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INSURANCE AND PRIVATE PENSIONS COMPENDIUM FOR EMERGING ECONOMIES

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PRIVATE HEALTH INSURANCE IN OECD COUNTRIES: COMPILATION OF NATIONAL REPORTS

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This report is part of the OECD Insurance and Private Pensions Compendium, available on the OECD Web site at www.oecd.org/daf/insurance-pensions/ The Compendium brings together a wide range of policy issues, comparative surveys and reports on insurance and private pensions activities. Book 1 deals with insurance issues and Book 2 is devoted to Private Pensions. The Compendium seeks to facilitate an exchange of experience on market developments and promote "best practices" in the regulation and supervision of insurance and private pensions activities in emerging economies.
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AUSTRALIA

1. Structure, Cost and Finance of Health Care

Impact of Community Rating

In community rating the same price is paid for the same product, but consumed at different rates. The assumption of private health insurance in the past has been life-time investment/insurance, so that fluctuations in drawing rates over the life cycle are accommodated by each member/contributor.

Community rating does not affect efficiency. The most significant barrier is a default benefit which is payable to service providers. This does not allow funds to negotiate efficiently with service providers. If private health insurance can actually be measured by the cost drivers within the industry, then it needs to be recognised that it is an intermediary negotiating costs of service on behalf of its members. It therefore needs information on providers to effectively negotiate, however that information is not currently available as hospitals do not publish cost data. It should be noted that conversely, the information in relation to private health insurers is available to the public at large through PHIAC.

It has only been in recent times when members have been moving in and out of insurance ("hit and runs") according to their perception of risk/usage that the lifetime distribution of risk has broken down.

Two examples which illustrate this point are as follows:-

Family A (two adults and five children) and Family B (one adult and one child) pay the same premium in relation to coverage for their families. Family A is likely to have a significantly higher drawing rate, the cost of which is subsidised by Family B.

Male Single D (Age 25) and Male Single E (Age 64) pay the same premium in relation to their insurance cover. Single E is likely to have a significantly higher drawing rate, the cost of which is subsidised by Single D.

Over many years, under community rating, these general categories tend to even out as young singles move to couples, families and back to couples and singles. This assumes that a representative cross-section of the population maintains private health insurance.

Although some redistribution of risk occurs by spreading the cost of caring for the aged and chronically ill, substantial inefficiencies within the system remain as shown in the examples above.

The total cost to an organisation of fund benefits and reinsurance payment or refund is therefore appropriate, as it assumes that after redistribution of the costs relating to the chronically ill and the aged, that the profile of all organisations is the same.

New categorisations of membership - singles, (couples), (single parent) and families will have the effect of better matching the cost of service to the price of service. Large families will no longer be subsidised by single parent families or families without children. However, the cost of family cover may rise, the price elasticity of which is not yet known.

Impact of external factors on efficiency

The following external factors also impact upon the efficiency of an individual registered organisation:-

Individual bargaining power.
Accessibility to medical/hospital resources.
Diversity of products offered by market at large

The size of a fund within its market can have a significant impact on efficiency. For example small funds tend to have less market power than large funds when negotiating purchaser provider agreements, limiting their ability to control costs and to ensure access on equal terms for their members. This has been addressed in part by a grouping of smaller open and restricted membership organisations who have formed an alliance which gives some increased bargaining power both for negotiation of prices and acquisition of equipment for operation of the funds.

Any assessment of the efficiency of an organisation may be conducted in very general terms by reference to the key financial indicators shown in the statistical report, however the individual performance of any organisation may only be assessed when the relevant structural and external factors applicable are considered.

Efficiency measures for funds

The private health insurance industry is not comparable with the general or life insurance industries. This industry is relatively short term compared with the long underwriting periods for general and life insurance. To illustrate, claims for benefits must be lodged within two years of the date of service, or they are not payable, as compared to lifetime policies.

PHIAC's perspective of efficiency of an organisation would vary significantly from the perspective of individual organisations. Organisational measures from PHIAC's perspective may include the following:-

number of claims processed in a period,
processing turnaround,
negotiations with providers,
internal delivery costs,
return on investments of reserves
in the case of for profit organisations, the return to shareholders.

Indicators of efficiency from PHIAC's perspective are:-

average contribution income per SEU;
average benefits per SEU; and
average management cost per SEU.

2. General Outline of Health Insurance System

The private health insurance industry is highly regulated. Regulatory responsibilities are administered by various authorities: the Department of Health and Family Services, PHIAC and the Private Health Insurance Complaints Commissioner (PHICC).

PHIAC is a Commonwealth statutory authority that is funded by industry. Appointments to PHIAC Council are made by the Minister for Health and Family Services. PHIAC is responsible for monitoring the financial status of health funds and administering the reinsurance arrangements.

The registration of health funds and the regulation of rules, including prices, remains with the Department of Health and Family Services subject to PHIAC's comments on the financial impact of rule changes.

The NHA has a number of limiting requirements defined in Schedule 1 which has implications for funds in developing innovative and competitive products. Community rating by definition has a requirement for regulation.

Community rating is an underlying principle of health insurance. Community rating means that there is no difference because of factors such as age, gender, family size, claims history or other risk factors. A single contributor would pay half the family rate of contribution. As from 1 October 1996 two new categories of membership have been added; couples and single parent families. This will change the relativities between memberships from the half rate previously occurring between single and family rate. Part of Community rating means that funds must accept all members.

In forms of insurance other than health insurance, premiums are calculated on a risk rating basis according to the probability of claim; the higher the probability of claim, the higher the premium. In contrast, health insurance premiums and benefits are the same, regardless of risk. The premium price does not vary and a fit couple in their twenties would pay the same premium for the same cover as an ailing couple in their seventies.

Health insurance was conceived and largely endures on a basis of membership for mutual benefit, where contributors support each other on a long term basis, through the life cycle with ebbs and flows of contribution and drawing, according to need as it naturally arises; high costs during child bearing, accidents and developmental traumas in child rearing years, adulthood and old age. For community rating to be effective, either a large participation rate is required or an insured population with a risk profile similar to the community at large.

Policy debate occurs frequently over the efficacy of community vs risk rating and is argued in both equity and market terms. A move to risk rating would disenfranchise current fund members. Community rating has held out against risk rating (through many changes of Government) on its sustainability on both grounds: mutuality underpinning the equity argument and price underpinning the market argument because risk rated health insurance would be unaffordable to those who would most want to buy it.

Given the mutual and long term nature of the product, the health insurance industry is most concerned about 'hit and run' contributors who take out insurance for short, high risk periods. While economists would regard this as rational individual behaviour, it undermines the essential social policy basis which has characterised private health insurance in Australia. Industry and Government are currently considering means by which longevity of contribution can be rewarded without undermining community rating.

Another facet of community rating that distinguishes private health from other forms of insurance is the requirement for funds to accept all applicants, regardless of their claims history or potential risk, with the pre-existing ailment condition and waiting periods being the only risk management tools.

The “mutual” principle of community rating is further reflected through the provision of the NHA providing for a levy to be raised on the industry as a whole to protect the members of a health fund which collapses. This provision was introduced after the failure of a Tasmanian fund which had a devastating effect and left health fund members and hospitals severely out of pocket with unpaid benefits.

Community rating is at present being interpreted relatively liberally however there is a risk that the market could segment, through the use of exclusionary products, into what is effectively a series of products which exclude high cost members. This would leave those high cost members in the high cost tables which becomes, by default, a risk rated product.

The recent changes allowed by the Minister introduce two new categories of membership: couples and single parent families. It is not yet certain what the demand will be. If the new categorisation does not increase the size of the market and the only effect of the new couples and single parent categories is a transfer away from family membership or from single memberships (where couples currently have two memberships) the result is likely to be a lowering of premium income to the funds and an increase in the cost of family membership.

In designing new products in the past, funds have, as a matter of commercial practice estimated drawing rates, target markets, demand, reinsurance impact and so on.

Within community rating, funds have been able to design products to attract or discourage market segments. For instance, a fund wanting to attract younger members may design a product excluding services generally used by elderly people (hip replacement etc). A fund wanting to attract older people could design a product excluding maternity for example. The new categorisation increases the opportunity for funds to tailor products to target niche markets and offer a greater range of choice and price within community rating, the efficiency benefit will be a better matching of users with payers. However, this runs the significant chance of implementing risk rating by default.

Barriers to Entry

The industry considers that it is competitive and that control of price by Government is a considerable barrier to entry.

The requirement to have either two contribution months of reserves or $1 million, whichever is the greater, required by Section 73BAB of the NHA also constitutes a barrier of entry to the market. However PHIAC would regard such solvency minimum’s as necessary and appropriate as a means of protecting members of a new fund, and not as an anti-competitive measure.

The NHA also requires proposed new entrants to the market to provide information to a Registration Committee of the Department of Health and Family Services, which makes the decision to allow registration of a new health fund. PHIAC has a place on that committee although it acts in an advisory role.

Community rating in its current form could also be seen as a barrier to entry, and the not for profit nature of a significant part of the industry.

3. History of Private Health Insurance and Nature of Private Health Insurance Providers

The industry commenced from a mutual background, where groups of people would get together to provide mutual support for services they individually lacked, such as health insurance, by making a small donation to a common fund. Some organizations have existed for more than 100 years.

Apart from the four "for profit" organizations, the remaining forty registered organizations retains a mutual status.

From PHIAC's enquiries the following is an outline of the major types of organizations operating health benefits funds at present:-

	PROFIT	NON-PROFIT	TOTAL	OPEN	RESTRICTED	TOTAL
Public Companies Limited by Guarantee	0	15	15	11	4	15
Public Companies Limited by Shares	4	4	8	7	1	8
Friendly Societies	0	10	10	4	6	10
Incorporated Association	0	6	6	5	1	6
Unincorporated Association	0	5	5	2	3	5
TOTAL	4	40	44	29	15	44

Thirty-nine registered organizations' have health insurance as their primary business activity.

The remaining five organizations conduct a variety of businesses where health insurance forms a relatively minor part of the overall operations.

Hostile takeovers are not available within the present legislative framework, and mergers are dependent upon the consent of the respective organizations, whether they are both industry participants or not.

A change in ownership is dependent upon the agreement of members, particularly in the case of many friendly societies. From the history and psyche of many industry participants (particularly friendly societies and restricted membership organizations), members consent could be difficult to obtain.

Conversion to "for-profit" type entities could also be a prerequisite for a sale to an external party to the industry where profit is the motivating factor. It is likely that many industry participants would resist moves of this type in the interests of preserving the foundational basis of their organization.

4. Range of Benefits

The behaviour of both providers and persons covered is an important factor in the cost of benefits. The following is a summary of the major categories of benefits during the past two full years:-

HOSPITAL BENEFITS	1998	1999	% OF TOTAL	% OF CHANGE
ACUTE				
DAY HOSPITAL BENEFITS	55,239,309	62,643,180	1%	13%
RECOGNISED PUBLIC HOSPITAL DAY ONLY BENEFITS	17,323,095	15,449,297	0%	-11%
RECOGNISED PUBLIC HOSPITAL OVERNIGHT BENEFITS	248,795,468	225,409,838	5%	-9%
PRIVATE HOSPITALS DAY ONLY BENEFITS	191,165,729	203,364,354	5%	6%
PRIVATE HOSPITALS OVERNIGHT BENEFITS	2,011,823,843	2,050,168,655	49%	2%
TOTAL ACUTE HOSPITAL BENEFITS	2,524,347,444	2,557,035,324	61%	1%
NURSING HOME TYPE				
RECOGNISED PUBLIC HOSPITAL BENEFITS	6,911,290	6,699,964	0%	-3%
PRIVATE HOSPITAL BENEFITS	10,114,456	9,527,601	0%	-6%
TOTAL NHT	17,025,746	16,227,565	0%	-5%
MEDICAL BENEFITS				
MEDICAL BENEFITS UP TO SCHEDULE FEE	228,440,275	240,949,935	6%	5%
MEDICAL BENEFITS UP TO 16% ABOVE SCHEDULE FEE	737,803	6,105,584	0%	728%
MEDICAL BENEFITS MORE THAN 16% ABOVE SCHEDULE FEE	847,941	6,068,592	0%	616%
TOTAL MEDICAL BENEFITS	230,026,019	253,124,111	6%	10%
PROSTHESIS	206,556,625	239,237,018	6%	16%
INELIGIBLE BENEFITS	21,637,653	21,061,646	1%	-3%
TOTAL HOSPITAL	**2,999,593,487**	**3,086,685,664**	74%	3%
ANCILLARY BENEFITS	1,077,461,509	1,095,254,180	26%	2%
ALL BENEFITS	**4,077,054,996**	**4,181,939,844**	100%	3%

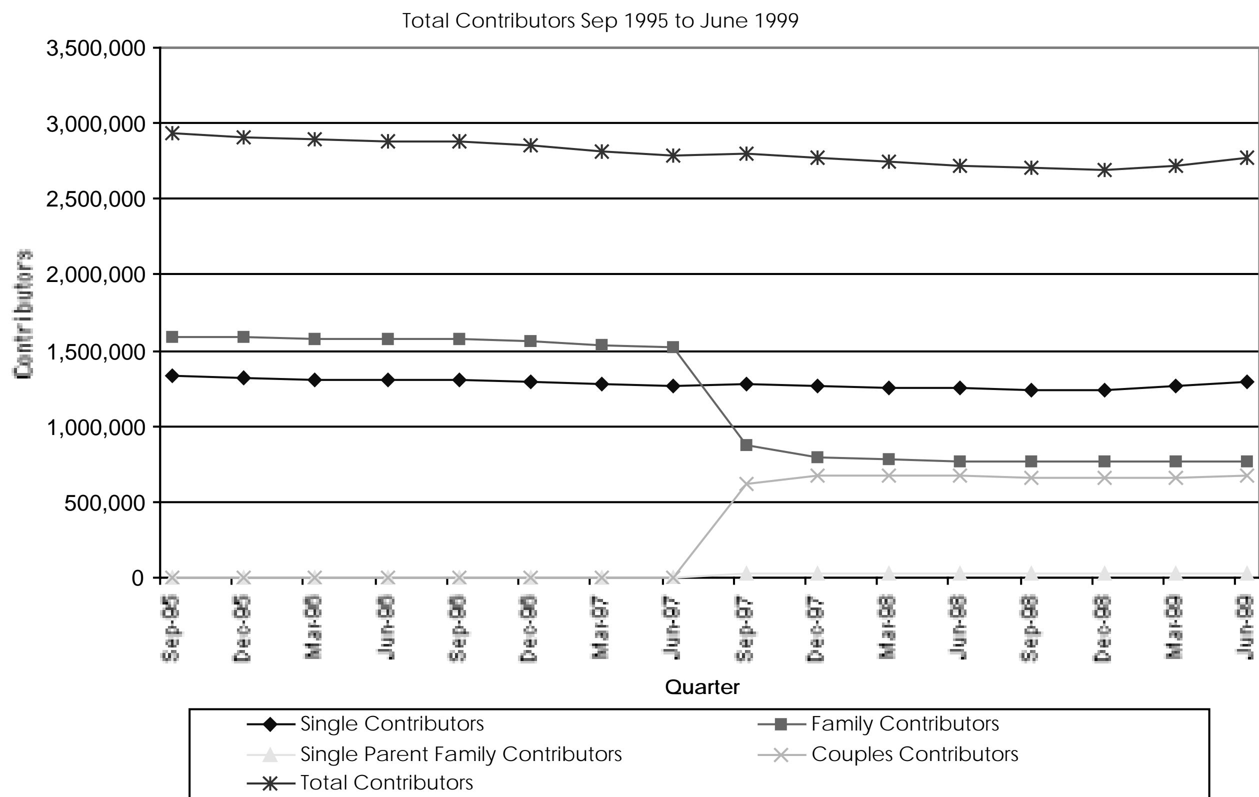
5. Finance of Private Health Insurance

The private health insurance industry effectively competes with a free alternative in the Medicare system. The Medicare system is government sponsored and is partially funded from a Medicare surcharge, and partially from consolidated revenue. The private health insurance system finances the cost of health care in excess of the medicare schedule charge, and the cost of ancillary services where no government system exists. The main incentives for membership in terms of hospital treatment is doctor and hospital of choice and no waiting periods as for the public system.

The number of contributors insured is affected by the health insurance environment generally. The price of the product is a driving factor, as is the level of benefits received for dollars spent by contributors.

The past two quarters have shown a reversal in the trend of falling membership, as result of the 30% rebate scheme. The PHIIS and the Medicare levy surcharge slowed the decline to an extent, however the price reduction to contributors appears to have had a much greater effect on membership numbers.

Following is a chart which shows the number of contributors for the quarters September 1995 to June 1999.



As membership increases the total cost of benefits increases. Waiting periods for new members will defer the full effect of the increase, however anecdotal evidence suggests that after eighteen months of coverage there is no difference in the claiming patterns of old versus new members.

The conversion of contributors to the number of people covered will also have an effect on the total benefits paid. For example if there is more incentive for families than for single people to join, each new membership converts to at least two or more claimers.

6. Current Situation and Future Prospects

The industry, during the past year, has been faced with many uncertainties which have impacted upon the contribution rates set, including the following:-

Uncertainty about the date available for the next contribution rate increase, when determining 1999 prices;

Lifetime Health Cover proposal;

Reinsurance review;

The prospect and effect of GST;

Loyalty bonuses and their financial impact.

The 30% rebate has had an effect on participation rates, however the long term outcome of the scheme is uncertain.

AUSTRIA

1. Structure, cost and finance of health care system

Out-patient treatment

Out-patient treatment is provided largely by doctors practising privately. The fees payable for contracted doctors are in most cases settled by the social security bodies in the form of a lump-sum quarterly payment, in some cases by the payment of fees for individual services; in all other cases fees are arranged independently.

The provision of out-patient treatment is supplemented by out-patient surgeries (“Ambulatorien”), in which a number of doctors specialising in the same or different fields provide out-patient treatment. The total number of independent out-patient surgeries in Austria in 1995 was 754, of which 148 (19.6%) were operated by one statutory insurance institution.

In-patient treatment

In-patient care is the exclusive preserve of hospitals. Under the Austrian Hospital Law (KAG) these may be divided into general hospitals, special hospitals (for the treatment of specific population groups or diseases) and sanatoria (the equipment of which meets higher standards in terms of care and accommodation).

General hospitals and special hospitals may be run as either State or private institutions. Operation in the public interest is a significant criterion for the purpose of financing from public funds. A hospital is considered to be operating in the public interest only if it is run on a non-profit-making basis and if the number of “special category beds”, i.e. beds in rooms for which higher fees are payable because their location and facilities meet higher standards in terms of accommodation and care, does not exceed one quarter of the total number of beds.

Situation at 1997:

Since 1.1.1997 the funding of hospitals on a services-related and diagnosis-related (LKF/LDF) basis is to be extended throughout Austria after having been introduced in Vorarlberg and Lower Austria.

Financing is organised around nine “Länder funds”. Finance for which is being provided as before by the State, the “Länder”, local authorities and statutory insurance institutions to be used exclusively for funding previously subsidised hospitals. Services are invoiced according to “standard periods of hospitalisation” and individual treatments on the basis of set flat-rate prices which correspond to a list of services-related groups of diagnoses, each of which is allocated points according to the cost values of the set flat-rates. In addition to the core costs, the invoice will also incorporate a tax so that the provision of adequate staff and

equipment, the fabric of the building, standards of quality as well as specific regional requirements can be taken into account. "Structure committees" have been set up at both national and regional level to monitor the effects of the changeover. In future, hospitals which are exclusively private and have direct settlement contracts with the statutory insurance institutions will settle bills with the latter on the basis of compensation for nursing fees specific to each "Land"; services-related billing will not be available in 1997 but should be developed eventually.

At the end of 1995, there were approximately 74,863 beds available in 330 hospitals. 156 of those hospitals, which account for 54,777 beds, i.e. 73% of total beds available, are entitled to receive payments from the KRAZAF.

2. General survey of health insurance in Austria

There are two complementary forms of health insurance in Austria: State insurance, which is a compulsory form of State-operated, statutory insurance, and voluntary private health insurance. Statutory insurance is compulsory for almost all occupational groups, regardless of income. Some 99% of the population is covered by statutory health insurance. Since individual insureds are not entitled to choose between private and statutory health insurance schemes, private health insurance contracts in Austria are almost always taken out as a means of supplementing statutory health insurance cover.

Some professional groups, which are organized by law in "chambers", e.g lawyers, medical doctors, veterinaries, notaries… are now alloed to choose between private insurance as a group insurance and State insurance.

Unlike private health insurance, statutory insurance is not based on a contractual relationship but almost always arises directly from the fulfilment of a stipulated statutory condition. The stipulated statutory condition associated with compulsory insurance is gainful employment. The overall content and scope of the insurance are generally laid down by law and there is no scope for individual, private arrangements.

Statutory insurance is financed by social security contributions which are paid by both employers and employees. The self-employed must also pay contributions.

The level of employees' contributions depends on the insured's gross remuneration: 3.7% (blue collar workers) or 3.15% (white collar workers) of gross wages or salaries is paid by both employers and employees as statutory health insurance contributions. The wage or salary used as a basis for the calculation is, however, subject to a statutory "maximum contribution basis" (1997: Sch. 40,800 per month).

Members of the insured's family are included in the statutory insurance cover. This does not affect the level of the contributions payable.

The statutory insurance funds are required to make payments in respect of treatment for any kind of sickness or accident.

Given that a high proportion of the Austrian population is covered by statutory insurance, the main function of private health insurance today is to provide cover for treatment by doctors who are not under contract to the insurance institution concerned or to cover the cost of additional comforts in the event of admission to hospital.

Unlike statutory insurance, private health insurance is based on a private-law contract between the company and the insured. Premiums are calculated on the basis of actuarial criteria.

3. History of private health insurance

In Austria, private health insurance paved the way for statutory social insurance. The principle of the association of individuals for the provision of mutual assistance in the event of sickness or occupational incapacity first took shape in early types of private health insurance and was subsequently incorporated into legislation in the form of statutory welfare insurance.

The main legislative instruments forming the basis of private health insurance are the 1978 Law on Insurance Supervision, amended in 1996, and the 1958 Insurance Contract Law, also amended in 1996. The Law on Insurance Supervision has its basis in the Association Patent of 1852. The insurance organisations of the time operated as "associations for insurance operations" and were even then subject to State supervision in order to protect the interests of association members.

For a long time private and statutory health insurance fulfilled the same functions, although they applied to different population groups. That state of affairs changed completely with the introduction of the General Social Security Law of 1955 and the subsequent gradual inclusion of almost all population groups - in particular the self-employed - in the statutory insurance scheme. Today, private health insurance is almost exclusively supplementary insurance.

In recent years there have been several extensive amendments to both the above-mentioned laws as a result of Austria's participation in the Single European Market and the transposition of EU laws into national law, and particularly by the amending laws of 1996.

As a result of the amendment to the Law on Insurance Supervision:

- ⇒ "material control" no longer applies,
- ⇒ Approval or regular submitting of insurance conditions, tariffs or other business conditions are no longer required, but it is still permissible to require that calculation bases used for calculating tariffs and technical reserves for "health insurance operated on the basis of life insurance" be submitted regularly.
- ⇒ To counter the absence of approval of business conditions the insurer's obligation to disclose information has been extended.
- ⇒ As a result of the amendment to the Insurance Contract Law, legal provisions specifically concerning health insurance were introduced for the first time.

Health insurance is regarded as a "whole life contract" and so excludes the setting of time limits and the insurer's right to cancel a contract. However, exceptions to this rule are group insurance contracts, sickness benefit and dental insurance contracts.

Given that approval of tariffs is not required and contracts must be for life, adjustment factors which can be confirmed and checked must be laid down for premium adjustments.

The following factors are allowed as adjustment factors:

- an agreed general cost index,
- increase in the average life expectancy of insureds under this tariff,
- increase in the morbidity rate,
- increased costs of the statutory insurance scheme,
- and changes in the health system.

⇒ Health insurers are obliged to set up old-age reserves to prevent premium increases resulting from a higher incidence of sickness in old age.

⇒ An action can be taken against an insurer through the insurance supervisory authority, in addition to the Chamber of Commerce, the Chamber of Labour and the Consumer Information Association, in respect of claims that unauthorised changes have been made to a premium or changes have been made to a contract.

⇒ In addition, those insured under a group policy have been given the right to continue this cover under an individual policy with the premium being calculated according to the insured's age at entry to the group insurance policy. The insured must be able to transfer without the risk being re-examined and new qualifying periods being introduced.

4. Private health insurance providers and range of benefits

Contracts taken out with private health insurers (2.64 million) as a rule provide for hospital expenses insurance (covering 1,040,221 insureds, approx. 12,87% of the total population at the end of 1999). In the case of hospital expenses insurance, accommodation costs, treatment costs and material expenses are refunded. In Austria, this type of private insurance is generally taken out as a policy to supplement statutory health insurance. It provides cover for the extra cost of staying in a special category ward in a State, non-profit-making hospital or sanatorium and primarily offers better benefits in terms of quality than statutory insurance (free choice of doctor, more comfortably furnished room, smaller number of beds in rooms, unrestricted visiting hours, choice of menu and so forth).

In 1999, premium income was Sch. 15,629 million (+1,6% compared with the previous year) against claims amounting to Sch. 11,767 million of which Sch. 9,217 million represented compensation for hospital expenses, that is 77,6%, of which 45% accounted for compensation for so-called running costs and 55% for compensation for fees. In 1999, private health insurance claims have increased by 1,6% and compensation for hospital expenses by 1,8%.

The additional expenditure on nursing fees and doctors' fees arising from an insured's decision to opt for the higher (special) fees category or for treatment in a private hospital is generally settled in full between the private insurer and the hospital.

A decision made in 1995 by the constitutional court which concerns special category additional payment costs of public hospitals in Upper Austria specified that special category patients may be charged in future for additional special category services actually provided. This decision led to a decrease of costs for special category of services in most public hospitals – regarding the hotel-component, not the schedules of surgical fees.

Hospital daily payments insurance is a cash benefit insurance which pays a fixed sum per day's stay in hospital with no proof of the costs incurred being required. This type of insurance may be taken out separately or in conjunction with a hospital expenses policy, although it is not very common.

Insurance for out-patient medical treatment can be taken out only in conjunction with one of the types of hospital insurances mentioned above. This combination is known as "medical expenses insurance" and is selected mainly by people who are not covered by the statutory scheme. This type of insurance is occasionally taken out by insureds who are covered by the statutory scheme but who do not wish to consult the health insurance fund doctors (or who want a second opinion) or whose insurance organisation provides only a partial refund of the cost of out-patient treatment. In four Austrian "Länder", private insurers have established framework agreements for the established medical profession with the medical associations concerned governing the direct settlement of doctors' fees for out-patient operations (but not for other services). In eight "Länder", agreements have been made with day hospitals or other hospitals for covering the costs of operations performed on an out-patient or day basis.

Sickness benefit insurance and foreign travel insurance are still available as additional special forms of insurance in Austria. Sickness benefit insurance is also a cash benefit insurance. After the expiry of an agreed waiting period, this type of insurance pays an agreed sum per day's total occupational incapacity, regardless of whether treatment is given on an in- or out-patient basis.

Foreign travel insurance is taken out for a fixed period of time, viz. the duration of a foreign visit. This type of insurance refunds 90% of the cost of in- or out-patient treatment which becomes necessary abroad up to an agreed maximum sum, subject to proof of treatment.

5. Tax treatment of private health insurance

Private health insurance premiums are calculated in accordance with actuarial procedures. They depend upon contractually-agreed benefits, age at entry and the gender of the policyholder and are subject to a 1% insurance tax.

Regardless of the type of private health insurance involved, all private health insurance premiums and contributions are deductible from taxable income as special expenses. However, payments made in respect of private health insurance are deducted together with other special expenses. An annual maximum limit for total social expenses of Sch. 40,000 per taxpayer and non-working spouses has been fixed (plus a further Sch. 20,000 if there are at least three children, which cannot be taken into account as special expenses).

Up to that maximum limit, 25% of attested special expenses may be used for tax reduction purposes. As of 1996, health insurance is no longer fully tax-deductible from taxable annual incomes over Sch. 700,000 and deductibility for incomes from Sch. 500,000 to Sch. 700,000 is reduced on a linear basis (as at 1.1.1997).

Generally speaking, private health insurance benefits are exempt from income tax: this applies to both hospital expenses insurance and hospital daily payments insurance (as from 1.1.1989).

Tax treatment of the revenue of hospitals and doctors

1. Public-law hospitals or non-profit-making hospitals

Since1.1.1997, the revenues of hospitals operated on a public law or a non-profit-making basis are artificially exempt from VAT, i.e. VAT will no longer be added to services provided after 1.1.1997. These hospitals lose the right to deduction of prepaid tax.

When calculating the subsidy, 10% of the revenue from special category payments and from private patient payments must be deducted from the payable tax prepayment. If 10% of the revenue from special category payments and private patient payments amounts to more than the payable tax prepayment, the excess amount must be paid automatically as a "special tax" to the tax authorities. Consequently, tax exemption of hospitals affected is cancelled where revenue from private patients is concerned.

2. Profit-making private hospitals

As a rule, the revenue of profit-making private hospitals will also be subject in future to the reduced rate of 10%. Entitlement to deduction of prepaid tax is retained.

3. Doctors

Income from services provided by a doctor is artificially tax exempt with effect from 1.1.1997. So no VAT is added to bills. The doctors haven't anymore their entitlement to deduction of prepaid tax.

6. Current position and future prospects

Private health insurance, in common with statutory insurance, is affected by the steady increase in the cost of health care services. Given that private health insurers provide a form of voluntary supplementary insurance - and there is no reason to expect any fundamental change in the division of responsibilities between private and statutory health insurance in the near future - they will need to make even greater efforts to curb costs than those made by the statutory insurance sector. Transferring treatment from the in- to the out-patient sector, where costs are lower (the difference in cost being reflected in their rates), contracts with providers of out-patient treatment and other incentives are regarded by private health insurers as some of the most effective means of containing costs.

In principle, private health insurers view services-related funding of hospitals (LKF system) favourably. The question of linking private insurers into the LKF system under consideration does not arise, however, insofar as the new funding system will have to pay for those services which have to be provided for all patients alike regardless of the category of fees. However, under the LKF system, private insurers will cover only those costs for special category patients actually arising from additional special category services. The introduction of the LKF system does not have any immediate effects on private health insurers with regard to special category fees. The question of quality assurance, particularly in the medical field, will certainly be seen as having greater significance than before.

BELGIUM

1. Structure, cost and finance of health care system

1.1 Structure

In Belgium, as in many European countries, compulsory statutory insurance plays a dominant role, while private insurance provides cover which complements statutory insurance.

If private insurance is to be described and its role in relation to statutory insurance to be established, the latter type of insurance must be considered in a legislative, institutional and operational context.

Almost the entire population has compulsory statutory insurance.

Statutory health and disability insurance stems originally from initiatives taken in the private sector by the establishment of basic mutual assistance associations which gradually gained legal recognition as mutual companies. At the instigation of the authorities, mutuals were incorporated into the social security system in 1944.

A legislative Decree of 28th December 1944 introduced a compulsory scheme for employees.

The definitive form of this compulsory statutory scheme was established by the Law of 9th August 1963, in accordance with which the scheme is divided into two sectors :

- **the compensation sector**, providing cover in the event of occupational incapacity initially only for employees (insureds) up to retirement age;

- **the medical care sector**, providing cover for insureds and their dependants until death.

Successive Royal Decrees have extended statutory cover to other population groups.

The Law of 9th August 1963 established the INAMI (National Institute of Health and Disability Insurance) under the auspices of the Ministry for Social Security. The INAMI is a State institution with corporate body status. The Institute is responsible for administering both the above sectors in conjunction with five National Unions of mutual society federations and the Auxiliary Health and Disability Insurance Fund, which is a State body.

The statutes of these mutual societies are governed by the Law of 6 August 1990.

A supervisory body called the Office for the Supervision of Mutual Societies has been part of the general structure since 1992.

As regards the health care sector, agreements are negotiated between insurance organisations and representatives of providers of services (hospitals, doctors, pharmacists, nurses etc.), the negotiations are conducted by national joint committees.

Agreements come into force once a minimum percentage of service providers has joined the agreement. If this not the case, the authorities take a decision on fixing the prices.

a. Medical care

Fees and the cost of services contained in the classified list of health care services are established by the agreements.

The benefit amounts contained in the classified list are reimbursed more or less in full according to the beneficiary's status (widow, disabled, pensioner, orphan). It should be noted that generally patients' contributions apply.

As regards fees, providers of services who are contracted to the state sector may deviate from these agreed rates only at the specific request of the patient. Those not contracted to the State sector may fix their fees as they wish. Reimbursement to beneficiaries is the same in either case.

b. Pharmaceutical products

The amount of any reimbursement in respect of pharmaceutical products included in the agreed scale of pharmaceutical products is determined by a system of internal classification. It should be noted that a patient's contribution applies which could amount to the full price of a medicament. The current trend is towards declassification of medicaments (so reducing refunds).

c. Hospitalisation

The INAMI establishes for each hospital the daily maintenance charge to be paid for accommodation in a general ward. The charge is then refunded, subject to the deduction of a patient's contribution which is the same for each hospital. It should be noted that from the first day the patient's contribution is increased by a fixed admission rate.

Accommodation in a private room is regarded as a special requirement on the part of the patient and the supplements payable are freely determined by each hospital.

1.2 Cost

The cost of health care services under the statutory scheme accounts for approximately 5.7 % of gross national product.

1.3 Finance

The employees' scheme is partly funded by compulsory employers' and employees' contributions. These percentage sums, which are not subject to any ceiling, are deducted from gross remuneration. The self-employed pay flat-rate contributions.

Additional funding is provided in the form of payments from the State. Since 1992 the amount paid by the State is limited to 192 billion BF per annum.

Further funding is provided by parafiscal taxes which are being developed more and more.

2. History of private health insurance

As mentioned above, the development of private health insurance in Belgium must be considered in relation to the comprehensive statutory scheme.

Although it existed in embryonic form prior to 1945, it was not until after that date that private insurance developed fully. Its development began with group insurance contracts taken out by employers on behalf of their employees. It was then gradually extended to include individual cover and culminated in the emergence of full-scale private health and disability insurance from 1967 onwards.

The scope of activity of private health insurance includes medical expenses and compensation to be paid in the event of occupational incapacity or disability where no reimbursement is provided under the statutory scheme. It encompasses:

- payment of an annuity based on replacement income in case of occupational incapacity or disability

- reimbursement of a patient's contribution and fees and services not fixed by agreements in the case of a health care insurance.

The regular increase in patients' contributions provided for under the statutory scheme and the demand for more personalised health care have undoubtedly contributed to the growth of this class of private insurance.

3. Private health insurance providers

Private health insurance is generally written by composite companies; however, a number of specialist companies hold a significant share of the market.

Under the Law of 1975 governing general supervision, the Insurance Supervisory Office (OCA) monitors the activity of companies writing private health insurance.

Since the introduction of "a posteriori" control following the EU Third Directive on non-life insurance, companies need no longer notify the OCA of general policy conditions or rates. The OCA may request this information, but will not do so as a matter of course.

Rates must, however, be submitted to the Insurance/Credit Division of the Ministry for Economic Affairs before or as soon as they become applicable.

4. Range of benefits and finance

Companies offer members of the public contracts covering the reimbursement of medical expenses, the payment of daily compensation in the event of incapacity, or the payment of disability annuities.

Where medical expenses contracts are concerned, the section of the market open to private insurers consists almost exclusively of those insureds whose special requirements are not covered by the standard benefits offered under the statutory scheme on the basis of the principle of compulsory collective responsibility; the level of protection offered by the latter is diminishing even for an insured who has no special requirements (as defined in the agreements).

Consequently it is becoming easier for the private health insurance market to extend to all categories of insureds covered by the State scheme.

Private health insurance may take one of two forms :

- **group insurance**, where the policyholder is an employer who takes out a policy on behalf of his employees, together with members of their families where applicable. Premiums are uniform and take no account of age or gender, unless the policy provides for the continuation of cover beyond the retirement age.

- **personal insurance** which is taken out by individuals. In this case, premiums are established according to age and gender, or determined by age group, or established on the basis of gender alone.

Insurance company business in force consists mainly of "large risk" insurances providing hospitalisation cover and possible out-patient cover for the treatment of certain serious diseases. Such insurances fall into two categories : insurance of costs (reimbursement of actual costs) and flat-rate insurances (paying a flat-rate sum per day's stay in hospital).

Some insurance companies also provide "small risks" insurances, which give cover for all out-patient treatment.

5. Current position and future prospects

In the face of major financial difficulties, there is a trend towards a reduction in payments made under the statutory scheme.

The personal contributions of insureds under the statutory scheme increase regularly and will continue to increase.

6. Prospects for the development of private health insurance

A bill on long-term care insurance has been passed by the Flemish Regional Parliament, and the relevant implementing decrees are under discussion. This insurance will be administered by a special fund, based on a mix of pay-as-you-go and fully-funded group schemes. The scheme will provide indemnity cover for people of any age group.

The points currently being discussed relate to the funding system, the introduction of "care cheques" and the exclusion of what is considered as non-medical treatment by service providers who are not recognised as professional practitioners.

Private insurers have pointed out their readiness to play a role in setting up the long-term care scheme on the basis of the added-value services that they are able to provide.

a. Drawbacks of private medical insurance

The information below is taken from a study carried out by a consumer organisation

When taking out a policy, applicants have to fill out a medical questionnaire.

Most policies contain a list of specific exclusions (existing ill health, mental illness, etc.).

Most companies will no longer insure new customers over a certain age.

Some companies limit reimbursement to two or three times the sum automatically paid out by the mutual, which is based on the statutory amount, and the sum reimbursed is therefore not enough to cover the fees required.

Yet, the limitations and restrictions pointed out by consumers can be put down to the fact that private health insurance is optional and that insurance companies have to show a profit on each product category.

b. Advantages of private medical insurance

In future, private insurance for both sickness and disability risks may play a more significant role since it offers more individual flexibility (tailored policies) as a means of complementing the rigid or inadequate framework of standard statutory insurance.

Some companies cover the expenses of out-patient treatment and transport as well as other services not covered by mutuals.

Employers can take out group insurance policies for their employees: these have certain advantages over individual policies:

No eligibility criteria for groups of more than five to ten insured.
Almost no exclusions.
Possibility on reaching pensionable age of maintaining cover under a personal policy.
Lower premiums.

7. Regulation of Private Health Insurance

a. Private health insurance providers

Belgian insurance law derives essentially from three statutes.

The Law on supervision of 9 July 1975, which stipulates the basic requirements and regulations applicable to the business conducted by insurance companies and provides for their supervision.

The Law of 25 June 1992 on inland insurance, which is designed to achieve a balance between the rights and obligations of the parties to a contract of insurance. It also contains provisions on the issue, endorsement, execution and duration of the contract.

The Law of 27 March 1995 on insurance brokers and distribution.

The Law of 14 July 1991 on commercial practices and consumer protection and information also applies to insurance.

b. Mutuals

Belgium's mutual insurance companies are non-government organisations that provide a public service and are instrumental in the provision of compulsory health and disability insurance under the Law of 9 August 1963, which introduced and structured a compulsory health and disability insurance scheme. The Auxiliary Health and Disability Insurance Fund (Caisse Auxiliaire d'Assurance Maladie-Invalidité, CAAMI) is the equivalent public sector body.

