

ALTERNATIVE HEALTH CARE FINANCING MODELS

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“One of the greatest investments which we can make is to invest in health, for there is no other investment like it. Health is Life Insurance, success and happiness insurance”

... *Mahatma Gandhi*

With the growing mechanized life styles, human beings, especially the female generations are increasingly getting exposed to a variety of health and life risks and hazards. It has therefore, become imperative on the part of individuals and also governments to focus their efforts on a search for alternatives to meet the phenomenal rise in the expenses related to health care.

The problem at a macro level is still more serious for the governments across the globe, to meet the growing demands of **provisioning** and **financing** of health care in the face of already wide spread adversities facing them such as incessantly growing population, hostile economic environment, and ever increasing pressure on the availability of the general tax bases.

Health Risks & Health Insurance

People face a variety of risks besides the risks of ill health, like unemployment, death, old age, lawsuits, and loss of property. Moreover, more than a premature death or an accidental death, the major worry today, for people is the fact of living long. The matter becomes more catastrophic if old age added with ill health or disability persists with inadequate financial support. For health care, more than any thing else, financing the healthcare expenses becomes a major issue.

The risk of poor health includes both the payment of very large medical bills and the loss of earned income. Unless human beings have adequate health insurance, or private savings or other sources of income to meet these expenditures, they will otherwise feel insecure. The loss of earned income becomes a cause of still greater insecurity if the individual is suffering from disability either partial or total. In the case of long-term disability, besides substantial loss of earned income, the most difficult part of the whole problem is that someone must take care of the disabled insured person.

With the degeneration of the joint family tradition or in other words with the growth of the nuclear family culture, the risk of old age with lack of financial preparedness on the part of the individual as well as the family has become an **economic risk** of the present century. There is no room for the caring and sharing family culture.

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Significance of Health Insurance

Health insurance has become a necessity today because it plays a major role in the financing of health care. This is because one never knows when illness may strike. Sometimes hospitalization and medication expenses can be unaffordable. At such times, health insurance can prove to be a source of financial support. Moreover, healthcare is unusual in nature, because health care is irregular and unpredictable, sometimes, care can be lengthy and expensive. Insurance, at such times, aims to protect the individual and family against uncertain events (*Mills, Anne*).

Hence the need of the hour is to have at the national, regional, community, family, and individual levels, a **collective mechanism** to meet the growing needs and demand for health care provisioning and financing. While a section of people may have rely on **private mechanism**, a majority of people would definitely benefit through a collective approach at appropriate level. The function of Insurance is to safeguard against such misfortunes by having contributions of the many pay for the losses of the unfortunate few.

Health insurance rightly provides timely and affordable medical help. But unfortunately not all those who need are able to take this insurance cover. Health Insurance aims at protecting the welfare of individuals who fall seriously ill. By pooling financial contribution from many people, insurance plans can cover the hospital expenses of those experiencing catastrophic events, such as fatal illness or injury. Without access to such insurance, many people are unable to obtain treatment or sometimes incur debts to pay hospital bills. (*Aims Worth, 1998*). In fact, studies have revealed that one of the major causes of rural indebtedness is the payment of large medical expenses.

Insurance Mechanisms can generate large volumes of finances for health services. Health insurance is virtually the only practical instrument through which Government can get out of this expensive business of subsidies for hospital care and thus release funds for public health, preventive and primary services that benefit the poor. Hence, some form of **health insurance** is needed to protect the individuals and families against uncertainties.

Organization of Health Care

Health insurance can be organized in a number of ways. It can be purchased by

- Individuals, or
- Groups

From

- Profit or non-profit firms
- Health care services delivered by independent providers
- Facilities owned by insurers

Health Care: An Economic Commodity

In deed, it is true that health care is an economic good and requires a market place with buyers, suppliers, and providers of this health care. Health care refers to both curative and preventive care. Health has no value –in- exchange. It is **health care**, which has both **value-in-use** and as well as **value-in-exchange**. Therefore, it is health care that is Tradeable. While health cannot be purchased health care can be. Health care is consumed very specifically and singularly Therefore **Insurance** is sought to cover at least some of the risks of cost bearing.

Before discussing further on Health care, essentially there is a need to focus on two main key issues, which are common to any type of health care financing or provisioning systems adapted by the governments to suit the requirements and needs. These key issues are:

- Public – Private mix in finance and provisioning
- Rewarding the Providers

Public-Private mix in Finance and Provision

- The organization of financial intermediaries may be on a monopolistic, oligopolistic or competitive basis.
- In a monopolistic system, the financial intermediary is usually a public agency such as a government, or a health corporation.
- In an oligopolistic system (i.e. one in which there are a small number of large intermediaries) finance can be controlled by public or private agencies, such as insurance companies or a combination of these.
- In a competitive system, a large number of small private intermediaries would exist.

