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

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A B S T R A C T

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.

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

<table>
<thead>
<tr>
<th>Population Covered</th>
<th>Denmark</th>
<th>Finland</th>
<th>Norway</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006 (or nearest available year)</td>
<td>Supplementary 10% (n = 565 000)</td>
<td>15% (n = 819 000), year 2009</td>
<td>2% (n = 84 000)</td>
<td>2% (n = 218 000)</td>
</tr>
<tr>
<td></td>
<td>Complementary “danmark” 37% (n = 2 000 000)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016 (or nearest available year)</td>
<td>Supplementary 32% (n = 1 856 072)</td>
<td>21% (n = 1 157 000)</td>
<td>9% (n = 482 000)</td>
<td>6% (n = 611 000)</td>
</tr>
<tr>
<td></td>
<td>Complementary “danmark” 42% (n = 2 411 000)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>VPHI share of total spending on health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005 (or nearest available year)</td>
<td>2%</td>
<td>≤1%</td>
<td>≤1%</td>
<td>≤1%</td>
</tr>
<tr>
<td>2015 (or nearest available year)</td>
<td>2%</td>
<td>3%</td>
<td>≤1%</td>
<td>1%</td>
</tr>
<tr>
<td>Type and scope of coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complementary</td>
<td>Covers co-payments for pharmaceuticals, adult dental services, glasses and contact lenses, physiotherapy.</td>
<td>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. 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.</td>
<td>n/s</td>
<td>n/s</td>
</tr>
<tr>
<td>Supplementary</td>
<td>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.</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TYPE OF POLICIES</td>
<td>90% are group policies purchased by employers</td>
<td>Majority of policies are individual policies, around 15% are group policies</td>
<td>90% are group policies purchased by employers</td>
<td>90% are group policies of which two thirds purchased by employers</td>
</tr>
</tbody>
</table>

* Source: Forsikring & Pension, Sygeforsikring “danmark”.
* Source: Finance Finland.
* Source: Finans Norge.
* 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, under-resourcing 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
that the middle class has been one of the driving forces behind the reforms which emphasize choice [22,23]. However, this influential group also has a tendency to opt out of the statutory system if its demands are not met, and if there are options to do so [8]. Services acquired through VPHI may demonstrate more flexibility and responsiveness compared to the statutory healthcare system in terms of faster access and an increased choice of providers or even treatment options [e.g. 24].

Finally, it can be discussed if VPHIs are occurring as a result of policy responses to voting behavior or lobbying. A classical perspective on the dynamics of politics suggest that organized interests are likely to exercise their influence in situations where benefits are concentrated and costs are dispersed [57]. Many countries have used tax-incentives to promote VPHI. This means that costs are dispersed to all tax payers, while benefits are concentrated to private providers and those holding insurance. The groups receiving benefits have higher stakes than the rest of the population, and are likely to invest resources in shaping policy opinions through policy networks or advocacy coalitions [25]. In the case of VPHIs, these might include for instance private providers. Theories about the relationship between voters and politicians emphasize the importance of the median voter. When populations become more affluent it is likely that median voters will have higher demands. If politicians fail to accommodate these demand then voters may turn to private alternatives. The positive income elasticity of healthcare and growing wealth mean that more people are willing to pay for extra services. This can explain the willingness to buy VPHIs even in health systems that do invest substantial public resources to meet the demands for equity in healthcare, such as in the Nordic countries [26]. Over time, this increase in VPHI may lead to cuts in public expenditures. Under a system that permits private purchase, higher income voters will prefer a lower level of public spending than otherwise, choosing to top up with private purchases. Permitting private purchases will move the winning median voter down the distribution of health care service demand [26]. There is some empirical support for this theoretical result: the existence of private insurance tends to be associated with future reductions in public spending in the analyses completed across the OECD [27]. However, such a trend has not (yet) been reflected in the Nordic countries.

3. Methods and materials

Our empirical analysis draws on secondary data in the form of policy documents, research literature and grey literature. The paper is also based on the authors’ knowledge and understanding of the dynamics of the healthcare sectors as a result of various research projects and ongoing studies [e.g. 1]. The analysis is not all-encompassing but explorative and it contributes to the limited knowledge on VPHI in the Nordic countries. We develop a theoretical framework that can be useful for understanding the developments of the VPHI within and beyond the Nordic context.

