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Private health insurance and access to health care in the European Union

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Private or voluntary health insurance (VHI) does not play a significant role in many health systems in the European Union (EU), either in terms of funding or as a means of gaining access to health care. In most EU member states it accounts for less than 5% of total expenditure on health and covers a relatively small proportion of the population (see Table 1). The exceptions to this trend are France, Germany and the Netherlands.

VHI fulfils different roles in different contexts. In the EU context it can be classified according to whether its role, in relation to statutory health insurance (SHI), is substitutive, complementary or supplementary. Substitutive VHI provides cover that would otherwise be available from the state. It is purchased by those who are excluded from participating in some or all aspects of the SHI scheme – for example, Dutch residents with an annual income over 30,700 a year and their dependants (around a quarter of the population) – or by those can choose to opt out of that SHI scheme, such as German employees with annual earnings over 45,900 and their dependants (about 5% of the population). Complementary VHI provides cover for services excluded or not fully covered by the state, particularly cover for statutory user charges, as in Croatia, Denmark, France and Slovenia. Supplementary VHI provides cover for faster access and increased consumer choice and is available in most EU member states.

Table 1
Levels of VHI coverage as a percentage of the total population in the EU, 2000 or latest available year

Country	Substitutive	Complementary	Supplementary
Austria*	0.2%	18.8% (inpatient 12.9%)	
Belgium	7.1%	30–50%	
Denmark*	None	28%	
Finland***	None	None	Children <7: 34.8% Children 7–17: 25.7% Adults: 6.7%
France**	Marginal (frontier workers)	85% (2000 estimate 94%)	
Germany*	9%	9% (mainly)	
Greece	None		10%
Ireland	None	45%	
Italy*	None	15.6%	
Luxembourg	None	70% (mainly)	
Netherlands*	24.7% (+ 4.2% WTZ)	>60%	Marginal
Portugal**	None		12%
Spain*	0.6%	11.4%	
Sweden*	None		1.0–1.5%
UK	None		11.5%

* 1999, ** 1998, *** 1996

Source: Mossialos and Thomson (2004)[1]

VHI may increase access to health care for those who are able to purchase an adequate and affordable level of private cover. At the same time it is likely to present barriers to access, particularly for older people, people in poor health and people with low incomes. The greater the role of VHI in providing access to effective health services that are a substitute for or complement to those provided by the government, the larger the impact it will have on access to health care.

Access to health care within VHI markets is heavily dependent on the regulatory framework in place and the way in which insurers operate. It may be affected by how premiums are rated, whether they are combined with cost sharing, the nature of policy conditions, the existence of tax subsidies to encourage take up or cross-subsidies to the statutory health care system and the characteristics of those who purchase it. It may also be affected by whether or not benefits are provided in cash rather than in kind, the way in which providers are paid and the extent to which policies are purchased by groups – usually employers – rather than individuals.

Due to information failures in VHI markets, insurers need to find ways of assessing an individual's risk of ill health in order to price premiums on an actuarially fair basis. However, accurate risk assessment is technically difficult and expensive to administer. Consequently, insurers have strong incentives to select risks – that is, to attract people with a lower than average risk of ill health and deter those with a higher than average risk. Some regulatory measures will increase insurers' incentives to select risks – for example, requiring insurers to offer community-rated premiums – while others, such as risk adjustment mechanisms, aim to reduce these incentives.

Table 2
Conditions usually excluded from VHI cover in the European Union, 2001

Country	Usual exclusions
Austria	*Individual*: pre-existing conditions usually excluded (but not from group policies); insurers cannot reject applications but may charge higher premiums and/or introduce cost-sharing arrangements for people with chronic illnesses
Belgium	*Mutual*: psychiatric and long-term care (lump sum) *Mutual*: psychiatric care (co-payment) *Commercial*: pre-existing conditions, infertility treatment, sporting injuries
Denmark	Pre-existing conditions
Finland	Pregnancy and childbirth, infertility treatment, alcoholism, herbal remedies, treatment covered by statutory health insurance
France	Excluding any disease is forbidden by law, although it can be authorized in individual policies under certain conditions: the disease has to be clearly stated and the insurer has to prove that the patient had the disease before purchasing the policy
Germany	Pre-existing conditions are excluded if they were known at the time of underwriting and were not disclosed by the insured; declared pre-existing conditions are covered but generally result in higher premiums
Greece	Pre-existing conditions
Ireland	Open enrolment
Italy	*Individual*: pre-existing conditions, chronic and recurrent diseases, mental illness, alcohol and drug addiction, cosmetic surgery, war risks, injuries arising from insurrection, natural disasters etc; also often excludes dental care not caused by accident/illness *Group*: pre-existing conditions such as diabetes, drug and alcohol addiction, HIV/AIDS, severe mental health problems such as schizophrenia, voluntary termination of pregnancy and war risks
Luxembourg	*Mutual*: open enrolment (but no cover for treatment excluded from Statutory Health Insurance) Commercial: pre-existing conditions
Netherlands	Some dental plans may require people to have their teeth restored before acceptance
Portugal	*Individual*: pre-existing conditions, long-term chronic illnesses (such as diabetes, multiple sclerosis and asthma), HIV/AIDS, haemodialysis, self-inflicted injuries, psychiatric treatments, check-ups, dental care, outpatient drugs, alternative medicine and non-evidence based treatment; dental care, delivery costs and outpatient drugs are only covered by the most expensive policies
Spain	HIV/AIDS, alcoholism and drug addiction, dental care (often available for a supplementary premium), prosthesis, infertility treatment, orthopaedics etc; some insurers do not have general restrictions but may reject certain conditions; most insurers offer extra benefits for a supplementary premium eg organ transplants, second opinion, family planning, assistance during trips, treatment abroad, certain prosthesis; only one insurer offers homeopathy or spa treatment
Sweden	Emergency care, long-term care, HIV/AIDS, some other communicable diseases, diseases and injuries as a result of the use of alcohol or other intoxicating substances, pre-natal care, child birth (normal or with complications), termination of pregnancy, infertility treatment, vaccinations
UK	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

Source: Mossialos and Thomson (2004)[1]

However, even if explicit risk selection is prohibited by requiring insurers to offer open enrolment and to cover pre-existing conditions, insurers may engage in covert forms of risk selection.

