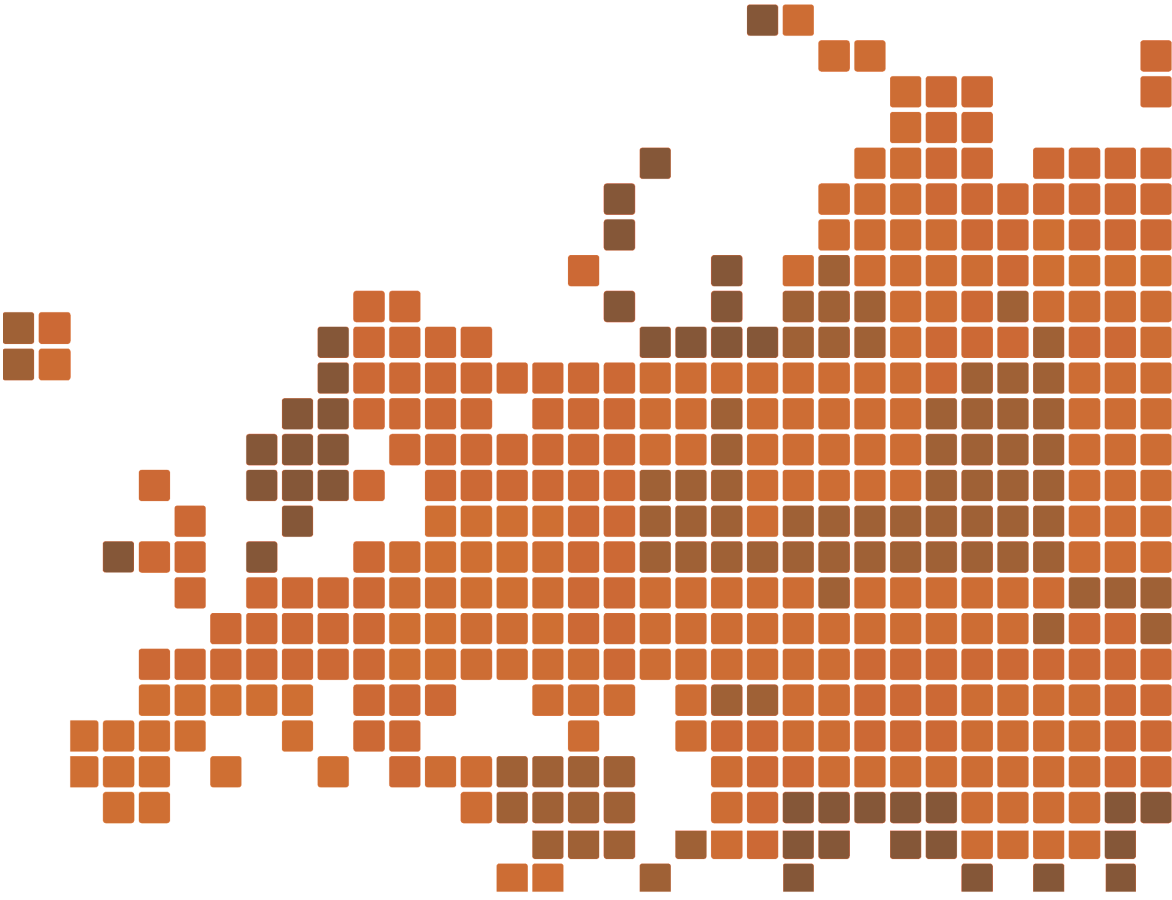
Voluntary health insurance in Europe

Role and regulation

43
Observatory Studies Series

Anna Sagan
Sarah Thomson



World Health Organization
REGIONAL OFFICE FOR Europe

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Voluntary health insurance in Europe: role and regulation

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in Europe. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues.

The Observatory is a partnership hosted by the WHO Regional Office for Europe, which includes the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Sweden, the United Kingdom and the Veneto Region of Italy; the European Commission; the World Bank; UNCAM (French National Union of Health Insurance Funds); the London School of Economics and Political Science; and the London School of Hygiene & Tropical Medicine. The Observatory has a secretariat in Brussels and it has hubs in London (at LSE and LSHTM) and at the Technical University of Berlin.

Voluntary health insurance in Europe: role and regulation

Written by

Anna Sagan and Sarah Thomson

World Health Organization
REGIONAL OFFICE FOR Europe

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Keywords:
INSURANCE, HEALTH
DELIVERY OF HEALTH CARE
FINANCING, HEALTH
EUROPE

ISBN 978 92 890 5038 8

Printed in the United Kingdom

Typeset by Peter Powell

Cover design by M2M

Contents

Acknowledgements

We are indebted to the many country experts who contributed to the study by providing country-specific information and data, reviewing an earlier draft of this book and writing the country profiles in its companion volume. We are also grateful to Anna Maresso (European Observatory on Health Systems and Policies) for her valuable help in reviewing the country profiles for Chapters 3, 4 and 5 of this volume. We thank Champa Heidbrink (LSE Health) for the financial management of the study and our colleagues at the European Observatory on Health Systems and Policies and the WHO Barcelona Office for Health Systems Strengthening for vital project and production support. The production and copy-editing process for this book was coordinated by Jonathan North with the support of Caroline White. Additional support came from Sonia Cutler (copy-editing) and Peter Powell (typesetting).

Country experts

Natasha Azzopardi-Muscat University of Malta, Msida

Peter Balik Health Policy Institute, Bratislava

Konstantin Beck Institute for Empirical Health Economics, Lucerne and University of Zurich

Karen Berg Brigham URC Eco (Paris Health Services and Health Economics Research Unit, AP-HP)

Girts Brigis Riga Stradins University

Karine Chevreul URC Eco (Paris Health Services and Health Economics Research Unit, AP-HP)

Joan Costa-i-Font London School of Economics and Political Science

Thomas Czypionka Institute for Advanced Studies, Vienna

Antoniya Dimova Medical University of Varna

Martin Dlouhy University of Economics, Prague

Mónica Duarte Oliveira Centre for Management Studies of Instituto Superior Técnico, University of Lisbon

Caj Skoglund Independent scholar, Lulea

Alicja Sobczak University of Ecology and Management, Warsaw

Szabolcs Szigeti WHO Country Office, Hungary

Mamas Theodorou Open University of Cyprus, Nicosia

Brian Turner University College Cork

Viktor von Wyl University of Zurich

Karsten Vrangbæk University of Copenhagen

Lauri Vuorenkoski Finnish Medical Association, Helsinki

List of tables, boxes and figures

Tables

Boxes

Figures

List of abbreviations

ABI	Association of British Insurers
ACS	*Aide à la complémentaire santé* (complementary health assistance) (France)
CAM	complementary and alternative medicine
CAP	capitation
CAS	*contrat d'accès au soin* (access to care contract) (France)
CMU-C	*couverture maladie universelle complémentaire* (complementary universal health coverage) (France)
DRG	diagnosis-related group
EC	European Council
ECJ	European Court of Justice
EFTA	European Free Trade Area
EHIF	Estonian Health Insurance Fund
EU	European Union
EU13	EU members since 2004
EU15	EU members before May 2004
EU-SILC	European Union Survey on Income and Living Conditions
FFS	fee-for-service
FSU	Former Soviet Union
FYROM	Former Yugoslav Republic of Macedonia
GDP	gross domestic product
GKV	*Gesetzliche Krankenversicherung* (statutory health insurance) (Germany)
GP	general practitioner
HM	Her Majesty
HTA	health technology assessment
IGAS	*Inspection générale des affaires sociales* (General Inspectorate of Social Affairs) (France)
INN	international non-proprietary name
IPT	insurance premium tax
IVF	in vitro fertilization
LTC	long-term care
MIP	Medical Insurance Programme
NHS	National Health Service

OECD	Organisation for Economic Co-operation and Development
OFT	Office of Fair Trading (United Kingdom)
OOP	out-of-pocket
PD	per diem
PKV	*Private Krankenversicherung* (private health insurance) (Germany)
PPN	preferred provider network
SSN	*Servizio Sanitario Nazionale* (Italian National Health Service)
THE	total health expenditure
UHC	universal health coverage
US	United States
VHI	voluntary health insurance
WHO	World Health Organization

Note

This study on voluntary health insurance (VHI) in Europe has been prepared by the European Observatory on Health Systems and Policies and the WHO Regional Office for Europe.

The study is published in three separate volumes:

- An analytical overview of markets for VHI in 34 countries in the WHO European Region: 27 out of 28 Member States of the European Union (EU), Armenia, Georgia, Iceland, Norway, the Russian Federation, Switzerland and Ukraine (this book)
- Short profiles of VHI in each of the 34 countries (a companion book)
- A review of VHI's impact on health system performance and implications for policy (a policy summary)

The WHO European Region[1] consists of 53 countries in the following groupings:

EU15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, the United Kingdom
EU13: Bulgaria, Croatia, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia
European Free Trade Area (EFTA): Iceland, Norway, Switzerland
Non-EU Balkans: Albania, Bosnia and Herzegovina, Montenegro, Serbia, the Former Yugoslav Republic of Macedonia (FYROM)
Former Soviet Union (FSU): Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan
Other: Andorra, Israel, Monaco, San Marino, Turkey

Throughout the book we use the following colour codes for these country groupings:

EU15+EFTA EU13 FSU Non-EU Balkans Other

1 Throughout the book we refer to this group of 53 countries as 'the European Region' or 'Europe'.

Chapter 1
Introduction

This book offers a succinct overview of the size, operation and regulation of markets for voluntary health insurance (VHI) in countries across Europe. We define VHI as health insurance that is taken up and paid for at the discretion of individuals or employers on behalf of employees, including group policies sponsored by employers that come with the job and are thus not strictly voluntary. VHI can be offered by public and quasi-public bodies and by for-profit (commercial) and non-profit-making private organizations.

Building on earlier work,[1] and drawing on data and experience in 34 countries, the book addresses the following questions: Why do people buy VHI? What role does VHI play in relation to publicly financed health coverage? Who buys VHI? How much does VHI contribute to spending on health? How do markets for VHI operate? How do they interact with the wider health system? How have VHI markets changed over time? How does public policy towards VHI vary across countries and what are the most common policy concerns?

In **Chapter 2** – VHI at a glance – we provide a snapshot of VHI's contribution to public and private spending on health across Europe and summarize the rest of the volume.

In **Chapter 3**, we look at the reasons why people buy VHI and examine the different roles VHI plays in relation to publicly financed coverage.

In **Chapter 4**, we review the share of the population covered by VHI, the composition of those who buy VHI (the balance between individuals and groups) and the socioeconomic characteristics of VHI policyholders.

In **Chapter 5**, we examine different aspects of the way in which markets for VHI operate. We review the number and types of entities selling VHI, look at the policy conditions associated with the sale of VHI, the methods insurers use to set premiums, the scope and depth of VHI benefits, the extent of consumer choice, how insurers purchase services from providers and how much insurers spend on health services and administration.

1 Mossialos & Thomson (2004), OECD (2004), Thomson & Mossialos (2009), Thomson (2010).

In **Chapter 6**, we review public policy towards VHI, including regulation at national and EU levels, major developments that have taken place since 2000 and the use of tax incentives to encourage take-up of VHI. We conclude the chapter with a discussion of national policy developments and concerns around VHI.

Chapter 2
VHI at a glance

In this chapter, we set VHI in context by discussing its contribution to private and total spending on health. We also provide a visual summary of and a brief commentary on the information included in the rest of the volume.

VHI's contribution to total spending on health

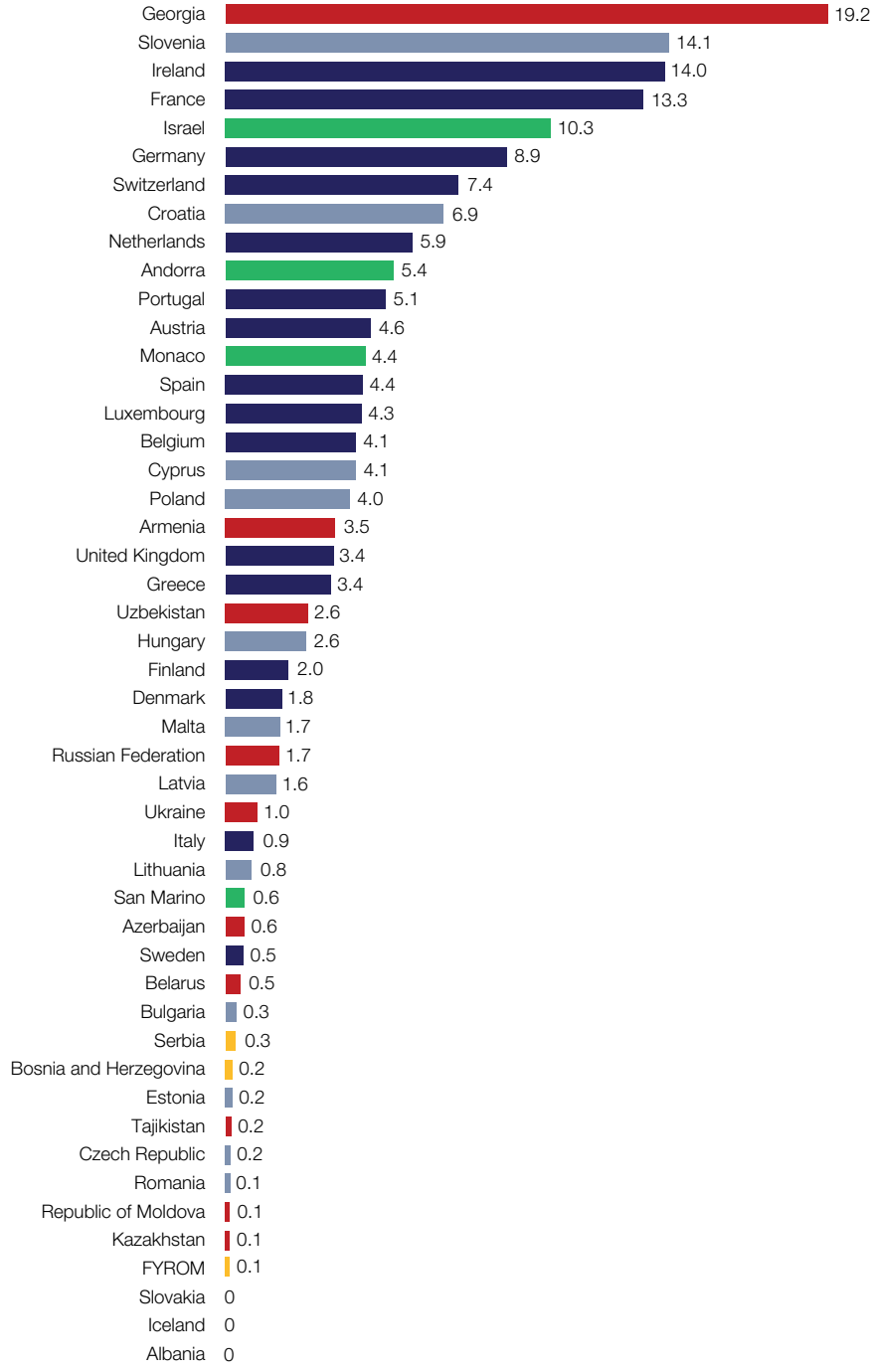
Health spending channelled through VHI is low in most countries. In 2014, VHI accounted for over 5% of total health spending in only 11 out of the 53 countries in the WHO European Region (Figure 2.1). The largest markets for VHI – in terms of contribution to total spending on health – are in EU and EFTA countries.

Between 2000 and 2014, VHI grew as a share of total spending on health in many countries (Figure 2.2). In about a third of these countries, however, growth amounted to less than half a percentage point. Strong VHI growth in Armenia and Georgia can be attributed to the introduction of the government paying for VHI to cover specific groups of people. Georgia stopped doing this in 2013 and spending through VHI is likely to fall there.

Some of the growth in VHI's share of total spending can be attributed to increases in VHI spending per capita, which grew rapidly between 2000 and 2014 in many of the countries in which VHI's share of total spending grew the most (over 200%) – Armenia, Georgia, Poland, Croatia, Malta, Israel and Ireland (Figure 2.3).

The Netherlands experienced the most significant decline in the VHI share of total spending on health between 2000 and 2014 (Figures 2.4 and 2.5). This is due to the extension of publicly financed health coverage to the whole population in 2006, which effectively abolished the market for substitutive VHI.

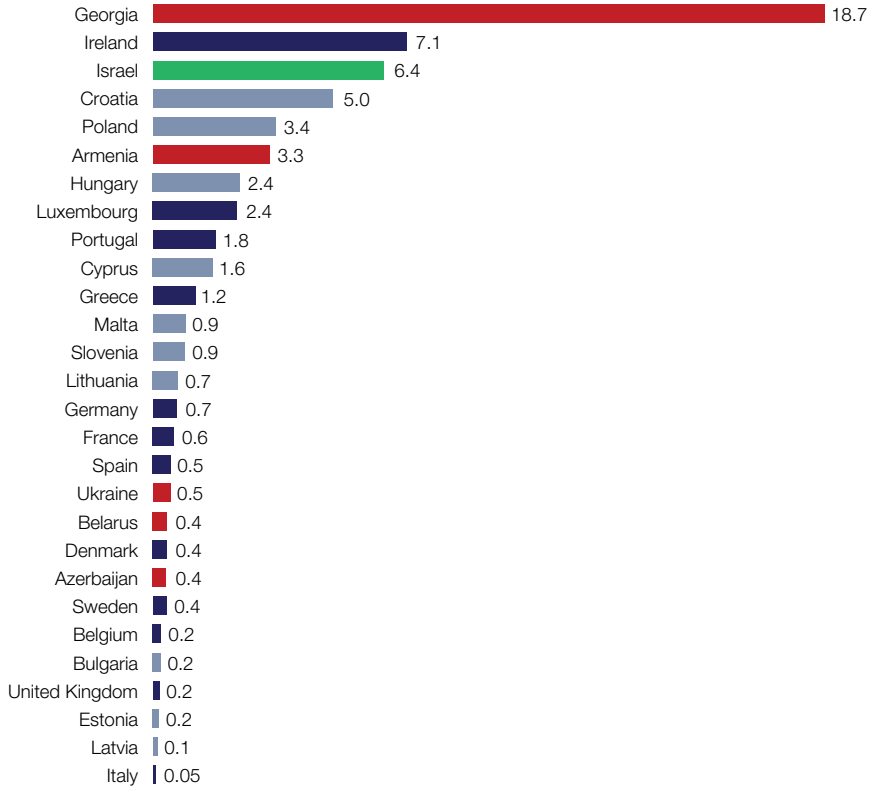
Figure 2.1 *VHI as a share (%) of total spending on health in 2014*



Source: WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts (see Szigeti, Lindeisz & Gaál, 2016). See Appendix B for information on data availability and assumptions made.

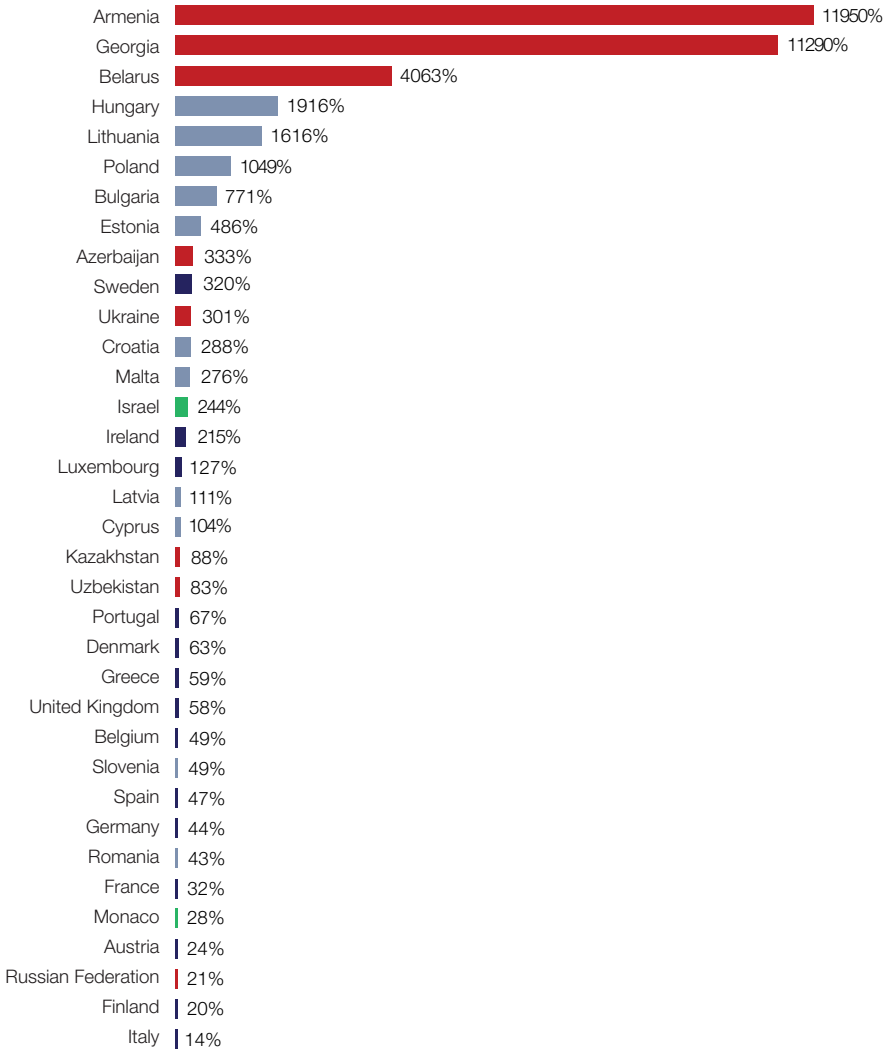
Figure 2.2 *Countries in which VHI's share of total spending on health grew between 2000 and 2014 (% point change)*



Source: WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). See Appendix B for information on data availability and assumptions made.

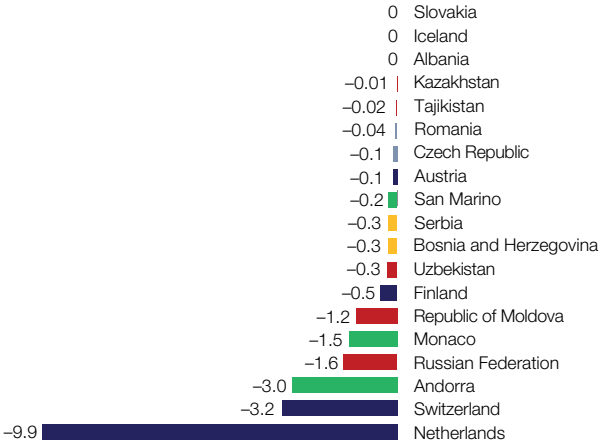
Figure 2.3 *Growth in VHI spending per capita between 2000 and 2014 (% change)*



Source: WHO (2016).

Notes: VHI spending in millions of constant (2005) national currency units. Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). See Appendix B for information on data availability and assumptions made.

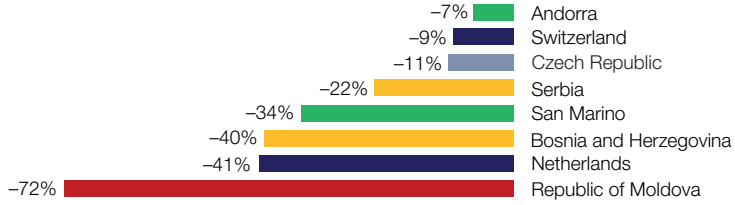
Figure 2.4 *Countries in which VHI's share of total spending on health did not change or declined between 2000 and 2014 (% point change)*



Source: WHO (2016).

Notes: See Appendix B for information on data availability and assumptions made.

Figure 2.5 *Decline in VHI spending per capita between 2000 and 2014 (% change)*



Source: WHO (2016).

Notes: VHI spending in million constant (2005) national currency units. See Appendix B for information on data availability and assumptions made.

VHI's contribution to private spending on health

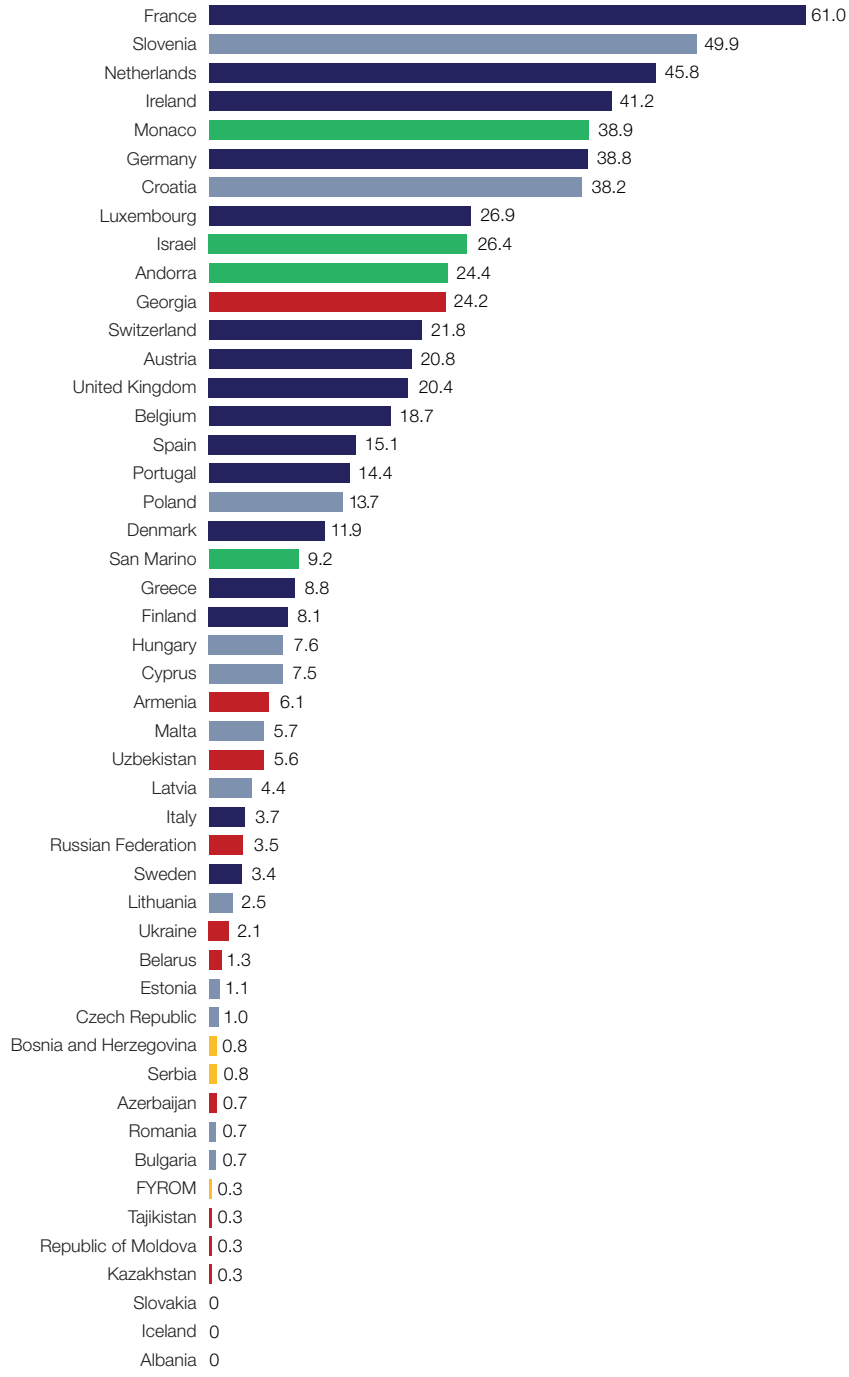
VHI is generally low as a share of private spending on health (Figure 2.6). In 2014, it accounted for over 20% in only 14 out of 53 countries. With the exception of Croatia, Slovenia and Israel, countries in which VHI accounts for a higher share of private spending on health are heavily concentrated in Western Europe.

Between 2000 and 2014, VHI grew as a share of private health spending in just over half of the countries in the European Region (Figures 2.7 and 2.8).

Why do people buy VHI?

People buy VHI to cover gaps in publicly financed health coverage or to benefit from faster access to treatment and enhanced choice of health care provider (Table 2.1).

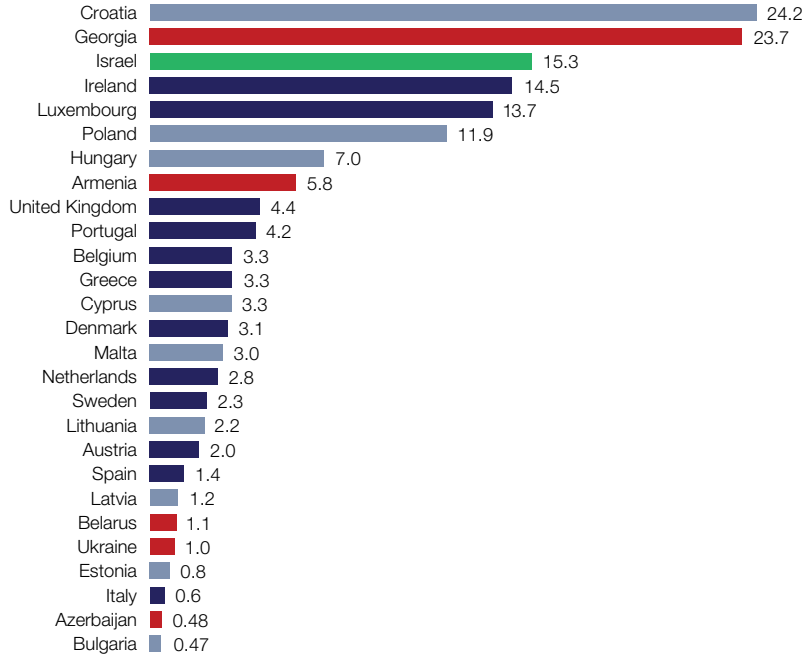
Figure 2.6 *VHI as a share (%) of private spending on health in 2014*



Source: WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of private spending in Hungary is overestimated (see Szigeti et al., 2016). The Netherlands underestimates out-of-pocket (OOP) payments because it does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending in national health accounts data (OECD, 2015a). This means that VHI's share of private spending in the Netherlands is overestimated. See Appendix B for information on data availability and assumptions made.

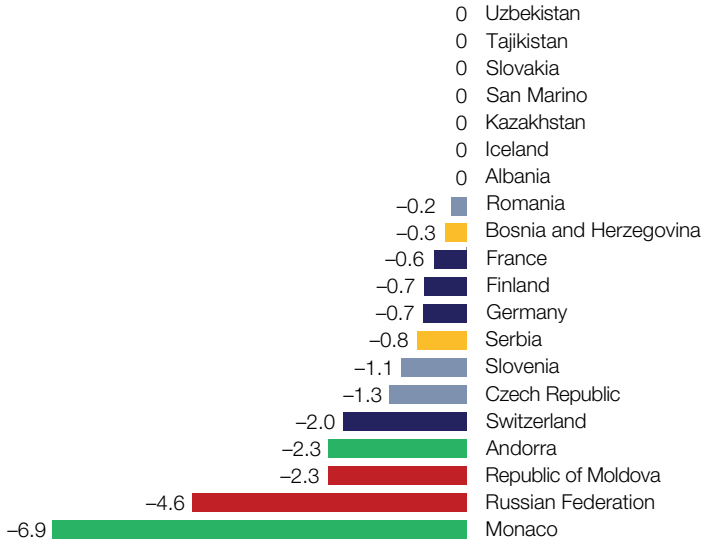
Figure 2.7 *Countries in which VHI's share of private spending on health grew between 2000 and 2014 (% point change)*



Source: WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of private spending in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). See Appendix B for information on data availability and assumptions made.

Figure 2.8 *Countries in which VHI's share of private spending on health did not change or declined between 2000 and 2014 (% point change)*



Source: WHO (2016).

Notes: See Appendix B for information on data availability and assumptions made.

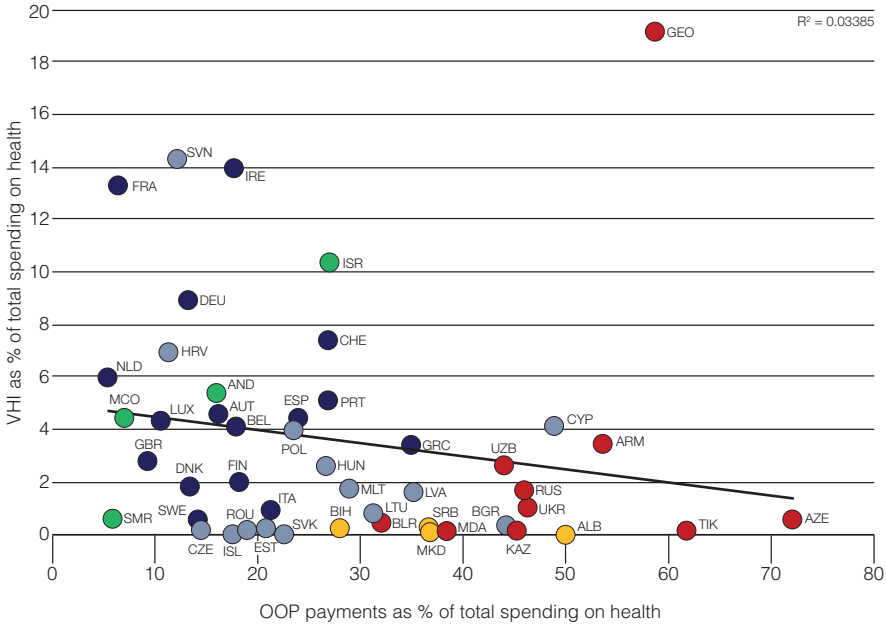
Table 2.1 *Drivers of VHI market development*

Market role	Driver of market development	Nature of VHI coverage
Supplementary	Perceptions about the quality and timeliness of publicly financed health services	Offers faster access to services, greater choice of health care provider or enhanced amenities
Complementary (services)	The scope of the publicly financed benefits package	Services excluded from the publicly financed benefits package
Complementary (user charges)	The existence of user charges for publicly financed health services	User charges for goods and services in the publicly financed benefits package
Substitutive	The share of the population entitled to publicly financed health services	People excluded from or allowed to opt out of publicly financed coverage

Source: Foubister *et al.* (2006).