The analysis builds on “the most similar cases” drawing on the idea that the Nordic countries represent national context that rely on the principle of universalism. However, there are also differences in the health systems as well as in political and institutional contexts. The Finnish healthcare system is built on three parts: A tax-funded system run by the municipalities, an obligatory social and health insurance system (SHI) reimbursing, for instance, the use of private health care and prescription medicine, and an occupational healthcare system funded by employer and employee premiums. In Norway, municipalities organize primary care, while the central government represented by four regional health authorities governs specialized care. In Denmark, five regions are responsible for organizing both specialized and primary care. In Sweden, 21 county councils are responsible for specialized care and primary care.

In the next section we discuss the main characteristics, resourcing and gaps in the Nordic healthcare systems. After that, we take a more in-depth look at each of the countries. To draw conclusions we use a theoretical framework drawn from the literature reviewed above. We compare VPHI developments by discussing (1) the performance of the statutory system (real and perceived); (2) lack of coverage; (3) governmental interventions or inability to reform the system; (4) policy trends and the general socio-cultural environment; (5) policy responses to voting behavior or lobbying by interest groups. The framework is illustrated in Fig. 1 and the summary of the analysis can be found in Table 3.

4. Main characteristics and gaps in the Nordic Healthcare Systems

The Nordic countries provide their residents with universal access to healthcare with relatively low user fees. With regard to health care resources (see Table 2), all countries spend above the OECD average on healthcare. The share of OOP expenditure as a share of final household consumption is close to OECD average in all countries. Denmark, Finland and Sweden are close to OECD average (3.4) in the number of doctors per capita, while Norway is above the OECD average (4.4). In terms of the number of nurses per capita Sweden has the lowest number of nurses [3].

User fees for hospital and primary care services are non-existing (Denmark) or relatively low in the Nordic countries. All countries also have relatively low annual high cost ceilings for user fees. In the four countries over half of the OOP medical spending goes to pharmaceuticals and dental care [3]. However, there are annual ceilings also for pharmaceutical expenditures in all the countries.

In Norway and Sweden patients are seldom deterred from the use of services by financial barriers [28] and they have relatively low rates of unmet needs for health care due to cost [3]. There is, however, a higher likelihood to seek specialist care among higher-income groups in all four countries. In Sweden and Finland, a similar pro-rich bias has been also reported for access to GPs [29,30].

In the Nordic countries the access to services is rationed by waiting times and patients often wait longer for elective treatments than in many other OECD countries [28,31,3]. However, all the countries have introduced waiting time guarantees, which have become a popular policy tool to tackle waiting lines [3]. Notable exceptions in the length of waiting times exist in Denmark that, for instance, had the second lowest waiting times for hip and knee replacement among the OECD countries in 2015 [3]. A distinct feature of Finland is that there have been problems in access in both primary and specialized care (e.g. [6]).

5. Exploring the different VPHI market developments in Nordic countries

5.1. Denmark

In Denmark, the high level of complementary insurance can be explained by the concentration of co-payments for specific types of services and the historical traditions of private cooperative solutions, exemplified by the creation of the non-profit organization “danmark”. The explanations for the rise in the supplementary VPHI in Denmark include a complex mix of perceived problems with access in the public sector, high marginal income taxes, competition for employees, and a secondary reputational effect where at least in some parts of the population it has become a “natural” expectation to get VPHI coverage.
Lack of coverage in certain areas of healthcare system

Policy responses to voting behavior or lobbying by interest groups

Policy trends and the sociocultural environment

Governmental interventions or inability to reform the system

The performance of the statutory system (real or perceived)

DEVELOPMENT OF VPHI MARKETS

Source: OECD [3].

Unlike the other Nordic countries, there are no co-payments for primary care or hospitals in Denmark. Instead, there are significant co-payments for dental care, pharmaceuticals, and various auxiliary services, such as physiotherapy and psychology. The non-profit insurance company “danmark” was established to cover such co-payments when the Danish sickness fund system was abolished in 1973. Since then, “danmark” has grown to include more than 41% of all Danes, and it has developed a broader range of coverage options and products.

In spite of this high coverage level, it is remarkable that there are no controversies tied to this type of complementary health insurance. This view can probably be explained by a long historical tradition of private cooperative solutions for agriculture, education and religious matters in Denmark. The non-profit organization “danmark” can thus be interpreted as a solution to a specific configuration of co-payments based on deep historical roots [32]. The business model of “danmark” makes economic sense to its members, as the entry costs are low at a young age, while the membership can be upgraded to cover a higher percentage of costs when needed in later life.

