UNIVERSAL HEALTH INSURANCE – a global perspective

MELANIE DA COSTA, MCom, CFA
Director of Health Policy, Netcare.

Da Costa has been with Netcare for over two years. She had previously spent 12 years in the investment industry as a stockbroking analyst, covering healthcare, a fund manager, running both local and global equity funds invested in healthcare and information technology, and later as head of research for multi-national stockbroker HSBC.

Co-authors

DR MARK FERREIRA,
Manager, Health Economics and Strategy, Netcare. MB BCh, M Fam Med (Wits), M HEcon (Curtin)

Dr Ferreira joined Netcare Primary Care Division from Discovery Health, bringing more than ten years of healthcare experience in the funding and managed care.

DR VICTOR LITLHAKANYANE,
Executive Director, Netcare. MB ChB (UKZN), M Med, MBA (UFS)

Dr Litlhakanyane, a radiation oncology specialist, is a visiting professor at the University of Free State and has presented over a dozen papers at both national and international conferences.

BARRY CHILDS
Independent Consultant, Actuary

Childs is an independent consultant, with wide experience in analysis and modelling of medical scheme business, strategic risk management initiatives, product design, payment mechanisms and hybrid clinical and analytical reporting tools.

An analysis of universal health systems across 13 countries reveals much about the principles that need to be considered when debating the building blocks for a National Health Insurance (NHI).

Countries analysed:

Australia
United Kingdom
Canada
China
India
Netherlands
Taiwan
Japan
Ireland
France
Germany
Sweden
Denmark

Areas of analysis are:

- Prevalence of single versus multi-payer environments

- Level of benefits covered under universal care
- Financing of healthcare
- Prevalence of private health insurance
- Purchasing of health services
- Risk management tools used
- Co-payments
- Provision of health services
- Consumer choice

SINGLE OR MULTI-PAYER SYSTEM

There are varying models of both the single- and multiple-payer systems, though the latter seems to enjoy more popularity. The funds from these systems are managed by public statutory bodies and/or private, and usually competing, insurers (either for or not for profit). SA should consider its circumstances when investigating the best solution for universal medical insurance. Local experience, for example, has shown that competing bodies perform better than centrally-controlled funds.

LEVEL OF BENEFITS COVERED

Developed or developing countries with high levels of formal employment offer universal cover of a comprehensive benefit package. Taiwan is the exception, due to high levels of formal employment[1].

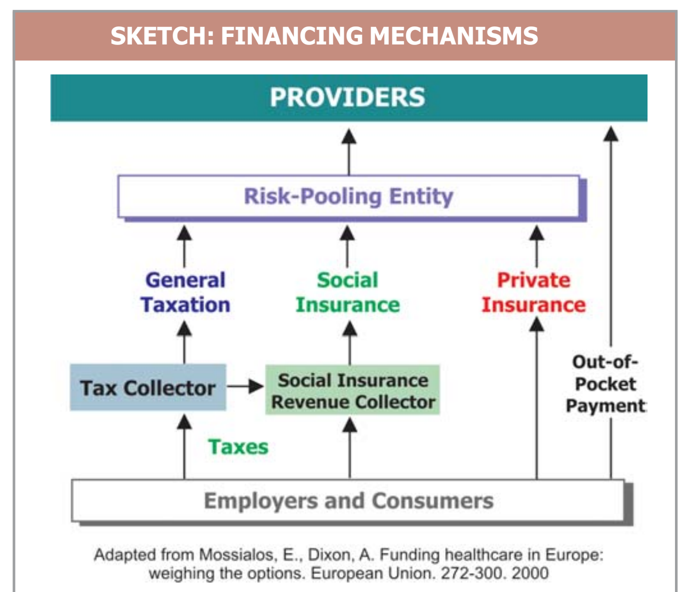
In environments with resource constraints, the trade-offs involve either offering a richer benefit package to fewer people, or a less comprehensive benefit package to everyone. International experience does not support a system where everyone has equal access to a very low minimum benefit package. A more comprehensive benefit package is desirable, but will require more income cross-subsidisation than the current national health system.

In order to attract, retain and manage their workforce, employers take a hard look at benefit packages, particularly those elements related to healthcare. In the context of this debate we need to appreciate that in global markets competing for skills it is imperative from a public purse-perspective that SA attracts and retains skills. Are the basic coverage levels being debated sufficiently attractive?