Gaps in publicly financed health coverage are a prerequisite for VHI, but they are not sufficient for a VHI market to develop and grow. The relationship between VHI and OOP payments is very weak (Figure 2.9). In spite of significant gaps in coverage in many countries in the European Region – as demonstrated by very high levels of OOP payments in some countries – VHI's contribution to private spending on health is low in all but a handful of countries (Figure 2.10).

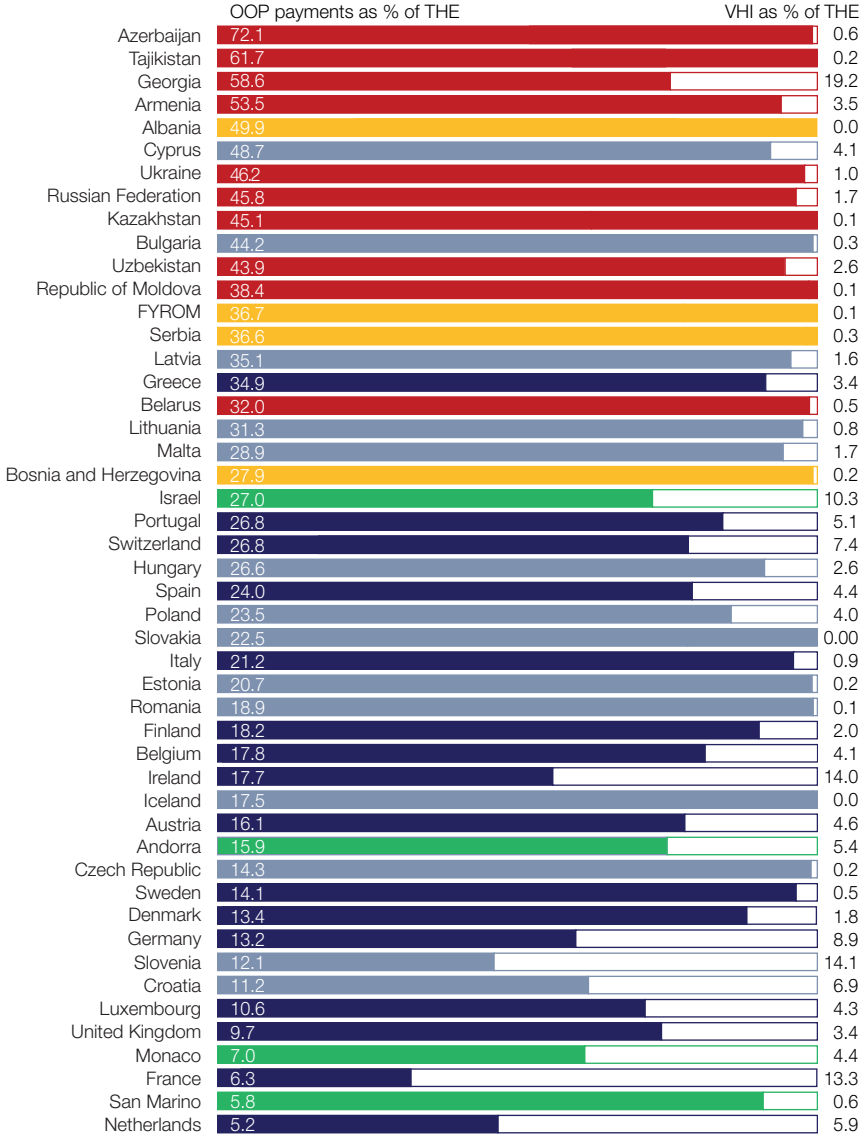
Figure 2.9 *Relationship between VHI and OOP payments in the European Region in 2014*



Source: Authors based on WHO (2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands underestimates out-of-pocket (OOP) payments because it does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending in national health accounts data (OECD, 2015a). See Appendix B for information on data availability and assumptions made. See Appendix C for a list of country codes used in this figure.

Figure 2.10 *Breakdown of private spending on health in 2014 (countries ranked from low to high by OOP payments share (%) of total spending)*



Source: WHO (2016).

Notes: THE = total health expenditure. Each bar shows the ratio of OOP payments to VHI as a share of private spending on health. Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of private spending in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands underestimates out-of-pocket (OOP) payments because it does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending in national health accounts data (OECD, 2015a). See Appendix B for information on data availability and assumptions made.

What role does VHI play?

Most markets for VHI play a *supplementary* role (Table 2.2), providing people with faster access to treatment, greater choice of provider or enhanced amenities. Supplementary markets are usually small both in terms of contribution to spending on health and share of the population covered.

Substitutive VHI plays a minor role in three countries, covering a very small group of people who are not eligible for publicly financed coverage. It plays a more significant role in Cyprus, covering around 20% of the population not eligible for fully publicly financed coverage. The most important substitutive market is in Germany, where it covers people who choose to opt out of the publicly financed system and people who have opted out and are now no longer eligible for publicly financed coverage because they are over 55 years old.

Complementary VHI covering user charges or excluded services is available in a small number of countries. France and Slovenia have the only really substantial markets for complementary VHI covering user charges, followed by Croatia. The only large market for complementary VHI covering excluded services is in the Netherlands.

Table 2.2 *Summary of VHI markets in Europe (34 countries), (2014)*

VHI role	VHI share (%) of total spending on health (2014)			
	≤1%	≤5%	≤10%	>10%
Supplementary	Bulgaria Hungary Italy Lithuania Norway Romania Slovakia Sweden Ukraine	**Austria** **Belgium** Finland Greece **Latvia** **Malta** Poland Russian Federation Spain United Kingdom	Georgia **Portugal** **Switzerland**	**Ireland**
Complementary (services)		Armenia **Denmark**	**Netherlands**	Georgia
Complementary (user charges)		**Denmark** Finland	**Croatia**	**France** **Slovenia**
Substitutive	Czech Republic Estonia Iceland	**Cyprus**	Germany	

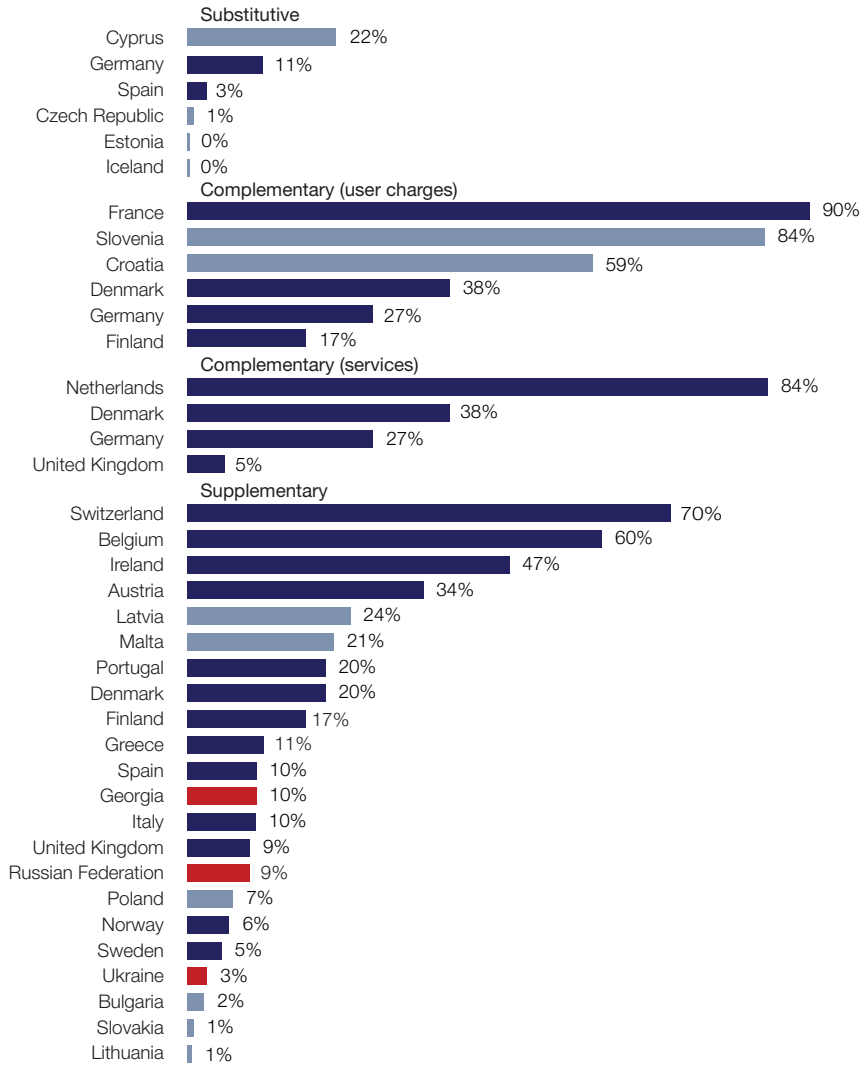
Source: Sagan & Thomson (2016).

Notes: Only the dominant VHI roles are considered here. For Denmark, Finland and Georgia, it was not possible to determine which role was dominant. In countries marked in bold, VHI covers >20% of the population.

How many people buy VHI?

The share of the population covered by VHI varies widely across countries (Figure 2.11). The largest markets for VHI are those playing a complementary role. A few supplementary markets cover >35% of the population. These tend to be

Figure 2.11 *Share (%) of the population covered by different types of VHI, latest available year*



Source: Authors based on information from the national experts and country profiles.

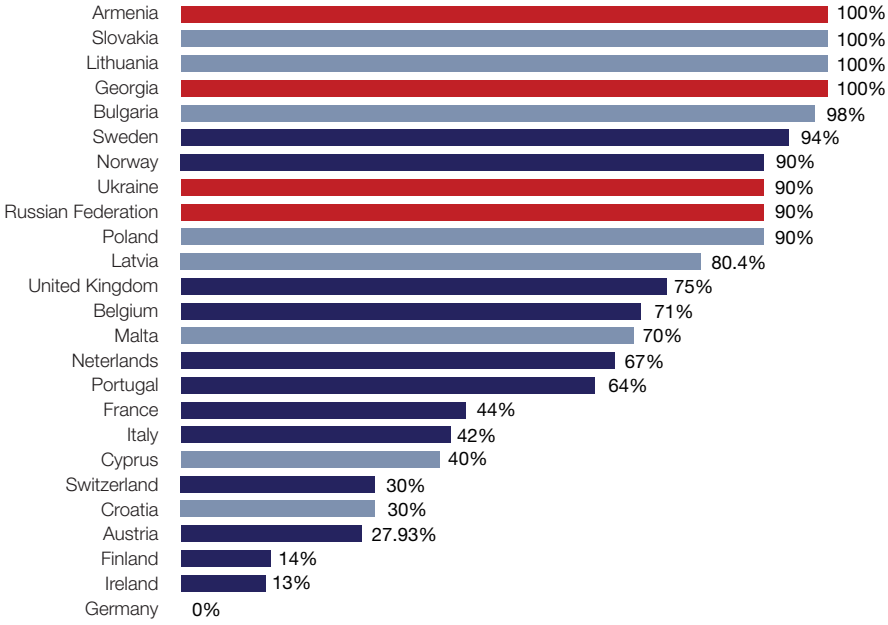
Notes: Belgium: estimates of the share of population covered by VHI range from 60 to over 80% (see Gerkens 2016); we use the more conservative figure. Finland: it is not possible to distinguish between supplementary VHI and complementary VHI covering user charges. Germany: it is not possible to distinguish between complementary VHI covering user charges and services. Russian Federation: only total VHI population coverage is known and we have reported it as supplementary because VHI mainly plays a supplementary role. Slovenia: the share of the population covered by VHI refers to the population aged over 18 (and therefore eligible for paying user charges). Denmark: it is not possible to distinguish between complementary VHI covering user charges and services and 37% of people with complementary VHI also have supplementary VHI (CEPOS, 2014).

markets in which there is a long history of VHI (Belgium, Ireland, Switzerland) and in which non-profit-making entities have traditionally dominated the VHI market (Belgium, Ireland).

Who buys VHI?

Sales to groups of people (usually employees) dominate in 16 out of 25 countries for which data are available (Figure 2.12).

Figure 2.12 *Share (%) of VHI policies sold to groups, latest available year*



Sources: Kroneman (2014) for the Netherlands; Sagan & Thomson (2016).

Notes: For Ukraine and the Russian Federation, the share of plans purchased by employers is shown. All substitutive plans in Germany are purchased by individuals. 2009: Cyprus, Italy; 2010: Belgium, Latvia, Malta, Portugal; 2011: Norway. Year unknown for all other countries. No data for the Czech Republic, Denmark, Estonia, Greece, Hungary, Iceland, Romania, Slovenia and Spain.

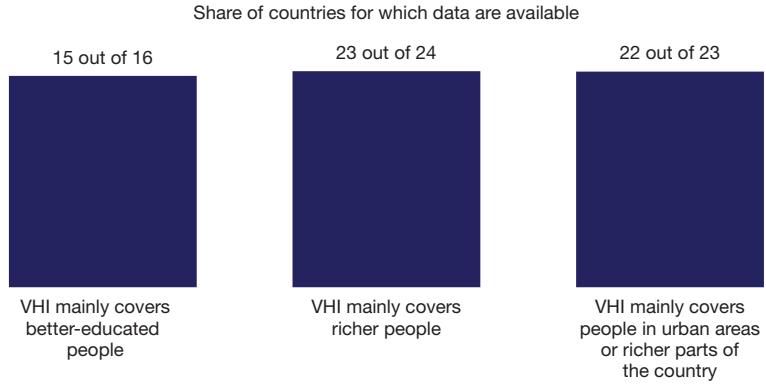
What is the socioeconomic status of people with VHI?

In almost every country covered in this study, VHI is more likely to be taken up by people of higher socioeconomic status and people living in urban areas or in richer parts of a country (Figure 2.13). This systematic bias in VHI coverage, combined with incentives that encourage providers to prioritize people with VHI, means that VHI typically exacerbates inequalities in access to health care.

Who sells VHI?

Many countries have a mix of commercial (for-profit) and non-profit-making

Figure 2.13 *Socioeconomic and geographical bias in VHI coverage within countries, 2012 or later*



Source: Authors (based on Table 4.1).

Notes: *Richer parts of the country* refers to the capital cities in Armenia, Ireland and the Russian Federation, the northern region of Italy, and London and south-east England in the United Kingdom.

entities selling VHI. We refer to any entity selling VHI as an insurer. In almost half of the countries in this study, VHI is sold by commercial insurers only (Figures 2.14 and 2.15). Non-profit-making entities (often mutual associations) have historically played an important role in the EU and used to dominate the VHI market in many EU countries, but this is now the case in 10 countries only. The only non-EU country in this study in which it is possible to buy VHI from non-profit-making entities is Ukraine.

The number of insurers selling VHI varies across countries (Figure 2.16). The VHI market is generally highly concentrated, with some notable exceptions (Figure 2.17). The last two decades have seen a clear trend towards increasing concentration in the VHI market in many countries, mainly through mergers.

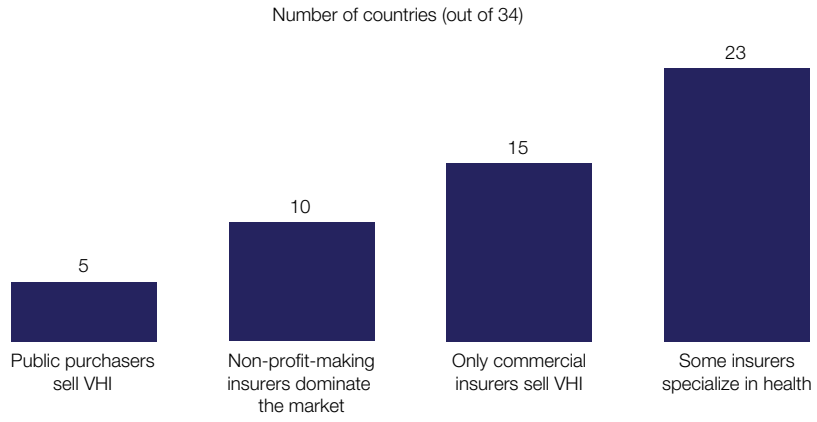
Who can buy VHI and on what terms?

Publicly financed health coverage is typically compulsory and characterized by automatic enrolment, in which people do not have to do anything to be covered, or open enrolment, which means that coverage cannot be refused to anyone who is eligible.

VHI operates in a different way. Insurers selling VHI are usually free to decide for themselves who is eligible for coverage and the conditions under which coverage is provided. This is partly in response to fears about adverse selection,[1] even though VHI markets in Europe are systematically biased in

1 When cover is voluntary and more attractive to people who have a higher risk of ill-health, take-up may be concentrated among high-risk people, a situation known as adverse selection. Where this is the case, insurance may not be viable in the long run, especially if premiums rise to cover a higher than average risk pool and people with lower than average risks subsequently give up their cover, potentially leading to the collapse of an insurer.

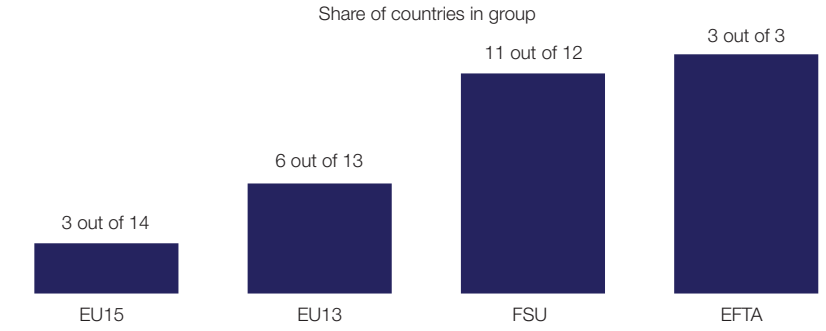
Figure 2.14 *Types of entities selling VHI, latest available year*



Source: Authors (based on Table 5.1).

Note: Public purchaser refers to entities responsible for purchasing publicly financed health care.

Figure 2.15 *Countries in which VHI is only available from commercial insurers, by country group, latest available year*

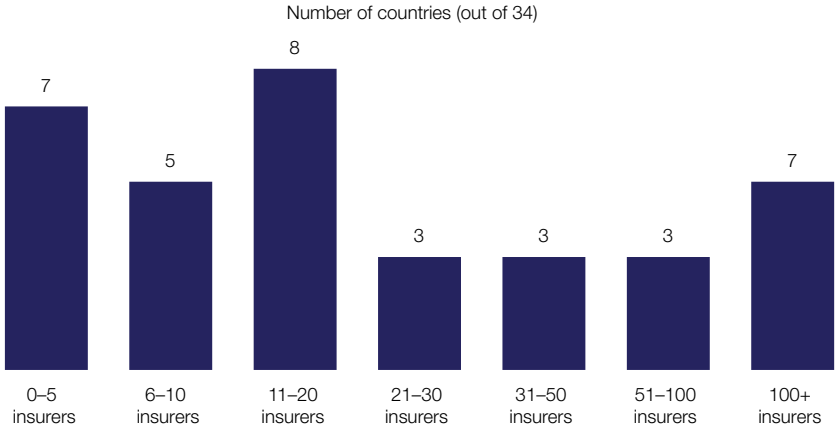


Source: Authors (based on Table 5.1).

favour of wealthier – and therefore generally healthier – people. The freedom given to insurers probably reflects the fact that most VHI markets in Europe are supplementary and do not play an important role in providing financial protection.

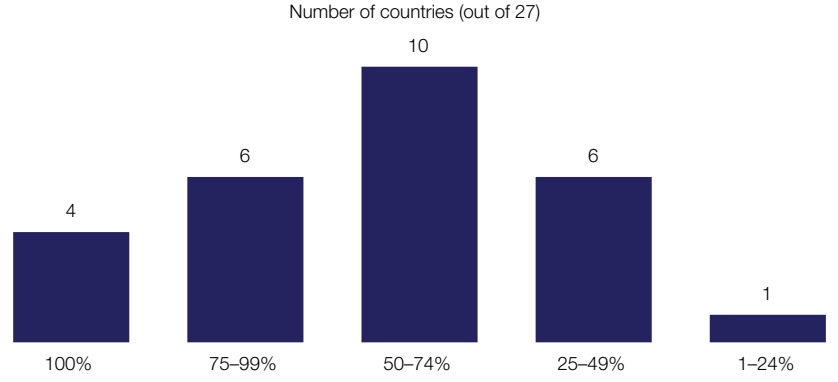
Insurers in many countries prevent people from buying VHI for the first time if they are over 65 years old; make people wait for weeks or months between buying VHI and becoming eligible to benefit; only sell annual VHI contracts, enabling them to terminate contracts at the end of a year or when someone retires; can refuse to sell VHI to people they feel are likely to be too risky to cover; and do not have to cover any pre-existing health conditions a person already has on buying VHI (for example, diabetes) or can charge higher premiums in return for covering pre-existing conditions (Figure 2.18).

Figure 2.16 *The number of entities selling VHI, latest available year*



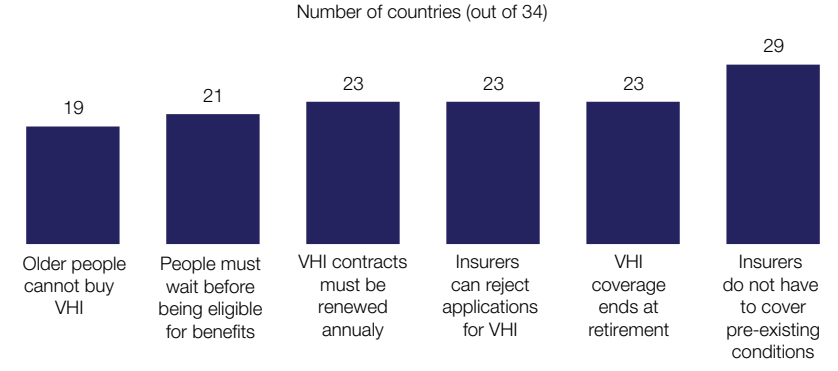
Source: Authors (based on Table 5.1).

Figure 2.17 *VHI market share of the three largest insurers, latest available year*



Source: Authors (based on Figure 5.1).

Figure 2.18 *VHI policy conditions, 2012 or later*



Source: Authors (based on Tables 5.2, 5.3 and 5.5).

As a result of these freedoms for insurers, VHI may not be accessible to older people, people with disabilities, people who are already ill or people with a higher risk of ill-health.

How do insurers set VHI premiums?

Publicly financed health coverage is typically funded through contributions (taxes) that are not related to a person's risk of ill-health. In Europe, it is usually linked to a household's ability to pay through the use of income taxes and contributions set as a proportion of household earnings or income. In contrast, contributions for VHI – VHI premiums – are almost always linked to a person's risk of ill-health. Insurers in most countries in this study use age and some measure of health status to determine how much people should pay for VHI (Figure 2.19). This means VHI is often more expensive for older people and people with a higher risk of ill-health.

In many countries, VHI policies are subject to a ceiling on benefits – that is, VHI policyholders are only entitled to benefits up to a maximum monetary amount (Figure 2.20). VHI-financed health care is often subject to user charges also.

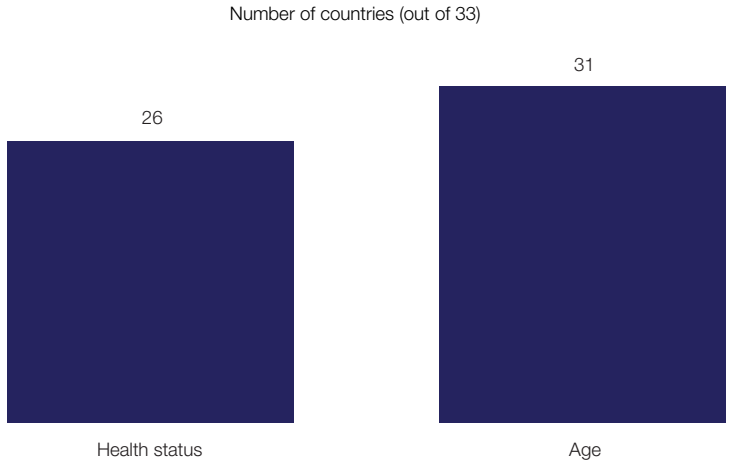
How do insurers purchase health services?

Provider payment, vertical integration and selective contracting are tools that enable purchasers to influence health care quality and costs (active purchasing). Other tools for active purchasing include the use of evidence-informed priority-setting processes; decision support mechanisms, such as evidence-based care pathways, clinical and prescribing guidelines, international nonproprietary name (INN) prescribing and generic substitution; performance monitoring and feedback to health care professionals; and public reporting of performance information. Very few insurers selling VHI make use of such tools.

In most countries, insurers selling VHI allow policyholders to choose their health care provider. Vertical integration of insurers with health care providers is the exception and, even where it occurs, insurers will often allow policyholders to use other providers (Figure 2.21). Selective contracting of health care providers is also rare (Figure 2.22).

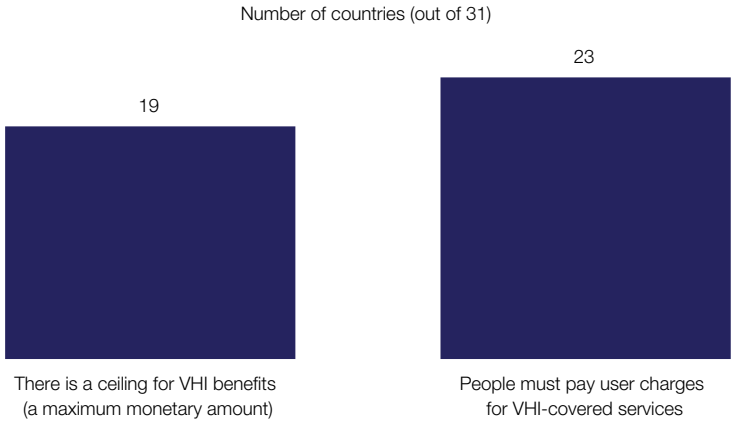
Insurers typically pay health care providers on a fee-for-service (FFS) basis (Figure 2.23). Although FFS payment has the advantage of limiting the likelihood of underserving patients, used on its own (as in most VHI markets) it creates strong incentives to overprovide services and may contribute to suboptimal patterns of use.

Figure 2.19 *Risk factors used to rate VHI premiums, 2012 or later*



Source: Authors (based on Table 5.4).
Note: People pay penalties for joining over the age of 35 (Ireland) or not buying VHI as soon as they are eligible to do so (Slovenia), which may be similar in effect to an age-related premium.

Figure 2.20 *Benefits ceiling and user charges for VHI-financed care, 2012 or later*

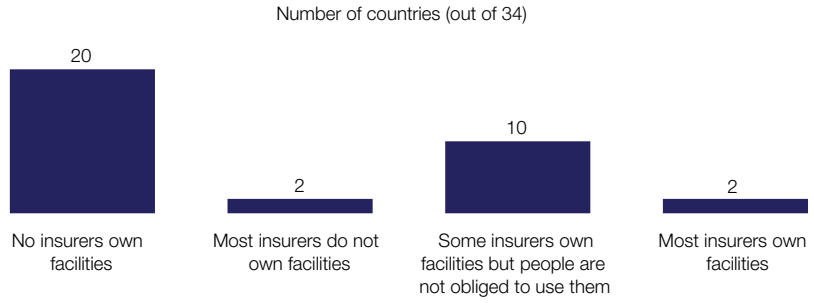


Source: Authors (based on Table 5.6).

In many countries, the fees insurers pay to health care providers are higher than the fees providers receive for treating publicly financed patients. This creates incentives for providers to prioritize VHI-financed patients, which exacerbates inequalities in access to health care between those with and without VHI.

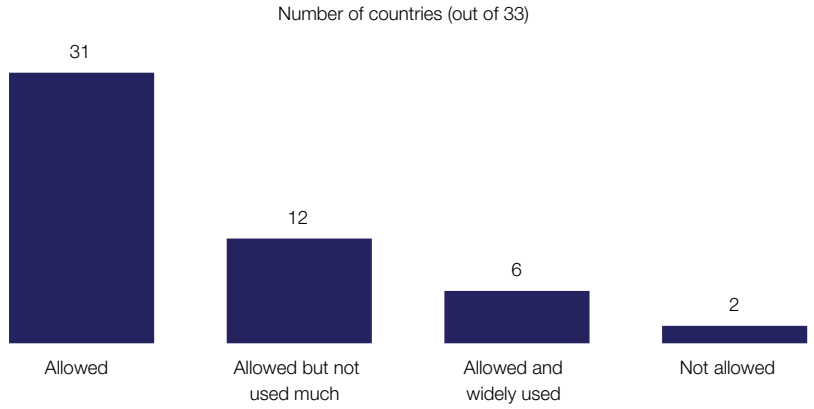
The risk of creating or exacerbating inequalities in access to health care – two-tier access – is higher where doctors are permitted to work for public and private facilities at the same time (32 out of 34 countries), or be paid publicly and through VHI, or where VHI-financed patients can use beds in public hospitals

Figure 2.21 *Extent of vertical integration between insurers and health care providers, 2012 or later*



Source: Authors (based on Table 5.9).

Figure 2.22 *Extent to which insurers selectively contract health care providers, 2012 or later*



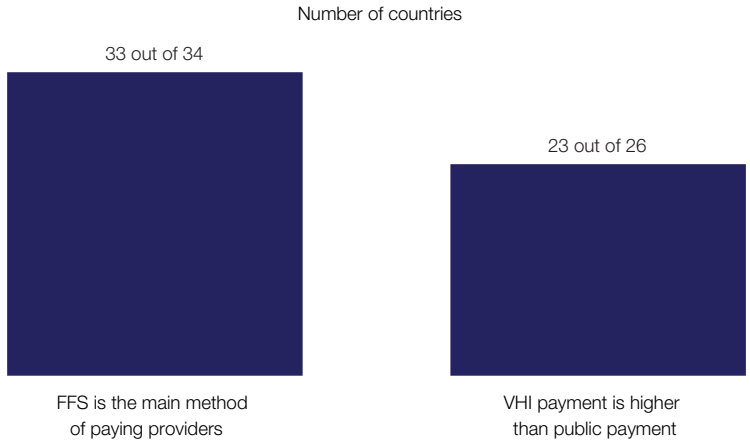
Source: Authors (based on Table 5.9).

(14 out of 34 countries) where public hospital capacity is constrained (Figure 2.24).

How do insurers spend their revenue?

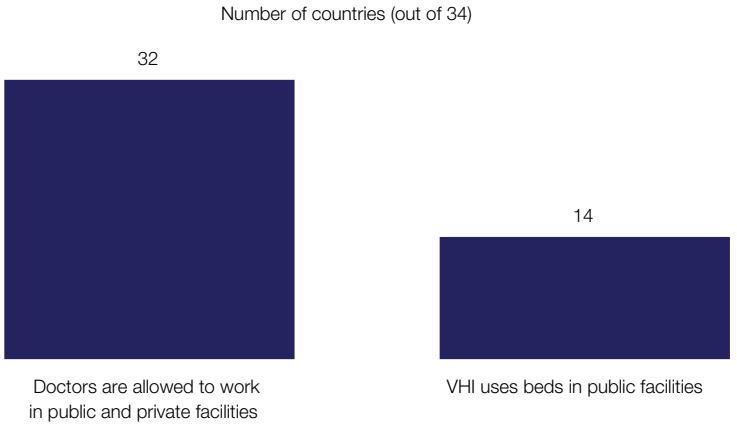
Publicly financed purchasers typically spend around 5% of their revenue on administration (OECD, 2015b). Insurers selling VHI tend to spend a much higher share of their revenue on administration (Figures 2.25 and 2.26).

Figure 2.23 *The most common method insurers use to pay health care providers, 2012 or later*



Source: Authors (based on Table 5.10).

Figure 2.24 *The public–private mix in health care provision, latest available year*

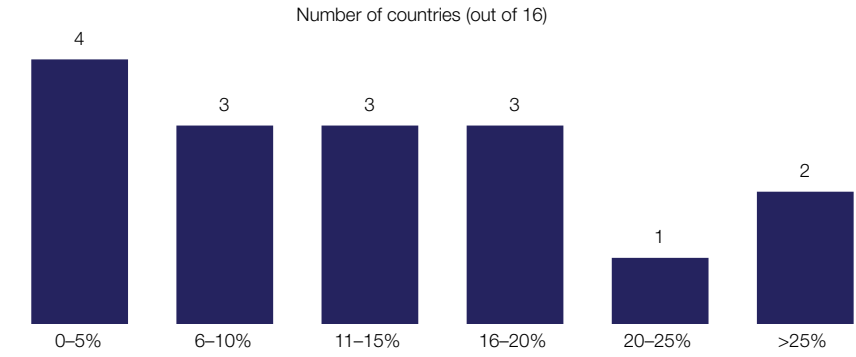


Source: Authors (based on Section 5.4).

