HEALTH FINANCING POLICY BRIEF NO 5

VOLUNTARY HEALTH INSURANCE: POTENTIALS AND LIMITS IN MOVING TOWARDS UHC

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Key Messages

- Voluntary health insurance (VHI) as a mechanism to finance health systems plays a marginal role in most countries, with only 41 countries having VHI expenditure above 5% of total health expenditure (THE).
- Although modest, VHI as a share of THE is growing overall in many countries. One key factor for VHI growth in low- and middle-income countries is the emergence of a middle class comprised of many people who are able and willing to pay VHI premiums, as they seek to access what they perceive to be better quality or more convenient care in the private sector.
- Depending on the specific role of VHI in a health system, it could pose opportunities and risks for equitable progress towards universal health coverage (UHC).
- VHI often disproportionately benefits people of higher incomes with lower health risks. Beyond direct consequences of VHI on equity in access, there are other potential effects of serious concern: where governments pay the employer share of premiums for civil servants affiliated to a voluntary health insurance system or where tax credits are granted in relation to VHI premium payments, public spending becomes more pro-rich.
- VHI can negatively affect health system performance, in particular equity in service use, by creating or reinforcing a two-class system. In contexts of health worker shortage, high VHI payments to private sector providers can lead to exit of staff from the public sector and put increasing pressure on salaries across the system.
- There is need to pay attention to the potential as well as the likely risks of VHI expansion. Health financing strategies need to be clear about and regulate the role given to VHI in order to create complementarity between VHI and publicly funded pools and to progress equitably towards UHC.
- In sum, it is difficult to attain universal health coverage by relying primarily on voluntary insurance scheme contributions: "Compulsion, with subsidization for the poor, is a necessary condition for universality".

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1 WHAT IS VOLUNTARY HEALTH INSURANCE (VHI)?

The purpose of this brief is to explore the potentials and limits of voluntary health insurance (VHI) for progress towards universal health coverage (UHC), with particular attention to low- and middle-income countries. VHI can be defined as a prepaid pooling arrangement that receives *voluntary* funds and pools them *separately*. The decision to obtain such coverage is not required by government but is rather a decision made by individuals, households, or private companies (Jowett and Kutzin 2015). As such, VHI differs from a compulsory insurance mechanism (social health insurance is the most common form) under which membership and payment of contributions are made obligatory by the government (by law) for some or all of the population (OECD/Eurostat/WHO 2011).

Because it is voluntary does not mean that VHI is always privately run. It can be provided by various types of orgnisations, including both commercial and not-for-profit health insurance companies, enterprises that run their own insurance arrangements for their employees, non-governmental organisations or other local entities that operate *community-based health insurance* (see Mathauer et al. 2017 for a specific policy brief on CBHI), and even government agencies.

In some cases, however, governments do provide funding for VHI, either directly (e.g. private medical scheme coverage as a negotiated employee benefit for civil servants, as in South Africa) or indirectly by granting tax allowances[1] (deductions or tax credits) for the purchase of VHI. Thus, VHI can be funded from both public and private sources.

VHI can take on different *roles* in health financing, and in particular in relation to the *statutory system* (i.e. the "main" publicly funded system for the population). As described in Table 1, these roles can be defined as substitutive, complementary and supplementary.

1 For example, the amount paid for the health insurance premium can be excluded from taxable income. This lowers the employee's tax bill.

Table 1: Key features of the different VHI roles

VHI role	Key features
Substitutive	Covers population groups that are excluded from publicly financed coverage or allowed to take their mandatory contributions out of the compulsory insurance system ("opting out").
Complementary (user charges)	Pays for some of the costs for services that are covered by the statutory system (typically patient co-payments).
Complementary (services)	Pays for services that are explicitly excluded from the statutory system's package of benefits.
Supplementary	Provides enhanced access (e.g. jumping queues/waiting lines), a higher level of inpatient amenities or greater user choice of providers in comparison to those covered by the statutory system.

Source: adapted from Thomson (2010)

2 WHY IS IT IMPORTANT TO REFLECT ON THE CONTRIBUTION OF VHI TO UHC?

Depending on the context and role that VHI plays in the health system, it may contribute to or detract from progress towards UHC. Thus, explicit attention to it within overall health financing arrangements and the wider health system is an important consideration for public policy. However, such attention is often not adequately reflected and specified in national health sector plans and health financing strategies.

There is no global overview on VHI population coverage rates, but available evidence shows that population coverage via VHI, particularly in its substitutive role, is generally below 10% in low- and middle-income countries (LMICs), with the exception of a few countries, for example South Africa and Lebanon(Preker et al., 2010). There are very few high-income countries (HICs) that have substitutive VHI, and even fewer countries with population coverage via substitutive VHI above 10%. A detailed account is available on 34 European countries that shows that supplementary or complementary VHI is more widespread. The respective population coverage rates vary, but number of countries in which VHI accounts for at least 5% of total health expenditure is growing among LMIC. Across regions, VHI% is highest in Latin American and Southern African countries (ibid.). The specific pattern of very high VHI expenditure shares in South Africa, Botswana and Namibia results from a historical legacy of segregation and inequalities. For example in South Africa, the overall health financing architecture has not changed since the transition to democratic rule, with over 40% of THE being spent via VHI (WHO 2016), the highest share of any country in the world. However, VHI covers only 16% of the population (CMS 2016), and as a result, strongly skews the available system resources to those with such coverage. In such a situation, VHI is a public policy concern because of the spillover effects for the wider system, for instance in terms of distribution of health workers, rising prices and overall costs.

Another critical point is that VHI% is relatively higher in countries with larger income inequalities. VHI is usually demanded