If medical scheme members have to make do with public funding below current medical benefits, beneficiaries could find themselves in a position of losing a significant proportion of health services currently purchased per annum without any comfort that their health needs will be met by the new system[2]. The existence of either supplementary insurance (to cover the funding and service gaps in the public programme) or substitutive insurance becomes critical.

FINANCING OF HEALTHCARE

Policy-makers have broad options to consider when debating financing mechanisms that will protect people from financially catastrophic effects of illness: taxation, social security and private health insurance. “Ultimately, all money comes from household income, but in public insurance programmes this money is channelled through the State, via a general or social insurance tax collector, whereas in private insurance the money is paid directly to the risk pooling entity[3]” (see Sketch, below).



Adapted from Mossialos, E., Dixon, A. Funding healthcare in Europe: weighing the options. European Union. 272-300. 2000

The public financing requirements for a comprehensive social health insurance or national health insurance system are onerous and have typically been achieved in countries with high GDPs and high formal employment rates. This allows significant expenditure on healthcare to ease the burden on both the fiscus, and the individual, through the spreading of that financial load over the largest possible employment base.

It must, however, be noted that even in developed and wealthy countries, the demands of healthcare financing are burdensome. For example, Canada spends 30% - 50% of total social

spend on healthcare[4], France funds its health system with an onerous tax of 18% of payroll[5] and the United Kingdom's National Health Service (NHS) yielded an operating deficit of £700m in 2006[6].

Table 1 contextualises the debate. Financial restrictions in SA are significantly higher than in these developed countries who are also struggling to fund universal health.

TABLE 1		
	Nominal GDP per capita (US$)	**SA GDP per capita as a ratio**
Canada	43 485	14%
France	41 511	14%
South Africa	5 906	100%
United Kingdom	45 575	13%

Source: IMF, 2007

Many developing countries have very low levels of public expenditure on health with large informal sectors. "Their ability to generate tax revenue or fund social insurance systems to provide broad financial protection for healthcare is limited. Private coverage, when appropriately regulated[7], may be one way to move towards prepayment and risk-pooling until publicly funded coverage can expand sufficiently. It also allows policy-makers to target limited public resources towards the most vulnerable groups, while those who can afford it, can contribute to their medical costs[3]".

Given South Africa's current public health budget versus the level of public health provision, it is clear that new money is needed to finance any expansion of access or benefits above current levels. The amount of this new money depends on the envisaged scope of benefits and access. The two points are juxtaposed against each other – providing comprehensive benefits across a wide membership base, is prohibitively expensive in the South African context in the medium term. This means either the benefit package cannot be expanded as widely as hoped, or access will suffer.

To gain a substantial reallocation of existing budgets does not seem feasible given the other national imperatives in infrastructure development, education and other critical areas of policy including competing needs that also have an impact on health such as housing, water and sanitation. Such a reallocation would take many years as the other areas of budget disbursement could likely not take such a significant decrease in allocation in one year. Alternatively, new taxes can be raised. It could be a burden to many as Table 2 indicates.

