Insurance in the welfare state

The insurance industry’s contribution to the welfare debate
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Preface

One of the characteristics of rich and well-developed economies is good and broad insurance cover for the population. Together with government benefits, private insurance benefits form the core of any welfare state. The distribution of responsibilities between the public and the private sector is not unchangeable, which is also true for Denmark. To some extent it is even random. Insurance benefits and government benefits complement each other and interact in ways which change over time in response to changing conditions. This will also be needed in future.

Reforms of the welfare system are needed to secure the sustainability of the welfare state when the number of elderly people outside the labour market increases in relation to the number of persons in the labour market. The Welfare Commission has already established the fact that changes in the composition of the population mean that some choices have to be made about where and how the Danish welfare model can best be adjusted to secure future welfare without raising taxes or incurring further debts.

The Welfare Commission has invited citizens to an open dialogue about its work. The Danish Insurance Association is happy to accept this invitation. For many years, the insurance and pension industries have been responsible for important parts of individual citizens’ welfare insurance. Ordinary fire insurance is one of the oldest examples, and occupational pension schemes, which are very common today, are one of the more recent examples. Private insurance solutions will undoubtedly also be playing a key role in connection with the necessary adjustments of the Danish welfare state.

This discussion paper illustrates through some specific welfare areas relevant to insurance how, interacting more or less with the public sector and the political system, private insurance solutions can contribute alternatives and supplements to government welfare benefits. Emphasis is given to describing the weaknesses and strengths of both public and private solutions. Moreover, the paper shows that insurance can be a solution also in areas where tradition dictates that it would be difficult to involve the insurance industry. Depending on the right conditions, insurance solutions can play a positive role in developing the welfare state. The Danish Insurance Association is ready to discuss partnership agreements on the solution to specific welfare tasks with politicians and authorities.

The examples described also show that there are limits to the tasks the insurance industry can perform. This is important to bear in mind when the design of the future welfare state is being debated.

The Danish Insurance Association’s intention with this contribution to the welfare debate is thus to illustrate some of the key issues that must be considered in the important debate on reforms of welfare benefits and services and the possibilities of leaving a greater share of welfare tasks to privately based insurance solutions.

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Steen Leth Jeppesen, Managing Director
The Danish Insurance Association
By setting up the Welfare Commission, the Government has enlivened the debate about how to secure Danish welfare over the coming decades when the share of elderly people who are no longer active in the labour market grows in relation to people of working age. As highlighted in the terms of reference of the Welfare Commission, one of the motives for setting up the Commission is that until 2025 the number of elderly people over the age of 64 will grow by more than 40 per cent, while the number of persons of working age between 18 and 64 will fall by 5 per cent in the same period.

This trend inherently implies that the pressure on public welfare benefits and services will increase significantly. Furthermore, as a consequence of the general increase in prosperity, the demands for the contents and scope of welfare benefits and services will be sharpened, it appears from the terms of reference.

Several circumstances combine to cause government expenditure on welfare benefits and services to increase considerably and require higher taxation, unless reforms (of the welfare benefits and services) are implemented in time. The Welfare Commission is to present proposals outlining how such reforms can be implemented so as to ensure that good welfare benefits and services are maintained for those who need them while taxes are kept in check.

The Government has announced that it wants a broad and open dialogue with citizens and the parties in the Danish Parliament about welfare reforms. Consequently, the Government wants the Welfare Commission to work openly with a view to having an ongoing discussion about the Commission's work and themes.

The insurance industry welcomes dialogue
This invitation to an open dialogue and debate with the Welfare Commission, politicians and citizens about the design of the future welfare system is readily accepted by the Danish Insurance Association.

There is more to “the welfare state” and “the benefits and services of the welfare state” than early-retirement benefits, old-age pension, homehelp services, kindergartens and hospitals, which are all to a wide extent publicly financed services. Private insurance such as fire and motor insurance are also welfare benefits.

The occupational pension scheme that have been established over several years as part of agreements in the labour market are an important example showing that the development of an otherwise public welfare task has been successfully “privatised” and left to life insurance companies and pension funds. Today almost all employees are covered by these pension schemes. In the coming decades – just when the demographic shifts reach their peak – payments from these pension schemes will constitute a very significant element in the coming pensioners' income and will consequently relieve the public payments.

But the importance of insurance as a supplier of welfare does not stop here. Insurance serves a purpose in relation to both small corners of the welfare state and in relation to big social welfare tasks.

Examples are many and varied. For example, probably not many people know about the Danish Motor Insurers’ Bureau (DFIM). But if a Dane is involved in a car accident abroad or in an accident with a foreign car in Denmark, DFIM sees to it that indemnity is paid via the car's liability and comprehensive insurance. DFIM has helped thousands of Danes when they have had an accident.

There are also examples that new insurance products are being introduced which meet specific needs and requirements. This is, for example, true of the so-called critical illness insurance policies, which provide a cash amount if a specified life-threatening illness is diagnosed. Over a short number of years, several hundred thousand Danes have been covered by this type of insurance.

Furthermore, the “ordinary” and well-known types of insurance are also an important part of the welfare state. The individual citizen's household insurance is, for example, a welfare scheme granting financial compensation to the individual in the event of burglary, etc.

These ordinary insurance schemes are essential in the welfare state. When during a few hours in December 1999 a heavy storm devastated Denmark, damage was caused to houses, farms, factories, cars and personal property for a two-digit billion amount. The damage caused could involve considerable financial losses for individuals and business operators. Hardly anyone will dispute the claim that in this situation a welfare scheme was needed to pay compensation to the victims. It could have been a public welfare scheme where the Danish taxpayers stepped in and paid the claims. However, claims amounting to more than DKK 10 billion were paid not by the taxpayers, but by the insurance companies.

Insurance and welfare are thus inextricably connected. This fact is also acknowledged by the Welfare Commission, which in its first report calls the public, tax-financed welfare solution “implicit” insurance – because premiums are not paid directly but via taxes. The report compares public welfare benefits in a number of areas with private insurance solutions, which may thus be termed “explicit insurance”.

Insurance Denmark
The Welfare Commission thus acknowledges that
public welfare benefits and private insurance benefits are mutually complementary and together increase overall welfare. This is an important conclusion, which contrasts the view that the development of the Danish welfare state into “Insurance Denmark” should be avoided. This concept has probably never been defined, but it involves an assumption that the growth of private insurance will lead to a reduced supply of public welfare benefits. Private insurance solutions are a threat to a solitary welfare state, where citizens make common cause with each other, the slogan goes.

However, the figures reveal another reality. Government expenditure on welfare benefits and services has never been higher than now. At the same time, the scope of private welfare benefits in an insurance context has continued to grow over the years. Payments to pension schemes set new records every year, and new areas of insurance such as unemployment insurance and health care insurance shoot up. Public and private welfare benefits exist side by side, supplement each other and increase overall economic welfare.

Besides, it is not clear what is in practice implied by political demands that key welfare benefits and services should be public. It may mean that benefits and services should be produced (carried out) by the public sector. But it may also mean that the benefits and services must meet certain political requirements, but may be supplied by private producers, as is known from home help services, refuse collection and private schools. Finally, the meaning may be that the financing of the benefits and services should be public. In general, a political demand for “public benefits and services” can probably be interpreted to mean that the public sector must lay down requirements for the contents of the benefits and services and who is to receive them, but not necessarily who is to supply the benefits and services.

Insurance as a supplier of welfare benefits does not exclude public management and control of the benefits. The public sector can set requirements for the contents of insurance policies and demand compulsory cover, possibly for special groups. In this way, the effectiveness of providing benefits and services can be maintained on the basis of the competition between suppliers.

Insurance as a supplier of welfare benefits and services differs from public welfare benefits and services mainly through the form of financing, which is an alternative to tax financing. More welfare benefits and services can be delivered without increasing taxes. But it requires that public authorities do not fix the price structure. For example, a policy which by statute must be taken out by everybody, and where there is no connection between the individual’s risk and the price of the policy, will in reality be financed through a “hidden tax”.

**Random demarcation**

While public and privately based insurance benefits coexist and are mutually complementary, it is more unclear why the demarcation line between public and private welfare benefits has been drawn as it is the case.

Many people will probably feel that receiving free — i.e. tax-financed — hospital treatment is just and fair. Illness can hit anyone, and financial capabilities should not dictate how quickly a person can receive treatment. But if this is a political starting point, why are substantial user charges accepted for drugs, chiropractic and dental treatments and much more? User charges so high that the health insurance company “danmark” presently has 1.8 million members with policies aimed precisely at the areas in the overall health system where user charges are highest.

One could also ask why it should be a public task to transport injured Danish ski tourists back from Austria or France – with cover via the Health Care Reimbursement Scheme – but not from Canada? Generally speaking, why should the public sector provide insurance cover in case of illness when Danes go on holiday in Europe, while it is up to the individual to take out a household policy?

The demarcation lines between the welfare tasks handled by the public sector and those handled via market-based insurance solutions, respectively, are drawn more or less at random. If one looks at the distribution of responsibilities between the public sector and the insurance industry in other countries, it also turns out that there is no exact systemisation in the way in which the responsibility of tasks is organised.

