Opinion of the Economic and Social Committee on 'Supplementary health insurance'

(2000/C 204/11)

On 11 April 2000 the European Parliament decided to consult the Economic and Social Committee, under the fourth paragraph of Article 262 of the Treaty establishing the European Community, on 'Supplementary health insurance'.

The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee's work on the subject, adopted its opinion on 5 May 2000. The rapporteur was Mr Bloch-Lainé.

At its 373rd plenary session of 24 and 25 May 2000 (meeting of 24 May 2000), the Economic and Social Committee adopted the following opinion by 113 votes to two with two abstentions.

1. INTRODUCTION

1.1. A working document of the European Parliament's Committee on Employment and Social Affairs, on supplementary health insurance (PE.286.193 — DT/402.876), was referred to the Economic and Social Committee. The Committee warmly welcomed this referral for two series of interlinked reasons: firstly, the importance and seriousness of the subject in question; and secondly, the role the Committee believes it can and should usefully play in the future in the on-going preparation of the basic building blocks of a European social model.

1.2. In its preamble to the present opinion, the Committee highlighted how the document in question forms part of a series of discussions and documents aimed at a clearer definition and establishment of the Union's social mission. The initiative taken by the EP's Committee on Employment and Social Affairs bears witness to the growing attention which has focused since the early 1990s on the question of social protection, of which health cover is a major factor in combating social exclusion. Following the recommendation of 27 July 1992 on the convergence of social protection objectives and policies [1], recognition of this aspect has been expressed in three Commissions communications in 1995, 1997 and 1999 [2]. On 1 March 2000, the Committee issued an opinion on the Communication from the Commission on a concerted strategy for modernising social protection [3].

1.3. The working document on which the Committee is now being consulted marks a new stage in this process.

I. Analysis of the Working Document

Three elements can be identified for the purposes of analysing this text: a judicious reminder of certain basic rules laid down by the Union Treaties, governing how the question should be approached and handled (A); recognition of a worrying situation (B); and proposals (C).

A. *The constraints of the institutional context*

1. The document recalls that responsibility for organising and funding national social protection systems lies with the Member States.

2. It emphasises that social protection is implemented according to models, and shaped by social and historical factors, unique to each Member State.

3. It highlights the fact that by virtue of the direct application of the principle of subsidiarity, the Member States must retain their own responsibilities in this field.

4. It points out that free competition, which is one of the basic principles of the European Union, will of course continue to govern the insurance industry.

5. It indicates that in this field as in others, in accordance with the approach laid down in the Treaties, the Union should take action 'by establishing minimum standards' with the aim of creating a 'safety-net'.

6. The document states that so-called 'comfort' treatment lies beyond its scope.

The Committee has highlighted these points from the document in order to illustrate the clear concern of its authors not to underestimate any of the constraints to be observed, and difficulties to be overcome, in responding adequately to the challenges raised by this issue.

(1) OJ L 245, 26.8.1992, pp. 49-52.
(2) COM(95) 466 final — COM(97) 102 final — COM(1999) 347 final.
(3) CES 238/2000 — OJ C 117, 26.4.2000, p. 33.

B. *An alarming picture*

To sum up: in spite of the diversity of national circumstances, emerging or worsening discrimination in terms of prompt access to high-quality care can be seen in all the Member States. This inequality — which there is no reason to suppose will disappear spontaneously — is a particularly damaging and unacceptable form of social exclusion and can only tarnish the image and future of the European venture.

1. Reasons

Although the Parliament document sets out to define the scope of supplementary health insurance, the direction and scale of problems in this area cannot be clearly grasped without an understanding of the background. This may be summarised as follows:

— regardless of their specific features, all European health protection schemes are confronted with a number of powerful trends, i.e.:

  — a history of 25 years of sluggish growth, generating unemployment and restricting the contributory capacity — tax or social security contributions — of households and businesses;

  — an ageing population;

  — the appearance of new diseases and, as a result of progress in research and treatment, increasingly costly care.

The combination of these factors has, with very few exceptions, inevitably led to a decline in the proportion of total health spending — which is everywhere rising as a percentage of GDP — covered by public funds. At the same time, and in several parts of Europe, it has been seen that access to prompt, high-quality care for the most disadvantaged individuals has become more difficult, or even that the quality of care available to them has deteriorated. In other words, statutory solidarity-based health systems have, to varying degrees, reached their limits.

As overall cover funded by compulsory contributed has contracted, cover by supplementary insurance has expanded. Private sector social protection systems — whether profit-based or otherwise — have grown, at varying rates and in different ways.

Use of supplementary health insurance, together with any improvements broadening its availability, can and should be hailed as fundamentally beneficial. To do so is simply to recognise the facts. Recognising the facts, however, entails not idealising supplementary cover, but rather striving as far as possible to eliminate any ambiguity. To this end, and at this stage of its opinion, the Committee would emphasise the following points:

a) For quite understandable reasons, which it would be facile to condemn, political discourse often tends to obscure the reality of existing constraints and, with regard to public opinion, to perpetuate the illusion that states can and will continue to be able to satisfy aspirations, regardless of their contributory base. It is to be hoped that courageous steps can be made in the direction of plain speaking to public opinion.

b) Whether we like it or not, supplementary insurance mechanisms respond, in varying ways, to essentially different operating principles to statutory schemes, from two interlinked points of view:

  — their costs depend on the nature of the risks. The cover they provide depends on the financial capacity of clients or members. These costs can act as a deterrent. A selective approach, in one form or another, is therefore in play.