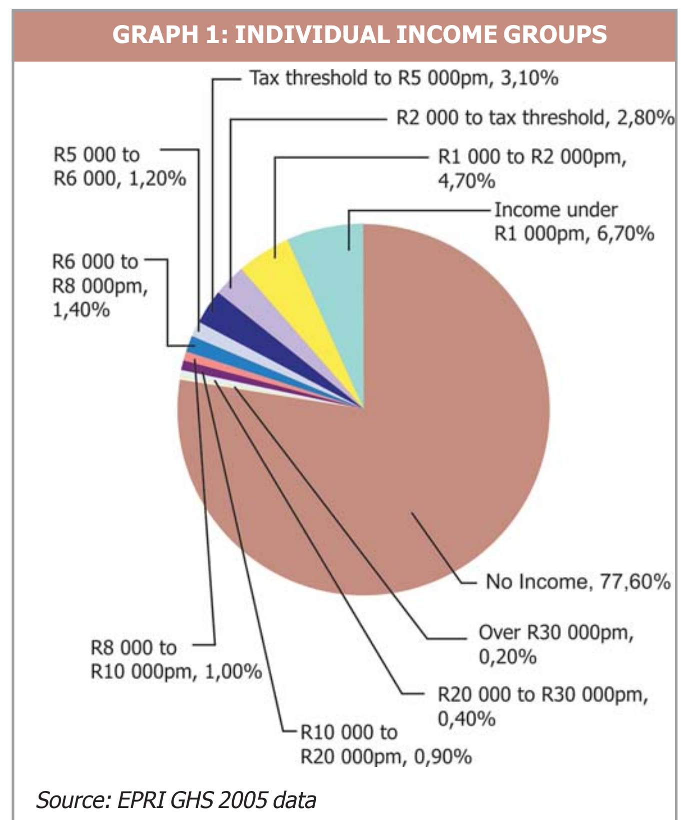
TABLE 2: DISTRIBUTION OF EMPLOYED OVER THE AGE OF 20 AND UNDER 65		
Earning over tax :	3 819 136	(32,5%)
R2 000 to tax threshold:	1 283 254	(10,9%)
R1 000 to R2 000 p/m:	2 128 153	(18,1%)
Income under R1 000 p/m:	3 008 260	(25,6%)
Income not specified:	1 164 871	(9,9%)

Source: Professor H McLeod, Transformation to Social Security. UCT August 2007

Graph 1 indicates that only 22% of South Africans report having income.

It does not seem likely that the existing tax system would be sufficiently progressive to support a large additional tax burden. The already strained low and middle income groups, and socially vulnerable groups such as pensioners and single parents, will suffer the most. It is therefore likely that most of the tax burden will fall to the higher income groups, which by virtue of South Africa's skewed income-distribution are in the vast minority. Affordability is a concern. The trends in this high-income group are unclear. Is it growing

GRAPH 1: INDIVIDUAL INCOME GROUPS



Source: EPRI GHS 2005 data

or shrinking, for instance? If the system is structured to rely on a large tax burden on a small group, funding becomes very sensitive to the net movements and size of that population.

PREVALENCE OF PRIVATE HEALTH INSURANCE (PHI)

PHI is present in all countries in some form or another. "Generally, we find that the term 'single-payer health system' is a misnomer. Even in the most well-known government healthcare systems, private insurance, especially that provided by employers, plays a significant and, in many cases, growing role[8]."

"Private health insurance plays a large and increasing role around the world... international experience shows that private health insurance is significant in countries with widely different income levels and health system structures[9]."

Many of the countries reviewed use PHI to fund the cost sharing amounts present in the universal system. Depending on the trade-off decision on comprehensive benefits versus comprehensive access, PHI should be allowed to be substitutive or supplementary. If, for example, the benefit package is comprehensive but only made available at public facilities to keep costs artificially low, then substitutive insurance should be allowed to maintain voluntary access to the level of care desired through policies covering co-payment or other service gaps in the public programme. If, on the other hand, access to cover is wide but for a very low benefit package, supplementary insurance should be allowed to provide additional cover. This line of thinking is very prevalent in literature on health cover in India and China, where scarcity of skill means that corporate India and China need to be innovative in ensuring they attract and retain globally-competitive skill and foreign direct investment [8].

One needs to further recognise individuals' constitutional right to access healthcare. Global legal precedent is emerging. An example includes the Supreme Court of Canada's ruling in 2005 that individuals of Quebec have the right to obtain private health insurance for services already available under the public healthcare system[10].

There is a significant precedent in SA on topics, including the access to healthcare and the right to trade. A challenger may put forward an argument based on the constitutional right of access to healthcare. In terms of this right, the state must not only take reasonable measures within its available resources to achieve the progressive realisation of the right, but must not engage in retrogressive measures, which undermine existing access to healthcare. This argument would require one to show that the removal of private medical aid will undermine access to healthcare.

PURCHASING OF HEALTH SERVICES

The majority of universal health systems, by far, use a combination of multiple purchasers in both the public and private domain.

