

# **Private Voluntary Health Insurance in Low-Income Countries.**

## **Market Outcomes, Regulation, and Recommendations for Policy**

Presentation prepared for the

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by

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# Outline

1. Market equilibria in voluntary insurance markets (P. Zweifel)
2. The likely structure and intensity of regulation of health insurance (P. Zweifel)
3. Recommendations for policy (P. Zweifel)
4. Subsidized and regulated insurance (M. Pauly)
5. Ideal and alternative public-private combinations (M. Pauly)
6. Conclusion (M. Pauly)

# 1. Market equilibria in voluntary insurance markets I

- Given: substantial out-of-pocket payments for medical care in LDCs
  - Replace those stochastic payments by a **regular flow** of premiums
  - What are the other conditions that must hold for a voluntary health insurance market to emerge?

# 1. Market equilibria in voluntary insurance markets II

- Demand-side conditions affordability = maximum possible out-of-pocket payment
- Poor households will need a subsidy to enhance their ability to pay
- Supply-side conditions: Premium  $>$  expected expenditure of insured individual
  - Poor people with low future expenditure must be able to pay low premiums (**minimal adverse selection**)
  - Poor people's demand for care must not increase to that of risk people under the influence of insurance (**minimal moral hazard**)

# 1. Market equilibria in voluntary insurance markets III

- Supply-side conditions: Existence of property rights, contract law, and financial infrastructure to support insurance policies
  - Permit insurers to adjust premiums when claims are unusually high
  - Permit less-than-guaranteed insurance; this is still **better than no insurance**

## 2. The likely structure and intensity of regulation of health insurance I

- Even in market economies, (health) insurance is one of the most regulated industries
- Why is this so both in democracies and authoritarian regimes?
- Explanation crucial to avoid recommendations that are in strong contradiction to **governments' objectives** (Kumaranayate, 1998)

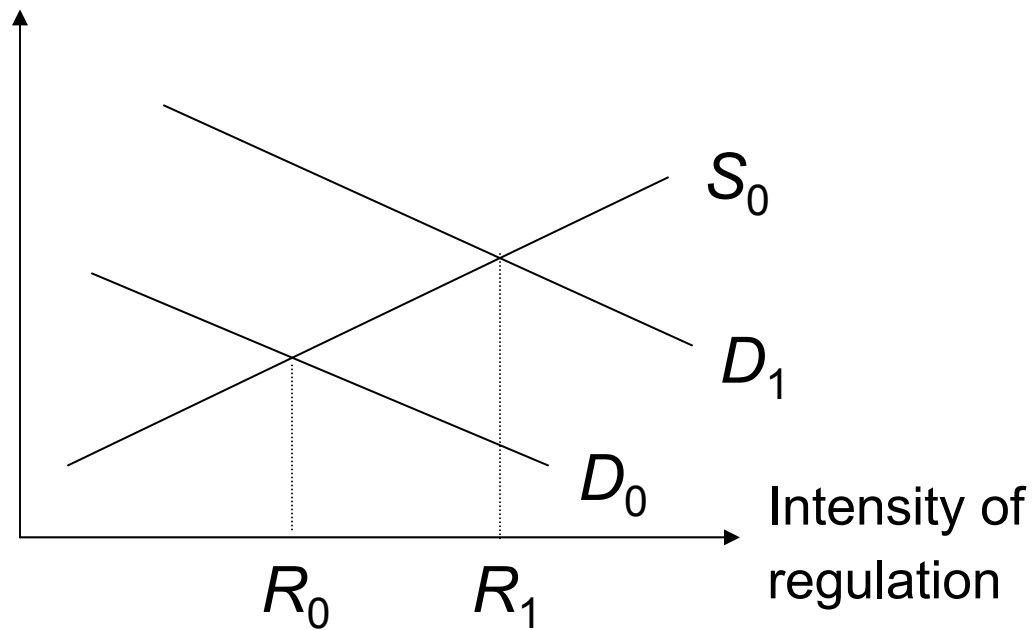
## 2. The likely structure and intensity of regulation of health insurance II

