

# Private Health Insurance (PHI) As A Mechanism For Attaining Universal Health Coverage (UHC) In Developing Countries: Opportunities And Challenges

R Ofori-Asenso

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## Abstract

In this essay, I explore the extent to which expansion of private health insurance (PHI) can contribute to achieving Universal Health Coverage (UHC) in developing countries. The essay utilises country-experiences to highlight issues of equity and efficiency in PHI as a financing mechanism and proposes interventions that need to be implemented if such approaches are to be adopted by developing nations.

## INTRODUCTION

Health is regarded as a basic human right and a necessity for development<sup>1, 2</sup>. Such recognitions have been underpinned in many international instruments<sup>3</sup>. For instance, Article 25(1) of the 1948 Universal Declaration of Human Rights highlights that;

‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services, and the right to security in the event of ... sickness, disability... in circumstances beyond his control.’<sup>4</sup>

In view of this, the 1978 Alma-Ata declaration impressed upon national governments to develop ‘universally accessible’ health systems<sup>5</sup>. However, many years after this declaration, several governments have failed to live up to this responsibility and access to healthcare still remains challenging for many populations<sup>6</sup>. Nearly 1.3 billion persons worldwide cannot access health care<sup>7</sup>. Although, the reasons underlining this span severely, in many developing countries, financial-barriers such as out of pocket payments (OOPs) have been identified as a key factor<sup>8</sup>. What is disturbing is that these measures (e.g. OOPs) are driving nearly 100 million individuals across the world into poverty annually<sup>9</sup>. The glaring catastrophic impacts emanating from financial-barriers to healthcare and in recognition of the fact that systems in many states have failed to address such

problems, the WHO in 2005 passed a resolution impressing upon governments to develop effective health-financing mechanisms towards achieving universal health coverage (UHC)<sup>8,10</sup>. By this, Universal health coverage has been defined as;

‘ensuring that all people can use the promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship’<sup>11</sup>.

However, a 2007 report by the Social Watch group highlighted that at the pace of many developing countries, UHC can only be realised in 2108 (95 years from now) unless drastic reforms are implemented<sup>12</sup>. This call has renewed interest in how health should be financed in developing countries to attain UHC<sup>13</sup>. Although, there seems to be a consensus that health-insurance can be a useful tool for delivering UHC in developing countries, there are divergent views as to the form in which it should assume<sup>6</sup>. While many donor-countries and institutions like The World Bank have been pushing for Private Health Insurance (PHI), many critics have highlighted equity and efficiency issues in such mechanisms<sup>14</sup>. The objective of this essay was therefore to consider the pros and cons of PHI as a modality for achieving UHC in the developing world.

**UNIVERSAL HEALTH COVERAGE (UHC): HEALTHCARE FINANCING MECHANISMS**

The three main goals that UHC seeks to achieve are; (a) ‘equity in access to health services - those who need the services should get them, not only those who can pay for them;’ 15 (b) that the quality of health services is good enough to improve the health of those receiving services; and’ 15 (c) ‘financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship’ 15. Nevertheless, as Kutzin indicates, the realisation of these goals depends on the existing health financing mechanism16. Every health-financing mechanism has three key functions- ‘revenue collection, risk pooling and purchasing’ 17(Table.1).

**Table 1**

<b>Revenue Collection</b>
Raise sufficient and sustainable revenue in an efficient and equitable manner to offer population with basic essential packages that enhances health outcomes and provides financial protection and customer satisfaction
<b>Risk Pooling</b>
Manages these resources to equitably and efficiently create insurance pools
<b>Purchasing</b>
Utilise contributions to purchase health services in an efficient and equitable manner

Over the years, many countries have adopted different mechanisms towards executing the health financing functions to deliver UHC19. For instance, whilst countries like France and Germany have adopted a mandatory Social Health insurance Scheme (SHI), the UK is well noted for its fully general-tax funded mechanism20. Moreover, service–user charges supported by donor-funding have been the main stay in many low-resourced countries whilst others have utilised multiple mechanisms6. Nevertheless, according to Ataguba and Azakili, although, the health-financing functions remain fundamental, UHC cannot be achieved if the mechanisms in place to execute these functions are not equitable and efficient10.