Purchasing (distinct from the payer) of healthcare services from competing healthcare providers, should be done on a multiple purchaser basis to ensure that administration functions yield the efficiency allowed by competition. This purchaser-provider split has some clear advantages over direct service provision, that is where the services are provided by the single payer. Contracts between purchasers and providers, which should include a clear specification of how the agreed service will operate, what it will provide, and how it will be monitored, must be drawn up. This, in theory, frees decision making from provider influence, and should allow for responsive priority setting. This includes contracting, administration, case-management of health utilisation and negotiation.

The success of multiple purchasers will depend upon whether there are real opportunities for competition, as well as individual choice in choosing a purchaser. This suggests that it is preferable for purchasers to have a national rather than a regional footprint. It is not clear whether a single regional/district purchaser will be sufficiently responsive to constituents who have neither chosen it as a representative nor are able to seek alternative representation given the expertise needed and costs associated with assessing needs, inviting tenders, awarding contracts and monitoring performance. While the model has the potential to promote technical and allocative efficiency, when the competing purchasers have the ability to shift resources across existing service boundaries to substitute more effective care provided in less traditional settings and to ensure that patients receive appropriate continuity of care regardless of their geographical situation, the limitation of local

purchasers is demonstrated by the failure of the Primary Health Care Trust (PHCT) to reduce waiting lists in the UK.

This model proposes that the private sector operates within the national health system, rather than outside it. Individual beneficiaries should be given the option of having their care requirements administered by private purchasers and subject to conditions for managed competition.

- **Risk management tools used:** Whatever methodologies for disbursing monies to multiple purchaser or providers, it is crucial that such allocations are properly risk-adjusted. The full scope of risk management activities regarding utilisation management, price levels and general cost containment should be carefully considered to ensure that the affordability and access aimed for can be maintained. These measures include, for example, formal evaluation of new technologies, managed care and disease management programmes, cost sharing, and effective negotiation.

- **Co-payments:** "Out-of-pocket spending on health services is the most common form of health financing in developing countries and represents a significant financial burden for households[11]." Co-payments have been shown to be effective in lowering costs of care and managing utilisation levels. However, at some socio-economic levels co-payments lower necessary and discretionary care. If used as a means of utilisation management, targeted co-payments with specific incentives should be used instead of an overall annual deductible as used in some other countries, which is too blunt a tool and brings unintended consequences.

- **Single-tier delivery structure:** It needs to be recognised that the existence of significant income disparities in developing countries creates incentive for a "two-tier" market with the more wealthy able to influence preferential treatment through cash payments.

PROVISION OF HEALTH SERVICES

The provision of health services should combine the best that the public and private sector facilities have to offer, with efficiency among providers being driven by competitive tendering. Regulations on doctor employment should be revisited to ensure the best supply chain model can be used with regards to both quality of care and efficiency in both the public and private sectors.

It would be imprudent to disregard the significant national asset in the private sector, from health providers through to the management expertise available in these institutions. Attention must be paid to both the price of services as well as the quality of care provided.

- **Single-tier delivery structure:** An area that was not analysed in this report, but is equally, if not more important, is the capacity for SA to offer expanded health access in the context of available resources. It will not be possible to provide universal comprehensive cover unless there are enough appropriately trained health professionals. To train, recruit and retain them may be an additional financial challenge.

Medical professionals are a national asset globally, but even more so in developing markets where there is a grave scarcity of skill and globally uncompetitive income levels. Overall health policy debates need to consider and balance the need for health professionals in the public sector with the health professional's right to earn a fair income.

CONSUMER CHOICE

Gatekeeper models are used in various other jurisdictions as a means of containing cost, and this is often done using an allocated primary care physician practice.

From the analysis of the health systems in this study, it is clear that most countries offer freedom of choice – provider or clinical. Even in countries with historically more restrictive environments such as the UK, election of GP practice is an individual choice. The UK department of health introduced the patient choice programme in 2006. "'Free Choice" – patients choosing any hospital or clinic that provides NHS standards of care at NHS prices – will arrive in April 2008[12].

CONCLUSION

When observing the differences from country to country the terms "national healthcare" or "universal coverage" can be misleading. Each country's system is the long-term product of its unique conditions, history, politics, and national character. Those systems range from the managed competition approach of the Netherlands and Switzerland to the more rigid single-payer systems of Great Britain, Canada and Norway, with many variations in between.

