THE PRIVATE HEALTH INSURANCE MARKET IN THE EUROPEAN UNION

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Abstract: Private health insurance serves three distinct functions in western European health systems. The first is as an alternative for mandatory (statutory) social health insurance arrangements. The second function is to supplement statutory insurance, providing coverage for services not covered by social insurance. A third function of private health insurance is to provide what can be termed complementary coverage, in which insured persons purchase additional private insurance even while they have to participate in existing social schemes.

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Key words: private health insurance, statutory health insurance, substitutive health insurance, complementary health insurance, supplementary health insurance.

1. INTRODUCTION

There is a major contradiction between the goal of improving health and the reality in most European health systems. If this is to change what must happen? Perhaps the most important thing, that is often overlooked, is that health policy makers must take account of the changing nature of disease and the responses to it.

The systems introduced in this region since 1990 imply that health care involves only brief, clearly defined interactions between individual patients and providers. Yet a combination of aging populations and new therapeutic opportunities mean that an increasingly large volume of health care will be for chronic disorders, requiring co-ordinated interventions by different professionals and specialists over a prolonged period of time. But many of the detailed reforms of health services, such as the introduction of Diagnosis Related Groups, go in the opposite direction, seeking to package health care into isolated, homogenous interventions.

This paper sets out a series of functions that are required if the impact of health care on health is to be optimised. Unfortunately, many of the reforms introduced so far have done little to address previous and present issues. Of course the situation in western Europe, and mainly the one in Eastern Europe, is far from ideal, with many health care systems failing to address health needs equitably or to optimise use of resources.

The question remains wheather Romania is able to assess the benefits, learn from mistakes and find a way to become a player on this market, thus improving healthcare thoroughout the nation.

2. THE EUROPEAN HEALTH INSURANCE MARKET

Private or voluntary health insurance 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. The exceptions to this trend are France, Germany and the Netherlands. Voluntary health insurance 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, is substitutive, complementary or supplementary. Substitutive voluntary health insurance provides cover that would otherwise be available from the state.

Complementary voluntary health insurance 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 voluntary health insurance provides cover for faster access and increased consumer choice and is available in most EU member states. Voluntary health insurance 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 voluntary health insurance 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 voluntary health insurance 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 private health insurance 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 mower 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 private health insurance markets are generally subject to a low level of regulation. In most non-substitutive voluntary health insurance 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. Elsewhere insurers are permitted to reject applications for cover, exclude or charge higher premiums for pre-existing conditions, rate premiums according to risk, provide nonstandardized 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 voluntary health insurance 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.

Governments intervene more heavily in markets for substitutive voluntary health insurance 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 statutory health insurance scheme, which covers a disproportionate amount of older people in both countries.

Changes in regulation to prevent further destabilization of statutory health insurance 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 voluntary health insurance. For this reason insurers in both countries are required to provid e 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 voluntary health insurance cover. In the Netherlands younger people with substitutive voluntary health insurance are required to cross - subsidize the premiums of older people and all policy holders must make an annual contribution to the statutory health insurance scheme. Complementary voluntary health insurance 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 voluntary health insurance.

Complementary voluntary health insurance is most prevalent in France, where it covered 85% of the population in 1998. Research shows that the likelihood of being covered by complementary voluntary health insurance is highly dependent on social class, income levels, employment status, level of employment and age. Furthermore, the quality of coverage provided by complementary voluntary health insurance increases significantly with income. In order to address the inequalities in access to health care arising from unequal access to complementary voluntary health insurance, the French government introduced a law on universal health coverage in 2000, extending free complementary voluntary health insurance coverage to people earning less than €550 per month.

Supplementary private health insurance 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 health insurance 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 voluntary health insurance 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 private health insurance can reduce access for publicly funded patients and are taking steps to clarify the boundaries between public and private provision of health care.

Voluntary health insurance tends to incur higher management and administrative costs than statutory health insurance, 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. 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 voluntary health insurance markets in the EU since 1994. In Ireland higher levels of advertising following liberalization have actually increased transaction costs. Overall, private health insurance requires careful regulation to ensure access to health care, guarantee consumer protection and stimulate efficiency gains. The existence of voluntary health insurance 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, voluntary health insurance may distort the allocation of public resources for health care, to the detriment of those who are insured by statutory health insurance.

3. THE NEED FOR REFORM IN THE ROMANIAN HEALTH SECTOR

Romania's health insurance market is stuttering into life, but is restricted by the financial crisis, a lack of comprehensive private medical providers and an absence of long-term Government policy. On the whole, health insurance is a product purchased by companies for their employees as an extra incentive - it is a professional, middle-management and middle-class product. Rich people do not need an insurance policy, because they can pay private medical providers cash up-front. But in 2009 companies looking to cut back on expenses made health insurance a casualty, thus the system has been blocked while many individuals could not afford to pay for comprehensive health insurance from their own pocket.

