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Contents

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

Sarah Thomson and Elias Mossialos

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

VHI fulfils different roles in different contexts. In the EU context it can be classified according to whether its role, in relation to statutory health insurance (SHI), is substitutive, complementary or supplementary. Substitutive VHI provides cover that would otherwise be available from the state. It is purchased by those who are excluded from participating in some or all aspects of the SHI scheme – for example, Dutch residents with an annual income over €30,700 a year and their dependants (around a quarter of the population) – or by those can choose to opt out of that SHI scheme, such as German employees with annual earnings over €45,900 and their

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

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

* 1999, ** 1998, *** 1996

Source: Mossialos and Thomson (2004)[1]

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

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

Source: Mossialos and Thomson (2004)[1]

dependants (about 5% of the population). Complementary VHI provides cover for services excluded or not fully covered by the state, particularly cover for statutory user charges, as in Croatia, Denmark, France and Slovenia. Supplementary VHI p rovides cover for faster access and increased consumer choice and is available in most EU member states.

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

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

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

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

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

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

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

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

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

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

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

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

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

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Recent reforms affecting private health insurance in France

Dominique Polton

In addition to compulsory health insurance covering all legal residents, the market for private voluntary health insurance (VHI) is well developed in France. VHI mainly covers user charges that are not eligible for reimbursement by the public health insurance system: co-payments for ambulatory doctor visits, a per diem charge for accommodation in hospital and extra billing authorized for a small number of ambulatory doctors. It also covers the difference between actual prices charged and official reimbursement tariffs, which are particularly high for dental prostheses and spectacles, and may reimburse medical goods and ervices that are not on the public health insurance funds' positive reimbursement lists. Finally, it covers the cost of facilities such as a single room in hospital. In total, VHI accounts for 13% of current expenditure on health care, 18% of expenditure on drugs and 22% of expenditure on other goods (mainly dental prostheses and spectacles).

Since the introduction of Universal Health Coverage (CMU) in January 2000, the numbers covered by VHI have increased. In 2002 over 90% of the population had VHI coverage, compared to 85% in 1999.[1] 7% of the population obtained this coverage free of charge through CMU (that is, the government pays their premiums for them), which is available to people on low incomes – currently defined as those with monthly earnings below €570 for a single person or €1020 for a couple with a child. They can choose to obtain this coverage from their compulsory health insurance fund or from any voluntary health insurer.

CMU beneficiaries have access to a standard package for a fixed premium per person covered (around €230) paid to voluntary health insurers by the government. Non-CMU beneficiaries can choose from a wide range of policies and packages available for different premiums. The VHI market is shared by non-profit mutual insurance associations, commercial (for-profit) insurance companies and non-profit provident institutions (with market shares of 57%, 24% and 18% respectively). The mutual insurance associations own health facilities such as eye and dental centres, ambulatory care centres and even some small hospitals, but the insured are not obliged to use them. More than 50% of VHI policies are purchased through employers, who often pay a part of the premium as a fringe benefit. These group contracts tend to be more generous than contracts purchased on an individual basis.

Although the CMU reform has been viewed as potentially leading to important changes in the health system, these changes are actually limited. This is partly due to the fact that only 15% of CMU beneficiaries have chosen to obtain coverage from a voluntary health insurer – most CMU coverage is provided by compulsory health insurance funds – but also because the way in which CMU was designed left little room to voluntary health insurers. When the reform was being considered, some voluntary health insurers put forward a proposal that would allow them to select a network of providers and negotiate their own prices. However, the government rejected this proposal, so prices continue to be defined nationally (although some providers refuse to apply these prices) and the insured must be given access to all providers without any restriction.

Nevertheless, CMU has raised new debates about the role of VHI in France. First, the reform clearly acknowledges that compulsory health insurance has not been sufficient to guarantee fair access to

health care for poor people, particularly for dental and eye care, for which out-of-pocket payments are high. Second, it recognizes that VHI needs to be subsidized for those who cannot afford it. As a result, voluntary health insurers have gained new legitimacy in the health system.

These developments have led to further proposals for changing the organization and regulation of the health system. For example, a report commissioned by the Ministry of Health and published in April 2003[2] advocates the creation of 'general medical coverage', which would include public and voluntary health insurance, the latter subsidized for people up to a defined income level above the CMU ceiling. Public subsidies to purchase VHI are strongly supported by the mutual benefit movement, which is an important force in French political life. However, the just-published report of the High Council on the Future of National Health Insurance[3] does not support this recommendation.

