

# Healthcare financing: Social health insurance vs revenue financed systems

Proposal inspired by Malaysia's  
Citizens' Health Initiative

# Outline

- Objectives and principles of health care
- Historical and current healthcare situations in Malaysia
- Some proposed solutions:
  - Voluntary Health Insurance
  - Social Health Insurance
- Maintain revenue-based health financing in Malaysia
- Summary and Conclusion

# Objectives and principles of health care

- **Universal** health care (UHC)
- **Equitable** access to quality healthcare
  - ability to pay and geographic location should not be barriers to access to quality health care
- **Sustainable** financing over long term
- **Social solidarity** and cross-subsidization

# Healthcare System Out of Pocket Model: Market System

- **Pay for service**: Health care treated like any other service, i.e., those who need a service pay directly for it
- **No pooling** of risk
- Far from **universal access**

# Healthcare System Model Choices 1

## **Mixed Arrangements (US Model)**

- Complex and fragmented
- Includes out-of-pocket elements, traditional sickness insurance
- Partial, not universal access

## **Traditional Sickness Insurance (German Model)**

- Private insurance market approach
- State subsidy fund via employers and/or employees
- Needs high degree of labour market formality
- Not quite universal access

# Healthcare System Model Choices 2

## National Health Service (UK Model)

- Government dominant service payer and provider
- Funded by taxes
- Universal access

## National Health Insurance (Canadian Model)

- Government is single payer
- Providers, hospitals are public/private mix
- Funded by taxes
- Universal access

# Current situation

- Initially predominantly public (hospitals), with private sector confined to GPs providing primary care.
- In recent decades, many countries have moved more to 2-sector system (public/private) polarizing social access to health care
- Perceived higher quality in private sector
  - Private healthcare preferred → increasing **perceived need for private insurance**
- Problem of “**brain drain**” from public to private
  - Longer waiting times, complaints of deteriorating quality care in public sector
  - Reinforces perception of higher quality, and demand to seek private sector care
  - Private sector specialists often govt trained, utilizing public funds

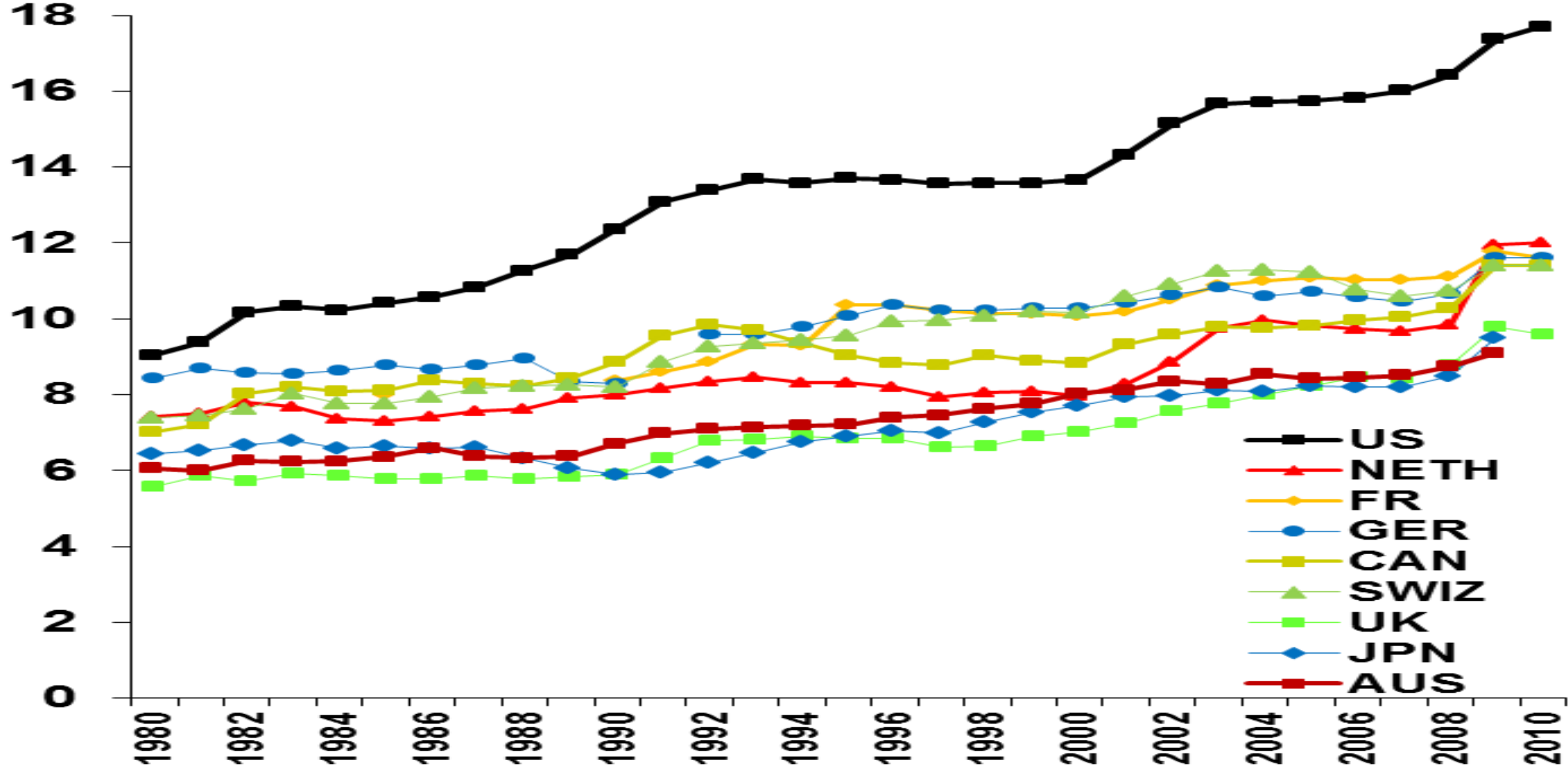
# Recent challenges

## Challenges for government healthcare

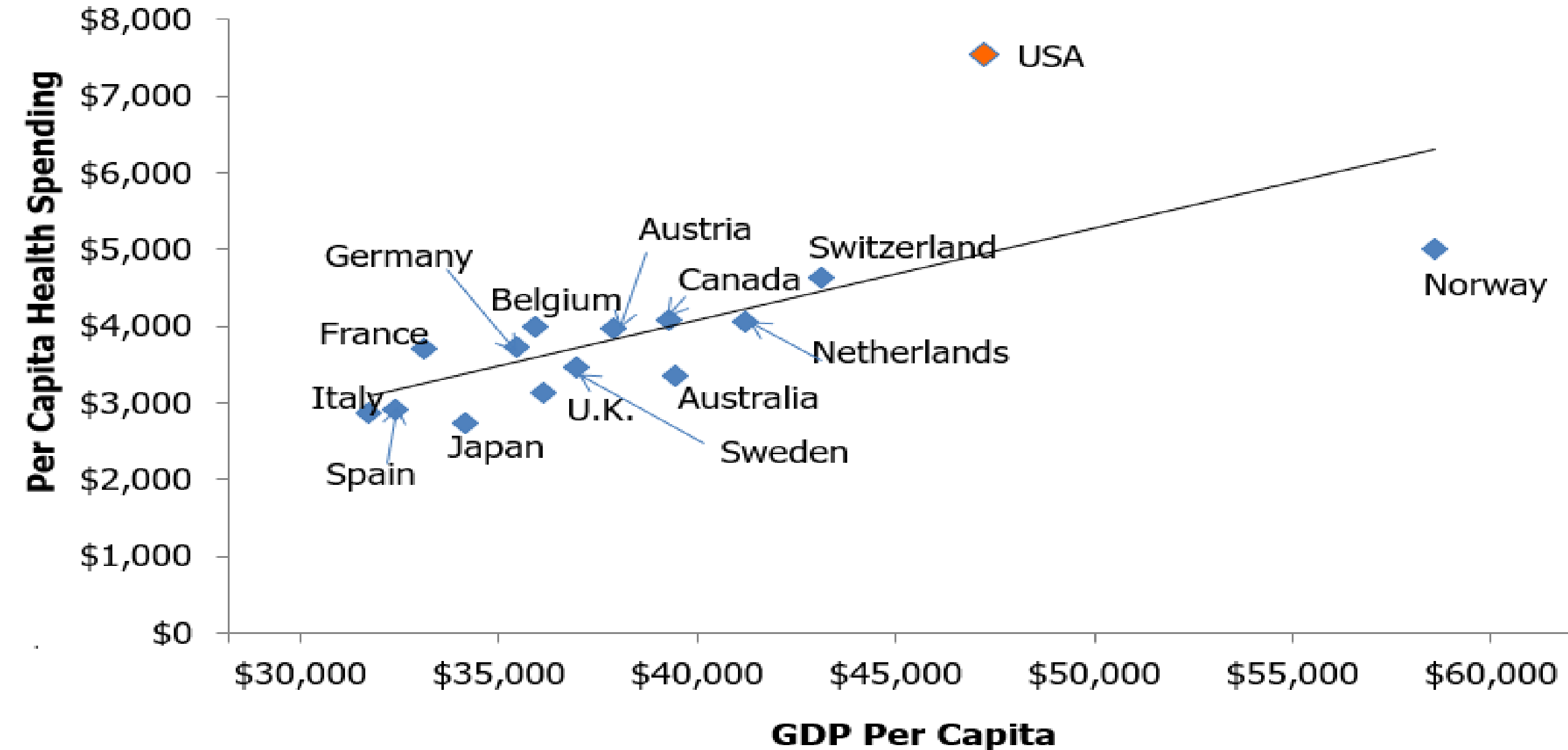
- under-resourced, worsened by leakages and inefficiencies
- loss of experienced staff (specialists, nurses, etc.) to private sector
- geographically uneven improvements in health indicators



