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Health Insurance

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Abstract

Health insurance is one of the ways that people in various countries finance their medical needs. It is estimated that out-of-pocket expenditure of over 15–20 % of total health expenditure or 40 % of household net income of subsistence needs can lead to financial catastrophe. When people on low incomes with no financial risk protection fall ill, they face a dilemma: they can use health services and suffer further impoverishment in paying for them, or they can forego services, remain ill, and risk being unable to work or function.

Variation in financing and organization structures in various countries notwithstanding, there is now nearly a unanimous commitment to assuring universal access to medically necessary care in high-income countries. Internationally, health insurance serves to improve service utilization and protect households against impoverishment from out-of-pocket expenditures. Analysis of how health insurance schemes function in a particular country, especially in relation to other funding aspects and health outcomes, can provide a glimpse of the performance of the whole healthcare system.

Keywords

Health insurance; Access to healthcare; Right to health; Distributive justice; Universal health coverage; Safety net; Medically necessary; Resource allocation; Patient Protection and Affordable Care Act; World Health Organization; National health insurance; Social health insurance; Private health insurance; Community-based health insurance; Socialized medicine

Introduction

Health insurance, which is coverage against the risk of incurring medical and related financial costs, is one of the ways that people in various countries pay for their medical needs. In every country, there are people who are unable to pay directly or out of pocket for the healthcare services they need, or financially they may be seriously disadvantaged by doing so. In lower-income countries, many forms of health insurance – whether public or private – cover only a minimum set of services, such that they do not provide full financial risk protection. The World Health Organization (WHO) estimates that out-of-pocket expenditure of over 15–20 % of total health expenditure or 40 % of household net income of subsistence needs can lead to financial catastrophe (Doetinchem et al. 2010). When people on low incomes with no financial risk protection fall ill, they face a dilemma: they can use health services (if available) and suffer further impoverishment in paying for them, or they can forego services, remain ill, and risk being unable to work or function.

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Variation in financing and organization structures in various countries notwithstanding, there is now nearly a unanimous commitment to assuring universal access to medically necessary care in high-income countries, with the United States being one of the last developed countries to achieve such goals. Internationally, health insurance serves to improve service utilization and protect households against impoverishment from out-of-pocket expenditures (Spaan et al. 2012). The WHO considers health insurance a promising means for achieving universal health coverage. Analysis of how health insurance schemes function in a particular country, especially in relation to other funding aspects and health outcomes, can provide a glimpse of the performance of the whole healthcare system.

History and Development

The history of health insurance has evolved internationally. Delivery of medical care, particularly in industrialized countries, is no longer confined to the offices of primary care physicians. As medical technologies become increasingly advanced, acute and critical care can now treat many catastrophic, complex, chronic, and serious conditions and injuries that used to be fatal or disabling. While the development of new treatments that can restore functioning and/or extend life is welcoming, the costs of these interventions and accompanying hospital stays can be prohibitively high for many people. The WHO (2013) estimates that 150 million people worldwide suffer financial catastrophe each year because of out-of-pocket expenses for their healthcare needs.

Different countries have been utilizing various models of insurance and financing schemes to pay for medical services based on their respective socioeconomic realities and cultural contexts. These insurance plans, whether public or private, have different components and payment requirements depending on the nature of the insurance plan and the services being covered. Some insurance plans require members to pay premium costs for enrolling in the program and have various levels of out-of-pocket payments such as deductibles, co-payments, or coinsurance. They may also require prior authorization from insurance companies to activate coverage for certain procedures or may impose coverage limits for enrollees. Some insurance companies may also utilize payment capitation for healthcare providers to control costs by motivating providers to provide only needed services and in the lowest cost setting.

In general, there are three salient categories of health insurance. Nonetheless, variations abound for each category, and some countries with diverse populations across vast geographical areas (e.g., China) have multiple insurance programs even for basic healthcare.

