Health Policy xxx (2018) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Development of voluntary private health insurance in Nordic countries – An exploratory study on country-specific contextual factors☆

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ARTICLE INFO

Article history:
Received 28 April 2017
Received in revised form 5 February 2018
Accepted 9 March 2018

Keywords:
Private health insurance
Healthcare
Access to care
Primary care
Specialized care
Nordic countries

ABSTRACT

The Nordic countries are healthcare systems with tax-based financing and ambitions for universal access to comprehensive services. This implies that distribution of healthcare resources should be based on individual needs, not on the ability to pay. Despite this ideological orientation, significant expansion in voluntary private health insurance (VPHI) contracts has occurred in recent decades. The development and role of VPHIs are different across the Nordic countries. Complementary VPHI plays a significant role in Denmark and in Finland. Supplementary VPHI is prominent in Norway and Sweden. The aim of this paper is to explore drivers behind the developments of the VPHI markets in the Nordic countries. We analyze the developments in terms of the following aspects: the performance of the statutory system (real or perceived), lack of coverage in certain areas of healthcare, governmental interventions or inability to reform the system, policy trends and the general socio-cultural environment, and policy responses to voting behavior or lobbying by certain interest groups. It seems that the early developments in VPHI markets have been an answer to the gaps in the national health systems created by institutional contexts, political decisions, and cultural interpretations on the functioning of the system. However, once the market is created it introduces new dynamics that have less to do with gaps and inflexibilities and more with cultural factors.

1. Introduction

The Nordic welfare state ethos starts with the idea that distribution of healthcare resources should be based on individual needs, not on the ability to pay. Despite this, there has been a significant expansion of voluntary private health insurance (VPHI) contracts during the recent decade (Table 1). In terms of healthcare financing, the contribution of VPHI is small [2,5] but the number of people with VPHIs has increased rapidly. This expansion is challenging because VPHI is primarily available to individuals with higher socioeconomic status and better health [2,6].

The market developments for VPHIs in Denmark, Finland, Norway and Sweden are different [1]. VPHI schemes cover out-of-pocket (OOP) payments for services only partly financed by the public system (*complementary VPHI*), or they provide preferential access to care available in the public sector, but with waiting time (*supplementary VPHI*) [2]. Supplementary VPHI is the prominent insurance type in Norway and Sweden. In Finland and Denmark both types of VPHIs exist (Table 1).

In this paper we map the VPHI markets in the Nordic countries and discuss why VPHI market has developed differently in the systems that share the similar welfare state ethos. We describe and analyze factors which are related to political and institutional contexts that influence the type and scope of VPHI markets. To do this we use a theoretical framework based on the literature.

☆ Open Access for this article is made possible by a collaboration between Health Policy and The European Observatory on Health Systems and Policies.

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https://doi.org/10.1016/j.healthpol.2018.03.008

Table 1
An overview of the main characteristics of the vphi markets [1–4].

	Denmark[a]	Finland[b]	Norway[c]	Sweden[d]
Population Covered				
2006 (or nearest available year)	Supplementary 10% (n = 565 00) Complementary "danmark" 37% (n = 2 000 000)	15% (n = 819 000), year 2009	2% (n = 84 00)	2% (n = 218 000)
2016 (or nearest available year)	Supplementary 32% (n = 1 856 072) Complementary "danmark" 42% (n = 2 411 000)	21% (n = 1 157 000)	9% (n = 482 000)	6% (n = 611 000)
VPHI share of total spending on health				
2005 (or nearest available year)	2%	≤1%	≤1%	≤1%
2015 (or nearest available year)	2%	3%	≤1%	1%
Type and scope of coverage				
Complementary	Covers co-payments for pharmaceuticals, adult dental services, glasses and contact lenses, physiotherapy.	Covers co-payments in the SI reimbursed system, also co-payments in the municipal primary care centers and public hospitals. Co-payments on prescription medicines.	n/s	n/s
Supplementary	Faster access to specialists in services that are also available in the public system. Covers expenses for examinations and treatments at private hospitals, preventive services by physiotherapists and chiropractors, and general health examinations.	VPHIs often function as a duplicate to the municipal system. Offers better access to care and a direct access to a specialist; allows the choice of doctor and provider organization	Provides guaranteed access to a specialist/elective surgery within a specified period. Typically covers diagnostics, examinations, specialist consultations and treatments, hospitalizations and elective surgeries as well as rehabilitation, physiotherapy and psychological treatment.	Typically covers healthcare advice, care planning and coordination and specialist care with a focus on elective surgeries and rehabilitation, and preventive care.
TYPE OF POLICIES	90% are group policies purchased by employers	Majority of policies are individual policies, around 15% are group policies	90% are group policies purchased by employers	90% are group policies of which two thirds purchased by employers

