and, when allowed, to their families. Maximum age for enrolment is usually required, people over 75 are usually not eligible. Non-corporate PHI, both for-profit and non-profit, usually covers individuals and their

families. In the case of for-profit insurance, in most cases eligibility is not allowed for people affected by severe/expensive conditions, such as drug and alcohol addiction, AIDS, severe mental health problems (schizophrenia etc.) and voluntary abortion. Moreover, a maximum age for enrolment is usually required; people over 65 are usually not eligible.

In the case of non-profit insurance we must distinguish between corporate and mutual organizations. The latter are "open" to the whole population, and age limits for enrolment sometimes are fixed at around 65 years, sometimes 75. As they are informed by a solidarity principle, retired people remain covered and pay a lower price. In the case of non-profit corporate PHI, age restrictions do not apply normally, all funds allow retired people to enrol, but usually under the requirement of a minimum previous enrolment period of 5-10 years.

Looking at market performance, according to the biannual national households income survey made by the Bank of Italy, the proportion of Italian families covered by PHI in 2006 was 6.13%. However this survey does not distinguish between different types of coverage. According to Ania, the Italian National Association of Insurers, there are 5.8 million Italians covered by PHI.

Table IT2- Numbers of insured in Italy

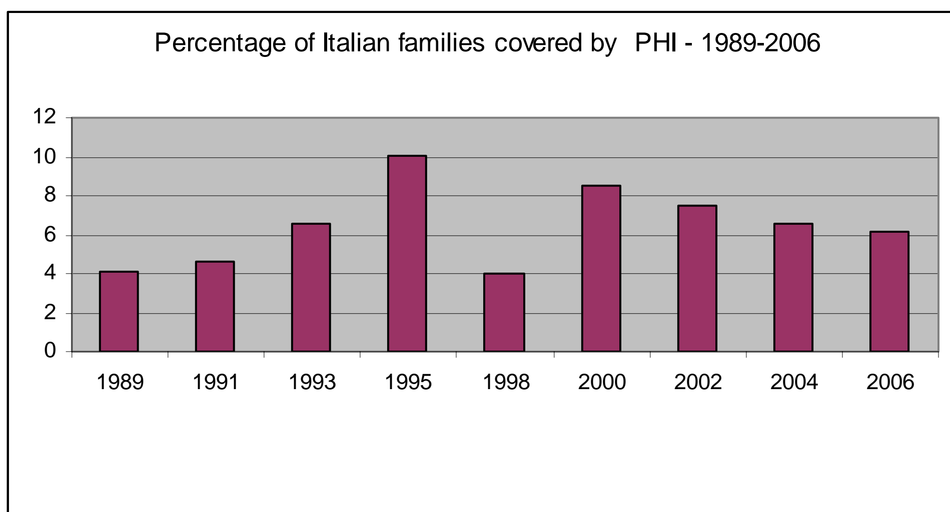
	Number covered (thousand)	Average premium (current euro)	Total premia (millions euro)
non-profit mutual organisations, named "Società di Mutuo Soccorso" (SMS),	400	200	90
non-profit self-administered organisations	1,500	440	660
non-profit organisations – managed by insurance companies	1,500	310	435
For-profit corporate	900	270	245
For profit- individual	1,500	530	790
Total	5,800	390	2,250

Source: Ania, *L'Assicurazione Italiana 2003-3004*, www.ania.it

Ania estimates report that other third-party payers accounted for a further 500 millions euros. These data relate to 2003-2004, however, we found them reported also for 2006 (Bifone, 2007). Looking at the evolution of PHI coverage over time, Figure IT4 reports on the proportion over time of Italian families paying annual premia for PHI coverage. It can be seen that levels of coverage have not been changing dramatically over time, increasing from 4.1% to 6.13% in 2006 190.

Figure IT4 % of Italian households covered by PHI over time

[190] There is a 10.1% peak value in 1995 survey, but this seems to be due a change in the questionnaire (including also other types of private insurance) and of the sampling strategy over time.



Source: our calculation based on Bank of Italy Households Income survey data.

As mentioned above, over time there has not been so much space for the health insurance market to further develop. This was because of insurance companies' internal factors as well as external factors. Internal factors relate to the Insurance Companies' choice as to the products, offering larger coverage and increased guarantees. Insurance companies tend to encourage the use of public hospital services in many cases, but for specialist care they do not always cover statutory co-payments, probably for the moral hazard problem. Moreover, premia and contributions for complementary coverage appear relatively high and not affordable for many Italian families compared to their income, particularly in the poorer Southern areas of the country. The lack of development of the complementary health insurances depends also on the fiscal treatment of contributions and services. Fiscal exemption for complementary coverage, for example, actually is not so favourable to make an incentive for increasing subscriptions[191].

Market structure

Looking at buyer characteristics, from Bank of Italy survey data it appears that households with a male head of the family have higher probability of being insured than women-headed families. This is also true for families where the head of the family has an age between 41 and 50 years old, and where the family size is larger. This holds over time, and continues to hold also if family average size has progressively reduced in the last 10 years. Education (having a university degree or more) is positively correlated with the probability of being insured. Comparing the survey of 1991 with those of 2002 and 2006 it can be seen that the diffusion of PHI has been higher in the North of Italy (9.7% of families have at least one member covered in the North, vs 6.9% in the Centre and 1.6% in the South).
Managers and professionals are more likely to be covered by PHI. This holds particularly for the self-employed. High income families are more covered than low income families. In 2004, only 3% of the first quintile of income distribution had PHI, vs 22.5% of households in the top quintile.

According to a national Istat survey on Italian lifestyles (2002), households tend to be insured when the size of the household increases as for children, and when their members approach middle age and start to experience a chronic condition. According to a market

[191] For a discussion on this point, see below the section on fiscal treatment.

survey conducted in 1999, most policies are sold in order to complement services covered by NHS (32.39%). Other determinants are related to particular employment needs (23.9%), and search for better qualiy of care (10.5%) (Databank,1999).

Table IT2, above, reports data on subscriptions for different types of PHI in Italy, as reported by industry sources. Individual policies sold in 2003 accounted for 1,500 out of a total (individual and collective) of 5,800. Therefore, the proportion of individual PHI subscribers is approximately 35%. This proportion appears to have remained constant over the last 3-4 years (Bifone, 2007).

Health insurance policies, either collective or individual, are supplied by both for-profit and non-profit organisations (Table IT1). The market is characterized by the presence of three types of non-profit organizations. The first are voluntary mutual insurance organizations. The rest is made up by corporate and collective funds organized by employers/professional categories for their employees/members. The two sectors market shares have been quite stable over time.

In 2005, there were 95 private insurer companies operating in the non-life PHI market. Of these, 91 are corporations whose shares are traded at the stock exchange market, 3 are mutuals and 1 is a cooperative (Ania, 2008)[192]. In 2006 the share of total premia collected by the first 3 companies was 33% (see table below).

Table IT3: The first 20 PHI operators in Italy

N.	INSURER NAME	2006 PREMIA (thousand euro)	% VAR. 2005/2006	% MARKET SHARE
1	Assicurazioni Generali	294.103	12,0	15,79
2	Ina Assitalia	168.170	16,2	9,03
3	Fondiaria - Sai	160.789	-6,4	8,63
4	Riunione Adriatica di Sicurtà	142.807	8,0	7,67
5	Unisalute	86.241	14,8	4,63
6	Compagnia Ass. Unipol	73.821	18,1	3,96
7	Società Reale Mutua	65.441	-2,9	3,51
8	Toro Assicurazioni	59.434	7,9	3,19
9	Zurich Insurance Company	56.556	-4,7	3,04
10	Axa Assicurazioni	56.119	13,4	3,01
11	Compagnia di ass. di Milano	53.121	8,1	2,85
12	Aurora assicurazioni	50.447	0,2	2,71
13	Società cattolica	45.487	6,1	2,44
14	Unionvita	44.106	-16,4	2,37
15	Eurizontutela	42.073	40,8	2,26
16	Europ Assistance Italia	39.858	9,5	2,14
17	Lloyd Adriatico	37.792	-9,7	2,03
18	Bpu Assicurazioni	34.340	0,9	1,84
19	Uniqa Assicurazioni	32.093	4,1	1,72
20	Cardif assicurazioni	21.204	30,5	1,14

Source: Ania (2008)

e for the non-profit sector.

hat specialise in health and
the case of for-profit PHI,
were specialist (see Table
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[192] Source: Ania, accessed in April 2008 at: http://www.ania.it/studi_statistiche/stat_attuariali/documentazione/ParteVTavole%20statistiche2007.pdf.

Table IT4 Specialist vs non-specialist insurers in the EU: 2004-2005

	Country	2005	Specialist	Non-specialiste	Specialist	Non-specialiste		2004	difference
AT	Austria	7	0	7	0%	100%		7	0
BE	Belgium	32	1	31	3%	97%		33	-1
CH	Switzerland	53	17	36	32%	68%	Data 2004	53	0
CY	Cyprus	15							
DE	Germany	50	50	0	100%	0%		51	-1
DK	Denmark	68	14	54	21%	79%		66	2
ES	Spain	87						93	-6
FI	Finland	20	0	20	0%	100%		20	0
FR	France	113	3	110	3%	97%		111	2
GB	United Kingdom	21	8	13	38%	62%		30	-9
IT	Italy	94	5	89	5%	95%		97	-3
LV	Latvia	13						13	0
MT	Malta	5	4	1	80%	20%		5	0
NL	The Netherlands	31	18	13	58%	42%		31	0
NO	Norway	5	2	3	40%	60%		5	0
PT	Portugal	20	0	20	0%	100%		20	0
SI	Slovenia	4	2	2	50%	50%		4	0
TR	Turkey	33	0	33	0%	100%		33	0
Total		671	124	432	22,3%	77,7%		672	-1

Note for Belgium:
Includes all companies actives in health care, disability/invalidity and dependancy. Only 28 companies out of the 32 are effectively active in Health. Specialist: Companies whose health insurance business is over 50% in comparison with any other business

Source: CEA (http://www.cea.eu/index.php?page=health-2)

In 2006, total premia collected were 1,828,403 thousand euros, and the share of total health insurance premia income on the accident sector was 4.92% (ANIA, annual report 2006). After 1997, the share on total premia had a slow decrease (from 4.7% to 4.4% in 2005, but in 2005 and 2006 it increased again although reaching again a level similar to 1997 (Table IT5).

Table 5 - Evolution of premia collected by Italian private health insurance companies 1982-2005

Years	Share on total premia of accident sector	% Annual increase of premia
1982	1.5	
1983	1.8	34.31
1984	1.9	29.35
1985	2.1	23.11
1986	2.3	23.55
1987	2.6	27.62
1988	2.9	26.19
1989	3.3	25.56
1990	3.3	23.91
1991	3.9	21.94
1992	4.1	9.31
1993	4.4	18.03
1994	4.6	12.40
1995	4.5	7.73
1996	4.6	6.71

1997	4.7	8.08
1998	4.5	9.53
1999	4.4	3.2
2000	4.5	7.8
2002	4.40%	6.02
2003	4.41%	5.08
2004	4.45%	4.05
2005	4.73%	8.8
2006	4.92%	6.5

data source: our calculations on ANIA (Italian Insurance Companies Association); annual reports

Market conduct

Products offered by Insurance Companies usually include three major types of reimbursements:
1 partial or total reimbursement for all expenditures associated with hospital stay of 1 day or for longer, surgery interventions, birth & delivery, diagnostic care, treatments etc. Most of these policies foresee direct payment by the insurance companies to the providers only if the insured chooses among PPOs. This type of policies can be subscribed to also only for high surgery interventions.
2 fixed daily reimbursement for each day spent in hospital, if the hospital stay was fully paid by the SSN and optionally for the period of recovery following hospital stay.
3 Permanent invalidity policies, which cover the onset of conditions which lead to invalidity; these are indemnities proportional to the level of invalidity, calculated as a proportion of the insured capital.
A lower proportion of the market is represented by other two types of coverage:
4 "LTC", i.e. policies for Long Term Care
5 policies for "dread disease", which give a fixed indemnity not dependent on health care expenditures when an individual get a severe disease such as a malignant one.[193] The main covered benefits include:
- expenditures for inpatient care with and without surgery, and all expenditures related to the hospital stay following hospitalisation for a fixed time limit (varying from 90 to 180 days)
- expenditures for organ transplantation
- expenditures for 1 day inpatient care (in some cases)
- expenditures relating to diagnostics and outpatient visits (in many cases)

The level of coverage varies according to the type of policy:
1- "compete coverage" with 100% of expenditures paid;
2- "complementary coverage", less expensive than type 1, reimburses expenditures in excess of those covered by the NHS. In this case if the insured goes private, he is paid with a 20-25% deductible; if he has not claimed for expenditures because he used NHS services, he is paid with a fixed bonus. Alternatively, or additionally, he can receive a daily reimbursement for hospital stay, with a maximum length of stay between 180 and 360 days.
3- "coverage for high risks" type allows reimbursements only for special surgery or severe conditions treatments, the premium is lower than types 1 and 2.

[193] (Source: http://www.humanitasalute.it/realeinforma.html?id_p=577)

Most contracts do not reimburse starting from the 1st day of sickness; many do not allow an unlimited reimbursed amount, but set a maximum amount reimbursable per each reimbursable type of adverse event (Mastrobuono, 1999).

Aesthetic surgery, treatment of mental health, addictions, alcoholism and AIDS are usually not covered.
- For-profit corporate policies

In Table IT6, a comparison is made between the two forms of individual and corporate insurance cover.

Table IT6- Characteristics and benefits of for-profit policies

Principal characteristics	Individual policies	Corporate policies
Age limit	Usually 75 years	Usually 75 years
Geographic validity	Whole world	Whole world
Costs	High	Moderate/low
Contractual conditions	Restrictive	wide
Health questionnaire or medical examinations	Yes	no
Period with no coverage at the beginning of the contract	Yes (usually 30-180 days)	no
Coverage for pre-existing, chronic, and relapsing diseases	Usually no	Not for the individual insured but for the whole convention
Benefits :		
Hospital stay (with or without surgery)	Maximum per-year and per-family limit varying according to the type of contract (from few millions liras to unlimited amounts)	Maximum per-year and per-family limit varying according to the type of contract (from few millions liras to unlimited amounts)
1 day hospital stay (« day-hospital »)	Maximum per-year and per-family limit varying from 10 to 20 millions	Maximum per-year and per-family limit varying from 10 to 20 millions
Dental care	Not reimbursed usually	Reimbursed within a maximum yearly limit with deductibles and partial coverage levels
Contact lenses/ Eyeglasses/ Prosthesis	Not reimbursed usually	Partial coverage with per-year and per-family fixed maximum limits
Ambulatory care/Home care	Reimbursed within a maximum yearly limit with varying deductibles and partial coverage levels, usually limited to care related to surgery	Reimbursed within a maximum yearly limit with varying deductibles and partial coverage levels. Often also reimbursement for drugs is allowed.

Source: adapted from various sources

The main benefits covered by non-profit policies are the following:
- expenditures for Inpatient care with and without surgery, and all expenditures related to the hospital stay occurred after the hospitalisation within a fixed time limit (varying from 90 to 180 days)
- expenditures for organ transplantation

- expenditures for 1 day inpatient care (in some cases)
- expenditures diagnostic and outpatient visits (in many cases)

Complementary non-profit funds usually cover also a set of services not covered (or partially covered) by the NHS. Table IT7 shows the benefits covered by the three types of non-profit organisations that offer group policies defined in table 1 above. These data are taken from a survey conducted in 2001 (Muraro et al., 2003):

Table IT7- Type of benefits covered by non-profit funds in Italy

Benefits covered	% non-profit funds
Aesthetic treatment and surgery	14,29%
Eye surgery	57,14%
Dental care	67,86%
Dental implants	57,14%
Eyeglasses and contact lenses	67,86%
Artificial prosthesis	64,29%
Rehabilitation and long term inpatient care	60,71%
Thermal care	46,43%
Alternative medicine care	53,57%
Payments for out-of-pocket pharmaceuticals	32,14%
Other	17,86%

Source: Muraro et al. (2003).

In the case of for-profit PHI, most contracts do not reimburse starting from the 1st day of sickness, many do not allow unlimited reimbursed amounts, but set a maximum amount reimbursable per each reimbursed type of adverse event. Both in cash and in kind benefits can be allowed in all types of policies. Benefits in kind ("direct reimbursements") are provided through the network of PPOs of the insurer. Benefits in cash are retrospectively paid. Usually exclusions from PHI cover apply for the following type of services: mental health care, alcohol, drug and psyco-pharmaceuticals addiction, pre-existing physical disabilities and defects, aesthetic treatments, war, insurrection, earthquake etc., nucleus transmutation of atom, voluntary abortion. A survey of non-profit organisations providing complementary PHI in Italy showed that many restrictions apply for enrolment (Table IT8).

Table IT8- Reasons for exclusion from coverage – non-profit complementary funds

Exclusions - NO	69,44%
Exclusions – Yes	30,56%
If answered YES, criteria for exclusion are the following:	
Gender	0%
Age	63,64%
Chronic conditions	36,36%
Limitations in daily activities	0%
Physical disability	0%

Psychic disability	9,09%
Alcohol addiction	36,36%
Drug addiction	36,36%
Professional status	0%
Other	9,09%

Source: Muraro et al. (2003), pag. 161

Insurers are not required to offer a minimum level of benefits or a standardized benefits package. However, in the for-profit sector there seems to be a tendency towards doing so. The lack of a standard is a reason for low levels of customer satisfaction in terms of the quality of health care services covered. "Tailor-made" cover is also increasingly used by for-profit sector in Italy as well as by non-profit sector. Results from a survey conducted among non-profit funds in Italy in 2001, showed that 43.48% of them were offering tailor-made packages (Muraro et al, 2003, p. 160).

Overall, it is not possible for a privately insured person to opt out of the system. However, actual regulations forbid double coverage of risks among different insurers, but this regards insured people not the insurance companies. Insurance companies tend to promote the utilisation of public hospitals offering a daily fixed reimbursement each day of inpatient stay to insured people not claiming any expenditures following an admission in public hospitals. In Italy public hospital stay is free of charge, although hospital patients have to pay if they choose to stay in higher-quality rooms instead of normal rooms. Group policies and policies offered by mutual organisations often cover services not covered by the statutory health system (Table IT6). Moreover, it is possible for subscribers to 'combine' public and private funding streams, particularly regarding co-payments for drugs and specialist care publicly provided. A lower proportion of the market is represented by "LTC", i.e. policies for Long Term Care. LTC in 2004 accounted only for 0.3% of total premia in the life sector[194].

Setting premia

For-profit VHI apply individual risk rating for both individual and groups. In the case of the non-profit sector, the biggest funds adopt group risk rating, otherwise they do not seem to apply risk rating procedures and use community rating. Variables used for risk rating are usually age, sex, medical (both personal and family) history of disease, region and town of residence. Both Corporate and Non-corporate for-profit PHI also use age, sex, area of residence, history of disease. Corporate for-profit PHI , however, seems to be less based on history of disease. In the case of non-profit mutual policies, usually premia do not vary according to age or sex, or family composition. Usually group policies do not cover severe pre-existing conditions, such as cancer and diabetes, until a specified symptom or treatment free period after their policy has started (like, e.g., 1 month). In contrast to to other countries, such as The Netherlands, there are not risk equalisation mechanisms operating in Italy. For-profit companies tend to avoid asymmetric information problems typical of the insurance markets. Exclusion from coverage for pre-existing conditions, age limits and fixed length of contracts are a way to cream-skim for low risk people. Both annual and life types of PHI contract are available in Italy. The type of contract available

[194] source: Marchionni, F. "Il ruolo delle Assicurazioni nel sistema economico e sociale italiano" http://www.ania.it/documenti_salastampa/convegni/36_56_05072005_con.ppt#684,16,Diapositiva 16.

varies with age or sex or any other personal characteristic (see Table IT5). Also mutual associations offer different package of benefits according to the age of insured. Premia rise with age in the case of for-profit PHI. In the case of non-profit PHI this does not necessarily apply. Particularly, Mutual fund premia are lower for retired people, as a solidarity mechanism applies. Insurers can exclude pre-existing conditions from cover. This is allowed for several conditions (Table IT6). Waiting periods are imposed in most cases. Usually 30 days for sickness, 180 days for diseases not pre-existing or unknown at contract subscription. After 300 days from birth delivery[195].

Individual policies provided by for-profit companies usually foresee coverage for dependants but at extra cost based on family composition and age of dependants. In this case, usually family premia are much lower than the sum of individual premia for separate contracts of the same members of the family. Regarding commercial group policies, the proportion paid by employers/employees varies, depending on contractual agreements between unions and firms or by internal firms regulations. Usually, its is shared between employers and employees. However, it can be also foreseen that the contribution is totally paid by the employers (Rebba and Marcomini, 2003).

Results from a survey conducted in 1999 (Giannoni, 2001) on non-profit group VHI show that the average contribution rate for the employers was 51.7% for corporate insurance funds (Fondi aziendali); and 46.7% for funds managed by organizations of categories of professionals workers (Casse di categoria). Policies offered by non-profit funds can cover dependants (80.65% of funds provide coverage for families, see Rebba and Marcomini, 2003) but usually at extra cost, although the individual premium cost decreases as number of family components enrolled increases.

Group-purchased PHI cover stops when the employee retires in the case of for-profit companies. Regarding non-profit organisations, results from a survey conducted in 2002 showed that 30.56% excluded from coverage people over 65 or 75 years old, these are particularly represented by mutual association organised on a territorial basis (Rebba and Marcomini, 2003). Conversely, Corporate non-profit funds for categories of workers (Fondi di categoria) and corporate, firm-specific funds (Fondi aziendali) cover retired people provided that they were enrolled for a certain minimum time span before retiring.

In these last years premia have risen in the for-profit sector, usually at rates higher than the cost of living. For-profit companies argue that the reason is the increase of administrative costs and of tariffs paid to health care providers. Unfortunately, I have no statistics available on this. I can provide statistics on total premia collected by private insurers for the for-profit private health insurance sector.

In this sector usually premiums, reimbursements, and deductibles are indexed with the national consumer price index. The effective cost of the policy varies according to several parameters, particularly the region of residence of subscribers. Prices vary on average in a range +/- 20%, being lower in Apulia and in Northern regions and higher in South of Italy and in the largest metropolitan areas. Usually consumers can choose from a number of at least three products. The three largest Italian insurers offered four products each in 2008.

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(http://www.miaeconomia.it/ASSICURAZIONI/Lepolizzemalattia_9_326_55836_Limitidirisarcimentoscope rtiefranchigie_articolo.html)

It is normal practice to refer patients to PPOs for all services partially covered or excluded from public coverage, particularly specialist and diagnostic care; or they reimburse the co-payment if they use public or accredited private providers, so the insured need to get a prescription for accessing the services by a GP or other public sector provider. Individuals can switch in principle from one insurer to another, but they have limits set in terms of timing for communicating this to the company in advance of the annual deadline for payments. Diffusion of information about policy price and contracts does not seem to be widespread. Consumers association in Italy are increasing in number and importance. In the health care sector there is increasing awareness of patients regarding their rights which reflects on issues such as, e.g., risk management for hospital services. However, comparisons of health insurance policies offered in all Italian provinces are not officially/regularly available, whereas for the car accident sector this is available.

The role of the press is quite important. Occasionally the press reports articles which reported price and policies comparisons over time for individual policies, both for-profit and non-profit. However, rarely do they report comparisons between the two sectors, mostly reporting comparisons within the two sectors.

A significantly positive signal is given by the development in the Internet of web sites which are specifically performing comparisons of both prices and policy conditions for all insurance sectors. Information are related to comparisons made for individual policies sold by commercial companies (see e.g. www.miaeconomia.it).

These sites usually contain recommendations and warnings to consumers for the correct purchase of health insurance. The following prospect contains a set of recommendations for the Online purchase of insurance.

Box IT1 - Recommendations for the online purchase of insurance

1. Check the identity of the company and whether it is authorised to operate in Italy (calling ISVAP or at www.isvap.it) or consult the list of companies located in other EU member States which are authorised to operate in Italy, published every three months in the Italian Official Journal).
2. Avoid to stipulate policies with foreign insurance companies which are not authorised to operate in Italy as they might offer products which are not in compliance with Italian legislation, thus violating unintentionally fiscal and insurance provisions (this concerns above all third party liability car insurance (RC-Auto))
3. Before stipulating any contract, please read carefully the information notes (nota informativa) on line. Such information notes must be transmitted by the company before stipulating the contract.
4. Check in the information note what law applies to the contract in case of controversies. If the law is not the Italian one and you do not know very well the applicable foreign law, there might be major difficulties in case of controversies.
5. Please keep in mind that in case the applicable law is not the Italian one, any controversy with a foreign insurance company may be assigned to a foreign judge, with all consequential disadvantages of a proceeding abroad.

Source: www.miaeconomia.it

Also the National Association of Mutual Insurance Companies (Società di Mutuo Soccorso) FIMIV (Federazione Italiana Mutualità Volontaria) has a web-site from which consumers can access policy conditions of some companies, and get information about the

concept of mutual insurance, membership conditions, and so on (www.fimiv.it). The potential of ICT in rendering a more competitive health insurance market in Italy has been explored in Giannoni (2001). A survey conducted on the use of ICT by non-profit health insurance companies revealed that these companies are developing e-commerce as well, but at slower rate with respect of the for-profit sector. Moreover, the diffusion of ICT, although quite widespread, is higher in Northern than in Southern Italy.

At least two or three options are usually offered by each commercial private insurer. However, the process is not easy at all, as policies are not standardized and policy conditions vary from one company to another. Moreover, products offered by for-profit and non-profit are not compared by the press etc.

Regarding subscriber access to information and consumer protection in Italy there is an institution called ISVAP – Istituto per la vigilanza sulle assicurazioni private (Supervisory organism on private insurance companies of public interest) is an public authority with legal personality, instituted under law n.576 of 12 August 1982, for the supervision of insurance and reinsurance companies as well as of any other entity subject to the discipline of private insurance companies, including insurance agents and brokers. ISVAP is carrying out its functions according to the guidelines of insurance policy fixed by the Government. National legislation attributed to ISVAP powers which concern in particular the transparency of the relationships between insurance companies and the insured and consumer information. Such powers are ecercised by ISVAP towards all companies operating in the Italian market, including those having their legal seat in another European member state. ISVAP has the duty to collect complaints made by the interested persons against the insurance companies subject to ISVAP control, to facilitate the swift and correct execution of contracts, to ask for clarifications to companies, to facilitate the solution of queries which have been presented to ISVAP. The new law regulating the insurance sector in general in Italy (Codice delle Assicurazioni- Leg. Decree n.209- Sept. 7th 2005), reformed in 2005, states that insurance companies need to guarantee transparency in contractual information to subscribers (Ibid. art.n.120).

Under PHI, subscribers are usally required to pay part of the costs of the health services they use. Moreover, liability limits are set from most policies. Insurers are permitted to contract selectively with providers. They can contract tariffs paid to private health care structures, but not the one user-charges/tariffs paid to the public sector. This is why many insurers offer to their insured the choice between going to public hospitals (as in Italy this is free of charge) or PPOs without anticipating expenditures, or going to public structures or private not PPOs anticipating expenditures. In Italy traditional fee-for-service or contracted providers are set up among single categories of providers and the insurance companies.