Unlike the CAAMI, which may provide only basic compulsory insurance, mutual companies offer, in addition, supplementary services – both optional and compulsory – to cover certain risks involving illness and disability.

The Law of 6 August 1990 sets forth the requirements that mutual companies must meet in order to be recognised as corporate bodies, specifies their obligations and standing procedures and provides for their supervision.

This law covers the duties of mutual companies as regards both compulsory insurance and voluntary insurance and provides for the extension of their activities.

In order to fulfil their obligations as insurance providers, mutual companies draw on:

a. members' contributions;

b. a range of state subsidies;

c. donations and bequests;

d. various taxes on statutory old-age, retirement, seniority or survivors' pensions, automobile insurance premiums (third party liability and accident damage), hospital stay insurance premiums, excise duties, etc.

However, the fact that mutual companies engage in a fairly wide range of business by offering services relating to the health of their members and their members' families is apt to draw criticism from insurance undertaking that operate in the same sector and cover health care risks involving out-patient care as well as hospitalisation.

Insofar as mutual companies, pursuant to the special legislation that governs them, are required to act in compliance with the three principles of providence, mutual assistance and solidarity, they are treated differently, on a technical as well as financial and fiscal level, from private insurance undertakings, which are subject to stricter supervision and tax requirements in these various respects.

c. Main regulatory differences between the various insurers

The differences of a technical nature stem from the fact that mutual insurers with a monopoly in the area of compulsory sickness/disability insurance:

- are free to make the enrolment of a person in a compulsory insurance scheme subject to payment of a statutorily set contribution for supplementary insurance activities. There is therefore a joint provision inasmuch as many mutual insurers make their compulsory insurance benefits conditional on being affiliated to the supplementary insurance service that they organise;

- have preferential access to the databanks generated by the management of compulsory insurance [files on the insured, i.e. almost the entire population, on care providers, i.e. those who practice the art of curing people, paramedical auxiliaries, hospitals];

The differences of a financial nature stem from the obligations imposed on insurance undertakings by the Act of 9 July 1975:

- to maintain a solvency margin and a guarantee fund; and

- to ensure sufficient technical reserves, without being able freely to determine of what assets the latter should be composed.

Mutual insurers, on the other hand, are not subject to the Act of 9 July 1975 and their sole financial obligation is to set up separate reserve funds for certain services. What is more, they have the advantage of being subsidized, as described under 8 above, which is not justified by the fact that mutual insurers are non-profit making and comply with the principle of solidarity.

Insurance undertakings are not subject to the same tax regime as mutuals.

Insurance company premiums are liable to the annual tax on insurance contracts and their income is liable to corporation tax, whereas the contributions received by mutual insurers in respect of non-compulsory insurance cover for the self-employed, whether supplementary or voluntary, are exempt from any annual tax and their income is liable to tax on legal entities.

In exchange for contributions, mutuals are entitled to provide legal expenses insurance without being subject to the same rules as insurance companies operating in that branch.

8. Health insurance statistics (in BF '000)

	1995	**1996**	**1997**	**1998**
Personal insurance	5 430 863	5 876 603	6 358 062	7 412 832
Guaranteed income	2 907 203	3 009 520	3 039 325	3 043 154
Other personal insurance	2 523 660	2 867 083	3 318 737	4 369 678
Group insurance	7 502 282	8 607 290	9 264 292	10 389 575
Guaranteed income	2 810 940	3 072 657	3 148 067	3 319 360
Other group insurance	4 691 342	5 534 633	6 116 225	7 070 215
Overall total	12 933 145	14 483 893	15 622 354	17 802 407

Guaranteed income = income guaranteed in the event of incapacity for work or disability.

Other = health care (as in-patient or out-patient), daily allowances for stay in hospital, travel insurance cover, etc.

CANADA

1. Introduction

Canada has a predominantly publicly financed and privately delivered health care system. Management and delivery of health services fall under provincial jurisdiction. There are ten provincial and two territorial health programs. National standards for hospitals and medical services are set out in federal legislation, the *Canada Health Act*, which ensures a minimum level of uniformity. The federal government provides funds to provinces through fiscal transfers that are conditional on provincial adherence to national standards (Canada Health and Social Transfers).

Through provincial networks of publicly owned hospitals and independent health facilities, all Canadians have access to medically necessary hospital and physician services with no user fees. Residents are entitled to coverage when they move to another province as well as when they travel, although some limits may apply to Canadians travelling abroad. There are no deductibles, co-payments or dollar limits on coverage for insured services. Doctors are private practitioners and are mostly paid on a fee-for-service basis directly by the government.

Beyond basic coverage for hospital and medical care, provinces also provide some coverage for other benefits such as prescription drugs, dental care, vision care, crutches and other appliances. These benefits are usually only covered for certain groups of individuals (e.g. elderly, children or welfare recipients). Many Canadians must therefore pay for them privately, hence the need for private insurance.

2. Cost and Finance of Health Care System

The Canadian health care is essentially financed through provincial and federal general income tax revenues. Sales taxes and lottery proceeds often complement health care funding. Two provinces (Alberta and British Columbia) also use health care premiums as a supplemental source of financing. However, these premiums are not risk-based, nor is their prior payment a pre-condition for treatment.

According to the Canadian Institute for Health Information (CIHI), total health expenditures in Canada amounted to $77.1 billion in 1997, or $2 545 per capita. This represented 9.1% of the Gross Domestic Product (GDP), down from a peak of 10.2% in 1992. Governments accounted for 69.8% of the financing, with disbursements of $53.8 billion. Through supplementary insurance or out-of-pocket disbursements, the private sector contributed the remaining $23.3 billion (30.2%) for non-government insured items, such as drugs or dental services.

The main areas of health care spending were in institutions, physicians and drugs. CIHI's 1997 data suggests that about $35.8 billion, or 46.4% of total spending, went to the financing of hospitals and other related institutions, $11.1 billion (14.4%) to the compensation of physicians, and $10.6 billion (13.7%) to the purchase of drugs. The remaining $19.6 billion went to areas of spending such as dental services, vision care, research, and plan administration.

3. Private Health Insurers

Private providers of health insurance in Canada can be divided into five broad categories: life insurers, property and casualty insurers (P&C), fraternal benefits societies, non-profit groups, and employers.

Life insurers

Most of Canada's private health insurance is provided by life insurers. In 1997, premium income from such business amounted to $7.8 billion, or 22.7% of total life insurers' premium income. Benefits payments totalled $6.6 billion, according to the Canadian Life and Health Insurance Association.

Property & casualty insurers

The health insurance business constitutes a marginal source of income for P&C insurers. Only a few Canadian general insurers are involved in this business. Statistics from the Insurance Bureau of Canada indicate that net health insurance premiums collected by P&C insurers totalled $353 million in 1997, or 1.9% of their overall net premium income.

Fraternal benefit societies

These societies operate for fraternal, benevolent or religious purposes. They usually provide accident, sickness, disability or death coverage to members as well as to their spouses and children.

Non-profit groups

The main non-profit providers of health coverage are part of the Canadian Association of Blue Cross Plans, an association of seven independent Blue Cross member plans that operate regionally across Canada (Atlantic Canada, Quebec, Ontario, Manitoba, Saskatchewan, Alberta/Northwest Territories, British Columbia/Yukon). In addition to health coverage, Blue Cross companies offer Canadians travel and life products. Blue Cross plans assume a significant role in the provision of health insurance in Canada as they administer more than $1.6 billion in annual premiums.

Employers (uninsured plans)

Health insurance coverage is sometimes provided directly by the employer. These plans are sometimes administered by an insurance company even though the benefits are not guaranteed by the insurer.

4. Products & Benefits

Although available on an individual basis, private health insurance is most commonly offered on a group basis through employers, unions or professional associations. The products are classified in three categories: health care, disability income and dental care insurance.

Health care insurance

Health care insurance provides coverage for medical and hospital expenses that are not covered under public health plans. Typical benefits from these plans include the cost of private or semi-private hospital rooms, out-of-country coverage, prescription drugs, special duty nursing, ambulance service and various medical appliances (e.g. wheelchairs, crutches). Eyeglasses and chiropractic treatments are also included.

Generally, health insurance does not provide full coverage of expenses. The insured person is often required to pay a fixed amount or deductible every time a claim is made, as well as a small fraction of the costs incurred (the co-insurance). Moreover, overall yearly benefit limits often apply.

Disability income insurance

Also called wage-loss insurance, disability insurance helps replace income losses resulting from a short or long-term disability by providing periodic cash payments. Short-term plans usually commence payments on the first day of incapacity or soon after, whereas long-term plans normally start paying at the end of a specified period after the onset of disability. Benefits are often integrated with those from government plans, so that compensations do not exceed a certain proportion of the individual's normal income.

Dental care insurance

These plans usually provide cover for preventive and maintenance services as well as for major restorative procedures. Dental care plans frequently have a deductible combined with co-insurance and maximum annual benefit features.

According to the Canadian Life and Health Insurance Association, health care insurance was the most popular of these three products in 1997, covering approximately 21.3 million people. Dental care and disability income insurance came second and third respectively, with 14.1 and 7.8 million individuals covered.

5. Insurance Regulation

Insurers active in Canada are either domestic entities, set up as companies or mutual societies, or foreign companies doing business in Canada through a registered branch. Although incorporation of a domestic insurer can be done under Canadian federal law or the law of the province where the entity does most of its business, insurers tend opt for the federal charter. This structure allows them to be active nationally with one license. A provincially registered insurer would, on the other hand, be required to obtain a license in each province in which it operates.

Canadian insurance regulation distinguishes between life and P&C insurers. These constitute the two broad components of the insurance industry in Canada and the main providers of health insurance products – no regulatory framework has been developed specifically for the health insurance business.

Federal and provincial governments share jurisdiction over the insurance industry. Federally incorporated entities as well as foreign life and P&C insurers are subject to the federal *Insurance Companies Act*. In the case of federal insurers (companies and mutual), this Act establishes business and investment powers, corporate governance regime and outlines directives for making fundamental changes to corporate structure. For federal as well as foreign companies, the Act sets adequate reserves for policy liabilities and requirements of minimum capital or assets. The Act also requires financial reporting to and prudential

examination by the Superintendent of Financial Institutions, the regulator of federally incorporated financial institutions.

Provincially incorporated companies are subject to similar regulatory frameworks set up by the provinces. Examination of provincial company is undertaken by the respective provincial superintendents of insurance, except in Manitoba and Newfoundland which have agreements with the federal supervisor. The provinces also regulate the marketing of insurance products, such as the licensing and conduct of agents, contractual issues and consumer disclosure.

6. Financing of Private Insurers

Insurance companies are not authorised to accept deposits in Canada. They may, however, issue classes of share as stipulated in their by-laws. In particular, a company other than a mutual company must have one class of shares designated as "common shares". These provide their holders with the right to vote at shareholders' meetings, to receive declared dividends, and to have a share of the company's residual value in the event of dissolution. Since they are owned by their policyholders, mutual companies are not allowed to issue any share that either provide voting rights or entitle their holder to a share in the company's remaining property on dissolution.

In addition, federal insurers and financial subsidiaries not engaged in rich insurance may enter into debt obligations, whether secured or unsecured. However, a company's aggregate debt obligation and the stated capital of any shares included as part of its regulatory capital shall not exceed 20% of total assets for a life insurer, and 2% for a P&C insurer. In the Act, these restrictions are referred to as the Life and P&C Companies Borrowing Regulations. Similar restrictions apply to provincial companies.

7. Financial Security of Insurers

Regulations aimed at ensuring that Canadian insurers are solvent and that commitments to policyholders are met were designed on the basis that insurers are either life or non-life (P&C) insurers. The regulations can be divided into two broad types: business and investment restrictions, and capital/asset requirements.

Business & investment restrictions

The Act limits business powers of federal insurers and branches of foreign companies. It defines their main business and imposes restrictions on additional powers they may want to exercise (e.g. debt issuing mortgages, reinsurance, partnership). The Act also limits the investments that a federal insurer, its prescribed subsidiaries, or a foreign company may acquire, including restrictions on lending, real property interest and equity acquisitions.

Capital/asset requirements

Under the act, federal insurers and foreign companies doing business on a branch basis are required to maintain adequate capital and liquidity, as specified by the superintendent. Standards have been established for both life and P & C companies to distinguish between weakly and strongly capitalised entities. Accordingly, life insurers are expected to maintain capital in accordance with the Minimum Continuing Capital and Surplus Requirement (MCCSR). Minimum capital is determined by applying factors for each of four risk components to specific on- and off-balance sheet assets or liabilities and by

adding the results. The four risks considered are default, mortality/morbidity, interest margin pricing and interest rate risks.

Federal property and casualty insurers are subject to a similar capital requirement, called the Minimum Asset Test (MAT). Total assets of P & C insurers must exceed a threshold based on a prescribed formula which takes into account the firm's liabilities, including policy obligations, earned and unearned premiums, claims, and risks reinsured.

The assets that a foreign company is required to maintain in Canada pursuant to the capital/asset requirements must be vested in trust in a Canadian financial institution chosen by the insurer and approved by the Superintendent.

8. Protection of Policyholders' Rights

A consumer protection plan was created in 1989 to protect Canadian policyholders against loss of policy benefits from the insolvency of their life and/or health insurer. Administered by the Canadian Life and Health Insurance Compensation Corporation (CompCorp), the plan is entirely financed by its members, which include all federal and most provincial life and health insurance companies as well as P & C insurers selling health products. It covers health benefits up $60,000 and disability income up to $2,000 per month. The Act stipulates that every insurance company that has outstanding policies in Canada of a class of insurance must be a member of any compensation association designated by the Minister of Finance for that class of insurance.

9. Future Prospects

Private health insurance does not play a major role in Canada. Public plans limits the market of private insurers to a few specific products, complementary to the relatively comprehensive public coverage. Nevertheless, two factors could potentially affect the demand for private health insurance industry in Canada: the ageing of the Canadian population, and the potential expansion or withdrawal of governments from the financing of certain services.

Canada's population is ageing. Data from Statistics Canada suggest that that 7.8% of Canadians were 65 years or older in 1951, as opposed to 11.7% in 1991. By 2016, this percentage is expected to reach 16%. Since seniors tend to use more health services (they accounted for 38.3% of total expenditures in 1991), such a demographic change means a greater demand for insured health services and a potentially increasing need for complementary insurance to cover uninsured services (e.g. drugs, home care and medical equipment).

Canadians regard health insurance as a basic right, but fiscal realities have put increasing pressure on public financing. Federal transfers to provinces for health care were reduced significantly in the mid-1990s to meet deficit reduction targets, resulting in a relatively greater financial participation of the provinces. As a result, during the early to mid 1990s, health care had become a key target of most provinces trying to balance their budget by containing expenditures.

Recently, both the federal and provincial governments have increased funding for health care as fiscal conditions have improved. Health care spending now represents between 28% and 36% of total program expenditures of each province. Depending on economic and fiscal circumstances, it is conceivable that some provincial governments may decide to withdraw from the financing of specific services, introduce co-insurance, or impose stricter eligibility criteria to various benefits, creating opportunities for private

insurers to expand the range of products offered. This happened in the past years to the coverage of dental services (for people over a certain age) and eye exams in certain provinces. Coverage for out-of-country services was also redesigned to fill the gap left by provincial cutbacks.

On the other hand, it is also conceivable that the scope of public coverage be broadened to ensure that basic health care needs are met, particularly in areas such as drug coverage and home care.

Obstacles

As noted above, this history of health insurance in Canada suggests that the scope of private health insurance depends critically on the scope of public health insurance plans. Beyond this fundamental issue, the growing costs of health care, drugs in particular, is probably the most serious impediment to the future development of the private health insurance industry. A study of Health Canada indicates that spending on prescription and non-prescription medicines amounted to $10.8 billion in 1996, or 14.4 % of total health spending. Medications received as part of institutional care as well as seniors and welfare recipients are funded by he public health care plans. But these plans only provide limited benefits to a relatively small portion of the population. According to Health Canada, public health plans covered 35.6% of total drug spending in 1996. Therefore two thirds of drug expenditures in Canada were paid by the private sector (i.e. individuals, employers and private insurers).

Since the early 1980s, the share of total health monies allocated to drugs has continuously expanded; from 9.8% in 1983 to 14.4% in 1996. Federal and provincial governments have been relatively successful in containing drug expenditures in recent years, with public drug spending increasing by 1.5% in 1995 and decreasing 2.6%. Private drug expenditures, however, continue to increase steadily. In fact, private sector spending on drugs increased by 5.5% in 1995 and by 5.9% in 1996. A conference Board of Canada survey shows that on average, the cost of employee drug plans has increased from 0.72% of payroll to 1.07% between 1990 and 1994. If sustained, this trend is likely to impact on the profitability of private insurers which, combined with employers, provide drug coverage to roughly 62% of Canadians.

CZECH REPUBLIC

1. Structure, cost and finance of health care system

1.1 Structure and cover

The health care in the Czech Republic includes both ambulatory and hospital care. The ambulatory health care comprise primary health services, specialized ambulatory services and special ambulatory services.

The primary health services are assured by physicians by whom patients are registered. The specialized health care is provided on the recommendation of the physician of the primary care. Persons with acute or chronic diseases, mental or other disability receive the special ambulatory services.

The hospital care is provided by hospitals or special medical institutes which may provide also ambulatory care.

Almost any health care which is necessary from the medical point of view is covered by the obligatory public health insurance provided through sickness funds (so called health insurance companies). Every citizen of the Czech Republic is obliged to join one of the sickness funds (total number of sickness funds decreased from 27 in 1995 down to 10 in 2000 by mergers or bankruptcies.) Sickness funds have the status of public institutions, their individual plans of incomes and costs are every year approved by the Parliament of Czech Republic. Sickness fund, whose plan has been finally disapproved looses licence and goes into liquidation.

1.2 Finance

Primary health care is partly financed on the basis of number of clients registered with the given physician and partly on the basis of the volume of health care provided to the patients in the given period.

Specialized ambulatory health care is financed on the basis of the volume of health care provided to the patients in the given period.

Hospital health care is financed on the basis of the lump sum remuneration, based on the lump sum remuneration of the previous year, multiplied by agreed percentage to cover inflation. In case that the volume of health care provided to patients drops substantially against previous year, remuneration is reduced accordingly.

Contributions to the sickness funds represent 13,5% of the net income by self employed, 4,5% paid by employees (deducted automatically by employer from their salary) plus 9% paid by employers for their employees. Contributions for children, pensioners, unemployed and mothers on mothers leave are paid by the state on the basis of the minimum salary stipulated by the government.

60% of the contributions collected by individual sickness funds are re-distributed between all sickness funds on the basis of the age groups included in the portfolios of individual sickness funds.

2. History of private health insurance

Until end of 1989 when the Communist regime fell no private health insurance existed as all medical care was provided to the patients free of charge. This medical care was financed by the state budget. The only exception to this rule was travel insurance during tourist and business trips to non-communist countries to cover substantial difference of their cost.

First private health insurance company started operations 1st July 1993. This was a joint venture of a leading German private health insurance company and the largest, previously the only state insurance company. The specialized company offered financial products like daily allowance during stay in hospital, temporary disability income insurance, costs of high standard hospital treatment.

Other (composite) insurance companies started to offer these products since 1996. For the year 1999 out of 42 insurance companies licensed 9 insurance companies have shown business results for this class of insurance and further 8 insurance companies have these products on offer or prepare them.

In 1997 the specialized private health insurance company offered first true healthcare product, namely „high standard dental treatment not covered by public health insurance“. In the spring of the same year Parliament approved the Public Health Insurance Act, which substantially reduced the range of treatments covered by the public health scheme. Two more insurance companies offered similar products in 1998 (plus high standard dental replacements).

3. Nature of private health insurance providers

Private health insurance providers are insurance companies licensed for this class of insurance by state supervisory authority at the Finance Ministry. In addition, also the largest sickness fund, called VZP or General Health Insurance Company, is licensed for some private health insurance products. Latest draft Public Health Insurance Bill now in Parliament provides for the VZP to completely leave the private health insurance activities within 2 years.

The specialized a.m. insurance company still dominates the private health insurance market. All other competitors are either composite insurance companies or life insurance companies.

4. Range of benefits

Private health insurance companies offer:

- temporary disability income
- permanent disability income
- daily allowance during stay in hospital
- high standard care in hospital (1-2 bed room)
- high standard dental treatment
- high standard dental replacements
- operation costs

5. Compulsory long-term care insurance

Compulsory long-term care insurance does not exist in Czech republic. Two companies offer voluntary long-term care insurance.

6. Statistics

Czech Insurance Association (•AP) started to gather statistics on this class of insurance (premiums written) since 1998. The 1999 figures show total premium written to be 204 million CZK (Czech crowns, 1 USD is now cca 40 CZK). Midyear results of the year 2000 of the •AP members amount to 105 million CZK. Other figures are not yet reported by the •AP.

The most important products are temporary disability income and daily allowance during stay in hospital, where average premiums amount to 3 000 – 4000 CZK per year. Premiums depend on the age, sex, health status and daily amount covered.

7. Taxation

Self employed people are since 1994 free to leave the state sickness income scheme, which offers daily allowances during temporary disability with limits on the allowances set very low. If they leave the state sickness income scheme and buy temporary disability private insurance, the part of their premium equal to the contribution to the state sickness income scheme is tax-deductible.

8. Current situation and future prospects

Private health insurance has grown since its greenfield beginnings in 1993 to a recognized, but still small class of private insurance business. The latest figures – mid 2000 – show that private health insurance premiums written represent 3,7 per mille of the overall non-life premiums of the members of the Czech Insurance Association.

Czech Insurance Association proposes to the Health Ministry since 1998 to open to the self-employed people the possibility to conclude private insurance cover not only for their disability insurance, but also for their health insurance. These proposals have not yet been accepted by the Health Ministry, nor they gained necessary political support.

DENMARK

1.Public health sector

Organisation

The Danish health care system comprises hospital services and primary health services including preventive health programmes. The regions are responsible for the major health care services such as the hospital services and the primary health services while the local authorities are responsible for home nurses, infant health visitors, school health and dental services.

Financing is mainly through taxation but patients are sometimes requested to pay part of the expenses.

In 1995, total expenditures on public health services amounted to approx. 6.6 per cent of the gross national product (GNP). All residents in Denmark are covered.

1.1 Hospital services

Hospital services cover the whole spectrum of physical and mental illness, providing diagnoses, treatment and care. This includes also childbirth and stays at public convalescent homes. Hospital treatment is free of charge and patients are only admitted to hospital after referral from a General Practitioner or via the hospital emergency units. In public hospitals, it is not possible to get (pay for) special treatment such as a private or semi-private room, etc.

1.2. Primary health-care

The National Health Insurance System operates with two groups, and anyone aged 16 or over is free to choose between these two groups. 97.6 per cent have chosen group 1, and 2.4 per cent group 2. Children under the age of 16 will be in the same group as their parents. There is only a difference between the two groups concerning General Practitioners and practising specialists.

1.2.1. General Practitioners and Specialists

1.2.1.1. Group 1

Members of group 1 choose their own general practitioner and the treatment is free of charge. It is only possible to change from one GP to another once a year. If the patient has a referral from his GP to a practising specialist the treatment by the specialist is free too. The GP and the specialist must have an agreement with the National Health Insurance Scheme.

1.2.1.2. Group 2

Members of group 2 may change to a new GP whenever they want and need no referral if they want to consult a specialist. In return they must pay part of the expenses themselves. In fact they receive the same amount from the public system as members of group 1, but the GP or the specialist is allowed to charge them more, which is not the case for group 1 members.

1.3. Dentists

The population has a free choice of dentist and an agreement with the National Health Insurance Scheme gives patients the possibility of reimbursement of approx. 40 per cent of the expenses for normal dental treatment. There is no public subsidy available for more expensive treatment, e.g. gold crowns and bridgework.

1.4. Medication

The Ministry of Health and The National Board of Health decide a list of subsidised medicine. For items on this list, the National Health system pays between approximately 49 per cent and approximately 74 per cent of the cost depending upon the prescription. For elderly patients and some with chronic diseases there are special possibilities for free medicine.

1.5. Chiropractic and Physiotherapy Treatment

General Practitioners can refer patients for treatment by physiotherapists while patients can visit chiropractors without any referral. When the physiotherapist or the chiropractor works under an agreement with the National Health Insurance Scheme, patients can have the fees paid partly reimbursed.

1.6. Spectacles

The National Health Insurance Scheme pays only a very small amount for children's spectacles. The social sector pays for spectacles and lenses for people with extremely bad eyesight.

1.7. Burial Expenses

The public system pays DKK 5,500 (= approx. ECU 738) for children under 18 years and DKK 6,600 (= approximately ECU 886) for people over 18 years (1996 figures). But payment depends on financial circumstances. If a child has private means of more than DKK 17.650 (= approximately ECU 2,369) or a person over 18 years has private means of more than DKK 28.650 (= approximately ECU 3,846) nothing is paid.

1.8. Travel Health Insurance

The National Health Insurance Scheme pays all costs for hospitalisation, medical and dental treatment, medicine and transport back to Denmark for all persons covered when sickness or accidents occur during their holidays (only the first month of every holiday) in Europe and the Mediterranean.

1.9. Home Nurses, Infant Health Visitors, School Health and Dental Services

Visits of home nurses are free on referral from a doctor and all children have the right to free infant health visitors, school health and dental services.

2. Private health sector

Some clinicians do not have an agreement with the National Health Insurance Scheme but they are very few. A patient in group 2 will get the same reimbursement as always if he is treated by a GP or specialist without agreement. Group 1 patients must pay all the expenses.

In Denmark, there are also very few private hospitals and clinics. The total number of beds are approximately 775 which in many cases are paid by the public (e.g. in special hospitals for diabetics). There are about 100 private beds in Denmark and they are in most cases used in connection with surgery.

3. Private health insurance

In Denmark, the social sector comprises services which in other countries are considered as parts of the health sector, e.g. care of elderly people in their homes or in nursing homes and payment in case of occupational incapacity or disability. This means that private health insurance in Denmark is understood more narrowly as insurance in the same field as the public health sector. The exception is private health insurance for people who are abroad.

Organisation and Background

One non-life company (mutual) offers health insurance as non-life insurance, which is supplementary to National Health Insurance.

Three non-life companies offer insurance against sickness and accidents arising during a journey (travel health insurance). These companies and one other company offer health insurance for customers living abroad. Some non-life companies sell travel health insurance in connection with household insurance.

Four life companies offer alternative health insurance which primarily covers private hospitalisation.

Critical illness insurance is available together with compulsory group life insurance or pension and can be taken out in a company which provides group life insurance for several life insurance companies and in at least two life insurance companies (not part of the company mentioned).

3.1. Private Health Insurance as Supplement to National Health Insurance

The mutual company mentioned earlier covers about 27 per cent of the total population (1996). So far the company has only dealt with individual insurance. To become a member (policyholder) one must be under 60 years old and be completely healthy. Children under the age of 16 are covered with their parents without extra charge. Applicants do not have to complete a medical history and applications are not scrutinised, but applicants must make a solemn declaration on their health. Currently the company offers four kinds or groups of insurance, of which three are designed to supplement the National Health Insurance Scheme and one gives the right to enter later on even if one is not completely healthy at that time (option).

Compensation is paid as fixed amounts per service (e.g. doctor's call) and is only paid as per account rendered or as a percentage thereof.

The groups are:

3.1.1. Group 1

This group is designed for group 1 members of the National Health Scheme (see I.2.). Membership of group 1 provides cover for expenses in those cases where the National Health Scheme provides either no or only partial reimbursement.

3.1.2. Group 2

The same kind of cover as for group 1 members applies for members of group 2. However the difference is that this group has been designed especially for people who have chosen group 2 in the National Health System. Thus, in addition to the cover described above, group 2 members are reimbursed for the expenses relating to GP and specialist assistance for which the National Health System does not provide cover.

3.1.3. Group 5

The premiums for group 5 are lower than for the other two groups. This group is aimed at people who are members of group 1 of the National Health Insurance Scheme. Whereas in structure it is similar to that of group 1 (III.1.1.), the cover provided differs as this group is primarily intended for young people who require only limited health insurance cover. Also, group 5 is often people's first private insurance against unforeseen expenses and functions as a kind of preparation for subsequent transfer to group 1 or 2.

3.1.4. Group 8

In this group the premium is very low. Membership only gives the right to enter one of the other groups later on - even if one is not completely healthy at that time (option).

3.1.5. Premiums

Group				
Group	1:	DKK 1,820 per year	(= approx.	ECU 244)
-	2:	DKK 2,464 - -	(= -	ECU 330)
-	5:	DKK 860 - -	(= -	ECU 115)
-	8:	DKK 320 - -	(= -	ECU 43)

Premiums do not rise with age.

4. Private health insurance covering private hospitalisation, health insurance during permanent stay abroad, travel health insurance, critical illness insurance

4. 1. Hospitalisation

The mutual non-life company provides group 1 and 2 (III.1.1. and III.1.2.) insurance cover for hospitalisation in private hospitals and clinics as well as in public hospitals located outside the health district to which the patient belongs. Coverage amounts to 50 per cent of the total cost, but with a maximum amount of DKK 5,250 (=approximately ECU704) per day in hospital. In addition, cover is available for operations carried out on an outpatient basis. There are, however, a number of exceptions, e.g. treatment for alcoholism. Group 1 and 2 also have cover for a stay in a hospice which amounts to 50 per cent of the total cost but with a maximum of DKK 10,000 (= approximately ECU1342).

Four life companies provide insurance cover for hospitalisation in private hospitals including out-patient treatment, even in private hospitals outside Denmark if the price is the same or if the patient cannot be treated in Denmark or if he will have to wait for treatment for an unacceptable length of time. Treatment for alcoholism is covered by some companies. The companies deal with both individual and group health insurance. The most usual customer is a company seeking cover for some of its employees (« key people »).

4.2. Health insurance during permanent stay abroad

Four non-life companies offer cover when a customer is abroad for more than a holiday. Insurance can be taken out to fit individual needs and is often employer-paid. A broad range of cover is possible (e.g. for hospitalisation, dental care, medicine, accidents, funeral expenses). Premiums depend on cover, age, location and whether it is a temporary assignment or long-term posting.

4.3. Travel health insurance

As already mentioned, some companies offer insurance against sickness and accidents arising during a journey. This is supplementary to the National Health Insurance Scheme (see 1.7.) which does not cover business travel or combined business/holiday travel and does not provide cover outside Europe and the Mediterranean. The product is sold as a standard product, e.g. for customers of travel agents, or as special products paid by employers for their employees.

4.4. Critical illness insurance

Critical illness insurance is available together with compulsory group life insurance or pension and can be taken out in a company which provides group life insurance for several life insurance companies and in at least one life insurance company (not part of the company mentioned). At the beginning of 1997, there were approximately 12,000 policies but the market is growing. Maximum cover is 10,000 DKK (approximately ECU 1,342). The premium is about 450 DKK per year (approximately ECU 60). Since 1998 critical illness insurance is also provided as individual insurance.

4.5. Long-term care insurance

In 1999 one insurance company has started selling long-term care insurance and at least one more company is expected to enter this market.

5. Prospects for the development of private health insurance

Private Health Insurance providers in Denmark expect the demand for private health insurance schemes to increase, mainly because the Danish people are getting wealthier, especially the elderly, and they are increasingly willing to pay for their own health.

When the perceived quality of life declines the elderly are not likely to accept and might prefer to avoid waiting lists and other forms of rationing by subscribing for a private health care scheme.

According to the private insurance companies survey many employers are not willing to accept sick leave due to long waiting times, consequently they subscribe for private insurance schemes for their employees.

On the other hand an estimate for the capacity on private hospitals/clinics compared to the total public sector is 1-2 % of the total no. of beds.

In Denmark there is a high growth in three types of health insurance schemes:

- Insurance schemes supplementary to the public system.
- Insurance schemes which ensures treatment.
- Insurance schemes against critical illness which disburses a cash-payment in the incident of critical illness.

6. Regulation of private health insurance

The regulations applicable to providers - in Denmark it means insurance companies - of private health insurance services is partly the Insurance Business Act which regulates the supervision of the insurance company and the legal and financial conditions of its activity and partly the Act on Insurance Contracts which governs the insurance contracts and regulates the terms between the insurer and the policy-holder/the insured.

FINLAND

1. Structure, cost and finance of health care system

1.1. Structure and cover

Health care in Finland is based on a national health service system. The basic responsibility for providing health and social services lies with the municipalities. National health services are supplemented by private practice.

Municipalities (approximately 450) bear the main responsibility for organising the health care system. They can provide services in their own facilities, or alternatively they can also co-operate by forming joint municipal boards for providing health services or buy services from the private sector.

National health service is organised around local health centres (265 in 1999), which form the backbone of primary health care. Their services include examination, treatment and rehabilitation. Most health centres have at least four general practitioners. Few centres have specialists of their own but also consultants can be used. In addition, many centres run small hospitals or have a small ward and supply home nursing. Other services include maternal and child health care, school health services and free dental care for children.

Specialist treatment is given in hospitals. For this purpose the country is divided into 20 hospital districts, all run by intermunicipal organisations, each with a central hospital, a psychiatric hospital and other kinds of hospitals.

National health services are available to all residents without restriction.

1.2. Cost

In 1998 the expenditure of the health care system amounted to FIM 30 billion. This is about 4 % of GNP.

1.3. Finance

The state's share of the above-mentioned health care expenditure is at the moment approximately 25 %. Municipal funding accounts for about 65 of the costs. The households' share is 10 %.

2. General outline of health insurance system

Sickness insurance is a compulsory insurance scheme covering all residents. It is financed by contributions from employers and the insured and by the state.

All residents are entitled to national health service. In addition, doctors' fees, costs of examinations and treatment provided in the private sector are partially compensated from the sickness insurance scheme. It also refunds part of the medical costs, ambulatory care costs and costs of transportation by ambulance or taxi. Also daily allowances in case of sickness, maternity or parental leave are paid from the sickness insurance scheme.

3. History of private health insurance

In addition to the statutory sickness insurance, private insurance cover is offered by many companies as additional coverage linked to life insurance and personal accident insurance.

Starting from 1911, insurance companies have been offering supplementary disability insurance, which was at first of a waiver premium benefit type. Soon thereafter disability pension insurance policies were introduced. New features were added in the 1930's in the form of temporary disability periods. The products were further expanded in the 1940's and 1950's.

The statutory sickness insurance scheme was introduced in 1964. The public health care system was inadequate, too. To cover the inadequacy of the health care system, the insurance companies started to offer sickness insurance policies. The companies tried to learn from the unfavourable experiences gained abroad via insurance terms and conditions and by granting contracts only as additional insurance to life insurance.

In spite of the precautionary measures sickness insurance proved quite unprofitable in the late 1960's. From 1968 on the companies gave up offering sickness insurance with disability pension insurance adjoined.

In the 1980´s insurance policies for children's medical expenses were very popular. Unfortunately, they proved to be very unprofitable, which led to a remarkable increase in premiums.

Also funds of different kinds have provided sickness insurance cover. The first such funds were established in the first half of the 18th century. They grant benefits in case of sickness, disability and death.

4. Nature of private health insurance providers

Most life and non-life insurance companies offer additional health insurance.

Contributory sickness funds are insurance institutions which can grant either statutory or voluntary sickness benefits, or both. The sphere of activity of such a fund usually covers the employees of one or more employers.

5. Range of benefits

Disability insurance provides security against temporary periods of disability: the insured is entitled to compensation provided that he/she has become disabled during the term of the contract; before 1973 the degree of disability of the insured had to be 75 per cent, but nowadays there is no such general percentage limit. Disability insurance is an all-risk type of insurance. There are however some restrictions: for example pregnancy, parturition, abortion and infertility treatment are usually not considered to be a ground for disability compensation. The duration of the possible disability compensation (daily benefit) period is usually limited to a maximum of 365 days, but there are products involving compensation up to 730 days. The benefits in 1997 amounted to FIM 46 million.

Insurance against permanent disability: the benefit can be a lump sum or a disability pension. The definition of disability is the same as in the previous case, with the exception that the disability has to be permanent. A disability is considered permanent provided that the condition of the insured which caused the disability has become medically stable. In 1997 the benefits in the private sector amounted to FIM 33 million.

Hospitalisation insurance: the purpose of the insurance is to cover the expenses of the insured in case of possible hospital treatment period. The reason for the treatment must be sickness or injury. The compensation can be fixed (per day) or bound to the actual daily bed charge. Payment of the benefit is independent of possible other benefits from other sources. There is usually a conditional waiting period for entitlement to the benefit. The benefits in 1997 amounted to FIM 12 million.

Medical treatment insurance: the forms of accident insurance have often included coverage for the expenses of medical care. Medical treatment insurance is, however, often of an all-risk type, thus covering illnesses, apart from accidents. This form is rather new in Finland; it was introduced in the 1970’s. Special forms of medical treatment insurance include children’s medical treatment insurance, individual and group medical treatment insurance, and specially designed dread disease products (dental care insurance; in the past there was also tuberculosis insurance). The benefits in 1997 amounted to FIM 143 million.

Waiver of premium assurance: the insured is freed from the payment of premiums for example in case of accident or some other type of insurance for temporary disability. The benefits in 1997 amounted to FIM 12 million.

Burial grants are often included in life and accident insurance.

The benefits paid by contributory sickness funds are defined in the by-laws of each fund. They may include deductibles of statutory benefits or types of benefits not payable under the statutory sickness insurance scheme (e.g. spectacles, dental care).

6. Finance of private health insurance

Private health insurance is offered by both life and non-life companies. Premiums are fixed in accordance with the risk, age at entry and state of health of the person to be insured. They are written in the same way as life insurance, i.e. using an actuarial basis which follows a technical business plan containing all the calculation bases used.

The total premium income of voluntary health insurance (non-life insurance class 2) was FIM 300 million in 1997. The total premium income of the statutory workers' compensation was FIM 2 535 million (out of total FIM 11 800 million of the non-life insurance premium income).

For life insurance companies, the total premium income of voluntary disability insurance amounted in 1997 to FIM 290 million, of which the premium income of medical treatment insurance was FIM 150 million (out of FIM 11,280 in total of the life insurance premium income).

The voluntary benefits of contributory sickness funds are financed by the insured employees. Also employers sometimes participate in the financing.

7. Current situation and future prospects

The public health care system as well as the sickness insurance scheme have been developed at a very rapid pace. The importance of private health insurance is, owing to the comprehensive public system, quite small.

The possibility of tax allowance for insurance policies for the care of elderly people has, however, recently been brought up by the industry. The present position of the Ministry of Social Affairs and Health on the subject is that such a system should not question the present system of public health care based on the Nordic welfare ideology. However, if a private policy proves profitable without any tax allowance it is a welcome addition to the system. It is probable that without any public subsidies the private insurance policies for the care of elderly people are not likely to become significant. Another problem is of a more technical nature: from the actuarial point of view it is not easy to insure for the need of care.

The increased international competition will possibly affect the Finnish insurance market, too. For example, Finnish insurance policies for medical treatment expenses are of an all-risk type although dread disease insurances are offered in international markets.