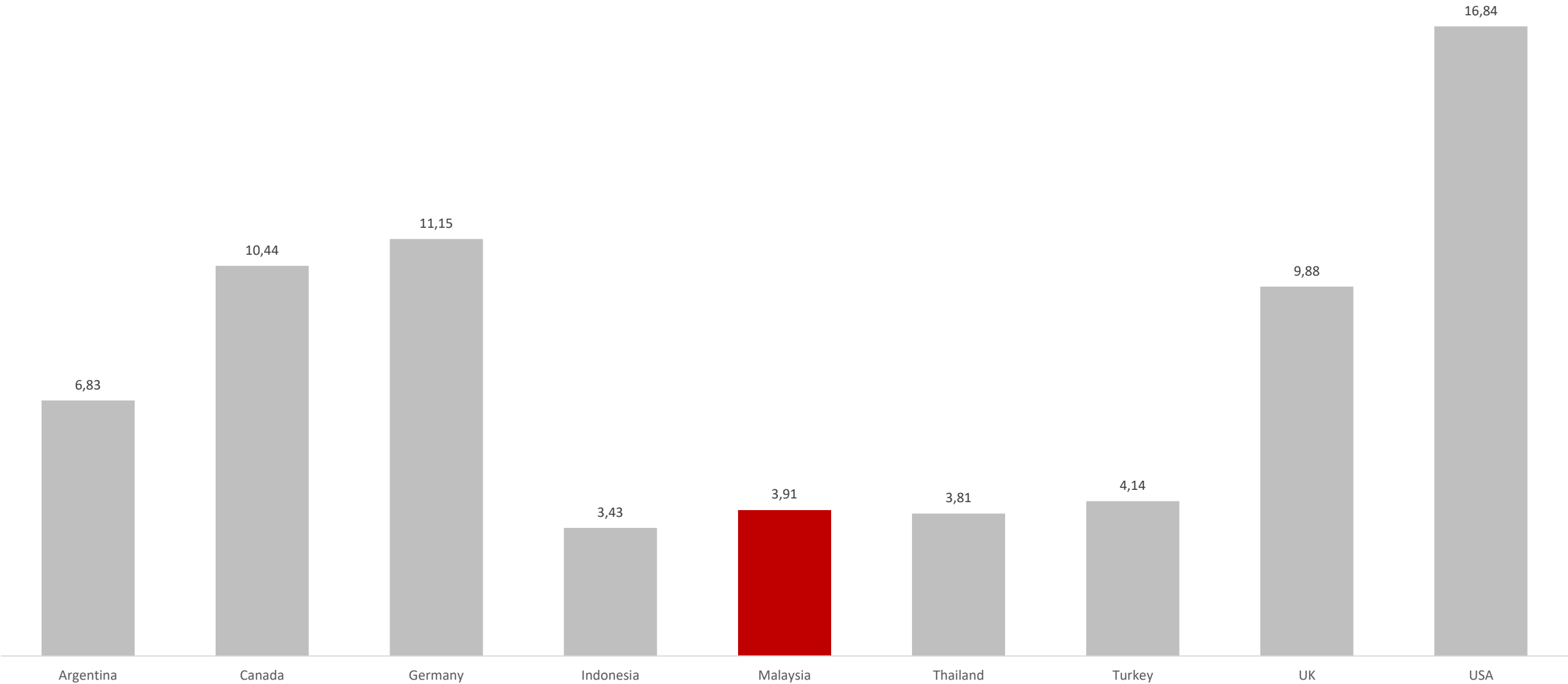
# Total health expenditure as % of GDP



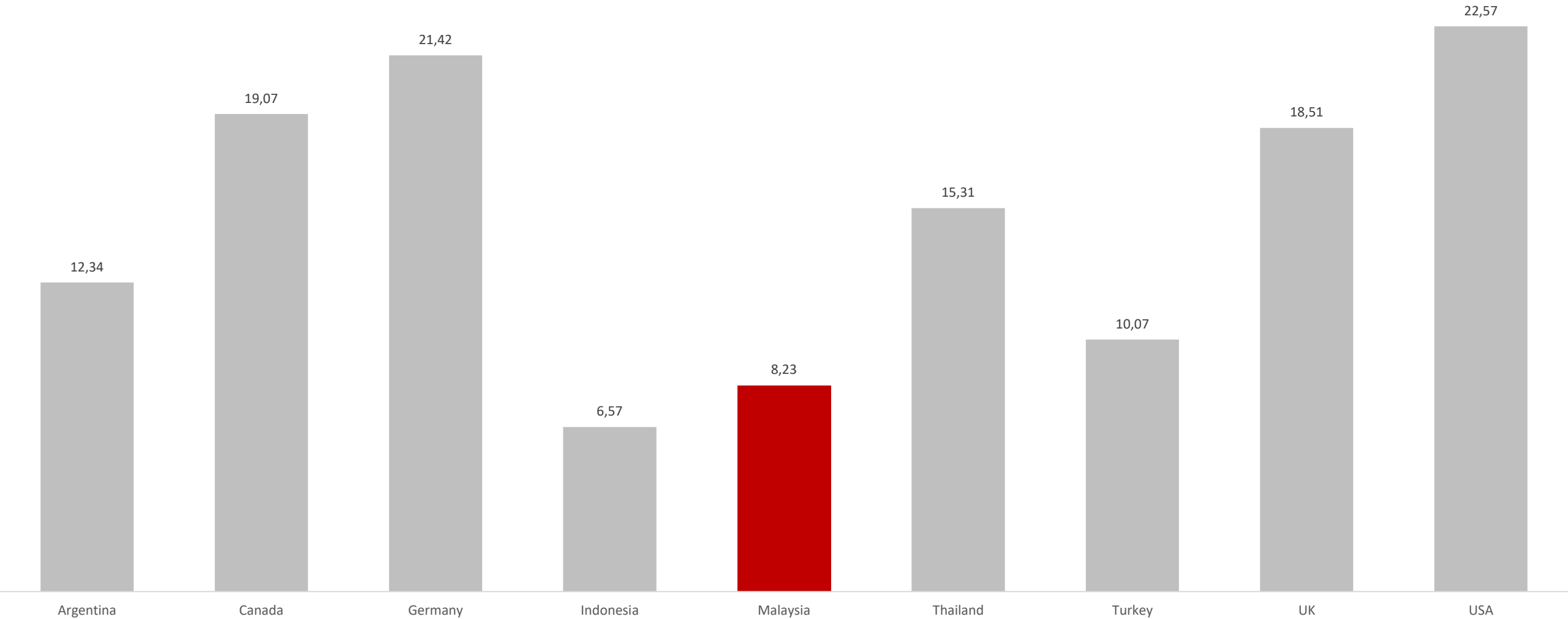
# Total health spending as % of GDP



# Current health expenditure as % of GDP, 2015

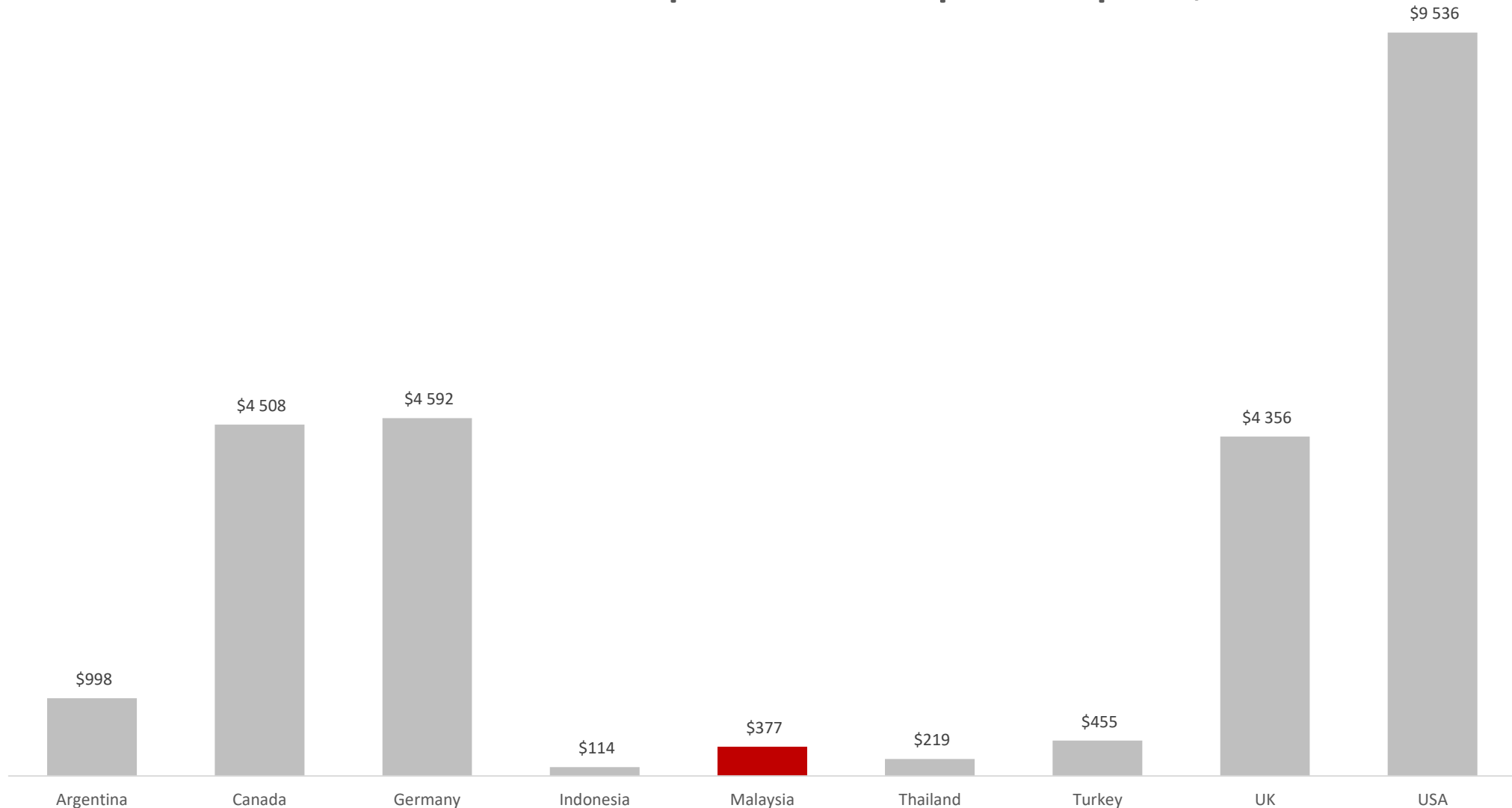


# Govt health spending as % of govt expenditure, 2015



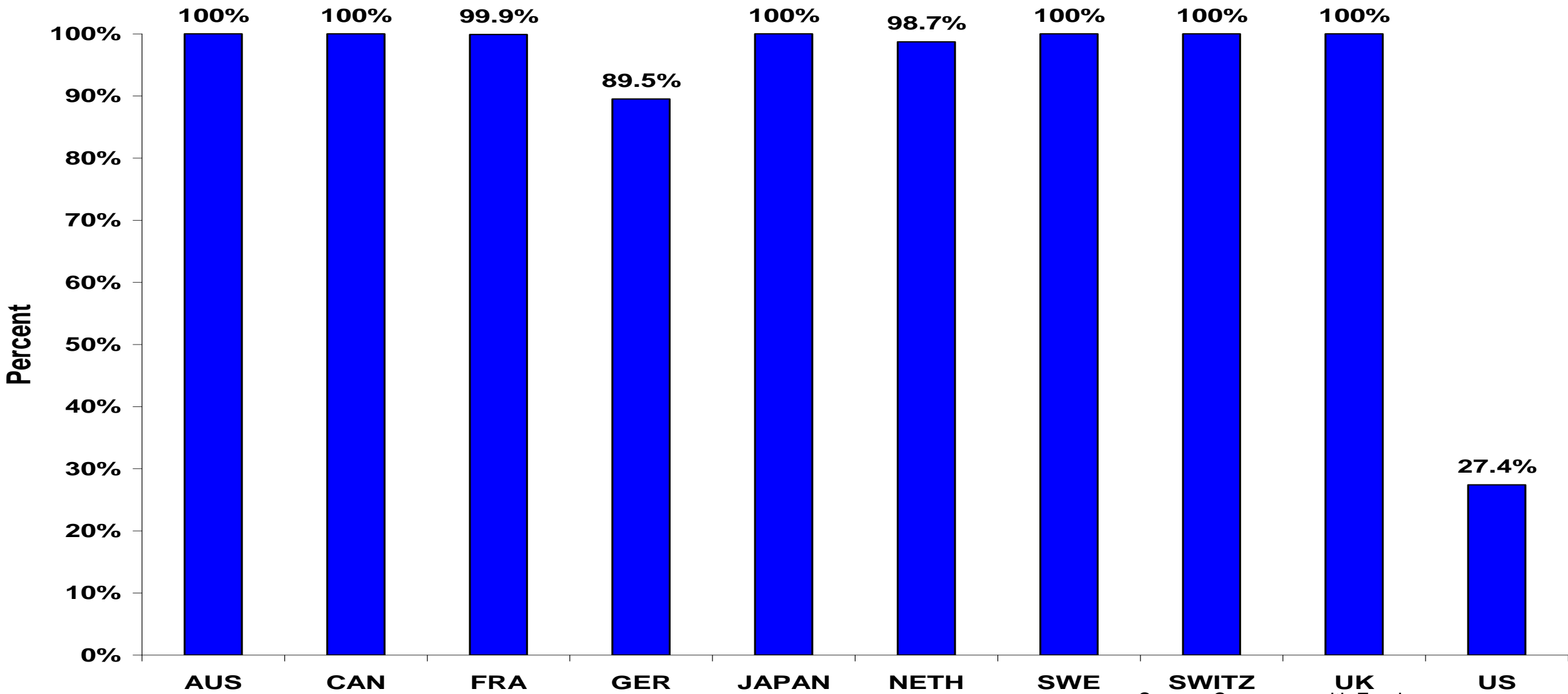