National or Social Health Insurance (NHI/SHI)

National or social health insurance (NHI/SHI) is one mechanism for raising and pooling funds to finance health services for a national population, generally in terms of what is deemed medically necessary. In the late 1880s, Germany's (Bismarck) social health insurance model was developed as part of the effort to build and unify the nation as well as to solve health-related problems due to industrialization (e.g., tuberculosis, sexually transmitted diseases, and alcoholism). This model relied on household premiums and payroll taxes, many risk pools, and services purchased largely from private but nonprofit insurance providers (Lagomarsino et al. 2012). Employers and employees both contribute to these sickness funds, which are required to provide a comprehensive benefit package. In the early twentieth century, the Beveridge National Health Service model in the United Kingdom relied on general taxes, one national risk pool, and publicly provided services (Lagomarsino et al. 2012). These two general models continue today and have been adapted for many systems that strive to provide healthcare coverage for their people.

As various versions of these models evolve into more mature SHI systems, enrollees and in some cases their employers are mandated by national legislation to pay contributions, either through taxation

(e.g., Australia, Canada, United Kingdom, Thailand) or separate levies. For example, in Singapore, residents and citizens with employment are required to contribute to the Provident Fund. Together with employer contribution, a portion of an individual's fund goes to a Medisave account that can be drawn upon for healthcare expenses. These various schemes across the globe would cover a package of services available to the insurees and their dependents.

Many governments also contribute into these systems in order to ensure or improve their financial sustainability and to extend coverage to people who cannot afford to pay (Doetinchem et al. 2010). In China, the most populous nation, the Urban Employee Basic Medical Insurance Program (UE-BMI) was established in 1998. It mandates urban employers and employees of state-owned or private enterprises to contribute to the insurance program administered at municipal level (Barber and Yao 2010). The newest scheme in the country, the Urban Resident Basic Medical Insurance (UR-BMI), which was piloted in 2007 and rolled out nationwide subsequently, is a voluntary scheme that enrolls children, students, elderly, disabled, and other non-working urban residents.

Despite similar basic ideas, there is considerable variation in how SHI systems have developed across countries. Contributions are held either in a single fund (e.g., Italy) or several competing funds (e.g., "sickness funds" in Germany) (Thomson et al. 2013). These funds may be administered by the public sector (e.g., Australia), the private sector (e.g., Switzerland, the Netherlands), or a combination of both, such as in Japan, which has a mix of noncompeting public, quasi-public, and employer-based insurers. For NHI/SHI, contributions do not typically vary with health status, such that the financial risks of paying for care are shared across the population. Multiple ways of paying providers can be observed even within one country, from unrestricted fee for service (e.g., the United States) to selective contracting at negotiated rates (e.g., the Netherlands) (Doetinchem et al. 2010).

NHI/SHI schemes of various countries also offer different coverages. For example, Germany includes optometry and dental care as part of their schemes, whereas provincial plans in Canada exclude these services but may cover fertility treatments (e.g., Quebec). Taiwan's NHI scheme, which is also more comprehensive than that of many other larger countries, covers dental services, traditional Chinese medicine, and prescription drugs. One of the lower-middle-income countries, Thailand, provides coverage for over 99 % of the population, ranging from HIV treatment to primary care and health prevention and hospitalization.

There are some systems that only provide NHI/SHI for a subset of population as a safety net and require or encourage the rest of the population to purchase their own insurance. In the developed world, the United States is one such example. Medicaid – a joint states and federal social insurance program – is a means-tested program that pays for basic medical services and drug coverage for Americans with the least income and resources. It is the biggest health safety net program in the country for people who have low income and fit into one of the designated needs-based eligibility categories. Another federally legislated program, Medicare, provides low-cost hospitalization and medical insurance primarily for seniors over the age of 65, although some low-income seniors and people with disabilities are "dual enrollees" in both Medicare and Medicaid.