Notes: Cyprus and Denmark do not allow doctors to work in both sectors; Greece, Ireland, Italy and the United Kingdom restrict how much doctors can work in both sectors.

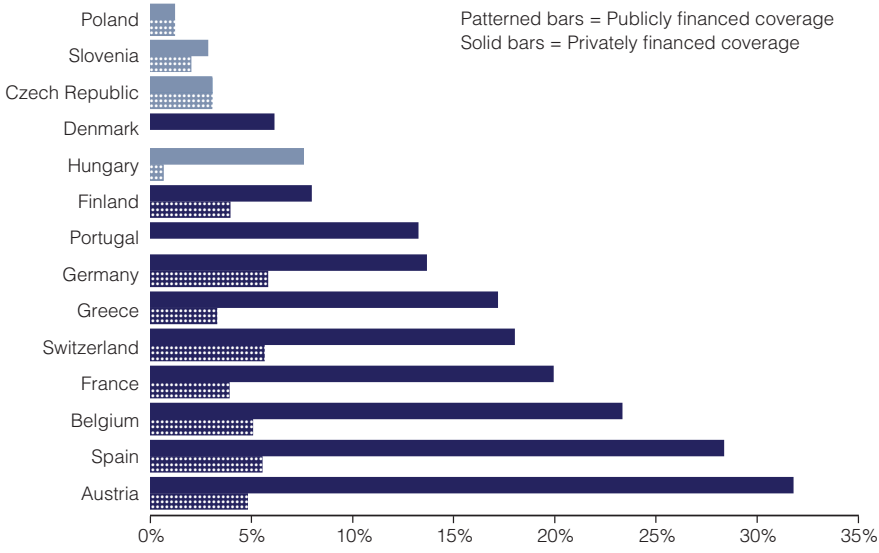
In two thirds of countries for which data are available, insurers spend less than 70% of their revenue on health care (Figure 2.27). Even accounting for relatively high administrative costs and the costs of reinsurance, this suggests that VHI is a profitable business in many countries.

Figure 2.25 *Insurer administrative costs as a share (%) of total revenue, 2012 or later*



Source: Authors (based on Figure 5.3).

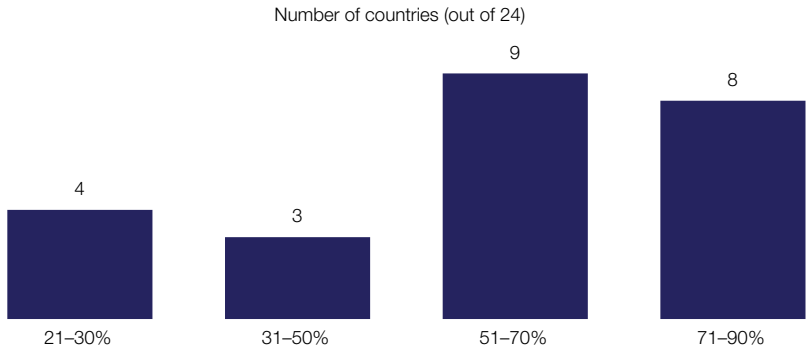
Figure 2.26 *Administrative costs for publicly and privately financed coverage as a share (%) of current spending, European OECD countries, 2012*



Source: OECD (2015b).

Notes: Countries are ranked from lowest to highest administrative costs for privately financed coverage. 2011 data for Portugal (the reason why administrative costs are zero in Portugal may be because a very low amount of health care spending is technically classified as social security funds, which are separate from the budget of the Ministry of Health); no data for public insurance for Denmark.

Figure 2.27 *Insurer spending on health care as a share (%) of total revenue, 2013*



Source: Authors (based on Figure 5.4).

Note: This ratio is known as the claims ratio or the medical loss ratio.

Who regulates VHI markets?

VHI is regulated exclusively as a financial service in most countries in Europe. Regulatory bodies are typically financial supervisory authorities, central banks or insurance regulators under the Ministry of Finance (Table 2.3). In a handful of countries, the Ministry of Health or another health care authority also plays a role. This tends to be in countries where VHI's role is complementary, covering user charges.

How is VHI regulated?

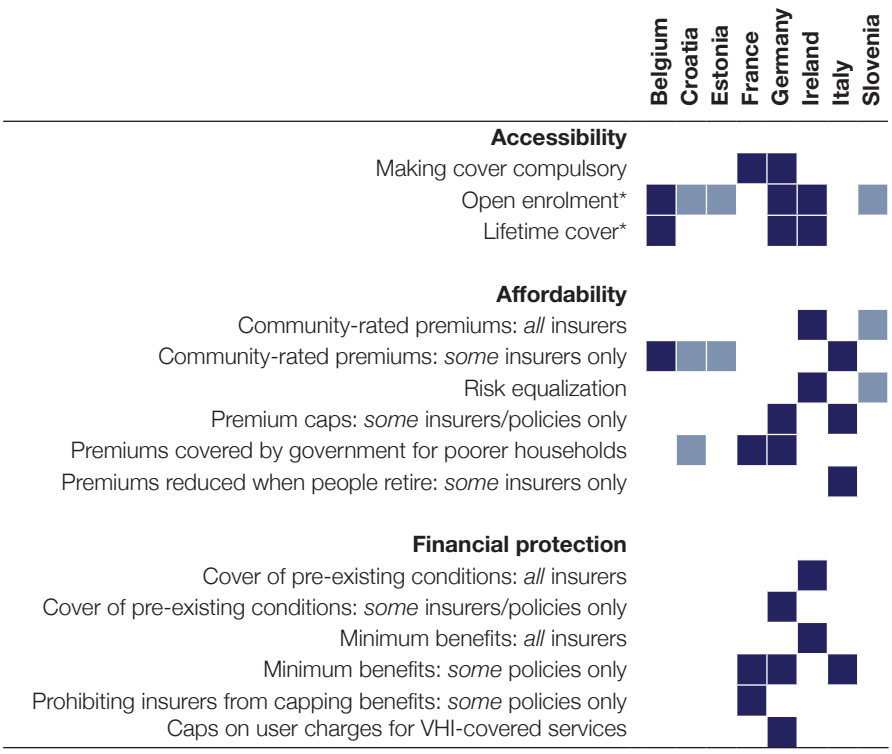
VHI is commonly regulated in the same way as any other financial service. Interventions to ensure VHI policies are accessible, affordable and provide good financial protection are highly concentrated. Only 8 countries out of the 34 in this study adopt such measures, as set out in Table 2.4. It is no coincidence that this group of countries includes almost all of Europe's largest markets for VHI. It also includes VHI markets with a strong mutual or non-profit-making insurer presence (Belgium, France, Ireland, Italy) and countries in which VHI plays a significant substitutive role (Germany) or a complementary role covering user charges (Croatia, France, Slovenia). The intensity of regulation has increased in all of these eight countries in the last decade. Greater regulation has overwhelmingly aimed to make VHI more affordable and to enhance financial protection for people with VHI.

Table 2.3 *Entities responsible for regulating the VHI market, 2012 or later*

	Financial supervisory authority	Central bank	Insurance regulator	Ministry of health	Other health authority
Austria	■				
Belgium (commercial)	■	■			
Bulgaria	■				
Denmark	■				
Estonia	■				
Finland	■				
Germany	■				
Hungary (commercial)	■				
Iceland	■				
Latvia	■				
Malta	■				
Norway	■				
Poland	■				
Russian Federation	■				
Sweden	■				
Switzerland	■				
Ukraine (commercial)	■				
United Kingdom	■				
Armenia		■			
Czech Republic		■			
Georgia		■			
Greece		■			
Lithuania		■			
Netherlands		■			
Cyprus			■		
France			■		
Portugal			■		
Romania			■		
Ukraine (non-profit-making)			■		
Italy			■	■	
Slovenia			■	■	
Slovakia		■			■
Spain		■		■	
Ireland		■		■	■
Croatia	■			■	
Belgium (mutual)					■
Hungary (mutual)					■

Source: Authors (based on Table 6.1).

Table 2.4 *Use of policies to ensure VHI is accessible, affordable and provides financial protection, 2012 or later*



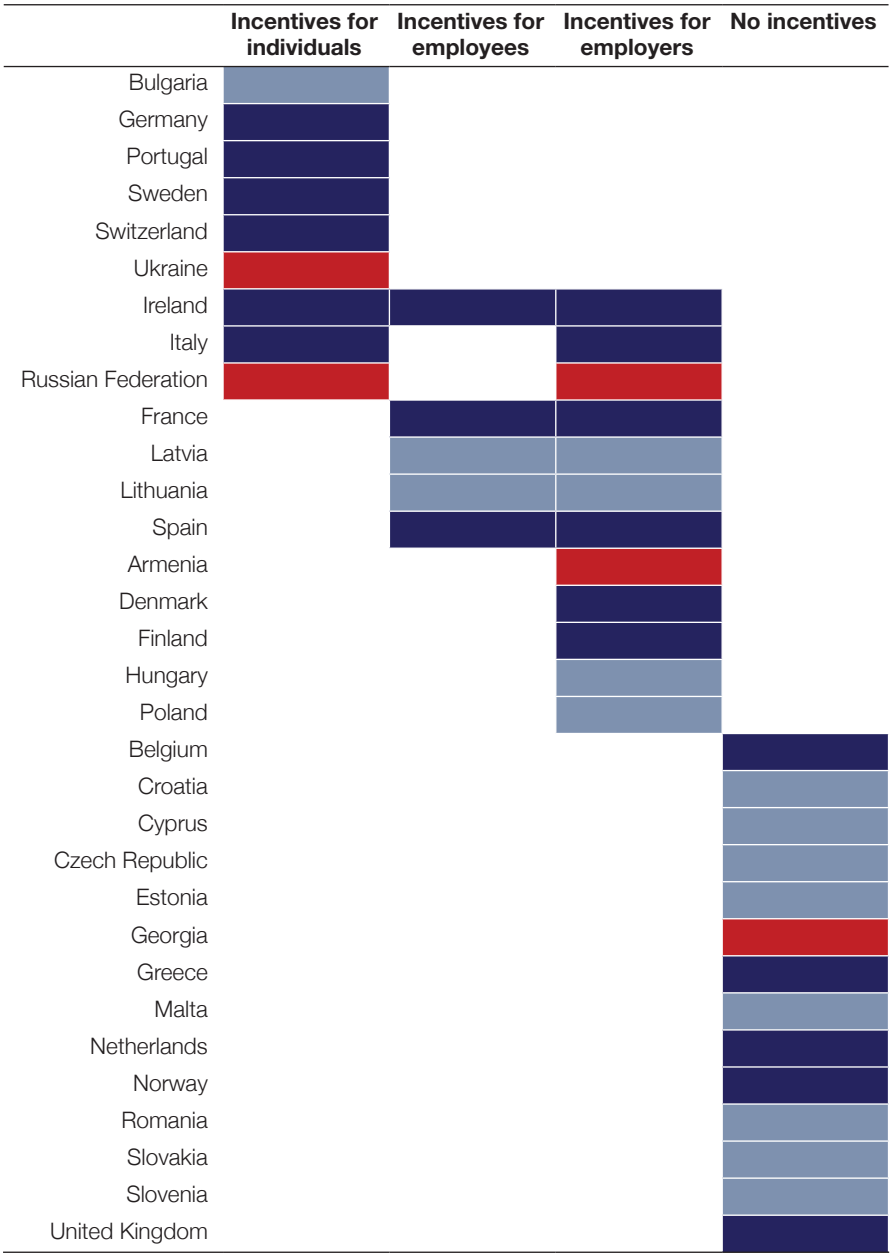
Source: Authors (based on Table 6.2).

Notes: *Some* insurers refer to a statutory health insurance fund (Estonia) or non-profit-making entities (all other countries). In Germany, *some* policies refer to the basic substitutive VHI policy; in France it refers to responsible contracts. *Refers to some insurers in Croatia, Estonia and Germany.

Tax incentives for VHI

In spite of well-established evidence about the inefficiency and inequity of many forms of tax incentive for VHI, over half of the countries in the study provide tax incentives to encourage people to buy VHI (Table 2.5). In the last 20 years, the trend has been to reduce or abolish these tax incentives, largely because they have been found to be expensive for governments and a poor use of public funds. The abolition of tax incentives has not usually had a significant effect on the demand for VHI. A few countries have reduced or abolished tax incentives for equity reasons. Some countries have started to use tax incentives aimed at employers to promote equity within firms, for example, only providing tax relief where VHI is offered to all employees in a firm (as opposed to just senior staff).

Table 2.5 *Tax incentives to encourage people to buy VHI, 2012 or later*



Source: Authors (based on Table 6.4).

Note: The tax incentive for individuals in Romania is for all types of insurance, not just VHI, and does not therefore encourage VHI take-up.

National policy developments and concerns around VHI

The period from 2000 to 2015 was marked by policy developments in four main areas.

- *Several countries strengthened and expanded publicly financed coverage, abolishing VHI's substitutive role* in Croatia (2001), the Netherlands (2006), Belgium (2008) and Georgia (2013), and *limiting its scope* in Germany (2000 and 2009). In Croatia and Germany, opting out of publicly financed coverage was prohibited (Croatia) and restricted (Germany) to address fiscal pressures created by risk segmentation.
- Armenia and Georgia tried to promote VHI by allowing publicly financed coverage to be offered by private insurers. However, both countries have recently moved away from this option. Several countries, mostly in the EU13, tried to promote VHI in other ways, but with little success, perhaps due to the presence of informal payments in these countries, and households' limited ability to pay for VHI.
- *Measures to make VHI more accessible and affordable have increased, mainly where VHI plays a significant substitutive or complementary role*.
- *There has been an increase in domestic legal challenges to some of these measures*, most often concerning differential treatment of insurers based on legal status (consistently found to be in breach of EU rules) and the use of risk equalization to support community rating of VHI premiums (consistently found to be in line with EU rules).
- *Countries have reduced or abolished tax incentives to take up VHI* (see the previous section).

National policy concerns about VHI often include one or more of the following:

- *inequitable (two-tier) access to health services* linked to the systematic bias of VHI coverage in favour of people of higher socioeconomic status and provider incentives to prioritize the delivery of care to VHI-financed patients;
- *the challenge of ensuring affordable access to VHI for some groups of people*, especially those who are older, disabled or suffer from chronic conditions, and poorer households;
- *the magnitude of explicit and implicit public subsidies for VHI*, which have generated fiscal, efficiency and equity concerns in some countries; implicit subsidies may come from public funding of medical education, failure to charge VHI the full economic cost of using beds in public hospitals and the backup function of the publicly financed system;

- *high administrative costs among insurers;* and
- *transaction costs associated with the complexity VHI brings to health systems*, particularly in larger markets for VHI; these include the costs of monitoring, regulation, improving access and affordability and legal challenges.

Chapter 3

Why do people buy VHI?

In this chapter, we look at the reasons why people purchase VHI. We discuss the drivers of demand for VHI, then examine the different roles VHI plays in relation to publicly financed coverage.

3.1 What drives the demand for VHI?

There is no country in Europe – and few, if any, globally – in which VHI is the only source of health coverage. European countries generally provide universal or near-universal entitlement to publicly financed health coverage on a *compulsory* basis as part of a wider system of social protection. As a result, markets for VHI are heavily shaped by statutory institutions and usually play a modest role, although there are some exceptions.

People buy VHI to cover gaps in publicly financed health coverage or to benefit from faster access to treatment and enhanced choice of health care provider. These drivers of demand are summarized in Table 3.1 and correspond to the different roles for VHI.

Most countries have a market for VHI that supplements publicly financed coverage. A *supplementary* market offers access to health care that is covered publicly, but gives policyholders greater choice of provider and level of amenity (usually including access to private providers) and may enable them to bypass waiting lists for publicly financed services. It is often bought by employers on behalf of employees and, because it covers people and services already publicly covered, its contribution to financial protection is minimal.[1]

Complementary VHI covers services excluded from or only partially covered by the publicly financed benefits package. It contributes to financial protection where it lowers or removes financial barriers to accessing essential health services. Complementary VHI can be understood as completing coverage where there are gaps in the scope and depth of publicly financed coverage.

1 The OECD (2004) classifies this type of market as duplicate because it covers health services that the statutory scheme already covers. However, the OECD's classification fails to capture the extra benefits VHI offers in this role: choice of provider, faster access to care and access to superior amenities.

Table 3.1 *Drivers of VHI market development*

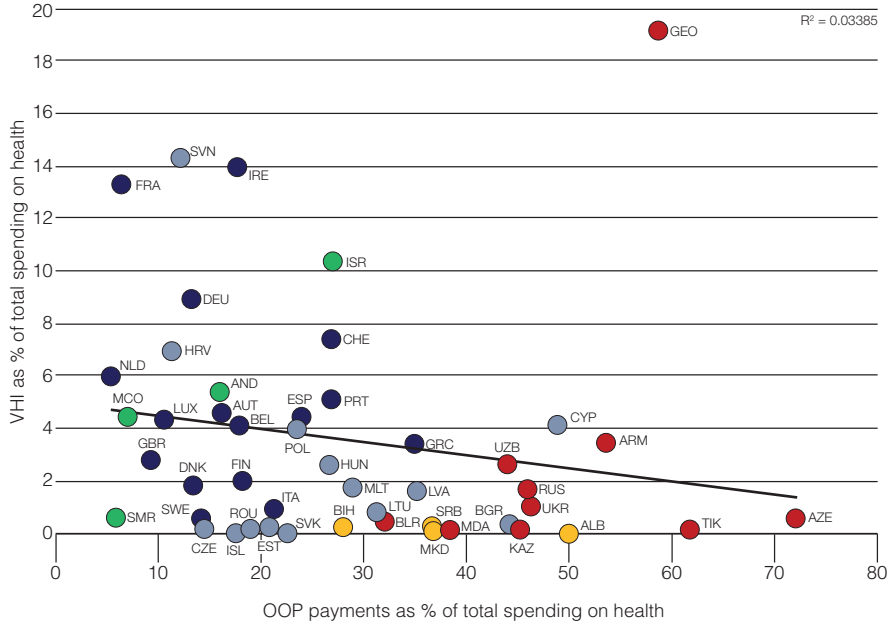
Market role	Driver of market development	Nature of VHI coverage
Supplementary	Perceptions about the quality and timeliness of publicly financed health services	Faster access to services, greater choice of health care provider or enhanced amenities
Complementary (services)	Scope of the publicly financed benefits package	Services excluded from the publicly financed benefits package
Complementary (user charges)	Existence of user charges for publicly financed health services	User charges for goods and services in the publicly financed benefits package
Substitutive	Share of the population entitled to publicly financed health services	People excluded from or allowed to opt out of publicly financed coverage

Source: Adapted from Foubister et al. (2006).

VHI can also provide *substitutive* cover for people excluded from significant aspects of publicly financed coverage or for those who are not required to be publicly covered, thereby ensuring completeness in terms of breadth of coverage.

Gaps in publicly financed health coverage are a prerequisite for VHI, but they are not necessarily sufficient for a VHI market to develop and grow. The relationship between VHI and OOPs as a share of total spending on health is very weak (Figure 3.1); in spite of significant gaps in coverage in many countries

Figure 3.1 *Relationship between VHI and OOP payments in the European Region in 2014*

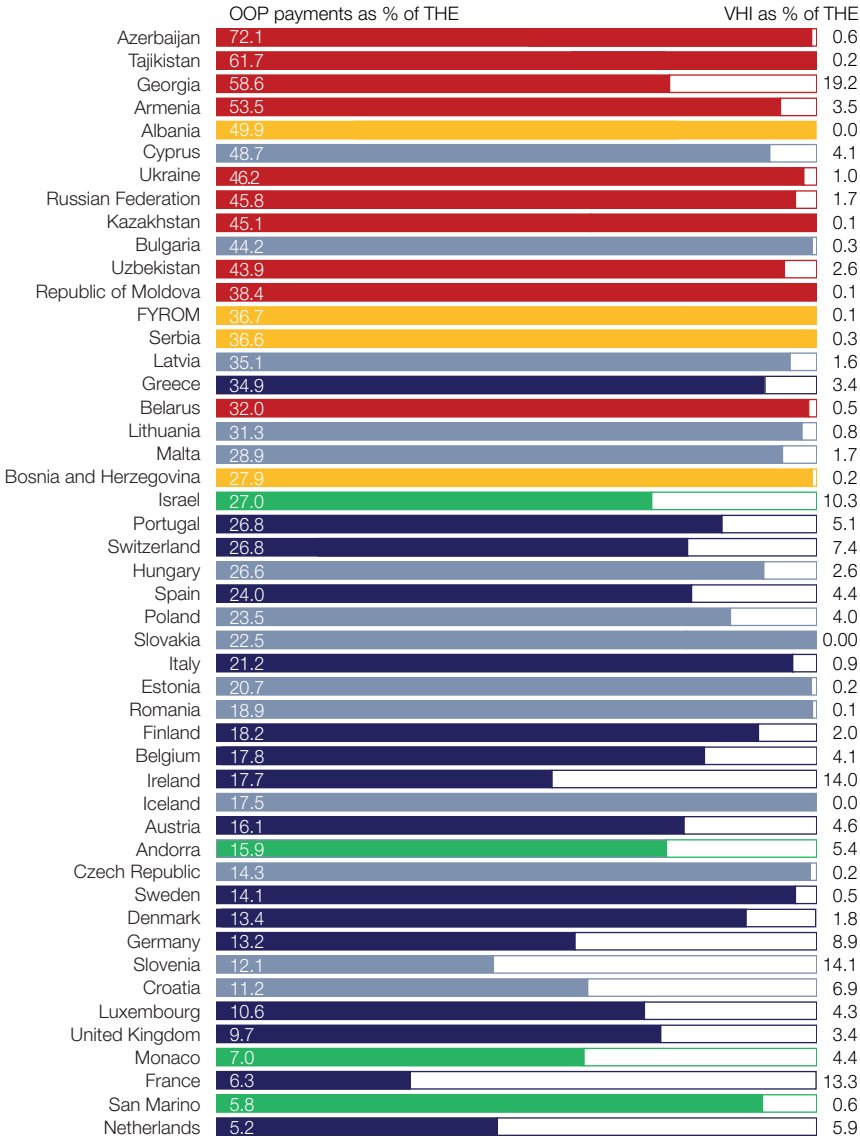


Source: Authors (based on WHO, 2016).

Notes: Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands underestimates out-of-pocket (OOP) payments because it does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending in national health accounts data (OECD, 2015a). See Appendix B for information on data availability and assumptions made. See Appendix C for a list of country codes used in this figure.

in the European Region, as demonstrated by very high levels of OOP payments in some countries (Figure 3.2), VHI's contribution to private spending on health is low in all but a handful of countries.

Figure 3.2 *Breakdown of private spending on health in 2014 (countries ranked from low to high by OOP payments share (%) of total spending)*

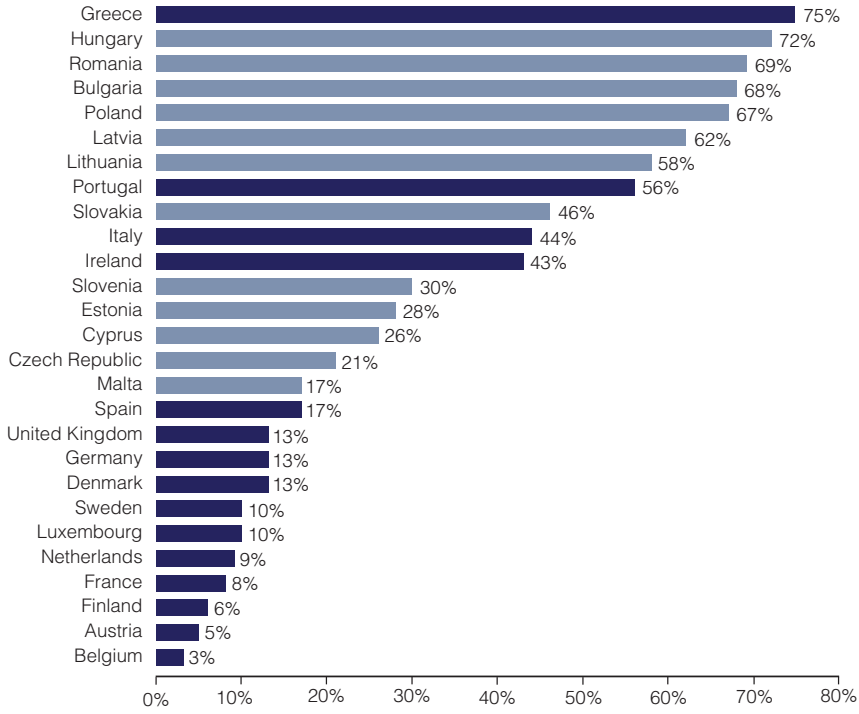


Source: WHO (2016).

Notes: THE = total health expenditure. Each bar shows the ratio of OOP payments to VHI as a share of private spending on health. Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of private spending in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands underestimates out-of-pocket (OOP) payments because it does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending in national health accounts data (OECD, 2015a). See Appendix B for information on data availability and assumptions made.

Some argue that the quality and timeliness of publicly financed health services may be key determinants of demand for VHI. Public perceptions of health care quality vary substantially across countries. Within the EU, people appear to be less satisfied with the quality of care in the newer Member States (Figure 3.3). Satisfaction with the quality and efficiency of publicly financed health care also seems to be lower in the eastern part of the European Region in comparison to Western Europe (EBRD, 2011). Again, however, there does not seem to be any relationship between quality of care, as measured in these studies, and demand for VHI. In the United Kingdom, where the relationship between waiting times and demand for VHI has been studied very extensively, evidence of a clear relationship between the two is inconclusive (King & Mossialos, 2005).

Figure 3.3 *Public perception that quality of care is bad (% of respondents), European Union, 2009*

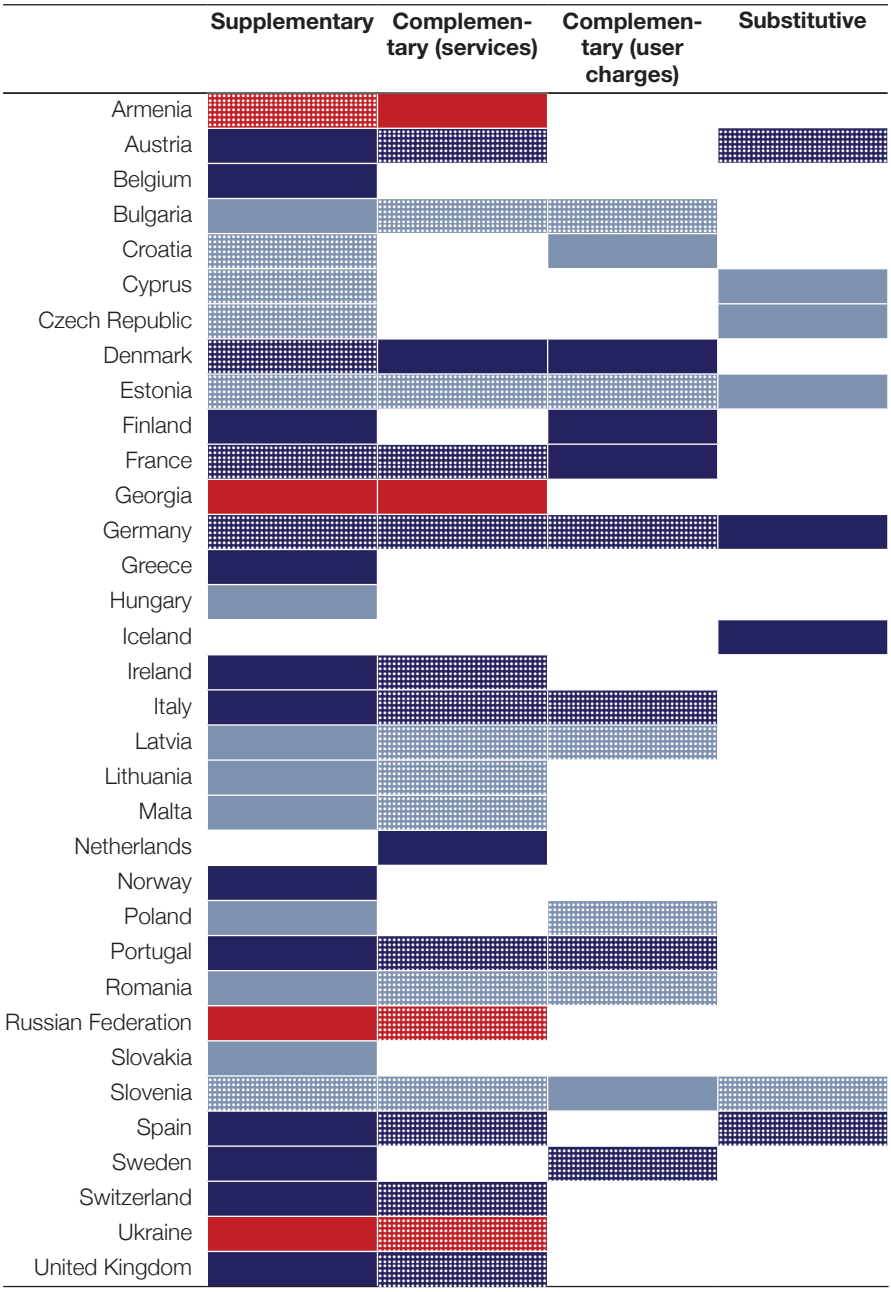


Source: European Commission (EC) (2010).

3.2 VHI plays different roles

VHI plays different roles in Europe, as summarized in Table 3.2. The role VHI plays in a given health system is largely determined by public policy regarding publicly financed health coverage and the regulatory environment for VHI. This in turn may reflect historical developments, political ideology, the relative

Table 3.2 *Summary of VHI roles in Europe (34 countries)*



Source: Authors (based on country profiles).

Note: Main VHI role is marked in a solid colour.

power and interests of different stakeholders (particularly providers and insurers, but sometimes including employers, civil servants and higher earners) and the capacity of governments to shape and develop the market.

Understanding differences in market role is important for several reasons. First, market role may provide some indication of the rationale for VHI in a given context. Second, the role a VHI market plays may be closely correlated to its size, notably in terms of its contribution to public and private spending on health. Third, a market's role often determines the way in which it is regulated, which has implications with respect to EU internal market and competition rules (see Chapter 6). Finally, market role may tell us about VHI's interaction with publicly financed coverage and its likely impact on health system performance.

A supplementary role for VHI

In the absence of a clear government strategy for VHI, the type of market most likely to emerge is a supplementary one offering faster access to care, often through private providers. Almost every country in Europe has a market for supplementary VHI, often sold in combination with some form of complementary cover. Only Iceland and the Netherlands did not report having a supplementary market (Table 3.3). Supplementary markets are usually small. The exceptions are Austria, Belgium (see Box 3.1), Ireland (see Box 3.2) and Switzerland.

Table 3.3 *Benefits offered by supplementary VHI*

Country	Examples of benefits covered
Armenia	Better quality of care
Austria	**Private care, choice of hospital doctor, faster access (elective care in public hospitals), better hospital accommodation, per diem cash benefits for inpatient care**
Belgium	**Copayments or extra billing for better facilities in hospital (single room, physician's fees)**
Bulgaria	**Direct and faster access to specialist visits and inpatient care, free choice of hospital physician, better facilities in hospital (single room)**
Croatia	Preventive exams, direct access to specialists, diagnostic imaging, laboratory tests, physiotherapy, better standard of hospital accommodation
Cyprus	Faster access, choice of provider and better amenities for elective care, private inpatient care, outpatient care, diagnostics, ambulance transport, psychiatry, routine maternity care, physiotherapy, dental care, cash benefits, CAM, treatment abroad
Czech Republic	Private room

Table 3.3 *contd*

Country	Examples of benefits covered
Denmark	Choice of doctor, private hospital and diagnostic care, faster access
Estonia	Faster access (for example, five days waiting times guarantee), private care
Finland	**Private care, faster access**
France	Superior amenities in hospital, private room
Georgia	**Access to better hospital amenities**
Germany	Private hospitals, choice of specialist (chief physician), better hospital amenities
Greece	**Consumer choice, better quality of services, faster access**
Hungary	**Superior amenities in hospital, faster access**
Ireland	**Semiprivate/private rooms in public/private hospitals, faster access**
Italy	**Faster access, enhanced choice (private specialists in public hospitals)**
Latvia	**Direct access to specialists, access to noncontracted providers, faster access (consultations and clinical examinations)**
Lithuania	**Faster access (private providers) to outpatient care including surgery, general practitioner (GP) consultations, diagnostics, prevention, prenatal care, home visits, physiotherapy, eye and dental care, rehabilitation, inpatient care**
Malta	**Faster access to treatment, superior hospital amenities, treatment abroad**
Norway	**Faster access to elective treatment and care in private hospitals**
Poland	**Private care (hospital, rehabilitation, transport, nursing care, dental care), faster access to and better quality of outpatient services, including diagnostics and specialist consultations and procedures (often related to the provision of occupational health services; see Sobczak, 2016), medicines[a]**
Portugal	**Choice of provider, faster access, direct access to specialist care**
Romania	**Superior hospital accommodation, choice of provider, private care**
Russian Federation	**Faster access to better facilities, private care**
Slovakia	**Faster access to outpatient care, superior hospital room amenities, faster access to outpatient care (eye and dental care, rehabilitation)**
Slovenia	Superior amenities in hospitals and health spas, superior medical devices, faster access
Spain	**Private care, faster access, enhanced choice and better amenities**
Sweden	**Faster access, private elective care**
Switzerland	**Choice of physicians within hospitals, double or single hospital rooms**

Table 3.3 *contd*

Country	Examples of benefits covered
Ukraine	**Enhanced choice of provider, better facilities and accommodation (state-owned and private), faster access to essential diagnostic and curative services**
United Kingdom	**Faster access, choice of private provider and of specialist acting in a private capacity, better amenities**

Sources: National experts and country profiles.