# International cost comparisons

Current Health Expenditure per capita, 2015



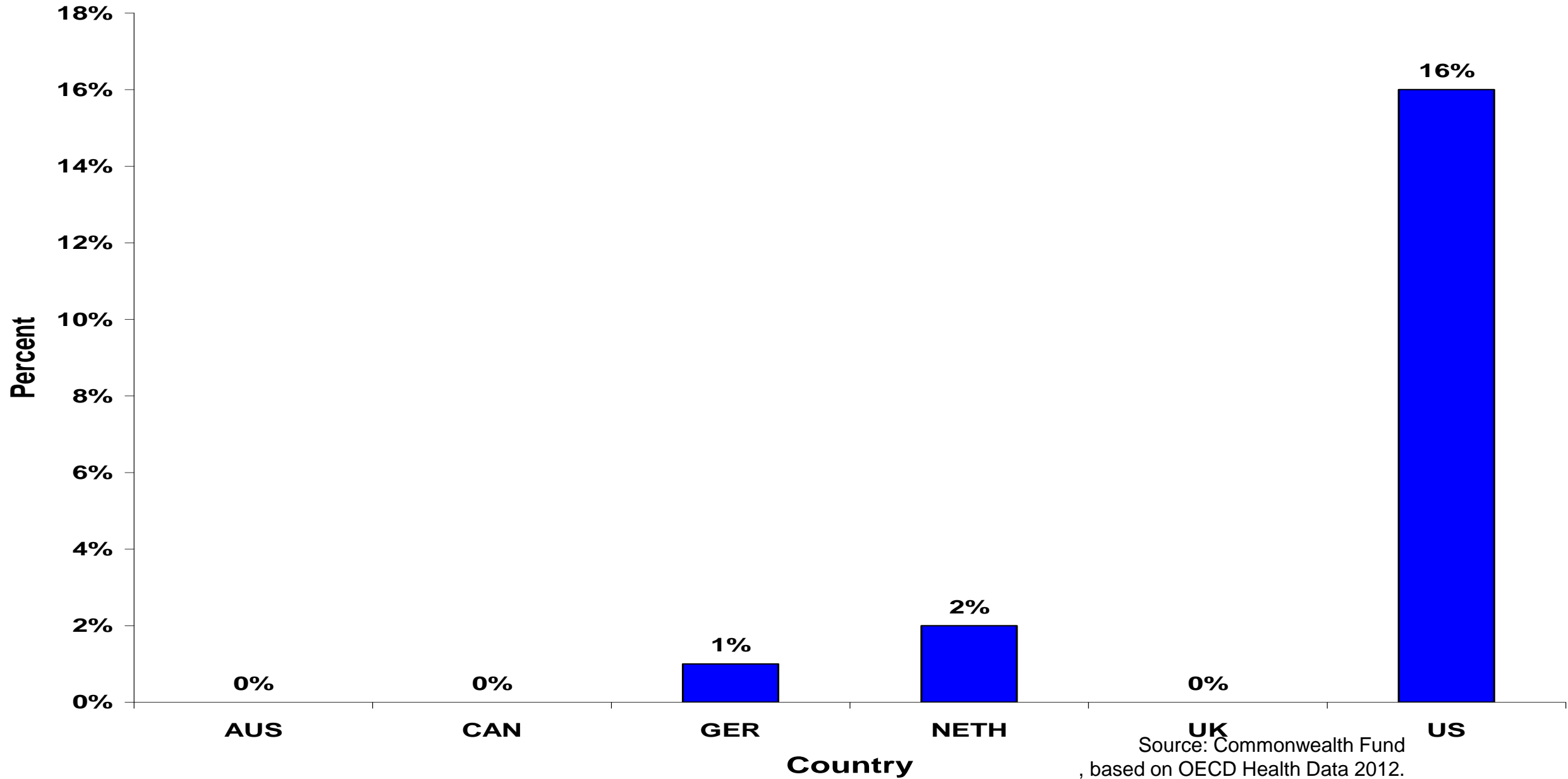
Source: WHO Database, <http://www.who.int/gho/database/en/>

# Percentage covered by public programs, 2008



Source: Commonwealth Fund  
, based on OECD Health Data 2012.

