Voluntary health insurance in Europe

Country experience

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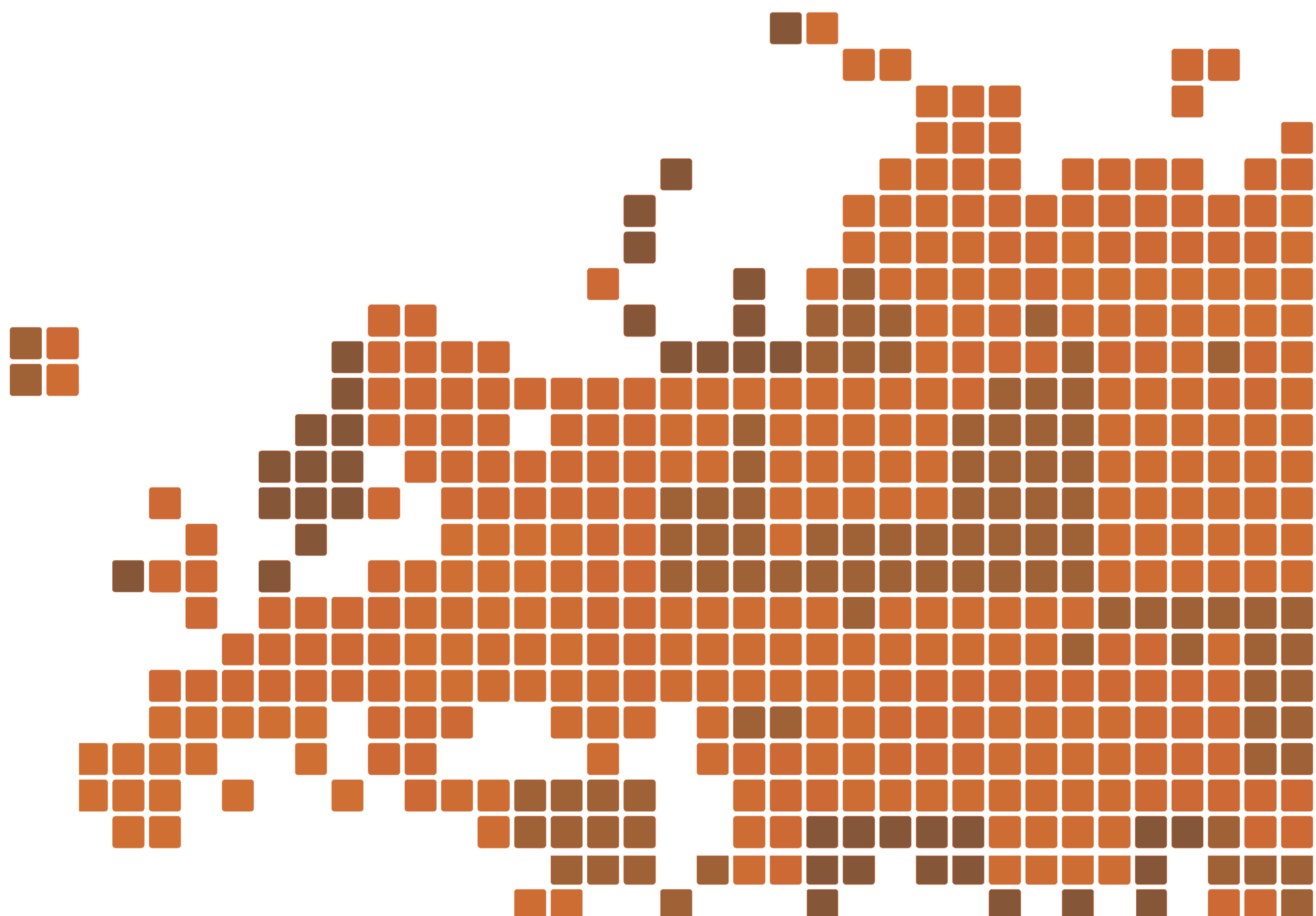
42
Observatory Studies Series



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Health system context

The health financing mix

In 2014, public spending accounted for 61.7% of total spending on health and came from general taxes and earmarked payroll taxes. OOP payments and VHI accounted for 34.9% and 3.4% of total spending on health, respectively (WHO, 2016).

Entitlement to publicly financed health care and gaps in coverage

Health is enshrined in the Greek Constitution as a social right. There are two main principles of entitlement. One is citizenship in the case of outpatient services provided by the NHS (*Ethniko Systima Ygeias* (ESY)). The other is occupational status and payment of payroll taxes in the case of services provided or financed by social insurance funds, including services provided in urban polyclinics owned by social insurance funds, inpatient care provided by ESY hospitals and services provided by private providers contracted by social insurance funds. The poor are also entitled to services and free access to ESY health centres and hospitals. Undocumented migrants are entitled only to access hospital emergency services for the treatment of life-threatening conditions and may remain there only until their health has stabilized. They also have free access to primary care offered in a small number of local authority settings and to services provided by nongovernmental organizations.

