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# Voluntary Health Insurance in Development

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# Overview

- What are we talking about?
- What are we trying to do?
- How does it work?
- What do we know?
- What do I think?
- What do we need to know or agree?

What are we talking about?

# Voluntary or Private?

Voluntary – not mandated by government

Private – from an economic, ownership or equity perspective

# Context

The role and performance of voluntary health insurance is influenced by: the nature of government mandated health financing, the nature (and market structure) of available health services provision and the roles it is permitted to play.

# Financial Services

- Risk pooling
- Information
- Store of value
- Divisibility?

See Carmichael, M. and Pomerleano, J.  
(2002)

# Roles

- Primary or additional
- If primary, principal or substitutional
- If additional, duplicate, supplementary or complementary

See OECD (2004) Private Health Insurance  
in OECD Countries

ISBN 9264015639

# Scope

- Individual, household or group
- High cost, low frequency, health services
- Most cost effective health services
- Benefits in kind or cash including income protection during illness
- Care services for elderly, chronically sick or disabled?
- Short term or long term insurance?

What are we trying to do?

# Potential benefits

- Financial protection
  - Reduce financial shocks of illness to prevent poverty
- Health Gain
  - Improve health services and outcomes
- Risk sharing and wealth transfer
  - Share uncertain risks
  - Share unequal certain risks for indirect benefit
  - Share unequal certain risks out of altruism
- Store of value

# What improvements to health services are most important?

- Increased access – for some or all
- Higher technical quality through third party purchasing
- Higher efficiency – lower unit costs or better value for money
- More or better capital formation
- More choice
- Greater transparency

How does it work?

Health insurance is all about  
“managing risks”

# What risks?

- Income risks
- Expenditure risks
- Asset risks
- Liability risks

# Or...

- Contextual risks
- Policy and regulatory risks
- Operational risks – Bowie eleven key operation competencies
- Commercial risks – Porter five forces or risks from market structures and behaviors
- Asset risks – Cash, investments and other

# Bowie 11 competencies

- Develop products
- Price products
- Sell products
- Collect income
- Process claims
- Manage risks
- Manage external relations
- Provide info and service
- Leverage ICT
- Manage (operationally)
- Govern (strategically)

Contextual and policy	Income risk	Expenditure risk	Asset risk	Liability risk
Poor economy – low and unstable growth	↑		↑	
High and unstable burden of disease		↑		↑
Demography – dependent population increasing	↑			
Unclear or unstable public policy context and allowed roles	↑	↑		
Arbitrary or heavy regulation		↑		↑

Product	Income risk	Expenditure risk	Asset risk	Liability risk
Low control over composition of benefit package	↑	↑	↑	↑
Low control over price of benefit package and/or low loading	↑		↑	
Low economies of scope – increase in marketing costs, decrease in risk diversification		↑		

Operation	Income risk	Expenditure risk	Asset risk	Liability risk
Low pool size	↑			
Low control over utilization		↑		↑
Low control over provider payments		↑		↑
High diversity of preferences	↑			
Low density of provision	↑			
High density of provision		↑		↑
Degree of own horizontal Integration	↓			
Degree of own vertical integration		↓		

Market structure	Income risk	Expenditure risk	Asset risk	Liability risk
Low concentration of supply	↑			
Low concentration of provision		↑		↑
Barriers to exit		↑	↑	↑
Threat of new entrants	↑			
Threat of substitute products	↑			

Behavior	Income risk	Expenditure risk	Asset risk	Liability risk
Abuse and fraud	↑	↑	↑	↑
Moral hazard	↑	↑	↑	↑
Adverse selection	↑	↑	↑	↑
Bargaining power – suppliers		↑		
Bargaining power – buyers	↑			

What do we know?

# Know

- Shortages of high quality health services provision and human resources in many LMIC's
- Know that economic and epidemiological context less stable and secure in many LMIC's
- VHI contributions less progressive than mandated contributions: but by how much in LMIC's?