**Limits to what can be insured**

When the insurance industry’s possible involvement in the performance of welfare tasks is up for debate, it is often stressed that there are narrow limits to what can be insured. This is also a theme that the Welfare Commission has touched upon in its first report. It is a problem in private insurance solutions if the risk that the policyholder inflicts on the other policyholders and the insurance company cannot be estimated reasonably correctly. If the policyholder can influence the event that triggers compensation, or if there are great differences in the risks that various policyholders bring into a collective insurance plan, it can be difficult to fix the right premium.

It is, however, important to note that the problems that can make it difficult to set up insurance schemes on market-based terms also manifest themselves in public welfare solutions.

If, for example, one imagines that an unemployment insurance policy provides full compensation for
loss of income during unemployment, it will, from a financial point of view, be an incentive for the individual to remain unemployed instead of working. In more general terms, the incentive to choose unemployment will be greater, the higher the compensation granted in connection with unemployment. This applies regardless of whether unemployment insurance is paid by public funds or by a private insurance policy.

Private insurance schemes have various measures - such as deductibles and waiting periods, etc. - to counter these problems. The same measures exist in a number of public welfare benefit schemes, but still the motivation to stem such incentive problems, etc. will be more pronounced in market-based insurance solutions than in public welfare schemes where the taxpayers pay the bill.

It is often maintained as an argument against market-based insurance solutions that political demands for redistributing income are difficult to handle on market conditions. In their pricing, insurance companies and pension funds have to take into account, for example, that in an insurance context “good and bad lives” have to be priced differently. Otherwise, the good lives would opt out of insurance, while the bad lives would flow in.

It is true that there are limits to the redistribution that can be handled by market-based insurance solutions. Redistribution of income between “rich and poor” must take place via the tax system.

But some redistribution extending beyond the general actuarial redistribution from “those who are not affected to those who are” can be handled in private insurance solutions. Occupational pension schemes are examples of this. As part of the collective agreements, pension schemes have been set up where the individual is a compulsory member. In some cases, as part of the collective agreements, employed pay earners are also included without them having to submit health statements. Similarly, redistribution takes place between women and men.

Collective insurance agreements between the social partners and the compulsory taking out of insurance are means that can be applied to handle political requests for redistributing income in private insurance solutions besides the redistribution that follows from general actuarial principles, thus making it possible to preserve competition between insurance companies and reap the benefits thereof, while also taking political considerations into account.

The insurance industry’s role in the welfare state therefore goes further than to handle only the tasks that can be covered on a commercial basis, when a number of theoretical conditions for the function of the market have been met. Insurance encompasses a broad spectrum of schemes. At one end, they consist of services supplied under completely free market conditions, only subject to public framework regulation and supervision, where the individual policyholder decides the scope of the desired insurance cover, and where the companies compete on cover, price, service, etc.

At the other end of the spectrum are statutory schemes that satisfy political and societal desires that insurance cover must be established, possibly with statutory regulation of insurance terms. Compulsory motor vehicle liability insurance is one example.

The insurance industry’s strengths in relation to the performance of public tasks

Market-based insurance can be better differentiated and tailored to the individual citizen’s specific needs than public standard benefits. Insurance is better at ensuring consistency with the citizen’s standard of living prior to the occurrence of an insurance event, irrespective of whether this event is the attainment of a certain age or a welfare-threatening event such as disability. The public sector cannot ensure this consistency with the previous standard of living and has difficulties handling tasks, other than supplying more or less the same benefit to everybody who meets certain criteria.

An obvious model, known from the pension system, is that the public system supplies a uniform basic benefit to everybody, while private insurance provides an additional benefit, the overall welfare system thus ensuring the individual’s usual standard of living. The model is also known from unemployment insurance and health insurance.

The population’s willingness to pay may be greater in relation to insurance that gives individual rights than in relation to (new) publicly financed welfare benefits requiring increased taxes, and where there is no connection between the individual’s risk and payment.

The population’s confidence in individual insurance rights may be greater than in political promises, especially if the political promises are related to future events and benefits. The policyholders’ financial rights in insurance schemes must be financed on an ongoing basis. The future income of pension savers thus exists as funds in the pension companies. If a pension company promises higher benefits in future, the funds to cover the benefits must be present; cf. statutory provisions and ongoing public supervision.

A special problem of public welfare benefits is that one generation of politicians could make promises that future generations of politicians may have difficulty fulfilling or may wish to revise. The voluntary early-retirement pay scheme is a textbook example that today’s politicians are bound by a scheme that was introduced
under completely different economic conditions than those of today, and which in the present economic situation needs a major overhaul that is politically difficult to implement. It is a political dilemma that changes to the voluntary early-retirement pay scheme risk undermining the voters' trust in public welfare schemes. This dilemma does not arise in insurance schemes where the financial rights are more clearly defined and financially hedged.

Insurance is better at pricing welfare benefits to the individual citizen. It makes it easier to control society's resource allocation when welfare benefits do not appear as free benefits to the population.

**Partnership agreements**

This discussion paper presents a number of examples of the insurance industry's present and possible role in the welfare state. The aim of the examples is to illustrate that insurance can play a role also in areas where it is traditionally seen as difficult to find a place for market-based insurance solutions – both for political reasons as in insurance policies related to the health area, and for more technical reasons as in hidden defects insurance, which is characterised by the fact that the policies cover damage that has already occurred at the time of insurance.

The selected examples also illustrate some of the difficulties that may be encountered in certain welfare schemes handled by the political system. The example of the flood insurance scheme shows that public welfare benefits are not necessarily awarded only when objective criteria have been met, but also when political pressure arises. Political demands for cover are met, even if the conditions have not been satisfied, with the result that conditions are gradually eased.

Other examples than the ones selected might have been presented. The problems relating to the use of genetic technology or to establishing insurance solutions in the environment field might very well be essential in the years ahead. The insurance industry is ready to discuss these problems, too. The examples chosen illustrate some important factors that must be taken into consideration when the weighting between public benefits and insurance benefits in the welfare state is debated. The aim has not been to highlight all specific areas where the insurance industry could play a bigger part in future than it does today.

The examples are meant to point to the debate on the welfare state and illustrate that there are alternatives and supplements to public welfare, but also that there are limits to the tasks that the insurance industry can perform.

Insurance solutions must be introduced with due consideration to political requests for the design of the welfare state. It is necessary to adjust the expectations connected with the insurance industry's involvement in new welfare areas. There are tasks that the insurance industry can perform on given terms, and there will be tasks that cannot be performed with insurance. It is important that the framework for the role of the insurance industry is specified and defined to ensure, among other things, that the hard-earned experience from the introduction of hidden defects insurance is not repeated.

Such adjustment of expectations could be handled in the form of partnership agreements of a more or less binding nature. Such agreements should involve the political system, the insurance industry and in some areas the social partners. The advantage will be that a forum is established for discussing and clarifying the contents of given insurance solutions, thus reducing as much as possible the risk of subsequent disappointed expectations.
Illness and insurance – large potential

Private health care insurance increases the total financing capacity in the hospital sector and consequently treatment possibilities. Increased use of health care insurance will reduce waiting lists for public treatment and increase total capacity in the health service. The Danish Insurance Association estimates that increased use of health care insurance can inject DKK 4.5 billion into the hospital sector within a relatively short span of years. In a welfare state like Denmark, the privately based health solutions will, however, always be a supplement to, and not a substitution for, the public health system.

Insurance policies that have illness as the factor triggering compensation from an insurance company have often been regarded as politically controversial. In contrast to a large number of other types of insurance such as ordinary motor and household insurance, industrial injury insurance and the business sector’s insurance against consequential loss, fire and much more, a certain political reluctance prevails towards insurance that grants compensation or entitles the policyholder to treatment, should he fall ill.

However, general welfare trends have intensified citizens’ demands for both the overall health system and financial compensation on illness. This has caused the introduction of various insurance schemes related to illness. It has also become increasingly clear that the growing and more individual demand for benefits and services from the health sector that follows from general welfare trends cannot be satisfied fully by the public sector. The political attitude towards insurance as a welfare supplier also in connection with illness seems to have softened somewhat with time.

That insurance in connection with illness can be politically controversial is probably due more to the fact that there are limits also in the health field to what the public sector can and will finance, than to the insurance solution in itself. It is widely held that the public sector has a duty to secure all citizens a free and equal right to the health benefits and services that the individual citizen may need. User charges for the use of health benefits and services – including private insurance solutions – are regarded as an indication that the public sector does not perform its task. The larger the private commitment in the health area, the more the public sector has failed its task, the argument seems to be.

But the Danish health sector is not characterised by full public financing. Some areas have a rather high degree of user charges. This is, for example, the case of dental services, spectacles, drugs and cosmetic surgery.

Nor is there totally free and equal access to the benefits and services of the health sector. For example, there are waiting lists for a number of operations, and, even if there is free choice of hospital, some areas of Denmark have longer waiting times than other areas.

User charges in selected areas and waiting lists for certain health services reflect the fact that activities in and expenditure on the health sector cannot be controlled by demand alone, given that, as a starting point, access to health benefits and services should be free. There is a need to prioritise which health benefits and services should be provided free of charge to the citizens as well as which amount of public funds should be allocated to the benefits and services. User charges in selected areas and the existence of waiting lists are examples of such prioritisation of limited public funds. It must, however, be questioned whether the prioritisation thus made is always the result of conscious political choices. For example, it is surprising that considerable user charges are accepted in the cases of dental services and drugs, while childlessness treatment is, with certain limitations, fully financed by the public sector.