8. Regulation of private health insurance

The Insurance Contracts Act is applicable to private health insurance contracts as well as to other private insurance contracts concluded with an insurance company. The providers are regulated by the Insurance Companies Act and the Insurance Funds Act.

FRANCE

1. Structure, cost and finance of health care system

In France, every individual has a free choice of doctor and hospital.

Hospital care is provided by a range of profit-making and non-profit-making institutions in the public and private sectors. However, under the 1997 agreement with independent practitioners "procedures" may be arranged, on an experimental basis, which specify that when treatment is required a general practitioner must be seen first.

In the majority of cases, out-patient care is provided by independent doctors, operating individually or in group practices, or by doctors who are employed by hospitals or a health care centre.

In 1995, health expenditure (OECD definition) accounted for 9,8% of GDP, of which 8,9% related solely to consumption of medical services. This was distributed between hospital treatment (49.5%), out-patient treatment (27.8%), non-hospital pharmacies (18.5%) and other miscellaneous items, spectacles, orthopaedics and travel (4.2%), all of this corresponding to a cost of nearly 12,000 Frs per head per annum.

Over the period 1980-1995, consumption of medical services rose at an average rate of +9% per annum, i.e. around 2 % higher than GDP, but the rate slowed down during the last three years (+4,4% in the period from 1992 to 1995).

The way in which health expenditure is funded changed considerably in the period 1980 to 1995 as a result of the compulsory social security schemes stopping or reducing the reimbursement of costs for certain treatments and medicaments. The social security schemes financed 76.5% of medical treatments in 1980 but only 73.9% in 1995. At the same time, the finance provided by the State and local communities fell from 2.9% to 0.8%. In contrast, that provided by complementary schemes rose from 5.0% in 1980 to 6.8% in 1995 for mutual societies and from 1.4% to 3.1% for private insurance companies. Payments due from private households remained more or less stable at around 14 to 15%.

2. General outline of health insurance system

Social security schemes operating on the basis of collective responsibility which were introduced in France in common with the majority of other Western European countries, have played a considerable role in this area. They have made a decisive contribution towards the improvement of living standards, access to health care and the achievement of greater social justice.

Although initially introduced for employees in trade and industry, this form of **compulsory state provision** has gradually been extended to cover other socio-occupational categories. 99% of the population in France is now covered by one or other of the following schemes :

- the general social security scheme, for public sector employees in trade, industry and agriculture;
- independent schemes, for self-employed workers outside the agricultural sector (the TNS scheme for tradesmen, manufacturers, craftsmen and professional persons) and farmers (the AMEXA scheme).

In addition, under a law of 2nd January 1978, individuals who had not previously been covered by any statutory provision scheme were able to join the general social security scheme by way of a personal insurance.

All the statutory schemes reimburse the same categories of **treatment costs** (medical, surgical and pharmaceutical expenses, hospitalisation costs, etc.) in the form of flat-rate benefits calculated on the basis of the health insurance funds' financial liability. In principle, all the schemes operate a system of patients' contributions (the difference between 100% of the amount payable under statutory schemes and the rate of reimbursement applied under these schemes). These variable contributions may be reduced or waived in cases stipulated by the regulations (for example long-term hospitalisation, instances of long-term and expensive illnesses, etc.).

As part of the 1996 Reform, Act No. 99-641 of 27 July 1999 instituting universal health cover, which enters into force on 1 January 2000, makes extensive changes to the organisation of the French health insurance system with regard to:

- Social Security schemes: It is compulsory for every person residing in France in a stable and lawful manner to belong to a Social Security scheme. Until now, membership has been compulsory within the context of occupational schemes. Persons who could not be assigned to an occupational scheme had the option of taking out personal insurance (Act of 2 January 1978). The reform introduced by the Act of 27 July 1999 does away with this personal insurance regime and provides effective cover for the entire population (between 150 000 and 200 000 highly disadvantaged persons had no cover).

- Supplemental insurance: The Act of 27 July 1999 introduces supplemental protection in the area of health care. This supplemental cover, provided on a means-tested basis, may be taken out by the beneficiary from a Social Security fund or from a private supplemental insurer. This mechanism, which is expected to cover six million persons, is being financed essentially by the State. It is intended to give effective access to health care to the most modest households. Such persons often forego medical attention because they cannot afford supplemental health insurance to cover the share of health care costs not paid by Social Security.

Only health insurance schemes for employees provide cover for the risk of temporary occupational incapacity and disability. Temporary occupational incapacity entitles the claimant to daily payments. In the case of disability, an annuity is paid in cases where the disability reduces the insured's occupational incapacity by more than two-thirds. Daily payments and annuities are calculated on the basis of earnings, subject to an upper limit.

Under current regulations, the schemes for self-employed workers (TNS, AMEXA) provide only limited protection in the event of total disability. However, where incapacity due to occupational accidents and diseases is concerned, farmers and craftsmen are covered compulsorily by special schemes separate from the health schemes.

The operation of the statutory schemes does not necessarily mean that the **private sector** has no part to play in provision. On the contrary, private means of provision, based on freedom of choice and tailored to individual requirements, have made a very positive contribution in recent decades.

In a world where the uncertainties of life mean that each individual is willing, rightly, to assume a degree of personal responsibility, private health insurance in particular seeks to satisfy those individual requirements by offering each individual scope for taking out personalised provision schemes offering either complete cover or, more often than not, cover which complements the benefits provided under the statutory schemes.

Consequently, although they meet different needs and are governed by their own separate regulations, both statutory welfare schemes and private insurance schemes exist side by side in France, as is the case in the majority of European countries.

3. History of private health insurance

Mutual aid associations, acting as corporate bodies, were the first organisations in France to offer their members protection against the financial consequences of sickness. They must take the credit for paving the way for the modern concept of the provision of cover for these risks.

Leaving aside a number of attempts to establish group insurance schemes at the beginning of the nineteenth century, private health insurance in its most modern form did not really begin to expand rapidly until the years immediately following the establishment and implementation of state insurance schemes (1930).

Private insurers provided cover for self-employed workers who fell outside the scope of the state scheme, such cover being limited initially to the reimbursement of costs incurred as a result of sickness or surgery. Subsequently, cover was extended to include the risk of incapacity or disability.

At the same time, private insurers through group insurance set about offering employees types of cover under which they would receive benefits complementing those paid under the basic scheme.

The introduction of the social security scheme for industrial and commercial employees, under orders passed in 1945, brought about virtually no change in that situation.

The introduction of independent statutory provision schemes for self-employed workers in 1961 and 1969 (the AMEXA and TNS schemes) confined private insurers to the role of complementary insurers in the provision of insurance for health care costs.

4. Private health insurance providers

Private health insurance business can be written only by “accident” (non-life) insurance companies which have received a specific authorisation to do so in accordance with the regulations currently in force.

However, there is an exception to this principle, in that life insurance companies may cover the risk of disability “by any cause” and accidental death either in the form of direct cover or as complementary cover under a life insurance contract.

All insurance companies governed by the Insurance Code are subject to the authority and supervision of the Financial Directorate of the Ministry for Economic and Financial Affairs.

Approximately 150 member companies belonging to the Federation of French Insurance Companies (FFSA) write health insurance business in the form of individual or group contracts. None of those companies writes health insurance alone.

Private health insurance, like other insurance operations, is governed by the Insurance Contract Law of 13th July 1930 and the law of 31st December 1989 on complementary social provision which are now included in the Insurance Code.

The mutual sector, which occupies a very significant position, has developed in parallel to these traditional insurance operations. A specific ruling on insurance mutuals in 1945 has since been incorporated into the Mutuals Code, which was amended in 1985.

The mutual sector, which is organised on an occupational or local basis, comprises all mutuals which developed from the mutual assistance associations existing previously.

5. Range of benefits

Private sector participation in the health sector is currently limited to the provision of supplementary insurance, plus also the possible provision of cover with full reimbursement of costs for the risks of incapacity or disability which are not covered by statutory schemes for self-employed workers, together with health insurance for very limited categories of the population not subject to a compulsory scheme (cross-border workers, French resident abroad, etc.).

Against that background, and as part of their traditional insurance operations, private health insurers seek to satisfy consumers' requirements by offering an extremely wide range of types of cover providing benefits in kind (reimbursement of treatment costs) and in cash (cover for the risks of incapacity and disability and flat-rate hospitalisation allowances) on either a separate or an inclusive basis.

Cover for the reimbursement of treatment costs provides for a total or partial refund of the expenses for which an insured is liable (patient's contribution) under the compulsory scheme to which he belongs and may also include certain expenses which are not provided for under that scheme (for example a supplementary charge for a private room, a flat-rate hospitalisation payment, any excess fees, etc.). Private insurers are less involved in reimbursement for hospital treatments, the cost of which is covered mainly by social security, and reimburse principally costs for out-patient treatment: more than three quarters of their benefits cover treatments by a doctor, medicaments, dental treatment, spectacles and orthopaedics.

Subject to contractual limits on the sums payable, which are established on the basis of the insured's income in real terms, cash benefit cover provides for the payment of the following :

- a daily sick leave allowance in the event of temporary occupational incapacity resulting from an accident or sickness. In principle, the term of benefit payment is fixed at 365 days per annum, the benefit being payable from the date of incapacity. On request, this cover may be provided until the end of the third year;

- an annuity or capital sum (in the event of accident) payable in the event of permanent disability resulting from sickness or accident and where the insured sustains permanent occupational incapacity (either partial or total). That incapacity is assessed on the basis of both physical or mental incapacity and occupational incapacity.

Hospitalisation cover makes provision for the payment of a flat-rate allowance per day's stay in hospital, usually limited to 365 days or even 2 years.

These types of cover may be provided under individual contracts or group contracts.

It should also be noted that individual companies or groups of private health insurers, in conjunction with mutuals, participate in the management of compulsory schemes for the self-employed (AMEXA, TNS) by collecting contributions and paying benefits under the supervision of the bodies responsible for the administration of those schemes.

6. Private health insurance

Statutory health insurance is financed largely by a system of earnings-related contributions (contributions on earned income, general social contribution on all income) fixed without reference to the specific nature of the risks involved, under which each individual pays according to his means and receives benefits according to his requirements. This type of finance involves a transfer of resources within an organised system of collective national responsibility.

On the other hand, private health insurance, like any insurance system, is based on the principle of the mutual acceptance of risks according to which insureds' contributions are linked to the nature and extent of the risks to be insured.

In individual insurance (approximately one third of contracts) various rating techniques are used depending on the company in question. More often than not premiums vary throughout the term of the contract according to the age of the insured. More rarely, the level premium system is used. In that case premiums are fixed in accordance with the insured's age at entry and the insurer is responsible for setting up reserves for increasing risks. As a general rule, there is an increasing tendency for insurers to apply uniform rates, regardless of gender.

In group insurance (approximately two thirds of contracts) premiums are used to cover risks for each successive one-year period. In the case of the majority of company insurances, premiums are fixed as a percentage of earnings and shared between the employer and the employee on a 60/40 or 50/50 basis. Therefore, they depend neither on the insured's age nor his marital status and so the risk is borne on a completely mutual basis.

7. Current position and future prospects

Private health insurance represents a significant field of activity for insurance companies and makes a positive contribution to health provision.

The main difficulties encountered in this area relate to the constant need to adjust premiums to changes in the cost of risks, bearing in mind that costs are influenced by various factors such as the continuing increase in heath care consumption, the revaluation of the cost of medical treatment and hospital stays, the emergence of new (and often expensive) medical techniques, changes in the population, the variation in morbidity, etc.

In order to take account of all these external factors, which are beyond the control of insurers and may combine with the effects of changes in cover provided under the statutory schemes, insurers are seeking procedures which will allow a more satisfactory adjustment to trends in an economic climate where there is a tendency towards a reduction in individuals' ability to pay.

8. Prospects for the development of private health insurance

In France, private health insurers may operate only as a back-up to Social Security schemes. There are no plans to alter the respective areas of responsibility of the various bodies.

Just like the Social Security schemes, private health insurers are facing steadily rising health care costs. In order to keep cost trends under control, they have had to expand co-operation both with Social Security funds and with health care professionals (setting up health care networks and channels).

Main advantages and disadvantages of private health insurance

The main advantage of private health insurance is that it enables the insured to choose the level of cover that they feel is best suited to their own particular needs.

Nevertheless, in a competitive market in which such cover is optional, private health insurers select the risks they cover in order to avoid anti-selective behaviour. This selection effectively excludes certain groups from access to insurance, their state of health preventing them from taking out cover, either because the insurers consider the level of risk involved to be unacceptably high, or because the would-be clients lack the financial resources to pay the premiums corresponding to their level of risk.

9. Regulation of private health insurance

In France, three types of organisations may provide health insurance: insurance undertakings, provident societies and mutual insurers. Each is governed by a distinct set of regulations (respectively: the Insurance Code, the Social Security Code and the Mutual Insurance Code).

However, all three types of entities fall within the scope of EU non-life directives. These directives have been implemented in respect of insurance undertakings and provident societies; the relevant domestic legislation for mutual insurers is being prepared.

The regulatory differences between the various types of insurers stem from their respective forms of incorporation:

- Insurance undertakings are commercial companies.
- Provident societies are private non-profit entities administered jointly by business firms and their employees. They may offer guarantees only in connection with contracts taken out by businesses for the purpose of insuring their employees.
- Mutual insurers are non-profit organisations that serve their members by providing insurance cover, welfare benefits and mutual assistance.

Implementation of the directives with regard to insurance undertakings and provident societies provided an opportunity to harmonise the rules applicable to such institutions. Mutual insurers have still retained a large number of differences. Here too, implementation will mean that only those features that are compatible with the directives and justified by the mutual insurers' non-profit nature will be kept.

GERMANY

1. Structure, cost and finance of health care system

Virtually the whole population (approx. 99.9%) has some form of health insurance. More than 85% of the 88.5% of the population covered by the statutory scheme have compulsory membership and just under 15% voluntary membership. The latter may, therefore, choose between statutory health insurance and private health insurance. Approximately 9% of the population have private health insurance cover only, in the form of full cost medical expenses insurance. A further 2.4% have entitlements to cover of various kinds, while the remainder have no insurance cover.

In the out-patient sector, medical care is generally provided by GPs and specialists operating in private practices, and in the in-patient sector by acute hospitals and hospitals for the treatment of long-term conditions run by the State, non-profit and private organisations. Doctors and hospitals have to have the approval of the health insurance funds to treat members of the State health scheme. It is on that basis that the funds make medical and hospital treatment available to their members as a benefit in kind. The funds, however, settle fees directly with the doctor or the hospital concerned. In the case of out-patient treatment, settlement takes place on the basis of an agreement on fees negotiated between the medical associations and the funds. Under that agreement, payment is as a rule made for individual services, but limited in respect of the overall sum to be distributed among the doctors. Where a doctor treats a private patient, his bill must be based on an official scale of fees. However, that scale allows doctors a degree of leeway in the calculation of the charges to be made for each medical service provided.

In the case of in-patient treatment, a uniform, services-related charge is applied to all State and private hospital patients. That charge includes accommodation, subsistence, nursing care and medical treatment, including operations. In addition, the cost of accommodation in a single or twin-bedded room and private medical treatment by senior hospital consultants is calculated separately, where the patient wishes to avail himself of such services.

Health expenditure, almost 59% of which is accounted for by the cost of actual treatment, but which also includes the cost of preventive measures and rehabilitation, benefits paid following illness, the cost of training, research and various ad hoc measures, accounted for 10.6% of gross national product in 1993. Approximately half of this expenditure (47%) was financed by statutory health insurance, slightly more than 5% by private health insurance, approximately 15% and 14% by employers and public expenditure respectively, while the balance was taken up by annuity insurance, private households and statutory accident insurance.

2. Overall picture of the health insurance system in Germany

Private health insurance in the form of medical expenses insurance covers the cost of medical care and services in the case of illness or accident, pregnancy and childbirth. Daily hospitalisation allowance insurance provides hospitalisation payments and daily payments insurance provides a payment of daily compensation in the event of loss of earnings resulting from occupational disability brought about by sickness or accident. Statutory health insurance also provides benefits covering medical expenses and providing compensation for loss of earnings in the event of sickness, pregnancy or sickness resulting from an accident. Since 1 January 1995 there has also been a general insurance scheme for long-term care needs.

The dual health insurance system for the protection of the population in the event of sickness which exists in the Federal Republic of Germany is characterised by the simultaneous operation of private and statutory insurance institutions.

The division of health insurance into public and private sectors has led to the adoption of the following legal provisions regarding the existence or absence of an obligation to take out insurance:

In principle, the law requires that all persons undertaking paid employment must be insured against sickness. However, compulsory insurance ceases to apply, in the case of both white and blue collar workers, where an employee’s income reaches a certain level which is adjusted annually in accordance with movements in average earnings. As a result of this cut-off limit for compulsory insurance, employees may choose between statutory and private health insurance and may change from one sector to the other:

- Employees whose occupational income exceeds the cut-off limit for compulsory insurance from the start may belong to the statutory insurance scheme as voluntary insureds during a short transitional period; beyond that, however, they are not subject to compulsory insurance.

- As a further consequence of the cut-off limit for compulsory insurance, employees whose earnings are initially below the limit, but then exceed the limit as a result of an increase in wages or salaries, are no longer subject to compulsory insurance. They may then either remain members of the statutory health insurance scheme as voluntary insureds, or choose to take out private health insurance.

- Conversely, employees who have already left the statutory health insurance scheme but who are brought back within the scope of compulsory insurance by an increase in the cut-off limit, may be exempt from compulsory membership of the statutory health insurance scheme.

In addition to employees, there are other occupational categories which are not subject to the statutory health insurance scheme and where no compulsory insurance applies. Consequently, the self-employed and members of the professions operating independently are left to make their own arrangements for health provision. Likewise, civil servants who are in receipt of sufficient insurance cover as a result of benefits provided by their employers are not subject to compulsory membership of the statutory insurance scheme. Civil servants and the self-employed may not belong to the statutory insurance scheme on a voluntary basis, even when their remuneration or income falls below the cut-off limit for compulsory membership. In the case of pensioners, compulsory membership of the pensioners’ statutory health insurance scheme which, in principle, comes into force on retirement, no longer applies where pensioners have not been members of the statutory health insurance scheme for the greater part of their working lives. The provision of cover for all those people is the exclusive responsibility of private health insurance.

There are further population groups, for example students, trainees and part-time workers, who are subject to compulsory membership of the statutory health insurance scheme by law, but who may be exempt in the majority of cases.

3. History of private health insurance

The division of the health insurance system is linked to its historical development. The origins of modern State insurance date back to 1881, a year which saw the implementation of a three-tier insurance system protecting workers against the risk of sickness, accident, disability and poverty in old age, following an Imperial Address in the Reichstag.

The principle of a hierarchy of entitlement which formed the basis of this State insurance was a crucial factor in the development of private health insurance.

Given the principle that statutory provision should be limited to those who actually require protection, only a relatively small section of the population became subject to statutory health insurance. The protection of the remainder of the population was left to the initiative of private institutions, which thus gained access to a substantial private health insurance market, a market within which they could operate in parallel with state institutions in pursuit of the same objectives. Private insurers profited from those available opportunities and fulfilled their designated functions in the provision of insurance for the sickness risk by the establishment of efficient companies offering a wide range of cover. To that end, private health insurers called upon a large number of professional self-help organisations which were already in existence and which operated on a mutual basis. For that reason, the majority of companies writing private health insurance in Germany today are insurance mutuals, in which the overall economic risk is borne by the insureds themselves, viz. the members of the mutual.

Responsibilities continued to be shared in the above manner until the 1970s. Since then the balance between of sole responsibility for cover on the one hand and collective responsibility for protection on the other has shifted away from sole responsibility. However, the financial difficulties resulting from this opened up the debate on systematic restructuring of the health system on a regulative basis. The 1989 Health Care System Reform Law, the 1993 Law on the Structure of the Health Care System and, lastly, the 1995 Law on Long-term Care Insurance specifically refer to the role and responsibilities of private health insurance.

4. Nature of providers

The fact that there were approximately 7.2 million people covered by health insurance on an exclusively private basis at the beginning of 1999 demonstrates the important role played by private health insurance in the German health care system. The 51 companies belonging to the Association of Private Health Insurance (Verband der Privaten Krankenversicherung) have more than 99% of the private health insurance market in terms of premium income. Within the private insurance industry as a whole, health is the second largest class with almost 16% of the overall premium income in 2000.

Since certain population groups may take out health insurance solely on a private basis - for which the term “substitutional health insurance” has become generally accepted in Europe - there is a range of measures designed to provide the maximum possible protection for insureds. Although, in principle, the State is no longer obliged to approve insurance conditions and tariffs as part of the process for completing the internal market for insurance products under the Third Non-Life Directive of 18 June 1992, the general policy conditions for substitutional health insurance must be submitted to the Federal Office for Insurance

Supervision before they are first implemented and every time there is an amendment, in accordance with European Law. The supervisory authority checks that the conditions comply with the minimum standard laid down in the Insurance Contract Law and other regulations which concern the general interest for this insurance class. The obligation to submit insurance conditions applies equally to insurance undertakings registered in Germany and foreign undertakings wishing to offer substitutional health insurance in Germany.

Insurance undertakings registered in Germany must also submit their premium calculation to the Federal Office for Insurance Supervision which checks that the calculation complies with the legal provisions on calculations designed to ensure that the interests of the insured are protected and that obligations arising under contracts taken out for life can be fulfilled. In the case of foreign undertakings offering substitutional health insurance the supervisory authority of the country of registration is responsible in this respect. In addition, any modifications in policy conditions and premiums must be agreed by an independent trustee.

Protection of the insured is also provided by the requirement for specialisation under which health insurance may be written only by specialist undertakings independently of all other classes. This requirement is limited, however, to insurance undertakings registered in Germany.

5. Range of benefits

Private health insurance is characterised by the wide range of types of cover on offer (insurance covering the cost of out-patient treatment, hospital treatment, dental care, daily hospitalisation allowances, cover for loss of earnings resulting from sickness, the risk of the need for long-term care, supplementary cover for expenses not borne by statutory insurance, health insurance for travel abroad etc.) which allow each individual insured to choose insurance cover which is fully adaptable to his own wishes and requirements. The insured may choose between policies refunding health care costs in full and those which cover only certain elements or a fixed percentage of medical expenses. Insureds may also choose to pay an excess, in which case the premiums are reduced in return for an undertaking on their part to pay a fixed amount of costs per annum; costs exceeding that amount are then reimbursed in full.

A standard tariff is applied uniformly within the class of individuals who have completed their 65th year and who have a previous insurance period of at least 10 years of substitutional health insurance – i.e. health insurance able to substitute statutory health insurance – and the class of individuals who have completed their 55th year who also have a previous insurance period of at least 10 years of substitutional health insurance, and whose income does not exceed a certain threshold (at present approx. DM 77 400). This tariff provides for benefits which match the benefits of statutory health insurance and guarantees that premiums will not exceed the average maximum premiums of statutory health insurance. For married couples, the premium is limited to 1.5 times the average maximum premiums payable in statutory health insurance if their annual total income does not exceed the above-mentioned threshold.

The patient enters a contract for the provision of health care with a doctor or hospital under his own name and receives an invoice which he must then settle. Under his health insurance contract, he may then request the reimbursement of costs from his private health insurer. This method of payment establishes direct contractual relations between the insured and those responsible for his treatment, with all the consequent entitlements and scope that allows him to make a free choice of doctor or hospital without the need for his health insurer's approval. Furthermore, it allows him to freely choose how to use the benefits to which he is entitled under his contract. At the same time the cost transparency associated with individual account settlement encourages a more responsible attitude to claims for medical benefits.

6. Private health insurance finance

Private health insurance premiums are fixed in accordance with the risk, age at entry, gender and state of health of the individuals to be insured, together with the required scope and level of insurance cover. Since the middle of the 1930s, private health insurance has been written in the same way as life insurance, i.e. using an actuarial basis which follows a technical business plan containing all the calculation bases used. This is prescribed by law for substitutional health insurance. Health insurance in Germany is characterised by the fact that premiums are not dependent on increasing age and the consequent increase in the sickness risk, that reserves for increasing age are constituted and that contracts may not be cancelled (they are usually taken out for life). Where there is a discrepancy between the actual cost of health care and the costs used as a basis for calculation, insurers are able to adjust premiums to the increased level of treatment costs using an adjustment clause.

50% of employees' contributions are paid by the employer and 50% by the insured, regardless of whether the policy has been taken out with a private or a statutory institution. Nevertheless, contributions can only be made to private health insurance schemes if the undertaking from which cover is requested meets certain quality criteria defined by social law.

Health insurance premiums are deductible from taxable income as specially-allowed expenditure in the same way as expenditure for other types of provision and within certain specified limits.

7. Compulsory long-term care insurance

Many people reach an old age without ever falling seriously ill. Nevertheless, the risk of not only falling ill, but even requiring long-term care may materialise any time. Statistically, one in four men who are 25 years old today will at some stage in his life require nursing care. This risk is even higher for women of the same age: one in three will sometime no longer be able to live without help from others.

In former times, individuals with public or private health insurance were able to cover the enormous costs only by taking out private supplementary long-term care insurance. The Law on Long-term Care Insurance which became effective on January 1, 1995, now requires all health-insured persons to take out insurance covering the risk of being in need of nursing care. The purpose of compulsory long-term care insurance is to support individuals in need of nursing care who cannot do without assistance because the amount of care they require is very great.

It has played a special role in private health insurance, usually seen as a voluntary system. Anyone who has taken out private substitutional health insurance is obliged to insure himself and his dependants against the risk of long-term care needs with his insurance undertaking or another insurance undertaking which writes this class of insurance. Civil servants entitled to long-term care benefits from their employers are also obliged to take out private long-term care insurance for that portion of the expenses not covered by this benefit. Those insured under statutory health insurance are insured against the long-term care risk through their sickness fund (social long-term care insurance).

The benefits offered by private health insurers under compulsory long-term care insurance are, in terms of type and scope, equal to those offered under social long-term care insurance which has been included in the Eleventh Book of the Code of Social Law as a new independent class of insurance.

Under private compulsory long-term care insurance, the following benefits, inter alia, are paid monthly for care at home, care partly in a nursing home, as well as short-term care and care completely in a nursing home (in each case refund of costs):

Care at home by qualified staff or nursing care partly In a nursing home	Benefits under nursing care insurance of up to
Level of care I (considerable degree of care needed)	DM 750
Level of care II (very high degree of care needed)	DM 1 800
Level of care III (extremely high degree of care needed)	DM 2 800
in extremely serious cases:	up to DM 3 750

Care at home e. g. by relatives	Benefits under nursing care insurance of up to
Level of care I	DM 400
Level of care II	DM 800
Level of care III	DM 1 300

If the person providing the care is not gainfully employed, premiums are paid into his/her pension insurance by the long-term care insurance.

An individual is entitled to short-term care – not exceeding four weeks per calendar year – if care at home or care partly in a nursing home is not sufficient. Irrespective of the level of care, expenses of up to DM 2 800 are reimbursed.

If care is provided completely in a nursing home, expenses of up to DM 2 800 are reimbursed irrespective of the level of care, and in particularly severe cases up to DM 3 300.

The premiums for private long-term care insurance are calculated according to the qualification procedure and are dependent on the age of the insured at the time of entry into the insurance contract and are the same for men and women. In addition, premiums for persons who were obliged to take out long-term care insurance on 1 January 1995 are limited to the maximum premium for social long-term care insurance and premiums for insured married couples with only one income are also limited. Premiums for persons who were not obliged to take out private long-term care insurance until after this date are limited after a five year previous insurance period. To ensure these regulations are durable all insurance undertakings which write private long-term care insurance must participate in a system which guarantees constant and effective equalisation of the different costs without making access to the market difficult for new providers. Under this system premiums excluding charges will be determined uniformly on the basis of joint calculation bases for all undertakings writing private long-term care insurance. The equalisation procedure is subject to supervision of the Federal Office for Insurance Supervision. Also in private compulsory long-term care insurance, the employer pays half of the premium. Civil servants are not granted an allowance from their employer towards the premium. Their claim to benefits is reduced and their premium is thus correspondingly lower. Privately insured pensioners are granted an allowance towards their premium from the responsible pension insurance institution.

Contrary to the pay-as-you-go procedure applied under social insurance, a reserve is set up under the qualification procedure with portions from premiums to cover the long-term care risk which increases with age. The setting up of capital in this way means that the funding of cover for this risk in the case of those insured privately is not affected by the inherent risks of a constantly ageing population. Consequently

private long-term care insurers will be able to offer in future more favourable premiums than the social insurance system for the same range of benefits.

An individual in whose opinion the long-term care insurance provided by the state may not be adequate can apply for supplementary private long-term care insurance with a private health insurer. The options available are policies providing for the reimbursement of costs, and daily benefits policies.

What needs to be considered, however, is that there is no obligation to contract in respect of supplementary long-term care insurance. In this case, the principle of freedom of contract generally applicable in private insurance prevails. Hence, health insurers are allowed to make the acceptance of such applications conditional upon the result of a risk assessment. Another possibility is to take out long-term care annuity insurance with a life insurer.

8. Current position and future prospects

Following a considerable loss of private health insurance policyholders, resulting from legislation in the early 1970s, the crisis in the statutory insurance system has led to a gradual re-establishment of the position of the private health insurance sector. That position was confirmed in an impressive fashion in past years by various legal reforms (1989 Health Care System Reform, 1993 Law on the Structure of the Health Care System), 1995 Law on Compulsory Long-term Care Insurance and lastly the 2000 Health care System Reform.

It is now essential that the challenges associated with the incorporation of the private sector into the dual health insurance system should be met and that private health insurance is established in the public consciousness as a high-performance and cost-effective alternative to statutory health benefits. The introduction of a standard tariff for older insured individuals and additional calculations for reducing premiums for these individuals provides these policyholders with reassurance that they can still have affordable protection in old age.

All the relevant authorities must be convinced that private health insurance is an integral and indispensable element of the health care system and that the private sector, although operating on the basis of private enterprise, takes its socio-political responsibilities extremely seriously.

9. Prospects for the development of private health insurance

The development of private health insurance depends on the overall economic situation, as well as the framework of statutory health.

Statutory health insurance, in which the majority of members are insured compulsorily, suffers from progressive financial problems. One of the proposed solutions to these problems which has been discussed repeatedly in this context, i. e. extending the circle of persons who are liable to take out health insurance, could considerably weaken the competitive position and thus the further development of private health insurance.

Worrying in the health sector is the trend of costs. Disproportionately increasing benefit payments for in-patient and out-patient treatment as well as for medicines burden the private health insurance sector and its insured who face – in some cases considerable – premium increases, especially in the older age groups. A panel of experts was called in by the Federal government to deal with this problem and develop proposals on how to solve it. The proposals have meanwhile been put into practice in the course of the "health care system reform 2000". For instance, in substitutional health insurance, a surcharge of 10% is to be added to

the insurance premium and to be used to fund higher premiums resulting from premium increases from completion of the insured's 65th year. Moreover, 90 % of the yield exceeding the yield obtained by applying the technical interest rate are to be credited to the insured and also to be used to limit premium increases.

In the past, the number of persons taking out private health insurance has been increasing continuously. It is expected that the net figure for new business, i. e. persons who purchased full health insurance cover in 1999, will be 150 700.

Premiums in public health insurance are levied on a pay-as-you-go basis, i.e. the total costs are periodically distributed among the total number of insured persons who are liable to pay premiums. In doing so, the individual economic capacity of the insured is taken into account. Due to the ageing of the population which is forecast to increase, a considerable shortage in the cover required is to be expected.

Private health insurance is able to avoid this shortage of cover because it is based on the principle of funding. A portion of the premium calculated is used for covering the risk, and another portion is used for setting up an ageing provision. Thus, the risk which increases commensurate with the insured person's age can be covered by gradually running off this ageing provision. As a consequence, the premiums to be paid by the insured remained constant over time, under otherwise unchanged conditions.

Another advantage of private health insurance is that the components of the insurance cover can be combined according to the individual's needs and wishes. The different components available range from basic cover to the luxury cover that leaves nothing to be desired. In public health insurance, however, the scope of cover is fixed by law.

The advantage of statutory health insurance to those with a low income is its social orientation, i. e. premiums are charged in relation to the insured's income, and the insurance cover generally includes the entire family. Young and healthy people with a relatively high income, in turn, appreciate the premiums charged in private health insurance on the principle of equivalence, because the calculation is based on the tariff chosen and the individual risk, whereas the insured's income is not considered.

GREECE

1. Structure, cost and finance of health care system

The social security health care system in Greece is based on more than 100 occupational Health Funds.

IKA (IDRIMA KINONIKON ASFALISEON—Social Security Institution) is the most important of these Health Funds. All salaried employees of the private sector as well as the members of their families join it compulsorily, regardless of the nature of their work. The self-employed can also join IKA through the system of self-insurance.

Services provided by IKA are almost completely covering:

- Primary medical treatment through its own doctors' network
- Pharmaceutical treatment
- Hospital treatment in all Public hospitals as well as in linked private clinics
- Specialised doctors' medical treatment.

Financing of Health Insurance Funds comes from:

- the State budget
- employers' contributions
- employees' contributions
- patients' participation in the treatment cost in a limited number of cases, mainly in the cost of medicines.

Expenses for health and social security (mainly IKAs) are divided as follows:

- 28.6% for hospital treatment
- 24.7% for primary treatment
- 38.5% for medicines
- 8.2% for the other services.

2. Historical development

Private health insurance started appearing mainly from the 1960s under the form of medical and pharmaceutical indemnity in independent personal accident policies. Since the early 1970s insurance policies covering hospital treatment have appeared. Coverage offered by these policies concerns:

a. hospitalisation costs when the insured was hospitalised in a private clinic not linked with IKA or in case of upgrading of the medical attendance class provided by social security;
b. payment of a daily allowance for hospitalisation, regardless of the carrier covering the hospitalisation costs.

In the middle of the 1980s, coverage was grouped in 'packets', matching the way public hospitals charged hospitalisation expenses. Since 1980 more flexibility of product designs for hospital indemnity insurance appeared. They now offer e.g.:

- unlimited cover
- 100% hospitalisation expenses cover
- direct payment of expenses by insurance companies to hospitals.

In most policies, childbirth is covered normally as an illness.

3. Nature of providers - private health insurance companies

Today, the private Greek life insurance companies offer quite often individual and autonomous contracts for health insurance, which no longer need to be attached to a life insurance contract. A big turnover is effected through group health and accident insurance policies. Every insurance company is free to fix its tariffs and to set the insurance general conditions.

In the past few years health insurance has attracted attention mainly due to the decrease in the role of social security. As a result health insurance premiums represent 40-50% of the total life insurance premiums.

4. Benefits

Policies providing reimbursement of cost cover both illness and accidents. A comprehensive range of schemes is offered by health insurers, including:

- reimbursement of the costs of hospitalisation (accommodation, medical and surgical treatment etc) and costs associated with convalescence
- reimbursement of out-patient costs in case of accident
- daily cash benefits during hospitalisation
- reimbursement of the costs of dental treatment (group insurance only)
- daily benefits against loss of income due to sickness or accident
- death by accident and permanent total disability.

Individual private health insurance contracts normally run up to the age of 65 and may be automatically extended to whole life. The insured has the right to cancel the contract at the end of the contract term, if he so wishes.

5. Private health insurance finance

Private health insurance premiums are calculated according to the age of the insured and are paid annually. Premiums and sums insured in respect of policies providing for reimbursement of costs may be varied on the basis of the company's experience.

6. Current position and future prospects

The present situation in private health insurance is marked by uncertainty. In spite of the rapid turnover increase, the health branch suffers from excessive losses that make insurance companies consider whether to continue offering current types of coverage.

Most insurance companies have already taken measures to limit coverage. The most important of these measures are:

- limitation of cover for childbirth expenses replacing it with an allowance,
- adoption of patient-paid 'excesses',
- drastic premium increase in policies with high specifications, etc.

Apart from these, in collaboration with and with the assistance of the Association of Insurance companies-Greece, the insurance market has made agreements with private hospitals or clinics providing e.g.:

- Fixing surgeons', anaesthetists' etc. fees
- Agreed reduction of clinics' prices
- 'Packaging' hospitalisation expenses depending on the surgery involved
- Creation of the Association's out-patients department in a big hospital to control patients admitted.

During the last years, as a result of consumers' demands for private health services, there has been an impressive growth in the private health insurance sector, which is for Greece a new area with prospects. Already big private medical institutions have entered or intend to enter the area of health insurance. Insurance companies have already entered in the health area by private clinics. Insurance companies create health administration companies which are responsible for their hospital plans. This activity has, as a result, the offer of a wide variety of new services through agreements with diagnostic centres and clinics, such as for example distribution of health and insurance products by banks in an effort to enlarge the distribution of medical and hospital products and services.

7. Regulation of private health insurance

The regulations applicable to private health insurance are the regulations of the EU Directives, with regard to insurance products, services and institutions.

HUNGARY

1. Structure, cost and finance of health care system

In Hungary health insurance is based on 3 pillars.

- As in most of the European countries, compulsory statutory health insurance plays a dominant role. This health care system covers all Hungarian nationals, including those who are not employed. It comprises visits to General Practitioners, specialists and hospital services. The basic services are defined by the Act on Services of Compulsory Health Insurance. The amount of subvention in respect of pharmaceutical products and therapeutical aids vary according to the types of sicknesses and the financial circumstances of the sick person.

- Employers pay 11 % of the gross wage and HUF 3 900 to the State Health Fund, while employees' contribution is 3%. According to the estimations about one fifth of the expenses is covered by the inhabitants, but this sum includes gratification paid by the patients to doctors.

- Since 1994, mutual health funds are allowed to operate. They are supervised by the Supervisory Authority of Financial Services.

- Insurance companies offer a wide range of health insurance products

2. Historical development

National health service costs rose from 448 billion HUF in 1996 to 696 billion HUF (planned for 1999). It can be stated that it hardly follows the inflation due to the financial restrictions took place in this field.

Health expenditure includes the costs of actual treatments, preventative measures, payments of sick-allowances and administrative costs of the system. All the expenditures sum up approximately to 10% of the GDP

The number of health insurance funds has not changed during the past 3 years (29 funds operate), but the number of members grew rapidly. However the fact that at the end of 1998 there were only 22 thousands person covered by this kind of insurance shows that these funds have only an extremely minor role.

Although the development of private health insurance seems to be successful according to the figures: number of policies rocketed from 37.000 to 67.700 from 1996 to 1998 respectively, premium income tripled (exceeded 2 billion HUF), but these data include short-term travel health insurance too. The effective demand of the population at the moment is not sufficient, they do not buy supplementary health insurance.

3. Private health insurance companies

There are 9 insurance companies in Hungary (from the total of 21) which offer health insurance. There are not specialist companies in this field. Since the introduction of "a posteriori" control, companies do not have to ask for authorization of general policy conditions, just to submit them - with the rates - to the Supervisory Authority of Financial Services.

4. Range of benefits, finance

Health insurance is a class of non-life insurance, however life insurers can offer health insurance in connection with their life insurance policies. Recently there are about 200 different products on the market. There are the traditional products (payment of disability annuities, payment of daily compensation in the event of incapacity) and new products, -such as e.g. insurance for dread diseases, -are available. There is demand for private hospital accommodation, plastic surgery, which are not covered by the state system.