# Percentage uninsured, 2008

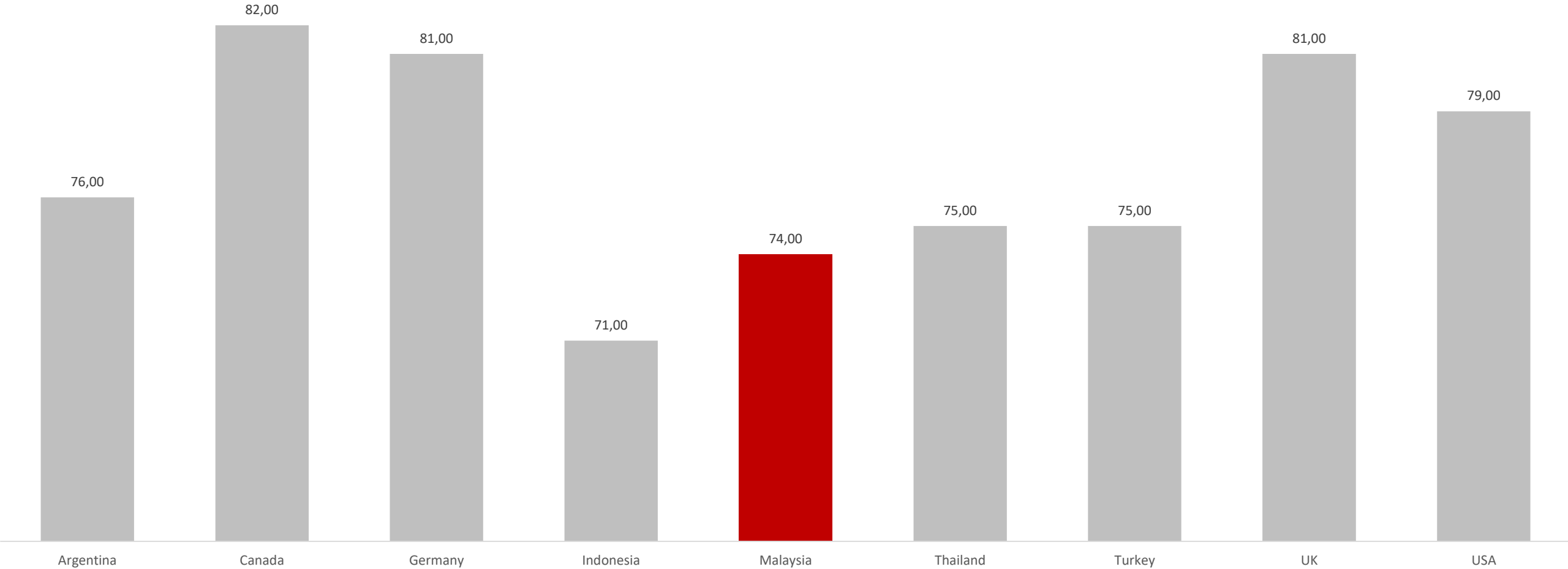


# Life expectancy, 2009: Top 10 countries

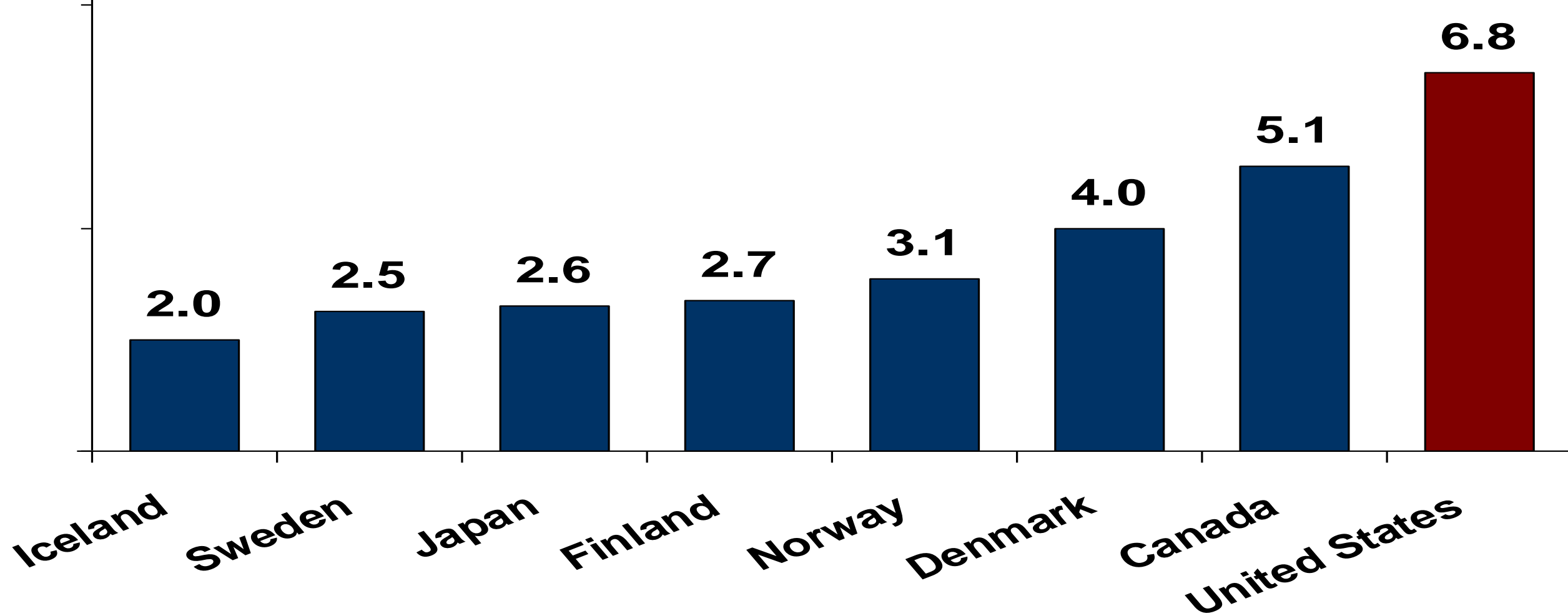




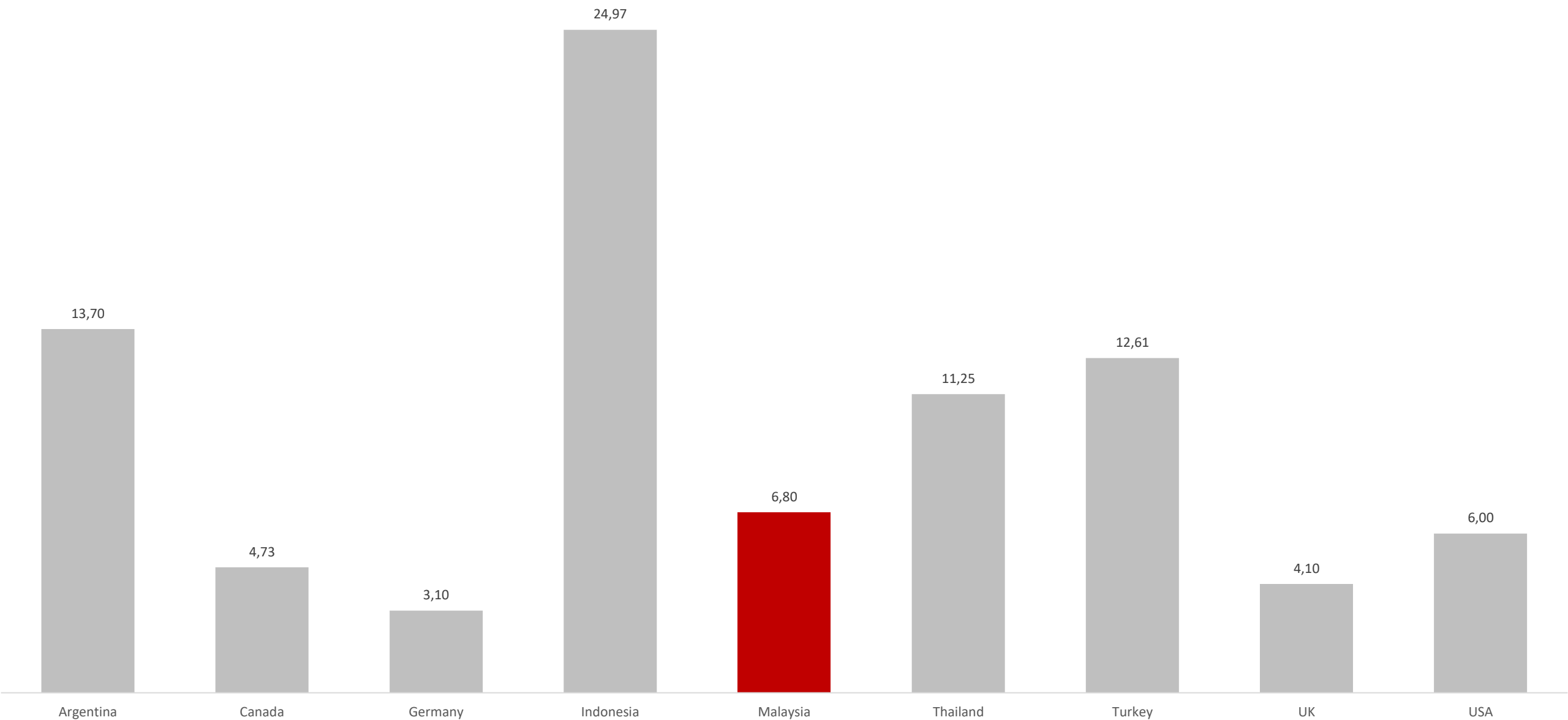
# Life expectancy, 2013



# Infant mortality per 1,000 live births

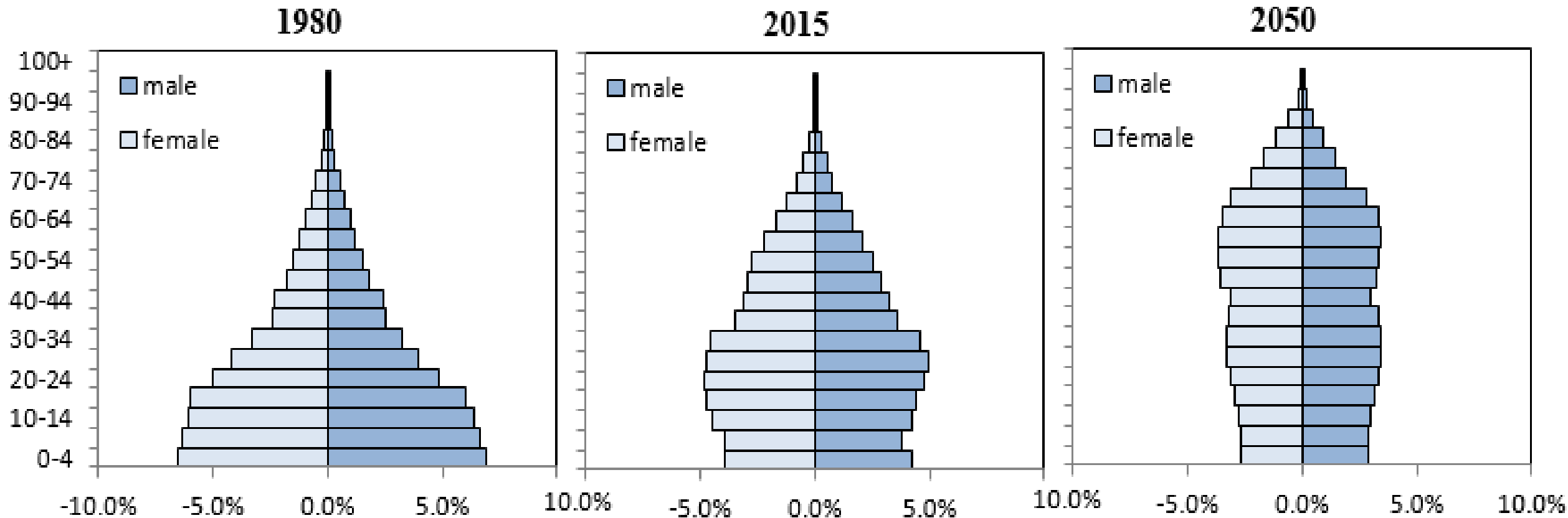


# Infant mortality, 2015



# Polarising Access to Health Care 1

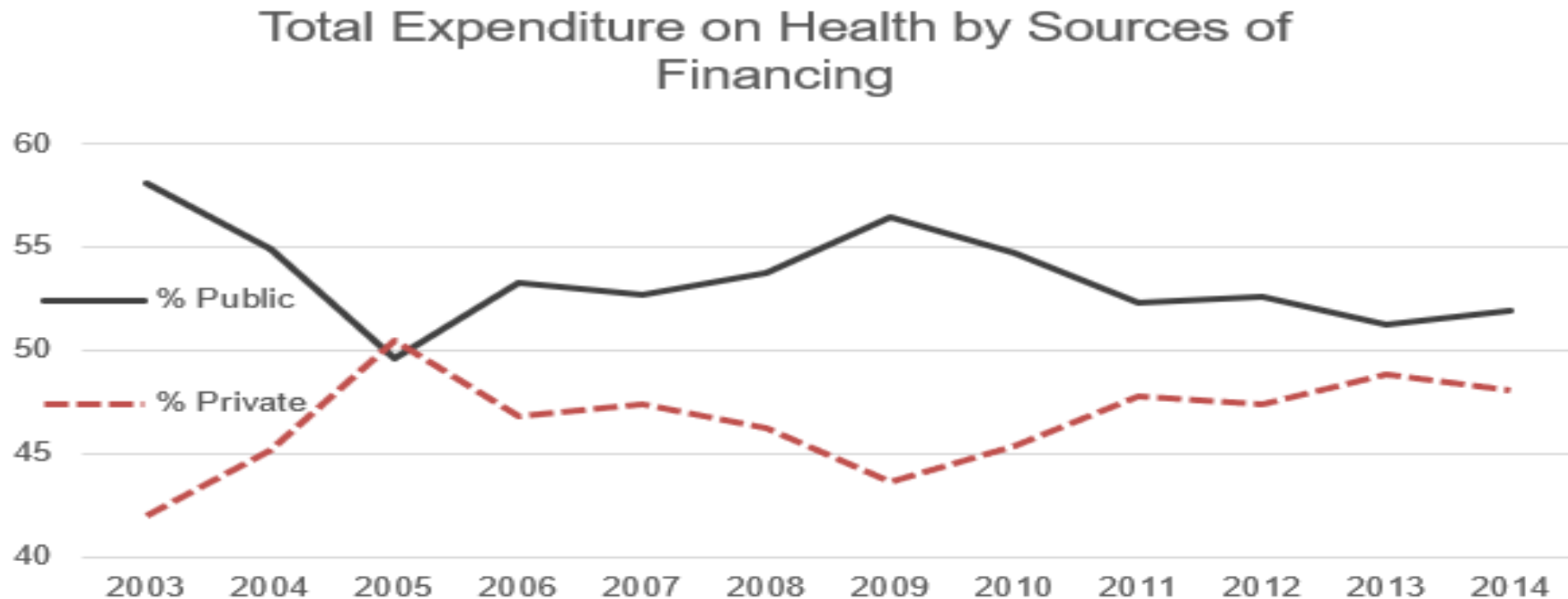
- Example: Malaysia's demography is changing rapidly.



- Utilization of health care services generally follows a J-curve:
  - high utilization in first few years of life and old age
- ➔ changing age structure can increase demand even if population size unchanged

# Polarising Access to Health Care 2

While Malaysia has historically maintained UHC through publicly-provided healthcare on the basis of need, in the last 3 decades, Malaysia has moved towards a 2-sector (public/private) system, polarising access to health care



# Polarising Access to Health Care 3

- Perceived higher quality of private sector
  - Private healthcare preferred → increasing perceived need for private insurance
- 'Brain drain' from public to private
  - Longer waiting times, complaints of deteriorating quality care in public sector
  - Reinforces perception of higher quality, and demand for private sector care
- If current trends not checked, gap between private and public sectors will grow in terms of charges and quality, and increasing polarization in access to quality health care between haves and have-nots, eroding principle of social solidarity through cross-subsidies, i.e., healthy subsidizing ill, rich subsidizing poor.