Providers are mostly paid on a fee for service basis if they have a direct contract with the insurer. Otherwise if they operate as accredited providers with the NHS and operate indirectly with the company, they receive the user-charges usually anticipated by the insured. Accredited private providers operating for the public sector are regulated by fees set at regional/national level. However, insurers can directly contract and negotiate prices with private providers, depending on arrangements. Regarding incentives to lower/control health care and operating costs, insurers behaviour seems to be variable. Usually they use choice of provider payment method referring patients to preferred provider networks where they do not have to anticipate expenditures and have lower dedutibles. Moreover, GP

referral to outpatient or inpatient specialist care can be required, by requiring patients to obtain prior authorization. Insurers purchase services from private providers (Hospital, ambulatory, clinics). Many insurers offer to their insured the choice between going to public hospitals (in Italy this is free of charge) but they do not pay the public sector for this. What can be allowed by policies is the reimbursement (either partial or total) of user charges paid by patients to the public sector.

In the context of the 1999 NHS Reform, doctors working in the public sector were required to choose between public and private, with the possibility of working privately within the hospital ("intra-moenia") both for inpatient and specialist services. Most of them have chosen to remain in the public sector and opted for intra-moenia practice type. According to the National Agency for Health care services (A.S.S.R.- Agenzia per I servizi Sanitari regionali) intra-moenia utilisation rates for hospital services increased by 38.1% in the period 2001-2004. However, according to a report prepared for the Health and Hygiene Commission at the Parliament (Commissione Igiene e Sanità del Senato) in 2007, there are significant differences accross regions and inside regions across local health units in the degree of implementation of intra-moenia. Partcularly, intra-moenia is more widespread in those regions where health care is better organised, i.e. mostly in Central and Northern Italy (Ibid.). Doctors don't have financial incentives to treat PHI patients differently in the public sector, but they do in the private sector where they get paid through FFS. There is some evidence that privately referred patients to hospitals (for "intra-moenia") face shorter waiting time and waiting lists than the others.

Administrative costs and claims ratios

Statistics on PHI sector costs and activity are reported in the following table. In 2006 premium income was 18.5 million euro (Table IT9).

Table IT9 The Private Health Insurance Sector in Italy- statistics (1)

	1999	2000	2001	2002	2003	2004	2005	200
Gross written premiums	6	8	12	10	17	18	24	23
Incurred claims (-)	1	2	3	3	7	9	12	7
Changes in technical provisions (-)	4	4	8	4	2	2	2	3
Balance of other technical items	-1	-1	0	1	0	0	-2	0
Operating expenses (-)	0	0	0	0	4	2	3	3
Investment income	1	1	1	1	0	0	1	0
Direct technical account result	1	2	2	5	4	5	6	10
Reinsurance result and other items	-1	1	0	-2	-5	-4	-5	-9
Overall technical account result	0	3	2	3	-1	1	1	1
Annual % changes in premiums	n.a.	36.1%	46.8%	-10.3%	61.3%	9.2%	28.9%	-2.
Expense ratio	7.2%	3.6%	3.3%	2.3%	21.8%	11.6%	12.5%	12.
Investment income/Technical provisions	n.d.	5.9%	6.0%	5.9%	1.4%	3.9%	5.6%	2.8
Technical account result/Gross written premiums	13.7%	21.4%	14.8%	44.2%	24.2%	27.7%	23.6%	44.

Overall technical account result/Gross written premiums	-0.2%	34.1%	20.6%	28.9%	-6.2%	3.5%	6.0%	3.6
Overall technical account result/Technical provisions	n.a.	21.60%	12.71%	12.48%	-6.93%	9.67%	14.93%	7.1
Premiums to total life premiums ratio (%)	0.016%	0.020%	0.026%	0.018%	0.027%	0.027%	0.032%	0.0

Note: Indexes and % changes are calculated on data in thousand Euro, data are reported in million Euro.

Source: Ania reports (L'assicurazione italiana 2006/2007- http://www.ania.it/studi_statistiche/stat_attuariali/documentazione/Statistical%20appendix.xls)

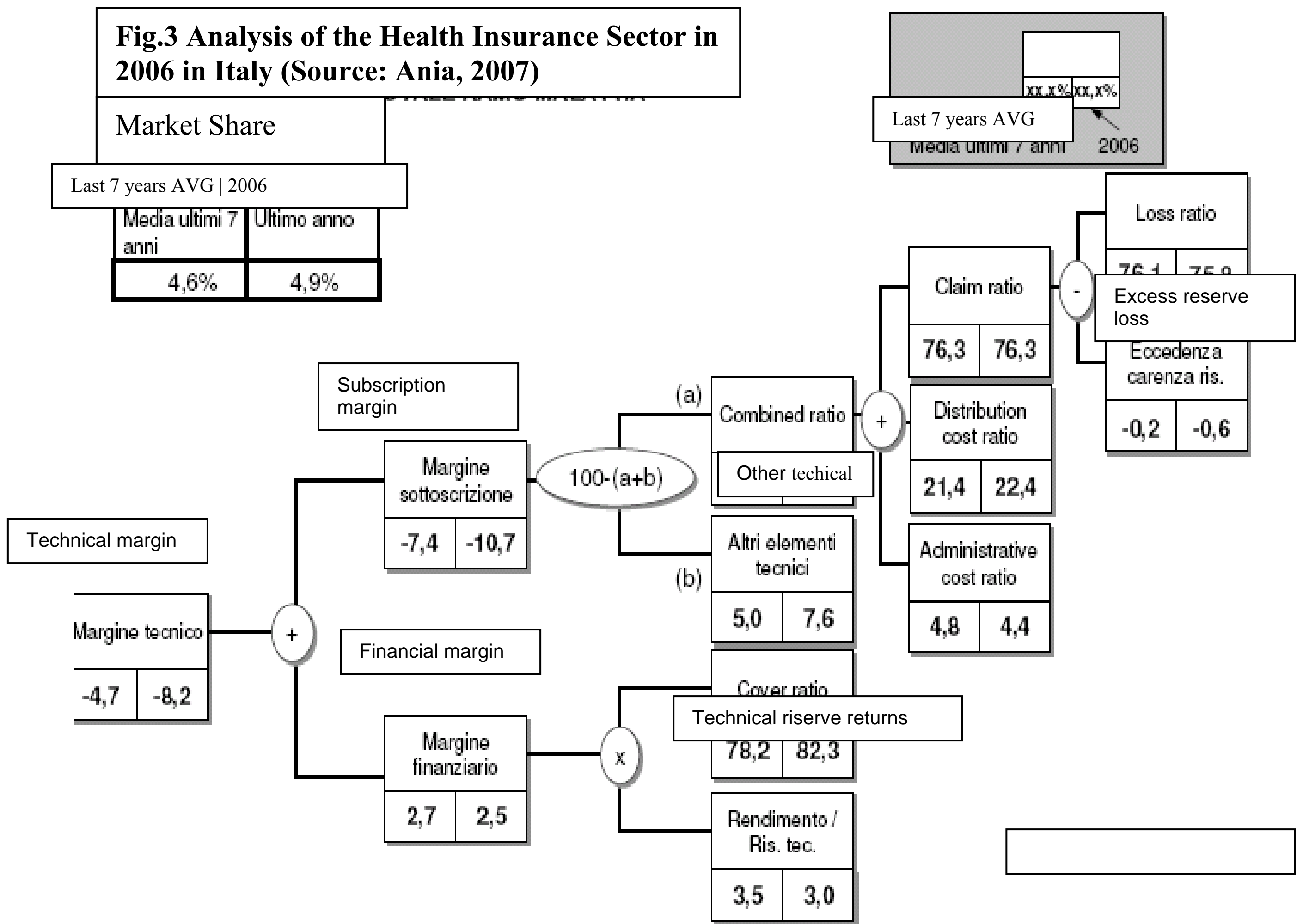
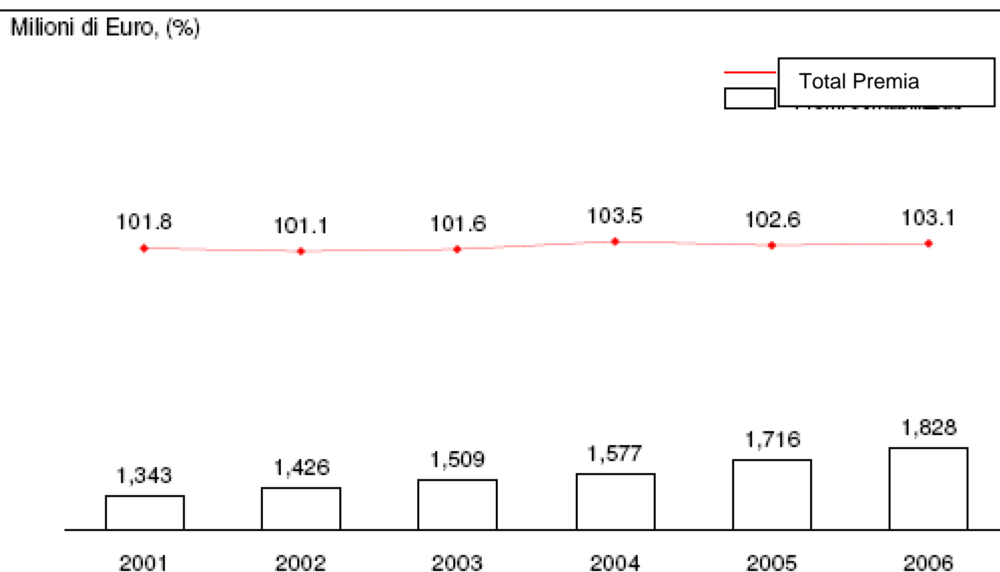


Fig.3 Analysis of the Health Insurance Sector in 2006 in Italy (Source: Ania, 2007)

Fig.4- Combined Ratio - Premia accounted - Health insurance sector - % - Million euro



Source : Ania (2007)

Overall, in all the insurance sector, in 2006 total expenditures were 13,349 million euro. Their incidence was 12.3% in 2006 and it has increased over time (Table IT9). Administrative cost ratio was 4.4% in 2006, not so different from the average 4.8% relative to the period 1999-2005 (Figure IT3). Expenditures are very high in South of Italy, where claims and frauds expenditures are higher. A survey conducted by ANIA (2002-2006) on a sample of companies representing approx. 40% of total gross premiums collected in 2006, aiming to obtain – as distinguished into individual and collective policies – the average cost of reimbursements for hospital and non-hospital healthcare. Average costs of healthcare services have been calculated distinguishing according to the type of policy guarantees:
– reimbursement guarantee: when the health insurance policy covers healthcare expenses for hospital admissions, surgery interventions or diagnostic care;
– indemnity guarantee: when the health insurance policy provides the payment of per-diem allowances or other amounts in the event of a disease.

Regarding individual policies, average cost of healthcare for hospital admission and/or surgery was 3,350 euro in 2006, more than ten times the cost for non-hospital healthcare. While the trend of the former has increased over the time, the cost of non-hospital healthcare has decreased from 370 euro in 2002 to 280 euro in 2006. Cost differences are less apparent for the policies providing the payment of per-diem allowances in the event of disease: while in 2006 the amount paid during the whole disability period for hospital admission and/or surgery was approx. 600 euro (and almost stable over the targeted five-year period), the amount paid for non-hospital healthcare was 830 euro (compared to approx. 1,000 euro in 2002-2003).

For individual policies, other quantity information was collected besides cost indicators, namely:
– contract duration: in the targeted five-year period, the average contract duration for a multiyear policy was approx. 7-8 years;

– percentage of individual policies: if compared to the aggregate of sickness policies, the share of individual contracts has increased from 20% in 2002 to more than 35% in 2006;
– average premium: based on sampled data, in 2006 the market showed the presence of more than one million individual contracts (twice the figure in 2002); the average premium paid by policyholders for a sickness insurance was approx. 600 euro (in 2002 it was more than 400 euro).

Regarding collective policies, the average amounts due by insurance companies for hospital healthcare under collective policies are substantially in line with the amounts due under individual policies: in 2006 the average expenditure for repayment guarantees was 3,100 euro, and the average amount for indemnification guarantees was 600 euro.

Non-hospital healthcare expenses – either of the repayment or indemnification type – were lower as an average (approx. one half) than the expenses under individual policies.

Regarding collective policies, it was also possible to evaluate the average cost supported by insurance companies for each healthcare service, under the repayment guarantee for non-hospital healthcare. In 2006, the most expensive sub-guarantees were those for cancer treatments (more than 1,000 euro), followed by dental care (approx. 700 euro). The figures observed for other types of services were generally stable over the targeted five-year period, with the exception of the costs for drugs and medicines.

Insurers' claims ratios in 2006 was 76.3%. This value was the same during the period 1999-2005 (Figure IT3).

Legislative framework and market regulation

The legislative framework for PHI can be described by looking at the to two main types of PHI:

1. The first are collective complementary private health insurance funds (Fondi integrativi del SSN), introduced in 1999 within the last SSN reform, in order to manage the growth of private health care expenditure, without loosing the NHS characteristics of solidarity and universality. This type of insurance funds have been introduced setting special fiscal benefits for its promotion . The newly created funds (called "Fondi Integrativi del SSN") are allowed to reimburse user charges, services provided privately within public facilities and expenditures for services complementary with respect to the "NHS essential services", i.e. not included in the benefits package funded by the NHS and supplied only by accredited private structures integrated with the NHS or by the NHS itself .

These funds are regulated by the following laws:

- Definition: 1999 Italian National Halth Care System (Servizio Sanitario Nazionale) Reform (Law D.lgs. 229/99 "Norme per la razionalizzazione del Servizio Sanitario Nazionale")
  - degree of coverage provided: Art.9 c.4 D.Lgs. 229/99
  - management rules : Art. 6 e 7 D.Lgs. 229/99
  - surveillance and control: Art. 8 D.lgs. 229/99
  - fiscal treatment: Law n. 132/1999 art.10 "Nuove disposizioni in materia di perequazione, razionalizzazione e federalismo fiscale" Trattamento fiscale (normativa); Income tax regulations (TUIR – Dpr . n. 917/1986 modificato con il

D.Lgs. n. 41 febbraio 2000); contribution system and other regulations (D.lgs. 314/1997 - D.lgs. 460/1997 - D.lgs. 2 settembre 1997 n. 314).

2. The other types of PHI are mainly provided by private insurance companies and their regulation has been reformed in 2005 when the new Code for Private Insurance (Codice delle Assicurazioni Private : D. lgs. 7 settembre 2005 n. 209) has been introduced. The main aspects that the Code regulates regarding PHI are the following:

- Art 2 c. 3- classification of insurance branches;

- Art. 20 – PHI - (Assicurazione malattia in sostituzione di un regime legale di previdenza sociale);

- Art. 37 – Technical reserve of non-life insurance sector (Riserve tecniche dei rami danni).

The regulatory body for the market for PHI in Italy is a National institution ISVAP – Istituto per la vigilanza sulle assicurazioni private (Supervisory organism on private insurance companies of public interest) that is an public authority with legal personality, instituted under law n.576 of 12 August 1982, for the supervision of insurance and reinsurance companies as well as of any other entity subject to the discipline of private insurance companies, including insurance agents and brokers. ISVAP is carrying out its functions according to the guidelines of insurance policy fixed by the Government.

The assembly of ISVAP consists of the President with representative powers - he is also exercising the functions of general manager - and the Board charged with the internal organisation as well as the external relationships. The internal organisation of the body is split up in services which are structured in sections. Presently, the Services take care of the following matters: insurance of damages; insurance of persons; patrimonial sector; consumers' protection; professional registers; legal questions; administration and staff; organisation and systems. The legislation concerning the insurance sector has conferred to ISVAP the functions of supervision and regulation, qualifying the organism as an independent body with its own legal, juridical, and financial autonomy as well as autonomy in accounting, organisation and administration with specific technical competence and far-reaching operational instruments. The objective is to ensure the stability of the market and of companies as well as the solvency and efficiency of the operators and guarantee the interests of the insured/consumers and, in general, of the clients. The main duty of the organism is to supervise the insurance companies by controlling their technical, financial, and patrimonial administration and their accounts and by checking whether these correspond to the legal, regulatory, and administrative provisions in force. Furthermore, ISVAP is controlling the activities of insurance agents and brokers as it is obvious that correctness and transparency are fundamental in the whole framework of insurance policy and its development. For exercising its functions, ISVAP has, among other things, the faculty to request from the controlled companies the communication of data, elements, and information; it may order to hold inspections and any other kind of inquiries; it may convene legal representatives, general managers and the presidents, as well as the Board of Auditors and, if necessary, the representatives of the auditing company charged to certify the budget. ISVAP, in particular, authorises the insurance companies to exercise their activity as well as to extend their insurance activity to other sectors and to exercise any connected activity by releasing the respective authorisation after having checked the conditions which are necessary for such an activity.

A particularly important duty of the supervision and control ISVAP is charged with and which is to guarantee the safe and careful administration of insurance companies is the financial control: it has to constantly control the patrimonial and financial situation of the company and, in particular, the margin of solvability and the amount of technical reserves which must correspond to all the activities carried out as well as the amount of assets which must totally cover all the insurance policies. It must be pointed out that due to the development of legal provisions the supervisory system is paying more and more attention to data treatment and to the real time analysis of data concerning the administration of the company in order to strengthen the precautionary character of the supervision and to intervene in time when risky situations are coming up. A key role has in this context information which the companies must communicate during the exercise of their activities and which complete and integrate traditional controls based on the annual budget.

The evolution of financial activity has led to the creation of more and more complex groups of insurance companies: therefore, taking into account the need to control the relationship between the companies belonging to the same group and for evaluating the effects upon the administration of each single insurance company, ISVAP was conferred the power to authorize the taking over of controlling shares and qualified shares of insurance companies. Moreover, ISVAP has the faculty to order the sale of shares in insurance companies if it considers them not connected with the company's object or prejudicial for the company's stability. Furthermore, ISVAP has been entrusted the discipline of consolidated budgets for insurance groups. Finally, the companies are obliged to previously communicate to ISVAP some deeds of patrimonial character they intend to realise and which involve the whole group. ISVAP has moreover the duty to collect complaints made by the interested persons against the insurance companies subject to ISVAP control, to facilitate the swift and correct execution of contracts, to ask for clarifications to companies, to facilitate the solution of queries which have been presented to ISVAP.

It is important to note that in Italy, contrary to other European markets, the so-called “ombudsman” for insurance problems does not exist; however, national legislation attributed to ISVAP powers which concern in particular the transparency of the relationships between insurance companies and insured and consumers’ information. Such powers are exerted by ISVAP towards all companies operating on the Italian market, including those having their legal seat in another European member State but which are operating in Italy under the form of offering their services to customers.

Complementary PHI funds (Fondi integrativi del SSN) are regulated also by the Ministry of Health, which has introduced in March 2008 a Decree setting a body inside the Ministry in order to control these funds (see hereinafter). Regulations may apply to the following types of PHI :

1. Complementary PHI (Fondi integrativi del SSN) regulations apply according to the following prospect.

Box 2 - Complementary SSN Funds Regulatory Aspects

	References to legal provisions	Description
1 - specification of the field of application	**Art. 9, subparagraph 4, letter a, b, c and subparagraph 5, bill called "Provisions for the Rationalisation of the Public Health Service S.S.N."**	**- The Decree defines the services that complementary fun allowed for fiscal benefits by the SSN The services that funds c cover. These are: - Services excluded from SSN coverage but integrated wi public services, among these there are: - non conventional therapies; - thermal care; - copayments for services coverei by the SSN ; hotel inpatie extra-payments; - user charges for health and social services provided accredited residential or partially residential providers ; - complementary (i.e. not covered by the SSN) health and soc services provided by accredited residential or partially resident providers for long term care treatments, including both home a residential LTC care for disabled and elderly people and for peop invalid for temporary disease or accident; - dental care not covered by the SSN;**
2. Definition of fiscal treatment	**Art. 10 – Law 132 "New provisions as to the equalization, rationalization and fiscal federalism" and other references (see the related questions on this point)**	**See the related questions on this point**
3. Definition of the degree of coverage offered to the assisted	**Art.9, subparagraph c.4 – Bill of legislative decree with the title "Provisions for the Rationalization of the SSN". National Financial Law (legge Finanziaria) for the year 2008.**	**See point 1 above. If funds provide exclusively health care, they can cover health ca and social services according to their own regulatory and statuto mechanisms, user charges for publicly provided services and f specialist care provided inside public hospitals (intra-moenia). Starting from 2010, funds will have to demonstrate that at least l 20 of services covered is related to health and social long term care a dental care.**
4. Definition of the rule for the administration	**Art. 6 and 7 Bill of legislative decree with the title "Provisions for the Rationalization of the SSN".**	**The principle of self-management has been introduced: this shou make regions and municipalities responsible for the rationalization health care expenditure. However, the process must be structured such way as to have the funds administered competently at a loc**

		level, and there is no previous experience in this area.
5. Definition of the activity of controlling the effectiveness of F.I.	**Art. 8 Bil of legislative decree with the title “Provisions for the Rationalization of the SSN”.** **National Financial Law (legge Finanziaria) for the year 2008.**	**The new funds should guarantee solvency, should be adequat capitalized and rate premia competitively,** **- Following the last financial act for 2008, a Decree of the pa Ministry of Health in charge, has established a Commission at t Ministry of Heath for the monitorino and control of Funds activiti**

Results from surveys conducted on the market of complementary health insurance in Italy show that generally existing funds appear to be only partially complementary according to the 1999 reform (Giannoni, 2002; Rebba and Marcomini, 2003). The scarce degree of complementarity of existing funds may be determined in the scarce use of specialists’ examinations offered within public facilities (Ibid.) One of the reasons for this, is due to the difficulty to have access to such type of service in many regions of the Country, the supply being lower, e.g., in suburban areas. The Italian health system is characterised by a deep geographic regional variability in the supply of public and private health care services. The supply of public centres adequately equipped for such integrative services as well as the length of waiting lists and waiting times, differ widely across regions, particularly as far as the private services supplied by specialists within hospitals are concerned.

ISVAP has further been conferred the power to intervene with disciplinary measures on the insurance market: not only does it control whether the operators on the insurance market respect laws and regulations in force, but it also enacts directives and introduces behavioural rules which are to ensure the necessary links between legal provisions and the concrete reality in which insurance activities are exercised.

Tax treatment of the various types of health insurance may vary greatly. The premiums of collective health policies of any type paid on a voluntary basis can be tax deductible from income at a given rate, up to a maximum amount of 1,250 euro that is the same for all insurance premiums (prior to 1992 premiums could be tax deducted only at a marginal rate).

Tax treatment for supplementary health plans is governed by the Single Text on Income Taxes (Tuir – Dpr n. 917/1986), as amended by D.Lgs. n. 41 dated February 2000, and healthcare contributions are regulated by D.Lgs. 314/1997.

D.Lgs n. 41/2000 revised the regulation and tax treatment of voluntary and contractual healthcare contributions. The act regulates both the field of tax deductible charges (see art. 10 par. 1 of Tuir) and the tax treatment of the health contributions paid by the employer and the employee (art. 48, par. 2, item a) of Tuir), assuring tax relief both for supplementary healthcare funds under art. 9 (Doc funds) and for non-supplementary healthcare funds (Non Doc funds).

Originally, the employer’s and employee’s contributions to health plans in compliance with unions agreements or company regulations benefited from total tax deductibility both at the employer and employee level.

With the enforcement of the new law, tax relief are differentiated according to the type of health plan ("doc" and "non-doc" funds) selected, based on a "tax bonus" criterion (see Table IT9).

Tax bonus is used in the form of a tax deductible charge from total income, composed of the contributions paid to the funds. Within the established maximum amount, also the health contributions paid for dependent family members can be tax deducted from income. Conversely, in the case of collective, cumulative and individual sickness policies, neither the old regulation nor the new rules introduced by D.Lgs. 41/2000 grant any tax relief on the premiums paid. However, policyholders can deduct from their tax dues 19% of the medical expenses supported – despite these expenses have been refunded by an insurance company – with a 129 euro deductible.

Table IT9: tax deductibility of contributions paid to health funds

YEAR	**DOC FUNDS**[196] **(in Euro)**	**NON DOC FUNDS**[197] **(in Euro)**
2000	**-**	**3.615**
2001	**1.033**	**3.615**
2002	**1.033**	**3.615**
2003	**1.549**	**3.099**
2004	**1.549**	**2.841**
2005	**1.808**	**2.582**
2006	**1.808**	**2.324**
2007	**2.066**	**2.066**
2008	**2.066**	**1.808**

Source: Nomisma 2003

The above table suggests how far the legislator has levelled off the discrimination between employed workers and the generality of taxpayers which had characterised the prior tax treatment of health funds. However, the new law does not fully remove the tax benefit of the deductibility of contributions to non-supplementary health funds, since the state will continue – although to a lesser extent – to grant a tax allowance to those health funds that guarantee a cover that is substitutive or non-supplementary to the national health service. The reasons for the preservation of this tax benefit for non-supplementary health funds can be seen in the historical role played by the old sickness funds in offering healthcare, in order not to jeopardize the equilibrium of existing funds (Tubertini 2000). When the new law is fully enacted, the relative benefit for the new funds compared with those under art.

[196] Art. 1, par. 1, item a) of D.Lgs. 41/2000
[197] Art. 1, par. 1, item b) of D.Lgs. 41/2000

48 of Tuir will be 258 euro (in 2008 it will be 2,066 euro compared with 1,808 euro of non-supplementary funds), and this might involve a different behaviour of policyholders and, above all, a different strategy of health insurance funds (Nomisma 2003).
The Decree introduces the principle of cumulative limits for tax deductibility when payments are made to "doc" funds and other supplementary health funds. Therefore, starting from 2003, it is be possible to cumulate the tax relief under art. 10 for supplementary health funds with the tax relief under art. 51 of the Tuir for non-supplementary health funds, up to a general limit of 3,357 euro. On the other hand, the institutionary sources of the health funds existing prior to the enactment of Dlgs. n. 229/1999 may be viewed as funds fulfilling the requirements of the new regulation, to be managed jointly with the existing section of the same organisational context.

Table IT10 Limits of deductibility under cumulation of insurance covers

YEAR	Max. cumulation limit (in Euro)
2000	3.615
2001	4.648
2002	4.648
2003	3.357
2004	3.357
2005	3.357
2006	3.357
2007	3.357
2008	3.357

Source: Nomisma (2003)

The last financial act for the year 2008, foreseen that a Decree of the Ministry of Heath should define the minimum basket of services required to be provided by funds in order to get the guarantees. Following this, the ministry of Health of the past government (Mrs. Livia Turco) signed a Decree in march 2008 (*Decreto ministeriale - attuativo dell'articolo 1, comma 198, della legge finanziaria 2008*). This stated that complementary SSN health funds will have to provide coverage for long term care and dental services in order to get fiscal benefits. Moreover, in order to get the fiscal benefits, dental care and long term care should be provided by complementary funds for what is not fully/partially covered by the SSN. Starting from 2010, in order to have guaranteed the "doc" fiscal regime, funds will have to demonstrate that at least 20% of services covered is related to health and social long term care and dental care. This will also apply for contributions for mutual funds, provided that they cover services satisfying those requirements. Individual premium for LTC are allowed to be deducted from income tax, with a maximum annual € 1.291,14, provided that they do not foresee the possibility of resolving the contract for the insurer and that guarantee lifetime coverage.