The growth of supplementary insurance is due to a combination of factors. Initially it was spurred by tax-exemptions for employer-paid VPHIs introduced by a liberal-conservative government in 2002. The aim behind this policy was an ideological attempt to boost the private healthcare sector. Tax exemptions were applicable to VPHIs, covering illness and accidents including psychiatric treatment and preventive treatment. It was conditioned on the coverage of all employees within a firm and a referral from a doctor. The introduction of tax incentives resulted in substantial growth of the market for supplementary VPHIs [33]. In 2012, the majority of the tax exemptions were abolished by the Social Democratic coalition government. Their main arguments related to equity [34].

While the tax exemptions were a vehicle to fuel the expansion of supplementary insurance, it also appears that the market was driven by a growing preference for private sector solutions and concerns about quality, and access to elective surgeries within parts of the population. This explanation is somewhat paradoxical, as the Danish waiting times remain lower than those in the other Nordic countries, and the general level of satisfaction with the Danish healthcare system remains high [35]. Furthermore, Denmark has implemented laws to guarantee access within specific maximum waiting times. The first “waiting time guarantee” was introduced in 2002 (LOV nr 143 af 25/03/2002). It states that public hospitals must provide access to treatment within two months after referral. Otherwise, the patient is entitled to treatment in private hospitals. The current legislation provides the right to a diagnosis within one month after referral to hospital and a subsequent right to treatment within one month after diagnosis. In spite of these policy measures, it appears that the reputation for inferior service and relatively long waiting times remains, at least within some parts of the society. In addition, some patients have preferences for access to privately practicing specialists that may have much longer waiting times than the public hospitals. VPHI allows them to bypass the waiting lists for publicly referred patients.

To understand this situation fully, it is necessary to supplement the ideological and reputational explanations with two other explanatory components. First, most supplementary VPHIs in Denmark are provided as part of employment contracts in individual firms or in general agreements between employers and employees. VPHI has thus become a factor in the competition to attract and retain skilled employees. Secondly, this situation has created a dynamic whereby there is a perception that such VPHIs are a “natural” benefit if you are a valued and important employee.

Table 2

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>OECD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>9.0</td>
<td>3.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Finland</td>
<td>10.4</td>
<td>2.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Norway</td>
<td>9.3</td>
<td>3.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>10.5</td>
<td>2.9</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td>11.0</td>
<td>3.3</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Source: OECD [3].

Fig. 1. The framework for the analysis.
Starting in management positions in the private sector, this benefit has now spread to large parts of the labor market.

5.2. Finland

The emergence of the VPHI market in Finland can be explained by the mix of institutional structures, long waiting times for primary and specialized care, and high co-payments in the private sector. Especially the Social Health Insurance (SHI) system has shaped the institutional context in a direction where people who want, and can afford them are able to use private services [36].

The current structure of the Finnish public health care system started to emerge in the 1960’s. Initially the system was built on SHI, which gave patients the possibility to seek treatment in the private sector and have part of those costs reimbursed by the SHI. Tax-based system was built in the 1970’s but the SHI system was not terminated. It remained along with the new “Nordic type” structures [37].

Instead of terminating the SHI the governments have incrementally lowered the reimbursement rates. The reimbursement is not tied to actual price development, but to an administratively determined rate. When the SHI system was created, the rate was set at 60%, while in 2014 the actual rate was around 17% of the total cost making the co-payments in the SHI system high [38]. Combined with poor access to the public services especially at primary care level the SHI-reimbursed private sector has produced a viable market for complementary VPHI.

While the initial emergence of the VPHI market is mostly related to poor access to the public system and high copayments in the private sector, the growth of the VPHI market can be interpreted also in relation to a broader change in the culture of ‘consumerising’ healthcare. It has been shown that the past use of private healthcare may be a determinant of the current use of private healthcare [39]. In Finland, the SHI system and occupational healthcare have created conditions in which a large proportion of working-age people are used to visiting the private sector. While the willingness to contribute to the public system is high, many people have still exited the public system for more satisfactory services and better access in the private sector. More satisfactory services could mean, for instance, that people can visit a specialist without first visiting a GP, book an appointment online or they can visit a doctor in the evenings [24,39].