The role of insurance in the health field

The political reluctance towards insurance solutions in the health field, which continues to exist to a certain extent, relates primarily to insurance policies that entitle the holder to hospital treatment. In other areas with a significant degree of user charges, it is accepted that insurance solutions gain ground, when the market is sufficiently large. One example is the health insurance company "danmark", which provides co-financing precisely in the areas where the use of user charges is significant. In the area of travellers’ health insurance, it is also acknowledged that there are limits to the public sector’s responsibility, reflected in the fact that a number of insurance companies are in keen competition in this field.

The claim that precisely privately financed hospital treatments give rise to political debate is supported by the fact that the building of a number of private hospitals and the increased popularity of insurance policies covering hospitalisation have led to a political decision to introduce a guarantee against waiting times in excess of given periods for selected hospital treatments.

However, private solutions play only a minor role in the hospital field. In Denmark, at the beginning of 2003, there were some 165 private hospital beds against some 20,000 public ones, meaning that private hospitals hold less than one per cent of the beds. Moreover, 86 per cent of patients wait less than three months for treatment; waiting lists have been falling over the last couple of years, and Denmark has the lowest waiting times compared with other countries that record waiting times.

The number of insurance policies allowing for full or part cover of the expenses of hospitalisation on specified terms and conditions has increased in recent years. The Danish Insurance Association estimates that from mid-2002 to 2003, the number of health care insurance

1 DSL, Danish Institute for Health Services Research, "Helix" no. 3 - March 2003.
policies rose from some 120,000 to some 235,000, and by mid-2004 almost 300,000 insurance policies had been issued. Moreover, “danmark” offers certain forms of surgery insurance policies. Some 10,000 policies have been sold, corresponding to other insurance companies’ health care insurance policies, and more than 500,000 surgery insurance policies have been taken out which provide a limited contribution to a number of approved operations in private hospitals.

It should, however, be borne in mind that health care insurance policies have a limited area of cover, cf. the fact box on health care insurance. Furthermore, to a wide extent, the insurance policies have gained ground as part of agreements in the labour market. As the working population’s pension savings have increased significantly for many years, a desire for prioritising new areas, such as health care insurance, has emerged. In any given year, only a relatively small share of policyholders will actually use the insurance policies.

The wish to maintain health benefits and services in the public system − both as regards production and

What is health care insurance?
Health care insurance is primarily offered through company schemes where they are taken out as group schemes. If the insurance scheme is offered to all the company’s employees, full tax exemption is granted for the premium, which may be deducted as an operating cost.

Tax exemption under the company tax schemes is conditional on treatment being medically justifiable, for which reason health care insurance policies that are limited to include only routine health checks are not tax exempt. However, tax exemption applies also to preventive treatment.

The price for health care insurance taken out under company tax schemes is typically DKK 1,500-2,000 annually, depending on the number of employees, degree of cover, etc.

The price for health care insurance taken out individually is higher and depends on the policyholder’s age, the premium being increased each year with the policyholder’s increasing age. Several unions are offering health care insurance to their members at a lower price than the one offered to individuals.

Irrespective of whether insurance has been taken out as a group scheme or individually, persons must typically be between 18 and 64 years of age to be covered by a scheme, and, if a person has been accepted, he or she can stay until the age of 65-70.

Health care insurance policies differ significantly from one company to the other as regards contents and degrees of cover. The typical minimum degree of cover is certain treatments at a private hospital, including preliminary examination and control of treatment given. If treatment cannot be offered in Denmark, it may be provided abroad.

Some health care insurance policies are divided into different “packages”, with further treatment areas as optional extras in addition to hospital treatment, such as counselling by a psychologist, physiotherapy and alcohol detoxication.

Other health care insurance policies cover the entire range, while there are some that are limited to cover “health care” as such in the form of preventive treatment, primarily counselling in various areas, i.e. psychological help.

In general, illnesses occurring before enrolment in an insurance scheme are also covered, when the individual has been in the scheme for at least two years, provided that the illness was not known at the time when insurance was taken out.

Health care insurance does not, for example, cover cosmetic surgery and alternative treatment.

Usually, there are ceilings to the treatment period (six months), the number of treatments (e.g. 15 physiotherapy treatments per diagnosis) and the sum total paid per diagnosis (e.g. DKK 500,000).

financing – springs from a principle of equality, reflected in a political wish to put everybody on an equal footing in connection with illness. The individual’s financial capabilities must not affect treatment made available. It is a characteristic of the health field that this principle of equality is extended to apply to the individual’s access to specific health benefits and services, including the individual’s lack of possibility to buy, for example, a private room or special food for his own money.

In many other areas, wishes to even out consumption possibilities are handled over tax and expenditure policies in general, but not by specific regulation of the individual’s consumption. For example, anyone is free to buy a car instead of using public transport, as long as he will pay for it and thus increase his tax payment, or to give priority to his housing consumption instead of other consumption.

The reluctance against private health care insurance, which still exists to a certain extent, is based on an assumption that the supply of specific hospital services is more or less constant. If Mr Smith cannot wait two months for a back operation and has his insurance scheme finance the operation instead, Mr Smith will jump ahead of Mr Jones in the queue, the argument goes.
Is the supply of health services constant?
The number of tasks – such as the number of operations – that can be performed in the health sector in a given period depends on the number of production factors available. Somewhat simplified, the activity in the sector will not only be determined by the political will to find funding, but also by the number of highly qualified employees such as doctors and other health-care professionals available, and by the amount of apparatus. On top of this come the current collective agreements, which determine working hours and job demarcation.

In the short term, the possibilities of increasing activities in the health sector – with a given number of health-care professionals and a fixed stock of apparatus – depend on whether, with insurance solutions, health-care professionals can be made to work longer hours than would be the case without insurance solutions. It must be assumed that the further influx of financial means to the health field as a result of the introduction of insurance solutions will make it possible to increase the supply of highly qualified labour, also in the relatively short term. There is no reason to assume that doctors and other health-care professionals react differently to financial incentives than everybody else.

This suggests that private insurance solutions can lead to higher treatment capacity, meaning that the existing apparatus is also utilised more efficiently. There are many indications that the hospital system has no real capacity problem, but that the system is not utilised well enough. Insurance solutions may help ensure better capacity utilisation.

Moreover, the introduction of private insurance solutions may open for better access to treatment abroad. In principle, there is nothing to prevent the buying of health services abroad for public means, but it is not a possibility willingly used in publicly financed treatment.

In the medium term, there is reason to assume that insurance solutions supplementing public treatment will increase total treatment capacity more than in the short term. The introduction of alternatives to the public health system sharpens competition, which helps increase efficiency in the total health care supply. This effect can be seen already today.

Moreover, the increased financing capacity offered through insurance solutions may help attract qualified staff from abroad. Furthermore, one important effect will be that insurance solutions will provide possibilities of investing in the latest and most efficient apparatus, which will increase total treatment capacity.

So if Mr Smith cannot wait for two months for his back surgery and instead has the operation financed via his insurance scheme, there will be one person less on the waiting list, and Mr Jones will thus be treated earlier in the publicly financed hospital.

Increase of the financing capacity on extended use of private health care insurance:
The Danish Insurance Association estimates that, together, close to 300,000 health care policies have been issued by the Danish insurance companies, a figure that may rise to 1 million within a relatively short span of years.

It is further estimated that payments are made on 5-8 per cent of the policies annually, and this figure seems to be on the increase. A conservative estimate is that the share may rise to 10-13 per cent in the near future.

Claims covered by health care insurance can roughly be divided into three categories:
- 1/3 of the claims cost DKK 50,000-150,000 per claim (hospitalisation)
- 1/3 of the claims cost DKK 10,000-30,000 per claim (minor, out-patient surgery)
- 1/3 of the claims cost DKK 1,500-2,000 per claim (examination by specialists).

The figures presented above suggest that private health care insurance could increase the financing capacity in the hospital sector by DKK 4-5 billion. By comparison, public expenditure on hospitals amounted to DKK 47 billion in 2002.

Distributional issues
Private insurance solutions in the health field will be able to increase total financing capacity and efficiency in the health sector, especially in the medium term. These positive effects result from the breaking of the public monopoly, leading to the introduction of a certain kind of competition. As in other fields of the economy, competition increases efficiency for the benefit of the citizens.

The achievement of positive effects so great that it makes a difference in the overall picture will, however, require that insurance solutions gain some ground. To lead to larger investments in improved apparatus and to help increase flexibility in the public system, the private supplement to public health solutions needs to be of a certain size. To the extent that the private hospital sector should be further developed, the investors need to have confidence in the public sector's acceptance and possible use of the privately based solutions. Otherwise, the risk involved in enhancing private treatment capacity would be too great.

In a society like Denmark, there are limits to how comprehensive privately based health solutions can be. They will always remain a supplement to, and not a substitution for, the public basic solution. Consequently,
the private solutions in the health field will not be able to offer the basic functions that are made available free of charge by public health service.

The private solutions can primarily be extended to apply to operations of which a given number must be carried out and which are fairly well known and standardised. This is because the price of such services can be determined fairly precisely, so that a basis exists for calculating insurance premiums reflecting the risk of a given population. It must also be taken into account that there are limits to the willingness to pay for supplementary insurance, not least since the citizens who are covered by private health care insurance already contribute to public health service via taxes.

A broad range of tasks such as emergency functions and specialised, costly operations, which there is a political desire to make available, will have more difficulty gaining a foothold in a privately based health system.

