

# VOLUNTARY HEALTH INSURANCE: POTENTIALS AND LIMITS IN MOVING TOWARDS UHC



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Organization



HEALTH FINANCING POLICY BRIEF NO 5

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## Key Messages

- Voluntary health insurance (VHI) as a mechanism to finance health systems plays a marginal role in most countries, with only 41 countries having VHI expenditure above 5% of total health expenditure (THE).
- Although modest, VHI as a share of THE is growing overall in many countries. One key factor for VHI growth in low- and middle-income countries is the emergence of a middle class comprised of many people who are able and willing to pay VHI premiums, as they seek to access what they perceive to be better quality or more convenient care in the private sector.
- Depending on the specific role of VHI in a health system, it could pose opportunities and risks for equitable progress towards universal health coverage (UHC).
- VHI often disproportionately benefits people of higher incomes with lower health risks. Beyond direct consequences of VHI on equity in access, there are other potential effects of serious concern: where governments pay the employer share of premiums for civil servants affiliated to a voluntary health insurance system or where tax credits are granted in relation to VHI premium payments, public spending becomes more pro-rich.
- VHI can negatively affect health system performance, in particular equity in service use, by creating or reinforcing a two-class system. In contexts of health worker shortage, high VHI payments to private sector providers can lead to exit of staff from the public sector and put increasing pressure on salaries across the system.
- There is need to pay attention to the potential as well as the likely risks of VHI expansion. Health financing strategies need to be clear about and regulate the role given to VHI in order to create complementarity between VHI and publicly funded pools and to progress equitably towards UHC.
- In sum, it is difficult to attain universal health coverage by relying primarily on voluntary insurance scheme contributions: “Compulsion, with subsidization for the poor, is a necessary condition for universality”.

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# 1 WHAT IS VOLUNTARY HEALTH INSURANCE (VHI)?

The purpose of this brief is to explore the potentials and limits of voluntary health insurance (VHI) for progress towards universal health coverage (UHC), with particular attention to low- and middle-income countries. VHI can be defined as a prepaid pooling arrangement that receives *voluntary* funds and pools them *separately*. The decision to obtain such coverage is not required by government but is rather a decision made by individuals, households, or private companies (Jowett and Kutzin 2015). As such, VHI differs from a compulsory insurance mechanism (social health insurance is the most common form) under which membership and payment of contributions are made obligatory by the government (by law) for some or all of the population (OECD/Eurostat/WHO 2011).

Because it is voluntary does not mean that VHI is always privately run. It can be provided by various types of organisations, including both commercial and not-for-profit health insurance companies, enterprises that run their own insurance arrangements for their employees, non-governmental organisations

or other local entities that operate *community-based health insurance* (see Mathauer et al. 2017 for a specific policy brief on CBHI), and even government agencies.

In some cases, however, governments do provide funding for VHI, either directly (e.g. private medical scheme coverage as a negotiated employee benefit for civil servants, as in South Africa) or indirectly by granting tax allowances<sup>1</sup> (deductions or tax credits) for the purchase of VHI. Thus, VHI can be funded from both public and private sources.

VHI can take on different *roles* in health financing, and in particular in relation to the *statutory system* (i.e. the “main” publicly funded system for the population). As described in Table 1, these roles can be defined as substitutive, complementary and supplementary.

<sup>1</sup> For example, the amount paid for the health insurance premium can be excluded from taxable income. This lowers the employee's tax bill.

**Table 1:** Key features of the different VHI roles

VHI role	Key features
Substitutive	Covers population groups that are excluded from publicly financed coverage or allowed to take their mandatory contributions out of the compulsory insurance system (“opting out”).
Complementary (user charges)	Pays for some of the costs for services that are covered by the statutory system (typically patient co-payments).
Complementary (services)	Pays for services that are explicitly excluded from the statutory system's package of benefits.
Supplementary	Provides enhanced access (e.g. jumping queues/waiting lines), a higher level of inpatient amenities or greater user choice of providers in comparison to those covered by the statutory system.

Source: adapted from Thomson (2010)

## 2 WHY IS IT IMPORTANT TO REFLECT ON THE CONTRIBUTION OF VHI TO UHC?

Depending on the context and role that VHI plays in the health system, it may contribute to or detract from progress towards UHC. Thus, explicit attention to it within overall health financing arrangements and the wider health system is an important consideration for public policy. However, such attention is often not adequately reflected and specified in national health sector plans and health financing strategies.