Health insurance can be a form of remuneration when employers take out a policy on behalf of their employees.

Private health insurance premiums are calculated in concurrence with the risk, age, and the state of health.

5. Current position and future prospects

Private health insurance is strongly connected to state health insurance, it has a supplementary role. Due to the reform of the state system, the private system might have different business prospects. It can be a difficult, ethical problem to define, what kind of services should be financed by the state system and what should be excluded as it might cause a growing financial burden on the families. This could be a point where health funds and private health insurance might have beneficial market positions, however the economic situation resulted in a low rise in earnings.

ICELAND

1. Structure, cost and finance of health care system

Structure

The Icelandic health care system accords all citizens of Iceland access to the best health service at any given time for the protection of their mental, physical and social health.

The health sector is regulated according to the health act of 1990. The administration of the health service is divided between the Government on one hand and regional and local boards on the other. The role of the Government is, however, significantly larger than that of the local and regional boards, where particularly the regional boards play a very limited role.

There is one public institution, the State Social Security Institute (SSSI), that administers in accordance with law from 1993 on social security pension insurance, health insurance and insurance against accidents at work on behalf of the government.

There are three types of hospitals in Iceland which are all administrated by the state: Three highly specialised hospitals of which two are placed in Reykavík and one in Akureyri, regional hospitals with a certain degree of specialisation, and local hospitals. The local hospitals also function as old age and nursing homes. Other health institutions include rehabilitation hospitals and clinics for alcohol abusers.

Patients are free to contact a specialist, whereas treatment in a hospital requires a referral either from a physician in the primary health care or from a specialist. There are both private practising specialists and specialists connected to the hospitals.

The primary health care is run from the health centres and to a minor degree also by private general practitioners. The health centres are administrated by the state and have the responsibility for the general treatment and care, examinations, home nursing as well as preventive measures such as family planning, maternity care and child health care, school health care, immunisation, etc. Physiotherapy is partly provided at the health centres, but mostly by private practising physiotherapists.

The health centres provide home nursing, whereas home help is part of the municipal social service system.

Most of the nursing and old age homes function as private foundations. They are run by the municipalities, charity organisations etc. They are partly financed by user charge, but the major part of the financing is provided by the government either through the national pension scheme as is the case for the old age homes, or through the health insurance scheme as is the case for the nursing homes.

Private practising dentists normally carries out dental treatment. In Reykjavík there is a school dental service. Such service is also provided at some of the health centres, which supply clinical facilities for private practising dentists.

Patients fees

All expenses in connection with hospitalisation are free of charge.

Since 1993, a new system of charges to be paid by the patient involves that the charges for a consultation by a general practitioner within normal working hours are ISK 700 (USD 9,00). The charge is ISK 300 (USD 4,00) for old age pensioners, disabled people and children with a supplementary care allowance as well as other children under 16 years of age. The consultation with a specialist is a) ISK 1.400 (USD 19,00) as well as 40% of the remaining cost of the consultation, b) for old age pensioners, disabled people and children with supplementary care allowance one third of a). Within the present system, the charges to be paid by patients in the age group 16-67 years are reimbursed if they, in the course of one calendar year, exceed ISK 12.000 (USD 161,00). The same applies for children under 16 years and for old age pensioners and disables people if the charges exceed ISK 6.000 (USD 80,00).

Consultations with a view to preventive health care for mothers and children as well as the school health care are free of charge.

Dental health care is subsidised by 75% for pensioners and children up to the age of 18. It does not include though orthodontic care except in cases of congenital defects, accidents or illness.

Finance

Health care expenditure was 34,9 billion IKR (USD 470 million) in 1997, which was 6,6% of Gross Domestic Product. Health care expenditure is divided into 5 groups; 1) general hospital services with 3,46% of the expenditure, 2) nursing care and rehabilitation with 1,04%, 3) health care outside institution with 0,98%, 4) drugs and medical equipment with 0,81% and 5) other health care expenditures with 0,30%.

2. General outline of health insurance system

Health insurance is individual and based on residence. In order to be health insured in Iceland, an individual must have resided in Iceland for at least 6 months prior to his application. The State Treasury finances health insurance. Health insurance benefits include i.e. hospitalisation, medical assistance, medicines, technical aids, and physiotherapy and cash sickness benefits.

The individual pays a minimum fee for the services of a general practitioner or of a specialist, outside of a hospital, while the rest is covered by the insurance. This applies to most services. Old-age pensioners, invalid persons, children with disabilities and those who have been unemployed for more than half-year pay a reduced rate.

Insured persons are entitled to free hospitalisation, including in maternity clinics, as prescribed by physicians. Hospitalisation is ensured for as long as necessary, along with medical care, medicine and other hospital services. The health insurance covers insured persons for hospitalisation costs abroad, which cannot be provided for in Iceland. This includes costs for medicine and medical assistance that is needed during the hospitalisation.

The health insurance covers fully medicine costs that an insured person must for vital reasons use regularly. In other cases, the insured person has to participate in the costs of medicines.

Participation of the health insurance in dental care costs varies according to certain provisions. As mentioned above, children under 18 and pensioners are entitled to certain reductions depending on the service rendered. The insurance takes no part in payments of orthodontic care except in cases of congenital defects, accidents or illnesses.

Women permanently residing in Iceland are entitled to free maternity care. Hospitalisation is ensured for as long as necessary, along with medical care, medicine and other hospital services. Working women are entitled to 6 months childbirth leave.

Insurance against accidents at work covers employees working in Iceland. Self-employed persons are also insured, unless they voluntarily exempt themselves. Domestic workers can ensure their entitlement to insurance if it is specifically specified on their tax return forms at the beginning of the year.

An insured person, who has reached the age of 18, receives on application a per diem sickness benefit, when she/he is unable to work due to sickness.

3. History of private health insurance

The first indicator of health insurance in Iceland was in the end of nineteenth century. A law on endowment for elderly and weak common people was passed at the parliament in 1889. In 1936 a law on national insurance came into effect. This legislation recommended that the National Insurance Institute (later SSSI) would be established. The institute was divided into four departments; accident department, sickness department, elderly and disabled department and non employment department.

Insurance companies started selling accident insurance early in the century but it was not until 1970 that they began selling sickness insurance. Icelandic consumers were able to buy sickness insurance though before that time from foreign insurance companies. In 1987 Icelandic insurance companies began to sell an insurance that falls under the definition of health insurance.

4. Nature of private health insurance providers

There are three Icelandic life insurance companies that have license to provide health insurance, accident insurance and sickness insurance. Life insurance companies from the European Economic Area that provide services in Iceland with establishment or without an establishment also provide health insurance. Non-life insurance companies do also provide services in accident and sickness insurance.

IRELAND

1. Structure of Health Care System

The Irish health care system is a mixture of a universal public health service, free at the point of consumption, and a fee-based private system where individuals pay, generally by way of voluntary private medical insurance, for expenses incurred for private medical treatment. A further characteristic of the Irish system is that both public and private services may be secured from the same providers.

2. General Outline of Private Health Insurance System

The Health Insurance Act, 1994 was enacted on 30 June 1994 in order to implement the EU Third Non-Life Directive and regulations thereunder were made in 1996. The Act provides that only insurers entered in the Register of Health Benefits Undertakings, which is maintained by the Minister for Health, are permitted to carry on health insurance business in Ireland. However, it provides for insurers authorised in other Member States to carry on such class of business to be entitled to entry in the Register. Insurers carrying on health insurance bust comply with the following provisions:

- Community Rating
- Open Enrolment
- Lifetime Cover
- Minimum Benefit
- Risk Equalisation Scheme

Community Rating means that the same premium is charged for a specified level of cover regardless of age, gender, sexual orientation or current or prospective health status of the insured person.

Open Enrolment requires health insurers to accept all individuals aged under 65 who wish to enrol in any health insurance scheme, but allows insurers to impose waiting periods of up to a specified maximum in respect of an initial period following first time cover and regarding pre-existing conditions.

Lifetime Cover means that an insurer cannot refuse to renew a contract for any member.

Minimum Benefit provides that all insurers offering cover for hospital in-patient services are required to provide a minimum level of cover across a range of services, including general hospitals, out-patient and maternity benefits, convalescence, psychiatric treatment, substance abuse and day care.

Risk Equalisation provides that all insurers offering health insurance cover for hospital in-patient and day patient services must be prepared to participate in a Risk Equalisation Scheme.

Risk Equalisation

Community rating in Ireland has made health insurance accessible to a high proportion of the population who might otherwise not be able to afford it, particularly the elderly and the chronically ill. A risk equalisation system is an essential feature of a competitive market which operates under the principles of community rating, open enrolment and lifetime cover.

Risk equalisation provides for the equitable distribution of risk between insurers. It aims to counter the effects of either inadvertent or intentional preferred risk selection of younger healthier lives. Without risk equalisation, the system of community rating/open enrolment would be inherently unstable.

Risk Equalisation provides for insurers with a lower than average risk profile to pay into a fund from which payments are made to insurers with a higher than average risk profile. It provides for contributions to be calculated so that the net outgo of each insurer (i.e. after payments to/receipts from the fund) would be as if they had similar risk profiles.

Without risk equalisation, each health insurer would have a strong incentive to 'select' low-risk individuals in order to be able to charge a lower community rate (or take a higher profit margin) than its competitors. It is widely recognised that there are many ways in which health insurers can select preferred risks, even with a legal requirement for community rating. If competing health insurers have a strong incentive to select preferred risks, it would be expected that per capita claims costs would spiral for those insurers who are relatively unsuccessful at preferred risk selection. This, in a community rated environment, would lead to significant market instability and lack of public confidence, ultimately resulting in a downsizing of the market. It would be particularly inequitable on those who have contributed to community rating over their young and healthy years and on the elderly and chronically ill.

Risk equalisation does not prevent insurers from gaining competitive advantage. It seeks to remove an insurer's incentive to select preferred risks, but still allows for competition in many areas, including product diversity, efficiencies in relation to claims management, cost containment and customer service. While risk equalisation has an objective of equalising risk profiles between insurers, it also aims to:

a. allow each insurer to retain its own claims management/cost containment efficiencies; and

b. differentiate between differing benefit levels.

In January 1999, the Department of Health and Children issued a Technical Paper to registered health insurers and other interested parties setting out detailed proposals for an amended risk equalisation scheme. Consultations have taken place on these proposals and legislative proposals will be incorporated in the White Paper.

3. History of Private Health Insurance

Prior to 1 July 1994, the provision of private health insurance in Ireland was subject to the terms of the Voluntary Health Insurance Act 1957. This Act established the Voluntary Health Insurance Board (VHI) – a statutory body set up to make and carry out schemes of voluntary health insurance on a 'not for profit' basis – and required other bodies engaged in the business of health insurance to be licensed by the Minister for Health. The number of persons covered by the VHI has increased virtually continuously since its establishment, notwithstanding the extension of eligibility for public health services in 1991 and a curtailment of income tax relief on health insurance premium payments with full effect form 1996/97.

BUPA Ireland, a branch of the British United Provident Association, entered the market in January 1997 to provide competition to the VHI in the provision of private health insurance to the general public.

It is estimated that, currently, in excess of 1.5 million people, or almost 42% of the population have opted for private health insurance.

4. Current Developments in Private Health Insurance

The Minister for Health and Children is preparing a White Paper on Private Health Insurance for consideration by the Government. The White Paper will set out fundamental policy objectives regarding the role of private health insurance in the overall health care system, the regulation of the private health insurance market, and the future corporate status and functioning of the VHI. It will detail such legislative and structural changes as the Government considers desirable and appropriate to improve the operational and competitive effectiveness of the voluntary community rated private health insurance system.

ITALY

1. Structure, cost and finance of health care system

The national health service in Italy covers all Italian nationals, including those without any form of employment. In principle, the health service pays benefits in full. However, there are patients' contributions (the so-called «moderating charges). In January 1999 they have started to test a new system for the determination of the amount of the contribution to the costs of health. This system, is called «Sanitometro»; it envisages that citizens shall be subdivided into three ranges according to their Isee (Indicatore della Situazione Economica Equivalente = indicator of the equivalent economic situation) income, i.e. the income is calculated on the basis of the household's global economic-financial situation as well as of the presence of certain needs (minors, absence of one parent, relatives with serious physical or mental disabilities). Households having an Isee income up to 18 million ITL shall be exempt from paying the charge, whereas those with an income up to 36 million ITL shall be subject to a partial exemption; households having an income exceeding these thresholds shall pay the full charge.

The range of benefits provided under the national health service is very extensive; it includes:

a. visits to a General Practitioner (chosen by patients insured under the State scheme from lists maintained by the health service) and also visits to a specialist (to whom the General Practitioners may refer their patients whenever they consider necessary);
b. pathology and radiology;
c. hospitalisation and medical costs;
d. pharmaceutical costs (in full or in part depending on the type of medicament);
e. additional benefits such as spa treatments.

2. Historical development

The current system of the national Health Service has been put into practice by the law n. 833 of 1978 which has completely renewed the former system based on mutual aid.

However the 1978 model has proved to be excessively bureaucratic and too unbalanced in favour of the hospital services.

In the years 1992 and 1993 it has been therefore intervened through wide measures of amendment of the law in favour of a model based on the improvement of the Regions as far as choices of health politics are concerned and on the making directly responsible the managers of the medical facilities (so-called "transformation of the hospital into a company").

These interventions have permitted to achieve a reduction of the public health expense within the period of the nineties.

In comparison we have witnessed a very substantial increase of the private health expense which has arrived to set up about a third of the global expense.

3. Private health insurance companies

Although the strong component of private expense, it is still low the part mediated by insurance companies, company health funds, mutual aid corporations.

Particularly, the 110 insurance companies operating in the health branch have collected, in 1999, premiums for 2.252 thousand million lire.

4. Benefits

A comprehensive range of schemes is offered by Italian health insurers, including:

- reimbursement of the costs of hospitalisation (accommodation, medical and surgical treatment etc.) and costs associated with convalescence;
- reimbursement of out-patient costs (always in the form of reimbursement of expenses) before hospitalisation;
- daily benefits for loss of earnings, during hospitalisation;
- reimbursement of diagnostic and specialist costs irrespective of hospitalisation (as an additional guarantee to the basic policy).

In addition to traditional policies under which medical expenses are reimbursed, policies will be made available which provide for direct payment of expenses by the insurer to a health care body provided there is an agreement between the latter and the insurance undertaking. Such insurance is valid for both sickness and accident. Furthermore, cover for total or partial permanent disability as a result of an illness also exists.

In general, undertakings waive the right to cancel an individual contract, a right which in any case is only granted by law for the two years following inception of the contract.

5. Private health insurance finance

Private health insurance premiums are calculated according to the age of the insured on joining the scheme and are paid annually. Premiums and sums insured in respect of policies providing for reimbursement of costs may be varied on the basis of index-linking clauses; such index-linking is based on national indices which generally take account of health care costs and are published by ISTAT (Istituto Centrale di Statistica).

6. Current position and future prospects

By the law act of 19th June 1999 the public health system has suffered its third important reform since the National Health Service has been set up in 1978.

The main contents of this reform are following:

- simultaneity in identifying resources for the fund of public health and of identifying of primary levels of health assistance that the public system must assure uniformly on the national territory; then a higher control of expenses and the allocation of services in close connection with the available resources;

- reinforcement of the "territory health", with reduction of hospitalization and improvement of the district, that's to say of that territorial reality consisting of about 60.000 beneficiaries (into which the local health Agencies are divided) where all pre- and posthospital services are organized. The district assures the primary assistance, coordinates the activity of family doctors and provides surgery and specialist services. Besides, in the district the integration between social services and health services is realized;

- completion of the process of "transformation into a company" of the health system: the local health Agencies have public purposes but they are organized in accordance with private principles (company independence, direct liability of the management).

An important change concerns the incompatibility with the exercise of the free profession for doctors employed in the National Health Service. The ones which will make the choice to remain in the public structures ("intramurial" free profession) and after finishing their own work time as employees.

Public hospitals will have to equip themselves so as to be able to give surgical and medical services in a private way and they will have to equip themselves with free-paying rooms in a suitable amount.

7. Prospects for the development of private health insurance

Another important aspect of the new health reform concerns supplementary funds of the National Health Service. It's funds that can be set up by collective agreements, even of the company, agreements between independent workers and professionals, regional regulations, rules of non-profit organizations and acts of private subjects (as insurance companies). These funds will have to provide for additional services as regards those provided by the SSN. Particularly, supplementary funds can refund:

- costs sustained for dental treatments, spa services and non-conventional therapies, not covered by the SSN;

- tickets for specialist tests and examinations;

- services as "intramurial" free profession;

- contributions charged to the beneficiaries for social-health services. Besides, it's in discussion at the Parliament a law for the reform of the social assistance that foresees the extension of the ambit of effectiveness of health funds even to the costs for social services given in favour of seriously non-self-sufficient people.

While so far the entry to a Health Fund was involving advantages only for employees, by a recent reform law it has been foreseen that, from 2008, after a period of gradual adaptation, all members of the new Supplementary Funds of SSN can deduct from the income the contributions paid till a maximum of 4 millions lire a year. On the other hand employees can continue to be members of Health Funds, not subject to the above obligations for the new Supplementary Funds with regard to the services that they can give, by taking advantage from further tax facilities.

8. Long-term care

The public assistance system assures to seriously non-self-sufficient people, apart from their income, a monthly indemnity. Moreover, the whole public assistance system is the subject of a wide reform; with regard to this a bill has been approved recently by one of the two branches of the Parliament.

As far as insurance companies are concerned, LTC policies will benefit from 2001 from a preferential tax treatment. A next issuing decree will have to fix the features of LTC insurances that can benefit from this facility.

JAPAN

1.Structure of health insurance system

(1) All the residents, including non-Japanese nationals who are regularly employed by companies which are subject to health insurance or plan to stay in Japan for at least one year, are compulsorily covered by the public health insurance systems. The public health insurance systems are roughly divided into two categories: work -place based insurance and community-based insurance. All the necessary medical care services are provided by these public systems. The insurers are the State, health insurance societies, municipalities and others. Private enterprises are not authorized to become insurers of the public health insurance systems.

(2) Cost-sharing of patients is 20% or 30% of the health care expenses (excluding those covered by the health services system for the elderly) and a certain amount of medicine fee in case of outpatient. However, in order to lessen cost-sharing burden of the patients, if the amount of cost- sharing of a patient at the same medical institution in a month exceeds Yen 63,600 (Yen 35,400 in case of a low income patient), excessive cost is paid to them as the high-cost medical care benefit.

Cost-sharing of those covered by the health services system for the elderly (those aged 70 years or over and bed-ridden people aged 65 years or over) is Yen 530 per visit for outpatients (with a limit of four times within a month), and Yen 1200 per day for inpatients.

When the patients receive high level medical care which is not common in Japan, for example a liver transplant, or use a special room, the basic portion of the medical care expenses is covered by the insurance while the patients pay the remaining. And physical check-ups are not covered by the insurance but may be provided as the insurers' voluntary services.

The patients have free choice of medical institutions. So, any hospital is available for not only inpatient but also outpatient.

A lot of medical institutions are managed by private capital and private hospitals account for 71% of all hospital and 54% of all hospital beds (as of 1997). The insurers pay the medical fees to medical institutions by fee-for-service basis. The medical fee is calculated by the table of points for medical fees which is common throughout the country.

The public health insurance systems are financed by premiums (54%), national subsidies (32.2%) and cost-sharing (13.8 %)(as of 1997). A lot of national subsidies are paid to the regional health insurance systems managed by municipalities.

The ratio of total national health expenditure to GDP is 7.2%, rating 20th among 29 0ECD countries according to the OECD Health Data'99.

2. History of private health insurance

Non-life insurance companies began to sell purely private health insurance policies in 1986. Since then, non-life insurance companies have sold medical expense insurance policies while life insurance companies have dealt with medical expense guarantee insurance policies. Both policies are less widespread than other accident and sickness insurance policies. It is believed that the demand for insurance policies covering medical expenses is comparatively small because individuals are required to shoulder less burdens for medical expenses in Japan which has an excellent public medical insurance system than most of the other countries.

Since the progress of fewer children and an ageing population makes fiscal condition of each insurer in a grave situation, the high-cost medical care benefit system, which set a cap on co-payments, is going to be reviewed and the amount the beneficiaries bear would be proportional to their medical expenses. This movement is considered to have some effect on the development of private insurance policies.

The following is the history of accident and sickness-related insurance systems:

(1) Beginning

There were many insurance companies and mutual aid associations that were selling similar insurance policies in around 1880. Many of the policies paid a certain amount of sickness and maternity benefits. However, none of these companies dealt with disaster and sickness insurance policies when the Commercial Code was enacted in 1898 because these companies were irresponsible and there was overly keen competition in the industry.

Nihon Songai Hoken Kabushiki Gaisha (Japan Non-life Insurance Co., Ltd.), which was founded in 1910, became the nation’s first insurance company to sell full-fledged disaster and sickness insurance policies. The companies actually started selling its policies in 1911. The holders of the injury insurance policies sold by the company were entitled to receive what we now call death benefits, sequela injury benefits and medical expense benefits. Since then, non-life insurance companies have sold insurance policies in this category. In 1940, 14 of the non-life insurance companies were dealing with such policies.

(2) Growth period

In 1948, life insurance companies started to sell these policies as additional policy conditions of life insurance policies. After that, non-life insurance companies were selling these policies as independent policies while life insurance companies were dealing them as an additional policy condition of their life insurance policies. The number and diversity of insurance policies in this category increased rapidly in the 1960s when non-life insurance companies started selling insurance policies exclusively covering the payment of damages for car accidents as the nation’s motorization was progressing.

Life insurance companies put on sale sickness-related insurance policies as part of their life insurance policies in 1967. Since then, many life insurance companies have been selling a wide variety of such insurance policies.

Furthermore, post offices began in 1974 to sell postal life insurance policies with personal accident and sickness insurance. As a result, the current line-up of private health insurance policies has been firmly established.

(3) Diversification period

Non-life insurance companies started to deal with income indemnity insurance policies that cover losses caused by the policyholders' inability to work because of sickness or injuries. Even though these policies do not cover medical expenses, they have become popular as policies that guarantee the policy holders' income during the period when they cannot work.

Following the revision to the public medical insurance system in 1984 to require policyholders to shoulder 10 percent of the premiums, life and non-life insurance companies launched a system to cover a portion of the fee that medical expense insurance policyholders are required to pay when they are hospitalized.

In 1989, they started selling nursing care expense insurance policies to cover expenses of nursing care for bed-ridden or senile elderly people in the face of the ageing of the nation's population.

As mentioned above, a wide variety of private insurance policies are available -- such as policies paying fixed amount of benefits to cover medical expenses according to the period of hospitalization and going to a hospital, those covering the actual amount of the expenses of hospitalization and those guaranteeing the income of policyholders if they become unable to work.

3. Characteristics of suppliers of private health insurance policies

(1) Supplies of such health insurance policies can be divided into non-life insurance companies, life insurance companies, the postal life insurance program and mutual aid associations.

(2) Non-life and life insurance companies are supervised by the Ministry of Finance, the Financial Reconstruction Commission and the Financial Supervisory Agency in accordance with the Insurance Business Law.

Currently, there are 63 non-life insurance companies -- including Japanese and foreign subsidiary companies -- as well as 47 life insurance companies(as of October 1999). They are either companies limited or mutual insurance companies. Many of the mutual insurance companies are considering transforming themselves into companies limited in order to strengthen their capital basis.

4. Scope of benefits

(1) Outline of benefits of insurance policies sold mainly by non-life insurers

The following are the details of benefits of private health insurance policies sold mainly by non-life insurance companies (accident insurance, income guarantee insurance and medical expense insurance):

(A) Accident insurance

Accident insurance pays death benefits, sequela injury benefits as well as those covering the expenses of hospitalization, going to a hospital and receiving a surgical operation in cases where the policyholders suffer injuries as a result of a sudden and unforeseen accident caused by external factors.

Many of the insurance policies in this category fix the amount of a daily hospitalization benefit and pay the benefit for the period of hospitalization. Many of the policies pay such benefits for up to 180 days from the day when the accident occurs. Many of these policies pay 10 to 40 times the amount of a daily hospitalization benefit to the holders if they undergo a surgical operation to cure their injuries caused by

the accident covered by the insurance policies. The amount of such benefits depends on the type of operations. These benefits are paid regardless of whether the policyholders receive benefits from the public health insurance program.

(B) Income indemnity insurance

Income indemnity insurance is aimed at paying benefits to cover the loss of income in cases where the policyholders suffer injuries or sickness and thereby become unable to work. The amount of payment depends on the period when the policyholders are unable to work. The amount of benefits of this type of insurance is set to less than the average monthly income of the previous year. (The income that the policyholders got despite their inability to work is not included.)

In many income indemnity insurance policies, the period of paying benefits is set at either one year or two years. The period of exclusion in many of these insurance policies is seven, 14 or 30 days. There is strong demand for insurance policies in this category from not only company employees but also professionals, such as doctors, lawyers and certified accountants. Some insurance companies have recently put on sale insurance policies that cover housework done by housewives.

(C) Medical expense insurance

Medical expense insurance policies have been developed as full-fledged policies that complement the public health insurance program. Policies in this category pay benefits to cover the fee that the holders are required to pay for hospitalization that is covered by public health insurance policies. Only public health insurance policy holders -- excluding those aged 70 years or over who are covered by the health_services system for the elderly and bed-ridden people aged 65 or over -- can be covered by medical expense insurance. The following are the types of benefits and expenses covered by such insurance policies:

- medical aid insurance: the fee that policyholders are required to pay to medical institutions but that is not covered by the public health insurance program;
- hospitalization expense insurance:
- *portion of the fee of a hospital bed that is not covered by the public health insurance program;
- *Expenses of hiring home helpers;
- *Transportation expenses for hospitalization, transfer to another hospital and being released from hospital;
- *miscellaneous expenses of hospitalization;
- Insurance to cover highly-advanced medical treatments: expenses of treatment methods that the government recognizes as such.

Policyholders typically can select the period of hospitalization covered by insurance benefits from among 180 days, 365 days and 730 days when they buy the policies. Insurance companies usually do not set any exclusion period but instead set a Yen 5,000 exclusion amount for each hospitalization. The upper limit to the amount of benefits is calculated by multiplying the upper limit to the amount of daily benefit -- which is fixed when making a contract -- by the days of hospitalization. Regarding the miscellaneous expenses of hospitalization, some policies set the exclusion days and others set the exclusion amount of benefits. The upper limit to the benefit to cover highly-advanced medical treatments is 200 times the upper limit to the daily benefit of miscellaneous expenses of hospitalization.

(2) How life insurance companies pay health insurance benefits

Insurance companies calculate benefits to cover hospitalization for injuries caused by disasters and sickness by multiplying the amount of a daily benefit for hospitalization by the days of hospitalization. The upper limit to the period of benefit payments for each hospitalization is set at around 120 days. In total, the upper limit is 700 days to 1,000 days regardless of how many times the policyholders are hospitalized. Many insurers designate the first four days of hospitalization as the exclusion period. Policies in this category usually pay 10 to 40 times the daily benefit for a surgical operation that the policyholders undergo during their hospitalization covered by the insurance. Furthermore, contracts on many of these policies include a clause that provides for the payment of benefits for serious after-effects of injuries and sickness depending on the conditions. These benefits are paid regardless of whether the policyholders receive benefits from the public medical insurance program.

5. Future outlook

The public demand for private health insurance policies is believed to be comparatively small in Japan because the public medical insurance system is widespread throughout the country. Nevertheless, a majority of the nation's insurance companies are dealing with insurance policies in this category. Their importance is expected to increase if insurance companies develop insurance policies in this category that will meet the requirements of consumers1. The structure of the health insurance system.

KOREA

1. Structure, cost and finance of health care system of Korea

The Korean health care system consists of the public medical insurance scheme (PMIS) and private health insurance (PHI). PMIS was introduced in 1977 as a social insurance system which is compulsory for all nationals. The financing of the public health care system consists of contributions levied in portion to the income level of the insured and the Government's subsidy for the self-employed society which makes up about 36 percent of insurance funds. The Government's subsidy amounted to 1.0 trillion Won in 1996. PMIS does not cover all the costs of medical care service, so that the insured should share the cost. In case of hospitalization, the insured pay twenty percent of the costs. The scheme is managed by the health insurance societies, which are nonprofit organizations established on the basis of either the work place for wage earners or residence area for the self-employed.

There are cash benefits and benefits in-kind. Benefits in-kind constitute a majority of the public insurance benefits. There are also statutory benefits including medical care benefit, maternity benefit, medical care expenses and maternity expenses. Additional benefits include funeral expenses, maternity allowance, and compensation for cost sharing by the insured. All of these additional benefits are flexibly applied to the financial condition of the insurer.

As many other countries the private health insurance plays complementary role to the public medical insurance. Some medical services are excluded from the coverage of public medical insurance; for example, the sharing of the insurer over 1,500,000 Won a year, the expense for higher quality sick ward, special treatment expenses, ultramodern medical services, long-term nursing expenses, etc.

Private health insurance has not been fully developed because it is not long since it was introduced. Although Korean insurers, life and non-life, sell products related to private health insurance, comprehensive private health insurance system does not exist. About nine percent of households' medical care expenses are covered by private health insurance.

2. History of Private Health Insurance

However Korean life insurance companies sold health insurance products in 1970 prior to the public medical insurance, it was not successful. Korean non-life insurance companies, also, sold group health insurance in 1977, which was discontinued in 1984 because of the high loss ratio.

The typical kind of health insurance sold in the Korean insurance market is the cancer insurance. It had been sold from the December 1980 and the number of contracts reached to seven million by the end of March 1998, which amounts to nineteen percent of the total amount of retained contracts in the life insurance industry. The main content of the cancer insurance products is that insurer pays fixed amount of cash in the case of the insured's death, medical treatment, surgical operation, or hospitalization.

The Financial Supervisory Commission is in charge of the supervision of private health insurance. Non-life insurance companies usually sell products that compensate the medical expenses, while life insurance companies deal with specific diseases

3. Finance and Benefits

Private health insurance is operated by the premium paid by the insured according to the insurance contracts. Medical expense is covered in lump-sum or by some portion of the expense by the contracts. We do not have enough statistics about the premium of private health insurance because most of the existing health insurance products are in the form of rider(s) of life insurance contracts, and thus, it is not possible or easy to estimate the pure amount of health insurance premium. However, we roughly guess the premium of health insurance to be one trillion Won in 1998.

The coverage of present health insurance is limited to a certain disease such as cancer, diseases of the aged, diseases of the liver, etc. and the coverage is paid only in the case of hospitalization of surgical operation. The coverage of the medical expense is in the form of lump-sum in accordance with the amount of premium paid by the insured, and thus, it often may not cover the real expenses. It does not equip with the full function of health insurance, the comprehensive coverage relating diagnosis, treatment, rehabilitation, etc.

4. Tax Treatment of Private Health Insurance

Private health insurance in Korea is not linked to public medical insurance. The tax deduction for the premium of which the ceiling amounts to 500,000 Won a year.

5. Current Position and Future Prospects

In the near future, the role of private health insurance seems to become bigger. Korean insurance companies are studying the introduction of comprehensive health insurance products to meet the diverse demand for private health insurance. Accordingly, our future task will be: to gather information on disease ratio, to establish a relationship between private insurance companies and providers of medical service, and to reform our system to render tax benefits. In addition, insurance companies need to develop comprehensive health insurance products covering all the range of the medical expenses from the treatment of disease to the income compensation for the disabled people.

LUXEMBOURG

1. Structure, cost and finance of health care

In the Grand Duchy of Luxembourg, the structure of the Social Security system is based for historical reasons on occupational categories. Social Security currently provides cover, in the form of uniform benefits, for the entire population.

With respect to how Social Security is financed, the costs are borne (1) by individuals (for wage earners' contributions are shared by employees and employers) in proportion to their earned income, and (2) by the State, which provides massive subsidies in order to reduce social insurance contributions.

With a view to decentralisation, all Social Security institutions are legally distinct civil entities and enjoy administrative and financial autonomy. This autonomy is reflected in the fact that the system owns property and assets in financial institutions, and that its budget is separate from that of the State. Nevertheless, social institutions are subject to State oversight and supervision.

Since its creation, Social Security has aimed to provide every person, whether in the work force or not, with a certain level of security, consisting of a range of guarantees against life events that could either reduce or eliminate income from gainful employment or give rise to additional expenses. Most of the benefits are intended to guarantee income; it is only the first item on the list below that serves to preserve, restore or improve the health of the people protected. The last item on the list serves to provide assistance and care to dependent people rather at home or in an institution.

- medical care;
- sickness allowances;
- unemployment benefits;
- old-age benefits;
- benefits in the event of workplace accidents or occupational illness;
- family benefits;
- maternity benefits;
- disability benefits;
- survivors' benefits;
- long-term care.

Social Security is currently divided into six distinct branches:

- sickness-maternity insurance;
- old-age/disability and survival insurance;
- family benefits;
- unemployment benefits;
- insurance against workplace accidents and occupational illness;
- long-term care.

With regard to health care benefits, a distinction must be made between coverage of costs stemming from care-giving and financial indemnities intended to compensate for loss of income due to an illness-related inability to work.

The hospital sector is subject to the principle of budgetary funding; for each hospital, the union of public health insurance funds (*Union des Caisses de Maladie*, UCM) negotiates a separate budget on the basis of projected activity and depreciation of plant and equipment, unless such depreciation is covered by the budget of the State. “Projected activity” encompasses all acts performed in compliance with hospital legislation.

The principle of payment by act applies outside the hospital sector. Accordingly, a classification system lists the relative value of each act, in the form of a coefficient which is then multiplied by a monetary value specified in a collective agreement.

Aggregate Social Security expenditure comes to approximately 20% of the State budget. Over one-third of all Social Security spending involves sickness and maternity benefits. Due in particular to the ageing of the population in the years to come, these outlays can be expected to increase.

2. General outline of the health insurance system

At present, Luxembourg has nine health insurance funds which are organised on the basis of their members’ socio-professional status. Their regimes were harmonised by the Act of 27 July 1978, which set a uniform ceiling on the amount of assessable income and a single rate of contribution for all funds. In addition, the Act introduced a system of compensation between the funds.

Nevertheless, rising health care costs prompted the Act of 27 July 1992, which was both an administrative and a financial innovation. The legislation created the UCM while preserving the nine separate health insurance funds. UCM is run autonomously by a board of directors chaired by a State civil servant and composed of representatives of employers and employees, and by a general assembly. The general assembly is required to adjust the rate of contributions if reserves dip below a certain threshold. From this standpoint, UCM is an appropriate instrument for preserving the model of national solidarity on which the financing of health insurance benefits is based.

Among UCM’s tasks is to conduct annual negotiations for hospital budgets, and for the rates charged by other health care providers.

The nine health insurance funds, organised according to the socio-professional status of the people affiliated thereto, handle direct contacts with the insured and order disbursement of cash benefits and reimbursement of benefits in kind for which there is no third-payer system (i.e. that are not paid for by UCM directly). For its part, the State's contribution comes in the form of additional premiums depending on health insurance revenue.

In order to preclude any funding shortfalls, the Act of 27 July 1992 introduced indicators designed to trigger remedial measures in the event of budgetary and/or financial imbalance.

3. History of private health insurance

The introduction of the various Social Security systems transformed the health insurance sector by prompting cover that:

- is indispensable for persons not subject to a compulsory Social Security scheme;
- provides supplemental benefits for persons covered by a Social Security scheme, insofar as it reimburses:
- expenditure in excess of the amounts covered by the compulsory scheme;
- certain benefits not covered by the compulsory scheme.

The aim of health insurance is therefore to offset lost income and cover residual expenses accruing to the insured following an illness, accident or pregnancy, whether involving hospitalisation or not.

4. Nature of private health insurance providers

There are ten Luxembourg insurance undertakings licensed to write health insurance in the Grand Duchy of Luxembourg. Eight of them are licensed as public limited liability companies and two as mutual associations. Nine branches of foreign undertakings, eight of which are public limited liability companies and the other a mutual association, are authorised to be established, and 111 foreign insurers are authorised to write health insurance, in the Grand Duchy of Luxembourg.

5. Range of benefits

Health insurance benefits include:

Cash benefits

These benefits compensate for the loss of wages/income in the wake of temporary or permanent disability.

Benefits in kind

These primarily involve reimbursement for health care administered in the event of sickness. In this case, the principle of indemnification applies—i.e., the indemnity may be no greater than the expenses actually incurred. Under this principle there can be no net gain for the insured.

Insurable guarantees

There are three guarantees to which supplementary guarantees may be added individually.

1. Reimbursement of expenses.

2. Daily hospitalisation allowance.

This is a flat-rate daily amount, usually payable from the first day of hospitalisation, and it may be received in addition to other payments.

The daily hospitalisation allowance is paid without requiring evidence of costs incurred and may be used at the insured's discretion, e.g. for a single-room supplement, transport costs for family visitors, etc.

3. Temporary incapacity and infirmity.

4. Temporary incapacity: A daily allowance to compensate for lost income.

5. Infirmity: A lump sum or annuity paid in the event of partial or permanent disability.

Among the health insurance risks **excluded**, which vary from one insurer to another, are claims relating to war, deliberate acts, experimental medical or pharmaceutical practices, etc.

6. Compulsory long-term care insurance

Luxembourg's earliest social protection provisions, comprising the introduction of a compulsory health insurance scheme, date back to the turn of the century. Later, the principle of national solidarity prompted fundamental improvements in social protection. Even so, responsibility for meeting long-term care needs was never really assumed by the community: most services for dependent persons were either provided free of charge by informal care-givers or administered by an entity, in which case the cost had to be met by the recipient.

In view of the ageing population and rising health care costs, the Act of 19 June 1998 introduced a new insurance scheme for long-term care. The Act instituted protection for dependent persons through a new branch of Social Security ensuring all persons, in the workforce or not, unconditional entitlement to long-term care benefits.

From this standpoint, the creation of long-term care insurance as a new pillar of Social Security may be seen as an historic development in the evolution of social protection in Luxembourg.

The main features of the Act are as follows:

a) Creation of an unconditional entitlement of protected persons to benefits in kind or, alternatively, cash benefits with which to procure assistance and care from third parties for the essential acts of everyday life (unconditional recognition of entitlement to long-term assistance and care, irrespective of the beneficiary's age). Dependency is assessed exclusively in respect of essential acts of everyday life. The required assistance and care (individualised needs) are evaluated using a questionnaire and determined from a standard checklist of benefits.

b) Creation of compulsory insurance based on occupational activity or replacement income with cover for members of the insured's family.

c) Institution of a system to assess, guide and provide for dependent persons.

d) Organisation of dealings with assistance and care providers, for at-home or institutional care.

e) Institution of a system of mixed funding to give the new form of insurance a financial base.

It should be noted that no specific personal scope of application is specified for long-term care insurance, but that all persons receiving it on either a compulsory or voluntary basis, or in their capacity as family members under the health insurance scheme, are automatically entitled to long-term care insurance protection.