Despite the 1999 reform and the Leg. Decree D.lgs 41/2000 there is a certain degree of discrimination of those citizens who cannot or don't want to adhere to private or company funds and decide to join individually a social security fund dealing in the healthcare sector or to enter an insurance policy on an individual, collective or cumulative basis. In the former case these individuals can deduct contributions up to 19% of the premiums paid, up to a maximum of 1,219 euro; in the latter case they cannot deduct the premiums paid to insurance companies.

Moreover, the law allows the healthcare expenses supported personally to be deducted, for the part exceeding the amounts repaid by health funds. In other words, an individual may tax deduct 19% of the healthcare expenses covered (provided these are not covered by the fund) after 129 euro of deductibles.

As far as contributions are concerned, the health funds (either complementary or not) provided for in employment contracts or per company regulation enjoy a reduced social contribution rate pursuant to D.Lgs. 314/1997. In other words, the employer is subject to a solidarity contribution of 10% to Inps (the Italian Social-Security Institute), instead of the ordinary social-security contributions, whereas the employee is subject to standard pension contributions and payments are considered as belonging to the pensionable salary.

European Union regulatory framework

Legislative decrees n.174 and. 175 of 1995, which implemented the so-called "third" EU Directives concerning non-life insurance, have - among other things - increased the power of ISVAP. Now, ISVAP has the duty to supervise also those companies which have their legal seat in Italy but which are exercising part of their activity on a EU level under the form of offering services according to the EU principle of "home country control" and the mutual recognition of national legislation. If an insurance company violates the provisions it is held to respect or behaves in a way which could prejudice its stability, ISVAP may adopt corrective and repressive measures. For exercising the functions attributed to ISVAP, it may request data, information, and co-operation from all public authorities; the organism is further promoting any other form of co-operation considered necessary with other authorities of the financial control and supervision and the controlling organisms of insurance companies of other EU member States. The new Insurance code (Codice delle Assicurazioni) approved in 2005 reflects the aims of the Directive, particularly regarding consumer protection issues and transparency.

Public policy towards PHI

With the 2007 financial act, the Government started a new strategy made of interventions aiming at improving the efficiency of the health care system and at the same time bringing once more the public expenditure's growth rate in line with the GDP. This should be accomplished through a greater financial responsibility for regions, an increase in the "ticket system", decrease in the price of drugs and laboratory analysis, reduction of waiting lists for serious diseases, are some of the measures that are being adopted. Among the further interventions expected, there was the launching of complementary health funds, funds already expected by the 1999 law reforming the healthcare system but that have not been yet implemented. According to CEA (2007) for the insurance sector there will be significant medium-term development perspectives, naturally linked to relevant issues connected to the detection of their scopes and to their management criteria. However, as recently the government has changed in Italy, it seems difficult to predict if this will be further pursued.

Over the last ten years, there have been periodical debates regarding the role of PHI, mainly originated by the private sector. According to a representative of UNIPOL, a main insurance company (Bifone, 2007), the main problems of this market are related to :

–adverse selection in individual policies

–inappropriate excess demand for health care services with problems of supplire indiced demand;

–High variability of health care costs across areas;

- High administrative and management costs;

Among the reasons for this, there is a lack of a national standard for the definition of contracts set with providers. This implies variability in costs (as e.g. the formulary for setting tariffs is extremely detailed and variable across the country), higher costs, higher timing for updating tariffs/contracts, higher probability of errors in the management of contracts, higher need for controlling the process and, ultimately, higher claims and related costs.

As it stands, the market has not significantly increased over time. Unless the government will push the system towards an increased role of PHI (via, e.g., reforms affecting tax treatments), it seems unlikely that it will develop so much, given the existence of a statutory system. The actual government in charge has given priority in his agenda to furthering devolution of power and fiscal federalism. We can expect higher variability in public/private mix across regions and consequently, higher variability in the diffusion of PHI, with PHI coverage prevalence increasing further in Northern regions. Recently, however, , the government has published in May 2009 a "White paper on Welfare" in which there is clear statement in favour of the development of PHI [198]. As there is evidence that most types of Phi contribute significantly to increase income-related horizontal inequity in access to specialist services in Italy and that it further contributes to the North-South divide (Giannoni and Masseria, 2008) , there is a risk that increasing PHI coverage without taking into account existing inequities across regions could further weaken the capacity of the SSN to guarantee uniform access to services on the national territory.

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Latvia

Girts Brigis

Market role and context

Latvian health care can be classified as a mixed tax-based and private system, with social insurance funds playing an additional role. There is a purchaser-provider split, where the State Compulsory Health Insurance Agency (SCHIA) contracts private and public health care providers for services on behalf of the government (Tragakes et al 2008). The government of Latvia is responsible for statutory health system financing through general tax revenue; unlike in other similar systems, neither a payroll tax nor a social tax is used. Also, health services are financed through direct out-of-pocket payments and private health insurance.

In the Latvian example, it would be more appropriate to refer to private health insurance as voluntary health insurance because it is not exclusively private: at least one commercial company selling insurance belongs to the municipality of Riga city and in many cases insurance buyers are public institutions and enterprises. The system is regulated and controlled by the central government, and the main regulatory tool is contracting between the agency and providers mentioned above. Local governments may also provide some additional minor financial support mainly for infrastructure substitution, depending on their budget capabilities and priorities. In 2007, the allocation from the state's budget to health care was 518,089,234 Latvian Lats (EUR 737,174,566.45) (Ministry of Health of Latvia 2008) . In 2006, Latvia spent 6% of its GDP on health. Government spending was about 63.2% of total population spending for health. The proportion of non-public health financing increased dramatically after the country restored independency in 1991, but this has stabilized and even slightly decreased over the last few years (Xu et al 2009).

Table LV1 Main indicators on health system financing

	2002	**2003**	**2004**	**2005**	**2006**
Total expenditure on health as % of GDP	6.2%	6.1%	6.8%	6.4%	6.0%
Per capita health expenditure in US$ (at exchange rate)	246	292	402	443	533
General government expenditure on health as % of total expenditure on health	51.8%	52.4%	58.6%	60.5%	63.2%
Out-of-pocket payment as % of total expenditure on health	45.5%	46.1%	40.6%	38.6%	35.8%
Private prepaid and risk-pooling plans as % of total expenditure on health	2.7%	1.5%	0.8%	0.9%	1.0%

Source: (Xu et al 2009) - WHO National Health Accounts

The proportion of private out-of-pocket expenditure on health in Latvia is high in the EU context. However, one has to be cautious in interpreting this data because it is difficult to estimate direct private expenditures, and the proportion of private contributions could be even higher. For instance, the Latvian Insurers Association in 2007 published data saying

that PHI claims made up 5.2% of total health expenditures (data source currently not available).

At the time this case study was written (March 2009), the Latvian economy was suffering from a dramatic and growing recession. Beginning on March 1, 2009, co-payments for health services in the Latvian statutory system were increased dramatically: for specialist consultation from 2 LVL to 5 LVL and for hospital treatment bed-days from 5 LVL to 12 LVL. For these additional reasons, estimates on PHI's proportion of total and private expenditure are approximate. Currently, the Latvia Central Statistical Bureau is not providing data on this. Despite the relatively small proportion of estimated health expenditures covered by PHI, the National Health Survey showed that 15.6% of respondents in 2003 (aged 18–74) are reporting that they have additional voluntary (private) health insurance (Central Statistical Bureau of Latvia 2004) .

Latvian PHI is a mixture of complementary and supplementary coverage. It covers services that are not covered by the statutory public financing system, such as dentistry for adults, physiotherapy and massage, rehabilitation, some types of vaccines (influenza, tick borne encephalitis, hepatitis) and prescribed drugs (usually a proportion of price). Some PHI schemes cover only patient fees and co-payments that patients must pay in addition to state budget paid services. Also, specific services such as optician services, hearing aids and prostheses are covered by some schemes. Plastic surgery, extra uterus fertilization, traditional healers and products of hygiene are the exception and covered only in some specific insurance schemes. In addition to complementary coverage, many PHI schemes are offering supplementary coverage. Supplementary coverage allows subscribers to avoid waiting times for consultations and clinical examinations, to have direct access to specialists without GP referrals, to have access to service providers who do not have contracts with the governmental agency and to have better services and comfort at hospitals and outpatient clinics and for emergency care.

Market overview

PHI sellers are exclusively commercial for-profit organizations in Latvia. Their total number is 10-12 (depending on the data source), and most of them are international non-specific general insurance companies. Their market activity in PHI is quite unequal, and this again makes it difficult to count the real number of health insurers. The municipality of Riga city owns one of these commercial companies. Historically, it was founded as a specific PHI company to insure against co-payments, but later it became involved with other types of insurance. At present, there are plans to privatize it.

Every company offers a variety of different health insurance plans--from coverage of co-payments that are double covering services paid for by the public sector to coverage allowing for better access and quality with improved inpatient conditions. Service providers and insurers sometimes disagree over what should be reimbursed and to what degree though. Also, the large number of insurance plans available with varying levels of coverage can make it difficult for health care providers to know what is covered and what is not. For example, Company *Ergo Insurance* offers two options, one (called *Fortuna*) that allows subscribers to choose price and services covered (40–50 sub-schemes) and another (called *Gloria*) with the highest possible price and most services.

Despite the controversial available data, it is clear that PHI premiums and claims are growing in Latvia. The governmental organization supervising insurance and other financial commercial enterprises is publishing data that supports this observation (Financial and Capital Market Commission 2007) .

Table LV2 Health insurance premiums and claims (real Latvian Lats, millions)

	2002		2003		2004		2005		2006	
	LVL	%	LVL	%	LVL	%	LVL	%	LVL	%
Life insurance										
Premiums	0.9	16	1.6	21.3	2.1	23.7	5.2	31.6	6.8	28.5
Claims	0.7	25.7	0.9	21.6	1.3	19.3	3.1	53.4	4.2	59.2
Non-life insurance										
Premiums	1.2	12.1	1.4	11.9	1.6	13	1.2	13.7	2.5	13.5
Claims	0.9	23.3	0.9	23.6	1.1	21.7	1.2	19.2	1.5	17.2

Source: Latvian Insurance Market in Numbers, 2002 – 2006

The Latvian Insurers Association newsletter of the first quarter in 2007 noted, “The second most required type of insurance is health insurance. Premiums of this type of insurance [totalled] 17.2 mill. LVL (22% of the market), [which] is 5 mill. LVL or 41% more than in the first quarter of 2006. Regarding health insurance [claims, this] takes the third position with payments of 5.9 mill LVL (20% of the market), [which is] 1.4 mill. or 32% more than year ago.”

According to the National Health Survey data in 2003 (Central Statistical Bureau of Latvia 2004), the biggest proportion of individuals with PHI is made up of those with the highest education (25.5%); on the other hand, PHI take-up rates for those with only first level secondary and basic education were 15.1% and 9.9%, respectively. Also, PHI take-up is related to age; individuals are more likely to obtain PHI after the age of 40, but the likelihood of having PHI then gradually decreases after the age of 50. In addition to education and age, it has been shown that intermediate and higher managers are insured more often. Gender differences were not found, but there is a tight correlation between PHI take-up and household income; higher income corresponds to more frequent rates of PHI cover. Also, urban populations (especially in Riga city) are more frequently insured. Finally, this latest data is influenced by the fact that predominantly employed persons obtain PHI; for all the insurance companies except for one are selling PHI only to employers for their employees.

The only institution that supervises the Latvian insurance market is the Financial and Capital Market Commission. It is an autonomous public institution, which carries out the supervision of Latvian banks, insurance companies and insurance brokerage companies, participants of financial instruments market and private pension funds. There are no specific laws, regulations and prerequisites for PHI, only general laws regulating all the financial institutions.

Market development, public policy and impact on the wider health system

Latvia restored its independence in1991, and it turned to a free market economy after the Soviet Union's centrally administered and unified public health care system collapsed. This system was characterized by low quality, but highly accessible, health services and forbidden private initiatives. Following the restoration of its independence, Latvia politically declared the reinstallation of the social insurance (Bismarck) health system, which had been in place during the first period of the state's independence in the 1920s and 1930s. Actually this political statement later was not fulfilled, but it influenced health care reforms to great extent. Examples of those reforms were decentralization, privatization, deregulation and independent entrepreneurship in providing services. Also, growing economic difficulties due to a lack of financial recourses decreased access to health services.

Co-payments for services were introduced in mid-1990s. This was the time when the first voluntary (private) health insurance initiatives appeared in Latvia. The first was the Riga municipal public health fund, which started to sell insurance against co-payments. Later, a separate commercial company, Riga Sickness Fund (*Rīgas Slimokase*), was created to take over these PHI and other general insurance functions. Other insurance companies gradually started to offer health insurance initially against co-payments.

Eventually, PHI was extended to cover increased comfort options and treatment in private beds without waiting times at public hospitals. Despite the insurers' complaints about this being a non-profitable business, the market was gradually growing amid decreasing public health care access. After a set of health services were excluded from public coverage, moreover, PHI got to play not only a supplementary, but also a complementary, role in providing Latvian health coverage.

An essential point in the development of Latvian PHI was its gradual shift from selling insurance to individuals to exclusively selling PHI to employers. Government stimulated this process through reliefs of enterprise, the individual income tax and the social tax. The main policy aim for this has always been to attract additional financial resources to the health care system, creating savings for more socially vulnerable groups of the population. In reality, the effect—"cream skimming"--was adverse. This is because PHI offers higher reimbursements for services, so health care providers are spending more time and technical resources on this segment at the expense of access to public services. Many specialists currently are even refusing to contract with the public sector, complaining about irrelevant payments for services (prices often are estimated not according to real costs, but budget capabilities).

Moreover, the risk of spending on health for the working age population is lower, and this is also stimulating PHI market growth. Other stimuli include the proportional (but not progressive) income tax system and the capital growth tax exemption. On the other hand, the limiting factors for PHI market growth are poverty, a limited ability to pay for health services and growing inequality (Gini coefficient) in Latvia (Trapenciere 2005). These factors, together with the current economic recession (minus 12% GDP) and growing unemployment may influence the PHI market in unpredictable ways. Furthermore, the International Monetary Fund, which is offering to provide credit for the government, is demanding essential public health care reform, reduction of spending and increase in efficiency in turn.

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The Netherlands

Hans Maarse

Introduction

After more than 15 years of political debate, the new Health Insurance Act (*Zorgverzekeringswet)* came into force on the first of January in 2006. HIA introduced a mandatory health insurance scheme covering all residents of the Netherlands and put an end to the old dividing line between the Sickness Fund Scheme, which covered about 63% of the population, and private health insurance[199], which covered the remaining 37% of the population (Maarse & Okma 2004).

Since the introduction of HIA, health insurance in the Netherlands consists of the following three compartments (see Table 1):

Table NL1 Structure of health insurance in the Netherlands, 2007

Compartment	Name of law	Status	Coverage	Package	Net fraction in health care financing (x 1 million)
First	Exceptional Medical Expenses Act (AWBZ)	Public	Mandatory covering all legal residents	Mainly long-term care	€ 22.972 42 %
second	Health Insurance Act	Quasi-private	Mandatory, covering all legal residents	Ambulatory and hospital care. outpatient pharmaceuticals, maternity care, and so on	€26.266 52 %
Third	Complementary health insurance (no specific law)	Private	Voluntary, about 92% of the population	Complementary services, not covered by HIA or AWBZ	€3.584 6 %

Source: Vektis (2008). Direct patient payments and tax-funded health care are excluded.

The overview in this report is restricted to health insurance in the second and third compartment.

[199] Note that private health insurance was in fact a heterogeneous category. It not only included strictly private health insurance schemes, but also schemes for public servants and, since 1986, a heavily regulated scheme to guarantee specific categories of persons who did not qualify for the Sickness Fund Scheme access to health insurance.

The basic structure of HIA

The adoption of HIA was a major step in the introduction of *regulated competition* in Dutch health care. Regulated competition has never been intended as a goal in itself, but as a policy instrument to transform Dutch health care from a mainly supply-driven system into a demand-driven system. In addition, the current reform aims to improve the quality, efficiency and affordability of health care, while preserving the values of solidarity and universal access. In policy documents on Dutch healthcare reform these values are often referred to as the 'public constraints to competition.'

Why HIA?

For a long period of time, the division of health insurance into a social (public) and a private part had been considered a relict from the past. Already in the early 1970s, there were voices to integrate both parts into a single and integrated health insurance scheme covering the entire population. Political arguments to do so were were based on the wish to strengthen the solidarity in health insurance and to reduce administrative and political complexities related to the dual structure of health insurance. Furthermore, the dividing line between social and private health insurance was seen as a source of inequities in paying for health insurance. There were many examples of what was considered to be an unfair distribution of the financial burden.[200] Despite these arguments, there was no political majority to reform health insurance. Political resistance was particularly strong among private health insurers who feared losing their business by such a reform.

The Dekker Commission, which published its report *Willingness to Change* in 1987, repeated these arguments and added another important one. The integration of the Sickness Fund Scheme and private health insurance was also considered a prerequisite for the introduction of regulated competition in health care. The Commission even went a step further by its proposal to integrate both insurance arrangements with the Exceptional Medical Expenses Scheme. The latter was a universal mandatory scheme that had been put in place since 1966. It mainly covered long-term care.

It is important to note that HIA is designed as a more modest insurance reform. It only integrates the Sickness Fund Scheme with private health insurance arrangements. To avoid political opposition and other complexities, it does not integrate HIA with the Exceptional Medical Expenses Scheme. Nevertheless, various services (for example, ambulatory mental health and some forms of community nursing) that were once covered by this scheme have been shifted to the benefit package of HIA because they are not really long-term care services and thus better fit in the benefit package of HIA. This operation is also assumed to advance the integrated delivery of health care. Whether the remaining parts of the Exceptional Medical Expenses Act will be integrated with HIA in the future is uncertain yet.

Arrangement under private law

HIA is construed as an arrangement under private law. The relationship between subscriber and insurer is shaped as a one-year contract that the subscriber can renew each year, but also terminate and replace with a contract with another insurer. Any person who fails to purchase a basic health insurance policy (hereafter health plan) is uninsured. This is an

[200] For instance, millionaires with a part-time job and a salary under the earnings ceiling were covered by the Sickness Fund Scheme and only paid a low (income-related) contribution for their health insurance.

important difference with the former Sickness Fund Scheme, which automatically covered each person for whom the scheme was intended.

With its choice for an arrangement under private law, the government explicitly followed another route then outlined in all earlier government reports on regulated competition in health insurance. These reports had opted for an arrangement under public law to express the social nature of health insurance and continue the tradition of social health insurance in Dutch health care. The choice for an arrangement under private law was both for ideological and political reasons. It underscored the revised role and responsibilities of the government and the private sector in health care. Furthermore, the arrangement was necessary to overcome the opposition of the private health insurers. One of their fears was that an arrangement under public law would lead to greater state involvement in health insurance. In their view, competition required 'by definition' a private model.

Consumer choice
A cornerstone of healthcare reform is to increase *consumer choice*. To stimulate competition between health insurers, consumers must be free to choose their own health insurer and health plan that best fit their preferences. HIA gives all subscribers the legal right to terminate the plan by the end of each year and to switch to another insurer (the so-called exit option). HIA forbids health insurers to terminate the contract. However, HIA contains various restrictions to consumer choice in order to find a proper balance with solidarity (Maarse & Ter Meulen 2006). The most important restriction is the obligation in HIA that each legal resident[201] of the Netherlands must purchase a *basic* health plan (note that the purchase of a *complementary* plan is voluntary). There is no opt-out provision. In addition, there are restrictions in regard to the benefit package of the basic health plan.

Regulated competition
To stimulate competition, HIA gives insurers the freedom to set their nominal or flat-rate premium rates. As will be discussed later, this policy measure has elicited fierce competition on the health insurance market. Furthermore, HIA offers insurers some freedom to shape their basic health plans. For instance, they can offer benefit-in-kind plans, reimbursement-plans or a mixture of both types. Furthermore, they are permitted to offer plans with preferred providers or plans with a voluntary deductible on top of the obligatory deductible (see below). Yet, the discretionary power of health insurers in regard to the package of the basic health plan they offer should not be overstated. This is because the government decides upon the benefit package of HIA. What this means can be illustrated by a simple example. Because GP care, maternity care and dental care for the youth are in the benefit package of HIA, health insurers must cover these services in their plans. This provision implies that consumers cannot take out a basic plan not covering these services. The objectives of the central (government) regulation of the benefit package are to preserve solidarity and prevent consumers from making 'wrong choices.' Below, we will see that freedom of choice for both insurers and consumers is much larger in complementary health insurance.

Solidarity and universal access
To achieve market competition that does not violate the principles of solidarity in and universal access to health care, HIA contains many regulations:

[201] Persons staying illegally in the Netherlands do not have access to HIA.

- To preserve *risk solidarity*, health insurers must accept each applicant. HIA contains a formal ban on risk selection. In addition, HIA obligates health insurers to apply community rating to calculating their nominal premium. They are forbidden to use risk rating or experience rating. Note, however, that premiums may vary by the type of health plan. For instance, a plan with a preferred provider or a high deductible will have a lower premium than a plan without preferred providers or a voluntary deductible.
- To preserve *income solidarity*, the government pays an income-related health insurance allowance to the lower incomes to compensate them for the steep rise of the nominal premium rate in 2006 due to the introduction of HIA. For instance, whereas in 2004 nominal premiums[202] ranged from 239 Euro to 455 Euro, they averaged at 1028 Euro in 2006 (NZa 2007).
- Other regulations to preserve solidarity include the introduction of a single mandatory scheme, the obligation for each resident to purchase a basic health plan and the central regulation of the benefit package discussed above. The end to the traditional dividing line between the Sickness Fund Scheme and private health insurance, in fact, *reinforced* solidarity in health insurance.
- Health insurers are also obligated to guarantee their subscribers good access to health care. They must contract sufficient care of high quality for their subscribers.

These regulations to protect the 'social good' contrast the new health insurance scheme with 'strict' private arrangements that, generally speaking, feature a high degree of voluntary action, differentiated benefit packages, application of risk-related premium setting, absence of income-related premium rates, utilisation of medical underwriting and limited state intervention. One may therefore consider HIA to be a hybrid arrangement combining a public function with a private structure (Maarse & Bartholomée 2007). For this reason, we see HIA as a 'quasi-private' or 'private social health insurance scheme.' Though this may seem an academic or semantic discussion, it is not from the perspective of EU regulation. The key question is whether HIA can be considered *Europroof*. This question will be addressed later.

Premium setting

Each person has to pay a nominal or flat-rate premium for health insurance plus an income-related premium. As said earlier, health insurers are free to set their nominal premium rate. In addition, employers have to pay an income-related contribution for each employee. The contribution rate is set by government. The present contribution rate is 7.2 percent. The contribution is levied up to an earnings ceiling of 31.231 Euro. Self-employed persons pay 5.1 percent of their earnings with a maximum ceiling of 1592 Euro.[203] The government pays the premium for children until they are 18 years of age.

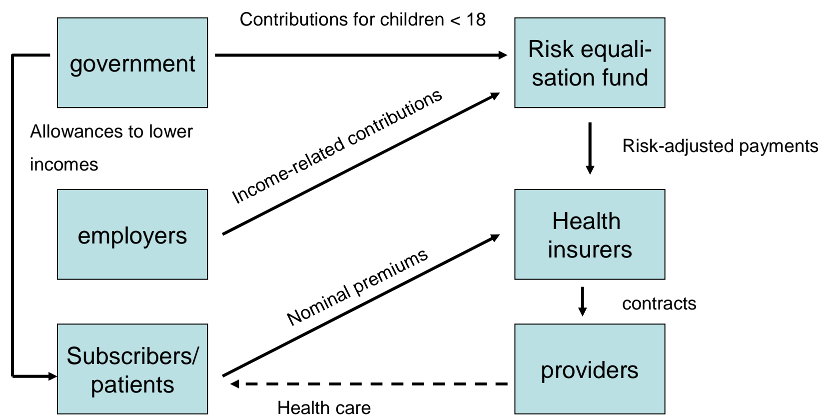
Figure 1 gives a stylized overview of the financial flows in HIA. As can be seen, the nominal premiums directly flow as premium revenues to the insurers. The contributions paid by the employers, the self-employed and the government flow into a risk-equalisation fund. The fund pays insurers by means of risk-adjusted capitation payments. The underlying idea of the fund is that differences in the nominal premium rates of insurers only reflect differences in efficiency instead of differences in the risk structure of their

[202] Sickness Fund subscribers have been paying a nominal rate since 1989 on top of their income-related contribution. The nominal rates have gradually increased since then and were different for each sickness fund.

[203] These percentages and maximum rates may change every year.

subscriber population. The current risk adjusters are: age, sex, socio-economic status, region, social security recipients, pharmaco-related cost groups and diagnosis-related cost groups. The latter two categories point to the inclusion of morbidity-related adjusters in risk equalisation. The list of adjusters illustrates the highly sophisticated system for risk equalisation in the Netherlands.

Figure 1: The structure of Dutch health insurance since the 2006 reform



Direct patient payments

To encourage cost consciousness, HIA initially contained a no-claims arrangement. Under this arrangement, each subscriber had to pay a government-set premium of 255 Euro on top of the insurer-set nominal premium. This extra charge was refunded one year later to subscribers proportionate to their medical consumption in the previous year. The maximum refund was 255 Euro. The costs of a visit to a GP or maternity care were excluded from the arrangement.

The no-claims arrangement–in fact nothing other than a prepaid co-payment–has always been criticised. Because of the time lag between medical consumption and refunding, it was considered an ineffective instrument to encourage cost consciousness. Patients with chronic disease saw it as an unfair instrument because they could not benefit from it. Finally, the arrangement was seen as inefficient because of its high administrative complexity.

For these reasons, the no-claims arrangement was replaced in 2008 with a mandatory deductible of 155 Euro. GP care and maternity care have been excluded again. To compensate patients with chronic disease, the deductible is set at 103 Euro. Note that subscribers can opt for a health plan with a higher deductible (HIA limits the maximum voluntary deductible to 500 Euro).

For the rest, direct patient payments are very low for health care covered by HIA. Patients visiting a provider not contracted by their insurer must pay in principle the difference between the price charged by the hospital for the treatment and the average price of the treatment that the insurer has negotiated with its contracted hospitals. So far, this has

mainly been a theoretical possibility because insurers have contracted all hospitals.[204] Direct private payments also exist in outpatient pharmaceutical care if a patient uses a medicine with a price higher than the reference price. Interestingly, health insurers are currently developing a new type of reference-pricing to save costs. For certain categories of medicines with an identical chemical substance, they reimburse only the lowest-priced medicine in that category (for instance, cholesterol-lowering medicines). Patients using a more expensive drug must pay the difference, unless their insurer has authorised them to do so.

The structure of the private health insurance market

HIA has made the traditional dividing line between sickness funds and private insurers obsolete. It is operated by private health insurers, which are permitted to work for-profit. However, the health insurance market is dominated by mutual companies operating on a not-for-profit basis. Some insurers are part of a multi-branch insurance concern. Table 2 gives an overview of the present structure of the health insurance market. It illustrates the highly concentrated structure of the health insurance market. The four largest insurance concerns ('the four bigs') are Achmea, Uvit, Menzis and CZ.