- Theoretical basis laid by Peltzman (1976)
- 3 explanations of regulation:
  - (1) **Public interest**
  - (2) **Capture** (of regulator, by industry to be regulated)
  - (3) **Supply** (by government) **and demand** for regulation (by parts of consumers and industry)

## 2. The likely structure and intensity of regulation of health insurance III

Marginal cost of regulation

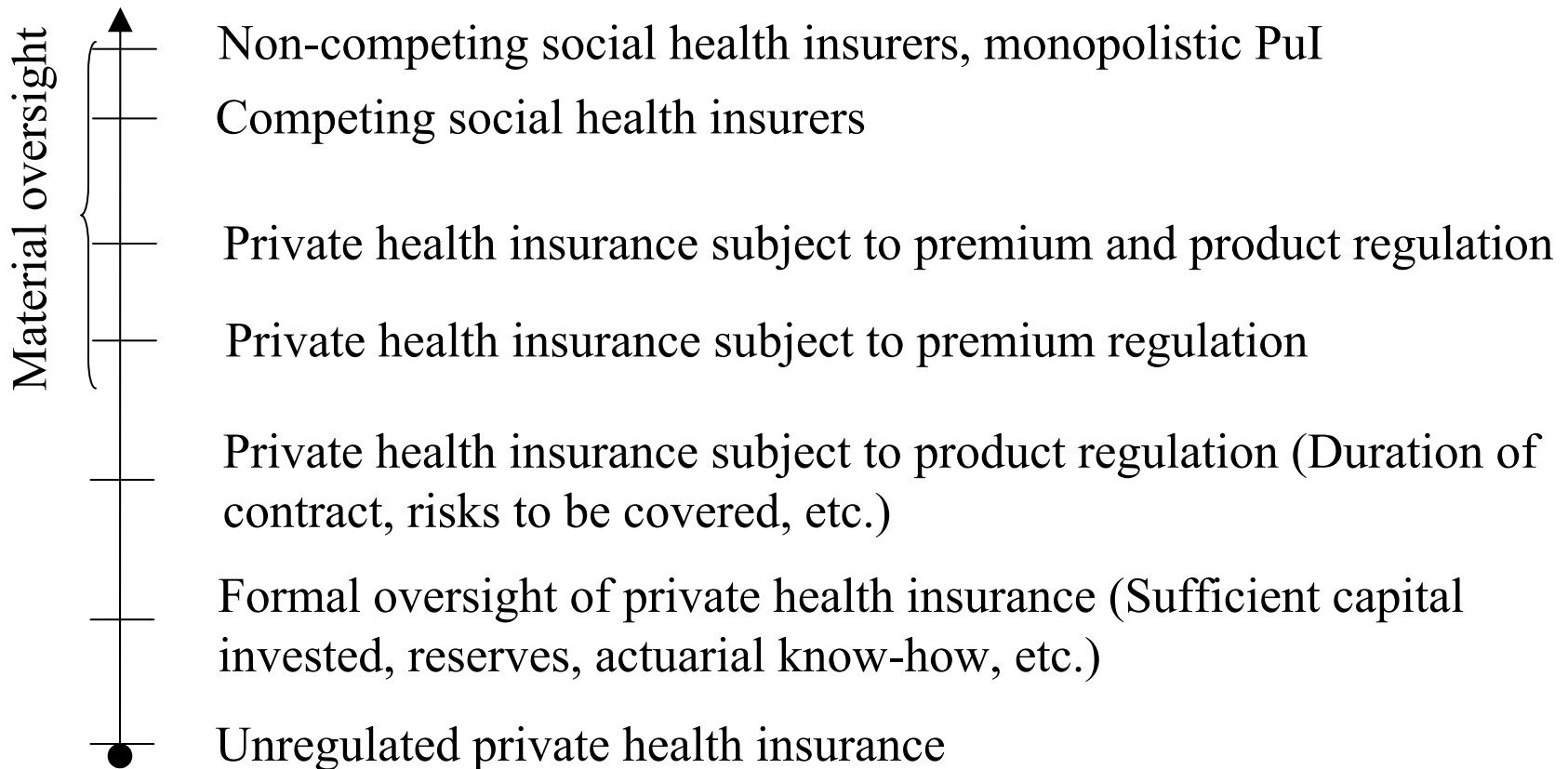
Marginal benefit of regulation



## 2. The likely structure and intensity of regulation of health insurance IV

- Depending on where the demand function is located in a market, the predicted outcome is a high intensity of regulation
- For example, **crises** (such as insolvencies of health insurers) is expected to shift **demand** out
- Conversely, governments **under close control** of citizens face a high (marginal) cost of providing regulation, causing the **supply curve to run close** to the origin

## 2. The likely structure and intensity of regulation of health insurance V



## **2. The likely structure and intensity of regulation of health insurance VI**

**Hypotheses concerning the regulation of health insurance:**

**H1: Crises cause to shift demand out**

- FDA's-reaction to Thalidomid disaster of 1960
- Argentina's Obras Sociales had to have reinsurance in the later 1990s (Jack, 2000)

## **2. The likely structure and intensity of regulation of health insurance VII**

### **H2: Given a high intensity of regulations, health insurance invest heavily in lobbying**

- US tobacco industry increased lobbying expenditure from \$ 38 to 67 mn. from 1967 to 1968
