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**SUPPLEMENTARY SOCIAL PROVISIONS
IN SECOND AND THIRD PILLAR HEALTH CARE**

SUMMARY

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Introduction

This investigation of supplementary health insurances (the second and third pillar in health care) was ordered by the Belgian Science Policy Office and the FOD Social Security. It concerns a study that is part of a larger AGORA research programme which wants to provide a consolidated picture of the Belgian population in terms of social protection categories. For this purpose a classification scheme had been developed, the so-called AGORA-concept matrix. This study only concentrates on cost compensating supplementary health insurance schemes.

We focus attention on three objectives:

1. Collecting macro statistical information concerning the number of participants, revenues, expenses, reserves... of different sorts of products to get an idea of the scope of the pillars and their evolution during the last 10 years.
2. Collecting statistics about the socio-economic and demographic profile of the participants of these supplementary health insurances, to gain insight into the issue of participants and non-participants.
3. Setting up an inventory of the supplementary products which are offered by sickness-funds and insurance companies.

The pillars of Belgian health care insurance

As the insurance for medical costs embraces much more these days than the statutory health insurance organised by the government, this study must provide a systematic overview of supplementary health insurance. The analogy with the pension sector¹ can be a good help. Still the pillars of the health insurance are not operationalized in the same way as the pension pillars.

The first pillar consists of those insurances that are organised and (partly) financed by the government or by a public institution. These products are obligatory for who is part of the scope of application of the insurance. The contributions for the first pillar show at least some solidarity and are in a few cases income-related. The following products are being classified under the first pillar: the statutory health insurance for employees, civil servants, and the self-employed and the Flemish Care Insurance.

¹ Gieselink, G., Peeters, H., Van Gestel, V., Berghman, J. en Van Buggenhout, B. (2003). *Onzichtbare pensioenen in België. Een onderzoek naar de aard, de omvang en de verdeling van de tweede en derde pensioenpijler*. Gent: Academia Press.

To the second pillar of health insurance belong products which are not part of the statutory system, but are still financed by a premium that is based on solidarity, and which can possibly be supported financially by the government. Because of the solidarised character of the premium all the insurance products of the second pillar are obligatory or accessible to all the members of a particular group. The second pillar encompasses the following products: the supplementary services and activities of the sickness-funds and work-related supplementary health insurances.

Within the third pillar of the health insurance one finds the products which are organised outside the statutory system and are taken on an individual basis. These products are not financed by means of a premium based on solidarity. The insurer uses instruments of risk selection to decide under which conditions someone may join the insurance. Given these conditions, joining depends on an individual decision. Nevertheless support of the government is not excluded. The products of the third pillar include the facultative hospitalisation insurances and their guarantees, the facultative insurances for dependents, the insurance for 'small risks' for self-employed workers and the medical care insurance of the overseas social security system.

The central question of this overview is to define the scope of social security. To be considered as social security, insurances must, according to Berghman², offer protection against 'collective recognized human loss' and must have a redistributive character. On the basis of these two conditions the insurance products with the following qualities are part of social security:

- Products which are organised and supported by the government, either by subsidies or by awarding tax benefits.
- And/or products which are accessible to everyone from a well-defined group and where a premium based on solidarity is at stake (in other words: the contribution level is not dependent on the individual risk of the contributor).

From a legal point of view this three pillar classification is not self-evident. The legal regulations of the different products cut across the pillar system. Juridically a distinction can be made according to the institutions which offer the products. Yet, the supplementary insurances of the sickness-funds³ are regulated by other laws than the private insurances⁴. As a consequence of this distinction, two identical products may have a different legal base. A few legal initiatives have

² Berghman, J.(1986). De onzichtbare sociale zekerheid. Deventer: Kluwer.

³ Wet van 6 augustus 1990 betreffende de ziekenfondsen en de landsbonden van de ziekenfondsen

⁴ Wet van 9 juli 1975 betreffende de controle der verzekeringsondernemingen en de wet van 25 juni 1992 op de landverzekeringsovereenkomst bevatten de belangrijkste wettelijke bepalingen voor de private sector

been taken in the past to submit the sector of the supplementary health insurance to a more uniform and clear legal framework. For the moment those attempts were all without practical effect. Thus a specific regulation seems necessary.

The evolution of the second and third pillar in health care

To indicate how the second and third pillar evolve, we first consider the scope and evolution of the first pillar. The expenditures of the *first pillar* have increased with one third, for the general system as well as for the system for self-employed workers. These numbers are of importance as they allow indicating the relative position of the second and the third pillar provisions compared to the first one.

We first take a look at the *number of participants* in second and third pillar insurances. As for the second pillar the supplementary services of sickness-funds are obligatory to all their members. 9.403.703 persons are affiliated with these supplementary services. The number of participants with a work-related insurance has increased with 43%. This means that more and more enterprises offer extra-legal advantages by way of a supplementary hospitalisation insurance. In the third pillar, we also find a considerable increase in the number of participants with facultative hospitalisation insurance. The latter are offered by the sickness-funds as well as by the insurance companies. The facultative hospitalisation insurances, offered by the insurance companies, reach a membership of more than 1 million members while, in addition, the sickness-funds have more than 2 million members in their third pillar.

