Health insurance – with special emphasis on the Nordic market

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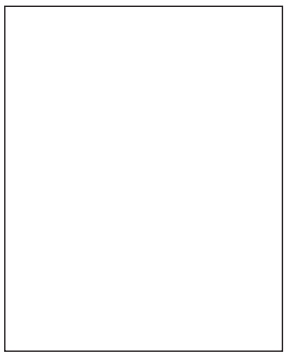

Jørgen Gawinetski

This article is based on a presentation given by Jørgen Gawinetski at the Nordic Insurance Congress in Copenhagen on 28-30 August 1996. Among the questions raised by Jørgen Gawinetski were the following:

The financing of the costs of health care in the Nordic countries is widely different from that seen in the other European countries. Will it be possible for the Nordic countries to retain their present system, in which taxation is the main source of finance for the health care system, or will they have to adjust to the systems used in other European markets?

In what ways will this affect the private insurance market?

1. A general outline of the market.

1.1. Introduction.

Private insurance for health care costs, i.e. insurance in which the insurance event triggering the payment of compensation is sickness, is not a frequent phenomenon in the Nordic countries, the reason being that their national, tax-financed health nets are much more finely meshed than those of other countries both inside and outside Europe.

In the Nordic countries, the real role of private health insurance is to act as a supplement to the national, tax-financed health service schemes or to cater to any areas may have been excluded from coverage under the national health service scheme.

Private insurance is only to a very modest degree a real alternative to the national health service.

Private health insurance schemes typically provide coverage for exceptionally large and welfare-threatening risks, such as the loss of earnings due to sickness or considerable costs for surgery or treatment which are non-refundable under the national health service scheme. Only in Denmark (and, since 1 February 1996, also in Norway) is it possible to arrange a health insurance which covers a proportion of the non-refundable part of the more general health and medical costs of e.g. dental treatment, physiotherapy, chiropractors, examination by a physician, etc.

1993	*No. of beds in public hospitals*	*No. of beds in private hospitals*	*%*
Denmark	26,500	70	0.2
Finland	35,000	2,500	7.1
Iceland	1,530	0	0
Norway	18,300	100	0.5
Sweden	49,200	4,500	9.1

Source: Yearbook of Nordic Statistics, 1995.

1.2. A financial comparison between national health services and private insurance

1.2.1. The Nordic region.

With all citizens in the Nordic countries being covered by the national health services and the service offerings contained therein, the 'insurable' part of the health care costs consists mainly of the non-refundable proportion of the costs to be paid by the citizens.

In the Nordic countries, approx. 82% of the total costs of health care is borne by the state, and this leaves a non-refundable share of about 18% which has to be paid by the citizens themselves. This amount represents an average of all health care services, and there are variations in the coverage available under the national systems.

In one country emphasis is on a refund of part of the costs of dental treatment, whereas in another country such costs are non-refundable. As it is a general feature of the systems in the Nordic countries that all citizens have equal access to the publicly-run hospitals free of charge, the variations between the systems are found in other (secondary) health services.

It further appears that, in a modest number of cases, citizens decide to opt out of the national health service, preferring instead to pay for the entire cost of the treatment themselves. This occurs in connection with treatment at private hospitals and clinics. Although it is possible to arrange insurance coverage of these costs, the demand for such insurance is only moderate.

As a result, the number of beds in private hospitals is very limited.

In Finland and Sweden, where the number of private hospital beds is highest, a refund is available for certain types of treatment at private hospitals and clinics. Thus the real size of the private market is smaller than indicated by the figures above.

The low figures show that citizens are generally satisfied with the public hospitals, as is also confirmed by surveys. However, citizens are far from satisfied with the long waiting lists for medical treatment.

1.2.2. Outside the Nordic region.

It is a characteristic feature of the Nordic countries that they generally use less resources on health care costs than countries outside the region.