**(a)Equity**

The understanding of the meaning of equity as applied to healthcare remains very varied with different interpretations and conceptualisations21. However, in relation to healthcare-financing, many economists have outlined equity to mean ‘a situation where individuals are able to contribute to healthcare funding according to their ability to pay and benefit from health services according to their need for care’22(p12). Hence, for a healthcare-financing mechanism to be equitable demands cross-subsidisation among high and

low health-risk individuals as well as between the affluent and the deprived22-23.This is necessary to avert healthcare demands driving low-earning households into poverty24. In view of this, ideal health-financing mechanisms that seek to deliver UHC should not be regressive22. Regressive implies a health-financing mechanism in which persons or households with lower-incomes contribute a higher proportion of their earnings to healthcare-financing than groups in higher-income quintiles25. The reverse is progressive whilst proportional means that every group contributes same fraction of their earnings22. Furthermore, as Zere et al indicates, equity can also be conceptualised from 2 perspectives of Horizontal and vertical26. Horizontal equity implies, ‘equal treatment of equals’27.That is, individuals must be able to utilise health-services as demanded by health-needs22.Vertical equity implies ‘the unequal treatment of unequals’27.That is, preferential treatment for those with greater health needs, for instance the elderly has more health needs than the young’22(p12).

**(b)Efficiency**

Efficiency as applied to health care remains subjective28. Nevertheless, the term as applied to health-financing implies a mechanism capable of generating ‘a relatively large amount’24(p6) of financial revenue without relying on multiple funding streams to do so22. Furthermore, according to Hoare and Mills, for a mechanism to be efficient, revenue-collection as well as administrative costs must maintained be at the lowest-minimum possible29.This is necessary to ensure the availability of sufficient funds for actual health services delivery. Hence, the analysis of the efficiency of any health-financing mechanism can be approached from 2 perspectives- allocative and technical22. According to McIntyre, these 2 perspectives can be summarised as ‘doing the right thing’ and ‘doing it the right way’ respectively24.Therefore, in terms of allocative efficiency, it involves efficiently allocating resources between various level of care such as between tertiary services and community or primary healthcare services24. Technical efficiency according to Donaldson and Gerard, requires that in the provision of resources to fundable services, cost minimisation should be pursued but in doing so without a compromise on delivering quality care30.

**WHAT IS PRIVATE HEALTH INSURANCE (PHI)?**

Health insurance has been conceptualised as ‘A group of persons contributing to a common pool usually held by a third party. These funds are then used to pay for all the costs