The explanations can also been sought from the perspectives of organized interests, path dependency, and institutional stickiness of the public system. It has been widely acknowledged that the Finnish healthcare system, which has been suffering from, for instance, poor access to primary care and further to specialists should be reformed. However, the governments have been unable to implement the planned structural reforms due to path dependency created by the strong institutions [40]. For instance, while maintaining the SHI system along the universal tax-based system has not been beneficial for the healthcare system as a whole, the governments have not been willing to face the political troubles of demolishing it. Many key stakeholders involved in the governance of the system, like municipalities, citizens with higher socio-economic status, private providers and the medical profession, benefit from the coexistence of the two systems [41]. The co-existence of tax-based and insurance-based systems has, for instance, made it possible for municipalities to shift their costs to the private sector reimbursed by the SHI. Also, individual doctors can be employed in both the public and the private sector at the same time. Working in the private sector has given the medical profession autonomy and higher income.

Finally, the strong occupational healthcare system has paved the way for a rise in employer purchased insurances. In the period from 2009 to 2016 the amount of insurances purchased by employers has grown from some 100 000–216 000 policies [42]. In contrast to Norway and Denmark, Finland has not, however, introduced any specific incentives to stimulate the expansion of this market. Instead, it may be anticipated that the growth of employer purchased VPHIs is reinforced by cultural factors. There are indications that a view of VPHIs as a status symbol of a ‘good’ employer has started to emerge also in Finland [43].

5.3. Norway

In Norway, the observed developments of the VPHI market can be explained by a combination of observed weaknesses in the public system, governmental policies, and marketing by private insurers. The VPHI market in Norway grew during a period when i) the government introduced reforms to improve access; ii) one observed a reduction in public sector waiting times; and iii) tax incentives for VPHI were removed.

The main weakness of the Norwegian public health system is long wait-times for elective treatment. Norwegian governments have launched various reforms such as waiting time guarantees and hospital choice reforms to address the problem but waiting times are still long. The emergence and expansion of supplementary VPHI can be seen as a market response to long waiting times still prevalent in the public system.

Governmental policies contributed to the initial growth and structure of the VPHI market. The market was almost non-existent until the start of the millennium. It started to expand in 2003 when the Center-Right government gave employers and employees’ tax exemption for private health insurance. Employees were given a tax-exemption for the benefit of having medical treatment expenses covered by an employer, and employers could deduct medical expenses on their social security contributions [1]. These tax incentives were applicable only in the case of treatments and for the associated expenses covered by the public system. The tax incentives were removed in 2006 after the Parliamentary election that gave a majority to a Center-Left government. However, expansion of the VPHI market still continued.

In addition to giving faster access to treatment, VPHI also improved the business opportunities of the private providers, which were typically not included in the (public) system. This “unequal access to private for-profit” was regarded as unacceptable by the current Right-Progressive government. During its terms purchasing health services also from for-profit providers was introduced. These services are available for all inhabitants, irrespective of their VPHI status. Another illustration of the interplay between governmental policies and the expansion of the collective employment-based VPHI market is the introduction of the obligatory ‘occupational injury insurance’ and ‘mandatory occupation pension’ in January 2006. The introduction of the obligatory occupation pension gave private insurers an opportunity to sell health insurance as a complementary product.

In recent years, private insurers have taken an active role in stimulating the demand for VPHIs among employers by advertising their services and products to address the potential financial and productivity losses that can result due to long wait-times in the public system. Insurers claim they can provide employees with guaranteed access to both examination and treatment within a given time-frame, thus giving both employers and employees greater certainty of timely access to medical treatment. In addition, private insurers emphasize the point that VPHI is a valuable benefit to employees and that by offering insurance, employers are projecting their image as a good employer. A significant predictor for buying VPHI in Norway is employee preferences for health insurance and employers’ perception that such insurance can facilitate recruitment and reduce financial losses from sickness absence.
Another Norwegian study finds however no evidence that private health insurance reduces sickness absence [46].

5.4. Sweden

In Sweden, factors that have contributed to the growth of supplementary VPHI market first of all relate to the real and perceived performance of the statutory system. Although Swedish health care performs well in terms of health and clinical outcomes, problems related to access and waiting times have been discussed since the late 1980s [47].

Access problems can also be described as the main driver behind several reforms that have focused on choice and competition. Employers as well as self-employed individuals have expressed concerns about productivity loss and loss of income due to sick leaves when waiting for diagnosis and elective treatment [47]. This creates a strong incentive to purchase a guaranteed quicker access to care when needed. For employees, insurance premiums are currently a non-deductible expense. Employees usually pay nothing for the insurance, and the benefit is currently excluded when calculating their income taxes. Co-payments for the first visit and use of premiums can be high, however. This high initial co-payment means that individuals often have an incentive to first visit the publicly financed health center or GP-practice where they are registered. Visiting a private practice and using VPHI is used as an alternative to the public system because of problems in access.