Health care costs as a percentage of the gross domestic product (1992):

Denmark	6.5
Finland	9.4
Iceland	8.5
Norway	8.3
Sweden	7.9
USA	14.0
Canada	10.1
France	9.4
Switzerland	9.3
Germany	8.7

Source: OECD, 1994

Health care costs per capita (1992):

	DKK
Denmark	6,409
Finland	7,551
Iceland	8,055
Norway	8,093
Sweden	7,307
USA	17,993
Canada	10,686
France	9,683
Switzerland	9,833

Source: OECD, 1994

Another characteristic feature is the rare occurrence of tax-financed national health services outside the Nordic region. Other countries finance their health care systems by means of compulsory, often employer-paid, contributory sickness funds or health insurance schemes, supplemented by private insurance schemes.

This is also reflected in the size of the insurance markets outside the Nordic region, which are much larger than within it. A case in point is Germany, where 12% of the cost is borne by the state and 71.1% by contributory sickness funds, etc., which leaves a non-refundable payment for citizens of 16.9%.

This 16.9% is the market share available to private insurers, and it corresponds quite well in size with the Nordic market, cf. above under 1.2.1.. To this should be added the possibilities of these insurers to participate in the 71% of the market which is today catered to almost exclusively by contributory sickness funds. This share of the market is practically closed to private health insurers, and it will be up to the German politicians to decide the future structure. There is reason to believe that, over the next couple of years, the distinct borderlines currently existing in the market will become blurred, among other things because of the final implementation of the rules of the three EU non-life directives.

A similar pattern for the financing of health care costs is found in France: 6.2% is borne by the state, 66.2% by the contributory sickness funds, and the remaining 27.6% constitutes the non-refundable payment for citizens.

The private market in France is thus larger than in Germany, and moreover the structure of the French market is currently undergoing a change.

2. Health insurance in the Nordic countries

2.1. General remarks.

Below is an outline of the insurance types available in Denmark, Finland, Iceland, Norway, and Sweden.

2.2. Denmark.

2.2.1. Loss of earning capacity .

In the Danish market, several insurers are offering special insurance schemes in which illness is the event triggering pay-out. One such scheme involves an insurance policy arranged in a combination with a pension insurance, either on a group basis or individually.

The insurance covers loss of earning capacity due to accident or sickness.

The insurance benefit typically takes the form of regular monthly payments, whenever the insured's earning capacity has been reduced by 50% or more. Regular payments will be made for as long as the earning capacity is reduced, however only for the duration of the maximum period agreed between the parties.

In case of a lasting reduction of the earning capacity, a lump sum will be paid out.

2.2.2. Insurance for specific, major health care costs.

Within the past 6 years, a small number of insurers has offered insurance providing coverage for the cost of more expensive types of treatment of sickness, typically at private hospitals and clinics. These insurance prod-

ucts are marketed under names such as e.g. 'Helbredssikring', 'Helbredsforsikring', 'Sundhedssikring', or 'Lifeline–Helbredssikring'.

The insurances cover non-refundable costs of medical treatment and hospital treatment, cf. above under 1.2.1..

Some of the insurers offer this insurance to employers who wish to arrange for cover of selected employees, the so-called 'key employees'.

The size of this market is extremely limited, cf. above under 1.2.1..

The insurer named in 2.2.3. below offers 'Cover for surgery, both on an out-patient basis and during hospitalisation' to some of its policyholders as part of the 'insurance package'.

A novelty is the product offered by 3 insurers: an insurance for serious, life-threatening illness' inspired by the British insurance product 'Dread Disease/ Critical Illness'. The Danish product is marketed under the name 'Critical Illness' and is available on a group basis, typically under a pension insurance via the employer.

The insurance sum will be paid out if the insured is diagnosed as suffering from a specified illness, such as cardiac thrombosis, cerebral haemorrhage, cancer, or chronic kidney failure.

