

# Voluntary health insurance in the European Union

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**Elias Mossialos and Sarah Thomson**

European Observatory on Health Care Systems  
and LSE Health & Social Care, London School of Economics and Political Science

with (in alphabetical order)

**Reinhard Busse**, Technical University, Berlin

**Charalambos Economou**, National School of Public Health, Athens

**Margherita Giannoni-Mazzi**, University of Perugia

**Jean Hermesse**, Université Catholique de Louvain

**Tony Hockley**, The Policy Analysis Centre, London

**Maria M Hofmarcher**, Institute for Advanced Studies, Vienna

**Hans Maarse**, University of Maastricht

**Hennamari Mikkola**, National Research & Development Centre for Welfare & Health, Helsinki

**Monica Oliveira**, London School of Economics & Political Science

**Marisol Rodríguez**, University of Barcelona

**Simone Sandier**, Arguments Socio-Economiques pour la Santé, Paris

**Caj Skoglund**, BCS Kompetensutveckling AB and The Swedish Welfare Group

**Philippe Ulmann**, Conservatoire National des Arts et Métiers, Paris

**Karsten Vrangbæk**, University of Copenhagen

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**The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the European Commission or the European Observatory on Health Care Systems.**

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In alphabetical order:

**John Armstrong**, Actuarial Executive, Vhi Healthcare, Ireland

**Tara Buckley**, General Manager, Corporate Communications, Vhi Healthcare, Ireland

**Olaf Engemann**, Director, Le Foyer Santé, Luxembourg

**Costas Fotakis**, Directorate General for Employment and Social Affairs

**Florence Gérard**, Secrétaire Générale Adjointe, Association Européenne des Institutions Paritaires

**Christine Gersching**, Maison Européenne de la Protection Sociale / European Social Insurance Partners

**Michael Huebel**, Directorate General for Health and Consumer Protection

**Ralf Jacob**, Directorate General for Employment and Social Affairs

**Colm Keenan**, Principal Officer, Health Insurance, Department of Health and Children, Ireland

**Rita Kessler**, Project Manager, Secretariat, L'Association Internationale de la Mutualité

**Sean Murray**, Marketing Director, BUPA, Ireland

**Jean-Yves Muylle**, Directorate General for the Internal Market

**Patrick O'Barrett**, Health Insurance Unit, Department of Health and Children, Ireland

**Willy Palm**, Director, Secretariat, L'Association Internationale de la Mutualité

**Javier Palmero Zurdo**, Directorate General for the Internal Market

**Christian Pierotti**, Comité Européen des Assurances

**Sybille Sahmer**, Verbandsdirektorin, Verband der privaten Krankenversicherung / Comité Européen des Assurances

**Michel Schmitz**, President, Conseil Supérieur de la Mutualité, Luxembourg

**Armindo Silva**, Directorate General for Employment and Social Affairs

**Luc Tholoni**, Directorate General for Employment and Social Affairs

**Herwig Verschueren**, Directorate General for Employment and Social Affairs

**Franz-Josef Werle**, Deputy Secretary General, Comité Européen des Assurances

## Executive summary

This report provides an overview of markets for voluntary health insurance (VHI)<sup>1</sup> in the European Union (EU). It examines their role in providing access to health care; assesses their impact on the free movement of people and services; and analyses recent trends and future challenges for voluntary health insurers and policy-makers at national and EU levels.

VHI markets in the European Union are diverse. This diversity arises from different historical patterns of development, variations in the rules and arrangements of statutory health care systems and discrepancies in national regulatory regimes. These factors underlie the wide range of: types of VHI on offer, levels of expenditure on VHI, levels of population coverage, types of insurer, mechanisms for premium-setting, selection criteria, policy conditions, benefits provided, premium prices, tax incentives, loss ratios, administrative costs, levels of access, equity implications and impact on free movement.

The types of VHI on offer in a particular member state reflect both the historical development and the current rules and arrangements of that member state's statutory health care system. Public policy in EU member states has aimed to preserve the principle of health care funded by the state or social insurance and made available to all citizens, regardless of ability to pay. As a result, statutory health care systems in the European Union are broadly characterised by near universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure.

These characteristics have been important determinants of the scope and size of VHI markets in the European Union, and the voluntary nature of such markets means that they generally operate in areas that the state does not cover. In the EU context, therefore, we classify VHI according to whether it:

- substitutes for cover that would otherwise be available from the state (substitutive VHI)
- 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 (complementary VHI)
- provides supplementary cover for faster access and increased consumer choice (supplementary VHI)

Complementary and supplementary VHI are open to the whole population and some form of complementary and/or supplementary VHI is available in every member state. In contrast,

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<sup>1</sup> We define VHI as health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. VHI can be offered by public or quasi-public bodies and by for-profit (commercial) and non-profit private organisations.

substitutive VHI is limited to specific population groups in a handful of member states. It is usually purchased by:

- those who are excluded from participating in some or all aspects of the statutory health insurance scheme (high-earners in the Netherlands and self-employed people in Belgium and Germany)
- those who are exempt from contributing to the statutory health insurance scheme because they are allowed to opt out of it (high-earning employees in Germany and some self-employed people in Austria)

The proportion of the population covered by VHI varies between member states. Levels of substitutive VHI cover range from 0.2 per cent of the population in Austria to 24.7 per cent in the Netherlands. Data on levels of complementary and supplementary VHI coverage are less comparable, partly because they do not always distinguish between the two types of coverage and partly due to variation in the quality of coverage. In member states where complementary VHI predominates, levels of coverage range from about 20 to 70 per cent. Since the introduction of free complementary VHI cover for people on low incomes in France in 2000, coverage has risen from 85 per cent to 94 per cent. Where supplementary VHI predominates, it generally covers around 10 per cent of the population.

Information about the characteristics of VHI subscribers suggests that those who purchase supplementary VHI are more likely to come from higher income groups, have a higher occupational status and live in wealthier regions. The characteristics of complementary VHI subscribers are more varied, but those most likely not to have complementary VHI coverage include people on low incomes and people without employment (such as students, some women, the unemployed and elderly people). Because access to substitutive VHI is determined by income or employment status, those with substitutive VHI tend to be high-earning or self-employed people.

VHI does not play a significant role in funding health care in the European Union. Spending on VHI as a proportion of total expenditure on health care is low. In 1998 it accounted for less than 10 per cent of total expenditure in every member state except France (12.2 per cent) and the Netherlands (17.7 per cent) and well under 5 per cent of total expenditure in Belgium, Denmark, Finland, Greece, Italy, Luxembourg, Portugal, Spain, Sweden and the United Kingdom (UK). Although the last twenty years have seen some growth in levels of private expenditure as a proportion of total expenditure on health care, this growth has been influenced more by increases in cost-sharing through user charges than by rising demand for VHI. However, sustained economic growth and cutbacks in public expenditure on health care during the 1980s did increase demand for VHI in many member states. Demand for VHI continued to grow throughout the 1990s in some member states, but the pace of growth was much slower. The fact that levels of VHI coverage in many member states have remained



fairly stable for some time now suggests that the market for VHI may have reached saturation point (within current health care system structures).

Over the last twenty years the demand for VHI in several member states has been fuelled by an increase in policies purchased by groups (usually employers, as a fringe benefit for their employees). Stagnant or falling levels of individual demand for VHI have forced insurers to rely even more heavily on sales to groups. Group policies gained an increasing share of the VHI market in many member states during the 1990s and currently account for almost all VHI policies in Sweden, Ireland, Portugal, Greece and the United Kingdom, over half of all policies in the Netherlands, and about half of all policies in France. Group policies usually benefit from group-rated premiums, discounted prices and less stringent policy conditions. The price of group policies has also increased at a much slower rate than the price of individual policies.

It was expected that the framework for a single market for VHI established by the third non-life directive in 1994 would increase competition between insurers, leading to greater choice and lower prices for consumers. However, increased competition does not appear to have reduced the price of VHI premiums, particularly for policies purchased by individuals. In fact, the price of individual VHI policies has often risen at a faster rate than health care expenditure in general. Since 2000, insurers offering substitutive VHI in Germany have been required by law to inform potential subscribers of the likelihood and magnitude of premium increases. The competition watchdog in the United Kingdom has asked insurers to do the same, also suggesting that they should publish figures showing applicants how much premiums have risen in previous years. Some industry commentators predict that future growth in the market for VHI is more likely to come through increases in price than increases in population coverage.

However, VHI markets in certain member states are characterised by a high level of product differentiation, perhaps as a result of the abolition of national price and product controls for complementary and supplementary VHI in 1994, which suggests that insurers may employ strategies other than price increases to sustain profitability by keeping existing subscribers and attracting new subscribers. While product differentiation can benefit consumers by increasing the range of products available to them and by providing them with products that are tailored to meet their needs, it can also be used to segment the market, giving insurers greater opportunity to distinguish between 'good' and 'bad' risks. Either way, the presence of multiple insurance products may reduce price competition unless it is accompanied by a level of information sufficient to permit consumers to compare products in terms of value for money. EU consumers in many member states now have a wide choice of VHI products, but it is not clear that such choice always works to their advantage. Evidence from several member states suggests that consumers may not have sufficient access to comparable information about VHI products, which can lead to consumer detriment. The UK competition watchdog

and consumer associations in some member states have noted that consumers can be easily confused by multiple VHI products and may therefore purchase inappropriate policies.

Information asymmetry between insurers and consumers arising from the proliferation, variability and complexity of VHI products 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 accessible sources of comparable information on the price, quality and conditions of VHI products. However, in the absence of product controls, insurers have little incentive to reduce consumer confusion by introducing standardised terms or standard benefit packages. Late in 2001 the UK government announced that general insurance sales (including the sale of VHI) would now come under the statutory regulation of the Financial Services Authority. In making its decision the government stated that statutory regulation of general insurance would “help true competition to flourish in this area, because it would help correct the information asymmetry that presently exists against the customer”.

Insurers operating in a competitive environment may have strong incentives to lower their costs by risk selection, encouraging custom from individuals with below average risk and discouraging or refusing custom from individuals with above average risk. Risk selection may raise concerns about equity (particularly where substitutive VHI is concerned) and also presents serious efficiency problems, lowering the optimal level of competition in an insurance market. Risk selection is likely to occur where voluntary health insurers are able to reject applications, exclude pre-existing conditions and cancel contracts. Incentives to risk-select can be addressed to some extent by obliging all insurers to: guarantee access to coverage (open enrolment), provide automatic renewal of contracts and limit exclusions for pre-existing conditions. This type of intervention would radically alter the nature of VHI markets in many member states: at present open enrolment policies are rare among voluntary health insurers in the European Union, most insurers exclude pre-existing conditions (the norm) or charge higher premiums for them, short-term (usually annual) contracts are the most common form of VHI contract and lifetime cover is the exception rather than the rule. Furthermore, VHI premiums in many member states rise with age and most insurers set a maximum age limit for purchasing VHI (usually between 60 and 75 years), while some actually cancel contracts when people reach retiring age. Incentives to risk-select can also be reduced by the introduction of sophisticated risk-adjustment mechanisms, but these are only found in Ireland (where a risk equalisation scheme is in place but has not yet been activated) and Belgium (for substitutive VHI provided by mutual associations).

For largely historical reasons, some of the most extensive VHI markets in the European Union are currently dominated by non-profit mutual or provident associations. Many (but not all) of these non-profit insurers adhere to solidarity principles in their provision of VHI. In recent years

their share of the VHI market has declined in some member states and in future they may lose further market share to for-profit commercial insurers.

The extent to which VHI affects access to health care depends, in part, on the characteristics of the statutory health care system. Access to VHI may concern policy-makers in so far as VHI provides primary protection against the consequences of ill health. While this is usually the case for substitutive VHI, it may also apply to complementary VHI covering co-payments imposed by the statutory health care system and necessary and effective health services excluded or only partially provided by the state. The high price of VHI premiums in some member states (particularly for individual policies), the absence of open enrolment, lifetime cover and community rating, and the imposition of stringent selection criteria and policy conditions present barriers to VHI for those on low incomes, people with pre-existing conditions, elderly people and people without employment.

Access to VHI has been an issue of concern to policy-makers in some member states. In recent years governments in Germany, the Netherlands and, to a lesser extent, Belgium have intervened heavily in the market for substitutive VHI to ensure that people on lower incomes, people with pre-existing conditions and elderly people have access to adequate and affordable levels of VHI coverage. The German and Dutch governments have also intervened to prevent or address the consequences of risk selection between statutory and voluntary health insurance schemes.

Other governments have taken steps to increase access to complementary and supplementary VHI. Since 2000, the 1999 law on universal health coverage (CMU) in France enables those who did not benefit from any health insurance to be covered by a basic, compulsory, statutory health insurance scheme. The law also provides free complementary VHI coverage for people on low incomes. In Ireland the government continues to oblige voluntary health insurers to offer open enrolment, lifetime cover, community-rated premiums, maximum waiting periods and a minimum level of benefits. It also subjects insurers to a system of risk adjustment through a (not yet activated) risk equalisation scheme. Insurers in Sweden have voluntarily agreed to refrain from requesting information about family history of disease, a type of genetic information that is required by insurers in several member states. Genetic testing for insurance purposes may emerge as an issue for VHI in future and therefore requires further debate at an EU level.

The existence of VHI could present a barrier to access in the statutory health care system for some individuals and population groups if it creates distortions in the allocation of resources. This is most likely to happen where the boundaries between public and private health care 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. While research into this issue is limited, there is evidence to suggest that VHI in some member states does create or exacerbate existing inequalities in access to health care. Policy-makers should pay greater attention to the equity (and efficiency) implications of the existence of VHI for statutory health care systems, particularly when considering any expansion of VHI markets.

Whether or not VHI conforms to the principle of free movement of people within the European Union depends on the extent to which the benefits provided by VHI are portable. Mobility may be limited if insurers are unwilling to provide cover for health care obtained in another member state and if individuals who move to another member state to work or live are unable to obtain cover on the same terms as those already living in that member state. The portability of benefits may also be restricted by differences in gaps in statutory coverage. Some voluntary health insurers do seek to provide cover for subscribers who regularly travel across national borders, but the role of VHI in covering health care provided beyond national boundaries is, at present, extremely small.

Even if insurers are prepared to extend VHI coverage to cover the costs of health care in another member state, the extension of coverage is likely to come at an additional cost; some subscribers may find themselves being charged higher premiums for the same level of coverage. The problems involved in obtaining VHI coverage in the host member state include non-legal barriers such as language, information and unfamiliarity (which may be a cause for concern when the information problems inherent in VHI markets are taken into account) and the extent to which applicants are treated as new risks and therefore subject to higher premiums, the exclusion of any pre-existing conditions and mandatory waiting periods. These factors may disadvantage people of all ages, but they are most likely to present a significant barrier for older people.

A key aspect of the third non-life insurance directive was its extension of the principle of free movement of services to voluntary health insurance. To date, however, cross-border sales of VHI have been limited and the few insurers that sell VHI in several member states do so from distinct host member state operations and rarely on the home member state freedom to provide services basis introduced by the directive. Although there have been some notable cross-border mergers and acquisitions in the market for VHI, it seems that insurers have been slow to sell VHI products across national borders without a branch presence in another member state and individuals have been slow to purchase VHI products in member states other than their own.

Although the third non-life insurance directive removed potential barriers to entry in theory, in practice some barriers may persist. Commonly-cited barriers to the free movement of services include differences in the design and availability of VHI caused by variations in statutory

entitlements to health care, the high cost of technical investments, lack of harmonisation in certain areas (particularly differential tax treatment) and bureaucratic procedures. The extent to which some of these factors present genuine obstacles to free movement is debatable.

Lack of harmonisation with respect to the directive itself may also be problematic for insurers. When the directive came into force in 1994 most member states amended existing legislation or passed new legislation to bring national insurance laws in line with it, but its implementation was not so smooth in a small number of member states, at least from the perspective of certain stakeholders. Some member states initially refused to implement the directive, although by 1997 Spain was the only member state in this position and the European Commission subsequently referred it to the European Court of Justice. Others selectively incorporated those aspects of the directive that posed the least political difficulty; as a result, the European Commission referred France and Germany to the European Court of Justice for infringement of the directive. Problems with incomplete implementation or possible infringement of the directive are of continuing concern to insurers in Belgium, France, Germany, Ireland and the Netherlands.

What are the prospects for expansion of VHI markets in future? Any expansion is likely to depend on developments in statutory health care systems. Expansion could also occur as a result of market interventions such as obliging voluntary health insurers to offer open enrolment, but this type of regulatory action would fundamentally alter the nature of VHI markets in most member states and may be problematic under the current regulatory framework.

At the present time member states demonstrate commitment in principle to publicly-funded health care for all or almost all citizens, but the sustainability of funding health care from public sources continues to be called into question. It is often suggested that factors such as the ageing of the population, the high cost of new technology and rising public expectations will increase demand for health care, causing expenditure on health care to escalate beyond the willingness or ability of citizens to pay for it (particularly through collective means such as taxation or social insurance). As a result, governments may no longer be able to provide sufficient levels of health care to the whole population and citizens may be forced to rely on additional methods of funding the health care they require. In such a situation, there would be significant opportunity for VHI to play a more substantial role in funding health care.

However, recent studies have shown that population ageing is unlikely to put significant pressure on health care expenditure in future. Expected rises in the number of older people, particularly the 'old old', may have an impact on health care costs in future, but they are much more likely to affect the costs of long-term care (which is outside the terms of reference of this report). The impact of new technology on health care costs is not clear and cannot be used as

an accurate predictor of future expenditure on health care. Public expectations may increase demand for health care, but it is neither evident nor logical to assume that a country's ability to sustain a given level of expenditure on health care is increased by raising money from one funding source (VHI) rather than another (tax or social insurance). In this respect it is worth noting that although health care is mainly provided through private health insurance in the United States, the level of public expenditure on health care in the United States is substantial, the level of overall spending on health care (as a proportion of GDP) is much higher than in any EU member state, and a significant proportion of the US population is not covered by any type of health insurance. Therefore it does not follow that expanding VHI will automatically result in reduced levels of public spending on health care or increased levels of coverage.

Three options open to EU policy-makers might influence the future expansion of VHI markets in different member states: allowing more individuals to opt out of the statutory health care system, further excluding specific health services from statutory cover (either explicitly or through non-explicit rationing) and introducing or increasing tax incentives to purchase VHI.

Allowing people to opt out does not appear to be a growing trend in the European Union. Where high-earning individuals are given a choice to opt out (as in Germany), very few actually choose to leave the statutory health insurance scheme. Governments in Belgium and the Netherlands, where some individuals are excluded from statutory coverage, are currently considering the possibility of extending statutory health insurance to the whole population.

Explicit reductions in statutory coverage of some health services could increase demand for complementary VHI, while less explicit reductions through rationing might increase demand for supplementary VHI. However, increased demand for complementary VHI may not always be met, as VHI to cover the cost of co-payments or products excluded from statutory reimbursement may be less profitable for insurers to provide. Voluntary health insurers may only be able to meet increased demand for supplementary VHI where there is sufficient private sector capacity.

Most member states do not use tax incentives to encourage individuals to purchase VHI, although tax incentives to firms have fuelled demand for group-purchased VHI in some member states. The current trend is to reduce or remove existing tax incentives for individuals as they are not particularly successful in stimulating demand. Resources devoted to tax relief might be better spent on improving the quantity and quality of statutory health care.

This report's analysis should be seen in the context of public policy objectives for health care systems (equity, efficiency, responsiveness, choice). Facilitating access to health care is the responsibility of governments. Any discussion of the access implications of the existence of VHI or the way in which VHI markets operate is incomplete without broader consideration of

access to statutory health care. More attention should be paid to the determinants of unequal access and existing inequalities in access to health care arising from the funding and provision of statutory health care. Policy measures such as the imposition of user charges may present greater financial barriers to health care and therefore require further study.

Overall, the analysis presented in this report has been constrained by poor data availability. The operation of VHI markets in the European Union and their implications for issues such as access to health care or the free movement of people and services are under-researched areas that would benefit from greater scrutiny.

# Introduction

## Background

In October 2000 the European Parliament adopted a report on supplementary health insurance written by the Parliament's Committee on Employment and Social Affairs (European Parliament 2000a). This report highlighted the difficulty of sustaining access to good quality health care for all in light of the ageing of the population and the rising costs of health care, and underlined the growing importance of VHI in providing access to health care in the European Union (EU). The report also raised questions about the extent to which differences between VHI systems might create barriers to the free movement of people and services within the European Union. Finally, the report identified a need for further research into voluntary (as opposed to statutory) health insurance systems in the European Union.

At the request of the European Parliament, the European Commission's Directorate General for Employment and Social Affairs commissioned this report in July 2001, with the aim of:

- responding to some of the questions raised by the European Parliament's report
- forming a basis for any further research or other initiatives the Commission may take in this area
- stimulating debate between the key actors involved

## Terms of reference

The report's terms of reference required us to:

- characterise supplementary health insurance systems in the European Union, taking into account their relations with statutory and legal health insurance systems, the size and characteristics of groups covered by supplementary health insurance and the benefits they provide
- identify the trends, challenges and threats facing supplementary health insurance systems in the European Union today
- analyse the role supplementary health insurance systems play in providing access to health care for all (using national and international indicators where available)
- address the issue of the difficulties and barriers to the free movement of people and services within the European Union potentially caused by the diversity and the characteristics of supplementary health insurance systems in the European Union, with respect to the subsidiarity principle and in agreement with articles 18, 39, 42, 43, 136, 137 and 152 of the Treaty



## **Outline**

The report is structured as follows:

### **Section 1: Context**

This section aims to:

- review briefly the rules and arrangements of statutory health care systems, noting that their characteristics have been important determinants of the scope and size of VHI markets in the European Union
- assess the size of the market for VHI in the European Union in terms of levels of expenditure on VHI, levels of insurers' premium income and levels of population coverage
- examine the demand for VHI in the European Union, presenting information on subscriber characteristics in different member states
- review the EU framework for regulating VHI markets

### **Section 2: The market for VHI in the European Union**

This section aims to:

- present a classification of VHI in the European Union
- describe (in some detail) the operation of substitutive VHI in Belgium, Germany and the Netherlands
- describe the benefits provided by complementary and supplementary VHI
- examine the structure of the market for VHI, in terms of types of insurer and buyer characteristics
- examine the conduct of VHI markets, in terms of premium-setting, selection criteria, policy conditions and the provision of benefits
- examine subscriber's costs (the price of premiums and the influence of tax incentives)
- examine insurers' costs (claims and administrative expenditure)

### **Section 3: Access, equity and consumer protection**

This section aims to:

- discuss the ways in which different types of VHI might affect access to health care
- examine barriers to access to VHI in different member states
- examine the equity implications of VHI in different member states

### **Section 4: Implications for the free movement of people and services within the European Union**

This section aims to:

- review briefly the free movement of patients in statutory health care systems
- examine the impact of VHI on the free movement of people within the European Union
- examine the impact of VHI on the free movement of services within the European Union

## Section 5: Trends and challenges

This section aims to:

- review trends and challenges in the market for VHI
- review trends and challenges in public policy
- review trends and challenges in EU regulation

## Section 6: Concluding remarks

### Definitions

Although the European Parliament's report refers both to 'voluntary' and 'supplementary' health insurance systems, in this report we prefer to use the term 'voluntary', as it covers all types of non-statutory health insurance in the European Union. We define voluntary health insurance (VHI) as health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of individuals. VHI can be offered by public or quasi-public bodies and by for-profit (commercial) and non-profit private organisations.

VHI can be classified in many different ways, as demonstrated by the numerous definitions in current usage. Traditionally, the literature on VHI has distinguished between insurance that *duplicates* statutory insurance and insurance that constitutes the *principal* means of protection for sections of the population (Couffinhal 1999). In the context of the European Union we find it more appropriate to classify VHI 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)
- provides *supplementary* cover for faster access and increased consumer choice

### Methodology

#### Sources of information

The information and analysis presented in our report are based on the following:

- a comprehensive review of the literature in several languages
- the participation of independent national experts in the following member states who completed detailed standard questionnaires: Austria, Belgium, Denmark, Finland, France,

Germany, Greece, Italy, the Netherlands, Portugal, Spain, Sweden and the United Kingdom (UK)

- study visits to two member states (Ireland and Luxembourg)
- collection of statistical data
- a survey of national and EU-wide industry representatives
- a survey of national and EU-wide consumer associations
- a survey of regulatory bodies in France, Germany, Ireland, the Netherlands and the United Kingdom
- interviews with European Commission officials in Luxembourg and Brussels
- interviews with the Association Internationale de la Mutualité (AIM) and the Comité Européen des Assurances (CEA) in Brussels

## **Comprehensive review of the literature**

In addition to literature identified by the national experts, literature was identified from internet searches, the websites of relevant organisations, government reports, market research reports and the following databases:

- **International Bibliography of the Social Sciences (IBSS)**: comprehensive references to journal articles, book reviews, book monographs and selected book chapters in the social sciences
- **PubMed**: a service of the National Library of Medicine, provides access to citations from MEDLINE and additional life science journals
- **EconLit**: a comprehensive, indexed bibliography with selected abstracts of the world's economic literature produced by the American Economic Association
- **Decomate II**: the European electronic digital library for economics
- **Social Science Information Gateway (SOSIG)**: internet resources in the social sciences selected and described by subject specialists
- **Electronic Access to Subject Information (EASI)**: a service provided by the British Library of Political and Economic

## **National experts**

We identified national experts from independent organisations in Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, Portugal, Spain and the United Kingdom to complete a detailed questionnaire on VHI (see Appendix C for experts' affiliations). The questionnaires were standardised to facilitate systematic comparison between member states, but they were flexible enough to allow the analysis of country-specific characteristics and developments.

## **Study visits**

We made study visits to Ireland and Luxembourg, where the following kindly agreed to be interviewed:

- Sean Murray, Marketing Director of BUPA, Ireland
- John Armstrong, Actuarial Executive, Vhi Healthcare, Ireland
- Tara Buckley, General Manager, Corporate Communications, Vhi Healthcare, Ireland
- Patrick O'Barrett, Health Insurance Unit, Department of Health and Children, Ireland
- Colm Keenan, Principal Officer, Health Insurance Unit, Department of Health and Children, Ireland
- Michel Schmitz, President, Conseil Supérieur de la Mutualité, Luxembourg
- Olaf Engemann, Director, Le Foyer Santé, Luxembourg

## **Collection of statistical data**

Statistical data was obtained from the following sources:

- OECD Health Data 2001
- CEA
- AIM
- Eurostat
- government reports
- market research reports
- national statistical data

## **Surveys**

We sent brief, standard questionnaires to the following organisations:

- CEA and its member organisations in the European Union
- AIM and its member organisations in the European Union
- Maison Européenne de la Protection Sociale / European Social Insurance Partners (ESIP)
- Consumers International, Bureau Européen des Unions de Consommateurs (BEUC) and consumer associations in each EU member state
- regulatory bodies in France, Germany, Ireland, the Netherlands and the United Kingdom

The organisations that responded to our questionnaires are listed in Appendix B.

## **Meetings and interviews**

We met with European Commission officials from the Directorate General for Employment and Social Affairs (DG EMPL) and the Directorate General for Health and Consumer

Protection (DG SANCO). The authors also submitted a written questionnaire to the Directorate General for the Internal Market (DG MARKT). We interviewed representatives from CEA, AIM and ESIP. The purpose of these meetings and interviews was to obtain further information and clarification.

## **Report limitations**

This report aims to provide an overview of voluntary health insurance systems in the European Union, covering the four areas outlined in the terms of reference. The European experience of VHI is poorly documented in the literature; most literature on VHI focuses on the United States. To date, the only attempt to provide an overview of VHI in the European Union was made by BASYS in 1995 (Schneider 1995). The information and analysis we present in this report therefore represents a contribution to the literature. However, we should draw attention to limitations in the information we present.

First, we must emphasise that much of the variation between VHI systems in the European Union is caused by the influence of socio-political and cultural factors on the historical development of health care systems in different member states. An analysis of these factors is beyond the terms of reference of this report.

We should also point out that VHI markets in the European Union are diverse and offer a wide range of different products. It is important to note that what happens in one member state may be quite different from what takes place in other member states. This is particularly true of complementary VHI, which exists to provide cover for services that are excluded from the statutory health care system. Excluded services will differ from country to country, although there may be some commonly-excluded services, such as dental care. It is therefore impossible to generalise from the experience of some countries.

Where possible, we have attempted to provide country-specific information, but our attempt has been hindered by poor and uneven data availability. The quality and quantity of the data we present varies from country to country, leading to problems of comparability. The availability of information generally reflects the size of a member state's market for VHI, so there is less information on member states with small markets. But even in countries with significant markets for VHI it is difficult to find complete and reliable data on the most basic variables, such as the number of insured people. The lack of detailed data does impede attempts to provide a rigorous analysis of VHI markets in the European Union.

There is a need for better and more systematic collection of data on VHI in the European Union, but it is not clear who is able or willing to collect it. Governments in most member states have shown little interest in collecting data on VHI, probably because it is not a

significant source of health care funding in any member state, and the current regulatory environment does not require insurers to collect or publish anything other than data relating to solvency margins. The data we present in this report have been obtained from insurers, insurers' associations, market research reports, household surveys and academic research rather than official statistics. Eurostat, the statistical office of the European Commission, does not collect the required data.

## **Section 1: Context**

This section aims to:

- review briefly the rules and arrangements of statutory health care systems, noting that their characteristics have been important determinants of the scope and size of VHI markets in the European Union
- assess the size of the market for VHI in the European Union in terms of levels of expenditure on VHI, levels of insurers' premium income and levels of population coverage
- examine the demand for VHI in the European Union, presenting information on subscriber characteristics in different member states
- review the EU framework for regulating VHI markets

### **1.1 The rules and arrangements of statutory health care systems**

VHI does not play a significant role in funding health care in the European Union, as it does in countries such as the United States, Australia and Switzerland. Public policy in EU member states has generally aimed to preserve the principle of health care funded by the state or social insurance and made available to all citizens, regardless of ability to pay. This has led to the development of health care systems broadly characterised by near universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure. These characteristics have been important determinants of the scope and size of the market for VHI in the European Union.

#### **Universal coverage**

The existence of near universal coverage by the statutory health care system reduces consumers' need for additional coverage through VHI in many member states. In 1997 universal rights to health care could be found in Denmark, Finland, Greece, Ireland, Italy, Luxembourg, Portugal, Sweden and the United Kingdom, and near universal rights (99 per cent coverage or higher) in Austria, Belgium, Germany, France and Spain (Organisation for Economic Co-operation and Development 2001a). Statutory health coverage was lowest in the Netherlands (74.6 per cent), but this does not account for the fact that everyone resident in the Netherlands is automatically covered for long-term care, including mental health care and care for disabled people. Data for 1999 were only available for Austria, Denmark, Finland, Ireland, the Netherlands, Sweden and the United Kingdom, but they showed the same levels of statutory health coverage (Organisation for Economic Co-operation and Development 2001a).

## **Mandatory participation**

Because health care systems in the European Union are mainly financed through taxation or contributions from employers and employees, participation in the statutory health care system is usually mandatory. Where there are exceptions to this rule, individuals are allowed to purchase VHI as a substitute for statutory protection. This type of substitutive VHI is currently only available to clearly defined groups of the population in Austria, Belgium, Germany and the Netherlands.<sup>2</sup>

## **Comprehensive benefits**

Governments in most member states provide their citizens with comprehensive benefits, thereby reducing the need for additional coverage by VHI. However, the exclusion of certain health services from statutory coverage (particularly dental care and pharmaceuticals) and the rise in co-payments for statutory services have led to the development of a market for complementary VHI in many member states (see Section 2.1.2). Supplementary VHI has developed to increase consumer choice and access to different health services. It is particularly prevalent in member states with NHS-type health care systems (where it is often referred to as 'double coverage'), although it is available in some form in most member states. This type of VHI generally guarantees a wider choice of providers, faster access to treatment and superior accommodation and amenities in hospital (rather than improved clinical quality of care) (see Section 2.1.2).

The rules and arrangements of statutory health care systems in the European Union are clearly important determinants of the type of VHI on offer in different member states, leading to the development of substitutive VHI in Austria, Belgium, Germany and the Netherlands, predominantly complementary VHI in Belgium, Denmark, France, Luxembourg, Sweden and the Netherlands, and predominantly supplementary VHI in countries with NHS-type systems.

## **Levels of public expenditure on health care**

Health care systems in the European Union are characterised by high levels of public expenditure (see Table 1). With the exception of Austria, Greece, Portugal and Italy, public expenditure accounted for three quarters or more of all expenditure on health care in 1998 in most member states, while in Belgium, Luxembourg, Sweden, the United Kingdom and

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<sup>2</sup> The Spanish government permits civil servants to choose between health care provided by the statutory health care system or health care provided through voluntary health insurance, while the Portuguese government allows individuals and groups of employees to opt out of the statutory health care system, but as these groups are neither excluded from the statutory health insurance scheme, nor exempt from contributing to it, they do not fall within our definition of substitutive VHI and we therefore consider them separately (see Appendix A).



Denmark, public expenditure accounted for more than 80 per cent of total expenditure on health care (Organisation for Economic Co-operation and Development 2001a).

The last twenty years have seen some decline in levels of public expenditure as a proportion of total expenditure on health care in the European Union. Table 1 shows that between 1990 and 1998 the share of public expenditure on health care decreased slightly in the United Kingdom (-0.3 per cent), France (-0.7 per cent), Denmark (-0.8 per cent), Luxembourg (-0.9 per cent) and Spain (-2.3 per cent). It decreased more substantially in Finland (-6.2 per cent), Sweden (-6.8 per cent), Greece (-9.4 per cent) and Italy (-12.9 per cent). Finland's reduction in public expenditure can be attributed to the severe economic recession that began in 1991 and forced households' share of expenditure on health care to rise from 13 to 21 per cent between 1990 and 1994 (Häkkinen 1999). In Italy the reduction was caused by radical changes in pharmaceutical policy, leading to a steep decline in public spending on pharmaceuticals; in 1990 public spending accounted for 66.3 per cent of total expenditure on pharmaceuticals, but by 1997 the public share had fallen by almost 40 to 40.6 per cent of total expenditure (Fattore 1999, Organisation for Economic Co-operation and Development 2000). Public expenditure on health care increased in Greece during the 1980s, after the introduction of a national health system, but public funding was not sustained by the conservative government that came to power in 1990; lower levels of public funding during the 1990s were accompanied by rapid growth in private expenditure on health care (Sissouras et al. 1999). Sweden also experienced a relative shift in the balance of health care funding during the 1990s, when private expenditure on health care grew much faster than public expenditure, mainly due to large increases in co-payments for doctors' services and pharmaceuticals (Anell and Svarvar 1999).

More recent trends have shown a tendency for some governments to increase the amount they spend on health care. This is particularly evident in the United Kingdom, where the average annual real increase in spending on the NHS almost doubled between 1992 and 1997, from 2.6 to 4.7 per cent (Emmerson et al. 2000). Spending on the NHS is set to rise even further in future, with a projected average annual real increase of 6.2 per cent between April 1999 and March 2004, which is substantially higher than the 3.4 per cent real increase in spending that the NHS has received on average over its 52-year history.

**Table 1 Public and private expenditure as a percentage of total expenditure on health care in the European Union, 1975-1998**

Country		1975	1980	1985	1990	1995	1996	1997	1998	Overall growth 1975-90 (%)	Overall growth 1990-98 (%)
Austria	public	69.6	73.7	68.1	66.1	71.8	70.5	70.9	70.6	-5.3	6.8
	private	30.4	26.3	31.9	33.9	28.2	29.5	29.1	29.4	10.3	-13.3
Belgium	public	79.6	83.4	81.8	88.9	88.7	88.8	89.3	89.7	10.5	0.9
	private	20.4	16.6	18.2	11.1	11.3	11.2	10.7	10.3	-83.8	-7.2
Denmark	public	-	87.8	85.6	82.6	82.5	82.4	82.4	81.9	-5.9	-0.8
	private	-	12.2	14.4	17.4	17.5	17.6	17.6	18.1	42.6	4.0
Finland	public	78.6	79	78.7	80.9	75.6	75.8	76	75.9	2.8	-6.2
	private	21.4	21	21.3	19.1	24.4	24.2	24	24.1	-12.0	26.2
France	public	77.2	78.8	83.4	76.9	76.3	76.3	76.3	76.4	-0.4	-0.7
	private	22.8	21.2	16.6	23.1	23.7	23.7	23.7	23.6	1.3	2.2
Germany	public	79	78.6	77.4	76.3	78	78.3	76.9	-	-3.5	0.8
	private	21	21.4	22.6	23.7	22	21.7	23.1	-	11.4	-2.5
Greece	public	-	55.6	-	62.7	58.7	58.7	57.7	56.8	12.8	-9.4
	private	-	44.4	-	37.3	41.3	41.3	42.3	43.2	-16.0	15.8
Ireland	public	79	81.6	75.7	71.7	72.7	72.5	75	75.8	-10.2	5.7
	private	21	18.4	24.3	28.3	27.3	27.5	25	24.2	25.8	-14.5
Italy	public	84.5	80.5	77.2	78.1	67.7	67.8	68	68	-8.2	-12.9
	private	15.5	19.5	22.8	21.9	32.3	32.2	32	32	29.2	46.1
Lux-embourg	public	91.8	91.2	89.4	93.1	92.5	-	91	92.3	1.4	-0.9
	private	8.2	8.8	10.6	6.9	7.5	-	9	7.7	-18.8	11.6
Netherlands	public	69.5	71.1	72.8	68.7	72.5	67.7	69.7	74.7	-1.2	8.7
	private	30.5	28.9	27.2	31.3	27.5	32.3	30.3	25.3	2.6	-19.2
Portugal	public	58.9	64.3	54.4	52.9	54	64.2	66.7	66.9	-11.3	26.5
	private	41.1	35.7	45.6	47.1	46	35.8	33.3	33.1	12.7	-29.7
Spain*	public	77.4	79.9	81.1	78.7	78.3	78.5	76.5	76.9	1.7	-2.3
	private	22.6	20.1	18.9	21.3	21.7	21.5	23.5	23.1	-6.1	8.5
Sweden	public	90.2	92.5	90.4	89.9	85.2	84.8	84.3	83.8	-0.3	-6.8
	private	9.8	7.5	9.6	10.1	14.8	15.2	15.7	16.2	3.0	60.4
UK	public	-	90.1	86	86	85.8	83.8	83.6	85.7	-4.6	-0.3
	private	-	9.9	14	14	14.2	16.2	16.4	14.3	41.4	2.1

Source: OECD (Organisation for Economic Co-operation and Development 2001a); INE (INE 1998)

\* Data from the Spanish Family Budget Survey of 1998 show that the share of public and private expenditure would be 81.5 per cent and 18.5 per cent respectively.

Increases in public expenditure on health care are also likely to occur in member states that are trying to increase statutory coverage by extending it to groups that were previously excluded. In 1999 the French government passed a law on universal health coverage (Couverture Médicale Universelle; CMU) to enable those who did not benefit from any health insurance (estimated on 31 December 2000 as 1.1 million people) to be covered by a basic, compulsory, statutory health insurance scheme (Paris et al. 2002 forthcoming). Based on the proposals of a working group of senior government officials, led by an academic, set up to examine the social security status of self-employed people in Belgium, the Belgian

government is considering the possibility of extending statutory coverage of minor risks to self-employed people or legally obliging them to purchase substitutive VHI (Cantillon 2001). The Dutch government has recently announced widespread reform of its health care system, including its plans to extend statutory coverage to the whole population by merging the existing health insurance schemes into one universal, compulsory, public health insurance scheme (Ministry of Health Welfare and Sport 2001).

Although it would seem that member states remain committed in principle to publicly-funded health care for all citizens, the sustainability of funding health care from public sources continues to be called into question. Debate focusing on the possibility of further cutbacks in statutory health care, either by excluding certain services or offering a 'core' service with limited benefits, has been accompanied, in some member states, by calls for greater reliance on private expenditure through an expansion of VHI. At the beginning of the 1990s both Italy and Portugal considered allowing individuals to opt out of the statutory health care system and purchase VHI instead, with Portugal going so far as to enact and apply legislation in 1993 (see Appendix A). Since 1999 certain groups of people in Austria have also been able to opt out. To date, however, these developments do not appear to have made a significant impact on the market for VHI in the European Union, as we will discuss in the following section.

## **1.2 The size of the market for VHI**

In Section 2.1 we present a detailed analysis of the different types of VHI available in the European Union. Here we attempt to assess the overall size of the market for VHI. Market size can be estimated in three ways: in terms of levels of expenditure on VHI (as a proportion of private and total expenditure on health care), in terms of levels of premium income per year and in terms of levels of coverage (that is, the proportion of people covered by VHI in a given population). Trends in levels of expenditure on VHI or levels of premium income could be used as an indirect measure of coverage levels, but these types of data should be interpreted with caution. A recent report on VHI in Europe notes that although the market for VHI in the European Union grew at a compound annual rate of 5.4 per cent in real terms between 1994 and 1999, a large proportion of this growth was caused by increases in the price of VHI (rising premiums) rather than increases in coverage (Datamonitor 2000a).

### **1.2.1 Levels of expenditure on VHI**

Spending on VHI as a proportion of total expenditure on health care is low in the European Union, accounting for less than 10 per cent of total expenditure in every member state except France (12.2 per cent) and the Netherlands (17.7 per cent) and well under 5 per cent of total

expenditure in Belgium, Denmark, Finland, Greece, Italy, Luxembourg, Portugal, Spain, Sweden and the United Kingdom (see Table 2). Table 2 shows that VHI as a proportion of total expenditure on health care rose in every member state except Luxembourg between 1980 and 1990. Although it continued to rise in most member states between 1990 and 1998, it did so at a substantially slower rate and even declined in member states such as Spain (-59.9 per cent), Ireland (-32.4 per cent), Austria (-21.1 per cent) and Germany (-4.2 per cent). The only exception is the Netherlands, which experienced a rise of 46.3 per cent in spending on VHI as a proportion of total expenditure during this period.

As a proportion of private expenditure on health care, spending on VHI is also relatively low, accounting for less than five per cent in Greece, Italy and Portugal and for less than 25 per cent in Austria, Belgium, Denmark, Finland, Luxembourg, Spain and the United Kingdom (see Table 3). VHI has a much larger share of private expenditure on health care in member states offering substitutive VHI, particularly in the Netherlands (70 per cent), where about 30 per cent of the population is excluded from statutory coverage. Its share is also much larger in France (51.7 per cent), where 85 per cent of the population is covered by complementary VHI to cover the cost of co-payments imposed by the statutory health care system.

The relatively small proportion of private spending on VHI can be attributed to the fact that governments in the European Union have tended to rely on other methods of shifting health care costs onto consumers, such as user charges (co-payments and direct payments), rather than promoting and subsidising VHI. Consequently, out-of-pocket payments make up the bulk of private expenditure on health care in all member states except France and the Netherlands (see Table 3).