The establishment of the ESY in 1983 aimed to achieve comprehensive and universal coverage of the population

based on the principle of equity. Until recently, there were significant differences among social insurance funds regarding the scope and quality of coverage and freedom of choice; this means that this objective has been only partially met. Health care reform measures introduced by the government after 2010 aimed to confront this problem by merging all the major social insurance funds (IKA, OGA, OAEE, OPAD) into a single health insurance fund (National Organization for Health Care Provision, EOPYY). However, the adopted measures also included an increase in user charges for outpatient visits, diagnostic services in public hospitals and health centres, and medicines.

Overview of the VHI market

Market origins, aims and role

VHI mainly plays a *supplementary* role, with commercial insurers providing cover for faster access, better quality of services and increased choice. VHI is largely sold in combination with life insurance policies or private pension schemes. A major milestone took place in 1998, when two privately managed health care schemes with their own health care facilities were established. In addition, large companies started to offer group VHI contracts to their employees as employment perks.

Types of plan available

Supplementary VHI can be classified as follows (Siskou et al., 2009):

- *plans covering expenses in private hospitals*: accommodation, food, laboratory tests, medicines, surgical expenses, physicians' fees, dedicated nursing
- *plans covering expenses for private outpatient care*: reimbursement for expenses including physicians' fees, medicines and diagnostic tests; and
- *managed care programmes*: providing an integrated package of outpatient and inpatient services.

VHI plans do not cover plastic surgery, alternative medicine, routine ophthalmological services, and pre-existing conditions and chronic illnesses such as diabetes. Insurers use risk-rating in setting their premiums (risk factors include age, profession and individual medical record). People who wish to purchase VHI must provide information about their own and their family's medical history and undergo medical examinations and tests.

Why do people buy VHI?

According to the results of a survey conducted in 2003 on behalf of the Hellenic Association of Insurers (*n*=1100, aged 25–45 years, living in urban areas), VHI plans were purchased to:

- obtain access to better quality services (54% of those with VHI plans);
- avoid trouble and discomfort in relation to the way services are provided (49%);
- obtain faster access to services and jump waiting lists for publicly financed treatment (45%);
- supplement other forms of coverage (43%);
- because they did not trust social insurance (31%);
- because they were not covered by other schemes (8%); and
- to cover childbirth expenses (8%) (ICAP, 2003).

Who buys VHI?

During the 1980s, only 2% of the population was covered by VHI. This percentage had risen to 10% by 2005 and to about 11% in 2012. Most subscribers are middle to high earners and are about 45–60 years old. They are mainly employers (purchasing VHI cover for their employees), professionals, civil servants, white-collar workers and managers working for large private companies and banks and living in urban areas (Siskou et al., 2009). According to the 2003 survey, 53% of those with VHI plans were males, 43% had tertiary education and 68% belonged to the middle and upper classes.

Who sells VHI?

The overwhelming majority of insurers are non-specialist private commercial entities also engaged in other insurance activity, mainly life insurance. Most of them (87.5%) are Greek joint-stock insurers; the others are branch offices of foreign companies. The number of insurers operating in the life insurance and VHI market has fallen over time due to mergers and buyouts. Measured in premium revenue, the five biggest companies had 71% of the market share in 2010 (Hellenic Association of Insurers, 2011).

Insurer relations with providers

Private insurers can contract selectively with providers. They negotiate prices and pay providers on a FFS basis. Physicians in managed care schemes may also be paid on a salary basis. Capitation is applied mainly to outpatient diagnostic centres. However, in recent years, there is a growing trend among private insurers to engage in active purchasing and not simply to reimburse providers or subscribers, to control costs. In this context, either insurers develop their own health services or they make use of PPNs and apply financial incentives to encourage subscribers to use those providers.

Until 2010, insurers had been purchasing services from private hospitals and clinics; the law forbade the use of private beds in public hospitals. The situation changed in 2011, when new legislation allowed private insurers to use up to 10% of public hospital beds with the aim of giving public hospitals an additional source of income.

Public policy towards VHI

Table 14.1 summarizes the relevant legislation pertaining to the VHI market in Greece. The main changes in public policy in the last 20 years include the lowering of tax incentives for people to take up VHI in 1997, the abolition of these tax incentives in 2013 and the move to allow private insurers to use beds in public hospitals in 2011.