Moreover, it is a politically clear priority that, as a starting point, everyone should have equal access to health care services. This is a basic political demand in terms of income distribution. In a supplementary insurance-based system, a decision must be made on how to handle diagnosed and chronic illnesses. It is difficult to make insurance benefits available at a reasonable price to persons who are afflicted – already at the time of insurance – by an illness which is otherwise included in the insurance cover or to persons who are chronically ill.

The problems of handling already known illness, etc. are, of course, not only related to private insurance. They also apply in the publicly financed health system. But in this system, it has been decided that access to health services should not be subject to the restrictions that would apply in a market system. The tax-based form of financing has been chosen and the needed prioritisation is subsequently made through budgeting and framework control and by accepting waiting lists to a certain extent.

In the supplementary insurance system, such problems can to some degree be handled if the insurance policies are compulsory for the individual. This model is known from the system of supplementary occupational pension schemes, where individual schemes can offer, for example, disability cover without medical evidence of health.

A partnership agreement?

Long-term demographic trends imply that gradually there will be more elderly people outside the labour market in relation to the number of persons of working age. This in itself tightens the requirements for the public sector's supply of, for example, health benefits and services. It must also be expected that future generations of elderly people will make heavier and more individual demands for the benefits and services they receive from the health sector. The greater individuality in the demand for health benefits and services is based on increasing income among the older section of the population. It will be difficult for the public health system both to meet the total financing requirements and to satisfy more individual requirements for public services.

Privately based insurance solutions may help the health service address the challenge posed by demographic change. Especially to the extent that insurance solutions are agreed and set up as part of collective agreements in the labour market, insurance policies may play a real and positive role in the overall health system.

To ensure that insurance solutions will play a positive role in the overall health system, while at the same time satisfying political requests for overall task performance, including the incorporation of political requests for income distribution, a partnership agreement between the players involved could be established. The players are politicians, the owners of private hospitals (which may include insurance companies) and insurance companies. A partnership agreement would have to relate to the basic terms of the supplementary private solutions. A partnership agreement may include agreements on the following elements:

- Meeting political objectives on income distribution in private health solutions set up as a supplement to public ones.
- Pricing of privately offered health solutions paid for by the public sector, and other terms for referring patients from public to private hospitals.
- Drafting of public requirements for the contents of private insurance solutions with a view to ensuring that the public and private solutions supplement each other in the optimum manner.
- Investments in and use of new apparatus, thus optimising the sector's total investments and production capacity.
- Seeking to have insurance solutions built into collective agreements.
- Investigating the possibilities of introducing insurance solutions in the caring area in the form of so-called long term care insurance. These are care insurances policies where the insurance event is the determination, on the basis of objectively ascertainable criteria, of a certain need for care. The insurance policies can include a specific care service or an amount to cover the costs of care. Such insurance is known from the USA, the Netherlands and Germany and also seems interesting in the light of the demographic trends in the coming decades.
Unemployment insurance – supplementary cover is greatly needed

Interest in supplementary unemployment insurance is very high. Even pay earners with quite ordinary incomes witness a large reduction in their earnings if they lose their jobs. Many unemployment benefit plans offer their members supplementary unemployment insurance to be taken out with private insurance companies. But unemployment depends on economic trends, so premiums must rise when unemployment rises. Premiums may be adjusted frequently, and pay earners should be aware of this possibility. Private supplementary insurance allows the costs of unemployment to be borne by the working population to a larger degree and more quickly than in the case with public unemployment insurance, thus boosting the incentive to limit any growth in unemployment through pay formation.

A characteristic feature of unemployment insurance is that the insured event is defined as the individual insured losing his job. In this event, a policy provides some financial compensation, depending on the cover taken out.

Originally, unemployment insurance was introduced as a secondary product to guarantee the repayment of mortgage credit loans. This type of insurance guaranteed that mortgage credit loans would be serviced in the event of illness, unemployment or the like. Later, in the mid-1990s, the product was offered by banks as so-called loan insurance policies. Through its cooperation with primarily a few local banks, an insurance company offered insurance policies that, in the event of unemployment, would cover principal and interest payments on selected loans and credits granted by the banks in question. These policies were designed to allow principal and interest payments to be covered for a period of up to two years. However, these policies did not gain much ground, but still exist in the market.

The first policies to provide cover in the event of unemployment were thus limited in that they covered specific loan payments and did not cover any discrepancy between income earned as an employee and income received as an unemployed person.

Such a product was introduced in 1997 when Civiløkonomernes Tillægsforsikring (an insurance company set up by the Danish Association of Graduates in Economics and Business Administration to provide supplementary insurance) began offering insurance policies as a supplement to public unemployment benefits. In the event of unemployment, it was possible to receive an additional income of 50 per cent as a supplement to public unemployment benefits.

Unemployment and insurance

Characteristically, securing a certain amount of income for those out of work for some reason during a short or long period of time has been a public task for many years. Admittedly, the right to unemployment benefits requires membership of an unemployment plan, but the majority of the benefits (about two-thirds) paid every year in the form of unemployment benefits are financed through general taxation. In other terms, the membership fees collected by the unemployment plans would have to be increased substantially to cover the actual costs of providing unemployment benefits. Incidentally, the state-financed share is smaller than previously because of the relatively low rate of unemployment.

Unemployment benefits represent up to 90 per cent of income after deduction of labour market contribution before unemployment. But the maximum amount payable before tax is just under DKK 14,000 a month. This means that cover provided in the form of public unemployment benefits is relatively smaller, the higher an individual’s income is. The following figure illustrates this fact.

The figure shows the average loss of income on an annual basis compared with maximum benefits receivable for different income ranges. The average income per year of DKK 165,916 in the event of unemployment was less than DKK 300,000.

Source: Statistics Denmark, the Danish National Directorate of Labour and calculations made by the Danish Insurance Association.

The figure indicates a huge need for insurance to supplement basic public benefits in the event of unemployment. Of course, there are other ways of securing one’s own financial situation than taking out an insurance policy. For example, voluntary savings, owner’s equity (real property) or current household consumption taking into account the risk of unemployment are all instruments that can be used for handling the financial consequences of becoming unemployed for a certain period of time.
However, none of these instruments provides income security in the event of unemployment. As regards large groups of people, these instruments must therefore be considered relatively unstable mechanisms for providing security against the financial consequences of unemployment.

Recent years’ trends

During the past few years, interest in supplementary unemployment insurance has turned out to be very high indeed. In mid-2004, 20 unemployment funds offered just under 1.7 million members the possibility of taking out supplementary unemployment insurance – via an agreement concluded with an insurance company – whereas 13 unemployment funds with more than 700,000 members currently offer no such insurance cover. Furthermore, one insurance company offers supplementary unemployment insurance, but does not require policyholders to be members of an unemployment fund.

These data relate to the number of employed people who are in a position to take out unemployment insurance as a supplement to basic public benefits. No data are available to specify the number of people actually taking out such insurance. According to a rather uncertain estimate made by the Danish Insurance Association, the number of policies currently taken out is about 50,000; this means that a little more than 3 per cent of those able to take out supplementary insurance have actually done so. It may sound modest, but it is a well-known fact (also from the introduction of occupational pension schemes) that it takes time to make individuals aware of the need to prioritise supplementary insurance in addition to basic public benefits.

The number of policies taken out is also increasing rapidly. A conservative estimate is that 20 per cent of the potential policyholders will take out supplementary insurance within a period of 5-10 years. This would provide cover for about 350,000 pay earners. Furthermore, a number of the unemployment funds currently not offering this type of product are likely to begin offering it in the next few years.

A great, latent need for supplementary unemployment insurance has characterised the product’s popularity. But it was not until a number of unemployment funds took the initiative to set up schemes through separate agreements with various insurance companies that interest in the product began to manifest itself and gain ground. There is hardly any doubt that introducing the product to a large group of potential policyholders is an important way of keeping costs at a low level, just as many pay earners are not likely to recognise their need for this type of insurance until it is available and they no longer consider it a new and untested product.

Is unemployment insurable?

The background to the market interest in recent years in supplementary insurance in addition to basic public cover in the event of unemployment is obvious. State-financed unemployment benefits are relatively modest for quite a large number of employed people, who will thus see a sharp reduction in their earnings if they lose their jobs.

But this quite apparent need for supplementary insurance in addition to basic public cover is not new. It is a need that has manifested itself through many years and especially so during periods when general unemployment was higher than is the case today.

However, supplementary unemployment insurance has been regarded as an area where it would be difficult to introduce private-market insurance solutions. Several causes account for this situation.

a) Interdependence

If a pay earner wants to take out motor insurance, the insurance company can safely assume that Mr Smith’s risk of damage or injury is independent of Mr Jones’ risk of damage or injury. But this picture is not seen in relation to the risk of being made redundant. If the general risk of unemployment increases, this means that Mr Jones’ risk of being made redundant increases if Mr Smith loses his job. This is especially the case if Mr Smith and Mr Jones work within the same trade – and, for example, if they have taken out supplementary insurance through the same unemployment programme.