Notes: Main VHI role is marked in bold (see Tables 2.2 and 3.2).

[a] Coverage of medicines has been introduced recently and is still rarely offered. CAM = complementary and alternative medicine.

Box 3.1 *Supplementary VHI for hospital services in Belgium*

OOP payments for health care in Belgium include official user charges for publicly financed services and extra billing (known as supplements) for hospitalization in a private room and for physician's fees (charged if the physician does not abide by the official tariffs or treats the patient in a private room) (Gerkens, 2016). Fee supplements in hospitals can range from 100 to 300% of the agreed tariff and are generally seen as compensation for the alleged structural underfunding of hospital care (Palm, 2009). Supplementary VHI is offered by private insurance companies and mutual funds and focuses on hospital stays, since this is where patients typically face high OOP payments. The supplementary market mainly developed during the 1990s, when OOP payments saw steep increases (Palm, 2009).

Despite measures to limit OOP payments (for example, through increased reimbursement levels and a maximum ceiling on extra billing) between 2001 and 2007, OOP payments increased by 49.2%. This trend was mainly caused by the increasing cost of hospital care (extra billing for private rooms) and was reflected in higher premiums for supplementary VHI (an increase of over 60% between 2001 and 2007). Constant premium increases have generated political debate about the affordability of hospital VHI and led to more regulation of contract conditions (for example, changes in premiums can be linked to changes in the consumer price index or in the medical index, which were described in a Royal Decree in 2010; see Gerkens, 2016), but also measures to strengthen the social measures of complementary services, the abolition of extra billing for double rooms (2009/2010) and the abolition of fee supplements in double rooms (2013) (Gerkens, 2016; Palm, 2009).

Box 3.2 *Supplementary VHI in Ireland*

Access to some elements of publicly financed coverage in Ireland is means tested (McDaid et al., 2009). Richer groups must pay out-of-pocket for primary care and are subject to user charges for publicly financed inpatient care. VHI mainly provides faster access to elective inpatient treatment in private hospitals and private beds in public hospitals.

In 1994, the VHI market was opened to competition, to comply with EU law, and the dominant quasi-public insurer Vhi Healthcare was joined by three commercial insurance companies in subsequent years. The 1994 Health Insurance Act enshrined in law the VHI market's regulatory framework (open enrolment, community-rated premiums, lifetime cover), which was amended in 1996 to include minimum benefits and risk equalization (Mossialos & Thomson, 2002a). The risk equalization scheme was unsuccessfully challenged at national and EU levels (Thomson & Mossialos, 2010) and came into effect in 2013.

VHI currently covers about 46% of the population (HIA, 2015) and benefits from tax relief equal to 20% of the cost of the premium, although since October 2013 the premium subject to tax relief has been capped at €1000 per adult and €500 per child. Following a general election in 2011, the Irish government committed to providing publicly financed coverage for the whole population and only allowing VHI to cover things like more luxurious accommodation in hospital (Burke, 2014a; Government of Ireland, 2011). If implemented, this seems likely to diminish the role of VHI in the future.

In December 2014, a public consultation was started on the scope for private insurers to cover a fuller minimum range of services provided by GPs in primary care settings (currently, the emphasis within VHI contracts is on acute hospital care), which indicates that there may be a new role for VHI (Department of Health of the Republic of Ireland, 2014). Recently, there has been a continuous increase in the cost of VHI and a decline in the numbers of people with VHI (from a peak of 50.9% of the population covered in 2008).

A review of measures to reduce the cost of VHI was published in 2014 (Burke, 2014b; Department of Health of the Republic of Ireland, 2013). As part of these measures, to encourage younger people into the market, lifetime community rating with late entry loadings (penalties) for those who join over the age of 35 was introduced in May 2015 (Burke, 2015). This was designed to increase the number of VHI members, similar to what was achieved in Australia after lifetime community rating was introduced there in 1999/2000 (Department of Health of the Republic of Ireland, 2013). In the month before lifetime community rating was introduced, the number of people with VHI in Ireland increased by 74 000, or 3.6% (HIA, 2015).

A complementary role: VHI covering services excluded from the publicly financed benefits package

Complementary VHI for excluded services is often sold in combination with supplementary VHI. The benefits it provides are generally limited to eye and dental care, physiotherapy and complementary and alternative medicine (CAM) (Table 3.4) and this type of market does not usually cover a large proportion of the population or make a significant contribution to health expenditure. A key exception is the Netherlands (Box 3.3).

Table 3.4 *Benefits offered by complementary VHI covering services excluded from the publicly financed benefits package*

Country	Examples of benefits covered
Armenia	**Benefits not very well defined (can cover immunizations, emergency care, care in acute stages of chronic diseases, inpatient care, diagnostics, medicines, dental and eye care, cardiac and neural surgery)**
Austria	Dental and eye care, physiotherapy, home visits, psychotherapy, health resorts, rehabilitation, CAM
Bulgaria	Dental care, medical devices, outpatient drugs, laboratory tests, elective procedures
Denmark	**Eye and dental care, physiotherapy, psychiatric care, chiropractic, medical aids, chiropody**
Estonia	Dental care, post-accident rehabilitation and medical aids not included in statutory cover
France	Eye and dental care, elective procedures (for example, eye correction surgery)
Georgia	**Services not covered by the statutory benefits package (for example, many diagnostic services and pharmaceuticals)**
Germany	Dental care
Ireland	GP visits, physiotherapy, eye and dental care, CAM
Italy	Eye and dental care, home care, cosmetic treatment, prostheses, rehabilitation, transplants, inpatient and outpatient care, CAM
Latvia	Eye and dental care, physiotherapy and massage, rehabilitation, vaccines, hearing aids, prostheses, plastic surgery, IVF, CAM
Lithuania	Odontology (including dental prostheses), some medicines and medical rehabilitation devices, optical devices, health therapies (including spa treatments, psychotherapy and homeopathy)
Malta	Dental care
Netherlands	**Eye and dental care, physiotherapy, speech therapy, some preventive care, some forms of cosmetic surgery, CAM**
Portugal	Dental care
Romania	Services excluded by the publicly financed system
Russian Federation	Dental care
Slovenia	CAM, superior dental care, elective care (for example, cosmetic surgery), drugs not on positive and intermediate lists

Table 3.4 *contd*

Country	Examples of benefits covered
Spain	Dental care for adults, chiropody, CAM
Switzerland	Additional non-essential medications, certain types of CAM not already included in the mandatory package (for example, osteopathy), dental care, part reimbursement of glasses and contact lenses
Ukraine	Payments for pharmaceuticals and access to different services that are de facto not financed by the statutory system (due to inadequate public financing)
United Kingdom	Dental care, CAM

Sources: National experts and country profiles.

Notes: Main VHI role is marked in bold (see Tables 2.2 and 3.2). CAM = complementary and alternative medicine; IVF = in vitro fertilization.

Box 3.3 *Complementary VHI covering excluded services in the Netherlands*

VHI in the Netherlands covered 84% of the population in 2015 (Vektis, 2015). This relatively high take-up may reflect various factors: voluntary cover is sold alongside publicly financed cover, often by the same entities (even if they may be separate for accounting purposes); the market has been in place for many years, so people are familiar with it and understand its purpose; VHI covers services that are valued by a well-educated and relatively affluent society (eye care, dental care for adults and physiotherapy); and it is increasingly purchased on a group basis and paid for by employers, enhancing its accessibility and affordability. Factors like these may be difficult to replicate in other settings. The VHI market is also relatively accessible to older people and people in poor health. Between 2006 and 2008, insurers voluntarily agreed to offer open enrolment and community-rated premiums for VHI (Maarse, 2009). However, the period of agreement has now concluded (Roos & Schut, 2011) and this practice has changed. In 2012, 42% of plans had entry requirements (Maarse, 2016).

Although VHI population coverage is high, it has steadily declined in the last 10 years from a peak of 93% in 2006 (Vektis, 2015). The reasons for this trend include the increasingly high cost of VHI, which makes direct OOP payments more attractive, and the belief that VHI covers services that people may never use (Maarse, 2016).

This form of complementary VHI would be attractive, from a policy perspective, if it allowed policymakers to systematically exclude non-cost–effective services from publicly financed cover. This would have the dual advantage of streamlining the publicly financed benefits package and removing concerns about access to VHI. In practice, however, such an approach presents both technical and political challenges (Sorenson et al., 2008). As a result, policymakers sometimes exclude whole areas of less politically visible services (for example, eye and dental care and physiotherapy) rather than systematically delisting interventions of low value.

A complementary role: VHI covering user charges

Complementary cover of user charges is the dominant role VHI plays in Croatia, France and Slovenia and, to a much lesser extent, Denmark, Finland, Latvia and Poland (Table 3.5). The presence of user charges in the form of coinsurance[2] appears to be a key determinant of demand for this form of VHI. Croatia, France (Box 3.4) and Slovenia (Box 3.5) are the only EU countries that apply coinsurance to inpatient care.[3] Where coinsurance is applied to essential health services without exemptions for low-income people or regular users of health services, and without a cap on OOP spending, paying for publicly financed health care at the point of use is likely to be at once unavoidable, unpredictable (especially for inpatient care, where the volume and price of services used may be difficult to estimate in advance) and expensive.

Table 3.5 Benefits offered by complementary VHI covering user charges

Country	Examples of user charges covered
Bulgaria	Dental care, medical devices, outpatient drugs
Croatia	**User charges for all publicly financed health services**
Denmark	**Outpatient drugs**
Estonia	Dental care, post-accident rehabilitation, medical aids
Finland	**Outpatient prescription drugs**
France	**Full cover of coinsurance for most services; varying cover of the cost of convenience medicines, medical devices and extra billing; no cover of deductibles**
Germany	Outpatient care, per diem cash benefits for hospitalization
Italy	Outpatient drugs
Latvia	n/a
Poland	Copayments for some non-refunded medicines, dental services, over-standard procedures and treatment courses
Portugal	Outpatient drugs
Romania	n/a
Slovenia	**User charges for all publicly financed health services**
Sweden	Outpatient visits and prescription drugs

Sources: National experts and country profiles.

Notes: Main VHI role is marked in bold (see Tables 2.2 and 3.2). n/a = no information available.

2 Coinsurance is a form of user charge in which the user pays a set percentage of the service price.

3 The rates are 20% in France (Chevreul et al., 2010), 20% in Croatia (Lončarek, 2016) and range from 5 to 25% in Slovenia, with exemptions for low-income households (France) and people aged under 26 (Slovenia) (Albreht et al., 2009).

Box 3.4 *Complementary VHI covering user charges in France*

The French VHI market predates the establishment of national health insurance in 1945 and is dominated by non-profit-making mutual associations. Coverage has grown from about 30% of the population in 1950 to 86% in 2000 and 90% in 2010, fuelled by a combination of factors including diminishing publicly financed coverage for outpatient care, rising user charges, rising gross domestic product (GDP) and tax subsidies for VHI (Chevreul et al., 2010).

Worried about low VHI take-up among poorer households and social inequities in access, in 2000 the government introduced vouchers for low-income people to purchase VHI (*Couverture maladie universelle complémentaire*; CMU-C), followed by subsidies (from 2005) for those just above the threshold for CMU-C (*Aide à la complémentaire santé*; ACS) (Chevreul et al., 2010). Health professionals are not permitted to apply extra billing to CMU-C or ACS beneficiaries (Franc & Pierre, 2015).

After the establishment of CMU-C and ACS, the proportion of people with complementary cover increased from 86% in 2000 to a peak of 94% in 2008 and then fell to 90% in 2010 (Chevreul, 2016). Therefore, VHI accessibility remains a challenge.

In 2008, nearly 4 million people did not have VHI (Perronnin, Pierre & Rochereau, 2011). The most commonly cited reason for not having VHI among those not eligible for CMU-C who would have liked voluntary cover was lack of means (42% of respondents); among the general population the most commonly cited reasons for loss of voluntary cover were financial problems and becoming unemployed (20 and 15% of respondents, respectively) (IRDES, 2010). Rises in VHI premiums, partly reflecting steady increases in user charges for publicly financed health services, have not been matched by a concomitant rise in the level of VHI benefits (Chevreul & Perronnin, 2009). This suggests an aggregate reduction in the quality of VHI coverage in France and, therefore, in the degree of financial protection it provides.

From 2016, employers (irrespective of the size of their business) will have to offer VHI to their employees. The objective is to secure and improve access to group VHI contracts, which are known to be more advantageous than individual VHI contracts. This is likely to reduce inequity in access to VHI among employees but may increase inequity between salaried employees and other groups (students, retirees, the unemployed and self-employed). It will also change the risk structure of the individual VHI market and may lead to higher premiums for individual contracts. As a result, the government may need to implement measures to subsidize individual VHI contracts (Franc & Pierre, 2013).

Box 3.5 *Complementary VHI covering user charges in Slovenia*

The Slovenian VHI market was established in 1993 and covered 74% of the population by 2005 and 83.5% in 2010 (Albreht et al. 2009; Milenkovic Kramer, 2009). Over 90% of those who are eligible to pay user charges (adults) are covered by VHI. User charges in the publicly financed system can be very high (coinsurance of up to 90%; see Milenkovic Kramer, 2016).

VHI was initially sold by the statutory health insurance fund. The VHI part was turned into a mutual association and two commercial insurers entered the market. In 2000, complementary VHI was defined as being in the public interest. In 2005, open enrolment and community-rated premiums were introduced and supported by a risk equalization scheme (Thomson, 2010). In the same year, the government also introduced penalties for people who do not buy VHI as soon as they are eligible to pay user charges.

A substitutive role

Substitutive VHI is rare in Europe. With the exception of Germany, markets for substitutive VHI are generally very small. Substitutive cover is usually only available to selected groups determined by occupation (Austria, Spain), level of earnings and age (Germany) or (non)eligibility for publicly financed coverage (Cyprus, the Czech Republic, Estonia, Georgia (before 2013), Iceland and Slovenia) (Table 3.6).

The role of substitutive VHI has declined since the 1970s following significant expansions of publicly financed coverage. Ireland extended publicly financed coverage of inpatient care to the whole population in 1979 (eligibility for accommodation in public hospitals) and 1991 (eligibility for treatment by public hospital consultants). In 2006, the Netherlands extended publicly financed coverage to the third of the population that had previously been excluded on the basis of having higher earnings. Belgium extended publicly financed coverage of ambulatory care to self-employed people in 2008 (Gerkens & Merkur, 2010; McDaid et. al., 2009; Schäfer et al., 2010). In Germany (Box 3.6), failed attempts to abolish substitutive coverage in the mid-2000s were followed by efforts to limit the market's expansion (Ettelt & Roman, in press). Georgia has also recently experienced a shift in policy away from promoting publicly and privately financed health coverage through VHI towards extending entitlement to publicly financed coverage provided by the government to almost the whole population (Box 3.7).

Table 3.6 *Benefits offered by substitutive VHI*

Country	Benefits covered	Eligibility
Austria	Similar to publicly financed cover	Those allowed to opt out of the publicly financed scheme (available for certain self-employed occupational groups)
Cyprus	**Varies**	**Those not entitled to publicly financed cover (people with high incomes, people from non-EU countries)**
Czech Republic	**Similar to publicly financed cover, but excludes treatment of some chronic conditions, for example, HIV/AIDS, drug addiction, mental health, spa treatment**	**Those not entitled to publicly financed cover (mainly foreign workers from non-EU countries and economically inactive immigrants)**
Estonia	**Varies**	**Those not entitled to publicly financed cover (for example, non-working spouses of the EHIF-insured)**
Germany	**Similar to publicly financed cover**	**Those allowed to opt out of the publicly financed scheme (available for households with earnings over a threshold, eligible self-employed people, civil servants)**
Iceland	**Similar to publicly financed cover**	**Those not entitled to publicly financed cover (people newly resident, during first six months of stay)**
Slovenia	Similar to publicly financed cover	Those not entitled to publicly financed cover
Spain	Similar to publicly financed cover	Those allowed to opt out of the publicly financed scheme (available for civil servants)

Sources: National experts and country profiles.

Notes: Main VHI role is marked in bold (see Tables 2.2 and 3.2). EHIF = Estonian Health Insurance Fund.

Box 3.6 *Substitutive VHI in Germany*

In Germany, people with earnings over a certain threshold (€54 900 in 2015) can choose to be covered by private insurance (*Private Krankenversicherung*; PKV) rather than the publicly financed scheme (*Gesetzliche Krankenversicherung*; GKV); if they opt for private cover, the GKV no longer benefits from their contributions, but nor does it subsidize their care (Busse & Blümel, 2014). Those who have opted for private cover can only return to the GKV if their earnings fall below the threshold and they are under 55 years of age. Since 2009, it has been compulsory to have some form of health insurance (Federal Constitutional Court, 2009), so anyone who opts to leave the GKV must buy private cover (including paying separate premiums for dependants). However, private cover still benefits from employer financing equal to half of what the employee and employer would have paid for GKV cover up to 50% of the cost of the premium. Only about a quarter of those who have the option of being privately insured actually choose to leave the GKV (Busse & Blümel, 2014).

Box 3.6 *contd*

Risk segmentation is a key issue where substitutive VHI is concerned. It has contributed (with other factors) to deficits in the GKV (Wasem, 1995). Fiscal pressure attributable to risk segmentation is accentuated by the voluntary nature of the decision to leave the GKV, the regulatory framework for VHI and people's ability to return to the GKV if they no longer find it beneficial to be privately insured. The regulatory framework for substitutive VHI allowed private insurers to reject applications for cover (though from 2009 this was prohibited for the basic policy), risk-rate premiums, exclude cover of pre-existing conditions, charge separate premiums for dependents and offer discounted premiums in exchange for high deductibles. VHI is therefore more attractive and more accessible to younger and healthier individuals with smaller families. There are clear differences in health status and use of health services between those compulsorily covered by the GKV and those voluntarily covered by private insurance and, due to the income eligibility criterion, the average earnings of the privately insured are about 60% higher than those of contributing GKV members (Leinert, 2006).

Steady rises in GKV contribution rates can be partly attributed to risk segmentation (Wasem, 1995), which in turn encourages younger people with higher earnings to opt for substitutive VHI. Research estimates that the GKV loses about €750 million a year as a result of people changing from public to private cover or from private to public cover. Between 2000 and 2004, more than half of those leaving the GKV were low risks in terms of age and family status, while most of those joining the GKV were high risk: older people with dependents (Ettelt & Roman, in press). Extending publicly financed coverage to the whole population would alleviate fiscal pressure by lowering the GKV's average risk profile and at the same time increase the average amount it has to spend per person.

The government has taken numerous steps to mitigate the porosity of the border between public and private cover. In 1995, people aged 65 and older lost the right to return to the GKV, even if their earnings fell below the income threshold. In 2000, the age limit for returning to the GKV was lowered to include people aged 55 and older. The income threshold for opting out rose in 2003 by a higher than usual amount (11%) and in 2009 the government extended the waiting period for eligibility to opt out of the GKV to 3 years. Although the latter reform was estimated to have lowered the financial loss to the GKV by 15–20% a year (Albrecht, Schiffhorst & Kitzler, 2007), it was reversed in 2011 by the Christian Democrat–Liberal Democrat coalition, reflecting the government's commitment to maintaining the market for substitutive VHI.

Substitutive VHI is heavily regulated and efforts to ensure access to this type of VHI have grown since the mid-1990s, when the government first began to make it more difficult for those who opt for substitutive VHI to return to the GKV and therefore

Box 3.6 *contd*

needed to ensure that those reliant on VHI had access to affordable cover of good quality. Earlier regulation was limited in achieving its goals. VHI premiums more than tripled between 1986 and 2006, rising almost twice as fast as increases in statutory contributions (Grabka, 2006).

Cost sharing in VHI has also increased. Between 2001 and 2005 the proportion of substitutive VHI policyholders opting to pay deductibles in return for lower premiums rose continuously, with older people more likely to have higher deductibles than younger people (contrary to what economic theory would predict) (Grabka, 2006). In 2005, 5% of those with substitutive VHI (about 350 000 people) were found to be paying premiums that were higher than the maximum GKV contribution (Grabka, 2006). The government introduced further regulation in 2009, including a cap on deductibles. However, the maximum deductible permitted in substitutive VHI is €5000 per year, which is very limited in terms of protection when compared to the cap on OOP payments for publicly financed care, equivalent to 2% of an individual's annual income or 1% for people with chronic conditions (Busse and Blümel, 2014). Two per cent of income for a person with earnings equal to the threshold for opting out (€54 900 in 2015) would be around €1000. Thus, the level of financial protection available in the GKV is much higher than in the VHI market.

Since 2009, private health insurers have been required to offer highly regulated basic policies with a standardized basket of services and premium caps, to assure access to substitutive VHI. They must accept all admissible applicants to the basic policy and are also prohibited from dismissing enrollees defaulting on paying premiums; however, they may restrict the level of services. Also in 2009, the ageing reserves (the insured pay a bit more at a younger age to pay a bit less at an older age to reduce premium increases at an older age) were made transferable to enhance competition among insurers (Busse & Blümel, 2014). Demand for basic policies is moderate, with only about 21 000 individuals enrolled in 2010. This can be explained by adverse selection (people who opt for these policies are mostly bad risks) and high premiums. Although premiums are capped at a rather high level, health insurers still incur a deficit that has to be covered by non-basic policyholders. The same is true for the costs caused by the rising number of defaulters. To relieve financial pressure faced by substitutive VHI providers, recent legislation (2011) has allowed private health insurers to take advantage of the discounts for pharmaceuticals negotiated for publicly financed coverage (Greß, 2016).

The Netherlands faced similar risk segmentation issues in its substitutive market (Thomson & Mossialos, 2006). In 2006, the Dutch government effectively abolished substitutive VHI by extending publicly financed coverage to the whole population. The continued existence of substitutive cover in Germany has created tension in recent years, resulting in increasingly stringent regulation and efforts to introduce universal

Box 3.6 *contd*

publicly financed coverage (Ettelt & Roman, in press). However, current arrangements favour specific groups in the population – the highest-earning employees (who can choose between publicly financed and private cover), civil servants (who do not have to pay GKV contributions), physicians (who benefit from higher fees for treating privately insured patients) and private insurers – which may explain their longevity.

Box 3.7 *Substitutive VHI in Georgia*

The VHI market in Georgia emerged in 2007/2008 as a result of government policy to reduce the role of the state in public life and target social benefits at poorer people. The changes also sought to improve transparency in the system and formalize informal payments. The Medical Insurance Programme (MIP) was the key measure that was introduced to achieve these goals. Between 2008 and 2010, under the MIP, households registered as living below the poverty line were initially given a voucher with which they could purchase a comprehensive annual health insurance policy from the private insurer of their choice. The government also purchased comprehensive private insurance cover for certain other groups (children in care, government workers, teachers and recent internally displaced persons), but the majority of the population had no insurance cover.

As the government was by far the largest purchaser of VHI, insurers focused on competing for households covered under the MIP or professionals working for the government. Until 2013, those who were not eligible for cover under the MIP or other statutory schemes (for example, schemes for government workers) were expected to purchase their own insurance and the government supported a number of initiatives to encourage uninsured citizens to purchase cover and thereby grow the VHI market. In 2012, around 10% of the population purchased their own VHI cover and approximately 45% of the population had state-financed VHI cover under MIP.

Between 2007 and 2013, public policy was very supportive of VHI and regulation of the insurance sector and the VHI market was very light touch. The legislation did not require open enrolment or guaranteed renewal of contracts, although under the MIP insurers had to provide a standard benefits package as defined by the government.

An evaluation of the impact of the MIP reform identified a range of concerns, including the very narrow breadth, scope and depth of coverage, the technical efficiency of the system, the weak regulation of private insurance providers and the quality of care provided (Smith, 2013). During the time the MIP was in operation, the VHI market expanded from covering less than 1% of the population in 2006 to around 30% in 2011 and 45% in late 2012. However, while the MIP was well targeted to the poorest households, and had a positive impact on financial protection for its beneficiaries, this

Box 3.7 *contd*

did not translate into greater financial protection for the population as a whole (Smith, 2013). In fact, health care costs continued to drive significant numbers of households into poverty and imposed a catastrophic financial burden on many other households. Analysis of Household Budget Survey data has shown that the share of households facing catastrophic levels of OOP payments for health care rose from 6.1% in 2006 to 8.5% in 2010, with the poorest fifth of households most likely to face catastrophic health spending (Rukhadze & Goginashvili, 2011). The MIP did not lead to greater use of health care among its beneficiaries, better health outcomes or greater provider responsiveness to patients (Smith, 2013). A combination of lack of awareness of eligibility for the programme, low quality of care and the absence of good coverage of medicines may have reduced people's motivation to seek care (Smith, 2013).

In addition, the efficiency gains expected from increasing competition in the health insurance sector did not materialize, particularly as transaction costs appeared to be extremely high (Zoidze et al., 2012). In 2012, the two largest insurers spent less than 5% of their gross premium revenue on health care. A system in which 14 insurers covered fewer than a million people was also inevitably fragmented.

Finally, weak regulation of the VHI market led to adverse selection and cream-skimming by private insurers. There were reported cases where MIP beneficiaries were denied services, particularly expensive diagnostic procedures, even when all the correct administrative procedures were followed and the interventions were clinically indicated (Zoidze et al., 2012). In this regulatory environment, the integration of private insurers (many owned by pharmaceutical companies) with hospitals as the main means of privatizing the inpatient network is also potentially fraught with conflict of interest (Transparency International Georgia, 2012).

In the run up to the 2012 parliamentary elections better financial access to health care was recognized as an important political issue. The MIP programme was broadened to cover all children aged under six years, all pensioners and all full-time students; the scope of cover was also broadened.

The government elected in 2012 abolished the system of using private insurers to purchase health care on behalf of publicly financed MIP beneficiaries and extended publicly financed coverage provided directly by the government – initially to all those who were completely uninsured and then to all those not covered by individual or corporate VHI – around 90% of the population.

Chapter 4
Who buys VHI?

In this chapter, we review the share of the population covered by VHI, the composition of those who buy VHI (the balance between individuals and groups) and the socioeconomic characteristics of VHI policyholders.

4.1 Share of the population covered by VHI

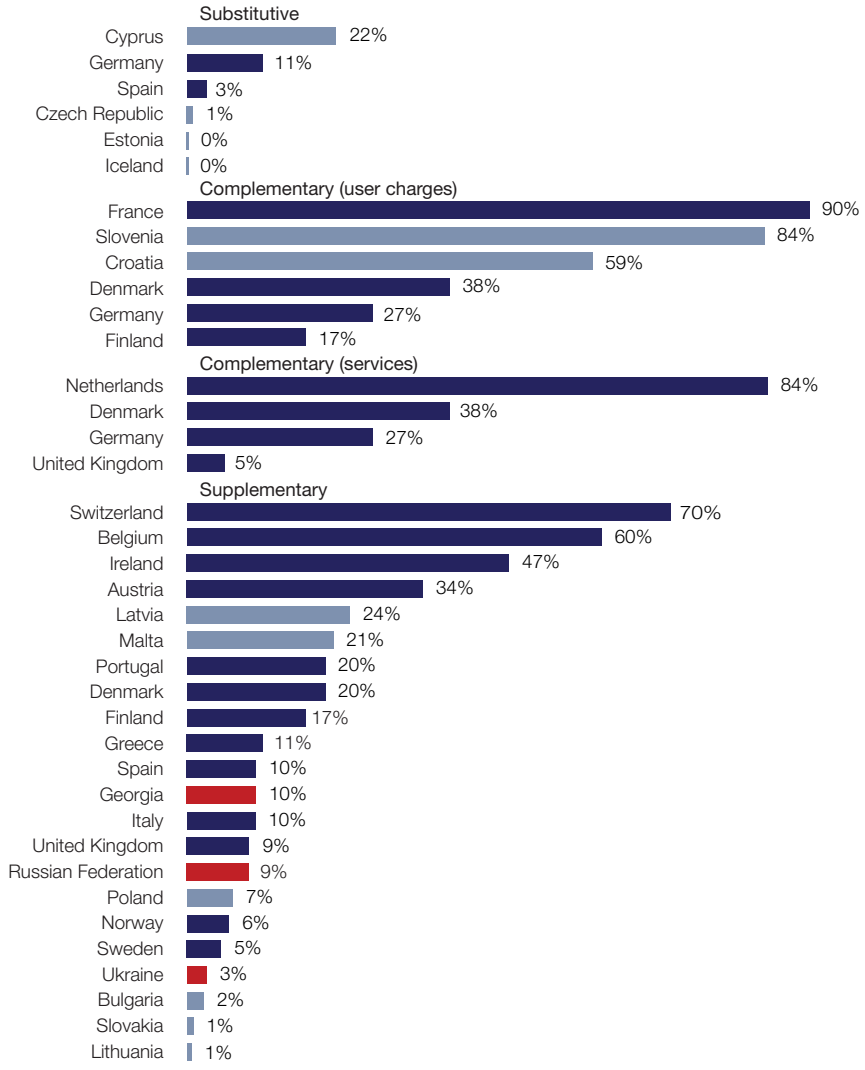
The share of the population covered by VHI in different countries varies widely (Figure 4.1). The largest markets are those covering user charges. In France, population coverage has reached 90%, largely due to the introduction of government-financed vouchers for VHI for poorer households in 2000. VHI population coverage is also high in Slovenia (84% of the population, but over 90% of those who are eligible to pay user charges) and Croatia (59%). Among complementary VHI markets covering excluded services, the Dutch market is the largest in terms of population coverage (84%). Austria, Belgium, Ireland and Switzerland have the highest levels of supplementary coverage.

A note of caution: while these figures tell us how much of the population is covered in each country, they do not reveal the scope and depth of VHI coverage – in other words, whether the policies people have purchased cover a narrow or a broad range of benefits.

The high levels of population coverage achieved by markets covering user charges suggest that, in certain contexts, the widespread application of user charges for publicly financed health care can encourage the development of VHI. However, this is not necessarily always the case. Some of the newer EU Member States have increased user charges in the last five years, but VHI has not developed in response. The VHI markets in France and Slovenia have grown over a relatively long period of time, with VHI traditionally provided by well-established and trusted mutual associations in both countries, heavy government subsidies for poorer people in France and penalties for not buying VHI in Slovenia.

VHI population coverage is low in countries in which informal payments are a problem. Where people are used to paying their doctor or hospital directly to

Figure 4.1 *Share (%) of the population covered by VHI, latest available year*



Source: Authors (based on information from the national experts and country profiles).

Notes: Where population data for various types of VHI were not available, the dominant role of VHI was chosen. 2007: Switzerland; 2008: Latvia; 2009: Cyprus, the Russian Federation; 2010: Bulgaria (also includes complementary VHI), France, Germany, Malta, Poland, Portugal and Slovenia; 2010–2011: Ukraine (also includes complementary VHI); 2011: Greece, Lithuania, Norway, Slovakia, Sweden, United Kingdom; 2012: Croatia, Finland, Ireland; mixed data for Denmark (2010 supplementary, 2011 complementary); 2013: Spain; 2014: Austria; 2015: Netherlands; unknown: Italy. In 2012, substitutive VHI in Georgia covered 10% of the population. Population coverage of other VHI roles (dominant since 2013) is not known. Belgium: estimates of the share of population covered by VHI range from 60 to over 80% (see Gerkens, 2016). We use the more conservative figure. Finland: it is not possible to distinguish between supplementary VHI and complementary VHI covering user charges. Germany: it is not possible to distinguish between complementary VHI covering user charges and services. Russian Federation: only total VHI population coverage is known and we have reported it as supplementary because VHI mainly plays a supplementary role. Slovenia: the share of the population covered by VHI refers to the population aged over 18 (and therefore eligible for paying user charges). Denmark: it is not possible to distinguish between complementary VHI covering user charges and services and 37% of people with complementary VHI also have supplementary VHI (CEPOS, 2014).

obtain better quality of care, paying an insurer may be seen as limiting a patient's leverage over providers (Thomson, 2010). In some countries, lack of trust in insurance and insurance markets is also an issue. More generally, demand for VHI is likely to be affected if the market is not accessible or premiums are regarded as being expensive.

The European experience suggests that VHI only really takes root and grows in countries where governments are able to ensure a degree of transparency in the health system (no informal payments), trust in insurance and insurance markets and an accessible and affordable market for VHI.

