Possible approaches to benchmarking voluntary health insurance funds in Bulgaria

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2010

POSSIBLE APPROACHES TO BENCHMARKING VOLUNTARY HEALTH INSURANCE FUNDS IN BULGARIA

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Abstract: Following the adoption of the Health Insurance Law in Bulgaria (1999), which provided the legal framework for the development of the voluntary health insurance, several health insurance funds had been established. Bulgaria had two licensed voluntary health insurance funds in 2001; in 2003 their number grew to six; and in 2009 this number stands over twenty. Despite the increased number of funds in recent years, their share of healthcare spending stayed at 1-1.5%, which is below European average.
To this date, there are no serious and profound studies in the field among the scientific community in Bulgaria. The economic data published by the Commission of Financial Surveillance (CFS), conforms to EC regulations, but do not allow non-specialists to assess realistically voluntary health insurance funds (VHIF).
This article introduces a methodology for comparing VHIF and establishment of a complex index (Benchmark Index - BI) based on 5 groups of indicators, related to several available variables. This index is intended as a tool for analyzing the voluntary health insurance sector and managing resources through a set of analytic indicators and variables. It can be used to create a certain type of ranking of VHIF.

Key words: voluntary health insurance, market, comparing methods, benchmark index.

Introduction

The development of the insurance markets changed to a great extent the roles of businesses dealing with the organization and provision of insurance services. The constant demand for new forms of insurance, the development of competition and free market of offered services, the growing motivation of companies and individuals for inclusion into new insurance schemes, the higher insurance culture of businesses and individuals, are challenging all involved market players.
The main challenges to voluntary health insurance are related to:

- Honesty, loyalty, transparency and heightened social sensitivity to the clients needs;
- Strict knowledge of legislation, regulatory mechanisms and requirements concerning different forms of insurance;
- Individualized marketing and client servicing;
- Development of forms and models increasing the motivation for inclusion in insurance schemes;
- Provision of measures for safeguarding the clients interests – security for the invested funds, collected information, etc.
- Perfect knowledge of the theory and practice of insurance relations, the forms of insurance, the different methods and models;
- Provision of clear, accessible and understandable information regarding the insurance relations;
- Knowledge of the options for meeting the different individual or company insurance problems and needs;
- Transformation of the “service seller” role to the “personal consultant and counselor” role for all involved in this business;
- Introduction of innovations – organizational, informational and others focused on the client.

Following the adoption of the Health Insurance Law in Bulgaria (1999), which provided the legal framework for the development of the voluntary health insurance, several health insurance funds had been established. Bulgaria had two licensed voluntary health insurance funds in 2001; in 2003 their number grew to six; and in 2009 this number stands over twenty. Despite the increased number of funds in recent years, their share of healthcare spending stayed at 1-1.5%, which is below European average.

Table 1. Comparison of public and private funds

	General government (Percentage of GDP)				Private insurance enterprises (other than social insurance) (Percentage of GDP)			
	2003	2004	2005	2006	2003	2004	2005	2006
Austria		7,57				0,53		
Belgium	7,11	7,43	7,36	7,16	0,17	0,18	0,18	0,18
Bulgaria	4,65	4,37	4,53	3,97	0,01	0,01	0,02	0,03
Switzerland	6,67	6,70	6,78	6,41	0,65	0,73	0,71	0,71
Cyprus	1,60	1,44	1,45	1,52	0,07	0,08	0,08	0,09
Czech Republic	6,39	6,17	6,06	5,84	0,02	0,02	0,02	0,01
Germany	8,22	7,86	7,94	7,86	0,91	0,93	0,95	0,94
Denmark	7,42	7,48	7,53	7,70	0,13	0,14	0,14	0,15
Estonia	3,82	3,86	3,86	3,71	0,00	0,00	0,01	0,05
Spain	5,53	5,57	5,63	5,71	0,46	0,47	0,49	0,50
Finland	5,55	5,67	5,86	5,82	0,15	0,15	0,15	0,15
France	8,42	8,48	8,55	8,47				
Hungary	5,79	5,57	5,80	5,64	0,05	0,09	0,09	0,11
Iceland	8,48	8,04	7,68	7,49				
Japan	6,36	6,39	6,56		0,20	0,20	0,20	
Lithuania		3,68	3,79	3,95		0,02	0,02	0,02
Luxembourg	6,65	6,78	6,81					
Latvia		3,65	3,44			0,18	0,14	
Netherlands	5,85	5,83	5,83		0,97	1,08	1,11	
Norway	6,28	7,49	7,07		0,00			
Poland	4,14	4,01	4,02	4,05	0,04	0,04	0,03	0,03
Portugal	6,69	6,81	6,91	6,66	0,19	0,21	0,21	0,23
Romania	3,84	3,52	3,85	3,42	0,19	0,13	0,23	0,02
Sweden	7,49	7,30	7,24	7,23				
Slovenia	5,91	5,86	5,86	5,68	0,00			
Slovakia			5,08	4,91				
United States	6,64	6,71	6,77	6,92			5,52	5,49