# Kakwani Indices – De Graeve and Van Outri (2003)

Kakwani Indices of the Financing Sources of Health Care in Selected European Countries<sup>4</sup>

	<i>Public Finance</i>				<i>Private Finance</i>			<i>Total</i>
	<i>Direct Taxes</i>	<i>Indirect Taxes</i>	<i>Social Insur.</i>	<i>Total Public</i>	<i>Private Insur.</i>	<i>Out-of-Pocket</i>	<i>Total Private</i>	
B (1997)	0.180	-0.180	0.102	0.061	-0.210	-0.260	-0.250	-0.000
DK (1987)	0.062	-0.113		0.037	0.031	-0.265	-0.236	-0.005
FIN (1994)	0.087	-0.106	0.123	0.066	0.000	-0.198	-0.198	0.050
F (1989)			0.111	0.111	-0.196	-0.340	-0.305	0.001
G (1989)	0.249	-0.092	-0.098	-0.053	0.122	-0.096	-0.007	-0.045
IRL (1987)	0.267	n.a.	0.126	n.a.	-0.021	-0.147	-0.096	n.a.
I (1991)	0.155	-0.114	0.107	0.071	0.171	-0.081	-0.061	0.041
NL (1999)	0.281	-0.091	-0.094	-0.060	0.073	-0.074	0.015	-0.035
P (1990)	0.218	-0.035	0.185	0.072	0.137	-0.242	-0.228	-0.045
E (1990)	0.213	-0.153	0.062	0.051	-0.022	-0.180	-0.163	0.000
S (1990)	0.053	-0.083	0.010	0.010		-0.240	-0.240	-0.016
CH (1992)	0.206	-0.072	0.055	0.139	-0.255	-0.362	-0.295	-0.140
UK (1993)	0.284	-0.152	0.187	0.079	0.077	-0.229	-0.095	0.051
US (1987)	0.210	-0.067	0.018	0.106	-0.237	-0.387	-0.317	-0.130

# Know

- Latent demand in LMIC's— high OOP
- Shortage of supply in LMIC's
- Supply concentrated in HIC's
- Horizontal and vertical integration strategies increasingly prevalent in HIC's
- Margins comparatively low, even in HIC's
- Some evidence re positive impact of VHI in primary care .e.g. Hadley (2002) re USA

What do I think?

# Think

- If to develop VHI in LMIC's first objective must be to make schemes financially secure – large scale, prudential regulation, horizontal integration, concentration, financial and actuarial expertise

# Think

- Risk rating of premiums would maximize demand, reduce cream skimming, adverse selection and moral hazard – at the cost of reducing access for the less well off – thus VHI should prevent but not ameliorate poverty

# Think

- Premium subsidy by government for high risk and/or less well off should be preferred method for increasing access to health services through VHI, in preference to tax relief or risk equalization – the former is regressive, the latter will reduce demand for VHI

# Think

- Success in growing VHI market requires both commitment and competence within government:
  - to develop policy for an evolving role for VHI as scope for mandated financing increases
  - To develop regulatory framework that encourages increasing focus on health gain as economy and market matures and possibly expansion in scope

# Think

- Voluntary health insurance is not about “privatization” – it can be and is supplied by government agencies, not for profit and for profit organizations. The underlying trend however in HIC’s may be towards privatization

# Fads & fashions



create unstable markets, qed Amsterdam 1636

What do we need to know or  
agree?

# Need to know

- Which markets to target? Ensor (1999)
- How to develop such policy and regulatory competencies in target governments?
- How to assess risks in target markets?
- How to evaluate progress, constraints and opportunity costs in target markets?

# Can we agree?

- VHI should not be proposed as a primary funding source where the political will and economic capability exists to establish and maintain a universal and equitable system of mandated health financing
- VHI in duplicate, supplementary and complementary roles can however be promoted even where such universal systems exist.

# Can we agree?

- Scope of risk sharing and solidarity in VHI is ultimately a set of sovereign political decisions within each country
- “The perfect can be the enemy of the good”



# References

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