Debates and challenges

Some experts believe that the expansion of the VHI market will lower the public sector's contribution to health care financing and further increase private spending. Others see the role of VHI as purely supplementary and thus not affecting the public–private mix. Politicians have not generally supported a stronger role for VHI, although the 2011 reform allowing private insurers to use 10% of public hospital beds may indicate a change in direction.

In fully covering new technologies (in contrast to social insurance funds), VHI may have supported the development of the private diagnostic services and hospital market. While this has been beneficial in assuring faster access to new technologies, it may also have induced overuse of services and increased health care costs.

Table 14.1 *Development and regulation of the VHI market in Greece, 1970–2013*

General legislation	
1970	Legislative Decree 400/1970: Establishment and functioning of private insurance undertakings
2011	Ministerial Decision Y4a/oik.93320: NHS hospitals are allowed to conclude contracts with private insurance companies
Regulation of technical reserves of insurers	
2001	Ministerial Decisions K3-4382/7-6-2001 and K3-9124/30-11-2001
Regulation of the mediation process in private insurance contracts	
1985	Law 1569/1985
2006	Presidential Decree 190/2006
2007	Ministerial Decision K3-8010/8-8-2007
2011	Decision Number 2647/7-11/2011 of the Bank of Greece Board of Directors
Underwriting and duration of private insurance contracts	
1997	Law 2496/1997: Tax incentives for purchasing VHI are lowered
2013	Law 4110/2013: Tax incentives for purchasing VHI are abolished
Supervision of private insurance	
2004	Law 3229/2004
2010	Law 3867/2010: Supervision of insurers is transferred to the Bank of Greece
Adaptation of the Greek legal framework to EU Directives	
1985	Presidential Decree 118/1985 adopted Directives 73/239/EEC, 73/240/EEC, 76/580/EEC, 79/267/EEC
1996	Presidential Decree 252/1996 adopted Directives 88/357/EEC, 90/618/EEC, 90/619/EEC, 92/49/EEC, 92/96/EEC
2005	Presidential Decree 23/2005 adopts Directive 2002/83/EC
2009	Law 3769/2009: The principle of equal treatment between men and women in the access to and supply of goods and services is implemented

Source: Author.

VHI offers people an alternative to OOP payments and is thought to have helped improve transparency by formalizing informal payments and lowering waiting times (Economou, 2010). In recent years, it may also have allowed some costs to be shifted from social insurance funds to private health insurers, especially where people have double coverage. Social insurance funds contract private hospitals to provide their subscribers with faster access to elective surgery, but due to delays in payment from EOPYY and growing scrutiny of private hospital expenditure by EOPYY – leading to legal actions – private hospitals and their patients prefer to pay through VHI.

The effects of the 2011 change are hard to evaluate since there are no studies on the topic and the health sector is in a situation of continuous change due to the financial and economic crisis. On the one hand, it seems unlikely that patients with VHI would opt to be treated in public hospitals, given the problems the latter face because of austerity measures. On the other hand, recent cuts in hospital budgets may motivate hospital managers to attract VHI subscribers, for example, by offering better quality of accommodation if they pay through VHI. This may result in a two-tier system within the public delivery system.

There is much discussion in Greece about the optimal level and content of VHI regulation, and the cost–effectiveness of such policies. Data on the pros and cons of VHI are still being gathered and it is thus difficult to provide definitive policy conclusions. For example, there are no scientific studies to document whether VHI provides a stimulus for better quality or higher efficiency. The crisis and policy responses to the crisis – increased user charges and other OOP payments, cuts to public hospital budgets and high long-term unemployment leading to the loss of entitlement to social insurance fund coverage – have negatively affected access to health care and, at the same time, exacerbated the fact that only the better off can afford VHI. In these circumstances, mechanisms may be needed to ensure broader access to VHI coverage and to ensure VHI does not undermine the social character of the health system.

The future of VHI

VHI coverage remains relatively low in Greece due to economic, social and cultural factors – downward pressure on household incomes, high unemployment, full coverage provided by the social insurance system, people's preference to pay a doctor or hospital directly when the need arises – and factors concerning the VHI market itself, such as low organizational capacity, cream-skimming and the absence of insurance products meeting consumer requirements – for example, increased market concentration does not seem to have led to efficiency gains being passed on to consumers in the form of lower premiums (Siskou et al., 2009).

A significant determinant of future VHI development is the evolution of the publicly financed health system and the effects of the reforms introduced since 2010. Many of the measures implemented (for example, increased user charges) limit social insurance coverage and raise serious questions about the accessibility of publicly financed health services (Economou, 2012). These measures can be seen as a stimulus for the growth of VHI. However, austerity measures have reduced disposable incomes and the ability of citizens to take up VHI. VHI market growth may therefore depend on the willingness and capacity of private insurers to introduce plans that cover the needs of consumers at reasonable cost.

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