Table NL2 Structure of health insurance market in 2007

Number of subscribers	Number of insurers (N=32)
>1.000.000	5
500.000 – 1.000.000	3
400.000 – 500.000	4
300.000 – 400.000	5
200.000 – 300.000	0
100.000 – 200.000	7
50.000 – 100.000	5
< 50.000	3

Source: Vektis (2008)

Another important characteristic of the health insurance market concerns the role of collective or group contracts. In the pre-2006 period many employers negotiated a group contract, in particular to obtain a premium discount for their employees and/or to make an agreement on specific services. In the Sickness Fund Scheme, group contracts did not play a significant role. HIA permits groups to negotiate group contracts, but it limits the maximum discount for the basic health plan to 10%. HIA does not set a maximum discount for complementary health insurance.

There are two types of group contracts. Employer-based contracts are the most important category though, as two-thirds of all group contracts are employer-based. The second category consists of open-group contracts. This is a heterogeneous category. For instance, there are now contracts for social minima (signed by local governments), the elderly, union members and general consumer organisations. Interesting, some patient organisations also obtained group contracts for their members (Bartholomée & Maarse 2007). A patient group contract may cover some health services in the complementary plan specifically geared to the needs of its members (e.g. podotherapy for patients with diabetes).

[204] Insurers did not contract all Independent Treatment Centres delivering routine care to patients (e.g. cataracts, hip replacements or some kinds of cardiac care).

Governance of HIA
Apart from the government and in particular the Minister of Health, the following agencies play a significant role in the governance of HIA:

- The Dutch Health Care Authority (NZa) is, among others, in charge of the supervision of the market behaviour of insurers. It also monitors developments on the health insurance market.
- The Health Insurance Board (CVZ) is, among others, in charge of advising the government on the benefit package of HIA. It also administers the risk equalisation fund and advises the government on various health insurance topics.
- The Dutch Competition Authority (NMa) is, among others, in charge of the approval of consolidations between insurers.
- The Nederlandse Bank (DNB) is, among others, in charge of the financial supervision of insurers (solvency).

This brief overview (there are many more agencies involved) illustrates the significant role of so-called Independent Regulatory Agencies in health insurance governance. The delegation of various administrative tasks to IRAs is intended to increase the credibility and expertise of insurance administration. As a consequence, the Minister of Health may lack effective instruments to intervene in specific cases (for instance, he could not forbid a NMA approved consolidation between provider organisations heavily criticised in the Parliament). On the other hand, the position of the Minister should not be underestimated either because of his legal competence to issue general policy instructions to IRAs.

The wider context of HIA
HIA can be considered the most visible part of the reform so far. It implied a significant alteration in the structure of the health insurance market and had far-reaching implications for insurers and subscribers. Yet, it is important to note that HIA is only one part of the reform. The current market reform is not only intended to introduce regulated competition in health insurance, but also in the provision of care. As said earlier, its ultimate objective is to make health care more customer-driven and to improve its quality, innovative power, efficiency and affordability. Insurers have been accorded a significant role in this respect. They are expected to negotiate contracts with providers on the quality and price of health care on behalf of their subscribers. This is the so-called purchasing or agency role of insurers.

To stimulate market competition in health care, the following market-making policy decisions were taken or are scheduled to be taken:

- Health insurers and hospitals can negotiate the prices for hospital care. In 2005, the room for price negotiations was set at 10% of the total hospital budget. In 2007, this percentage was elevated to 20% and in 2009 to about 33%.
- To facilitate price negotiations, the system of fixed hospital budgets is stepwise being abolished and replaced with a new funding model based upon case-based payments, termed Diagnosis Treatment Combinations (DBCs). Presently, there are about 30,000 DBCs. Price negotiations regard the price of DBCs. The government is currently working on a large simplification of the system.
- Hospitals (and other provider organisations) are given much more discretionary power in planning decisions and capital investments. Because central planning is considered to be at odds with market competition, it has largely been abolished (except for some specific top clinical services). Hospitals are paid a mark-up price on each DBC to finance their capital investments. The underlying assumption is

that this new capital funding model will discipline them in planning and capital investments.

- Another market-making plan scheduled for the near future regards the lifting of the ban on for-profit hospital care. Until now, for-profit hospital care has always been forbidden in healthcare legislation, but there is a strong lobby for lifting the ban because it is considered to be at odds with competition. It is unclear how the government will decide on this topic. There are signs that it will opt for a social enterprise model that accords providers the ability to make a profit, but obligates them to reinvest this profit into their own organisation.

These developments indicate the unfolding character of market competition in Dutch health care. To avoid disruptive effects upon the delivery of health care and to learn from experience, the government follows a cautious strategy of gradually staging in market reforms (Maarse & Bartholomée 2008).

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The European dimension of HIA

Earlier we have seen that HIA is shaped as a privately operated scheme under private law. In order to preserve the social good, in particular with respect to solidarity and universal access, it contains many regulations constraining the freedom of choice of both health insurers and subscribers. Therefore, we called it a 'quasi-private' or 'private social scheme.' This design of HIA raises questions about its compatibility with the regulations of the European Union. EU regulation gives the member states great discretionary power in shaping their social health insurance scheme. However, private arrangements are subjected to Community law, in particular the Third Directive on Non-Life insurance.

This is not the place for a detailed discussion on how HIA fits into Community law (Thomson & Mossialos 2009). The Dutch government has always declared the applicability of the Third Directive because of its choice for an arrangement under private law. The Directive forbids member states from regulating prices and conditions of insurance products because such interventions would distort market competition and free trade. However, it does not fully abolish the regulatory competence of the member states. Public regulations can still be justified if private arrangements conflict with the social good. The Dutch government has taken the position that its extensive regulation of health insurance is both necessary and proportional to protect the social good. In response to letters to the Dutch government, Dutch Commissioners have accepted this position. Yet, it remains uncertain whether the European Court of Justice, as the ultimate arbiter, will accept the Dutch position in its rulings. There is also uncertainty on the compatibility of the risk equalisation model with the Third Directive because risk equalisation may be interpreted as a kind of state support to economic undertakings (health insurers).

Complementary health insurance

Complementary health insurance constitutes the third compartment of healthcare financing in the Netherlands. This type of health insurance covers health services that are beyond the scope of the benefit package of HIA or AWBZ. In fact, HIA does not contain regulations on complementary health insurance with only one exception. To counteract conditional sale, insurers are forbidden to terminate a complementary health plan if a subscriber switches to another insurer.

The purchase of a complementary health plan is voluntary. Nevertheless, about 92% of subscribers have purchased a complementary plan in addition to their basic plan. Health insurers are free to develop the benefit package of their complementary plans. HIA does not regulate their 'package decisions.' Usually each health insurer offers their subscribers several complementary plans ranging from plans that provide only limited coverage ('simple plans') to plans providing extensive coverage ('golden plans'). As a consequence, subscribers have many options to select a complementary plan. Some subscribers make the choice of the health insurer dependent upon the benefit package of the complementary plan.

Table 3 gives a global impression of the health services covered by complementary plans. Note that these plans may include specific conditions. The maximum reimbursement is usually capped. Plans may also require prior authorisation for specific treatments. The type of health services covered, plus conditions and maximum reimbursement rate, depend on the type of complementary plan.

Table NL3 Types of health services covered by complementary plans

Acne therapy	Alternative medicines	Asthma center Davos
Glasses	Alternative therapies	First-line mental care
Vaccinations for travelling to foreign country	Cross-border care	Physiotherapy
Aftercare for cancer patients	Circumcision on religious ground	Various physical exercise programs for persons with chronic disease
Lifestyle training programs	Treatment of patients with serious overweight	Various forms of cosmetic surgery
Vasectomy	Podotherapy	Patient transport
Various forms of dental care	Various preventive courses	Diet advice
Specific treatment programs of psoriasis	Various preventive screening programs	Holiday camps for children and disabled
Single room	Stuttering therapy	
Physical		

Health insurers are also free to set the nominal premium rate of their complementary plans. Premiums vary with the coverage of the plan. Some health insurers also link the premium to the age of the subscribers. Furthermore, health insurers may apply risk selection.

Effects of HIA

This section presents a brief overview of some of the most important effects of HIA known so far. They give an impression of what has been achieved. In our view, however, it is too early yet to draw conclusions on the ultimate impact of HIA. There are several reasons for being cautious in drawing conclusions. Firstly, it often takes some time before the real impact can be assessed and interpreted. Secondly, it is important to note that the impact of HIA also depends on other reform programs. To illustrate, we simply refer to the fact that the capability of insurers to negotiate prices for hospital services heavily depends upon the scope of price competition which, in turn, depends on the market-making decisions to be undertaken by the government. Another relevant factor in this respect is the further development of the new hospital funding model by means of case-based payments. Finally, we must emphasise the unfolding character of the current reform of Dutch health care. The introduction of HIA in 2006 is only an important element of the reform. Various *market-making decisions* are yet to be taken (Maarse & Bartholomée 2008). This implies that there is still uncertainty on the eventual design of market competition and, by implication, on its (ultimate) effects.

Effects on consumer behaviour

Table 4 summarises information on consumer behaviour during the last year before the reform and the first three years after the reform.

Table NL4 Consumer behaviour before and after the introduction of HIA

	2005	2006	2007	2008
Voluntary deductible				
- yes	--	93,9	94,7	94,8
- no	--	6,2	5,3	5,2
Complementary health insurance *before* HIA				
- sickness fund subscribers	91,9	--	--	--
- private insurance subscribers	98,4	--	--	--
Complementary health insurance after reform	--	92,6	92,9	92,0
Group health plan *before* HIA				
- sickness fund subscribers	16,3	--	--	--
- private insurance subscribers	52,0	--	--	--
- average (own calculation)	23,3	--	--	--
Group health plan *after* HIA	--	53,0	57,3	59,2
Consumer mobility *before* HIA				
- sickness fund subscribers	7,5	--	--	--
- private insurance subscribers	15,4	--	--	--
Consumer mobility *after* HIA	--	18	4,4	3,5

Sources: Health Monitors of Vektis; Health Insurance Monitors of NZa

Voluntary deductible
The percentage of subscribers opting for a voluntary deductible is consistently very low. This probably illustrates the high degree of risk aversion among Dutch subscribers. A further explanation may be that subscribers consider the premium reduction in exchange for a voluntary deductible to be relatively low.

Complementary health plans
These plans are very popular. The coverage of extra dental care is frequently mentioned as an important reason to purchase a complementary plan. Patients with chronic illness tend to scrutinise complementary plans from the specific perspective of their illness ('what is in for me?').

Group health plans
The figures on group health plans illustrate their popularity. The market share of group plans negotiated by patient associations has always remained quite small (about 1%). Subscriber and health insurer interest in these plans does not seem particularly strong (with the exception of one insurer). Much also depends upon whether the risk-equalisation scheme includes the relevant morbidity parameter. If not, the insurer is not likely to be interested in a patient group contract because of a predictable loss.

Consumer mobility
The figures on consumer mobility suggest a shock effect of HIA. Contrary to what most insiders had expected, in 2006 almost one-fifth of all subscribers switched to another insurer. Switching rates were relatively high among young subscribers, subscribers with high education and subscribers with high self-reported health. After 2006, however, mobility turned out to be only a one-off effect, despite significant differences in the premium rates of health insurers. It is not easy to interpret this decline of mobility. Does it indicate a high level of satisfaction or high transaction costs? Are subscribers concerned

that they will not be accepted for complementary health insurance (see section on complementary health insurance)?

Uninsured and defaulters
Another effect concerns the number of uninsured. Any resident who fails to purchase a basic health plan is automatically uninsured. Statistics Netherland estimated the number of uninsured in 2007 at about 1.4% (CBS 2008). The government has developed a monitoring program to track the uninsured as soon as possible. It also uses administrative penalties to keep the number of uninsured as low as possible. Uninsured persons must be distinguished from defaulters, defined as subscribers who failed to pay their premium for a period of at least six months. The estimated number of defaulters increased to an estimated 1.9 percent in 2007 (CBS 2008). The government agreed with health insurers on a monitoring program to track defaulters as soon as possible. Several instruments are used to compel them to pay their premium. However, insurers cannot dispel defaulters from their list. Insurers have agreed to bear the financial risk over the first six months of defaulting, after which the government takes over this risk.

Consumer satisfaction
Consumer satisfaction on health insurance is high. On a scale from 0 to 10, the CQ index varied from 7.4 for the insurer with the lowest score to 8.7 for the insurer with the highest score. Only 8.9 percent of the respondents were said to be dissatisfied.

Effects on insurer behaviour

Consolidations
HIA made the traditional dividing line between sickness funds and private health insurers obsolete. Hence, it came as no surprise that in 2006 the number of insurers fell from 57 to 33 because of consolidations between sickness funds and private insurers. Note, however, that the number of health insurers had already been falling over a much longer period of time (58% over the period 1985-2005). Important reasons to consolidate in the pre-HIA period were the need for greater administrative efficiency and effective risk pooling and the attempt of each insurer to reinforce its market position.

Consolidations have led to significant market concentration. Presently, the total market share of the four biggest insurance concerns is about 89%. Not surprisingly, there is some concern (not shared by NZa) that this concentration may undermine competition and consumer choice, in particular in those areas where the HHI-index is more than 1800.

Risk selection
HIA contains a formal ban on risk selection for basic health insurance. Therefore, it is no surprise that insurers do not engage in explicit risk selection. However, there may be some subtle forms of risk selection. We discuss three alternatives.

First, insurers may deny a group contract to what they see as groups with a predictable loss. There is no evidence for this practice because, so far, efforts of insurers were directed at protecting and extending market share. However, group contracts may evolve as an instrument for risk selection in the future.

Second, one insurer launched a new health plan by the end of 2007. Subscribers accept the restriction that they may visit only the eleven hospitals for non-acute care that have been

contracted by the insurer as preferred providers. In exchange for their restricted choice, they pay a lower premium. This plan is only attractive to young people reporting very good health. It is not an attractive plan for a young couple with children. Importantly, the plan also contains the provision that a subscriber, in case of an illness requiring frequent medical consumption, may immediately terminate the plan and switch to a 'normal' health plan. In order words, it may elicit opportunistic behaviour.

Third, there is some concern that health insurers may use complementary health insurance as an indirect tool for risk selection. As said before, HIA does not include a formal ban on risk selection for these plans. In 2006 and 2007, insurers announced that they would apply open enrolment except for their most inclusive and expensive plans. They did so because of their strategy of protecting and extending market share. However, in 2008 the percentage of insurers asking applicants to fill in a medical questionnaire more than doubled from 12 to 25 insurers after it had declined from almost 50% in 2004 to 10% in 2006 (Roos & Schut 2008). There is also some evidence that subscribers do not switch to another insurer for their basic health plan because they fear not being accepted for a complementary plan with the new insurer (Bartholomée et al 2009). In other words, complementary health insurance may restrict consumer choice.

Purchasing
An important effect of HIA concerns the development of purchasing. A cornerstone of the current market reform regards the reconfiguration of the role of health insurers. In the market model, they not only function as an agent to guarantee access to health care and cover the costs of medical care, but they are also expected to play an active role in purchasing health care on behalf of their subscribers. This is the so-called agency role of insurers. By contracting with provider agents, insurers are expected to improve the quality and efficiency of health care rendered. To empower them, insurers are in principle no longer obligated to contract each provider agent. Selective contracting has become a formal option.

Experience so far indicates that purchasing is still in its infancy. As of yet, selective contracting hardly exists. The explanation of this state of affairs is complicated and falls beyond the scope of this report. We mention a few important factors. First, insurers still miss good information on the quality of health care, despite significant progress in measuring the quality of care. Recently, some insurers started to use this information to contract preferred providers for some specific forms of care. A second factor concerns the (quasi-) monopolistic position of hospitals in some regions. Not contracting with these hospitals has been a totally unrealistic option so far. Third, insurers have abstained from selective contracting because of their concern that it could damage their market reputation. Fourth, insurers consider it extremely difficult to steer their subscribers in need of medical care. They believe that only positive incentives work. For that reason, some insurers are now forgiving the mandatory deductible if patients go to a preferred provider.

Premium setting
HIA has elicited fierce competition in both basic and complementary health insurance. The strategy of insurers to protect and extend market share forced them to calculate competitive premium rates. Because of the very competitive structure of the market for group contracts, they granted substantial premium discounts. For instance, the average discount for employer-based group contracts grew from 7% in 2006 to 8% in 2008, and some employers managed to negotiate a 10% discount. The discount for open-group contracts

averaged 6.2% in 2007. Not surprisingly, patient organisations were less successful in negotiating discounts (4.2% in 2007) (NZa 2007). Discounts were also sizeable in complementary health insurance.

In fact, many premiums generated a net loss. In its role as oversight agency, DNB found that the aggregate technical result of the basic health insurance scheme amounted to 563 million Euro in 2006 and 507 million Euro in 2007 (DNB 2008). DNB also reported for 2006 a loss of 23 million Euros in complementary health insurance in 2006, which was in fact quite remarkable given the high profitability of complementary health insurance in the pre-reform period. The loss in 2006 was followed by a positive result of 93 million Euros in 2007, as insurers strategized to raise premiums and, if necessary, to restrict the consumption of complementary services.

Unfortunately, it is difficult to compare the nominal premium rates for basic health insurance over a longer period of time. This is mainly due to the replacement of the no-claims arrangement with a mandatory deductible. Other changes, including the extension of the benefit package of HIA, also complicate such a comparison.

Administrative efficiency
Table 5 clearly indicates that HIA has improved administrative efficiency. Administrative costs taken as a percentage of total costs did significantly drop. Note that the administrative costs of complementary health insurance, though falling, are relatively high compared with the costs of the basic health insurance scheme. There is also evidence that insurers have significantly lowered their the marketing costs.

Table NL5 Administrative costs of insurers as percentage of total costs

	2003	**2004**	**2006**	**2007**
Before HIA				
Sickness funds	4.0	4.01	--	--
Complementary plans sickness funds	22.8	18.3	--	--
Private insurers	12.1	12.3	--	--
After HIA				
Basic health insurance	--	--	4.8	4.6
Complementary health insurance	--	--	15.7	14.6

Source: Based upon the Health Care Monitors of Vektis (own calculations).

Other effects

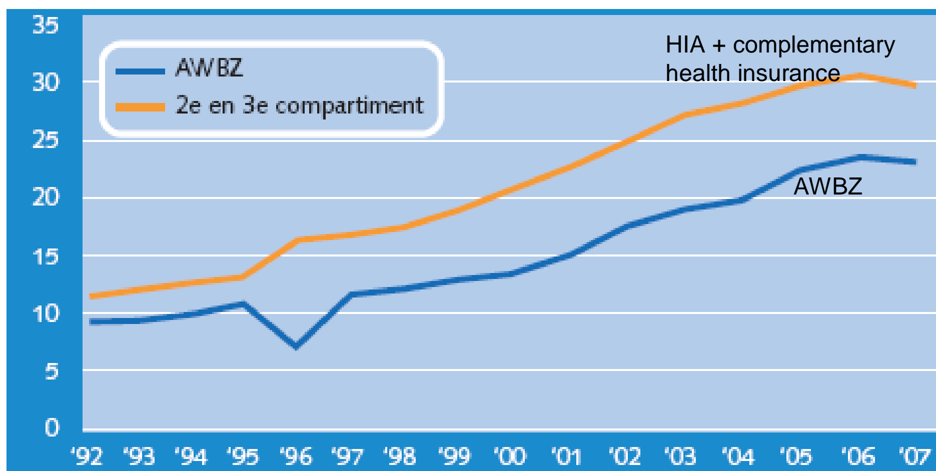
Freedom of choice and transparency
HIA is intended to increase consumer freedom of choice on the health insurance market. The extent of this freedom is affected by many factors including the range of choices available to consumers. So far, the range of choices in basic health insurance has remained limited. The differences between the health plans offered tend to be marginal, which is of course due to a great extent to the extensive public regulation of these plans. The choice options in complementary health insurance are much bigger, but the conditional sale arrangements of insurers may reduce the choice options. A further complication concerns the lack of transparency. Many consumers complain about the great difficulties in understanding and comparing their options. To support them, website have been

constructed which provide systematic comparative information on health plans (e.g. www.independer.nl).

Redistributive effects
Earlier we stated that HIA is also intended to achieve to a more equitable distribution of the financial burden in healthcare financing. The dual structure of the Sickness Fund Scheme and private schemes had created inequitable anomalies in the distribution of the costs of health insurance. Unfortunately, we have no insight into the redistributive effect of HIA. Group plans are an important source of complexity in this respect because of the variation in discounts insurers offer for groups to sign a group contract. However, it is reasonable to assume that individual subscribers 'pay the bill' because they do not benefit from a discount.

Impact on healthcare expenditures
Figure 2 gives a bird eye's overview of the evolution of healthcare spending in the first, second and third compartment. The figure demonstrates that the growth of healthcare expenditures has flattened since 2006 and even fell in 2007. This is a remarkable result because of the fact that the coverage of some health services was shifted from the AWBZ to HIA. The pattern is similar for AWBZ-related expenditures. However, the growth curve is somewhat misleading for 2006 and 2007, not only because of the shift of services from AWBZ to HIA but also because of the fact that the coverage of family help was removed in 2007 from the benefit package of AWBZ and shifted to local government.[205]

Figure 2 The growth of health care expenditures in the three compartments of health care



Source: Vektis, 2008

To disentangle the effect of HIA on healthcare expenditures is quite complicated because of the impact of many confounding factors such as the ageing of the population, decisions on the benefit package of HIA and the advance of medical technology. Nevertheless, there are some signs of a positive effect on the prices of hospital care. The Health Care Authority reported in 2008 that the negotiating power of health insurers in contracting health care had been reinforced (NZa 2008). It found that the real prices of hospital care

[205] This shift formed part of the adoption of the Law on Social Support (WMO).

that have been subject to price competition since 2005 declined in 2007. The price increase of hospital services for which price competition has been possible since 2008 appeared to be moderate. Not surprisingly, insurers with a big regional market share are capable of negotiating lower prices than insurers with only a small market share. Contracting so-called Independent Treatment Centres presumably plays an important role in this respect. The number of these centres increased from 31 centres in 2000 to about 160 centres in 2006. They usually deliver high-volume routine care, including cataracts, hip and knee replacement, diagnostic and many other services (Maarse & Normand 2009).

Unfortunately, we do not know whether these price effects will remain a lasting effect of competition and whether there is any form of cost shifting occurring. Furthermore, it is important to stress that competition may have (or is already having) an upward effect upon the volume of care. Will insurers be strong enough the effectively counteract the potential danger of supply-induced demand, propelled by market competition and the interests of private investors to expand the market for health care?[206]

Vertical integration

Recently, a regionally operating insurer announced its 40% participation in a consortium being formed to overtake a hospital in its region that is in financial trouble. This participation was heavily criticised in the Parliament because of its damaging effect on patient choice and the 'double role' of the insurer. Nevertheless, the Minister of Health declared vertical integration (integration of the insurance function with the delivery function) to be an interesting innovation in Dutch health care. An example of a more light form of vertical integration concerns insurer that have started to invest in centres for primary care.

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[206] The interest of private investors for health care is increasing because they see it as a growth sector. Even though the ban on for-profit hospital care has not been lifted yet and it is still unclear what the government will decide on this issue, two hospitals in financial trouble have been taken over by private investment companies.

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Poland

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Market role and context

How is the health system financed?

On 1 January 1999, the universal health insurance institutions commenced their activity by virtue of the Law of Universal Health Insurance of 1997, with amendments from 1998. As a result, sixteen Regional Health Insurance bodies (Sickness Funds) were established. According to the Law of Universal Health Insurance, Sickness Funds were expected to sign contracts with healthcare institutions. At the beginning, 7.5% of Poles' income was allocated to national health insurance, gradually rising to 9% in 2008. That contribution was defined by parliamentary law. Due to the fact that this contribution was obligatory, the system was thus named universal, which means that all citizens were covered whether they were paying contributions or not. Amounts were counted and deducted straight from citizens' income.

In the year 2001, the new government declared centralisation of the decentralised system by merging all sickness funds into a unified, universal National Health Fund (NHF). The National Health Fund was organized centrally, although lately regional branches have been given growing autonomy again. In 2009, there are 16 local offices of NHF that coincide with the administrative division of the country. Their management is responsible for contracting services in the region. General rules--including methods of contracting, universal contract provisions and reporting methods--are established by the NHF Headquarters.

What role(s) does PHI play and (how) has this changed over time?

For many years, supplementary private health insurance in Poland has been a topic of discussion due to numerous shortcomings in the public health insurance system and growing private expenditures on health. Until recently, the role of PHI was limited though. The premiums collected by all PHI companies totaled an estimated mEuro 300, having increased insignificantly since 2002, which was the first year they were distinguished in the statistics. The number of insurance contracts (policies) may also look impressive; for at the end of 2006, insurance companies reported to the Financial Supervisory Commission (KNF) the following figures in regard to their life insurance schemes:

- 29.182 million people (out of 38,200 million population of Poland) were subjects of coverage against accident and sickness
- Including 6.724 million people who had sickness insurance as a supplement to the main life insurance.

This is misleading, however, since coverage against risk of accident is attributed to most car insurance policies, while sickness policies cover mainly the protection of tourists when traveling abroad (usually outside of the EU).

What proportion of the population buys/is covered by PHI?

The figures on the proportion of the population who buy PHI are difficult to find. To define this figure more precisely, one should distinguish the following types of coverage:

- Fragmentary or comprehensive private health insurance, unrelated to any other insurance policies,
- Comprehensive health insurance for travelers,
- Fragmentary sickness and accident coverage, attached to car insurance,
- Sickness and accident coverage attached to life insurance, and
- *Quasi-insurance* coverage, offering usually ambulatory care in the form of prepaid services.

Existing data allow estimates of the following figures:
- Categories 1 to 4 in 2006, regardless of how many policies were purchased for a single person during the year, accounted for more then 29 million,
- 6.7 million people had life insurance supplemented with sickness and accident insurance, usually offering cash benefits (category 4)
- Between 1.2-1.5 million are estimated to be covered by various quasi-insurance schemes (category 5), prepaid usually by employers.

Table 1 presents data on sickness and accident insurance within life-insurance schemes. The total number of persons insured (29 million) is significantly bigger than the number of contracts (12 million), which is a result of the common practice of group insurance contracting, whereby group contracts are mainly offered for employees. The large number of subscribers suggests also that many professionally active people have more then one sickness and accident insurance policy.

Table PL1 Number of insurance contracts (policies) within life insurance schemes, by range of insurance, in 2006

Specification	**Manner of contract conclusion**		**Number of insured**
	Individual	**Group**	
Personal	**5,504,600**	**6,598,906**	**26,501,541**
Life insurance	1,267,363	6,527,620	25,453,421
Life insurance linked to insurance capital funds	2,259,473	57,668	785,714
Annuity insurance	39,411	15	1,786
Accident and sickness insurance	3,323,400	2,444,557	29,182,571
of which sickness insurance	319,856	141,609	6,724,048

Source: Financial Supervision Commission, www.knf.gov.pl

With non-life insurance, which typically covers the insurance of property (i.e. houses and cars), one can also find sickness insurance. Over 15.9 million people purchased an insurance policy, mostly against the risk of accident, in 2006. Over 612,000 people, out of 15.9 million, were covered by sickness insurance.