# Problem

- A healthcare system where health insurance is dominant method of financing tends to raise health care costs, which will not be sustainable in long run.
- If current trends not checked, gap between private and public sectors will grow in terms of charges and quality, polarizing access to quality health care between haves and have-nots

# Health financing

- Key to equitable healthcare system lies in its financing.
- For universal coverage and equitable access, healthcare financing must be:
  1. based on the principle of social solidarity realized through **cross-subsidies**, i.e., the healthy subsidizing the ill, rich subsidizing poor.
  2. **financially sustainable** over the **long term**
- Healthcare markets function poorly, both in financing and providing healthcare. **Heavy reliance on market solutions lead to spiralling costs, reducing access to healthcare.**



# Heavy reliance on market solutions **raised** healthcare costs and **reduced** access

Example: US (overreliance on market) vs Canada (revenue-financed):

- **Huge cost differentials**, with 39% of the difference due to **administrative costs**.
- While **all** Canadians have access to health care, 16% of Americans have no coverage.
- In addition to lower costs and better access, Canada has much better results (e.g., infant mortality 6.8% (US) vs. 5.1% (Canada); Canada has 3 years more life expectancy).

Summary of results in spending differences between the United States and Canada

	Dollars saved per capita	Percent of total difference
Total difference	1,589	100
Incomes		
Physicians	193	12
Clinical staff	109	7
Non-clinical staff	188	12
Total savings on prices	490	31