7. Finance of private health insurance

Health insurance premiums written totalled about LF 490 million in 1999, accounting for 2.7 % of aggregate non-life premiums.

- Rates depend on age, sex, benefits covered, any additional guarantees and duration of cover.
- Any physical or legal person may take out health insurance.
- The age limit is 70.

Health insurance generally imposes a waiting period before cover becomes effective. This is essential to prevent claims for conditions of which the insured was aware at the time of subscription but did not disclose to the insurer. This period varies depending on the risks covered. It should be noted that there is no waiting period in the event of an accident.

The insurance proposal and the medical questionnaire that is an integral part thereof constitute the essential elements for assessing risk. The medical questionnaire covers prior illnesses and accidents as well as the family medical history.

8. Current situation and future prospects

Private health insurers are expecting growth in medium and long term. The legal health insurance scheme provides presently high benefits. However, due to increase of medical costs, demographic development and increase of life expectancy, the costs of the legal health insurance scheme will rise. Limitations of legal benefits are to be expected and the scope for private health insurance will widen.

MEXICO

The health system in Mexico includes a scheme established by the Social Security Law and a private health scheme. The former refers mainly to the Mexican Institute of Social Security (IMSS), a public institution funded through employees, employers and state contributions; another relevant public agency is the Institute of Social Security and Services of State Workers (ISSSTE) which provides health services to the state employees and receives employees and state contributions. As for the private system, health services can be obtained from a private institution through a registered contract, which in many cases takes the form of an insurance policy.

Those who contract health services under the private health scheme must still make their payments to IMSS or ISSSTE, having the alternative to use both schemes (generally, these agents prefer private services). However, most of the population only have the capacity to resort to the social security system. It is worth mentioning that there is a small portion who don't use either of the prevention schemes and pay the specific health service that they require.

The social security system covers not only basic medical care, but also hospitalizing and major medical care (e.g. surgery), including medication. It provides services by their own personnel and hospitals. On the other hand, the coverage of the private health system depends on the contracted plan.

1. General outline of private health insurance

Insurance companies in Mexico mostly operate the coverage of major medical care. In 1997, due to domestic and international trends, the Insurance Law (*Ley General de Instituciones y Sociedades Mutualistas de Seguros*) was modified in order to include the line of health insurance within the operation of Health and Accidents.

Accordingly, three lines now constitute the operation of Health and Accidents:

- Personal Accidents, defined as "insurance contracts regarding injury or incapacity that affect the personal integrity or health of the insured, as a consequence of an external event, violent, sudden and fortuitous".
- Medical Care, defined as "insurance contracts regarding the coverage of medical expenses, hospitalizing and others needed for the recovering of the insured's health, caused by an accident or sickness".
- Health, defined as " insurance contracts regarding the provision of services directed to prevent or restore health, through actions that benefit the insured".

The institutions that provide these insurance services are regulated by the Ministry of Finance, through the Insurance Law, and are supervised by the National Insurance and Surety Commission. These companies can be constituted as joint stock companies or mutuals.

As of December 1998, the amount of gross premium of the operation of Health and Accidents was USD$515.8 million, which represented 8.8% of the total of Mexico's insurance industry. The lines of personal accidents, medical care and health reached an amount of gross premium of $42.6, $451.6 and $21.6 million of USD, respectively. Thus, medical care represented 87.5% of the Health and Accidents operation, while personal accidents and health only shared 8.3% and 4.2%, respectively.

2. Developments in private health insurance

The operation of Health and Accidents insurance has been regulated in Mexico since the first insurance legislation, dating back to 1892.

Recently, some companies have been offering prepaid medical care services, i.e. contracts for the future provision of health services, through pre-payments. These activities have grown increasingly, and participants include not only insurance companies but also private institutions that operate outside current insurance legislation. These organizations give their customers the health services by contracting a group of providers.

Due to the characteristics of these operations, it became necessary to formulate a minimum regulatory framework in order to develop the market in an orderly fashion, eliminate unfair competition, introduce a prudential regime and solvency requirements for all companies involved, as well as protect consumer interests. Regulation must encompass not only financial/technical norms, but also take into account the quality of the services provided.

All the involved parties agreed that the ideal scheme would be to enact a specific law and an *ad hoc* supervisory organization, which would supervise not only technical and financial matters, but also medical ones. However, the period of time required to develop this approach was evaluated and a short-term alternative was proposed in order to take advantage of existing supervisory bodies.

The current proposal is that the Ministry of Finance should function as the regulatory body of these activities, viewing them as insurance operations. The National Insurance and Surety Commission would be in charge of supervising them, thus taking advantage of its technical and financial expertise. In addition, the Ministry of Health would have the responsibility of overseeing the quality and quantity of the medical services.

3. Range of benefits

When provided by an insurance company, a health plan may include integral coverage to several health needs, starting from simple medical consulting, to sophisticated treatments, such as dental coverage, medication, hospitalizing, therapy, etc.

Some current coverages of health plans are the following:

- Basic medical care and ambulatory
- Maternity and dental services
- Major medical care
- Hospitalizing services
- Physiotherapy and prosthesis
- Preventive medical care

These plans are characterized by the concept of "co-payment", by which the insured absorbs a percentage of the cost of each medical consulting, in order to take care of the proper use of the service. Such a concept does not apply in the case of preventive consulting, in order to encourage the insured to resort to health preventive mechanisms.

The health plans can vary with respect to the coverage offered. Nevertheless, in general terms, they give integral assistance to the insured's health problems due to accidents or sickness, cover preventive medical consulting, and allow the insured to choose the doctor who will be in charge.

The service is provided through a group of medical facilities associated to the insurance company program, and the insured is only charged for the co-payment. In the case of an emergency, the insured can go to a health institution not affiliated to the group, and the insurance company should reimburse the expenses.

4. Current situation and perspectives

In response to recent developments with respect to private health insurance, last April an initiative was presented to Congress to modify the Insurance Law, in accordance to the following:

- The activities of prepaid medical care organizations should be considered as insurance operations.
- Only authorized specialized insurance companies may offer health insurance.
- Among the requirements for a company to be licensed to operate, a technical (medical) report granted by the Ministry of Health should be included.
- Insurance companies that currently operate other lines of insurance would have a two-year period to separate and constitute a specialized health insurance institution.
- Companies that currently are not insurance institutions and provide health services would have a one-year period to request authorization to constitute themselves as an insurance company.

These measures have the objectives of: promoting an ordered market that forms a pillar for it's development; giving certainty to the investment made in this field; and protecting consumer interests.

Also, these modifications have the added benefits that they can be implemented in a short-time span and they take advantage from the experience and existing structure of the National Insurance and Surety Commission and the Ministry of Health.

NETHERLANDS

The Netherlands is a country with 15.6 million inhabitants. As in the neighbouring countries, the Dutch health care system is of a very high standard and is an important component of the Dutch economy. Average life expectancy is 77.5 (men: 74.6, women: 80.3) years. Health care in the Netherlands is characterized by a dual health care financing system. Both social insurance and private insurance play an important role in the financing of health care. Effective health insurance in the Netherlands ensures both universal (= 100% of population) and comprehensive (most forms of health care) coverage. Total turnover for the health care sector in 2000 is estimated on 32 billion euro (almost 10% of the gross national product).

1. Health insurance system in the Netherlands

Medical care in the Netherlands is largely funded through a system of public and private insurance systems. The Netherlands, where 37% of the population is not covered under the statutory health insurance scheme for medical care, pharmaceuticals and hospital care, have the largest private health insurance market in Europe.

In the Netherlands can be distinguished three layers, or three ‘compartments’, in the health insurance system:

I. social insurance for long term care; mental care, care for the handicapped, and homecare

II. public/private mix; insurance of ‘elementary’ medical care, such as hospital, medical specialist, general practitioner, pharmaceuticals, physiotherapy, dental care for children.

Within the second layer several methods of financing of care can be distinguished:

- II Social Insurance Act (63% of the population)
- II Private Insurance, of which:
- II a Private individual insurance (private company policy’s)
- II b Medical Insurance Access Act (WTZ)
- II c Civil servants scheme

III private insurance; additional voluntary insurance; dental care for adults, cosmetic surgery, homeopathy, acupuncture, orthodontist treatment.

<table>
<tr><td></td><td>AWBZ
(Exceptional medical expenses)

Long term care/mental care and cure</td><td>100% pop. covered</td></tr>
<tr><td>ZFW
(Social Health Insurance Act)

Normal care/cure

63%</td><td>Private Insurance

Normal care/cure

31%</td><td>Civil servants

Normal care/cure

6%</td></tr>
<tr><td></td><td>Supplementary or additional insurance</td><td></td></tr>
</table>

I. Long term care

The first section covers all long term care and care which is difficult to insure against in the private sector (care for chronic illness for example). To address these catastrophic costs there is a compulsory national insurance scheme, the Exceptional Medical Expenses Act, referred to as AWBZ in the Netherlands. Each person living in the Netherlands and subject to Dutch taxation is covered by the act. Benefits include long term residential and nursing care for the elderly, comprehensive psychiatric care, long term home-based care and comprehensive care for the physically and mentally handicapped. The funding of AWBZ is covered by a compulsory premium. This premium is levied together with the income tax.

In 2000 the premium is 10,25% of taxable income up to a maximum of 22.232 euro. The national tax revenue service collects premiums. This money is transferred to the central fund of AWBZ. This fund is administered by the Social Health Insurance Council. The Council, in turn, distributes the funds to its statutory agents, the so-called care offices. These care offices are the same as the regional social health insurance funds, which are responsible for the administration of the AWBZ. The regional social health insurance funds are responsible for services covered by the AWBZ. The AWBZ provides benefits in kind. Patients never receive bills (except for co-payments, which for stays in institutions are income-related); payments are made directly to providers according to rules laid down in contractual arrangements. Contacts between individual institutions and health insurers are generally maintained by so called ‘liaison offices’. The total turn-over of services covered by the AWBZ in 2000 is estimated at 12.89 billion euro. The procedures concerning the fixing of benefits, setting of premiums, and regulations concerning the administration and supervision of the AWBZ are very similar to the procedures followed under the Social Health Insurance Act (mentioned here-after).

II. Elementary medical care

Within the second compartment there is a distinction between:

II.1 Compulsory insurance
II.2 Private insurance:
II.2.1 private individual insurance
II.2.2 medical insurance access act
II.2.3 civil servants insurance

Almost everyone in the Netherlands has some insurance for 'elementary' medical care. About 63% of the population is compulsory insured under the Social Health Insurance Act (of 1964). For 6% (certain groups of civil servants) there is a special public insurance scheme. The rest of the population (31%) relies on private insurance for 'normal' medical care. Over the last few years the Government has proclaimed that it is aiming at a further gradual convergence between the social health insurance scheme and the private health insurance schemes. To this purpose the government has tried to persuade the private insurance companies to offer basic insurance packages comparable with the package of the social health insurance. In fact, many insurance companies have followed this request voluntarily.

II.1. Social health insurance

The Social Health Insurance Act (ZFW) came into force on 1 January 1966. Since 1986 the Social Health Insurance Act only deals with compulsory insurance. The insurance is carried out by competing Social Health Insurance Funds.

In 2000 the following groups of persons are covered by the obligatory social insurance:

I. salaried workers with a fixed salary under a statutory ceiling (for 2000: 29.310 euro)
II. recipients of social security allowances (with an income under the mentioned ceiling)
III. elderly people (over 65) with household income below 18.650 euro
IV. small businessmen with an tax related income below 18.700 euro.

Subject to certain conditions cover is extended to the partner and children of the insured person. If people do not meet the requirements of the obligatory insurance they may buy private insurance. In practice almost everyone does so. For the income ceilings November 1 is the reference date. An individual with a salary/income under the ceiling, as of the reference date remains in the compulsory insurance the following year, independent of possible increases in income in the following year.

Cover under the Social Health Insurance Act gives entitlement to benefits in kind in the form of medical treatment and care. In general, these services are free at the point of access, provided that contributions have been paid. For certain services (such as medicines with prices above the average price of comparable medicines, aids and devices) their is a specific co-payment.

The statutory basis for the medical care to which insured persons are entitled is provided by the Social Health Insurance Act. The treatments and services available under the Social Health Insurance Act are the following:

- Medical and surgical treatment by general practitioners and specialists
- Physiotherapy
- Speech therapy
- Obstetric care (normally provided by a midwife)
- Dental care (for children under 18 years there is wide coverage; for adults the entitlements are very limited)
- Admission and stay in a hospital
- Pharmaceutical care (medicines)
- Aids and devices
- Transport (ambulance)
- Maternity care
- Haemodialysis
- Services for patients with chronic recurring respiratory problems
- Services of a thrombosis prevention unit
- Audiological services
- Stay in a rehabilitation clinic.

To obtain medical services, individuals must apply to a practitioner with whom, or an institution with which, their health insurance Fund has concluded a contract and which are therefore defined as associated with it. In the case of general practitioners the sickness Funds apply a registration requirement: once individuals have chosen a doctor from among those who have contracts with their health insurance fund, they are registered with that doctor and may use only his or her services. This requirement is related to the remuneration of doctors, which is based on the number of people on their lists and on the average number of times that patients covered by health insurance funds consult them (per capita remuneration).

To obtain treatment from a medical specialist , a physiotherapist or another consultant, the health insurance regulations require referral by the general practitioner. For hospitalization pre-admission authorization by the Health Insurance Fund is required (except in cases of emergency). In certain circumstances a Health Insurance Fund may authorize treatment by a practitioner with whom, or institution with which, it does not have a contract.

The financing of social health insurance is of a contributory nature. Contributions vary depending on the income of the insured. Those who are co-assured do not have to pay contributions. Salaried workers pay 1.75% of their wage, their employers pay 6.35% of this wage.

The contributions linked to income and advance tax are transferred to the General Fund administered by the Social Health Insurance Council. For each insured person the Health Insurance Funds receive a risk adjusted capitation payment based on the following parameters:

- age
- gender
- disability
- region

The budgets that result from this allocation mechanism cover about 90% of the costs of the Health Insurance Funds. The deficit must be covered by a nominal (flat rate) premium which can be set by the individual Health Funds. Health Funds can, in theory, compete through the size on this nominal premium. In 2000 the nominal premiums range from 156.55 euro to 223.26 euro.

II.2 Private insurance

Persons not covered by the Social Health Insurance Act may buy insurance with a private insurance company. In practice, practically everyone does so. European Union directives differentiate between:

- injury insurance policies, and
- life insurance policies.

The activities of the injury insurance sector legally have to be separated from the activities of the life insurance sector. According to Dutch law the activities of the injury insurance sector can be run by:

- mutual insurance companies
- limited companies.

All these insurance organizations have to respect the conditions put forward by the Insurance Industry Supervision Act. In the Netherlands the legal status of mutual insurance companies is most often chosen to offer private insurance against the costs of health care, invalidity, incapacity to work and pension payments. Due to its not-for-profit nature this structure seems rather appropriate for insuring human risks.

The Insurance Chamber supervises the activities of the private insurance companies. It concentrates particularly on checking whether solvency requirements are met. The Insurance Chamber is not particularly interested in health care affairs.

Private insurance is carried out by competitive private insurance companies. In principle, they are free to accept or refuse clients, with the exception of the Standard Packet Policy of the Medical Insurance Access Act (mentioned hereafter). Private insurance companies offer nominal premiums. These are often related to the age of the person requesting a private insurance policy. The average nominal premium for a package which is comparable to the Sickness Fund package and the Standard Packet Policy is approximately 730 euro.

In general privately insured persons pay the costs of the medical care they receive (reimbursement system). This is a reimbursed by the Health Insurance Company (if the care is covered by the benefit package). Private insurance offer an extensive choice: of various coverages, deductibles and rates (as said, mostly depending on age). In general, the private insurers determine in their policy-conditions, for example, that a referral by a general practitioner for medical treatment in a hospital is required. Fee-for-service is the usual system of provider reimbursement.

II.2.1 Medical Insurance Access Act

The abolition, from 1 April 1986, of the voluntary social insurance scheme meant that some of the people formerly covered by this scheme now had to rely on private insurance. In order to guarantee access to the private insurance market, insurers where required to include among their policies one offering cover as defined in the Medical Insurance Access Act (WTZ). The benefit package defined on this basis very much resembles the package of social health insurance described above. While no insured person is obliged to take out cover as defined in the Act, all insurance companies are required to offer such a policy to any individual requesting it and who meets the statutory criteria. Of the 31% of the population who has a private insurance, 14 % has a standard package policy and 86% has an individual private policy.

The standard package policy is available to the following groups:

- People resident in the Netherlands who, for whatever reason, have to leave the compulsory health insurance scheme or one of the schemes for civil servants;
- People resident in the Netherlands who are uninsured and who do not know, and cannot reasonably be expected to know that they have an above-average risk of sickness;
- People taking up residence in the Netherlands who have previously had some form of health insurance;
- Those over 65 years who had previously some other form of private health insurance.

People who meet the statutory criteria may apply within four months of the date on which they first fulfil these criteria to any private health insurer operating in the Netherlands for standard package coverage. Insurers are normally obliged to accept such applications.

The payments gap between revenues and expenditures made under the standard package policy scheme are subsidized by the premiums paid by private policy holders. A fixed sum is paid per person insured. For adults the premium is 1366.79 euro annually. Since the premiums set for certain groups entitled to a standard package policy do not fully cover the cost, the Medical Insurance Access Act includes a risk sharing provision for insurers offering standard package policy cover to the groups referred to in the Act. All insurers are required to enter into a contract with a central pooling organization set up for this purpose. The insurers have to collect a flat rate solidarity contribution from all their other policy holders which is transferred to the central pooling organization. For 2000 this solidarity contribution amounts 179,70 euro (children from 0 to 19 pay 50%, 89.85 euro). This organization then shares the revenue among insurers in proportion to their shortfall.

II.2.2 MOOZ

The abolition from 1 April 1986 of the voluntary social insurance scheme meant also an over-representing of elderly people in the obligatory social health insurance. Relatively more persons over 65 transferred to the social health insurance system and in order to compensate the higher costs for social health insurance, a new Act was created. This Act, is called MOOZ, the Act on Co-financing the Over-representing of the Elderly obligatory insureds. All private policy holders are obliged to contribute to compensate for this over-representation. Responsibility for the enforcement of the act falls to the Pooling Foundation. This Foundation, together with the Minister of Health and on the advice of the Sickness Fund Council sets a flat rate solidarity contribution which has to be paid by every privately insured person for the next year. For 2000 the MOOZ-contribution is 100.74 euro (20 to 64 years), 50.37 euro (0 to 19 years) and 80.59 euro (65+).

III. Supplementary or additional medical care

The third component or sector under the insurance system is insurance for services that are not covered by the Exceptional Medical Expenses Act (AWBZ) or the Social Health Insurance Act (and equivalent private insurance schemes). In principle, there is a free market for additional services. Both Social Health Funds and private insurers may offer additional services. They usually include: dental care for adults, ‘class’-level for stays in hospital (private room etc.), and ‘alternative’ medical treatments, such as medical care by homeopathic or anthroposophic doctors. For these types of supplementary insurance only the general rules for private insurance apply (solvency demands; supervision by the Insurance Chamber). The turnover in these supplementary services is rather limited.

2. Overall picture of the health insurance system in the Netherlands

Rising welfare levels, changes in demography and rising expectations about the quantity and quality of health care services available, have led to rapid growth of health care expenditures. The need for cost-containment has compelled the Dutch government to propose fundamental changes in the system of health insurance in the past decades. An element of the changes of the Dutch system is a greater emphasis on the individual responsibility of its citizens.

The present government, however, which consists of a coalition of left and right wing politicians has decided on a step by step approach to improve the existing system. The goal has not changed and remains to provide access for everyone living in the Netherlands, despite the rising costs. To that end measures have been taken to gradually harmonise the basic entitlements under the social health insurance fund scheme, the health insurance schemes for civil servants and private medical insurance (‘convergence’). At this moment, however, it is not envisaged to create one single health insurance scheme.

3. History of health insurance

The first organised form of health insurance dates from the Middle Ages, when guilds which were founded that provided financial support and benefits in kind in the event of sickness. At the end of the 18th century the guilds were disbanded, with the consequent loss of the medical support system which they had introduced. The resulting gaps were filled by charitable church institutions, by employers who had acknowledged their social responsibilities and - in terms of medical expenses- by doctors who, with a view to achieving a degree of financial security themselves, had begun to provide treatment in return for income-related contributions, by setting up ‘doctors’ funds.

‘Loss of earnings’ insurance remained in the background until the government introduced a welfare system for the benefit of certain population groups which were in need of particular protection, e.g. industrial and agricultural employees. As demand in this sector continued to increase, private insurance companies began to offer this type of cover.

Since the Second World War, there has been a further considerable increase in the demand for insurance cover as the economy has developed.

4. Nature of providers

In 2000 some 46 private health insurance companies are active on the Dutch market (next to 28 sickness funds and 3 for civil servants). All these health insurance companies, both the social as the private insurers are members of the Association of Dutch Health Insurers (Zorgverzekeraars Nederland).

The private healthcare insurers in the Netherlands may either write health insurance only or also write other classes of life and non-life business (so called composite insurers). A further division may be made according to the legal form of the companies. A large number of insurers operate as insurance mutuals. A third division may be made by the objectives of the companies. Some insurers operate on a commercial basis, while others, particularly those associated with the health insurance funds, are non-profit-making.

Non-life insurance companies are subject to supervision by the Insurance Supervisory Board (Verzekeringskamer). The powers of this body are laid down in the Insurance Business Supervision Act of 1993 (Wet Toezicht Verzekeringsbedrijf). One important task is the supervision of insurance company solvency.

5. Convergence in the Dutch health insurance system

In the so-called ‘second compartment’ of health insurance (‘normal medical care’), two components can be distinguished: social health insurance and private health insurance. Two types of ‘health insurers’ correspond with these types of insurers: the Social Health Funds and the private health insurers. New health insurance groups are working together, and sometimes emerging which usually have two branches: a social insurance department and a private insurance department. Legally and financially the two branches are strictly separated. Public money can only be used for public services. To the clients, however, these new Health Insurance groups increasingly appear as a single institution, or with other words they more and more show one window. The marketing concept is: whether you are obligatorily insured or need private insurance, we can always help you. If you have to leave obligatory insurance, we can offer private solutions.

NORWAY

1. Structure, Cost and Finance of Health Care System

1.1. Structure and cover

In Norway, the municipalities are responsible for the primary health care. They shall i.e. provide general practitioner services (including emergency ambulatory medical services), physiotherapy and remedial gymnast services, nursing services (including public health nurse and home nursing services), midwife services, nursing homes or other forms of accommodation for full time care and nursing and medical emergency report services.

The County Council is responsible for the planning, construction and running of hospitals and other health institutions for somatic and psychiatric illness and medical rehabilitation. The counties are also responsible for planning and providing medical specialist service, clinical psychologist services, medical laboratories and institutes for diagnostic radiology for ambulatory patients. Furthermore, the counties are responsible for the planning and providing of dental health, prophylactic and restoring services to children and young persons up to the age of 18, mentally handicapped persons, old people, long–term patients and invalids in hospitals, health institutions or under regular care of the municipal home nursing services, and if possible for other approved groups as may be determined. Establishing and providing medical emergency report services and ambulance transport are also a responsibility for the counties, except air ambulance transport, which is a state responsibility.

Some hospitals, basically established to provide highly specialised treatment, are run by the central government.

Hospitalisation including medication in public hospitals (run by central government or counties) is free of charge. Most hospitals in Norway are public.

1.2. Cost

The total public expenditure on Health Services in 1997 amounted to NOK 57.4 billion corresponding to 5.3 per cent of GDP, including care and attendance services for the elderly and disabled NOK 89.9 billion or 8.3 per cent of GDP.

More detailed information on the cost of the Norwegian health care system is supplied by the following publications:

- "Government expenditure on health care and social purposes/tasks" (in Norwegian), the Ministry of Health and Social Affairs, March 1999.
- "OECD Economic Surveys 1998 – Norway", pp. 73–102.

1.3. Finance

The Norwegian health care system is mostly publicly financed.

a. The municipal health services are financed through a combination of grants from the local government, retrospective reimbursement by the National Insurance Scheme and fees paid by the patients. The municipalities, in turn, receive block grants from the central government, which complement local revenues from taxes and charges.
b. The financing of the county health services is three–tiered:
   - The County Councils provide the bulk of hospital financing which, in turn, is funded by local tax proceeds and block grants received from the central government.
   - Reimbursement per patient from the National Insurance Scheme for ambulatory (outpatient) care and contributions from the education authorities for teaching services.
   - The central government provides earmarked grants through the county budgets targeted on specific activities to reflect national policy objectives (for example to reduce waiting lists) or to remove unacceptable differences in service levels between counties.
c. The National Insurance Scheme is mainly financed by contributions from employees, employers, self-employed and others, and by grants from the central government.

2. General Outline of Health Insurance System

All persons resident or working in Norway are compulsorily insured under the National Insurance Scheme.

The National Insurance Scheme reimburses wholly or in part expenses in connection with medical care, i.e.

- physician's assistance, both by general practitioners and specialists,
- midwife assistance, family planning, regular examinations during pregnancy,
- physiotherapeutic treatment,
- certain medicaments of major importance,
- dental treatment of disease,
- treatment of speech and language defects by a speech therapist,
- treatment by a chiropractor, examination and treatment by a psychologist,
- hearing aids,
- necessary and appropriate prostheses or support bandages to counteract the effects of functional disturbances in the organs of support and motion, and breast,
- facial defect or eye prostheses and wigs.

The scheme moreover covers transportation and board in connection with examination and/or treatment for which benefits are granted. The National Insurance Scheme's expenses on medical benefits in kind were approximately NOK 12.5 billions in 1997, amounting to approximately 9 per cent of the insurance scheme's total expenditure.

In order to have the expenses for treatment by a medical practitioner outside institution covered, treatment must be given by a practitioner etc having a reimbursement agreement with the Norwegian National Insurance institution. Refunds (of expenses exceeding the stipulated cost–sharing charges) will be effectuated directly between the service provider (health institutions/medical practitioners etc) and the National Insurance institution, in so far the treatment is given by a practitioner etc having a reimbursement agreement with the National Insurance institution. The cost–sharing amounts vary according to circumstances. In connection with treatment by a general practitioner at his/her office by daytime, it is NOK 108 for each consultation. For prescription of important drugs, it is 36 per cent of the expenses (maximum NOK 330).[1]

There are certain exemptions from the cost-sharing provisions for special diseases and groups of persons. Free physician's assistance is granted in the case of occupational injury or occupational sickness, or delivery etc. In the case of delivery, free midwife assistance is granted as well. Necessary medical examinations during pregnancy and after confinement are free. There are also exemptions from cost–sharing for treatment of certain types of venereal or infectious diseases (HIV–infection, tuberculosis etc). Children under 7 years of age are exempted from cost–sharing for treatment by physician, physiotherapy, important medicines and transportation. Children under the age of 18 are exempted from cost–sharing for psychotherapy.

A ceiling for cost–sharing has been introduced for treatment by a general practitioner or a specialist outside hospital, treatment by a psychologist, prescriptions of important drugs and transportation expenses in connection with examination or treatment. The ceiling is fixed by Parliament for one year at a time. The ceiling for 1999 is NOK 1320. For cost–sharing charges incurred abroad the ceiling is set at 75 per cent of this amount. After the ceiling has been reached, a card is issued giving entitlement to free treatment and benefits as mentioned for the remainder of the year. Cost–sharing amounts for children between 7 and 16 years of age are added to those of a parent in order to reach the ceiling.

An insured person who has an annual income of at least NOK 56713 is entitled to daily cash benefits if he/she is unable to work due to sickness. Such benefits equal 100 per cent of the pensionable income, and are paid from the first day of sickness for a period of 52 weeks. The benefits for the first 16 calendar days are paid by the employer. Self–employed persons get sickness benefits corresponding to 65 per cent of the pensionable income from the 15th day of sickness for a period of 50 weeks, and may opt for additional cover for 100 per cent compensation and/or benefits from the 1st day of sickness on a voluntary basis.

Rehabilitation benefits are granted if the person concerned has a permanently reduced working capacity or substantially limited opportunities in the choice of occupation or place of work.

Rehabilitation allowance is granted to a person who is not entitled to daily cash benefits in case of sickness if he/she has been unable to work for one year, or to a person who is entitled to daily cash benefits in case of sickness, after the period of entitlement to such benefits has expired.

A person between 18 and 67, whose working capacity is permanently reduced by at least 50 per cent due to illness, injury or defect, is entitled to a disability pension. A basic benefit is granted if the disability involves significant extra expenses, and an attendance benefit is granted if the disabled person needs special attention or nursing.

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[1] The amounts and percentages refer to 1999. A similar comment applies to the figures in the remaining part of the present chapter.

3. Current Situation and Future Prospects

Private health insurance has a short history in Norway. The main reasons for this situation are summarised as follows in the above mentioned OECD report (the 1998 Economic Survey of Norway, page 73):

A key feature of the Norwegian health care system is the predominance of tax–financed public provision, akin to health systems in the rest of the Nordic area and the United Kingdom. This approach contrasts with the dominant model in many OECD countries, whereby privately provided health services are being funded by a mix of social and private insurance. The Norwegian health care system has succeeded in securing universal coverage and high quality service while, at around 8 per cent of GDP, absorbing resources around the international average.

However, according to this OECD report the Norwegian system is facing some challenges, which are highlighted in the following manner:

1. acute capacity shortages suggested by long waiting lists for hospital admission and the lack of physicians and other medical staff;

2. the need to strike a balance between the requirements of a cost–efficient health care system on the one hand and the ambition to maintain a full–fledged health service in even the remotest parts of the country on the other; and

3. the risk of major expenditure increases in the future.

In this situation it may turn out that the possibilities of marketing private health insurance will improve. At least this seems to be expected by the Association of Norwegian Insurance Companies. In the Association's "Annual Report 1998" it is stated that

> *[t]he sale of private health insurance policies is increasing in most European countries. In recent years, the products have arrived in Norway. These have primarily been products which cover the additional financial needs during life threatening illness, and policies which provide payment for certain operations. Health policies make it easier for most people to share in the constantly increasing private health service facilities.*
>
> *The market is showing interest in these types of products. In 1998, there will probably be more players and steadily more products available, and one will not only see opportunities to assist with cash payments, but also to help with treatment itself.*

However, the portion of the overall premium income of Norwegian insurance companies stemming from (private) health insurance is still very low. As an example, we will give a few figures related to a non–life insurance company specialised within health insurance that was established in August 1998.[2] The written premiums on a gross basis for this company were only NOK 1.1 million in 1998, but are expected to increase to some NOK 5–6 million in 1999.

Moreover, all the other Norwegian life and non–life insurance companies selling health insurance products have so far experienced a very modest premium income stemming from these products – in most cases within the interval running from NOK 100 – 200 000 to NOK 1 – 2 million. Even if neither exact figures nor (reliable) estimates are available, it seems unlikely that the Norwegian insurance companies in 1999 will have premium income stemming from health insurance that exceeds NOK 15 – 20 million.

[2] This company is owned on a 50–50 basis by Storebrand Insurance Group (the largest insurance group in Norway) and Deutsche Krankenversicherung AG.

On the other hand, there are some EU/EEA insurance companies that have notified that they – in agreement with the rules laid down by the EU Directives – intend to underwrite health insurance products in Norway either through branches or by way of freedom to provide services, including companies specialised within this insurance class. However, figures on the portion of these companies' premium income stemming from health insurance products are not available.[3]

The health insurance products presently being underwritten by Norwegian insurance companies are typically labelled "Critical Illness" or "Treatment Agreement". It remains to see whether these products – or any other health insurance products to be marketed by Norwegian insurance companies – will be viable, and whether (private) health insurance will become a significant insurance class or remain as a minor class to be handled by some "niche" companies.

[3] In fact, (private) health insurance is not considered as a separate insurance class in the context of the EU Directives, but is included in both the accident and the sickness insurance classes. Accordingly, information on the premium income stemming from health insurance as such will not be available through the implemented procedures for exchange of information.

POLAND

1. Structure, Cost and Finance of Health Care System

Organisation and functioning of the health care system in Poland is similar to the system existing in many other European countries. In the future the primary health care will be provided by family doctors. Presently, in time of transition, primary health care services are delivered by the internists, paediatricians and gynaecologists. In some regions of the country primary health care doctor purchases the services of the ambulatory specialists, playing the role analogous to the English GP found holder. Primary health care and specialist ambulatory services are delivered by public and in considerable part by private providers as well.

Stationary health care system, at three reference levels, is provided by public providers and by few private hospitals with a limited number of beds.

In 1997 total expenditure on health care system was approximately 6,2 % GDP, out of which 4,6, % came from public budget - i.e. state budget and local government funds. Other expenses of GDP – 1,6% were borne by households.

In 1997 - 51,3 % of total public budget designated for health care was spent by providers of stationary health care, 18,1 % for ambulatory services and 30,6% for other health care services.

In 1997 the annual *per capita* expenses for health care were equal to 789,96 PLN in Poland.

The Sickness Funds - of the Social Health Insurance system most of public expenditure for health care system, while the remnant portion of the funds is spent from the state budget and local government funds.

Household expenditures for health care augment very fast (in 1992-1997 they augmented by 400% at comparable rates) [*I. Dadas et al, 1998*]

2. General Outline of Health Insurance System

At the beginning of 1999 the Social Health Insurance system was introduced in Poland to separate payers from providers in order to develop an internal market in health care sector. As many as 16 Regional Sickness Funds and one branch fund are operating under the Social Health Insurance System. These funds finance health services for nearly all Polish citizens. The premium of 7,5% of its base is paid by the insured (no charges in this respect to the employers). The premium is refunded to the insured by the income tax system.

According to the Act on Social Health Insurance system the insured persons have access to all kinds of health services except the services indicated by the Act - such as over-standard services specified by the Minister of Health and Social Welfare, or protective vaccinations other than the Sickness Funds are decided by the MOH to provide.

Part of the costs for some of the services must be borne by the patient (for example, stomatological services).

The Sickness Funds do not provide services in respect of sick support payments.

The Public Health Insurance system is based on the following principles:

- social solidarity (the wealthier bear some of the health-related expenditures of the poorer social groups),
- self-governance (the Sickness Fund enjoys legal personality, members of its council are elected, the council appoints the members of the Fund's management),
- self-financing (the major source of income for the Funds are premiums from the insured, second in terms of significance are funds received from other Sickness Funds in respect of adjustment of financial disparity, third source is profit from investment of part of resources collected by the reserve funds),
- right of free selection of the Fund (this entered into force from 1st January 2000), This principle will effect in a competition among the Funds, although its nature and scope is not ultimately defined yet.
- activity of the Sickness Funds as non-profit-oriented institutions,
- effectiveness and purposefulness of their activity (improved financing of the health care system should be abstract unless this principle is observed).

In the course of the internal health care market development the primary health care doctor started to play a role of a *gatekeeper*. Moreover, definite majority of public providers became more independent having obtained legal personality and major independence of internal organisation and operation. Independent public providers can acquire financial means from diverse resources - they are not limited to public budgets. The last but not least, the competition among health care providers was introduced.

Though Poland is one of the most dynamically developing countries in Central and Eastern Europe (CEEC), the degree of its economic progress is still quite low. A comparison of GDP *per capita* in Poland against other countries is quite evident an affirmation.

Country	**GDP *per capita* (1997 in USD)**
Poland	3 702
Greece	11 354
Portugal	9 898
Germany	25 754
France	23 781
Great Britain	21 668
Czech Republic	5 184
Hungary	4 335

Source: Statistical Yearbook 1998, GUS 1998

Low level of economic development lies a material cause of the restrained financing of the health care system from public resources. In consequence the access to health-care services is at times constrained and their quality is low quite often as well. Furthermore, financial problems thus discussed are connected directly with low remuneration of medical professionals, leading to violent protestations (e.g. nurses' demonstrations) and informal considerations paid to the providers by the patients. [A. Zajenkowska-Koz•owska, 1994; J. Halik, 1995]

3. History of Private Health Insurance

For over a century till the end of WWI the Polish State was divided amongst three occupants: Austria, Prussia and Russia. Therefore, it is only the analysis of development of the private health insurance in these three countries that may provide relevant information on the subject with respect to the territory of Poland.

Towards the end of WWI there was a growing interest in Poland in health insurance. The reasons for that state of affairs were the following: deteriorated health condition of the population in consequence of the ongoing warfare, depressing economy and public strife for social reforms to respond to the economic and health postulates put forward by proletarians. Therefore, in 1920s the work on the Sickness Fund system launching was begun. This system was being developed in 1920-1933. Owing to the economic exigency at that time the Funds were thwarted by a number of problems; therefore the wealthier tended to insure with the private health care insurers. Legal regulations facilitated it, as they provided that all individuals whose annual income exceeded 30 thousand marks can be exempt from compulsory insurance. In 1934 social insurance system was introduced in Poland to bring among others together all kinds of health insurance within one institution, even this reform however, effective to 1939, failed to diminish the interest of the wealthier social groups in private insurance system [*J. Sadowska, 1990, p. 3, 8 and consecutive*]. It should be borne in mind that total demand for this insurance was little. It was the result of the breakdown of life insurance and related health insurance market after WWI [W. Adamczyk, 1997, p.56].

In Poland, after WWII the insurance business could be run exclusively by the state, legal and public and co-operative insurance companies. In consequence the private Polish and foreign insurance companies were dispatched. There were two monopolists established in insurance market, out of which one to provide the compulsory insurance and the other to deliver reinsurance. In this time the socialised property favouritism against the private assets could be observed (different insurance terms). Voluntary insurance of the population was developing very slowly. In consecutive years further growth of the centralised insurance monopoly took place until 1987 [*Development of insurance, A&RE, February, 1997, p. 16 and consecutive*].

After 1989 considerable changes occurred in the insurance sector as a result of the system transformation. New legal provisions (presented in item 4 of the study) opened a possibility to initiate the insurance market. Compared to the Western countries Polish market is in the preliminary phase of development. In developed economies the capital invested in the insurance companies often presents the value equal to the state budget value and is merely 2-3 times lower than the banks' assets. [*W. Jamro•y, 1997, p. 6*]. In Poland the insurance companies' assets are much more nonessential and are equal to no more than a few percent of the banking sector assets. In 1996 the premium share in GDP ratio was 2,28%, whereas in the European Union countries it reaches 6,8% and in OECD countries its average value is 8,18% [*Forum, A&RE, August 1997, p.12*]. Polish insurance market suffers from shortage of capital, which complicates the creation of adequate provisions to secure all potential compensations. In this situation many insurance companies seek for a strategic investor. Apart from that, the performance in this sector is not always satisfactory. For example, II quarter of 1997 brought a clear aggravation of premium against loss ratio [*J. Garczarczyk, 1997, p. 35*].

Transformation initiated the process of overcoming the monopoly in the insurance market. The emerging new insurance companies are the evidence for averting from the monopolist practices. In 1996 as many as 43 insurance companies operated in Poland; much more than in previous decades. This figure is still quite low, as in Germany, Great Britain and France for that matter a total number of this kind of companies reaches over 2,2 thousand [*W. Jamro•y, op. cit., p.7*]. At the beginning of 1999 (as of 31st March) - health insurance complementary to life insurance was covered by 17 companies (against 22 which have the licence). All of them are joint stock companies and started their business in the 1990s. Out of that:

- four started to provide the referred services in 1990-1993
- six in 1994-1996
- seven in 1997-1999.