The various combinations of Public/Private mix in health care financing and provision can be clearly depicted in the following figure:

		PROVISION	
		Public	Private
Public	(1)		(2)
FINANCE			
Private	(3)		(4)

- | | |
|--|---|
| (1) Public finance and public provision | (3) Private finance and public provision |
| (2) Public finance and private provision | (4) Private finance and private provision |

Quadrant (1) represents a system wherein the financing and the provision of health care is completely public.

Quadrant (2) represents public financing and privately provisioned system. In many countries the general practice falls in this category wherein the care is provided by the self-employed doctors who receive their income from the public purse.

Quadrant (3) represents a system like the Health Maintenance Organizations (HMO) where in the financing is privately done but the provision is in the public.

Quadrant (4) is purely privately funded and financed and provided.

Rewarding the Providers

The second issue common to any system of health care financing and provision system is the rules regarding the rewarding of the providers especially the doctors and the hospitals.

Doctors

The incentives that effect the doctors may not always be financial in nature. It can be a sense of personal pride also for a job done professionally. Some of the financial incentives include **FFS (fee-for-service)**. In some systems, it can also be a sort of **capitation payment** made according to the number of patients registered with a doctor. **Salary system** is also a means of payment effected in most of the countries. However, it is also possible to combine salary, capitation and FFS in a single remuneration system.

Rewarding the Hospitals

On the other hand reimbursement to the institutions can be done in a variety of ways under either public or private insurance such as:

- **Retrospective reimbursement** – involves the insuring agency paying the provider for all reasonable expenditures incurred on behalf of an insured person or group over the previous period.
- **Prospective Payment:** This system which is based on costing of **diagnosis-related-groups (DRGs)**. The funding is based on individual cases.

Alternative ways of Financing Health Care

The main health care financing models taken up for detailed evaluations here are:

- Private Health Care Insurance
- Direct Taxation
- Public Health Care Insurance
- Health Maintenance Organizations
- Other Sources of Financing

PRIVATE HEALTH CARE INSURANCE

This system of health care provisioning of the purely private insurance companies operates in an oligopolistic structure. Because of small number, they strengthen their market power. Premium payments are made either by consumers or their employer or from social security funds. These premiums are mostly tax-deductible also.

Existence of moral hazard is an inherent demerit of this system. In fact, there is no incentive for cost control, either by the consumer or the provider. There is also a possibility of the exclusion of **low-income people** and the **high-utilization groups**. Therefore, governmental intervention becomes inevitable for the poor and the aged.

However to combat the problem of moral hazard, cost –sharing, or co-payment schemes are usually introduced by most of the insurers. These schemes can take four main forms:

- Flat charge
- Co-insurance
- Deductible
- Combination of the last two

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

This system works on the basis of contractual arrangements between insurers and health providers. For the consumers it is Zero Price at the point of use. The user charges and deductibles are comparatively lower in this system than the private system. The consumers have ample choice to choose from the providers. However, hospitals have the incentives for controlling costs. The advantage in this system is that employers have control over the health care costs and can organize need - specific schemes. Demerits, however, include moral hazard and adverse selection.

DIRECT TAX SYSTEM

Under this system, like that of the UK health Service model, finance for health care may be provided by a Public Monopoly. Even in India, the government makes a budgetary allocation for health care through the government owned hospitals and the Public Health Clinics (PHC). Finance is raised by either by **general taxation**, or hypothecated **taxation (Medicare levy** under the Australian Health Care System) and also through the **general public insurance system**. The waiting lists and consultations to some extent help in controlling moral hazard. Thus, the Tax system redistributes according to the two indicators of individual well being:

- Health status
- Income

Tax System of financing can be made more effective by strengthening of community representation, designing of market-oriented policies and careful monitoring to prevent dual standards of medical care

PUBLIC HEALTH CARE INSURANCE

This model is popularly known as Social insurance. The administration of this system can be through a monopolistic agent such as a regional government, or national government. Canada, Australia, France, and Germany are the best examples of a public health insurance system. The Capital Expenditure is usually funded out of the public revenues or taxation. The system provides for different levels of subsidy for pharmaceuticals and dental care for the children, elderly, and poor people. The premiums can either be through contributions or from social security funds. To some extent there is a control on adverse selection because of lack of competition between the financial intermediaries.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Health Maintenance Organizations are a product of Private Insurance Systems. Under this system there is a provision for a comprehensive health care, for a fixed periodic per-capita payment. The premium paid by the consumer can be a subsidy from their employer or out of social security funds. There are, of course, no charges at the point of use. The premium is independent of the volume of services provided during the period. But adverse selection and experience rating are inevitable in this system because of competition. However, there is no inherent danger of a supplier or doctor - induced demand because the budget is generally fixed for the HMO annually.