Until recently, those who were not eligible for these two insurance programs but also could not afford private insurance made up a large proportion of the almost 50 million Americans without coverage. Many of these patients delay care due to the unaffordability of various healthcare services, and there are concerns that such delays can contribute to patients ending up with more costly procedures if their conditions worsen. In an effort to promote health insurance coverage in the United States, the Patient Protection and Affordable Care Act (now only known as the Affordable Care Act), which was signed into law in 2010, contains an individual insurance mandate that took effect in 2014 (The Henry J. Kaiser Family Foundation 2013). This mandate intends to produce similar effects of NHI/SHI by requiring most citizens and legal residents, unless exempted, to have health insurance. Individuals and/or their employers

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can obtain coverage from private companies, employers, or state-based insurance exchanges that are administered by non-governmental and/or nonprofit organizations. Penalties can be levied on those who do not have any form of insurance. Persons who would be paying greater than 8 % of their household incomes for health insurance can obtain subsidized premiums through the insurance exchanges.

Voluntary and Private Health Insurance (PHI)

While most people paying for NHI/SHI will utilize services rendered within the public scheme, voluntary and private health insurance (PHI) schemes are increasingly available in various countries. Some of these insurance plans are offered by nonprofit organizations, including the federally legislated Consumer Operated and Oriented Plan (CO-OP) program in the United States, whereas others are sold on the private market, such as various Medisave-approved integrated private insurance plans in Singapore. "Indemnity" and "cash plan" policies are also available in the private market in the United Kingdom. Depending on their risk perception, availability and comprehensiveness of public health coverage, quality and accessibility of public healthcare, and the relative and respective affordability of insurance premiums and healthcare procedures, some people may purchase additional PHI to substitute what would otherwise be covered by the NHI (Costa and Garcia 2003). Private insurance in healthcare systems that provide universal access to medically necessary services may offer choice among private hospitals, inhospital specialists, and shorter wait time for procedures, as in the case of Australia and the United Kingdom (Boyle 2011; Costa and Garcia 2003).

In other countries, private insurance plans can provide supplementary coverage such as income replacement in case of missed work due to sickness (e.g., Japan) or pay for costs or co-payments that are not fully covered by government subsidies or public services (e.g., France) (Boyle 2011; Thomson et al. 2013). In Canada, people can purchase PHI or extended health plans to finance non-covered services such as prescription medications, dental care, physiotherapy, ambulance services, and optometry. While some Canadian provinces prohibited private health insurance for covered services to prevent unequal access, and that private clinics cannot charge above the agreed-upon provincial fee schedule or for publicly insured services, the Supreme Court of Canada ruled in *Chaoulli v Quebec (AG)* in 2005 that prohibiting private medical insurance in the face of long wait times violated the Quebec Charter of Human Rights and Freedoms and Section 7 of the Canadian Charter of Rights and Freedoms.

In the United States, many people with private insurance are covered under an employer-based plan, although individual health insurance coverage can also be obtained through some companies. Given that the aforementioned Affordable Care Act mandates purchase of insurance plans, enrollment in insurance plans is not discretionary. Nonetheless, these plans are mostly offered on the private market, and unlike other countries with compulsory contributions (e.g., Germany, Singapore), enrollees are not required to contribute a particular percentage of their income toward their health insurance.

Unlike NHI/SHI, which generally does not implement differential premium or coverage eligibility based on people's health status, private health insurance plans often charge higher premium for preexisting conditions and family history or impose restrictions on coverage. Insurance companies may require applicants to disclose full individual and family medical health history and care-seeking activities and then decide which conditions to cover and at what price based on the companies' risk assessment. Preexisting conditions are often excluded from at least temporary coverage (e.g., first 2 years of coverage), and insurers may consider other factors such as age, sex, smoking status, and occupational status in determining coverage eligibility and setting premium prices. In the United States, where people are now required to purchase health insurance, companies are prohibited from canceling or rescinding coverage except in cases of fraud, or from excluding coverage or charging higher premiums for preexisting conditions. Before the Affordable Care Act came into effect in 2014, people with various prior conditions or disabilities could obtain coverage through the Pre-Existing Condition Insurance Plan.