The idea that VHI is of public interest has given rise to discussion about its role in the health system. Here, the views of the mutual insurance associations and the commercial insurers differ. The former propose managing the health system jointly with the compulsory health insurance funds, whereas the latter would rather separate the fields of competence and have full responsibility for specific areas such as dental and eye care. What is clearly emerging is the idea that voluntary health insurers should have access to medical information on claims in order to be better managers of care. So far, they have been passive buyers of health care.

It is worth noting that commercial insurers seem to have withdrawn from the debate. A few years ago some of them strongly supported the introduction of a competitive system of health insurance, along the lines of the Dekker-Simons reform in the Netherlands (that is, a system of competition between multiple health insurance funds). Their proposals were rejected by the government of the time and since then, they appear to be much less involved in policy debates.

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Recent developments in the Irish private health insurance market

Brian Turner

The Irish private health insurance (PHI) market remains dynamic, with continued expansion and a changing regulatory environment contributing to this dynamism. Ireland's PHI market consists of two 'open' insurers – Vhi Healthcare, a former state monopolist, and BUPA Ireland, a fast-growing branch of the British United Provident Association, which entered the market in 1996 – along with a number of smaller, restricted membership undertakings. The latter are mainly occupational schemes, such as those for prison officers or the police force.

PHI provides supplementary benefits, generally covering inpatient or day-care treatment in hospital and hospital accommodation. Most consumers opt for plans that cover at least a private room in a public hospital or a semi-private room in a private hospital; 20% of the 12,000 or so beds in public hospitals are designated private, and these account for about half of the private beds in the country, the other half being in private hospitals. There is an element of outpatient cover in most hospital-based plans but it is generally limited, while a small number of plans provide more comprehensive outpatient cover.

The market is characterized by community rating, open enrolment, lifetime cover (guaranteed renewal) and a prescribed set of minimum benefits that all hospital-based products must offer (for example, a semi-private room in a public hospital). These principles have helped to attract large numbers into the market. At the end of 2003 almost 2 million were covered by PHI in Ireland, nearly 3% more than at the end of 2002. This represents almost 50% of the population, despite universal access to the public health care system. In 1999 private health insurance covered about 1.5 million people (42% of the population).

Perhaps the greatest change in the market, however, has been in the regulatory environment. On 1 July 2003 new risk equalization regulations came into force (SI No. 261 of 2003). Risk equalization is a process that aims equitably to neutralize differences in insurers' costs due to variations in the health status of their members, by means of cash transfers from insurers with low risk profiles to insurers with high risk profiles. Under these regulations insurers covered by the scheme – both the open insurers and one restricted membership undertaking – are required to submit biannual returns to The Health Insurance Authority (the Authority), the independent statutory regulatory body for the industry, detailing claims by age and gender of their members.

If the market equalization percentage – the degree of difference between insurers' risk profiles – is less than 2%, the regulations specify that no risk equalization payments should be commenced. If it lies between 2% and 10%, then the Authority must make a recommendation to the Minister for Health and Children as to whether or not payments should be commenced. If it is above 10%, then the Minister is to sanction the commencement of payments unless, having consulted with the Authority, he determines that to do so would not be in the best overall interests of health insurance consumers. The Health Insurance Authority is currently examining the first set of returns from insurers and has calculated that the market equalization percentage is between 2% and 10%. The Authority will therefore make a recommendation to the Minister by the end of April, as prescribed by the regulations. Even if payments were recommended, the earliest possible commencement of such payments would be Spring 2005.

In 2002, BUPA Ireland made a complaint to the European Commission, claiming that risk equalization constituted state aid, as transfers were likely to take place from BUPA Ireland to Vhi Healthcare and the latter is owned by the state. The Commission investigated this and in 2003 determined that transfers under the equalization scheme do not constitute state aid, but BUPA Ireland is currently challenging this determination in the European Court of First Instance.

In addition, the Department of Health and Children has indicated its intention to change the legal status of Vhi Healthcare, which until now, has been exempt from certain other insurance legislation. The current status of the insurer, the largest competitor in the market, has been cited as a barrier to entry by various industry sources and commentators.