- Merger of Health Insurance Association of America and American Association of Health Plans in response to pending Medicare legislation

## **2. The likely structure and intensity of regulation of health insurance VIII**

### **H3: Within the demand side, producer not consumer groups are decisive**

- AMA – but not its Canadian counterpart – successful in blocking the creation of national health insurance in the 1940s
- Conversely, AMA successful in having certain benefits included in Medicare benefits (Folland et al., 2001)
- South African Fedsure started to influence legislation in the later 1990s

## **2. The likely structure and intensity of regulation of health insurance IX**

**H4: Highly regulated markets are characterized by small insurers – provided multinationals are kept out**

- 370 commercial funds in Germany for a potential enrolment of 80 mn.
- 1,000 numbers of AAHP in the United States (2.7x) for 270 mn. potential enrolment (3.4x)

## **2. The likely structure and intensity of regulation of health insurance X**

### **H5: Highly regulated markets have larger bureaucracies**

- High marginal costs imply high total cost of regulation
- China and (formerly) Ghana have bureaucracy indices of 6 and 7.67
- Argentina and South Africa, 3.34 and 3 (Business International)

## **2. The likely structure and intensity of regulation of health insurance XI**

**H6: Highly regulated health insurance markets are characterized by a high per-member contribution for lobbying effort**