**Table 2 Breakdown of private expenditure as a percentage of total expenditure on health care in the European Union, 1980-1998**

Country		1980	1985	1990	1995	1996	1997	1998	Overall growth 1980-90 (%)*	Overall growth 1990-98 (%)*
Austria	VHI	7.6	9.8	9	7.8	7.2	7.5	7.1	18.4	-21.1
	OOP**	16.3	19.6	22.4	14.8	15.9	17.7	18.3	37.4	-18.3
	Other***	2.4	2.5	2.5	5.6	6.4	3.9	4	4.2	60.0
Belgium	VHI	0.8	1.2	1.6	1.9	2	-	-	100.0	25.0
	OOP	15.8	17	9.5	9.4	9.2	-	-	-39.9	-3.2
Denmark	VHI non-profit	0.8	0.8	1.3	1.2	1.4	1.4	1.5	62.5	15.4
	OOP	11.4	13.6	16.1	16.3	16.2	16.2	16.6	41.2	3.1
Finland	VHI non-profit	0.6	0.6	0.5	0.4	-	-	0.5	-16.7	0.0
	VHI for-profit	0.8	1.2	1.7	2	-	-	2.2	112.5	29.4
	VHI total	1.4	1.8	2.2	2.4	2.4	2.5	2.7	57.1	22.7
	OOP	18.4	18.3	15.5	20.5	20.2	19.9	19.8	-15.8	27.7
	Other	1.2	1.2	1.4	1.5	1.6	1.6	1.6	16.7	14.3
France	VHI non-profit	-	5.8	6.8	7.5	-	-	7.8	17.2	14.7
	VHI for-profit	-	-	4.4	4.2	-	-	4.4	-	0.0
	VHI total	-	5.8	11.2	11.7	12.1	12.1	12.2	93.1	8.9
	OOP	-	10.8	10.8	10.9	10.6	10.5	10.3	0.0	-4.6
	Other	-	-	1.1	1.1	1	1.1	1.1	-	0.0
Germany	VHI	5.9	6.5	7.2	6.7	6.5	6.9	-	22.0	-4.2
	OOP	10.3	11.2	11.1	10.9	11	11.9	-	7.8	7.2
	Other	5.2	4.9	5.4	4.4	4.2	4.3	-	3.8	-20.4
Greece	VHI	-	-	0.9	-	-	-	-	-	-
	OOP	-	-	36.4	-	-	-	-	-	-
Ireland	VHI non-profit	-	9.9	13.9	15	-	-	9.4	40.4	-32.4
	OOP	-	14.4	14.4	12.3	-	-	14.8	0.0	2.8
Italy	VHI	0.2	0.5	0.9	1.3	-	1.3	-	350.0	44.4
	OOP	19.3	22.3	21	31	-	30.7	-	8.8	46.2
Lux-embourg	VHI non-profit	1.6	1.4	1.4	1.3	-	1.6	-	-12.5	14.3
	OOP	7.2	9.2	5.5	6.2	7.2	7.4	-	-23.6	34.5
Netherlands	VHI non-profit	-	-	-	-	-	-	6	-	-
	VHI for-profit	-	11.2	12.1	-	-	-	11.7	8.0	-3.3
	VHI total	-	11.2	12.1	-	23.3	22.1	17.7	8.0	46.3
	OOP	-	-	-	-	7.7	6.6	5.9	-	-23.4
	Other	-	-	-	-	1.3	1.6	1.7	-	30.8
Portugal	VHI	-	0.2	0.8	1.4	1.7	-	-	300.0	112.5
	OOP	-	45.4	46.3	44.6	34.1	33.3	-	2.0	-28.1
Spain****	VHI	3.2	3.7	3.7	5.2	-	1.5	-	15.6	-59.5
	OOP	-	-	-	16.5	21.5	22	-	-	33.3
UK	VHI	1.3	2.5	3.3	3.2	5.1	5.4	3.5	153.8	6.1
	OOP	8.6	11.5	10.7	11	11.1	11	10.8	24.4	0.9

Source: OECD (Organisation for Economic Co-operation and Development 2001a); INE (INE 1998)

Note: No data was available for Sweden

\* Or nearest year for which data are available

\*\* OOP refers to out-of-pocket expenditure

\*\*\* Other refers health expenditure incurred by corporations and private employers providing occupational health services and other non-funded medical benefits to employees plus expenditure by

non-profit institutions serving households (excluding social insurance) such as red cross, philanthropic and charitable institutions, religious orders and lay institutions

\*\*\*\* Data from the Spanish Family Budget Survey of 1998 show that the proportion of total health care expenditure funded through VHI and OOP in 1998 was 4.1 per cent and 14.4 per cent respectively.

**Table 3 VHI expenditure as a percentage of private expenditure on health care in the European Union, 1980-1998**

Country	1980	1985	1990	1995	1996	1997	1998
Austria	28.9	30.7	26.5	27.7	24.4	25.8	24.1
Belgium	4.8	6.6	14.4	16.8	17.9	-	-
Denmark	6.6	5.6	7.5	6.9	8.0	8.0	8.3
Finland	6.7	8.5	11.5	9.8	9.9	10.4	11.2
France	-	34.9	48.5	49.4	51.1	51.1	51.7
Germany	27.6	28.8	30.4	30.5	30.0	29.9	-
Greece	-	-	2.4	-	-	-	-
Ireland	-	40.7	49.1	54.9	-	-	38.8
Italy	1.0	2.2	4.1	4.0	-	4.1	-
Luxembourg	18.2	13.2	20.3	17.3	-	17.8	-
Netherlands	-	41.2	38.7	-	72.1	72.9	70.0
Portugal	-	0.4	1.7	3.0	4.7	-	-
Spain*	15.9	19.6	17.4	24.0	-	-	-
UK	13.1	17.9	23.6	22.5	31.5	32.9	24.5

Source: OECD (Organisation for Economic Co-operation and Development 2001a); INE (INE 1998)

Note: No data available for Sweden

\* Data from the Spanish Family Budget Survey of 1998 show that VHI accounted for 22.1 per cent of private expenditure on health care in 1998

## 1.2.2 Levels of premium income

In most member states accident and (voluntary) health insurance markets account for only a small proportion of non-life insurance, although their importance is increasing (Eurostat 1997). Accident and (voluntary) health insurance premiums in 1995 made up 43 per cent of total non-life business in the Netherlands and 31.3 per cent in Germany; in Austria, Denmark, Finland and Spain accident and health insurance premiums accounted for over 20 per cent (Eurostat 1997). In 1996 the accident and health market was fairly evenly divided in France and the Netherlands, whereas in Austria, Germany, the United Kingdom and Spain health insurance accounted for over two thirds of the accident and health market (Natarajan 1996).

Table 4 shows the income obtained from policies sold by voluntary health insurers in the European Union in 1999. The figures for Germany and the Netherlands include premium income from substitutive VHI, which explains why Germany and the Netherlands have such large shares of the market (50.1 per cent and 12.2 per cent respectively), although France has the second largest share (13.2 per cent). The smallest markets, with a share of less than one per cent, are Sweden, Luxembourg, Portugal, Finland, Denmark and Belgium.

According to data provided by the Comité Européen des Assurances, between 1995 and 1998 VHI premium income (adjusted for inflation) grew most in Belgium (14.8 per cent) and Portugal (14.4 per cent), followed by Spain (5.8 per cent) and the Netherlands (5.6 per cent) (Comité Européen des Assurances 2000). Most other member states experienced growth of three to four per cent.

**Table 4 Premium income of voluntary health insurers in the European Union, 1999**

Country	Euro (millions)	Growth 99/98 (inflation-adjusted %)	Share of total VHI market (%)	As a % of GDP (1999)
<b>Austria</b>	1,136.0	1.0	2.8	0.6
<b>Belgium</b>	317.0	10.5	0.8	0.1
<b>Denmark</b>	282.0	7.9	0.7	0.2
<b>Finland*</b>	221.5	N/A	0.6	0.2
<b>France</b>	5,290.0	4.3	13.2	0.4
<b>Germany</b>	20,094.0	2.3	50.1	1.0
<b>Ireland**</b>	660.3	N/A	1.6	0.8
<b>Italy</b>	1,163.0	1.6	2.9	0.1
<b>Luxembourg***</b>	29.5	N/A	0.1	0.2
<b>Netherlands</b>	4,884.0	5.8	12.2	1.3
<b>Portugal</b>	172.0	19.5	0.4	0.2
<b>Spain</b>	2,360.0	9.1	5.9	0.4
<b>Sweden</b>	27.0	N/A	0.1	0.0
<b>UK</b>	3,490.0	5.8	8.7	0.2
<b>TOTAL</b>	40,126.3	4.2	100.0	0.5

Source: CEA (Comité Européen des Assurances 2001a); OECD (Organisation for Economic Co-operation and Development 2001a); Mikkola (Mikkola 2001); Vhi Healthcare (Vhi Healthcare 2000); Schmitz (Schmitz 2001); Engemann (Engemann 2001)

Note: No data available for Greece

\* Accident and health insurance in 2000

\*\* Estimate for 2002

\*\*\* Figures for 2000

Market size in terms of premium income is reflected in the proportion of total expenditure on health care funded by VHI, although in 1998 VHI funded a higher proportion of expenditure on health in the Netherlands (17.7 per cent) and France (12.2 per cent) than in Germany (6.9 per cent) (see Table 2).

### 1.2.3 Levels of coverage

Levels of coverage indicate the proportion of people covered by VHI in a given population and are usually linked to the rules and arrangements of the statutory health care system. The level of coverage for substitutive VHI is largely determined by the level of mandatory or voluntary statutory coverage, while levels of complementary and supplementary VHI coverage will depend on the extent to which the state provides timely and comprehensive benefits of good quality. This partly explains the substantial variation in levels of coverage between member states.

Table 5 shows levels of coverage (as a percentage of the total population) for different types of VHI in the European Union.<sup>3</sup> At first glance the figures can be misleading and they may not be easily comparable across countries. For example, the relatively high levels of complementary VHI coverage for France (85 per cent) and the Netherlands (over 60 per cent)<sup>4</sup> may disguise extreme variations in the quality of coverage. The figures only tell us how many people purchase complementary VHI; it does not reveal whether they have purchased a basic or comprehensive product.

Where substitutive VHI is concerned, almost all those who are fully or partially excluded from the statutory health insurance scheme purchase VHI. This is the case in Belgium and the Netherlands. However, if people have the choice to opt out of the statutory health insurance scheme and purchase substitutive VHI instead, they are more likely to remain in the statutory health insurance scheme. In Germany fewer than a quarter of the high-earning employees eligible to opt out actually do so. Those that choose to opt out are likely to be young, healthy, single and without dependants (see Section 2.1.1).

France has an exceptionally high level of complementary VHI coverage (85 per cent of the population in 1998), but it is important to note that this is for the reimbursement of co-payments for treatment in the statutory health care system. Over the last 25 years the French government has used cost-sharing as a means of containing health care expenditure; instead of reducing consumption, however, this strategy has encouraged the growth of complementary VHI, with the result that most French people now purchase this type of VHI to reduce the financial burden of out-of-pocket expenditure (Lancry and Sandier 1999). The market for complementary VHI in France has grown dramatically, covering a third of the

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<sup>3</sup> It is not always possible to obtain official figures regarding levels of complementary and supplementary VHI coverage, so some of the data shown in Table 5 were obtained from surveys.

<sup>4</sup> The figure for the Netherlands may be even higher, as the only data published concerns complementary VHI purchased by those insured under the ZFW. About 93 per cent of those insured under the ZFW purchase complementary VHI (Vektis 2000)



population in 1960, 50 per cent in 1970, 70 per cent in 1980 and 85 per cent in 1998 (Sandier and Ulmann 2001) (see Section 3.2.1).

The French experience suggests that a reduction in statutory coverage of certain health services does increase the take up of complementary VHI (if it is available), but this is not always the case. Where governments in other member states have pursued a deliberate and explicit policy of encouraging private expenditure on health care, the results, in terms of VHI coverage, have been mixed. For example, the relatively low levels of VHI coverage in Denmark (28 per cent), Finland (6.7 per cent of adults) and Sweden (1-1.5 per cent) are traditionally attributed to the generosity of state benefits, but recent increases in cost-sharing have not made much impact on the size of the market for VHI in these member states. Although the impact of increased cost-sharing during the 1990s was greatest in Sweden, levels of VHI coverage in Sweden continue to be the lowest in the European Union. France is therefore an outlier in this respect.

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

Country	Substitutive	Complementary / Supplementary
<b>Austria (1999)</b>	0.2%	18.8% (complementary) 12.9% (supplementary; hospital expenses)
<b>Belgium (2000)</b>	7.1%	30-50% (complementary)
<b>Denmark (1999)</b>	None	28% (mainly complementary; some supplementary)
<b>Finland (1996)</b>	None	Children aged <7: 34.8% (supplementary) Children aged 7-17: 25.7% (supplementary) Adults: 6.7% (supplementary)
<b>France (2000)</b>	Marginal (frontier workers)	85% (1998) (complementary) 94% (2000 estimate) (complementary)
<b>Germany (1999)</b>	9%	9%
<b>Greece (2000)</b>	None	10% (supplementary)
<b>Ireland (2000)</b>	None	45%
<b>Italy (1999)</b>	None	15.6%
<b>Luxembourg (2000)</b>	None	70% (mainly complementary)
<b>Netherlands (1999)</b>	24.7% (+ 4.2% WTZ)	>60% (complementary) Marginal (supplementary)
<b>Portugal (1998)</b>	None	12% (mainly supplementary)
<b>Spain (1999)</b>	0.6%	11.4%
<b>Sweden (1999)</b>	None	1-1.5% (mainly supplementary)
<b>UK (2000)</b>	None	11.5% (mainly supplementary)

Source: National reports prepared for this report

Voluntary health insurers in some member states may be highly responsive to changes in state benefits. When some forms of dental care were removed from the statutory package of benefits in the Netherlands in the early 1990s (partly re-included in the package in 1996), the Minister of Health encouraged voluntary health insurers to cover it. Similarly, complementary VHI coverage was at its highest in Germany in 1997/98 (covering 7.6 million compared to 6 million in 1995/96), when access to dental crowns and dentures in the statutory health care system was restricted to people born after 1978; once these restrictions were reversed in

1999, the number of children with complementary VHI fell from 2.2 million in 1998 to 1.4 million in 1999 (Busse 2001).

VHI coverage remains low in southern member states such as Greece (10 per cent), Italy (15.6 per cent), Portugal (12 per cent) and Spain (11.4 per cent), in spite of the fact that individuals in these countries often make substantial direct payments to providers. This may be partly due to reluctance to pay a third party (Mossialos and Le Grand 1999). When 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 implications of this cultural element for the expansion of VHI in other countries with a high level of direct or informal payments, such as some Central and Eastern European states, should not be underestimated (Mossialos et al. 2002).

**Table 6 Insured individuals as a percentage of the total population in selected EU member states, 1992-1998**

Country	1992	1995	% change 95/92	1998	% change 98/95	% change 98/92
<b>Austria*</b>	36.8	34.2	-2.7	33.0	-1.2	-3.8
<b>Belgium**</b>	-	30.1	-	32.8	1.7	-
<b>Denmark</b>	25.1	24.9	-0.3	26.4	1.5	1.3
<b>France</b>	18.9	19.4	0.5	19.9	0.4	1.0
<b>Germany</b>	15.8	17.0	1.2	19.2	2.1	3.4
<b>Netherlands</b>	31.7	30.3	-1.3	30.1	-0.2	-1.5
<b>Portugal</b>	10.1	8.3	-1.8	12.2	3.9	2.1
<b>Spain***</b>	-	-	-	16.4	-	-
<b>United Kingdom</b>	11.4	11.1	-0.2	11.5	0.4	0.1

Source: CEA (Comité Européen des Assurances 2000)

\*The high figure for Austria reflects the propensity of Austrians to purchase complementary VHI covering the per diem hospital charge. However, many of these policies cover minor amounts and this type of VHI only accounted for about 11 per cent of total VHI benefits in 2000 (Hofmarcher 2001).

\*\*The high figure for Belgium may be as a result of including compulsory complementary VHI coverage offered by mutual associations, which we have not included in the figures shown in Table 5.

\*\*\*The figure for Spain includes the special schemes for civil servants, covering 5 per cent of the population, which we do not include in our definition of VHI (see Appendix A). This explains the difference between the 11.4 per cent VHI coverage shown in Table 5.

It is clear that member states' continued commitment to the principle of publicly-funded health care available to all citizens and the provision of comprehensive benefits has implicitly restricted the growth of VHI, leaving it to play a largely marginal role in funding health care in the European Union. It should be noted, however, that the demand for VHI may also be affected by the way in which insurers conduct their business. Data published by the Comité Européen des Assurances shows that between 1992 and 1998 the proportion of insured individuals declined in Austria and the Netherlands, remained largely the same in the United Kingdom and increased only slightly in Denmark, France, Portugal and Germany (see Table 6). Many of these countries experienced sustained economic growth during the same period,

but poor growth in levels of VHI coverage may be attributed to the high cost of VHI premiums in many member states.

### **1.3 The demand for VHI**

#### **1.3.1 Determinants of demand**

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 which the individual is prepared to pay (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 that illness might incur, 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 VHI in the European Union, where the state provides a high level of protection against the risk of financial loss in the event of illness, factors such as price, income and education may be more important determinants of demand than the magnitude of financial loss (at least where supplementary VHI is concerned).

Some analysts argue the performance of statutory health care systems affects the demand for VHI and that the degree and distribution of satisfaction with the statutory health care system are key determinants of the demand for VHI. It is not easy to confirm the extent to which statutory performance influences the demand for VHI, partly because it is not at all evident how best to measure the performance of a health care system, as the World Health Organisation's recent attempt demonstrates (World Health Organisation 2000, Navarro 2000, Williams 2001). The degree and distribution of satisfaction with the statutory health care system are also difficult factors to measure with accuracy, and satisfaction surveys may not be representative of citizens' views. Other often-cited indicators of performance and determinants of the demand for VHI include reductions in statutory benefits and waiting lists, although the evidence regarding waiting lists and VHI in the United Kingdom is inconclusive, as we will show below.

Evidence from the United States shows that the demand for VHI is price inelastic. Empirical studies reveal price elasticities<sup>5</sup> ranging from -0.03 to -0.54 (Marquis and Long 1995, Manning

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<sup>5</sup> Price elasticity is a measurement of the change in demand for a good or service caused by a change in the price of that good or service.

and Marquis 1989). They also show a relatively small income effect<sup>6</sup> (0.15 and 0.07 respectively), which may in part be due to the high level of tax subsidies for VHI in the United States, as well as the fact that most VHI in the United States is employment group rather than individually purchased. In 1998 tax expenditure on VHI cost the US government USD 111.2 billion (EUR 117.67 billion) and mainly benefited the rich: families with incomes of USD 100,000 (EUR 105,800) or more (10 per cent of the population) accounted for 23.6 per cent of all tax subsidies for VHI (Sheils and Hogan 1999).

A Spanish study found that the price elasticity of VHI premiums in Spain for the period 1972 to 1989 was -0.44 (Murillo and González 1993). This result is to be expected in health care systems where VHI is not heavily subsidised, but it cannot be generalised to other member states. A recent study of VHI in the United Kingdom estimated the price elasticity of VHI to be in the range of -0.003 to -0.044 (that is, highly price inelastic) (Emmerson et al. 2001). The much smaller effect of price on VHI shown in this study may be due to the fact that VHI in the United Kingdom is mostly purchased by high earners.

Very few similar studies have been conducted in different member states and we therefore have little direct evidence regarding the price or income elasticity of VHI in the European Union. Most of the information we present here concerns the characteristics of those who subscribe to VHI, although we do have some indirect evidence of the demand for VHI in the United Kingdom, which we examine in greater detail below.

### **1.3.2 Subscriber characteristics**

Data regarding the distribution of VHI coverage in the European Union show that most subscribers come from higher income groups. This is to be expected where substitutive VHI is concerned, as eligibility for this type of VHI depends on income or occupation, but complementary and supplementary VHI also reveal a strong bias in favour of higher income groups. In addition to income, determinants of the demand for VHI in the European Union include age, gender, occupational status, educational status and area of residence.

#### **Austria**

Most supplementary (hospital costs) VHI subscribers in Austria are in the higher income brackets (Hofmarcher 2001). About half of those with VHI are self-employed people and about 40 per cent are civil servants or salaried employees (Hofmarcher and Rack 2001). Self-employed people are most likely to subscribe to VHI (over 50 per cent of households, at least one individual per household), followed by 40 per cent of white-collar worker households, 32

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<sup>6</sup> Income elasticity is a measurement of the change in demand for a good or service caused by a change in the income of the individual purchasing that good or service.

per cent of blue-collar worker households and slightly over 20 per cent of farmers (Wieninger 1997). The distribution of VHI in Austria also varies substantially between regions. Individuals living in Carinthia are most likely to subscribe to VHI (over 50 per cent of the population in Carinthia), followed by individuals living in Salzburg, while only 17.5 per cent of those living in Burgenland are VHI subscribers (Hofmarcher and Rack 2001).

### **Denmark**

The demand for supplementary VHI in Denmark is fuelled by general conditions in the Danish labour market (including strong competition for employees and high levels of personal income tax) and the fact that companies benefit from tax deductions when purchasing VHI for employees (Vrangbæk 2001). Demand may also be fuelled by the critical tone of much public debate on the statutory health care system; quality and waiting times are perceived to be major problems in Denmark, although these perceptions are not always accurate or based on evidence, and insurers have been able to benefit from negative feelings about the statutory health care system (Vrangbæk 2001). Supplementary (for-profit) VHI in Denmark favours people in employment (at a certain level) as many policies are tied to job contracts, while generally having less significance for children, unemployed people, students, elderly people and people with pre-existing conditions and chronic illnesses (Vrangbæk 2001). For these reasons it introduces greater inequality in the health care system (that is otherwise unacceptable in Denmark) and stimulates the demand for private health care, which has generally been very limited (Vrangbæk 2001).

### **Finland**

In Finland children are much more likely to be covered by supplementary VHI than adults. According to a recent study based on the Finnish Health Care Surveys of 1987 and 1996, 24.8 per cent of children under the age of 7 were covered by VHI in 1996, compared to 25.7 per cent of children aged 7-17 and only 6.7 per cent of adults aged 18-64; the corresponding figures for 1987 were 36.7 per cent, 24.5 per cent and 8.9 per cent respectively (Häkkinen 2002 forthcoming).

### **France**

Access to complementary VHI in France varies according to income and social class, and those who have little or no access to complementary VHI are much more likely to be from the lowest social classes (Bocognano et al. 2000). Levels of coverage for complementary VHI are also strongly associated with employment and occupational status: employed and retired people are more likely to be covered than unemployed people, while employees and white-collar workers are more likely to be covered than unskilled workers (Sandier and Ulmann 2001). A recent study shows that 59 per cent of unskilled workers have little or no VHI, compared to only 24 per cent of executives and professionals (Bocognano et al. 2000). Another study found that 94 per cent of individuals belonging to a household with an annual

income over FRF 240,000 (EUR 36,600) and 89 per cent of employees had complementary VHI, compared to only 65 per cent of those with less than FRF 45,000 (EUR 6,850) a year and 61 per cent of unemployed people (Blanpain and Pan Ké Shon 1997).

The French system also appears to discriminate negatively against foreigners, young people aged between 20 and 24, and those over 70 years old, all of whom are less likely to be covered by VHI. Furthermore, poorer people tend to have insurance cover of a lower quality than richer people, with 28 per cent of individuals earning over FRF 240,000 (EUR 36,600) a year judging their cover to be of good quality, compared to only nine per cent of individuals with an annual household income under FRF 45,000 (EUR 6,850). This finding is strongly supported by Bocognano et al's study, which demonstrates that the level of coverage provided by VHI increases significantly with income (Bocognano et al. 2000).

Subscriber characteristics in France vary according to the type of insurer. Mutual associations are more likely to cover older people, women, employees and mid-level executives, while commercial insurers are more likely to cover farmers and self-employed professionals, and provident associations are more likely to cover unskilled workers and senior executives (Sandier and Ulmann 2001). A survey carried out by the Centre for Research and Documentation in Health Economics (CREDES) found that people aged over 65 are more likely to be covered by mutual associations than by commercial insurers or provident associations, and that people in poor health are under-represented by commercial insurers (although people with chronic illnesses are usually fully covered by the statutory health insurance scheme) (Sandier and Ulmann 2001).

### **Germany**

Substitutive VHI coverage in Germany varies considerably by income, occupational status, employment status, age, gender and area of residence. The majority of substitutive VHI subscribers are high earners (Busse 2001). According to a recent industry report, those who purchase substitutive VHI because their incomes are above the GKV contribution ceiling are mostly young and single people or married couples with double incomes (Datamonitor 2000a). Another industry report notes that substitutive VHI is growing in popularity among young and affluent Germans (Datamonitor 2000b). Only one per cent of unemployed people are covered by substitutive VHI (Busse 2001). In 1998 children accounted for 16 per cent of membership, men for 52 per cent and women for 32 per cent (PKV 1999). Data from 1992 and 1993 show that only 4.4 per cent of those with substitutive and 0.8 per cent of those with complementary and supplementary VHI were from the new Länder (PKV 1994). This discrepancy is still marked; in April 1999 overall coverage was 8.9 per cent, with 10.1 per cent coverage in the old Länder and 3.6 per cent coverage in the new Länder (Busse 2000b).

## **Greece**

Most supplementary VHI subscribers in Greece are medium to high earners aged between 35 and 45 years old; they tend to be employers, professionals, civil servants, white-collar workers and managers working for large private companies and banks and living in urban areas (Economou 2001).

## **Ireland**

The results of a recent econometric analysis of the probability of subscribing to complementary and supplementary VHI in Ireland (based on data from the 1994 Living in Ireland survey) suggest that this probability is strongly influenced by educational level attained, household income, age and marital status (Nolan and Wiley 2000). The analysis also found that poor health made an individual less likely to have VHI. VHI coverage is highest among individuals aged between 35 and 54 years old; married people are more likely to have VHI than single people; and coverage is highest for the professional and managerial social classes and those living in Dublin and lowest in small towns and rural areas (Nolan and Wiley 2000). The 1997 survey also found that the proportion of people with VHI rises significantly with household income, with coverage rising from 8 per cent of those in the bottom decile to 70 per cent of those in the top decile, so that only 15 per cent of adults with VHI are in the bottom half of the household income distribution, while about half are in the top 20 per cent (Harmon and Nolan 2001, Nolan and Wiley 2000).

An interesting finding of the 1994 survey is that those with VHI reported better health than those without VHI; only 7.7 per cent of those reporting 'very bad' health status and 11.2 per cent of those reporting 'bad' health status had VHI, whereas 89.2 per cent and 70.6 per cent, respectively, were medical card holders<sup>7</sup> (Harmon and Nolan 2001). Approximately 70 per cent of professionals and managers are privately insured, compared to only 11 per cent of semi-skilled and unskilled manual workers (Kennedy 1995).

## **Italy**

Data from the 1999 Italian Household Budget Survey of the National Institute of Statistics show that VHI is largely purchased by high-earning and highly educated people (Giannoni-Mazzi 2001). The demand for supplementary VHI varies substantially according to area of residence, with 32 per cent of insured families living in the prosperous north-eastern part of Italy and 31 per cent living in large urban centres (Databank 1999). Econometric analysis based on national survey data from 1995 shows that the probability of purchasing VHI (by individuals and groups) in Italy is positively influenced by the age of the head of the family (with a non-linear effect, 42 years old being the age at which the probability is highest), employment status (with managers and professionals having the highest probability)

education, income, and living in north east or central Italy (Lippi Bruni 2001). Individual VHI policies sold by commercial insurers are bought by medium to high-income people (but mostly by high-income people), whereas individual VHI policies sold by mutual associations generally have lower premiums and are bought by middle to low-income people (Giannoni-Mazzi 2001).

Data from a 1994 survey show that among people covered by group VHI policies, 64 per cent were high-level managers, 16 per cent were intermediate-level managers, 13 per cent were employees and 9 per cent were blue-collar workers (Giannoni-Mazzi 2001). Only 8 per cent of these policies limited coverage to individual employees; 61 per cent extended coverage to income-dependent family members and 31 per cent covered all family members. The average age of those insured by mutual associations was 44 years old between 1994 and 1997 and has increased over time; individuals aged 41-50 account for 45 per cent of those insured and individuals aged 41-60 for 70.1 per cent; 89.8 per cent of the insured were men and 10.2 per cent were women (Mastrobuono 1999).

### **Luxembourg**

According to the Conseil Supérieur de la Mutualité, the 30 to 35 per cent of the population who do not have complementary VHI are mostly foreigners who live in Luxembourg for work purposes and construction workers (largely Portuguese citizens who account for 10 to 12 per cent of the population) (Schmitz 2001).

### **The Netherlands**

Complementary and supplementary VHI accounted for 2.2 per cent of total expenditure on health care in the Netherlands in 1999 (Vektis 2000). The absence of a clear division between substitutive and complementary VHI has important consequences for data collection (Maarse 2001). The only data published concerns complementary VHI purchased by those insured under the ZFW. About 93 per cent of those insured under the ZFW purchase complementary VHI (Vektis 2000). However, as we mention above, this figure only tells us how many people purchase complementary VHI; it does not say whether they have purchased a basic or comprehensive product.

As eligibility for substitutive VHI in the Netherlands is determined by income, individuals covered by this type of VHI are relatively high earners. In 2000 28.9 per cent of the population was not covered by statutory health insurance for outpatient care, inpatient care and hospitalisation up to one year, but in 1999 only 1.25 per cent of the population (200,000 people) did not have either statutory or voluntary health insurance. According to the Public Information Office of the Dutch Ministry of Health, Welfare and Sport, most of these uninsured

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<sup>7</sup> Medical cards are issued to about a third of the population on the basis of income (people in Category I) and entitle the holder to free health care.



people were homeless; a few refused to insure themselves for reasons of principle (Ministry of Health Welfare and Sport 2000b).

### **Portugal**

Most individual supplementary VHI subscribers in Portugal are from high-income groups. Group VHI coverage depends on company policy; some companies offer VHI to all employees, while others restrict coverage to certain professional categories (Oliveira 2001). Between 1980/81 and 1989/90 expenditure on individual VHI increased for all income groups, although the increase was higher for higher income groups. According to recent survey data VHI coverage is higher among the working age population (those aged between 25 and 54 years old) (Oliveira 2001). The typical VHI subscriber is young (between 28 and 34), belongs to middle and middle to high-income groups, is a professional or self-employed and lives in urban areas (Oliveira 2001).

### **Spain**

According to the Family Budget Survey of 1998, the characteristics most commonly associated with buying complementary and supplementary VHI in Spain include area of residence, individual income, employment status and educational level (INE 1998, Rodríguez 2001). The demand for VHI Spain is highly concentrated. While the average national level of VHI coverage is 16 per cent, a quarter of the population is covered in the Balearic Islands (24 per cent), just under a quarter in Catalonia (22 per cent) and 17 per cent in Madrid (Costa and García 2000, Rodríguez 2001). Although these three regions are the richest in Spain, the association with regional income is not clear cut, since there are two or three other regions with high average incomes but very low VHI coverage (Rodríguez 2001). VHI coverage is as low as three per cent of the population in at least seven of the other regions (Asturias, Canarias, Extremadura, Galicia, Murcia, Navarra and Rioja). VHI also tends to be bought more often in urban than in rural areas.

The correlation between VHI coverage and individual income is very high, with the probability of purchasing VHI rising rapidly from middle to high income. 30 per cent of households in the highest income group purchase VHI, compared to only 3 per cent of households in the lowest income group. Employers and self-employed people are also much more likely to buy VHI than employees. Levels of VHI coverage have a strong positive correlation with the head of the family's status (in terms of education) (Lopez i Casanovas 1999), and income, education, social class and employment are found to be important in influencing the decision to take up VHI (Vera-Hernández 1999). The percentage of households that buy VHI is five times higher when the head of the household has a university degree than when s/he only has first level education.

According to most surveys the reasons given for subscribing to VHI are: faster access (to avoid waiting lists in the statutory health care system), better service (more kindness shown and more personal interaction with health personnel) and more choice (Rodríguez 2001). Hospital care in Spain enjoys considerable prestige, so when people buy VHI they are mainly trying to avoid the shortcomings of primary care in the statutory health care system. It is common for people with supplementary VHI to use VHI to gain access to ambulatory specialists, but to make use of their statutory coverage when they need to use hospital services. This is particularly true in rural and small urban areas, where good hospitals may not be so prevalent.

### **Sweden**

Purchasers of VHI in Sweden are highly likely to be private companies in the service sector. In the past group VHI used to cover top-level management (managing directors), but coverage is becoming more varied and it is now more common for companies to purchase VHI for key personnel, regardless of their formal position in the company. An even more recent trend is for companies in all sectors to purchase VHI for all their employees (Skoglund 2001).

### **United Kingdom**

The distribution of coverage for VHI in the United Kingdom is heavily skewed in favour of middle aged professionals, employers and managers based in London and the southern region. In 1995 22 per cent of professionals and 23 per cent of employers and managers were privately insured, compared to 9 per cent of intermediate and junior non-manual, 4 per cent of skilled manual and own account non-professionals, 2 per cent of semi skilled manual and personal services workers, and 1 per cent of unskilled manual workers (Laing and Buisson 1999). The proportion of employers and managers insured drops from 26 per cent aged 45 to 64 to 14 per cent aged 65 and over, probably because their employment based cover comes to an end when they reach retiring age. For intermediate and junior non-manual workers the corresponding fall is from 12 per cent to 6 per cent (Laing and Buisson 1999). This pattern of coverage has remained largely unchanged in the last decade, with very little growth among lower socio-economic groups or older people, in spite of the introduction in 1990 of tax relief on VHI premiums for individuals aged 60 and over (which was subsequently withdrawn in 1997) (Robinson 1999). Penetration by region in 1996/97 shows 11 per cent of the population covered in Greater London, 14 per cent in the rest of the South East, 10 per cent in the South West and only 4 per cent in Scotland (Association of British Insurers 2000).

In the United Kingdom it is estimated that 20 per cent of conditions, typically those with the longest NHS waiting lists, generate up to 60 per cent of claims by number (Natarajan 1996). A recent study found a positive association between longer waiting lists for NHS treatment and greater purchases of VHI, confirming the view that people link waiting lists with reduced quality of service (Besley et al. 1999). However, the association was much stronger for individual

rather than employer provided VHI, which suggests that the latter is less sensitive to the quality of the statutory health care system. This finding is important, given that rising demand for VHI in the European Union during the 1980s and early 1990s can largely be attributed to substantial growth in group policies. In addition, an earlier study showed that regions in which a relatively high proportion of the population were voluntarily insured appeared to put fewer resources into keeping waiting lists short, and that high income areas also seemed to enjoy shorter waiting lists for given VHI coverage, indicating a more complex reciprocal relationship between waiting lists and VHI (Besley et al. 1998). The studies by Besley et al are based on data taken from five years of the British Social Attitudes Survey, but because they do not address other factors that might have influenced the change in demand for VHI during that period, their results should be interpreted with some caution. A more recent study of the demand for VHI in Britain did not find a statistically significant association between demand for VHI and inpatient or outpatient waiting times overall, but did find a significant association between inpatient waiting times in 1996 and individual VHI coverage in 1998, which suggests that the individual purchase decision may be associated with previous information on the length of waiting times in the local health authority (King and Mossialos 2001 (in press)).

Further analysis of survey data reveals that while those who take out VHI are more likely to be dissatisfied with the NHS, their dissatisfaction is tied to broader socio-political values that emphasise individual responsibility, free market principles and consumer sovereignty (Calnan et al. 1993). Propper's study of the demand for VHI in the United Kingdom also stresses the importance of political belief in determining choice sets, and of income and health in determining choice between the NHS and VHI (Propper 1993). Another study finds that users of private health care, and VHI subscribers in particular, are less supportive of the equity goals of the NHS and increases in NHS spending (Burchardt et al. 1999).

Overall, the evidence regarding waiting lists and VHI in the United Kingdom is inconclusive and links between them may be tenuous given that waiting lists have continued to rise while VHI coverage has declined. Perhaps the most obvious explanation for the decline in VHI coverage is that premiums are expensive and have consistently risen above the rate of inflation. A recent report found that while 40 per cent of NHS users are worried about waiting for treatment in future years and concerned about a decline in services, the number of people subscribing to VHI is only slightly higher now than in 1990 because many subscribers think VHI cover is too expensive (BBC 2000). The replacement of full hospital coverage by health cash plans (HCP),<sup>8</sup> and the largest insurer's decision to exclude coverage of NHS pay beds

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<sup>8</sup> HCPs are very different from traditional VHI policies. Designed to pay the subscriber tax free cash benefits towards a wide range of treatments (including hospital stays, optical and dental care and some alternative treatment such as homeopathy and acupuncture), they cover a fixed percentage of treatment costs up to an annual ceiling and patients can spend the money however they like. HCPs are popular because they pay out whether subscribers use the NHS or opt for private treatment, they are generally much cheaper than VHI policies, they have no age related or regional premium differences and one premium can cover a whole family (Papworth 2000). But HCPs do not provide full protection and their cash benefit levels are unlikely to cover the full cost of private treatment.

(Buck et al. 1997), may also have contributed to the decline in VHI subscriptions in the United Kingdom.<sup>9</sup>

## **1.4 The regulatory framework for VHI in the European Union**

In recent years the regulatory framework for VHI in the European Union has become an increasingly important aspect of public policy towards VHI, largely as a result of a series of European Commission directives aimed at creating a single market for life and non-life insurance in the European Union. This section outlines recent regulatory developments at the EU level.

### **Background**

Prior to the introduction of these insurance directives, there were two main models for the supervision of insurance operations in the member states: material regulation and financial regulation (Freeman 1994). Material regulation is based on the premise that if insurers are sufficiently controlled in the type of business they write and the level of premiums at which they write, there can be no question of insolvency. This model applies in Germany, where the supervisory body scrutinises policies before they are offered for sale, restricts price competition by enforcing compulsory tariffs and only permits insurers who specialise in health insurance to operate in the field of VHI. Financial regulation, as practised in the United Kingdom, is concerned with ensuring that the insurer remains solvent; the supervisory authority's role is restricted to examining detailed financial returns on business. As a result of the introduction of European Commission's insurance directives, the focus of regulation has moved from material to financial control (Comité Européen des Assurances 1999).

The first generation of insurance directives (1973) allowed insurance companies to set up a branch office or an agency in another member state (European Commission 1973). The co-ordination of legal and financial conditions allowed authorisation to be obtained more easily. The second generation of insurance directives (1988) realised the principle of the freedom to provide services, allowing insurers to provide services in another member state without setting up a branch or agency in that member state (European Commission 1988). However, this freedom was limited to the cover of risks that were small enough not to require special protection. As a result, VHI was excluded from the freedom to provide services. The third generation of insurance directives, culminating in the third non-life insurance directive of 1992, extended the freedom to provide services to all types of risks, including those covered by VHI (European Commission 1992).

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<sup>9</sup> This decision was prompted by the 1989 NHS reforms, a key consequence of which was that the newly formed NHS trusts began to charge commercial rates for private beds, leading to problems for many insurers.

## The third non-life insurance directive

In theory the third non-life insurance directive was to be adopted by member states' national law on 1 July 1994, thereby creating a single market for VHI in the European Union and completing the process of economic integration started in the early 1970s.

Article 5 of the directive confirms EU insurers' freedom to:

- establish a branch or agency anywhere in the European Union (under the rules on establishment)
- sell their products anywhere in the European Union without a branch presence (under the rules on the freedom to provide services)

The third non-life insurance directive also introduced the following key changes:

- a single system for the authorisation and financial supervision of an insurance undertaking, including the business it carries out either through branches or under the freedom to provide services, by the member state in which the undertaking has its head office (home country control) (Article 9.1)
- financial supervision includes verification of an insurer's state of solvency, of the establishment of technical provisions and of the assets covering them in accordance with the rules laid down or practices followed in the home member state under provisions adopted at Community level (Article 9.2)
- the abolition of national controls on premium prices and prior notification of policy conditions (Articles 29 and 39)

Article 29 of the directive states that "member states shall not adopt provisions requiring the prior approval or systematic notification of general and special policy conditions, scales of premiums, or forms and other printed documents which an insurance undertaking intends to use in its dealings with policy holders. They may only require non-systematic notification of those policy conditions and other documents for the purpose of verifying compliance with national provisions concerning insurance contracts, and that requirement may not constitute a prior condition for an undertaking's carrying on its business. Member states may not retain or introduce prior notification or approval of proposed increases in premium rates except as part of general price-control systems" (European Commission 1992). Article 39 applies this rule to member states of the branch or provision of services.

The case law of the European Court of Justice (*José García and others v Mutuelle de Prévoyance Sociale d'Aquitaine and others*) demonstrates that insurance monopolised by a member state's social security system falls outside the scope of the third non-life insurance directive (European Court of Justice 1996). The directive applies to all other insurance and does not distinguish between for-profit and non-profit insurers.

## The general good

Governments are no longer allowed to apply material regulation in the insurance sector, as this could impede competition between insurers. Consequently, consumer protection has been reduced to financial safeguards against the negative consequences of insolvency. However, under certain circumstances, a member state may invoke the 'general good' to justify national regulation. Article 54.1 states that "notwithstanding any provision to the contrary, a member state in which contracts covering [health risks] may serve as a partial or complete alternative to health cover provided by the statutory social security system may require that those contracts comply with the specific legal provisions adopted by that member state to protect the general good in that class of insurance, and that the general and special conditions of that insurance be communicated to the competent authorities of that member state before use".

Recital 24 to the directive indicates the type of measure that a member state might take in order to protect the general good, noting that "whereas to this end some member states have adopted specific legal provisions; whereas, to protect the general good, it is possible to adopt or maintain such legal provisions in so far as they do not unduly restrict the right of establishment or the freedom to provide services, it being understood that such provisions must apply in an identical manner whatever the home member state of the undertaking may be; whereas these legal provisions may differ in nature according to the conditions in each member state; whereas these measures may provide for open enrolment, rating on a uniform basis according to the type of policy and lifetime cover; whereas that objective may also be achieved by requiring undertakings offering private health cover or health cover taken out on a voluntary basis to offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes; whereas, as a further possibility, it may be required that the technical basis of private health cover or health cover taken out on a voluntary basis be similar to that of life assurance" (European Commission 1992).<sup>10</sup>

What this seems to suggest is that where VHI substitutes for statutory health insurance, constituting the principal means of protection for some sections of the population, the government may invoke the general good in order to adopt or maintain regulations to protect the public interest, in so far as they do not unduly restrict the right of establishment or the freedom to provide services.

The concept of the general good is based on the case law of the European Court of Justice, which has never actually defined the general good, preferring to maintain its evolving nature (European Commission 2000a). For this reason, the concept is not defined by the third non-

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<sup>10</sup> Since the recitals to a directive have legal force as an aid to interpretation, they shed light for the reader on the intentions of the Community legislator.

life insurance directive either. The absence of a clear definition has led to confusion and tension between the European Commission, member states and insurance companies (Comité Européen des Assurances 1997, Mossialos and Le Grand 1999).

In 2000 the European Commission issued an interpretive communication regarding the general good (European Commission 2000a). The communication analyses the concept of the general good as developed by the case law of the European Court of Justice and systemises this doctrine and the ways in which it is applied to the freedom of establishment and the freedom to provide services. It also maps out the framework within which a host member state can invoke the concept of the general good in order to enforce compliance with its own rules by an insurance undertaking wishing to conduct insurance business within its territory, either through a branch or through the freedom to provide services. An insurance undertaking operating through a branch or under the freedom to provide services that is required by a host member state to comply with a national rule that, in its view, constitutes a restriction, may challenge the application of that measure if it considers that one of the following six criteria is not met. In order to be justified on grounds of the general good, a national measure (European Commission 2000a):

- must not have been the subject of prior Community harmonisation
- must not be discriminatory
- must be justified for imperative reasons relating to the general good (such as consumer protection, prevention of fraud, cohesion of the tax system and worker protection)
- must be objectively necessary
- must not duplicate home country rules
- must be proportionate to the objective pursued

The communication notes that the directive does not define the general good in order to make it possible to assess the conformity with Community law of a national measure that is taken in a non-harmonised area at Community level and hinders freedom of establishment and freedom to provide services. In non-harmonised areas the level of what is regarded as the general good depends first on the assessment made by the member states and can vary substantially from one country to another according to national traditions and the objectives of the member states. It is necessary, therefore, to refer to the relevant case law of the Court of Justice. In spite of this attempt to clarify when and how the general good might be invoked by member states, insurers continue to express dissatisfaction with what they regard as a lack of clarity (see Section 5.3.3) (Comité Européen des Assurances 2001b, BUPA Limited 2001).