There is no global overview on VHI population coverage rates, but available evidence shows that population coverage via VHI, particularly in its substitutive role, is generally below 10% in low- and middle-income countries (LMICs), with the exception of a few countries, for example South Africa and Lebanon (Preker et al., 2010). There are very few high-income countries (HICs) that have substitutive VHI, and even fewer countries with population coverage via substitutive VHI above 10%. A detailed account is available on 34 European countries that shows that supplementary or complementary VHI is more widespread. The respective population coverage rates vary, but are generally somewhat higher than that of substitutive VHI (Sagan and Thomson 2016).

Yet, when looking at VHI expenditures, it becomes clear that VHI plays a rather marginal role in most countries of all income levels. However, the share of VHI expenditure in THE (VHI%) is growing in most LMICs and many HICs, even though on a very modest scale in most countries (Pettigrew and Mathauer 2016). Nonetheless, the

number of countries in which VHI accounts for at least 5% of total health expenditure is growing among LMIC. Across regions, VHI% is highest in Latin American and Southern African countries (ibid.). The specific pattern of very high VHI expenditure shares in South Africa, Botswana and Namibia results from a historical legacy of segregation and inequalities. For example in South Africa, the overall health financing architecture has not changed since the transition to democratic rule, with over 40% of THE being spent via VHI (WHO 2016), the highest share of any country in the world. However, VHI covers only 16% of the population (CMS 2016), and as a result, strongly skews the available system resources to those with such coverage. In such a situation, VHI is a public policy concern because of the spillover effects for the wider system, for instance in terms of distribution of health workers, rising prices and overall costs.

Another critical point is that VHI% is relatively higher in countries with larger income inequalities. VHI is usually demanded by richer population groups who can afford the premiums (Preker et al., 2012). Much of the initial expansion of VHI expenditure in many countries was a result of underfinanced public health systems, limited investment in the public sector, dominant presence or growth of the private health sector and limited regulation of VHI. In some countries, explicit government policies sought to enhance VHI market expansion. These factors have to be seen in combination with the emergence



of a growing middle class with disposable income and a demand for VHI (Pettigrew and Mathauer 2016).

Once a VHI market is in place providing coverage to parts of the (usually better-off) population, vested interests may make it more difficult to introduce or expand publicly funded mechanisms to expand coverage to the wider population, including poorer people.

Another challenge in many countries is that VHI often does not fall under the domain and regulation of the Ministry of Health, but under a general insurance regulatory body without health-specific knowledge or another ministry responsible to promote private sector growth (including VHI). This may conflict with the efforts of the Health Ministry to put in place health financing and health sector policies that are driven by UHC objectives.

# 3 HOW DOES VHI FIT WITHIN HEALTH FINANCING POLICY?

VHI combines voluntary prepayment as a revenue raising mechanism with voluntary affiliation to a pool (in the form of the VHI scheme). The key features of VHI and

related alignment and regulatory issues are summarized along the health financing functions in Table 2 below.