Data from Eurostat, 2009 http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home

The market for voluntary (private) health insurance funds in Bulgaria is growing in recent years, but with some unfavorable features:

- Unclear packages of offered services;
- Supply of services identical to those offered by mandatory public insurance;
- Low share of total healthcare spending;
- Ambiguity concerning the type of insurance offered – additional, replacement or supplementary;
- Lack of motivation for inclusion among the general population (fear of financial pyramids);

- Predominantly corporative based insurance – inclusion of whole companies, due to tax concessions.

Table 2. Public healthcare spending by year

Public spending/years	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total healthcare spending, *including:*	977.7	1196.0	1437,3	1697,7	1769,1	1777,7	1997,4	2215,60	2368,9
Ministry of Health	291.9	462.0	540.0	599.6	644.6	576.4	405.5	514.4	560,80
National Health Insurance Fund	126.8	428.2	585.0	775.1	881.6	982.9	1357.6	1464.9	1550,00
Municipalities	413.8	183.2	209.5	218.8	109.2	138.8	155.2	174.7	179,10
Others	145.2	122.6	102.8	104.2	133.7	79.6	79.1	61.6	79,00

Table 3. Health insurance funds (number, premium income and paid off claims)

Voluntary (private) health insurance	2000	2001	2002	2003	2004	2005	2006	2007	2008
Number of funds			6	6	11	12	13	15	20
Premium income			3,315	6,405	11,628	17,788	22,297	25,353	30,307
Paid off claims			0,427	2,571	5,625	9,466	12,598	15,319	21,108
Premium income as a percentage from total public spending			0,23	0,38	0,66	1,00	1,12	1,14	1,28
Paid off claims as a percentage from total public spending			0,03	0,15	0,32	0,53	0,63	0,69	0,89

When analyzing the offered services and packages (table 4), it becomes clear that premium incomes come mainly from “other” packages, followed by those for outpatient medical treatment and reimbursement; the paid off claims demonstrate similar structure.

Table 4. Distribution of premiums and paid off claims according to types of packages during the observed period

	Premiums				Paid off claims			
	I	II	III	IV	I	II	III	IV
PACKAGE TYPE								
1. Health promotion and disease prevention	12,40%	12,55%	11,07%	10,75%	10,83%	12,51%	10,31%	10,28%
2. Outpatient medical services	18,47%	18,54%	26,51%	25,98%	23,81%	23,18%	26,13%	27,22%
3. Inpatient medical services	11,63%	12,10%	16,20%	16,10%	6,25%	6,55%	5,40%	4,97%
4. Dental services	3,30%	3,02%	0,94%	1,15%	8,69%	8,24%	5,45%	4,78%
5. Services related to daily wants, transportation and others during medical treatment	1,32%	1,49%	0,74%	0,73%	0,26%	0,27%	0,19%	0,19%

6. Reimbursement of expenses	9,98%	9,48%	15,07%	14,36%	18,36%	17,96%	17,18%	16,46%
7. Other packages	42,91%	42,82%	29,48%	30,92%	31,81%	31,29%	35,35%	36,09%
TOTAL:	100,0%	100,00%	100,00%	100,00%	100,00%	100,00%	100,00%	100,00%

The data demonstrates the ambiguity in the offered services; no fund is able to specify what it means by "other" packages and reimbursement of expenses.