Table PL2 Number of insurance contracts (policies) for accidents and sickness, within the non-life insurance scheme, by range of insurance, in 2006

Specification	Kinds of insurance		Number of insured in group insurance
	Individual	Group	
Number of policies (in items)			
Personal	**8,059,787**	**853,550**	**15,979,544**
Accident	7,952,959	835,618	15,449,181
of which industrial injury and occupational disease	38,083	26,621	771,820
Sickness	108,700	18,016	612,753

Source: Financial Supervision Commission, www.knf.gov.pl

For a population of 38.2 million, the figures are significant, although one has to note following:

- The group and personal insurance policies in the non–life scheme are dominated by the casualty insurances, which are usually limited to accident risk. An important part of this market are traveling abroad-related policies, which are time–limited and have a defined objective and subjective range of medical treatments covered abroad.
- The supplements (additional options for individual or group insurance that can be bought by the insured) usually take the form of partial insurance covering the given types of health risk
- One person can have many of those partial insurances connected with life insurance since it is very common for the insurance policy, with a small face amount, to be attached to products offered by banks or social packages granted by employers.

Quasi-insurance sector

The companies providing prepaid subscription-based medical services play an important role in the health market. Most of those companies act as businesses, but they are also registered as health care providers (NZOZ); as such, they have been accused of unfair competition with the insurance industry. Most of them follow the HMO and PPO model as the first and the biggest companies were established by people with American work experience.

The responses[207] of 41 companies that participated in a 2004 study revealed that the majority owned at least one medical facility. The business model of those companies is based on a subscription fee and the organization of access to the benefits included in the subscription. This includes access to both services and providers the company may own (e.g. as in an HMO) and partial access to external services and providers who may be equipped with the appropriate diagnostic and surgery equipment and with the facilities needed for hospitalization and rehabilitation (e.g. as in a PPO).

The most common features of subscription-based medical services are presented below:

207 Sobczak A, Juszczyk G., Dudzik – Urbaniak E., Prywatne ubezpieczenia zdrowotne, W Polsce i na Świecie(Private Health Insurance in Poland and in the world), WWZ, Warsaw 2004

- Execution of the formal duties (occupational medicine) of employers towards the employees according to provisions of the Labor Code within the scope of medical prevention (basic packages encompass entrance, periodical and follow-up examinations carried out by the doctor of occupational medicine, evaluation of work stations, inspections and benefits of a general practitioner)
- Easier access (without referral from a family doctor and with short waiting times) to specialists (mostly for internal diseases, gynecology and obstetrics, neurology, ophthalmology, ENT, dermatology, cardiology, orthopedics); the higher the price, the bigger the list of services.
- Greater capacity to carry out diagnostic examinations with a wide range of visual diagnostics (e.g. ultrasound and heart echo scan , x-rays, computer tomography and magnetic resonance).
- Wide range of preventive examinations.

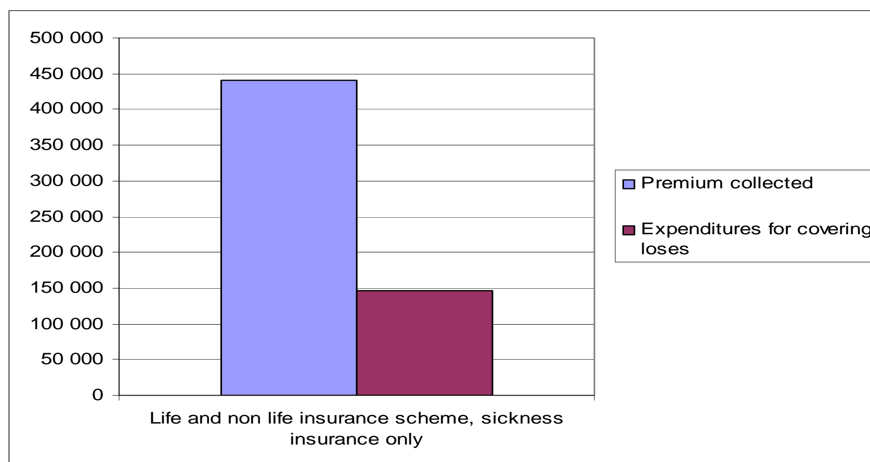
The seven biggest companies providing subscription-based medical services serve 40,000 - 150,000 thousand clients, mostly companies and institutions. Overall, the market for medical services based on subscriptions was assessed at 1.2-1.5 million beneficiaries in the year 2007[208].

What is the contribution of PHI to health care expenditure?
The overall volume of health financing constituted by PHI does not exceed 2% of total health expenditures (public and private together). It is worth noting, however, that the additional 2% of health expenditures flows through *quasi-insurance* schemes, which are offered for employees by employers. Legally they are not insurance, as they are not provided by insurance companies (who try to fight this model in the courts); however, they operate similarly to insurers—as they collect payments in advance, cover certain kinds of services and do not limit the number of those services available to patients.

The 2% contribution of health insurance to healthcare expenditures, however, has to be verified. According to Financial Supervisory Commission (KNF), only about 39% of collected PHI premiums is spent on health benefits. The rest of the premium money is spent on the insurance companies' own expenditures.

Figure 1 Share of premium collection spent on covering loses, only sickness insurance, both life and non-life in insurance schemes, year 2006, in PLN

[208] Adam Kozierkiewicz, author of this study was an executive director of the Association of Private Healthcare Providers, gathering mainly companies offering this kind of products



Source: Financial Supervision Commission, www.knf.gov.pl

What is the PHI market's relationship with the wider health system?
PHI, despite the many efforts of the insurance companies, does not play an important role in the health market. Healthcare providers, both public and private, focus more on serving patients of the national insurance system and supplement their revenues by admitting private patients paying out-of-pocket.

Market overview

What is the mix of PHI sellers (e.g. mutual, other non-profit, commercial) and how has this changed over time?
According to the law, PHI can be offered by insurance companies and mutual insurance associations. Both are operating based on the insurance acts. Mutual insurance, however, is rather weak and is almost non-existent in the health sector.

Besides the two, there are also *quasi-insurance* companies functioning on the market in the legal form of healthcare units. These companies are legally healthcare providers, as they are operating for profit and are owned either by medical specialists or sometimes, increasingly, by venture capital investors.

What are the characteristics of those most likely to subscribe to PHI?
A study performed in 2007 (Diagnoza społeczna 2007)[209] revealed the willingness of respondents to purchase medical insurance to cover treatment costs. In total, 51% (in 2005 it was 42%, in 2003, 38%) of households were not interested in purchasing any kind of medical insurance policy, and 31% (44% in 2005 and 47% in 2003) of households believed that they could not afford such expenses. In the remaining group of households (15%, while in 2005 it was 17%), some expressed interest in such insurance only if the price of the policy was not higher than PLN 100. More households interested in health insurance worth up to PLN 100 could be observed among families with one and two children who were living in large towns. The number of households that would be willing to purchase a health policy at a larger price is minimal and does not constitute a sufficiently large population for the insurance companies to be able to distribute risks. At the same time, it is rather unlikely that an insurance policy priced at PLN 100 per month would be sufficient to cover the expenses of medical treatment for all the members of a household even if all the

[209] Czapiński J, Panek, Diagnoza społeczna (Social diagnosis), 1999, 2003, 2005, 2007 (www.diagnoza.pl)

households that declared their willingness to purchase such a policy really bought it. The table below presents figures regarding *willingness to buy PHI* and not *actual characteristics* of present clients of the PHI companies.

Table PL3 Declared willingness to purchase PHI by social category and place of residence, in 2007

Category of respondents	*Willing to pay monthly*				*Can't afford*	*Not interested*
	do 100 zł	101–250 zł	251–500 zł	> 500 zł		
Socio-econiomic category						
Employees	19,1	4,6	0,6	–	28,9	46,3
Farmers	12,0	–	–	–	32,0	54,4
Agricultural workers	10,9	–	–	–	33,0	53,9
Pensioners and disability benefits takers, incl:	9,0	1,3	–	–	32,4	56,7
pensioners	10,0	1,7	–	–	30,4	57,4
benefits takers	5,1	–	–	–	39,9	54,3
Self-employed	23,1	8,6	–	–	15,3	50,4
Other sources incl.	7,8	–	–	–	50,9	40,4
With unemployed	15,7	3,6	–	–	27,8	52,1
W/o unemployed	8,9	1,5	–	–	46,5	42,4
Type of household						
One family						
Couple with children	15,0	3,6	–	–	24,7	56,1
Couple with 1 child	21,6	5,1	–	–	24,4	47,8
Couple with 2 children	16,4	4,6	–	–	30,4	47,5
Couple with 3 and more	13,1	3,3	–	–	39,7	43,1
Single parents	11,6	–	–	–	42,1	43,9
Multifamily (generations)	13,1	–	–	–	32,2	52,3
Non-family households						
Singles	9,0	1,5	–	–	29,7	59,2
Multiple	13,8	–	–	–	26,3	57,5
Place of living						
Cities > 500 k	19,7	6,1	–	–	28,9	44,2
Cities 200k - 500 k	19,8	4,5	–	–	26,5	47,8
Cities 100k - 200 k	16,8	2,9	–	–	29,7	48,9
Cities 20k - 100 k	14,5	3,6	–	–	30,3	51,1
Town < 20k	14,0	3,9	–	–	30,2	51,0
Villages	10,8	1,6	–	–	33,0	54,1
Region	16,2	4,5	–	–	26,0	53,2
Kujawsko-pomorskie	12,2	–	–	–	30,0	54,4
Lubelskie	15,7	–	–	–	29,1	52,4
Lubuskie	10,0	–	–	–	42,5	42,5
Łódzkie	15,6	–	–	–	35,0	47,4
Małopolskie	11,6	–	–	–	29,2	54,6
Mazowieckie	17,3	4,6	–	–	29,6	47,9
Opolskie	13,5	–	–	–	30,1	53,4
Podkarpackie	12,5	–	–	–	34,4	50,2
Podlaskie	13,6	–	–	–	32,0	51,0
Pomorskie	21,2	3,9	–	–	35,2	37,9
Śląskie	14,2	–	–	–	25,4	55,5
Świętokrzyskie	10,5	–	–	–	28,2	58,4
Warmińsko-mazurskie	20,0	–	–	–	33,0	45,1
Wielkopolskie	11,4	4,7	–	–	30,7	52,0
Zachodniopomorskie	13,1	–	–	–	32,6	50,6
Ogółem ***Total***	**14,7**	**3,2**	**0,5**	**0,4**	**30,5**	**50,7**

Source: Czapiński, Panek, Diagnoza społeczna 2007, www.diagnoza.com

What is regulated, why and by whom?
Insurance companies in Poland were operating until the end of year 2003 on the basis of the insurance activity law[210], which was replaced by a set of four laws and about 60 ordinances regulating this market on 1 January 2004. For the classification of risks covered by insurance in this sector in Poland, a two-level segregation is applied. This has been defined in annex to the Law on insurance activity, and risks are into life insurance (Division I) and non-life insurance (Division II).

Private insurance covering expenditures related to health status offered by the private insurance sector are therefore classified as follows:

- Division I: Accident and illness insurance, which complement insurance mentioned under groups 1-4 of life insurance
- Division II: (1) Accident insurance, including employment accidents and job-related illness; (2) sickness insurance

A characteristic of Division I insurance is that it is an option for covering health costs, defined according to a consumer's preferences, as part of life insurance. It cannot be sold independently from life insurance in this division. In Polish practice211, this insurance usually offers financial compensation in the event of hospitalization (both medical and surgical) or onset of a serious illness. The compensation is paid as a single cash benefit or as financial support for every day spent in hospital.

The two insurance products in Division II can be sold independently from other products, or as a part of wider coverage. They usually are benefits in kind and, in Polish practice, used mainly for ambulatory care; they may also include some cash benefits associated with more serious and costly treatment, like hospital care. Circumstances and conditions under which an insured person may use services or be refunded are defined in insurance agreements. There are various limitations, exclusions and co-payment mechanisms for using benefits. The insurance sector is supervised by the National Commission for Financial Supervision, which covers both the banking system and the insurance system.

Assessment of market performance

To what extent does PHI meet health financing policy goals (see below)?
Being a marginal contributor to the overall health insurance system, PHI does not play any role in meeting health policy goals. Some attempts to employ PHI in national health policy were undertaken in recent years; however, they appeared not to be successful until recently.

Market development, public policy and impact on the wider health system

Why and how did the market emerge? How has it evolved into its current form?
The PHI market has stagnated since the 2002, when it began to be observed in statistics. The rise in revenue is insignificant, as PHI market share has been declining in the recent years even when overall health expenditures were rising by 10-15% yearly.

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210 Act of 29 July 1990 on Insurance Business
211 Sobczak A, Juszczyk G., Dudzik – Urbaniak E., Prywatne ubezpieczenia zdrowotne, W Polsce i na Świecie (Private Health Insurance in Poland and in the world), WWZ, Warszawa 2004

Why does the market play one particular role and not others (where relevant)?
The reason for such stagnation is probably the universal character of the statutory health insurance system, the relative ease of access to care in the public system (especially regarding hospital care) and the rather low costs of incidental care purchased out-off-pocket.

Why does the market not play a larger role (where relevant)? What are some of the barriers to market development (where relevant)?
Additionally, research results show[212] that the tendency of Polish society to purchase private insurance for risk of sickness is low and has gotten lower in recent years. It looks as though the risks associated with medical treatment and paying for this treatment from public and private sources, despite relatively high expenses borne by households, are not high enough to encourage customers to purchase PHI. The healthcare system, although criticized, does not undermine the sense of healthcare safety or the economic safety of households during illness. The reason is not only the level of affluence of society, and, in general, the low level of willingness to buy insurance, but also the rules governing the functioning of the healthcare system--including the opportunity to shift costs between the private and public sector, which allows the maintenance of low prices on the market of privately paid services.

What are the explicit/implicit objectives underlying public policy towards the market? How and why has government intervention in the market (including the use of tax incentives or disincentives) changed over time?
The present and the former Governments tried to promote and regulate PHI to increase the volume of funds available in the healthcare system, without increasing the financial risk of individuals. The attempts failed, however, since there were many objections both from the public and the opposition parties to differentiated access to health care for citizens. Since the issue became very sensitive, the Governments generally suspended their efforts in this matter.

To what extent has the national regulatory framework (including tax treatment) been controversial? In what way has the European Commission's Third Non Life Insurance Directive (or other aspects of EU law) affected the market for PHI?
Since the market was very limited and regulations generally compliant to the Directive before Poland entered the EU, the impact of the Directive was limited.

Discuss any national or EU-level court cases concerning PHI and its regulation.
No court cases are known at present concerning PHI.

To what extent are the boundaries between PHI and publicly financed health care clearly drawn?
Generally, the boundaries between the public and private parts of the health system are defined clearly. Services covered by the public system cannot be substituted by private funds, neither out-of-pocket nor prepaid (including insurance). There are cases where these regulations have been overcome, mainly by demanding additional co-payments for "extra standard,, but these examples are rather limited to *out-of-pocket* transactions. Insurance companies, being afraid of potential legal problems, avoid unclear situations. As a result,

[212] Czapiński J, Panek, Diagnoza społeczna (Social diagnosis), 1999, 2003, 2005, 2007 (www.diagnoza.pl)

their products look non-attractive; the customer wishing to use PHI is forced to cover the entire cost of care, regardless of whether he/she is insured publicly at the same time.

How does the existence of PHI affect the wider health system?
The impact of PHI is limited, although some good practices related to customer service have been recognized by patients and professionals.

What (if any) are the public and political debates about the role of PHI in the health system (including the relative influence of different internal and external stakeholders)?
Besides public discussion on equity in healthcare access in the context of PHI, there was controversy concerning the administrative costs of the private insurance companies. According to statistics provided to the National Commission for Financial Supervision, insurance companies in general, including those operating in health, spend less then 40% of collected premiums for benefits. An explanation of this phenomenon is high administrative and marketing costs, as well as 27% of premiums collected that must be held in a form of reserve assets.

Table PL4 Structure of expenditures in cash flow of insurance companies, total, in the first half of 2007

I. Locations (bank deposits, bonds, and other assets purchased)	27%
II. *Expenses*	73%
1. Expenses for direct insurance activity and active reassurance	64%
1.1. Pay back of premium paid	1%
1.2. Compensations and benefis paid brutto	39%
1.3. Sell	12%
1.4. Administrative expenditures	9%
1.5. Assessment of damage and vindications	1%
1.7. Other expenses on direct insurance activity and active reassurance	1%
2. Passive reassurance expenses	5%
2.1. Passive reassurance fees	4%
2.2. Other passive reassurance expenses	1%
3. Wydatki z pozostałej działalności operacyjnej / other operational activity	4%

Source: www.knf.gov.pl

The structure has been relatively stable over the last 5-6 years for which data are available. This correlates with low-level return from investment, which is perceived by a significant proportion of customers.

What are the outstanding issues/tensions/challenges (if any)?
In the context of the above structural limitations and the unwelcome reception of PHI amongst potential customers, the most important challenges for the PHI seems to be following:

- Developing a product that is legally acceptable and understandable for customers, as well as workable in an environment of universal public health insurance and a rather low level of population wealth,
- Providing service that would be relatively cheap (taking into account the limited population willingness to pay) and equipped with added value for customers, and
- Limiting insurer expenses compared to the costs of benefits delivered to customers.

In your view, how is the market for PHI likely to develop in future?
There are not many signs that the situation may rapidly change. It is unlikely that benefits within the statutory system could be significantly limited, and the financial situation of most of the citizens of Poland does not allow them to spend money freely for goods and services that are not necessities. This is additionally impacted by the fact that access to care in the public system, which is generally free of change, and the rather low costs of medical services purchased privately make the alternative cost of not having PHI coverage low; as a result, the incentive to purchase PHI is not sufficient.

Assessment of market performance

Table PL5 PHI impact on health financing policy goals

Policy goal	Within the market	Impact on the wider health system
Financial protection	In Poland, PHI offers higher perceived quality of care, mainly outpatient and usually low-cost care, for wealthier part of the population	No major impact of PHI on health system. Quasi-insurance companies take some burden of care, directed to wealthier and healthier part of population, and set standards on consumer side of healthcare
Equity in finance	No evidence	PHI (but quasi-insurance even more) is progressive in the sense that wealthier people purchase the policies "on top" of the statutory system, and limit usage of the statutory system, what allows the poorer easier access to care.
Equity of access	There are certainly issues regarding access to PHI; in individual policies many risk factors are taken into account, incl. age, sex, etc., what setting the level of premium.	Privately insured people have faster or better access to health care, however they pay for it additionally, on top of their statutory insurance premium. By using services paid from private source (PHI, quasi – insurance, out-of-pocket), the wealthier enhance access to care offered by statutory health system.
Transparency and accountability	Market is transparent, data are available, but neither consumers nor professionals are aware of financial side of PHI, which makes they are sometimes over-enthusiastic. Complexity of PHI agreements means that consumers are hardly able to assess different products.	Existence of PHI and quasi-insurance encourage transparency and accountability in the wider health system by setting clear rules of access to care. There is very little evidence of misconduct of professionals working for PHI and quasi-insurance, which partly is due to strictesupervision and partly due to the relatively small scale of the market. Both PHI and quasi-insurance providers actively participate in public debate on health system, lobby, and try to influence the authorities. The two parties often stand on opposite sides.
Rewarding good quality care	PHI and quasi-insurance select providers offering better	PHI and quasi-insurance drain the market of good professionals. On the other hand, if they did not

	(perceived) care.	exist, on the European open labour market, many professionals, mainly physicians and nurses would leave the country.
Providing incentives for efficiency	Not known	Not known
Administrative efficiency	Overall costs of PHI that are not spent on benefits (cash or in-kind) is high – approx. 60% of the premium collection. PHI representatives sometimes explain this as a low volume of market. Comparing to the 98.5% spent by the statutory health scheme, this figure looks caricatured.	

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Romania

Victor Olsavszky

Output and aims

Without legislation encouraging the development of the market for PHI, PHI remains in its early stages of development in Romania, and data on this field are limited. This case study was written based on three primary sources of information: two main laws regulating general insurance and PHI, the official website of the Romanian Insurance Supervisory Commission and a structured interview with a director of the sales department at one of the biggest insurers on the market and an expert from the National School of Public Health.

Market role and context

Romania has a mix of compulsory and voluntary elements of finance, but the dominant source of funding has been social insurance since 1998. Health funds derive primarily from the population, with the greatest portion coming from third-party payment mechanisms (social health insurance contributions and taxation) and with a smaller fraction coming from out-of-pocket payments (co-payments and direct payments). Social insurance contributions are collected by the Fiscal Administration National Agency of the Ministry of Finance (or in the case of the self-employed, by the District Health Insurance Funds). Taxes are also collected by the Ministry of Finance and then allocated to the Ministry of Public Health, which then funds the District Public Health Authorities for public health programmes. Additionally, tax funding is allocated to the National Health Insurance Fund to cover the social insurance contributions of the non-employed and exempt population groups. The Fiscal Administration National Agency allocates the social insurance revenue to the National Health Insurance Fund, which then distributes resources to the District Health Insurance Funds based on a formula of risk-adjusted capitation

The Law 95/2006, under the title X “Voluntary health insurances,” defines this type of insurance as an optional system through which an insurer sets up an insurance fund based on mutuality principles and then collects premiums from a number of insured persons exposed to risks in connection to their health. The way in which voluntary health insurance operates should be based on the general law on insurances and reinsurances (136/1995). All persons entitled to the basic package of benefits from the social health insurance system are eligible for services provided through PHI.

The Law 95/2006 stipulates that voluntary health insurance can play the role of both complementary and supplementary health insurance:

- Complementary insurance can fully or partially cover co-payments for the basic health care service package provided by the state social insurance fund
- Supplementary insurance can fully or partially cover any type of health care service not included in the basic health care service package of the social health insurance system; it can also cover the option for a specific provider, a second opinion, better accommodation for hospital care, etc.

Roles have not changed over time, as from the beginning PHI was designed to be complementary and supplementary.

Data on the number of people insured are not reported to any authority. Anecdotal reports estimate about 15,000-20,000 individuals with PHI. This represents a very low percentage of the 20 million inhabitants of Romania (0.1%). The estimated number of persons who are subscribed by their employer to a health service subscription roughly number 100,000-200,000 (rough estimation, no clear data available).

Providers have to make public financial data (yearly balance) and other data reported to the Insurance Supervision Commission. The Commission reports annually on the activities of all companies in the insurance field, including PHI. From the reports, one can extract information on the market share of different insurance companies, as well as on the total amount of premiums collected and benefits paid for each insurance class.

The data from Table 1 below confirms that PHI did not exist in Romania before 2004. Even the data from 2003 might describe PHI as mainly paying benefits but reported under PHI or some of the "subscribing" system reported under this category.

Comparing the figures for private expenditure on health as a percentage of total expenditure on health, one can observe that they vary from 13% to 35% constantly between 1996 and 2003; then this figure drops to 20% with a slight increase afterwards. One interpretation of this could be that PHI was coming on the market; another interpretation could be that the market of "subscriptions"[213] expanded. This could also be explained by the fact that since the year 2000, public expenditure on health has increased about five fold to date. In other words, the public system may have become more attractive to a certain extent, especially since the basic package of benefits remained comprehensive.

Table RO1 PHI as a proportion of private expenditure on health and total expenditure on health, 1996-2005, Romania

Data	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
PEH as % of TEH	33.5	30.6	37.9	35.0	32.7	34.2	34.8	20.5	28.5	24.7
PHI as % of PEH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	19.0	9.4	18.2
PHI as % of TEH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.9	2.7	4.5

Source: WHO (2007). Notes: PEH = private expenditure on health; PHI = private health insurance; TEH = total expenditure on health; n/a = estimates not available

Based on the definition provided by Law 95/2006, the scope of PHI has been reduced to a very small market due to the fact that the basic package of benefits from social health insurance is actually very comprehensive. In other words, there are few uncovered services to be offered by private insurers even if the market conditions for PHI were in place. The actual law, as mentioned above, would encourage in principle complementary PHI, but would not exclude supplementary PHI.

Market overview

[213] Important note: "subscription" in this document refers to the following concept/pattern: employers buy bulk health services from a provider for his employees. Usually such contracts are yearly based (like a season ticket). Every employee is then entitled to a limited and defined number of healthcare services provided only by the contracted provider. The employee might use or not these services. However the employer pays the services in advance regardless if the employee uses the services or not.

In the initial phase during the 1990s, a system of "subscription" for health services to a provider was popular among many employers, especially for international companies. This system grew together with the development of the market for private health providers as an alternative for better health services than those offered through the publicly financed system. These types of arrangements were organized by private companies that had their own medical facilities or that contracted health services from other providers (including state-owned or financed providers). The employer mainly would pay the contributions for these subscriptions, as PHI was regarded as an incentive for employees since it was usually included in benefit packages. The previous regulation from 2004 encouraged mainly supplementary PHI.

In 1999, the statutory health insurance fund, defined by a special law as a non-profit organization, appeared on the market,. The statutory health insurance fund holds the majority market share. At the same time, a number of for-profit insurers were operating in the market, offering the only type of benefit packages with or without life insurance in the health field.

The first company that specialised exclusively in PHI appeared on the market even before the 2004 law on private health insurance. After the introduction of this PHI law, several insurers started to offer packages that were both linked and unlinked to life insurance packages. All the current players on the PHI market are for profit.

In Romania, the PHI market is 100% private. In 2006, there were 41 for-profit insurance companies operating on the general insurance market. Of those, only 12 offered packages that reported under PHI. In 2004, there were 39 for-profit general insurance companies, of which 16 offered PHI. The total value of premiums was similar in 2006 and 2004. Although there was a decrease in the number of companies offering PHI, moreover, the value of the market is almost the same (about 8 million Euro).

In Romania, there are insurers that have their own hospitals and combine insurance with provision. It is a flexible system where insurers have the liberty to integrate insurance with provision. The insurers purchase services both from private hospitals and clinics, as well as from public providers. Private beds exist in public hospitals, but their actual numbers and utilization are not reported publicly.

It is difficult to provide official figures on the profile of the average PHI subscriber. Broadly, the typical subscriber could be broadly categorized as follows though: a wealthy employee of a successful multinational or national company, a successful self-employed worker, someone from an urban area, an individual with a higher level of education, someone who relies on the Internet for information and an individual no older than 45-50 years of age. On the PHI market, insurance package premiums vary from 20 to 40 Euros per month. The minimum salary one should make in order to afford this premium should be above 500 Euros, which is the average salary reported by the National Institute of Statistics in June 2007.

No data is available on the proportion of each type of PHI purchased by individual subscribers and by groups (usually employment-based groups). However, employment-based groups usually buy the "subscription" type of services rather than complementary or supplementary PHI. One of our key informants noted that in his experience, there are a

very few individuals who buy themselves PHI, as usually this is purchased by companies for the purpose of employee stabilization.

During the National Conference on PHI in April 2007, a survey was presented on the PHI market (www.xprimm.ro). Despite its limitations in sample structure, the study showed that 64% of the respondents felt that the quality of services was the major driver for buying PHI or "subscriptions." Also the study found that the current offer of PHI packages does not satisfy fully the buyer (over 40% unsatisfied); 65.4% believe a greater level of premium deductibility could influence positively their decision to buy.