Unlike the risk of motor car damage, the risk of unemployment for an individual pay earner is not independent of the risk of unemployment for another pay earner. Employment opportunities depend on economic trends. The greatest need for unemployment insurance is seen in periods of weak economic progress and – conversely – relatively smaller in periods of economic prosperity. The costs of unemployment insurance – and so its price – will fluctuate in line with economic trends.

b) Selection problem

Moreover, individual pay earners may possess knowledge of the risk of being made redundant that an insurance company is unable to uncover. Mr Smith and Mr Jones may be employed in the same company, working in the same functional capacity and earning the same amount of pay, but Mr Jones is more productive than Mr Smith. So Mr Smith will lose his job before Mr Jones if sales drop. But an external party – the insurance company – may

2 In some cases, unemployment insurance can be taken out via a trade union. An individual taking out such insurance must, however, be a member of an unemployment plan, and policies offered through trade unions and unemployment plans do not differ.
find it very difficult to identify the individual who has a high or low risk of being laid off. Therefore, the premium must be fixed on the basis of average risk, meaning that this type of insurance is mainly attractive to persons suffering a high risk of being made redundant.

c) Moral hazard
The individual employee is also in a position to influence his risk of being laid off. The reasons for Mr Smith’s low productivity may be that he finds his job rather uninteresting. If the total benefits payable in the event of unemployment are sufficiently high, Mr Smith could very well help trigger his own dismissal. By contrast, Mr Jones may find his job so interesting that he wants to go to work every day, even if the financial advantages are modest in comparison with being unemployed.

If the loss of income in the event of unemployment is relatively modest, the financial incentive to remain employed weakens. To persons already in employment this means that the incentive to remain employed is smaller with supplementary insurance than without it. To persons already without a job this means that the incentive to find a job weakens.

The last two causes – the selection problem and moral hazard – are well-known problems from other insurance areas such as motor insurance. Drivers have different risks of damage or injury; for one thing, driving experience matters. So the insurance companies use information such as data on claims records to identify the individual drivers’ risk of damage or injury.

Furthermore, it is a well-known fact that a motor insurance policy nearly always contains a deductible clause. One reason is that the companies want to offer drivers an incentive to drive carefully and avoid damage and injury. Similarly, the new unemployment insurance policies contain built-in provisions that policies will be adjusted to income earned as an employee. Benefits payable under a policy, public unemployment benefits and any income from part-time work, if permitted, are typically not allowed to exceed 80-90 per cent of pay earned before unemployment.

But the first problem – the fact that the risk of unemployment is cyclical and thus not independent for the individual policyholders – is rather difficult to address in policy conditions. The policies will be most attractive during periods of rising unemployment, and demand will increase. This puts pressure on insurance costs. This very problem probably accounts for the fact that unemployment insurance did not win much popularity at an earlier stage when unemployment was higher than it is now. Looking at the individual policyholder’s previous unemployment record to identify the selection problem, one may also find it difficult to distinguish between unemployment caused by economic trends and the risk of unemployment not rooted in such trends.

Recent years’ marked increase in the popularity of unemployment insurance should thus be seen in the light of a relatively favourable economic climate with a relatively low rate of unemployment – not least as compared with the early 1990s. But a return to a situation of high and rising unemployment cannot be ruled out. So it is important that fixing unemployment insurance policy premiums reflects the average risk of unemployment in an economic cycle or that policy conditions have a built-in option that allows the companies to make frequent premium adjustments to take fluctuations in actual unemployment into account when premiums are fixed.

It is of pivotal importance that the potential policyholders’ expectations for the insurance product are adjusted to match the current possibilities of offering unemployment insurance on an economically sustainable basis – given the fact that the dependence on economic trends will make itself felt.

One advantage of private supplementary insurance will be that the economic burden of rising unemployment will be passed on to the working population much faster than is the case with public unemployment insurance. A rise in unemployment will relatively quickly increase the costs of having taken out private supplementary insurance against unemployment. This process is rather slow in the case of public unemployment insurance as the increasing costs of unemployment are tax-financed and thus not paid for specifically by employees. In this way, the costs of unemployment with private supplementary insurance will be borne by the working population to a larger degree than is currently the case, thus boosting the incentive to limit any growth in unemployment through pay formation.

Conclusion
The possibility in recent years of taking out supplementary unemployment insurance is an example of how the insurance industry currently develops and adapts its products to meet the demand for insurance cover. The need for supplementary unemployment insurance springs from the fact that public unemployment benefits provide relatively modest cover for a large group of the labour force as compared with their previous earnings.

The introduction of unemployment insurance to potential policyholders has taken place over a brief span of years, and an increasing number of people are
expected to take out such insurance. The product has been marketed and become popular relatively quickly thanks to the unemployment funds.

Unemployment insurance is thus an example of how to identify and meet new insurance needs. The public sector has not participated in setting up the insurance scheme, and taking out unemployment insurance is optional. A few critics have expressed fears that the proliferation of private unemployment insurance policies could undermine state-financed cover. However, such fears are unfounded. Public unemployment cover is still the predominant scheme, and private schemes are only supplements to basic public cover.

The more important issues to be discussed in relation to private unemployment insurance relate to the problems whether policyholders know that policy conditions reflect the fundamental problem that unemployment depends on economic trends. This means that price and cover must be adjusted quickly to reflect changes in the basic conditions prevailing in society (see the fact box on unemployment insurance). Particularly in a period witnessing markedly rising unemployment, there is a risk that the policyholders' expectations for the product are incompatible with what is offered by the product. More extensive use of private supplementary insurance could, however, have a positive effect on the incentive to keep unemployment at a low level through pay formation.

Typical policy conditions, terms and options of unemployment insurance policies

Most companies offer cover up to the double amount of public unemployment benefits, and the extent of cover is linked to the amount of premium paid. Benefits payable under an unemployment insurance policy, daily cash benefits and income from any part-time work, if permitted, are typically not allowed to exceed 80-90% of income before unemployment.

The insurance companies issue relatively short notice periods for premium adjustments. Some companies even issue notice periods as low as one month for such adjustments.

Usually, it is a condition that "the employee does not know or has no reason to believe that he will be dismissed", and employees must therefore be in employment to be eligible to take out insurance.

Employees must be members of an unemployment fund (one company does not enforce this requirement).

The insurance companies stipulate different terms for the period during which a person is required to have been employed in a job from the time when the policy is taken out till it provides cover. Often, employment during a certain number of hours on a weekly basis is also a condition.

Different excess periods (waiting periods) exist from the time when an employee has lost his job until benefits are payable.

The length of the payout period must be determined. Typically, unemployment insurance works on a voucher basis as benefits paid in the chosen number of months will render the policy void, meaning that a new policy must be taken out.

Premiums are deductible for tax purposes, whereas benefits are subject to tax.
Natural disasters – public compensation in the event of flood and windthrow damage

Optional insurance taken out on a private basis is not suitable for providing risk cover for the few people who risk having their homes and property damaged by floods. The public scheme for compensation in the event of floods encourages people hit by such damage to take precautions to prevent losses, but the scheme itself has been under political pressure in that compensation should be given even in cases of no "real" flood event and that funds contributed should be spent on other purposes. Legislation on state-financed compensation in the case of "deforestation as a result of a windthrow event" was implemented even though the forest owners hit by the hurricane in 1999 had not taken out private insurance. However, one condition for being eligible to receive public help following future windthrow events is that private insurance must have been taken out. This is an example of how private insurance can form part of public welfare schemes.

Flood events
The Flood Act of 1991 governs funding and compensation matters in connection with damage caused by floods. One motive for such legislation was that some of the persons hit by floods in the 1980s had no insurance cover because floods are not covered in most standard policies against loss or damage. So a permanent compensation scheme was needed to prevent the State from having to consider compensation solutions on an ad hoc basis in specific situations as it had previously done.

The flood insurance scheme is funded by an indirect tax imposed on all fire insurance policies in Denmark. Thus there is no correlation between the risk of having property damaged by a flood event and the tax paid for such risk cover. The Flood and Windstorm Council, a public authority, decides when the conditions for regarding a heavy storm producing flood tide as a flood event have been met. One implication is that a flood event will occur relatively rarely in nature.

The Flood Act specifies the compensation provisions, one condition being a deductible of at least DKK 10,000. It also contains a variety of restrictions on compensation as well as a clause under which persons hit by flood damage can be ordered to take precautions against losses to be eligible to receive compensation in the event of any future floods. The secretariat handling flood insurance scheme matters is under the auspices of the Danish Insurance Association, and the loss adjusters of the insurance companies are in charge of loss calculations as instructed by the Flood and Windstorm Council.

Flood damage is not covered in standard buildings and contents policies because the probability of floods is limited to rather small risk groups. So it is possible to determine in advance who are likely to suffer in the event of a flood, and the insurance event will consequently not hit by chance among all policyholders. Any optional supplementary cover for flood damage will be unable to spread the risk sufficiently for calculating a premium that will be attractive to the high-risk groups needing such cover.

The political background to setting up the flood insurance scheme was that some homeowners had suffered losses during a flood event and that no policy provided cover against such damage. The fact that the risk groups in question had had no possibility of taking out the necessary risk cover on market terms was regarded as unsatisfactory in political circles. With the implementation of the Flood Act, protecting risk groups threatened by floods became a public task.

Consequently, the flood insurance scheme is a public provided and (partly) publicly managed, tax-financed compensation scheme where the only tasks to be performed by the insurance companies are to collect flood tax, receive claims forms from people having suffered losses and provide expert assistance when losses are assessed.