2.2.3. A general health insurance.

One mutual society (Sygeforsikringen 'danmark') offers only one product: a health insurance providing coverage for the non-refundable costs payable by its members for health care and the treatment of illness, including dental treatment, treatment by physicians, physiotherapy, chiropractor, spectacles, contact lenses, and drugs.

The company was founded in 1973 following the merger of a total of 13 so-called 'continuation health insurance funds'.

Its membership covers 27% of the Danish population - or about 1.4 million people - and offers them the possibility of taking out one of 4 different insurance schemes depending on the degree of coverage they need.

The insurance is designed to supplement the National Health Service.

As part of the 'insurance package' available under two of the insurance schemes offered, coverage is provided for the costs of non-refundable surgery, which occurs at private hospitals and clinics. This coverage applies to practically all types of surgery on an out-patient basis as well as to a specified list of operations at hospitals and clinics approved by the insurer.

Coverage is limited to DKK5,250 per operation on an out-patient basis, and to the same amount per day of hospitalisation.

Furthermore, maximum amounts are fixed for the coverage provided for surgery during hosptalisation, depending on the type of operation involved.

2.3. Finland.

2.3.1. Health care insurance and hospitalisation insurance .

Several insurers in the Finnish market offer sickness insurance as part of an 'insurance package', linking it to either an accident or a life insurance. The coverage thus provided is called 'sickness insurance' ('sjukförsäkring') and involves two insurance elements which may be arranged separately or together. Health care insurance ('sjukvårdförsäkring') covers non-refundable costs of treatment by a physician and other health care, drugs and medical assistance equipment.

Hospitalisation insurance ('sjukhusförsäkring') covers non-refundable costs for periods of treatment at hospital or clinic, both in Finland and abroad.

The period of coverage is limited to one year in a hospital or clinic.

2.3.2. Sickness insurance.

As a special feature a sickness insurance is available as an optional part of the householders' insurance package offered by a few insurers.

This type of insurance, called 'hemförsäkring', traditionally covers the standard contents of a home against fire, water damage and theft, and also includes coverage of legal expenses and liability insurance. As mentioned above it is possible to extend the coverage to include sickness insurance, and one company calls this package the 'Super Householders' Insurance' ('superhemförsäkring').

The element of sickness insurance covers non-refundable costs of medical treatment and drugs in the event of sickness (and accidents) worldwide. It also includes coverage for disability and death.

2.4. Iceland.

2.4.1. Loss of earning capacity.

A total of 9 companies are offering insurance for loss of earning capacity due to sickness not caused by an accident.

In the event of a temporary reduction of the earning capacity, daily benefits will be paid out on the basis of the reduction expressed as a percentage if above 50%.

In the event of a lasting loss of earning capacity, a fixed amount will be paid out the size of which depends on the extent of the lasting disability. No payment is available below 25%.

2.5. Norway.

2.5.1. Insurance for specific, major health care costs.

Two insurers have recently launched an insurance for critical illness under which a major amount becomes payable if the insured is diagnosed as suffering from a specified serious illness such as 'cardial infarction, heart failure, cancer, heart surgery, multiple sclerosis, or has gone through a transplantation of one of the inner organs....'

One insurer offers a Health Insurance which covers the cost of treatment at private hospitals and private clinics.

2.5.2. A general health insurance.

In spring 1996, the Danish mutual insurance company mentioned in 2.1.3. above (Sygeforsikringen 'danmark') launched a general health insurance product through a Norwegian subsidiary. The product is termed 'Norwegian Health Insurance' ('Norsk Helseforsikring') and acts as a supplement to the Norwegian National Health Service ('Folketryggden'). The coverage is as described under 2.1.3..

2.6. Sweden.

2.6.1. Loss of earning capacity.

In Sweden several insurers are offering insurance providing coverage for loss of earning capacity due to accident or sickness.

In the event of a reduction of minimum 25% of the earning capacity, regular benefits will be paid out at a level agreed between the parties. Apart from a short waiting period, benefits will be paid out until the insured has recovered, or until the condition turns out to be chronic.