The legislative framework for PHI consists of (1) Title X of Law 95/2004 on healthcare reform entitled "Voluntary health insurance"; (2) Methodological norms of 22 February 2007 regarding voluntary health insurance; (3) Law 46/2003 on patients' rights; (4) Law 136/1995on insurances and reinsurances.

The laws regulate the relationship between insurers and the insured and between insurer and services providers--in addition to the general terms of contracts, confidentiality issues, the continuity and renewal of contracts, changes in premiums within the same risk category, complaints procedures and solvency.

The Insurance Supervisory Commission supervises the activities of authorized insurers according to Law 32/2000. It publishes annual activity reports and notes the evolution of the insurance market. These reports are available on the internet (www.csa-isc.ro). Aside from these reports, there is no other information available on activities in the PHI field.

Assessment of market performance

It is rather difficult to assess this in a market where PHI is in its infancy and where the basic package of benefits offered by the compulsory social health insurance is comprehensive.

Market development, public policy and impact on the wider health system

The PHI system is very young; the first law regulating this market dates back to only 2004. Before that, any insurance falling within the field of health was regulated through the general insurance and reinsurances law, even though they were limited mainly to travel health insurances or accidents.

According to the opinions expressed during the last national conference on PHI in April 2007, one of the major barriers to market development is the comprehensive package of benefits in the statutory health insurance system. Except for the field of dentistry, almost everything is covered by statutory insurance so that very few healthcare services could be offered within a PHI system (at least theoretically). However, the governing laws and regulations do not exclude PHI from the market. An employee who is insured by the statutory system always has the possibility of buying PHI.

Another perceived barrier is the low level of co-payments for services covered by statutory insurance. The only co-payments in the statutory system are for the drug reimbursement scheme. Co-payments for prescribed drugs from a positive list are set at 10% of retail price for generic drugs and 50% of retail price for more expensive generic or brand name drugs.

A reference price system is in place, where the reference price is set at the level of the cheapest drug from a cluster. Apparently no PHI insurer is willing to offer a package to cover this type of co-payment due to the lack of control over prescribing and possible fraud.

The only change over time in government regulation was at the level of the laws governing PHI, but the interventions were minor and were intended only to set the legislative framework.

The existing regulations provide no incentive for employers to buy PHI for their employees or to contribute to the premiums paid by their employees. There is a limit of 200 Euros per year for deductibles in each category of insurance, which is considered by insurers to be extremely low (actually a non-incentive for anyone). This limitation does not refer to statutory health insurance.

The boundaries between PHI and publicly-financed health care are clearly drawn: complementary insurance can fully or partially cover the co-payments for the basic health care service package provided by the state social insurance fund, and supplementary insurance can fully or partially cover any type of health care service not included in the basic health care service package provided by the social health insurance system; supplementary insurance would also cover the option for a specific provider, a second opinion, better accommodation for hospital care, etc.

At present, PHI affects the wider health system insignificantly. If PHI increased in volume though, it would be possible to improve the quality of services provided within the wider health system, and more money could be paid to the providers. At the same time, it is possible that this would simultaneously increase the costs of healthcare services.

Debates about PHI were stirred up by insurers advocating for more permissive legislation for PHI. Working groups and conferences also have been organized with the participation of insurers, providers, the Ministry of Public Health, the National School of Public Health and Management (the one managing the DRG system for hospital financing), etc. The main focus of the debates has been around the basic package of benefits provided by the statutory system, which is considered one of the main barriers to the development of PHI.

The problem perceived by PHI insurers lies at the level of money flow and coverage. If a client receives health services from a provider who has no contract with the statutory insurance system, then the money flow is clear. If a client receives services from a provider with a contract with the statutory insurance system, then the options for PHI are more complicated: it can pay benefits to the client: or it can pay for better service delivery conditions (facility premises, accommodation, meals, etc.), expensive investigations (MRI) or extra services. Even in the case of expensive investigations, the majority of such services are included in the basic package of benefits provided by the statutory insurance. Moreover, for publicly financed healthcare providers, there is no clear evaluation of costs.

Under the current regulations, the PHI market will continue to grow slowly from very small size to small. A major change in the regulations and public policy could produce a boom similar to the one witnessed recently in private pension insurance. The focus on the basic package of benefits provided by the statutory system should be shifted towards the

deductibility of premiums, which would be a better way to involve employers. Also, the law could move from "what" to insure towards "how" to insure.

Assessment of market performance

Again, the size of the PHI market in Romania means that PHI makes a rather small contribution to the overall performance of the health system. However, in Romania financial protection is assured through the social health insurance system, which theoretically covers all of the population with some sort of income; meanwhile those without income are covered by the social protection scheme.

Since PHI is complementary and/or voluntary and limited to services that are outside of the basic package of benefits from compulsory social insurance, its influence on equity of access is very marginal.

Finally, PHI and the "subscription" type of arrangements are contributing to better quality of care, efficiency, transparency and accountability. Due to the fact that their market share is still so small, their contribution to the aforementioned goals is still limited though.

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Slovenia

Anja Milenkovic Kramer

Introduction

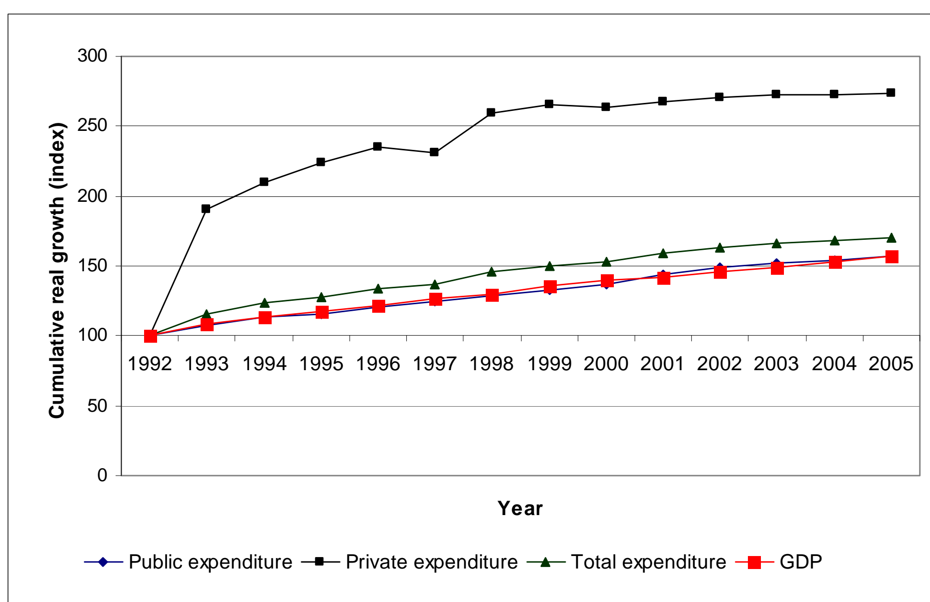
Private health insurance (PHI) in Slovenia was designed to diversify funding sources and to help achieve financial sustainability for the overall health system. Up until 1992, the Slovenian health care system involved a combination of the Beveridge and Semashko systems, whereby patients were provided with an unlimited benefit package that included all healthcare services available on the market. With increasingly expensive healthcare services and low economic efficiency, this unlimited benefit package experienced serious problems in securing funds and brought the Slovenian health care system to the verge of collapse in 1990 (Albreht et al. 1994; Markota et al. 1999). Consequently, the health care system in Slovenia underwent many major changes immediately after the country declared its independence in June 1991. These changes were based on the acceptance of three main documents: the Health Care and Health Insurance Act (ZZVZZ 1992), the Health Care Activity Act (ZZDej 1992) and the Pharmacies Activity Act (ZLD 1992). The new legislation revised the financing methods and transferred some healthcare costs to private funds. The Health Care and Health Insurance Act introduced social (compulsory) health insurance as a major source of funding. In addition, the Act established co-payments for most of the healthcare services included in the compulsory health insurance benefit package and allowed for the launching of private health insurance schemes.

This paper analyses private health insurance in Slovenia. It starts by explaining health expenditure in Slovenia and the private health insurance system. This is followed by a description of the market situation. In addition, market reforms in the last decade, as well as the implementation of risk adjustment, are explained. The paper finishes with an assessment of the market performance and possible future developments.

Health care expenditures in Slovenia

In 1992, total healthcare expenditure in Slovenia amounted to EUR 339.7 million, of which 90.18% represented public resources and a mere 9.82% private resources (Korosec 2003; HIIS 2002). After the introduction of health insurance schemes, total healthcare expenditure in 1993 rose by 16% in real terms. Further, the introduction of private health insurance in 1993 significantly increased the burden of expenditures originating from private resources. This increase was highest in the first year following the introduction of the private health insurance scheme (1993) when total health care expenditure paid from private sources grew by 90.5% and amounted to 16.2% of total expenditure on health. In the last 15 years, private expenditure on health has been growing faster than public healthcare expenditure, faster than total health expenditure and even faster than the country's GDP (see Figure 1).

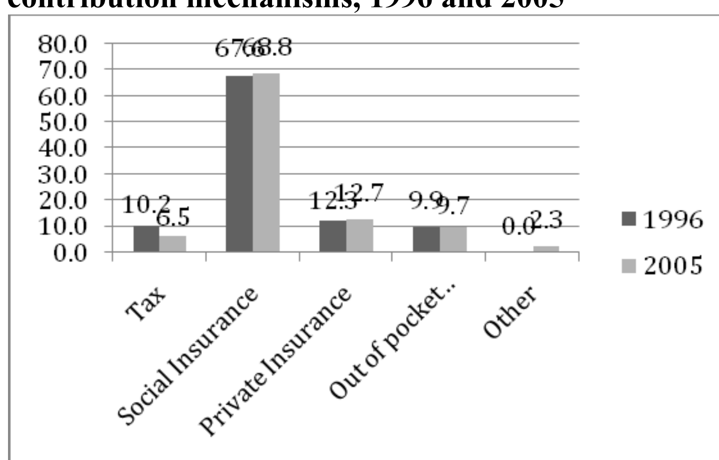
Figure SI1 Cumulative real growth (index) of total expenditure on health, public expenditure on health, private expenditure on health and GDP



Sources: Statistical Yearbooks (1998- 2005); White Paper (2003); Korosec (2003); HIIS (2002- 2006)

In 2005, total health expenditures in Slovenia reached EUR 2.467 million (8.73% of GDP). The health care system remained predominantly financed by social health insurance contributions (more than 70% of all health system funds come from the social health insurance scheme). Other forms of public sources, government and local community funding through taxes only played a marginal role (see Figure 2).

Figure SI2 Breakdown of the percentage of total expenditure on health by main contribution mechanisms, 1996 and 2005



Source: WHO (2007)

In addition, private health expenditure as a proportion of total health expenditure has been increasing over the years. By 2005, private resources already accounted for 22.4% of all health system funds. Approximately 60% of private resources come from private health insurance schemes, which represent the second most important source of funding health care in Slovenia (see Figure 2).

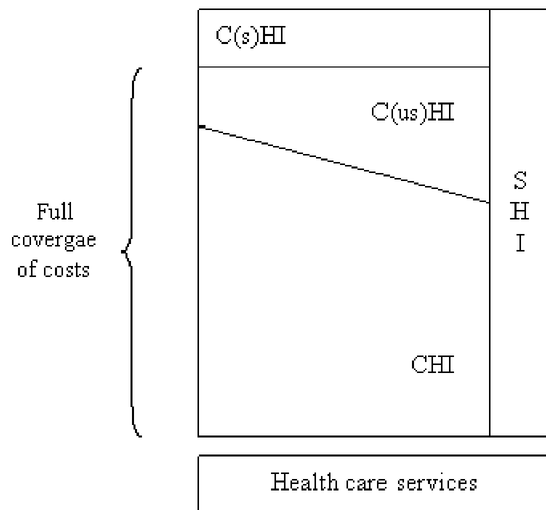
Private health insurance in Slovenia

Private health insurance in Slovenia was introduced in 1993. It was designed to diversify funding sources and has helped achieve financial sustainability. The system has undergone several changes and adaptations since its introduction, but its general framework remains the same. The private health insurance market in Slovenia comprises (also see Figure 3):

- *Substitutive health insurance*: The substitutive health insurance scheme covers all services included in the compulsory benefit package and is only available to those not eligible to be included in the compulsory health insurance scheme (i.e. foreigners).
- *Complementary (user charges) health insurance*: Complementary (user charges) health insurance covers co-payments for services included in the compulsory insurance benefit package[214]. The scope of benefits and the benefit package offered by this type of health insurance is limited and predefined by the compulsory health insurance benefit package.
- *Complementary (services) health insurance and supplementary health insurance*: The compulsory health insurance package in Slovenia includes an almost universal range of health services leaving little room for the development of complementary (services) and/or supplementary health insurance schemes. Some schemes were developed though including insurance for overnight treatments when there is no emergency, insurance for outpatient prescription drugs, insurance for cosmetic surgery procedures, insurance for above-standard living conditions in hospitals and health spas, insurance for covering the costs of more elaborate medical and technical aids, etc.

[214] Co-payments are calculated as a percentage of the price of the health services and can be paid either by complementary (user charges) health insurance or out of pocket. Their share ranges between 5 to 75%.

Figure SI3 The health insurance system in Slovenia



Legend: CHI – compulsory health insurance; C(us)HI – complementary (user charges) health insurance; C(s)HI – complementary (services) health insurance; SHI – supplementary health insurance
Source: Adopted from Dosenovic Bonca, Tajnikar, 2005

The most successful form of private health insurance in Slovenia is complementary (user charges) health insurance. Upon its introduction in 1992, it was first predicted that the scheme would be gradually rolled out and that only 300,000 would purchase it in the first year (Jaklič, 2004). On the contrary, more than 70% of people had already bought insurance policies by December 1992 even before it was introduced in January 1993. A year later, over 1,350,000 people or approximately 90% of all people eligible to make co-payments were insured. The trend continued, and by 1996 this share of the insured population had reached more than 95%. Since then, almost 98% of the population has been insured against the risk of making co-payments (Kosir et al. 1994; Keber 2003; Cotman 2005; Statistical Insurance Bulletin 2005).

Some argue that the large number of people taking out complementary health insurance indicates that Slovenians are positive and supportive regarding the introduction of co-payments to the system and the introduction of private health insurance to cover them, and that further they are prepared to actively contribute to the healthcare fund. According to this viewpoint, the adequacy of the system is seen in the fact that all people eligible for the insurance actually arranged it, implying that a flat-rate premium is also suitable and acceptable; as such, co-payments should be further developed and adjusted to reflect the interests of the people and their financial capabilities (Košir et al. 1994; Berkopec, 1995; Toth, Košir, 1998; Jošar, Toth, 2001; Toth, 2003).

Others argue that the reforms of the early 1990s lowered the level of solidarity in the health system. They agree that the partial withdrawal of the state from healthcare funding and the introduction of private funds to the system was inevitable; however, it was carried out in an unsuitable way. The introduction of co-payments for the majority of healthcare services included in the compulsory benefit package and the introduction a flat-rate (complementary (user charges) health insurance) premium to cover those costs both reduced solidarity in the collecting of funds and shifted the financial burden to individuals,

ultimately exacerbating the regressivity of the system. According to this viewpoint, the sole reason for the success of complementary health insurance is believed to be the high level of co-payments[215], making the complementary (user charges) scheme far from voluntary (Keber 2003; White Paper 2003).

Other forms of voluntary health insurance have not been as successful. Complementary (services) health insurance, supplementary health insurance and substitutive health insurance schemes were purchased by less than 1% of the population (Statistical Insurance Bulletin 2005). There are several reasons for that. The first is that dropping out of the compulsory health insurance scheme is not permitted. Second, the benefit package covered by the compulsory scheme completely or partially covers nearly all services provided. The third reason is that there is a lack of capacity to provide additional complementary and supplementary services and that the legal organisation of public providers still does not allow them to sign legal contracts with other organisations (i.e. health insurance companies). Such contracts would enable public providers (hospitals) to provide additional services paid for by complementary (services) and supplementary insurance (i.e. better equipped rooms, etc.) and would allow investors to have at least some control over the services supplied in the complementary (services) and supplementary health insurance schemes (Toth 2003; Tajnikar et al. 2006; White Paper 2003).

Market overview

In 2006, the private health insurance market represented 20.9% of the total private insurance market in Slovenia (AZN 2007). By estimating the size of the health insurance market according to the total premium income, it can be seen that the market size is nearly EUR 337 million. The major part, more than 98.39%, of total premium income comes from complementary (user charges) health insurance, whereas less than 2% of total premium income results from selling other forms of private health insurance schemes (see Table 1).

Table SI1 Size of the PHI market in 2006 according to total premium income

	Market size in 2006	Proportion of the PHI market
PHI	€ 336,361,020.70	
C(UC)HI	€ 330,953,718.08	98.39%
C(S)HI and SHI	€ 5,407,302.62	1.61%

Legend: PHI – private health insurance; C(uc)HI – complementary (user charges) health insurance; C(s)HI – complementary (services) health insurance; SHI – supplementary health insurance

Sources: Vzajemna (2008); Triglav (2008); Adriatic Slovenica (2008)

[215] The high level of co-payments can be presented via the following example: An individual has a minor car accident in which his/her collarbone is broken. The total price of the healthcare service involved is estimated to be EUR 2,221.71. The corresponding co-payment in this case would amount to EUR 970.20 or 44% of the total price for the necessary health care service (Vzajemna 2006). In addition, the co-payment would amount to 16.20% of the minimum yearly salary or 6.99% of the average yearly salary. The corresponding yearly premium for complementary health care insurance in both cases would be 4.01% of the minimum yearly salary or 1.73% of the average yearly salary (TARS 2006; Adriatic 2006; Vzajemna 2006; Triglav 2006).

There are three insurance companies operating in the Slovenian private health insurance market. Upon its introduction in 1992, two insurance companies started selling private health insurance in Slovenia: Vzajemna and the Adriatic Slovenica Insurance company. The largest, the Vzajemna Mutual Insurance Company, started as an integral part of the Health Institute of Slovenia, the sole public institute bound by statute to provide social (compulsory) health insurance in the Slovenian market. As a result of legal requirements to separate private health insurance providers and compulsory health insurance providers in Slovenia in 1999, Vzajemna started operating as an independent mutual insurance company. Since 1993, private health insurance has also been sold by the Adriatic Slovenica Insurance company. Organised as a joint-stock company, this firm, unlike Vzajemna, is also engaged in other insurance activities. The third company, the Triglav Health Insurance company, entered the Slovenian health insurance market in 2004. The Company is organised as a limited liability company and specialises in health insurance. It is an integral part of the large Triglav group, a joint-stock insurance company that is also engaged in other insurance activities. Since 2004, the number of insurance companies operating in the health insurance market has remained the same.

Table 2 shows estimates of the market shares of the three companies in the Slovenian health insurance market. The market shares are calculated from the total premium income. It can be seen in the table that there were practically no changes in market shares in the Slovenian health insurance market from 1999 until 2005. A possible reason for this is that people were resistant to changing their health insurer because they were in most cases faced with a higher health insurance premium. Up until March 2006, the premium an individual paid for the complementary (user charges) health insurance scheme depended on his entering age when joining the scheme. Entering age was determined on the date of signing the contract and did not change until its cancellation. A new entering age, brought about when switching an insurer, was in most cases connected with a higher premium.

Table SI2 Market shares

		Vzajemna, d.v.z.	**Triglav, d.d.**	**Adriatic Slovenica, d.d.**
PHI	1999	84.43%		15.57%
	2000	83.70%		16.30%
	2001	82.95%		17.05%
	2002	82.63%		17.37%
	2003	82.01%		17.99%
	2004	81.69%		18.31%
	2005	80.62%	0.34%	19.04%
	2006	65.64%	11.42%	22.94%
CHI (UC)	2006	66.25%	11.61%	22.14%
CHI (S) and SHI	2006	28.47%	0.00%	71.53%

Legend: PHI – private health insurance; C(UC)HI – complementary (user charges) health insurance; C(S)HI – complementary (services) health insurance; SHI – supplementary health insurance

Sources: Vzajemna, 2008; Triglav, 2008; Adriatic Slovenica, 2008

Major shifts in market shares only happened after acceptance of the new Act on Changes and Supplementation to the Health Care and Health Insurance Act in September 2005 (ZZVZZ-H 2005). The chief reason for this is that, before implementation of the new Act in March 2006, people were required to resign from their complementary (user charges) health insurance contracts. In a three-month period, people were free to consider and change their health insurer. After March 2006, complementary (user charges) premiums in Slovenia became community rated, and insurers now must offer open enrolment and a lifetime cover. People are free to change their health insurer every year.

Reforming the Slovenian private health insurance market

The biggest change introduced by the new Act in September 2005 was the implementation of a risk-adjusting mechanism in March 2006 (ZZVZZ-H 2005). Even though the Insurance Act (ZZavar 2000) had announced the introduction of a risk-adjusting system already in 2000 [the Act defined complementary health insurance as a public interest and stated that all insurance companies providing complementary (user charges) health insurance have to include a risk-adjusting scheme], risk adjusting at that time was not implemented.

The implementation of risk adjusting in the Slovenian health insurance system was further postponed because the Ministry of Health in its 2003 "White Paper" suggested a different way to reform the health insurance system in Slovenia. It proposed the elimination of the complementary (user charges) health insurance scheme. Compulsory and complementary (user charges) health insurance would be merged into one compulsory insurance scheme, with income-related contributions levied on employers and employees. Estimations showed that approximately 39% of employees would have to pay more, but lower income groups would have to pay less. The proposal predicted rises in governmental and local community funding, and it aimed to lower administrative costs (White Paper 2003). Supporters of the reform believed that according to the unique characteristics of the complementary (user charges) scheme, its premium should be income-related so as to create solidarity between population groups with different income levels. In addition, they were dissatisfied with the fact that health insurance companies selling complementary (user charges) health insurance were generating profits at that time, while the Health Insurance Institute of Slovenia was accumulating losses (Dosenovic Bonca, Tajnikar 2005). On the other hand, the reform was strongly opposed by employers and private health insurers. It also raised several concerns with the Ministry of Finance over increasing labour costs (Zagorac 2003).

In 2004, the Insurance Act (ZZavar-UPB1 2004), then aligned with the EU directives, again defined complementary (user charges) health insurance as a public interest and announced the implementation of a risk-adjusting mechanism. However, the scheme was still not prepared and implemented, and risk-rating premiums were still permitted. Premiums for complementary insurance were calculated on the basis of risk indicators for particular age groups of people. Determinants for calculating the premium were: gender, age, mortality rate tables, disease tables and the duration of the health insurance contract. The insurance companies were also competent to grant bonuses to some groups of people (blood donors, company contracts where the policyholder is a company and the subscribers were all workers, etc.). The complementary insurance contracts at that time were mostly long-term contracts, and insurance companies had to assure the long-term security of subscribers by forming provisions (ZZVZZ-UPB1 2004).

In the same year (2004), Vzajemna, started accruing losses, and in June 2004 it announced that it would be forced to increase premiums by 13.5% for complementary (user charges) health insurance subscribers aged 60 and over; this would have involved 383,000 people, or approximately 20% of the entire population of Slovenia, if the government did not prepare and implement a risk-equalisation scheme (STA 2004). According to Vzajemna, the growing losses were the result of an increasing level of co-payments over the years, the high share of pensioners in its portfolio in comparison to its competitors and the delays in introducing the risk-adjusting mechanism that had already been announced in the 2000 Insurance Act. At this time, it became clear that the existing form of complementary (user charges) health insurance had reached its limits (Dosenovic Bonca, Tajnikar 2005). The intention of increasing premiums was frozen in July 2004 after the government obliged itself to make the preparation and implementation of a risk-adjusting mechanism a priority task (STA 2004a). The idea of merging compulsory and complementary (user charges) health insurance was no longer considered.

Risk adjusting in private health insurance in Slovenia

Less than a year later in September 2005, the new Act on Changes and Supplementation of the Health Care and Health Insurance Act came into force (ZZVZZ-H 2005). With this, the new government proposed and implemented a different set of reforms that included the preservation of complementary (user charges) health insurance and introduced community rating and risk adjusting. Under the new Act, complementary (user charges) health insurance in Slovenia was once again defined as a public interest and started operating on the principle of inter-generational and gender mutuality. With the introduction of risk-adjusting schemes into the Slovenian health insurance market, companies selling complementary (user charges) insurance stopped forming provisions for ensuring the long-term sustainability of the system. To ensure the system's long-term sustainability, it is now mandatory for insurers to engage in a risk-adjusting scheme. The scheme enables them to align differences in costs of healthcare services that occur due to differences in portfolios, in terms of age and gender, between companies (Milenkovic 2005).

Immediately after the introduction of risk adjusting into the Slovenian health insurance system and even before its actual implementation in March 2006, Adriatic (in October 2005) and Vzajemna (in December 2005) challenged the scheme before the High Court, claiming that it might distort competition in the Slovenian health insurance market (Adriatic 2005; Vzajemna 2005). After the High Court's ruling in the government's favour, Vzajemna went even further. In June 2006, it informed the European Commission about the shortcomings of the complementary (user charges) health insurance market in Slovenia. According to Vzajemna, the Act on Changes and Supplementation of the Health Care and Health Insurance Act that came into force in September 2005 includes the following shortcomings (Rednak et al. 2007):

- Health insurance companies selling complementary (user charges) health insurance must be included in a risk equalisation scheme;
- Health insurance companies must inform the Insurance Supervision Agency about all new and/or changed conditions of the complementary (user charges) health insurance scheme;
- A premium increase must be confirmed in writing by an official actuary of the company, and a premium increase must be confirmed by the Insurance Supervision Agency;

- Complementary (user charges) insurance premiums must be equal for all subscribers of a particular insurance company, and the insurance policy must be made for no less than a year;
- An insurer cannot cancel the contract on complementary (user charges) health insurance unless the premium has not been paid;
- The returns from complementary (user charges) health insurance must be used exclusively for implementing the complementary (user charges) health insurance scheme; in the case of positive returns, 50% of the profit must be further engaged in implementing the complementary (user charges) health insurance scheme; and
- For operating in the complementary (user charges) health insurance market, a company must receive written approval from the Minister for Health. The approval proposal must incorporate information on the insurance company and any special conditions of the complementary (user charges) health insurance.

As a result of the issues raised, the European Commission issued an official warning regarding the health insurance legislation in March 2007. According to the warning, certain provisions of the Health and Health Insurance Act in Slovenia were not in line with European directives on non-life insurance. The Commission believes that complementary (user charges) health insurance in Slovenia is only a supplement and therefore cannot be considered part of obligatory insurance (Slovenia Business Week 2007).

The Ministry of Health prepared an official response to the warning, further explaining the specific/unique role of complementary (user charges) health insurance in Slovenia. The response also noted that complementary (user charges) health insurance is governed by a special law, which defines it as a public interest, and described the system of complementary (user charges) health insurance in Slovenia, its contextual and financial links to compulsory health insurance, their mutual dependence and their role in providing social security (Rednak et al. 2007).

Market performance and its implications for future development

Assessing market performance in the private health insurance market in Slovenia is a demanding task since there is very little information available. Some data can be found regarding financial protection, equity in finance and equity in access though. However, there is still no data available on transparency and accountability, rewarding high quality care, providing incentives for efficiency and evaluating administrative efficiency.

