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Introduction of a national health insurance scheme

Some challenges to introducing national health insurance

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As mentioned in the scope and objectives of the meeting, in an effort to cope with the spiralling cost of health care, several CARICOM governments are evaluating alternative models for delivering health services, in particular national health insurance (NHI). A common feature of the models under consideration is the requirement that employees and employers must contribute directly to the funding of health care services. Several countries have either implemented pilot schemes or are in the process of implementing a scheme.[1]

In my opinion, first of all we have to review the purpose of countries' health financing schemes. For the institution where I come from,[2] it is to make funding available, and to set the right financial incentives for providers, so as to ensure that all individuals have access to effective public and personal health services. A well performing health financing system, and by the same token a well performing NHI, should generate sufficient and sustainable resources for health, use these resources optimally and ensure that everyone has financial accessibility to health services.

A close look at the range of different systems of health service financing reveals that there are advantages and disadvantages with all financing methods. Nevertheless, depending on a country's specific circumstances, some methods may be more appropriate than others.

For the Pan American Health Organization universal coverage is a major goal. It should be understood as the access to health promotion and to key preventive, curative and rehabilitative health interventions for all in a timely, respectful, and good quality manner according to the principles of dignity, and regardless of the ethnic background, social class, gender and ability to pay, thereby achieving equitable access to health care.

Realization of universal coverage is dependent on mechanisms that make it possible to collect financial contributions for the health system efficiently and equitably from different sources; to pool these contributions so that the risk of having to pay for health services is shared by all and not borne by each person who is sick; and to use these contributions to

[1] International Social Security Association. 2005. *Scope and objectives*, Meeting of Directors of Social Security Organizations in the English-speaking Caribbean.

[2] World Health Organization. 2004. Executive Board, EB114/16, 114th Session, 29 April.

provide or purchase effective health interventions. The ways in which countries combine these functions determines the efficiency and equity of their health-financing systems.

I would like to make a strong statement that a system relying on voluntary contributions will not survive. Experience throughout the world tells us that a system that relies on voluntary contributions will not work. People tend to contribute to an insurance plan only when they know that they will need care. Women may join when they learn they are pregnant; people purchase insurance right before needing a serious operation. The result is that insurance plans assume the risk of paying for care for a pool of people who cost more to care for than the average person. This threatens the financial viability of the insurance plan over time.

A well-functioning NHI system places together people who face different degrees of risks of developing high-cost conditions in the future. When one person in the pool actually develops a high-cost condition, the cost of treatment far exceeds the amount of the contribution made by the individual to the insurance pool. The other people who remain healthy end up helping to finance the care of the unlucky person who contracts the high-cost condition. Insurance is attractive because it protects people against the possibility of high expenditures in the future. A NHI system pools together all people in a country and is funded by contributions by all people. Contributions to NHI are usually not related to the risk posed by a given individual. Instead, contributions are typically dependent on income. The result is that relatively high income and healthy members of society subsidize the relatively low income and sick.

NHI programmes certainly cost a great deal of money, but it is important to distinguish which costs are incremental. In other words, what are the additional costs to society from the imposition of NHI. The truly incremental costs stem from several sources. First, the incremental cost of newly covered population. Second, the insured population will incur some incremental cost to the extent that the national health insurance proposal chosen provides greater typical coverage than people already have provided to them. Finally, any tax-supported system of financing care necessarily entails a deadweight loss to society. This is true even if the programme is of the employer-mandated type because a law forcing employers to incur expenses is really a tax. The deadweight loss of a tax means that some efficiency is lost caused by the disincentives to work and invest that can result.

In one sense, the incremental costs are the real costs to society, whereas difference in financing methods are not as economically meaningful. It may be politically more palatable to choose a plan that does not greatly expand the government budget; employment-mandated plans may be attractive politically for this reason. Nonetheless, society incurs the cost irrespective of whether it is financed through the government or mandated to employers by law.