of a defined set of health services for the members of the pool'<sup>31</sup>(p18). According to the Organisation for Economic Co-operation and Development (OECD), the key characteristic that distinguishes public (social/SHI) from private (PHI) health insurance, is the manner in which revenue is collected<sup>32</sup>. Whilst in SHI revenue collected is channelled via the state, in the case of PHI direct payment is made to the entity in charge of risk-pooling<sup>33</sup>. Moreover whilst SHI generally depends on tax-based contributions, PHI usually involves 'a private contract between the insurance provider and its clientele, setting the level of insurance premiums in exchange for a given benefit coverage'<sup>35</sup>(p3). PHI is usually characterised 'as voluntary, for-profit commercial coverage'<sup>33</sup> as oppose to SHI which are usually compulsory. However, the distinction between PHI and SHI is not always straightforward and that the 2 exist as a continuum rather than separate entities when analysed on 3 parameters such as 'type of enrolment, type of contribution and type of management'<sup>33</sup>. With regards to enrolment, although, PHI and SHI are usually described as voluntary and compulsory respectively, in countries like Switzerland, purchasing PHI is compulsory<sup>33,36</sup>. With regards to type of contributions, PHI is usually based on individual or community risk-profiling whilst SHI is based on earnings (incomes) <sup>36</sup>. However, in countries like Chile, contributions based on earnings have been incorporated in PHI systems<sup>33</sup>. In relation to type of management; PHIs are usually privately owned, although in countries like Australia, the largest players in the PHI market are owned by the state. Moreover, PHI assumes different roles in different countries. These roles can be summarised as providing 'primary' or 'secondary' coverage<sup>33</sup>. In countries where PHI delivers primary coverage, it acts as the key funding mechanism for a section of the populace<sup>36</sup>. For instance, in the US, populations not covered under the Medicaid and Medicare will have to utilise PHI<sup>33</sup>. Moreover, in Netherlands, persons earning more than €30,700 per-annum are not covered under the public insurance and must purchase PHI<sup>37</sup>. In secondary role, PHI may assume the roles of 'complementary and supplementary'. Complementary roles exist in countries like Canada where PHI covers healthcare services that cannot be enjoyed under the statutory-health insurance. In certain countries too it may be meant for coverage of statutory user-charges<sup>36</sup>. In countries where PHI plays a supplementary role, it is intended to increase consumer choices as the coverage rendered under the PHI is usually same as those under statutory insurances<sup>36</sup>. Such practices are common in countries like Australia<sup>38</sup>.

## **PRIVATE HEALTH INSURANCE FOR DEVELOPING COUNTRIES: KEY ARGUMENTS**

Arguments in favour of PHI in developing countries are built on the premise that governments of many developing on their own have been unable to provide their citizens insurance coverage that meets their needs and offers financial-protection<sup>39</sup>. Moreover, it has been argued that out-of-pocket payments (OOPs) which are known to be regressive and which impose huge financial constraints are excessively high in developing countries<sup>39</sup>. For instance, the 2010 World Health Report indicated that in countries like Georgia, OOPs is as high as 81.6%<sup>40</sup>. Hence, as PHI allows pre-payment and risk pooling it can avert huge OOPs and deliver financial-protection lacking in many developing countries<sup>41</sup>. Furthermore, public spending on healthcare in many developing countries remains terribly-low. For instance, although, the commission on macroeconomics and health has indicated that developing countries spend at least US\$34.0 per capita or about 12% of GDP on health annually, expenditure in many developing countries, is below \$1041-42. This coupled with the fact that many developing states have a large informal sector and weak revenue-collection mechanisms, publicly-funded UHC will remain elusive for a long-time<sup>41</sup>. Moreover, it has been argued that high levels of corruption prevalent in many developing countries have made citizens develop mistrust and unwillingness to pay taxes and as such PHI presents as the best option since the receipt of direct entitlement can act as a motivation to contribute<sup>6</sup>. Proponents of PHI have also highlighted that by incorporating PHI reduces pressures on the already limited resources of many developing-nations and can afford the government to target the poor and vulnerable<sup>6,41</sup>. In this regard, Pauly et al has indicated that, PHI is needed because 'transferring the financing of a medical resource (or any other resource) from the private sector to the public sector involves an inefficiency cost or distortion—what economists call "excess burden." This distortion can sometimes be so large as to effectively prevent public-sector funding<sup>43</sup>(P372). They further stress that, PHI 'might be more efficient as a financing mechanism ....the high excess-burden cost of taxation generates a kind of public-sector failure that private market structures might help ameliorate'<sup>43</sup>(p373). They stretch the argument further by indicating that, 'Although the explicit administrative cost of private insurance is usually higher than that of public insurance, the offsetting excess burden usually associated with tax-financed public spending limits that spending and could mean that private insurance, on balance, is actually

more efficient' 43(P372). Moreover, as described by Drechsler and Jütting, PHI is seen to 'bridge financing gaps by offering consumers value for money and helping them avoid waiting lines, low-quality care.....problems often observed when household...participate in mandatory social insurance schemes' 34(p498). Furthermore, Sekhri and Savedoff also argue that SHI systems of many developed nations actually emanated from voluntary PHI and that PHI in developing countries may be a stepping stone in developing institutional-capacities towards moving to UHC41.