It is clear from the breakdown presented above that majority of insurers have offered the referred services only recently, and their number is growing every year.

Personal insurance covers accidents and sickness. Accidents insurance is offered by 21 joint stock companies and three mutual insurance companies. Out of which:

- one company has been operating since 1920
- one company has been operating since 1947
- two initiated their activity in 1988-1989
- twelve initiated their activity in 1990-1933
- five initiated their activity in 1994-1996
- two initiated their activity in 1997-1998

All three mutual societies began their activity in 1990s [*data from the State Inspection for Insurance*]

The breakdown shows that majority of the providers of the discussed type of insurance emerged in the initial stage of 1990s. Above that in most of the cases these insurers offer both 1 and 2 group of insurance. For each 24 insurers this was not the case for only 6 of them.

Increasing number of insurers is a clear indicator for demonopolisation process to have started, not to have ended, however. At the end of 1996 there were 42 insurers operating in the Polish market, however major part of premiums came to two from amongst these. The share of other companies was only 17% [*A. Morka, A&RE, December-January 1997, p. 10*].

Although the problems addressed in the present paper relate to the entire insurance sector, there is much to indicate a possibility for private health insurance system to develop fast (see item 7 of the paper).

4. Private Health Insurance Providers

In Poland private health insurance as type of personal insurance is governed by the Act on Insurance Activity dated July 1990. It provides that any kind of private insurance activity (direct and reinsurance) can be performed by the insurance company after it was granted a licence by the Minister of Finance. The company may perform its activity exclusively as the joint stock company or mutual insurance society operating on a non-commercial basis. Each of the companies establishes the general conditions of voluntary insurance and specifies the objective and scope of the insurance, manner of insurance contracting, extent and continuation of the insurer's liability and insurance tariffs and rates.

The activity of foreign insurance companies in Poland is subject to an approval of the proper Minister. The licence expires if the company does not initiate its activity within one year. The foreign company may perform insurance activity only through its main branch. Such companies are registered in public register kept by the Regional Court for the Capital City of Warsaw.

All insurance companies constitute the insurance economic self-government.

The insurance companies are for all time supervised by the State Office for Insurance Supervision, which is the central organ of the state administration. The inspection is to examine the observance of the legal regulations and appropriate code of activity by the insurers and brokers [*C. Gawlas et al, 1997*].

5. Range of Benefits

The Act breaks the risk down by sections, groups and kinds of insurance.

5.1 Section I

This section covers life insurance including accident and sickness insurance (group 5), provided it complements:

- life insurance (group 1)
- dowry insurance (group 2)
- life insurance (related to investment fund - group 3)
- annuity insurance (group 4)

In Poland, like in other countries as well, accident insurance covers for instance partial or entire sight or hearing loss, encephalopathy, body dismemberment (loss of upper or lower limb). Sickness and sickness-related insurance covers cardiac infarction, neoplastic diseases, stroke, renal failure, bypass, transplantation of major organs.

Total value of the gross written premium for all companies providing services of group 5 was 848 199 thousand PLN. It was approximately 16% of share (in overall premium of I section between 1st January and 31st December) [*Source: Bulletin of the State Office for Insurance Supervision, 1998*]

5.2. Section II

This section covers personal and property insurance and the Act specifies further:

- accident insurance including accident at work and occupational diseases (group 1)
- sickness insurance (group 2).

Popular accident insurance is the consequences of motor accidents and in respect of sickness insurance - costs of hospital service on a daily basis.

Total value of the written premium for all companies in group 1 was 403 241 thousand PLN (as of 31st December 1998), while in group 2: 93 285 thousand PLN.

Premiums in group 1 and 2 had approximately 5% share (in overall premium of section II between 1st January and 31st December 1998) [*Bulletin of the State Office for Insurance Supervision, 1998*] and:

- 2.3% total expenditures of public budgets on health care in 1997
- 6.5% total expenditures of household budgets on health care in 1997

6. Private Health Insurance

Methods employed by the private health insurance providers do not differ in Poland from other countries. Transfer of the Western know-how in terms of actuary accounts has begun while the renowned Western companies interested in life insurance appeared in our country. Moreover, at the beginning of 1990s some of the academic research centres (e.g. from Canada) provided series of thoroughly prepared seminars in co-operation with representatives of Polish universities.

The barrier facing some of the actuarial analyses in Poland is the insufficiency of data used in such kind of research. Some of insurance companies do not use effectively the professional expertise, which resulted in insolvency of a few of them over past few years due to negligence in respect of diversification of the insurance basket and underrating the premiums below the profitability threshold [*A. Morka, op. cit., p. 10, W. Adamczuk op. cit., p. 56*].

7. Current Position and Future Prospects

Development of the overall domestic insurance market (including private health insurance) over the forthcoming years is conditional on:

- processes in global economy (majority of countries experience capital concentration)
- universal development trends in insurance activity (such as high development dynamics over past 25 years, complementing the reinsurance instruments with financial and capital market instruments)
- specific conjuncture of the domestic insurance system (increased income flexibility of demand for insurance services, maintained rate of economic growth and population welfare, drop of the inflation level, reform of pension and health insurance, integration with the European Union) [*J. Monkiewicz, 7-8, 1997, p. 3, Rynek, A&RE, October 1997, p. 22*].

Development of private health insurance system in Poland - except the general conditions discussed above - is influenced by the processes taking place in Polish health care sector:

1. There is a clearly growing interest in prospect benefits that private entities operating in the health care system may bring. Such interest refers to health care services and insurance activity.
2. Such interest in privatisation of health care services is manifested through:
   2.1. accomplished privatisation of part of health care sector (pharmacy wholesalers, open pharmacies)
   2.2. numerous public disputes on further privatisation. Such disputes are attended by the political decision-makers, government officials, local government servants, providers and experts
   2.3. preparation of the expert privatisation projects
   2.4. initiated works on formal privatisation procedures more responsive to the specifics of health care than it used to be
   2.5. continued privatisation of particular providers (e.g. hospitals)
   2.6. implemented equal status of the public and private sector providers and tenders for health services contracts by the Sickness Funds of the Social Health Insurance system
3. Profound interest in development of the private insurance system is manifest through:
   3.1. evident development of life insurance system in Poland (often related to sickness insurance) [*W. Jamro•y, op. cit., p. 6*].
   3.2. maintained growth of a number of insurance companies offering private health insurance. This is evidence that the insurers predict the growing demand for such kind of insurance in future
   3.3. proposition put forward by politicians and experts that the material informal considerations paid by the household budgets for health care could be partially intercepted by the private health insurance system [*A. Windak et al,1998, p. 16*].
   3.4. initiated quasi-insurance activity. Recently some entities perform HMO type of activity in their attempt to combine the role of the insurer and health care services provider. They contract with physical persons and employers for defined package of health services and collect subscription fees thereof. The purchaser is provided the following free services (for the period the services are provided):

- family doctor service
- stomatological service
- special ambulatory service
- hospitalisation and rehabilitation
- ambulance service
- the sick transport
- occupational medicine services

The referred package services generally are not inclusive of such services as oncotherapy, transplants, contagious hospitalisation.

The referred providers - owing to skilful integration of ambulatory (including prophylactics) and hospital health services - are effective in reducing the costs of their patients' treatment to minimum.

The term *quasi-insurance* applied to that activity derives from the status of these entities, as they do not operate under the Act on the Insurance Activity. It should be considered however, that in a short-term part of them will satisfy the requirements of this Act.

3.5. implemented new legal grounds for health insurance activity. The Act on Social Health Insurance system provides that in 2002 the service of the insured under Social Health Insurance system can be provided not only by the regional and branch Sickness Funds, but also by the health care insurance institutions operating under the separate regulations governing the insurance activity. Such institutions should meet the following conditions:

- provide at least health service package as provided under the Act
- cover any applicant with insurance irrespective of the risk factors
- refrain from differentiating the premium subject to the risk factors
- operate all over Poland, refrain from differentiating the premium subject to regional factor
- cover the family of the insured with insurance
- obtain an approval of the Health Insurance Supervisory Office for the activities regulated by the Act on General Health Insurance (presently this organ is assigned for control of regional and branch Sickness Funds operating under Social Health Insurance system).

Open issue here is still the practical application of the presented legal enactment by the private health insurers.

3.6. expert analyses aimed at defining the future role of private health insurance. These analyses should define the problematic issues before the health policy of the state in respect thereof and submit the desired legal provisions. Preliminary studies carried out to date define for instance the objective of the private health insurance. Furthermore, the referred studies emphasise the benefits and challenges related to development of the discussed insurance.

REFERENCE

1. W. Adamczuk, "Ocena ryzyka w ubezpieczeniach na zycie" (cz. I), Wiadomosci ubezpieczeniowe, 11-12, 1997, p. 56-60

2. legal acts (Act on Insurance Activity 1996 Dz. U. No. 11, item 62), Act on the Public Health Insurance (1997 Dz.U. No. 28, item 52),

3. Biuletyn Paistwowego Urzedu Nadzoru Ubezpieczen za rok 1998 (Bulletin of the State Office for Insurance Supervision of 1998)

4. I. Dadas, M. Marek, E. Wilkoszewska, "Changes in Polish Public Health Care Sector (a text prepared for a forthcoming book titled : The Decade of Polish Independence 1989-1999),

5. "Forum: Polski rynek ubezpieczeniowy w okresie przemian, Berlin 1997", Asekuracja&RE, August 1997, p. 12-14

6. J Garczarczyk, M. Mocek, "Tendencje zmian na rynku ubezpieczeniowym w II kwartale 1997", Wiadomosci Ubezpieczeniowe 11-12, 1997, p. 35-39

7. C. Gawlas, R. Mikulski - commentary to the Act on Insurance Activity, C.H. Beck, Warszawa 1997

8. J. Halik "Oplaty nieformalne w polskiej sluzbie zdrowia - skala zjawiska i jego uwarunkowania spoleczne", all-Poland research on informal medical rents carried out in 1995, Centrum Organizacji i Ekonomiki Ochrony Zdrowia

9. Direct information from:

- State Office for Insurance Supervision
- individual insurance companies
- private quasi-insurers
- Central Statistical Office
- Ministry of Finance

10. K. Jacobs, A. Koronkiewicz, M. Marek, J.Wasem, C. Wlodarczyk, "Rola prywatnych ubezpieczen zdrowotnych w polskim systemie ochrony zdrowia", Warszawa, March 1997 (paper for 4 Assignment under PHARE Project on the public health insurance system) - unpublished

11. W. Jamrozy "Perspektywy rozwoju ubezpieczen na zycie w Polsce" Wiadomosci ubezpieczeniowe 3-4, 1997, p. 6-8

12. J. Lagowski, "Wstep do nauki o ubezpieczeniach", Lex, Sopot

13. J. Monkiewicz, "Perspektywy rozwoju rynku ubezpieczen w Polsce na przelomie XX i XXI wieku", Wiadomosci ubezpieczeniowe 7-8, 1997, p. 3-8

14. A. Morka, "Kryzys ubezpieczen", Asekuracja&RE, December-January 1997, p. 10 and consecutive

15. M. Narbut "Nic nie stracic, malo zyskac", Asekuracja&RE, April 1997, p. 42 and consecutive

16. J. Sadowska, "Lecznictwo ubezpieczeniowe w II Rzeczypospolitej" (dissertation on insurance health care in II Polish Republic), Lódz Medical Academy 1991

17. "Rynek ubezpieczen na zycie w Polsce, terazniejszosc i przyszlosc", Asekuracja&RE, October 1997, p. 22 and consecutive

18. "Rozwój ubezpieczen", Asekuracja&RE, February 1997, p. 16 and consecutive

19. K. Tymowska Sektor prywatny w systemie opieki zdrowotnej, Instytut Spraw Publicznych, Warszawa, luty 1999r.

20. A. Windak, M. Chawla, M. Kulis, "Kontraktowanie swiadczen zdrowotnych, od teorii do praktyki", Uniwersyteckie Wydawnictwo Medyczne "Vesalius", Kraków 1998

21. Zajenkowska-Kozlowska, Zdrowie w rodzinie i wydatki na ochrone zdrowia w 1994 r., badania modulowe, GUS Warszawa, 1996

PORTUGAL

1. Structure, cost and finance of health system

1.1 Structure

At present, the health care system in Portugal is founded on the national health service (SNS), which was established under Law No. 56 of 15th September 1979. That law is based on an article of the 1976 constitution which established the principle of the provision of free medical care in case of sickness for the whole population. The practice makes extremely heavy demands upon public funds.

The national health service is based largely on the following five sectors:

a. the network of state hospitals, comprising central and regional hospitals and specialist establishments;
b. regional health authorities (ARS), responsible for the supervision of all medical centres providing out-patient treatment in each region;
c. private (state-approved) medical and hospital institutions operating in parallel with the state hospital network for the provision of care;
d. the National Institute for Medical Emergencies (INEM), responsible for first aid and the transport of patients in emergency cases;
e. the network of state-approved private-sector pharmacies (a proportion of the cost of medicines to insureds covered by the state scheme is borne by the state).

A number of specific schemes operate in tandem with the general health care system described above, for example the health care scheme for government employees (ADSE), the health care scheme for military personnel (ADME), socio-medical care services for banking personnel (SAMS), etc.

Private health insurance has emerged as a means of filling gaps in the national health service and the specific schemes described above.

In 1990 the Basic Law on Health, followed by the new National Health Service Statute, modified the health system. The share of the private sector is to increase, supported by the State, encouraging particularly the initiatives by non-profit-making private organisations, and thus encouraging competition between the State and the private sectors. The number of agreements with private bodies is rising and these are seen as an integral part of the health system. Health insurance policies are encouraged.

The management of state health services is open to private management. For example one of the last large state hospitals has been opened under private management. In other respects, health care services are free to a certain extent rather than completely free of charge, with the patient paying a proportion of the cost of care (adjusted, however, according to the patient's financial and social circumstances).

1.2 Cost

In recent years, there has been a constant increase in the cost of national health service benefits. Health costs have increased at a rate substantially higher than other public and private costs. National health service expenditures rose at a constant rate between 1985 and 1994 and had doubled by the end of that period. Public health expenditure in 1989 in relation to public expenditure as a whole was the lowest in Europe (9.76% compared with 12.66% of the EU). The level for 1997 is estimated to be around 14%. The rise in private expenditure is even higher in relative terms.

The following factors are most significant in the increase in health care costs:

- medical and hospital services are provided free of charge, with the exception of patients' contributions, which are payable in respect of diagnostic examinations. However, certain sectors of the population are exempt from such contributions, for example senior citizens, pregnant women, etc.;
- the extension of statutory health insurance to cover virtually the whole population;
- improvements in life expectancy and the consequent increase in health care expenditure for senior citizens;
- the increasingly widespread use of complex techniques, such as magnetic resonance imaging (MRI or NMR), digital subtraction angiography etc.;
- the increasingly frequent use of specialist medical and surgical techniques for the treatment of chronic and acute illnesses (e.g. dialysis, transplants, etc.).

1.3 Finance

The national health service is financed out of public funds, i.e. through taxation, and by low contributions from patients.

In general, the other, specific schemes are financed through deductions at source from the wages or salaries of the individuals concerned; the amounts deducted are used to pay for the benefits guaranteed.

In the case of private health insurance, under the legal provisions in force, premiums paid in respect of either individual or group policies are wholly or partly deductible from IRS (personal income tax) and IRC (corporate tax).

2. Health insurance in Portugal

The purpose of health care provision, whether in the form of national health service benefits, benefits paid under the parallel specific schemes, or private health insurance cover, is to ensure the provision of medical and hospital treatment in the event of sickness or accident, with the exception of industrial accidents, which are subject to separate legal arrangements.

Daily benefits which may be paid under the statutory insurance scheme in case of temporary or permanent disability are paid by the Ministry of Employment and Social Security, although such benefits are completely separate from the medical and hospital health care systems.

Industrial accidents - which are subject to compulsory cover and, as mentioned above, do not fall within the scope of statutory insurance - and are also excluded from private health insurance cover. The provision of cover for industrial accidents is the sole responsibility of duly authorised private insurance companies.

2.1 Statutory health insurance

Statutory health insurance, which at present is free to a certain extent and available to the whole population, covers medical and hospital treatment given directly by the network of State hospitals or by State-approved hospitals. The insurance provides cover for standard medical and hospital care, which fulfils the following conditions:

- care must be provided completely free of charge of subject to the payment of a patient's contribution, provided that only the network of State or State-approved hospitals is used;
- no medical or hospitalisation costs will be borne, even partially, where they are incurred in establishments which do not form part of the State or the State-approved network;
- contributions will be made to the cost of medical care provided abroad, in duly attested emergency cases, subject to the granting of prior authorisation following an on-the-spot examination by the official competent authority;
- in the case of accidents where third party liability applies (e.g. industrial accidents or road traffic accidents), the cost of medical care arising from such accidents is borne by the parties liable, even where treatment is provided through the State hospital network.

2.2. Private health insurance - historical development, general information and benefits paid

Private health insurance, which was introduced in Portugal in 1970, did not expand rapidly until the years following 1980; notably in group insurance, which accounts for 90% of premium income, while individual insurance accounts for only 10%.

Private health insurance cannot be used to supplement statutory insurance: it pays for treatment outside the public sector.

The following are some of the advantages which private health insurance offers to insureds:

- a free choice of doctor and medical/hospital establishment outside the State system;
- greater flexibility in the medical and hospital care provided abroad;
- partial exemption of premiums paid from tax in accordance with the law;
- adjustment of cover provided to the requirements of insureds which may vary according to the extent of cover provided under the statutory scheme.

Private health insurance may offer the following three types of cover:

- payment of fixed daily benefits,
- the reimbursement of a given proportion of medical/hospitalisation expenses; that proportion is determined by reference to the cover provided and the sums insured, or
- an integrated system of care within contracted networks.

Cover provided varies from company to company. Companies may cover the following on either a group or an individual basis: the cost of hospital treatment, the cost of childbirth, GPs' or specialists' fees, the cost of diagnoses, the cost of prostheses, the cost of dentistry and the cost of medicines.

Both individual and group contracts are taken out for a one-year term and are renewable, with the proviso that the insurance companies are always entitled to increase premiums in accordance with overall statistics

and also in accordance with the features of, and experience of, individual contracts. Both the insurers and the insured are entitled to cancel the contract at term if they so desire.

2.3 Rating

Individual health insurance premiums are calculated either on the basis of the age and sex of the parties concerned, with index-linking, or on the basis of a fixed sum. In the case of group insurance, premiums are calculated in relation to the age and sex of the group members. Since health insurance contracts are never whole-life contracts, no reserves are set up for increasing age (although an exception, there is one company which offers whole-life health insurance policies and has set up a reserve for increasing age).

A high increase in premium income has been recorded in recent years showing a marked development in health insurance. In 1996, gross premiums issued amounted to 20,636 million Esc. representing a growth of 17% compared with 1995. However, health insurance did not increase its share in the total premium income, accounting for 2.2% of the total (Life and Non-life) - or the number of new policies - just over 1.8% compared with 1995 (i.e. 14,613 new policies in 1996). The cost of claims rose by 13.3% compared with 1995 to 16,974 million Esc. but the loss ratio fell 2.69% and stands at 82.3%.

3. Current position and future prospects

The Portuguese health system has developed over the past few years – with the expansion of private health insurance and the emergence of innovative concepts in health insurance (managed health care) – to some extent, in response to market demands.

4. Managed care and marketing of smart cards

As an alternative to the conventional health insurance system, which was basically a reimbursement system, a new concept of health insurance is currently being developed in Portugal. In addition to refunding costs, it assists with claims primarily through the direct provision of health services.

Companies exploring this health product operate as integrated insurance and health service (managed health care) providers through a system that liaises between insurers, service providers and policyholders.

The companies generally operate a 24hr telephone enquiry centre staffed by personnel who are medically qualified.

When policyholders telephone the centre, they are asked to complete a purpose-designed clinical questionnaire over the telephone. The health care professional assesses the problem and directs the policyholder/claimant to the most appropriate health care service (emergency service, home visit by a doctor, medical consultation, treatment at home, etc.)

The company uses policyholders' smart cards to update their records/medical situation and financial information on its database via the heath service provider/company information transfer register.

The aim of the managed health care service is to provide a customised service to each policyholder that (thanks to improved diagnosis) directs them to and provides access to the most appropriate care while at the same time ensuring continuity and follow-up.

While this type of operation does entail higher maintenance costs for telephone centres or contracts with specialist health care providers, the settlement of some claims by the telephone centres can also lead to cost reductions. In the long run, this should reduce the loss ratio.

However, not enough experience has yet been acquired to reach any firm conclusions on the real impact of this new health care concept.

The "managed health care" element of this new product was adapted from models developed in other countries (particularly the United States and Spain) and it gradually became apparent that some adjustments would have to be made to tailor it specifically to the situation in Portugal, where the health care system is run by the National Health Service.

	1998	1997	% Growth
Gross written premiums	27.794	23.752	17.0%
Cost of claims	22.739	19.641	15.8%
Premium income	26.560	22.132	20.0%
Loss ratio	86%	89%	
Number of policies	163.516	161.920	1.0%
- individual	156.861	154.777	1.3%
- group	6.655	7.143	-6.8%
Capital insured	1.686.892	627.027	169.0%
- individual	229.675	86.206	166.4%
- group	1.457.217	540.821	169.4%
Number of persons insured	1.105.515	985.223	12.2%
- individual	250.180	245.716	1.8%
- group	855.335	739.507	15.7%
Resident population	9.980.000	9.956.000	0.2%
% population with private insurance cover	11.1%	9.9%	
Non-life premiums	539.869		
Life premiums	541.493		
Total premiums	1.081.362		
% Health/Non-life	5.1%		
% Health/Total	2.6%		

SLOVAK REPUBLIC

1. Structure and coverage

In the Slovak Republic, health care consists of four segments: primary outpatient care, specialized outpatient care, institutional health care, and other health care.

Primary outpatient care is provided by physicians with whom patients are registered. It includes care for children and adolescents, adults, gynecological care, dental care, and agencies of home nursing care services.

Specialized outpatient care is provided to patients based on recommendation of primary care physicians or without recommendation pursuant to the corresponding legal regulation. It fulfills the role of preventive, diagnostic, and curative care. It also includes consulting and dispensary services.

Institutional health care is subsequent health care provided at hospitals, specialized medical institutions, health spas and/or other bed establishments. Also, these establishments provide outpatient care.

Other health care represents emergency health aid and specialized medical interventions (hemodialysis, oxygenotherapy, assisted reproduction, etc.).

Health care is covered by insurance schemes under Act of the National Council of the Slovak Republic (NR SR) No. 98/1995 Coll.LL. on Rules of Treatment through mandatory health insurance pursuant to NR SR Act No. 273/1994 Coll.LL. on health Insurance, Financing of Health Insurance, on the Establishment of General Health Insurance Company, and on the Establishment of Sectoral, Branch, Works and Civil Health Insurance Companies; the said acts are executed by **health insurance companies** (health funds). All persons who are domiciled in the territory of Slovakia as well as persons who are not domiciled in the territory of Slovakia but have a labor contract or a similar relationship with an employer with registered address in the territory of Slovakia, as well as persons who are involved in independent earning activities in the territory of Slovakia, foreign nationals and persons without citizenship who have been granted the status of refugee are mandatorily insured by the operation of the Health Insurance Act. Mandatory payers of health insurance premiums include employees, self-employed persons, collaborating persons, employers, state on behalf of a specified group of insured persons, and National Labor Office.

Any citizen of the Slovak Republic with a domicile in its territory and any foreign national employed by an employer in the territory of the Slovak Republic or any individual – holder of a permit for independent earning activities is liable to obtain health insurance with the corresponding health insurance company (health fund). Overall, there are currently 5 health insurance companies in Slovakia, thereof one civil and 4 sectoral. The health insurance companies administer public funds and take care of payments to health care providers on behalf of the citizen who have mandatory health insurance, and also transfer payments for the treatment of insured persons abroad. Health insurance companies are managed by self-governing bodies, and state surveillance of their activities is the responsiblity of the Ministry of Health of the Slovak Republic and Ministry of Finance of the Slovak Republic.

2. Financing

Primary health care is financed based on numbers of patients registered with the individual physicians.

Specialized health care is financed based on the volumes and types of medical performances provided to patients within a certain period of time.

Institutional health care is financed based on the determined volume of funds spent by health insurance companies during the preceding year with accounting for inflation. The utilization of funds by the medical institutions is controlled by health insurance companies for efficiency, economy and effectivity of the health care provided, based on reports of medical performances.

Other health care is financed based on the volume and types of medical performances provided to patients within a certain period of time.

For the time being, the Ministry of Health of the Slovak Republic directly manages 229 medical establishments, thereof 67 budgetary organizations financed under State Budget, and 162 so-called contributory organizations, also including health care providers financed through health insurance companies. Funds are allocated from State Budget to contributory organizations (including hospitals, medical institutions, psychiatric hospitals and sanitariums, specialized medical institutes – health care provided to bedridden patients) to cover a portion of the routine operations, for only selected activities and to selected establishments, and to cover capital expenditures.

Financing of health care is based on contracts made with the individual segments of health care. Drugs and medical aids are reimbursed based on invoices presented by pharmacies and medical aid counters for a specified period of time. The rate of Health insurance premiums to be paid to the health insurance company (health fund) represent 14% of the base (taxed income) for self-employed persons, the rate being 4% of the base and 10% of the base for the employee and employer, respectively. The rate for the National labor Office to be paid on behalf of individuals – recipients of unemployment benefits is 14% of the base being Sk 3,000.00, and 14% of the base being Sk 2,400.00 for Ministry of Public Health of the Slovak Republic (from State Budget) to be paid on behalf of pensioners, children and students preparing themselves for future occupation by regular studies, persons registered with the Labor Office who do not receive unemployment benefits, and on behalf of individuals – recipients of parent allowances and social care benefits. The rate to be paid on behalf of individuals who are not registered with the Labor Office is 14% of the base being Sk 3,000.00.

All the premiums collected by the individual health funds (health insurance companies) are redistributed among all the health funds (health insurance companies) based on numbers of insured evidenced, by age categories, multiplied by the health care costs risk index for the individual age groups.

The maximum calculation base is Sk 32,000.00.

3. Principle of private health insurance providers

Health funds (health insurance companies) may provide private health insurance under the Health Insurance Act in the form of contracts on insurance and supplementary insurance. This type of private health insurance only concerns individuals who are not mandatorily insured. This type of insurance is not applied by health funds since principal legislative conditions have not yet been created for it. Private health insurance is provided by commercial insurance companies dealing with life insurance, and these dominate the private health insurance market.

4. The scope of benefits

The insurance companies providing private health insurance offer:

- income upon temporary inability to work,
- income upon permanent inability to work,
- coverage of costs for selected medical interventions/performances that are not covered under mandatory health insurance,
- above-standard care in bed establishments (hospitals), only concerning services other than medical,
- coverage of costs of medical performances conencted with the provision of acute and unavoidable health care to individuals that do not have mandatory health insurance (contract-based insurance),
- coverage of costs of treatment of Slovak nationals abroad.

5. Mandatory insurance of long-term care

Mandatory insurance of long-term care in the Slovak Republic is not a separate insurance scheme. rather, it is a part of the mandatory insurance provided by health funds (health insurance companies).

6. The taxation system

The taxation system in place does not offer the payers of premiums of mandatory or private health insurance any advantages.

7. The current situations and future prospects

Private health insurance schemes are not sufficiently developed due to legislative and economic reasons. The major problem are of economic nature since the public lacks sufficient funds to be able to afford mandatory insurance of insurance losses. The legislative reasons reside in the fact that the scope of health care provided under the Rules of Treatment Act and mandatory health insurance is such that people do not perceive the need to obtain policies to cover insurance losses that would not be covered under the Act.

Ministry of Public Health of the Slovak Republic has been attempting to change the system of health care and the associated health insurance system. The establishment of a system of non-mandatory (voluntary) health insurance is being envisaged, and this will need amendments to the Rules of Treatment Act, Income Tax Act, Health Care Act, and to some other related legal regulations.

Plurality of health funds (health insurance companies) and their experience with the provision of mandatory health insurance represent a warranty for the provision of voluntary health insurance (private health insurance). It is assumed that the development of the voluntary health insurance system might take 5 – 10 years after the adoption of the corresponding law. This system will be entirely dependent on the funds available to the public to cover the costs of health care, as well as on the readiness and trust of the public to accept a product that has not been known before – voluntary (non-mandatory) health insurance.

SPAIN

1.Structure, cost and finance of health system

The Spanish health system is characterised by the co-existence of the national health system with private health insurance. To date, 99% of the Spanish population is covered by the statutory system, more than 15% of which also holds insurance from private insurance undertakings. Only civil servants, members of the military service and the judicial service, which represent 6.5% of the Spanish population, may choose between private and statutory insurance with 85% of cases opting for private insurance.

The cost of the statutory health system stands at 4.3 billion Pesetas. It is financed mainly (over 90%) from the State budget, i.e. through taxation. In a system such as the Spanish one in which two payments are made - to the statutory system and to the private system - it is very difficult to estimate how much each individual contributes to the statutory system. Persons who take out private health insurance with an insurance undertaking have to make two payment: firstly, the corresponding amount to the statutory health insurance system and, secondly, the insurance premium to the insurance undertaking.

With regard to cover provided, the statutory health insurance system covers both primary medicine and specialised and hospital medical services. Only the cost of dental treatment is excluded, except for extractions. It also covers a proportion of medicaments on prescription, which are free for pensioners. Industrial accidents and occupational illnesses are only covered by social security through “Social Security Industrial Accident Mutuals”; cover for this may not be provided by private insurance.

2. The Spanish health insurance system

In the last years private health insurance has only experienced a slight increase in the number of persons insured. However, medical costs are rising gradually resulting in increased claims for medical benefits and a rise in the cost of health.

In private health insurance a differentiation must be made between sickness or hospital benefits, for which the premium is fixed at a flat rate, and health insurance which guarantees the insured any all forms of primary and/or secondary medical and surgical treatment. In the latter case reimbursement may be paid to the insured (reimbursement of costs) or directly to the health establishment (medical care insurance - “benefits in kind”). Medical care insurance covers 90% of those insured privately and the cover provided is the same as that provided by statutory insurance. In fact, this is the only alternative to statutory insurance for civil servants, members of the military service and of the judiciary service. There is a large number of undertakings also offering dental cover as a supplement.

With this dual payment system, those privately insured have a choice between statutory insurance and private insurance when looking for medical treatment.

3. History of private health insurance

Before Law 30/1995 on the supervision of private insurance was passed, there were two classes of insurance in Spain which covered the health risk: health insurance (reimbursement of costs) and medical care insurance. The reason for making this distinction here is that each has developed differently and each is subject to a different supervisory body.

Since legislation on insurance was first introduced in Spain (1908), the health class - reimbursement of costs or benefits in kind - has always been considered as insurance and came under the responsibility of the Ministry of Finance. On the other hand, the medical care class was not considered as insurance until the Insurance Law of 1954 was passed. Under this law, medical companies - principally made up of doctors - were obliged to convert into insurance companies. This insurance was subject only to supervision by the Ministry of Health which had regulated this activity since 1925, until the Insurance Law of 1984 was passed. Under this law, insurance activities became liberalised, even though the Ministry of Health retained some powers, such as requiring a favourable loss ratio or supervision of medical services contracts. It was not until Law 30/1995 was passed that all legislation on health was changed. This law combined the two classes, with medical care insurance being made a sub-class of health insurance.

4. Private health insurance providers

Health insurance is a class of non-life insurance. Insurance undertakings writing this class of insurance are at present subject only to the Law on private insurance and supervision by the Ministry of Finance.

Private health insurance undertakings may take any legal form recognised by law: limited liability company, mutual, "social provident and co-operative insurance mutual". They must have the same financial and technical guarantees as other insurance undertakings.

Today there are 138 undertakings writing the health class.

5. Range of benefits and finance

Private health insurance is financed on the basis of premiums calculated by actuaries. In contrast, the premiums charged by mutuals covering civil servants are based on the budget allocated by the State for financing them.

Benefits

Benefits are divided into three categories:

<u>Benefits in the event of sickness or surgery</u>: The insured is normally paid a daily sick leave or hospital benefit. The amount is specified in the contract.

<u>Reimbursement of medical expenses in the event of sickness or surgery</u>: Reimbursement may be calculated either on the basis of a flat rate using tables or equivalent values (e.g. reimbursement of expenses for surgery is a fixed amount in the table) or by the system of reimbursement of costs.

The latter case, known as medical expenses insurance, is being used more and more in Spain. Reimbursement can be as much as 100% of costs, making it similar to medical care insurance, or other percentages can be fixed within the contract.

Medical care -"benefits in kind": The insurance undertaking sets out the method of care available to the insured who will only be entitled to those services defined by the undertaking. There are two systems which differ according to the method of payment to doctors: on the basis of medical treatment provided and on a "per capita" basis. Under the system of payment for medical treatment, the undertakings pay doctors according to the number of cases of treatment carried out and provides the insured with a choice of doctors. Under the per capita payment system, there are usually one or two doctors with a specialisation who are paid a salary according to the number of persons allocated to them.

The cover provided by the medical care insurance undertakings is not much different to statutory insurance cover. Primary medicine and surgery, specialists and all forms of diagnostic and medical treatment are covered. Furthermore, the undertakings regularly introduce new medical techniques and new benefits.

Dental treatment policies are being taken out more and more and are even being offered separately from conventional medical care policies.

Taxation

The following are the most prominent changes introduced:

1. Elimination of the tax on insurance premiums to which such policies were formerly subject.

2. New tax treatment after the approval of amendments to the personal income tax.

- Elimination of the 15% deduction for health care costs that taxpayers were allowed in their income tax returns.

- Change, in certain cases, of the tax status of health insurance premiums paid by employers to insurers, which are no longer considered to be emoluments in kind.

6. Prospects for the development of private health insurance

Rising life expectancy and increasing medical costs have led to a substantial upturn in public health spending. This, together with public sector budgetary constraint, explains the introduction of a series of measures that affect health care. Some of these measures are:

a. The Law 50/98 establishes the possible conversion of public hospitals into foundations to enhance their autonomy and introduce new kinds of public health management.

b. Changes in tax treatment of health insurance.

As a result of the new Personal Income Tax Law (effective January 99) taxpayers are no longer allowed to deduct 15% of their health care costs from their income tax returns. In an attempt to mitigate the 15% suppression the Government adopted the following two measures:

1. In certain cases, the premiums paid by employers to insurance undertakings for health coverage are not considered to be salary-in-kind to employees.

2. The elimination of the 6% Insurance Premium Tax (IPT) levied on health policies since January 97.

These tax measures are obviously justified to the extent that the existence of private health insurance is presently contributing to lower public health spending which is being taken over by the private sector.

c. Private sector participation in public health.

For the first time, an Autonomous Region -Valencia - has awarded hospital management to the private sector, specifically to a Private Medical Insurer who won the public tender, for an entire health area – Alzira – with a population of over 230.000 lives.

In this Autonomic Region, a per capita management system will be introduced to finance area hospitals, promoting competition between public hospitals.

d. In order to reduce waiting lists the public health service has established agreements or programme-contracts with most private hospitals for specific kinds of surgery or treatments.

Whereas the tax measures indicated above may somewhat favour the development of private insurance as far as the capture of new corporate customers is concerned, the major problem that such insurance encounters is the mandatory payment of public health care fees, as Spaniards holding private medical insurance have to pay twice for both public and private insurance.

At this time, only certain groups (which comprises civil servants, members of the armed forces and the judiciary and their families) may choose between public health care and the private coverage provided by the insurance entities operating in Spain. The insurance industry submits that these arrangements are an example to be followed in the event of a possible change in the Spanish health care model.

Indeed, the role that private initiative should play in the provision or management of health services, whether to supplement or replace the public system, is a subject of political debate at this time.

Major advantages and disadvantages to this insurance

The major advantages for the public sector, in times of constraint in public expenditure, is that the existence of private medical insurance relieves part of the public health care burden. The major disadvantage, affecting the insured only due to the design of the Spanish system, is that they have to pat twice for both public and private health insurance premiums.

7. Regulatory framework for private health care insurance

The companies operating in this line of insurance, like all other such institutions, are subject to the regulations on organisation and supervision of private insurance that lay down the conditions for both access to and the conducting of the insurance business.

SWEDEN

1. Structure, cost and finance of health care system

The Swedish health care system covers all residents in Sweden regardless of nationality as well as patients seeking emergency attention from EU/EEA countries and some other countries with which Sweden has a special convention. The responsibility for the system's services rests primarily with the county councils which levy taxes to finance the costs. They also operate almost all the services provided.

The primary care sector has the aim of improving the general health of the people and treats diseases and injuries which do not require hospitalisation. This sector employs many different professional categories - physicians, nurses, midwives and physiotherapists, organised in health centres. In addition to local health centres, primary care is also provided by private doctors and physiotherapists, district nurse clinics and at clinics for child and maternity health care.

For conditions which require hospital treatment, medical services are provided at county and regional level. In Sweden, a relatively large proportion of the resources available for medical services has traditionally been allocated to the provision of care and treatment at hospitals.

Under the Health and Medical Services Act, the county councils are responsible for providing health services and for striving to achieve a good standard of health in the population. The county councils are also responsible for free dental care for all children up to the age of 19. Adults receive an economic subsidy from the National Dental Insurance for basic dental care. The pricing has been deregulated, which means that providers set their own fees for each form of treatment. There is also an option to sign two-year agreements on the provision of basic dental care at a fixed price. For certain more extensive dental procedures there is a high cost protection system, limiting patients' outlay. Approximately 50% of all dentists work in the national dental service run by the county councils, the remainder are private dentists. The national dental service treats patients on the same conditions as private dentists.

Local authorities are responsible for the care of elderly and disabled persons and for those suffering from long-term mental illnesses.

Private Health Care

Private Health care exists only to a limited extent. Less than 10% of all physicians work full-time in private practices and in the occupational health field. However, more than 50% of the dentists work as private practitioners.

Most of the care provided in the private field is financed by public means. The patient only pays a small direct fee.

There are only a few private hospitals for short-term care and these usually have contracts with the county councils. Therefore, only a small part of these hospitals' services are financed by private means such as patient fees and health care insurance.

Finance

Sweden's costs for its health services amounted in 1998 to SEK 139 billion, a figure which includes costs of pharmaceutical preparations and dental care. This corresponds to 7.4% of GNP.

Patients' fees

In the case of in-patient treatment, a uniform charge per day's stay in hospital is applied to all patients 20-69 years of age. For patients aged over 70, the charge is SEK 70. No charge for children.

For out-patient care and other medical treatments, each county council sets its own fees for care within certain limits. The fee can therefore vary.

To limit the costs incurred by patients there is a high-cost ceiling. A patient who has paid a total of SEK 900 for medical care is entitled to free care for the remainder of the twelve month period, which is calculated from the first visit to a doctor. The high-cost ceiling for pharmaceutical preparations is SEK 1 800.