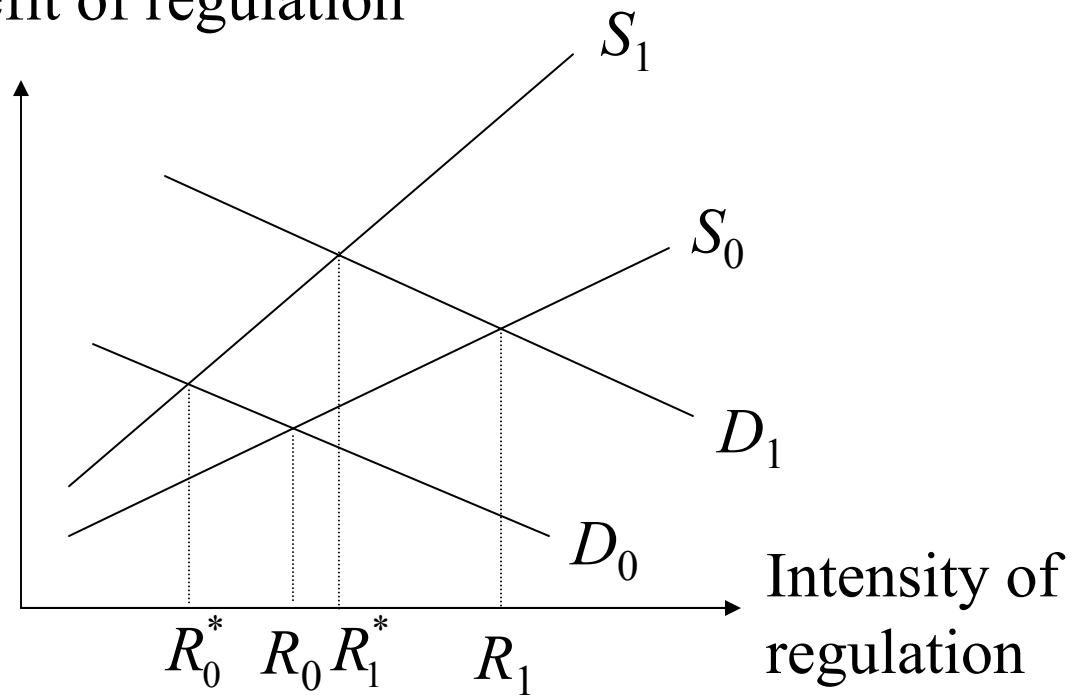
- With comprehensive regulation, amounts of assets affected are high
- This creates an interest in influencing regulation by the owners of these assets

### 3. Recommendations for policy I

- From the point of view of suppliers and demanders of regulation, the market outcome is an optimum
- But regulation of health insurance typically causes **negative externalities**: higher barriers to entry, increased efficiency costs to finance regulation, less catering to consumer preferences
- Perfect government would have to take these marginal social costs of supplying regulation into account

### 3. Recommendations for policy II

Marginal cost of regulation  
Marginal benefit of regulation



### 3. Recommendations for policy III

- In the initial situation, regulatory intensity should optimally be  $R_0^* < R_0$
- $R_1^*$  could be attained by the government levying a **Pigou internalizing tax on itself (!)**
- **Note:** Any increase of demand for regulation from  $D_0$  to  $D_1$  aggravates the problem, since  $R_1^{**} \ll R_1$

### 3. Recommendations for policy IV

How to limit **consumers' demand** for regulation

- (1) Keep probability of insolvency low (guarantee funds protect insurers as much as the insured)
- (2) Mitigate consequences of insolvency (risk-based capital requirements constitutes a barrier to entry)
- (3) Rely on (international) reinsurance?

### 3. Recommendations for policy V

- The threat of insolvency is particularly imminent in the **case of CBI**
- (1) Lower the probability of occurrence by improving their actuarial know-how
- (2) Mitigate the consequences: Difficult because
  - in-kind payments would have to be stored
  - no local competitors available to take on the business of a failing CBI
  - mutual reinsurance costly (Dror, 2000)

### 3. Recommendations for policy VI

How to limit **insurers' demand** for regulation?

- (1) Keep benefits of regulation low by avoiding barriers to entry (difficult in the case of CBI)
- (2) Keep the cost of organizing a pressure group high by avoiding material oversight (cost of organization high for CBI to begin with)

### 3. Recommendations for policy VII

How to make the **supply of regulation** costly to government?

- (1) Let the budgetary cost of regulation be high!
  - **Note:** One way to lower cost is to deal with few rather than many insurers
- (2) Make administration bear more of the externality caused
  - International investors can threaten to pull out, thus decreasing the incumbent government's chance to remain in power

### **3. Recommendations for policy VIII**

- Improving access to health insurance through regulation? (Mark Pauly)