Expenditure figures of the second and third pillar do not tell very much as such. Yet, expressing them in terms of GDP gives an idea of their *absolute importance*. Table 1 shows that both the supplementary provisions and the work-related insurances increase. The work-related insurances increase by more than 100%. This indicates that more and more companies offer extra-legal advantages to their employees by way of a facultative hospitalisation insurance. For the third pillar we also find a strong increase in expenditure, for both the sickness-funds and the insurance companies. We notice that in terms of GDP, expenses for the third pillar are much smaller than for the second pillar. In comparison with supplementary pensions (representing 1.4% of GDP in 2001) it is a rather small percentage.

The increased absolute importance of the work-related insurances, however, does not say anything about the importance of supplementary health insurance. Within the overall health care sector its *relative importance* can be examined by expressing the expenses as a percentage of the expenditure for statutory health insurance. In doing so work-related insurances are only compared with the general system for employees because self-employed workers have no claim to work-related health insurance (they do not receive a wage). Third pillar expenditure and supplementary provisions, however, are compared with what is spent in the systems for employees and the self-employed together. The relative importance is doubled for all the provisions of the insurance companies between 1993 and 2001. The hospitalisation insurances of the sickness-funds grow not so fast as the insurances of the insurance companies. The provisions of the sickness-funds remain constant more or less.

Table 1: Overview absolute and relative importance of the second and third pillar provisions

			1993	2001	%
Absolute*	Second pillar	Supplementary insurances	0.091	0.101	+11%
		Work-related insurances	0.038	0.082	+116%
	Third pillar	Hospitalisation sickness-funds	0.026	0.042	+62%
		Hospitalisation private	0.015	0.035	+133%
Relative **	Second pillar	Supplementary insurances	0.0183	0.0186	+1.6%
		Work-related insurances	0.816	1.626	+100%
	Third pillar	Hospitalisation sickness-funds	0.51	0.77	+50%
		Hospitalisation private	0.30	0.66	+116%

* Absolute importance as percentage of the GDP

** Relative importance as percentage of the expenditures of the statutory system

Source: RIZIV, CDZ and CBFA

An analysis of the (non)participants of additional health insurances

Exploring the profile of the participants of the supplementary health insurances is an important aim of this research. Here analyses at micro-level are necessary. Yet, finding a usable data base is not so evident. A few data bases help us to sketch a picture of the (non) participants on individual and collective products: the Health Survey (an initiative of the Scientific Institute of Public Health), the Salary Survey (a cooperation between the Katholieke Universiteit Leuven en Vacature) and the Panel Study of Belgian Households (a project of the Federal Science Policy). On the basis of these data bases the following questions are addressed: How are the supplementary products spread among ages and sexes? Does the sector of employment or the size of the enterprise play a part? To what extent does the income or the educational level lead to a different participation in supplementary health insurances?

Within the budget and time constraints of the research project we have also launched a company survey by email to get some idea of the content and the entitlement conditions of supplementary hospitalisation insurances. Yet, it should be emphasized that the company survey has only an exploratory character. This web survey has yielded an unsatisfactory response to do representative statements about the business world as such. So we did not intend to verify our 9 hypotheses (cfr. *infra*) on the basis of it. With this survey we merely tried to find out the content and the entitlement conditions of the work-related hospitalisation insurance. The first analyses indicate that certain categories participate more in hospitalisation insurances than others. A multivariate analysis gives a more decisive answer about possible spurious relationships. As it is not possible to take into account all the variables in the analysis, we formulated a set of hypotheses which we tried to confirm later on in ways that fit the specificities of the various data bases. By using a logistic regression we tested 9 hypotheses. Table 2 brings the findings together. As the Health Survey focuses on individual characteristics whereas the Salary survey focuses on company-related characteristics, not all hypotheses could be tested in each data base.

Table 2: Testing the hypotheses: an overview

	Health	Salary	PSBH
1. There is a significant difference between men and women in participation in facultative hospitalisation insurance.	-	+***	n.t.
2. Certain age groups participate more often in supplementary hospitalisation insurance than other age groups.	+***	+*	n.t.
3. Higher educated persons take more part in supplementary hospitalisation insurance than lower educated persons.	+***	+*	n.t.
4. Individuals from higher income strata are more likely to have hospitalisation insurance than individuals from lower strata.	+***	+**	n.t.
5. Couples have more often hospitalisation insurance than single persons.	+***	n.t.	n.t.
6. Flemish people are more likely to join facultative hospitalisation insurance than inhabitants of the Brussels or Walloon region.	+***	n.t.	n.t.
7. Employees with a permanent contract are more likely to participate in work-related hospitalisation insurance than employees on fixed-term contracts.	n.t.	+**	n.t.
8. Employees in a large enterprise are more likely to join work-related hospitalisation insurance than employees in small enterprises.	n.t.	+**	+*
9. The probability of getting a work-related hospitalisation insurance depends on the branch in which the person is employed.	n.t.	+*	+***

n.t. not tested
+ H₀ excepted
- H₀ rejected

* p < 0.05
** p < 0.01
*** p < 0.001

We found confirmation for the first hypothesis in the Salary Survey. Men and women do not take part in supplementary hospitalisation insurance in the same way. As far as age is concerned, there seems to be significant differences between the age groups, both in the Health Survey and in the Salary Survey. So, we can accept the second hypothesis.