**Table 2:** Key features of VHI and related policy issues for alignment and regulation to achieve UHC goals

	Key features	Policy issues for alignment and regulation
Revenue raising	<ul style="list-style-type: none"> <li>- Prepayment in the form of voluntary premiums</li> <li>- Usually non-income related premiums (risk-rated or community-rated<sup>2</sup>) and thus regressive</li> <li>- Government may subsidize contributions either indirectly (through tax allowances) or directly for certain population groups</li> </ul>	<ul style="list-style-type: none"> <li>- How can VHI lead to a net increase in financial resources for health services that serve the large part of the population who relies on the publicly financed system?</li> <li>- In view of regressive premiums, how to make the purchase of a VHI policy affordable to low-income people with higher health risks?</li> <li>- How to limit tax subsidies that tend to be pro-rich?</li> </ul>
Pooling	<ul style="list-style-type: none"> <li>- Limited risk sharing: pools are often small and fragmented, limiting redistributive capacity across the whole population</li> <li>- Voluntary membership: people with higher health risks may be more inclined to purchase VHI, resulting in a pool largely consisting of higher health risks ("adverse selection")</li> </ul>	<ul style="list-style-type: none"> <li>- How to ensure that VHI pools do not destabilize or otherwise undermine compulsory pools, particularly when individuals are allowed to take their mandatory contributions out of the public pool (opting out)?</li> <li>- How to limit the extent to which insurers engage in risk selection (i.e. insurers' practices of trying to enroll only individuals with low health risks), so that people with high health risks are not excluded?</li> </ul>
Purchasing	<ul style="list-style-type: none"> <li>- VHI schemes have their own separate purchasing mechanisms and management systems</li> <li>- Due to small pool size, the purchasing power of a VHI scheme often remains limited when contracting providers</li> </ul>	<ul style="list-style-type: none"> <li>- How to regulate payment methods and reimbursement rates of private sector providers so as to avoid spillover and distortive effects on the overall health system?</li> <li>- How to ensure that providers do not prioritise and prefer to treat patients with VHI coverage that often comes along with higher provider payment rates ("cream-skimming")?</li> <li>- How to ensure that data on service use and payments for VHI patients are reported in national health information systems?</li> </ul>
Benefits and service use	<ul style="list-style-type: none"> <li>- Substitutive VHI often provides a larger benefit package than the one provided in the public system</li> <li>- Supplementary VHI gives access to health services in the private sector and increases care seeking at private providers</li> <li>- Complementary VHI covers the patient cost-sharing (e.g. co-payments) of the statutory system</li> </ul>	<ul style="list-style-type: none"> <li>- Is the public benefit package clearly defined for the VHI market to provide additional and appropriate coverage?</li> <li>- How to limit inequities in access to health services between those with VHI coverage and those without, especially if this is just for the rich?</li> <li>- In the case of complementary coverage (for user fees), how can unnecessary service use be managed? (Though debatable, the absence of any co-payments may be a source of expenditure growth of the publicly funded system if it leads to unnecessary service use.)</li> </ul>

2 Risk rated premiums: the premium amount is set in relation to the person's health status and health risks. An individual with higher health risks will have to pay a higher premium. Community rated premiums: The premium amount is the same for all members of the same policy, regardless of their health risks.

# 4 WHAT DO WE KNOW ABOUT VHI FROM THEORY AND PRACTICE

## INHERENT CHALLENGES OF VHI

VHI suffers from a number of inherent challenges. First, there is the potential challenge of “adverse selection”, a problem resulting from the fact that individuals with greater health needs are more likely to join a voluntary scheme. This could lead to an imbalance of risks in the scheme and limit the ability to share risks across people with different health needs. In turn, this may result in a cycle of increasing premium rates and setting up benefit ceilings, in fewer and fewer healthier individuals joining the scheme, and thus leading to a further reduction in the scope for risk sharing (Jowett and Kutzin 2015). In practice, however, adverse selection may be less of an issue: it is usually higher income people with lower health risks that join VHI (Sagan and Thomson 2016). As to CBHIs, there is limited and inconclusive evidence on the severity of adverse selection (Parmar et al. 2012).

Another challenge relates to administrative costs of VHI, which are considerably higher than in compulsory or automatic coverage arrangements due to costs for underwriting<sup>3</sup>, advertisement and commissions. Profits made by for-profit insurance companies are also captured under administrative costs. As a

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3 This is the process of evaluating the health information of an applicant for a VHI policy to determine whether to offer or deny coverage and what premium rate to set for the VHI policy.

share of total health insurance expenditure, administrative costs in VHI were found to range from 6%–39% in middle-income countries and from 20%–65% in low-income countries (Mathauer and Nicolle 2011). Inevitably, this further increases premiums, which make them even more unaffordable for lower income groups.

## OVERALL LIMITED COVERAGE IMPROVEMENTS

VHI may expand protection to some extent against the financial risks of ill health for those with VHI coverage (WHO 2010) if it leads to a net decrease in their out-of-pocket (OOP) expenditure. It may be argued that VHI as a form of prepayment could be preferable to OOP expenditure, particularly if there is not sufficient public financing available. However, it is found that the general trend of increasing VHI expenditure cannot be consistently associated with declining OOP. This suggests that VHI is overall not effective in covering the gaps in publicly financed health coverage (Sagan and Thomson 2016, Pettigrew and Mathauer, 2016). But most importantly, lower income groups do not gain in financial protection.

While VHI is said to help uptake new health technologies in the long term (Preker et al. 2007), service coverage expands only for the limited part of the population enrolled in VHI, whose utilisation rates are likely to increase. The key concern, however, is that usually the

better-off have VHI coverage, whereas people with higher health risks (e.g., sick and older people) with lower incomes cannot afford to purchase a VHI policy. This is exacerbated by risk selection attempts of insurers to enrol only 'good' risks with expected lower health care costs. As a result, people with higher health risks remain with limited coverage and inequities in access further increase (Thomson 2010). Subsidising complementary VHI for low-income households, for example as in France, can help reduce such inequities.