### **EQUITY AND EFFICIENCY PROBLEMS/CHALLENGES WITH PHI**

Even though, PHI can offer financial risk-protection and improve access to healthcare-services it has many disabilities inherent in market-based ideologies44. These disabilities which relate to equity and efficiency can hinder the attainment of UHC. Firstly, in PHI, Premiums are usually determined on the basis of individual health risks or based on averagely profiled community expenditure or risk45. It therefore does not promote risk-sharing between groups with different risk profiles6. Moreover, as there is no clear linkage to personal economic standings (for instance, income), PHI is generally regressive in that poorer households are likely to spend a greater proportion of their income than richer households36. Furthermore, according to Marmot, individuals in lower socio-economic status (income, employment, education) tend to suffer worse health than persons in higher socio-economic status46. This means that poor households are more likely to have co-morbidities increasing their risk profile which in PHI will therefore attract higher premiums. Such hikes in premiums may render many individuals unable to afford or where they are able to pay, this can drive them into poverty. In many countries in Latin America that experienced a boom in PHI in the eighties, the schemes generally covered populations in the highest income-quintiles whilst majority of persons in lower-income quintiles were left out6. Also, in view of the non-solidarity nature of PHI, it encourages cream-skimming in an effort to avert adverse selection44. The consequence is discrimination and in-admission of groups such as geriatrics and persons living with HIV or persons with riskier health-behaviours like smoking and sedentary behaviours6. Discrimination can result in risk fragmentation when only particular schemes are enrolling people with high-risks. However, such schemes concentrated with high-risk individuals alone are prone to collapse thereby totally

depriving such persons of any coverage. The practice of cherry-picking is well documented in many PHI dominated countries such as the US market. For instance, in 2006, Humana, a PHI company in US introduced a package 'HealthMiles' targeting only persons who could prove that they undertake regular physical exercises47. The rampant practices of cream skimming and high premium charges have been identified as contributing significantly to the US' 52 million uninsured population48. Studies by Harvard University indicate that about 44,789 people die in America every year because of lack of health insurance49. PHI also has many factors that drive inefficiency. Firstly, because it is usually voluntary, pools are usually smaller and as such the proportionate management and administrative cost becomes higher45. Moreover, 'extensive bureaucracy required to assess risk, rate premiums, design benefit packages and review, pay or refuse claims'36(P13) have been identified to significantly drive managerial and administration costs. Moreover because of the competing nature of private health markets, PHI also incurs extra expenditures through means such as advertisements, marketing promotions and distribution. Many economists posit that these costs are markers of inefficiencies which can be prevented under different financing mechanisms. It has been estimated that the administrative costs in PHI could be as high as 10 times that of SHI6. Trends in many countries like the US indicate that PHI companies are continually spending more on administration to the neglect of actual healthcare delivery. In 2009 for instance, the US healthcare spending was nearly \$2.5trillion with about \$100billion estimated to have gone into administrative costs of PHI50. Inefficiencies in PHI is highlighted also by the fact that although US has a high uninsured population, it spends about 6.7% of its GDP on health-almost like Canada that spends about 7% but has a UHC publicly funded51. Another issue that can emanate from PHI like most insurance schemes is moral hazard-which is 'the tendency for insured individuals to increase their consumption of health care'44(p7). For instance, Trevidi in studying 'Patterns of Health Care Utilization in Vietnam' drew the conclusion that health-insurance strongly influence utilisation of out-patient services at public facilities and the estimated income elasticity was 0.452. Moral-hazards may arise also through supplier-induced demands such as over-prescribing by physicians44. This can make coverage expensive and reduce insurance demand. Although insurers may introduce measures such as capitation and case payment to counteract this, it may reduce consumer confidence and enrolment can become poor and it can also

affect quality of care<sup>41</sup>. In Ghana for instance, capitation has been greeted with stiff opposition<sup>53</sup>.