The insurances can be arranged individually or as part of a collective wage agreement.

2.6.2. Insurance for specific, major health care costs.

One or two companies are offering a so-called Health Insurance ('Helbredsforsikring') which covers the cost of treatment at private hospitals and clinics.

2.7. Travel insurance in all countries.

In addition to the insurances mentioned above under the individual countries, travel insurance is offered in all countries which in-

cludes coverage for costs due to sickness during travelling.

Coverage is typically arranged as a supplement to the coverage for sickness available under the national health service schemes which, as you will all know, do not cover travelling for business purposes in the broad sense, i.e. also excluding coverage for combined business and/or holiday travels, travelling as part of an educational or training programme, and the like.

Moreover, the national travel insurance schemes cover only travelling in Europe and the Mediterranean countries. In Norway the national scheme does not cover repatriation.

Coverage is provided for the cost of recovering on the destination, the cost of examination/treatment by a physician or at a hospital, drugs, etc., and repatriation if necessary.

In addition to these basic elements, most travel insurances offer supplementary coverage for costs caused by delay, theft, etc.

Most of these insurances are arranged by companies, either individually or for groups of employees.

Sickness insurance can also be arranged in the form of package solutions for holidays and other travelling by private individuals, even where coverage of health care costs is provided by the national health service. The coverage offered in the packages is more refined, consisting of e.g. money for a new trip if the insured falls ill for more than half of the planned travel time, or if it becomes necessary to cancel or give up the trip because of sickness.

3. Issues to be addressed.

3.1. EU trends.

Practically all EU member states have witnessed a considerable growth in health care costs. Over the past 30 years, the proportion of the GDP accounted for by these costs has doubled, and today most European countries spend between 7 and 9% of their GDP on health care.

Health care costs are expected to continue their upwards trend in practically all countries in Europe, the reasons being that

- the number of elderly people is growing,
- the demands to service from the health sector have grown, and
- the possibilities offered by medical technology are rapidly advancing.

At the same time, there is a clear (political) recognition of the fact that it is no longer possible for the countries to finance the growing demands by means of taxation.

As a result, it is likely that the EU countries, headed by the EU Commission, will look for alternative financing sources or try to reprioritise the current ones.

Such a restructuring or reprioritisation is likely to involve a recommendation from the EU Commission through political channels to the private insurers, requesting them to be aware of their 'social responsibility'.

This might include a demand for universal coverage, irrespective of sickness already contracted, and at a premium fixed by law ('the Dutch model').

In its recommendations for discussions based on the report 'Social Protection in Europe' issued on 31 October 1995, the EU Commission says, inter alia:

'The Commission calls upon the Council to:

- acknowledge the importance of developing a framework for debate on the future of social protection in which the Member States and the Union could pool their efforts towards improving the workings of their social protection systems and make them more employment-friendly and more efficient,
- agree to associate all the players concerned at national and Community level, notably the social partners,

- take note of the Commission's intention to take stock of reactions to this invitation to debate befor the end of 1996, and to propose appropriate follow-up.'

3.2. Questions relating to the future.

3.2.1. Are the Nordic countries likely to deviate, wholly or partially, from their main principle of operating a tax-financed health sector?

If so, will this constitute a threat or a challenge to private insurers?

In what ways are the non-refundable health care costs payable by citizens expected to be insured in the future?

3.3. Answers.

The above questions were discussed by the some 130 participants at the meeting.

It clearly appeared from the discussions that politicians in the Nordic countries cannot maintain a tax-financed health sector at the level hitherto seen. However, at the same time it was recognised that a possible 'revolution' is unlikely.

The development trend is towards more private financing, as indicated by the European Commission, but it is being hampered by the fact that the service providers in the health sector (hospitals, clinics, etc.) are a public matter, too.

The private insurers should respond to this development by offering part of the increased financing requirements.

4. References

The present report was inspired by the following sources:

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