Due to the main characteristics of complementary (user charges) health insurance in Slovenia (insurance is limited to covering co-payments for those services included in the compulsory health insurance benefit package), this type of insurance was already in the 2000 Insurance Act (ZZavar 2000) since it was defined as a public interest. Under the Act, it should have been developed based on the principles of financial protection and mutuality (intergenerational and gender mutuality); it is also supposed to provide equity in access to health insurance and equity in access to health care (ZZVZZ-H 2005).

As already noted, the sole reason for the success of the complementary (user charges) health insurance scheme is the high level of co-payments. It can therefore be concluded that this form of private health insurance is enhancing the financial protection of the population by making it possible for people to buy this health insurance and thus escape the high treatment costs most citizens would be unable to pay for. However, financial

protection is further undermined by the unique characteristics and organisation of compulsory health insurance in Slovenia. The Health Care and Health Insurance Act of 1992 (ZZVZZ, 1992) only specified the minimum or maximum coverage for specific groups of services and allowed further changes that would shift costs of services or costs of medicines to private health insurance schemes or out-of-pocket payments without any resistance from the public; this is leading to increases in premiums for complementary (user charges) health insurance and out-of-pocket payments. Due to this shifting of costs, the premiums for complementary (user charges) health insurance already increased by 12.6% in the last two years. The average yearly premium in March 2006, upon the introduction of risk-adjusting schemes, was EUR 238.20. Today (2008), the average premium for complementary (user charges) health insurance is EUR 268.16 (Adriatic 2008; Triglav 2008; Vzajemna 2008). Together with the average 18.2% increase in premiums that occurred when the community rating and risk-adjusting schemes were set up, premiums for complementary (user charges) health insurance in Slovenia have risen by almost 31% since January 2006, whereas compulsory health insurance contribution rates throughout this time have remained the same.

The abovementioned increases in the lump sum premium people pay for complementary (user charges) health insurance is adding to the regressivity of the private health insurance system in Slovenia. Another element adding to the system's regressivity is the fact that premiums paid for private health insurance are tax deductible (ZDoh-1-UPB4 2006). However, more disturbing than these two elements of private health insurance in Slovenia is the problem that the premium paid for the complementary (user charges) health insurance scheme may determine the access an individual has to healthcare services provided within the compulsory health insurance benefit package. Namely, an individual who cannot afford to pay either the complementary (user charges) health insurance premium nor co-payments may, because of the combined financing, encounter problems when in need of most services included in the universal benefit package (White Paper 2003).

Future developments in the private health insurance market in Slovenia

The diversification of funding sources at the beginning of the 1990s through the introduction of private funds into the system has had some positive effects and has helped achieve financial sustainability for a short period of time (Albreht et al. 2002). In health care today, however, we face ever-increasing expenditures as a result of advances in medical sciences, demographics and the epidemiological transition and growing public expectations.

Future rises in total health expenditures are expected. Increases in the compulsory health insurance contribution are not easily negotiated since there is usually significant resistance from the population to any higher taxes. When levied on employers, higher contribution rates can exert a negative impact on the overall competitiveness of the economy and on the level of foreign direct investment because they raise labour costs. Other public resources for funding health care in Slovenia (the national budget, local community funding) only play a marginal role and are not expected to change significantly in the near future. Therefore, it is reasonable to expect a further increase in the level of private resources involved, including voluntary insurance and out-of-pocket payments, in the next few years.

Considering the public debate, today what is seen as the most likely solution is a greater future role for private funds through the increased presence of private health insurance packages. In order to achieve this, however, there is a need to redefine the role and benefit package of compulsory and private health insurance in Slovenia, as well as to make a clear determination of the role each health insurance scheme is to play in the Slovenian market.

Redefining the health insurance scheme would have to result in long-term financial sustainability and the creation of real incentives for the rational use of healthcare services. In order to so, it would be reasonable to withdraw from the principle of universality in the Slovenian healthcare system and transform the compulsory health insurance benefit package. This would mean that we would need to change our private health insurance companies, which mainly sell complementary (user charges) health insurance, into health insurance companies that sell complementary (services) health insurance and supplementary health insurance. In addition, co-payments should not be eliminated, but they should be limited in size, no longer insurable and set in such a way as to create demand-side incentives for the efficient use of healthcare services. Compulsory health insurance would cover a benefit package that included services on different levels of the healthcare system for all citizens, ensuring them access to basic health care. A number of services that are not directly linked to health care or do not comprise minimum healthcare services could be shifted to complementary (services) and supplementary health insurance schemes, which would be offered by private health insurance companies in the market (Tajnikar, Milenkovic 2006).

One of the most important issues to address in reforming the Slovenian health insurance system is developing four normal sources of funding health care: compulsory health insurance, complementary health insurance, supplementary health insurance and out-of-pocket payments. These funding sources should not be combined within the same services, as is the situation today; for this has created the unique characteristics of the complementary (user charges) health insurance scheme. Different services in the future should be financed by different sources (Tajnikar, Milenkovic 2006).

Conclusion

Since 1992, the health insurance system in Slovenia has not changed much. Fifteen years after its introduction, social (compulsory) health insurance still represents a major source of funding, followed by private health insurance and out-of-pocket payments. Even though the Health Care and Health Insurance Act of 1992 has undergone many changes, it still represents the cornerstone of private health insurance in Slovenia. Despite cost pressures, the compulsory health insurance package has not undergone any significant changes in the number of services covered since 1992. Changes to the benefit package have been limited to lowering the level of coverage for some groups of services and shifting medicines from positive to intermediate and negative lists. The costs of these changes were levied either on private health insurance or directly on consumers.

Today what is seen as the most likely solution to the rising healthcare costs in Slovenia will be a higher level of private healthcare funds in total healthcare expenditure. In order to achieve this and assure the long-term sustainability of the system, an environment enabling the development of other private health insurance schemes and an environment creating demand-side incentives for the rational use of healthcare services should be established. This can only be done by closely and thoroughly revising the existing health insurance system in Slovenia and redefining the exact role each healthcare funding source is to play in the future.

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Spain

Joan Costa-i-Font

Introduction

Although the National Health System (NHS) finances the vast majority of health care in Spain, a remarkable and growing number of people subscribe to private health insurance (PHI). This pattern is not unique to Spain, but is consistent with what we find in other countries organised under NHS systems where health care is uniform and there is limited flexibility for adjusting coverage to different preferences over quality of care (Besley and Gouveia 1994) [216]. This is the case in the UK and Spain, among others. When PHI is individually purchased, this gives rise to 'double coverage.' That is, because individuals are entitled to receive care both from the NHS and from PHI organisations, those that go private do not totally opt out of the NHS; instead, they choose one or the other depending on their own preferences on specific health services[217]. However, health care competition is restricted to an array of elective health care where private providers might be able to improve upon NHS care (e.g., amenities, information, treatment, etc)[218]. PHI stands as financial arrangement that gives *ex-ante* access to those benefits at a 'reasonable price.'[219] In Spain, about 15% of the population annually purchases PHI, although there are significant regional differences mostly related to income and availability of private health care. Furthermore, PHI premiums account already for some 10-15% of private health expenditure, and recent data highlights significant increasing patterns in the last decade. Some studies have been undertaken using publicly available (Gonzalez 1995; Vera 1999; Jofre-Bonet 2000) and specifically designed surveys (Costa and Garcia 2003). In 2006, 18.4% of the Spanish population purchased some form of PHI.

The coexistence of private health insurance with the NHS may be problematic. Although theoretical models suggest that the purchase of PHI results from a willingness to bear the risks of paying for health care out-of-pocket, non-market barriers to health care might explain the demand for PHI rather than pure 'economic reasons' when the main public insurer finances health care on a free-access basis,. PHI subscribers might be those contentious of publicly financed health or those who support conservative policies (as those relatively better-off might prefer to individually pay for improved quality of care). Therefore, ideological determinants may well influence individual decisions whenever one has to choose to "fill the quality gap" of the NHS.

The institutional setting

[216] The mix of private and public health care substantially differs between different EU countries, such as the interaction links existent between them. Whereas in statutory health insurance systems PHI primarily plays a substitutive role (e.g., Germany) or complementary role (e.g., France) in countries where the health system is built along the lines of a NHS, public mainstream health care coverage coexists with private supplementary health insurance.

[217] Unlike some countries e.g., Canada, the purchase of PHI does not constrain access to the NHS.

[218] The only possible competition is among public servants who still maintain the privilege of choosing between the private health care insurance of the NHS within the insurance fund so-called MUFACE.

[219] Because insurance premiums are ex-ante prices based on a pool of PHI subscribers and the probability of receiving them is smaller than one, they are cheaper alternatives than health care purchased out-of-pocket.

The NHS in Spain has experienced a transition from the pre-1980s statutory social health insurance schemes to a fully tax-funded system legally established in the 1986 General Health Care Act (although not fully accomplished until 1999). The universalisation objective was a main priority of socialist governments; however, it turned out to be complex to implement in practice due to the fragmented structure of the ancient social insurance schemes. The NHS consists of an 'increasing array of regional health services' progressively gaining health care responsibilities from 1981 up to 2002[220]. Indeed, from the early 1990s, seven (accountable) regional health services were given health care responsibilities (61% of the Spanish population). With the exception of 9% of the funds collected at the regional level, the NHS is centrally financed. Regional resource allocation was accomplished through a central block grant transfer up until 2001 when, fuelled by pressures for decentralisation, it became integrated into the general system of regional financing. Health care is the foremost policy responsibility of autonomous communities (AC), joined with education, and accounts for 30-40% of the total public funds in their hands. The share of health care expenditure of total GDP has been relatively stable in the last decade at 7.5%--as has the share of private expenditure, which has not varied from 2.1%.

The Spanish NHS provides health care free of charge at the point of use, except for pharmaceuticals and dental care. The Spanish health system is regionally decentralised**,** and Catalonia is legally one of the seven Spanish autonomous regions that has taken over responsibility for health care from the central government. In contrast with the situation in other regions, more than half of Catalan health expenditure is private, and the system works on a contractual basis[221].

The Spanish Insurance Law defines PHI–so called 'seguro de asistencia sanitaria'--as the one that "provides to the insured with the medical, hospital and surgery care, with own staff of doctors whereby the insurer takes care of its own enrolees in exchange of a premium." Unlike in other EU countries, insurance policies are mainly individually (rather than corporately) purchased and, typically, benefits are received in kind rather than reimbursed to the patient. Normally, to control ex-ante moral hazard after purchasing PHI, there is a 6-month period during which no claims can be satisfied with the exception of urgent care[222]. Contracts have an undetermined duration and can be cancelled by both insurer and insured. Normally, insurers cover the family head and do modify the contract at the age of 65; individuals with chronic diseases are excluded, as are those suffering from alcoholism, diabetes and AIDS, among others. PHI provides the subscriber with a list of medical doctors and hospitals to see in case of need. Furthermore, coverage includes domiciliary care and some specific health (e.g. dental care) care, depending on the policy contracted. Premiums are estimated according to the age and gender of the subscriber, and normally women pay more if they are of fertile age. Monthly premiums range between €30 and €50, depending on the company. Furthermore, the purchase of PHI was fiscally incentivized via tax relief up until 1999 when it was substituted for deductibility in the corporate tax.

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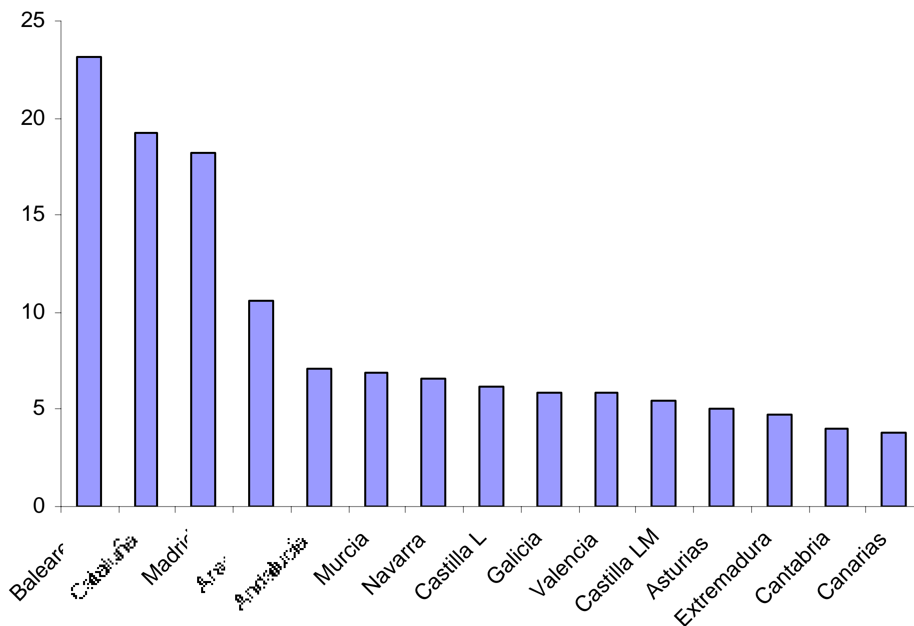
[220] After Catalonia in 1981 followed Andalusia (1984), the Basque Country and Valencia (1987), Galicia and Navarre (1990), Canary Islands (1994) and finally completed in 2002 to the remaining ten regions

[221] PHI in Spain provides coverage against the need of private medical treatment. With the exception of civil servants choosing private substitutive PHI (less than 5% of the population in Catalonia), PHI purchasers have *double coverage*.

[222] This include obstetric care which has a 12 month waiting period; specific interventions are excluded (e.g., vasectomies, prosthesis, etc).

Figure ES1 Share of population with PHI by region (AC)



Source: Encuesta Nacional de Salud (1993)

Existing evidence from Spain points out that in recent years there has been a significant rise in the share of the Spanish population purchasing PHI. Normally, individuals with higher incomes who perceive a lack of quality of care in the NHS and are slightly more risk averse are more likely to purchase PHI (Costa and Garcia 2003). Age patterns are important as well, but they tend to follow a non-linear pattern whereby individuals at middles age tend to be more likely to purchase PHI (Costa and Garcia, 2003; Gonzalez, 1995). Figure 1 highlights important differences across Spanish Autonomous Communities (AC) in regard to the share of the population with PHI. Catalonia, joined by the Balearic Islands and Madrid, are the region states with the largest share of people with double coverage. Interestingly, the three ACs are the richest of the Spanish regions, confirming individual predictions that PHI is a luxury good (Costa and Garcia 2003).

Because the NHS is the principal supplier of health care in Spain, developments in the NHS have a significant influence on the demand for PHI and on the structural links between the private and public sectors. An increasing proportion of the Spanish population perceives that the NHS needs substantial changes. However, opinions in favor of re-defining the NHS, as well as those thinking that the NHS already works well, tend to decline or remain stable over time. Because it is the perception of the NHS rather than the 'objective' satisfaction that determines the demand for PHI we should expect that the number of people supplementing the NHS would rise over time unless the determinants of satisfaction are fulfilled.

Reasons for PHI purchase

One of the most often quoted reasons for purchasing insurance is risk aversion. However, when public insurance exists and provides coverage to the entire population, then catastrophic risks are normally covered though public schemes. Therefore, the purchase of PHI might arguably be less grounded in risk aversion motives. However, because people who are risk averse tend to be keener on purchasing insurance, we must examine whether those people holding other forms of insurance were more likely to purchase PHI. Moreover, using data from 1999 from Catalonia, we measured risk aversion using a rating scale that ranges from 1 to 10, with 1 being avoid all risks and 10 being never avoid risks. Results suggest individuals with PHI display a higher risk aversion (2.74) as compared to those without (2.94).

Our study suggests that PHI subscribers tend to have higher income, are more likely to have completed university studies and live in the capital where there is a higher availability of private health care. Other determinants such as age, lower levels of education, health and household size turn out not to be statistically different. Age displays a non-linear pattern in affecting the demand for PHI (Costa-Font and Garcia 2003). Education might be connected to income, and household size seems not to be a clearcut explanatory variable. Perceived health is ambiguous as far as people who already have some illness might be excluded from coverage or alternatively might be charged a higher premium.

Tables 1 and 2 provide the set of most repeated motives to purchase PHI. 67% of those insured privately stated that improving health care coverage and choice was the primary reason to purchase PHI. Notice that their quality perceptions do not differ from those of the average PHI subscriber. 57% purchased PHI to improve personalised care. Consistently, those stating these reasons provided a smaller valuation to the quality of the NHS, as well as to PHI quality. Again 57% reported that PHI was a means to avoid waiting lists, which are significant for certain procedures. Finally, a less important, but significant, reason is family tradition, which was reported by 7% of those with PHI coverage.

Table ES1 Reasons for purchasing PHI

Reasons	%	NHS quality	PHI quality
Improve health care coverage	67	5.82 (0.42)	8.82 (0.23)
Improve personalised treatment	57	4.86 (0.43)	8.42 (0.30)
Avoid waiting lists	57	5.24 (0.42)	8.60 (0.24)
Family tradition	7	5.83 (0.40)	9.0 (0.36)

Source: self-designed survey (1999)

Table ES2 Reasons for not purchasing PHI

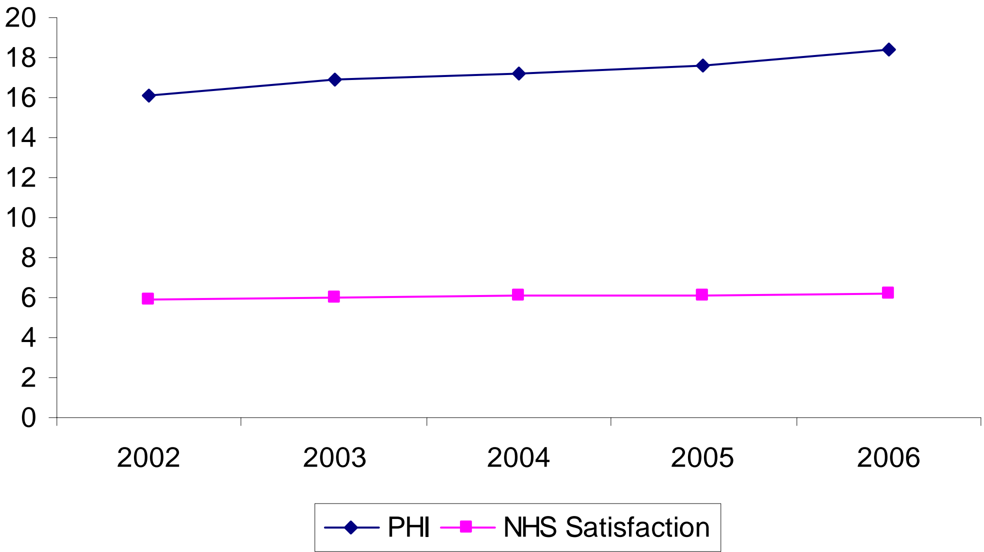
Reasons	%	NHS quality
Never would purchase (captive)	23	6.87 (0.25)
Too expensive	32	7.22 (0.16)
Unsatisfactory benefits	65	6.81 (0.20)

Never thought about	23	6.81 (0.17)

Table 2 reports the reasons why those without PHI chose not to purchase PHI. Interestingly, 65% would not be satisfied with the benefits that PHI provides. 32% thought PHI was too expensive, and 23% either never thought about or never would purchase PHI because they are captive to the NHS (Propper 1993; Costa and Garcia 2002).

Finally, Figure 2 provides current patterns of PHI from 2002 to 2006, and we find that over the last years there has been a slight increase in PHI purchase so that 18% of the Spanish population purchased PHI in 2006. We plot parallel to this the evolution of NHS satisfaction. Interestingly, the patterns are quite consistent on aggregate, suggesting that changes in the satisfaction with the NHS are likely to translate to PHI purchase.

Figure ES2 Satisfaction with the NHS (range from 1-10) and PHI purchase (%)



Discussion

PHI is a tool to assure access at a reasonable price to private health care in Spain, which is afforded by people who are significantly better-off, who value and are willing to pay for promptness of health care delivery, and who express a larger risk aversion as compared to those who do not purchase PHI. Financial risk aversion, coupled with people's lack of trust in the NHS, might explain why some people do not wish to open themselves up to risk and prefer to purchase PHI. Another important reason for PHI purchase is the ex-ante demand for comfort, as well as access to certain benefits that non-rationed private services provide (e.g., intimacy with family members). Evidence suggests that the purchase of PHI has increased to 18% in 2006 and that its behavioural patterns parallel those of NHS satisfaction.

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The United Kingdom

Thomas Foubister

Introduction

The main type of private health insurance (PHI) in the United Kingdom (UK) is supplementary PHI. Generally, supplementary PHI develops in response to dissatisfaction with elements of the public system. This may relate to the quality of clinical care, but more commonly relates to non-clinical quality dimensions of care. The latter is the case in the UK.

In the UK PHI is purchased to enable insured access to care that is delivered quickly and/or at a date or time that is convenient for the patient; to permit choice of doctor and treatment facility (although there may be restrictions on these depending on the policy purchased); to allow higher-quality face-to-face time with the doctor; to secure care in a preferable environment (for example a private or semi-private room); and to enable insured access to some items – such as alternative therapies – not covered by the National Health Service (NHS). The largest part of the market is the corporate market, where PHI is provided as a perk or as part of a broader programme of occupational health.

In the UK supplementary PHI is known as private medical insurance (PMI), and it will be referred to as such here.

History

PHI had been in existence for over a hundred years before the NHS was introduced in 1948. In the early nineteenth century friendly societies and other organisations began to contract general practitioners (GPs) on a capitation basis to provide their members with medical attention. The inclusion of the 'medical benefit' alongside the cash sickness and funeral benefits became standard practice over the course of the century, and later in the century it became common for the benefit to be extended to dependants of members too. Towards the end of the century, doctors established their own insurance or pre-payment organisations (misleadingly called public medical services), partly in response to their dissatisfaction with their working conditions (work was hard and the pay was poor for doctors contracted to the friendly societies and others) and partly in response to the – ultimately short-lived – entry of commercial companies in the form of the industrial insurers (life insurers), whose manner of operation and for-profit status the doctors viewed with contempt.

This system of PHI for GP care continued after the introduction of National Health Insurance (NHI) in 1911 (1913 for the medical benefit). NHI covered GP care for manual workers and low income non-manual workers, and therefore those above the income threshold who were not able to pay GP fees continued to rely on PHI – as did NHI member dependents (NHI was conceived of more as an income protection measure than a public health or health gain measure, and did not extend cover to dependents of members – a choice out of keeping with public sentiment and subject to a great deal of criticism).

A further important criticism of NHI was that it did not cover hospital care. When hospitals began to introduce means-tested charges around the time of the end of the First World War, already-existing collective worker contributions to support the maintenance of the hospitals were formalised into 'hospital contributory schemes', membership of which exempted the user of hospital care from having to pay the charge – a form of complementary PHI for hospital care (Gorsky et al 2006). At the same time as the contributory schemes were being developed, advances in hospital medicine were making the prospect of being treated in a hospital attractive to the middle class for the first time. Middle class patients were not entitled to free or subsidised hospital care, and were prohibited – primarily by hospital doctors, whose income depended on treating middle class patients outside the hospital – from joining the contributory schemes. A third kind of PHI – the provident schemes, precursors of PMI – emerged to facilitate access to hospital care for the middle class on terms the doctors would accept (in particular, these included cover for the full cost of hospital treatment, including the doctor's fee).

The introduction of the NHS in 1948 led to the immediate disappearance of PHI for GP care, and hospitals ceased charging, leading to the disappearance of PHI for hospital care (the contributory schemes). The provident schemes survived, however. The legislation accompanying the introduction of the NHS allowed private medicine to continue, and allowed NHS hospitals to provide private 'pay beds' where private medicine could be delivered. This was done to secure the support of hospital doctors who wanted to maintain the right to practise privately should they choose to do so, and to placate those who wanted to continue to pay for health care. Another reason that private medicine was allowed to continue was that is was thought that it would become redundant or, failing that, become too marginal to be of significance – for the NHS, so it was intended, would 'universalise the best' (in Aneurin Bevan's phrase).

Just before the introduction of the NHS the provident associations joined forces as the British United Provident Association (BUPA) (some other associations remained independent) and waited to see what would happen (Bryant 1968). Demand for PMI immediately after the introduction of the NHS was low, but quickly began to grow as the insurers (the main three insurers were BUPA, PPP and WPA) worked to focus on areas where the NHS was perceived to be falling short of 'the best' and to provide precisely what the NHS fell short of – privacy, environment, rapid access, choice and so on. The insurers had no desire – nor had they the ability – to finance a comprehensive service; rather they concentrated on providing cover for non-complex surgical treatments, offering a clinical quality similar to that offered by the NHS (the doctors providing private treatment were, after all, senior NHS doctors and the treatment itself was being provided in NHS hospitals).

Between 1950 and 1974 subscriber numbers rose steadily from 50,000 to 1,096,000. Taking into account the extension of cover to dependants, the figures for persons insured are over double these (Higgins 1988). Between 1974 and 1977 there was a decline in the number of subscribers to 1,057,000 due to adverse economic circumstances and to the complex, ideologically-charged dispute around the presence of pay beds in the NHS, which saw the Labour government phase out the pay beds in a move to rid the NHS of private medicine, but which had the unintended consequence of encouraging the rapid development of private provision outside the NHS (Klein 1979; Higgins 1988).

Following the introduction of the NHS, individual subscribers accounted for the bulk of PMI subscribers, and their number grew steadily until the mid-1960s after which it went into a period of decline. By far the largest growth of the post-NHS period (up to the end of the 1970s) was in group schemes (corporate schemes; but also discounted employer-organised/employee paid schemes); and by the end of the 1970s over three quarters of all subscribers were in group schemes. The election of a Conservative government in 1979, favourably disposed to private medicine and supportive of the development of private medicine through tax and other measures, led to a short-lived boom in subscriber numbers, but this stabilised in 1982 when insurers raised the price of premiums by 30-40% to cover higher claims expenditures. Between 1985 and 2006, subscriber numbers grew from 2,380,000 to 3,626,000 (Laing and Buisson 2007) – although growth was not continuous, with 1994, 1999. and 2002 to 2005 inclusive seeing yearly reductions in subscriber numbers (Laing and Buisson 2007). Between 1989 and 2004, persons covered as a percentage of the UK population has varied between 11% and 11.7%, with the slightly lower 10.7% and 10.6% in 2005 and 2006 (Laing and Buisson 2007).

Market overview

Individual and corporate market

The market for PMI currently consists of two sub-markets: the individual market and the corporate market (incorporating employer organized/employee paid schemes). In the individual market, policies are purchased by individuals (the 'subscriber') and cover is extended to the purchaser and to his or her dependants (if this option is chosen). Contracts are renewed on an annual basis.

In the corporate market, policies are purchased by the employer – in some instances, about 12.5% of corporate schemes (AON Consulting 2004), employees have to make a contribution to the premium – and cover is extended to named employees and to their dependants (if this option is chosen). Contracts are renewed monthly, six-monthly or annually.

Contribution to total health expenditure

The contribution of PMI (as measured by premium income) to total health care expenditure is minor relative to that of public expenditure, both in absolute terms and as a proportion of total expenditure on health care (see Table 1). In 2002, for instance, public expenditure amounted to GBP 67.2 billion, or 83.35% of the total, while the contribution of PMI was GBP 2.86 billion, or 3.55% of the total. By 2003 it had risen by 4% to GBP 2.98 billion (Laing and Buisson 2004b).