## **INTEGRATING PHI INTO HEALTH SYSTEMS IN DEVELOPING COUNTRIES**

In instituting PHI in developing countries, the above factors and many more can derail the attainment of UHC. The non-risk sharing nature means that it can drive inequalities in accessing health services<sup>6</sup>. The profit-oriented attitude coupled with the need to beat competition pricing means that discrimination and exclusion can become the order of the day<sup>54</sup>. Moral hazard attitudes can trigger cost hikes whilst adverse selection can actually make some groups uninsured. In order for developing countries to address these failures and to use PHI as a modality for UHC, political commitment is needed to address very key questions. This includes the question of ‘Who can enter the insurance market?’

Firstly, governments must assess the potential contribution of PHI in their healthcare-financing mechanism<sup>54</sup>. If there is the realisation that PHI can significantly contribute to healthcare-financing and that large populations may be covered then boarder consumer-protection mechanisms should be framed<sup>54</sup>. This will involve deciding on issues like who is eligible to sell insurance, how much competition should be allowed and what level of insurer’s collaboration can be permitted<sup>54</sup>. Moreover, one key issue is for governments in a new PHI market to strengthen financial requirements for entry into market as a way of guarding against insolvency<sup>54</sup>. For instance, Lebanon in 1999 passed a legislation requiring companies entering markets to have a minimum of \$800,000 to operate<sup>54</sup>. Such approaches can reduce the spring up of many small PHI with smaller pools and which are less sustainable.

The question of ‘Who/what is covered?’ also remains important as it has future implications on adverse selection. Governments need to identify for themselves whether PHI will be compulsory or voluntary and which population will be covered<sup>54</sup>. However, many country experiences suggest that mandatory PHI may be ideal to minimise adverse-selection. For instance, in Uruguay all persons whose earnings fall within the range of earning (\$600-\$1800) must take up a compulsory PHI<sup>55</sup>. If PHI will be voluntary, governments must develop ways to attract low-risk individuals such as through providing tax-breaks as done in Australia<sup>54,56</sup>. If high-risk populations are targeted, mechanisms that allows for risk-equalisation among schemes should be instituted<sup>54</sup>. Moreover, the basic packages

delivered must be defined bearing in mind the need to offer financial protection. Consumer-induced demand should be addressed via cost-sharing approaches but must be balanced equitably. In terms of determining premiums, community ratings should be used or where possible income-level based premiums should be adopted as done in Chile<sup>57</sup>. Risk adjustments in premiums should be restricted as practised in Netherlands<sup>54</sup>.

If developing countries seek to adapt PHI as a modality for achieving UHC, they must develop capacities to address the market failures emanating from such financing mechanism. This can be done through;

(a) Developing a strong legal framework guarding market-entry and practice compliance. Uruguay for example developed a comprehensive legal -regulatory framework for the PHI market<sup>54</sup>

(b) Procedures and mechanisms should be instituted that requires PHI firms to declare financial, standings and healthcare utilisation by insurees. This may be useful in assessing the long-term sustainability of firms. Such methods have been employed in Morocco to identify insurance firms likely to be insolvent<sup>54</sup>.

(c) There is the need to institute stronger auditing mechanisms for the PHI market. Morocco for instance has a body called ANAM that audits NHI firms on a regular basis<sup>54</sup>.

## **CONCLUSION**

The prevailing conditions such as high out-of-pocket payments (OOPs) in many developing nations presents private health insurance (PHI) as a useful alternative or healthcare financing mechanism for providing risk-protection. Nevertheless, to achieve UHC through such financing mechanism demands that its inherent failures or challenges related to equity and efficiency are addressed. For countries to effectively tackle these inherent challenges associated with PHI, there is the need for political commitment as well as learning from other countries experiences to develop stronger capacities in safeguarding PHI towards achieving Universal health coverage.

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**Author Information**

**Richard Ofori-Asenso**

Research Intern, Centre for Primary Care and Public Health, Queen Mary, University of London  
London