2. Overall picture of health insurance system in Sweden

Sweden has an extensive public system of social insurance benefits. These provide mainly financial security for families and children (including parental insurance), financial security in case of sickness, handicap and old-age. Work injuries insurance, for both sickness and accident, is part of the public system.

The whole population of Sweden is covered by the uniform system, on an individual basis, irrespective of occupation and, in many cases, regardless of whether the person is employed.

In addition to the public system, collectively agreed insurance schemes cover almost all Swedish employees. The collectively agreed insurance schemes are schemes where the labour-market organisations conclude agreements regulating insurance terms and conditions. The organisations also exercise joint influence over management and administration via the special private insurance companies' boards of directors and advisory councils.

Because such « first and second pillars » dominate health insurance, the traditional private insurance market is comparatively small.

3. History of private health insurance

Swedish social insurance originated in the early 20th century and has a very universal nature. Also the public health care system is universal. This, together with the extensive collectively agreed insurance schemes, has meant that the Swedish private health insurance market is not as developed as in other countries. For example, health care insurance was only introduced on the market in the 1980's.

However, owing to the country's economic straits in recent years, many public benefits have been reduced or their conditions otherwise tightened up. The social insurance system is also in a phase of fundamental change. A new system of old-age pensions has come into force and other changes in the social insurance systems are under way or already carried out.

The public sector is also having financial problems regarding the health care system, which is resulting in waiting periods for both out-care and in-treatment and a fear amongst the population that the health care system cannot provide the care needed.

Because of the uncertainty regarding the public sector's ability to cope with the problems, private insurers are now finding new market opportunities.

4. Range of benefits

The collectively agreed insurance schemes include benefits for, for example, sickness, occupational injury and supplementary pension.

Traditional private health insurance offers several types of products; health care, sickness benefit, health insurance for travel abroad, child's sickness and accident. These are supplements to the public schemes and there is no possibility of opting out of the public system.

5. Private health insurance finance

The collectively agreed schemes are financed by the employers. The premiums are not fixed on an actuarial basis but are usually calculated as a percentage of the company's gross pay.

Traditional private insurance premiums are fixed on an actuarial basis.

6. Current position and future prospects

As a result of the extensive public system of health care, only a minority of the population has any experience of private health care insurance, but to minor groups of employees such insurance has become more and more attractive. Both health care and sickness benefit insurance are growing markets. Long-term care is also a product for the future.

7. Prospects for the development of private health insurance

The political majority in the Swedish parliament sees the main costs for health care and for loss of income during sickness as part of the costs to be borne by the social security system. There are also collectively agreed labour market schemes compensating for loss of income. This reduces the role of private health insurance but such insurance still can be of value as a complement for individuals or employees, as part of pension schemes or giving access to specific health care services.

8. Regulation of private health insurance

Since private health insurance is transacted only by authorised insurance companies or friendly societies, regulations do not differ from other insurance activities under supervision by Finansinspektionen.

SWITZERLAND

1. Structure, cost and finance of health system

The health care system in Switzerland reflects the federal structure of the country's political system. The cantons act autonomously in the organisation of health care within their territory.

In most cantons in-patient treatment is provided in cantonal or regional (district) hospitals. In addition, those cantons with universities have university clinics. Most cantons also have private clinics. There are nursing homes providing long-term care (treatment of chronic illnesses) as well as psychiatric hospitals, psychotherapy centres, medical test laboratories and physiotherapy treatment centres. A large number of towns have centres providing care outside the hospital ("Spitex" centres, district nurses, home nursing service).

The cantons are encouraged to enter into mutual agreements on the co-ordination and joint provision of hospital planning and training.

Out-patient treatment and partial in-patient treatment is provided in private surgeries, in some hospital units and in polyclinics (particularly in cities). As a result of the development of alternative health insurance models there are also self-financed medical centres (similar to Health Maintenance Organisations) in some large towns.

For decades the overall cost of health care has been rising continuously with growth rates constantly exceeding the general cost of living. In 1995 the figure stood at SF 33 billion which exceeded the threshold of 10% of gross domestic product. Hospitals account for 60% of that total, out-patient treatment for 18% and medicaments etc. for 8%, whilst dental treatment accounts for 5%. The balance is made up by the cost of paramedical care, laboratory tests, etc. Research costs and the cost of man hours lost due to accidents and sickness have not been included in this figure.

The financing of the health care system is distributed as follows :

- the authorities (the Confederation, cantons, communes),
- social insurance (state disability and military insurance as well as compulsory health and accident insurance),
- private insurance (accident, supplementary health and liability insurance),
- private households.

2. Overall picture of health insurance in Switzerland

The health insurance system in Switzerland can be broken down into three sectors:

- compulsory basic insurance
- voluntary supplementary insurance
- daily benefits insurance in the event of loss of earnings due to illness (daily sickness benefits insurance)

Following several attempts to reform State health insurance a new Health Insurance Law (LAMal) was passed on 1 January 1996. Under this law the whole Swiss population is subject to **compulsory basic insurance**, covering the cost of providing good quality basic medical care. Although 98% of the population already had basic insurance with State-approved health funds by the time the Health Insurance Law came into force, the obligation to insure became necessary in order to achieve the new law's objectives for collective responsibility. Insurers must operate State health insurance on a reciprocal basis and guarantee that insureds will be given equal treatment. There is an obligation to accept any individual without imposing any conditions, together with freedom for insureds to transfer to other funds. Premiums must be the same for men and women and for all ages from the age of 18 (or 25 if still in full-time education); however, they may be staged up to certain limits in cantons and regions. The insurance is financed on the pay-as-you-go principle. Both the health funds and private insurers may be providers of basic insurance. In this case both are subject to the conditions of the Health Insurance Law and supervision by the Federal Social Insurance Office. As yet, however, no private insurers have become involved in operating State health insurance. On the other hand, some insurance companies are working together with health funds in the provision of health insurance or have even incorporated health funds into their insurance group so that they can provide a full range of health insurance.

Subsidies from the State and the cantons for reducing premiums are no longer paid to the health funds, as was the case before the Health Insurance Law, but directly to insureds. The law stipulates that the premiums of insureds with limited financial means should be reduced. The cantons decide on the system for distributing these subsidies; in this way they can reduce their subsidies by up to a half if premium reductions for insureds with limited financial means can still be guaranteed. In this case, the State reduces its contributions to the canton proportionately. At present, around half the cantons are making use of this option and only around 2/3 of the State contributions allocated were called on by the cantons in 1996.

Voluntary **supplementary insurance** may also be offered by both health funds and private insurers. For this insurance class both insurance providers are subject to Insurance Contract Law (VVG) and supervision by the Federal Supervisory Office for the private insurance sector. At present, supervision is based on the preventive system, i.e. tariffs and conditions must be submitted to the Federal Supervisory Office for approval before they can be applied. There are plans to adopt the system of supervision based on solvency requirements in a few years time. The insurance is financed by risk-related premiums, and may vary with age and gender.

Daily sickness benefits insurance is taken out mainly by employers in favour of their employees to cover their statutory obligation to continue to pay wages in the event of incapacity for work due to illness. These are group contracts in which the employer is also usually insured. Some collective labour agreements stipulate that this form of daily sickness benefits insurance should be taken out with the amounts (expressed as a percentage of earnings), the waiting period and the benefit period specifically defined.

3. History of private health insurance

The beginnings of private health insurance go back to the early 1930s, although it was not until after the Second World War that it really expanded. Group contracts for daily sickness benefits insurance played an important role in this as the health funds were the main providers of basic medical care insurance before the introduction of the Health Insurance Law. Only these funds received subsidies from the State which they used to reduce their premiums substantially so making it impossible for private insurers to be competitive in the provision of basic insurance.

With regard to supplementary insurance, the health funds and private insurers were not on an equal footing as the health funds were not subject to supervision by the Federal Supervisory Office. Consequently, they were not obliged to apply the funding method of finance and could amend their policy conditions and rules without approval. In spite of this, private insurers were able to hold a substantial share in the supplementary insurance market up to the beginning of the 1990s, due to innovative products and by providing good services. Rising losses, which could no longer be offset by premium increases, have meant that several large insurers have withdrawn from supplementary insurance and transferred their portfolios to health funds. As a result of this, premium income for individual insurance (which mainly comprises supplementary medical expenses insurance) fell from SF 500 million in 1992 to SF 300 million in 1995.

In contrast, premium income for daily sickness benefits insurance has risen steadily. Private insurance companies continue to hold a market share of more than 50% and the premium income rose from SF 800 million in 1988 to SF 1.94 billion in 1998. The joint minimum tariff developed by the Association of Private Health and Accident Insurers was abolished in 1991. Since then insurance companies have been applying their own tariffs. The unfavourable loss experience has meant that tariffs have had to be increased.

4. Private health insurance institutions and range of benefits

In Switzerland, private health insurance can be written by life and non-life insurance companies as well as health funds. At present, 60 health funds, 21 life insurance companies and 39 non-life insurance companies have authorisation to write health insurance. Many private health insurers are completing their portfolios in supplementary medical expenses insurance and not accepting new business. On the other hand, the majority of these companies are still actively writing daily sickness benefits insurance.

As basic insurance according to the Health Insurance Law already provides a high standard of medical care cover, the available margin of supply for supplementary insurance has been reduced substantially. The latter essentially meets demands for comfort and choice in respect of in-patient treatment not covered by basic insurance. These are as follows:

- freedom to choose any hospital within the whole of Switzerland, including treatment in hospitals not included in the canton hospital lists used by the basic insurance scheme;
- semi-private (twin-bedded room) or private (single room) hospital accommodation;
- treatment by the head physician;
- treatment abroad;
- medicaments and applications not covered by basic insurance or which exceed the limits set by basic insurance;
- complementary and alternative medicine.

Since it is not always in the interest of the insured to take out cover for the full range of supplementary benefits, and especially as this has become too expensive, supplementary insurance is divided up into the above-mentioned modules. The insured can then choose the modules which best meet his needs and his financial situation.

As already mentioned in paragraph 2, supplementary insurance is written by practically all health funds. According to the new Health Insurance Law, these are subject to the law on private insurance concerning this class.

Daily sickness benefit insurance designed to cover the obligation to continue to pay wages in the event of illness tends to be taken out in the form of group contracts between employers and insurers. As a rule, the daily benefit corresponds to a percentage (60 to 100%) of the insured's earnings and is paid at the end of a waiting period which can be anything from 0 to 90 days. The maximum period for payment of benefits is usually 720 days from the 900 days. Occasionally cover is taken out for benefits for a maximum of 720 days per illness. It is also possible for self-employed persons to insure themselves in a group contract. Their premiums are generally higher and their benefits are defined as fixed sums ("fixed sum" insurance). A "birth" benefit can also be insured as supplementary insurance. Daily benefits in the event of incapacity to work due to an accident are not normally paid as employees are subject to compulsory accident insurance up to a maximum level of earnings. In the case of insureds not subject to compulsory accident insurance (e.g. employers) and the proportion of earnings which exceeds the above-mentioned earnings limit, accident insurance can be provided on payment of an additional premium.

5. Private health insurance finance

In contrast to state health insurance, which under the Health Insurance Law has to be financed according to the pay-as-you-go principle and whose premiums must not be influenced by age or gender, voluntary supplementary insurance is financed by matching premiums to risks. For private insurance companies this has always been regarded as the natural thing to do. However, before the health funds were made subject to Insurance Contract Law, i.e. came under the supervision of the Federal Social Insurance Office, they did not make a clear distinction between basic and supplementary insurance and applied the principle of collective responsibility, as is usual in social insurance, to supplementary insurance as well. The transfer to private insurance law on 1 January 1996 and the obligation to calculate premiums according to risks

resulted in marked premium increases in most health funds, although most funds are not financed according to the pure funding method. In the case of private insurers, this method of finance - excluding any temporary forms of cover - is still the predominant method.

As a rule, group sickness benefits insurance is financed with annual premiums which are calculated as a percentage of earnings and which are usually guaranteed for a contractual period of several years (3 to 5 years). The tariffs usually contain additional age-related premiums according to the average age of the insured group of employees. They also contain additional premiums for higher daily benefits which take into account increased risks in the case of benefits based on a high percentage of earnings.

With regard to taxation, there is no tax or parafiscal levy on health insurance contracts nor any charges (e.g. stamp duty) on health insurance premiums. Insureds may deduct health insurance premiums from taxable income up to certain limits which vary according to canton. Health insurance benefits become taxable if they replace earnings or income. With regard to taxation of health insurance profits, there are no special provisions governing the insurance providers; they are subject to all taxes imposed on companies like all other classes of insurance. In the case of supplementary insurance subject to Insurance Contract Law, the same tax rules which apply to private insurance companies also apply to the health funds, although these only have to pay half the supervisory tax.

6. Current position and future prospects

In Switzerland, private health insurance is becoming insurance for "good risks" only, i.e. for the young and healthy.

Supplementary health insurance premiums for semi-private and private hospital care have soared over the past few years. The new Health Insurance Law (Loi sur l'assurance-maladie, LAMal), which entered into force on 1 January 1996, resulted in a large number of policy cancellations. There are many elderly people who can no longer afford supplementary health insurance, as risk-based premiums become too high for people over a certain age. This is a particularly shocking state of affairs when one considers that these are the very people who – sometimes for years under the old Health Insurance Law – have been paying solidarity premiums benefiting older people who had taken supplementary insurance cover. This type of insurance policy has virtually disappeared with the introduction of age-class rated premiums, which are not prohibited as such.

The current situation as regards private health insurance is unsatisfactory and solutions will have to be found. Various initiatives and motions have been tabled by the Swiss parliament requesting amendments to the legislation on insurance contracts, which currently does not contain any provisions on supplementary health insurance.

One such motion is asking for the introduction of the funding principle as a means of cushioning the hike in premiums for older people and for free transfer of old-age clauses when there is a change of insurer. People should also be free to change insurers without restriction. These measures would help to ensure a competitive market.

A parliamentary initiative is calling for the calculation of premiums for supplementary health insurance to be based on the age at issue. The age at issue should also be the reference age for successive policies taken out with the same insurer. Furthermore, insurers would no longer be allowed to launch a new product providing exactly the same cover, with the sole aim of creating a closed fund of selected policyholders. This initiative should ensure that older people do not find themselves no longer able to take out supplementary health insurance.

Another parliamentary initiative, if successful, would mean that men and women would pay the same premiums for supplementary health insurance. According to its proponents, excluding health problems with reproductive organs, the cost differential for men and women would be no more than 2%. It would therefore be fair to invoke the "causality principle" and charge the same premiums for men and women.

Parliament has reached no decision on these initiatives as yet. While the solutions advanced by the proponents of these initiatives do not go far enough to solve supplementary health insurance problems, the initiatives will certainly provide an opportunity for wide-ranging discussions on all of the issues.

7. Accommodation-only cover

With soaring premiums for supplementary health cover for semi-private and private hospital care, a new product has been launched on the market that covers the costs of private and semi-private hospital rooms only. For medical costs, the policyholder would receive only basic insurance benefits. As basic insurance is very good in Switzerland, the product – which covers the costs of a semi-private or private room – has created a demand on the market. It is much less expensive than other hospital cover policies, which include

cover for medical costs. How the new cover develops will inevitably depend on insurers' underwriting policies.

TURKEY

1. Structure, cost and finance of health care

Contributions are made by employees, employer and sometimes government but the contribution rates are changing from one coverage to another. However, generally, the individual does not pay at the point of service.

2. General outline of health insurance system

In summary, the Turkish health system is a combination of national health insurance and private health insurance. The coverage of compulsory health insurance provided by social security foundations is comprehensive. The private sector is small but growing rapidly, and complements rather than competes with the state system.

Table 1 and 2 show general health expenditures and rates of private health insurance:

Table 1- Total Health Expenditures (million TL)

	1994	1995	1996	1997	1998
Social Health Expenditure	96,726,546	184,669,467	400,496,078	879,161,215	1,814,524,129
Private Health Expenditure	43,496,124	75,882,292	161,348,333	335,487,860	738,933,430
Private Health Insurers' Expenditure	556,290	1,727,432	5,068,660	14,673,770	32,487,726
Total Health Expenditures	140,778,950	262,279,191	566,913,071	1,229,322,845	2,585,945,285

Source: Ministry of Health and Undersecretariat of Treasury.

Table 2- Total Health Expenditures in GNP (%)

	1994	1995	1996	1997	1998
Social/GNP	2.488	2.351	2.648	2.960	4.10
Private/GNP	1.119	0.966	1.067	1.130	1.40
Private Insurers/GNP	0.014	0.022	0.034	0.080	0.10
Total/GNP	3.621	3.339	3.748	4.170	5.60

Source: Ministry of Health and Undersecretariat of Treasury.

There are three main social security organizations which provide health insurance coverage. These are as follows; illness, work related accident and maternity. Although coverage is extensive, there are several problems related to the quality and efficiency of the system.

3. History of private health insurance

Before 1990 private health insurance schemes were given within life insurance schemes. In order to satisfy the rising demand, in January 12, 1990 the Decree No. 90/55 was legislated and the health insurance schemes have started to be given separate from the life insurance schemes. Firstly, 10 insurance companies supplied health insurance, and by the end of 1997 this number increased to 49 as of today.

Along with these improvements in private health insurance branch the direct premium production increased to 107 469.2 billion TL (1999). This means that the share of the private health sector direct premiums is 11.1 % of total insurance sector direct premium production in Turkey.

4. Nature of health insurance providers

The Law no. 7397, i.e. "Insurance Supervisory Law", provides that two types of organizations may operate in the Turkish insurance market. Joint- stock companies, incorporated under the Insurance Supervisory Law and Turkish Commercial Code, are the most common type whereas the second type the law permits, the establishment of mutual companies with 200 shareholders (which must be formed pursuant to the provisions introduced for co-operatives in the Turkish Commercial Code), does not exist. The health insurers have to operate in either of these types.

As for the three main social security organizations, which are public institutions, namely Emekli Sand••• to serve pension for civil servants, SSK to serve for workers and Ba•- Kur to serve for self-employed are also the public providers of the health care system. The distribution of the insured population to the institutions mentioned above as well as with regard to the whole population obtained from a study made by the Ministry of Labor and Social Security is shown below:

Table 3- The distribution of the insured population in terms of health services

INSTITUTIONS	Number of Insured	The percentage in whole insured population
Emekli Sand•••	1,865,000	4.3
SSK	26,933,000	61.6
Ba•- Kur	4,324,833	9.9
Private Pension Funds (*)	308,000	0.7
Green Card Owners	5,265,096	12.1
Public Institutions	5,016,765	11.4
Total	43,712,694	100.0
The percentage of the insured to the whole population		69.2

(*) Funds similar to occupational pension scheme

Source: Ministry of Labour and Social Security.

5. Range of benefits

The private health insurance generally covers physical treatment, in-patient and out-patient expenditures and daily hospital benefits. Dental and pharmaceutical insurance coverage are would be candidates for addition; however, costly to administer and much more risky, because there are large discretionary elements in both types of service and their usage is difficult to supervise. Since anti-selection and moral hazard highly exists in these type of insurance branches, there is co-payment especially for out-patient expenditures.

6. Compulsory long- term care insurance

This type of insurance is not available in Turkey, yet.

7. Finance of private health insurance

To begin with, as it is observed from Table 3 above, SSK has the largest number of insured when compared with all the other public institutions. In order to finance the expenditure made by the insured in terms of healthcare, it collects the premium amounting to 11 % of the gross wage, 5 % of which is collected from the insured and 6 % from the employer whereas Ba•- Kur collects 12% and Emekli Sand••• does not collect at all.

In case of private health insurance, since 1990 the premiums in this particular branch is settled freely among the insured and the insurer; because, the private health insurance products are designed to last for less than one year and assumed to be less hazardous as the duration of the insured's commitment is less than that of a life policyholder. However, long term health insurance products are currently under way and the ongoing debate arising from the interpretations of provisions for renewal in health insurance agreements with the duration of one year paves the way to further supervision of agreements and premium calculation methods of private health insurances.

Table 4. Direct Premium Production and Share of Private Health Insurance

Years	**Direct Premium Production (*)**	**Increase (%)**	**The share of private the health sector in total insurance sector direct premium production**
1992	141.3	193.9	1.73
1993	352.3	149.4	2.05
1994	921.5	161.5	2.90
1995	3,021.9	227.9	4.78
1996	8,358.3	176.6	6.52
1997	24,197.6	189.5	8.55
1998	56,148.1	121.4	9.70
1999	107,469.2	91.4	11.10

(*) Billion TL

Source: Undersecretariat of Treasury.

The improvement observed in the premium production in health insurance branch led some of the insurance undertakings to work with consultancy firms in transition period. These firms which help the insurance undertakings in the whole process of underwriting legally are not parties to the contract; therefore, when a conflict arises between the parties during the duration of the insurance contract they can not be held responsible for any of their activities.

Generally, individuals do not pay at the point of service providing that he/she uses the service offered by the network organizations. On the other hand, if he/she takes the services from out of network organizations, the system works as a reimbursement system.

8. Current situation and future prospects

The health insurance system provided by the state has few problems. Namely, there are substantial differences in offered health coverage and about thirty percent of the population are uninsured. To tackle these problems as is the case in other countries, Turkey has initiated reform studies. There are two major approaches; first of which is that in particular regions, private health insurance sector may take the place of the social security system. In addition it is assumed that, according to their level of income, the individuals who have got high income can buy luxurious health products offered by the private health insurers. That is, private health insurers can offer products that are supplementary to those of the social security organizations.

However, this idea has proved to be practically difficult. In Turkey private health insurance products have a duration less than or equal to one year. There is no permanent health insurance which can compete with social security organizations in coverage and contents. Moreover, understructure of the companies in this respect has to be taken into consideration.

The second approach seems more optimal, however the way in which the coverage can be given as a supplementary basis has not been determined and in the reform studies private health sector has a special role. According to the health reform, public satisfies the basic needs of individuals who have low income and the remaining individuals who are in the high income can take luxury health products offered by private health insurers.

In summary, recently increasing problems of social security systems have pointed out the importance of the private insurance in recent years. As mentioned earlier, there is a high potential in the sector (approximately 12 million person who can afford health insurance) and the demand is also high. Be that as it may, there is a strong need for the prudent private health insurers to take necessary precautions to abolish moral hazard and make antiselection in order to keep up with the steadily rising demand for private health insurance products in good faith. In addition, since the loss/ premium ratio of private health insurance is comparatively higher than that of the other branches, the private health insurers retain less and therefore transfer more to the reinsurance companies. This fact leads the reinsurance companies to pressurize the insurers to take further essential precautions such as introducing a certain period for the insured before fully claiming a coverage offered by them.

Nevertheless, it is assumed that because of the reasons stated above, according to the current trends private health insurers will continue to gain larger proportion in terms of healthcare.

9. Additional issues

The three main social security organizations are suffering worsening financial imbalances and to tackle this problem the government is introducing short-term adjustments like changes in legislation and medium and long- term comprehensive structural reforms to put pensions and healthcare system on a sound financial basis.

As for the regulatory framework for health insurance, provisions are mostly the same as for all the other insurance branches and for the insurance companies under the Law No. 7397 with particular provisions for various branches when necessary. According to this particular law, insurance companies may work in either one of these insurance groups; life and non-life insurances. However, each insurer, regardless of the group they belong, may write private health insurance as long as its duration is less than one year.

The most specific regulation for this branch is "policy conditions for health insurance" issued by the Undersecretariat of Treasury pursuant to Law. No. 7397 in which it is stated that insurance agreements should be agreed upon in conformity with the policy conditions issued by the Undersecretariat.

To continue with figures, in 1995 there were 275 thousand insured in the private health sector and the number rose to 400 thousand insured in 1996. However, the research made in 1996 by the State Planning Organization showed that approximately twenty percent of the population has a capacity to afford the private health insurance product.

Table 5. The Private Health Sector Direct Premiums in Constant Price

Years	S.I.S. Wholesale Price Index (*)	Direct Premium Production (**)	Direct Premiums in constant price (**)	Increase in Direct Premiums in constant Price (%)
1992	6,852.2	141.3	2.062	-
1993	10,984.0	352.3	3.207	55.53
1994	27,449.0	921.5	3.356	4.65
1995	45,455.6	3,021.9	6.648	98.09
1996	83,692.5	8,330.2	9.945	49.51
1997	159,852.3	24,062.3	15.045	51.28
1998	246,651.2	-53,324.6	21.631	43.77
1999	402,534.7	107,276.9	26.642	23.16

* 1981=100

** billion TL

Source: Undersecretariat of Treasury.

By constant prices the rate of increase in private health insurance direct premium production is greater than the whole sector's rate of increase.

The following table gives some indicators about private health sector in Turkey.

Table 6. Some Indicators In Private Health Sector

Years	Loss/Direct Premiums	Retention Ratios	Technical Profits (*)
1992	72.5	69.6	24.3
1993	66.9	65.7	54.3
1994	75.1	100.0	134.6
1995	75.8	59.3	421.4
1996	79.3	56.9	922.8
1997	84.2	58.9	2,327.6
1998	87.4	58.9	4,005.2
1999	84.6	60.3	8,478.4

(*) Billion TL

Source: Undersecretariat of Treasury.

UNITED KINGDOM

1. Structure, cost and finance of health system

State health care in the UK is provided through the National Health Service (NHS), available to all those normally resident in the UK.

The NHS comprises services provided by General Practitioners (primary care), dentists, opticians and the community health services, e.g. health visitors, ambulance services etc, together with specialist care in State hospitals.

About £50 billion per year are currently spent on the NHS. Around 85% of the cost is met from general taxation, 13% from the NHS element of the National Insurance (NI) contributions paid by employers, employees and the self-employed and 2% from patient payments.

The comprehensive services are generally free at the time of use. Nominal charges are made for pharmaceutical, dental and ophthalmic services, although there are widespread exemptions from payment e.g. for pregnant women, children, the elderly and the chronically sick.

Benefits for unemployment, loss of income following long- and short-term sickness, industrial injury and disablement are available under the separate State Social Security system, which is financed mainly from the NI contributions (about 88%) with the remainder coming mainly from government subsidy.

2. Overall picture of health insurance

The term private health insurance encompasses a range of different insurance types, each meeting different needs: private medical insurance for medical expenses; income protection insurance (previously called income replacement insurance and Permanent Health Insurance (PHI)) for income replacement in the event of long-term illness or disability; personal accident insurance for income replacement in the event of short-term illness or disability, and critical illness insurance which normally provides a lump sum on diagnosis of certain serious illnesses. Private medical expenses insurance is more broadly defined to include hospital contributory schemes and hospital cash plans as well.

Private medical expenses insurance and income protection insurance can be offered as employee benefits as well as being purchased by individuals.

Private medical expenses insurance is purchased by approximately 11% of the population to supplement or provide a private alternative to some benefits otherwise available under the NHS. It covers the costs of specialist treatment and acute surgery but benefits may also be available for e.g. the treatment of alcoholism or psychiatric treatment.

Individuals with private medical expenses insurance continue to pay for the NHS through general taxation and NI contributions. Individually-paid premiums may not be offset against tax. Thus, these people are effectively paying twice for parts of their health care. They do, of course, remain entitled to use all NHS facilities.

3. History of private health insurance

Some elements of medical expenses insurance pre-date the introduction of State medical benefits by well over fifty years.

The National Insurance Act of 1911 established a statutory, compulsory scheme which supplemented benefits already being offered by "Friendly Societies". For manual workers in employment, the Friendly Societies continued to offer insurance cover to those not protected by the 1911 Act.

From 1911 to 1939, both the State and private schemes extended their roles substantially and in 1948 the NHS was established, against opposition from sectors of the medical profession. It was thought that the demand for private health insurance would decline after the introduction of the NHS but instead the private insurers have experienced over fifty years of almost unbroken growth.

Income protection insurance was being sold in the UK 100 years ago by two major companies and by the Friendly Societies. It has enjoyed significant growth in recent years.

“Hospital contributory schemes” also began over 100 years ago, their main purpose being to assist the financing of local voluntary (private) hospitals. In 1948, there were over 400 schemes but with the introduction of the NHS, the number fell to a little over thirty. These survived by introducing a number of benefits paid directly to the contributor and they now form part of the private health insurance sector.

4. Private health insurance companies and the range of benefits

Private medical expenses insurance is sold by "provident associations" (who have no shareholders) and by other insurance companies offering health insurance as part of their general portfolio. All are registered as insurance companies, complying with the provisions of the Insurance Companies Act of 1982 and various other regulations.

Insurance companies are supervised by the Financial Services Authority (FSA). In accordance with the statutory rules enforced by the FSA, insurers must allocate money to various reserves at the financial year-end. The FSA has extensive powers of investigation into the financial affairs of insurance companies.

The UK private medical expenses insurers do not receive any financial support from the State. Consequently, all private medical expenses insurers, with or without shareholders’ capital, must be financially self-supporting.

Income protection insurance is classified as «long-term» insurance business for the purposes of supervision. This means that it may be sold only by companies authorised for this class and is subject to financial requirements regarding the calculation of premiums, and the adequacy of reserves and solvency margins similar to those which apply to life assurance business. Private medical expenses insurers were not previously authorised to sell long-term insurance but may now do so under European legislation. Over 45 companies offer income protection insurance products.

In total, there are twenty-five provident associations and insurance companies active in the private health insurance market. In 1999, the market as a whole covered 6.4 million people, had a subscription income of £2,173 million and paid out £1,794 million in claims.

There are around thirty hospital contributory schemes which are not-for-profit bodies classed as insurance companies and which operate under the same legal provisions as provident associations. Hospital cash plans are available from a number of organisations including provident associations and insurance companies.

5. Private health insurance finance

Private medical expenses insurance is designed to meet the costs of private specialist acute treatment, on either an in- or an out-patient basis. The main areas not covered are primary (General Practitioner) care, normal maternity, long-term illness, routine dentistry and out-patient drugs.

Many NHS hospitals make beds available for private patients and charge for them but the majority of patients is treated in private hospitals although the role of NHS private beds is increasing.

Most consultants (as specialists are known in the UK) who undertake private medical practice also work for the NHS. They are not employed by the private health insurers or private hospitals and there is no legal relationship between consultants and the insurers i.e. there are no standard fee schedules.

A. Cover

The cover available under private medical expenses insurance is of two main types. Some schemes cover each part of the private medical treatment needed up to fixed cash limits e.g. £600 for a major operation, £500 per year for out-patient treatment etc. The other kind of scheme offers, in effect, full cover for all eligible private medical treatment up to a fixed annual maximum. A fixed daily benefit may be payable when free treatment is received in an NHS hospital.

Private medical expenses insurers offer both group and individual contracts, each of which may include dependants. For individual contracts, the right to renew lies with the insured, although the insurer can alter the general terms of the insurance and the premiums from the renewal date. For group contracts, the right to renewal normally lies with the group. However, for large experience-rated groups, generally no right of renewal is given to the company and terms are negotiated at each contract renewal. Private medical expenses insurance is an annual contract. A few companies offer longer-term contracts, especially to employers as employee benefits.

‘Voluntary’ groups are a hybrid category, in which premiums are negotiated by employers, associations or unions on behalf of employees or members, but paid by individual employees/members typically via deduction from salary.

Benefits available under hospital contributory schemes are less comprehensive than those available from the medical expenses insurers and are generally not intended to meet the full costs of medical treatment. They include limited benefits for hospital in-patient stays, whether as an NHS or as a private patient, together with optical, dental, maternity and convalescence grants. Hospital cash plans provide an income of a fixed daily sum during the member's stay in either an NHS or a private hospital, to be spent as the individual wishes.

Income protection insurance is a long-term contract designed to provide an income for people whilst they are unable to work owing to disability through illness or accident, irrespective of whether hospitalisation is necessary but subject to exclusions like pregnancy and self-inflicted injury. Broadly speaking, there are two types of cover: for those who are totally unable to follow their own occupation and for those who are unable to follow any occupation. The maximum benefit payable ranges from 50% to 80% of earnings over the twelve months preceding disability, less any money received from State benefits (social security) and other health insurance schemes. Benefits, which may be increased to offset the effects of inflation, take the form of an income which commences after incapacity has continued for a deferred (specified) period.

Once a person has been accepted for income protection insurance, he cannot be refused continuation of cover by the insurer unless one of the policy conditions is broken. Under the newer forms of individual policy and group business, the insurer does, however, have the right to increase premiums in the light of overall experience, rather than for selected policyholders only.

Personal accident contracts are annual and renewable, and can be altered at the option of the insurer. Both group and individual contracts are available, designed to provide an income for around two years when an insured person is temporarily disabled following an accident, and to pay a lump sum if the accident results in death or permanent disablement. Payment can be made after the first day of incapacity or after a specified waiting period. Although payment from the first day is normally made only when the incapacity is for one week or more, the income benefit can be extended to include incapacity from sickness.

B. Premiums

Private medical expenses premiums for individuals are related to both age and the claims experience of the entire individual purchase sector i.e. individuals are community-rated. Premiums generally rise with age. Most insurers require a proposer to complete a medical history form and each application is scrutinised. Restrictions on cover for existing conditions or potential recurrences of past conditions may be imposed. A few companies allow proposers to join without completing a medical history form. Instead a moratorium on treatment operates, whereby proposers cannot claim for treatment of conditions or associated conditions which they developed in the previous five years, until they have remained free of advice and treatment for (usually) two consecutive years.

Company-paid group schemes, where the employer pays the entire premium, normally have specially calculated premiums. Generally, the larger the group, the lower the effective premium per member. For the largest groups, the insurer may not even request the names of the individuals covered or any details of medical history, so members' risks are not individually scrutinised. Instead, the employer reports the number of group members at the beginning and end of each contract period so that the total premium can be calculated. Premiums for such groups are experience-rated with each group's claims experience taken into account when calculating the subscription rates for further periods of insurance. Formulae vary but a group with a light claims history can expect to see an allowance in the cost of its insurance for the forthcoming period. Equally, a group with a heavy claims experience might expect to pay more at the contract renewal.

Similar premium-rating factors would also be taken into account in the rating of short-term personal accident and sickness policies. For group schemes, these vary considerably, from those financed in full by the employer to arrangements under which the employer merely acts as a collecting agent.

C. Tax

Individuals purchasing private medical expenses insurance for themselves and their dependants may not offset the cost against income tax. Employees receiving private medical expenses cover under a group scheme are treated as receiving a «benefit in kind», which is subject to personal income tax on the value of the premium paid by the employer. However, very low-paid employees are not taxed on such benefits, whatever their purpose.

Insurance Premium Tax (IPT), at a rate of 5%, applies to non-life health insurance including private medical expenses insurance.

In the past, there were differences in the regimes for taxation of surplus, depending on the statute of the health insurer, but these differences are no longer material.

Income protection insurance policies attract no tax relief. If any benefit becomes payable, it is liable to tax as unearned income after one full tax year. Where benefit is paid under a group scheme, it is channelled through the employer and taxed as earned income.

6. Current position and future prospects

The role of private health insurance in the UK is considerably influenced by the existence of the NHS and State social security system: the private medical sector is intended primarily to meet the need for specialist treatment on a relatively short-term basis. The role for income protection insurance is likely to increase as State benefit reduces and stricter eligibility criteria for benefits are imposed.

Since it was established in 1948, the NHS has suffered from problems of financing and keeping facilities up-to-date. Nevertheless, the accident and emergency services offered by the NHS are of a high standard, as is the treatment of acute, life-threatening illness. The demand for non-urgent surgery especially among an ageing population, eg hip replacements, minor gynaecology etc, has resulted effectively in rationing by informal waiting lists. There are currently over 1 million people awaiting admission to NHS hospitals and many of them can expect to wait for many months.

The private medical sector and, in particular, private medical expenses insurance have evolved in part to meet the need for non-urgent surgery without the long wait experienced under the NHS. This kind of surgery forms the major part of the private sector's workload although sophisticated facilities mean that eg the most complicated heart surgery and cancer treatment routinely take place.

Generally, those with private medical expenses insurance use free NHS services for General Practitioner care, maternity, chronic and mental illness, and the private sector mainly for specialist care on an out-patient basis and for surgical hospitalisation. Private medical expenses insurance enables them to use private health services instead of NHS facilities when specialist out-patient or hospital in-patient treatment is required. Around 15% of private patients are uninsured and pay all costs themselves.

During the 1990s, the NHS underwent substantial reform, a major feature of which was the separation of purchasers from providers. The main substance of many of these reforms has been retained by the Labour government elected in 1997, albeit with modifications. The Labour government is now introducing its own reforms to the UK health system with a particular emphasis on more equal access to treatment nation-wide, quality and clinical excellence. In addition, the financing of health care is under close scrutiny by all interested parties but, under a continuing Labour government, no major development of the role of private medical expenses insurance in the UK is currently envisaged.

7. Prospects for the development of private health insurance

«What are the prospects for the development of private health insurance in your country?»

Market stability

Even after 50 years of the tax-financed National Health Service, private health insurance in the UK has maintained a stable position. For many years, it has met the market demands of at least 10% of the population for treatment rights in addition to their NHS entitlement. This stable equilibrium continues to balance ever-rising consumer expectations against the ever-increasing costs of health care. Private health insurers compete to develop new types of coverage to meet expectations and new methodologies to control costs.

State/Private frontier

Successive governments have renewed their commitment to service quality and efficiency in the NHS. There have been no serious moves to health finance «privatisation» or indeed any evidence of public support for such ideas, although financial management in the public health sector has been sharpened. There is a continued trend to making people's rights within the NHS more explicit and more uniform across the UK. This trend may in future produce a clearer demarcation of the core services in which the NHS should excel, contrasting with other activities (whether 'cure' or 'care') in which the private sector and private insurance could play a developing role.

Competitive innovation

In recent years, private health insurance has become more competitive as new entrants to the market have launched schemes targeted at particular consumer groups and at new types of cover (such as long-term care insurance). New ideas for clinical cost containment are a central feature of competition, and electronic trading has developed rapidly to lower infrastructure costs.

Group schemes

Employer-paid (or employer-negotiated) schemes account for more than three-quarters of total volume, with surveys showing private health insurance as among the most valued staff benefits of many employers. Development of this part of the market relies on business confidence in the UK generally, on growing competition to attract employees with skills in new technologies, and on the growth of smaller enterprises and self-employment, in which health insurance is seen as vital protection for business continuity.

International schemes

The UK also has a flourishing market for international health insurance of expatriates (whether or not UK nationals). Demand from globalising businesses for cost-effective schemes, and possible development of cross-border insurance in the European Union, present further opportunities for private health insurance development.

«What are the obstacles to its development?»

Regulatory freedom

Availability of a 'largely free' NHS puts a natural ceiling on UK domestic private health insurance development. Within that constraint, the market is notably free of regulatory obstacles because, when fundamental guarantees for everyone come from the State, full scope in the private sector can be left to competition and consumer choice.

Personal tax neutrality

In recent years the fiscal environment has shifted from mildly encouraging (with personal tax relief for premiums for the elderly, now withdrawn) towards tax neutrality (with recent full application of imputed taxes on staff benefits, for example).

Premium tax

Insurance Premium Tax has been imposed on non-life health insurance and the rate has steadily increased (to 5% from July 1999). This is now a significant 'tax on illness', given that a very high proportion of tax-liable premiums go directly to reimbursement of annual claims for medical treatment. The tax is also regressive because it hits harder the significantly higher premiums for the elderly which are needed to fund actual claims in an age-rated system.