Administration		
Non-clinical staff	306	19
Physician time	29	2
Other expenses	281	18
Total savings on administration	616	39
Care received		
Inpatient and outpatient hospital care	187	12
Specialist physician spending	37	2
Total savings on care received	224	14
<b>Total dollars saved</b>	<b>1,330</b>	<b>84</b>

Source: Rozen and Cutler. "Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses", Inquiry, 2010 Summer;47(2):124-34

# Health insurance—social and voluntary

- Social health insurance often advocated in the face of the spread of voluntary private health insurance in recent decades
- Worse, some countries launched Voluntary Health Insurance schemes as supposed precursors to social health insurance.
  - Danger of **entrenchment** of voluntary health insurance scheme
  - Tendency for **adverse selection** (i.e., healthy “opt out”)
  - A health financing system dominated by health insurance leads to **cost escalation** and will **require heavy public expenditure to insure poor**, especially those with pre-existing illnesses and health conditions

# Why private health insurance not the answer

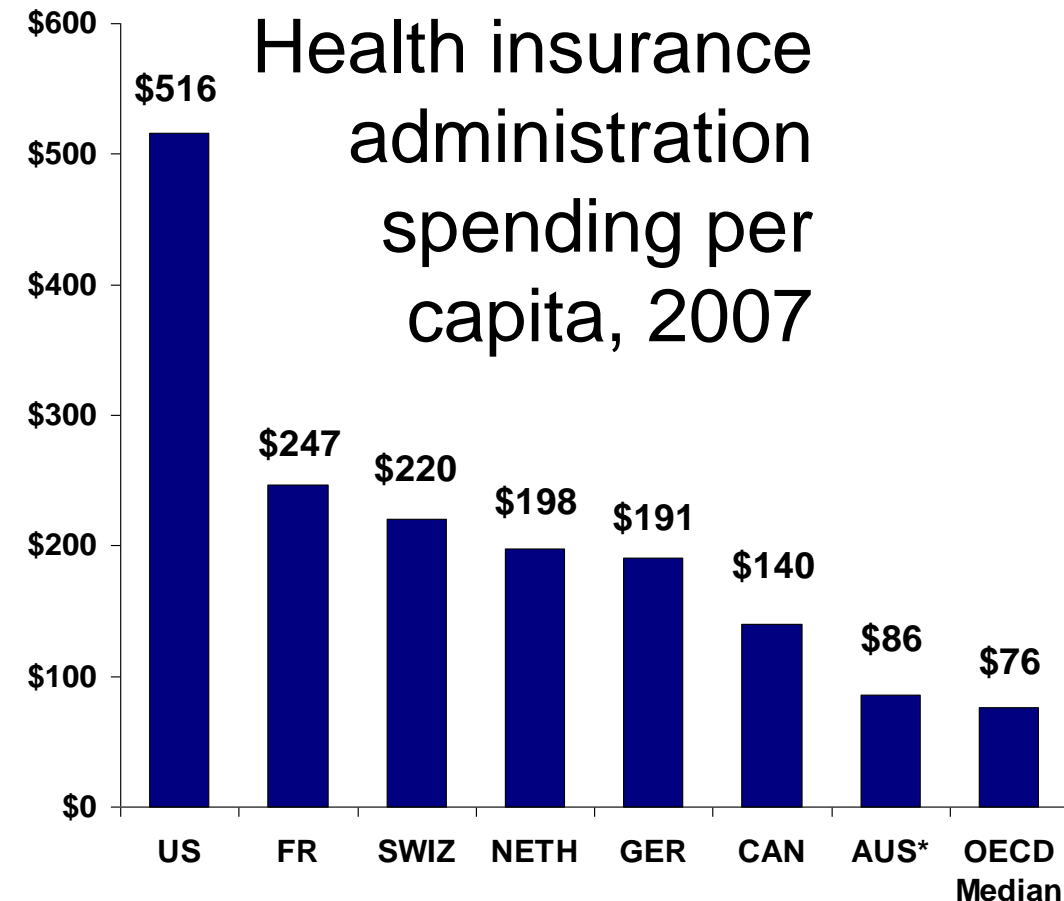
- Premiums are risk-rated, meaning that individuals with pre-existing conditions and higher risks (such as having a family history of illness or being older) will be faced with un-affordably high premiums or be denied coverage.
- The 'moral hazard' problem coupled with fee-for-service imperatives will lead to unnecessary investigations and over-treatment.
- Insurance companies turn to profit-driven managed care services which then leads to problems of under-investigation and under-treatment