Insurers in European VHI markets are generally subject to a low level of regulation. In most non-substitutive VHI markets regulation is exclusively concerned with ensuring that insurers remain solvent rather than issues of consumer protection. Ireland is the only country in which insurers are required to offer open enrolment, community-rated premiums and lifetime cover and are subject to a risk equalization scheme (see the article on Ireland). Elsewhere insurers are permitted to reject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums according to risk, provide non-standardized benefit packages and offer annual contracts. Benefits are usually provided in cash – that is, insurers reimburse individuals for their health care costs. In loosely regulated VHI markets older people, people in poor health and people with low incomes are likely to find it difficult to obtain affordable coverage. People in poor health may not be able to purchase any cover (see Table 2).

Governments intervene more heavily in markets for substitutive VHI in Germany and the Netherlands where, as a result of risk selection by insurers, older people and people with chronic illnesses have not been able to purchase sufficient cover. Risk selection by insurers has also contributed, to some extent, to the financial instability of the SHI scheme, which covers a disproportionate amount of older people in both countries. Changes in regulation to prevent further destabilization of SHI in the Netherlands in 1986 and in Germany in 1994 and 2000 mean that some people with relatively low incomes no longer have access to statutory coverage and must rely on substitutive VHI. For this reason insurers in both countries are required to provide older people with standardized benefit packages – providing similar benefits to statutory coverage – for a premium regulated by the government. Insurers in Germany are also required to offer lifetime substitutive VHI cover. In the

Table 3
A comparison of administrative costs among voluntary and statutory insurers, 1999

Country	Voluntary (% of premium income)	Statutory (% of public expenditure on health)
Austria	22% (early 1990s)	3.6% (2000)
Belgium	25.8% (commercial individual) 26.8% (commercial group)	4.8%
France	10–15% (mutuals) 15–25% (commercial)	4–8%
Germany	10.2%	5.09% (2000)
Greece	15–18% (commercial life insurers)	5.1%
Ireland	11.8% (Vhi Healthcare 2001) 5.4% (Vhi Healthcare 1997)	2.8% (1995)
Italy	27.8% (2000)	0.4% (1995)
Luxembourg	10–12% (mutuals)	5.0%
Netherlands	12.7%	4.4%
Portugal	About 25%	-
Spain	About 13–15%	5.0%
UK	About 15%	3.5% (1995)
United States	About 15%	About 4.0%

***Source*: Mossialos and Thomson (2004)[1]**

Netherlands younger people with substitutive VHI are required to cross-subsidize the premiums of older people and all policy holders must make an annual contribution to the SHI scheme.

Complementary VHI covering cost sharing is likely to present barriers to access for people with low incomes, particularly those with incomes just above the threshold for any exemptions from cost sharing that may exist. It is both inequitable and inefficient for governments to establish a price mechanism through cost sharing and then negate the effect of price for those who can afford to purchase complementary VHI. Complementary VHI is most prevalent in France, where it covered 85% of the population in 1998. Research shows that the likelihood of being covered by complementary VHI is highly dependent on social class, income levels, employment status, level of employment and age. Furthermore, the quality of coverage provided by complementary VHI increases significantly with income. In order to address the inequalities in access to health care arising from unequal access to complementary VHI, the French government introduced a law on universal health coverage (CMU) in 2000, extending free complementary VHI coverage to people earning less than 550 (US$ 645) per month (see the article on page 4).

Supplementary VHI often provides faster access to health care by enabling people to bypass waiting lists in the public sector. It can also provide access to a wider range of providers. However, if supplementary VHI does not operate independently of the statutory health system, it may distort the allocation of public resources for health care, which may restrict access for those who are publicly insured. This could happen if boundaries between public and private provision are not clearly defined, particularly if capacity is limited, if providers are paid by both the public and the private sector and if VHI creates incentives for health care professionals to treat public and private patients differently. Governments in some countries, for example, Ireland, have found that the existence of VHI can reduce access for publicly funded patients and are taking steps to clarify the boundaries between public and private provision of health care.

VHI tends to incur higher management and administrative costs than SHI, partly because pool size is smaller, but mainly due to the extensive bureaucracy required to assess risk, set premiums, design benefit packages and review, pay or refuse claims (see Table 3). Insurers also incur additional expenses through advertising, marketing, distribution, reinsurance and the need to generate a profit or surplus. Within the EU context, these additional costs cannot be justified on the grounds that insurers are innovative in devising mechanisms to contain costs. In practice, EU insurers are more likely to compete on the basis of risk selection than through competitive purchasing. Most attempts to contain costs operate on the demand side, through cost sharing. Transaction costs have not been lowered as a result of increased liberalization of VHI markets in the EU since 1994. In Ireland higher levels of advertising following liberalization have actually increased transaction costs.

Overall, VHI requires careful regulation to ensure access to health care, guarantee consumer protection and stimulate efficiency gains. The existence of VHI is likely to create barriers to access and may reduce equity and efficiency in the health system as a whole. Furthermore, unless there are clear boundaries between the public and the private sector, VHI may distort the allocation of public resources for health care, to the detriment of those who are insured by statutory health insurance.

References

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