4.2 Individuals versus groups

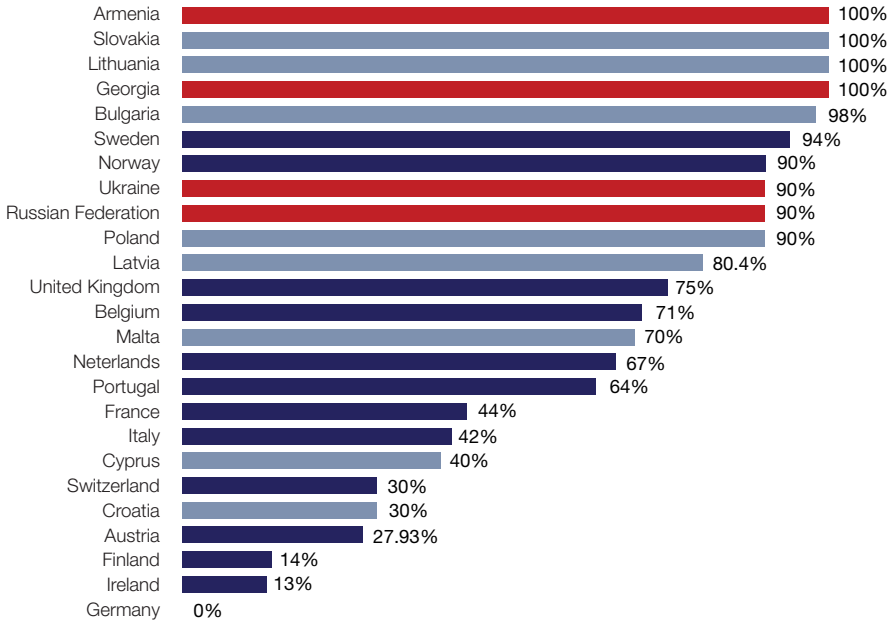
The extent to which VHI is purchased by individuals or through groups (usually employment-based groups) may influence the degree and distribution of population coverage. Figure 4.2 shows how group policies dominate in 16 out of 25 countries for which data are available.

Insurers often favour group policies because they generally have a lower unit cost and provide high volumes of business without a correspondingly large market outlay (BMI Europe, 2000). Also, offering discounted premiums and favourable policy conditions to groups means that insurers automatically cover a younger, healthier, more homogeneous population (Gauthier, Lamphere & Barrand, 1995). If insurers regard group sales as important in preventing adverse selection, they may be reluctant to sell to individuals (as in Armenia and Latvia, for example).

Employers benefit from group policies if faster access to health care lowers absence from work due to ill-health. Their enhanced purchasing power, relative to individuals, can lower the cost of coverage and this also benefits employees; group policies are often much cheaper than individual policies and subject to lower price increases. In addition, group policies are usually group rated, which improves access to VHI for older people and people with pre-existing conditions. Because of this, from 2016, all French employers will have to half-fund group VHI covering a minimum set of benefits for all employees.

However, a market dominated by group policies is likely to increase inequalities in access to VHI in several ways. First, in some countries individual policies may subsidize the discounted policies offered to groups. This possibility is given credence by the fact that insurers' margins are often much tighter for group-purchased than for individually purchased VHI. Second, employers may be more likely to pay the premium on behalf of better-paid employees. In the United Kingdom, 51% of people in the top income decile reported that their

Figure 4.2 *Share (%) of VHI policies sold to groups, latest available year*



Sources: Kroneman (2014) for the Netherlands; national experts and country profiles.

Notes: Ukraine and the Russian Federation: the share of plans purchased by employers is shown. All substitutive plans in Germany are purchased by individuals; 2009: Cyprus, Italy; 2010: Belgium, Latvia, Malta, Portugal; 2011: Norway; year unknown for other countries; no data for the Czech Republic, Denmark, Estonia, Greece, Hungary, Iceland, Romania, Slovenia and Spain.

VHI policy was paid for by their employer, compared with only 25% of those in the bottom four income deciles (Emmerson, Frayne & Goodman, 2001). Third, this potential source of inequality is exacerbated where group policies benefit from tax subsidies. As a result, governments in Austria and Denmark only provide tax subsidies to companies that purchase VHI for all their employees (as opposed to restricting group coverage to senior management, for example).

4.3 The socioeconomic status of VHI policyholders

Information on the socioeconomic status of VHI policyholders shows that in almost every country VHI is more likely to cover better educated people, richer people and people living in the capital city or in the richer parts of a country (Table 4.1). This is to be expected where substitutive VHI is concerned, as eligibility for this type of VHI usually depends on income or occupation. However, non-substitutive forms of VHI also reveal a strong bias in favour of people with higher socioeconomic status.

Table 4.1 *Socioeconomic characteristics of people with VHI, 2012 or later*

Country	Age	Education	Income	Type of employment	Area
Armenia	35–40	Better educated	Higher incomes	International firms	Mainly Yerevan
Austria	20–50	n/a	n/a	n/a	Regional variation
Belgium	Working age	Better educated	Higher incomes	Larger firms; civil servants	Regional variation
Bulgaria	<65	n/a	Higher incomes	n/a	Mainly urban
Croatia	Working age	Better educated	Higher incomes	n/a	Mainly urban
Cyprus	43 (median age)	n/a	Higher incomes	Private firms; public universities	n/a
Czech Republic	n/a	Better educated	Higher incomes	Non-EU migrant workers (substitutive VHI)	n/a
Denmark	Mutual: 45–60	n/a	n/a	White-collar workers	n/a
	Commercial: 15–29	n/a	Higher incomes	Private sector	n/a
Estonia	Working age	n/a	Higher incomes	n/a	n/a
Finland	Working age	n/a	Higher incomes	n/a	Mainly urban
France	30–80	Better educated	No difference	Skilled workers	Rural areas
Georgia	All ages	n/a	Medium to higher incomes	Private sector	Mainly urban
Germany	All ages	Better educated	Higher incomes	Self-employed, public servants	n/a
Greece	25–45	Better educated	Higher incomes	Skilled workers; large firms	Mainly urban
Iceland	n/a	n/a	n/a	n/a	n/a
Ireland	45+	n/a	Higher social classes	Working people	Dublin
Italy	n/a	Better educated	Higher incomes	Managers, professionals, self-employed	Northern Italy
Latvia	Men: 55–64; Women: 35–55	Better educated	Higher incomes	Managers	Mainly urban
Lithuania	n/a	n/a	Higher incomes	Multinational or large firms	Mainly urban

Table 4.1 *contd*

Country	Age	Education	Income	Type of employment	Area
Malta	n/a	Better educated	Medium to higher incomes	Employers paying for group plans	n/a
Norway	35–45	Individual: less educated Groups: better educated	Higher incomes	Profitable firms, smaller firms	Regional variation
Poland	Working age	Better educated	Higher incomes	Larger firms; non-agricultural self-employed	Mainly urban
Portugal	65	n/a	Medium to higher incomes	Medium to large firms	Mainly urban
Romania	<45–50	Better educated	Higher incomes	Multinational or large firms	Mainly urban
Russian Federation	n/a	n/a	n/a	n/a	Mainly Moscow
Spain	n/a	Better educated	Higher incomes	n/a	Mainly urban
Sweden	n/a	n/a	n/a	Private sector	Mainly urban
Switzerland	45+	Better educated	n/a	n/a	n/a
Ukraine	n/a	n/a	Higher incomes	Larger firms	Mainly urban
United Kingdom	40–65	Better educated	Higher incomes	Professionals and managers	London; south-east England

Source: National experts and country profiles.
Notes: No information for Hungary, the Netherlands, Slovakia and Slovenia; 2013 information on Georgia. n/a: information not available.

The profile of VHI policyholders has not changed much over time. For older people, survey data[1] from 2004 suggest that VHI coverage is concentrated among people with higher educational levels and better cognitive functioning in many European countries (Paccagnella, Rebba & Weber, 2008); also, older people with VHI are more likely to be at low risk of ill-health than those who do not have VHI (Bolin et al., 2010).

1 Data from the first wave of the Survey of Health, Ageing and Retirement in Europe. The survey interviewed 28 000 people aged 50 and older in 11 European countries: Austria, Belgium, Denmark, France, Germany, Greece, Italy, the Netherlands, Spain, Sweden and Switzerland.

Chapter 5
How do markets for VHI work?

In this chapter, we examine different aspects of the way in which markets for VHI operate. We review the number and types of entities selling VHI, and look at the policy conditions associated with the sale of VHI, the methods insurers use to set premiums, the scope and depth of VHI benefits, the extent of consumer choice in VHI markets, the way in which insurers purchase services from providers and how much insurers spend on health services and administration.

5.1 Type and number of entities selling VHI

Entities providing VHI include non-profit-making mutual, provident and citizen associations, commercial companies, statutory health insurance funds and employers (Table 5.1). Historically, *mutual and provident associations* dominated the VHI market in many EU15 countries, and still do in Belgium, Denmark, France, Ireland, Italy (and also in Malta and Slovenia). However, their share of the VHI market has declined in several countries since the 1990s due to the entry of commercial insurers or the acquisition of mutual associations by commercial insurers, notably in Finland, where the share held by mutuals was already insignificant, but also in Denmark, Ireland, Malta, the Netherlands, Slovenia, the United Kingdom and, to a lesser extent, France. Ukraine is the only non-EU country in Europe in which non-profit-making entities operate in the VHI market (Lekhan, Rudiy & Richardson, 2010).

Commercial insurers are the only source of VHI in many countries (Armenia, Bulgaria, Cyprus, Georgia, Greece, Hungary, Iceland, Latvia, Lithuania, the Netherlands, Norway, Portugal, the Russian Federation, Sweden and Switzerland) or have the largest share of the market (Austria, the Czech Republic, Finland, Spain and the United Kingdom).

Employers organize their own health schemes (company self-insurance) for employees in Poland, Romania and the United Kingdom. Company schemes called subscriptions are a key feature of the Polish VHI market and increasingly

important in the United Kingdom, where they have proved to be a cheaper alternative to traditional VHI (Foubister et al., 2006). In Romania, subscriptions offer an alternative to publicly financed coverage and used to be popular among employers; however, the introduction of a law encouraging the provision of complementary and supplementary VHI in 2004 has prevented further expansion of the subscription market. Poland and Romania are the only countries where medical subscription packages are offered directly by health care providers. They are open to all and are mainly bought by employers for employees.

Statutory health insurance funds and other agencies responsible for purchasing publicly financed health services compete with other entities to sell VHI in several countries, but in almost every case (the exceptions are Croatia and Romania) there is a requirement to separate statutory health insurance and VHI business. As a result, VHI sales take place through separate legal entities in Belgium and Slovenia and through subsidiaries or links with commercial insurers in the Czech Republic, Germany, the Netherlands and Poland. In Croatia and Romania, statutory health insurance funds dominate the VHI market. In Slovakia, health insurers offering publicly financed coverage negotiate discounts with commercial insurers for their enrollees (Pazitny & Balik, 2016).

Some insurers offer only health products – that is, they specialize in health. Others may sell a range of life and non-life products. Mutual associations generally specialize in health (except in Austria) and are required by law to do so in Belgium, France and Hungary, while statutory health insurance funds always specialize in health.

In countries where commercial and non-profit-making entities compete with each other, they are sometimes treated differently, for example, with regard to taxation or solvency requirements. Discriminatory national laws have been successfully challenged under EU law in Belgium, France and Ireland. In 2010, Belgium was required to place VHI sold by sickness funds on the same footing as VHI sold by commercial insurers. In 2001, the EC asked France to abolish insurance premium tax exemptions favouring non-profit-making insurers. In 2011, the European Court of Justice (ECJ) ruled that Ireland should apply the same financial regulations to all insurers, regardless of their legal status (ECJ, 2011). After missing a number of deadlines for this, the state-owned insurer was finally authorized by the Central Bank of Ireland in 2015.

There is considerable variation in the numbers of insurers operating in European VHI markets (Table 5.1) and the VHI market is highly concentrated in many countries in terms of the number of insurers and the market share of the largest insurers (Figure 5.1). The last two decades have seen a clear trend towards increasing concentration in VHI markets, mainly through mergers

Table 5.1 *Type and number of entities selling VHI, latest available year*

Country	Commercial insurers	Non-profit-making insurers	Total (year)	Insurers specializing in health
Armenia	5	0	5 (2015)	n/a
Austria	8	Mutuals: 1	8 (2011)	No
Belgium	26	Mutuals: 13	39 (2010)	Mutuals and very few commercial
Bulgaria	20	0	19 (2012)	No (2013)
Croatia	6	Statutory fund: 1	21 (2010)	Statutory fund
Cyprus	17	0	17 (2010)	No
Czech Republic	52	Statutory funds: 8	60 (n/a)	Statutory funds and very few commercial
Denmark	10	Mutuals: 1	11 (2011)	Mutual and some commercial
Estonia	1	Statutory fund: 1	2 (2013)	Statutory fund
Finland	10	Mutuals: 140	150 (2010)	Mutuals
France	92	Mutuals: 587 Provident funds: 34	713 (2010)	Most mutuals, half provident funds, some commercial
Georgia	14	0	14 (2012)	No
Germany	24	Mutuals: 19	43 (2012)	n/a
Greece	≈24	0	24 (2011)	Very few
Hungary	5	0	5 (2012)	n/a
Iceland	4	0	4 (2012)	n/a
Ireland	3	Quasi-public entity: 1	4 (2015)	Quasi-public entity
Italy	65	Mutuals: 3 Cooperatives: 1	69 (2010)	All non-profit-making; very few commercial
Latvia	8	0	8 (2012)	No
Lithuania	7	0	7 (2011)	Very few
Malta	7	Provident funds: 1	8 (2011)	Provident funds
Netherlands	33	0	33 (n/a)	Few
Norway	8	0	8 (2011)	Very few
Poland	Subscription: ≈200 Commercial: 15–20	Statutory fund: 1	≈220 (2012)	Subscription and statutory fund
Portugal	19	0	19 (2011)	No
Romania	Commercial: 12 Subscription: n/a	Statutory fund: 1	13 (2012)	Subscriptions and statutory fund
Russian Federation	≈350	0	≈350 (2010)	n/a
Slovakia	3	0	3 (2012)	One
Slovenia	3	Mutuals: 1	4 (2010)	Mutuals and one commercial

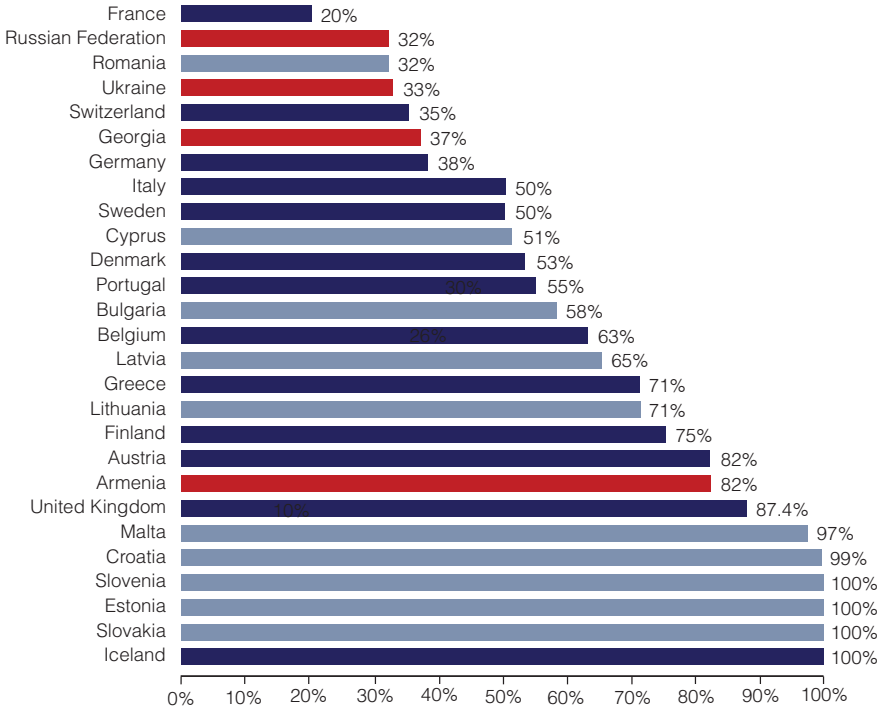
Table 5.1 *contd*

Country	Commercial insurers	Non-profit-making insurers	Total (year)	Insurers specializing in health
Spain	22	Mutuals: a few		Mutuals
Sweden	17	n/a	17 (2013)	Very few
Switzerland	56	0	56 (2010)	Almost all
Ukraine	≈20	Citizen associations: ≈200	≈220 (2012)	Citizen associations
United Kingdom	11	7	18 (n/a)	Some

Sources: National experts and country profiles.

Notes: Not all Czech commercial insurers offer VHI. Mutual funds in Hungary provide voluntary medical savings accounts and are not included. For Ireland, we have excluded restricted membership undertakings, which limit membership to occupational groups and accounted for about 2% of those covered by VHI in 2010, and HSF Health Care (trading as Hospital Saturday Fund), which only sells cash plans. In Italy, commercial insurers include collective private insurance funds (Fondi Integrativi Sanitari del Servizio Sanitario Nazionale (SSN)) which may be for-profit or non-profit-making. The total number of entities selling VHI in Romania excludes subscriptions. Some United Kingdom firms underwrite policies and do not sell VHI policies directly. n/a = information not available.

Figure 5.1 *VHI market share (%) of the three largest insurers, 2011*



Sources: National experts and country profiles.

Notes: Data include commercial only (Belgium), eight largest insurers (Italy), five (Greece), four (Estonia, United Kingdom), two (Georgia). Data for 2008 (Portugal); 2012 (Bulgaria, Croatia, Slovakia, Sweden); 2013 (United Kingdom); not known (Ukraine); no data (Czech Republic, Hungary, Iceland, Netherlands, Norway, Poland, Spain).

(Austria, France, Finland, Greece, Italy, Luxembourg, Portugal and Spain). In some countries this has reflected increased concentration in the banking and insurance sectors as a whole (Portugal). In others it reflects changes in EU legislation concerning solvency margins, which has particularly affected the mutual market in France. Between 2000 and 2006, the number of insurers in the VHI market in France fell by 40%, although the high level of competition among insurers in a saturated market was probably partly responsible for some of the mergers that took place (Chevreul & Perronnin, 2009).

The national experts involved in this study report that market concentration measured as the market share of the largest three insurers (Figure 5.1) has increased in Bulgaria, Denmark, Lithuania and Slovenia. Conversely, the VHI market has become less concentrated in some countries, as the number of insurers has increased (Bulgaria, Ireland, Malta, Sweden) or the market share of the largest insurers has declined (Armenia, Cyprus, Finland, Greece, Slovakia, Sweden, United Kingdom). Most VHI markets have remained stable in terms of market concentration.

5.2 Policy conditions, premiums and benefits

VHI is often linked to employment in Europe and group policies dominate the VHI market in many countries (see Figure 4.2).

Policy conditions

VHI take-up is usually restricted to people aged under 65. Cover is most commonly provided as a short-term (annual) contract and insurers are generally free to reject applications, exclude or charge higher premiums for pre-existing conditions, rate premiums on the basis of individual health risk, set limits to benefits and impose waiting periods[1] and user charges. Dependents almost always have to be covered separately at additional cost. Group policies often benefit from community-rated premiums and less stringent policy conditions. There are very few countries in which VHI premiums and policy conditions are regulated beyond the usual rules governing non-life insurance contracts (Belgium, France, Germany, Ireland, Slovenia; see Chapter 6). Table 5.2 provides an overview of the main policy conditions applied in the countries included in this volume. Policy conditions have not changed much in recent years.

1 That is, a period of time before which benefits will not be paid. A classic example is benefits relating to childbirth, which some insurers will not cover if the birth occurs within nine months of buying VHI.

Table 5.2 *VHI age limits, open enrolment and exclusion of pre-existing conditions, 2012 or later*

Country	Upper age limit for buying VHI for the first time	Open enrolment	Insurers can exclude pre-existing conditions
Armenia	Yes (65–70)	No	Yes
Austria	Yes (65–70)	No	Yes
Belgium	No	Yes	Yes
Bulgaria	No	No	Yes
Croatia	Commercial: yes (60–65) Statutory fund: no	Commercial: no Statutory fund: yes	Commercial: yes Statutory fund: no
Cyprus	Yes (>65)	No	Yes
Czech Republic	Yes (>65)	No	Yes
Denmark	Yes (usually >60)	No	Yes
Estonia	Yes (63–65)	Commercial: no Statutory fund: yes	Commercial: yes Statutory fund: n/a
Finland	Yes (typically >60–65)	No	Yes
France	No (age limits for some contracts)	Usually, but not required	Usually no
Georgia	No	No	Yes
Germany	No	Yes, for substitutive basic policy only	Yes
Greece	Yes (>65)	No	Yes
Hungary	Yes (<60)	No	Yes
Iceland	No	Yes	Yes
Ireland	No	Yes	No, but age-related waiting period is permitted
Italy	Yes (>65–75)	Commercial: no Mutuals: n/a	Commercial: yes Mutuals: no
Latvia	Varies by employer	No	Yes
Lithuania	Yes (>60)	Usually, but not required	Yes, if diagnosed within two months of contract
Malta	Yes (>60–65)	No	Yes, except for large groups
Netherlands	No	Usually, but not required	Yes
Norway	Yes (>67)	No	Yes
Poland	Some	No	Yes
Portugal	Yes (>60)	No	Yes
Romania	Yes (>65)	No	Yes
Russian Federation	No	Yes	Yes
Slovakia	n/a	Yes	Yes

Table 5.2 *contd*

Country	Upper age limit for buying VHI for the first time	Open enrolment	Insurers can exclude pre-existing conditions
Slovenia	Complementary: no; other: yes (>60–65)	Yes, for complementary	Yes
Spain	Yes (>65 years for new contracts)	No	Yes
Sweden	For some products (>65–70)	No	Yes
Switzerland	Varies by insurer	No	Yes
Ukraine	Yes (>60–70)	No	Yes
United Kingdom	Yes (>65, sometimes 74 to 75 for new contracts)	No	Yes

Sources: National experts and country profiles.

Note: n/a = information not available.

Age limits

Age is almost universally used to set premiums. Insurers in many countries also set a maximum age limit for purchasing VHI, usually between 60 and 75 years of age (Table 5.2). EC Directive 2000/78/EC of 27 November 2000, which established a general framework for equal treatment in employment and occupation, prohibits discrimination based on age; in the future, this may change the practice of restricting VHI cover for people aged 65 and older.

Length of contract

VHI cover can be offered as a short-term or long-term contract whereby premiums are used to finance both current year costs and build reserves for increasing age. Short-term (usually annual) contracts are the norm for VHI in Europe (Table 5.3). However, some mutual associations offer lifetime cover voluntarily. Lifetime cover is required by law for all policies in Austria, Belgium and Ireland and for substitutive policies in Germany. Some insurers terminate contracts when people reach retirement age. This is particularly common among group policies. Policyholders often have the option of switching to an individual policy, sometimes for the same level of benefits and at a reasonable rate.

Open enrolment

Open enrolment entitles everyone in a given population to coverage and means that insurers cannot reject applications on the grounds of disability or ill-health. It is a key regulation designed to ensure access to coverage and is

Table 5.3 *VHI contract duration, 2012 or later*

Country	Annual or lifetime contracts	Group cover ends at retirement
Armenia	Annual	Yes
Austria	Lifetime (except for group insurance)	Yes (can transfer to individual contract)
Belgium	Lifetime	Yes (can transfer to individual contract)
Bulgaria	Both	Commercial: yes
Croatia	Annual	No
Cyprus	Annual and lifetime	Yes
Czech Republic	Varies between one month to two years	n/a
Denmark	Commercial: annual Mutuals: quarterly	Commercial: yes
Estonia	Commercial: lifetime (to 65) Statutory fund: annual	No
Finland	Annual and lifetime (up to 60–65)	Usually
France	Annual	Yes (can transfer to individual contract)
Georgia	Annual	Yes
Germany	Lifetime	No
Greece	Annual and lifetime	Yes
Hungary	Lifetime	Yes
Iceland	Six months	Only individual policies
Ireland	Annual, subject to lifetime cover	Yes (employer cover; other group cover may be available)
Italy	Annual and lifetime	Commercial: yes Mutuals: not usually
Latvia	Annual	Yes
Lithuania	Annual	Yes
Malta	Annual	Yes (can transfer to individual contract)
Netherlands	Annual	n/a
Norway	Annual	Yes
Poland	Annual	Yes
Portugal	Annual	Varies
Romania	Annual	No
Russian Federation	Annual	No
Slovakia	Annual	n/a
Slovenia	Typically biennial or triennial	No
Spain	No lifetime cover	No
Sweden	Annual	Yes
Switzerland	Annual	No
Ukraine	Annual	Usually
United Kingdom	Annual	Usually

Sources: National experts and country profiles.

Note: n/a = information not available.

therefore standard practice for publicly financed health coverage. It is much less common for voluntary coverage in Europe (Table 5.2), but is a regulatory requirement for all insurers in some countries (Ireland since 1996, Belgium since 2007).[2] In other countries, it applies to insurers offering substitutive VHI (Germany, since 2009, for the basic substitutive policy only) or in markets offering complementary VHI covering user charges (Slovenia since 2005). In France, open enrolment is not a regulatory requirement, but has been common practice among mutual associations and is now encouraged through fiscal policy. In 2006 and 2007, following pressure from parliament, insurers in the Netherlands agreed to offer open enrolment for complementary VHI covering excluded services, but the agreement was not renewed in 2008.

Exclusion of pre-existing conditions

Insurers in most countries are allowed to exclude from cover pre-existing conditions that were disclosed at the time the VHI contract was signed or cover them in return for a higher premium or longer waiting periods (Table 5.2). The exceptions are Germany (for the basic substitutive policy only), Ireland and Slovenia.

In addition to pre-existing conditions, the list of typical exclusions from VHI policies can be very long. VHI in the United Kingdom[3] is an extreme example, but in most countries insurers do not cover drug abuse,[4] self-inflicted injuries, HIV/AIDS, infertility, cosmetic surgery, sex reassignment, experimental treatments and drugs, organ transplants, war risks and injuries arising from hazardous pursuits (Association of British Insurers, 2001).

Premiums

Setting premiums

Contributions for publicly financed health coverage are usually related to income or wages. In this sense, they are based on ability to pay and do not account for an individual's risk of ill-health. In contrast, VHI premiums are rarely related to income (Croatia and France are the only examples). They are much more likely to be rated according to individual risk or assessed on a community, experience or group basis.

2 It is a temporary regulatory measure in Belgium. Commercial insurers can still exclude or limit cover for costs related to chronic conditions or disability.

3 United Kingdom 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 childbirth, cosmetic surgery, gender reassignment, preventive treatment, kidney dialysis, mobility aids, experimental treatments and drugs, organ transplants, war risks and injuries arising from hazardous pursuits (Association of British Insurers, 2001).

4 Under the minimum benefit regulations in Ireland, insurers must provide cover for drug- or alcohol-related treatment for up to 91 days in any continuous 5-year period.

Risk-rated premiums take into account an individual's current health status and future risk of ill-health and may vary based on risk factors such as age, sex, occupation, medical history and family history of disease. Community- and group-rated premiums are based on the average risk of a defined community or firm, but community rating does not usually involve a specific assessment of risk, while group rating may. Experience rating involves adjusting premiums based on claims history. For each of these three options, premiums would be the same for all policyholders in a given group. The method used to set premiums (risk, community/group or experience rating) and the variables used in risk rating have implications for cost and access. VHI premiums also vary depending on the level of benefits to be provided, including any user charges involved (see further on).

EU internal market legislation introduced in 1994 precludes governments from specifying how VHI premiums are to be set in non-substitutive markets (see Chapter 6). Insurers offering substitutive VHI are often subject to some degree of regulation regarding the price of premiums and policy conditions, at least as it applies to specific groups of people (those eligible for the basic policy in Germany). Generally, however, risk rating is the most common method used by insurers to set VHI premiums. Table 5.4 shows the variables used to set VHI premiums in different countries.

Differentiating premiums according to gender has been prohibited by the Test-Achats decision of the ECJ and EU Member States were required to implement this decision by the end of 2013 (see Chapter 6). Belgium had already prohibited differentiating premiums according to sex in 2007. Among the non-EU countries analysed here, the Russian Federation and Switzerland continue to use sex as a risk factor in rating premiums. Other, albeit less common, variables used to rate premiums include: place of residence (Austria, Belgium, France, Italy – commercial insurance, Switzerland and the United Kingdom); employment status/occupation (Denmark – commercial insurance, Italy – commercial insurance, Slovakia); and income (Croatia – mutuals, France – mutuals and group policies).

Group rating is used in Denmark (most policies), Greece (group policies), Italy (policies sold by the largest mutuals) and Ukraine. Premiums may be experience-rated in Cyprus and Malta (for large group policies) and in the United Kingdom (for employer-paid group policies).

Community-rated premiums are rare, particularly among commercial insurers. They are usually only available from non-profit-making insurers – for example, France (compulsory employer-paid group policies and typically also optional group policies), Malta (smaller groups) and Italy (for most policies sold by non-

profit-making insurers). Ireland and Slovenia are the only EU Member States in which community rating is prescribed by law for all insurers offering VHI. However, in both countries, people face penalties if they do not buy VHI when they are younger.

Information required from people wanting to buy VHI

The information required from VHI applicants is closely related to the rating method used to set premiums (Table 5.5). Insurers that use health status as a variable for risk rating premiums will require applicants to complete a medical questionnaire, which may also include questions about family history of disease (a form of genetic information) (Mossialos et al., 2002). 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), but it is required by insurers in most other countries (Greece, Poland, Portugal, Romania and the United Kingdom). Medical exams may take place in some countries (Table 5.5). In France, only commercial insurers require medical information, but this is discouraged by fiscal policy and rarely used in practice. In some cases, insurers will not require applicants to provide any medical information at all, but may impose waiting periods or undertake moratorium underwriting (see further on).

Waiting periods

Open enrolment is usually accompanied by mandatory waiting periods. Waiting periods range from 1 month to a year for most forms of health care, but may be up to 10 years for cover of long-term care (LTC) (Table 5.5).

Moratorium underwriting

Insurers in some countries 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 exam, but for a specified period, any pre-existing conditions are not covered. These types of policy are not common and mainly occur in Portugal and the United Kingdom. They tend to be cheaper than normal policies (Senior, 2015), but have raised concerns about the potential negative consequences of people forgoing or delaying treatment to qualify for full coverage (OFT, 1996; OFT, 2000).[5]

5 In 1996, the United Kingdom competition and consumer authority (the Office of Fair Trading, OFT) took the view that people with moratorium-based VHI were more likely to suffer detriment through failing to understand what was covered and recommended that insurers abandon the practice (OFT, 1996). The Association of British Insurers (ABI) suggested that improved consumer education would help to reduce consumer detriment (OFT, 2000). The OFT agreed but felt that the ABI's initiative fell short of what was required. In a second report, it called for tighter self-regulation than the ABI's codes and guidance provided (OFT, 2000).

Premium prices

The price of premiums within a country may vary according to the method used to set them. Where premiums are risk-rated and insurers can charge higher premiums for cover of pre-existing conditions, premiums are likely to be higher for older people and people with health problems. They are also usually higher for women of childbearing age. Employees with access to group cover will generally benefit from lower premiums than self-employed people and others who rely on individual policies. They may also benefit from group-rated premiums. In Ireland, a maximum level of discounts for group policies (up to 10% lower than individual premiums) was introduced to prevent risk selection (Department of Health and Children, 2001; Mossialos & Thomson, 2002b).

It is very difficult to make meaningful comparisons of VHI premiums across countries due to differences in the benefits covered. In most countries, premiums appear to rise with age and commercial policies tend to have higher premiums than VHI purchased from mutual associations. It was expected that the creation of a framework for a single market for VHI in the EU would increase competition among insurers, leading to greater choice and lower prices for consumers (see Chapter 6). However, VHI premiums have sometimes increased above the rate of inflation in the health sector as a whole (Mossialos & Thomson, 2004) and there is little evidence of increased competition leading to lower prices for VHI.

A couple of countries have tried to reduce or moderate the growth rate of VHI premiums through regulation. Since 2008, the *Fondi Integrativi Sanitari del SSN* (collective private insurance funds[6]) in Italy must offer premiums that are lower than premiums in the private insurance market. Sustained premium increases in Belgium led to the introduction of constraints on premium increases (in 2007) and the abolition of extra billing for double rooms (in 2009/2010) and fee supplements in double rooms (in 2013) (see Box 3.1).

Cover for dependents

Dependents are usually required to buy their own policy or may be covered by the policyholder but at extra cost. Denmark and France (some policies only) are exceptions. Discounts for dependents or family packages are available in Armenia, Belgium and Bulgaria.

6 The difference between private insurance companies and Fondi Integrativi Sanitari del SSN is that the latter must maintain sufficient financial reserves and are included in a special register of private health insurance funds that constitute the second pillar of health insurance. Registration is voluntary. See Ferré (2016) for more information.

Table 5.4 *Variables used to set VHI premiums, 2012 or later*

Country	Age	Health status
Armenia	✓	✓
Austria	✓	✓
Belgium	✓	x
Bulgaria	✓	✓
Croatia (mutual)	✓	x
Croatia (commercial)	✓	✓
Cyprus	✓	✓
Czech Republic	✓	✓
Denmark (mutual)	✓	✓
Denmark (commercial)	✓	x
Estonia (commercial)	✓	✓
Estonia (statutory fund)	x	x
Finland	✓	x
France (mutual)	✓	x
France (commercial)	✓	✓
Georgia	✓	✓
Germany	✓	✓
Greece	✓	✓
Hungary	✓	✓
Iceland	n/a	n/a
Ireland	Penalties for not buying VHI when younger	x
Italy (commercial)	✓	✓
Italy (mutual)	x	x
Latvia	Varies	Varies
Lithuania	✓	x
Malta	✓	x
Netherlands	✓	✓
Norway	✓	✓
Poland	✓	✓
Portugal	✓	✓
Romania	✓	✓
Russian Federation	✓	✓
Slovakia	✓	✓
Slovenia (complementary VHI)	Penalties for not buying VHI when younger	x
Slovenia (other VHI)	✓	✓
Spain	✓	✓
Sweden	✓	x
Switzerland	✓	x
Ukraine	✓	✓
United Kingdom	✓	✓

Sources: National experts and country profiles.