Another concern is that VHI often pays higher remuneration rates to providers. This may result in patient *cream skimming* at provider level and exacerbate inequitable access if patients with VHI coverage get preferential treatment. Through resource shifting, patients with VHI get more attention and possibly better quality of care and have shorter waiting times. Yet, cream skimming could also turn into (undesirable) over-provision of health services that are unnecessary and even harmful. On the other hand, it is argued that VHI may allow for cross-subsidization at provider level via higher provider remuneration rates paid by VHI against lower remuneration rates or exemption from user charges for poorer patients (Preker et al. 2010, Colombo and Tapay 2004). Evidence of this effect is, however, rather anecdotal.

Equity in financing ("fair financing") is also an issue: premiums for VHI are usually risk- or community-rated, thus being disconnected to people's ability to pay, and turning out to be regressive. In other words, persons with a low income and high health risks would have to spend a much higher proportion of his/her income on premiums than better-off people, and the premiums would often turn out to be unaffordable. As a result, usually the better-off buy VHI. This is further exacerbated by the

inequitable service use, since persons with a low income and high health risks are unable to afford this coverage and end up using far fewer services as a result. And the financing of VHI becomes even more pro-rich to the extent that uptake is subsidized through the tax system.

## **DISTORTING IMPACTS OF VHI ON THE HEALTH SYSTEM**

While benefitting its members, VHI may negatively affect the health system by contributing to or reinforcing a two-class system because people with VHI coverage have enhanced access to larger benefits including privately delivered health services.

Where people with higher income can withdraw from the public coverage system and choose substitutive VHI, this leads to risk segmentation, in particular because better-off income groups have usually lower health risks. The VHI pool consists of individuals with low health risks, whereas the public system loses contributions of better-off people and ends up covering a disproportionate share of higher risk people (Thomson and Mossialos 2009).

Moreover, as VHI expenditure largely occurs in the private sector, it contributes to higher income opportunities of health workers (doctors in particular), as such motivating health workers to shift to the private sector. This could lead to shortages of skilled health workers in government facilities, thus further reinforcing inequities as to health service availability. It also may lead to spillover effects, such as rising prices and costs across the health system. These negative effects are more problematic to the extent that both expenditures through VHI are larger and population coverage with VHI is limited to persons with higher incomes.

## 5 WHO'S PERSPECTIVE

It is difficult to attain universal health coverage by relying primarily on VHI premiums, and in fact no country has moved equitably towards UHC with VHI as a main pillar. Evidence suggests that VHI is limited in expanding population coverage and bringing in additional resources to the system to reduce OOP. It is public financing that contributes to improving health system performance on key UHC indicators such as financial protection (Jowett and Kutzin, 2015).

There is no set threshold of a VHI share as of total health expenditure that would hinder countries' efforts to move towards UHC. Nonetheless, it is crucial to be aware of VHI (expenditure) trends and to address potential challenges deriving from changes in VHI expenditure (WHO 2010). Given the many risks and potential spill-over effects to the rest of the health system, VHI needs to be managed and regulated in such a way that it contributes to equitable progress towards UHC, or at least does not harm such progress.

Implications for UHC differ across VHI roles. Thus, a conducive contribution to UHC is more likely to happen with VHI in a complementary and supplementary role. A pre-requisite for such roles is a health financing policy framework that provides clarity on what will be publicly funded so that the space for the VHI market to be able to provide *additional* coverage is identified, with the aim of voluntary

funds being complementary to public funds. Moreover, a “do no harm” approach would explicitly limit subsidies to better-off people for VHI premiums. Regulation, in particular on payment methods and rates, is needed to restrain potential cost escalations and to address spillover effects on the entire health system, such as a “brain drain” of health workers from the public to the private sector. Likewise, there is a need to align policy objectives around private sector promotion (including VHI promotion) with UHC policy objectives across different ministries.

As to CBHI as a specific form of VHI, it is suggested to transform their voluntary nature and integrate them into a national scheme or else to link these small pools with each other to increase the level of pooling, as outlined in a more detailed policy brief on CBHI and its potential contribution to progress towards UHC (Mathauer et al. 2017).

In sum, equitable progress towards UHC requires public policy attention to VHI. It should neither be ignored nor blindly promoted, but instead managed wisely. Through a well-designed health financing strategy, countries can clarify the main public and complementary private (including VHI) funding roles in the system. Without this, unmanaged VHI is likely to pose a threat to UHC goals.

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