During the recent decade private insurers have taken a more active role in stimulating the demand among different kinds of employers. In many professional groups, access to VPHI is perceived as a fringe benefit that is expected [47]. VPHI is indeed common in small private companies that employ professional staff, especially in large cities. On average, about 15% of employees in small private firms have access to VPHI. VPHIs have also been purchased by other types of organizations, such as municipalities, although it is less common. Currently, the fastest growing segment of the market is group based insurance paid by individuals themselves, e.g. provided by unions. Parallel to the growth in the VPHI market in the recent decade, access and waiting times in the public system first improved and later worsened. This suggest that the continual growth in the private market is explained by other factors besides actual documented access problems in the publicly financed system.

The Social Democratic led minority government elected in 2014 has suggested regulation of VPHI within the publicly financed health care and changes in tax policies. The main purpose behind the suggested regulation is to clarify that within publicly financed health care (irrespective of whether such care is being provided by public or private providers) the criteria for need-based access and priority setting as determined by the Parliament must be followed. Another suggestion from the government, to be introduced in July 2018, is to abolish the tax exemptions. These suggestions have potential consequences for private providers who are operating using a mix of funding sources and for the general growth in VPHI. It is, however, highly uncertain if the plans will be accepted by the Parliament.

6. Discussion

Our analysis shows that the demand for VPHI has increased gradually over time in response to real and perceived gaps and inflexibilities in the public system. The institutional contexts and cultural interpretations have contributed to shaping a variation in patterns across the four countries. National governments’ direct or indirect actions have stimulated the growth of the VPHI markets, especially in Norway and Denmark, where liberal-conservative governments have implemented tax exemptions for employer paid VPHIs. The results seem to be in line with the literature giving explanatory power to the performance of the statutory healthcare system and the lack of coverage in certain areas of healthcare. Also, powerful policy trends and growing demands for choice and individualized treatment seem to have created a lack of satisfaction and even trust in the public sector, which have further fueled the growth of the markets. The concluding picture of the explanations is provided in Table 3.

Many of the theoretical explanations behind the existence and growth of VPHI markets refer to the individual willingness to pay for VPHI. However, in Norway, Denmark, and Sweden, supplementary policies are mainly purchased by employers which makes employers and also some unions are active players in this respect. This indicates that the market in Nordic countries is largely driven by the actions of employers who want to get their sick employees back to work as quickly as possible. However, while this explains the initial emergence of the market, it seems that after the market was in place, it also started to grow based on other logic, which has more to do with cultural trends. Over time, it seems that the use of VPHI as a fringe benefit has led to a situation where many employees, particularly in the private sector, have become to expect the benefits as indications of them being a valued employee. These results suggest that the rise of VPHI should not solely be seen as an expression of individuals who are dissatisfied with the statutory system, but rather as an addition to the public system, that has been further fueled by institutional conditions and rising expectations in today’s relatively affluent Nordic populations.

Finland is somewhat different from the other Nordic countries. Most of the policies have been purchased by individuals while the occupational healthcare system undermines the need for employer

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Summary of the contributing factors to the developments of VPHI in the Nordic countries.</th>
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<tbody>
<tr>
<td>Denmark</td>
<td>Finland</td>
</tr>
<tr>
<td>Employer</td>
<td>Individual</td>
</tr>
<tr>
<td>The performance of the statutory system (real or perceived) X (S*)</td>
<td>X (S)</td>
</tr>
<tr>
<td>Lack of coverage in certain areas of healthcare X (S)</td>
<td>X (S &amp; C)</td>
</tr>
<tr>
<td>Governmental interventions and inability to reform the system X (S)</td>
<td>X (S &amp; C)</td>
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<td>Policy trends and the general socio-cultural environment X (S)</td>
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*S = supplementary. **C = complementary.
purchased VPHIs. The explanations for the emergence of VPHI market in Finland stem largely from an institutional environment and poor access in the core primary healthcare system. The SHI system has shaped the institutional environment towards a system with a strong tradition of private health care provision. However, there has also been a long-lasting tendency to incrementally decrease the SHI contribution, which has further supported an expansion of the VPHI insurance market. In addition, the poor access of the municipal primary care system and the governments’ inability to undertake comprehensive reform has encouraged more people to use private services. Finally, many parents perceive that VPHI provides a possibility to gain faster access and receive more customer-oriented and high quality services [24].