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Community-Based Health Insurance (CBHI)

In lower-income countries including the Democratic Republic of Congo, Ghana, Rwanda, and Senegal, micro health insurance schemes such as community-based health insurance (CBHI) have been established as a nonprofit financing mechanism to benefit the poor (Spaan et al. 2012). CBHI is usually based on voluntary membership, whereby members are linked to a healthcare provider (often a hospital in the area). It is based on an ethic of mutual aid/solidarity whereby members who are susceptible to risk put together their resources and contribute into mutual health organizations, medical aid societies, and micro-insurance schemes (Odeyemi 2014). Funds are thereby accumulated and managed to spread the risk of payment for healthcare among all scheme members. In the 1990s, many rural residents in China lost insurance coverage due to dissolution of rural cooperatives. However, efforts to revamp and expand the voluntary rural schemes under the New Rural Cooperative Medical Scheme have resulted in a sevenfold increase (from 13 % to 93 %) of insurance coverage rate for rural residents between 2003 and 2008 (Barber and Yao 2010). In addition to individual contributions, the central and local governments also subsidize the program.

While CBHI improves resource mobilization for health and health service utilization and protection for financial risks, it is vulnerable to adverse selection, where disproportionate enrollment by high-risk contributors accompanies nonparticipation by low-risk individuals (Odeyemi 2014). While Ghana and Rwanda have introduced schemes with effective government control and support coupled with intensive implementation programs, poor support for CBHI is repeatedly linked in other places with low uptake (e.g., Nigeria), failure to engage and account for the actual needs of beneficiaries, lack of clear legislative and regulatory frameworks, inadequate financial support, and unrealistic enrollment requirements (Odeyemi 2014).

Conceptual Clarification/Definition

The various forms of health insurance and different coverage these schemes offer reveal a complex and evolving healthcare financial system across the globe, particularly in the face of new diagnostic technologies and interventions that offer uncertain levels of benefits (e.g., genetic tests, stem cell therapies). While international organizations such as the WHO have been keenly advocating for universal health coverage, the path to achieving such goal is not without ethical and political controversy as well as conceptual confusions.

In the United States, which is undergoing a major overhaul of its healthcare financing system, confusion abounds regarding whether the Affordable Care Act is advocating for “socialized medicine,” a misnomer that has come to denote government or bureaucratic control and lack of patient choices. SHI/NHI socializes the financial risks of getting injured or sick by setting up national insurance schemes or funds. Nonetheless, in almost all healthcare systems that utilize such insurance schemes, with Cuba’s highly controlled and tightly structured system being a notable exception, the government does not directly deliver the services or own the healthcare facilities – most hospitals are privately owned and compete with each other. Even in systems where the government owns some of the hospitals, as in the United Kingdom, physicians are private practitioners. In England, for example, there has been an increasing emphasis on developing patient choice, provider competition, and the use of private providers to deliver publicly funded healthcare (Bevan et al. 2014).

Another conceptual issue that is ethically important is how a system determines what services ought to be covered in an insurance scheme. Even among more mature systems, there continue to be questions of what should be covered and whether these schemes can sustainably fulfill enrollees’ health needs in the long run, given the aging population and increasingly advanced and thus more expensive care. Resource

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constraints and increasing needs have begged for ethically, economically, and clinically justifiable criteria in allocating healthcare dollars.

In determining what services should be covered, many NHI/SHI systems assess the medical necessity of the procedure. In Canada, when a healthcare service to be provided to a patient is deemed medically necessary, it is fully funded by the provincial insurance plan. Otherwise, patients must pay for it directly. The basic idea is to have needs, not wants, determine what the insurance system would cover. Nonetheless, the Canada Health Act does not provide a national definition of medical necessity, and coverage for hospital and medical services differs in every province, which makes its own determination of medical necessity. Some scholars believe that any attempt to define this term will either result in a definition too broad and too vague to assist in developing policy, or it could result in long lists of diverse needs of many groups, which do not add up to a meaningful whole (Canadian Health Services Research Foundation 2002). The American federal program, Medicare, defines medically necessary services as any healthcare services and/or supplies that a doctor decides are required to diagnose, prevent, or treat an illness, injury, or disease. Nonetheless, since most Americans rely on insurance plans purchased in the private market, it is unclear that this definition provides meaningful guidance to people operating private insurance plans that fund the majority of Americans' medical needs.