## **Further implications of the third non-life insurance directive**

While harmonisation initiatives appear to be a necessary prerequisite for the creation of a single market in insurance, they may pose problems for member states that attempt to reach a compromise between deregulation and consumer protection. Home country control effectively removes the right of member states to operate material regulation in the insurance sector. Furthermore, the risk of reserve discrimination could put pressure on strictly regulated countries to reduce their regulatory constraints, resulting in harmonisation towards the lowest common denominator. Home country control also raises the issue of regulatory capacity: to what extent are supervisory authorities able to monitor the activities of insurers from third countries?

According to the European Commission, the ultimate objectives of a single market are to provide consumers with a greater choice of insurance products and to increase competition between insurance companies (European Commission 1997). The third non-life insurance directive outlawed price and product regulation in the expectation that competition would benefit the consumer by lowering prices and increasing choice, but to date there is no clear evidence to suggest that this expectation has been fulfilled. The European Union's current approach to regulating the market for VHI centres around financial solvency. However, given the failures inherent in VHI markets (Barr 1992), it could be argued that relying on the market to determine the best degree of regulation runs contrary to the objective of a stable and sound financial system. The implications of the third non-life directive are discussed further in Section 5.3.



## Section 2: The market for VHI in the European Union

This section aims to:

- present a classification of the different types of VHI available in the European Union
- describe (in some detail) the operation of substitutive VHI in Belgium, Germany and the Netherlands
- describe the benefits provided by complementary and supplementary VHI
- examine the structure of the market for VHI, in terms of types of insurer and buyer characteristics
- examine the conduct of VHI markets, in terms of premium-setting, selection criteria, policy conditions and the provision of benefits
- examine subscriber's costs (the price of premiums and the influence of tax incentives)
- examine insurers' costs (claims and administrative expenditure)

We must emphasise that VHI systems operate differently in different member states. The comparative information and data we present should therefore be interpreted in the context of the systems to which they relate.

### 2.1 Types of VHI in the European Union

In this section, our discussion of the way in which substitutive VHI operates in Belgium, Germany and the Netherlands attempts to be comprehensive because the examination of market structure and conduct that follows mainly focuses on complementary and supplementary VHI. Some of the information we present in those sections refers to all three types of VHI (substitutive, complementary and supplementary), while some refers exclusively to complementary and supplementary VHI. Where possible we have tried to distinguish clearly between substitutive VHI on one hand and complementary and supplementary VHI on the other, but it is not always possible to separate data in this way. There seems to be less information available on complementary and supplementary VHI in Germany and the Netherlands, perhaps because substitutive VHI is so extensive in these member states.

VHI can be classified in many different ways, as demonstrated by the numerous definitions in current usage. Traditionally, the literature on VHI has distinguished between insurance that *duplicates* statutory insurance and insurance that constitutes the *principal* means of protection for sections of the population (Couffinhal 1999). In the context of the European Union we find it more appropriate to classify VHI 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)

- provides *supplementary* cover for faster access and increased consumer choice

### 2.1.1 Substitutive VHI

Substitutive VHI in the European Union is limited to specific population groups in a handful of member states<sup>11</sup>. It may be purchased by:

- those who are *excluded from participating* in some or all aspects of the statutory health insurance scheme
- those who are *exempt from contributing* to the statutory health insurance scheme because they are allowed to opt out of it

Eligibility for substitutive VHI may be determined by income (Germany and the Netherlands), employment status (the self-employed in Austria, Belgium and Germany) or occupation (certain professions in Austria).

The following groups of people are excluded from participating in the statutory health insurance scheme:

- The Netherlands: individuals earning over EUR 30,700 per year (in 2002) are excluded from the statutory health insurance scheme covering outpatient care and the first year of inpatient care (28.9 per cent of the population in 1999) (Vektis 2000)
- Belgium: self-employed people are excluded from statutory health insurance covering minor risks
- Germany: self-employed people are excluded from the statutory health insurance scheme unless they have been a member previously, with the exception of those who fall under compulsory statutory cover, such as farmers
- Germany: active and retired civil servants are excluded from the statutory health insurance scheme as they are directly reimbursed by the government for most of their health care and only need VHI to cover the remainder; they therefore purchase complementary rather than substitutive VHI
- Spain: 1 per cent of the population is not covered by the statutory health care system (for example, lawyers practising independently); in 1998 about 60 per cent of these individuals purchased substitutive VHI (accounting for 6 per cent of VHI expenditure); according to survey data, those who purchase substitutive VHI tend to have high incomes and high levels of education (Rodríguez 2001)
- France: substitutive VHI is only purchased by a few hundred frontier workers (Sandier and Ulmann 2001)

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<sup>11</sup> AIM defines substitutive VHI as VHI “to cover medical expenses for persons excluded or exempted from statutory protection” (Association Internationale de la Mutualité 2001). CEA notes that substitutive VHI “is only found in member states where health insurance operates entirely or partly in lieu and place of social security schemes” (Comité Européen des Assurance 2001b).

The following groups of people are exempt from contributing to the statutory health insurance scheme if they choose to opt out of it:

- Germany: employees earning over EUR 40,000 per year (about 20 per cent of the population) (Busse 2001)
- Austria: since the social security law was amended in 1999, certain groups of self-employed people (such as veterinary doctors, notaries and priests) are allowed to opt out of the statutory health insurance scheme if their relevant professional organisation can purchase substitutive VHI for them; to date the numbers covered by this type of VHI are small (only 0.2 per cent of the population) (Hofmarcher 2001)

Substitutive VHI in Austria, France and Spain is marginal and will not be discussed further in this study. It is available to much larger sections of the population in Belgium (9.5 per cent), Germany (about 20 per cent) and the Netherlands (about 28.9 per cent). Substitutive VHI in these member states will be discussed in some detail below.

### **Substitutive VHI in Belgium**

The statutory health insurance scheme in Belgium (Rijksinstituut voor ziekte en invaliditeitsverzekering / Institut National d'Assurance Maladie Invalidité; RIZIV-INAMI) does not cover self-employed people for 'minor risks'. Minor risks are defined as outpatient care such as visits to a general practitioner or specialist, drugs, nursing care, most types of physiotherapy, dental care and minor operations (Association Internationale de la Mutualité 1999).

Self-employed people make up 9.5 per cent of the Belgian population. If these self-employed people want cover for minor risks, they must purchase substitutive VHI. Substitutive VHI to cover minor risks for the self-employed can be provided by mutual associations (mutualités) or commercial insurers, but to date all substitutive VHI is provided by mutual associations. Mutual associations currently provide substitutive VHI cover to 742,552 self-employed people (76 per cent of self-employed people and 7.1 per cent of the population) (Hermesse 2001). The remaining 24 per cent of self-employed people without substitutive VHI cover must pay out-of-pocket for treatment (for minor risks). It has been suggested that these individuals do not purchase substitutive VHI because they are young and healthy and/or because they are either wealthy or too poor to afford it (Hermesse 2001).

There are two key differences in the way in which mutual associations and commercial insurers offer substitutive VHI (Hermesse 2001):

- the benefits provided by mutual associations are clearly defined by the state; mutual associations are obliged to cover all the minor risks excluded by RIZIV-INAMI, whereas the commercial insurers are not

- mutual associations receive subsidies from the state for this type of VHI, whereas the commercial insurers do not; these state subsidies are designed to facilitate access to substitutive VHI for self-employed people

There is no variation in the content of cover provided by different mutual associations. Self-employed people enjoy exactly the same benefits as those provided by RIZIV-INAMI, which means that they are subject to the same co-payments. However, different mutual associations are allowed to charge different premiums, enabling a degree of price competition to take place. The price of premiums may depend on factors such as age, household size, number of dependants, employment status and length of employment. Premiums may vary as follows (Hermesse 2001):

- premiums for a single person of 25 years insured from the age of 20 vary from BEF 690 (EUR 17) to BEF 2,390 (EUR 59) per month
- premiums for the head of a family with three dependants and insured from the age of 20 vary from BEF 1,315 (EUR 33) to BEF 3,390 (EUR 84) per month
- premiums for the retired 70-year old head of a family with spouse and insured from the age of 40 vary from BEF 1,315 (EUR 33) to BEF 3,600 (EUR 89) per month

Premiums may be adapted once a year by the mutual associations' competent authorities. Only self-employed people under the age of 50 can purchase substitutive VHI. Some mutual associations require potential subscribers to complete a medical questionnaire.

Commercial insurers have more freedom than mutual associations to define the level of cover and the reimbursement rate they offer self-employed people. For example, one commercial insurer offers a reimbursement rate equal to 80 per cent of RIZIV-INAMI's tariffs (Hermesse 2001). Dental care may be an optional extra, while some commercial insurers offer cover for treatment beyond the scope of minor risks, such as acupuncture and homeopathy. Premiums vary according to the age and gender of the insured.

In January 2001 a working group of senior government officials led by an academic was set up to examine the social security status of self-employed people in Belgium. This group proposed that self-employed people should either be covered by the statutory health insurance scheme for minor risks or obliged by law to purchase substitutive VHI (Cantillon 2001).

### **Substitutive VHI in Germany**

Health care in Germany is largely funded through social security contributions by employers and employees and provided by the statutory health insurance scheme (Gesetzliche Krankenversicherung; GKV).

Substitutive VHI can be purchased by two groups:

- self-employed people who are excluded from the GKV (unless they have been a member previously), with the exception of those who fall under compulsory GKV cover, such as farmers
- employees earning over the GKV contribution ceiling, which has been index-lined to the contribution ceiling for pensions since 1971; in 2001 the GKV contribution ceiling was DEM 6,525 (EUR 3,336) per month in the old and the new Länder (that is, the western and eastern parts of the country), but prior to 2001, the ceiling was approximately DEM 1,000 (EUR 511) lower in the new Länder (PKV 2000)

### **Market features**

Substitutive VHI in Germany is provided by 52 voluntary health insurers united in the German Association of Private Health Insurers (Verband der privaten Krankenversicherung; PKV). All of these insurers are specialist health insurers; substitutive VHI is prohibited by law from being sold in conjunction with any other type of insurance.

### **The demand for substitutive VHI in Germany**

Employees earning over EUR 40,000 a year (about 20 per cent of the population) have a choice: they can opt out of the GKV and purchase substitutive VHI instead or they can stay where they are and continue to be covered by the GKV (Busse 2000a). Fewer than a quarter of these employees actually choose to opt out and purchase substitutive VHI; the vast majority (77 per cent) prefer to stay with the GKV. Although the GKV covers 88 per cent of the German population, 16 per cent of its members (equivalent to about 14 per cent of the population) are voluntary members – high-earning employees who have chosen not to opt out and purchase substitutive VHI (Busse 2000a).

The total number of people with substitutive VHI has risen from 4.2 million people in 1975 to 7.3 million in 1999 (9 per cent of the population) (PKV 2000). The number of people covered by substitutive VHI increased by 16 per cent between 1991 and 1999. About half of the increase resulted from people in the new Länder subscribing to substitutive VHI for the first time (as coverage was not available before 1991); the increase in the old Länder was much less pronounced (from about 9 to 10 per cent of the population) (Busse 2001).

About half of all those with substitutive VHI belong to the second group of high-earning employees; the rest are self-employed people (and active or retired civil servants, who only claim complementary benefits, but are included in the official figures for people covered by substitutive VHI). In 1999, children (up to and including 15 years of age) accounted for 15.3 per cent of those with substitutive VHI, men for 52.7 per cent and women for 32 per cent (PKV 2000). Substitutive VHI coverage also varies by geographical area; data from 1992 and 1993 show that only 4.4 per cent of those with substitutive VHI (and 0.8 per cent of those with complementary and supplementary VHI) were from the new Länder (PKV 1994). This

discrepancy is still marked; in April 1999 overall coverage was 8.9 per cent, with 10.1 per cent coverage in the old Länder compared to only 3.6 per cent coverage in the new Länder (Busse 2000b). Almost all substitutive VHI policies are purchased by individuals rather than by groups.

### **Selection procedures**

Substitutive VHI premiums are calculated according to the extent and level of cover required, in addition to risk, age at entry, gender and health status at the time of underwriting. 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 (Busse 2001).

### **Benefits provided**

In order to obtain comprehensive coverage, the individual opting for substitutive VHI may have to buy several different policies, as outpatient and dental benefits can be offered separately from inpatient benefits. So while individuals with substitutive VHI usually enjoy the same benefits as those insured by the GKV, their level of cover depends on the policies they buy (Busse 2001). It should be noted that because voluntary health insurers operate in direct competition with the public sector, substitutive VHI policies cover more than one type of insurance and may result in improved amenities, faster access and greater choice of provider.

### **Policy conditions**

Whereas the GKV automatically covers dependants, substitutive VHI policies can only be bought by individuals; dependants must buy separate policies and pay separate premiums. This makes family size a critical factor when choosing between statutory or voluntary health insurance (Schneider et al. 1992, Schneider 1995). As a result, substitutive VHI is more attractive to young people without dependants (Busse 2000a), which leaves the GKV to insure a disproportionately high number of elderly people, people with large families and people in poor health (Rupprecht et al. 2000).

### **Premiums**

Employers are allowed to contribute up to 50 per cent of employees' premiums (as in the GKV), but this contribution is limited to the average maximum GKV contribution, so that the insured individual bears the cost of any extra benefits (Bundesaufsichtsamt für das Versicherungswesen 2001, Busse 2001). Employers can only contribute to substitutive VHI policies offered by insurers that specialise in health.

The German government requires voluntary health insurers to operate on a technical basis similar to that of life insurance. This involves setting up ageing reserves (with the specific aim of preventing premiums from increasing with age) and effectively prohibits insurers from

terminating contracts. As a result, substitutive VHI premiums should not increase as people get older. However, an adjustment clause allows voluntary health insurers to increase premiums where there is a discrepancy between the costs used as a basis for calculating premiums and the actual costs of providing benefits, and in the past this has led to steep increases in premiums as people have aged.

Although the voluntary health insurers' main marketing strategy is to highlight the better facilities they provide, many people regard substitutive VHI as expensive compared to the GKV (Natarajan 1996). This is not surprising, given that gross written VHI premiums (for all types of VHI, including substitutive, long-term care, loss of earnings, hospital daily allowance and complementary and supplementary) grew in real terms at a compound annual growth rate of 5.2 per cent between 1993 and 1999, a trend that is expected to continue to 2004 (Datamonitor 2000a, Datamonitor 2000b). Between 1994 and 1998 total expenditure on health care grew at the much slower average annual rate of 2.7 per cent (deflated by the GDP deflator) (see Table 15) (Organisation for Economic Co-operation and Development 2000). Since 1994 the real compound annual growth in premiums for substitutive VHI has been lower, at 2.9 per cent, compared to a growth rate of 8.8 per cent for all other types of VHI (Datamonitor 2000b). According to an industry report, this is primarily due to the fact that many voluntary health insurers were forced to subsidise premium increases with their own reserves, in order to continue to attract new business, rather than raising existing premiums too high and risking the adverse publicity that surrounded the market in the early to mid 1990s, when voluntary health insurers came under fire for charging unreasonable premiums for older subscribers (Datamonitor 2000b).

### **Tax incentives**

VHI premiums are deductible from taxable income, as are other insurance premiums, within certain limits. However, they do not provide a strong incentive to purchase VHI as the limits are lower for individuals with substitutive VHI (that is, the limits decrease as income rises) and individuals interested in purchasing complementary or supplementary VHI will have exceeded the limit as a result of their GKV contributions.

### **Reimbursement**

Substitutive VHI provides benefits in cash rather than in kind and voluntarily insured people generally have to pay providers directly and are subsequently reimbursed by their insurer (Bundesaufsichtsamt für das Versicherungswesen 2001). Voluntary health insurers also offer a range of reimbursement options to reduce levels of coverage; voluntarily insured individuals may have the option of full reimbursement (100 per cent) or different rates of co-insurance, and some outpatient policies offer a range of deductibles (Datamonitor 2000b).

## **Expenditure**

Although insurers argue that the cost transparency associated with paying patients in cash rather than in kind encourages a more 'responsible' attitude to claims for medical benefits (Schneider 1995, Comité Européen des Assurances 1997), it has not stopped health care costs in the substitutive VHI sector from rising. Over the last 10 years, expenditure for individuals with substitutive VHI has increased on average by 40 per cent more than expenditure for those in the GKV, and by almost two or three times as much for ambulatory care, dental care and pharmaceuticals and (Busse 2000a). A likely explanation for this additional growth in VHI expenditure may be that providers are allowed to charge their voluntarily insured patients 1.7 or 2.3 times the reimbursement values set in the price list for private medical services issued by the Federal Ministry for Health (and sometimes even more) (Busse 2000a). Charging extra may reduce access for some patients, although providers are no longer permitted to charge more than 1.7 times extra for individuals with the 'standard rate' (Bundesaufsichtsamt für das Versicherungswesen 2001).

## **Public policy and regulation**

The German government has been forced to make substantial interventions in the market for substitutive VHI. High premium increases for older subscribers put considerable pressure on the GKV in the early 1990s, as people would opt for substitutive VHI when they were young and then attempt to return to the GKV when their substitutive VHI premiums became too expensive (either due to increasing age or ill health) (Wasem 1995). In 1994 the government took action to put a stop to this trend, announcing that the decision to opt for substitutive VHI would be irreversible for those aged 65 and over, even if their incomes dropped below the contribution ceiling (Busse 2000a). The recent Reform Act of Social Health Insurance 2000 tightened the rules even further by reducing the age limit for returning to the GKV to 54 (Comité Européen des Assurances 2000).

At the same time (1994) the government required voluntary health insurers to offer substitutive VHI policies at a standard rate (Standardtarif) to individuals aged 65 and over who had been voluntarily insured for a qualifying period of at least 10 years and (since 2000) a standard rate for individuals aged 55 and over who have been voluntarily insured for at least 10 years and whose incomes drop below the contribution ceiling. This standard rate provides benefits that match the benefits of the GKV and guarantees that premiums will not exceed the average maximum GKV contribution (or 1.5 times the contribution for married couples) (Comité Européen des Assurances 1997). To date, however, very few people have chosen this option (only 1,161 people in 1998 and 1,407 in 1999) (PKV 2000).

In 2000 the government also tackled the problem of inaccurate premium calculations and inadequate ageing reserves. Since 1 January 2001 a surcharge of up to 10 per cent of the gross premium has been imposed on all new substitutive VHI policies and paid into a shared



risk pool (for each insurer) (Datamonitor 2000a). Existing subscribers need to pay an additional two per cent a year for five years (Datamonitor 2000b). By paying this surcharge subscribers can ensure that the cost of their premiums will not rise when they reach the age of 65. New subscribers who choose not to pay the surcharge risk paying substantially increased premiums as they grow older. The law also stipulates that the surplus obtained by applying the technical interest rate to the extra funds received through this surcharge is to be credited to the insured and used to limit premium increases in older age (Bundesaufsichtsamt für das Versicherungswesen 2001). One side effect of the requirement to accumulate ageing reserves is that voluntarily insured individuals have little incentive to change insurer, as reserves cannot be transferred from one insurer to another, which means that those who do switch insurer face a higher entry premium with the new insurer (Busse 2001).

In order to enhance consumer protection, the Reform Act of Social Health Insurance 2000 stipulates that voluntary health insurers must inform potential substitutive VHI subscribers of the likelihood of increasing premiums, the possibility of limiting the increase in premiums with old age and the irreversibility of the decision to opt out of the GKV (Comité Européen des Assurances 2000, Bundesaufsichtsamt für das Versicherungswesen 2001). Voluntary health insurers are also required to inform policy holders of the possibility of switching to another tariff category when their premiums go up and to advise policy holders aged 60 or over to switch to the standard tariff or to switch to another tariff category that includes the same benefits for a lower premium (Bundesaufsichtsamt für das Versicherungswesen 2001).

Since the third non-life Directive of 1992, the government is no longer obliged to approve VHI premiums or policy conditions. However, the government still requires the general policy conditions for substitutive VHI to be submitted to the Federal Supervisory Office for the Insurance Sector (under the authority of the Federal Ministry of Finance) before they are implemented and every time there is an amendment. The supervisory authority checks that the conditions comply with the minimum standard laid down in the Law on the Supervision of Insurance Undertakings and other regulations concerning the general interest for this insurance class. The obligation to submit insurance conditions applies equally to insurance undertakings registered in Germany and foreign undertakings wishing to offer substitutive VHI in Germany. Insurance undertakings registered in Germany must also submit their premium calculations to the Federal Supervisory Office for the Insurance Sector, which checks that the calculation complies with the legal provisions on calculations designed to ensure that the interests of the insured are protected and that obligations arising under contracts taken out for life can be fulfilled. Any modifications in policy conditions and premiums must be agreed by an independent trustee.

## **Substitutive VHI in the Netherlands**

### **Health insurance in the Netherlands**

The Dutch health care system operates on three levels (Ministry of Health Welfare and Sport 2000a).

The first level is a universal statutory scheme for exceptional medical expenses (known as Algemene Wet Bijzondere Ziektekosten; AWBZ), which provides benefits in kind to all those resident in the Netherlands for expensive, uninsurable, long-term care such as nursing care in hospitals (after the first 365 days) and nursing homes, mental health care and care for the disabled. This scheme is implemented by statutory sickness funds and voluntary health insurers. The level of benefits provided and the income-related contribution rate are set by the state.

The second level of the Dutch health care system (known as Ziekenfondswet; ZFW) comes under the Health Insurance Act, which automatically insures all those who meet the eligibility criteria. The ZFW covers the first year of hospital care, physician services, prescription drugs and some physiotherapy and basic dental care (again, in kind). This scheme is implemented by statutory sickness funds. The eligibility criteria, the level of benefits provided and the income-related contribution rate are set by the state, although the statutory sickness funds are allowed to set their own additional flat rate premium. The following groups are eligible for the ZFW (Ministry of Health Welfare and Sport 2000a):

- resident employees up to the age of 65 earning less than a certain amount (EUR 30,700 in 2002)
- residents living on state benefits
- self-employed people up to the age of 65 (since 2000) who are insured under the Incapacity Insurance (Self-Employed Persons) Act (WAZ) and whose taxable income is less than NLG 41,200 (EUR 18,700 in 2000) per year
- those who are covered by the Act when they reach 65 can remain covered under the 'stay where you are' principle, while those who are not covered by it when they reach 65 can join it on a voluntary basis if their annual household income is below a certain level

Level three of the Dutch health care system consists of complementary and supplementary VHI.

### **The demand for substitutive VHI in the Netherlands**

Individuals earning over EUR 30,700 per year are not eligible for the ZFW and may purchase substitutive VHI instead if they wish to. Although it is not compulsory for these individuals to take up VHI, most of them do. In 2000, only 1.6 per cent of the population did not have either statutory or voluntary health insurance; according to the Public Information Office of the Dutch Ministry of Health, Welfare and Sport, most of these uninsured people were homeless, while a

few refused to insure themselves for reasons of principle (Ministry of Health Welfare and Sport 2000b). Some civil servants are also excluded from the ZFW; they are covered by a separate statutory health insurance scheme (Publiekrechtelijke ziektekos-tenverzekering; PKV), which closely resembles the ZFW (Maarse 2001).

In 2000 24.7 per cent of the population purchased substitutive VHI, down from 27.2 per cent in 1990 (see Table 7) (Vektis 2000). The size of the market for substitutive VHI is very sensitive to developments in the ZFW. For example, if the ZFW's eligibility criteria are widened, the market for substitutive VHI shrinks correspondingly. Substitutive VHI is purchased by individuals and by groups. The market for group policies purchased by companies has grown rapidly over the last decade and it is estimated that currently more than 50 per cent of policies are purchased by groups.

**Table 7 The proportion of the population covered by statutory and voluntary health insurance schemes in the Netherlands in 1990 and 2000 (%)**

Health insurance scheme	1990	2000
AWBZ	100.0	100.0
ZFW	61.5	64.6
Substitutive VHI	27.2	24.7
WTZ	5.1	4.2
PZV	5.6	4.9
Uninsured people	1.6	1.6

Source: Vektis (Vektis 1993, Vektis 2000)

### **The WTZ scheme**

The Dutch Health Insurance (Access) Act of 1986 (known as Wet op de Toegang tot Ziektekostenverzekeringen; WTZ) was adopted following the abolition of two voluntary ZFW schemes (one for the elderly and the other for self-employed people) due to large deficits. The WTZ guarantees access to substitutive VHI for specific groups of people. It was originally designed for individuals with substitutive VHI aged over 65 and younger self-employed people who had difficulty in purchasing substitutive VHI due to pre-existing conditions, but it currently also covers other groups, such as students whose parents are in the ZFW. The Act enables the government to determine the level of benefits and the price of a fixed premium for a 'standard package policy' that provides similar benefits to the ZFW. In 1999 this premium was fixed at NLG 2,500 (EUR 1,135) per year for those aged under 65 and NLG 2,809 (EUR 1,275) for those aged 65 and over (Vektis 2000). Unlike statutory cover, however, standard package policy cover does not extend to the insured individual's dependants, who must be separately insured. Another essential difference from the ZFW is that costs are reimbursed rather than paid for directly (Ministry of Health Welfare and Sport 2000a). In 2000 4.2 per cent of the population was covered by the WTZ (see Table 7).

Children under the age of 18 and children between the ages of 18 and 27 who are studying and who are included in the policy of the principal policyholder pay only half the amount paid by the main policyholder.

The WTZ is implemented by voluntary health insurers. Because the fixed WTZ premium only covers half the cost of providing the standard package policy, insurers receive full compensation from a central equalisation fund financed by an annual solidarity payment made by all those with substitutive VHI. This payment is currently fixed at EUR 117.12 per year for children up to the age of 19 or EUR 234.24 for individuals aged 20 to 64.

Since 1985 substitutive VHI has lost 17 per cent of market share to the WTZ. However, this loss of market share has actually benefited voluntary health insurers, because they have tended to encourage high risk individuals to opt for the WTZ (which they also implement), and until recently the costs of providing health care to all those insured under the WTZ were subsidised by the central equalisation fund. As a result, the level of financial risk borne by voluntary health insurers has been extremely low. The government recently reduced insurers' financial incentive to push high risks into the WTZ by making them liable for the full cost of providing health care to WTZ members under the age of 65 (that is, the costs of providing health care to those aged under 65 can no longer be subsidised by the central equalisation fund).

### **The MOOZ scheme**

The ZFW insures a disproportionately high number of elderly people (see Table 8). In order to compensate for this, all those with substitutive VHI are required to make an annual solidarity payment to the ZFW of: EUR 40.80 (0 to 19 years), EUR 81.60 (20 to 64 years) or EUR 65.28 (65+) (Ministry of Health Welfare and Sport 2000a). This is known as the MOOZ scheme.

**Table 8 Age distribution in the ZFW, substitutive VHI and the WTZ in 2000**

	<b>Population</b>	<b>ZFW</b>	<b>Substitutive VHI + WTZ</b>
0-19	24.4	21.3	30.9
20-64	62.0	63.4	59.0
65+	13.6	15.2	10.1

Source: Vektis (Vektis 2001)

### **Market features**

Voluntary health insurers in the Netherlands operate on a non-profit or commercial basis. Some of them specialise in health insurance, while others are part of larger insurance conglomerates offering other types of insurance. Voluntary health insurers incurred substantial deficits in 1999 and 2000 of NLG 436 million (EUR 198 million) and NLG 471 million (EUR 214

million) respectively; VHI is often sold as a loss leader, to enable insurers to market other, more lucrative insurance products (Vektis 2000).

### **Benefits provided**

Voluntary health insurers are free to determine the substitutive VHI benefits they provide and are not required to offer a standard package. In general, however, the benefits they provide are very similar to those provided by the ZFW. Developments in the statutory health care system are important to the market for VHI. Any change in the benefits provided by the ZFW is usually followed by a change in the benefits provided by substitutive VHI. For example, when prescription drugs were moved from the ZFW to the AWBZ in the early 1990s, as part of the Simons reform, voluntary health insurers reacted immediately, by removing prescription drugs from their benefit package. When this measure was cancelled in 1993, voluntary health insurers followed suit and added prescription drugs to their package. All substitutive VHI packages cover general practitioner care.

### **Selection procedures**

Premiums for individual subscribers are rated according to individual risk. Applicants must complete a medical questionnaire that includes questions about family history of disease. Group rating is applied to premiums for groups. Risk rating does not apply to applicants who purchase a policy from the sickness fund with whom they were insured under the ZFW (that is, before they became ineligible for ZFW cover). Applicants refused substitutive VHI cover can obtain cover through the WTZ.

There is little information regarding risk selection by voluntary health insurers, but risks may be selected by targeting groups, by selective marketing and by restricting entry to high risks and encouraging them to join the WTZ instead. Until recently, voluntary health insurers encouraged high risk individuals to switch to the WTZ on a large scale, but the government has now reduced the financial incentive to do this, by making insurers liable for the full cost of providing health care to WTZ members under the age of 65 (that is, the costs of providing health care to those aged under 65 can no longer be subsidised by the central equalisation fund) (see above).

### **Policy conditions**

Voluntary health insurers cannot terminate policies or raise premiums on the basis of an individual's health care consumption, although policies are automatically terminated when subscribers reach the age of 65 and move to the WTZ. As subscribers age or fall ill, they become 'locked in' to their current substitutive VHI policy. Moving from one insurer to another becomes an unrealistic option because the new insurer is likely to charge much higher premiums. If an individual's substitutive VHI premium has been higher than the WTZ premium for three consecutive years, s/he has the right to move to the WTZ. Although subscribers have

access to information about price and policy conditions, comparison can be difficult and the VHI market as a whole is considered to be opaque (Maarse 2001).

### **Premiums**

Premiums tend to rise with age. The average annual substitutive VHI premium per insured in 1999 was NLG 1,538 (EUR 698), although premiums vary substantially (Vektis 2000). The annual fixed WTZ premium was NLG 2,809 (EUR 1,275) for those aged 65 and over, and NLG 2,500 (EUR 1,135) for those under 65 years old. This compares to average annual income-related contributions of NLG 1,784 (EUR 810) in the AWBZ and NLG 2,095 (EUR 950) in the ZFW (including an average annual flat-rate payment of NLG 316 (EUR 145)) (Vektis 2000).

In addition to their annual premium, individuals with substitutive VHI are required to make two annual solidarity payments, one of EUR 117.12 (under 20 years) or EUR 234.24 (20 to 64 years) to the WTZ and another of EUR 40.80 (under 20 years), EUR 81.60 (20 to 64 years) or EUR 65.28 (65+) to the MOOZ scheme (see above) (Vektis 2000).

### **Tax incentives**

Expenditure on health care, including premiums, can be deducted from taxable income once it exceeds a certain percentage of income, but the percentage is set relatively high, so that in practice the tax incentive is not significant.

### **Reimbursement**

Substitutive VHI uses the reimbursement model of providing benefits in cash rather than in kind, although in practice most voluntary health insurers provide some benefits in kind, as a special service to their subscribers. Voluntary health insurers also offer a range of reimbursement options in terms of deductibles. Most voluntary health insurers require their subscribers to obtain a general practitioner's referral before visiting a specialist.

### **Expenditure**

Substitutive VHI and the WTZ accounted for 13.7 per cent of total expenditure on health in 1999. The largest share of expenditure was borne by the AWBZ (43.6 per cent), followed by the ZFW (37.6 per cent) (Vektis 2000). In 1999 annual per capita health care expenditure was NLG 1,771 (EUR 804) in the AWBZ, NLG 2,487 (EUR 1,129) in the ZGW and NLG 1,755 (EUR 796) for substitutive VHI and the WTZ combined (Vektis 2000). Between 1993 and 1999 per capita expenditure increased by 25.7 per cent in the AWBZ, by 57 per cent in the ZFW and by 41.4 per cent in substitutive VHI and the WTZ (Vektis 2000). This contrasts with Germany, where the costs of substitutive VHI rose much faster than those of the statutory health insurance scheme (the GKV) (see above), and may be explained by the disproportionately high number of elderly people covered by the ZFW.

Voluntary health insurers commonly pay individual providers on a fee-for-service basis, although they may set a fixed budget for hospitals. Selective contracting is possible, but only for individual providers (as opposed to hospitals).

Voluntary health insurers involved in substitutive VHI and the WTZ spend a much higher proportion of their total costs on administration (12.7 per cent in 1999) than insurers involved in the AWBZ (0.7 per cent) or the ZFW (4.4 per cent) (see also Table 19) (Vektis 2000).

### **Public policy and regulation**

The market for substitutive VHI is not as tightly regulated as the statutory health insurance schemes. Voluntary health insurers are free to set their own terms and conditions, leading to great variety in selection procedures, benefits provided, premiums, reimbursement etc. The only important form of supervision concerns insurers' solvency. Insurers involved in VHI as well as the AWBZ or ZFW are also prohibited from using the public resources of the AWBZ and the ZFW for their VHI activity.

For various reasons the current system of health care funding in the Netherlands is increasingly seen as a source of inefficiency and inequity, leading the government to announce widespread reform of the health care system in 2001, including its intention to extend statutory coverage to the whole population by merging the existing health insurance schemes into one universal, compulsory, public health insurance scheme (Ministry of Health Welfare and Sport 2001).

## **2.1.2 Complementary and supplementary VHI**

Some form of complementary or supplementary VHI is available in every member state. We must emphasise that the distinction between complementary and supplementary VHI is not always clear and in some member states there may be significant crossover between them. It is also important to note that the benefits provided by complementary and supplementary VHI are heavily influenced by the benefits provided by the statutory health care system and may therefore vary substantially from country to country. Complementary and supplementary VHI are usually available to the whole population.

### **Complementary VHI**

In contrast to substitutive VHI, complementary VHI provides full or partial cover for services that are excluded or not fully covered by the statutory health care system. Some insurers restrict benefits to inpatient care, but where cover is available for outpatient care it may include a significant part of the costs of visits to primary care practitioners and specialists, nursing staff, drugs, tests, medical appliances, transport costs, spectacles, dental care, maternity care

and complementary or alternative treatment. Levels of reimbursement vary from country to country and may also vary according to the insurance package chosen.

Complementary VHI provides cover for the reimbursement of co-payments in Belgium, Denmark (mainly pharmaceuticals and dental care), France (ambulatory care), Ireland, Luxembourg (hospital co-payments), the Netherlands (mainly dental care) and Sweden (mainly pharmaceuticals and dental care). As a result of recent reforms in Italy, Italian mutual associations are allowed to cover co-payments and the costs of services excluded from the statutory benefit package funded by the national health service (SSN) (Taroni 2000). With the exception of France, the market for VHI to cover co-payments is not substantial in the European Union. For example, coverage of co-payments for pharmaceuticals varies considerably, accounting for a large part of complementary VHI in Denmark, but hardly any in the Netherlands and none at all in Spain. VHI coverage for co-payments is also less likely to be offered by commercial insurers, perhaps because it is not particularly profitable.

Patients can purchase complementary VHI to cover outpatient costs in Austria (in conjunction with a supplementary VHI package), Belgium, France, Germany, Ireland, Italy, Portugal and Spain.

Although statutory health care systems increasingly exclude dental care, the VHI market for dental care in the European Union is not as large as might be expected. The reasons for this are not clear. Some cover for dental care is available in Austria, Belgium (for self-employed people), Denmark, France, Germany, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom.

### **Supplementary VHI**

Supplementary VHI serves to increase consumer choice and access to different health services, traditionally guaranteeing superior accommodation and amenities in hospital (a single room with en suite bathroom, for example) rather than improved clinical quality of care and, crucially, faster access to treatment, particularly in areas of health care with long waiting times, such as surgery. In some cases supplementary VHI increases choice of provider and benefits; subject to availability in different countries, individuals with supplementary VHI may see private general practitioners and specialists, be treated in private hospitals and private beds in public hospitals or receive benefits in cash rather than in kind. Supplementary VHI is particularly prevalent in member states with NHS-type health care systems such as Greece, Italy, Portugal, Spain and the United Kingdom, where it is often referred to as 'double coverage'. It is of growing importance in Scandinavian member states such as Denmark, Finland and Sweden. In health care systems characterised by waiting lists or long waiting times for treatment, supplementary VHI may allow individuals to 'jump the queue'.



Table 9 gives examples of the benefits covered by complementary and supplementary VHI in each member state.

**Table 9 Examples of the benefits provided by complementary and supplementary VHI in the European Union**

Country	Complementary	Supplementary
<b>Austria</b>	<ul style="list-style-type: none"> <li>▪ hospital per diem charge (cash benefit)</li> <li>▪ alternative treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ physician costs</li> <li>▪ supplementary hospital costs</li> <li>▪ faster access / increased choice</li> </ul>
<b>Belgium</b>	<ul style="list-style-type: none"> <li>▪ legal co-payments for non-reimbursed in/outpatient costs</li> <li>▪ carer costs (loss of independence)</li> </ul>	<ul style="list-style-type: none"> <li>▪ supplementary hospital costs</li> </ul>
<b>Denmark</b>	<ul style="list-style-type: none"> <li>▪ co-payments for drugs, dental care, physiotherapy, spectacles etc</li> </ul>	<ul style="list-style-type: none"> <li>▪ access to private hospitals in Denmark and abroad</li> </ul>
<b>Finland</b>	<ul style="list-style-type: none"> <li>▪ some public sector hospital costs</li> <li>▪ travel expenses</li> </ul>	<ul style="list-style-type: none"> <li>▪ private care for children</li> <li>▪ faster access</li> <li>▪ increased choice (including access to private hospitals)</li> </ul>
<b>France</b>	<ul style="list-style-type: none"> <li>▪ co-payments (including differences between negotiated and real prices)</li> <li>▪ treatments excluded by public sector</li> <li>▪ home help</li> <li>▪ hospital per diem charge</li> </ul>	<ul style="list-style-type: none"> <li>▪ faster access to specialist consultations</li> <li>▪ choice of private room in hospital</li> </ul>
<b>Germany</b>	<ul style="list-style-type: none"> <li>▪ outpatient care</li> <li>▪ dental care</li> <li>▪ hospital daily allowance (cash benefit)</li> </ul>	<ul style="list-style-type: none"> <li>▪ choice of specialist</li> <li>▪ amenity beds</li> </ul>
<b>Greece</b>	<ul style="list-style-type: none"> <li>▪ hospital daily allowance (cash benefit)</li> </ul>	<ul style="list-style-type: none"> <li>▪ faster access</li> <li>▪ choice of private provider and accommodation</li> </ul>
<b>Ireland</b>	<ul style="list-style-type: none"> <li>▪ outpatient cover for GP visits, specialist consultations, x-rays and other items (subject to a deductible)</li> <li>▪ outpatient cover for alternative treatment (BUPA Ireland)</li> <li>▪ hospital per diem charge</li> <li>▪ cost of OT fees, x-rays, lab tests, drugs in hospital</li> <li>▪ consultants' fees for inpatient, day care and some outpatient treatment</li> <li>▪ maternity benefits</li> <li>▪ convalescence in a nursing home</li> </ul>	<ul style="list-style-type: none"> <li>▪ cost of hospital accommodation in private beds in public hospitals and in private hospitals (including day care surgery)</li> </ul>
<b>Italy</b>	<ul style="list-style-type: none"> <li>▪ co-payments</li> <li>▪ non-reimbursed services</li> <li>▪ dental care</li> <li>▪ hospital per diem charge</li> </ul>	<ul style="list-style-type: none"> <li>▪ increased choice of provider</li> <li>▪ increased access to private hospitals</li> </ul>
<b>Luxembourg</b>	<ul style="list-style-type: none"> <li>▪ hospital co-payments</li> <li>▪ pre- and post-operative and convalescence costs</li> <li>▪ dental prostheses</li> <li>▪ surgical treatment abroad</li> <li>▪ partial reimbursement where no agreement on the cost of a treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ additional charges for a private room in hospital</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>▪ mainly dental care</li> <li>▪ drug co-payments (marginal)</li> <li>▪ cross-border care</li> <li>▪ alternative treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ faster access to acute and long-term care</li> </ul>
<b>Portugal</b>	<ul style="list-style-type: none"> <li>▪ dental care</li> <li>▪ ophthalmology</li> <li>▪ co-payments</li> <li>▪ cash benefits</li> </ul>	<ul style="list-style-type: none"> <li>▪ access to private providers</li> </ul>
<b>Spain</b>	<ul style="list-style-type: none"> <li>▪ dental care</li> </ul>	<ul style="list-style-type: none"> <li>▪ increased choice of provider</li> </ul>
<b>Sweden</b>	<ul style="list-style-type: none"> <li>▪ some reimbursement of co-payments, drugs, dental care, alternative treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ faster access to elective outpatient care</li> <li>▪ access to private hospitals</li> </ul>
<b>United Kingdom</b>	<ul style="list-style-type: none"> <li>▪ cash benefits</li> <li>▪ dental care</li> <li>▪ alternative treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ faster access to specialists and elective treatment</li> <li>▪ choice of amenities in public hospitals</li> </ul>

Source: National reports prepared for this report

## **2.2 Market structure**

In this section we describe the types of insurers selling VHI in the European Union and examine the extent to which VHI is purchased by groups rather than by individuals.

### **2.2.1 Types of insurer**

Voluntary health insurers in the European Union can be distinguished in terms of their legal status and in terms of their degree of specialisation in health.

#### **Legal status**

In terms of legal status, three types of insurers are present in the EU market for VHI: mutual or provident associations (distinguished by their non-profit status) and commercial companies (distinguished by their for-profit status). The distinction between non-profit and for-profit is important because an insurer's profit status is likely to influence its motivation and may have a significant bearing on its tax burden.

Mutual and provident associations in the European Union have a long history of involvement in social protection based solidarity principles (Palm 2001). AIM<sup>12</sup> define solidarity as a mechanism that enables everyone to "contribute according to their financial resources and benefit from services according to their needs". AIM's member organisations in 11 member states therefore "strive to maintain access to high quality care for everyone regardless of age, sex, health status, income or any other social, professional, religious or ethnic criterion". However, as there is variation in the extent to which the principle of solidarity is pursued by mutual or provident associations in different member states at the present time (even among AIM member organisations), we cannot make assumptions about insurers' conduct on the basis of their legal and non-profit status.

Mutual or provident associations are present in most member states. The exception is Austria. For largely historical reasons, they dominate the market in many countries, including Belgium, Denmark, France, Ireland, Luxembourg and the Netherlands. Nevertheless, their share of the VHI market is declining in some member states, notably in Finland (where it was already insignificant), Denmark, the United Kingdom and, to a lesser extent, France.

Provident associations in the United Kingdom used to enjoy a share of about two thirds of the market in the 1990s, but in 1999 the second largest provident association (and second largest voluntary health insurer) was acquired by a commercial undertaking (AXA Sun Alliance) (Laing and Buisson 1999). Provident associations now account for about half of all premiums in the United Kingdom, with the largest provident association holding a market share of 40 per cent

(Laing and Buisson 2001). In France the mutual associations (mutuelles) gained market share between 1980 and 1996, when the proportion of total expenditure on health care financed by them rose from five to seven per cent (Lancry and Sandier 1999), while the proportion financed by commercial insurers stabilised at around three per cent (Smosarski and Jack 1998). Since then, however, the mutual associations' share of the market appears to have declined slightly and they now account for 61 per cent of the overall VHI market (in terms of number of people covered). Commercial insurers account for 22 per cent and provident associations (instituts de prévoyance) for 17 per cent (Sandier and Ulmann 2001).

The Irish market is dominated by Vhi Healthcare (previously the Voluntary Health Insurance Board; VHIB), which was established in 1957 as a non-profit, quasi-public but independent body and developed as a virtual monopoly until the market was opened to limited competition in 1994, in order to comply with the third non-life insurance directive. To date only one other company (BUPA Ireland, a subsidiary of BUPA International) has established itself in the Irish market. Since entering the market in 1996, BUPA Ireland has gained a 14 per cent share of the market. The Irish government's 1999 White Paper on VHI included plans to convert Vhi Healthcare to a state-owned public limited company with full commercial freedom, in the hope that privatising the company and removing its links with the Department of Health and Children would encourage a more level playing field (Department of Health and Children 1999), but the effect this will have on competition remains to be seen. For the time being at least, the government does not show signs of privatising Vhi Healthcare.