In spite of the upward trend in this type of insurance in Bulgaria, there are no serious and profound studies in the field among the scientific community. In the course of the last 9 years there are 36 publications related to voluntary health insurance; where 1/3 of them are literature reviews, 2 are monographs on the underlying principles of different insurance models, 5 investigate the activities of certain insurance funds and several represent discussions on future developments of the health insurance system.

Real and accessible data regarding health insurance activities can be found exclusively among the data published by the Commission of Financial Surveillance (CFS).

In principle, managerial and customer decisions can only be based on reliable data concerning insurance companies. In view of this, economists, statisticians and managers around the world, have come up with increasingly complex methods of comparisons and assessments of organizational structures in healthcare.

Comparing voluntary health insurance funds in Bulgaria is a daunting task due to the lack of readily available data and the vagueness surrounding assessment practices. Decisions seam to be based on general considerations and "expert statements" and do little to reflect objective realities.

To this day, the only comparisons are based on the market shares of different insurance funds. The economic data published by CFS, conforms to EC regulations, but do not allow non-specialists to assess realistically voluntary health insurance funds (VHIF).

This article introduces a methodology for comparing VHIF and establishment of a complex index (Benchmark Index - BI) based on 5 groups of indicators, related to several available variables. This index is intended as a tool for analyzing the voluntary health insurance sector and managing resources through a set of analytic indicators and variables. It can be used to create a certain type of ranking of VHIF. By easing the comparative analysis theses indicators can be used for evidence-based management.

The creation of complex mathematical methods introducing abundant data is one of the challenges for decision-makers and managers, who prefer to use clear and concise data in their practice.

The establishment of a simplified and easy to use integral BI is a compelling task for the scientific community. Such an index could help the healthcare system in several directions:

- Patients – when choosing a VHIF (*social efficiency*);
- Politicians – when deciding on resource management and allocation (*economic efficiency*);
- Managers – assessment of operative management (*operative efficiency*)
- Medical professionals – assessment of medical activities (*medical efficiency*)

Methodology for the creation of a benchmark index and the comparison of voluntary health insurance funds

The main challenges and limitations when creating the BI can be summarized like this:

- Diversity in size, type and activities of different VHIF;
- Hard to find reliable and accessible data on VHIF activities;

- Choice of easy to use mathematical and statistical models for data processing and summarization;
- Slow adoption of new IT technologies;
- The desire of politicians to support and managers to participate in the process of evaluating VHIF.

The creation of a BI had the following algorithm:

- Grouping of indicators in separate groups (pillars) and the calculation of an index fro each pillar;
- Calculation of a complex BI as a derivative of pillar BI;
- Comparison of VHIF on the basis of BI.

This approach allows for swift analysis and assessment both with non-professionals with no formal evaluation skills, and professionals who want to base their managerial decisions on such estimates. The approach foresees some pretty straightforward comparisons among VHIF, which can no less be used to illustrate complex aspects of organizational stability, economical stability and efficiency, public importance and technological development.

It also looks easier to understand from the general public, when component indicators are analyzed and not general tendencies (Saltelli, 2007)

The main considerations "for" and "against" the usage of component indicators of the complex BI, are the following (adapted from Saisana & Tarantola, 2002):

For and against the BI component indicators usage	
• Summarize a complex of multi-mathematical realities to support decision-making. • Easier to interpret. • Able to evaluate progress over time. • Diminish the discernible size of indicators set, without losing information. • Allow the inclusion of more information in the framework of existing limits. • Facilitate communication with the public (i.e. general public, media, etc.) and promote accountability. • Allow customers to compare options effectively.	• May send misleading signals. • May simplify political decisions without profound analysis. • May create the basis for misuse, e.g. raise support for a certain policy or organization, especially if the adoption of such indicators is not a transparent process and has no statistical or conceptual notability. • The choice of certain indicators is subject to political and scientific arguments. • May be interpreted incorrectly and lead to serious decisions, discordant with the objective situation.