More and more people have become willing to pay for extra services, which may explain the relatively high prevalence of VPHI in systems that invest substantial public resources to meet the demands for equity in healthcare, such as the Nordic countries [26]. At least in Finland, it is possible to find some support for the arguments assuming that there is a positive income elasticity of health care, as more and more people are willing to pay for extra services [6,24]. The existence of private insurance tends to be associated with future reductions in public spending [27] and in the future research, it will be important to study whether these results will hold true in the Nordic countries with traditionally strong support to a universal healthcare system.

Related to this issue, we can see differences between the countries when we look at the governments’ abilities to reform the statutory service systems. In at least Denmark and Norway, radical structural reforms have been able to tackle the most crucial problems in their healthcare systems. In Finland, in turn, the institutional inertia toward reforms has created gaps in the system, then filled with VPHI by those who can afford it (compare [15,16]). In addition, introduction of choice reforms within the statutory healthcare systems has occurred in all the Nordic countries, although less so in Finland — at least to current date.

In Norway and Denmark, and in Sweden when it comes to primary care, structural reforms have mainly implied an introduction of market-type reforms within the publicly funded system without influencing the public coverage. In spite of the increasing importance of markets, recent evidence of public concerns about privatizing of the healthcare sector, together with the promises from the new government to strengthen control of private for-profit providers, suggests that Sweden maintains a strong commitment to healthcare equality [48]. Also in Norway, several reforms have expanded the opportunities for patients to use private providers. This change reflects both the general policy trend toward increasing the importance of patient choice that we observe in all the Nordic countries and an attempt to increase competitive pressure and improve the utilization of existing capacity across public and private providers, the primary goal being to reduce waiting times. At the same time, these reforms indirectly have reduced the importance of VPHI that, among other things, exists to increase the choice of provider and reduce waiting times.

According to some scholars, healthcare markets are shaped by political decisions [49]. In Denmark and Norway, right-wing governments in the 2000’s introduced tax-exemptions to boost the private market. The justification for these reforms was largely ideological, as the tax-exemptions were removed when more leftist parties took office. Similarly, removal of tax-exemptions has been suggested by the Social democratic government in Sweden. While a VPHI may appear to be a beneficial option for governments to use to shift the demand of services to the private sector, the increasing number of VPHI policies also raise the question of equity. VPHIs give preferential access to treatment, cover high copayments and provide access to the services excluded from the public coverage. At the same time the access to a VPHI is often based on the ability to pay, employment status, and other socio-economic factors seldom (positively) related to the individuals’ needs for health care.

Even though VPHI so far does not play a major role in the Nordic health systems the growth in the number of policies needs to be followed. The public sector’s ability to provide adequate services may be affected in a number of ways by VPHI [50]. Firstly VPHIs could affect the resourcing of the public sector, because a significant increase in the use of private services would make the public and private sectors compete for workforce resulting in suboptimal allocation of resources (see e.g. [51]). Second, an increase in the use of private services could result in or be accompanied by decreasing support, willingness to pay taxes and express ‘voice’ for the public sector. In the worst case this could lead to the evolution of Nordic health care systems into a ‘poor service for the poor’ [50, 856]). In connection to this it is important to point out that VPHI policies are mostly available for the healthy, the young (under 65) and those who are either employed or able to pay for the premiums (e.g. [52,53]). Finally, it is worth considering if the VPHI affects the overall demand of services. There are studies indicating that, after controlling for adverse selection, VPHI increases health care consumption due to moral hazard (e.g., [54,55]). Hence, VPHI might even be detrimental for welfare as they are available primary to low risk patients and do not eliminate (ex post) moral hazard. In the future it would be important to take the equity aspect of VPHI developments under a closer investigation.

7. Conclusions

We find a number of similarities in the developments in VPHI markets in Denmark, Norway and Sweden. In these countries VPHI developments have been mainly driven by the employers who purchase insurance policies to their employees. Finland seems to have followed its own path. A relatively large proportion of individually purchased insurance policies provide a possibility to gain a faster access to a specialist and jump long waiting times in the primary care sector. This development in Finland has been strongly influenced by the existing institutional structures and resilience to undergo change. While the VPHI still plays a minor role in the Nordic welfare states, the growth of these markets represents an interesting counter-trend in the global developments. In many countries, the goal has rather been to extend the public coverage of healthcare (the US) or increase State regulation of market systems (the Netherlands). VPHI’s in the Nordic region may, thus, provide an interesting window to look through and examine the flaws present in the Nordic model of care and then rethink the systems to make them better able to meet the needs of these populations.

Conflict of interest statement

We declare that we have no competing interests.

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