The third non-life insurance directive does not distinguish between different types of insurer and specifically outlaws the preferential treatment of one type of insurer over another. For example, mutual or provident insurers are currently exempt from the insurance premium tax that is levied on policies sold by commercial insurers in Belgium, France and Luxembourg. Member states that use national tax laws to favour non-profit over commercial insurers may contravene EU competition law (for further details see Sections 2.4 and 4.3). More broadly, the French government has so far failed to transpose the third non-life directive with regard to mutual associations, and in December 1999 the European Court of Justice ruled against this incomplete transposition (European Commission 2000b). The French government has since agreed to transpose this aspect of the directive, although the legislation will not be implemented until the beginning of 2003 (see Section 5.3.1) (European Commission 2000b).

### **Specialisation in health and EU law**

Germany is the only member state in which substitutive VHI is sold entirely by specialist health insurers (Comité Européen des Assurances 2000). Traditionally, the German supervisory body has only allowed insurers specialising in health to sell VHI, in order to protect policy

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<sup>12</sup> The international grouping of autonomous health insurance and social protection bodies operating according to

holders from insolvency arising from other business (Bundesaufsichtsamt für das Versicherungswesen 2001). The legislation transposing the third non-life insurance directive into German law formally abolished this rule (Article 5 of the directive), but the German government added a new provision to German social law, prohibiting employees from benefiting from employer-paid contributions if the insurer combined health with other types of insurance (Busse 2001). The European Commission considered this to be an indirect infringement of the directive and sent a so-called 'reasoned opinion' to Germany in 1996 (European Commission 1996). In the absence of a satisfactory response from the German government, the European Commission has referred Germany to the European Court of Justice (Case C-298/01). The principle of separation of VHI from other types of insurance does not apply to foreign insurers (Bundesaufsichtsamt für das Versicherungswesen 2001).

Elsewhere, the proportion of specialist health insurers ranges from none in Austria and Portugal, to very few in Italy (0.8 per cent), Belgium (4.3 per cent) and France (5.6 per cent), to over a third in the United Kingdom (36 per cent) and almost half in the Netherlands (47.2 per cent) (Comité Européen des Assurances 2000). Some types of insurer may be more likely to specialise in health than others. In France, for example, more than half of all mutual associations specialise in health, and EUR 8.3 billion of the EUR 8.9 billion in premiums collected by mutual associations in 1999 were for VHI (Sandier and Ulmann 2001).

### **Number of insurers**

According to a recent industry report, 54.9 per cent of all VHI premiums in Europe in 1998 were written or earned by 25 companies, 17 of which were German (Datamonitor 2000a). Four out of the top five insurers in the European Union were German; the fourth largest insurer was British. There is considerable variation in the number of insurers operating in each member state. Some national markets are highly concentrated (for example, Ireland, Denmark, Finland, Austria, Greece and the United Kingdom), while France, Italy and Spain have the greatest proliferation of companies (over 100 in each country), although the number of insurers is not indicative of market size.

The 1990s have seen a clear trend towards increasing concentration in the market in many member states. In Spain, for example, there were 269 insurers selling VHI in 1981 and 135 insurers in 1991, but the number of insurers has now dropped to about 100 (Rodríguez 2001). The number of insurers has also declined in Italy (from 125 in 1997 to 104 in 2000 (Giannoni-Mazzi 2001)), Luxembourg (from 13-14 commercial insurers in the 1990s to 11 in 2001 (Engemann 2001)) and Portugal (from 45 insurers in 1996 to 39 in 1999 (Oliveira 2001)). The same pattern has been observed in Austria and Greece (Hofmarcher 2001, Economou 2001).

The share of the three largest insurers in each market is highest in Ireland (100 per cent), Luxembourg (92 per cent out of commercial insurers), Austria (84 per cent), Sweden (80-90 per cent), the United Kingdom (75 per cent), Finland (62 per cent out of commercial insurers) and France (59.5 per cent out of commercial insurers) (Engemann 2001, Hofmarcher 2001, Skoglund 2001, Laing and Buisson 2001). VHI markets are much less concentrated in Portugal (31.6 per cent), Italy (33 per cent) and Belgium (49 per cent out of commercial insurers) (Oliveira 2001, Giannoni-Mazzi 2001, Hermesse 2001). In Greece the share of the five largest insurers is relatively high (70.4 per cent) (Economou 2001).

During the 1990s statutory sickness funds in the Netherlands were allowed to offer complementary and supplementary VHI and to co-operate or merge with voluntary health insurers, leading to significant mergers that reduced the number of sickness funds by almost 50 per cent (from 53 to 27), in spite of the entry of six new funds (Organisation for Economic Co-operation and Development 1998a). The current market is dominated by three insurance conglomerates, two of which are also the largest non-life insurance companies (Ohra and Achmea) (Organisation for Economic Co-operation and Development 1998a). Co-operation between the sickness funds and voluntary health insurers enables the sickness funds to market an integrated statutory and voluntary employee benefits package to employers (covering life insurance, VHI, sickness fund cover, invalidity benefit, advice on benefits and value-added management services). It also allows large voluntary health insurers to take advantage of the sickness funds' existing customer base (Natarajan 1996). The Dutch government has introduced legislation preventing insurers involved in providing both voluntary and statutory health insurance from using public funds for private business, but in practice it may be difficult to ensure that this distinction is observed (Maarse 2001).

### **2.2.2 Buyer characteristics: individual vs group policies**

A key factor in the degree and distribution of VHI coverage is the extent to which insurance is purchased individually or through groups (usually employment-based groups). Group policies are popular with insurers for three reasons:

- they generally have a lower unit cost and provide high volumes of business without a correspondingly large market outlay (BMI Europe 2000)
- offering reduced premiums and favourable conditions to groups also means that insurers automatically cover a younger, healthier, more homogenous population (Gauthier et al. 1995)
- in terms of competition, an employer may be more likely than an individual to 'shop around' for cheaper policies, and to switch from one insurer to another as a result of finding a better deal

The distinction between policies purchased by individuals and groups is also important from the subscriber's perspective, partly because group premiums are often group-rated, whereas individual premiums are more likely to be adjusted for risk (see Section 2.3.1), and partly because they are usually substantially cheaper than individual policies.

Relatively low levels of individual demand for VHI in many member states has forced insurers to rely more heavily on sales to groups. The 1980s saw rapid expansion of the market for group policies, largely as a result of the sustained economic growth experienced by several member states during this time. The trend for increasing sales of group policies continued into the 1990s, albeit at a slightly slower pace. Table 10 shows that group policies currently account for almost all VHI policies in Sweden, Ireland, Portugal, Greece and the United Kingdom, over half of all policies in the Netherlands, and about half of all policies in France. Group policies are not significant in Spain (15 to 18 per cent of those covered by VHI), Austria or Germany (where the proportion of group contracts is as low as 6.6 per cent) (Datamonitor 2000a), and there are very few in Denmark or Finland. In some countries commercial VHI policies are more likely to be purchased by groups than individuals (73.6 per cent of commercial Belgian VHI policies in 1998 (Comité Européen des Assurances 2000) and most commercial VHI policies in Denmark (Vrangbæk 2001)). During the 1990s, group policies gained an increasing share of the VHI market in Austria, Greece, Ireland, Luxembourg, the Netherlands, Spain, Sweden and the United Kingdom. Group policies are likely to increase in Belgium, Denmark and the United Kingdom, but have decreased in France. The majority of group policies are voluntary, although group policies provided as a compulsory component of an employee's contract account for 23.6 per cent of all VHI policies in France. Group policies 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 (see Table 10).

Much of the growth in VHI in the United Kingdom in the 1980s was due to the increase in sales of employer-paid group policies (Association of British Insurers 2000). Currently, around 59 per cent of VHI policies are purchased by employers (compared to 48 per cent in 1993 (Youngman 1994)) and 31 per cent by individuals; a further 10 per cent are bought by professional associations or trades unions but paid for by employees (Robinson 1999). Almost a third of group policies are fully or partially paid for by employees themselves (Robinson 1999). The likelihood of insurance being paid for by an employer increases with income; 50.7 per cent of those with VHI in the top income decile report that their policy was purchased by their employer, compared with only 25.5 per cent of those with VHI in the bottom four income deciles (Emmerson et al. 2001). This may be for two reasons: first, highly paid jobs are more likely to provide fringe benefits such as VHI; second, employers may be more concerned about the health of highly paid employees (Emmerson et al. 2001).

Since 1990 the number of UK subscribers with employer-paid policies has grown by an estimated 23 per cent, compared to a fall of 6 per cent in the number of subscribers who pay for their own policies (Laing and Buisson 2001). The disparity between employer-paid and other policies has been particularly noticeable since 1996, as the sale of employer-paid policies grew by 21.5 per cent, while the sale of other policies fell by 14 per cent (Laing and Buisson 2001). In 1999 the number of people with VHI in the United Kingdom fell by 4.5 per cent in 1999, with the fall in demand concentrated solely in individual/employee-paid policies; employer-paid policies grew by 1.2 per cent, but individual/employee-paid policies were down by 5 per cent (Laing and Buisson 2000).

According to Laing and Buisson, the leading compiler of statistics on the UK VHI industry, the growth of employer-paid policies purchased by groups in the United Kingdom has been driven by the underlying strength of corporate economic performance, low unemployment, strategic price discounting, increased concentration of marketing and the changing attitude of employers, who are recognising the potential costs of long absence from work due to accident or ill health (Laing and Buisson 2001). Strategic price discounting is almost certainly the most powerful explanatory factor for the continuing rise in sales of group policies; not only are group policies in the United Kingdom much cheaper than individual policies, their annual price increases have also been much smaller (Papworth 2000).

In 1999 the Irish government predicted that the provision of VHI as an employee benefit would expand in Ireland (Department of Health and Children 1999). The proportion of VHI policies purchased by groups has risen since the mid 1990s, when it was about 70 per cent (Kennedy 1995), to between 75 and 80 per cent, although only 20 to 25 per cent of all VHI policies are employer-paid (Vhi Healthcare 2001c). The rise in the sale of group policies can be attributed to sustained economic growth, the presence of multinational corporations and discounts of up to 10 per cent (the maximum allowable discount by law) (Vhi Healthcare 2001c, Department of Health and Children 2001b).

A 1992 survey found that 35 per cent of French households purchased complementary VHI individually, while 49 per cent received it from their employers (Natarajan 1996). The proportion of group policies was estimated at 61.1 per cent in 1998 (Comité Européen des Assurances 2000) and at 48.8 per cent in 2000 (Sandier and Ulmann 2001).<sup>13</sup> French mutual associations dominate the individual policies market and have a 60 per cent share of the overall market for VHI. As in Belgium and Denmark, most commercial VHI policies are sold to employers rather than individuals (Imai et al. 2000). Commercial insurers in France are increasingly looking to the individual sector for profit generation, but find it difficult to compete with the provident associations, partly because of the fiscal advantages awarded to provident

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<sup>13</sup> This apparently large decline in group policies may be due to differences in sources of data.

associations and partly because of their historical involvement in the pension sector (Sandier and Ulmann 2001).

Substantial growth in the Portuguese VHI market between 1996 and 1999 was largely the result of growth in the sale of group policies. In 1999 the market grew by 13.6 per cent, with higher growth in the market for individual policies (an increase of 25.4 per cent) (Oliveira 2001).

Finally, group policies in the Netherlands rose from 34.5 per cent of all policies in 1980 to 46.6 per cent in 1990 and 53.8 per cent in 1998 (Comité Européen des Assurances 2000).

**Table 10 The extent to which VHI policies are purchased by groups and individuals in the European Union**

Country	Policies purchased by groups (employers)	Are group policies employer paid?	Policies purchased and paid for by individuals
<b>Austria</b>	29.2% (gained market share 1996-2000)	Yes	70.8% of premium income (2000)
<b>Belgium</b>	Some commercial policies	Some group policies	All mutual and almost all commercial policies
<b>Denmark</b>	80+% commercial policies	Yes (part of job contract)	Almost all policies sold by 'Danmark' (mutual)
<b>France</b>	23.6% compulsory (1998) 25.2% voluntary (1998)	Partially or fully (compulsory); partially (voluntary)	46.8% (1998)
<b>Germany</b>	Very few	N/A	Almost all
<b>Greece</b>	Increased by 106.1% (1989-1995)	Yes	Increased by 64.1% (1989-1995)
<b>Ireland</b>	75-80% (2000)	20-25% (2000)	20-25% (2000)
<b>Italy</b>	26.3% (1999); in 1994 only 24% of firms did not offer any group policies	Yes	53.3% commercial (1999) 20.3% mutuals (1999)
<b>Luxembourg</b>	5% of commercial policies (2000)	N/A	100% mutuals (2000) 95% commercial (2000)
<b>Netherlands</b>	More than 50% (2000)	N/A	Less than 50% (2000)
<b>Portugal</b>	71% (1998)	Most group policies	29% (1998)
<b>Spain</b>	15-18% (1998)	Yes, for senior managers; some for other employees	82-85% (1998)
<b>Sweden</b>	90%	Yes	10%
<b>UK</b>	69.5% of persons covered by employer paid policies in 2000	Some group policies	30.5% of persons covered by policies paid for by individuals and employees in 2000

Source: National reports prepared for this report

Note: No data available for Finland



## 2.3 Market conduct

### 2.3.1 Premium-setting, selection criteria and policy conditions

#### Premium-setting

Contributions to the statutory health care system via tax or social health insurance are usually related to income or wages (although they may be restricted by ceilings on the amount of income or earnings to be taxed). In contrast, VHI premiums are rarely income-related.<sup>14</sup> They are much more likely to be rated according to risk or on a community or group basis.

Community-rated and group-rated premiums are based on the average risk of a defined community or firm; premiums are the same for all subscribers or a group of subscribers in a given community or firm. Risk-rated premiums are based on an individual assessment of the future risk of ill health and therefore vary according to one or more risk factors. The method used to set premiums (community, group or risk rating) and the variables used in risk rating may have implications for cost and access (see Section 3.2.1).

Since the third non-life insurance directive abolished national price and product controls in 1994, voluntary health insurers in the European Union are in theory free to rate premiums on any basis they choose, although insurers offering substitutive VHI are generally subject to some degree of regulation regarding the price of premiums and policy conditions.

Risk rating is the most common method used by insurers in the European Union to set premiums for complementary and supplementary VHI (and it may also be used to set substitutive VHI premiums). It is used to varying degrees and for different types of VHI in Austria, Belgium, Denmark (some policies), Germany, Greece (individual policies), Italy (commercial insurers), Luxembourg (commercial insurers), the Netherlands (luxury dental policies), Portugal (individual policies), Spain, Sweden (policies for those with pre-existing conditions) and the United Kingdom (individual policies). Table 11 gives examples of the variables used in risk rating in different member states. These include age, sex, occupation, household size, health status, medical history, family history of disease and extent of coverage (both in terms of benefits provided and cost-sharing required).

Group rating is used in Denmark (most policies), Greece (group policies), Italy (policies sold by the largest mutual associations), Portugal (group policies), Sweden (group policies) and the United Kingdom (group policies).

VHI policies with community-rated (flat-rate) premiums are much less common. They can be purchased in Belgium and Luxembourg (for complementary VHI sold by mutual associations)

and the Netherlands. Flat-rate premiums with some variation depending on age are available in Portugal. Ireland is the only member state in which community rating is prescribed by law. All insurers in Ireland must offer community-rated premiums, open enrolment and lifetime cover. The Irish Health Insurance (Amendment) Act of 2001 introduced the concept of lifetime community rating. Once this is implemented, voluntary health insurers will be free to impose a premium loading on any individual who purchases VHI after the age of 35 (The Society of Actuaries in Ireland 2001).

**Table 11 Examples of the variables used for rating VHI premiums and the medical information / procedures required from applicants**

Country	Variables used for rating premiums	Medical information / procedures required from applicants
<b>Austria</b>	Age at entry, sex, marital status, individual health status	Insurers are prohibited by law from carrying out examinations
<b>Belgium</b>	<i>Mutual</i> : age, household size <i>Commercial</i> : age, sex, area of residence (higher charges in the Brussels area), level of coverage, level of deductible	<i>Mutual</i> : only some mutuals require a medical questionnaire <i>Commercial</i> : medical questionnaire and/or examination
<b>Denmark</b>	<i>Mutual</i> : group rates according to level of coverage <i>Commercial</i> : age, employment status	Medical questionnaire
<b>Finland</b>	Age	
<b>France</b>	<i>Group</i> : socio-economic and demographic status <i>Individual</i> : age	<i>Commercial</i> : medical questionnaire (usually for >55 years only) <i>Mutual</i> : none
<b>Germany</b>	Age at entry, sex, health status	
<b>Greece</b>	Age, sex, profession, family and individual health status	Medical questionnaire, examination, x-rays
<b>Ireland</b>	Age (late entry loading for applicants aged over 35)	None
<b>Italy</b>	<i>Commercial / individual</i> : age, sex, health status, area of residence <i>Commercial / group</i> : age, sex, area of residence, less emphasis on health status	<i>Commercial</i> : medical questionnaire <i>Mutual</i> : none
<b>Luxembourg</b>	<i>Commercial</i> : age, sex, family and individual health status, level of coverage, duration of cover, any additional guarantees	<i>Commercial</i> : medical questionnaire <i>Mutual</i> : none
<b>Netherlands</b>	<i>Dental policies</i> : age	
<b>Portugal</b>	Age, sex, family and individual health status	<i>Individual</i> : medical questionnaire, examination in rare cases <i>Group</i> : occasionally, examination
<b>Spain</b>	Age, sex	Medical questionnaire
<b>Sweden</b>	Age, health status	Medical questionnaire, examination (in rare cases) Insurers refrain from obtaining information about family history of disease
<b>UK</b>	Insurers use a wide range of variables including family and individual health status	<i>Individual</i> : Medical questionnaire

Source: National reports prepared for this report

<sup>14</sup> The VHI 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 2001), but this may be the only example of income-related VHI premiums in the European Union.

### **Information required from applicants**

The information required from applicants may be closely related to the rating method used to set premiums (see Table 11). Insurers that use health status as a variable for risk rating premiums will require applicants to complete a medical questionnaire. Medical questionnaires may also include questions about family history of disease, which is 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 Greece, Luxembourg, Portugal and the United Kingdom. The issue of genetics and insurance is discussed in some detail in Section 3.2.5. Austrian law prohibits the use of medical examinations, but medical examinations may take place in Belgium (commercial policies), Greece, occasionally in Portugal (group policies) and in rare instances in Sweden. In some cases insurers will not require applicants to provide any medical information, but they may impose waiting periods or undertake moratorium underwriting (see below).

### **Age limits and types of contract**

VHI cover can be offered as a short-term (non-life) contract or on a long-term (life) basis 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 VHI in the European Union and most insurers set a maximum age limit for purchasing VHI, usually between 60 and 75 (see Table 12). Some insurers also cancel contracts when people reach retiring age. Lifetime cover is required by law in Ireland, where it applies to all policies. It is also available for hospital cost insurance policies in Austria, for some policies in Greece and Sweden and for the most expensive policies in Portugal. Substitutive VHI in Germany is written on a lifetime basis.

### **Exclusions**

Open enrolment entitles everyone in a given population to insurance cover and means that insurers cannot reject applications. The Irish government requires all voluntary health insurers in Ireland to offer open enrolment and mutual associations in Luxembourg offer open enrolment, but it is otherwise rare in the European Union (Department of Health and Children 1999).

Insurers in Austria cannot refuse to insure someone with a chronic illness, but they are permitted to charge higher premiums or introduce some form of cost-sharing (see Table 13) (Hofmarcher 2001). French insurers are also usually prohibited from excluding particular conditions, although they may do so if the insurer can prove that the subscriber suffered from the condition before purchasing the policy (Sandier and Ulmann 2001).

**Table 12 Age limits and types of contract**

<b>Country</b>	<b>Age limits</b>	<b>Type of contract</b>
<b>Austria</b>	No	Per diem hospital cost policies: annual contracts Hospital cost insurance: lifetime cover
<b>Belgium</b>	65	
<b>Denmark</b>	60	Annual or long-term contracts
<b>Finland</b>	60-65	
<b>France</b>	<i>Commercial</i> : 65-70 <i>Mutual</i> : usually none <i>Provident</i> : usually none (if covered before 65)	Annual contracts
<b>Germany</b>	No (substitutive VHI)	Lifetime cover (substitutive VHI)
<b>Greece</b>	Insurers can set age limits	Annual contracts and lifetime cover available (lifetime cover more popular); insurers can reject applications
<b>Ireland</b>	Open to over 65s since 2001	Lifetime cover
<b>Italy</b>	<i>Commercial individual</i> : over 75s usually not eligible <i>Commercial group</i> : access restricted to employees and (sometimes) dependants <i>Mutual group</i> : no age limits; retired people can continue to be covered if they have been covered for 5-10 years <i>Mutual individual</i> : 65-75	Mostly annual contracts
<b>Luxembourg</b>	<i>Commercial</i> : 60	Annual contracts; insurers cannot cancel contracts
<b>Netherlands</b>	Age limits may apply	Annual contracts; insurers cannot cancel contracts on the basis of claims experience
<b>Portugal</b>	65 (70 if covered between 55 and 64 years old)	Annual contracts; not always clear whether insurers can cancel contracts or not; the most expensive policies offer lifetime cover
<b>Spain</b>	60-75 (but the two largest insurers do not set an age limit)	Annual contracts
<b>Sweden</b>	65-70	Annual contracts; some insurers offer lifetime cover if purchased before 65
<b>UK</b>	No age limits but only 5 per cent of the over-65 population are covered (against an average of 9 per cent for all age groups)	Mostly annual contracts

Source: National reports prepared for this report

In all other member states, VHI policies are generally subject to exclusions (see Table 13). Complementary and supplementary VHI policies usually exclude pre-existing conditions, although some insurers will cover them for an increased premium. The list of exclusions can be very long. In the United Kingdom, for example, VHI policies 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 2001a).

**Table 13 Conditions usually excluded from VHI cover**

<b>Country</b>	<b>Usual exclusions</b>
<b>Austria</b>	<i>Individual:</i> pre-existing conditions usually excluded (but not from group policies); insurers cannot refuse to insure someone with a chronic illness but may charge higher premiums and/or introduce cost-sharing arrangements
<b>Belgium</b>	<i>Mutual:</i> psychiatric and long-term care (lump sum) <i>Mutual:</i> psychiatric care (co-payment) <i>Commercial:</i> pre-existing conditions, infertility treatment, accidents arising from sports
<b>Denmark</b>	Pre-existing conditions
<b>Finland</b>	Pregnancy and childbirth, infertility treatment, alcoholism, herbal remedies, treatment covered by statutory health insurance
<b>France</b>	Excluding any disease is forbidden by law, although it can be authorised 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
<b>Germany</b>	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
<b>Greece</b>	Pre-existing conditions
<b>Ireland</b>	Open enrolment
<b>Italy</b>	<i>Individual:</i> 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 exclude dental care not caused by accident/illness <i>Group:</i> 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
<b>Luxembourg</b>	<i>Mutual:</i> open enrolment (but no cover for treatment excluded from statutory health insurance) <i>Commercial:</i> pre-existing conditions
<b>Netherlands</b>	Some dental plans may require people to have their teeth restored before acceptance
<b>Portugal</b>	<i>Individual:</i> 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
<b>Spain</b>	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, in one policy, offers homeopathy or spa treatment
<b>Sweden</b>	Emergency care, long-term care, HIV/AIDS, some other communicable diseases, diseases and injuries as 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
<b>UK</b>	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: National reports prepared for this report

### **Waiting periods and moratorium underwriting**

Open enrolment is usually accompanied by mandatory waiting periods. For example, insurers in Ireland will only cover treatment after a waiting period of 12 months, and will only cover treatment of pre-existing conditions after a waiting period of 2 to 7 years with Vhi Healthcare

(the dominant insurer) or up to the legally allowed maximum of 10 years with BUPA Ireland. Non-profit insurers stipulate a waiting period of 6 months in Belgium, 3 months to 2 years in France and 12 months in Luxembourg (see Table 14).

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, and, 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 VHI policies in the United Kingdom 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, nor otherwise sought advice about it (including related check ups), nor 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.

As long as subscribers are clearly informed in advance, the existence of mandatory waiting periods should not present a problem. However, moratorium underwriting is more controversial and its use in the United Kingdom has been criticised by the OFT, particularly with regard to the potential of moratorium underwriting to discourage individuals from seeking treatment when they need it. In a report published in 1996 the OFT took the view that subscribers of moratorium-based VHI were more likely to suffer detriment through failing to understand what was covered, and recommended that insurers abandon the practice (Office of Fair Trading 1996). The Association of British Insurers (ABI) was not able to reach a consensus on the issue and suggested that improved consumer education, with new leaflets, would help to reduce consumer detriment (Office of Fair Trading 2000b). While the Office of Fair Trading agreed that improved information for consumers could represent an acceptable alternative to abandoning moratorium underwriting, it felt that the ABI's initiative fell short of what was required. In a second report, published in 1998, the OFT called for tighter self-regulation than the ABI's codes and guidance provided, but this has not been forthcoming (Office of Fair Trading 2000b).

Moratorium underwriting is not common in the European Union. It is mainly operated by some insurers in the United Kingdom and Portugal.

**Table 14 Waiting periods**

Country	Waiting periods
<b>Austria</b>	No
<b>Belgium</b>	<i>Mutual</i> : 6 months 9-10 months for delivery (lump sum), 12 months for delivery (co-payment)
<b>Denmark</b>	No
<b>France</b>	3 months to 2 years
<b>Germany</b>	May be required but in practice only exist as limitations on dental surgery and dentures during the first years of subscription; for example the maximum reimbursement is limited to EUR 2,000 in the first year, EUR 4,000 in the second and EUR 8,000 in the third
<b>Greece</b>	No; but moratorium underwriting may emerge in future
<b>Ireland</b>	12 months Pre-existing conditions: up to 10 years (BUPA), 2-7 years (Vhi Healthcare) Limits on psychiatric care in hospital (BUPA 100 days, Vhi Healthcare 180 days) and inpatient stays (180 days)
<b>Italy</b>	<i>Individual and mutual</i> : usually 30-180 days
<b>Luxembourg</b>	<i>Mutual</i> : 12 months <i>Commercial</i> : 3 months
<b>Portugal</b>	<i>Individual</i> : minimum 3 months for all insurers; some insurers operate moratorium underwriting
<b>Spain</b>	9-12 months for delivery 6 months for surgery and high-tech diagnostic tests (MRI, CAT) Psychiatric hospitalisations usually limited to 30-60 days per year
<b>Sweden</b>	Only for group policies where no individual health information is required.
<b>UK</b>	Some insurers use moratorium underwriting; the moratorium is typically 2 years

Source: National reports prepared for this report

Note: No data available for Finland and the Netherlands

### 2.3.2 The provision of benefits

#### The range of benefits

VHI in the European Union covers a wide range of health services and offers a variety of benefit options, from total reimbursement of hospital costs to payment for cosmetic surgery or alternative treatment (see Table 9 above). Substitutive VHI schemes offer the most comprehensive benefit packages, largely as a result of government intervention, providing benefits similar to those covered by the statutory health care system. However, the benefits arising from complementary and supplementary VHI are largely unregulated, leaving insurers free to determine the size and scope of the packages they offer. This has led to a proliferation of complementary and supplementary VHI products in many member states; individuals may be able to choose from a wide selection of packages with differences in coverage levels, payment mechanisms, reimbursement (in kind or cash) and the extent of cost-sharing through co-payments, deductibles and ceilings on benefits.

#### Reimbursement

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 amongst voluntary health insurers in Belgium, Denmark, Germany and the

Netherlands (although Dutch insurers are increasingly paying providers directly), and takes place to a lesser extent in Austria, France and Spain.

### **Cost-sharing**

Cost-sharing in the form of ceilings on benefits (usually annual expenditure caps), deductibles (excesses) and co-payments seek to increase subscribers' awareness of the costs of health care and reduce their level of coverage. The extent to which subscribers are subject to cost-sharing varies considerably in different member states, but the trend in some member states 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. While some analysts argue that expanding the use of no claims bonuses would be an effective means of containing costs, others have expressed concern regarding their potentially negative impact on beneficial health care utilisation (Zweifel 1987). As with moratorium underwriting in the United Kingdom, no claims bonuses may encourage subscribers to postpone treatment for as long as possible.

### **Choice of provider**

Most supplementary VHI policies aim to widen subscribers' choice of provider, allowing subscribers to consult doctors working in the private as well as the public sector. Complementary and substitutive VHI 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 varies considerably between member states. On the whole, preferred provider networks and integrated care still play a minor role in most member states, although there is a tendency towards some forms of vertical integration amongst the largest insurers in some member states, notably BUPA and PPP Healthcare in the United Kingdom and SANITAS in Spain (acquired by BUPA in the early 1990s), where insurers have traditionally been providers as well. Vertical integration takes place to some extent in France and Belgium, but is actually precluded by legislation in the Netherlands, at least for the time being (Ministry of Health Welfare and Sport 2000a). In recent years the three largest voluntary health insurers in Portugal have made significant investments in the creation and development of PPNs (Oliveira 2001). PPNs also exist in Italy.

The transition from indemnity insurance to integrated care is possible in countries with large VHI markets, such as the United States. It is much harder to effect in smaller markets such as the European Union, where coverage is voluntary, double coverage is a possibility and subscribers may object to any restriction in choice. The experience of SANITAS in Spain suggests that insurers have had to strike a delicate balance between limiting preferred providers and maintaining subscriber choice. SANITAS owns and manages two major



hospitals in Madrid; it also contracts services from about 450 private or public hospitals or clinics and 15,000 private practitioners. The company recently piloted a scheme offering lower premiums in return for more limited choice of provider, but this had to be discontinued for lack of profitability.

Policy holders of the largest insurer in the United Kingdom are discouraged from using services outside the insurer's preferred network of providers (that is, their own consultants and hospitals) by having to pay co-payments ranging from about GBP 65 (EUR 103) for a minor operation to GBP 575 (EUR 913) for a major operation. However, following complaints of anti competitive practice, primarily from private consultants and hospitals, the UK competition watchdog (The Office of Fair Trading; OFT) launched an inquiry into the two largest insurers' development of preferred provider networks, vertical integration and negotiation of hospital charges. Although the OFT did not uphold the complaints, it did conclude that it would closely monitor any further moves towards vertical integration (Office of Fair Trading 1999). It also 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. At the same time the OFT recommended that the British Medical Association and the private medical sector should develop a Code of Practice on charging, a recommendation that it first made in 1996 (CareHealth 2000).

Larger voluntary health insurers in France are trying to establish a network of preferred providers, but there is no general tendency towards vertical integration, partly due to the public's negative perception of US-style Health Maintenance Organisations (HMOs). In Belgium recent experiments with integrated care systems for specific medical treatments in mutual associations have met with limited success (Stevens et al. 1998).

### **Restrictions**

VHI subscribers in some member states may be subject to a referral system or require prior authorisation for treatment. Subscribers in the United Kingdom need a general practitioner's referral before they can consult a specialist or receive inpatient treatment. In the Netherlands, too, many voluntary health insurers stipulate that patients should obtain a letter of referral from their general practitioner before seeing a specialist (Maarse 2001), but there is some evidence to suggest that on the whole this is not a practical requirement, as few insurers conduct checks before reimbursing subscribers (Kulu-Glasgow et al. 1998). Insurers in most member states do not require general practitioner referrals.

Some insurers in the United Kingdom 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. In most member states, however, prior authorisation may only be required for treatment abroad.

### **2.3.3 Insurers' relationship with providers**

#### **Methods of paying providers**

Voluntary health insurers usually pay providers on a fee-for-service basis, although there is deviation from this norm in some member states. For example, a small number of providers in Spain are paid on a capitation basis, providers employed in insurers' own facilities may be paid a salary or a combination of salary and fees for service (in France and Greece), insurers in Ireland pay hospitals according to a fixed rate per diem, some insurers in the Netherlands fix budgets for hospitals and fee-for-service payment may be supplemented by a lump sum in Austria.

In some member states fees for service are paid on the basis of a fixed fee schedule (Luxembourg and France) or reference price (Portugal), while providers in other member states may be able to charge higher rates than the schedule (some doctors in France and doctors in Germany, the Netherlands and Sweden). From the insurers' perspective, allowing providers to charge higher rates is likely to have cost implications. From the perspective of public policy, allowing providers to charge higher rates may have equity and efficiency implications. For example, German doctors are allowed to charge VHI patients 1.7 or 2.3 times the reimbursement values set in the fee schedule for private medical services issued by the Federal Ministry for Health (and sometimes even more) (Busse 2000a). Charging extra may reduce access for some patients, although German providers are no longer permitted to charge more than 1.7 times extra for individuals with the standard tariff (see Section 2.1.1) (Bundesaufsichtsamt für das Versicherungswesen 2001). Furthermore, over the last 10 years, expenditure for individuals with substitutive VHI in Germany has increased on average by 40 per cent more than expenditure for those in the statutory health insurance scheme, and by almost two or three times as much for ambulatory care, dental care and pharmaceuticals and (Busse 2000a).

#### **Selective contracting**

Some voluntary health insurers contract providers on a selective basis (that is, they contract with some rather than all providers) in Austria, Denmark, Greece, Ireland, Italy, Portugal, Spain, Sweden and the United Kingdom. Selective contracting is more difficult to operate in member states where VHI subscribers are reimbursed and where there is free choice of provider in the statutory health care system (as in Belgium, France, Germany and Luxembourg) . In the Netherlands it is only possible for insurers to contract selectively with individual providers, not with hospitals, but this practice is rare. Selective contracting may be limited in some member states due to lack of capacity in the private sector. This is currently

the case in Denmark, where private for-profit hospitals are low in number and contracting with public hospitals is prohibited.

Voluntary health insurers in Austria make full use of selective contracting. For example, a large insurer recently issued guidelines specifying the size they would like private rooms in public hospitals to be and the facilities they would like them to contain (Hofmarcher 2001).

### **Private beds in public hospitals**

Private beds in public hospitals (beds reserved for private patients) are used by voluntary health insurers in Austria, Ireland, Portugal and the United Kingdom. Private beds do not exist in public hospitals in Belgium, Denmark, France, Germany, Greece, Italy, Luxembourg, the Netherlands, Spain and Sweden.

The existence and use of private beds in public hospitals may have equity and efficiency implications for the public sector. Up to 25 per cent of hospital beds can be reserved for private patients in Austria. Because these beds retain about 90 per cent of supplementary VHI income for hospital expenses, there is an incentive for hospitals to maximise the number of beds they set aside for private use. This means that bed capacity may be kept unnecessarily high (Hofmarcher 2001).

Another factor related to efficiency concerns the way in which insurers are charged for the use of private beds in public hospitals. Insurers in Ireland make extensive use of such beds and it is estimated that the cost of providing private care in public hospitals substantially exceeds the current level of charges for such care, by as much as twice the charge currently levied on a semi-private bed (Nolan and Wiley 2000). The total annual cost of what is effectively a public subsidy of private beds is estimated to be IRP 35 million (EUR 44.4 million] (O'Shea 2000). The Irish government's White Paper on private health insurance proposed to introduce economic pricing for private beds in public hospitals over a period of five to ten years, but this has not yet materialised (Department of Health and Children 1999).

In 1989 the UK government did introduce economic pricing for private beds in NHS hospitals. As a result of NHS reforms, the newly-formed NHS trusts began to charge commercial rates, leading to financial problems for many voluntary health insurers. The largest UK insurer was eventually forced to exclude coverage of private beds in NHS hospitals (Buck et al. 1997).

### **Doctors practising in the private and the public sector**

Doctors are prohibited from working in both the private and the public sector in Belgium, Greece (except, until recently, university doctors), Luxembourg and Sweden. Doctors work in both sectors in Austria, Denmark (limited), Finland, France, Germany, Ireland, the Netherlands, Portugal, Spain and the United Kingdom. Doctors in Italy must choose to be

employed in one or the other sector, but public doctors may engage in a limited amount of private practice.

Discrepancies between the way in which doctors are paid by the statutory health care systems and voluntary health insurers may create incentives for doctors to treat VHI patients differently from public patients. In Spain, for example, doctors have a clear incentive to pay more attention to VHI patients because insurers pay them on a fee-for-service basis, while the state pays them a salary (Rodríguez 2001). There is anecdotal evidence to suggest that doctors treat VHI patients more favourably in Austria, Finland, France, Spain and Portugal, spending more time with them and providing them with a larger amount of tests and examinations etc (Hofmarcher 2001, Mikkola 2001, Sandier and Ulmann 2001, Rodríguez 2001, Oliveira 2001), but there is no evidence to suggest that this happens in Denmark, Germany, Greece, Italy or Sweden.

Doctors in other member states may have incentives to treat VHI patients before public patients, so that VHI patients may have shorter waiting times than public patients. This is the case in Austria, Ireland, Italy, Portugal, Spain, Sweden and the United Kingdom (Hofmarcher 2001, Murray 2001a, Giannoni-Mazzi 2001, Oliveira 2001, Rodríguez 2001, Skoglund 2001, Hockley 2001).

The equity and efficiency implications of voluntary health insurers' relationship with providers in different member states are issues that concern public policy rather than insurers themselves.

## **2.4 Subscribers' costs**

### **2.4.1 The price of premiums**

The price of premiums within a member state may vary according to the method used to set premiums (that is, community, group or risk rating). Employees will generally have better access to lower premiums than self-employed people or people without employment (students, unemployed people, those in retirement), as they may benefit from group policies, which are usually group-rated and often offered at reduced prices. In the United Kingdom, for example, group VHI policies are not only much cheaper than individual policies, their annual price increases have also been much smaller (Papworth 2000). Group VHI policies in Ireland also benefit from discounts of up to 10 per cent, the maximum allowable discount by law, and those with higher employment status are more likely to benefit from employer-paid group policies (Vhi Healthcare 2001c, Department of Health and Children 2001b). The price of VHI

premiums will also vary according to the variables used in risk-rating, with generally higher premiums for older people, women, people with lower health status etc.

The level of variation between VHI policies in different member states makes it difficult to compare average premium prices across member states. Furthermore, there is substantial variation in the price of VHI premiums within member states (for the reasons given above). However, there is evidence to suggest that the price of VHI premiums in many member states has not been stable. On the contrary, VHI subscribers in some member states have been subject to premium increases above rate of inflation in the health sector as a whole. Table 15 shows the real compound annual growth rate of VHI premiums during the 1990s in member states for which we were able to obtain data, and compares this increase to the average annual growth rate of total expenditure on health care (TEH) deflated by the GDP deflator. The price of VHI premiums in these member states appears to have risen much faster than total health care expenditure. While the compound annual growth rate of VHI premiums ranged from 2.3 to 12 per cent, the average annual growth rate of total expenditure on health care was between -1.1 and 2.7 per cent.

Commercial voluntary health insurers in Italy argue that premiums rose above inflation due to increases in their administrative costs and rises in the fees paid to health care providers (Giannoni-Mazzi 2001). The premiums of complementary and supplementary VHI in the Netherlands have also risen over the last few years; in 1999 they rose by 10 per cent (Vektis 2000).

**Table 15 Annual increases in the average price of VHI premiums in selected member states**

Country	Compound annual growth rate (CAGR) of VHI premiums (%)	Average annual growth rate (AAGR) of TEH (deflated by GDP deflator) (%)
<b>Austria</b>	2.3% (1996-2000)	0.4% (1996-1999)
<b>Germany</b>	7.6% (1994-1998)	2.7% (1994-1998)
<b>Greece</b>	6.8 – 10.4% (1997-2000)	-1.1% (1997-1998)
<b>Italy</b>	6.5% (1994-1998)	1.6% (1994-1998)
<b>Spain</b>	10.5% (1993-1997)	2.3% (1993-1997)
<b>United Kingdom</b>	12.0% individual policies (1994-1999) <3.0% group policies (1994-1999)	2.5% (1994-1999)

Source: Datamonitor (Datamonitor 2000a), OECD (Organisation for Economic Co-operation and Development 2001a); Hofmarcher (Hofmarcher 2001); Economou (Economou 2001)

Note 1: We have used the average annual growth rate of total expenditure on health care because the OECD database does not provide an index of health or consumer prices

Note 2: We have deflated annual total expenditure on health care using the GDP deflator as the health deflator was not available for these years; inflation in the health sector is likely to be higher than inflation in GDP

The Portuguese consumer association DECO (Associação Portuguesa para a Defesa do Consumidor; DECO) notes that the costs of private health care and the price of VHI premiums in Portugal have risen well above the rate of inflation in the last five to seven years, making VHI seem unacceptably expensive to consumers (Associação Portuguesa para a Defesa do

Consumidor 2001). DECO argue that the only reason more VHI is being purchased in Portugal is because employers are increasingly purchasing it as a fringe benefit for their employees (Associação Portuguesa para a Defesa do Consumidor 2001).

The proportion of spending on VHI in Spain increased from 23.7 per cent of private expenditure in 1986 to 30 per cent in 1995 (Lopez i Casanovas 1999). The number of insured people has increased relatively slowly in the last ten years; in 2000 VHI covered only 25 per cent more people than in 1990 (Rodríguez 2001). In contrast, VHI premiums have experienced a sharp rise, with the average premium per insured person increasing by 250 per cent during the same period (Rodríguez 2001). The sharp rise in the price of premiums has probably contributed to slow growth in the number of people subscribing to VHI in Spain.

VHI premiums have also risen sharply in Ireland in recent years. The cost of premiums increased by more than double the rate of inflation between 1993 and 1998 (Consumer Choice 1998). Vhi Healthcare's premiums have risen by 72 per cent in total over the last ten years and by 15 per cent in 2001 (Move To Ireland 2001). According to Vhi Healthcare, its premium rises have been caused by the high cost of new treatments, the ageing of the population and the Irish government's delay in activating the risk equalisation scheme (see Section 3.2.4) (Move To Ireland 2001).<sup>15</sup> The price of BUPA Ireland's VHI premiums usually rise in line with those of Vhi Healthcare (Murray 2001a).

Between 1991 and 1996 the real price of VHI premiums in the United Kingdom rose at an average rate of nearly five per cent per year (after inflation) (Couchman 1999), with the average annual premium per subscriber rising from GBP 323 (EUR 513) in 1989 (or GBP 373 – EUR 592 – for individual subscribers) to GBP 582 (EUR 924) (GBP 746 – EUR 1,185 – for individual subscribers) in 1998 (Laing and Buisson 2000). In 1988 the average individual premium was 15.5 per cent higher than the average group premium, but by 1998 it was 28.2 per cent more expensive (Laing and Buisson 2000). Not only are individual premiums much more expensive than group premiums, their annual increases have also been higher, typically over ten per cent (Papworth 2000). Because VHI premiums in the United Kingdom have risen by significantly more than inflation, the OFT's 1998 report on VHI recommended that subscribers be given a comprehensive warning about the likely increase in VHI premiums supported by reliable data on average increases over the last five years. Although the latter recommendation was initially deemed infeasible by the industry, it eventually agreed to include a warning of premium increases (Davey 1999). However, by July 2000 insurers had failed to take any action with regard to providing consumers with statistics on their average premium increases in the previous five years (Office of Fair Trading 2000b).

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<sup>15</sup> Because Vhi Healthcare has a larger proportion of older subscribers than BUPA Ireland, under the RES it would be compensated by BUPA Ireland.

The data we have collected suggest that poor growth in the VHI market in some member states may be attributed to expensive premiums and annual premium rises above the rate of inflation. Where there has been market growth, this may be largely due to steep increases in the price of premiums and not as a result of greater take up of VHI (see Table 15). A recent market research report predicted that any future growth forecast in some VHI markets was more likely to come through increases in price than increases in coverage (Datamonitor 2000a).