The flood tax of DKK 20 imposed on every buildings and contents fire insurance policy is collected once a year and paid into a pool currently amounting to about DKK 235 million. The funds of this pool were originally earmarked for compensation and administration in connection with floods. This was changed by a legislative amendment in 2000, meaning that the pooled funds may now also be used for other purposes (see the following section on windthrow events).

Conclusions
- In risk areas such as flood events where only few citizens risk being hit, the possibilities of taking out risk cover on free market-based insurance terms are limited.
- Insurance companies base the tasks to be performed on insurance and business terms. Compensation is only paid if specific conditions are met. Insurance solutions cannot fulfil political requests to consider specific groups. The establishment of the flood insurance scheme shows that claims for assistance can be difficult to refuse politically – even in cases where persons having suffered losses are themselves responsible, to some extent, for the risk in question (in this case, by living in areas susceptible to floods).
- The introduction of the Flood Act reflects the idea that private market-based schemes are, in isolation, not necessarily suitable for meeting societal requests for redistribution of resources for the benefit of very small risk groups. Private insurance solutions redistribute resources within fairly homo-
geneous risk groups between those hit and those not hit by losses. Making a more far-reaching redistribution in terms of insurance requires public/private interaction on an insurance solution.

- The detailed rules and administration of the flood insurance scheme mean that claims handling is more cumbersome and slow than claims handling usually is in private insurance companies.

- There is a risk that a public body such as the Flood and Windstorm Council, when determining whether an insurance event has occurred or not, will be subject to political expectations or direct pressure to pay compensation although the underlying conditions have not been met. In other words, disaster assistance as originally contemplated would be diluted into a scheme of regular compensation payments. The fact box on flood damage shows that a "flood verdict" has been given in many cases; also when losses have been rather limited. This indicates that the flood insurance scheme is no longer just a scheme providing disaster assistance. This shift has taken place on the basis of no previous political decision.

- The provisions on deductibles, the possibility of ordering people to take precautions against losses and the rules on reduction or lapse of compensation as specified in the flood insurance scheme are examples proving that public implicit "insurance schemes" can indeed contain mechanisms designed to regulate behaviour and require people to use "common sense" as conditions for compensation.

Windthrow events
The Flood and Windthrow Act of 2000 expanded the flood insurance scheme to include rules on financial help to reforest new trees in private woodland areas hit by a windthrow event. The background to this amendment was the hurricane in December 1999 (and the subsequent storm in January 2000) destroying considerable woodland areas. Most private forest and orchard owners had not taken out insurance against deforestation as a result of a windthrow event. Following an inspection made by the then minister for the environment in the destroyed forests immediately after the hurricane, political support was obtained to set up a scheme to compensate private forest and orchard owners by windthrow events.

The windthrow insurance scheme is financed on the basis of the same tax as that funding the flood insurance scheme and is imposed on all buildings and contents fire insurance policies. In this case, there is no correlation between risk and payment either. The Flood and Windstorm Council decides on reforestation subsidies. The rules governing the Council's allocation of reforestation subsidies are defined specifically by law, including the fact that subsidies are granted upon recommendation by the National Forest and Nature Agency.

Unlike people hit by floods who had had no possibility of taking out insurance cover against their flood risk, private forest and orchard owners had been able, before the hurricane in 1999, to take out windthrow insurance, as is common in several other EU member states.

The fact that persons having suffered losses had had a possibility of taking out appropriate insurance before the disaster occurred makes the windthrow insurance scheme distinct from the flood insurance scheme. It has also had an impact on the public help scheme set up. One condition for being eligible to receive public reforestation subsidies is that basic private windthrow insurance must have been taken out.

The compensation system laid down by law in connection with deforestation as a result of a windthrow event thus contains a public tax-financed subsidy element in respect of reforestation as well as a private (partly) market-based insurance element for compensation in cash, with the minimum conditions contained in the basic insurance policy being formulated in concert by the public authorities and the insurance companies. The cash compensation payable under the basic insurance policy will be triggered when the Flood and Windstorm Council has given a "windthrow verdict" and minimum cover per hectare has been fixed, but risk assessment and premium fixing take place in open competition between the companies.

The negotiations on how to design the windthrow insurance scheme will not be described in detail in this

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Source: Flood and Windstorm Council.
report. However, it should be noted in relation to the issue of private insurance versus public and political interests that financial compensation to persons hit by windthrow damage is linked to strong claims from "forest circles" for reforestation with particularly robust trees.

When the Flood Act was amended to the Flood and Windthrow Act, it was laid down that funds from the tax-financed flood pool, in addition to flood and windthrow compensation, could also be allocated for storing wood from government forest trees overthrown as a result of a windthrow event and for expenses incurred in connection with flood warnings issued by the Danish Coastal Authority and the Danish Meteorological Institute and their assistance provided to the Flood and Windstorm Council.

Conclusions

- The windthrow insurance scheme adopted in 2000 had to provide compensation for the damage caused by the hurricane in 1999 in addition to covering any such future damage, and the funds should also cover the operating costs incurred by the Danish Coastal Authority and the Danish Meteorological Institute. Public tax-financed pooled schemes (in this case, the flood insurance scheme) thus contain no guarantees that the funds saved will be spent as originally planned.

- With conventional private insurance, on the other hand, no general saving of funds will take place, and no political decisions on any other use of premiums contributed are possible.

- Windstorm damage is a classic example of so-called aggregated risks where many policyholders are hit by the same insured event. Private insurance requires a large number of policyholders to spread the risk as much as possible. Being a public, tax-financed "implicit insurance policy", the reforestation subsidies under the windthrow insurance scheme are not subject to such actuarial and business problems.

- The establishment of the windthrow insurance scheme illustrates very clearly that, in some cases, the political system has difficulty withstanding claims for financial compensation to groups hit by damage — even though such groups could have assumed a responsibility for risk cover to some extent. The Welfare Commission has pointed out windthrow compensation as an example where a so-called "charity hazard" may induce the public system to provide compensation — out of political considerations — to groups that could have taken out insurance by themselves.

- Before the hurricane in 1999, private forest owners had no sufficient incentive to take out insurance against their storm risk. The fact that eligibility to receive public reforestation subsidies from the Flood and Windstorm Council presupposes that basic private insurance is taken out, has led the majority of forest owners to take out such insurance today. It remains an open question whether the extensive losses sustained as a result of the hurricane in 1999 as such — with no public windthrow insurance scheme — would have been sufficient to induce forest owners to take out private insurance.

- The windthrow insurance scheme is an example showing that a political request to fulfil the needs of a specific risk group can be met by combining tax-financed subsidies with private insurance schemes as a condition for the payment of public subsidies.

- On balance, the flood and windthrow insurance schemes and their very detailed rules and participation of many bodies (the Danish Coastal Authority, the Danish Meteorological Institute, the National Forest and Nature Agency, the Flood and Windstorm Council, the Ministry of the Environment, insurance companies and many others) constitute a bureaucratic and complicated compensation system in relation to the objective of providing compensation to a few specific groups for damage suffered as a result of flood or windthrow events.

- It remains an open question whether the aim of the scheme could be achieved by more simple insurance schemes — possibly in pooled partnerships between non-life insurance companies and possibly combined with compulsory insurance cover.
Hidden defects insurance – consumer protection with (too) great expectations

The overall aim of the Consumer Protection on Acquisition of Real Property Act – to reduce the number of legal disputes on property transactions – has been achieved, but the politically defined and unclear terms of hidden defects insurance imply that policyholders’ expectations for cover are too high. For political reasons, the insurance companies have been unable to lay down insurance terms and fix premiums that match the true risk and market conditions, only reluctantly accepting to offer such insurance. However, a legislative amendment in 2000 introduced improvements in relation to the hard-earned experience from the insurance scheme’s first year. Experience from hidden defects insurance shows the importance of ensuring a proper dialogue between the insurance industry and the authorities when insurance is to fulfil a political purpose.

The Consumer Protection on Acquisition of Real Property Act was put on the statute book in 1996, its aim being to reduce the number of legal disputes between private sellers and buyers of real property. The objective was to reduce the workloads of the courts in this respect and to protect consumers against mutual long-term conflicts and welfare-threatening claims for compensation for defects. Another aim was to provide better property details, thus allowing property transactions to be made at "true prices".

The first main element of such legislation is hidden defects insurance covering the buyer against existing damage to a newly acquired property which is not apparent from the second main element, a structural survey on the physical condition of the house (see the fact box on hidden defects insurance polices and structural surveys).

The scheme has received strong criticism. For one thing, some people maintain that hidden defects insurance provides inadequate cover and is too expensive, that the structural surveys are poor, that consumers do not receive proper information and that the scheme, on balance, is cumbersome and time-consuming.

Furthermore, hidden defects insurance was not developed in response to a market-determined demand. The rules and the insurance cover aim to meet some political expectations of consumer protection, implying that hidden defects insurance is more complicated than conventional insurance in some respects. The following sections describe some of these problems from an insurance point of view.

Seller and buyer incentives

The instruments contained in the Consumer Protection Act are optional to consumers. A seller is not required to order a structural survey, and a buyer is under no obligation to take out hidden defects insurance. The seller has a substantial incentive to use the scheme as he will be able to discharge himself from the 20-year liability for defects (standard tort liability in all other respects) by ordering a structural survey at the price of about DKK 6,000 by obtaining a quotation for a hidden defects insurance policy and by agreeing to pay half the premium for such policy. When the seller presents a structural survey and an insurance quotation to the buyer – and nearly every seller does so – the buyer encounters a seller who has released himself of nearly every liability and has to decide whether to take out a rather expensive and incomprehensible policy.