The strengths and weaknesses of BI ensue to a great extent from the quality of the main variables, included in its calculation. In the perfect case, all variables should be selected on the basis of their significance, analytic stability, timeliness, availability and other solid considerations.

For the purposes of comparing and the creation of a BI we selected the following groups (pillars) of indicators:

- **I pillar – activities, organization, efficiency**, which includes the following indicators – 1) number of concluded individual insurance policies; 2) number of concluded family policies; 3) number of concluded group policies; 4) number of concluded corporate policies; 5) total number of insured persons; 6) number of regional representatives (offices); 7) number of contracts concluded with medical facilities – medical, dental and pharmacies; 8) number of reused claims; 9) number of complaints 10) number of granted complaints.
- **II pillar – premium income** according to package type – 1) health promotion and disease prevention; 2) outpatient medical services; 3) inpatient medical services; 4) dental

services; 5) services related to daily wants, transportation and others during medical treatment; 6) reimbursement of expenses; 7) other packages; 8) total

- **III pillar – market share**
- **IV pillar – paid off claims** according to package type – 1) health promotion and disease prevention; 2) outpatient medical services; 3) inpatient medical services; 4) dental services; 5) services related to daily wants, transportation and others during medical treatment; 6) reimbursement of expenses; 7) other packages; 8) total
- **V pillar – financial parameters** – 1) non-material assets; 2) investments; 3) claims; 4) other assets; 5) expenses for future periods and accumulated capital; 6) liabilities.

The selection of these indicators is based on the following criteria – availability, transparency, potential for collection and analysis, respect for trade secrets. During the creation of a BI other indicators can be selected as well.

Mathematical model used in calculations

The model min-max normalization was chosen for calculating the separate indicators. The way of applying this method is to subtract the maximum value from the value in question and then divide by the range of data of the indicator. However, a danger exists that the so called extreme values could obstruct the transformation of data into an indicator. On the other hand, the min-max normalization could enhance the scope of the indicators situated in a small interval, which enhances the effect of the complex index.
The formula used during the calculations according to this method:

$$I = \frac{x - \min(n)}{\max(n) - \min(n)}$$

Where:

x - value of the indicator for the fund in question;
min (n) – minimum value from the group of indicators;
max (n) – maximum value from the group of indicators;

When calculating and comparing VHIF we used published data from CFS prior to October 2008.

When calculating and comparing we did not utilize the **I pillar**, due to lack of actual data.

Results

After calculating the separate indicators in the pillars, we obtained the following results:

Table 5. Integral Benchmark Index (IBI) of VHIF

Insurance fund	IBI (October 2008)	IBI (end of 2008)	IBI (March 2009)	IBI (April 2009)
	I	II	III	IV
GENERALI ZAKRILA	0,802	0,800	0,769	0,824
DOM-ZDRAVE	0,472	0,472	0,286	0,297
MEDICO 21	0,269	0,253	0,282	0,329
DZI-HEALTH INSURANCE	0,317	0,287	0,178	0,185
DOVERIE	0,294	0,278	0,448	0,445

NADEZDA	0,252	0,253	0,198	0,212
UNITED HEALTH INSURANCE	0,187	0,183	0,148	0,170
BULSTRAD ZDRAVE	0,126	0,138	0,119	0,135
EVROINS-HEALTH INSURANCE	0,115	0,122	0,098	0,129
BULGARIA ZDRAVE	0,149	0,138	0,515	0,526
MUNICIPAL HEALTH INSURANCE FUND	0,120	0,157	0,185	0,212
VSEOTDAINOST	0,107	0,125	0,099	0,129
TOKUDA HEALTH INSURANCE FUND	0,077	0,099	0,067	0,070
HEALTH INSURANCE INSTITUTE	0,081	0,088	0,069	0,070
PLANETA	0,095	0,090	0,084	0,088
DALBOG: ZIVOT I ZDRAVE	0,073	0,096	0,170	0,181
PRIME HEALTH	0,067	0,064	0,060	0,060
CKB	0,054	0,058	0,056	0,058
WEISS MEDIKA	0,082	0,045	0,067	0,065
EVROPA	0,082	0,073	0,073	0,060

It is evident from the data, that there is a tendency for increase in the indicators for the leading insurance funds. The opposite result for some funds hints at deterioration in their activities (last four in the table).