## **2.4.2 Tax incentives**

National tax laws can influence the behaviour of individuals and firms by providing them with incentives or disincentives to purchase VHI. Tax incentives usually operate in the form of tax relief, which allows individuals and firms to deduct all or some of the cost of VHI premiums from income tax (individuals) or corporate tax (firms). Disincentives usually operate in the form of a tax on VHI premiums: either insurance premium tax to be paid by the firm selling insurance or a tax on benefits in kind to be paid by the individual receiving employer-paid VHI as a benefit in kind and/or the firm providing VHI as a benefit in kind.

The extent to which tax laws succeed in encouraging or discouraging the purchase of VHI appears to depend on whether they are targeted at individuals or firms (and at specific groups of individuals, such as employees or elderly people) and whether they are applied in conjunction with other incentives (or disincentives) that might enhance or diminish their effect.

Tax incentives are sometimes suggested as a means of encouraging more people to purchase VHI or rewarding those who have already purchased VHI. It is argued that providing tax incentives for VHI is in the public interest because increasing the demand for VHI reduces the demand for statutory health services, thereby relieving upward pressure on public expenditure. This argument is based on the assumptions that tax incentives are successful in encouraging more people to purchase VHI (rather than simply rewarding existing VHI subscribers) and that increased take up of VHI reduces the demand for statutory health services. Tax incentives that aim to compensate individuals with VHI (either for the additional amount they spend on their own health care or for the reduced amount of statutory health care they consume) do not take into account the fact that these individuals may be paying for better amenities, such as a single room in hospital, and may still be using statutory health services.

It is also possible to argue against tax incentives on other grounds (Davies 1999):

- tax relief distorts price signals
- tax relief is administratively complex and therefore generates additional transaction costs

- tax relief is a type of government subsidy, and because VHI in the European Union is largely purchased by people in higher income brackets (see Section 1.3.2), tax relief for VHI acts as a government subsidy to wealthier people
- tax relief can be regressive in terms of funding health care if it is applied at the marginal rate of tax, as the relief will then be greater for those who have a higher marginal tax rate
- it may create opportunities for tax avoidance or evasion

Tax incentives (and disincentives) to purchase VHI do feature in the European Union (see Tables 16 and 17), although the last fifteen years have seen efforts to reduce or remove tax incentives in many member states. Currently, there are no tax incentives for individuals to purchase any type of VHI in Denmark, Finland, Spain or the United Kingdom, and there are no tax incentives for firms to purchase VHI on behalf of their employees in Finland, France, Germany, Greece, Italy, Luxembourg, the Netherlands, Sweden and the United Kingdom. Tax relief for individually-purchased VHI policies in Germany, Italy, Luxembourg and the Netherlands does not operate as an incentive to purchase VHI because the relief applies jointly to different types of insurance and is limited by a ceiling.

#### **Trends in tax incentives for individuals**

In recent years governments in the following member states have taken measures to reduce or change the direction of tax incentives: Austria, Greece, Ireland, Italy, Spain and the United Kingdom. Portugal is the only member state to have increased tax incentives for individuals to purchase VHI.

The Austrian government reduced tax incentives in 1996 by limiting tax relief to people earning less than a specified amount per year (Bennett et al. 1993). In 1999 they also reduced the tax deductible amount from 100 to 25 per cent of the cost of VHI premiums and imposed a ceiling on the deductible amount (Comité Européen des Assurances 1999, Hofmarcher 2001). Tax relief for VHI premiums in Greece were introduced in 1992, but in 1997 the government imposed a ceiling on the amount deductible from income tax (Economou 2001). Until 1992, tax relief on VHI premiums in Italy was applied at the marginal tax rate; its effect was therefore regressive (Dirindin 1996). In 1992 the Italian government reduced tax relief on commercial group and all mutual VHI premiums from the marginal to the standard rate of tax. In 1999 increased tax relief was established for contributions paid to the complementary SSN funds (as opposed to other types of VHI) and will be applied in increasing annual increments up to 2005 (Giannoni-Mazzi 2001). The Spanish government abolished tax relief of 15 per cent of all medical expenses, including VHI premiums, in 1999 (Freire 1999, Rodríguez 2001). At the same time the government introduced tax relief for firms purchasing VHI on behalf of their employees (see Table 16). The abolition of tax relief for individuals does not appear to have had any negative effect on the demand for individual VHI policies in Spain (Rodríguez 2001).



Tax relief provides a large government subsidy to VHI in Ireland, but in recent years its effect has diminished, partly because it changed from being applied at the marginal tax rate to being applied at the standard tax rate in 1994 (as in Italy in 1992), and partly due to reductions in the standard rate of income tax during the late 1990s. During the 1970s, 1980s and early 1990s full tax relief for VHI premiums was available at the marginal rate of income tax (27 per cent or 48 per cent in 1994) (Harmon and Nolan 2001). The importance of this relief increased as both tax rates and the numbers paying the top rate of tax rose through the 1980s (Harmon and Nolan 2001). At the same time, a 1982 Commission on Taxation and a 1989 Commission on Health Funding questioned the availability of tax relief on the grounds that it was neither equitable nor effective, and recommended that it be abolished (Commission on Taxation 1982, Commission on Health Funding 1989). However, the Finance Act of 1994 only went so far as to reduce relief to the standard rate of income tax (27 per cent) (Department of Health and Children 1999).

The standard rate of tax fell from 27 per cent to 24 per cent in 1998, to 22 per cent in 2000 and to 20 per cent in 2001. Since 2001 tax relief for VHI premiums has been granted 'at source' (that is, instead of individuals claiming a 20 per cent tax rebate at the end of the year, the amount paid to the insurer is simply reduced by 20 per cent, and the onus is on the insurer to claim the tax back from the government). The Irish Revenue Commissioners have recently decided that VHI premiums for primary care products will also benefit from tax relief at the standard rate of 20 per cent (Vhi Healthcare 2001c).

Tax relief on VHI premiums costs the Irish government around EUR 79 million a year (the equivalent of 2.5 per cent of public expenditure on health in 1997), but there are no plans to withdraw it as it is calculated that this would increase the net cost of premiums by as much as 32 per cent (Department of Health and Children 1999). However, the change from the marginal to the standard rate of tax and reductions in the standard rate of income tax alone would have doubled the net cost of VHI premiums to Irish subscribers since the mid 1980s, even if the gross price had not increased at all (Harmon and Nolan 2001). Reductions in the net value of tax relief do not appear to have negatively affected the demand for VHI in Ireland, as the proportion of the population covered by VHI has increased from 21.8 per cent in 1979 to 37.3 per cent in 1994 and 45.5 per cent in 2001 (Department of Health and Children 2001b). Nevertheless, in its submission to this report Vhi Healthcare noted that tax relief on VHI premiums may be "one of the main reasons for the high take-up of insurance in Ireland" (Vhi Healthcare 2001c).

In 1990 the UK government introduced tax relief on VHI premiums for individuals aged 60 and over. This was subsequently abolished by the incoming government in 1997, because research showed that in spite of annual public spending of GBP 135 million (EUR 214 million) on these incentives, the number of VHI subscribers rose by only 50,000 in seven years (a total

increase of 1.6 per cent) (Department of Health 2000). Although the industry claims otherwise, it is also unlikely that the cost of this government subsidy to VHI would be less than the public (NHS) expenditure saved. Recent estimates find that at least an additional 1.8 million individuals would have to take out VHI (equivalent to a 28 per cent growth in coverage) for a subsidy to all adults, equal to the basic rate of income tax, to be self financing (Emmerson et al. 2000, Emmerson et al. 2001). However, if the health care provided by the NHS actually costs less than the health care provided by VHI (and Department of Health statistics suggest that NHS costs for treatment such as cataract extractions and hip replacements are approximately a third less than the same treatment in the private sector), then an additional 3.1 million VHI subscribers would be needed to make the tax subsidy self financing (Emmerson et al. 2001). The evidence from the United Kingdom suggests that tax incentives aimed at individuals does not appear to be particularly successful in encouraging more people to purchase VHI, although the abolition of tax relief in 1997 may have caused some elderly people to give up their VHI policies. Emmerson et al use multivariate analysis to estimate that the abolition of tax relief reduced coverage among those aged 60 or over by 0.7 per cent (a reduction in coverage of 4,000 people) (Emmerson et al. 2001). They conclude that although this will have led to some increase in demand for NHS services, it would be much less costly than the GBP 135 million (EUR 214 million) saved by the abolition of the government subsidy.

As we noted above, Portugal has been the only member state to increase tax incentives for individuals. In 1999 the Portuguese government passed new legislation to establish a tax deductible amount exclusively for VHI premiums, which had previously been capped at approximately EUR 348 for all types of insurance premiums (Dixon and Mossialos 2000). 25 per cent of the cost of VHI premiums can now be deducted from income tax (rather than taxable income) up to a ceiling of PTE 14,000 (EUR 70) or PTE 28,000 (EUR 140) for single people or married couples respectively, plus an additional PTE 7,000 (EUR 35) for each dependant (Oliveira 2001).

Finally, VHI may permit employers to provide employees with tax-free 'income' where policies provided to employees (by employers) as a benefit in kind are not subject to tax on benefits on kind (to be paid by the employee and/or the employer). VHI policies are only subject to benefit-in-kind tax in Ireland and the United Kingdom (see below), which means that employer-paid group VHI policies in most member states provide employees with an untaxed benefit in kind.

### **Trends in tax incentives for firms**

Corporate tax relief is available for firms that choose to purchase and pay for some or all of the VHI premiums of their employees in Austria, Belgium, Denmark, France, Ireland and Spain (see Table 16). Tax incentives for firms appear to have fuelled the demand for group VHI policies in Austria, Denmark, Ireland and Spain. Corporate tax relief for employer-paid VHI premiums was abolished in Portugal in 1999 (although it is still available for employer

contributions to subsystems – see Appendix A). Previously, firms could deduct employer-paid premiums from tax if the benefits were offered to all employees and by insurers established in Portugal (Oliveira 2001).

**Table 16 Tax incentives to purchase VHI in the European Union in 2001**

<b>Country</b>	<b>Tax incentives for individuals / employees</b>	<b>Tax incentives for firms</b>
<b>Austria</b>	Single people can deduct 25 per cent of VHI premiums from taxable income (up to a limit of EUR 2,907) if their annual gross income does not exceed EUR 36,336; the deductible rate declined from 50 per cent in 1988 Sole earners can deduct 25 per cent of VHI premiums from taxable income up to a limit of EUR 5,814; the deductible rate declined from 100 per cent in 1988 to 25 per cent in 1999	Firms can deduct employer-paid premiums from tax
<b>Belgium</b>	Self-employed people can deduct substitutive VHI premiums from taxable income	Firms can deduct employer-paid premiums from tax
<b>Denmark</b>	None (since 1986)	Firms can deduct employer-paid premiums from tax
<b>Finland</b>	None	None
<b>France</b>	Employees can deduct employer-paid VHI premiums from taxable income (up to the amount paid by the employer)	None
<b>Germany</b>	VHI premiums are deductible from taxable income, as are premiums for all other types of voluntary insurance and contributions for statutory insurance (including pensions); tax relief does not constitute an incentive to purchase substitutive VHI (because the ceiling for tax-deductible expenses decreases with rising income) or complementary or supplementary VHI (as the ceiling will have already been reached through statutory contributions)	None
<b>Greece</b>	VHI premiums are deductible from taxable income (since 1992) up to a maximum deductible amount of EUR 587 per year (since 1997)	None
<b>Ireland</b>	VHI premiums are deductible from taxable income at the standard rate of tax	Firms can deduct employer-paid VHI premiums from tax
<b>Italy</b>	VHI premiums for group (but not individual) commercial policies and all mutual policies are deductible from taxable income at the standard rate of tax up to an annual ceiling for all insurance premiums (EUR 1,250) (before 1992 premiums were deductible at the marginal rate of tax)	None
<b>Luxembourg</b>	Individuals can deduct mutual VHI premiums from taxable income up to a ceiling for all insurance premiums	None
<b>Netherlands</b>	Exceptionally high health care costs, including VHI premiums, can be deducted from taxable income once they exceed an income-related ceiling; tax incentives are not significant because this ceiling is set very high	None
<b>Portugal</b>	25 per cent of VHI premiums can be deducted from income tax (rather than taxable income) up to a ceiling of EUR 70 or EUR 140 for single people or married couples respectively, plus an additional EUR 35 for each dependant (since 1999)	None (abolished in 1999)
<b>Spain</b>	None (since 1999)	Firms can deduct employer-paid VHI premiums from tax up to a limit of EUR 360 per person (EUR 1,202 per family) (since 1999)
<b>Sweden</b>	Employees can deduct employer-paid VHI premiums from taxable income	None
<b>UK</b>	None (since 1997)	None

Source: National reports prepared for this report

### Trends in tax disincentives for individuals and firms

Tax disincentives tend to be applied to commercial and employer-paid VHI policies (see Table 17), although insurance premium tax is levied on all VHI policies in the United Kingdom at a rate of 5 per cent (up from 1.5 per cent when the tax was introduced in 1994). The chargeable amount includes any commission paid to (or retained by) brokers and other intermediaries (HM Customs and Excise 1999). Insurance premium tax on other types of insurance in the United Kingdom can be much higher. For example, travel insurance premiums are subject to the full rate of value-added tax (17.5 per cent). Insurance premium tax is also levied on policies sold by commercial insurers in Belgium (9.25 per cent), France (7 per cent) and Luxembourg (4 per cent). Policies sold by mutual and provident associations in these three countries are exempt from insurance premium tax.

Employer-paid VHI policies are treated as a benefit in kind and subject to income tax at the difference between an individual's marginal and standard rate of tax in Ireland. It has been suggested that in practice many individuals do not pay this tax (Vhi Healthcare 2001c). In the United Kingdom employer-paid VHI policies are also treated as a benefit in kind for employees in higher tax bands and are subject to income tax at the marginal tax rate. UK employers are subject to employers' national insurance contributions (a payroll tax of 11.7 per cent) on employer-paid VHI policies. Industry commentators in the United Kingdom claim that insurance premium tax and the benefit-in-kind tax on employer-paid VHI policies dampens the sale of group VHI policies, but as the latter tax does not apply to individuals in the lowest tax band, and the actual amounts involved are relatively small, it is unlikely to make much impact on sales.

**Table 17 Tax disincentives**

Country	Tax disincentives
<b>Belgium</b>	<ul style="list-style-type: none"> <li>▪ Commercial VHI policies are subject to insurance premium tax of 9.25 per cent</li> <li>▪ All insurers pay a 10 per cent contribution to RIZIV-INAMI for hospital coverage with benefits above EUR 12.50 per day</li> </ul>
<b>France</b>	<ul style="list-style-type: none"> <li>▪ Commercial VHI policies are subject to insurance premium tax of 7 per cent</li> <li>▪ VHI policies sold by mutual and provident associations are exempt from this tax</li> </ul>
<b>Ireland</b>	<ul style="list-style-type: none"> <li>▪ Employees are charged a benefit-in-kind tax on employer-paid premiums based on the difference between their marginal tax rate and their standard rate of tax</li> </ul>
<b>Luxembourg</b>	<ul style="list-style-type: none"> <li>▪ Commercial VHI policies are subject to insurance premium tax of 4 per cent</li> <li>▪ VHI policies sold by mutual associations are exempt from this tax</li> </ul>
<b>UK</b>	<ul style="list-style-type: none"> <li>▪ All VHI policies are subject to insurance premium tax of 5 per cent (up from 1.5 per cent when it was introduced in 1994)</li> <li>▪ Since 1999, all benefits in kind (including employer-paid VHI premiums) are subject to employers' national insurance contributions at the rate of 11.7 per cent</li> <li>▪ Employees in all but the lowest tax band are charged a benefit-in-kind tax on employer-paid premiums</li> </ul>

Source: National reports prepared for this report

### Tax incentives and market structure

Tax incentives can be used to influence market structure by favouring certain types of insurers over others or by encouraging the purchase of group rather than individual policies (and vice

versa). As we have seen, tax incentives in Belgium, France, Italy and Luxembourg favour mutual or provident associations over commercial insurers. The exemption from insurance premium tax for mutual and provident associations in France has been valued at FRF 3 billion (EUR 457.35 million) a year (Sandier and Ulmann 2001). In March 1993 the French Federation of Insurance Associations (FFSA) lodged a complaint against the French government with the European Commission (Sandier and Ulmann 2001). In November 2001 the European Commission asked the French government to put an end to the aid resulting from this exemption, either by abolishing the exemption or “ensuring that the aid does not exceed the costs arising from the constraints inherent in a service of general economic interest” (for further details, see Section 4.3) (European Commission 2001: 1).

The trend towards reducing or removing tax incentives to purchase VHI in the European Union suggests that many governments have found better ways of spending this money, considering tax incentives for individuals to be expensive, regressive and largely unsuccessful in stimulating demand. Tax incentives for firms appear to enjoy greater success in encouraging employers to purchase and pay for VHI on behalf of their employees. Tax incentives that favour certain types of insurers over others can have an impact on market structure, but differential tax treatment of insurers is unlikely to be a sustainable form of national public policy as it may contravene EU competition law.

## **2.5 Insurers' costs**

### **2.5.1 Claims expenditure**

Between 1995 and 1998, the growth in claims expenditure (benefits paid) exceeded the growth in premium income in some member states (Comité Européen des Assurances 2000). Nevertheless, claims expenditure as a proportion of premium income (loss ratios) did not show a significant increase during this period (see Table 18).

There is substantial variation in loss ratios between different member states and between individual and group VHI policies. In Germany, for example, the loss ratio decreased significantly from 80 per cent in 1995 to 65.8 per cent in 1999, but this decline was caused by increases in the legal requirements for old age reserves, rather than a fall in claims expenditure (Busse 2001). Overall, loss ratios appear to be highest in Denmark (91.7 per cent in 1998) and over 80 in the Netherlands and Spain. However, most loss ratios are in the range of 72-76 per cent.

The variation between loss ratios for commercial individual and group policies is much more marked, which may reflect that fact that many insurers offer group policies at reduced rates

(see Section 2.2.2). Commercial insurers in Belgium had a loss ratio of as low as 60.2 per cent for individual policies in 1999, whereas group policies showed much tighter margins, with a loss ratio of 88.8 per cent (Hermesse 2001). Commercial individual policies had a loss ratio of 68.7 per cent in France in 1998, compared to a loss ratio of 85.4 per cent for commercial group policies (Sandier and Ulmann 2001). Loss ratios were also higher for group policies in Portugal and the United Kingdom (Oliveira 2001, Laing and Buisson 2001).

Loss ratios in the United Kingdom have decreased considerably during the 1990s. In 1985 voluntary health insurers had a loss ratio of 88 per cent, but by 1995 the loss ratio had gone down to 81 per cent, and in 2000 it was even lower, at 79 per cent (Laing and Buisson 2001). While the loss ratio for employer-paid group VHI policies in the United Kingdom was 85 per cent in 2000, it was as low as 73 per cent for VHI policies paid for by individuals and employees (Laing and Buisson 2001). A recent 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).

In Ireland Vhi Healthcare (the dominant insurer) has projected a loss ratio of 87 per cent in 2002 for itself, and a loss ratio of 55 per cent for its rival BUPA Ireland (the only major voluntary health insurer to have entered and stayed in the Irish market since it was liberalised in 1996) (Vhi Healthcare 2001c). Vhi Healthcare has also projected profits of 25 per cent of premium income for BUPA Ireland and 1.5 per cent for itself. When we asked BUPA Ireland to comment on Vhi Healthcare’s projected figures, its Marketing Director described them as “a complete fiction” (Murray 2001b). However, as BUPA Ireland declined to provide us with any financial data regarding their premium income, claims expenditure and operating costs, we are unable to confirm or refute Vhi Healthcare’s projections for 2002.<sup>16</sup>

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<sup>16</sup> BUPA Ireland is not obliged to publish any financial data in Ireland due to its status as a branch of BUPA International. Although BUPA Limited publishes an annual report in the United Kingdom, which includes data for business in Ireland, these data are not disaggregated from other international business. It proved impossible to obtain disaggregated data regarding business in Ireland from the Financial Services Authority (FSA), the regulatory authority in the United Kingdom. BUPA Ireland will have to provide financial data to the new Health Insurance Authority in Ireland, but these data will not be publicly available.

**Table 18 Loss ratios of voluntary health insurers**

Country	CEA – 1995	CEA – 1998	National reports – various years
<b>Austria</b>	74.1	75.8	74.4% in 2000
<b>Belgium</b>	75.2	74.1	Commercial individual: 60.2% (1999) Commercial group: 88.8% (1999)
<b>Denmark</b>	90.9	91.7	N/A
<b>Finland</b>	N/A	69.4	Commercial (includes accident + health) 75.2% (1998) 75.8% (1999) 72.5% (2000)
<b>France</b>	77.5	78.7	Commercial individual: 66-70% (1999) 71.9% (1989) to 68.7% (1998) Commercial group: 100% (1993) 82% (1996) 85.4% in 1997 84.5% (1998)
<b>Germany</b>	80.0	70.4	65.8% (1999)
<b>Greece</b>	N/A	N/A	76.6% (1999)
<b>Ireland</b>	N/A	N/A	Vhi Healthcare: 86% (2001)
<b>Italy</b>	74.1	78.1	75.2% (1999)
<b>Luxembourg</b>	N/A	N/A	Mutuals had a deficit of LUF 20 m in 2000. In 1998 they had a much larger deficit, but membership fees have since increased.
<b>Netherlands</b>	87.7	89.3	81.3% (2000)
<b>Portugal</b>	76.3	78.1	83-87% (1996-1999) lower for individual policies
<b>Spain</b>	82.0	84.0	83%
<b>UK</b>	82.0	83.3	Overall: 79% (2000) Individual: 73% (2000) Employer-paid: 85% (2000)

Source: CEA (Comité Européen des Assurances 1997, Comité Européen des Assurances 2000); national reports prepared for this report

Note 1: loss ratios are obtained by dividing benefits paid by premium income

Note 2: No data available for Sweden

## 2.5.2 Administrative costs

The transaction costs of management and administration tend to be much higher under voluntary than statutory health insurance systems because of the extensive bureaucracy required to assess risk, set premiums, design benefit packages and review, pay or refuse claims. Voluntary health 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 funding and providing health care (Barr 1992). Some commentators in the United States 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 voluntary health 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 VHI markets in the European Union, where the majority of insurers do not, on the whole, adopt the above-mentioned measures to contain costs. Insurers in the European Union are more likely to compete on the basis of risk selection than through competitive purchasing and their attempts to contain costs generally operate on the demand rather than the supply side.

Data on the administrative costs of voluntary health insurers in different member states are limited, although the available evidence suggests that these costs are high compared to those of the statutory health care system (see Table 19). Voluntary health insurers' administrative costs range from about 10 per cent in Germany, Luxembourg (mutual associations), the Netherlands and France (mutual associations) to as much as about 25 per cent in Austria, Belgium, Italy and Portugal. In contrast, the administrative costs of statutory health care systems are substantially lower: between three and five per cent in most member states and even lower in others such as Denmark and Italy.

The development of voluntary health insurers' administrative costs in Ireland provides an interesting case study of the side-effects of increasing competition in VHI markets. When the Irish market was liberalised in 1994, it was expected that the entry of new insurers would stimulate competition and increase efficiency, but this does not appear to have been the case, at least where administrative costs are concerned. In 1996 the administrative costs of Vhi Healthcare (the only major voluntary health insurer in Ireland) were equal to two per cent of premium income, while those of BUPA Ireland (the new market entrant) were 12 per cent (Light 1998). By 1999 administrative costs had risen for both insurers, probably as a result of increased expenditure on marketing by both insurers, as Vhi Healthcare now had to compete with BUPA Ireland for new subscribers. However, Vhi Healthcare's administrative costs were still considerably lower than BUPA Ireland's (4.7 per cent of premium income compared to 14.2 per cent) (BUPA 2000, Vhi Healthcare 2000). In fact, the Department of Health and Children have noted that the advent of competition has been accompanied by a marked increase in the level of advertising in the Irish market (Department of Health and Children 2001b). According to Vhi Healthcare's latest annual report, its administrative costs for 2001 were 11.8 per cent of premium income (Vhi Healthcare 2001b).

**Table 19 Administrative costs as a proportion of VHI premium income compared to administrative costs in the statutory health care system**

<b>Country</b>	<b>Voluntary health insurers</b>	<b>Public expenditure on administration as a % of public expenditure on health</b>
<b>Austria</b>	22% (early 1990s)	3.6% (2000)
<b>Belgium</b>	25.8% commercial individual (1999) 26.8% commercial group (1999)	4.8% (1999)
<b>Denmark</b>	N/A	1.1%*
<b>Finland</b>	N/A	3.1%*
<b>France</b>	10-15% (mutual associations) 15-25% (commercial)	4-8%
<b>Germany</b>	10.2% (1999)	5.09% (2000)
<b>Greece</b>	15-18% (commercial life insurers)	5.1%
<b>Ireland</b>	11.8% (Vhi Healthcare 2001) 5.4% (Vhi Healthcare 1997)	2.8%*
<b>Italy</b>	27.8% (2000) 26.8% (1999)	0.4%*
<b>Luxembourg</b>	10-12% (mutual associations)	5%
<b>Netherlands</b>	12.7% (1999)	0.7% AWBZ (1999) 4.4% ZFW (1999)
<b>Portugal</b>	About 25%	N/A
<b>Spain</b>	About 13-15%	5%
<b>UK</b>	14.2% (BUPA 1999) 16.9% (PPP Healthcare 1998)	3.5%*

Source: National reports prepared for this report; OECD (Organisation for Economic Co-operation and Development 2001a)

Note: No data available for Sweden

\* OECD data for 1995

## Section 3: Access, equity and consumer protection

This section aims to:

- discuss the ways in which different types of VHI might affect access to health care
- examine barriers to access to VHI in different member states
- examine the equity implications of VHI in different member states

### 3.1 Access to health care

Facilitating access to health care involves helping people to command appropriate health care resources in order to preserve or improve their health; it includes at least four dimensions (Gulliford et al. 2001):

- service availability (if an adequate supply of health services is available then a population may 'have access' to health care)
- service utilisation (when services are utilised, the population 'gains access' to health care, but this may depend on personal, financial and organisational barriers to access and not just on the adequacy of supply)
- service relevance and effectiveness (services must be relevant and effective for a population to 'gain access to satisfactory health outcomes')
- equity (achieving 'equity of access') .

Ensuring equal access for equal need is a key principle of equity in health care (Mooney 1983) and an implicit or explicit equity goal of health care systems in most member states. Equal access for equal need gives everyone an equal opportunity to use health care. Health care provided and utilised according to this principle should result in horizontal equity (equal treatment of equals) and vertical equity (unequal treatment of unequals). As we noted in Section 1.1, universal or near universal rights to health care can be found in every member state except the Netherlands. It is widely acknowledged, however, that universal rights do not automatically ensure universal access to health care (Glennister et al. 2000). In fact, barriers to access in the statutory health care system are present in every member state of the European Union.

A major distinction between statutory and voluntary health insurance is that, in theory, access to statutory health care in member states depends on an individual's status as a citizen, resident or employee, and is usually independent of ability to pay, whereas access to health care through VHI is almost always dependent on ability to pay. Nevertheless, the recent trend in shifting health care costs from the state to individuals has given rise to concerns about inequalities in access to statutory health care in many member states. For example, the increase in user charges in Sweden's statutory health care system has had a much higher

impact on access than the market for VHI, which is relatively limited in size and scope (Whitehead et al. 1997). Access to statutory health care may also be constrained by explicit or implicit rationing of services through reductions in levels of statutory coverage or budgetary restrictions. Moreover, there may be considerable geographical inequity in the distribution of resources in the statutory health care system, and health care utilisation is likely to be influenced by socio-cultural factors, including different preferences, knowledge, information, incomes and opportunity costs across individuals. Any discussion of access to health care should therefore take place from a broad perspective, within the context of existing inequalities in access to statutory health care.

The extent to which VHI affects access to health care depends, in part, on the characteristics of the statutory health care system. If the statutory health care system guarantees all citizens equal access to health care for equal need (or, even better, equal utilisation for equal need), then access to VHI need not be an issue of concern to policy-makers. Put another way, access to VHI may concern policy-makers in so far as VHI provides primary protection against the consequences of ill health. As the Association of British Insurers notes in its submission to this report: “the greater the role of private health insurance in providing access to services that are alternatives to the basic health care system, the larger the impact it is likely to have on access to health care” (Association of British Insurers 2001b).

Substitutive VHI may be the only source of protection against the potentially catastrophic costs of ill health for individuals who are excluded from the statutory health care system or choose to opt out of it. It therefore plays a vital role in providing access to health care and protection against some or all of the financial consequences of ill health for certain sections of the population in some member states (for example, it covers self-employed people for minor risks in Belgium, high-earning people for the costs of outpatient care and inpatient care for the first year of hospitalisation in the Netherlands, high-earning employees for all types of care in Germany and some groups of professionals for all types of care in Austria) (see Section 2.1.1). For this reason the third non-life insurance directive allows the state to impose special conditions and regulatory controls on insurers providing substitutive VHI, and in recent years the Dutch and German governments have made substantial interventions in the market for substitutive VHI in order to ensure that elderly people, people with chronic illnesses and people on lower incomes have access to an adequate and affordable level of coverage (see Section 2.1.1).

Unequal access to complementary VHI may be problematic where complementary VHI provides full or partial cover for necessary and effective health services that are excluded or not fully covered by the statutory health care system. There is some evidence to suggest that access to complementary VHI covering the cost of co-payments imposed in the statutory health care system is problematic for people with low incomes, particularly those who are just

above the income threshold for any exemptions that may exist. Such individuals will be doubly disadvantaged in having to make co-payments in the first instance and then being unable to afford complementary VHI to cover the cost of the co-payments. This type of complementary VHI is most prevalent in France, where it covered 85 per cent of the population in 1998 (see Section 1.2.3), and where the likelihood both of being covered and of having a high quality of coverage are largely dependent on income levels, employment status and age (see Section 1.3.2). In 1999, 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) extending complementary VHI coverage to the 15 per cent of the population that was not already covered by it (see Section 3.2.1).

Where different types of VHI available in the European Union provide some degree of protection against the consequences of ill health, it is relevant to examine the extent to which individuals have access to VHI. Access to substitutive VHI is largely on the basis of eligibility criteria set by the state. Consequently, it is only available to clearly defined groups of people in a small number of member states. In contrast, complementary or supplementary VHI are available to the whole population in every member state. However, the extent to which those who want to purchase any type of VHI are able to do so may depend less on eligibility than on demand-side factors (ability to pay) and supply-side factors relating to the way in which voluntary health insurers conduct their business (price, selection procedures, policy conditions and product differentiation). In its submission to this report, the Groupe Consultatif Actuariel Européen points out that: “in practice, access [to VHI] is determined by the operation of the insurance market” (Groupe Consultatif Actuariel Européen 2001), recognising that the behaviour of insurers may have a significant bearing on access to VHI.

Whether VHI affects access to health care may also depend on the extent to which it operates independently of the statutory sector. The existence of VHI could present a barrier to access in the statutory health care system by drawing on public resources, to the detriment of public patients. This is most likely to happen when the boundaries between public and private health care 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.

Finally, there is the issue of consumer protection, which may be of interest to policy-makers.

In the following sections we explore potential barriers to access to VHI, including price and ability to pay, other non-price barriers and the possible implications of information asymmetry for access and consumer protection (risk selection, the use of genetic testing and whether product differentiation leads to consumer detriment). We also examine the equity implications of the existence of VHI in different member states, although evidence is limited in this area.

## **3.2 Potential barriers to access in VHI markets**

By definition, VHI in the European Union does not require individuals to be compulsorily insured. The decision to purchase VHI is a voluntary one. Unless there is a system of open enrolment in place, requiring insurers to accept all applicants, insurers will have considerable discretion in deciding whom to cover, the terms on which they provide cover and how much they charge for cover. Due to the voluntary nature of the services they provide, voluntary health insurers in some member states have traditionally enjoyed a high level of freedom from statutory regulation. Since the third non-life insurance directive outlawed statutory price and product controls in 1994, voluntary health insurers in all member states are largely exempt from statutory regulation in this respect, although they are subject to financial scrutiny regarding solvency levels. In theory, this means that they are free to select applicants, rate premiums on any basis they choose and set their own policy conditions. However, insurers offering substitutive VHI remain subject to some degree of statutory regulation regarding the price of premiums and policy conditions (see Section 1.4).

### **3.2.1 Price and ability to pay**

The price of VHI premiums within a member state will vary according to the method used to set premiums (that is, community, group or risk rating). Price will also vary according to the variables used in risk-rating, with insurers often charging higher premiums for older people, women and those with chronic illnesses etc. Employed people will generally have better access to lower premiums than people without employment (students, unemployed people, those in retirement), as they may benefit from group policies that are group-rated and usually offered at reduced prices. Within this sub-section, people with higher employment status are more likely to benefit from employer-paid group policies. VHI is therefore less likely to be purchased by elderly people, unemployed people, unskilled workers, people on low incomes and people in poor health. The existence of tax incentives may also favour people on higher incomes, particularly if relief is granted at the marginal rate of taxation. As we noted in the introduction to this section, however, the importance of financial barriers to the purchase of VHI in the European Union is largely dependent on the extent to which VHI acts as a primary source of protection against the consequences of ill health. This type of VHI is currently limited in many member states.

Although eligibility for substitutive VHI depends on earning above a certain amount in Germany and the Netherlands, there may be individuals in both member states who find price an obstacle to obtaining an adequate level of substitutive VHI coverage. In the German context, where individuals can choose between the statutory health insurance scheme (GKV) and substitutive VHI, price is most likely to be problematic for those who have already made

the decision to opt out and are now prevented by law from returning to the GKV, even if their income falls below the GKV threshold (see Section 2.1.1). For this reason the German government has required voluntary health insurers to offer substitutive VHI policies at a standard rate (since 1994) to individuals aged 65 and over who had been voluntarily insured for a qualifying period of at least 10 years and (since 2000) at a standard rate for individuals aged 55 and over who have been voluntarily insured for at least 10 years and whose incomes drop below the contribution ceiling. Substitutive VHI policies sold at the standard rate provide benefits that match the benefits of the GKV and guarantee that premiums will not exceed the average maximum GKV contribution (or 1.5 times the contribution for married couples) (Comité Européen des Assurances 1997).

To date, however, very few people have chosen this option (only 1,161 people in 1998 and 1,407 in 1999), which may be because price does not present a barrier to those who have already decided to opt out, but may also be because insurers do not always inform people when they become eligible to switch to the standard rate (Busse 2001). Consequently, the Reform Act of Social Health Insurance 2000 stipulates that voluntary health insurers must notify individuals as soon as they are eligible to switch to a cheaper policy (Bundesaufsichtsamt für das Versicherungswesen 2001). The number of people opting for standard rate policies may increase in future.

Through the WTZ scheme, the Dutch government has also taken steps to ensure that people who are excluded from the statutory health insurance scheme for outpatient care and the first year of inpatient care (ZFW) are able to purchase an adequate level of VHI coverage for a fixed premium (see Section 2.1.1). The WTZ scheme allows the government to fix the premium of a 'standard package policy' that provides similar benefits to the ZFW.

In theory, complementary or supplementary VHI are available to the whole population in every member state. However, this is subject to willingness and ability to pay. As we showed in Section 1.3.2, subscribers of complementary and supplementary VHI in many member states are more likely to come from high-income groups, which suggests that income and price may be determinants of the demand for these types of VHI. Other determinants include age, gender, occupational status, educational status and area of residence.

Unfortunately it has not been possible to obtain comparative data about complementary and supplementary VHI premium prices in different member states. Survey data from Ireland, Spain and the United Kingdom reveal that VHI is perceived to be expensive by a significant proportion of the population. A consumer survey of 2,620 people carried out by the Irish Economic and Social Research Institute in Dublin found that very few people regard the current price of their VHI coverage as 'quite cheap' (1.6 per cent), 35 per cent regard it as 'good value', 43.1 per cent regard it as 'expensive', 17.7 per cent as 'very expensive' and a

few found it 'close to unaffordable' (2.6 per cent) (Nolan and Wiley 2000). Those regarding the current price as very expensive or close to unaffordable comprised more older respondents than those not giving those responses, as well as more retired people; they were also drawn less often from the top income range employed in the survey. In a survey carried out by a private consulting company in Spain in 1998, 51 per cent of people that did not have VHI gave as a reason for this the fact that the statutory health care system 'works well', 22 per cent had not even thought about it and 26 per cent said that VHI was too expensive and they could not afford it (Rodríguez 2001). A recent survey by a British consumer analyst and research group found that 58 per cent of British subscribers considered VHI cover to be 'too expensive' (BBC 2000). The Portuguese consumers' association DECO (Associação Portuguesa para a Defesa do Consumidor; DECO) claimed in its submission to this report that the costs of private health care and the price of VHI premiums in Portugal have risen well above the rate of inflation in the last five to seven years, making VHI seem unacceptably expensive to consumers (Associação Portuguesa para a Defesa do Consumidor 2001).

Prior to 2000 the price of VHI premiums in France clearly reduced access for low income people, who were much less likely to purchase complementary VHI and much more likely to have coverage of a lower quality than richer people (see Section 1.3.2) (Sandier and Ulmann 2001). In June 1999 the French government decided to rectify this situation by passing a law on universal health coverage (CMU) to enable those who did not benefit from any statutory health insurance (estimated on 31 December 2000 as 1.1 million people) to be covered by a basic, compulsory, statutory health insurance scheme (Paris et al. 2002 forthcoming). CMU also facilitates access to complementary VHI for people on low incomes (less than FRF 3,600 (EUR 550) per month) who did not have any cover of this type (estimated on 31 December 2000 as 4.9 million people) (Paris et al. 2002 forthcoming). This represents a major development in the French social security system: in addition to affiliation to a compulsory health insurance scheme, those with incomes below a certain threshold now have the right to complementary VHI coverage. CMU beneficiaries can choose complementary VHI cover from all types of insurers, paid for by the government and by a compulsory contribution of 1.75 per cent on the VHI premiums of all non-CMU individuals with complementary VHI.

Since the CMU settlement in January 2000, the price of VHI premiums in France is, in theory, no longer a barrier to access, except for people whose income is just above the threshold. Some insurers also provide benefits in kind to CMU beneficiaries. Survey results reveal that this system of benefits in kind, which largely benefits low income people, increases equity in the French health care system (Sandier and Ulmann 2001). However, there is also evidence that not everyone who should have benefited from CMU has done so, particularly those who have not had access to information about the scheme (Sandier and Ulmann 2001). Complementary VHI now covers about 94 per cent of the population.



### **3.2.2 Non-price barriers**

There are several ways in which insurers may restrict subscribers' access to health care (see Section 2.3.2). This can be achieved by requesting prior authorisation of treatment, by imposing cost-sharing, by introducing no claims bonuses, by insisting on waiting periods or moratorium underwriting, or by reimbursing subscribers rather than providing benefits in kind. With the exception of no claims bonuses, mandatory waiting periods and moratorium underwriting, these measures to restrict access may also be present in statutory health care systems.

Non-price barriers may also be created by information failures in VHI markets. In the following sections we examine:

- whether there are information failures in markets for VHI in the European Union
- whether insurers have incentives to select risks in a competitive environment
- the possibility of introducing a system of risk adjustment to reduce insurers' incentives to select risks
- existing risk-adjustment or cross-subsidisation schemes in Belgium, Ireland and the Netherlands
- the implications of genetic testing for insurance purposes
- whether the presence of multiple VHI products leads to consumer detriment

### **3.2.3 Asymmetrical information, adverse selection and risk selection in VHI markets**

Information is vital to buyers and sellers in a competitive insurance market. Less than perfect information can be problematic for insurers, who may find it difficult to distinguish between high risk individuals and those who are merely risk averse. Asymmetrical information is a type of market failure that may give rise to adverse selection and risk selection (cream-skimming).

The information failure known as adverse selection arises when individuals purchasing VHI can conceal their level of risk from the insurer (Barr 1998). Insurers can address this by charging a common (community-rated) premium, but this might encourage low risk individuals to forego insurance coverage because they are unable to purchase coverage at a premium that reflects their actuarial risk. If low risks opt out, insurers will have to increase premiums, forcing more low risks to opt out. Eventually, the market will fail. Adverse selection can also be addressed by making insurance compulsory, as is the case with statutory health insurance, thereby preventing low risks from opting out.

Risk selection is the process by which insurers seek to encourage custom from individuals with below average risk and discourage or refuse custom from individuals with above average risk. In a competitive environment, insurers may attempt to lower their costs by risk selecting for three reasons (Oliver 1999):

- by maintaining the same premium rate and the same quality of coverage, the lower costs can result in increased profits
- lower costs and maintaining the same premium rate may allow the insurer to improve the quality of coverage in order to keep the same level of subscribers or attract new subscribers
- lower costs and the same quality of coverage may allow the insurer to reduce its premium rate in order to keep the same level of subscribers or attract new subscribers

It is argued that adverse selection and risk selection are more likely to take place under regulatory regimes that restrict insurers' freedom to rate premiums according to individual risk (that is, where insurers charge community or group-rated premiums). One way of addressing this problem is to allow insurers to adjust premiums according to individual levels of risk (risk rating), which will prevent adverse selection and reduce insurers' incentives to risk select. From an equity perspective, risk rating may be considered unfair because people in poor health will have to pay higher premiums and if poor health correlates with low income it may be difficult for some people to obtain the level of coverage they desire. From the point of view of efficiency, the methods used by insurers to risk rate premiums are limited in scope. Many insurers rely on crude indicators of future health care expenditure such as age and gender. Crude risk rating exacerbates insurers' incentives to risk select, to the detriment of both equity and efficiency (Puig-Junoy 1999).

One consequence of risk selection is that certain individuals may be denied access to adequate cover. However, given the high levels of statutory health coverage in the European Union, ensuring equitable access to VHI coverage may only concern policy-makers in so far as VHI does not act as a primary source of protection against the consequences of ill health.

Policy-makers may be more concerned with the effect of risk selection on efficiency. Risk selection is likely to lead to inefficiency if the financial advantages arising from risk selection outweigh potential gains from improvements in efficiency, leaving insurers with little incentive to compete on the basis of efficient management or quality (Gauthier et al. 1995). For example, in a competitive market insurers may attempt to reduce premiums by attracting low risk individuals rather than by increasing efficiency (van de Ven and van Vliet 1992). This lowers the optimal level of competition in the insurance market (Puig-Junoy 1999).

Voluntary health insurers in EU member states are likely to have incentives to risk-select if they are able to reject applications, exclude pre-existing conditions and cancel contracts. Incentives to risk-select in this way can be addressed to some extent by guaranteeing access to coverage (open enrolment) and automatic renewal of contracts, and by limiting exclusions for pre-existing conditions. As we noted in Section 2.3.1, however, open enrolment policies are rare among voluntary health insurers in the European Union and most insurers exclude pre-existing or chronic and long-term conditions (the norm), or charge higher premiums for them. Short-term (usually annual) VHI contracts are the most common form of contract in the European Union; lifetime cover is the exception rather than the rule. Furthermore, many insurers set a maximum age limit for purchasing VHI (usually between 60 and 75 years), while some actually cancel contracts when people reach retiring age. VHI premiums also tend to rise with age, so even those eligible to purchase cover at older ages may not be able to pay for it.