If buying his dream house with his heart rather than his head, the buyer is not always responsive to advice on the contents of a hidden defects insurance policy, either from his legal adviser or from his insurance company. The insurance company’s possibilities of providing advice on such insurance are hampered by the fact that the buyer is free to choose or not to choose to take out hidden defects insurance without any dialogue with the insurance company. During the first years of the scheme, many buyers chose not to take out hidden defects insurance, and until the year 2000 only 10 per cent of all insurance quotations would result in buyers taking out insurance.

When a property is put on the market, the seller will take the initiative to use the first instrument contained in the Consumer Protection Act: the structural survey. The seller chooses to discharge himself from his liability for defects and – apparently – thus has the biggest advantage of using this scheme. Therefore, the seller should perhaps pay for the second instrument: hidden defects insurance. A political will to balance the incentives of the seller and the buyer meant that legislation was amended in 2000, and the seller must now pay half the premium if the buyer chooses to take out hidden defects insurance. The result is that about two thirds of homebuyers take out such insurance today.

The seller is able to discharge himself from the 20-year defects liability by:

- Presenting a structural survey on the property to the buyer
- Issuing a declaration on the property’s condition
- Presenting a hidden defects insurance quotation to the buyer and
- Undertaking to pay half of the insurance premium (until 2000, the buyer paid the full premium).
Information problem
During the first years, hidden defects insurance was hit hard by the fact that claims were reported on a large number of policies taken out. It was thus quite obvious that, generally speaking, only homebuyers "having a hunch" that properties could contain defects would take out hidden defects insurance. The insurance companies had made a commitment to legislators to offer this type of insurance in compliance with the statutory minimum conditions and at premiums and deductibles that were quite inadequate in relation to preventing speculation against the scheme.

The insurance companies have been unable to differentiate premiums and deductibles sufficiently according to the actual risks of the different types of property – partly for political reasons, partly because the individual insurance company is unable to decide which information is to be obtained for calculating premiums and for submitting an insurance quotation.

The insurance companies are bound by the publicly defined structural survey on which the individual company has no influence, which describes the condition of the relevant property only in relation to similar properties and which only specifies defects that are immediately visible to the surveyor.

The insurance companies have been compelled to offer a type of insurance that, during its first years, could be sold only to so-called high-risk groups – on the given political terms and at standard prices – and which was almost never sold to low-risk groups. Presumably, it is attributable only to the political focus on the Consumer Protection Act that the insurance companies did not remove hidden defects insurance from their product range.

Following the legislative amendment in 2000, according to which the seller must pay half the insurance premium, an increasing number of homebuyers began taking out hidden defects insurance, and the insurance risk is now spread more evenly between risk groups.

The buyer is free to take out hidden defects insurance covering:
- Damage not specified in the structural survey
- Damage mistakenly not included by the surveyor in the structural survey
- Typical damage:
  - Floor damage
  - Base damage
  - Roof and roofing damage
  - Subsidence damage
- Hidden defects insurance does not cover:
  - Trivial damage
  - General wear and tear and
  - Replacement of construction parts due for replacement.

Insurability
Whereas most policies against loss or damage cover loss or damage occurring after the commencement of the policy in question, a hidden defects insurance policy covers damage already existing at the time of insurance, i.e. retrospectively. Technically speaking, it is not impossible – in theory – to cover damage that has occurred but which is not discovered until the insurance period, but it is a condition that no one – neither the policyholder nor the insurance company – must have any knowledge of any specific damage before a policy is taken out. The small number of policies taken out and the multitude of losses reported on such policies during the first few years clearly suggest that this condition was not met.

Normally, the seller of a property will possess better knowledge of the property than both the buyer and the insurance company. However, this aspect has been taken into consideration in that the seller is unable to discharge himself completely from his defects liability if he fails to disclose information about the property's condition.

A structural survey
- Costs about DKK 6,000
- Describes the areas where the property's condition deviates from other properties of the same type and age
- Must be prepared by a surveyor who is licensed to do so and has taken out relevant liability insurance
- Contains a statement made by the seller on the property's condition and
- Must meet a number of specific regulatory requirements.
Voluntary versus compulsory insurance scheme

As mentioned above, the structural survey and hidden defects insurance are optional to both the buyer and the seller. The actual option available to the homebuyer is, however, doubtful when the seller is practically free of any liability. Had hidden defects insurance been compulsory for example in cases where the seller chose to present a structural survey and a quotation to the buyer, the risk and funding would be spread to most buyers and risk groups. The speculation problem referred to above could have been avoided, but it was originally considered important that the scheme be optional.

A hidden defects insurance policy

- Costs DKK 10-15,000 depending on the type, size and age of the property in question
- Carries a deductible of DKK 5-10,000 per event of damage, however not exceeding a total of DKK 30,000
- Provides cover for at least five years following the acquisition of the property in question and
- Must at least provide cover as stated in the statutory minimum conditions.

Policy conditions

Hidden defects insurance must at least comply with the minimum statutory conditions. These conditions have been drawn up on the basis of political and rather unclear statements to the effect that such insurance is to cover the buyer’s disappointed expectations, either because the property does not match the description as given in the structural survey and the seller’s declaration or because the property is not in such a condition as must be expected in relation to other properties of the same type and age.

Such unmet expectations are difficult to express in specific and operational policy conditions. Many homebuyers have greater expectations for hidden defects insurance cover than stated in the policy conditions if defects are discovered. For example, many homebuyers are not aware of the fact that the policy is only to cover any damage reducing the value or use of the property in comparison with properties of the same type and age. For hidden defects insurance, the problems of too great expectations are far more evident than for the majority of other types of consumer insurance.

The processing of complaints about hidden defects insurance cover shows that the insurance companies meet the wording of the minimum conditions (and so also the intentions of legislators). The policy conditions can probably be improved and made more specific, and the homebuyers’ advisers, i.e. legal advisers and estate agents, can become better at providing information about hidden defects insurance. However, such improvements will not eliminate the fundamental problem, viz., that hidden defects insurance has been defined on the basis of political expectations rather than the more objective claims criteria on which insurance policies are normally based.

Conclusions

The overall purpose of the Consumer Protection Act is to reduce the number of private legal disputes on defects in connection with the acquisition of real property, and today the seller and the buyer have a better level of information at their disposal to perform the property transaction at the “right price”. So, despite much criticism and worries about the scheme, it has been possible to:

- Implement a private insurance scheme for the purpose of solving a societal problem:
- Eliminate the risk of welfare-threatening claims for compensation in that the risk of disputes between the individual sellers and buyers has been spread to all policyholders.

The insurance element of the Consumer Protection Act is problematic because the insurance companies have been unable to establish and offer hidden defects insurance according to general insurance principles on normal market terms:

- The insurance companies were reluctant to agree to offer hidden defects insurance as defined by legislators.
- The insurance companies were compelled to sell such insurance at politically acceptable prices irrespective of the actual conditions of risk and the need for greater differentiation between “good and bad” properties.
- Hidden defects insurance is not taken out and paid fully by the party that, apparently, has the greatest interest in the consumer protection offered by the scheme, i.e. the seller.
- The insurance companies are not free to decide which information to use for risk assessment and submission of quotations, but are compelled to
write policies on the basis of – inadequate – structural surveys determined by the authorities.

- The insurance companies do not draw up policy conditions according to general technical principles, but must at least comply with the (unclear) statutory minimum conditions.

- The unclear and rather incomprehensible minimum policy conditions imply that the majority of policyholders have greater expectations for compensation than actually provided for in the conditions.
Professional liability insurance – state-guaranteed confidence through private insurance

Through compulsory liability insurance for attorneys and other professionals, clients' trust in the legal profession is guaranteed because one can remain confident that financial losses caused by any error or mistake will be covered by an insurance policy. Insurance terms, risk assessment and pricing are, to a large extent, left for the free insurance market to determine. This type of insurance can be offered in many other areas. Compulsory liability insurance will also help support confidence in the efforts to privatise public tasks with regulatory or advisory functions.

The practise of many professions entails a risk that errors and omissions may cause other people to suffer financial losses. Consequently, professionals take out insurance covering their liability for such losses – advisory insurance or professional liability insurance.

For specific professions where it is of material importance to society at large that people have full confidence that the professionals perform their work correctly, such liability insurance is now compulsory. For example, attorneys and accountants need to take out professional liability insurance in order to be able to practise their profession. The statutory requirement for liability insurance enables clients to trust an attorney as they can remain absolutely sure that any loss caused by any error or omission made by the attorney will be covered by a policy.

Compulsory liability insurance is offered on market terms in open competition between the individual insurance companies. As a result of the typically limited number of policyholders, professional liability insurance is often taken out with one or two companies, and frequently group schemes are taken out by the members of the individual professional organisation, for example through the Danish Bar and Law Association. Legislation does not necessarily stipulate any detailed requirements for such insurance as the individual professional groups have a considerable self-interest in upholding trust in the profession in question and therefore see to it that liability insurance provides adequate cover.

From an insurance point of view, it is necessary for the individual policyholder to keep the incentive to avoid errors and omissions even though a liability insurance policy has been taken out. As a result, such policies often carry a rather large deductible, meaning that the policyholder himself must pay a substantial part of any amount to be paid in compensation. Similarly, the policyholder knows that any licence to practise the relevant profession will be revoked at no notice if the insurance company decides to cancel the policy.