Table 6. Ranking analysis of VHIF

Insurance fund	**RANK (October 2008)**	**RANK (end of 2008)**	**RANK (March 2009)**	**RANK (April 2009)**
	I	**II**	**III**	**IV**
GENERALI ZAKRILA	1	1	1	1
DOM-ZDRAVE	2	2	4	5
MEDICO 21	5	5	5	4
DZI-HEALTH INSURANCE	3	3	8	8
DOVERIE	4	4	3	3
NADEZDA	6	6	6	7
UNITED HEALTH INSURANCE	7	7	10	10
BULSTRAD ZDRAVE	9	9	11	11
EVROINS-HEALTH INSURANCE	11	12	13	12
BULGARIA ZDRAVE	8	10	2	2
MUNICIPAL HEALTH INSURANCE FUND	10	8	7	6
VSEOTDAINOST	12	11	12	13
TOKUDA HEALTH INSURANCE FUND	17	13	18	16
HEALTH INSURANCE INSTITUTE	16	16	16	15
PLANETA	13	15	14	14
DALBOG: ZIVOT I ZDRAVE	18	14	9	9
PRIME HEALTH	19	18	19	19
CKB	20	19	20	20
WEISS MEDIKA	14	20	17	17
EVROPA	14	17	15	18

Table 7. Market share of VHIF for the III and IV observed period

Insurance fund	**Market share**	**Market share**

	III	IV
GENERALI ZAKRILA	19,46%	19,25%
DOM-ZDRAVE	8,50%	8,43%
MEDICO 21	12,61%	13,36%
DZI-HEALTH INSURANCE	2,51%	2,35%
DOVERIE	16,07%	13,83%
NADEZDA	2,86%	3,13%
UNITED HEALTH INSURANCE	2,50%	3,15%
BULSTRAD ZDRAVE	1,26%	1,89%
EVROINS-HEALTH INSURANCE	1,28%	2,34%
BULGARIA ZDRAVE	21,43%	18,51%
MUNICIPAL HEALTH INSURANCE FUND	4,52%	5,08%
VSEOTDAINOST	0,22%	1,25%
TOKUDA HEALTH INSURANCE FUND	0,66%	0,70%
HEALTH INSURANCE INSTITUTE	0,51%	0,44%
PLANETA	0,36%	0,41%
DALBOG: ZIVOT I ZDRAVE	4,26%	4,92%
PRIME HEALTH	0,22%	0,27%
CKB	0,05%	0,09%
WEISS MEDIKA	0,74%	0,61%
EVROPA	0,00%	0,00%

When comparing data from IBI, rank analysis and market shares, it becomes evident that, although VHIF “Bulgaria Zdrave” occupies in the III period first place according to market share, it doesn’t come first in terms of IBI and ranking.

The IBI presented here allows assessing and comparing the position of each and every VHIF, additionally allowing interested professionals to base their managerial decisions on supplementary analysis of each indicator and pillar. The comparison by each indicator separately demonstrates that real analysis and ranking is impossible without the application of the integral index. When looking at the VHIF ranking according to market share, one finds it different from the ranking according to IBI, because of the inherent higher informational value of the latter.

Conclusions and recommendations

On the basis of the presented analysis and proposed methodology we formulated the following conclusions and recommendations:

1. It is necessary to develop models and methods for analysis, assessment and ranking of VHIF, allowing the spreading of transparent and adequate information for the needs of the general public and involved professionals.
2. The data published by CFS, which is a predominantly regulatory and surveillance body, are not sufficient for the analysis and comparison of VHIF activities.
3. It is necessary for the Association of VHIF to assist in the introduction of independent assessment and ranking of VHIF, which will make their activities transparent in society.
4. The proposed methodology enhances the opportunities for patients and company managers to make informed choices when choosing health insurance policies.
5. More studies and analyses in the field are necessary, which will accelerate the adoption of evidence-based policies in voluntary health insurance.

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