What role for voluntary health insurance?

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Outline

- what role for VHI?
- complementary VHI covering user charges
- complementary VHI covering excluded services
- what can we learn from the experience of other countries?
Health financing policy goals

- promote protection against financial risk
- distribute the burden of funding the system relative to individual capacity to contribute
- distribute health services (by distributing system resources) in relation to need
- promote efficiency (in organisation, service delivery, administrative arrangements)
- promote quality
- be transparent, understandable, accountable

Source: WHO/Kutzin 2008
http://www.euro.who.int/__data/assets/pdf_file/0004/78871/E91422.pdf
Can we lower public spending and improve efficiency?

- the question should be: how can we ensure a good return from public expenditure (growth)?

- it is difficult to increase out of pocket payments (OOP) without undermining policy goals

- could VHI help to relieve fiscal pressure and contribute to policy goals?
## What role for VHI?

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<th>Market driver</th>
<th>VHI role</th>
<th>VHI covers</th>
<th>Examples</th>
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<td>coverage breadth</td>
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<td>groups excluded or opting out</td>
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<td>coverage scope</td>
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<td>Canada, NL, Hungary</td>
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<td>complementary (user charges)</td>
<td>statutory user charges</td>
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<td>Ireland, Poland, UK</td>
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Gaps in statutory coverage create space for VHI – but are not sufficient for market development.
Large VHI markets globally

countries in which VHI = >10% of total health spending, 2009

are few and far between…
% population covered by VHI in the EU (2008)

Mainly complementary cover of user charges

Source: Thomson and Mossialos 2009
A role for complementary VHI covering user charges?

Requirements

- statutory user charges: unavoidable, unpredictable, expensive
- regulation for affordable access to VHI
- careful design to avoid undermining value in public spending

Risks

- inadequate financial protection
- equity concerns
- Efficiency concerns
- labour market costs?
- EU legal challenges

As in substitutive markets: regulation has intensified over time
VHI in France

- % health care costs publicly financed: 80% in 1980, 75.5% in 2009
- VHI market dominated by non-profit insurers
- 2000: government vouchers for low-income people to buy VHI (CMU-C)
- 2005: tax subsidies for people just above the CMU-C threshold (ACS)
- still 4 million people without VHI (financial barriers most common reason for not having VHI)
- the quality of VHI coverage has declined
- concerns for financial protection
VHI in France

- regressive VHI premiums: 3% of income for the richest quintile, 10% of income for the poorest quintile
- income-related inequality in likelihood of having VHI (97% in richest quintile vs 65% in the poorest quintile) and quality of VHI coverage
- variation in health care use and foregone care by VHI status
- concerns for equity
Variation in health status by VHI status, France (2008)

Source: Perronin et al 2011
### Variation in use of health care by VHI status, France (2008)

<table>
<thead>
<tr>
<th>Service</th>
<th>VHI</th>
<th>CMU-C VHI</th>
<th>No VHI</th>
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<tr>
<td>% visiting a GP or specialist or foregoing care in the last 12 months</td>
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<tr>
<td>% visiting a dentist in the last 24 months</td>
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</table>

Source: Perronin et al 2011
VHI in France

- User charges are a blunt tool, reducing necessary & unnecessary use in equal measure.
- France has (some) value-based user charges intended to steer patients towards ‘high-value’ care and away from ‘low-value’ care.
- Examples: lower user charges for more effective drugs, referral to specialists, following care protocols.
- VHI undermines this policy tool.
- High transaction costs of tax subsidies for poor.
- Concerns for efficiency.
Lessons from France

- Avoid creating financial barriers to high-value care (especially for poor and regular users)
- Align incentives: protect value-based user charges from VHI
- Plan regulation to secure access to VHI: who will supply VHI? what rules are needed? tax subsidies for the poor?
Regulation of VHI in the EU

Access to VHI

- Open enrolment & lifetime cover: BE, DE (basic substitutive policy only), IE, SI
- Prohibition of age limits: n/a

Affordability

- Community-rated premiums: BE & EE (non-profit), HU, IE, SI
- Risk equalisation to support community rating: IE, SI
- Tax-financed vouchers for VHI: FR (poor households)
- Premium caps: DE (basic substitutive policy only)

Quality of coverage

- Cover of pre-existing conditions: BE, IE
- Minimum or standard benefits: DE (basic substitutive policy only), IE
- Cost sharing caps: DE (basic substitutive policy only)
A role for complementary VHI covering excluded services?

Requirements
- clear exclusions
- technical capacity
- political will
- willingness to supply VHI
- high population uptake

Risks
- political opposition
- no market will develop
- concerns for financial protection, equity & efficiency
International experience

- **Canada** (outpatient prescriptions): 13.5% of total spending, 67% of population, 90% via employment (voluntary?), financial protection and equity concerns

- **Netherlands** (dental, physio): 5.1% of total spending, 91% of population, efficiency concerns

- **Hungary** (physio, sporting equipment): 2.1% of total spending, 6% of population, expensive tax subsidies, efficiency concerns
‘Catastrophic’ health spending: poor Estonians don’t spend on dental care

Source: Vörk et al 2009; data for 2007
If VHI is to contribute to health financing policy goals…

- there must be a **strategy** for the market
- strategy & policy design should ensure **complementarity** with statutory coverage & avoid cross-subsidies from public to private
- otherwise VHI will not relieve fiscal pressure & may undermine value in public spending
- the larger the market, the larger the **challenges** & the need for careful & dynamic **regulation**
- if VHI is not **accessible** & **affordable** to those who need it, it is of limited use to health policy makers