What is also obvious is that universal health insurance does not necessarily mean universal access to healthcare. In practice, many countries

promise universal coverage, but ration care or have extremely long waiting lists for treatment. Likewise, a national healthcare system does not necessarily mean universal coverage. Some countries with ostensibly universal systems actually fall far short of universal coverage, and most rely to some extent on supplementary private insurance.

Rising healthcare spending is an international phenomenon. Costs are rising, leading to budget deficits, tax increases, and/or benefit cuts. Those countries that have single-payer or systems heavily weighted toward government control are the most likely to face waiting lists, rationing, restrictions on the choice of physician and other barriers to care.

Those countries with national healthcare systems that work better, such as France, the Netherlands and Switzerland, are successful due to the incorporation of market mechanisms such as competition, cost-consciousness, market prices, and consumer choice. They also eschew centralised government control. Although no country with universal coverage is contemplating abandoning a universal system, the broad and growing trend in countries with national healthcare systems is to move away from centralised government control and introduce more market-oriented features. As Richard Saltman and Josep Figueras of the World Health Organisation (WHO) put it: "The presumption of public primacy is being reassessed". Alan Jacobs of Harvard points out that despite significant differences in goals, content, and strategies, European nations are generally converging toward market practices in healthcare. Many countries are loosening government controls and injecting market mechanisms, particularly cost sharing, market pricing and increased competition among insurers and providers. Moreover, the growth of the government share of healthcare spending, which had increased steadily from the end of World War II until the mid-1980s, has stopped. In many countries the private share has begun to increase and, in some cases, substantially. Some evidence shows a growing shift from public to private provision of healthcare.

Given these findings and the context in which we find ourselves – with an under-funded and under-resourced public system and a small tax pool – it would be prudent to work inclusively. We believe the skills and intellectual property required to roll out efficient purchasing and payment of health at a national level exists within the medical administration market and this advantage should not be dispensed with.

A simple illustration of the relative efficiencies can be seen in the administration of the average medical scheme versus the Road Accident Fund (RAF) and Commission for Occupational Injuries and Diseases (COID) where it can take the latter up to a factor of ten times longer to administer payment for a service rendered.

A mal-administered fund places significant pressure on the sustainability of a system due to lack of working capital and the pressure that it places on service providers.

Funding constraints indicate that any universal cover will be limited to a basic level of benefits, which makes supplementary or substitutive insurance inevitable. SA is plagued by a shortage of health personnel and hospital capacity. Therefore it is prudent, and vital, to safeguard the existing health assets and the sustainability of a national health insurance so that further investment in skill and infrastructure is encouraged.

References

1. *Does Universal Health Insurance Make Health Care Unaffordable? Lessons from Taiwan.* Jui-Fen Rachel Lue and William C. Hsiao. Health Affairs – Volume 22, Volume 3. 2003
2. Alex van den Heever. *National Health Insurance: Comments on areas of consensus and dissensus,* Submitted to the ANC Task Team on National Health Insurance, June 2008.
3. World Health Organisation. *Private Health Insurance: Implication for developing countries.* Discussion Paper, Number 3 – 2004
4. Brett J. Skinner*, Paying More, Getting Less 2005: Measuring the Sustainability of Provincial Public Health Expenditure in Canada,* Fraser Institute, October 2005.
5. Victor Rodwin*, The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States,* American Journal of Public Health 93, Number 1 (2003)
6. Rudolf Klein*, The Troubled Transformation of Britain's National Health Service,* New England Journal of Medicine 355 (2006): 409-15.
7. "In this group of African countries, only South Africa has a strong regulatory framework through the quasi-government Commission for Medical Schemes..." World Health Organization. *Private Health Insurance: Implication for developing countries.* Discussion Paper, Number 3 – 2004
8. Jeffery D. Munn and Lynn Wozniac. *Single-Payer Health Care Systems: The role and responsibilities of the public and private sectors.* Benefits Quarterly, Third Quarter 2007
9. World Health Organisation. *Private Health Insurance: Implication for developing countries.* Discussion Paper, Number 3 – 2004
10. Chaolli vs Quebec. Supreme Court of Canada. 2005
11. World Health Organisation. *Private Health Insurance: Implication for developing countries.* Discussion Paper, Number 3 – 2004
12. *Choice matters 2007-08. Putting patients in control.* NHS