Table 5.5 *Medical information required and waiting periods, 2012 or later*

Country	Medical information required from applicants	Waiting periods
Armenia	Medical declaration and exam	No
Austria	Medical history	Usually not
Belgium	Medical declaration (not for collective plans)	Yes, usually 3–6 months (longer for childbirth)
Bulgaria	Medical declaration and/or certificate	n/a
Croatia	None (mutual), medical declaration or certificate (commercial)	Usually not
Cyprus	Medical history, exam allowed	Yes (in some cases)
Czech Republic	Medical exam (substitutive)	n/a
Denmark	Medical declaration (for eligibility and exclusion of pre-existing conditions)	Usually not
Estonia	Medical exam on entry and contract extension	Commercial: 1–9 months Statutory fund: 1 month
Finland	Medical history	n/a
France	Medical history (commercial); rarely used	No
Georgia	Yes	No
Germany	Medical history	Yes, 3–8 months
Greece	Medical history (including family history), medical exam, X-ray	Yes
Hungary	Medical history, medical exam	Yes, 3–6 months
Iceland	n/a	No
Ireland	None	Yes, 6–12 months; 5 years for pre-existing conditions
Italy	Commercial: medical history	Yes, 1–9 months
Latvia	Medical exam for some insurers	n/a
Lithuania	Medical history (companies <20 employees)	n/a
Malta	Medical history (except for large groups) and exam (mainly for older people)	No
Netherlands	Medical history (increasingly used)	n/a
Norway	Medical history	Yes
Poland	Moratorium underwriting or medical exam (plus family history)	No
Portugal	Medical history (including family history) and exam (may be requested)	Yes
Romania	Medical history (including family history) and exam (may be requested)	Yes
Russian Federation	Medical history (individual)	No
Slovakia	Medical history (may be requested)	No
Slovenia	Non-complementary VHI: medical exam	Complementary (user charges): 3 months Other VHI: 2–24 months

Table 5.5 *contd*

Country	Medical information required from applicants	Waiting periods
Spain	Medical history	Yes, typically 6 months
Sweden	Medical declaration for cover for companies with 10–20 employees; medical exam (rare)	Yes (different lengths)
Switzerland	Medical declaration	Yes
Ukraine	Medical exam or health documentation	No
United Kingdom	Medical history (including family history), medical exam (rare)	No

Sources: National experts and country profiles.

Note: n/a = information not available.

Benefit design

The range of benefits covered by VHI

VHI covers a wide range of health services and offers a variety of benefit options, from hospital costs to complementary and alternative treatment (see Section 3.2). Substitutive VHI offers the most comprehensive benefits packages, largely as a result of government intervention, typically matching publicly financed benefits. In contrast, the benefits arising from complementary and supplementary VHI are largely unregulated, leaving insurers free to determine the scope and depth of the packages they offer. This has led to a proliferation of complementary and supplementary VHI products in many countries. Individuals may be able to choose from a wide selection of packages with differences in coverage levels, reimbursement (in kind or cash), the extent of user charges and benefit ceilings.

Very few countries regulate the scope and depth of VHI benefits. France (responsible contracts) and Ireland require insurers to offer minimum benefits and Germany requires substitutive VHI policies to cover both ambulatory and inpatient care and caps the level of user charges in VHI. In Italy, the provision of certain benefits is fiscally incentivized; the Integrated Health Funds of the SSN have to provide coverage for long-term care and dental services that are not fully covered by the SSN to qualify for fiscal benefits.

Benefit ceilings and user charges

Insurers in many countries cap the amount VHI will cover by imposing benefit ceilings (Table 5.6). Benefit ceilings and user charges (copayments, coinsurance, deductibles and extra billing) limit the financial protection provided by VHI. Deductibles are by far the most common form of user charge associated with VHI policies. No-claims bonuses (a form of incentive, rewarding policyholders

Table 5.6 *VHI user charges and benefit limits, 2012 or later*

Country	User charges	Upper ceiling on benefits
Armenia	x	✓
Austria	✓	✓
Belgium	✓	✓
Bulgaria	x	✓
Croatia	✓	✓
Cyprus	✓	✓
Czech Republic	Varies	✓
Denmark (mutual)	✓	x
Denmark (commercial)	Usually not	n/a
Estonia	n/a	x
Finland	✓	✓
France	✓	x
Georgia	✓	✓
Germany	✓	x
Greece	✓	✓
Hungary	x	✓
Iceland	n/a	x
Ireland	✓	✓
Italy	✓	✓
Latvia	n/a	✓
Lithuania	✓	✓
Malta	✓	✓
Netherlands	✓	x
Norway	x	x
Poland	Varies	n/a
Portugal	✓	✓
Romania	x	x
Russian Federation	x	x
Slovakia	x	✓
Slovenia	✓ (non-complementary VHI)	x
Spain	✓	x
Sweden	Varies	x
Switzerland	✓	✓
Ukraine	✓	x
United Kingdom	✓	x

Sources: National experts and country profiles.

Note: n/a = information not available.

who make few or no claims) are not widely applied. Protection from VHI-related user charges through, for example, a cap on deductibles, is not usually available.

In Slovenia, complementary VHI covering user charges must cover all user charges. In France, however, responsible contracts prohibit insurers from covering small deductibles (€0.50 per drug package, €1 per GP visit and €2 for medical transport) or the additional user charges patients must pay if they opt out of following a coordinated care pathway.

Benefits provided in cash versus in kind

VHI benefits can be provided in cash, through reimbursement or direct payment of a specified sum, or in kind, through the direct provision of health services (Table 5.7). Reimbursement requires policyholders to pay providers OOP first and then claim back their expenses at a later date. It is, of course, the norm in markets for complementary VHI covering user charges. It is also the norm across most VHI markets in Europe. Benefits provided in kind are the norm in Ireland, Norway, Spain, Ukraine and the United Kingdom.

Table 5.7 *Purchasing from providers versus reimbursement of patients, 2012 or later*

Country	Purchasing	Reimbursement
Armenia	✓ (doctor visits, mainly in contracted facilities)	✓ (prescription drugs)
Austria	✓ (some hospitals for inpatient and outpatient care)	✓ (office-based physicians)
Belgium	x	✓
Bulgaria	✓	✓
Croatia	x	✓ (mainly)
Cyprus	✓ (inpatient care)	✓ (outpatient care)
Czech Republic	✓	✓ (substitutive VHI)
Denmark	✓	✓
Estonia	✓ (statutory fund)	✓ (commercial insurers)
Finland	x	✓
France	x	✓ (mainly)
Georgia	✓	(some reimbursement of copayments)
Germany	x	✓
Greece	✓ (increasing)	✓ (mainly)
Hungary	✓	x
Iceland	x	✓
Ireland	✓	x
Italy	✓	✓
Latvia	x	✓ (since 2008)
Lithuania	x	✓
Malta	✓ (mainly)	✓
Netherlands	✓	✓

Table 5.7 *contd*

Country	Purchasing	Reimbursement
Norway	✓	x
Poland	x	✓
Portugal	✓ (mainly)	✓
Romania	✓	✓
Russian Federation	x	✓
Slovakia	x	✓ (mainly)
Slovenia	✓	✓ (mainly, complementary VHI)
Spain	✓	x
Sweden	x	✓
Switzerland	x	✓
Ukraine	✓	x
United Kingdom	✓	✓

Sources: National experts and country profiles.

5.3 Consumer choice and information

People with VHI usually have choice of insurer, benefits and health care provider. Individuals may be able to choose from a wide selection of packages with differences in coverage levels, reimbursement (in kind or cash), user charges and benefit ceilings. However, in many cases, choice may be circumscribed by eligibility criteria (people aged 60 and older are not usually allowed to buy VHI), health status (many insurers can reject applications or exclude pre-existing conditions), ability to pay premiums and ability to make informed comparisons of insurers and products.

Choice of insurer

In almost every country, people can choose between at least two insurers (Table 5.1). Some VHI markets have traditionally been dominated by a single insurer – for example, Croatia before 2004 and Ireland before 1994. In Croatia, Ireland and Slovenia, a single insurer continues to dominate the VHI market (the statutory health insurance fund in Croatia's case).

Portability of VHI benefits

VHI policyholders can generally switch from one insurer to another without incurring direct costs, although most contracts require one to three months' notice prior to termination. However, the indirect costs of switching can be high, particularly for older people or people with pre-existing conditions, mainly because the majority of new policies will be priced according to current

age and health status, but also due to the transaction costs of finding a suitable new policy (see further on in this chapter). Also, since insurers can reject applications for cover, some people may not be able to take out a new policy with a different insurer.

The lack of portability of benefits from one contract to another is not normally considered to be problematic from a public policy perspective where complementary and supplementary VHI markets are concerned. It has been an issue in Germany's substitutive market, however, largely due to the non-portability of the ageing reserve each policyholder has been required to build up to finance cover when older and to prevent premiums from rising as policyholders age.[7] This inability to transfer ageing reserves from one insurer to another prevented many VHI policyholders from switching; it had the effect of limiting competition among private insurers to competition for new entrants to the market. In 2007, the government introduced new regulation to facilitate portability; from 2009 ageing reserves have been fully portable for all new VHI policyholders. Existing policyholders could transfer their reserves if they switched private insurer between January and June 2009, but the ageing reserve could not be transferred if an individual switched from private to publicly financed cover.

Choice of VHI products

How much choice of VHI products people have depends to some extent on the number of insurers in the market. It may also depend on the type of contract in place. Those covered by group contracts may not have much or any choice at all if coverage decisions are made by employers. In other cases, people often have a wide range of choice of product, options around user charges and health provider.

Insurers are usually free to offer a range of VHI products and often differentiate products as a way of segmenting the market. Differentiating products may benefit some people, but in general it lowers transparency and is therefore likely to increase transaction costs for most people wanting to buy VHI. Because product differentiation often makes it difficult for people to compare products in terms of value for money, it can also undermine price competition and lead to consumer detriment (OFT, 1997). Consumer detriment is defined as the loss to consumers incurred from making misinformed or uninformed choices (OFT, 2000).

Where there is a lack of transparency regarding VHI premiums, coverage and policy conditions, people may over-insure or refrain from buying VHI – in

7 The ageing reserve has been financed by an additional 10% added to all premiums since 2000.

Belgium, for example, few people are aware that people with chronic conditions have access to VHI. During the 1990s, consumer and competition authorities found evidence of consumer detriment due to product differentiation in Germany, Portugal, Spain and the United Kingdom (Datamonitor, 2000; Mossialos & Thomson, 2002b; OFT, 1998; Thomson & Mossialos, 2009). We are not aware of more recent investigations.

Problems caused by the multiplicity, variability and complexity of VHI products on offer can be mitigated by the use of standardized terms, standardized benefits, an obligation for insurers to inform potential and existing policyholders of all the options open to them and accessible sources of comparable information on the price, quality and conditions of VHI products. However, the EU regulatory framework does not in principle support government intervention in non-substitutive markets (see Chapter 6).

Other approaches to addressing this problem have included a mix of regulatory and voluntary measures. The United Kingdom government brought general insurance sales (including the sale of VHI) under the statutory regulation of the Financial Services Authority in 2001 (HM Treasury, 2001). United Kingdom insurers have also published a guide to VHI and agreed to use some standardized terms in describing their products.[8] In some countries, consumer associations or independent websites and other media provide comparative information (Table 5.8), but it is not clear if these are sufficient to ensure transparency (Maarse, 2009).

Table 5.8 *Countries with central sources of comparative information about VHI products, 2012 or later*

Country	Source
Finland	Finnish Financial Ombudsman Bureau (https://www.fine.fi/)
France	National Union of Complementary Health Insurance Organizations (http://www.unocam.fr/)
Germany	Websites such as Stiftung Warentest (https://www.test.de/) or Bund der Versicherten (https://www.bundderversicherten.de/)
Ireland	Health Insurance Authority (http://www.hia.ie/)
Italy	Italian Federation of Integrative Voluntary Mutuality (http://www.fimiv.it/) (mutual policies)
Netherlands	Websites such as Independer (https://www.independer.nl/)
Switzerland	Websites such as Comparis (https://www.comparis.ch/) (not all providers included)

Sources: National experts and country profiles.

8 The latest version of this guide (2012) is available at the website of the Association of British Insurers (www.abi.org.uk).

Group VHI policies may present fewer problems than individual policies in terms of comparison. There may be a reduced choice of product or less variation between products. In some cases, employee representatives may also play a role in negotiating the terms on which group policies are offered, which could compensate for lack of information (Mossialos & Thomson, 2002b).

Choice of provider

Most supplementary VHI policies aim to widen choice of health care provider, allowing policyholders to consult doctors working in the private, as well as the public, sector. Complementary and substitutive VHI policies may also give people a wider choice of health care provider.

The extent to which choice is restricted through the use of preferred provider networks (PPNs) or as a result of vertical integration of insurers and providers varies across countries (Table 5.9). On the whole, PPNs and vertical integration play a minor role (see further on).

Referral and prior authorization

VHI policyholders in several countries need a GP's referral before their VHI policy will reimburse them for consulting a specialist or receiving inpatient treatment (Denmark, Estonia, managed care plans in Greece, Ireland, Norway, Portugal, Romania, Sweden in return for lower premiums, the United Kingdom).

Some insurers in the United Kingdom encourage policyholders to obtain permission prior to undergoing treatment, while others insist that policyholders 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 people to their PPN. Insurers in other countries also require prior authorization for the use of specific treatments or for all services (Austria, managed care plans in Greece, Malta, the Netherlands, Portugal, Romania). In most countries, however, prior authorization is only required for treatment abroad.

5.4 Purchasing health services

Purchasing is broadly defined as the transfer of pooled funds to providers. The purchasing spectrum ranges from passive, involving little more than retrospective reimbursement of provider costs, to active, which implies that purchasers attempt to influence health care costs and quality (Figueras, Robinson & Jukubowski, 2005). Provider payment, vertical integration and

selective contracting are tools that enable active purchasing. Other tools for active purchasing include: the use of evidence-informed priority-setting processes; decision support mechanisms such as evidence-based care pathways, clinical and prescribing guidelines, INN prescribing and generic substitution; performance monitoring and feedback to health care professionals; and public reporting of performance information. In general, very few insurers selling VHI in Europe make use of such tools.

Selective contracting

Insurers are allowed to contract providers on a selective basis in most countries (Table 5.9), but the extent to which selective contracting actually takes place varies greatly. In the vast majority of health systems in the EU, publicly financed health coverage offers people free choice of primary care provider, office-based specialist and publicly financed hospital. In many countries, VHI aims to extend this choice to include health care providers who are not contracted by the statutory system. As a result, insurers offering VHI may be reluctant to adopt purchasing tools that restrict people's choice of provider.

Selective contracting could be limited for other reasons. For example, lack of capacity in the private sector may mean there are not enough providers to make selection a feasible option; insurers may not have the information and skills needed for selective contracting; or insurers may be relatively fragmented in comparison to providers and lack the power to negotiate effectively. It is also possible that, in the absence of competitive pressures, insurers simply do not feel the need to ensure efficiency in spending on health services.

Vertical integration

Vertical integration in VHI is very much the exception in Europe, although it has long been a feature among dominant insurers in countries such as Spain and the United Kingdom (Table 5.9). More recently, however, the United Kingdom competition authorities have required a strict separation of insurance and hospital business (Foubister et al., 2006). Regulations in Germany also prohibit insurers from owning polyclinics. In a handful of EU countries, there seems to be a small trend towards vertical integration (Greece, Ireland, the Netherlands), but insurers do not usually restrict choice by requiring policyholders to use their own providers only. Efforts to vertically integrate in Belgium and France have met with limited success (Stevens et al., 1998), in France partly due to the public's negative perception of US-style Health Maintenance Organizations.

Table 5.9 *Insurer relations with providers, 2012 or later*

Country	Insurers free to contract selectively?	Insurers vertically integrated with providers?
Armenia	Yes	Most insurers own facilities, but policyholders are not obliged to use them
Austria	Yes	Some insurers part-own private facilities, but policyholders are not obliged to use them
Belgium	Yes, but limited use	No
Bulgaria	Yes	Some insurers own facilities, but policyholders are not obliged to use them
Croatia	Yes, in supplementary VHI market	Some insurers own facilities or have exclusive agreements with providers, but policyholders are not obliged to use them
Cyprus	Yes	No, but the largest insurer has a PPN
Czech Republic	Yes, but not applied in practice	No
Denmark	Yes, used frequently	No, but some insurers have exclusive agreements with providers
Estonia	Yes, but limited use	No
Finland	Yes, but not used in practice	No
France	No	No
Georgia	Yes	Used increasingly since hospital privatization
Germany	Yes, but only providers treating only VHI patients	Not typically; insurers cannot own polyclinics
Greece	Yes, used frequently	A small minority of insurers own facilities; others encourage use of PPNs
Hungary	Yes	No, but some insurers use PPNs
Iceland	n/a	No
Ireland	Yes, but in practice most providers are contracted	Not traditionally; Vhi Healthcare recently set up SwiftCare Clinics for minor ailments
Italy	Yes (private sector)	No
Latvia	Yes, but limited use	No
Lithuania	No	No
Malta	Yes, but limited use	No
Netherlands	Yes, but limited use	Not typically, but one insurer is investing in primary care centres
Norway	Yes	No
Poland	Yes	No, but some insurers use PPNs (subscriptions)
Portugal	Yes, used frequently	Some large insurers own facilities; insurers offer PPNs
Romania	Yes, used frequently	A few insurers own hospitals, but vertical integration is the exception
Russian Federation	Yes	Some insurers own facilities
Slovakia	Yes	No

Table 5.9 *contd*

Country	Insurers free to contract selectively?	Insurers vertically integrated with providers?
Slovenia	Yes, used frequently in supplementary VHI market	No
Spain	Yes, used frequently	Insurers typically own hospitals and use beds in other private hospitals
Sweden	Yes, used frequently	No
Switzerland	Yes, but limited use	No
Ukraine	Yes	Not typically; some insurers own facilities but policyholders are not obliged to use them
United Kingdom	Yes	No; insurance and hospital business have to be kept strictly separate

Sources: National experts and country profiles.

Notes: PPN = preferred provider network; n/a = information not available

Provider payment

Insurers offering VHI overwhelmingly opt to pay providers on a retrospective FFS basis, even where this is not the norm for publicly financed health services (Table 5.10). Prices may be set by providers, especially where there is no purchasing, only reimbursement of policyholder costs. Usually, however, prices for VHI-financed services are negotiated by providers and insurers or their representatives. Insurers use nationally determined prices in several countries. In almost all countries, providers are permitted to (and do) charge higher prices for treating VHI-financed patients. This encourages the prioritization of people with VHI and has had a negative impact on efficiency and equity in the use of health services in some countries. For hospital services, there is a small trend to move away from FFS or per diem payment, towards use of diagnosis-related groups (DRGs).

The public–private mix in service delivery

VHI-financed care is provided by a mix of public and private providers in most countries. Private provision usually dominates in supplementary VHI markets – for example, in Denmark, Greece, Italy, Malta, Norway, Poland (outpatient care), Portugal, Slovakia, Spain, Sweden and the United Kingdom.

Private beds in public hospitals (beds reserved for the use of privately financed patients) are used by insurers in many countries, including Armenia, Austria, Bulgaria, the Czech Republic, Germany, Greece (since 2011), Ireland, Italy, Latvia, Luxemburg, Norway, Romania, Switzerland and the United Kingdom. In Austria and Greece, the share of public beds that may be reserved for private use is capped at 25 and 10% respectively. In Ireland it was capped at 10%, but

Table 5.10 *Provider payment, 2012 or later*

Country	Provider payment method	Who sets prices?	Different from public prices?
Armenia	FFS	Insurer–provider negotiation (big hospitals often dictate prices)	Yes (higher)
Austria	FFS	Insurer representative negotiates with hospitals, hospital doctors and regional medical associations	Yes (higher)
Belgium	FFS mainly	National negotiations between statutory fund and provider representatives	No, but some extra billing permitted
Bulgaria	FFS	Reimbursement: providers; purchasing: insurer–provider negotiation; insurers set prices at own facilities	Varies; similar to public prices plus a fee for each patient visit
Croatia	FFS	Insurer–provider negotiation	Yes
Cyprus	FFS	Providers, except in PPNs	Yes (higher)
Czech Republic	FFS	Providers	n/a
Denmark	FFS	Insurers typically negotiate lower prices based on volume and type of employer	Yes (double for specialists)
Estonia	CAP, DRG, FFS, PD	Statutory fund prices used (defined by the government)	Yes (20% higher)
Finland	n/a	Providers	Yes
France	FFS, DRGs	Ambulatory care prices nationally negotiated by statutory fund and provider representatives; hospital prices set by the government	No, but some extra billing permitted
Georgia	FFS mainly	Insurer–provider negotiation	n/a
Germany	FFS, DRGs	Prices set by government	Yes (higher)
Greece	CAP, FFS, salary	Insurer–provider negotiation	Yes (higher)
Hungary	FFS	Fee schedule for statutory benefits; insurer–provider negotiation for rest	Yes (higher)
Iceland	FFS	Varies	n/a
Ireland	FFS mainly	Vhi Healthcare leads negotiations with providers; other insurers follow and most providers accept the prices	Yes
Italy	FFS mainly	Prices for accredited private providers working for the public sector are set at regional/national level; insurers negotiate prices with non-accredited providers	Yes (higher)
Latvia	FFS	Insurer–provider negotiation	Yes (higher)
Lithuania	FFS	Providers (expensive care prices agreed)	Yes
Malta	FFS, PD, block payments	Insurer–provider negotiation for hospitals	Yes, but extra billing for ambulatory care
Netherlands	CAP, FFS, standard tariffs	n/a	n/a

Table 5.10 *contd*

Country	Provider payment method	Who sets prices?	Different from public prices?
Norway	FFS	Insurer–provider negotiation	Yes
Poland	FFS, DRGs	Insurer–provider negotiation	n/a
Portugal	FFS	Insurer–provider negotiation; in practice, providers often accept insurer prices	n/a
Romania	FFS, salary	Insurer–provider negotiation	Yes (higher)
Russian Federation	FFS mainly	Insurer–provider negotiation	Yes (higher)
Slovakia	FFS	Insurer–provider negotiation	Yes
Slovenia	FFS	Insurer–provider negotiation	n/a
Spain	FFS, some CAP	Insurer–provider negotiation; in practice, providers accept insurer prices	Yes (higher)
Sweden	FFS	Insurer–provider negotiation	Yes (higher; based on government tariffs, with extra pay for handling VHI claims)
Switzerland	FFS; DRGs	Insurer–provider negotiation	n/a
Ukraine	FFS, PD	Insurer–provider negotiation	Yes
United Kingdom	FFS	Insurer–provider negotiation for hospital prices; insurers typically stipulate a maximum price for doctors	Yes (higher)

Sources: National experts and country profiles

Notes: CAP = capitation; DRG = diagnosis-related group (used to pay hospitals); FFS = fee-for-service; PD = per diem (used to pay hospitals); n/a = information not available. In Ireland, hospital payment is moving from PD to FFS; in Switzerland before 2012 payment for hospital care was FFS and PD; in Greece and Romania, salary payment occurs where there is vertical integration.

the bed designation was effectively removed from 2014, and insurers are now charged for the use of any beds in public hospitals. In the United Kingdom, there is full economic costing for the use of private beds in public hospitals, but this is not the case in Ireland.

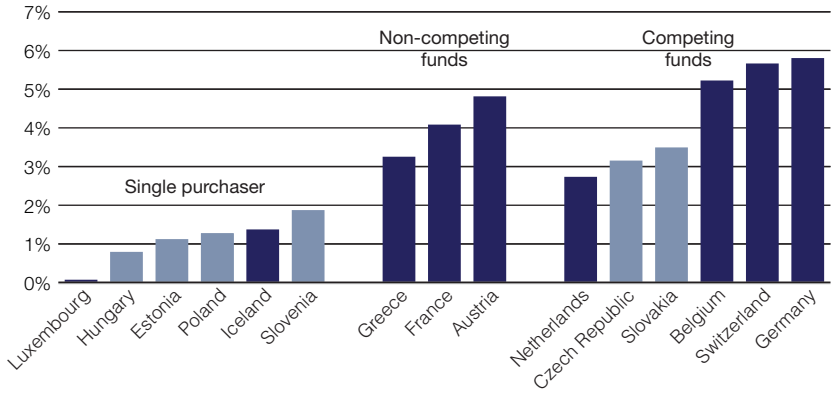
Doctors are free to work in both the private and the public sector in all countries except Cyprus and Denmark. However, some countries impose limits on the extent to which doctors can do this (Greece, Ireland, Italy, the United Kingdom).

5.5 VHI spending on health services and administration

Information on VHI and publicly financed spending on administration are not routinely available. OECD data suggest that administrative costs as a share of total revenue vary across countries depending on the market structure of purchasing, with lower administrative costs in health systems with single

purchasers than in health systems with multiple, non-competing funds or competing funds (Figure 5.2). In the countries for which data are available, the administrative costs of insurers selling VHI are almost always higher than the equivalent cost for social security funds – sometimes several times higher (Figure 5.3).

Figure 5.2 *Administrative costs among social security funds as a share (%) of social security fund spending on health, European OECD countries, 2011*



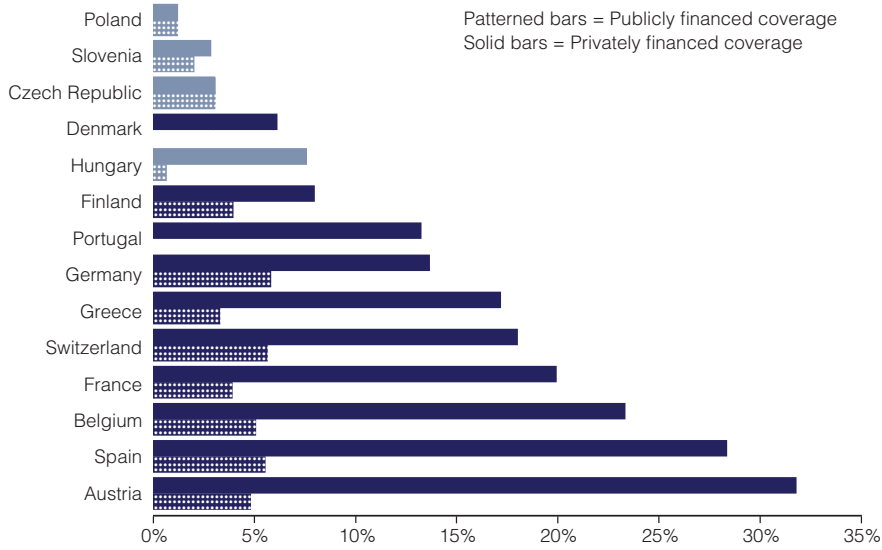
Source: OECD (2015b).

Notes: The figure includes all European OECD countries reporting health spending by social security funds in which social security funds (private entities in the case of the Netherlands, Slovakia and Switzerland) are responsible for the vast majority of public spending on health. Spending refers to current expenditure.

Other sources of data indicate that there is substantial cross-country variation in the amount insurers spend on VHI-financed health services (claims) (Figure 5.4). Claims expenditure as a share of premium income is well under 70% in most countries for which data are available. According to national experts, in most countries (15 out of the 24 shown in Figure 5.4) this figure has increased in recent years (2007–2013), but it fell in 7 countries (Austria, Belgium, Bulgaria, Cyprus, Greece, Poland, Romania).

Insurers in a competitive market may be required to maintain minimum solvency margins. They are also likely to spend money on developing and marketing different products, assessing risk, rating premiums and reviewing claims and, in many instances, will want to generate a surplus. As a result, they will inevitably spend less on health services and more on non-clinical items than insurers who do not engage in such activities. It is for policymakers to determine what a reasonable level of administrative costs should be. In some countries, administrative costs are capped for insurers offering publicly financed benefits in a competitive environment (Belgium and Germany, for example) (Thomson et al., 2013). Where this is the case, the cap tends to be around 5% – much lower than the norm in VHI markets.

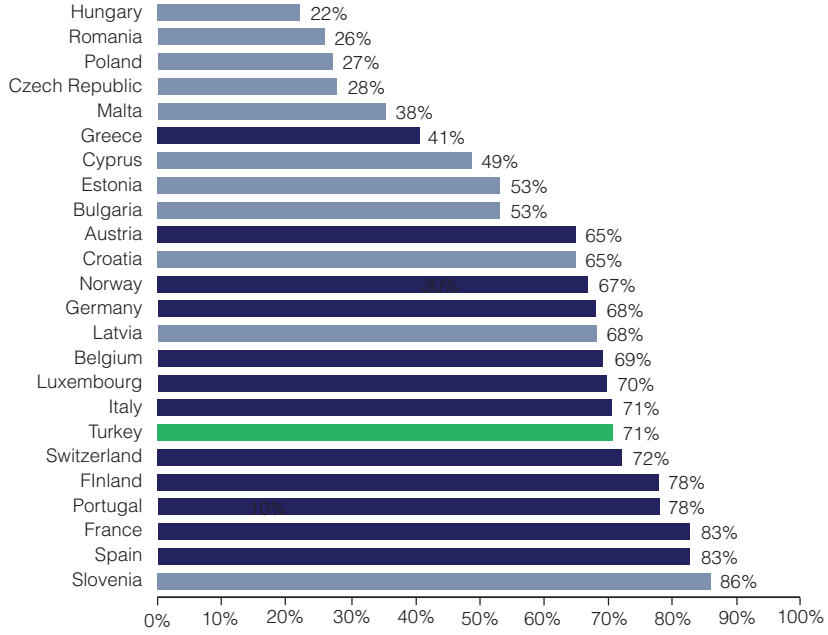
Figure 5.3 *Administrative costs for publicly and privately financed coverage as a share (%) of current spending, European OECD countries, 2012*



Source: OECD (2015b).

Notes: Countries ranked from lowest to highest for administrative costs for privately financed coverage. 2011 data for Portugal (the reason why administrative costs are zero in Portugal may be because a very low amount of health care spending is technically classified as social security funds, which are separate from the budget of the Ministry of Health); no data for public insurance for Denmark; according to the national experts, administrative costs for privately financed coverage in the Netherlands were significantly higher than for publicly financed coverage (13.4% of total premium revenue in 2014).

Figure 5.4 *VHI spending on health care as a share (%) of premium income (claims ratios), selected European countries, 2013*



Source: Authors' calculations based on Insurance Europe (2015).

Note: 2008 data used for Cyprus, the Czech Republic, Greece and Romania.

Chapter 6

Public policy towards VHI

In this chapter, we provide an overview of VHI regulation at EU and national levels. We highlight major policy developments that have taken place since 2000 and review the use of tax incentives for VHI. We conclude the chapter with a discussion of national policy concerns about VHI.

Regulation of VHI has three main goals (Chollet & Lewis, 1997):

- **ensuring market stability** by setting financial and non-financial standards for insurer entry and operation; conditions for insurer exit; and requirements for financial reporting, scrutiny and oversight;
- **protecting consumers** by governing insurers' marketing practices and their relations with health service providers;
- **ensuring affordable access to VHI** through a wide range of rules, including: open enrolment (guaranteed issue); lifetime cover (guaranteed renewal); community rating (delinking premiums from individual risk of ill-health); premium review, approval or caps; mandated (usually minimum) benefits; prohibition of exclusion of pre-existing conditions from cover; caps on user charges for VHI-covered services; prohibition of benefit ceilings.

Measures to secure the first goal are known as financial or prudential regulation; measures to secure the second and third goals are known as material or contract regulation.

6.1 EU regulation

VHI and EU law

Since 1994, health insurance has been subject to EU internal market and competition rules. In 1992, the legislative institutions of the EU adopted regulatory measures in the field of health insurance for the first time, through

the third non-life Insurance Directive, which affirms the free movement of health insurance services across the EU (EC, 1992). Previous non-life insurance directives did not apply to health insurance. The 1992 Directive does not apply to health insurance that forms part of a social security system, but all other forms of health insurance fall within its scope.

The EU-level regulatory framework created by the non-life Insurance Directive imposes restrictions on the way in which governments can intervene in markets for VHI. There are areas of uncertainty in interpreting the directive, particularly with regard to when and how governments can intervene to promote public interests. As in most spheres of EU legislation, interpretation largely rests on ECJ case law, so clarity may come at a high cost and after considerable delay. This section briefly summarizes the main implications of the directive and some aspects of EU competition law for the regulation of VHI in EU countries. For a full discussion of the impact of EU law on VHI, see Thomson & Mossialos (2010).

Regulation and the third non-life Insurance Directive

Before the directive came into force, the extent to which EU governments intervened in VHI markets was largely determined by the role VHI played in the health system, aspects of market structure (for example, the number and types of insurers in operation) and political ideology. Under the EU's subsidiarity principle, governments were free to decide on the appropriate form of regulation required in a given context. Over the last 30 years, the EU legislature has restricted this freedom through a series of directives aimed at creating an internal market in insurance services (EC, 1973; EC, 1988; EC, 1992). The internal market is intended to enhance competition and consumer choice.

EU competence in this area comes from the fact that insurance is considered to be an economic activity. ECJ case law confirms that insurance activities fall under the scope of the directive when they are carried out by insurance undertakings "at their own risk with a view to profit" (ECJ, 2000). ECJ case law also suggests that activities with an "exclusively social purpose involving solidarity" are beyond the scope of internal market and competition rules (ECJ, 1993; ECJ, 2004).