Table UK1 Expenditure on Health Care by Source, 1997-2002 (GBP billions)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Public Expenditure	44.568	47.552	52.192	55.996	62.090	67.201	73.696	81.806	87.566	95.125
Private Expenditure	10.894	11.626	12.541	13.246	12.743	13.419	12.451	13.004	13.240	13.891
of which: PMI	1.999	2.071	2.224	2.456	2.661	2.862	2.969	3.030	3.138	3.258
Total	55.462	59.178	64.733	69.242	74.833	80.620	86.147	94.810	100.806	109.016

Source: (Laing and Buisson 2004b; Lee et al 2004; Office for National Statistics 2004)

Population coverage

In 2006, there were 3.63 million subscribers to PMI, and PMI cover was extended to a further 2.77 million persons (subscriber dependants) (see Table 2). The number of individuals with PMI stood, therefore, at 6.4 million, or 10.6% of the UK population, down from a high of 11.7% in 2000 (Laing & Buisson 2004, Laing & Buisson 2007).

Table UK2 Subscriber Numbers, Total Persons Covered, and Total Persons Covered as a Percentage of the UK Population, Broken Down by PMI Sub-Market, 1997-2006

Year	Subscriber Numbers (millions)		Total Persons Covered (millions)		Total Persons Covered as % of UK population		
	Ind Mkt	Corp Mkt	Ind Mkt	Corp Mkt	Ind Mkt	Corp Mkt	Total Mkt
1997	1.378	2.108	2.392	4.277	4.1	7.4	11.5
1998	1.335	2.250	2.214	4.601	3.9	7.9	11.7
1999	1.285	2.275	2.121	4.415	3.7	7.5	11.1
2000	1.242	2.437	2.102	4.769	3.6	8.1	11.7
2001	1.216	2.506	2.049	4.621	3.5	7.8	11.3
2002	1.193	2.515	2.005	4.720	3.4	8.0	11.4
2003	1.157	2.514	1.956	4.679	3.3	7.9	11.2
2004	1.161	2.440	1.975	4.540	3.3	7.6	10.9
2005	1.122	2.445	1.899	4.564	3.2	7.6	10.8
2006	1.097	2.529	1.814	4.584	3.0	7.6	10.6

Source: (Laing and Buisson 2004b)

Using PMI

Subscribers to PMI retain right of access to the NHS. If they (or their covered dependants) need to access health care, they are in a position to choose between the NHS and the private system. If they opt to access private care through their PMI, the process begins in the same way as if they were seeking care through the NHS: that is, they begin by consulting their GP. The GP will then refer them to a consultant (specialist) on a private rather than public basis.

The consultant will set a date, time and place for treatment that is convenient for the patient. The subscriber will probably have to contact the insurer to confirm that the

treatment and the treatment facility are covered by the policy, and may also have to check that the consultant is on a list of those approved by the insurer.

Once treatment has been provided, the insurer will reimburse the facility charge directly, and either reimburse the specialist fee directly or expect the subscriber to pay the specialist fee and reimburse the subscriber. Insurers operate fee schedules, and if the specialist charges above the set fee for the procedure they have performed, the subscriber will (usually) be expected to make up the shortfall. Facility charges will already have been negotiated between the facility and the insurer.

PMI benefits

PMI provides cover for 'the costs of private treatment for what are commonly known as acute medical conditions' (Association of British Insurers 2003). This definition is important for three reasons: i) it names what is common to all products available on the market for PMI; ii) it is sufficiently vague as to allow substantial product differentiation; and iii) it highlights the fact that the care financed by PMI is more narrow in scope than the 'comprehensive' cover offered by the NHS. PMI also covers items attached to the principal procedure, such as diagnostic tests, accommodation, nursing, and outpatient care. However, these associated benefits will usually be limited in some way.

Some items of health care are not covered by PMI. These are referred to as standard exclusions. Some serve to avert the emergence of moral hazard and adverse selection problems, thus the exclusion of services over which the individual is thought to exert significant control such as GP-provided care, pregnancy-related care and preventive care, and the exclusion of pre-existing conditions (conditions existing at the time of application). Other exclusions are in place to protect the insurer from catastrophic loss. Cover will not, for instance, be extended to claims resulting from war or mass accident. Cover for accident and emergency care is also excluded, as this service is particularly high cost and is, moreover, provided by the NHS alone.

Another important category of exclusion relates to the type of care that PMI is designed to finance, so that chronic conditions, in so far as they are distinguishable from acute conditions, will generally not receive cover or, if they do, it will be limited to a set period of time or monetary amount. Regarding this type of exclusion, problems of understanding may emerge as insurers tend not to follow clear, shared definitions of certain key terms such as 'acute care' and 'chronic condition' (although the Association of British Insurers has been working to bring greater clarity to terminology here – see www.abi.org.uk) .

There are three product categories: Budget, Standard and Comprehensive. They differ according to the scope of cover they provide beyond the core 'acute care' benefits that are common to all PMI products. These differences in scope of cover are reflected in the attached price, with comprehensive policies being significantly more expensive than budget policies.

Comprehensive policies may offer, in addition to the core benefits, items such as treatment for mental illness, repatriation to the United Kingdom, treatment for complications arising from pregnancy and childbirth, access to alternative therapies, limited dental treatment and optical treatment, a cash payment if care is received as an NHS patient rather than as a

private patient, provision of a guest room for a family member, home nursing and private ambulance transport.

At the other end of the scale, budget policies will limit cover to treatment for acute conditions and will significantly restrict access to associated outpatient care. Budget policies may also incorporate automatic restrictions on choice of treatment facility, or place restrictions on the initiation of PMI-financed care; for example, limiting PMI cover to conditions for which the local NHS waiting list is longer than six weeks.

PMI premiums

There are four basic dimensions to the price of PMI:

- scope of cover or product category chosen
- the addition of product options (discussed below)
- the loading charge, which reflects insurer's profits, administrative costs and reinsurance payments, and also captures Insurance Premium Tax, which is currently 5% of the premium
- the nature and degree of risk that the insurer assumes; this dimension rests on underwriting and risk rating, and on experience rating in the main part of the corporate market

Underwriting refers to the process by which the insurer decides the nature and amount of risk it is willing to assume. PMI insurers use two principal forms of underwriting: full medical underwriting and moratorium underwriting. Under the former, the applicant completes a form requiring information relating to his or her past and present health status and care-seeking activities. On the basis of the information the applicant provides (and sometimes after further consultation with the applicant's GP), the insurer will decide which conditions to exclude from cover. Pre-existing conditions are excluded automatically. But the insurer may also exclude conditions that the applicant has suffered from in the past for fear that they might re-emerge, or conditions that the applicant has not suffered, but that the insurer believes may emerge in future as a result of past conditions.

Whilst full medical underwriting involves gathering information about the subscriber prior to purchase, moratorium underwriting involves gathering it closer to or at the point of claim. Under moratorium underwriting, conditions suffered in the (usually) five years prior to the commencement of the policy are automatically excluded from cover for the first two policy years (an exclusion may also be extended to conditions that are directly related to conditions suffered in the five years preceding purchase, but that emerge for the first time in the course of those two years). If any symptoms appear or if treatment or advice is sought during the two year moratorium period, the period will commence anew.

The lower administrative cost associated with moratorium underwriting is attractive to both insurers and applicants; moreover, moratorium underwriting is also attractive to applicants because conditions that might be permanently excluded under full medical underwriting may in time receive cover under moratorium underwriting. However, there are risks attached, including that of dispute at the point of claim and the possibility that the applicant will forgo seeking advice or treatment in order to secure cover once the two year period is complete.

Once the insurer has determined the nature and amount of risk it is willing to assume, it has to price the product so as to reflect the risk the applicant presents. Insurers do this on the basis of risk rating, with a focus on the category of age. As individuals age, so, generally, the risk they present of incurring a loss increases. Older subscribers are therefore charged higher premiums than younger ones (see Table 3), and insurers usually place a ceiling on the age at which new applicants can be accepted: 65, 74 or 75 (Cover 2004).

Table UK3 Average Indexed Premium by Age

Age	Indexed premium (%)
35	100
40	116
45	125
50	148
55	161
60	208
65	268

Source: (Association of British Insurers 2003)

Insurers will also use other risk categories. The most common are sex, smoking status and occupational status. Some insurers are beginning to include information on height and weight too, although currently this information is provided by the applicant on a voluntary basis, and is intended to enable the applicant to better signal their low-risk status and to secure a premium lower than that which would be offered by the insurer's competitors based on calculations that do not take into account information on height and weight.

There is no individual underwriting or risk rating (except in some marginal instances) in the main part of the corporate market. Rather, the premium is priced on the basis of the group's previous year's claims experience. Corporate schemes do require cover to be extended to all employees within a given category, however (for example, all those at a particular level of seniority, or all those in a particular age group), so as to avoid the adverse selection problems which would arise from employers choosing to extend cover only to employees whom they know to be at higher risk of incurring a loss.

In the small group section of the corporate market (companies with fewer than fifty employees), alongside claims history, insurers may use individual underwriting and risk rating, as well as make fuller use of information relating to company location, company type, group size, and age composition of the group, all items that help the insurer to determine the level of risk that the group presents.

Changes in price at renewal

In the individual market there is guaranteed renewal of the policy at the end of the contract year, with the premium being adjusted only to reflect: the previous year's (if higher than expected), and expected changes in, aggregate claims expenditure across the insured pool as a whole; general and medical inflation; and changes in the loading charge. The premium will also be adjusted to reflect the subscriber's move into a new age band, but other than in relation to the category of age, there is no new risk rating (thus, if the subscriber has suffered conditions and made claims in the preceding year, the price at renewal will not try to capture this). In the corporate market renewal is not guaranteed, and the insurer may

decide to alter the terms of the contract or to refuse to renew if the claims experience has been sufficiently adverse.

Although there is no significant risk rating at the point of renewal, in both markets the benefits covered by the policy may change (in the corporate market this will usually apply at the level of the individual rather than that of the group as a whole) without this being reflected in the price of the premium. For instance, PMI cover for a given condition may be withdrawn if treatment has exceeded a certain time period or if the condition has become chronic (that is, is no longer amenable to care designed to be applied to acute conditions).

Product options
Purchasers of PMI may opt to incorporate options that will affect the price of the premium. Product options are mainly designed to reduce price, although opting to extend cover to dependants will raise the price. The most important product options are restriction of choice of treatment facility and cost sharing.

'Hospital network' options provide subscribers with a reduced premium in exchange for accepting a restriction of their choice of hospital to a list of those with which the insurer has negotiated a discount. This option is popular in both individual and corporate markets, with one survey showing that in 2002 some 63% of corporate schemes had opted to restrict employees' choice of treatment facility to those on a network (Aon Health Solutions 2002).

The second major product option is cost sharing. The most popular form is the excess (deductible), the amount the subscriber pays towards the cost of any claim (for example, the first GBP 100) with the insurer paying the balance. There may or may not be a limit to the out of pocket contribution in any policy year. Recently, the market has offered high-excess policies requiring the subscriber to pay the first GBP 1000 to GBP 5000. Although these figures are high, savings on the premium can be significant. Such policies are designed for those who are content to be covered only for care that is especially high cost.

Excess policies are widespread across both the individual and the corporate markets. Regarding the latter, and according to the survey cited above, in 2001, some 36.5% of employers operated an excess, up from 33.9% in 2000 and 27% in 1998 (Aon Health Solutions 2002). A subsequent survey found that this proportion had risen to 36.9% in 2002-2003, and to 43.5% in 2003-2004 (AON Consulting 2004).

Product development
Historically, product development has focused on offering reduced cover at a lower price – thus the introduction of budget policies and product options – in an effort to expand the size of the market. These lower-priced products are now a basic feature of the PMI market, and insurers have been looking for other ways to make their offerings more attractive both to potential and to existing purchasers.

In the corporate market, product development has centred on health management processes designed to promote health and to identify illness earlier on. These include information and counselling services, screening, rehabilitation services, occupational health services, physiotherapy and health promotion. Any resulting savings in claims expenditure can be passed on to the purchaser in the form of a reduced premium or reduced premium inflation.

Recent developments in the individual market have seen some insurers offering screening, and the appearance of products that reward subscribers – by lowering their premiums – who pursue healthy activities such as exercising. Perhaps the major development in the individual market, however, has been the introduction of products that allow subscribers to combine PMI with other forms of private payment for health care (the inclusion of an investment component in a PMI policy, for instance), or to combine PMI with other forms of insurance (such as critical illness cover). The PMI market has also seen the recent introduction, by one insurer, of a health savings account type product.

Regulation

Unlike in the PHI markets of some other European countries, in the market for PMI there is no regulation of the product or of pricing – something that has been prohibited in markets for supplementary PHI by European legislation. Instead, formal regulation has historically been limited to financial regulation – that is, to ensuring company solvency. Since January 2005, and partly in response to the need to incorporate the Insurance Mediation Directive into UK law, there has also been formal regulation of insurance sales and administration.

Although there has been no product or price regulation, regulatory pressure has been applied in the past in respect of the individual market product. Prompted by concerns regarding the presence of consumer detriment due to the nature of the product and the high degree of product proliferation, in the 1990s the Office of Fair Trading (OFT) (the regulatory agency responsible for consumer protection) launched two inquiries into the PMI market. The reports that emerged were strongly critical of the industry, and highlighted three major areas of concern: i) the difficulty of product comparison in terms of value for money; ii) moratorium underwriting (again, clarity regarding exclusions only at the point of claim makes comparison of products in terms of value for money difficult; but also the risk of subscribers forgoing medical attention in order to secure cover); and iii) the failure of insurers to provide information on past and on likely future premium increases (Office of Fair Trading 1996; 1998).

The insurance industry's response to the OFT reports was lukewarm, but in January 2004 the General Insurance Standards Council (GISC) (the industry's self-regulatory body) introduced a 'Practice Requirement' for insurers selling PMI. This partially addressed the OFT's concerns by requiring insurers to include a common-format core benefits table in their product literature to aid product comparison, and to improve the information and advice provided in relation to moratorium underwriting. This Practice Requirement was in place for one year only, as GISC was disbanded in January 2005 and regulation of insurance sales assumed by the Financial Services Authority (FSA). Regulation under the FSA is in the spirit of the Practice Requirement, but makes more stringent demands around the provision of information and advice at the point of sale (FSA 2004).

Tax incentives

There are no tax incentives to encourage take up of PMI. Tax relief was introduced for subscribers aged over 60 years in 1990 under the Conservative government but abolished

by the Labour government in 1997. Analysis of the effect of the tax subsidy shows that it did not stimulate demand among this group (Emmerson et al 2001).

Tax 'disincentives' take three forms:

- all PMI policies are subject to Insurance Premium Tax, currently 5% of the premium, up from 1.5% when it was introduced in 1994 (paid by insurers but, presumably, passed onto subscribers in the form of higher premiums)
- since 1999 all benefits in kind, including employer-paid PMI premiums, are subject to employers' National Insurance contributions
- employees in all but the lowest tax band are charged a benefit-in-kind tax on employer-paid premiums

Demand for PMI

Level of demand for PMI has been relatively static for several years, with the steady decline in subscriber numbers in the individual market since the early 1990s offset by the increase in corporate market subscriber numbers (see Table 1). Growth in the individual market from 1991 to 2003 was minus 15%; in the corporate market it was 30%; and overall it was 11.3% (based on figures in (Laing and Buisson 2004a). For the cluster 1999 to 2003, growth was minus 10% in the individual market, 10% in the corporate market, and 3.11% overall. For the first time, in 2002 to 2003 there were contractions in the overall subscriber base for two years in a row – 0.3% and 1.02% respectively. In 2004 individual market subscriber numbers rose slightly, but growth has been negative since. Similarly, thee corporate market saw growth between 2003 and 2004, but subscriber numbers there have since declined.

In 2003 the corporate market, formerly the driver of overall market growth, saw a contraction in its subscriber base for the first time since 1994. One contributing factor may have been the general slow-down in economic growth. But another may have been the growing popularity of non-insured medical expenses schemes (NIMES), a form of corporate self-insurance operated through a trust fund. For employers, these schemes are an attractive substitute for PMI because they are exempt from insurance premium tax and solvency-related capital requirements; they avoid margins going to external insurers; and they give employers more control over the design and operation of the scheme (Incomes Data Services Ltd 2003). NIMES enrolee numbers (enrolees might be thought of as PMI subscribers foregone) have grown rapidly, from 53,000 in 1992 to 473,000 in 2003 (Laing and Buisson 2004b).

Negative growth in the individual market has been significant; from a peak of 1.452 million in 1996, subscriber numbers declined to 1.157 million in 2003 (Laing and Buisson 2004a) and further to 1.097 million in 2006 (Laing and Buisson 2007). This contraction can be related, in part, to growth in the corporate market, with individuals newly-covered by their employers giving up their individual cover. It may also, however, reflect a combination of several other factors, including the removal of tax relief on PMI for over-60 year olds in 1997 (although the effect of this is likely to have been small), the success of substitutes for PMI such as 'self pay', and large premium increases introduced in response to high expenditure on claims (Datamonitor 2003; Laing and Buisson 2004b).

The principal determinants of demand for PMI are thought to be NHS waiting lists, the price of PMI, and subscriber characteristics. Although the rapid delivery of care is structural feature of PMI, studies of the link between NHS waiting lists and demand are inconclusive. Some show a clear link, and others do not. What does emerge is that there appears to be a significant relation between perceptions around waiting lists and demand for PMI; that is to say, negative reporting by newspapers (for instance) may be a more significant determinant of demand than real waiting times, the experience of having had to wait, or knowing somebody who has had to wait.

PHI is thought to be price inelastic, meaning that if, for instance, price increases by 10%, demand will fall by less than 10%. It is possible to infer from this that other factors may override price in the purchasing decision. The effect of the removal of tax relief for the purchase of PMI by the over-60s in 1997 (tax relief having been in place since 1990) confirms the low price elasticity of demand for PMI: the 29.9% increase in the price of the premium for the affected group led to only a negligible fall in demand (Emmerson et al 2001), suggesting that those receiving tax relief would have purchased PMI regardless, and that introducing tax relief did not stimulate demand. The fact that demand is price inelastic, however, does not mean that price rises will not lead to reductions in the subscriber base (it means only that reductions will be smaller than the rise in price). Continuous above-inflation price rises for PMI may partly explain why subscriber numbers in the individual market have been declining so markedly and why the market has remained static overall.

Studies of subscriber characteristics also help to explain what determines demand for PMI. These studies show that generally, PMI subscribers share certain features across certain key dimensions. Subscribers tend to be aged between 55 and 64, to be male, to live in London, the East and the South East, to have some post-school education, to be employed with higher occupational status, to vote for the centre-right Conservative Party, and to belong to higher-income groups. These studies capture characteristics of subscribers across the market as a whole (both individual and corporate), and their findings also reflect, therefore, the nature of the distribution of PMI-related employment benefits and the make-up and structure of the workforce (Foubister et al 2006).

Industry composition and performance

There are currently some 27 insurers (UK-based and foreign) operating in the market for PMI, as well as several carriers of PMI who do not have an underwriting (or insurance) capacity of their own. Eight of the 27 insurers do not provide PMI in their own right, but are rather providers of underwriting services. Four both provide PMI in their own right, and provide underwriting services to carriers without an underwriting capacity. The industry comprises a mixture of provident associations and commercial companies. This distinction, however, appears to be insignificant in terms of market behaviour and in terms of the operation of regulatory oversight.

The three most important industry developments in the past few years have been the entry of insurers into the market on an underwriting-only basis (and allied to this, the entry of carriers on an outsourced-underwriting basis); development of joint ventures, with functions (such as underwriting, product design, claims administration, general management and so on) being separated across companies and across countries; and the entry of high-street banks and supermarkets into the market as carriers of PMI.

Since the early 1990s, the industry has seen a relatively high level of entry and exit, suggesting on the one hand that the costs associated with entry and exit are not high, but on the other that companies entering the market have been unable to make inroads into the market share held by the major insurer-providers. The four major players in the market (BUPA, AXA PPP, Norwich Union and Standard Life) have between them held a stable majority of market share since the early 1990s; 78.5% in 1992 and 78% in 2003, as measured by premium income (Laing and Buisson 2004b).

An important measure of industry performance is industry gross margins – defined as the excess of premium income over claims expenditure, and usually represented as a percentage of the latter. Expenditure on claims must be at least matched by premium income if underwriting losses are to be avoided. Moreover, the excess of premium income over claims expenditure must be sufficiently high as to permit the insurer to cover profit and costs associated with the operation of the business. Any growth in claims expenditure (relative to level of demand) will therefore be met with a rise in the price of the premium. Because insurers are able to invest their premium income, returns may be sufficiently high as to allow them to risk making an underwriting loss; in the interest, for example, of keeping their prices lower than those of their competitors. But sacrificing margins in this way will usually be considered only when investment markets are particularly strong.

In 2003, insurer gross margins (aggregated for the industry as a whole) were at their highest level since the late 1970s (see Table 4) (Laing and Buisson 2004b). Between 2003 and 2006 they dropped by about one percentage point. The trough in margins in 1998 and 1999 was unacceptably low, at 17.8% and 17.5% respectively, and insurers instituted substantial premium increases during 1999 to compensate. Premium income growth increased substantially following these price rises, but due to a parallel growth in claims expenditure, margins were maintained at around 22-23%.

Table UK4 Gross Margins (%), 1997-2003

Year	Ind Mkt	Corp Mkt	Total Mkt
1997	26.1	14.7	20.7
1998	21.7	13.8	17.8
1999	21.1	13.9	17.5
2000	26.7	14.9	20.9
2001	24.9	19.8	22.3
2002	25.7	20.4	23.3
2003	n/a	n/a	23.6
2004	n/a	n/a	22.6
2005	n/a	n/a	23.0
2006	n/a	n/a	22.5

Source: author calculations based on figures for premium income and claims expenditure in Laing and Buisson (2004b) and (2007)

Higher margins in the individual market than in the corporate market reflect the more intense price competition characteristic of the latter and, despite the higher acquisition and other administrative costs in the individual market, the ability of insurers in that market to

pass on price increases without significant reduction in subscriber numbers. However, recent increases in corporate market premiums have led to a narrowing of the gap in margins between the two markets. It appears that insurers in the market for PMI need to achieve margins in excess of 20% if administrative costs are to be covered and an adequate level of profit secured.

Insurer-provider relations

Financing by PMI mainly flows to private hospitals and (to a lesser extent), NHS private patient units and pay beds. It also flows to other providers, for example providers of alternative therapies or of home nursing services. This section focuses on payment to private hospitals, which consists of two elements: the facility charge and the specialist fee. The former tends to be reimbursed directly to the provider, while in the latter case patients usually pay specialists first and the claim reimbursement from the insurer.

Private hospital charges are the outcome of bilateral confidential negotiations between insurers and providers and, as the Competition Commission reported in 2000, 'reflect the bargaining strengths and abilities of the two sides, rather than the underlying structure of supply costs' (Competition Commission 2000). This means that larger insurers have an advantage over smaller companies, and is of particular advantage to BUPA, which is not only the largest insurer, but the only insurer that is also a significant provider of private services. In 2000 the Competition Commission investigated and prevented the proposed merger of BUPA Hospitals and the Community Hospitals Group fearing that it would lead to unfair competitive advantage for BUPA and result in higher PMI premiums (Competition Commission 2000).

Private insurers generally reimburse specialists' fees on the basis of published fee schedules, leaving the patient responsible for paying any difference between the fee schedule and the actual fee charged by the specialist. The BMA also provides guidelines to doctors for fees for named procedures. In 1994 the Competition Commission (then known as the Monopolies and Mergers Commission), found the BMA guidelines to distort competition in the supply of medical services. A recent report found that specialist fees in the United Kingdom were considerably higher than fees charged for comparable procedures by specialists in other countries (Bramley-Harker and Aslam 2003).

BUPA has been active in pursuing managed care-style relations with consultants, seeking to develop case-based pricing agreements, standard care pathways, reductions in fees in return for specific volumes, reward for increased productivity and a focus on quality outcomes (Jones et al 2004). However, while a MORI poll found that 38% of doctors providing services to PMI subscribers have some form of agreement with BUPA with regard to fee levels, some of BUPA's attempts to introduce elements of managed care have met with strong criticism from specialists.

Discussion

Before the introduction of the NHS, PHI had an important function – it facilitated access to health care for those who were unable to pay the fees charged by doctors (and later by hospitals) (the very poor, those who were unable to pay the monthly or weekly contribution to the insurance pool, had free access to the hospitals and had to rely largely

on the despised Poor Law medical service for non-acute care). Following the introduction of the NHS, which made comprehensive health care available to all, the principal rationale for PHI disappeared. The PMI market, however, was able to carve out a niche for itself by focusing on offering what the NHS aspired to offer but could not – enhanced non-clinical dimensions of quality. Whereas within the NHS competing priorities meant that non-clinical quality was rationed in favour of enhanced clinical quality, in the PMI market access to non-clinical quality was rationed by ability to pay.

PMI occupies a marginal place in the UK's health care system. It provides cover for a limited range of treatments and services which are available without charge to all through the NHS. Overall then, PMI's financial protection function is minimal. Moreover, PMI accounts for only a small proportion of total spending on health care in the UK. However, to say that PMI is marginal is not to say that it is without significance.

PMI – together with private spending more generally – may have an impact on the performance of the NHS. Critics of the private market have charged that private spending has an adverse impact on NHS performance: with doctors working both for the NHS and in the private sector, it is inevitable – critics contend – that the time the doctor spends in private practice could be used more productively in the NHS (furthermore, it may be that the existence of private medicine exacerbates waiting lists in the NHS as doctors who might be providing care in the NHS are instead working privately). Research supporting this view is available in (Yates 1995); but little research has been conducted in this area since.

More generally, critics appeal to equity and equality in access as important values in health care, and point out that there is no question that PMI undermines equity of access – for those with the ability to pay are able to access care more rapidly and in a more congenial environment than those not able to pay. Here, ability to pay replaces relative need as a determinant of health care access.

Supporters of PMI and other forms of private financing alongside the NHS contend that people who 'go private' (but who nevertheless pay taxes towards the financing of the NHS) are relieving pressure on the NHS. The point here is that people are not using care for which they have paid and to which they are entitled, and are thereby improving access for others. The contention is intuitively attractive, but difficult to support – particularly given that the use of private medicine draws on human resources which would otherwise be available for NHS care.

Equity in financing is a principle held by most developed health care systems, and is codified in the WHO's health system performance framework. There is little doubt that the NHS is equitably financed. But taking the health care system as a whole, the picture is less clear. One influential article of 1992 (Wagstaff et al 1992) found that the presence of private financing in the UK increased the progressivity of financing overall – the logic here being that the rich are paying more. However, this finding does not reflect that fact that those using PMI and other forms of private financing are not paying 'more for the same', but are rather paying for something over and above what the NHS offers; nor does it reflect that fact that the benefit had from this 'extra' spending accrues in its entirety to the payer. Furthermore, if it is indeed the case that the existence of the private market has an adverse impact on NHS performance, this further – albeit indirectly – undermines the claim to equity and progressivity in financing across the health care system.

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