  — all these schemes, whatever their motivations, cultures or strategies, operate in a competitive environment. Membership or contracts are voluntary. This cannot be changed without running counter to their nature and destroying their own basis, and without the state abandoning to them its fundamental mission of solidarity. From this point of view, as well as others, the Parliament document is perfectly clear. This does not, however, imply that we should simply sit back and watch an unfolding situation leading to financial and/or health-determined exclusion, on the grounds of not interfering with competition.

Whether they say so openly or not, the Member States are all aware of the implications of the choices they must make:

— to increase the burden of compulsory contributions (taxes and/or social security);

— to allow the quality and rapidity of care to be reduced;

— to optimise the growing role of supplementary cover systems; or

— to make statutory schemes work more effectively.

The question raised in the document submitted to the Committee concerns the steps to be taken in this third direction.

2. Identifying obstacles

It should be pointed out that here, we are touching upon difficult and delicate matters, on account of the diversity of circumstances, traditions and approaches of the EU Member States:

— taxes in one place; contributions in another; elsewhere, both, to varying degrees;

— legislation in one place; negotiation and contracts in another;

— differentiated procedures in one place; uniform ones in another, etc.

II. **Specific comments**

N.B.: This part of the Committee's opinion follows the paragraph by paragraph order of Parts II and III of the Parliament document.

Preamble — Part II

The Committee welcomes and endorses the restatement of the purposes of social protection for which the European Union is responsible, both in recognising specific characteristics and in acknowledging the common objective of solidarity.

§ 1-2. The Committee believes that the figures quoted would be clearer if they indicated the portion of expenditure which is reimbursed.

§ 1-3. The Committee considers that to make the point more effectively, European-level data — if available — should be provided. This would help to clarify which types of care, treatment or products have to be paid for in part or full by the patient. In an attempt to control spending, while maintaining a basic minimum level, some Member States have introduced new arrangements to determine selection priorities. Information on this point would be welcome.

§ 1-5. The Committee believes that solidarity, as a principle, firstly concerns statutory schemes. The question of possible sharing solidarity with supplementary schemes should be subject to open debate. This point cannot be left hanging.

§ 2. Figures on the number of people covered by supplementary health insurance should be made available.

§ 2-3. The purpose of the right to health care is to guarantee prompt access to medical care which is judged necessary under medical criteria deemed to be objective. This can only involve medically-recognised needs.

§ 3-5. It should be ascertained whether optical and dental care are covered by statutory schemes, and to what level.

Part III of the document

§ 3. This paragraph states that 'the laws of the market would tend to introduce selection on the basis of risk'. The Committee notes that all the market players are seeking clients. Some offer the lowest premiums. They select 'good risks': young, healthy people. Others pool risks, preventing the most economically disadvantaged, the most sick and the oldest from being excluded. In a crude interpretation of the law of the market, systematic risk selection can only lead to the eviction of the weakest from the market.

The document advocates minimum rules in order to prevent withdrawal of social cover. If this refers to absence of the minimal care which would be covered by the statutory schemes, then the quality of care and time limits for provision of care should be specified.

A pool system should be organised for 'major risks', setting up, for example, guarantee funds, to be financed by insurance operators, shouldering the cost of additional premiums.

§ 5. The Committee fully endorses the remark.

III. **Opinion on the proposed measures**

A. *Charter of fundamental rights*

The Committee feels that the charter should lay down strong principles: it should be based on the Council of Europe's social charter and the charter of workers' fundamental rights.

B. *Follow-up instruments*

The Committee believes that the Union should set up effective means for European-level monitoring of this important subject:

— either by means of an some existing agency;

— by allocating the necessary logistic and budgetary resources to the social protection committee, which it has recently been agreed to set up;

— or, if such resources are not allocated, by setting up an observatory.

C. *Framework of basic rules*

1. The Committee advocates retaining a shared concept of universal service with regard to access to high-quality, prompt care.

2. It considers that the aim should be to lay down guidelines rather than to legislate in an area whose complexity has been clearly shown. The objective would be to ensure that contractual specifications, serving as codes of good conduct, would be negotiated with private insurers in each Member State. This would prevention the exclusion which over-zealous use of a risk-selection approach might cause.

The Committee favours a recommendation to this end, under the provisions of Treaty Article 152.

3. The Committee is in favour of the idea of life-long cover.

4. In the Committee's view, every effort should be made to mobilise supplementary insurers in prevention activities.

5. The Committee opposes the use of genetic data for discriminatory insurance purposes.

6. The Committee would like to see an ombudsman established in each Member State to help assessment and resolution of disputes between insurance companies and policy-holders on the basis of the ethical codes advocated in point 2 above.

Brussels, 24 May 2000.

The President

of the Economic and Social Committee

Beatrice RANGONI MACHIAVELLI