NHI can only be successfully introduced if the conditions are suitable. It must make a contribution to the achievement of health policy goals, notably the improvement of health status, and it must serve to improve both funding for health services and access to care for the population. NHI must clearly be viewed as a policy tool, rather than an end in itself. This means that the goals of health policy must be clear, so that the new arrangements can be seen to help to meet them.

A dilemma that policymakers have to face is whether to fund NHI coverage by individual mandate, employer/employee mandate, or general revenue. An individual mandate is a law that requires individuals to buy health insurance for themselves, and establishes subsidies for those who can’t afford it. The subsidies are funded out of general revenue. The employer/employee mandate requires taxes on wages for the employer’s share. The

employee's share may fall on the employee in the form of lower wages. Subsidies out of general revenues provide for the unemployed. Yet, another alternative is government revenues providing all of the funding for national health insurance.

If NHI is going to be funded mainly by contributions, either individual mandate or employer/employee mandate, a decision has to be made regarding if it's going to be flat rate and equal, wage-related (percentage of wage), or income related (total income – not just wages – is taken into account). Since NHI is going to be funded, partially or totally, through general revenues, it has to be taken into account that taxes can be levied on income, property, sales, profits, imports, and/or exports. Some countries develop targeted taxes on products, such as cigarettes or alcohol, which affect health when consumed.

As was mentioned at the beginning of this document, a common feature of the models under consideration by CARICOM governments is the requirement that employees and employers must contribute directly to the funding of health care services. In the established jargon we can call it the social health insurance way of funding health services.

When considering the introduction of a social health insurance it is critical to consider: the development of the country's economy, the capacity of the government to assume leadership and regulatory roles, and the realities of the current health financing and delivery system. Assessment of these circumstances provides information about constraints that exist and interventions that might be needed to facilitate implementation.

One clear constraint is the overall income in a country. It is clearly not feasible to propose a health system that costs USD1,000 per capita in a country with a per capita income of twice that amount. Another constraint is the ability of governments to collect taxes from the population. Countries with a large informal sector and a history of tax evasion will not be able to implement a health insurance scheme funded by a large increase in tax revenue unless more effective tax collection procedures are introduced, a change that spans beyond the health sector. Policymakers have to face the issue that tax evasion and under-reporting of income and assets are serious problems in many countries.

The introduction of a social health insurance could involve the creation of new institutions and the transformation of existing institutions. New laws and regulations are needed to protect clients and to ensure that the system functions as designed. In most countries, a comprehensive review of existing laws and regulations is needed to identify conflicts between existing and new laws and to identify gaps.

The introduction of a social health insurance could depend on a change in the role of the government and the Ministry of Health from payer and provider to steward and regulator. Careful consideration must be given to assessing the current capacity of the government to perform these new roles. A reorganization of the Ministry of Health may be necessary as well as a change in staff skills.

The current institutions that finance and deliver health services form a critical part of the environment. Individuals who work in or own existing institutions form powerful interest groups that must be considered if national health insurance reforms are to be successful. People who currently work in the health sector must have the capacity to assume new roles in the reformed system.

If contributions are going to be made through wages, it will be necessary to determine the formula for wage deductions. Care must be taken to ensure that imposing deductions on

wages for health will not distort the labour market by increasing tax evasion or reducing the size of the formal sector. Countries are relatively successful at collecting wage contributions from people employed in medium and large firms. Collecting from the informal sector, from small businesses, and from independent workers has proven to be extremely difficult and no good solutions currently exist.

Mandating contributions from the informal sector brings challenges. Imposing the same charge on the informal sector as is charged to the formal sector (employer plus employee) may pose a large financial barrier to participation. On the other hand, a policy that allows the informal sector to pay a smaller percentage of income or a smaller fee encourages employers to hire more workers through the informal sector labour markets with unfortunate consequences for the development of formal sector employment. No easy answers exist, but policy makers must be aware of economy-wide consequences.

Decisions will be needed to determine the degree of client choice in the system. In many current social security systems and public systems, the only client choice comes when clients choose to "vote with their feet" by paying a fee to consult a private practitioner. A NHI system can be organized to allow a wide degree of client choice and to include public, non-profit, and private sector providers.