The directive established, for the first time, an EU-level framework for regulating health insurance, with two key components:

- governments must open VHI markets to competition at national and EU levels; this means that the sale of VHI cannot be limited to specific types of insurer or to national insurers or to insurers with a local branch presence;

- governments should not introduce VHI regulation that goes beyond financial regulation, with some exceptions.

Governments can introduce tighter regulation of VHI in the interest of the general good if health insurance serves "as a partial or complete alternative to health cover provided by the statutory social security system" (Article 54(1)). Article 54(2) and recitals to the directive list the types of legal provisions that may be introduced if private or voluntary health insurance provides a partial or complete alternative to publicly financed coverage: open enrolment; community rating; lifetime cover; policies standardized in line with the cover provided by the publicly financed system at a premium rate at or below a prescribed maximum; participation in risk equalization schemes (referred to as loss compensation schemes); and operation on a technical basis similar to life insurance. Measures taken to protect the general good must be shown to be necessary and proportional to the aim of promoting the general good, not unduly restrict the right of establishment or the freedom to provide services, and apply in an identical manner to all insurers operating within a Member State.

While the directive allows regulation of VHI under the general good principle, which broadly refers to any legislation aimed at protecting consumers (in any sector, not just the insurance sector), there is some scope for legal uncertainty. It is not clear what is meant by complete or partial alternative to statutory health insurance or what types of intervention are necessary and proportional and there is no agreed definition of the general good – interpretation relies on ECJ case law.

Broadly speaking, the EU-level framework can be understood as permitting regulation of substitutive VHI – "health cover serving as a substitute for that provided by statutory social security systems" (Mossialos et al., 2010) – and, therefore, as prohibiting regulation of complementary or supplementary VHI. However, decisions by the ECJ indicate that this distinction is not always appropriate and cannot be relied upon by governments. For example, risk equalization to support community-rated premiums has not been found to breach EU rules in Slovenia's complementary VHI market or in Ireland's predominantly supplementary market. The ECJ's 2008 ruling on Ireland (the BUPA case) is important because it notes that it is for national governments to determine whether VHI is a service of general economic interest and to apply general good measures subject to the proportionality test.

The directive reflects the norms of its time – the late 1980s (Thomson & Mossialos, 2010). Since then, there has been increased blurring of the boundaries between normal economic activity and social security. On the one

hand, case law shows governments how they might put their health insurance arrangements beyond the scope of internal market law, either by placing them firmly within the sphere of social security or by invoking the general good defence. On the other hand, as developments in the Netherlands show, social security is no longer the preserve of statutory institutions or public finance, a development likely to bring new challenges for policymakers. Greater blurring of the public–private interface in health insurance gives rise to complexities that the directive is not equipped to address.

There is one area in which the EU-level framework has been consistently applied. This is regarding differential treatment of insurers based on legal status, which has frequently been outlawed.

Recent VHI-related developments in EU law include:

- the introduction of a new solvency directive, from 2016, which aims to harmonize solvency requirements across the EU;
- the ECJ Test-Achats decision outlawing premium differentiation based on gender (EC, 2011b);
- the draft Anti-discrimination Directive (of July 2008) on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, which is still pending in the European Council following revisions proposed in March 2012;
- Directive 2011/24/EU on the application of patients' rights in cross-border health care (due to be transposed by Member States by 25 October 2013 but in most cases transposed with delay), which gives patients experiencing long waiting times in the home country (undue delay) the right to seek care in another EU Member State, including private providers that are not part of the public system, and be reimbursed for it by the public payer at home.

The cross-border avenue to seeking care abroad could be seen by patients as an alternative to supplementary VHI. However, due to the extra administrative, travel and other costs of obtaining care via the directive compared to VHI, and due to the inelasticity of demand for VHI in some countries – for example, when VHI is obtained through work or is seen as a status symbol – it seems unlikely the cross-border directive will have a major impact on VHI uptake. If the directive is used by purchasers to address waiting time problems, however, this might lower demand for VHI in the longer term. So far, the late transposition of the directive and low awareness among EU residents about how to use it for seeking care (EC, 2015) suggest the directive's impact on VHI is not significant.

6.2 National regulation

VHI is regulated exclusively as a financial service in most countries in Europe. Regulatory bodies are typically financial supervisory authorities, central banks or insurance regulators under the jurisdiction of the Ministry of Finance (Table 6.1). In a handful of countries, the Ministry of Health or another health care authority also plays a role. This tends to be in countries where VHI's role is complementary, covering user charges. In recent years, health regulators have been replaced by financial regulators in Finland (2009), France (2010), Greece (2010), Lithuania (2012) and Ireland (2015). Non-profit insurers continue to be regulated by a separate body in Belgium and Hungary, but in Belgium the same rules apply to all types of insurer.

Regulatory approaches vary across countries. National regulations do not go beyond what is required at EU level in just under half of all EU countries. Thus, VHI is regulated in the same way as any other financial service and the legislative framework does not include specific mention of VHI. This is more likely to be the case where commercial VHI is concerned and in predominantly supplementary markets. General insurance legislation includes sections relating exclusively to VHI in Austria and Finland.

National regulation that goes beyond general insurance requirements mainly aims to improve affordable access to VHI (Table 6.2). It is concentrated in VHI markets with a strong mutual or non-profit-making insurer presence (Belgium, France, Ireland, Italy) and where the market plays a substitutive role (Germany) or a complementary role covering user charges (Croatia, France, Slovenia). The intensity of regulation has increased in all of these countries in the last 10 years, especially in Belgium, France, Germany, Ireland, Italy and Slovenia (Table 6.3). This intensification has overwhelmingly aimed to make VHI more affordable and to enhance financial protection for those covered by VHI. In Germany it has also aimed to address risk segmentation problems.

6.3 Tax policy

In this section, we focus on tax incentives (mainly tax relief) and disincentives to buy or sell VHI. Tax relief permits the deduction of all or some of the cost of VHI premiums from taxable personal or corporate income. Disincentives usually involve either a tax on VHI premiums (insurance premium tax) to be paid by the insurer, but often included in the price of the premium, or payment of tax on benefits in kind to be paid by the person receiving employer-paid VHI as a benefit in kind or by the employer providing VHI as a benefit in kind.

Table 6.1 *Bodies responsible for regulating the VHI market, 2012 or later*

Country	Financial supervisory authority	Central bank	Insurance regulator	Ministry of Health	Other
Armenia		✓			
Austria	✓				
Belgium	✓ (commercial)	✓ (commercial)			✓ (mutual)
Bulgaria	✓				
Croatia	✓			✓	
Cyprus			✓		
Czech Republic		✓ (commercial)			
Denmark	✓				
Estonia	✓				
Finland	✓				
France			✓		
Georgia		✓			
Germany	✓				
Greece		✓			
Hungary	✓ (commercial)				✓ Health Insurance Supervisory Authority (mutual)
Iceland	✓				
Ireland		✓		✓	✓ Health Insurance Authority
Italy			✓	✓	
Latvia	✓				
Lithuania		✓			
Malta	✓				
Netherlands		✓			
Norway	✓				
Poland	✓				
Portugal			✓		
Romania			✓		
Russian Federation	✓				
Slovakia		✓			✓ Health Care Surveillance Authority
Slovenia			✓	✓	
Spain		✓		✓	
Sweden	✓				
Switzerland	✓				
Ukraine	✓		✓ (np)		
United Kingdom	✓				

Sources: National experts and country profiles.

Notes: np = non-profit-making.

Table 6.2 *Measures to ensure VHI is accessible, affordable and offers good quality of coverage, 2012 or later*

Regulation	Application
Accessibility	
Making cover compulsory	**Germany**: People who choose to opt out must buy private insurance **France**: From 2016 for employees
Open enrolment	**Belgium**, **Croatia** (VHI covering user charges sold by the statutory health insurance fund), **Estonia** (no age limit for those covered by the statutory health insurance fund if covered for 12 months in the preceding 2 years), **Germany** (for the basic substitutive policy), **Ireland**, **Slovenia** (VHI covering user charges); between 2006 and 2007, insurers in the Netherlands operated an open enrolment policy for VHI
Lifetime cover	Austria, Belgium, Ireland, Germany (substitutive VHI)
Prohibiting switching penalties	**Netherlands, Switzerland**: Insurers are prohibited from terminating a VHI contract if a person switches to another insurer for mandatory health insurance
Affordability	
Community-rated premiums	All insurers: **Ireland**, **Slovenia**; in Slovenia, penalties for not buying VHI as soon as a person is liable to pay user charges are intended to keep younger people in the VHI risk pool and keep premiums down Non-profit-making insurers only: **Belgium**, **Estonia**, **Croatia** (complementary VHI in the statutory health fund); **Italy** (some of the non-profit-making providers; the largest ones use group rating)
Risk equalization to support community rating	**Ireland**, **Slovenia**
Ageing reserves	**Germany** (substitutive VHI):Insurers are required to build up ageing reserves to cover age-related increases in costs and slow the increase of premiums later in life
Premium caps	**Germany** (for the basic substitutive policy only): The premium is capped at the level of the maximum contribution for statutory health insurance; **Italy**: Integrated Health Funds of the SSN must offer premiums that are lower than in the commercial market
Premium discounts	**Italy**: Retired people insured in *Società di mutuo soccorso* (type of non-profit-making VHI provider) remain covered and pay lower premiums
Premiums waived or covered by the government	**Armenia**: The government offers its employees heavily subsidized VHI **Croatia**: The government provides low-income households and other vulnerable groups with free VHI covering user charges **France**: The government provides low-income households with vouchers to buy VHI covering user charges **Germany** (for the basic substitutive policy): Premiums are reduced by 50% if a person can demonstrate they cannot afford to pay the full premium; if this reduced premium is still unaffordable, individuals receive a state subsidy under the social benefits scheme (covering up to 100% of this reduced amount)

Table 6.2 *contd*

Regulation	Application
Scope and depth of coverage	
Cover of pre-existing conditions	**Belgium** (non-profit-making VHI only: Mutual associations cannot charge higher premiums for pre-existing conditions); **Germany** (for the basic substitutive policy only); **Ireland** (all VHI: subject to maximum permissible waiting periods)
Minimum or standard benefits	**France** (for responsible contracts), **Germany** (for substitutive VHI), **Ireland**, **Italy** (for the Integrated Health Funds of the SSN to qualify for fiscal benefits)
Caps on user charges in VHI	**Germany** (for substitutive policies only): Insurers cannot offer annual deductibles of more than €5000
Prohibition of benefit ceilings	**France** (for responsible contracts; except for physicians not subscribing to access to care contracts; see Mercer, 2014)

Sources: Country profiles and additional research.

Notes: SSN = Italian National Health Service (*Servizio Sanitario Nazionale*).

Table 6.3 *Developments in national regulation of or affecting VHI, 2000–2015*

Year	Regulatory change
2000	**France:** Vouchers for VHI for low-income households (CMU-C) introduced
	Germany: Age limit for switching from private to statutory cover lowered from 65 to 55
	Slovenia: VHI defined as being in the public interest; risk equalization permitted but not introduced
2001	**Croatia:** Opting out of publicly financed coverage prohibited to promote the financial stability of the statutory health insurance fund
2002	**France:** Exemptions from insurance premium tax for insurers who refrain from risk rating premiums (*contrats solidaires*) introduced
2004	**Slovenia:** Risk rating of premiums permitted
2005	**France**: Tax subsidies for VHI for people just above the CMU-C threshold introduced
	Slovenia: Risk rating of premiums prohibited; insurers must offer open enrolment and community-rated premiums; risk equalization implemented; premium increases must be approved by the regulator; premium penalties for those who do not buy VHI when they are younger introduced
2006	**Ireland:** Risk equalization scheme triggered by the Health Insurance Authority but later set aside by the Supreme Court (2008)
2007	**Belgium:** Open enrolment for VHI (all insurers), prohibition of premium differences on the grounds of disability or chronic condition (but no definition of disability and chronic condition) and cover of pre-existing conditions (non-profit-making insurers only); to prevent further sharp increases in VHI premiums, a new law specifies parameters for increases (2010)
2008	**Belgium:** Statutory coverage extended to include outpatient care for the self-employed
	France: Exemptions from insurance premium tax introduced for insurers who agree not to cover new compulsory deductibles for statutory treatment (*contrats responsables*)

Table 6.3 *contd*

Year	Regulatory change
2008	**Ireland:** Risk equalization scheme suspended and to be amended following national legal challenge by BUPA but ECJ upholds risk equalization
	Ireland: VHI (Amendment) Act 2008 stipulates that Vhi Healthcare is to be regulated by the Financial Regulator (now Central Bank of Ireland) as is the case for the other two (commercial) insurers but deadline extended on a number of occasions; later the ECJ rules against Vhi Healthcare exemption status
	Italy: Integrated Health Funds of the SSN must provide coverage for LTC and dental services (dental services that are not fully covered by the SSN) to qualify for fiscal benefits; Integrated Health Funds of the SSN must be solvent, adequately capitalized and offer competitive premium rates (for example, premiums lower than in the commercial market)
2009	**Germany:** Having health insurance of some sort made compulsory for the whole population; substitutive VHI must cover both ambulatory and inpatient care; basic policy introduced (replacing the standard policy) in substitutive VHI (open enrolment, cover of pre-existing conditions, benefits equivalent to the GKV at a price that cannot exceed the maximum GKV contribution); a cap on deductibles in VHI (of up to €5000 per year) introduced; VHI ageing reserves made portable; new ruling means people have to demonstrate earnings above the income threshold for three consecutive years before they can opt out of the statutory scheme
	Georgia: Terms and conditions set for the newly established MIP in which the government provides vouchers for private health insurance for people below the poverty line
	Latvia: Restrictions on purchasing VHI for government and municipal employees introduced due to the economic crisis (repealed in 2012)
	Switzerland: Specific alternative medicines included in mandatory health insurance (previously only covered by VHI)
2010	**Belgium:** Specific indexes developed to which private insurers can link changes in premiums and coverage; from 2012 statutory sickness funds can no longer offer VHI; these can only be offered by new independent *societies of mutual interest* and (as before) commercial insurers, both now regulated by financial regulators
	Croatia: Amendments to the VHI Act deprive many people of state-financed complementary VHI cover
	Italy: All Integrated Health Funds of the SSN required to be listed in the national register of Integrated Health Funds and to allocate at least 20% of their premium revenue to dental care and social care (that is, mainly LTC) for those requiring assistance with daily living (in terms of age and physical impairment) to gain fiscal benefits
2011	**Armenia:** Mandatory car insurance with a health insurance component introduced
	Germany: Three-year waiting period for eligibility for opting out of the GKV abolished
	Greece: VHI permitted to use 10% of public hospital beds
	Slovenia: Government calls for a revision of the statutory benefits package and abolition of complementary VHI covering user charges (but leaving scope for supplementary VHI)
2012	**Armenia:** Social Package for government employees with a VHI component introduced, in which the government pays for its employees to be covered by private insurers and offers its employees heavily subsidized VHI
	Belgium: Complementary services offered by sickness funds become mandatory for all members

Table 6.3 *contd*

Year	Regulatory change
2012	**France:** A new regulation sets out the communication requirements for VHI providers regarding the amount and breakdown of their administrative costs (to improve transparency)
	Switzerland: Nationwide choice of hospital (choice of hospital was previously a key reason for purchasing supplementary VHI) introduced
	EU countries: Must implement the ECJ Test-Achats decision outlawing gender-specific insurance tariffs and benefits
2013	**Georgia:** Universal publicly financed benefits package to uninsured people introduced, which effectively abolishes the need for substitutive VHI
	Ireland: Risk equalization scheme introduced
2014	**Armenia:** State Health Agency designated as the sole purchaser of health services included in the mandatory component (basic health package) of the Social Package (previously people could choose to be covered by private insurers)
	France: Amendment of requirements for responsible contracts in the Social Security Financing Act. Changes include: contracts must mandatorily cover the remaining amount paid by the insured person, corresponding to the difference between the Social Security Reimbursement Basis and Social Security Reimbursement (*ticket modérateur*) for all health expenses; coverage for extra billing charges levied by physicians depends on whether or not the practitioner subscribes to the access to care contract; the daily hospital charge must be covered in full for an unlimited period
	Ireland: Insurers charged for the use of all beds in public hospitals (not just those designated as private beds)
2015	**Ireland:** Premium penalties for those who do not buy VHI when younger introduced

Sources: Country profiles and additional research.

Note: Changes in fiscal policy (tax incentives) are not included here; these are covered in Section 6.3.

More than half of the countries in this study (19 out of 34) offer some form of tax incentive for people to buy VHI (Table 6.4). Tax incentives are most commonly provided to employers, followed by individuals. There are no tax incentives for those purchasing VHI in 13 countries. In Romania, capped tax relief applies to all insurance premiums, not just VHI, and therefore does not create an incentive to purchase VHI. This was the case in Germany until recently, but new legislation has introduced a specific tax relief for all health insurance (statutory and voluntary) (Ettelt & Roman, in press).

Over the last 20 years, the trend has been to reduce or abolish tax incentives for VHI, often because they have been found to be expensive for governments and a poor use of public funds. In the 1990s, tax incentives were reduced or abolished in Austria, Finland, Greece, Ireland, Italy and the United Kingdom (Mossialos & Thomson, 2002b). Spain abolished tax incentives for individuals and introduced them for groups in 1999. Several governments have abolished tax incentives that they introduced after 1999. In 2006, Norway abolished a tax reduction for companies purchasing VHI for employees introduced in 2003. In 2011, Croatia abolished the tax deduction for complementary and

Table 6.4 *VHI tax incentives for the insured and insurers, 2012 or later*

Country	Employers	Employees	Individuals
Armenia	✓	x	x
Austria	✓	✓	✓
Belgium	x	x	x
Bulgaria		x	✓
Croatia	x	x	x
Cyprus	x	x	x
Czech Republic	x	x	x
Denmark	✓ (supplementary)	x	x
Estonia	x	x	x
Finland	✓	x	x
France	✓ (2009)	✓ (2004)	x
Georgia	x	x	x
Germany	x	x	✓
Greece	x	x	x
Hungary	✓(2012)	x	x
Iceland	n/a	n/a	n/a
Ireland	✓	✓	✓
Italy	✓	x	✓
Latvia	✓	✓	x
Lithuania	✓	✓	x
Malta	x	x	x
Netherlands	x	x	x
Norway	x	x	x
Poland	✓	x	x
Portugal	x	x	✓
Romania	x	x	✓(2006)
Russian Federation	✓(2009)	x	✓
Slovakia	x	x	x
Slovenia	x	x	x
Spain	✓	✓	x
Sweden	x	x	✓
Switzerland	n/a	n/a	✓
Ukraine	x	x	✓
United Kingdom	x	x	x

Sources: Country profiles.

Note: n/a = information not available.

supplementary VHI premiums introduced in 2001. Portugal reduced the tax deduction for insurance premiums paid by subscribers from 30 to 10% in 2012. In 2013, Greece abolished tax incentives for VHI and Ireland capped the amount of the VHI premium that qualifies for tax relief.

A few countries have reduced or abolished tax incentives for equity reasons. Recently, some countries (Austria, Denmark, Finland) have started to use tax incentives aimed at employers to promote equity within firms – for example, only providing tax relief where VHI is offered to all employees in a firm (as opposed to just senior staff).

Tax disincentives in the form of insurance premium tax and tax on employer-paid benefits in kind apply to individuals in some countries (Estonia, Lithuania, Poland, Ukraine) and insurers in others (Austria, Belgium, Denmark, France, Italy, United Kingdom) (Insurance Europe, 2012). In Ireland and Sweden, there are tax disincentives for groups (for employer-paid cover only) and individuals respectively, but the size of the disincentive is small.

Some countries have in the past used tax policy to favour mutual associations, for example, by exempting their premiums from tax. In Belgium and France, it was found to contravene EU law. The French government now uses tax policy to reward insurers who behave in desirable ways; for example, favourable tax treatment is applied to insurers who provide responsible contracts involving coordinated care pathways and referral to specialists or who do not exclude pre-existing conditions and refrain from asking subscribers to complete a medical questionnaire (Mercer, 2014). However, due to austerity measures, responsible contracts are once again subject to tax, with rates starting at 3.5% in 2010 and rising to 7% in 2011; contracts not meeting these standards, previously subject to a 7% tax, are now subject to a 14% tax.

Other examples of tax incentives applied to VHI insurers can be found in Italy, where fiscal benefits apply to VHI plans that allocate at least 20% of premium revenue to cover dental care and social care for policyholders who require assistance with activities of daily living. In Denmark, tax exemption is granted to VHI plans that cover preventive services and employment-related health needs. In Belgium, hospital plans that provide greater protection than standard plans are exempt from the 9.25% tax on VHI premiums. Bulgaria exempts insurers from VAT on VHI activity.

While generous tax subsidies have succeeded in increasing or sustaining demand for VHI in a few countries (notably Denmark and Ireland), they can be expensive, there is no evidence to suggest they are self-financing and they are likely to be regressive because VHI tends to be purchased by richer people. In most countries that have lowered or abolished tax incentives, there has not been a significant negative effect on demand. In addition, tax incentives can involve a major financial outlay for governments. For example, tax relief on VHI premiums cost the Irish government €448 million in 2012, roughly equal to 3.1% of public spending on health care in that year (Turner, 2015).

6.4 National policy developments and concerns

In this section, we highlight major developments in national VHI markets since 2000. We then focus on concerns and challenges that have been raised in national debates about VHI.

National policy developments

The period from 2000 to 2015 has been marked by policy developments in four main areas: the extension of publicly financed coverage to groups of people previously excluded, which has effectively abolished several markets for VHI playing a substitutive role; an intensification of measures to make VHI more accessible and affordable, especially but not only where VHI plays a substitutive or complementary role; an increase in domestic legal challenges to some of these measures; and a reduction in the provision of tax incentives to take up VHI.

Several countries took steps to strengthen and expand publicly financed coverage, abolishing VHI's substitutive role in Croatia (2001), the Netherlands (2006), Belgium (2008) and Georgia (2013), and limiting its scope in Germany (2000 and 2009). In Croatia and Germany, opting out of publicly financed coverage was prohibited (Croatia) and restricted (Germany) to address fiscal pressures created by risk segmentation.

A proposal to extend publicly financed coverage to all permanent residents in Cyprus would diminish the substitutive VHI market there, although supplementary VHI would remain an option. A similar proposal in Ireland aims to extend publicly financed coverage and promote equity in the use of health services by prohibiting VHI from offering faster access to treatment, limiting its role to providing superior amenities in hospital. In Switzerland, a decision to extend choice of hospital to all those covered by mandatory health insurance may lower demand for VHI in the future. Successive governments in Slovenia have considered ways of removing the need for complementary VHI covering user charges.

In 2006, the Netherlands extended publicly financed coverage to the whole population and allowed mandatory health insurance to be offered by private insurers. The reform was not intended to promote VHI. The only other countries to have attempted something like this are Armenia and Georgia, where, in contrast to the Netherlands, the intention was to promote VHI. However, in both of these countries, government support for using private insurers to provide publicly financed coverage and using VHI to promote access to health care was reversed. In Armenia, analysis initiated by the central bank revealed that VHI spending on health services fell from 71% of premium revenue in 2011 to 33% in 2013, one year after the reform, making VHI an expensive and inefficient way of extending publicly financed coverage. Georgia's policy

reversal was prompted by a change of government and motivated by concerns about lack of financial protection, financial barriers to access and risk selection by private insurers.

A number of other countries have tried to promote VHI, including Bulgaria, Greece, Hungary, Lithuania, Poland and Romania, but with little success, perhaps due to the presence of informal payments in these countries, as well as households' limited ability to pay for VHI.

Many countries with already substantial VHI markets stepped up efforts to make VHI more accessible and affordable, especially in Belgium, France, Germany, Ireland, Italy and Slovenia (Table 6.3). Some of these countries also increased regulation to improve the financial protection VHI provides. Belgium made complementary VHI offered by statutory sickness funds mandatory, Germany made it mandatory to have some form of health coverage and France is making it mandatory for all employers to offer complementary VHI covering user charges from 2016.

The incidence of national and EU legal challenges rose between 2000 and 2015 in comparison to the five years following the introduction of the third non-life Insurance Directive. Most legal challenges concerned differential treatment of insurers based on legal status (consistently found to be in breach of EU rules) and the use of risk equalization to support community rating of VHI premiums (consistently found to be in line with EU rules).

In spite of well-established evidence about the inefficiency and inequity of many forms of tax incentive for VHI, over half of the countries in this study (19 out of 34) offer some form of tax incentive for people to buy VHI (Table 6.4). However, *there has been a notable trend to reduce or abolish tax incentives for VHI*, often because they have been found to be expensive for governments and a poor use of public funds. In France, Greece and Portugal, reductions in tax incentives were in part a response to fiscal concerns in the context of the economic crisis. Countries have also reduced or abolished tax incentives for equity reasons or used tax incentives in a targeted way to promote equity and access to health care. For example, some countries only provide tax incentives if all employees in a firm are offered VHI, or if private insurers also offer cover for LTC, dental care or preventive care, or cover pre-existing conditions at no additional cost. We are not aware of evaluations of the effectiveness of these targeted tax incentives.

National policy concerns

National policy concerns about VHI often include one or more of the following: inequitable (two-tier) access to health services; the magnitude of

public subsidies for VHI; the challenge of ensuring affordable access to VHI for some groups of people; the high administrative costs associated with VHI; and the transaction costs linked to the complexity VHI brings to health systems, particularly in larger markets for VHI.

Concerns about *unequal access to health care* – so-called two-tier access, in which people with VHI enjoy easier, faster or preferential access to treatment – have been debated in Austria, Denmark, Finland, France, Germany, Italy, Latvia, Poland, Portugal, Spain and the United Kingdom. These concerns are driven by a number of factors. For example, where providers receive payment from public sources and VHI (doctors work in both sectors or there are private beds in public hospitals – the case in most countries; see Section 5.4), and VHI-paid fees are higher than publicly paid fees (see Table 5.10), doctors and hospitals will have incentives to prioritize VHI-financed patients. This may result in longer waiting times for those who rely on publicly financed coverage, as well as their having to be treated by less experienced junior medical staff. In addition, the time doctors devote to working in a private capacity is lost to the public sector and doctors working in both sectors may experience role conflicts.

Differential access for people with VHI goes against the principle of access on the basis of need rather than ability to pay. In the United Kingdom, these concerns have been countered by arguing that users of VHI are paying for VHI coverage over and above their tax-financed contributions to the NHS and, furthermore, that their use of VHI-funded care relieves pressure on the NHS, to the benefit of people who rely on the NHS for treatment (Foubister & Richardson, 2016). Even if this claim is valid, the benefits of VHI may not outweigh the cost in terms of doctors' time and public subsidies. Similar claims have been made in Ireland in the past, where some have argued that public subsidies for VHI are justified because those who opt for VHI effectively forgo a statutory entitlement while continuing to contribute to the funding of the public health service through taxation. They have also argued that VHI reduces demand for publicly financed health care. However, the evidence does not support this claim; a significant proportion of VHI-financed care takes place in public hospitals at less than full economic cost – 60% of adult inpatients with VHI, according to recent figures (Turner, 2016).

Explicit and implicit public subsidies for VHI have generated fiscal, efficiency and equity concerns in some countries. Implicit subsidies may come from public funding of medical education; failure to charge VHI the full economic cost of using beds in public hospitals; the potential for VHI to shift costs onto the publicly financed part of the health system in other ways if the system lacks transparency and accountability – for example, where there is double coverage; and the backup function of the publicly financed system.

VHI take-up is systematically concentrated among people with higher socioeconomic status (see Section 4.3), partly because *VHI is less accessible to the most vulnerable population groups*: older or disabled people, people with chronic conditions, unemployed people and poorer households. This raises questions about policies that lower the breadth, scope or depth of publicly financed coverage in the expectation that VHI will fill the gap. Even in countries with well-established VHI markets that cover a large share of the population, such as France, there is evidence of inequities in the depth of VHI coverage, with resulting inequities in the use of health services. Earlier (see Section 6.2), we showed how some countries have increasingly adopted measures to address access and affordability issues, particularly in the larger VHI markets. Such measures have not always been sufficiently effective, however, as the French example reveals.

The *relatively high administrative costs* associated with VHI (see Section 5.5) have been a source of concern in several countries. This is especially the case in countries that have promoted VHI by allowing private insurers to offer publicly financed benefits. In such instances, private insurers have not been seen as providing good value for money.

VHI can bring significant complexity to a health system, adding to transaction costs for governments and households. Monitoring and regulation of VHI markets, efforts to ensure VHI is accessible and affordable for those who need it, developing policies to establish clear boundaries between public and private financing and service delivery, responding to domestic and EU legal challenges – all are likely to be time consuming and expensive.

References

Albrecht M, Schiffhorst G, Kitzler C (2007). Finanzielle Auswirkungen und typische Formen des Wechsels von Versicherten zwischen GKV und PKV. Beiträge zum Gesundheitsmanagement. N. Klusen and A. Meusch. Baden-Baden, Nomos.

Albreht T et al. (2009). Slovenia: Health system review. *Health Systems in Transition*, 11(3): 1–168.

Association of British Insurers (2000). *The private medical insurance market*. London, Association of British Insurers.

Association of British Insurers (2001). *Submission to the European Commission's study on voluntary health insurance in the European Union*. London, Association of British Insurers.

BMI Europe (2000). *Medical insurance*. London: BMI Research.

Bolin K et al. (2010). Asymmetric information and the demand for voluntary health insurance in Europe. National Bureau of Economic Research Working Paper 15689. Cambridge, MA, National Bureau of Economic Research.

Burke S (2014a). White Paper on Universal Health Insurance. HSPM 1 April 2014. European Observatory on Health Systems and Policies (http://www.hspm.org/countries/ireland18092013/countrypage.aspx, accessed 3 December 2015).

Burke S (2014b). Private health insurance review of costs. HSPM 15 January 2014. European Observatory on Health Systems and Policies (http://www.hspm.org/countries/ireland18092013/countrypage.aspx, accessed 3 December 2015).

Burke S (2015). Lifetime community rating. HSPM 1 May 201. European Observatory on Health Systems and Policies http://www.hspm.org/countries/ireland18092013/countrypage.aspx (accessed 3 December 2015).

Busse R, Blümel M (2014). Germany: health system review. *Health Systems in Transition*, 16(2):1–296.

CEPOS (2014). Halvdelen af danskerne har nu en privat sundhedsforsikring [Half of Danes now have private health insurance] (http://www.cepos.dk/sites/cepos.dk/files/media/import/analyser/notat_halvdelen_af_danskerne_har_nu_en_privat_sundhedsforsikring_apr14.pdf).

Chevreul K (2016). France country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Chevreul K, Perronnin M (2009). Private health insurance in France: a study for the European Commission. In: Thomson S, Mossialos E, eds. *Private health insurance in the European Union*. Brussels, European Observatory on Health Systems and Policies.

Chevreul K et al. (2010). France: health system review. *Health Systems in Transition*, 12(6):1– 291.

Chollet D, Lewis M (1997). Private insurance: principles and practice. Innovations in health care financing: proceedings of a World Bank conference, 10–11 March 1997. Washington, DC, World Bank (http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1997/07/01/000009265_3971113151206/Rendered/PDF/multi_page.pdf, accessed 3 December 2015).

Datamonitor (2000). *UK health insurance 2000: what price health?* London, Datamonitor.

Department of Health and Children (2001). *Submission to the European Commission's study on voluntary health insurance in the European Union*. Dublin, Department of Health and Children.

Department of Health of the Republic of Ireland (2013). Review of measures to reduce costs in the private health insurance market 2013. Independent Report to the Minister for Health and Health Insurance Council. Dublin, Department of Health (http://health.gov.ie/wp-content/uploads/2014/03/costs_review_report.pdf, accessed 3 December 2015).

Department of Health of the Republic of Ireland (2014). Public Consultation – Scope for private health insurance to incorporate additional primary care services. Dublin, Department of Health (http://health.gov.ie/wp-content/uploads/2014/12/PHI-pdf.pdf, accessed 3 December 2015).

EBRD (2011). *Life in transition. After the crisis*. European Bank for Reconstruction and Development. (http://www.ebrd.com/downloads/research/surveys/LiTS2e_web.pdf, accessed 3 December 2015).

EC (1973). First Council Directive 73/239/EEC of 24 July 1973 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct insurance other than life assurance. *OJ L* 228(16.8.1973):3–19.

EC (1988). Second Council Directive 88/357/EEC of 22 June 1988 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services and amending Directive 73/239/EEC. *OJ L* 172(4.7.1988):1–2.

EC (1992). Council Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC (third non-life Insurance Directive). *OJ L* 228(11.8.1992):1–23.

EC (2010). Patient safety and quality of healthcare. Special Eurobarometer 327. Brussels, European Commission (http://ec.europa.eu/public_opinion/archives/ebs/ebs_327_en.pdf, accessed 3 December 2015).

EC (2011a). Press release database [online database] State aid: Commission calls on France to put an end to certain tax exemptions for mutual and provident societies. Brussels, European Commission (http://europa.eu/rapid/pressReleasesAction.do?reference=IP/05/243&format=HTML&aged=1&language=EN&guiLanguage=en, accessed 3 December 2015).

EC (2011b). Press release database [online database] European Commission gives guidance to Europe's insurance industry to ensure non-discrimination between women and men in insurance premiums. Brussels, European Commission (http://europa.eu/rapid/press-release_IP-11-1581_en.htm, accessed 3 December 2015).