HMOs can be of one of four types:

- **A Staff model:** in which all the doctors are either employed or taken on a contract basis.
- **A Group model:** in which the HMO contracts with an independent group to provide services.
- **A Network model:** in which more than one independent group is contracted to provide services.
- **An Independent practice association.(IPA):** in which the HMO enters into contract with several doctors in independent practices.

OTHER FINANCING MECHANISMS

VOUCHERS

It is a system of tied subsidy, where in the holder can trade a voucher in return for a service. The vouchers are related to the means of the consumers and also vary according to the services to which the holder is entitled. The advantage in this system is that it gives ample choice to the holder and to some extent controls adverse selection, because the ability to pay automatically filters the consumers.

Lotteries, On-Site Services, Charitable Donations

These models can only be a supplementary health care services in nature, because they may be either inappropriate in scale or can prove to be administratively costlier. However, these methods do not have element of insurance integrated in them.

As seen above there is a lot of scope for permutation and combination in the models of health care financing and provisioning. But, no model can be said to be the best model. For a model, which is successful in one country may not be suitable in another country.

The domain of *health* is a typical variable, that is effected by so many factors such as financial and economic status of the individual as well as the country, occupation styles, food habits, surroundings, environmental conditions, awareness and above all health consciousness. Ultimately, which ever model is adapted by the government for the health care financing and provisioning for its masses and in the best interests of its citizens, the crucial questions one need to ask and be clear with the answers are such as:

Crucial questions:

- What financial intermediary stands between the consumer and the service provider?
- What form does the 'insurance premium' take and according to what principles is it set?
- What out-of-pocket payments does the consumer make at the point of use?
- How are professional providers to be paid?

- How are institutions to be reimbursed?

Indian Voluntary / Private Health Care Insurance Model

The Health Insurance sector in India is predominantly monopolized by the **Mediclaim policy** issued by the four general insurance companies till recently. The cover is grossly inadequate and unaffordable, very narrow in its scope and cover and mostly taken by the urban elite for the benefit of tax exemption.

Individual Mediclaim Insurance Policy

The limitations in the policy as a product for the health care cover include the application of a flat rate for premium, moreover the occupational details are not emphasized in the application and most often there are delays in claims settlement. The consumers also feel that the TPA's (Third Party Administrators) are further delaying the claims. Ushering in of the TPA system to monitor the large claims is also another reason for the slow performance of the health insurance sector (*Gupta, Alope*). A high degree of malpractices are also prevalent.

The portfolio of health business experiences high loss ratios. Income Tax benefits seem to be the driving force behind the procurement of a health insurance policy. Pre-existing diseases are excluded totally from the cover.

Areas identified for more focus

The following issues are to be addressed, if in principle and practice the health insurance policy, which is really health care insurance policy, is to be a holistic and comprehensive product:

- Old age Health care where in tailor-made plans for the aged can be designed.
- Long term care - for a term of three to five years in place of annual plans.
- Disability income insurance provision to be incorporated in the basic plans too.
- Treatments for the Mental disorders on par with other illnesses and diseases.
- Health cover for workers in informal / unorganized sectors, such as daily wage earners, seasonal workers, casual laborers, construction workers on site.
- Juvenile insurance exclusively to meet medical expenses associated with health related problems of children comprehensively.
- Exclusive health care cover for 'women' for gender related treatments.
- Group insurance covers to be encouraged with sizeable discounts and incentives.
- Micro health financing schemes to be introduced in rural areas for members who are to be formed into recognizable groups.
- Preferred Health Risks concept to be encouraged, like the Preferred Life concept in Life Insurance, incorporating incentives for healthy people.

- Exclusive Health Insurance Companies like the Pakistan Model to be introduced through regulatory amendments.

Conclusion

Health care is an essential economic good. It is also the right of a citizen to get health care service available and affordable when needed. At the same time, on purely economic grounds, no individual can be deprived of **Basic Health Care**. More so, in a democratic country where **welfare** of the population is a paramount consideration, government owes its duty to take care of the vulnerable sections of the community. A properly designed health insurance plan can also be indirectly an income protection plan for the poor. *(Krishnan, T.N)*

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