There is much evidence in the health economics literature that in certain circumstances "a bed built is a bed filled". This evidence also extends to the use of expensive medical technology; for example, once a magnetic resonance imaging (MRI) is in place it will be used. The health systems can control the excessive use of bed capacity and expensive technology by developing and enforcing regulations that control acquisition of medical technology and require government approval for additions to bed capacity. Reimbursement mechanisms that provide incentives to hospitals to control costs by managing length of stay and use of expensive technology are other approaches to control social insurance costs. In most settings it is necessary to apply both regulations and appropriate payment incentives to address this issue; regulations alone are not enough.

Before promising the population access to a wide range of services, it will be extremely important to assess whether resources are sufficient to fund this package. Some actions may be taken to improve the availability of revenue for the health system, but policy makers must be realistic about resources that will be available in the near term. In addition, even if a country must deal with scarce resources, it can almost certainly make better use of the resources that are already allocated to the health sector.

People can also pay co-payments for care. Co-payments serve several purposes: they help to fund health services; they make clients realize that they have the right to demand quality services because they are paying; and they discipline clients to use appropriate levels of care in the health system and not to consult multiple providers for the same condition. When implementing a system of co-payments, it is critical to design a mechanism to provide waivers for the poor.

The definition of a benefits package depends on the country’s financial resources, morbidity patterns, infrastructure, and preferences of the population. In most of the world, a benefits package includes primary care services and preventative care. Depending on the availability of resources, a country may elect to cover basic ambulatory services that are also important for public health and high-cost conditions that have the potential to cause financial ruin to a household. Other countries may choose to rank procedures based on the cost-effectiveness of treatment and the relative burden of the disease in the country. Policy makers have to

deal with the reality that there is never enough money to provide all services to all people. The health of the population is better served if explicit decisions are made about benefits package contents.

One of the important questions that have to be dealt with is: How many insurance funds? We can say that there are many advantages of having one fund that pools together all sources of revenue rather than multiple funds: no duplication of administrative systems, no duplication of information systems, reduced ability for provider fraud, better pooling of low-cost and high-cost health risks, better pooling of low-income and high-income contributions A single payer can pool together funds from all sources and finance all people. But it has to be considered that there may be historical, social, economic, and political reasons for establishing or retaining more than one payer.

Another important issue is cost control. One mechanism that has been used effectively throughout the world to control unnecessary consultation with high-cost specialists is the use of a "gatekeeper" to control referrals to higher levels of care. The "gatekeeper" is usually either a nurse practitioner or a general practitioner who can treat basic illnesses and can make the determination of whether referral to a specialist or to a hospital is required. When incorporated into a comprehensive health plan that covers a full package of benefits, this gatekeeper model has been very successful at delivering primary and preventative health care services and improving efficiency and controlling costs by managing the utilization of services. Paying capitation to primary health care groups that are not part of a comprehensive plan carries the risk that the independent groups will respond to incentives by shifting risk onto specialists and higher levels of care in the system.

How providers are organized and paid is central to the structure of any health system. Some key decisions will need to be made about whether a NHI will cover patients who consult with providers in the private for-profit and not-for-profit sectors as well as the public sector. How funds will flow will have a large impact on the way providers are organized and overall efficiency of the system. The payment mechanisms used to reimburse providers have important effects on system-wide costs and efficiency. Some payment mechanisms encourage over-provision of services while others run the risk of causing providers to restrict the provision of services that are necessary. The provider payment system influences both the quantity of services provided and their price. The combination determines total health care expenditures for a country.

Finally, the health system has to deal with the issue of the existence of barriers that impede access to health care, even with adequate financing. These barriers can be geographic (transportation, roads), lack of adequate health infrastructure and cultural. They can be determined by the hiring regime or employment situation (unemployment, informal nature of the employment), by the structure of the systems, or by a lack of models of care based on an intercultural approach.