Healthcare in Romania suffers from a massive budget shortfall. There are fewer than five million contributors and more than 20 million beneficiaries. There is a poor quality state service, which is plagued by bribes between patients and medical staff. Many have fought for health insurance to be fully deductible from all the social taxes. The hope is that a minority who take out health insurance for private care will lift the burden on the state system. Although this will mean less cash to the state, the capitalist argument is that the private system can use the money in a more efficient way. At present health coverage is only deductible from the profit tax of a company and few companies are making a profit.

Overall reform is needed in the health market. Therapeutic guidelines are not followed. Health costs are rising and the income from taxes is low. The state system is not well-managed and there is little competition.

Private health insurance is yet to grow in Romania, due in part to the Government's delay in deciding its minimum package of free healthcare services. The sector is worth less than 0.5 per cent of the country's total insurance market, a small figure of only ten million Euro.

The first major drawback, is the Government's failure to define a minimum package of medical services covered by the state. At present Romania's national health service is, on paper, free at the point of access. It is funded by five million of Romania's wage-earners, who pay a national health insurance contribution to the National House of Health Insurance (CNAS). There are moves in the Ministry of Health, however, to calculate a minimum package of free services for citizens, with any additional services requiring a charge. However this would mean an ideological shift in the credo of universal

health service in Romania, especially if paid-for services included operations which blighted the poorest and most vulnerable members of Romanian society.

Nevertheless such a definition would bring some clarity to a public system which is, at best, disorganised and, at worst, corrupt. It may help in decreasing the amount of informal payments or bribes which patients 'unofficially' pay doctors and medical staff for services, particularly in hospitals. It would also allow private insurance companies to know exactly which additional services they can provide.

It has been argued that there is a reality gap between the funding base of the health service and the needs of the population. The current public healthcare package, on paper, covers all forms of sickness. This puts huge pressure on a sum of money collected from only five million taxpayers with an average monthly salary of around 400 Euro, on a system which caters for 22 million people.

The government is reluctant to define this minimum package because it would have to inform its electorate that the money they contribute to the state for health insurance covers very few services. To make this assessment, the Ministry of Health must assess the precise cost for every medical service. This is also difficult to calculate because costs constantly shift in price.

It is believed that a model that could work in Romania is the Netherlands model, if both employer and employee pay a percentage to a centralised National House of Health Insurance, from which a part is redirected to the private sector and the remainder to the basic package for every individual. This would be a similar scheme to Romania's private pension market which, in 2006, became obligatory for people under 35 years of age.

The main reason Romania's private health insurance market is behind Poland, Germany and Austria is the slow reform in both medical infrastructure and allowing fiscal deductabilities or incentives to attract foreign investors. Investments needed in health are very large and an investor will put 10,000s Euro in a private hospital only if he has the certainty of a continuous flow of clients, in order to turn a profit.

The second major problem in the private health insurance market is an insufficient number of medical providers which can offer sophisticated services at a certain quality level. Private health insurance products are dependent on the quality of their network of suppliers, a consistency of which is still lacking in Romania.

But are Romanians willing to pay for private health insurance? One example of a private system successfully taken up by the Romanian people is in private pensions. In 2006, the Government enforced private pensions upon everyone under 35. It asked all its younger citizens to choose a private provider of pensions or they would risk being allocated one randomly. This worked, but only because the state compelled the behavioural change upon the people.

At present Romanians pay twice for medical services. Once through the 'official' public insurance payments as employees and again in informal payments to medics and hospital staff, especially for operations. This black market in medical care thrives in Romania. There is a chance that Romanians can gradually change their mentality and shift their priorities from paying such 'additional payments' for medical services to paying a prompt and fair amount up-front to insurance companies which will cover the risk.

Also there is a slight paradox in the industry since during this financial turbulence, the insurance business seems to be doing better because people's awareness of risk is higher. They are starting to secure their livelihood and avoid scenarios when they may suddenly need a lot of money. Because in Romania there are not enough providers of medical services, now is the best moment to launch a product that offers people the

possibility to be treated abroad, where they can benefit from high quality and services unavailable in Romania.

Part of Romania's reluctance to invest in private health insurance is also due to a lack of information on the subject. Health insurance has not been aggressively marketed to Romanians to the same extent as non-life products such as car and home insurance. Health insurance is not a luxury, but a commodity which does not enhance one's social status, such as a bigger plasma TV, and when all Romanians understand this, we will deal with a different market.