Risk selection can also take place in more subtle ways, for example through market segmentation (see Section 3.2.6) and selective advertising. Targeting certain groups of people, such as employees in a particular sector, may be a form of risk selection. Insurers can benefit from offering reduced premiums and favourable conditions to groups of employees because those too ill or too old to work are excluded from the workplace, allowing insurers to cover a younger, healthier, more homogenous population. However, group insurance schemes can limit adverse selection by imposing compulsory coverage, thereby spreading risk across a wider pool of people (Deber et al. 1999, Gauthier et al. 1995). In the 1980s and 1990s group policies rose substantially as a proportion of all VHI policies in the European Union (see Section 2.2.2). Growth in the group policy market may be the result, among other things, of much lower premium increases than in the individual policy market, which continues to be marked by premium rises above the rate of inflation (see Section 2.4.1). In an attempt to prevent voluntary health insurers from undercutting the individual policy market in this way, the Irish government has introduced a policy of only allowing insurers to reduce group policy premiums by up to 10 per cent (Department of Health and Children 2001b). Light's comparisons of the group premiums of Vhi Healthcare's most popular policy and BUPA Ireland's competing policy in Ireland in the late 1990s showed that BUPA Ireland's premiums were 10 per cent lower for subscribers under 19 years old, 4 per cent lower for those aged 19 to 49 and 20 per cent higher for those aged over 54 (Light 1998). This pricing trend suggests that BUPA Ireland had been trying to attract Vhi Healthcare's younger, and presumably healthier, subscribers, thereby following a policy of competition based on risk selection rather than quality or efficiency. BUPA Ireland have contested these figures and this suggestion, but did not provide us with any alternative data (Murray 2001a).

Insurers may resort to less explicit tactics to avoid covering potentially high risk individuals. A few years ago Irish doctors expressed concern about the possibility of reduced coverage for psychiatric patients under new market conditions (Murdoch 1995). In 2000 it was reported that BUPA Ireland insists on detailed diagnostic information before admitting psychiatric patients, including the diagnosis, prognosis and expected date of discharge, a requirement that does not apply to any of its other patients. Doctors claim that this causes serious delays in admission, as well as stigmatising individuals with mental illnesses (Payne 2000).

Where individuals are given a choice between statutory health insurance and substitutive VHI, risk selection may take place between the statutory health insurance scheme and substitutive VHI. It has been argued that this was the case in the Netherlands in the 1970s and 1980s and in Germany in the early 1990s, leading to a situation in which the statutory health insurance schemes were insuring a disproportionately high number of elderly people (Wasem 1995). Both the German and the Dutch government have since taken measures to address this imbalance (see Section 2.1.1).

### **3.2.4 Mitigating risk selection through risk adjustment**

How can risk selection be mitigated? Some analysts suggest that sophisticated risk adjustment is the only means of successfully preventing insurers from risk selection (van de Ven et al. 2000) and that risk adjustment should therefore be a permanent feature of a deregulated VHI market (Beck and Zweifel 1998). Risk adjustment is defined as “the use of information to calculate the expected health expenditures of individual consumers over a fixed interval of time (eg a month, quarter or year) and set subsidies to consumers or health plans to improve efficiency and equity” (van de Ven and Ellis 1999). A system of risk adjustment requires insurers with younger and healthier subscribers to compensate insurers with older or more high risk subscribers, which may reduce incentives to risk-select in the long run.

However, sophisticated risk adjustment is not only difficult to carry out with accuracy, it is also expensive to administer. These problems may be mitigated if a central agency undertakes risk adjustment on behalf of all insurers, as happens in the statutory health care system in Belgium, Germany and the Netherlands, but even these risk adjustment systems are limited in scope. Evidence from the Netherlands suggests that the Dutch system of risk adjustment between competing statutory sickness funds is too simple to correct completely the consequences of adverse selection and to eradicate incentives to risk-select (van de Ven and van Vliet 1992, Oliver 1999). The German system also appears to suffer from limitations that leave considerable scope and incentives for statutory sickness funds to risk-select (Oliver 1999).

A further problem with risk adjustment concerns feasibility. It is a common complaint among insurers that risk-adjustment mechanisms penalise attempts to operate efficiently and contain costs. If insurers perceive that risk adjustment will narrow their margins and limit their profitability, they may be reluctant to enter or stay in markets that introduce a system of risk adjustment. However, apart from some relatively small and theoretical trade-offs between risk adjustment and efficiency (relating to supplier-induced demand) that are unlikely to be a cause of concern for insurers, risk adjustment does not adjust for the degree of insurer efficiency in itself (Oliver 1999).

Risk adjustment may be an option for substitutive VHI, particularly if public policy favours an expansion of this type of VHI, but whether it would be appropriate for complementary or supplementary VHI is a matter for national debate. Taken to its limit, highly sophisticated risk adjustment (using genetic testing, for example) may erode the concept of insurance as a means of pooling risk, because subscribers would end up paying the full amount of their expected costs and insurance would then be no more than a form of pre-payment. This is why statutory health insurance is (usually) compulsory and contributions to it are community-rated or related to income.

Risk adjustment is rare in VHI markets in the European Union. A system of risk adjustment operates among mutual associations providing substitutive VHI in Belgium (Hermesse 2001). The Irish government has also set up a risk equalisation scheme, but has delegated responsibility for deciding when to activate it to an independent body (Department of Health and Children 2001b). Those with substitutive VHI in the Netherlands are subject to annual solidarity contributions to support the MOOZ and WTZ schemes (Maarse 2001). There are no risk-adjustment or cross-subsidisation schemes for VHI in other member states.

### **Risk adjustment for substitutive VHI in Belgium**

As we noted in Section 2.1.1, mutual associations providing substitutive VHI cover for minor risks to self-employed people in Belgium receive subsidies from the state, whereas commercial insurers do not; these state subsidies are designed to facilitate access to substitutive VHI for self-employed people (Hermesse 2001). Since the beginning of the 1990s the state subsidies have been capped at 20 per cent of premium income for this type of VHI. Until 1994 the subsidies were shared between mutual associations purely on the basis of each mutual association's premium income in the previous year. It was assumed that mutual associations with higher levels of premium income were insuring a larger proportion of self-employed people with higher risks.

In 1994 the system of distribution changed in order to adjust for differences in premium income caused by differences in risk profiles. The subsidies were adjusted on the basis of a benchmark level of expenditure that took into account age, gender and socio-economic

status. Since 1997 risk adjustment has taken place on the basis of four age groups (less than 40 years, 40 to 60 years, 60 to 80 years and over 80 years), levels of disability and levels of urbanisation. From the end of 2001, a refined risk-adjustment formula based on individual level data and taking into account morbidity indicators (such as days spent in hospital) will be used, although its introduction has been delayed due to uncertainties related to outpatient drug expenditure. As a result of this change in the risk-adjustment formula, some mutual associations will receive more subsidies than previously, and some fewer, which may have an impact on VHI premiums.

Commercial insurers offering substitutive VHI may be at a competitive disadvantage because they do not receive these state subsidies. It is claimed that they compensate for this by resorting to risk selection, mainly by excluding or limiting cover for services essential to chronically ill or elderly people, such as drugs and nursing home stays (Palm 2001). It could be argued that the system of state subsidies and risk adjustment should be extended to commercial insurers offering substitutive VHI, in order to reduce their incentives to risk-select (Palm 2001).

#### **The case of the risk equalisation scheme in Ireland**

Currently, Ireland is the only member state to pursue a system of risk adjustment that applies to all insurers in the VHI market. The Health Insurance Act of 1994, introduced by the Irish government to give effect to the requirements of the third non-life insurance directive, set out in law the three key principles that form the basis on which VHI operates in Ireland: community rating, open enrolment and lifetime cover (Department of Health and Children 1999). The Act also permitted, but did not require, the Irish government to introduce a system of risk adjustment, referred to in Ireland as a risk equalisation scheme (RES). The 1996 Health Insurance Regulations introduced such a scheme, reflecting the government's view that risk equalisation was a necessary support for community rating (Advisory Group on the Risk Equalisation Scheme 1998), and the more recent White Paper on VHI set out plans to implement the scheme on the basis of age, gender and prior utilisation by June 2002 (Department of Health and Children 1999). The Health Insurance (Amendment) Act, which came into force in 2001, established an independent Health Insurance Authority, giving it discretion to recommend to the government whether or not material differences in the risk profiles of competing insurers warrant the initiation of risk equalisation transfers (Department of Health and Children 1999). New insurers can choose to exempt themselves from participating in risk equalisation arrangements for a period of three years from the start of trading in Ireland (extended from the 18 months originally envisaged in the White Paper). The RES has not yet been activated.

The purpose of the RES is "to make transfers between insurers with the objective of equalising their risk profiles" (Advisory Group on the Risk Equalisation Scheme 1998). In its

submission to this report, the government noted that it sees the RES as (Department of Health and Children 2001b):

“a necessary provision in a community-rated / open enrolment system of voluntary private health insurance. In a market where open enrolment operates and premiums are community rated, insurers who benefit from risk selection can charge a lower community rate, and/or keep a higher profit margin. Risk equalisation provides for the equitable distribution of risk between insurers. Without risk equalisation the system of community rating/open enrolment would be inherently unstable. Those insurers who have lower risk members will be required to contribute to a central fund (called the risk equalisation fund), and insurers with higher risk members will receive compensation from the fund . . . The (proposed) risk equalisation scheme is entirely concerned with a more equitable distribution of risk profile across insurers as the means of addressing the serious dangers to a community-rated system which risk selection represents. It aims to counter the effects of either inadvertent or intentional preferred risk selection, so-called ‘cherry picking’ or ‘cream-skimming’ of generally younger, healthier lives.

While the risk equalisation scheme has an objective of equalising risk profiles between insurers, it also aims to allow each insurer to retain its own claims management/cost containment efficiencies and to differentiate between differing benefit levels.

If competing health insurers have a strong incentive to select preferred risks, it would be expected that per capita claims costs would spiral for those insurers who are relatively unsuccessful at preferred risk selection or, as a result of it, are left with a high proportion of the elderly or chronically ill insured population. This, in a community rated environment, would lead to significant market instability and lack of public confidence, ultimately leading to the down-sizing of the market. Any such development which would undermine community rating, and the inter-generational solidarity upon which it is based, would be extremely inequitable. This particularly applies to the large number of older people who, having contributed for many years to community rating, could be forced to opt out for economic reasons just when they are beginning to need health insurance cover most.

Risk equalisation, as envisaged in Ireland, is to be neutral regarding the flow of transfers between insurers. The flow of funds between insurers under risk equalisation will be solely determined by the respective risk profiles of the insurers concerned. As the market develops, conceivably the direction of such flows could change with initial net recipients becoming subscribers to the scheme and vice versa. The ultimate beneficiary of risk equalisation is the insured population, particularly the elderly and the ill, who would otherwise be vulnerable to the effects of risk selection. Risk equalisation seeks to remove an insurer's incentive to select preferred risks, but still allows for competition in many areas, including product diversity, efficiencies in relation to claims management, cost containment and customer service.

*The risk equalisation system will not be activated unless and until material distortions emerge between the risk profiles of competing insurers.* The details of risk equalisation are to be set out in a statutory scheme which will be brought forward for approval by each House of the Oireachtas (parliament). This will include the provision of significant discretion to the independent Health Insurance Authority, both as regards any commencement of risk equalisation and the calculation of any payments to be made between insurers thereunder.”

In support of the RES, the government notes that there is a substantial body of objective professional and academic opinion that supports the need for risk adjustment to maintain stability in a community-rated health insurance environment (Department of Health and Children 2001b).

However, the introduction of the RES in Ireland has been surrounded by controversy. On one hand, it is supported by an independent Advisory Group on the Risk Equalisation Scheme. In a report to the government in 1998, the Advisory Group stated that “based on its own deliberations and on the basis of the arguments made and evidence presented to it, risk equalisation is essential to underpin community rating” (Advisory Group on the Risk Equalisation Scheme 1998). It is also supported by the dominant voluntary health insurer Vhi Healthcare, who claim that it will guarantee a fair, equitable and stable market for VHI in Ireland, and that without it, the system of community rating will collapse (Vhi Healthcare 2001a).

On the other hand, BUPA Ireland, the other major voluntary health insurer in the Irish market, is heavily opposed to the RES, claiming that it is an attempt to “rig the market to protect the monopoly . . .” (BUPA Ireland 2000). BUPA Ireland’s argument against the RES is that it “penalises cost containment, is regressive from an income distribution point of view and breaches EU law” (BUPA Ireland 2000). In BUPA Ireland’s opinion, the RES would actually destabilise the market, as it would require BUPA Ireland to compensate Vhi Healthcare by about IRP 8 million (EUR 10.2 million), an amount that would make it difficult for BUPA Ireland to remain in the market (Murray 2001a).

BUPA Ireland has taken legal advice that suggests it could successfully challenge the government on the grounds that the RES is illegal under the third non-life insurance directive, but it has yet to make a formal legal challenge, citing expense as a factor in the decision to delay legal action (Murray 2001a). The issue of legality does not appear to concern the government, however, which states that the third non-life insurance directive permits risk equalisation or loss compensation schemes in the interest of the general good (see Section 5.3.1).



### **Cross-subsidisation schemes in the Netherlands**

Two separate schemes in the Netherlands require individuals with substitutive VHI to make annual solidarity contributions (see Section 2.1.1). One contribution goes to the ZFW (the statutory health insurance scheme for outpatient care and the first year of inpatient care) through the MOOZ scheme, which was set up to compensate the ZFW for the disproportionately high number of elderly people that it insures. The other contribution goes to the WTZ scheme, which guarantees access to substitutive VHI for specific groups of people excluded from the ZFW, providing a standard package policy that provides similar benefits to the ZFW for a fixed premium. The WTZ is implemented by voluntary health insurers. Because the fixed WTZ premium only covers half the cost of providing the standard package policy, insurers receive full compensation from a central equalisation fund financed by an annual solidarity payment made by all those with substitutive VHI.

The sustainability of these schemes was raised in a report presented to the Dutch Ministry of Health by the Dutch Council for Health and Social Services (an independent governmental advisory body), which expressed concern regarding the consequences of EU insurance law for health policy objectives such as accessibility and solidarity (Raad voor de Volksgezondheid & Zorg 2000). This issue is discussed further in Section 5.3.1.

### **3.2.5 Genetic testing and insurance**

In this section we discuss the wider implications of genetic testing, review the arguments concerning the use of genetic testing for insurance purposes and provide information on the use of genetic testing for life insurance. There is limited evidence to suggest that genetic testing is currently an issue where health insurance is concerned, although information about family history of disease is a form of genetic information that is used by health insurers in some member states.

Many governments have attempted to regulate the use of genetic information derived from genetic tests in the hope that a balance can be struck between the public's fear of discrimination or stigmatisation, the desire of the insurance industry to prevent fraud or financial instability and the need of scientists to conduct research. Information about human genetics is not new and is not simply a product of recent scientific tests. Knowledge of people's family history of disease has long presented clues to their genetic inheritance and such information has been used routinely by insurers as a means of assessing a person's probability of making a claim. As tests become more numerous, cheaper and more accessible, many more people will have information about their genetic make-up (although not all available tests are of proven validity or accuracy) (Holtzman 1997). In the context of the insurance market such information raises two concerns: adverse selection and the risk this

poses to the insurer, and discrimination by insurers against those with high or certain probability of claiming (Murthy et al. 2001).

There has been much deliberation in the United Kingdom about the issue of genetics and insurance. The Department of Health's Genetics and Insurance Committee (GAIC) has so far approved the use of genetic test results for Huntington's Disease (HD) by life insurers. They are currently considering the use of genetic testing for early onset Alzheimer's (for which there are currently two tests under scrutiny) and hereditary breast and ovarian cancer for a range of insurance products. GAIC's remit is restricted to an examination of clinical and actuarial relevance of genetic testing for insurance purposes and it is the task of the Human Genetics Commission to determine whether other regulatory provisions need to be put in place (Genetics and Insurance Committee 2000).

Insurers claim that disclosure of existing test results by applicants is necessary in order to avoid exploitative insurance purchasing. They fear that if applicants withhold information about their genetic status they might act fraudulently and may insure themselves for excessively large sums of money. On the other hand, the requirement to disclose the results of genetic tests means that people with an adverse test result are open to discrimination on the basis of genetic information and may face excessive premiums, significant exclusions or find it impossible to obtain insurance. There are already examples of people having been refused insurance on these grounds.

There is little evidence to support the insurers' view that high risk individuals over-insure themselves in life insurance markets. It was argued that the insurance industry in the United Kingdom suffered in the 1980s, when individuals who knew they were HIV positive took out insurance cover that they would not normally have taken out, without disclosing their HIV status. However, as the 1997 report of the UK Human Genetics Advisory Commission's (operational from December 1996 to December 1999) concluded (Human Genetics Advisory Commission 1997): "the insurance industry could currently withstand limited adverse selection that might occur as a result of non-disclosure of genetic test results for life insurance". MacDonald estimated that if life insurance companies refrain from using genetic test results in underwriting, the industry will face additional costs, but the magnitude of these costs will be nearer to 10 per cent than 100 per cent (MacDonald 1997). Thomas estimated that a 10 per cent increase would be indiscernible within the much larger variation that already exists between rates offered by different companies (Thomas 2001).

At the EU level, despite the introduction of legislation to harmonise the insurance market, there has been no binding legislation on genetics and insurance (Murthy et al. 2001). In its 1992 Recommendation R (92) 3 on Genetic Testing and Screening for Health Care Purposes (which is not legally binding) the European Parliament states that insurers should not have the

right to require genetic testing, or to enquire about the results of previously performed tests, as a precondition for the conclusion or modification of an insurance contract.

The lack of EU regulation means that it has been left to individual countries to enact legislation to limit the use of genetic information for the purposes of insurance. Table 20 provides a comparison of laws and regulations affecting the use of genetic tests in some member states, Norway and the United States. Belgium was the first country world-wide to prohibit the use of genetic testing and genetic test results; applicants are prohibited from submitting the results of genetic testing to insurers, whatever the results. The law also prohibits physicians from using genetic testing in medical examinations for insurance purposes. Use of genetic test results for the purposes of insurance is prohibited in Austria, Denmark and Sweden. Through its Civil Code, France has enacted human rights regulation that limits the use of genetic tests to medical and scientific research purposes. French insurers have also recently adopted a moratorium on the use of genetic tests for insurance purposes. In contrast, Germany requires by law that those applying to insurance companies disclose genetic test results, but the German government is currently planning to review this situation. In the Netherlands genetic information also includes family history information about hereditary diseases and the use of this information is not permitted except where large amounts of coverage are being sought (Murthy et al. 2001). In the USA over the past decade 28 states have passed laws that either restrict insurers' use of certain genetic information or completely ban the use of genetic data for underwriting purposes. These laws have sought to protect the interests of patients from the outset, by shaping industry norms and attitudes (Hall and Rich 2000).

In an attempt to overcome the problems that bad risks will over-insure themselves, a number of measures might be introduced to ensure cover for those with adverse genetic test results at the same time as protecting insurers from fraudulent behaviour. The Netherlands has specified a value of life insurance up to which disclosure of genetic information is not required. A similar cut-off was defined in the UK decision to allow insurers to require disclosure of HD genetic test results for the purposes of mortgage-related life insurance in excess of GBP 100,000 (EUR 159,000). Early in May 2001 insurers agreed to a new limit of GBP 300,000 (EUR 476,000) for life insurance, despite earlier resistance to such a change (BBC 2001). In October 2001 the UK government announced that it had struck a deal with the insurance industry to ban genetic testing when assessing all but the highest-value policies.

An alternative solution would be to subsidise life insurance through the imposition of modest premium increases levied on all subscribers, in order to ensure cover for the small minority of people requiring special consideration. Another suggestion is to establish a reinsurance fund to underwrite the policies of individuals with a genetic predisposition, although it is not clear whether such a fund should be funded by the government or not. These suggested measures arise from insurers' argument that genetic information is likely to result in adverse selection.

However, the wider social and ethical implications of genetic testing for insurance purposes should also be taken into account when deciding how to regulate genetic information.

A requirement to disclose genetic information has implications for confidentiality and patient autonomy, and the fear of discrimination may deter individuals from taking a test. Genetic testing may therefore touch on privacy laws, discrimination legislation, public health and the organisation of health care. Individuals will want guarantees that genetic information will not be disclosed to third parties. A balance should be struck between patients' privacy, the need of medical research to access data and the right of affected relatives to know that they may also be at risk. The growing use of genetic testing will require a re-examination of current health information management protocols to prevent the misuse of test results.

The absence of such guarantees may create severe disincentives for genetic testing in general. Fears of discrimination or isolation, and now the recognition that insurance may not be available, have caused patients to forgo a test that would otherwise prove beneficial to their health (House of Commons Science and Technology Committee 2001). The impact of a deterrent effect could be devastating for patients, the research community and the area of preventive medicine. Alternatively, people may seek such tests outside the doctor-patient relationship. This could have severe implications for both the health of the patient and the provision of health services. The nature of genetic testing makes the establishment of one standard with regard to familial disclosure difficult and doctors may be torn between their duty to protect a patient's confidentiality and informing family members about a potentially life threatening disease. Fear and uneasiness may force patients to conceal their results from their physicians and families, posing consequences for early detection and prevention efforts. It is also widely held that the complexity surrounding genetic testing demonstrates a clear need for extensive pre-test and post-test counselling (British Medical Association 1998).

The view of some insurers that genetic information is important in order to accurately assess the future risk of an individual making a claim also perpetuates a deterministic view of disease. In fact, defining the clinical utility of a genetic test is a complex task. Single genes can have several mutations occurring anywhere, all with varying levels of influence. The time of onset is often unpredictable, further complicating early detection and prevention efforts using genetic test results. Furthermore, as Vineis points out, although rare and highly penetrant mutations in cancer genes could act with no interaction with external factors, gene-environment interactions are intrinsic to the mode of action of low-penetrant genes (Vineis 2001). It is therefore important for policy-makers and other stakeholders to recognise that the causality between a particular gene and its associative illness may be weak.

There is a clear need for further discussion of genetic testing and genetic information at an EU level. This will need to take account not only the implications for insurance, but also wider

social and ethical implications such as confidentiality, discrimination, changes to the doctor-patient relationship and the impact on public health of advances in genetic science.

**Table 20 Comparison of laws and regulations affecting the use of genetic tests in selected countries**

Country	Relevant laws and regulations	Scope	Impact on insurers	Oversight
<b>Austria</b>	1994 Gene Technology Act	Specifically regulates the provision of genetic tests including laboratory quality, test accuracy, consent, counselling and information access	Use of information obtained by genetic testing (defined as molecular biological investigations of human chromosomes, genes and DNA segments) is prohibited	Austrian Advisory Board on Genetic Technology and the Austrian Minister of Labour, Health and Social Affairs set guidelines and handle quality assessments
<b>Denmark</b>	1997 Act 413 on Insurance Agreements and Pension funds	Regulates genetic testing in the context of insurance markets	Act 413 prohibits insurers from requiring a test and requesting, obtaining or receiving genetic information	Danish Council on Ethics and the Danish Board of Health (both of the Ministry of Health) interpret existing and proposed laws and offer quality guidelines
<b>Netherlands</b>	1998 Medical Examinations Act	Regulates the use of all medical examinations and health assessments	Insurers cannot require or inquire about genetic tests and no questions may be asked concerning hereditary disease; an exception is made for high coverage amounts	Dutch Health Council offers guidelines and advises Parliament
<b>Sweden</b>	1999 Agreement between the Swedish government and the Association of Insurance Companies	Formal agreement between regulators and insurance industry	Insurers refrain from use of information obtained by studying one's genetic characteristics	National Board of Health and Social Welfare makes recommendations to Parliament and writes quality guidelines
<b>Norway</b>	1994 Act Relating to the Application of Biotechnology in Medicine	Specifically regulates the provision of genetic testing, including consent, counselling and information access	Illegal to request, receive, retain or make use of information deriving from genetic tests	An Advisory Group of the Norwegian Board of Health assists in the interpretation of the Act and offers quality assurance guidelines
<b>USA</b>	State laws  1996 Health Insurance Portability and Accountability Act	State regulations specifically address the insurance industry  Federal law addresses group health insurers	State prohibitions range from the type of insurance, type of information or the use of information  Federal law prohibits insurance exclusions on the basis of genetic test results	State Insurance Commissioners; Federal Agencies under the Department of Health and Human Services (National Institutes of Health, Food and Drug Administration, Centers for Disease Control, Office for Protection from Research Risks, and the Health Care Financing Administration)

Source: Murthy 2001 (Murthy et al. 2001)

### 3.2.6 Multiple products

In this section we will review the extent to which consumers have access to clear information about the price, quality and conditions of VHI policies, how easily they can compare VHI products and whether they are able to make informed choices about the VHI product that is most appropriate for them. The information we present draws on the reports prepared by national experts in each member state. Although we sent questionnaires to consumer associations in every member state and two pan-European consumer associations, we only received information from the Consumers' Association of Ireland, the Associação Portuguesa para a Defesa do Consumidor (DECO) in Portugal and the Consumers' Association in the United Kingdom. Consumer associations in Belgium, Denmark, France, Luxembourg and the Netherlands informed us that they were unable to respond due to lack of resources.

As noted above, information is vital to buyers and sellers in a competitive insurance market. The absence of clear information about the price, quality and conditions of VHI policies is a type of market failure that prevents consumers from making informed comparisons between different products and puts them at a competitive disadvantage in the marketplace. The use of standard benefit packages allows consumers to compare insurance products in terms of value for money, but under the current regulatory framework, the VHI market is likely to be characterised by a proliferation of different types of insurance product.

In theory product differentiation can 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. Regardless of the motives behind product differentiation, the presence of multiple insurance products may result in consumer confusion unless it is accompanied by a level of information sufficient to permit consumers to compare products in terms of value for money. Without the provision of sufficient information, product differentiation may reduce price competition.

A recent OECD report on private health insurance notes that "as the [UK] market has become more competitive and the diversity of schemes has increased, so consumers have faced increasing difficulty in comparing premiums and benefits offered" (Organisation for Economic Co-operation and Development 2001b). Evidence from some member states also suggests that the multiplicity, variability and complexity of VHI products on offer may lead to consumer detriment. Consumer detriment can be defined as the loss to consumers from making misinformed or uninformed choices or "the difference between the outcome that consumers experience with the available information and the outcome they would experience with the further information they could usefully obtain and assimilate, perhaps by additional shopping

around” (Office of Fair Trading 2000a). It may occur in three main ways (Office of Fair Trading 1997):

- consumers may not buy the product or service at the cheapest price available to them
- consumers may not buy the most appropriate product, given their tastes and preferences
- consumers may purchase a product or service that is not of the quality they assumed ex ante

Each of these effects is common in markets characterised by imperfect information, although the cause of the detriment and its magnitude varies from case to case. In the context of the European Union, information asymmetry is more likely to be problematic for subscribers of complementary and supplementary VHI, as this market is largely free of price and product controls, although it can also pose problems for subscribers of substitutive VHI.

The problems caused by information asymmetry may be mitigated by some or all of the following factors:

- minimal variation between VHI products
- the use, by insurers, of standardised terms
- the existence of a standard package of benefits
- the extent to which insurers are required to inform potential and existing subscribers of all the options open to them
- the existence of a central source of information on the price, quality and conditions of VHI products
- the existence of comparative information on the price, quality and conditions of VHI products that is easily accessible to all sections of the population

As a result of the abolition of price and product controls (through the third non-life insurance directive in 1994), insurers may not have incentives to increase transparency and reduce consumer confusion by introducing standardised terms or standard benefit packages. Standard benefit packages are only found in substitutive VHI markets and changes in the regulatory environment have generally been accompanied by increased product differentiation in complementary and supplementary VHI markets, giving the appearance of fierce competition and increased choice for consumers.

VHI products in Spain were relatively homogenous until legislation was passed in 1995 to bring Spanish insurance law in line with the third non-life insurance directive. Prior to the introduction of this legislation insurers providing benefits in kind were prevented from providing benefits in cash, but the 1995 law removed this specification. This change in the law, together with convergence in the market, has encouraged competition through product differentiation, so there is now a growing diversity in the types of VHI product offered by insurers (Rodríguez 2001). It is not yet clear what effect this has had on consumers.

In its submission to this report the Portuguese consumers' association (DECO) identifies consumers' lack of access to clear information about supplementary VHI policy conditions, particularly exclusions, as a "major problem". Although DECO regularly publishes comparative information about existing VHI products, it finds it difficult to cover all possibilities, as voluntary health insurers often introduce new products with subtle differences (Associação Portuguesa para a Defesa do Consumidor 2001). DECO argues that the divergence of VHI products on offer makes it hard to compare prices both within and between insurers.

This also seems to be the case in the Netherlands and Greece, where potential subscribers of complementary VHI (the Netherlands) or supplementary VHI (Greece) must choose from a wide range of options regarding price, levels of cover, policy conditions, payment mechanisms and quality, making comparison difficult (Maarse 2001, Economou 2001).

With regard to substitutive VHI, subscribers in the Netherlands do have access to information about prices and policy conditions, but again, comparison is difficult and the market is not transparent (Maarse 2001). Consumer associations in Germany have recently noted that people find it increasingly difficult to distinguish between necessary and superfluous VHI products (Datamonitor 2000b). Individuals may have to buy several different policies in order to obtain comprehensive substitutive VHI coverage, as outpatient and dental benefits are offered separately from inpatient benefits. So although employees with substitutive VHI usually enjoy the same benefits as those insured by the GKV, their level of cover depends on the policies they buy (Busse 2001). This may not be problematic where inpatient care is concerned, as inpatient benefits are clearly defined and there is not much variation between inpatient policies, but policies offering outpatient benefits vary substantially, particularly with regard to marginal benefits such as psychotherapy, alternative treatment, rehabilitation and transport. As a result, some outpatient policies offer lower levels of coverage than would be provided by the GKV (Busse 2001).

In order to protect substitutive VHI subscribers in Germany, the Reform Act of Social Health Insurance 2000 stipulates that voluntary health insurers must inform potential subscribers of the likelihood of increasing premiums, the possibility of limiting the increase in premiums with old age and the irreversibility of the decision to opt out of the GKV (Comité Européen des Assurances 2000, Bundesaufsichtsamt für das Versicherungswesen 2001). Voluntary health insurers are also required to inform policy holders of the possibility of switching to another tariff category when their premiums go up and to advise policy holders aged 60 or over to switch to the standard rate policy (see above) or to switch to 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 between insurers, which is why a market for independent consumer information (for example, Stiftung Warentest) and independent



insurance brokers has developed (Busse 2001). The former appear to provide good value for money, although it is not clear how many people make use of their services.

The exclusions of VHI policies in the United Kingdom are numerous and often difficult to judge and the profusion of supplementary VHI products means that both subscribers and brokers are easily confused (Calnan et al. 1993, Youngman 1994). In the late 1990s the Office of Fair Trading (OFT)<sup>17</sup> launched two enquiries into the VHI sector in the United Kingdom, in order to identify consumer detriment and information gaps, and produced two critical reports (Office of Fair Trading 1996, Office of Fair Trading 1998b). The second report noted that “most of the leading [voluntary health] insurers seems to have developed their own preferred policy definitions, general conditions and exclusions. Although some of the reasons are historical, we suspect that competitive market pressures have encouraged some insurers to make their products difficult to compare with those of their competitors” (Office of Fair Trading 1998b). In 1999 the OFT finally cleared the VHI industry of major competition problems, but highlighted the need for much greater clarity and accuracy in the information available to policy holders, describing the information provided by the two largest insurers as unsatisfactory (Office of Fair Trading 1999).

The OFT's reports recommended that voluntary health insurers should introduce 'benchmark' or 'core term' products (standard benefit packages), publish statistics on the average increases in their VHI premiums over the previous five years, and draw these statistics to the attention of consumers and abandon moratorium underwriting (Office of Fair Trading 2000b). In response to the first recommendation, the Association of British Insurers claimed that standard benefit packages would have a restrictive effect, stifling innovation. However, the OFT argued that while innovation resulting in increased product complexity might give the appearance of fierce competition, it does little to improve the lot of subscribers, who sometimes pay more than they should and often purchase inappropriate policies (Office of Fair Trading 1998a). Voluntary health insurers eventually agreed to address the issue by producing a simplified VHI 'product outline' and generic guide to the product, which the OFT hoped would enable subscribers to understand and compare policies better (Davey 1999). In 2000 the OFT noted that VHI product literature had improved and core benefit tables now enabled buyers to compare products (Office of Fair Trading 2000b).

However, it is not clear whether the industry has succeeded in reducing subscriber confusion. For example, a table published in a consumer magazine showing the cheapest monthly comprehensive and budget VHI premiums currently on offer from 20 insurers in the United Kingdom is accompanied by no less than 69 footnotes (Knight 2000), and a 50 year old man considering buying a VHI policy from the second largest insurer in the United Kingdom still has

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<sup>17</sup> The OFT is an independent organisation promoting and protecting consumer interests in the United Kingdom and ensuring that businesses are fair and competitive.

to choose from 90 different monthly premium options ranging from £28.67 per month (£344.04 per year) to £363.82 per month (£4365.84 per year) (CareHealth 2000). Other major insurers in the United Kingdom also offer a high number of premium options, ranging from 18 to 54 (CareHealth 2000).

In late 2001 the UK government announced that general insurance sales (including the sale of VHI) would now come under the statutory regulation of the Financial Services Authority (FSA) (HM Treasury 2001a). In making its decision, the government stated that statutory regulation of general insurance would “help true competition to flourish in this area, because it would help correct the information asymmetry that presently exists against the customer” (HM Treasury 2001b).

The existence of a small number of comparable VHI products has enabled consumers in other member states to make appropriate choices. This is the case with complementary VHI in Luxembourg, complementary VHI to cover the cost of per diem hospital charges in Austria and the three most common individual supplementary VHI policies in Sweden (Schmitz 2001, Hofmarcher 2001, Skoglund 2001).

Group policies may also present fewer problems than individual policies in terms of comparison, as there may be a reduced choice of product 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 (Vrangbæk 2001).

In the absence of central sources of information about the price, quality and conditions of any type of VHI, consumers in most member states may have to rely on insurers and insurance brokers to provide them with information about the VHI products they can purchase, although alternative sources of comparative information may be becoming more readily available in some member states. These include consumer associations, independent websites and other media. As we mentioned above, consumer associations are active in Germany and Portugal. Consumer associations also provide information about VHI in Austria, Belgium, France, Ireland and the United Kingdom.

Obtaining adequate information about individual VHI policies in France can be a difficult process, but websites have recently developed to allow comparisons between the policies offered by different types of insurer. For example, the Conseil National de la Consommation (National Consumers' Council) has produced a questionnaire showing the questions a

consumer should ask before purchasing VHI. By comparing responses to questions such as 'How long will I have to wait before being reimbursed?', 'What are the limits to the reimbursement of a single-bed room?' or 'Does a third party payer system exist?', consumers are assisted in purchasing an appropriate policy (Sandier and Ulmann 2001).

Access to sufficient comparative information should not be a problem in Ireland, as there are only two major insurers in the market (Vhi Healthcare and BUPA Ireland), and price and product comparisons between the two insurers are commonplace in newspapers, through information provided by consumer associations and via independent websites. However, elderly people may have less access to comparative information (particularly if it is provided via the internet) and are less likely to act on it; changing from one insurer to the other is more likely to be done by employers providing group policies than by individuals. In spite of the fact that there are only two major insurers in the market, the magazine of the Consumers' Association of Ireland concludes that "on cost alone it is difficult to assess which organisation is cheaper overall as there are many variants, and savings depend on the medical requirements of the subscriber" (Consumer Choice 1998).

Overall, it seems that inadequate effort has been made at national levels to address the problem of information asymmetry between insurers and consumers. Changes in the regulatory environment have been accompanied by increased product differentiation in some member states, which may benefit consumers by increasing the range of products available to them and by providing them with products that are tailored to meet their needs, but can also be used to segment the market. As a result of the abolition of price and product controls, insurers have little incentive to increase transparency and reduce consumer confusion by introducing standardised terms or standard benefit packages.

### 3.3 Equity implications

In this section we examine the equity implications of VHI markets in terms of the funding and delivery of health care. Unfortunately empirical research concerning equity and VHI markets in the European Union is not extensive; much of the information we present here is based on studies by the EU-funded ECuity II Project.

#### 3.3.1 Equity in funding health care

Two ECuity studies have analysed vertical and horizontal equity in health care funding in 12 OECD countries in the early 1990s. Wagstaff et al's analysis of vertical equity (that is, the extent to which individuals on unequal incomes are treated unequally)<sup>18</sup> found VHI to be regressive in France, Ireland and Spain, proportionate to income in Finland and progressive in Denmark, Germany, Italy, the Netherlands, Portugal and the United Kingdom (Wagstaff et al. 1999). The analysis also found that over time VHI had become less progressive in every country except Spain. The finding that VHI was progressive in some countries can be attributed to the fact that only high earners are eligible to purchase substitutive VHI in Germany and the Netherlands, while most subscribers in the other countries come from higher income groups, as we have shown.<sup>19</sup> An accompanying study attempted to measure horizontal equity (that is, the extent to which individuals on equal incomes are treated equally) in health care funding in the same set of countries. The study's analysis of the redistributive effect of health care funding among individuals with equal incomes found that VHI caused income inequality in France and Ireland, had no redistributive effect in Denmark and had a very small redistributive effect in Germany and the Netherlands (van Doorslaer et al. 1999).

In terms of expanding VHI, it is argued that increasing levels of complementary and supplementary VHI coverage will not increase the regressivity of health care funding because individuals who take up these types of VHI will be paying twice for their health care. According to this argument it does not matter if people pay twice. In fact, double payment may even be beneficial because it will reduce demand in the statutory health care system, enabling more public resources to be spent on those without VHI. For example, in its submission to this report, the Association of British Insurers claims that VHI "provides choice to consumers and relieves pressure on the public health care system" (Association of British Insurers 2001b). Similar claims are made about tax incentives to encourage the purchase of VHI (see 2.4.2).

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<sup>18</sup> In a regressive funding system the poor spend a greater proportion of their income on health care than the rich; in a proportionate funding system everybody spends the same proportion of their income; and a progressive funding system is one in which the rich spend a greater proportion of their income on health care than the poor.

<sup>19</sup> Because access to substitutive VHI is mainly determined by income, those covered by this type of insurance are expected to be high earners. The distribution of coverage for complementary and supplementary VHI should show greater overall variation; in general it does, but it is also strongly biased in favour of high income groups.

Initially, the idea that increased take up of VHI will reduce demand and relieve pressure on the statutory health care system seems plausible, but it may not happen in practice, as we will discuss in the following section. Furthermore, tax relief for those who purchase VHI may be inequitable where it benefits those in employment at the expense of those without employment, and where it is applied at the marginal tax rate, thereby increasing the value of the relief to those in higher tax bands. As employer-paid VHI policies in most member states are not subject to a benefit-in-kind tax, they provide employees with a tax-free benefit in kind that is not available to those who pay for VHI themselves and that favours individuals in higher tax bands.

### **3.3.2 Equity in the delivery of health care**

As we noted in the introduction to this section, the existence of VHI could present a barrier to access in the statutory health care system by distorting the allocation of public resources, to the detriment of public patients. This is most likely to happen when the boundaries between public and private health care 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 (see Section 2.3.3). Under such circumstances the total equity effect of complementary and supplementary VHI (taking into account both equity in funding health care and equity in the receipt of health care benefits) is likely to be negative.<sup>20</sup>

With regard to the argument that increasing VHI coverage reduces demand for statutory health care, the extent to which an expansion of VHI results in lower demand for statutory health care also depends on whether boundaries between public and private health care are clearly defined. In the United Kingdom, for example, where both sectors make use of the same supply of doctors, an increase in private sector activity per se may not lead to an increase in the public sector's capacity to tackle waiting lists. In fact, increasing private sector activity might actually reduce public sector capacity.

A more recent study by the ECuity II Project attempted to assess the degree of horizontal equity achieved in health care utilisation in 14 OECD countries (the United States, Canada and 12 EU member states, excluding Finland, France and Sweden); that is, the degree to which the overall use of doctor visits is distributed according to need (van Doorslaer et al. 2001). Using data from the European Community Household Panel (for the European countries), the authors found that after standardising for need differences across the income distribution, significant horizontal inequity in total doctor visits were only evident in Austria, Greece, Portugal and the United States. However, when doctor visits were disaggregated into

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<sup>20</sup> It is also difficult to see how an expansion of complementary and supplementary VHI would increase the redistributive effect of health care funding.

visits to general practitioners and visits to specialists, it was found that in every country except Luxembourg, richer people visited specialists more often than expected on the basis of need, while the use of general practitioners was relatively closely correlated with need (and in some countries it was slightly pro-poor). 'Excess' specialist visits (not correlated with need) by higher income groups were particularly high in Ireland and Portugal.

The same study found that the degree and distribution of VHI coverage and regional disparities reduced equity in the use of doctor visits, although in most countries the negative effect on equity was fairly small. However, the effect of VHI coverage on the use of specialist visits in Ireland was very high, indicating that the lack of VHI coverage does act as a barrier to specialist care for lower income groups, in spite of their entitlement to free specialist care. VHI coverage also had a considerable impact on 'excess' specialist use in the United Kingdom (where supplementary VHI cover buys faster access to specialist care) and, to a lesser extent, in Spain, Belgium, Denmark, Austria, Canada and Italy.

A Spanish study suggests that the existence of VHI may increase inequality in the Spanish health care system, with negative consequences for the health of poorer people (Borràs et al. 1999). The authors found that Catalanian women with VHI showed a higher percentage of cancer screening tests than the rest of the population, perhaps because double coverage (by the SSN and VHI) provides women with more personalised care and increased involvement on the part of the physician. An investigation into inequalities by social class in access to and utilisation of health services in Catalonia found that although double coverage did not influence the social pattern of visits to health services provided by the SSN, there were social inequalities in the use of those health services provided only partially by the SSN (mostly dental care) and visits to a dentist were more frequent among those with complementary VHI (Rajmil et al. 2000).

In the Netherlands, weak gate-keeping in the private sector (leading to fewer general practitioner contacts for VHI subscribers) has negatively affected gate-keeping in the public sector. Until recently it was compulsory for individuals with statutory health insurance to obtain a general practitioner's referral before seeing a specialist or receiving treatment in hospital, but as a result of competition from voluntary health insurers, who do not insist on referral, some public sickness funds have decided to relax their gate-keeping requirements (Kulu-Glasgow et al. 1998).

In France, where insurers provide complementary cover for co-payments imposed by the statutory health care system, research shows that those with complementary VHI consume more health care than those without (Breuil-Genier 2000), particularly ambulatory care, dental care and spectacles (Bocognano et al. 2000). Individuals with complementary VHI made 1.5 visits to a doctor in a three month period (compared to 1.1 visits for individuals without

complementary VHI), seeking health care once every 73 days on average, compared to once every 100 days for those without this type of insurance (Breuil-Genier 2000).<sup>21</sup> The market for complementary VHI has grown rapidly in France, covering a third of the population in 1960, 50 per cent in 1970, 70 per cent in 1980 and 85 per cent in 1998 (Sandier and Ulmann 2001). As a result of concerns about complementary VHI exacerbating existing inequalities in access to health care in France, in January 2001 the French government introduced a law on universal health coverage (CMU) to extend complementary VHI coverage to the 15 per cent of the population that was not already covered by it (see Section 3.2.1).

There is also some evidence to suggest that higher social classes in Germany use more specialist care than lower social classes, and it is claimed that this reflects their VHI coverage (Wysong and Abel 1990), although it may also be linked to other determinants of access to health care, such as information and educational levels.

Irish patients with VHI are able to make use of private and semi-private beds in public hospitals and publicly salaried consultants' private services in both public and private hospitals, in spite of long waiting times for public patients in public hospitals for certain types of specialist care (Vhi Healthcare 2001c). Private and semi-private beds have accounted for about 20 per cent of acute hospital beds since the process was introduced in the early 1990s (Nolan and Wiley 2000). The results of a recent study by the Dublin-based Economic and Social Research Institute suggest that private patient usage of public hospital facilities is growing at a faster rate than that of public patients (Wiley 2001). Data presented in the study show that for each category of hospital admission, including planned (elective), emergency and day care, utilisation by private patients has been increasing at a faster rate than utilisation by public patients. The study also found that private patients accounted for close to 30 per cent of discharges in 1999 and 2000, even though only about 20 per cent of acute beds at the national level are designated as private.