Travel insurance tax

The health element of short-trip or annual travel insurance suffers from a 'selective higher' rate of premium tax equivalent to VAT at 17.5%. This was intended to block cost-shifting tax avoidance by certain intermediaries, but even though that avoidance has been ended by primary legislation, the 'selective higher' rate remains as an anomalous addition to travel health insurance costs.

«What are the main advantages and drawbacks of private health insurance?»

Discretionary spending

The UK experience has shown that a stable private health insurance sector can co-exist alongside a comprehensive 'free' NHS, meeting real market needs either for more consumer choice or for supplementary services. Private health insurance has the advantage of bringing into the health economy additional discretionary spending on acute services, potentially relieving pressure on tax-funded facilities.

Consumer choice

For the consumer, a fully competitive health insurance market offers a choice of comprehensive schemes with a wide range of premiums. Typically, full acute indemnity health coverage can be bought for less than the average family spends each year on the fixed costs of car ownership (and for at least half of the insureds these costs are paid by employers). Hospital cash schemes are also widely available to provide non-indemnity flat-rate support at very low premiums.

'Selection'

Private health insurance in the UK is voluntary but people should not expect to wait until they are ill before joining. To avoid this, any significant pre-existing medical conditions must be declared and cover can be excluded or deferred by insurers. Cover for all other conditions can then be offered on standard terms, so that no proposer need be 'excluded' from private health insurance. This process is not 'selection of risk' but 'anti-selection', in the interests of those already insured. Provided continuity of cover is maintained with one insurer, rights of renewal at standard terms are guaranteed, irrespective of any later deterioration in health.

Premium increases with age

Risks rise with age so most UK insurers must also increase premiums with increasing age. This economic imperative makes it harder for older people to continue their cover after retirement; in response, insurers offer essential-only benefit options to keep premiums affordable (two smaller insurers offer flat-rated schemes, one of which includes a supplementary single premium for older joiners). Most insurers offer a choice of 'excesses' (deductible from reimbursement) which can cut premiums by up to half.

Resource allocation

Some commentators have claimed that private health insurance, although reducing demands on the NHS, can compete for essential clinical resources, distort equity of access to care, and also reduce the pressure for necessary reforms which are in all patients' interests. However, given the relative sizes of the public and private sectors, such influences need not be difficult to control.

8. Regulation of private health insurance

«What are the regulations …. consumer provisions …. kinds of insurers ?»

EU Directives

Private health insurance, like all UK non-life insurance, is regulated by laws deriving from EU Non-Life Directives. In the UK, there is no special additional regulation for the health insurance sector. UK health insurance is not a 'substitute' for a state scheme (in terms of Article 54 of the Third Non-Life Directive) and there is therefore no need for special regulation in the interest of 'the general good'.

'Self regulation'

Although the health insurance sector is not regulated *per se*, there has always been a strong tradition of voluntary 'good practice' in the interests of the consumer (automatic renewal, for example).

As the market has become more competitive and the diversity of schemes has increased, so consumers have faced increasing difficulty in *comparing premiums and benefits* offered. Self-regulation is the preferred solution to this problem and the Government's 'Office of Fair Trading' is influencing the sector to simplify consumer choices and provide the necessary information clearly.

A *code of sales practice* has already been developed by insurers (through their national association), again to improve consumer information.

Health insurers have never asked for *genetic tests* and have willingly endorsed a code of practice maintaining this position in the light of current scientific evidence.

Guarantees

All health insurers are, as insurers, covered by the 'Policyholders' Protection Act' regime, which requires insurers to pay levies in the event of another insurer's insolvency. In any case, they maintain levels of financial solvency well above legal requirements. Health insurers are also members of either Ombudsman or Arbitration schemes, in case appeal procedures within the company cannot resolve a dispute arising with a customer. In practice, the level of disputes needing outside referral in this sector is very low.

Corporate statutes

Health insurance in the UK is provided by:

- traditional provident associations (companies 'limited by guarantee' – a special status available to corporate bodies having 'social' objects, no shareholders and without powers to distribute surpluses),
- insurance companies (shareholder- or mutual-owned),
- Friendly Societies (established under savings legislation).

Following a recent 'demutualisation', the health insurance market is now almost equally divided between provident associations and insurance companies. All these bodies' 'economic activity of insurance' is regulated by uniform insurance law, whatever the corporate statute. Historically, there were different regimes for taxation of surplus, depending on statute, but these differences are no longer material.

9. Network and pre-authorisation alternatives to «managed care»

Insurers' competitive drive to contain costs while improving service led to the development of new large-scale initiatives:

- Most insurers offer lower premiums to insureds who agree to use 'preferred providers', usually arranged as networks of independent hospitals and/or of hospital groups, giving reasonable coverage of the country at contracted cost levels. One such network covers the private beds which exist in many NHS (state-owned) hospitals, thus explicitly supporting the revenue-earning potential of those hospitals. Insureds in these network schemes may exceptionally use 'out-of-network' hospitals in approved cases of clinical necessity. There is no HMO (US-style 'Health Maintenance Organisation') activity in the UK and although one health insurer has ownership interests in hospitals, its insureds are not restricted only to these.
- There is early experience of similar 'networks' of consultants, who agree to participate in quality assurance processes and are guaranteed full reimbursement, and some incentives provided they follow guidelines agreed with the insurer. These guidelines can include clinical 'best practice' protocols, measures promoting surgical safety, and a matrix of charging limits negotiated with the profession. Some networks are being extended to include ancillary professions and complementary medicine.

- Pre-authorisation by insurers of clinical treatment is now a common and cost-effective requirement in many schemes, and in certain specialties. This procedure has proved welcome to all parties:

  hospitals and professionals know in advance that their reimbursement is secure and will be paid direct to them,

  insurers have a recognised 'best practice' influence from the outset of treatment,

  patients, too, are reassured by telephone contact with the insurer, with the chance to ask more questions about the condition and the medical facilities recommended.

To ensure correct medical ethics, the pre-authorisation procedure is carried out by advisers with formal nursing qualifications, with any problems resolved by discussion between doctors. After the initial authorisation for a case, renewed authorisation may be necessary at a later stage and this can be handled between hospital and insurer (by EDI or fax) without further involving the patient.

UNITED STATES

1. Outline of health insurance system

Most Americans have some sort of health insurance, either through the private sector or through government programs. One or more forms of private health insurance protect about 70 percent of the United States population. There has been tremendous growth in the industry since the early 1940s when it was estimated that only about 12 million persons had private coverage. The number of people with private insurance has remained relatively stable since the mid-1980s.

More than 1,000 private insurance companies in the United States write individual and group health policies. The predominant form of health insurance sold today is group insurance. In addition to commercial insurance companies, other private insurers include Blue Cross and Blue Shield plans and numerous managed care organizations.

A growing number of health insurance plans are self-insured--where an employer or union assumes all or part of the responsibility for paying claims. An additional expanding area for the private health insurance business is providing administrative or minimum premium services to self-insured plans. Under such arrangements, a fee is paid by the self-funding group to process claims and provide other administrative services, but all or most of the risk in paying claims is borne by the employer.

Health care benefits are available also through various government programs. These include Medicare for persons over age 65 and those with certain disabilities, and Medicaid for a portion of the indigent population as well as certain categories of the medically needy.

Despite the expansion of government programs, recent years have witnessed some growth in the number of uninsureds. At the end of 1997 there were an estimated 43 million persons without heath care insurance. A number of factors are responsible for the increase in uninsureds, including the erosion of Medicaid coverage for the poor, demographic shifts, more part-time workers, and the number of workers employed by small establishments that are less likely to offer group health insurance.

2. History of private insurance

Modern health insurance began in 1929, when a group of school teachers contracted with Baylor Hospital in Dallas to provide room, board, and specified medical services at a predetermined monthly rate. In the 1930s, a form of managed care developed with Kaiser

Industries providing health care services to employees located in the remote California desert through contracted providers.

Private health insurance greatly expanded during World War II, when, with wages frozen, employees began to explore the financial advantages of “fringe” benefits. Unlike real wages, benefits were not subject

to income or social security taxes; a dollar of health insurance was worth more than an after-tax dollar spent on medical services.

Health insurance continued to increase in importance in the post-war era when the Supreme Court ruled that employee benefits—including health insurance—were a legitimate part of the labor-management bargaining process. This decision, along with such other factors as advances in medical technology, rising affluence, and a growing population, stimulated the health insurance industry in America.

Beginning in the 1950s, commercial insurance companies offered health coverage to millions of Americans by pricing indemnity policies on the basis of case experience. However, even though many of the postwar policies were broad enough to cover the expenses of common accidents and illnesses, they did not cover extended sickness or long hospital stays. To correct this, commercial insurers offered major medical insurance to cover catastrophic cases. Blue Cross and Blue Shield followed with similar plans.

By the mid-1950s, 77 million people had hospital expense insurance, 60 million had surgical expense insurance, and 21 million had surgical expense insurance to cover physicians' fees. By the early 1960s, most commercial health insurance policies included the three basic coverages: hospital care, surgical fees, and related physicians' services.

The next three decades saw feverish activity in the realm of both public and private health insurance. Starting in the mid 1960s, Congress established government-financed insurance for the elderly (Medicare) and for the poor (Medicaid). While Medicare was solely federal, Medicaid was conceived as a joint federal and state program. (The end result has been wide state-by-state variations in Medicaid eligibility and benefits). There is some overlap between these two programs, and it is possible to be a "dual eligible."

The U.S. economy, coupled to the country's demographics and further influenced by the political ideologies and interests of elected officials and their constituents, have shaped Medicare and Medicaid from their very beginnings in the mid-1960s. Both programs have been subject to changes of fortune and have undergone countless refinements. A major expansion occurred, for example, in 1972, when Congress extended Medicare benefits to people with disabilities and those with end-stage renal disease.

While the federal government and the states entered the health care arena and became large insurers, private insurers also entered a period of unprecedented growth.

Insurance companies began offering more comprehensive coverage. Under major medical policies, benefits ranged from $50,000 to several million dollars. The changes in coverage led naturally to changes in risk assessment and benefits administration. In the 1970s, private insurance companies determined premiums through actuarial assessments of the risks of an insured group; premiums for each group were based on its own medical claims experience—a practice known as "experience rating." It was only one short step from experience rating to self-insurance.

Self-insurance began when large employers realized that the aggregate medical "experience" of their work force would vary little from year to year (except for inflation in medical prices). Given this predictability, it became feasible for a company to assume the risk for its employees by budgeting for claims, rather than paying insurers a premium to bear the risk. Self-insurance also allowed companies to control their funds until medical bills actually had to be paid.

Several regulatory factors also encouraged the growth of self-insurance. In virtually every state, insurance companies are required to pay a tax of several percentage points on their premiums—a cost they pass on to their customers. Companies that self-insure are not subject to a premium tax and are able to pass the subsequent savings on to their employees. In addition, some states have mandated benefits and services. In 1974, the Employment Retirement Income Security Act (ERISA) prohibited states from applying mandates

to self-insured plans. Thus an employer could avoid paying the costs for mandated benefits by self-insuring.

As self-insurance grew, self-insuring employers turned to commercial insurers to administer their plans through administrative services only (ASO) contracts.

But with self-insurance an option, community rating lost viability. Clearly, it became cheaper for any group with below-average risk to leave the "community" and to self-insure. (Community-rated premiums necessarily reflect the risk of the total community, which includes both high and low risk groups or persons.) Consequently, not only private carriers but also Blue Cross Blue Shield plans have turned to experience rating as the predominant method for determining premiums.

As indemnity insurance grew, so did the costs of health care. Managed care plans, growing steadily since the 1930s, increased dramatically in the 1970s. The 1973 Health Maintenance Organization Act set federal standards for HMOs and removed many restrictive state laws. The act provided grants for HMOs in diverse geographic areas and required employers to offer federally qualified HMOs. In the 1980s, the federal government set up programs to provide HMO services to Medicaid and Medicare recipients. Numerous hybrids of the HMO evolved throughout the 1980s; most offered the potential to control costs by organizing providers into networks and integrating the financing and delivery of medical care. By 1998 over 76 million persons were enrolled in HMOs, and together with other managed care arrangements, managed care now covers 85 percent of the United States population.

Despite the aggressive entry of managed care plans into the insurance marketplace, health costs continued to climb, although more slowly in the early to mid-1990s. Total national health expenditures grew from 5.9 percent of Gross National Product (GNP) in 1965 to 11.9 percent of GNP by 1987, with all payers sharing in the burden. By the end of the 1980s, health care inflation had hit consumers and employers alike, and an increasing number of Americans were joining the ranks of the uninsured. Health care, not surprisingly, became a hot political issue.

3. Regulation of insurance

The business of insurance is regulated primarily at the state level in the U.S. market. However, as more employers turn to self insurance, a smaller percentage of the total number of privately insured people are subject to these regulations. Because many in government and at the consumer level feel that more protections should be afforded to enrolees of health plans, legislators have turned to the federal government to enact laws to implement various health care reforms.[4]

From the late 1980s to the present, the United States has been debating health care financing and delivery. In the beginning, the focus was on the possibility of nationalized health care for the United States. Proponents pointed to universal coverage regimes, such as that of Canada; opponents stressed the unique characteristics and value of the U.S. private insurance system, with its ability to deliver high-tech, high-quality medical care quickly. And while polls showed that a majority of Americans were worried about health care coverage and costs, most did not want a government-run system. Nevertheless, affordability and "job lock" (the inability to switch jobs for fear of losing coverage) were significant worries for many. However, millions of Americans, including many who were self-employed or who worked for small businesses, remained without insurance.

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[4] See State-Federal regulation paper by Dean Rosen for more complete explanation of this regulatory environment

In response, the insurance industry adopted a policy position centering on reform of the small-employer market. The industry also emphasized private reinsurance (to permit insurers to spread losses for high-risk individuals), state risk pools for the medically uninsurable, and tax assistance or increased public coverage, like Medicaid, especially for children.

While these proposals pointed the way to piece-by-piece legislative reform, more broad-reaching positions—variations on the theme of national health insurance—were repeatedly advanced by others. Academics, think tanks, providers, payers, and consumers all joined the fray; a multiplicity of policy options filled not just technical journals and the trade press but were the subject of articles and commentary by the media. "Access," "choice," and "portability" became popular buzz words. Perhaps inevitably, health care started to show up as a factor influencing elections.

Ultimately, bipartisan legislation—the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—was passed. HIPAA provides a measure of portability of health insurance for people who change or lose their jobs. The following summarizes the basic requirements of the Act:

- *Limits on the use of preexisting condition restrictions*. Group health plans, and health insurance issuers offering group health insurance coverage, are prohibited from imposing a preexisting condition exclusion that exceeds 12 months (18 months for late enrollment) for conditions diagnosed or treated within 6 months prior to becoming insured. Preexisting conditions cannot include pregnancy and cannot apply to newborns and newly adopted children (including those newly placed for adoption). Such plans are required to credit periods of qualified previous coverage toward the fulfilment of a preexisting condition exclusion period when an individual moves from an individual or group source of health coverage to a source of group coverage. Plans and issuers have to provide a certification of the period of creditable coverage.
- *Guaranteed availability*. Group health plans, and health insurance issuers offering group coverage, cannot exclude from coverage or fail to renew coverage based on an individual's health status (or that of a dependent). A group health plan must provide for special enrolment periods for employees who experience a change in family composition, employment status, or employment status of a family member. The Act does not restrict the amount that an employer or issuer can charge for coverage or prevent the plan or issuer from establishing premium discounts or rebates or modifying applicable copayments or deductibles in return for adherence to programs of health promotion or prevention.
- *Requirements on issuers of group insurance*. Each insurer offering coverage in the small group market in a state is required to accept every small employer in the state that applies for coverage. It must also accept for enrolment under such coverage every individual who applies for enrolment during the initial enrolment period in which the individual first becomes eligible for coverage under the group health plan. No exclusions can be placed on the coverage of an eligible individual based on health status or the health status of the dependent. Exceptions apply to network plans that have limited capacity. (Many managed care plans are network plans.) The small group market is generally defined as employer groups with more than 2 and fewer than 51 employees. All health insurance sold in the group market must be guaranteed renewable, regardless of firm size, except for cause (e.g., fraud and nonpayment of premiums).

- Requirements on issuers of individual insurance. HIPAA also guarantees access to individual health insurance coverage, or access to coverage through an acceptable state alternative mechanism to certain eligible individuals. These individuals must have had 18 months of previous continuous coverage, the most recent of which was under an employer-sponsored group health plan. They also must have exhausted their access to any COBRA continuation coverage, and have no other group health coverage options available (e.g., from a new employer or from a spouse's employer).

These federal requirements apply to state-regulated insurers as well as employer-sponsored health plans. While HIPAA generally allows states to impose on insurers requirements that provide for greater protections to consumers in lieu of federal minimum standards, certain federal standards relating to preexisting condition exclusions override state laws. Moreover, if a state fails to enforce at least the federal minimum standards, then the federal government is charged with enforcing the law in that state. Direct federal enforcement of HIPAA actually has come to pass in some states.

The legislation also allows insurance companies to offer medical savings accounts (MSAs) to employees of small businesses (50 or fewer employees) and to self-employed persons. Participants must have coverage under a qualifying high-deductible health plan; deductibles can range from $1,500 to $2,250 per person or from $3,000 to $4,500 for families. MSA contributions are tax deductible and balances carry over from year to year; the interest earned is not taxed. Fund withdrawals to pay for qualifying medical expenses are not taxed, but withdrawals for any other purpose are taxed and assessed a 15 percent penalty.

HIPAA also affects long-term care insurance. This insurance covers persons for the cost of nursing home and other home health expenses. The number of companies offering this coverage totalled 120 in 1996 with nearly 5 million polices having been sold. The law's tax clarification provisions assure that the tax treatment for long-term care insurance is the same as for major medical insurance, i.e., benefits from long-term care coverage are generally not taxable. Consumers are able to take a tax deduction for the cost of long-term care insurance and deduct costs associated with receiving long-term care.

It should be noted that as debates over health care policy alternately simmered and raged, non-legislative, non-mandated change visited the insurance industry. It was no less than revolution from within. Mergers and acquisitions became commonplace; some "household name" health insurance companies left the market altogether; new players entered; and managed care became the predominant form of coverage for working Americans. While in 1988 the staff model HMO was still the dominant model of a managed care organization (MCO), by the end of the 1990s hybrids had proliferated, with preferred provider organizations (PPOs) and point-of-service (POS) plans gaining in favour with employers and health care consumers. In 1988 HMOs held 18 percent of all employee enrolment in health plans while PPOs held 11 percent. HMOs increased their market share to 33 percent in 1997, but have declined to 30 percent in 1998. PPOs have continued to increase their share of the market with 31 percent in 1997 and 34 percent in 1998.[5] In addition, sophisticated managed care techniques were increasingly applied to fee-for-service (FFS) coverage to contain costs. These include pre-certification of benefits, carve out plans for prescription drugs and mental health benefits, and medical claims review.

[5] KPMG Survey of Employer-Sponsored Health Benefits, various years; HIAA Survey 1988.

ANNEX

FEDERAL AND STATE REGULATION OF PRIVATE HEALTH INSURANCE

Introduction

Until very recently, private health insurers were regulated almost exclusively by the states in which they did business. This legal regime had the advantage of flexibility and the disadvantage of lack of uniformity. But, for good or ill, this arrangement is at an end. It is not that state regulation is over. Rather, it is that the federal government now has a new role--and a further reach--in the regulation of private health insurance.

Starting with the signing into law of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 106-191), states have begun to share greater power with the numerous federal agencies that now have a measure of regulatory authority over private health insurance and health plans. And, while the current division of state and federal responsibilities still flows largely from the provisions of the McCarran-Ferguson Act of 1945 (P.L. 79-15) and the Employee Retirement Income Security Act of 1974 (ERISA; P.L. 93-406), over time HIPAA could dramatically alter the respective regulatory roles of the state and federal governments. This would be in sharp contrast to the last two decades in which (despite significant state and federal legislative activity) regulatory responsibilities relating to private health insurance and health benefit plans remained largely unchanged.[6]

Currently, the federal government generally regulates health plans that are sponsored by private employers. The states regulate the business of insurance, including traditional indemnity plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other types of managed care organizations (MCOs) that sell health insurance coverage to individuals, employers, or other purchasers. States also oversee plans sponsored by state and local governments. If a private sector employer sponsors a plan that is not purchased from an insurer (i.e., the plan is self-insured), then the plan is regulated solely by the federal government. If a private sector employer contracts with an insurer to provide managed care to the employer's employees, then the regulation of that plan generally will depend on which entity bears the risk. [7]

This paper traces the history and evolution of private insurance regulation during the last half-century, focusing on the major legislative initiatives at both the state and federal level that have helped shape the private market. It also briefly discusses the important role that federal tax policy has played.

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[6] This paper does not discuss publicly funded programs, such as Medicare and Medicaid.

[7] It is important to note that state regulation can have a significant, albeit indirect, effect on self-insured health plans. For example, for purposes of administrative simplicity, insurers offering both insured products and administrative services in connection with self-insured employer-sponsored plans in a state may comply with a state's requirements for appeals procedures for both the insured product and in the administration of the self-insured plan.

1945: The McCarran-Ferguson Act

The story of state regulation of health insurance begins with the McCarran-Ferguson Act of 1945 (P.L. 79-15), which exempts the business of insurance from federal antitrust regulation to the extent that insurance is regulated by the states, and indicates that no federal law should be interpreted as overriding state insurance regulation unless it does so explicitly. The Act did not prevent the federal government from regulating insurance in the future; it merely affirmed that the government had so far abstained from doing so. It was not until three decades later that the federal government began to encroach upon state jurisdiction; significant legislation included the HMO Act of 1973, ERISA, the Medigap amendments of 1980 and 1990, and the Health Insurance Portability and Accountability Act of 1996.

1973: The HMO Act

The HMO Act of 1973 (P.L. 93-222) did not dramatically alter the regulatory reach of the state or federal government over private health insurance. But it did establish a federal presence in regulating private health care coverage. The HMO Act was enacted largely to encourage the growth of HMOs, thought by many to be a more cost-effective way to deliver health care than traditional, fee-for-service insurance. The Act originally provided federal funds to develop new HMOs and to help them through the start-up period. These funds are no longer available.

Seeking federal qualification under the HMO Act is voluntary. In fact, many HMOs operate only under state licensure because they choose not to meet some of the requirements of the HMO Act. At the end of 1997, about 40 percent of all HMOs were federally qualified, although qualified HMOs accounted for 66 percent of total HMO enrollment.

The HMO Act specifies that a federally qualified HMO is a public or private entity, organized under the laws of any state, which provides basic and supplemental health services to its members and meets certain financial and organizational requirements. Federally qualified HMOs also are subject to state insurance laws, with certain exceptions. The HMO Act explicitly preempts restrictive state laws and practices, including those that: (1) require as a condition of doing business that a medical society approve of the furnishing of services by the entity; (2) require that physicians constitute all or a specified percentage of its governing body; (3) require that all physicians or a specified percentage of physicians in a locale participate or be permitted to participate in the provision of services for the HMO; (4) require the HMO to meet state requirements for health insurers with respect to initial capitalization and establishment of financial reserves against insolvency that would prevent it from doing business in the state; and (5) otherwise impose requirements that would prohibit the HMO from complying with the requirements of the HMO Act.

Initially, one of the main reasons for an HMO to obtain federal qualification was to take advantage of the HMO Act's "dual choice" requirement. Any employer with 25 or more employees that was subject to the Fair Labor Standards Act and that provided group health insurance benefits was required to offer an HMO option as an alternative to its existing health plan, if a federally qualified HMO was available in its area. The employer had the right to choose among qualified HMOs if there were more than one in the area. This "dual choice" requirement was eliminated by the HMO amendments of 1988, and became effective seven years after enactment on October 24, 1995.

1974: ERISA

There is no doubt that ERISA has had a significant impact on the private health care market during the last two decades. While the legislative debate leading to passage of ERISA focused largely on its pension provisions, it is clear that the drafters of the 1974 law also intended to provide a workable framework of federal rules for all private employer-sponsored welfare benefit plans (including health plans) that balanced consumer protections with incentives to encourage employers to voluntarily offer benefits.

ERISA leaves the content and design of employer-sponsored health plans largely to employers, as they negotiate with their workforce. It does, however, establish certain requirements for health benefit plans. These relate to reporting and disclosure, fiduciary standards, claims review, and enforcement. It also provides participants in employer-sponsored plans limited protections against discrimination. (Exempt from ERISA are governmental plans, church plans, and plans offered by fraternal organizations, in which there is no employer-employee relationship.)

While Congress generally permits states to enact legislation that does not conflict with federal law, ERISA more broadly preempts most state laws that "relate to" employee benefit plans. State laws regulating the business of insurance, banking, and securities are saved from preemption through ERISA's "savings clause." But states are prohibited from deeming self-insured employers to be insurers in order to bring them under state regulatory jurisdiction. As a consequence of ERISA's preemption provisions, employers that self-insure are exempt from state regulatory requirements such as taxes on insurance premiums, requirements that health plans include specific benefits or pay specific providers, solvency and funding standards, requirements to participate in the financing of state risk pools, and laws regulating various characteristics and actions of managed care plans.

Prior to ERISA, nearly all health benefits were provided through state-regulated insurers. However, self-insurance has increased steadily over the past two decades, driven by employers' need for more direct control over cash flow, and the desire to avoid experience rating, state mandates, and taxes. Equally important, self-insurance allows employers greater freedom to offer innovative and cost-effective benefits and, for those with operations in multiple states, much greater ease of benefit administration. It is estimated that approximately 50 percent of employees with health coverage are now in self-insured plans.

It should be noted, however, that the effect of ERISA's preemption clause on the regulation of MCOs is significant, complex, and still evolving. With the growth of managed care, the distinction between plans that are fully insured from those that are self-insured has become less clear. When an employer pays an insurer the premiums for fee-for-service coverage for his or her employees, the plan is clearly fully insured. But when an employer contracts with an MCO to use its network of providers to offer participants an HMO, the situation becomes somewhat murkier.

Employers, and particularly large employers, have credited the flexibility provided by ERISA with enabling them to become sophisticated purchasers of health care, to drive innovation in health plans, to control benefit costs, to create more competitive health care markets, and to operate consistently from state to state. At the same time, states generally view ERISA as an impediment to their ability to regulate various aspects of health coverage and delivery, or to enact comprehensive health reforms.

Evidence from the legislative debates surrounding passage of ERISA suggests that some members of Congress expected national health insurance legislation to be adopted in very short order that would supersede all existing regulation. However, enactment of comprehensive federal health reform legislation never came to pass. Instead, state health reform activity intensified in the two decades following passage of ERISA.

State Regulation of Health Insurance and Managed Care Plans

Despite the restrictions imposed on the reach of state regulation by ERISA, states adopted legislation in the 1970s, 1980s, and 1990s that significantly expanded the regulation of private health insurance. Indeed, the number of state insurance mandates increased at least 25-fold between 1970 and 1996. Many states have been, and continue to be, influenced by various model acts developed by the National Association of Insurance Commissioners (NAIC).

During this period, nearly every state enacted some type of small group or individual health insurance market reform (e.g., rating restrictions, guaranteed issue, guaranteed renewability, limits on preexisting condition exclusions), levied some form of taxes on insured health plans, or required private health insurers to provide coverage for specified benefits or classes of providers. In addition to the dozens of mandates that have been enacted in recent years by the states, 43 of the 44 state legislatures that convened in 1998 proposed new mandates. Of the nearly 200 state mandate bills introduced so far this year, 40 new measures have been enacted in 31 states. By February 1999, 46 of 49 states convening for 1999 had introduced mandate legislation.

Some states also have considered employer mandates and other mechanisms to increase the number of individuals with insurance coverage in their states during the past several years. In addition, all 50 states have moved to regulate HMOs during the last 20 years under enabling laws that address the insurance and delivery aspects of HMOs. Furthermore, state legislatures have increased their activity in the wake of perceived dissatisfaction with managed care. In 1998, 33 states considered various forms of "reform" legislation, with Indiana, Nebraska and Virginia's legislatures approving comprehensive managed care legislation. Other proposals focused on "patient protections," provider networks, and/or utilization review. Also in 1998, 12 states considered external review mechanisms, with 5 approving such measures. Of the 27 states that considered health plan liability, no new legislation was enacted in 1998. The wave of anti-managed care proposals has continued into 1999, with legislatures focusing on health plan liability, external review, and defining utilization review as practice of medicine. By February, 27 states had already introduced bills in these three areas, with many more legislatures expected to consider these issues, as well as other "patient protection" measures, in 1999.

The Medigap Amendments of 1980 and 1990

In 1980, Congress enacted a set of minimum federal standards for the issuance and renewal of Medicare Supplemental ("Medigap") plans. Ten years later, Congress reduced the number of Medigap plans that could be offered to Medicare beneficiaries to ten different, standardized plans and added further rules governing Medigap policies.[8] Both the 1980 and 1990 legislation represented a departure from McCarran-Ferguson in that it set forth federal rules that directly affected the private health insurance market.

The 1990 federal Medigap amendments authorized the NAIC to develop model legislation and regulations, for approval by the Secretary of Health and Human Services. Once approved, the regulations were incorporated by reference into federal law and the states were given a certain period of time in which to adopt laws complying with the NAIC's models. If a state failed to do so (which none did), the federal government had the authority to directly regulate insurers offering Medigap policies in that state. Some commentators view the regulatory structure of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as similar to these federal Medigap rules. Others, however, view HIPAA as having more sweeping implications because it applies to all major medical coverage (and because the federal Medigap reform laws applied only to beneficiaries of an entitlement program funded by the federal government.)

[8] Congress again expanded Medigap regulatory requirements under the Balanced Budget Act of 1997 (P.L. 105-33).

1996: The Health Insurance Portability and Accountability Act

Federal laws such as ERISA and the Americans with Disabilities Act (ADA) imposed certain requirements on employer-sponsored health plans—and therefore indirectly on insurers. In addition, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, P.L. 99-272) established the right of employees and their families in employer-sponsored health plans with 20 or more employees to continue their coverage under such plans for a limited period if they experienced a change in job or family status. But HIPAA marked the first real, direct regulation by the federal government of the business of health insurance.

HIPAA amended three federal laws: ERISA, the Public Health Service (PHS) Act, and the Internal Revenue Code (IRC). The following summarizes the basic requirements of the Act:

- *Limits on the use of pre-existing condition restrictions*. Group health plans, and health insurance issuers offering group health insurance coverage, are prohibited from imposing a pre-existing condition exclusion that exceeds 12 months (18 months for late enrolment) for conditions diagnosed or treated within 6 months prior to becoming insured. Pre-existing conditions cannot include pregnancy and cannot apply to new-borns and newly adopted children (including those newly placed for adoption). Such plans are required to credit periods of qualified previous coverage toward the fulfilment of a pre-existing condition exclusion period when an individual moves from an individual or group source of health coverage to a source of group coverage. Plans and issuers have to provide a certification of the period of creditable coverage.

- *Guaranteed availability*. Group health plans, and health insurance issuers offering group coverage, cannot exclude from coverage or fail to renew coverage based on an individual's health status (or that of a dependent). A group health plan must provide for special enrolment periods for employees who experience a change in family composition, employment status, or employment status of a family member. The Act does not restrict the amount that an employer or issuer can charge for coverage or prevent the plan or issuer from establishing premium discounts or rebates or modifying applicable copayments or deductibles in return for adherence to programs of health promotion or prevention.

- *Requirements on issuers of group insurance*. Each insurer offering coverage in the small group market in a state is required to accept every small employer in the state that applies for coverage. It must also accept for enrolment under such coverage every individual who applies for enrolment during the initial enrolment period in which the individual first becomes eligible for coverage under the group health plan. No exclusions can be placed on the coverage of an eligible individual based on health status or the health status of the dependent. Exceptions apply to network plans that have limited capacity. (Many managed care plans are network plans.) The small group market is generally defined as employer groups with more than 2 and fewer than 51 employees. All health insurance sold in the group market must be guaranteed renewable, regardless of firm size, except for cause (e.g., fraud and non-payment of premiums).

- *Requirements on issuers of individual insurance.* HIPAA also guarantees access to individual health insurance coverage, or access to coverage through an acceptable state alternative mechanism to certain eligible individuals. These individuals must have had 18 months of previous continuous coverage, the most recent of which was under an employer-sponsored group health plan. They also must have exhausted their access to any COBRA continuation coverage, and have no other group health coverage options available (e.g., from a new employer or from a spouse's employer).

These federal requirements apply to state-regulated insurers as well as employer-sponsored health plans. While HIPAA generally allows states to impose on insurers requirements that provide for greater protections to consumers in lieu of federal minimum standards, certain federal standards relating to pre-existing condition exclusions override state laws. Moreover, if a state fails to enforce at least the federal minimum standards, then the federal government is charged with enforcing the law in that state. Unlike the situation with the federal Medigap amendments, direct federal enforcement of HIPAA actually has come to pass in some states.

In addition to rules on access to group and individual health insurance, HIPAA gradually increases the deductibility of health insurance for the self-employed, provides tax incentives for the purchase of long-term care insurance, authorizes a demonstration program for tax-preferred medical savings accounts, sets up a framework for the development of national standard for the electronic transmission of health claims data, and implements a process for the adoption of federal rules on confidentiality of health information. In this area, HIPAA gives the Secretary of Health and Human Services broad authority but little guidance on promulgating binding regulations governing the use of individually identifiable health information (if Congress fails to enact legislation in this area by August 1999). These rules, which could affect claims administration, enrolment and disenrolment processes, payment and remittance advice, referrals and authorization certifications, and other areas, would have a significant impact on the day-to-day operations of every health insurance carrier and health plan in the United States. These regulations—coterminous with existing state laws on patient confidentiality—show some of the pitfalls inherent in a combined state/federal regime, threatening to burden insurers with additional, duplicative, and, perhaps, conflicting administrative responsibilities, unless preempted.

It should also be noted that HIPAA's tax code provisions relating to medical savings accounts and long-term care insurance establish a relatively novel mechanism for federal regulation of private health insurance. Under these rules, tax preferences extend only to qualifying policies established in conformance with the rules set forth in the IRC.

The health insurance reform provisions of HIPAA were truly incremental relative to the sweeping Clinton health reform plan considered by Congress just two years earlier. Most states had already adopted small group insurance reform laws that met or exceeded HIPAA's minimum standards. Nonetheless, HIPAA did mark a departure both from McCarran-Ferguson and from ERISA in providing federal regulatory standards for private health insurance products sold in both the group and individual market, and for self-insured employer-sponsored plans. And, less than two months after HIPAA was signed into law, it was amended to provide for federal standards related to maternity stays and coverage for mental health services.[9] Since then, nearly every one of the dozens of federal legislative proposals in Congress—to mandate insurance coverage for certain health benefits or impose restrictions on managed care practices—has been drafted as an amendment to HIPAA. Some of the proposals would open ERISA's preemption structure to even more fundamentally alter the relationship of state and federal health insurance regulation.

[9] Another federal mandate was added in 1998 with passage of the "Women's Health and Cancer Rights Act," included as sections 901-903 of the "Omnibus Consolidated Appropriations Act for Fiscal Year 1999" (P.L. 105-277).

The Critical Role of Federal Tax Policy

The focus on state and federal regulation of health insurance and health benefits should not obscure or in any way diminish the critical role that federal tax policy has played in shaping the current private health care market. The foundation for the current employer-based health care system was laid during the Second World War. In response to wartime controls put in place to prevent companies from raising wages, employers began offering more generous health insurance and other non-cash "fringe" benefits to their employees and deducting such costs as normal business expenses under section 162 of the tax code.

In 1943, the Internal Revenue Service ruled that employer contributions toward premiums for group health insurance were not taxable to employees. And passage of ERISA helped make it easier in many respects for large, multi-state employers to manage their employee benefit programs and further cemented the relationship by which millions of workers receive health benefits through employer-sponsored plans.

As a result of these changes and the benefits derived from economies of scale, the number of people covered by group health insurance has grown from fewer than 12 million persons in 1940 to approximately 152 million today. At the same time, a series of amendments beginning in the early 1980s increased the floor for individually deductible medical expenses from 3 percent of adjusted gross income to its current 7.5 percent. These reductions in tax benefits for individually paid premiums are one of the most significant factors contributing to a steep decline in the number of people insured through individual health insurance over the past two decades. About thirteen million people have individual coverage today compared with 36.1 million in 1978.

A New Era of Commonality and Convergence?

While McCarran-Ferguson and ERISA established the respective jurisdictional reach of the federal government and the states over health insuring entities, other laws, such as the HMO Act of 1973, the Medigap amendments of 1980 and 1990, and HIPAA, affected both "who regulates what" as well as the content of that regulation. This intricate and confusing regulatory environment has led some to suggest that insurance regulation be federalized. In that way, one uniform set of laws would apply to all health plans, whether insured or self-insured. Of course, many adhere to the opposite view. Some advocate that the states be given greater latitude to regulate the health plans sponsored by employers so that insuring entities are competing on the same "level playing field."

However, there appears to be growing interest in the current Congress in legislation that applies federal minimum requirements to all health plans, regardless of whether they are purchased or self-insured, but that also give states the flexibility to apply their own laws if such laws are consistent with (or, in some bills, more restrictive than) the federal standard. (This approach is reflected in HIPAA and the federal Medigap rules.) Thus, both in Congress and in the states, legislators are pushing the limits of their regulatory bounds and enacting legislation that is increasingly redundant. Often, such legislation inadvertently imposes costly, burdensome requirements on the private health insurance market. Moreover, legislative issues that have arisen in the states are rapidly making their way into the federal arena—and being taken quite seriously for the first time. For example, federal maternity stay legislation passed Congress less than two years after the first state adopted similar legislation, and the same pattern is emerging with other mandates, such as mastectomy length-of-stay and anti-gag clause legislation. Because of HIPAA and its subsequent mental health parity and maternity mandates, the reverse is also true. During the most recent legislative sessions, many states reopened and reexamined their small group and individual market reform laws and reconsidered mental health parity legislation. In some cases, subsequent state enactments exceeded the minimum standards set forth in the federal law.

Thus, while HIPAA represents an important precedent, it stands as an even more momentous paradigm. The architects of HIPAA overcame years of infighting among Congressional committees about who would have jurisdiction over private health insurance reforms. The legislation also passed with political support (or, at least without significant political opposition) from consumer groups, employers, unions, governors, state legislators, state insurance regulators, and many in the insurance industry. As such, it provides a ready-made regulatory framework for future incremental federal health insurance reforms.

In the aftermath of HIPAA, and in an era of intensifying interest at both the state and federal levels in increased regulation of the private health insurance market, it is important to understand the complex interaction between state and federal insurance regulation. More than ever, if the public is to be well served by a dynamic and innovative private insurance market, it is critical that lessons learned in one forum be applied to the other, and that legislative challenges and opportunities be anticipated. Moreover, the proliferation of both state and federal health insurance regulation during the past few years suggests that the respective roles of different levels of government should be more thoroughly examined to ensure that innovation is not stifled and consumers are not harmed by contradictory, redundant, or overly burdensome requirements. The public may be well-served by a comprehensive review of this regulation to more critically examine its alleged value relative to its costs.