# Social Health Insurance

- SHI seems attractive:
  - **Additional revenue** source: “benefit tax”, contributions from employers; people may be more willing to pay more tax for healthcare rather than other taxes
  - **Reduces health financing from government expenditure** allocations.
  - May **facilitate desirable organizational reforms** (e.g., purchaser-provider split; new provider payment mechanisms; integration of public-private providers).
- But disadvantages important to consider:
  - **Difficult** to mandate and **collect** in countries with **large informal sectors and self- employed** (i.e., Malaysia)
  - **Requires extensive subsidization**/co-financing from government revenue to cover poor / vulnerable
  - Mandatory payroll contributions can **increase labour costs**, reduce competitiveness, and contribute to informality.
  - Moral hazard and **supplier induced demand**, leading to over-utilization.

# SHI does NOT Contain Costs or Provide Universal Coverage

- Universal Health Coverage (UHC) is a health system **objective**, **not** a health **financing model**; Social Health Insurance (SHI) is **not** a necessary precondition for attaining UHC.
- SHI tends to **escalate costs** and **requires strong administrative controls**
- SHI adds an **additional layer of administration and management** (for enrolment, collection, coverage, benefits, payments), creating more **expensive system** compared to revenue-based funding.



# SHI does NOT Ensure More Equitable Outcomes

- Wagstaff study for WB: Tax revenue funded system **more equitable, cost-effective** than SHI
- SHI replacing tax financing will **increase per capita health spending by 3–4%** without corresponding health outcome improvements
- Formal sector share of employment likely to be reduced by 8–10% (in OECD) as **employers casualize employment** contracts to avoid employer SHI obligations.
- While SHI can cover the formal sector relatively easily, it **poorly covers informal sectors and the self-employed** unless high level of formal sector employment.

# SHI divergence: declining in Europe

- SHI is enjoying something of a **revival in parts of the developing world** -- many countries have introduced SHI, or are thinking about doing so, and countries with SHI already in place are making efforts to extend coverage to the informal sector with uneven success.
- Ironically, this revival is occurring when the **traditional SHI countries in Europe** have either already **reduced payroll financing in favour of revenue-financing**, or are in the process of doing so.

# SHI: high costs, uneven coverage likely

- In various countries around the world, SHI has not necessarily delivered good quality care at low cost, partly because of poor regulation of SHI purchasers.
- In addition, the costs of collecting revenues can be substantial, even in the formal sector where non-enrolment and evasion commonplace.
- While SHI can cover the formal sector and the poor with significant government subsidies, it poorly covers non-poor informal sector workers.
- SHI payment requirements by employers generally have negative labour market effects, reducing formal sector employment.



# UHC $\neq$ SHI

- Universal health coverage (UHC) is a health system objective, not a health financing model
- SHI is certainly *not* a necessary precondition for attaining UHC.
- In fact, Malaysia can claim to have attained UHC without SHI

# SHI vs tax revenue in health financing

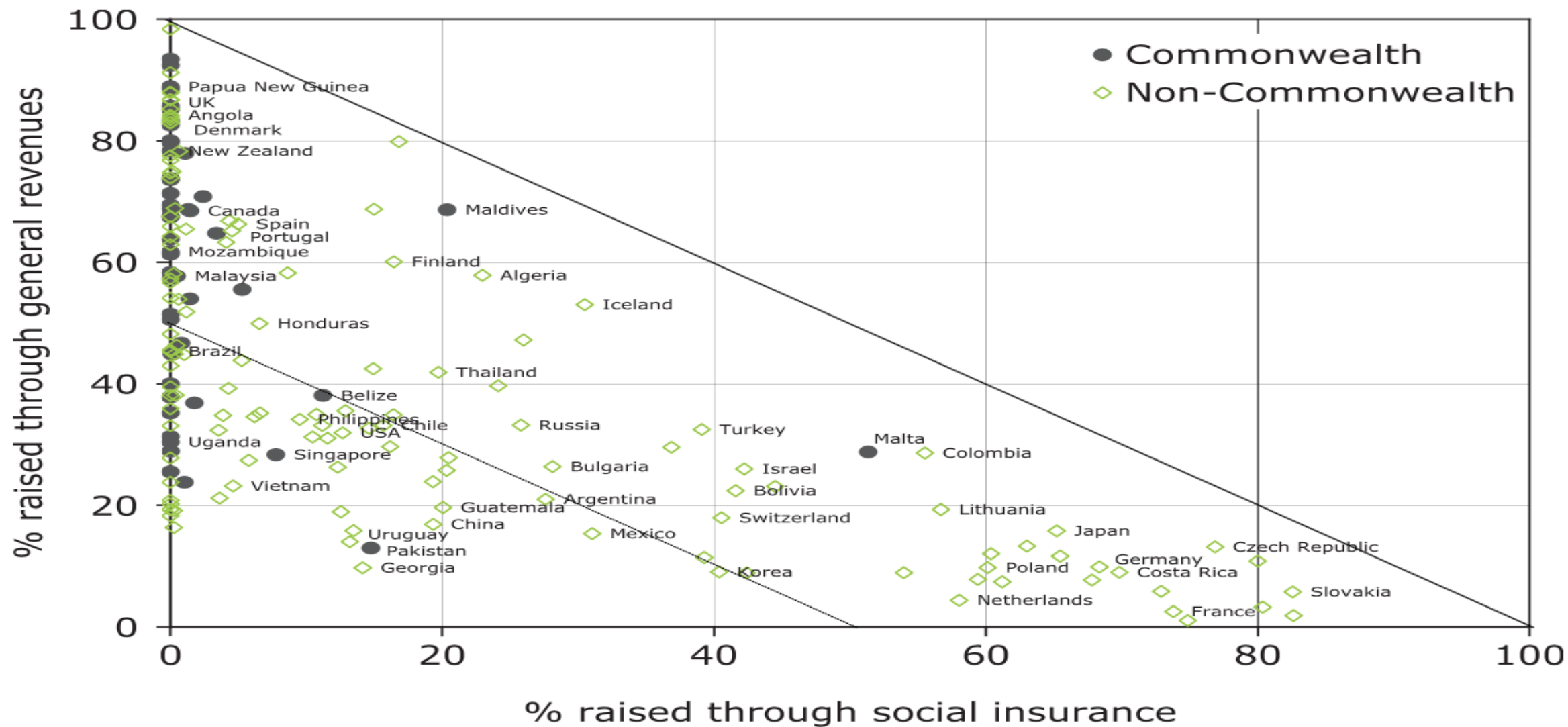


Figure 1. SHI vs taxes in health financing, 2003. *Source: WHO World Health Report 2007*

# Wagstaff World Bank study: Tax funded system more equitable, cost-effective than SHI

- SHI replacing tax financing will *increase per capita health spending by 3–4%* without corresponding improvement in health outcomes<sup>1</sup>
- Formal sector share of employment likely to be reduced by 8-10%<sup>1</sup> as *employers casualise employment* contracts to avoid employer SHI obligations

1. Adam Wagstaff 2009. *Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD*. World Bank Policy Research Working Paper 4812