EC (2015). Report from the Commission to the European Parliament and the Council. Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare. Brussels, European Commission (http://ec.europa.eu/health/cross_border_care/docs/2015_operation_report_dir201124eu_en.pdf, accessed 3 December 2015).

ECJ (1993). Case C-159/91 and Case C-160/91, Poucet and Pistre v AGF and Cancava [1993], joined cases, ECR I-637. Christian Poucet vs Assurances Générales de France (AGF) and Caisse Mutuelle Régionale du Languedoc-Roussillon (Camulrac) and Daniel Pistre vs Caisse Autonome Nationale de Compensation de l'Assurance Vieillesse des Artisans (Cancava) (http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A61991CJ0159, accessed 4 February 2016).

ECJ (2000). Case C-206/98, 18 May 2000, Commission v Belgium. Judgment of the Court (Sixth Chamber) of 18 May 2000. Commission of the European Communities v Kingdom of Belgium. Failure by a State to fulfil its obligations – Directive 92/49/EEC – Direct insurance other than life assurance. Case

C-206/98. (http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1449571857175&uri=CELEX:61998CJ0206, accessed 4 February 2016).

ECJ (2004). Case C-264/01, Case C-306/01 and Case C-355/01 AOK Bundesverband [2004], joined cases, ECR I-2493. References for a preliminary ruling: Oberlandesgericht Düsseldorf and Bundesgerichtshof – Germany. Competition – Undertakings – Sickness funds – Agreements, decisions and concerted practices – Interpretation of Articles 81 EC, 82 EC and 86 EC – Decisions of groups of sickness funds determining maximum amounts paid in respect of medicinal products. Joined cases C-264/01, C-306/01, C-354/01 and C-355/01 (http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1449571901493&uri=CELEX:62001CJ0264, accessed 4 February 2016).

ECJ (2008). Case T-289/03, 12 February 2008, British United Provident Association Limited (BUPA) and Others v Commission. *OJ C* 79(29.03.2008):25. Judgment of the Court of First Instance (Third Chamber, extended composition) of 12 February 2008. British United Provident Association Ltd (BUPA), BUPA Insurance Ltd and BUPA Ireland Ltd v Commission of the European Communities. State aid – Risk equalisation scheme introduced by Ireland on the private medical insurance market – Aid system – Services of general economic interest – Article 86(2) EC – Commission decision not to raise objections - Action for annulment – Admissibility – Principles of necessity and proportionality. Case T-289/03 (http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1449571975760&uri=CELEX:62003TJ0289, accessed 4 February 2016).

ECJ (2011). Case C-82/10, 29 September 2011, Commission v Ireland. Case C-82/10: Judgment of the Court (Fourth Chamber) of 29 September 2011 – European Commission v Ireland (Failure of a Member State to fulfil obligations — Directive 73/239/EEC – Articles 6, 8, 9, 13 and 15 to 17 – Directive 92/49/EEC – Articles 22 and 23 – Direct insurance other than life assurance – Amendment of statutes of an insurance body as regards its capacity – Non-application of the European Union insurance legislation in respect of insurance other than life assurance (http://eur-lex.europa.eu/legal-content/EN/TXT/?qid=1449572115259&uri=CELEX:62010CA0082, accessed 4 February 2016).

Emmerson C, Frayne C, Goodman A (2001). Should private medical insurance be subsidised? *Health Care UK* 51(4):49–65.

Ettelt S, Roman A (in press). Statutory and private health insurance in Germany and Chile: two stories of co-existence and conflict. In: Thomson S, Mossialos E, eds. *Private health insurance and medical savings accounts: history, politics, performance.* Cambridge, Cambridge University Press.

Federal Constitutional Court (2009). Press release no. 59/2009 (10 June 2009). Karlsruhe, Bundesverfassungsgericht (http://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/DE/2009/bvg09-059.html, accessed 4 February 2016).

Ferré F (2016). Italy country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience.* Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Figueras J, Robinson R, Jakubowski E, eds. (2005). *Purchasing to improve health systems performance*. Maidenhead, Open University Press.

Foubister T et al. (2006). *Private medical insurance in the United Kingdom*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Foubister T, Richardson E (2016). United Kingdom country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience.* Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Franc C, Pierre A (2013). Generalization of private health insurance offered by employers. HSPM 15 April 2013. European Observatory on Health Systems and Policies (http://www.hspm.org/countries/france25062012/countrypage.aspx, accessed 4 February 2016).

Franc C, Pierre A (2015). Compulsory private complementary health insurance offered by employers in France: implications and current debate. *Health Policy*, 119(2):111–116.

Gauthier A, Lamphere J, Barrand N (1995). Risk selection in the health care market: a workshop overview. *Inquiry* 32(1):14–22.

Gerkens S (2016). Belgium country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Gerkens S, Merkur S (2010). Belgium: health system review. *Health Systems in Transition*, 12(5):1–266.

Government of Ireland (2011). Government for National Recovery 2011–2016. (https://www.corkchamber.ie/UserFiles/file/programme_for_national_government.pdf, accessed 4 February 2016).

Grabka M (2006). Prämien in der PKV: deutlich stärkerer Anstieg als in der gesetzlichen Krankenversicherung. *German Institute for Economic Research* 73(46):653–659.

HIA (2015). Newsletter, June 2015 edition. Dublin, Health Insurance Authority (http://www.hia.ie/sites/default/files/HIA_June_Newsletter_2015.pdf, accessed 3 December 2015).

HM Treasury (2001). Consumers and industry to benefit from changes to banking, mortgage and general insurance regime. Press release, 12 December 2001. London, HM Treasury (http://www.wired-gov.net/wg/wg-news-1.nsf/54e6de9e0c383719802572b9005141ed/2e00dfa43ee3d9ac802572ab004b4e42?OpenDocument, accessed 3 December 2015).

Insurance Europe (2012). Indirect taxation on insurance contracts in Europe. Brussels, Insurance Europe (http://www.insuranceeurope.eu/sites/default/files/attachments/Indirect%20Taxation%20Booklet%202015.pdf, accessed 4 February 2016).

Insurance Europe (2015). Statistics no. 50: European Insurance in Figures (dataset). Brussels, Insurance Europe (http://www.insuranceeurope.eu/statistics-n°50-european-insurance-figures-dataset, accessed 3 December 2015).

IRDES (2010). Enquête sur la santé et la protection sociale 2008. Rapport n° 547 (biblio n° 1800) - Juin 2010 (http://www.irdes.fr/Publications/Rapports2010/rap1800.pdf, accessed 4 February 2016).

King D, Mossialos E (2005). The determinants of private medical insurance prevalence in England, 1997–2000. *Health Services Research*, 40(1):195–212.

Kroneman M (2014). Role of collectives in the Dutch health insurance market. Health Systems and Policy Monitor, 10 April 2014 (http://www.hspm.org/countries/netherlands25062012/countrypage.aspx, accessed 3 December 2015).

Leinert J (2006). Morbidität als Selektionskriterium. Fairer Wettbewerb oder Risikoselektion? In: Jacobs L, Klauber J, Leinert J, eds. *Analysen zur Gesetzlichen und Privaten Krankenversicherung*. Bonn, Wissenschaftliches Institut der AOK:67–76.

Lekhan V, Rudiy V, Richardson E (2010). Ukraine: health system review. *Health Systems in Transition*, 12(8):1–183.

Lončarek K (2016). Croatia country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Maarse H (2009). Private health insurance in the Netherlands: a study for the European Commission. In: Thomson S, Mossialos E, eds. *Private health insurance in the European Union*. Brussels, European Observatory on Health Systems and Policies.

Maarse H (2016). The Netherlands country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

McDaid D et al. (2009). Ireland: Health system review. *Health Systems in Transition*, 11(4):1–268.

Mercer (2014). Flash info. Sante/prevoyance. Paris, Mercer (http://www.mercer.fr/content/dam/mercer/attachments/europe/France/2014_12_HB_FlashInfoVUK.pdf, accessed 3 December 2015).

Milenkovic Kramer A (2009). Private health insurance in Slovenia: a study for the European Commission. In: Thomson S, Mossialos, E. *Private health insurance in the European Union*. Brussels, European Observatory on Health Systems and Policies.

Milenkovic Kramer A (2016). Slovenia country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Mossialos E, Thomson S (2002a). Voluntary health insurance in the European Union: a critical assessment. *International Journal of Health Services*, 32(1):19–88.

Mossialos E, Thomson S (2002b). *Voluntary health insurance in the European Union*. Report prepared for the Directorate General for Employment and Social Affairs of the European Commission. Brussels, European Commission.

Mossialos E, Thomson S (2004). *Voluntary health insurance in the European Union*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies.

Mossialos E, et al., eds. (2002). *Funding Health Care: Options for Europe*. Maidenhead, Open University Press:99–126.

Mossialos E, et al., eds. (2010). *Health Systems Governance in Europe: the Role of European Union Law and Policy*. Copenhagen, World Health Organization on behalf of the European Observatory on Health Systems and Policies.

OECD (2004). *Private health insurance in OECD countries*. Paris, OECD.

OECD (2015a). OECD iLibrary [online database]. Expenditure on health by type of financing, 2013 (or nearest year). Paris, OECD (http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2015/expenditure-on-health-by-type-of-financing-2013-or-nearest-year_health_glance-2015-graph156-en /, accessed 3 December 2015).

OECD (2015b). OECD iLibrary [online database]. Data extracted on 13 Feb 2015. Paris, OECD (http://stats.oecd.org/Index.aspx?DataSetCode=SHA#, accessed 4 February 2016).

OFT (1996). Health insurance: a report by the Office of Fair Trading. London, Office of Fair Trading.

OFT (1997). Consumer detriment under conditions of imperfect information. London, Office of Fair Trading (http://webarchive.nationalarchives.gov.uk/20140402142426/http:www.oft.gov.uk/shared_oft/reports/consumer_protection/oft194.pdf, accessed 4 February 2016).

OFT (1998). Health insurance: a second report by the Office of Fair Trading. London, Office of Fair Trading.

OFT (2000). Consumer detriment. London, HMSO.

Paccagnella O, Rebba V, Weber G (2008). *Voluntary private health care insurance among the over 50s in Europe: a comparative analysis of SHARE data*. Department of Economics and Management 'Marco Fanno', Working Paper 86. Padova, Università degli Studi di Padova.

Palm W (2009). Private health insurance in Belgium: a study for the European Commission. In: Thomson S, Mossialos E, eds. *Private health insurance in the European Union.* Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities. Brussels, European Commission.

Pazitny P, Balik P (2016). Slovakia country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Perronnin M, Pierre A, Rochereau T (2011). La complémentaire santé en France en 2008: une large diffusion mais des inégalités d'accès. Paris, IRDES (http://www.irdes.fr/Publications/2011/Qes161.pdf, accessed 3 December 2015).

Roos A-F, Schut F (2011). Spillover effects of supplementary on basic health insurance: evidence from the Netherlands. *European Journal of Health Economics*, 13(1):51–62.

Rukhaze N, Goginashvili K (2011). Distribution of health payments and catastrophic expenditures in Georgia: analysis for 2006–2010 (annual level data). Tbilisi, Ministry of Labour, Health and Social Affairs.

Sagan A, Thomson S, eds. (2016). *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Schäfer W et al. (2010). The Netherlands: Health System Review, *Health Systems in Transition*, 12(1):1–228.

Senior K (2015). What does a moratorium on private medical insurance mean? *Netdoctor*, 16 December 2013 (http://www.netdoctor.co.uk/private-healthcare/what-does-a-moratorium-on-private-medical-insurance-mean.htm#ixzz3Xwbf6ehy, accessed 3 December 2015).

Smith O (2013). Georgia's Medical Insurance Program for the Poor. Washington, DC, World Bank.

Sobczak A (2016). Poland country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience.* Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Sorenson C, Drummond M, Kanavos P (2008). *Ensuring value for money in health care: the role of health technology assessment in the European Union*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Stevens Y et al. (1998). Issues in complementary health insurance in Belgium. *International Social Security Review*, 51(4):71–91.

Szigeti S, Lindeisz F, Gaál P (2016). Hungary country profile. In Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience.* Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies

Thomson S (2010). What role for voluntary health insurance? In: Kutzin J, Cashin C, Jakab M, eds. *Implementing health financing reform: lessons from countries in transition*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Policies and Systems.

Thomson S, Mossialos E (2006). Choice of public or private health insurance: learning from the experience of Germany and the Netherlands. *Journal of European Social Policy*, 16(4):315–327.

Thomson S, Mossialos E (2009). *Private health insurance in the European Union*. Final report prepared for the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities. Brussels, European Commission.

Thomson S, Mossialos E (2010). Private health insurance and the internal market. In: Mossialos E et al., eds. *Health Systems Governance in Europe: the Role of EU Law and Policy*. Cambridge, Cambridge University Press:419–460.

Transparency International Georgia (2012). The Georgian health insurance industry. Tbilisi, Transparency International Georgia with the support of the Embassy of the Kingdom of the Netherlands (http://www.transparency.ge/sites/default/files/post_attachments/The%20Georgian%20Health%20Insurance%20Industry.pdf, accessed 3 December 2015).

Turner B (2015). Unwinding the State subsidization of private health insurance in Ireland. *Health Policy*, 119(10):1349–1357.

Turner B (2016). Ireland country profile. In: Sagan A, Thomson S, eds. *Voluntary health insurance in Europe: country experience*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

Vektis (2015). Verzekerden in beeld 2015 [The insured in 2015]. Zorgthermometer. *Vektis*, April 2015 (http://www.vektis.nl/downloads/Publicaties/2015/Zorgthermometer%20nr14/, accessed 3 December 2015).

Wasem J (1995). Regulating private health insurance markets. Four country conference on health care reforms and health care policies in the United States, Canada, Germany and the Netherlands, Amsterdam, 23–25 February 1995. Amsterdam, Ministry of Health, Welfare and Sport.

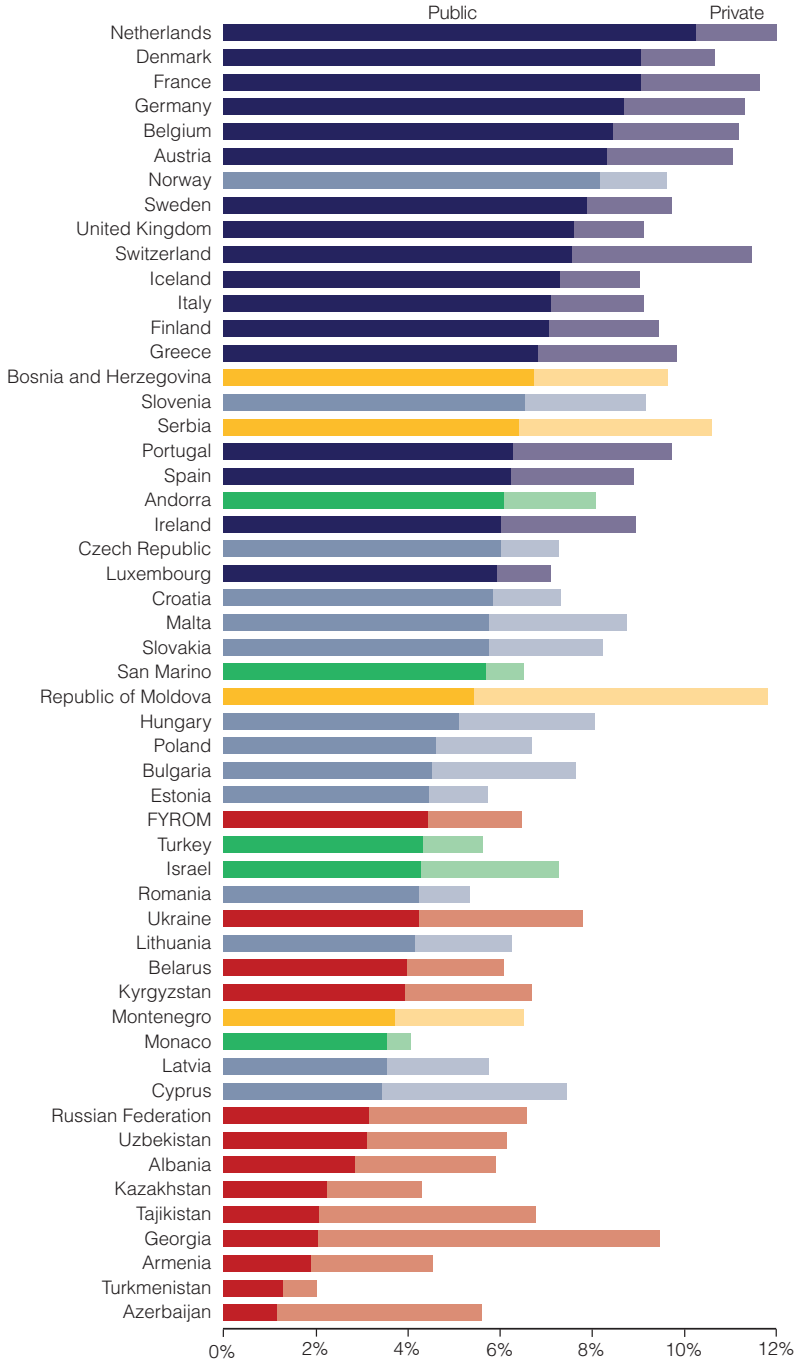
WHO (2016). Global health expenditure database (GHED) [online database]. Geneva, WHO (http://www.who.int/health-accounts/ghed/en/, accessed 5 April 2016).

Zoidze A et al. (2012). Health insurance for poor: Georgia's path to universal coverage? Tbilisi, Curatio International Foundation.

Appendix A

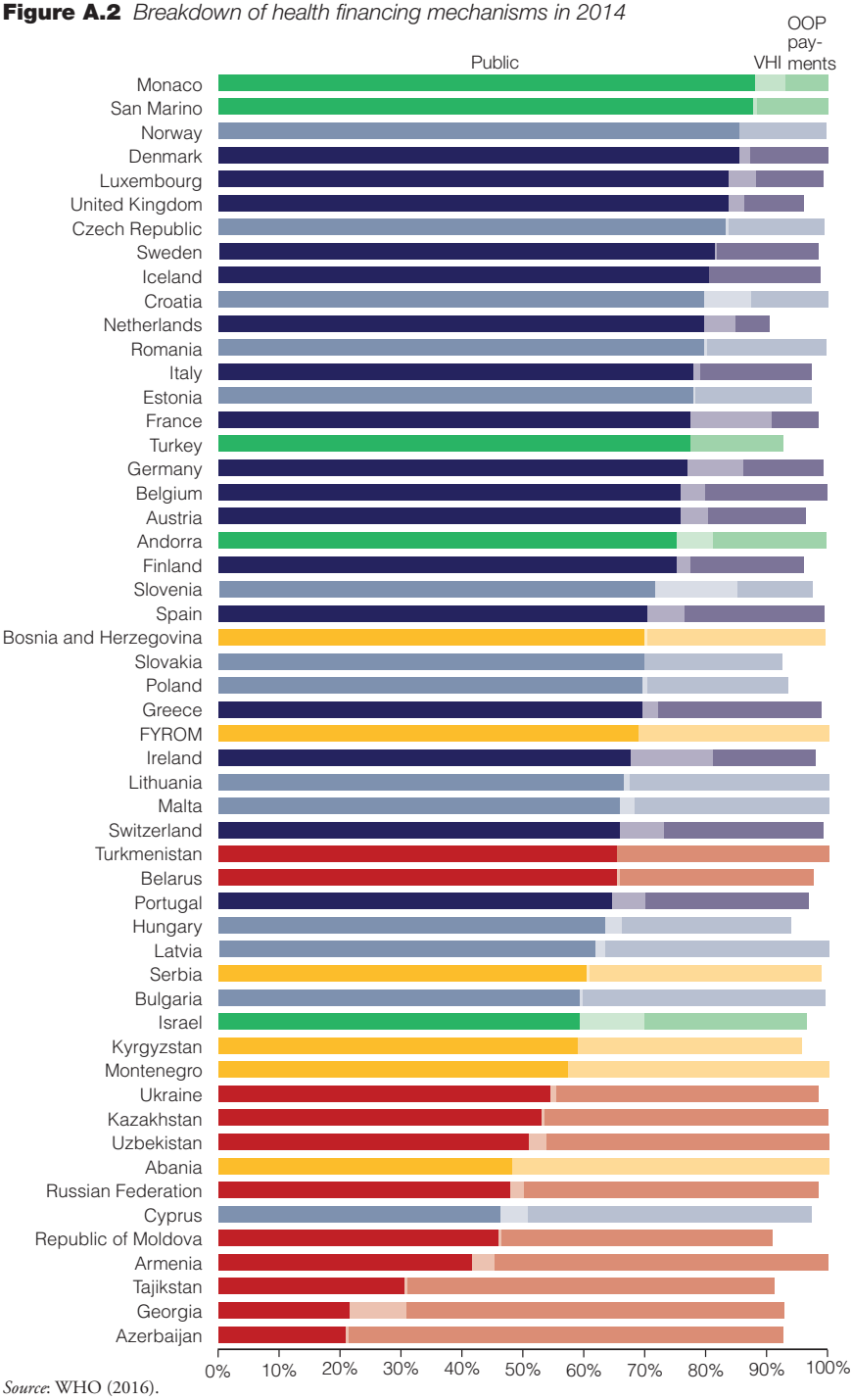
Data on health spending in the European Region

Figure A.1 *Public and private spending on health as a share (%) of GDP in 2014*



Source: WHO (2016).
Note: Countries ranked from high to low by public share.

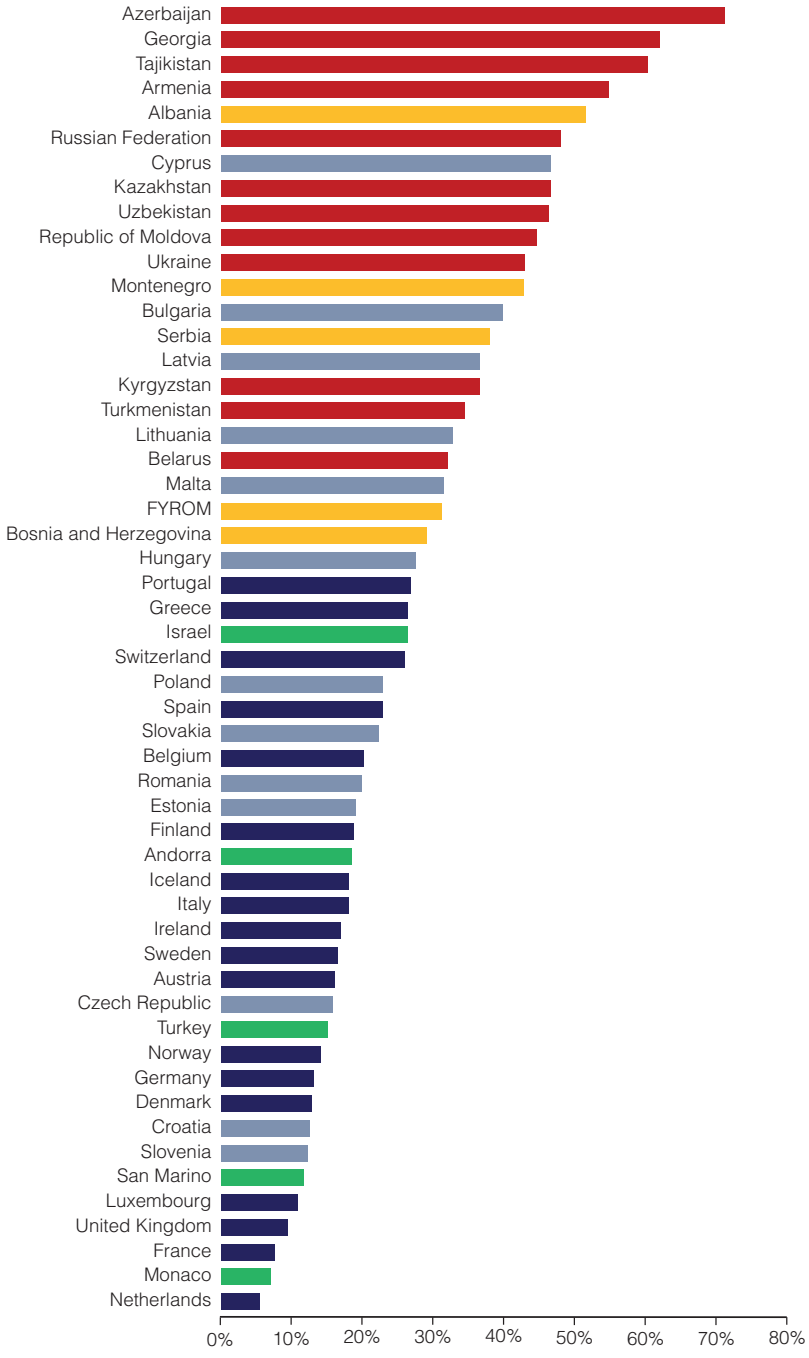
Figure A.2 *Breakdown of health financing mechanisms in 2014*



Source: WHO (2016).

Notes: *No data on VHI. Countries ranked from high to low by public share. Data on VHI share for Hungary includes voluntary medical savings accounts, which means that VHI's share of total spending on health in Hungary is overestimated (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending; OOP payments are therefore underestimated in national health accounts data for the Netherlands. See Appendix B for information on data availability and assumptions made.

Figure A.3 *OOP payments as a share (%) of total spending on health in 2014*



Source: WHO (2016).

Notes: Countries ranked from high to low by public share. Data on VHI share for Hungary includes voluntary medical savings accounts and OOP payments are therefore underestimated in the national health accounts data for Hungary (see Szigeti, Lindeisz & Gaál, 2016). The Netherlands does not include the compulsory deductible paid by all adults using health services (€375 per year in 2015) as OOP spending; OOP payments are therefore underestimated in national health accounts data for the Netherlands.

Appendix B

Information on the availability of data and on data assumptions made for figures based on WHO (2016)

Figure	Data availability and assumptions made
2.1 VHI as a share (%) of total spending on health in 2014	Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Kazakhstan, FYRM, the Republic of Moldova and Tajikistan the share of VHI in private spending on health was less than 0.5% and a mid-value (0.25%) was assumed for these countries and used to calculate the share of VHI in total spending on health. No data for Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.2 Countries in which VHI's share of total spending on health grew between 2000 and 2014 (% point change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland (2002), the Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, FYROM, Kazakhstan, Lithuania, the Republic of Moldova and Tajikistan the share of VHI in private spending on health was less than 0.5% (in 2000 or 2014) and a mid-value (0.25%)

Figure	Data availability and assumptions made
2.2 contd	was assumed for these countries and used to calculate the share of VHI in total spending on health. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.3 Growth in VHI spending per capita between 2000 and 2014 (% change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland (2002), Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Andorra (2013), Portugal (2012), Switzerland (2013), Tajikistan (2013). For Estonia, FYROM, San Marino and Tajikistan VHI spending per capita was less than 0.5 (in 2000 or 2014) and a mid-value (0.25) was assumed for these countries. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for Albania, FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.4 Countries in which VHI's share of total spending on health did not change or declined between 2000 and 2014 (% point change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland (2002), the Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, FYROM, Kazakhstan, Lithuania, the Republic of Moldova and Tajikistan the share of VHI in private expenditure on health was less than 0.5% (in 2000 or 2014) and a mid-value

Figure	Data availability and assumptions made
2.4 contd	(0.25%) was assumed for these countries and used to calculate the share of VHI in total spending on health. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.5 Decline in VHI spending per capita between 2000 and 2014 (% change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland (2002), Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Andorra (2013), Portugal (2012), Switzerland (2013), Tajikistan (2013). For Estonia, FYROM, San Marino and Tajikistan VHI spending per capita was less than 0.5 (in 2000 or 2014) and a mid-value (0.25) was assumed for these countries. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for Albania, FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.6 VHI as a share (%) of private spending on health in 2014	Data other than 2014 data used for: Albania (2009), Portugal (2012), Switzerland (2013), Tajikistan (2013). For FYROM, Kazakhstan, the Republic of Moldova and Tajikistan the share of VHI in private expenditure on health was less than 0.5% and a mid-value (0.25%) was assumed for these countries. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan).

Figure	Data availability and assumptions made
2.6 contd	No data for Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.7 Countries in which VHI's share of private spending on health grew between 2000 and 2014 (% point change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland 92002), the Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Albania (2009), Portugal (2012), Switzerland (2013), Tajikistan (2013). For Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, FYROM, Kazakhstan, Lithuania, the Republic of Moldova and Tajikistan the share of VHI in private spending on health (in 2000 or 2014) was less than 0.5% and a mid-value (0.25%) was assumed for these countries. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.8 Countries in which VHI's share of private spending on health did not change or declined between 2000 and 2014 (% point change)	Data other than 2000 data used for: Armenia (2001), Bosnia and Herzegovina (2009), Bulgaria (2001), Croatia (2001), Poland 92002), the Republic of Moldova (2002), Romania (2003), Serbia (2005), Slovakia (2007), Sweden (2001), Tajikistan (2007). Data other than 2014 data used for: Albania (2009), Portugal (2012), Switzerland (2013), Tajikistan (2013). For Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, FYROM, Kazakhstan, Lithuania, the Republic of Moldova and Tajikistan the share of VHI in private spending on health (in 2000 or 2014) was less than 0.5% and a mid-value (0.25%) was assumed for these countries. For the Czech Republic, Estonia and Uzbekistan VHI markets were non-existent in 2000 (VHI spending was zero). For these countries data from the earliest year with a positive value of

Figure	Data availability and assumptions made
2.8 contd	VHI spending was used (this was 2003 for the Czech Republic and 2004 for Estonia and Uzbekistan). No data for FYROM, Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.9 (and 3.1) Relationship between VHI and OOPs in the European Region in 2014	Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Kazakhstan, FYRM, the Republic of Moldova and Tajikistan the share of VHI in private spending on health was less than 0.5% and a mid-value (0.25%) was assumed for these countries and used to calculate the share of VHI in total spending on health. No data for Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
2.10 (and 3.2) Breakdown of private spending on health in 2014 (countries ranked from low to high by OOP share (%) of total spending)	Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Kazakhstan, FYRM, the Republic of Moldova and Tajikistan the share of VHI in private spending on health was less than 0.5% and a mid-value (0.25%) was assumed for these countries. No data for Kyrgyzstan, Montenegro, Norway, Turkey and Turkmenistan.
A2 Breakdown of health financing mechanisms in 2014	Data other than 2014 data used for: Albania (2010), Portugal (2012), Switzerland (2013) and Tajikistan (2013). For Kazakhstan, FYRM, the Republic of Moldova and Tajikistan the share of VHI in private spending on health was less than 0.5% and a mid-value (0.25%) was assumed for these countries and used to calculate the share of VHI in total spending on health.

Appendix C
Country codes

ALB	Albania
AND	Andorra
ARM	Armenia
AUT	Austria
AZE	Azerbaijan
BEL	Belgium
BGR	Bulgaria
BIH	Bosnia and Herzegovina
BLR	Belarus
CHE	Switzerland
CYP	Cyprus
CZE	Czech Republic
DEU	Germany
DNK	Denmark
ESP	Spain
EST	Estonia
FIN	Finland
FRA	France
GBR	Great Britain
GEO	Georgia
GRC	Greece
HRV	Croatia
HUN	Hungary
IRE	Ireland
ISL	Iceland
ISR	Israel
ITA	Italy
KAZ	Kazakhstan
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia

MCO	Monaco
MDA	Republic of Moldava
MKD	Former Yugoslav Republic of Macedonia
MLT	Malta
NLD	Netherlands
POL	Poland
PRT	Portugal
ROU	Romania
RUS	Russian Federation
SMR	San Marino
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
TJK	Tajikstan
UKR	Ukraine
UZB	Uzbekistan

If public resources were unlimited, there would be no gaps in health coverage and no real need for VHI. Most health systems face fiscal constraints, however, and VHI is often seen as a way to address these pressures. This study draws from the experiences of 34 countries to assess VHI's contribution to health spending and to understand its role in Europe and in relation to publicly financed coverage. It looks at who sells VHI, who buys it and why. It also reviews public policy on VHI at the national and EU levels and the related national policy debates.

The study shows that while different markets for VHI vary considerably in size, operation and regulation, the vast majority are small. Where there are substantial markets, these tend to be the oldest ones, having a tradition of non-profit insurers, and to be the most heavily regulated to ensure VHI policies are accessible and affordable. The study also suggests that VHI is normally a better way of meeting population health needs than out-of-pocket payments and medical savings accounts. VHI can contribute to financial protection, especially where it plays a substitutive and complementary role covering co-payments. However, it is a complex, challenging and highly context-specific policy instrument that may undermine other health system goals, including equitable access, efficiency, transparency and accountability, even where markets are well regulated. Policy-makers should therefore exercise real caution before expanding VHI.

This volume and its companion set of country profiles were developed jointly by the Observatory's LSE hub and the WHO Regional Office for Europe. The study draws on contributions from national experts from the EU, EFTA and other countries in Europe.

The authors

Anna Sagan, Research Fellow at the European Observatory on Health Systems and Policies, London School of Economics and Political Science

Sarah Thomson, Senior Health Financing Specialist at the WHO Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health, WHO Regional Office for Europe and Senior Research Associate at the European Observatory on Health Systems and Policies

Observatory Studies Series No. 43

www.healthobservatory.eu

European Observatory on Health Systems and Policies

a partnership hosted by WHO

ISBN 9289050388