The Authority has also made a submission to the Department of Health and Children about the proposed move to lifetime community rating, which would allow late entry loadings to be charged for people who wait until older age before taking out PHI, and has held a consultation process on proposed changes to the minimum benefit regulations. These changes are not expected in the short term.

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Private health insurance in Italy: Where we stand now

Vincenzo Atella and Federico Spandonaro

About 10% of the Italian population is covered by private health insurance (PHI). This is well below levels of private coverage recorded in many other EU countries, despite the fact that Italian household spending on health care now accounts for close to 30% of total expenditure on health care, giving Italy one of the highest levels of out-of-pocket payments among industrialized countries.

Historically, there are two main reasons why the PHI market has not expanded in Italy, even in the face of high levels of household spending on health care: the universal coverage provided by the public system and the absence of financial incentives to purchase PHI. Since 1978 the Italian health care system has been organized as a National Health Service (NHS) with the dual goal of promoting social justice by guaranteeing universal access to comprehensive care and improving expenditure control. The NHS replaced a mutual benefit system that had accumulated considerable debts over time and was therefore considered to be obsolete on equity and financial grounds. For this reason, Italian policy makers have shaped the NHS in a way that prohibits the funding of PHI from public resources and the possibility of opting out of the NHS. Two proposals put forward in the early 1990s failed to modify this position. The first tried to promote a referendum on abolishing the compulsory nature of the public system, but was rejected by the Constitutional Court because the Italian Constitution does not permit this particular question to be settled by referendum. A second attempt, originating from the Association of Italian Manufacturing Firms (Confindustria), was a proposal to permit people to pay a solidarity contribution to the NHS and then to opt out of the public system. These proposals are no longer officially on the policy agenda, nor does the current government have an official position of this issue.

As in many other industrialized countries, private spending on health care in Italy is predicted to increase in future due to changing needs – determined by

Forthcoming publication

Voluntary health insurance in the European Union

Elias Mossialos and Sarah Thomson

This study provides an overview of markets for private or voluntary health insurance in the European Union. It examines the role voluntary health insurance plays in different EU member states, in addition to covering issues such as the determinants of demand for voluntary health insurance; the structure, conduct and performance of national markets; access, equity and consumer protection in these markets; the impact of voluntary health insurance on the free movement of people and services across the European Union; and recent trends and challenges for voluntary health insurers and policy makers at national and EU levels.

Part of the Observatory's new Occasional Publications, the book is due to be published in May 2004.

socioeconomic developments and demographic ageing – and to rising public deficits, which often result in higher levels of co-payments. Issues of financial sustainability and equitable access to health care now pose serious problems for policy makers. Consequently, in recent years the policy debate has turned towards the idea of developing complementary PHI.

Since 1999, Law 229/1999 has provided the main framework for regulating the scope and conditions of complementary PHI covering co-payments. The law also introduced a higher level of tax deductibility for premiums paid to insurers that accept two strict limits on their activity: first, they cannot screen applications or adopt risk-adjusted premiums and second, they can only provide a limited number of health services in addition to those already covered by the NHS. This last limit is probably the most relevant, given that the additional coverage can only include complementary or alternative medicines, some thermal and dental services, the reimbursement of fees paid to access health services provided by NHS doctors working in a self-employed context (*intra-moenia*), more comfortable accommodation in hospital and the reimbursement of co-payments. Furthermore, policy holders can only use health facilities that have been accredited by the NHS, which creates organizational rigidities and barriers to entry for some private providers.

At present, the PHI market offers individual and group policies. The former mainly cover the payment of a daily cash allowance during absence from work due to ill health and are typically purchased by wealthier, self-employed people. Group policies offer supplementary coverage and are purchased by executives or high-earning employees in order to gain access to services with more comfort, typically single rooms in private hospital or faster access to specialist examinations. However, in spite of the existence of significant potential demand for complementary coverage and more generous tax subsidies to encourage uptake, private health insurers have found it difficult to develop the market for complementary PHI policies. This is mainly due to the absence of legislation providing rules for implementation (*norme attuative*).