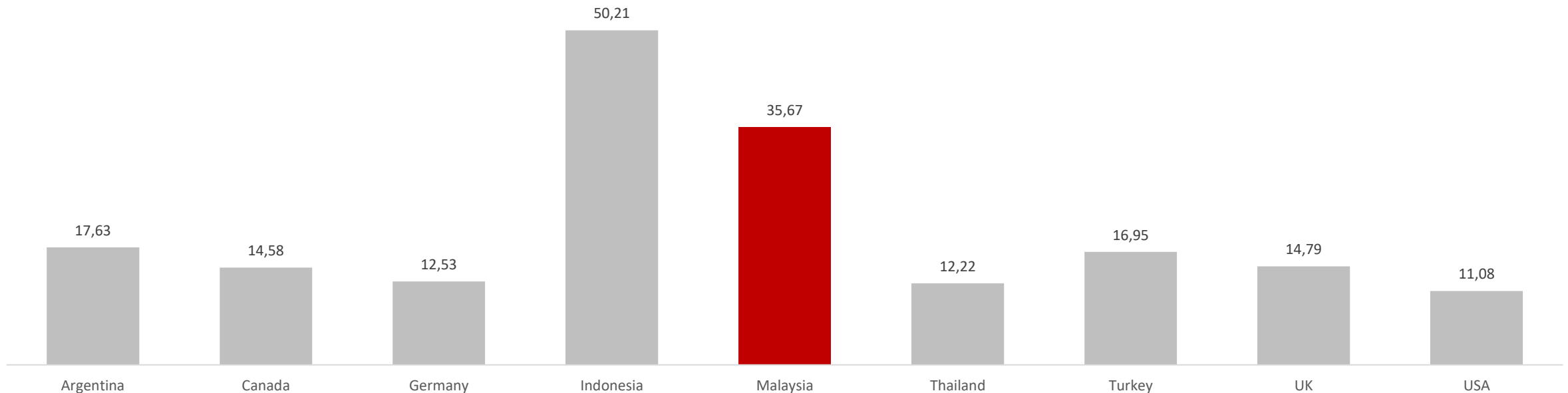
# SHI will not reduce 'brain drain' from public to private sectors

- Assumption: Believed that with SHI paying health care providers (hospitals, doctors) in both public and private sectors, the gap between the two can be narrowed. Thus, doctors' remuneration will be freed from government system, and public hospitals can be more autonomous in hiring, firing and rewarding personnel.
- While this may be the case, it will come at a cost—an **overall increase in costs for whole system**, and **likely cost escalation in long run**.
- Gap between public and private sectors may be narrowed—to a greater or lesser extent, **depending on how much resources** are available, but **difficult to completely close the remuneration gap**, even in an SHI system.

# Over-reliance on Out of Pocket Payments

- Unregulated direct charges often constitute a major access barrier to needed health care and contribute to high out-of-pocket payments generating problems of financial protection, especially in the incidence of catastrophic and impoverishing health expenditures.

Out of Pocket expenditure as % of Current Health Expenditure, 2015



# Update regulation of private sector

- Evaluate impact and implications of existing regulation of private healthcare delivery
- Study and limit (over)treatment and (over)medication in private sector
- Consider regulation of hospital charges and mark-ups in costs/prices of medications and consumables
- Find ways to better utilize private facilities (redress imbalances), e.g., 'pay for' underutilized diagnostic, treatment facilities
- Implement primary care referral system in private sector for access to private specialist care to ensure optimal use of expertise

# Summary of Challenges

Expected Increase  
in Demand due to  
**Demographic  
Changes**

**Polarising Access**  
to Health Care

**Supply  
Constraints**

Over-reliance on  
**OPP Financing**

# Options for reform

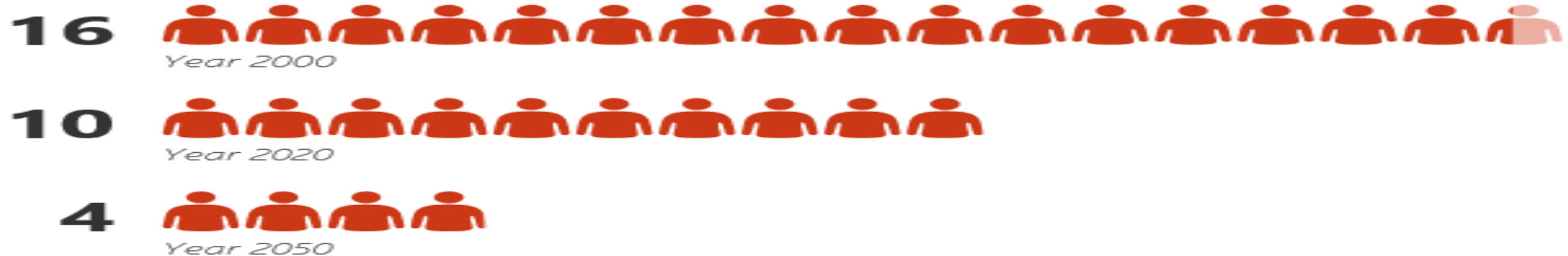
- Countries with social health insurance have **history** of social insurance and very dominant **formal** labour market
- For such countries that **do not have a strong public health care** system, social health insurance **may** represent progressive step forward.
- As discussed, a health financing system dominated by health insurance leads to **cost escalation and requires heavy public expenditure to insure the poor**, especially those with pre-existing illnesses and health conditions
- To transition from tax revenue financing to social health insurance would be **regressive in terms of equity**
- **Requires extensive subsidization**/co-financing from government revenue to cover poor / vulnerable



# Demographic transition threatens insurance model

- Insurance model undermined by demographic transition as premiums will continue to escalate with shrinking working share relative to non-working population → reducing competitiveness of Malaysian economy

Number of Working-Age Persons (15-64) for every Senior Citizen (65+), Malaysia



- Not surprisingly, countries in Europe have either already reduced payroll financing in favour of general revenue financing, or are in the process of doing so.

# Revenue-funded system sound, but can be better

- Revenue-financed healthcare systems are generally sound, and should be improved and reformed to eliminate waste and abuse. This will **avoid SHI costs of insurance system administration**
- Increase revenue for healthcare:
  - **Increase** government health care budget **allocations**
  - **Reduce 'leakages'** by reviewing crony procurement contracts, ensuring competitive bidding, eliminating abuse of public funds

# Strengthen Prevention and Primary Care in Public Sector

- **Consider** implementing system where MOH contracts with **GPs** under a **capitation payment** system to serve a certain number of people over specified time periods
- The **primary health care delivery** system should become **'gatekeeper'** to **specialist care** in the public health care system

# Strengthen public hospitals and services

- **Stem outflow** of doctors and specialists from public sector
  - Evaluate “push” factors; implement measures to address them
  - Establish clear, transparent criteria for promotions
  - Improve conditions and prospects for career medical officers
  - Other incentives, e.g., research opportunities; attend courses, conferences; sub-specialization training, etc.
  - Better link higher education planning and health care system needs to address health care personnel supply constraints
- Consider setting up **Health Services Commission** separate from Public Services Commission offering better remuneration, terms of employment, benefits
- Implement ways of **increasing efficiency** and **reducing wastage** in public facilities

# Update regulation of private sector

- Evaluate impacts and implications of 1998 Private Healthcare Facilities and Services Act on private healthcare delivery
- Study (over)treatment, (over)medication in private sector
- Consider regulation of hospital charges and mark-ups in costs/prices of medications and consumables
- Implement primary care referral system in private sector for access to private specialist care to ensure optimal use of expertise

# Summary and Conclusion 1/2

- Successive **social health insurance schemes proposed over the years have not been acceptable to most publics**. Additional tax that will further diminish take-home income will not be supported by majority.
- Governments have the responsibility to improve people's access to healthcare. Important that changes introduced lead to **greater equity and access** to high quality health care, and are **self-sustaining** in long run.
- This can be best achieved through **revenue-funded health care** financing while directing increased resources to expanding and upgrading primary health care and improving service conditions for medical personnel.

# Summary and Conclusion 2/2

- Healthcare system reforms should focus primarily on ensuring **greater cost effectiveness**
- Strengthening primary care and public hospitals will ensure **universal health care with equitable access to quality healthcare**
- Maintaining **revenue based financing system**, with better incentives for healthcare providers to stay in public sector will **reduce escalation of healthcare costs** typical of health insurance, and to ensure sustainable financing over long term
- Social Health Insurance regressive in most contexts

Thank you  
*for your interest and attention*