Now private health insurance packages are the only insurance product that benefit from fiscal deductibility from the state. If employers choose to give their employees a private health insurance package as a salary bonus, the business receives an annual deduction of 250 Euro per employee from taxes on their profit.

But providers of private health insurance believe there should be more incentives for individuals. Now very few choose to voluntarily invest in such products. However there is an appetite for private medical care. More than 40 per cent of the population used a private medical clinic between June 2008 and June 2009 and spent between 58 and 198 Euro on different medical services, such as medical examinations and, especially, for dental services.

Growth in the private health insurance market depends on the willingness of the corporate sector to buy these products. In this crisis period when many companies, although restructuring, want to retain their employees, they will want to offer these kind of benefits as an incentive.

Private health insurance can only expand if private medical providers invest and vice versa. What is needed is a Government 'road-map' on how healthcare will reform over five to ten years, agreed between all political parties, so investors can factor in the future. In general companies are not positive about growth in health insurance until there is a change in policy.

All in all under the current economic conditions and in the absence of a complete health reform, the health insurance market will most likely not register growth during the 2010-2011 period

4. CONCLUSIONS

Mechanisms in which funds are generated and allocated in European health systems are very complex and vary from country to country. Governments in all EU countries are involved in financing health care; most Member States use a combination of social contributions and direct government financing of health.

As for private insurance, they are a supplement rather than asubstitute for the primary health care system. Health systems are resource intensive, in the last 30 years recorded a continuous increase in the level of resources required, increase due mainly to: aging, drug discovery, more efficient and more advanced technologies, but also more costly, increasing number of people receiving healthcare.

Theoretically, financial support can be improved through a series of measures: limiting access to services, reduced service quality or increase the share of private funding (which, in turn, has consequences related to limiting access to services). But none of them is not desirable from a social perspective. From the perspective of social protection, the best way to improve financial support is to increase health system efficiency: efficiency concern herelowering costs while maintaining the same levels of quantity and quality, achieved by preventing overconsumption (which may be related to over-supply) of health

services and the allocation of sufficient resources for programs of prevention and health maintenance in order to reduce potential future expenses.

European Union does not require a role model in terms of funding health services or insurance system, leaving each Member State free to decide their own system. Without a successful and verified model, each country is forced to create their model without any major delays, threatening to cover mistakes made by other methods.

Aging population, high costs of new medical technology and increasing demands of growing population, in turn, demand for produce escalating health care costs over the ability of citizens to pay for them in particular through collective means that tax or social insurance. In these circumstances, European governments will not provide sufficient levels of care and will require additional methods of financing health services.

At present, Romanian reforms of health care are being implemented.They are intended to follow some principles as accessibility, universality, solidarity in funding health services, incentives for effectiveness and efficiency as well as providing service delivery linked to health care needs. But, little is known about what the people think about the reality covered by these principles. One of the major issues that should concern policymakers and service providers is the effect of reform on weaker population groups such as the poor, chronically ill and elderly. Having an impact on people's health status and with consequences readily visible to the affected publics the outcome of reforms of the Romanian health care system may be largely determined by the society's reaction.

In the literature, implementation is seen as the most crucial aspect of the policy process. It is also known that the outcomes of implementation efforts are highly variable (ranging from successful to unsuccessful). The range of outcomes results from the fact that implementation is an interactive and ongoing process of decision making by policy elites and managers in response to actual or anticipated reactions to reformist initiatives. Usually when reforms are implemented, there are some categories of people who are better off and some who are worse off than before. But involvement of the population in health care reforms may mean that changes are more easily accepted, therefore, there is a better chance that reforms are successfully implemented.

When co-payments will become common, it is essential that patients and doctors are willing to cooperate with it. If not, the utilization pattern may be changed and/or other ways of rescription/referral will be developed.

The Romanian health system reform is urgently needed in order to improve the health care financing system. Besides the public health insurance system that provides financing for a package of basic health services, while respecting the principles of solidarity and obligation of every citizen participation, a vital need for alternative options is needed through voluntary insurance, providing additional benefits in return of related premiums. This system is expected to influence current management practices of funds in hospitals and health insurance funds with the principles and values of the private system, contributing to good use the amounts collected.

REFERENCES

1. Bara AC, van den Heuvel WJA, Maarse JAM — Reforms of health care system in Romania. Croatian Medical Journal 2002
2. Saltman, R.B. Busse R., — Social health insurance systems in estern Europe, Berkshire, England 2004

Figueras J.
3. Zahorka M. Impact of economic transition on health care in Eastern Europe and the Newly Independent States, Bulletin of Medicus Mundi Switzerland No. 88, April 2003
4. * * * http://www.euro.who.int/document/e83126.pdf
5. * * * PMR Publications (www.pmrpublications.com)
6. * * * http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/romania_en.pdf;