We can also conclude that higher educated people join more often supplementary hospitalisation insurance than lower educated people. The same goes for the fourth hypothesis: higher income earners have more often supplementary hospitalisation insurance than is the case with lower income earners. These conclusions are confirmed in the company survey which shows that executives and white collar workers are offered supplementary hospitalisation insurance more often than blue collar workers.

Hypotheses 5 and 6 can be confirmed on the base of the Health Survey. Couples have more often supplementary hospitalisation insurance than single persons and Flemish people are also more often insured for hospitalisation than either Brussels or Walloon people. For hypothesis 7 we found an indicative confirmation in the company survey: enterprises seem to take the type of contract of their employees into account.

When we take a look at the company-related characteristics, employees in a large enterprise have more often work-related hospitalisation insurance than employees in a small enterprise. There are also significant differences between different branches of industry. Especially the non-profit sector offers less hospitalisation insurance.

An inventory of additional social provisions services in the health sector in Belgium

The inventory of supplementary health insurances should not only provide an overview of the different actors and products of the second and third pillar but also yield a first exploration of the content of these products. Without entering into too much detail we want to know which provisions are offered by a particular insurance product. We want to explore for example which supplementary insurance of the sickness-funds gives some compensation for transport of ill persons, or for preliminary and follow-up treatments. In the data base that was devised, quantitative data are linked to this inventory to provide a matrix with an accurate picture of the distribution of the different products and services over the population.

In order to extend the AGORA-product matrix to the health care sector, a typology of supplementary products has been designed. Every product is classified according to a number of variables of the social security matrix, more specifically those of the product matrix⁵. This product matrix is divided into 3 modules: a basic module, an expenditure module and a resource module. The first 'basic module' looks for a few general characteristics of the social security products under scrutiny: the policy level, the management level, the personal scope of application... In the 'expenditure module' the following variables are focussed at: the kind of benefit, whether the benefit is wage-related or lump sum, the periodicity of the benefit, the character of the benefit, the social security function. In the 'resource module' variables are used that describe possible ways of financing. Using this concept and design of the social security matrix it becomes possible indeed to present a clear and coherent overview of the products. Moreover, we took the opportunity to access the variables that are taken into account in the social security matrix in order to validate the latter for the supplementary health insurance provisions.

The set of variables on which a valid typology should rest was defined on the basis of the relevant literature (including an existing typology of facultative products⁶) but further tested on a few examples. Going on from this we made separate data bases in EXCEL-format for (1) the supplementary products of the sickness-funds, (2) the labour-related hospitalisation insurance, (3) the individual hospitalisation insurance and (4) the dependents' insurance. These data bases were made compatible with the existing AGORA-matrix.

The data base that contains information on supplementary products of the sickness-funds is filled up with information that was collected and verified in the relevant statutes of the sickness-funds. These latter statutes are a check on the products because sickness-funds are not allowed to offer provisions that are not explicitly mentioned in their statutes. To complete the data base with the work-related insurances and the data base on individual insurances, the general conditions and the number of participants of each product were checked.

⁵ The social security matrix provides a link between individual data and social protection schemes. The social security matrix consists of three parts: the product matrix, the individual matrix and the connecting matrix. In the product matrix all social protection measures are characterised by a set of basic variables that reflect some elementary characteristics of social protection schemes. Next to these basic variables the measures are also scored on some variables that point out specific characteristics of the benefits and the financing mechanism. In the individual matrix the individual is scaled according to individual and household characteristics. At least, the connecting matrix links persons to those benefits (expenditure measures) they are currently receiving (Berghman e.a., 2004; Berghman & Nijs, 2005).

Conclusion

This study makes it possible to give an adequate overview of second and third pillar health care protection. Both the collective hospitalisation insurances and the facultative hospitalisation insurance boomed during the last years. There has been a significant growth in the number of participants which caused a strong expenditure increase with both the sickness-funds and the insurance companies. The second and third pillar health care increased much stronger than the first pillar. This underscores the importance of the supplementary pillars.

With respect to the socio-economic and demographic profile of the recipients we noticed that some categories of the population are more likely to participate in supplementary schemes than others. The participants are rather highly educated, higher income earners, rather not single, Flemish, and with a permanent labour contract; they work in the 'richer' economic branches and are employed in large enterprises.

The last objective of this research project was to devise an inventory with all products that are offered in the second and third health care pillars. (Income replacing schemes were excluded from the analysis). The four data bases that were made offer an overview of the coverage of each product. Whenever possible this information was linked to its number of participants. For each data base a specific form has been devised that should allow the respective, competent institutions to update the data base. A methodological manual explains the variables that are used and the way they should be implemented.

⁶ Explored by the Federation for Insurance