In line with the general increase in welfare, the extent of losses inflictible on other parties by an ad

Key compulsory professional liability insurance:

- Attorneys' professional liability insurance
- Accountants' professional liability insurance
- Estate agents' liability insurance
- Insurance agents' and brokers' liability insurance
- Licensed surveyors' liability insurance
- Energy and energy management consultants' liability insurance.

Just as compulsory liability insurance can be used to inspire confidence in connection with legislation protecting consumers as in the case of compulsory liability insurance for licensed surveyors, such insurance can be used to inspire confidence in the privatisation of public tasks – such as the work performed by the Danish Motor Vehicle Inspection Office.

Compulsory professional liability insurance could be a tool for safeguarding the interests of citizens and society in more professional areas than is currently the case with no tax funding, no setup of any guarantee fund and no establishment of administratively cumbersome guarantee schemes, etc. However, as mentioned above, efforts should be made to ensure that

- Insurance terms, risk assessment and pricing are left for the free insurance market to determine to the greatest extent possible.
- Policyholders' incentive to avoid errors and omissions is kept at its present level or increased; and
- The number of policyholders is sufficiently large to ensure the required spreading of risk.
Supplementary pensions – a success story

Introducing occupational pension schemes as a supplement to the public old-age pension is a success story. Denmark is 15 years ahead of many other countries when it comes to setting up a sustainable pensions system. The fact that politicians and customers currently request more freedom of choice does not change the picture. The favourable lessons to be learnt from the development of the Danish pensions system illustrate that a model for the future welfare state is a system based on basic public benefits and supplementary insurance taken out on a private basis. It is important, also in future discussions on the design of the welfare state, that efforts are made to implement gradual changes and to calm down public feeling about and inspire confidence in basic public benefits.

As is well-known, the Danish welfare system is based on the idea that the public sector holds a large responsibility for providing welfare services at a relatively high level, which is reflected in the Danish tax level. This feature characterises the welfare state and is also seen in the other Nordic countries.

But the Danish welfare system distinguishes itself in one remarkable respect from most other welfare systems in highly developed countries, including those in the Nordic region. This difference relates to the way in which the responsibility for providing pension cover is divided between the public and private sectors. The Danish pensions system is an example of a system based on a distribution of responsibilities in which the public sector provides basic tax-financed benefits to all (old-age pension), whereas agreements in the labour market secure supplementary pension schemes that guarantee employees suitable income as pensioners in relation to their earnings as economically active persons. Furthermore, insurance schemes have been introduced in connection with pension savings to guarantee income in the event of disability and death.

In Denmark, nearly every pay earner is covered by a pension agreement under their contract of employment. Such an agreement usually implies that, as part of the most recently concluded collective agreements or agreements with a specific business, a percentage of monthly pay (a minimum of 10 per cent for low-paid employees and often up to 20 per cent for high-paid employees) is contributed to a pension scheme taken out with a life insurer or a pension fund.

The basic tax-financed benefits do not depend on the individual person’s previous income and the aim is to ensure basic support to persons leaving the labour market. The same role is played by ATP (the Labour Market Supplementary Pension Scheme), supplementing social pensions to persons affiliated to the labour market). But such pension cover does not provide an adequate standard of living in relation to income earned during working age. Supplementary pension cover is provided via private occupational pension schemes – collective agreement schemes and company pensions – based on previous savings. Moreover, there are individual pension schemes of course, savings in real property and securities can also meet individual demand for old-age savings.

So the Danish pensions system consists of a number of different schemes. However, a particular characteristic feature is the introduction of private occupational pension schemes to supplement old-age pension. Occupational pension schemes for white-collar workers have a long history in Denmark, but only in the 1980’s and 1990’s did they spread to most of the labour market. This happened as a result of an agreement between the social partners and the then government to set up supplementary pension schemes for “ordinary” pay earners in the private labour market as well. The pension contributions paid into the schemes to begin with were relatively modest, but have regularly been increased to their present levels (see above).

A unique system

The distribution of responsibilities between the public and the private sectors characterising the Danish pensions system must be considered unique. Nearly every highly developed country, both in Europe and in other parts of the world, faces the economic challenge, in the coming decades, of having to deal with a growing number of elderly people outside the labour force in relation to the number of economically active people. In most other countries, people depend on either publicly financed pension schemes or on pension commitments from employers not fully based on previous savings.

One of the recommendations made by leading economic organisations such as the OECD, the International Monetary Fund and the European Commission, is to meet these demographic challenges by initiatives such as the establishment of a supplementary savings-based pensions system as that seen in Denmark. But unlike a large number of countries, Denmark began reforming its pensions system about 15 years ago. This puts Denmark in a much better starting position to meet these challenges than a number of other countries.

When the then government and the social partners discussed expanding the pensions system, they were hardly thinking of partnership agreements. But, retrospectively, setting up supplementary pension schemes must be regarded as an example of a partnership agreement concluded with success.

The establishment of occupational pension
schemes has taken place as a superstructure on top of the public old-age pension. The very fact that the privately based pensions have been gradually established and developed without resulting in any reduction of basic public benefits has probably helped provide support for the occupational pension schemes. Had the expansion of privately based pension schemes, as part of the collective agreements, been met by a reduction of public pensions, this would have reduced confidence substantially in the value of earmarking a portion of the pay hikes for pension purposes.

Against this backdrop, it is important that, also in future discussions on the design of the welfare state, that efforts are made to implement gradual changes and to calm down public feeling about and inspire confidence in basic public benefits. Specifically in the pension area this implies signalling that the basic amount of the public old-age pension will be maintained as basic cover in future.

Changing occupational pension schemes
The occupational pension schemes are undergoing gradual change in these years. Requests for more individual options are made politically, and the same attitude is reflected, to some extent, in the demands made by customers.

A long-term trend allowing the individual customer to choose between different pension covers, for example survivorship annuity and the size of disability pension in relation to old-age pension, continues to develop.

A growing number of occupational pension schemes introduce individual investment options, for example the so-called unit link insurance policies, characterised by the individual having a certain amount of influence on the mix of assets, but also by the person in question having to bear a larger amount of the investment risk. Moreover, individual pension savings schemes increasingly offer individual options between different investment opportunities.

This trend illustrates – within the given framework – that private welfare schemes can be adjusted to individual and changing needs in ways that would hardly be possible for tax-financed solutions.

Lately, views expressed in the public debate suggest that the compulsory nature of the pension schemes for individuals should be softened. The first perspective in this debate is whether the individual pay earners should be able to mix their remuneration on the basis of pay, leisure time and pension contributions. The second perspective is whether the individual pension customers should have a right to choose their pension supplier – also in respect of occupational pension schemes.

This discussion touches a key element in the welfare debate. What is the best choice for an individual is not necessarily the best choice for the community. Welfare concerns community choices, and welfare considerations may motivate a reduction of the individual's freedom of choice.

As regards the mix between pay, leisure time and pension contributions, examples can certainly be found to indicate that another pension savings profile would be better for the individual person. One example could be a reduction of pension savings during the younger years, giving better room for quick repayment of housing debt. No one would maintain that a system based on the same contribution rate all through a person’s life is the only practicable model. Over time, one cannot rule out the development of a new practice.

However, such freedom of choice could result in problems for the private pension system as part of the welfare state. What action should be taken for persons who decide to save up neither in their property nor for their old age during their younger years? Should the community provide help or must they face the consequences of their own choices? None of these alternatives matches the general requirements for a welfare state. And there is no mention, in this context, of the far graver consequences for the tax-financed welfare benefits and services that will emerge if pay earners across the board choose leisure time over work.

The role played by the private pensions system in the welfare system must be borne in mind when it comes to the collective choice of pension supplier. A collective choice – i.e. compulsory membership for the individual – allows some solidarity between the members of the community, for example in relation to health terms and gender-specific risks. For purely individual insurance policies, the risk of individual policyholders must be approximately the same. Otherwise, a rival supplier would be in a position to offer a better price to the customers with the lowest risk. Therefore, the insurance company must ensure that all customers have the same risk and/or must differentiate the price or cover for customers with increased risk. Compulsory membership renders this process superfluous because, in its pricing, the company can apply average risks to the entire portfolio. The collective choice of supplier can thus be justified by the welfare consideration that all members of the given community should be subject to the same terms.

Naturally, other solutions are possible than compulsory membership of a collective-agreement scheme or a company-based scheme. But if the roles played by pension schemes in the welfare state are to be maintained, the alternative to the agreement-based system would probably be legislation laying down general
lines for the individual's choices and contributions to the community. A system where everything is left to the individual's free choice would not be consistent with the welfare idea.

**Expansion of the system**

Although pension contributions to supplementary occupational pension schemes have reached quite high a level, there is no reason to expect the expansion of the system to end. The requests and requirements for the standard of living as a pensioner increase as income in society at large rises, and this trend will continue.

Expanding the pension scheme to cover additional welfare tasks could imply that the insurance industry will play a bigger role in the welfare state. In any case, it is a characteristic feature that several of the "new" insurance products mentioned in this report are now an integral part of a number of occupational and company pensions. This is the case of critical illness and health care insurance.

This is a trend which is based on customers' demand, and the Danish Insurance Association will support and help provide the framework for this trend.