The situation in Ireland is a source of controversy, leading to a debate about the future of the public-private mix in the health care system. Voluntary health insurers are of the opinion that "the level of inpatient beds set aside for private patients in public hospitals should be reviewed upwards from its current notional level of 20 per cent to reflect the enormous growth in private health insurance take up over the last decade in Ireland, and to ensure that patients who have provided for their own health care can continue to access facilities to which they are entitled" (Vhi Healthcare 2001c). However, increasing use of public resources by private patients would appear to be at the expense of equity in the receipt of benefits in the overall health care system. Consequently, the Irish government's Health Strategy published in November 2001

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<sup>21</sup> A report on the French health care system published recently by the Organisation for Economic Co-operation and Development recommends that complementary insurers devise more appropriate methods of funding health care, in order to strike a better balance between preventive and curative care (Imai 2000).

proposes that all additional beds made available in public hospitals will be solely for public use; that is, there will be no additional private beds made available in public hospitals (Department of Health and Children 2001a). The government also proposes that the rules governing access to public beds should be clarified and suggests that action may be taken to suspend the admission of private patients for planned (elective) treatment if the maximum target waiting time for public patients is exceeded (The Society of Actuaries in Ireland 2001).

Ensuring clear boundaries between public and private health care is a matter for public policy at a national level. The equity (and efficiency) implications of voluntary health insurers' relationships with providers in different member states should also be of concern to policy-makers. Overall, however, knowledge about the equity implications of VHI is limited and more research is needed as the available research results may not be generalisable.



## **Section 4: Implications for the free movement of people and services within the European Union**

This section aims to:

- review briefly the free movement of patients in statutory health care systems
- examine the impact of VHI on the free movement of people within the European Union
- examine the impact of VHI on the free movement of services within the European Union

### **4.1 The free movement of patients in statutory health care systems**

The impact of VHI on the free movement of people must be seen within the context of statutory arrangements for the provision of health care across borders. In theory, national boundaries do not exist for individuals seeking health care in another member state, in so far as people are free to move and live anywhere within the territory of the European Union<sup>22</sup>. In practice, however, national authorities responsible for health care usually confine their activities to their own country, so statutory health coverage has traditionally been limited to providers established within national boundaries. This is known as the territoriality principle. Since 1958, the EC Treaty has provided an exemption to the territoriality principle in order to encourage the free movement of people within the European Union.

The Community mechanism for the co-ordination of social security systems, based on EC Regulations 1408/71 and 574/72, allows migrant workers and their dependants to obtain health care in the country in which they are living for work purposes (Council of the European Communities 1996, Council of the European Communities 1997). These regulations have subsequently been extended to almost the whole EU population (with the exception of nationals from third countries, who are excluded from this system even if they reside in the European Union and are affiliated to a national social security system).

Currently, there are two grounds for eligibility for health care during a temporary stay abroad. They differ as to whether they incorporate the principle of 'urgency'; in other words, whether their condition requires urgent investigation and treatment. People who may receive treatment regardless of whether their condition is urgent include:

- pensioners entitled to a pension or pensions and their families
- employed and self-employed persons in unemployment and their families who go to another member state to look for work

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<sup>22</sup> This principle of the free movement of persons, which is one of the cornerstones of the EC Treaty, has evolved over time from an essentially economic right to a right of European citizens (Article 18; ex Article 8A). See also van der Mei 2001.

- employed or self-employed persons exercising their professional activity in another member state
- frontier workers (although their families must obtain prior authorisation for non-urgent treatment if there is no agreement between the countries concerned)
- students and those undertaking professional training and their families (since October 1997)

For all other people, the condition of urgency of treatment needs to be met (under Article 22.1 of the EC Treaty). Access to health care outside the member state of residence is therefore essentially limited to urgent health care during a temporary stay in another member state (certified by form E111). Otherwise, those seeking planned health care in another member state, under Article 22.1 of EC Regulation 1408/71 must obtain prior authorisation from their competent social security institution (certified by form E112).

So far, however, these regulations have not resulted in widespread movement of patients, largely because member states have generally taken a restrictive approach to health care provided abroad. In 1978 and 1979, two ECJ judgements relating to the conditions governing the granting of prior authorisation under Article 22 of EC Regulation 1408/71 established the principle that authorisation must be granted in all cases where it will improve the medical state of the patient, irrespective of any other considerations (European Court of Justice 1978, European Court of Justice 1979). This interpretation led the Council to restrict the scope of the relevant regulation (Council of the European Communities 1981).<sup>23</sup> Under the amended regulation member states retain a wide discretion in defining their authorisation policy, as Article 22.2.2 only states that authorisation cannot be refused:

- when the treatment required by the interested party is part of the health care package covered by the social protection system in the area of health care
- and this treatment cannot be provided in his/her State of residence within the period that is normally necessary, in view of his/her current state of health and the probable course of his/her disease

Member states have tended to refuse to authorise any treatment in another member state that can be provided in the original State. Even now, a country such as the United Kingdom only grants about 600 E112 forms a year, France some 200 and Sweden not more than 20. Belgium and Luxembourg have been somewhat less restrictive, relative to the size of their populations, issuing about 2,000 and 7,000 E112 authorisations a year respectively (Palm et al. 2000). This reluctance on the part of member states to support greater patient movement partly explains the marginal financial impact of EU cross-border care on public budgets; on

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<sup>23</sup> It has been argued that the second condition was put in place in order to prevent patients from bypassing waiting lists by seeking authorisation for treatment abroad (van der Mei 2001), although this view could be contested on the grounds that waiting lists were not an issue in 1991.

average each member state spends approximately EUR 2 per inhabitant, representing less than 0.5 per cent of public expenditure on health care<sup>24</sup>.

However, other more natural obstacles also stand in the way of receiving treatment abroad, such as language, distance, lack of information about the type of health care provided abroad, unfamiliarity with a different health care system, the unwillingness of local doctors to refer patients to other countries, the administrative burden of the procedures involved and travel time and costs (Mountford 2000). The demand for cross-border health care appears to be concentrated in border areas (or very small member states like Luxembourg) and often involves high technology health care. It also concerns a limited group of people, in particular those with access to sufficient information (Hermesse 1999). But even in the cross-border 'Euregios', where the potential for cross-border health care is greatest, or between Northern Ireland and the Republic of Ireland, where patient movement is being promoted as part of the Irish peace process (Jamison et al. 2001), there is a lack of adequate information available to potential cross-border patients (Hermans 2000). The practical and legal obstacles to cross-border care are likely to remain considerable for some time (Coheur 2001).

Nevertheless, the demand for cross-border care will almost certainly increase in future, as the experience of the 'Euregios' shows (Hermans 2000) and as evidenced by the various claims before national courts and the European Court of Justice (ECJ; the Court), as well as by growing public interest in this issue. Several factors may further stimulate this demand, including:

- the increased movement of people in general
- increasing shortages of human and financial resources creating waiting lists and other access problems
- the development of new experimental treatments in some member states
- increased information among patients
- growing integration in border areas
- the increased ability to compare prices due to monetary union
- the possibility of distance selling
- the likelihood of further claims before the Court, in the light of recent ECJ rulings

Discussion about access to health care abroad has traditionally been based on the principle of the free movement of people within the European Union, but in 1998 the European Court of Justice was required to assess the rules regarding access to health care abroad in the light of the free movement of goods and services. Through the Kohll and Decker rulings of 1998, the Court appears to have established a dual system of social protection for non-urgent health

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<sup>24</sup> Luxembourg is a notable outlier, spending EUR 116 per inhabitant on EU cross border care (9% of its public expenditure on health). This is largely due to Luxembourg's limited medical infrastructure, leading to much greater use of authorised health care abroad than in other member states.

care received in another Member State, giving EU citizens a choice of two options for coverage of health care abroad (European Court of Justice 1998a, European Court of Justice 1998b, Palm et al. 2000). On one hand, the Court upheld the classic E112 procedure governed by EC Regulation 1408/71, in which the patient who has received prior authorisation from their social security institution is accepted by the social protection system of the country in which they receive the medical treatment 'as though [they] were insured with it' (Article 22.1.c). This implies that the patient is subject to the same arrangements regarding, for example, cost-sharing and referral for specialist care, and that any health care costs are settled between both social security systems according to the tariffs of the country in which the treatment was delivered. On the other hand, the Court created an alternative (Kohll and Decker) procedure, based directly on the EC Treaty, by which patients receiving treatment abroad without prior authorisation are not integrated into the social security system of another member state, but can claim reimbursement from their own social security system 'as if they received the treatment there'. This would mean that reimbursement in the home state is subject to the conditions and according to the tariffs applicable there.

The Kohll and Decker rulings established clearly, for the first time, that the economic rules regarding the free movement of goods and services within the European Union can be applied to health care systems. However, they also led to confusion on two issues. First, whether they applied to hospital as well as ambulatory care and, second, whether they applied to all types of health care system, and not just to the reimbursement systems of France, Belgium and Luxembourg. Subsequent cases brought before the European Court of Justice in July 2001 provided the necessary clarification. In Smits-Peerbooms and Vanbraekel the Court successfully answered the two questions raised by Kohll and Decker (European Court of Justice 2001a, European Court of Justice 2001b). First, that hospital services are considered services in the sense of Article 50 of the EC Treaty and are not, therefore, exempt from the rules on the freedom to provide services. Second, that the Kohll and Decker rulings apply to all types of health care system, including systems that provide benefits in kind.

These ECJ rulings have broadened the scope for patients to be treated in other member states at the expense of the social security system in their home member state, although in the case of Smits-Peerbooms, the Court noted that member states would be justified in requiring prior authorisation where there was a possibility of seriously undermining a social security system's financial balance and a need to guarantee a rationalised, stable, balanced and accessible supply of hospital services through planning and contracting (European Court of Justice 2001b).

It is generally considered that the ECJ rulings do not concern VHI, except where national legislation governing VHI restricts free movement, where voluntary health insurers are

responsible for providing statutory protection, and where their practices hinder free movement (Palm 2001).

## **4.2 VHI and potential barriers to the free movement of people**

The Kohll, Decker, Smits-Peerbooms and Vanbraekel rulings of the ECJ have broadened the scope for patients seeking health care in other member states to be reimbursed by the social security system of their home member state. In theory it is now easier for EU citizens to obtain health care in other member states (notwithstanding the non-legal barriers to the free movement of patients noted above: language, distance, lack of information, unfamiliarity, the unwillingness of local doctors to refer patients to other countries, the administrative burden of the procedures involved, and travel time and costs). In practice the number of people treated abroad remains small.

VHI becomes relevant to this debate when possible gaps in statutory coverage are taken into account. These might include substantial co-payments, long waiting times for treatment and exclusions from statutory coverage. Individuals living in a member state with few gaps in coverage could find, on moving to a member state with larger gaps in coverage, that the level of protection they were accustomed to can only be obtained with the additional assistance of VHI. For example, individuals moving to France would require complementary VHI to cover the cost of co-payments in the statutory health care system; individuals moving to Ireland might require complementary and supplementary VHI to avoid long waiting times and to cover the costs of consultants' fees and outpatient care; and self-employed individuals moving to Belgium or Germany would need to purchase substitutive VHI because statutory coverage for some (Belgium) or all (Germany) health services would not be available to them.

In order to ascertain whether VHI facilitates or hinders the mobility of EU citizens in this respect, we need to address the following questions:

- to what extent are voluntary health insurers able and willing to provide cover for health care obtained in other member state; that is, to what extent are VHI benefits 'portable'?
- and (perhaps more importantly) to what extent are individuals who move to another member state to work or live (for example, migrant workers or those who retire abroad) able to obtain VHI cover in the host member state on the same terms as those already living in the host member state?

A major obstacle to addressing these questions on an empirical basis is the lack of documented evidence concerning cases in which individuals' freedom of movement has been hindered by the non-portability of VHI benefits. On the basis of complaints it has received, the European Commission identifies the portability of VHI benefits as a key issue for migrant workers and individuals who wish to move to another member state on retirement, noting that

the arrangements for complementary and supplementary VHI do hinder mobility in the European Union (Directorate General for the Internal Market 2001). However, we are unable to assess the nature of these complaints as the European Commission has not been able to provide us with the details of specific cases for reasons of confidentiality.

One option for people who are already covered by VHI in their home member state would be to extend or transfer this coverage to the host member state, but not all insurers are able or willing to do this. The responses we received from voluntary health insurers with regard to the impact of VHI on the free movement of people indicate that most insurers do not consider VHI to have much effect on mobility within the European Union. However, there was a degree of divergence between the response of mutual associations and the response of commercial insurers. The Fédération Nationale de la Mutualité Française (FNMF) observed that complementary and supplementary VHI do not allow much portability of benefits (although substitutive VHI might be able to provide a greater degree of portability) (Fédération Nationale de la Mutualité Française 2001). While FNMF members attempt to overcome this problem by offering some reimbursement of cross-border care under certain circumstances, on the whole mutual associations feel constrained by their national rules (Association Internationale de la Mutualité 2001).

In contrast, commercial insurers do not find that the free movement of people poses many problems, provided that the use of providers in other member states does not cause costs to escalate. The German Association of Private Health Insurers (PKV) noted that they consider VHI as “well placed to guarantee these freedoms: contracts offered by private health insurers to persons living permanently in Germany are valid throughout Europe. When the person moves his/her permanent residence to another member state of the European Union, the contract can be transferred” (PKV 2001). CEA also commented that VHI is a natural ally of the free movement of people, based as it is on reimbursement rather than the provision of benefits in kind (Comité Européen des Assurances 2001b). CEA did acknowledge, however, that this potential has rarely been borne out in practice.

From the commercial insurers' perspective, the provision of cross-border care may not be problematic because they will provide additional cover as long as people are willing to pay for it. However, anecdotal evidence suggests that individuals insured with some commercial insurers will have to cancel their existing contract (in the home member state) and take out a new contract (in the host member state) provided by the same insurer. The new contract may not take into account their previous history of coverage, even though it is with the same insurer.

Even if insurers are prepared to extend coverage to another member state, the extension of coverage is likely to come at an additional cost and some subscribers may find themselves

being charged higher premiums for the same level of coverage. As commercial VHI premiums are generally calculated on an actuarial basis, subscribers seeking cover abroad could be required to pay extra charges if the costs of health care in the member state of treatment substantially exceed calculated costs (PKV 2001).

There is evidence to suggest that some voluntary health insurers do seek to provide cover for subscribers who regularly travel across national borders (Luginsland 2001), but this evidence is limited, and as CEA pointed out, the role of VHI in providing coverage for health care provided beyond national boundaries is, at present, extremely small.

The second question, concerning the extent to which individuals are disadvantaged when they purchase VHI in another member state (relative to those already covered by VHI), may be of more concern. As we noted above, empirical observations with respect to this issue are lacking. Nevertheless, as the European Commission notes, VHI benefits are rarely portable without some disadvantage to the subscriber, and it is possible to highlight areas of potential difficulty.

A key issue concerns the non-legal barriers we have already mentioned, such as language, information and unfamiliarity. Although these barriers are not specific to VHI, they may be a cause for concern when the inherent problems of information in VHI markets are taken into account (see Section 3.2.6), particularly if VHI contracts are written in a language the subscriber does not understand. This problem may be mitigated to some extent by the use of agents or brokers.

Other areas of potential difficulty revolve around the status of those applying for VHI coverage in host member states. If applicants are treated as new entrants to the market, without consideration of their previous history of VHI coverage, they may be subject to higher premiums, the exclusion of any pre-existing conditions and waiting periods. This may disadvantage people of all ages, but it is most likely to be a significant barrier for older people. According to the European Commission, people moving to another member state on retirement often find that they are regarded by voluntary health insurers as new and high risks due to their age; consequently, they may be required to pay extremely expensive premiums.

The Society of Actuaries in Ireland raised the issue of premium loading as a penalty for late entry in its submission to this report. In 2001 the Irish Health Insurance (Amendment) Act came into force. This Act introduces the concept of lifetime community rating, which allows voluntary health insurers to impose a premium loading on any individual who purchases VHI after the age of 35 (The Society of Actuaries in Ireland 2001). The Society questions whether such penalties should be applied to individuals who have been living in another member state. It is their view that "if a person can provide evidence of time spent abroad, consideration

should be given to requiring this period to be taken into account in calculating the maximum late entry penalty. Depending on the country the person lived in, health insurance may not have been required, affordable, available or normal practice. In this circumstance it would seem unfair to apply a penalty to the person for not having had health insurance while abroad. However, it could also be regarded as unfair that a person who has lived abroad is treated more favourably than a person who has always lived in Ireland, when neither person has had health insurance before” (The Society of Actuaries in Ireland 2001).

The same issue applies to risk-rated premiums. As we showed in Table 11 (see Section 2.3.1), age is used as a variable to rate premiums by many voluntary health insurers in most member states, so where individuals are treated as new risks, they will generally have to pay higher premiums than those of the same age who have been insured for longer.

Treating applicants as new risks will also put them at a disadvantage if pre-existing conditions are excluded. This is likely to be particularly burdensome for older people, who are more likely to have developed conditions, over time, that their home member state policy would have covered. Mandatory waiting periods may pose a similar disadvantage. For example, voluntary health insurers in Ireland are allowed to impose waiting periods on new subscribers (currently 12 months for any treatment and up to 10 years for pre-existing conditions). The Society of Actuaries in Ireland note that “it is not currently a requirement that time spent living in another EU country is recognised for the purpose of determining whether a person is new to health insurance and therefore whether a waiting period can be applied to them” (The Society of Actuaries in Ireland 2001).

Finally, older people will be even further disadvantaged if they are unable to obtain any VHI coverage at all because they have passed the age limit for coverage. Table 12 (in Section 2.3.1) shows that the majority of insurers in most member states restrict the purchase of VHI to those aged under 60, 65 or 70.

Some of these problems could be avoided if voluntary health insurers offered open enrolment and lifetime cover, or at least made reciprocal arrangements for migrant workers and people retiring abroad. However, some insurers might argue that this would undermine actuarial fairness, and within the current EU framework for the regulation of VHI markets insurers may not have much incentive to facilitate the free movement of people in this way.

Once complaints made to the European Commission have been made public, these issues may be studied further. Although they are unlikely to present major barriers to the free movement of people, they should be subject to greater scrutiny. In its 2000 Resolution on supplementary health insurance, the European Parliament justifies Community action in the area of health insurance on the grounds that the differences between health insurance



systems (both statutory and voluntary) may create serious obstacles to the free movement of people (European Parliament 2000b). The European Parliament therefore emphasises the need to ensure that individuals can retain their VHI benefits when staying or living in another member state. It also urges voluntary health insurers to be more flexible in their approach to reimbursing health care provided in other member states.

### **4.3 VHI and potential barriers to the free movement of services**

Since the third non-life insurance directive put in place the framework for a single market for VHI, there are no significant barriers (in theory) to the free movement of voluntary health insurers within the European Union. The principle of home-country control specifically aims to prevent national regulators from erecting barriers to the entry of insurers from other member states (Rees et al. 1999), but in practice, a number of difficulties remain. Commonly-cited problems relating to the proper functioning of a single market for VHI include:

- differences in the design and availability of VHI caused by differences in statutory entitlements to health care
- the high cost of technical investments
- lack of harmonisation in certain areas (particularly differential tax treatment)
- bureaucratic procedures

In their submissions to this report, several insurers and insurers' associations considered that the most significant barrier to the free movement of services in the European Union resulted from differences between statutory health care systems, rather than being specific to the market for VHI. For example, a VHI product marketed in one member state will typically be designed to complement any existing gaps in statutory coverage in that member state, whether those gaps involve co-payments, long waiting times for treatment or the exclusion of certain groups from statutory coverage. It will also be designed to fit in with national structures of health care provision. What this means in practice is that a VHI product marketed in one member state may be unsuitable for sale in another member state. This is clearly the case where substitutive VHI is concerned, but it also applies to complementary VHI and, to a lesser extent, supplementary VHI.

At the same time, some insurers have claimed that VHI is “well placed to guarantee [the] freedoms” set out in the EC Treaty (PKV 2001), and their propensity to develop new products for the home market suggests that they would not find it impossible to develop products for other markets. However, the cost of these developments and the technical investments required may be a significant barrier to entering new markets, as the European Commission has noted (European Commission 1997). In order to rate premiums according to individual risk, voluntary health insurers planning to undertake business in member states other than

their own need to invest in technical, commercial and actuarial studies; this investment may prove too expensive for an insurer to justify selling insurance policies outside its home market.

To date, cross-border VHI has been limited, as the Groupe Consultatif Actuariel Européen noted in its submission to this report. The few insurers that do sell VHI in several member states do so from distinct host member state operations and very rarely on a home member state freedom to provide services basis (Groupe Consultatif Actuariel Européen 2001). Most market expansion across borders has therefore occurred through cross-border mergers and acquisitions rather than through increases in cross-border sales or the establishment of branches in other countries. Although there have been some notable cross-border mergers and acquisitions in the market for VHI, it seems that insurers have been slow to sell VHI products across national borders without a branch presence in another member state and individuals have been slow to purchase VHI products in countries other than their own.

While the growth of internet-based insurance may promote cross-border sales in future, the lack of harmonisation in certain areas could pose problems for market expansion across borders. The Group Consultatif Actuariel Européen commented that both inbound and outbound cross-border trading is difficult for member states whose VHI markets do not harmonise with all aspects of the third non-life insurance directive (Groupe Consultatif Actuariel Européen 2001). According to insurers' submissions to this report, difficulties are most likely to arise in two areas: risk equalisation and differential tax treatment of non-profit and for-profit insurers.

The issue of risk equalisation specifically relates to the situation in Ireland, where the government has put in place a risk equalisation scheme (RES) to support community rating in its market for VHI (see Section 3.2.4 for details). Although the RES has not yet been activated, some argue that it represents a significant barrier to entering the Irish market and is likely to prevent new insurers from attempting to sell VHI products in Ireland on a branch or freedom to provide services basis. However, the existence of these provisions did not prevent a major UK insurer from setting up business in Ireland on a branch basis in 1996, and the RES permits new insurers to exempt themselves from participating in the RES for a period of three years from the start of trading in Ireland (extended from the 18 months originally envisaged in the government's White Paper on VHI (Department of Health and Children 1999). The UK insurer's branch in Ireland claims it could successfully challenge the Irish government on the grounds that the RES is illegal under the third non-life insurance directive, but it has yet to do so (Murray 2001a), and the issue of legality does not appear to concern the government, which states that the third non-life insurance directive permits risk equalisation or loss compensation schemes in the interest of the general good

Differential tax treatment of voluntary health insurers may be a more forceful restraint on insurers' freedom of movement. The Association of British Insurers point out that differences in tax regimes across the European Union "complicate the position for those moving between EU countries and for insurers aiming to offer a product in more than one country" (Association of British Insurers 2001b). The Groupe Consultatif Actuariel Européen and the Swedish Insurers' Association also make this point (Groupe Consultatif Actuariel Européen 2001, Sveriges Försäkringsförbund 2001).

The third non-life insurance directive does not distinguish between different types of insurer and specifically outlaws the preferential treatment of one type of insurer over another. Member states that use national tax laws to favour non-profit over commercial insurers may contravene this aspect of the directive. Examples of tax regimes that discriminate in favour of mutual or provident associations can be found in Belgium, France and Luxembourg (see Section 2.4.2). It is argued, on one hand, that preferential tax treatment of mutual and provident associations prevents foreign commercial insurers from entering the market on the same terms as domestic mutual or provident associations (Datamonitor 2000a). On the other hand, mutual associations argue that their commitment to solidarity results in increased costs, as they are less likely to reject applications, exclude pre-existing conditions or increase premiums as subscribers age. In its submission to this report, AIM referred to its members' adherence to solidarity principles and their ambition of 'mutually improving social conditions', stating that mutual associations "are committed to guarantee lifelong affiliation and non-selection of risks", which it argues justifies special status under national laws (Association Internationale de la Mutualité 2001).

In 1993 the French Federation of Insurance Companies (FFSA) lodged two complaints against the French authorities for their discriminatory tax policy. Eventually, in November 2001, the European Commission asked the French government to put an end to this discrimination either by abolishing mutual and provident associations' exemption from insurance premium tax or "ensuring that the aid does not exceed the costs arising from the constraints inherent in a service of general economic interest" (European Commission 2001: 1). The European Commission found that the existing aid in the form of exemption from the tax on insurance policies "introduces a distortion of competition to the benefit of mutual and provident societies, a distortion [that] is no longer compatible with the development of the common market" (European Commission 2001: 1). It also noted that the French authorities did not provide any evidence of special costs incurred by mutual and provident associations in their performance of a general interest task.

In spite of this recent action against the French government, the European Commission acknowledges that legislative measures to abolish the obstacles presented by differential taxation in general may not be adopted for some time, given that such measures would

require unanimous approval by the European Council of Ministers (European Commission 1997).

With regard to bureaucratic procedures and their impact on insurers' freedom to provide services, BUPA Limited commented that the rules for host-country notification of cross-border services can act as a restraint on the growth of such services in certain member states (BUPA Limited 2001). CEA also claimed that these rules create legal uncertainty and that greater clarity is needed on questions relating to the laws that apply to cross-border contracts (Comité Européen des Assurances 2001b). For example, German insurers are required to provide information in French for French subscribers, which CEA argue poses a financial burden for smaller insurers wanting to operate in other member states (Pierotti 2001). In this particular case, however, it is hard to see how the balance between consumer protection and costs to insurers could be tipped in favour of insurers. The requirement to publish contracts in the language of the member state of provision of services is a key element of consumer protection.

On balance, it would seem that some barriers to the free movement of services persist, in spite of the introduction of a framework for a single market in VHI. This is particularly evident in the area of tax harmonisation, although the European Commission has taken steps to address this issue. However, there may be reasons unrelated to the freedom to provide services that have restrained the growth of cross-border VHI in the European Union. It is possible that consumers in different member states prefer to purchase VHI from well-established insurers with whom they are familiar, which may partially explain why so much of the existing market expansion has occurred through cross-border mergers and acquisitions rather than through increases in cross-border sales or the establishment of branches in other countries.

## Section 5: Trends and challenges

This section aims to:

- review trends and challenges in the market for VHI
- review trends and challenges in public policy
- review trends and challenges in EU regulation

### 5.1 Market trends and challenges

#### 5.1.1 Demand

Sustained economic growth and cutbacks in public expenditure on health care during the 1980s led to increasing demand for VHI in many member states. In some member states rising demand was fuelled by an increase in policies purchased by employers as a fringe benefit for their employees. Between 1980 and 1990 spending on VHI as a percentage of total expenditure on health care rose in every member state except Luxembourg (see Table 2 in Section 1.2.1). Rises in spending on VHI were substantial in Italy (+350 per cent), Portugal (+300 per cent), the United Kingdom (+153.8 per cent), Belgium (+100 per cent) and France (+93.1 per cent). Spending on VHI continued to rise in most member states throughout the 1990s, but with the exception of the Netherlands the rate of growth was much slower and spending declined in Spain, Ireland, Austria and Germany. Levels of expenditure on VHI do not necessarily correlate with demand, as increased expenditure may reflect price rises rather than higher levels of coverage.

Levels of coverage grew in some member states during the 1990s, although a large part of this growth may be attributed to increases in group-purchased policies (see Section 2.2.2). In the United Kingdom, for example, the number of subscribers with employer-paid policies grew by an estimated 23 per cent between 1990 and 2000, while the number of subscribers paying for their own policies fell by 6 per cent. In 1999 the number of UK subscribers fell by 4.5 per cent, with the fall in demand concentrated solely in individual/employee-paid policies; employer-paid policies grew by 1.2 per cent, but individual/employee-paid policies were down by 5 per cent (Laing and Buisson 2000). These figures may to some extent reflect the fact that the average price of individual policies in the United Kingdom rose by 12 per cent a year between 1994 and 1998, whereas the average price of group policies rose by less than 3 per cent a year (Datamonitor 2000a).

Although levels of VHI coverage were fairly stable in most member states during the 1990s, there have been some notable exceptions. As a result of changes in French legislation leading

to the extension of complementary VHI coverage to the whole population from 2000 (CMU), the proportion of people covered by complementary VHI has risen from 85 per cent in 1998 to 94 per cent in 2001. VHI markets in Denmark, Finland and Sweden have always been relatively small, but recent trends suggest that the demand for supplementary VHI is rising, partly due to dissatisfaction with levels of public provision and partly due to increases in the purchase of policies by employers.

The challenge for voluntary health insurers in many member states is to sustain demand in markets that appear to have reached saturation point. Some industry commentators predict that future growth in the market for VHI is more likely to come through increases in price than increases in coverage (Datamonitor 2000a).

### **5.1.2 Buyer characteristics and premium trends**

The generally low level of individual demand for VHI in many member states has forced insurers to rely more heavily on sales to groups. The 1980s saw rapid expansion of the market for group policies and during the 1990s group policies continued to gain an increasing share of the VHI market in many member states. Group policies currently account for almost all VHI policies in Sweden, Ireland, Portugal, Greece and the United Kingdom, over half of all policies in the Netherlands, and about half of all policies in France (see Table 10 in Section 2.2.2). The rising proportion of group VHI policies is partly due to economic growth and the provision of VHI as a fringe benefit for employees, but it is also the result of many insurers offering employers group-rated premiums, discounted prices and less stringent policy conditions. Not only have groups benefited from discounted premiums, price increases for group premiums have been substantially lower than price increases for individual premiums, which may suggest that individual subscribers have subsidised the cost of policies purchased by groups and usually (but not always) paid for by employers. This is confirmed by the fact that insurers' margins are often much tighter for group-purchased than individually-purchased VHI (see Section 2.5.1).

It was expected that the creation of a framework for a single market for VHI in the European Union would increase competition between insurers, leading to greater choice and lower prices for consumers. However, increased competition does not appear to have reduced the price of VHI premiums, which have often risen faster than health care expenditure in general (see Section 2.4.1). Real compound annual increases in the price of VHI premiums in several member states were considerably higher (between 2.3 per cent and 12 per cent) than the average annual growth rate of total expenditure on health care deflated by the GDP deflator (between -1.1 and 2.7 per cent) (see Table 15 in Section 2.4.1).

The industry often argues that premium rises are the unavoidable consequence of ever increasing claims, the rising costs of health care, the high cost of medical technology and the ageing of the population (Datamonitor 2000a). However, while the growth in claims expenditure (benefits paid) exceeded the growth in premium income in some member states between 1995 and 1998, loss ratios (benefits paid divided by premium income) did not show a significant increase during this period (see Table 18 in Section 2.5.1) (Comité Européen des Assurances 2000). In member states such as the United Kingdom annual average increases of 12 per cent in the price of premiums for individual VHI policies between 1994 and 1999 (Datamonitor 2000a) have been accompanied by declining loss ratios (Laing and Buisson 2001). In 1985 UK insurers had an overall loss ratio of 88 per cent, but by 2000 the loss ratio had gone down to 79 per cent (Laing and Buisson 2001). Disaggregating the loss ratio for 2000 shows that it was 85 per cent for employer-paid group VHI policies and as low as 73 per cent for VHI policies paid for by individuals and employees (Laing and Buisson 2001).

Data on the administrative costs of voluntary health insurers in different member states suggest that these costs are high compared to those of the statutory health care system (see Section 2.5.2). Voluntary health insurers' administrative costs range from about 10 per cent in Germany, Luxembourg (mutual associations), the Netherlands and France (mutual associations) to as much as about 25 per cent in Austria, Belgium, Italy and Portugal. In contrast, the administrative costs of statutory health care systems are substantially lower: between three and five per cent in most member states and even lower in others such as Denmark and Italy (see Table 19 in Section 2.5.2).

### **5.1.3 Consumer choice**

The abolition of price and product controls for complementary and supplementary VHI in 1994 has been accompanied by higher levels of product differentiation in some member states. As we noted in Section 3.2.6, product differentiation can 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. Either way, the presence of multiple insurance products may reduce price competition unless it is accompanied by a level of information sufficient to permit consumers to compare products in terms of value for money.

Although EU consumers seem to have a wide choice of VHI products (at least in some member states), it is not clear that such choice always works to their advantage. Evidence from several member states suggests that consumers may not have sufficient access to comparable information about VHI products (particularly complementary and supplementary VHI products), which may lead to consumer detriment (see Section 3.2.6).

Information asymmetry arising from the proliferation, variability and complexity of VHI products 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 VHI products. However, under the current regulatory framework insurers have no incentive to reduce consumer confusion and increase transparency by introducing standardised terms or standard benefit packages, so while standard benefit packages may be required for substitutive VHI in some member states, they are rarely found in complementary and supplementary VHI markets.

Some insurers claim that regulation requiring them to offer standard benefit packages has a restricting effect and stifles innovation, but the competition watchdog in the United Kingdom (the Office of Fair Trading; OFT) points out that innovation resulting in increased product complexity does not benefit subscribers, who sometimes pay more than they should and often purchase inappropriate policies (Office of Fair Trading 1998a). A recent OECD report on private health insurance also notes that “as the [UK] market has become more competitive and the diversity of schemes has increased, so consumers have faced increasing difficulty in comparing premiums and benefits offered” (Organisation for Economic Co-operation and Development 2001b).

In its submission to this report BUPA Limited argue that “in the United Kingdom there have been claims that private health insurance schemes have become hard for consumers to understand, and that ‘best value’ premiums are hard to compare. This seems an inevitable consequence of competitive innovation, both in contract structures and ‘cost containment’ procedure, and there is already ‘good practice’ pressure on insurers to facilitate comparisons. We would respond that it is the competitive environment itself that keeps all propositions relatively efficient, and contracts must balance desirable simplicity against legal effectiveness” (BUPA Limited 2001). Nevertheless, the UK government announced in late 2001 that general insurance sales (including the sale of VHI) would now come under the statutory regulation of the Financial Services Authority (FSA) (HM Treasury 2001a). In making its decision the government stated that statutory regulation of general insurance would “help true competition to flourish in this area, because it would help correct the information asymmetry that presently exists against the customer” (HM Treasury 2001b).

Elsewhere in the European Union, inadequate effort has been made at national levels to address the problem of information asymmetry. Under the current regulatory framework, without requirements for the provision of standard benefit packages, or even the use of standardised terms, more effort may be needed to ensure that the sale of VHI products is monitored and that consumers have access to clear and comparable information.



A key feature of VHI in the European Union is its ability to give subscribers access to a wider range of health care providers. This is particularly true of supplementary VHI, but it may also be the case for complementary and substitutive VHI. Unlike the United States, where VHI subscribers' choice of provider has been severely restricted by the dominance of integrated care through Health Maintenance Organisations (HMOs) and Preferred Provider Networks (PPNs), subscribers to VHI in the European Union still enjoy considerable provider choice (see Section 2.3.2).

The extent to which EU subscribers' choice is restricted in this way varies considerably between member states. In general, integrated care and preferred provider networks continue to play a minor role in most member states, although there is a tendency towards some forms of vertical integration amongst the largest insurers in the United Kingdom and Spain and the largest insurers in Portugal have been investing heavily in the creation and development of preferred provider networks. Experiments in integrated care have met with limited success in France and Belgium, partly due to consumers' suspicion of US-style HMOs, but in future voluntary health insurers may be inclined to make greater use of this option as a means of reducing costs.

#### **5.1.4 Market structure**

In many member states the 1990s have seen a clear trend towards increasing concentration in the market. The available data show that market consolidation has taken place in Austria, Greece, Italy, Luxembourg, Portugal (as a result of concentration in the banking and insurance sectors) and Spain (see Section 2.2.1).

In theory, a degree of market consolidation should lead to efficiency gains for insurers and benefits for consumers if price competition is maintained. In practice, however, it is not evident that increasing concentration has resulted in efficiency gains (and the paucity of available data makes this difficult to determine). If there have been efficiency gains, it is unclear whether they have been passed on to consumers in the form of lower VHI premiums.

For largely historical reasons, some of the most extensive VHI markets in the European Union are currently dominated by non-profit mutual or provident associations (see Section 2.2.1). In recent years their share of the VHI market has declined in some member states and in future they may lose further market share to commercial insurers. As there is some variation in the extent to which solidarity principles are pursued by mutual or provident associations in different member states we cannot make assumptions about insurers' conduct on the basis of their legal and non-profit status.

### **5.1.5 The free movement of people and services**

Whether or not VHI restricts the free movement of people within the European Union largely depends on the extent to which the benefits provided by VHI are portable. Mobility may be limited if insurers are unwilling to provide cover for health care obtained in another member state or if individuals who move to another member state to work or live are unable to obtain cover on the same terms as those already living in the host member state.

Although some voluntary health insurers do seek to provide cover for subscribers who regularly travel across national borders, the role of VHI in covering health care provided beyond national boundaries is, at present, extremely small. Even if insurers are prepared to extend coverage to another member state, the extension of coverage is likely to come at an additional cost and some subscribers may find themselves being charged higher premiums for the same level of coverage.

The problems involved in obtaining VHI coverage in the host member state include non-legal barriers such as language, information and unfamiliarity (which may be a cause for concern when the inherent problems of information in VHI markets are taken into account) and the extent to which applicants are treated as new risks, without any consideration of their previous history of coverage, and are therefore subject to higher premiums, the exclusion of any pre-existing conditions and mandatory waiting periods. These factors may disadvantage people of all ages, but they are most likely to be a significant barrier for older people.

To date, cross-border sales of VHI have been limited and the few insurers that do sell VHI in several member states do so from distinct host member state operations and very rarely on a home member state freedom to provide services basis. Although there have been some notable cross-border mergers and acquisitions in the market for VHI, it seems that insurers have been slow to sell VHI products across national borders without a branch presence in another member state and individuals have been slow to purchase VHI products in countries other than their own.

Commonly-cited barriers to the free movement of services include differences in the design and availability of VHI caused by differences in statutory entitlements to health care, the high cost of technical investments, lack of harmonisation in certain areas (particularly differential tax treatment) and bureaucratic procedures. The extent to which some of these factors present genuine obstacles to free movement is debatable.

### **5.1.6 Data availability**

Our attempt to provide detailed country-specific information and data has been hindered by poor and uneven data availability. As we noted in the introduction to this report, the availability of information generally reflects the size of a member state's market for VHI, so there may be less information on member states with small markets, but even in countries with significant markets for VHI it is difficult to find complete and reliable data on the most basic variables, such as the number of insured people.

National experts in several member states comment on the absence of transparency in the VHI market. Data are collected on an ad hoc basis and by different types of organisation. In the United Kingdom industry statistics are collected by a private company, whereas in Germany they are collected by the PKV (the German Association of Private Health Insurers). Data may not be collected at all in some member states. In Spain, for example, industry officials acknowledge the lack of reliable data, but blame it on technical difficulties rather than bad will (Rodríguez 2001).

There is a need for better and more systematic collection of data on VHI in the European Union, but it is not clear who is able or willing to collect it. Governments in most member states have shown little interest in collecting data on VHI, probably because it is not a dominant source of health care funding in any member state, and the current regulatory framework does not require insurers to collect or publish anything other than data relating to financial solvency. The data we present in this report have been obtained from insurers, insurers' associations, market research reports, household surveys and academic research rather than official statistics. Eurostat, the statistical office of the European Commission, provides general information on insurance business in the European Union, but does not publish more detailed information on specific markets, such as VHI.

### **5.2 Trends and challenges in public policy**

As we noted in Section 1.1, public policy in the European Union has generally aimed to preserve the principle of health care funded by the state or social insurance and made available to all citizens, regardless of ability to pay. This has led to the development of health care systems broadly characterised by near universal coverage, mandatory participation, the provision of comprehensive benefits and high levels of public expenditure. These characteristics have been important determinants of the scope and size of the VHI markets in different member states.

## 5.2.1 Health care expenditure

We also noted that although the last twenty years have seen some growth in levels of private expenditure as a proportion of total expenditure on health care in the European Union, this growth has been influenced more by substantial increases in cost-sharing through user charges than by the expansion of VHI markets. Furthermore, recent trends have shown a tendency for governments in some member states to increase levels of public expenditure on health care, particularly in France (through the CMU) and the United Kingdom. At the present time, therefore, it seems that member states remain committed in principle to publicly-funded health care for all citizens.

Nevertheless, the sustainability of funding health care from public sources continues to be called into question. It is often suggested that factors such as the ageing of the population, the high cost of new technology and rising public expectations will increase demand for health care, causing expenditure on health care to escalate beyond the willingness or ability of citizens to pay for it (particularly through collective means such as taxation or social insurance). As a result, governments may no longer provide sufficient levels of health care to the whole population and citizens may be forced to rely on additional methods of funding the health care they require. In such a situation, there would be significant opportunity for VHI to play a more substantial role in funding health care.

It is beyond the scope of this report to examine in detail the likely effect of the potential cost-drivers mentioned above on future levels of public expenditure on health care. However, we can make the following points.

First, although ageing is likely to have a significant impact on statutory pension schemes, recent studies have shown that it is unlikely to put much pressure on health care expenditure (Fuchs 1998, Harrison et al. 1997, Lubitz et al. 1995, Evans 1985, Getzen 1992). Analyses of the determinants of health care expenditure growth find the impact of ageing to be incremental rather than substantial, leading to relatively modest annual increases in health care expenditure (Fahey and Fitz Gerald 1997). This suggests that while there may be a link between ageing and expenditure, demographic trends alone do not imply cost increases in excess of what can be readily sustained by normal economic growth (Barer et al. 1987). In the last five decades EU member states have already witnessed large increases in life expectancy; these increases have not brought statutory health care systems to the brink of collapse. In coming decades expected rises in the number of older people, particularly the 'old old', may have an impact on health care costs, but they are much more likely to affect the costs of long-term care (McGrail et al. 2000). An analysis of future demand for long-term care and long-term care insurance is outside the terms of reference of this report.

Second, although several studies have attempted to calculate the impact of new technology on health care costs, its impact is difficult to measure and remains largely unquantified. It cannot therefore be used as an accurate predictor of future expenditure on health care (Sassi et al. 1996).

Third, while public expectations may increase the demand for health care, it is neither evident nor logical to assume that a country's ability to sustain a given level of expenditure on health care is increased by raising money through one funding source (private health insurance) rather than another (tax or social insurance) (Evans 2002). In this respect it is worth noting that although health care is mainly provided through private health insurance in the United States, the level of public expenditure on health care in the United States is substantial: 44.8 per cent of total expenditure on health care in 1998 or 5.8 per cent of GDP (compared to an EU average of 5.9 per cent) (Organisation for Economic Co-operation and Development 2001a). Overall spending on health care is much higher in the United States than in any EU member state (12.9 per cent of GDP in 1998, compared to an EU average of 7.9 per cent) (Maynard and Dixon 2002, Organisation for Economic Co-operation and Development 2001a).<sup>25</sup> Moreover, a significant proportion of the US population is not covered by any type of health insurance (Maynard and Dixon 2002). Therefore it does not follow that expanding VHI will automatically result in reduced levels of public spending on health care or increased levels of overall coverage. The view that current levels of public expenditure on health care will be unsustainable in future also implies that governments cannot achieve efficiency gains in the health sector.

Is there scope for VHI to play a greater role in funding health care in the European Union in future? We identify three policy options that might influence the future expansion of VHI markets in different member states: allowing more individuals to opt out of the statutory health care system, further excluding specific health services from statutory cover (either explicitly or through non-explicit rationing) and introducing or increasing tax incentives to purchase VHI.