Another major issue relates to the regional re-organization of the Italian state. Potentially, the NHS can offer different coverage on a territorial basis. Consequently, private health insurers will face the problem of providing different coverage to people living in different regions, even though the insurers themselves are organized on a national basis. Moreover, fiscal benefits might be unevenly distributed across the country, favouring richer regions with a less fragmented occupational structure that are able to establish corporate cover. Finally, as co-payments will be reimbursed by private health insurers, they will no longer serve the purpose of controlling consumption, which will lead to increases in NHS expenditure.

Whether and how these problems will be solved is still a matter of discussion at both the technical (policy) level and the political level. In the meantime, private health insurers have not been able to offer complementary policies due to the absence of clear legislative implementation rules and insufficient incentives to compensate for the duplication of administrative costs.

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Dutch go private in health insurance reform

Hans Maarse and Kieke Okma

Recently, the Dutch government announced proposals for reform which would privatize health insurance from 2006.[1] The whole population will be covered through a universal private scheme implemented by private health insurers who will be allowed to operate on a for-profit basis. A set of public constraints will be introduced to ensure the new scheme's social character (see below). The government's decision is a key step in the political debate on the principal direction of health insurance reform that aims to provide a level playing field for public and private health insurers based on competition and reduced government intervention.

There have always been conflicting views on the compatibility of such a scheme with the EC *Third Non-Life Insurance Directive* issued in the mid-1990s. The directive promotes a single European market in all types of non-life insurance and prohibits EU member states from enacting legislation that distorts competition. However, article 54 of the directive does present member states with the possibility of intervening in the interest of the general good. The question remains: how much leeway does article 54 give member states to intervene in a market for health insurance?

This is a fundamental question given that the Dutch government considers intervention to be necessary to protect the social character of health insurance in the Netherlands. For example, health insurers will be obliged to accept all applicants (open enrolment). The standard package of benefits will be set by government, leaving no room for health insurers to offer a range of packages as a competitive tool. Health insurers will be able to set their own premium rates, although they will not be allowed to vary these rates on the basis of age, gender, health status or other risk factors (community rating). However, they may offer the option of a

higher deductible than the government-set minimum deductible in exchange for lower premium rates. The government also intends to introduce an equalization fund to avoid unfair competition due to differences in the risk profiles of individual insurers. Finally, health insurers will be able to offer their insured the choice between benefits-in-kind and cost reimbursement. In specific cases, however, the government wants to retain the ability to impose a benefits-in-kind system. It sees these public constraints as a minimum and considers that further constraints may be conceivable in the future.

In order to overcome uncertainty about the limits of article 54, the Minister of Health has asked the European Commission for its opinion on the proposed model of compulsory private health insurance subject to public constraints. In his reply to the Minister, the Dutch Commissioner, Frits Bolkestein, confirmed EU member states' right to adopt specific legal provisions aimed at protecting the general good, provided that these public constraints are proportional, objectively necessary and do not discriminate against insurance undertakings from other member states.[2] He pointed to the need to assess the establishment of a risk equalization scheme under the provisions of the EU Treaty concerning state aid. Furthermore, he hinted that the adoption of a benefits-in-kind system might be an important barrier to non-Dutch insurers.

The proposal for reforming health insurance in the Netherlands demonstrates that health policy making is no longer a purely sovereign activity. Although the EU Treaty recognizes member states' formal competence to establish a social security system as they see fit, legislation should respect the principles of free trade that the treaty sets out. In other words, member states' autonomy in health policy making has declined. Moving towards a private health insurance scheme with public constraints entails a policy risk. In the end, it is the European Court of Justice – not the European Commission – that will decide if the Dutch proposals are compatible with the *Third Non-Life Insurance Directive*. The Commission can only give its formal opinion, and until now has rarely done so.

It remains to be seen how the Ministry of Health will frame the public constraints in the new legislation. For example, open enrolment can be worded in different ways: will insurers be able to impose a waiting period, and if so, under what conditions? Furthermore, the framing of public constraints is not only a matter for government. In general, social policy in the Netherlands is not a top-down process; many well-organized stakeholders also play a role. In the past, stakeholder opposition has been proven to be effective in blocking or thwarting policy intentions and implementation. In this case, pressure from health insurers is likely to restrict the setting of public constraints. Another important question is whether health insurance reform will be effective. Until now, the media, academics, pressure groups and policy makers have paid little attention to the dynamics of a private health insurance market in the longer term. By handing over decision-making power and financial risks to the market, the government has started a process that may be difficult to control in future. This is the real political risk.

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