[a] Source: Forsikring & Pension, Sygeforsikring "danmark".
[b] Source: Finance Finland.
[c] Source: Finans Norge.
[d] Source: Svensk Försäkring.

2. What drives the market development of VPHIs?

The literature provides different explanations for what drives the development of VPHI markets. First, the poor performance of the statutory system (real or perceived) or lack of coverage in certain areas of healthcare can explain the developments [7]. Costa-Font and Jofre-Bonet [8] argue that the growth of the VPHI market in Europe has been driven by factors, such as the inability of the health systems to satisfy heterogeneous preferences and differences in certain quality dimensions. Waiting times, demands for choice, and perceptions of inadequate quality or capacity of public systems have been found to be important drivers in some European countries [9]. Also the general dissatisfaction with the public health care system has been found to be associated with the probability of being covered by VPHI [10]. The evidence also suggests that the perception of private health care being of higher quality can contribute to the greater demand for VPHI [11]. The effect of the performance of the statutory systems is less pronounced for employment-based VPHIs [10] and employment-based health insurances have been suggested to be less affected by waiting times in the public sector [12,13].

High co-payments in the public health system is another important reason for purchasing (complementary) VPHIs. Co-payments increase the price of services for patients and reduce the demand for (price-elastic) services [14]. From an individual's perspective, complementary VPHIs provide protection against financial risks and improve access to services by increasing their affordability. However, the view of OOP spending as the main driver of VPHI has been challenged. For instance Sagan and Thomson [2] state that gaps in the publicly financed health system are a prerequisite for VPHI, but they may not be sufficient for a VPHI market to develop and grow.

Secondly, governmental interventions may explain the growth of VPHI market. Governmental interventions may arise because of ideological standings or willingness to fill the gaps in a public system that have been created by institutional inertia and path dependency [15,16]. Practical examples of government involvement are the interpretation and implementation of regulation, tax incentives, exclusion of services from public package, underresourcing of services, and raising of user fees. It has been argued that one of the main benefits of VPHIs is that they may shift demand from the public sector to the private sector [17]. The overall evidence of this view is, however, inconclusive (e.g., [18].

Governments may also want the VPHI market to grow because it can lead to a more dynamic and competitive market with private providers pushing the public providers toward improved efficiency and better quality [9]. Also the relative benefits of maintaining the current institutional setting can be perceived as being more beneficial than a large reform, because the risk from the costs of switching to a new system will rise over time [16]. Filling the gaps in the current system with VPHI may be a tempting option for those governments not willing or able to reform the system.

Third, policy trends and the socio-cultural environment shape the ways policies develop and how individuals position themselves toward health systems [56]. The increasing policy emphasis on choice, individualism, and consumerism in healthcare [19–21] have created fruitful soil for the growth of VPHI. It has been suggested

Please cite this article in press as: Tynkkynen L-K, et al. Development of voluntary private health insurance in Nordic countries – An exploratory study on country-specific contextual factors. Health Policy (2018), https://doi.org/10.1016/j.healthpol.2018.03.008