### **Opting out**

As we noted in Section 2.1.1, individuals or groups of people in some member states are either excluded from participating in the statutory health insurance scheme or exempt from contributing to it if they choose to opt out of it. The most recent legislative changes allowing individuals or groups to opt out of the statutory health care system have taken place in Portugal (1993) and Austria (1999), but opting out has always been a possibility for high-earning German employees. High-earning individuals in the Netherlands are excluded from statutory cover for outpatient care and the first year of inpatient care, and self-employed

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<sup>25</sup> OECD figures for total expenditure on health care in the United States do not include tax subsidies for private health insurance, which totalled USD 111.2 billion (EUR 117.67 billion) in 1998 and mainly benefited the rich (see Section 1.3.1 (Sheils 1999).

people in Belgium are excluded from statutory cover of 'minor risks'. These individuals have the option of purchasing substitutive VHI. At the beginning of the 1990s the Italian government suggested allowing individuals to opt out of the statutory health care system, but finally decided against it (Fattore 1999).

Allowing people to opt out of some or all parts of the statutory health care system is therefore relatively limited in the European Union, and while it may occasionally emerge in debates about health care reform, it is rarely considered as a serious alternative to universal coverage. In addition to many governments' reluctance to reduce levels of statutory coverage in this way, there may be two further reasons why opting out has not been a popular policy option.

First, where individuals are actually excluded from statutory coverage, as in the Netherlands and Belgium, governments are forced to intervene in the market for substitutive VHI in order to ensure that these individuals have access to an adequate and affordable level of VHI cover. The Belgian government has introduced a system of risk adjustment for mutual associations providing substitutive VHI and stipulates that the substitutive benefits they provide must match the benefits of the statutory health insurance scheme. Substitutive VHI subscribers in the Netherlands are subject to two cross-subsidisation schemes that transfer annual solidarity contributions to the statutory health insurance scheme (the ZFW) and the WTZ scheme for individuals who are excluded from the ZFW but cannot afford substitutive VHI.

Recent developments in Belgium and the Netherlands suggest that governments in both member states find the current situation problematic. A working group of senior government officials, led by an academic, was set up to examine the social security status of self-employed people in Belgium. In January 2001 they proposed that self-employed people should either be covered by the statutory health insurance scheme for minor risks or obliged by law to purchase substitutive health insurance (Cantillon 2001). For various reasons, the current system of health care funding in the Netherlands is increasingly seen as a source of inefficiency and inequity (Maarse 2001). In 2001 the Dutch government announced widespread reform of the health care sector, including the possibility of merging the existing health insurance schemes into one universal, public health insurance scheme (Ministry of Health Welfare and Sport 2001). The Dutch government's decision to opt for a public rather than a private insurance scheme was based on the premise that a private scheme would be subject to the third non-life insurance directive, whereas a public one would not.

Second, given the choice to opt out (as in Austria, Portugal and Germany), the evidence suggests that most individuals prefer to stay where they are. Very few individuals or groups of employees have opted out in Portugal (Oliveira 2001) and fewer than a quarter of high-earning employees who can choose to opt out of the statutory health insurance scheme in Germany (the GKV) actually do so. As we noted in Section 1.3.2, those most likely to opt out of the GKV

are young and single people or married couples with double incomes (Datamonitor 2000a). Another industry report notes that substitutive VHI is growing in popularity among young and affluent Germans (Datamonitor 2000b). This leaves the GKV to insure a disproportionately high number of elderly people and people with large families. There has also been a tendency, in the past, for people to opt out when they were young and healthy and then attempt to return to the GKV as they got older and substitutive VHI premiums increased. The German government has introduced two reforms to address these issues (in 1994 and 2000), making it harder for those who have opted out to return to the GKV, but also ensuring that those who have opted out and cannot return have access to an adequate and affordable level of substitutive VHI cover (see Section 2.1.1 for details).

Opting out in Germany and the exclusion of high earners from statutory coverage in the Netherlands are the result of historical artefact rather than deliberate policy choice. Where a deliberate policy choice has enabled individuals to choose to opt out (as in Portugal and Austria), the number of people opting out has been relatively small and it is still too early to assess any potential long-term implications. Allowing people to opt out of the statutory health care system does not appear to be a growing trend in the European Union. In fact, if the Dutch government goes ahead with its intended reforms and the Belgian government decides to extend statutory coverage of minor risks to self-employed people, the level of opting out will be significantly reduced.

#### **Excluding specific health services from statutory cover**

Excluding specific health services from statutory cover is another option open to governments in some member states. Explicit reductions in statutory coverage of some health services could increase demand for complementary VHI, while less explicit reductions through rationing might increase demand for supplementary VHI (as has been the case in Denmark, for example). However, increased demand for complementary VHI may not always be met, as VHI cover for some services will be less profitable for insurers to provide. The provision of pharmaceuticals is the most commonly excluded type of major health service in many member states, but VHI markets do not always cover pharmaceutical costs. Although co-payments for drugs are the only existing user charge in the Spanish statutory health care system, VHI products to cover these co-payments have not yet emerged. Insurers may find it easier to respond to statutory reductions in other clearly-defined health services, such as dental care.

Voluntary health insurers may only be able to meet increased demand for supplementary VHI where there is sufficient private sector capacity. This is currently an issue in member states with low capacity in the private sector, such as Denmark. Lack of capacity more generally may encourage governments to address the equity implications of further developments in

supplementary VHI, in order to prevent the exacerbation of existing inequalities in access to statutory health care and the distortion of public resources.

### **Tax incentives**

Introducing or increasing tax incentives for individuals and firms to purchase VHI could stimulate demand for VHI. In its submission to this report, the Irish mutual association Vhi Healthcare note that tax relief on VHI premiums may be “one of the main reasons for the high take-up of insurance in Ireland” (Vhi Healthcare 2001c). The Spanish insurers’ association UNESPA claim that “the lack of specific tax deductions / incentives is a major barrier for the development of private health insurance in the European Union . . . [and] a barrier to competition” (Union Española de Entidades Aseguradoras Y Reaseguradoras 2001). However, the evidence suggests that existing tax incentives targeted at individuals do not have a significant impact on the take up of VHI, although tax incentives for firms appear to have fuelled the demand for group VHI policies in Austria, Denmark, Ireland and Spain (see Section 2.2.2).

The argument that tax relief for VHI works in the public interest because increasing the demand for VHI reduces the demand for statutory health services (and therefore relieves upward pressure on public expenditure) is not substantiated in practice (see Section 2.4.2). Furthermore, tax relief for VHI may give rise to equity concerns where it benefits those in employment at the expense of those without employment and where it is applied at the marginal tax rate, thereby increasing the value of the relief to those in higher tax bands. It could be argued that governments should target tax relief at low-income groups in order to improve access to VHI, but it is questionable whether this would be a prudent use of government resources. Resources devoted to tax relief might be better spent on improving the quantity and quality of statutory health care.

The current trend in the European Union is to reduce or remove tax incentives for the purchase of VHI. In recent years governments in Austria, Greece, Ireland, Italy, Spain and the United Kingdom have taken measures to reduce or change the direction of tax incentives; Portugal is the only member state to have increased tax incentives for VHI. Tax incentives that favour certain types of insurers over others can have an impact on market structure, but differential tax treatment of insurers is unlikely to be a sustainable form of national public policy as it may contravene EU competition law.



## 5.2.2 Access and consumer protection

As we noted in Section 3.1, the extent to which VHI affects access to health care depends, in part, on the characteristics of the statutory health care system. Access to VHI mainly concerns policy-makers in so far as VHI provides primary protection against the consequences of ill health. While this is usually the case for substitutive VHI, it may also apply to complementary VHI covering co-payments in the statutory health care system and necessary and effective health services excluded or only partially provided by the state. Supplementary VHI may create barriers to access in the statutory health care system if it distorts the allocation of public resources.

Voluntary health insurers' incentives to risk-select can be addressed to some extent by guaranteeing access to coverage (open enrolment), providing automatic renewal of contracts and limiting exclusions for pre-existing conditions. As we noted in Section 2.3.1, however, open enrolment policies are rare among voluntary health insurers in the European Union and most insurers exclude pre-existing conditions (the norm) or charge higher premiums for them. Short-term (usually annual) contracts are the most common form of VHI contract in the European Union; lifetime cover is the exception rather than the rule. Furthermore, most insurers set a maximum age limit for purchasing VHI (usually between 60 and 75 years), while some actually cancel contracts when people reach retiring age. VHI premiums tend to rise with age, so even those eligible to purchase cover at older ages may not be able to pay for it.

Incentives to risk-select can also be reduced by the introduction of risk-adjustment mechanisms, but these are rare in the European Union. In fact, they are only found in Ireland (where a risk equalisation scheme is in place but has not yet been activated) and Belgium (for substitutive VHI provided by mutual associations). Although the implementation of risk-adjustment mechanisms can be problematic (see Section 3.2.4), risk adjustment may be an option for substitutive VHI, particularly if public policy favours an expansion of this type of VHI. Whether it would be appropriate for complementary or supplementary VHI is a matter for national debate.

Genetic testing is not yet an issue where VHI is concerned, as to date it has only affected life insurance, but it may emerge as a problem in future. Many insurers (mostly, but not exclusively, commercial insurers) require applicants to provide details of their medical history. Some insurers also require information about family history of disease, which is a type of genetic information. The issue of genetic testing requires further debate at an EU level.

The Belgian, German and Dutch governments have all taken substantial steps to increase access to substitutive VHI for people with low incomes, elderly people and those with pre-existing conditions (see Section 2.1.1).

Where non-substitutive VHI is concerned, the Irish government has applied stringent measures to ensure access to affordable complementary and supplementary VHI, obliging voluntary health insurers to offer open enrolment, lifetime cover, community-rated premiums, maximum waiting periods and a minimum level of benefits, and subjecting insurers to a system of risk adjustment through the (not yet activated) risk equalisation scheme. Other member states have taken steps to protect consumers by prohibiting insurers from refusing to insure people with chronic illnesses (Austria and France). Insurers in Sweden have voluntarily agreed to refrain from requesting information about family history of disease (a type of genetic information). In Austria, insurers are prohibited from requiring medical examinations. Insurers in Germany (substitutive VHI) and the United Kingdom are required to warn subscribers of the likelihood of premium increases above the rate of inflation.

With regard to consumer protection in the United Kingdom, in late 2001 the UK government announced that general insurance sales (including the sale of VHI) would now come under the statutory regulation of the Financial Services Authority (FSA) (HM Treasury 2001a). In making its decision, the government stated that statutory regulation of general insurance would “help true competition to flourish in this area, because it would help correct the information asymmetry that presently exists against the customer” (HM Treasury 2001b). More could be done to address this issue in other member states.

However, the most radical measures to improve access to VHI have been taken in France. In June 1999 the French government passed a law on universal health coverage (CMU) to enable those who did not benefit from any health insurance (1.1 million people at the end of 2000) to be covered by a basic, compulsory, statutory health insurance scheme (Paris et al. 2002 forthcoming). CMU also facilitates access to complementary VHI for people on low incomes (less than FRF 3,600 (EUR 550) per month) who did not have any cover of this type (4.9 million people at the end of 2000) (Paris et al. 2002 forthcoming). In addition to affiliation to a compulsory health insurance scheme, those with incomes below a certain threshold now have the right to complementary VHI coverage.

## **5.3 Trends and challenges in EU regulation**

### **5.3.1 The impact of the third non-life insurance directive**

With the introduction of the third non-life directive in 1994, the European Commission was finally able to achieve its aim of creating a framework for a single market for VHI in the European Union (see Section 1.4). Where necessary, most member states amended existing legislation or passed new legislation to bring national insurance laws in line with the directive. While legislative changes have generally involved the introduction of tighter solvency controls, they may also have resulted in the loosening or outright abolition of price and product controls.

The directive's impact on VHI markets has been varied. Legislation transposing the directive into national law seems to have had the effect of increasing concentration in the market and increasing product differentiation, particularly in the commercial VHI sector. The available data suggest that these trends have taken place in Austria, Greece, Italy, Portugal (as a result of concentration in the banking and insurance sectors) and Spain. It does not appear to have had any direct impact in other member states, such as Belgium, Finland, Luxembourg, Sweden and the United Kingdom (Hermesse 2001, Schmitz 2001, Engemann 2001, Skoglund 2001, Hockley 2001).

However, implementation of the directive has been problematic in a small number of member states, at least from the perspective of certain stakeholders. The Groupe Consultatif Actuariel Européen observed, in its submission to this report, that the impact of the third non-life directive has been diluted "because member states who might otherwise have been more affected have maintained national legislation that is not fully harmonised with this directive. Germany and Netherlands have been mentioned as two such examples and there is good justification for local variations" (Groupe Consultatif Actuariel Européen 2001). Some member states initially refused to implement the directive, although by 1997 Spain was the only member state in this position and the European Commission subsequently referred it to the European Court of Justice (European Commission 1997). Others selectively incorporated those aspects of the directive that posed the least political difficulty; as a result, the European Commission has referred France and Germany to the European Court of Justice for infringement of the directive.

In the following sections we review the main issues arising from the implementation of the third non-life directive in Belgium, Germany, the Netherlands, Ireland and France.

## **Belgium**

In Belgium insurance laws incorporating the directive do not apply to mutual associations, which the commercial insurers claim creates an important distortion in competition (Union Professionnelle des Entreprises d'Assurances 2001). This issue has not yet been resolved.

## **Germany**

The German government has taken full advantage of both parts of Article 54 of the directive. Article 54.1 permits a member state to take measures to protect the general good where contracts covering health risks serve as a partial or complete alternative to health cover provided by the statutory social security system, and allows the general and special conditions of that insurance be communicated to the competent authorities of that member state before use (European Commission 1992). Article 54.2 allows a member state to require substitutive VHI to be operated on a technical basis similar to that of life insurance (European Commission 1992). As a result, the German government still requires the general policy conditions for substitutive VHI to be submitted to the Federal Supervisory Office for the Insurance Sector before they are implemented and every time there is an amendment. Insurance undertakings registered in Germany must also submit their premium calculations to the Federal Supervisory Office for the Insurance Sector (see Section 2.1.1).

Employers in Germany can only contribute to substitutive VHI policies offered by voluntary health insurers that specialise in health. Traditionally, the German supervisory body has only permitted insurers specialising in health to sell VHI products, in order to protect policy holders from insolvency arising from other business. The legislation transposing the third non-life insurance directive into German law formally abolished this rule (Recital 25), but the German government added a new provision to German social law, prohibiting employees from benefiting from employers' contributions if the insurer combined health with other types of insurance. The European Commission considered this to be an indirect infringement of the directive and sent a so-called 'reasoned opinion' to Germany in 1996 (European Commission 1996). In the absence of a satisfactory response from the German government, the European Commission has referred Germany to the European Court of Justice (Case C-298/01).

## **The Netherlands**

Like the German government, the Dutch government has also taken advantage of Article 54.1, but some aspects of health insurance in the Netherlands have raised concerns about their compatibility with the third non-life insurance directive.

Commentators in the Netherlands have questioned the legality (and therefore the sustainability) of the MOOZ and WTZ schemes, which require all those with substitutive VHI to make an annual solidarity contribution to the ZFW (statutory health insurance scheme for acute care) and the WTZ, respectively (see Section 2.1.1). The issue of whether or not these

schemes were legal under EU law was raised in a report presented to the Dutch Ministry of Health by the Dutch Council for Health and Social Services (an independent governmental advisory body) (Raad voor de Volksgezondheid & Zorg 2000). Broadly, the report suggested that these compulsory solidarity contributions contravened the third non-life insurance directive; the report also expressed concern regarding the consequences of EU law for health policy objectives such as accessibility and solidarity.

However, it has been argued that the obligation to provide WTZ policies is limited to insurers based in the Netherlands and does not therefore constitute a barrier to the freedom to provide services; in some cases, even Dutch insurers can opt out of it (if they obtain special permission) (Palm 2001). If the MOOZ contributions were regarded as a form of earmarked tax on substitutive VHI policies, they would fall under the fiscal competence of the Dutch government, rather than single market legislation, and therefore be exempt from EU competition law (Palm 2001).

Statutory and voluntary health insurance may be provided by the same insurer in the Netherlands. Some complementary and supplementary VHI policies specify that an insurer will automatically terminate the contract if a subscriber switches to another insurer for his or her statutory coverage. This practice is known as conditional sale and may prove to be illegal under EU law because it poses a barrier to competition (Maarse 2001).

## **France**

The transposition of the third non-life insurance directive into French law has been particularly problematic. Mutual associations in France come under a special 'Code de la Mutualité'. The directive appeared to be incompatible with the French concept of mutuality, enshrined in the Code de la Mutualité, and by 1999 the French government had failed to transpose the directive with regard to mutual associations. In December of the same year the European Court of Justice ruled against this incomplete transposition (European Commission 2000b).

The four main areas of incompatibility concern the contractual relation between insurer and insured, the speciality principle, the freedom of reinsurance and the free transfer of portfolio (Palm 2001). Contractual relations differ from the mutual principle of membership of a democratically-structured society. Also, the directive's obligation for insurers to specialise in insurance activity prohibits French mutual associations from managing their own social and health care facilities within the same structure. Furthermore, many French mutual associations operate on a small scale and would not be able to meet the directive's solvency requirements without further reinsurance, but the directive does not permit reinsurance to be confined to other mutual associations, unless mutual associations can show that this is in the general interest. Finally, under the directive, the transfer of portfolio can only be restricted on the

grounds of solvency margins, unless mutual associations can show that this is in the general interest.

After the ECJ ruling in December 1999 the French government agreed to bring national law in line with the directive, although the legislation will not be implemented until the beginning of 2003 (European Commission 2000b). In the meantime, the government has adopted a revised Code de la Mutualité, which tightens the solvency requirements for mutual associations and increases the powers of the supervisory authority. Previously, mutual associations under the Code were subject to less rigorous rules on financial, prudential and accountability than commercial insurers or provident associations (Sandier and Ulmann 2001).

France also contravenes the directive by continuing to insist on systematic notification of policy conditions, obliging insurers to fill in an information sheet whenever they launch a new insurance product. The European Court of Justice ruled against this in May 2000 and continued infringement of the directive is likely to result in the imposition of fines (European Commission 2000b).

Finally, France may contravene EU competition law by treating mutual and provident associations differently from commercial insurers in matters of taxation (see Section 4.3). In 1993 the French Federation of Insurance Companies (FFSA) lodged two complaints against the French authorities for their discriminatory tax policy. Their complaints were eventually upheld by the European Commission in November 2001.

## **Ireland**

Prior to the completion of the Irish regulatory framework for VHI in 1996, it was established that the European Commission accepted, in principle, the Irish government's entitlement to avail of Article 54.1 of the directive, permitting legislation to protect the general good. However, BUPA Ireland have taken legal advice that suggests they could successfully challenge the government on the grounds that the (not yet activated) risk equalisation scheme (RES) contravenes the third non-life insurance directive (although they have yet to make a formal legal challenge (see Section 3.2.4) (Murray 2001a).

The issue of legality does not appear to concern the government, however, who state that the third non-life insurance directive permits risk equalisation or loss compensation schemes in the interest of the general good. The Department of Health and Children note that "the changes now in train in relation to the framework for risk equalisation under the 2001 [Health Insurance Amendment] Act have particular regard to the need for proportionality in legislating to protect the common good" (Department of Health and Children 2001b). It is the Department's view that the directive "should continue to recognise the basis for adopting specific legal provisions to protect the common (general) good where the conduct of health

insurance business is concerned. It is important that it should be open to member states to adopt such measures in relation to the organisation of their health care systems, while also taking account of the fundamental principles of EU law. It is considered that any future change to the EU regulatory framework should retain the basis for the reasonable exercise of discretion of this nature by member states (Department of Health and Children 2001b).

### **5.3.2 The equal treatment of insurers**

The third non-life insurance directive does not distinguish between different types of insurer and specifically outlaws the preferential treatment of one type of insurer over another. Historically, however, national laws in many member states have made a distinction between non-profit and for-profit entities, including entities in the VHI sector.

Commercial insurers in some member states, such as Belgium and France, resent what they regard as discriminatory treatment under national law, both in terms of failure to incorporate the third non-life insurance directive with regard to mutual associations and in terms of favourable tax treatment of mutual or provident associations (see the sections on Belgium and France above). National tax laws also favour mutual associations in Luxembourg (see Section 2.4.2), but the existence of a 'gentleman's agreement' between mutual associations and commercial insurers has prevented the latter from lodging a complaint with the European Commission (Schmitz 2001). This informal 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.

AIM<sup>26</sup> defends such laws on the basis of mutual associations' commitment to solidarity and their ambition of 'mutually improving social conditions' (Association Internationale de la Mutualité 2001). It states that mutual associations are typically committed to guarantee open enrolment, lifelong affiliation and non-selection of risks. It argues that this justifies special status under national laws that explicitly acknowledge their more comprehensive role, including their involvement in activities related to prevention, health education, social cohesion, solidarity and reducing social inequalities in health (Association Internationale de la Mutualité 2001, Palm 2001). Because commercial insurers do not aim to provide access to more deprived groups and generally exclude coverage for mental health care and chronic illnesses, they fail to cover the full range of health care (Palm 2001).

Through the creation of a single market for VHI, the open and unregulated confrontation of these different approaches to protection against the negative consequences of ill health may be detrimental to VHI provided by mutual associations, as low risk individuals could be drained

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<sup>26</sup> The international grouping of autonomous health insurance and social protection bodies operating according to the principles of solidarity and non-profit making.

from mutual associations' pool of risks by insurers who rate premiums according to individual risk, leading to premium increases for high risks insured by mutual associations. The end result would be a forced shift towards lowest common denominator market practices, with potentially serious consequences for vulnerable groups of people such as those with low incomes or those in poor health (particularly where substitutive and complementary VHI are concerned).

It is not clear whether the European Commission anticipated harmonisation towards the lowest common denominator when it set in place the framework for a single VHI market in the European Union. However, the principle of home country control specifically aims to prevent national regulators from erecting barriers to the entry of insurers from other member states, which may bring national regulatory regimes into competition by placing insurers in a strictly-regulated member state such as Germany at a competitive disadvantage in relation to insurers in member states with more liberal regulatory regimes (Rees et al. 1999). AIM argues that the third non-life directive demonstrates an unwelcome acceptance "that the fundamental mechanism of the market economy is the ideal instrument for [ensuring] best quality services and goods at the best price" (Association Internationale de la Mutualité 2001). It would prefer an alternative in which all voluntary health insurers observe "commonly agreed rules of general interest".

Policy-makers could debate whether the equal treatment of commercial insurers and mutual or provident associations in the VHI sector is an issue that needs to be addressed at an EU level. As we noted in Section 2.2.1, the distinction between non-profit and for-profit entities is important in so far as an insurer's profit status determines its motivation and influences its conduct. We also note that because there is variation in the extent to which solidarity principles are pursued by mutual or provident associations in different member states (even among AIM member organisations) it is not possible to make assumptions about insurers' conduct solely on the basis of their legal and non-profit status. However, it may be that insurers offering greater access to VHI (particularly substitutive and complementary VHI) through open enrolment, lifetime cover and community rating should be distinguished in law from insurers that operate on the basis of individual risk and exclude people with pre-existing conditions. Policy responses to this issue should not be based on technical considerations alone, but should also take into account the principles and values of health care systems in the European Union.

### **5.3.3 Clarification of the general good**

There seems to be a consensus, among stakeholders making submissions to this report, that the third non-life insurance directive's lack of a clear definition of the general good has created legal uncertainty, and that there is a need for greater clarity in this area (see Section 1.4 for a



more detailed discussion of the general good). While it is clear that the directive permits application of the general good to substitutive VHI (with due respect to the principle of proportionality), it is much less clear whether (and how) the general good may be applied to complementary and supplementary VHI.

In its submission to this report, BUPA Limited noted that the enforcement of the general good should be simplified, stating that “the process of testing [the questionable use of the ‘general good’ provision] either through Commission Services or the ECJ has proved prohibitive – typically the Commission declines to rule in a socially sensitive area and the time scales for the ECJ make reference unattractive. The insurer can face a dilemma, where a successful launch requires market confidence, while any challenging of doubtful rules is portrayed by the media as challenging fairness – and therefore confidence. This can act as a serious barrier to cross-border competition” (BUPA Limited 2001).

BUPA Limited suggested that “national measures taken ‘in the general interest’ should be subject to scrutiny, if necessary, on the ‘case by case’ basis preferred by the ECJ – health insurance in the European Union is too diverse for very general principles to be workable. Our concern is that in practical matters, influencing market evolution in the interests of the citizen, the delays in obtaining ECJ judgement are themselves barriers to the development of a single market. More interpretative guidance from the Commission on the application of ‘general good’ criteria to non-state health insurance could be welcome, in the interests of ‘legal certainty’” (BUPA Limited 2001).

CEA also pointed out that, while general good guidance is not clear enough, its definition should be left to member states rather than the European Commission (Pierotti 2001). Its recommendation is for the European Commission to provide a central register of information on measures taken by member states to protect the general good in the health insurance sector.

## Section 6: Concluding remarks

In this report we have reviewed: the types of VHI available in the European Union; demand and levels of VHI coverage; the EU framework for regulating VHI; the operation of VHI markets; the role of these markets in providing access to health care; their impact on the free movement of people and services; and recent trends and challenges for voluntary health insurers and policy-makers at national and EU levels.

The remarks we make in this section should be seen in the context of public policy objectives for health care systems (equity, efficiency, responsiveness, choice). We should also emphasise that the operation and impact of VHI markets are under-researched areas.

There is a need for greater scrutiny of VHI markets in the European Union. The third non-life insurance directive established a framework for a single market in VHI, in the expectation that increased competition between voluntary health insurers would lead to efficiency gains for insurers and benefits for consumers in terms of greater choice and lower prices. In the absence of careful monitoring of VHI markets it is not possible to say whether these expectations have been fulfilled. If policy-makers are to be persuaded that the current regulatory framework works to the advantage of consumers (and not just insurers), they must have access to better information about how the market operates, and in whose interest.

Current levels of data availability are inadequate. A more systematic collection of data would assist policy-makers in monitoring the extent to which the current regulatory framework has increased competition and the extent to which the expected benefits of a competitive VHI market have been transferred to consumers.

Better co-ordination of and co-operation between supervisory authorities would assist efforts to collect data and might have the added advantage of facilitating the removal of some barriers to the free movement of people and services across national borders. At an EU level, a centralised source of information could enhance the clarification of existing rules and reduce the confusion caused by differential application of these rules at member state level.

There is also a need for greater transparency in VHI markets. Policy-makers should encourage voluntary health insurers to be more open in the way they operate. VHI markets in some member states are characterised by a proliferation of varied and complex insurance products. Product differentiation can benefit consumers by increasing the range of products available to them and by providing them with products that are tailored to meet their needs, but it can also be used to segment the market, giving insurers greater opportunity to distinguish between 'good' and 'bad' risks. Either way, the presence of multiple insurance

products may reduce price competition unless it is accompanied by a level of information sufficient to permit consumers to compare products in terms of value for money. As noted by the OECD, the UK competition watchdog (the Office of Fair Trading) and consumer associations, consumers may be easily confused by multiple VHI products and may therefore purchase inappropriate policies. It is not clear that the current regulatory framework gives insurers incentives to provide adequate levels of information. Policy-makers should consider whether consumers would benefit from: the use, by insurers, of standardised terms; a requirement for insurers to inform potential and existing subscribers of all the options open to them; and the introduction of accessible centralised sources of comparable information about the price, quality and conditions of VHI products.

The possibility of addressing voluntary health insurers' incentives to select risks is a further issue for policy debate. Despite insurers' protestations to the contrary, a competitive environment is likely to create incentives to resort to risk selection. The absence of adequate data availability and greater transparency will continue to provoke suspicion in this area. Risk selection may raise equity concerns in some VHI markets (particularly where substitutive VHI is concerned) and it may have serious implications for efficiency in all VHI markets. Incentives to risk-select in substitutive VHI markets may be reduced by sophisticated risk-adjustment mechanisms, although it is unlikely that voluntary health insurers will agree to be subject to such mechanisms.

Policy-makers should consider making better use of policy tools to encourage voluntary health insurers to operate in a way that is more conducive to social goals. Currently, insurers are permitted to set age limits for the purchase of VHI, require applicants to provide detailed medical information, including information on family history of disease (a type of genetic information), exclude pre-existing conditions, impose mandatory waiting periods and cancel contracts. This may result in discrimination against elderly people, people with pre-existing conditions or people with a history of family disease. The importance of such discrimination and the magnitude of the barrier it presents to access are dependent on the extent to which VHI acts as a substitute for statutory coverage, provides cover for necessary and effective services fully or partially excluded from statutory coverage, or provides faster access to treatment. It may also restrict citizens' mobility within the European Union.

Genetic tests for insurance purposes may emerge as an issue for VHI in future, and debate about the appropriate use of such technology should be initiated at an EU level.

VHI in the EU is sold by mutual or provident associations and commercial insurers. The issue of whether certain types of VHI based on solidarity principles should be subject to EU single market and competition law needs to be examined further. Policy responses to this issue

should not be based on technical considerations alone, but should also take into account the principles and values of health care systems in the European Union.

Policy-makers should pay attention to the equity (and efficiency) implications of the existence of VHI for statutory health care systems, particularly when considering any expansion of VHI markets. The existence of VHI may create or exacerbate inequalities in access to statutory health care for some individuals and population groups if it results in a distortion of public resources for health care. This is most likely to happen where the boundaries between public and private health care 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. More research is needed in this area.

Most member states do not use tax incentives to encourage individuals to purchase VHI.

Arguments in favour of tax relief for VHI on the grounds that increasing demand for VHI reduces demand for statutory health care are not substantiated by evidence. Tax relief for VHI may give rise to equity concerns where it benefits those in employment at the expense of those without employment and where it is applied at the marginal tax rate, thereby increasing the value of the relief to those in higher tax bands. Tax relief may lead to inefficiency because it distorts price signals, generates additional transaction costs and can create opportunities for tax avoidance or evasion. If tax relief for VHI is as expensive, regressive and unsuccessful in stimulating demand as the evidence from some member states suggests, policy-makers should consider whether resources devoted to tax relief might be better spent on improving the quantity and quality of statutory health care.

VHI does not appear to pose a major barrier to the free movement of people in the European Union, as long as adequate access to health care is available in the statutory health care system so that people do not have to purchase VHI when they move to another member state. Some barriers may persist with regard to the free movement of services. Further clarification of the concept of the general good and its application with regard to all types of VHI might go some way to reducing barriers to the free movement of services. It might also benefit member states in their attempts to protect the general interest.

Facilitating access to health care involves helping people to command appropriate health care resources in order to preserve or improve their health. Access to health care includes at least four dimensions: service availability, service utilisation, service relevance and effectiveness, and equity. No discussion of the access implications of the existence of VHI and the way in which VHI markets operate would be complete without a broader consideration of access to statutory health care. Policy-makers should take into account the wider determinants of

unequal access to health care and existing inequalities arising from the way in which statutory health care is funded and provided. Measures such as the imposition of user charges may also pose financial barriers to health care and therefore require further study.

# Appendices

## Appendix A – The case of Spain and Portugal

Spain and Portugal are sometimes listed as member states in which it is possible to purchase substitutive VHI. Since 1993 individuals and groups of employees have been allowed to opt out of the statutory health care system in Portugal. However, as the Portuguese health care system is organised in the form of a National Health Service (NHS) and largely funded through taxation, those who opt out are not so much exempt from contributing to the statutory health care system as exempt from using the services provided by the statutory health care system. The health services they use continue to be funded by the state, through a fixed annual contribution per person opting out to a third party, but are provided by the private sector (and sometimes the public sector as well). In Spain, civil servants are covered by a compulsory health insurance scheme run by public bodies and funded by social security contributions, but have the choice of obtaining all health services from the state, through the NHS, or from the private sector, via a voluntary health insurer. The choice offered to those that opt out in Portugal and civil servants in Spain is essentially a choice of provider. As these groups are neither excluded from the statutory health insurance scheme nor exempt from contributing to it, they do not fall within our definition of substitutive VHI.

### Opting out in Portugal

The Portuguese health care system is organised in the form of a National Health Service with universal coverage. In theory health care is funded through general taxation and is free at the point of use, but the Portuguese health care system is characterised by a public/private mix of health care funding and provision, a high level of private expenditure (at 33.1 per cent of total expenditure on health in 1998 it is the highest in the European Union after Greece (Organisation for Economic Co-operation and Development 2000)) and double/triple coverage (under the public and private sectors) of a significant part of the population. This pattern of double/triple coverage is explained by the presence of occupation-based 'subsystems' and, more marginally, a market for VHI. Most private expenditure goes towards co-payments for pharmaceuticals and out-of-pocket payments to private providers.

Subsystems, which existed before the introduction of the NHS in 1979, are health insurance schemes organised mainly by state corporations in the financial, military and telecommunications sectors (although many of these corporations were privatised in the 1990s). It was originally intended that they would be integrated into the NHS after 1979, but this has not happened in practice, and subsystems continue to provide their beneficiaries with

a choice of health care provider, while those in the NHS are assigned to a family doctor and only have access to NHS (or NHS-contracted) health services. Subsystems currently cover about 20-25 per cent of the population (Baptista 1999, Barros 1997, Organisation for Economic Co-operation and Development 1998b). Payment by subsystems to the NHS for any health services used by their beneficiaries is a controversial issue in Portugal (Pinto and Oliveira 2001). Although subsystems are required by law to pay the NHS for these services, many of them systematically refuse to do so on the grounds that their activities are complementary to the NHS and their beneficiaries continue to pay taxes.

Since 1993 individuals and groups of employees have been allowed to opt out of the statutory health care system. The decision to allow people to opt out represented a major change in the system, but so far only three subsystems have decided to opt out (the Portugal Telecom subsystem in 1997, the Portuguese Post Office in 1999 and, more recently, SAMS) (Oliveira 2001). This is largely because commercial insurers have been reluctant to accept the conditions attached to opting out (Pereira et al. 1999). For a fixed capitation fee of PTE 29,000 (EUR 145) per beneficiary per year, paid by the state to the subsystem, the subsystem must provide its beneficiaries with all health services. Individuals that opt out of the statutory health care system may still have access to statutory health services, but their insurer will have to pay for their use of these services. The number of people covered by the subsystems that have opted out is very small (Oliveira 2001).

Due to the compulsory nature of almost all participation in subsystems, including those that have opted out, we do not consider them as VHI as defined in this report.

### **The scheme for civil servants in Spain**

The Spanish health care system is organised as a National Health Service. It provides near universal coverage (99 per cent of the population) and is largely financed through general taxation (Rico 2000). Civil servants are covered by a compulsory health insurance scheme run by three mutual associations: MUFACE for ordinary civil servants, MUJEGU for civil servants in the judiciary and ISFAS for members of the armed forces (Rodríguez 2001). All three mutual associations are public bodies under the jurisdiction of the Ministry of Public Administration, the Ministry of Justice and the Ministry of Defence respectively, and funded by social security contributions fixed each year and deducted automatically from civil servants' wages. In January every year each civil servant can choose to obtain health services from the NHS or from a voluntary health insurer. Approximately 85 per cent of civil servants choose the latter option (95 per cent of civil servants working in the Ministry of Health (Rico 2000), while the rest choose the NHS (Rodríguez 2001). The social security contributions for health are passed on to the mutual associations and from there to the NHS or voluntary health insurers in the form of a flat fee per civil servant (equal to the NHS's per capita health care

expenditure). The flat capitation fee must also cover dependants, even though it is not adjusted to take into account the number of dependants. Only voluntary health insurers willing to accept this fee participate in the scheme, and for this fee they must provide benefits equal to the benefits provided by the NHS.

Civil servants do not have any financial incentive to choose health services provided by voluntary health insurers rather than health services provided by the NHS. The reason why so many civil servants choose health services provided by voluntary health insurers is the same reason other Spanish people purchase VHI: for faster access to health care, perceived better service and greater choice of provider. The 15 per cent of civil servants that choose NHS provision are generally people who value the public sector's alleged higher technical capacity (including a substantial proportion of health economists working in universities) (Rodríguez 2001).

Data published by voluntary health insurers in Spain do not always distinguish between policies purchased through these civil servants' mutual associations and policies purchased by other Spanish people. However, we do not consider policies purchased through MUFACE, MUJEGU or ISFAS to be VHI as defined in this report.

The establishment of the MUFACE system for civil servants in 1975 gave the VHI market a considerable boost and voluntary health insurers have often argued in favour of extending this system to the rest of the Spanish population. This has been opposed by those who prefer a purely public system of health care and by academics who argue that the insurance companies have not demonstrated adequate capacity to manage efficiently an enlarged market. Voluntary health insurers claim to be more efficient than the public sector, but this claim may be challenged on several grounds.

First, the VHI industry has been very opaque; it is almost impossible to find a series of complete and reliable data about basic variables, such as the number of insured people. The lack of detailed data has impeded any rigorous analysis of comparative efficiency. For example, while diagnostic-related groups (DRGs) are calculated for case-mix appraisal in the public sector, no insurance company is able to provide the same information for its own business. Industry officials recognise the lack of reliable data, but blame it on technical difficulties rather than bad will.

Second, the fact that most people with VHI do not rely on it for all their health care makes it hard to see how voluntary health insurers would fare if they were responsible for providing all health services for the people they insure. There is some evidence to suggest that civil servants in the MUFACE scheme use their MUFACE coverage for minor health problems, but turn to the NHS for more serious (and therefore more expensive) problems or for high



technology interventions, even though statutory regulation explicitly prohibits this (Puig-Junoy 1999, Rico 2000). In effect the state pays twice for these individuals: first, when it transfers the flat capitation fee to MUFACE and second, when they make use of the NHS.

Third, MUFACE itself has in the past been unable or unwilling to provide detailed data on its members, so that no sound economic analysis has been possible. The conclusions of the one PhD thesis on this issue (Pellisé 1994) were tentative due to weak data (Rodríguez 2001).

For these reasons it is difficult to make an evidence-based assessment of the effects of expanding the MUFACE system to the rest of the population.

## **Appendix B – List of organisations making submissions to the report**

### **International organisations**

Association Européenne des Institutions Paritaires (AEIP) – <http://www.aeip.net>

Association Internationale de la Mutualité (AIM) – <http://www.aim-mutual.org>

Comité Européen des Assurances (CEA) – <http://www.cea.assur.org>

Maison Européenne de la Protection Sociale (MEPS) / European Social Insurance Partners (ESIP) – <http://www.esip.org>

### **Regulatory bodies**

Bundesaufsichtsamt für das Versicherungswesen (BAV) (Germany) – <http://www.bav.bund.de>

Insurance Financial Supervision Section of the Department of Health and Children (Ireland) – <http://www.doh.ie>

The Office of Fair Trading (United Kingdom) – <http://www.oft.gov.uk>

### **Actuarial bodies**

Groupe Consultatif Actuariel Européen – [http://www.actuaries.org.uk/groupe\\_consultatif](http://www.actuaries.org.uk/groupe_consultatif)

The Society of Actuaries in Ireland – <http://www.actuaries-soc.ie>

### **Consumer associations**

Associação Portuguesa para a Defesa do Consumidor (DECO) – <http://www.deco.proteste.pt>

The Consumers' Association of Ireland (CAI) – <http://www.consumerassociation.ie>

UK Consumers' Association (CA) – <http://www.which.net>

### **AIM member organisations**

BUPA International

Danmark Sygeforsikring (DS)

Fédération Nationale de la Mutualité Française (FNMF)

Kontaktkommissie Publiekrechtelijke Ziektekostenregelingen voor Ambtenaren (KPZ)

Union Nationale des Mutualités Socialistes (UNMS)

Vhi Healthcare

### **Zorgverzekeraars Nederland (ZN)**

#### **CEA member organisations**

Association des Compagnies d'Assurances du Grand-Duché de Luxembourg (ACA) –  
Luxembourg Insurers' Association

BUPA International

Forsikring og Pension – Danish Insurers' Association

PKV (on behalf of Gesamtverband der Deutschen Versicherungswirtschaft – German Insurers' Association)

Sveriges Försäkringsförbund – Swedish Insurers' Association

The British Insurers' European Committee (BIEC) of the Association of British Insurers

Unión Española de Engidades Aseguradoras y Reaseguradoras (UNESPA) – Spanish Insurers' Association

Union Professionnelle des Enterprises d'Assurances (UPEA) – Belgian Insurers' Association

Verband der Versicherungsunternehmen Österreichs (VVO) – Austrian Insurers' Association

Zorgverzekeraars Nederland (ZN) – Dutch Insurers' Association

## **Appendix C – List of authors and their affiliations**

### **Reinhard Busse (Germany)**

Professor of Health Care Management, Institute of Public Health, Faculty of Economics and Management, Technical University, Berlin

### **Charalambos Economou (Greece)**

Senior Research Fellow, Department of Health Economics, National School of Public Health, Athens

### **Margherita Giannoni-Mazzi (Italy)**

Senior Researcher in Public Finance, Department of Economics, University of Perugia

### **Jean Hermesse (Belgium)**

Professor, School of Public Health, Université Catholique de Louvain  
National Secretary, Alliance Nationale des Mutualités Chrétiennes

### **Tony Hockley (United Kingdom)**

Director, The Policy Analysis Centre

### **Maria M Hofmarcher (Austria)**

Economist and Consultant to the World Bank  
Research Associate and Group Head, IHS-HealthEcon, Department of Economics and Finance, Institute for Advanced Studies, Vienna

### **Hans Maarse (Netherlands)**

Full Professor in Policy Science (with special reference to health care), Faculty of Health Sciences, University of Maastricht

### **Hennamari Mikkola (Finland)**

Researcher in Health Economics, National Research and Development Centre for Welfare and Health (STAKES), Helsinki

### **Elias Mossialos**

Research Director, European Observatory on Health Care Systems  
Reader in European Health Policy (Department of Social Policy) and Co-Director (LSE Health and Social Care), London School of Economics and Political Science

### **Monica Oliveira (Portugal)**

Researcher, LSE Health and Social Care, London School of Economics and Political Science

**Marisol Rodríguez (Spain)**

Associate Professor, Department of Economic Policy, University of Barcelona

**Simone Sandier (France)**

Research Director, Arguments Socio-Economiques pour la Santé (ARgSES), Paris  
Formerly Research Director of the Centre for Research and Documentation in Health Economics (CREDES), Paris, 1985-1997

**Caj Skoglund (Sweden)**

Managing Director, BCS Kompetensutveckling AB  
Project Manager, The Swedish Welfare Group

**Sarah Thomson**

Research Officer, European Observatory on Health Care Systems  
Research Associate in Health Policy, LSE Health and Social Care, London School of Economics and Political Science

**Philippe Ulmann (France)**

Assistant Professor, Department of Economics and Management of Health Services,  
Conservatoire National des Arts et Métiers, Paris (Public University and 'Grande Ecole' status)

**Karsten Vrangbæk (Denmark)**

Assistant Professor, Department of Health Services Research, Institute of Public Health and  
Institute of Political Science, University of Copenhagen

## List of abbreviations

Abbreviation	
ABI	Association of British Insurers
AIM	Association Internationale de la Mutualité
AWBZ	Algemene Wet Bijzondere Ziektekosten
CEA	Comité Européen des Assurances
CMU	Couverture Mutuelle Universelle
DECO	Associação Portuguesa para a Defesa do Consumidor
DRG	Diagnostic-Related Groups
EC	European Community
ECJ	European Court of Justice
EU	European Union
FSA	Financial Services Authority
GDP	Gross domestic product
GKV	Gesetzliche Krankenversicherung
HMO	Health Maintenance Organisation
MOOZ	Health Insurance Funds Act
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OFT	The Office of Fair Trading
PKV	Verband der privaten Krankenversicherung / German Association of Private Health Insurers
PPN	Preferred Provider Network
PZV	Publiekrechtelijke ziektekostenverzekering
RES	Risk Equalisation Scheme
RIZIV-INAMI	Rijksinstituut voor ziekte en invaliditeitsverzekering or Institut National d'Assurance Maladie Invalidité (National Institute of Health and Disability Insurance)
UK	United Kingdom
VHI	Voluntary health insurance
VHIB	Voluntary Health Insurance Board
WTZ	Wet op de Toegang tot Ziektekostenverzekeringen
ZFW	Ziekenfondswet

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