In lower-income countries, many of which have different disease patterns, economic realities, cultural practices, and technological capacities from the higher-income systems, coverage priorities differ accordingly. The WHO believes that these countries should cover "essential health services" and key interventions targeting the health Millennium Development Goals, such as to reduce child mortality, improve maternal health, and combat HIV/AIDs and other infectious diseases. In advising various countries in their journey toward universal health coverage (UHC), defined as ensuring all people receiving quality and comprehensive range of key health services without being exposed to financial hardship in paying for the services, the WHO pays specific attention to the backdrop of inequality in many low-income countries. It suggests progressively expanding priority services by considering relevant criteria such as cost-effectiveness, priority to the disadvantaged groups, and financial risk protection. A commitment to fairness and the overlapping concern for equity have been deemed important in guiding countries in making these decisions. Advancing UHC has been identified as a central theme in the ongoing deliberation over the post-2015 development agenda.

As technologies continue to advance and the global population continues to age, there will be increasing pressure on various countries in reconsidering how to prioritize their resources in maintaining and improving population health. There will be also questions regarding whether the gap in international access to healthcare services is widening. While lower-income countries continue to struggle with providing coverage for basic services, higher-income countries continue to debate whether to provide coverage for genetic tests that are predictive and probabilistic, aggressive treatments that are potentially non-beneficial, and other expensive experimental treatments (e.g., stem cell therapies).

Ethical Dimension

The last point regarding inequality and health access brings out the central ethical dimension of health insurance – whether unequal and inadequate access to health insurance or essential healthcare is a problem of justice.

In international discussion of health insurance, calls to ensure just allocation of healthcare resources are sometimes expressed in terms of rights. Article 25.1 of the Universal Declaration of Human Rights states that every person has the right to a standard of living adequate for the health and well-being of oneself and

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one's family, including medical care. Other international organizations such as the WHO also recognize the enjoyment of the highest attainable standard of health as a fundamental right of every human being.

There have been many debates regarding whether there is truly a right to health or to healthcare, given that rights claims are accompanied by duties and obligations from others. Libertarians, who emphasize noninterference from the states, would agree that people have a negative right to obtain health insurance on their own without state restrictions. If people in a society so desire, they can organize themselves so that everyone in the society can acquire the means to provide their healthcare needs. Nonetheless, libertarians deny that people have a positive right to have these needs met by others if they could not afford to purchase insurance coverage on their own.

The libertarian argument, which is an important political theory that elucidates the legitimate purposes and boundaries of the state, is sometimes juxtaposed with other theories of justice. Justice is about what is due or owed to persons, and distributive justice in particular deals with just allocation of resources to address or mitigate incidental inequalities based on moral luck and are beyond people's control. John Rawls, one of the most prominent liberal egalitarians in the twentieth century, argued that people should not be disadvantaged because of various morally arbitrary factors, such as their ethnic background, geographical location, health status, etc. He argued that the concept of justice as fairness implies that all people should have access to equal opportunity ranges in their society regardless of whether they were born rich or poor. Any social or economic inequalities can only be justified if the least-advantaged members of the society are to benefit from such inequality. Applying these ideas to access to health insurance, Norman Daniels and others (Saloner and Daniels 2011) have argued that liberal societies have an obligation to provide at least a decent minimum level of healthcare access (e.g., through affordable health insurance) to citizens so that their opportunity ranges would not be unduly compromised due to serious illnesses or disabilities. Healthcare can often maintain or restore normal species functioning and the array of life plans that people construct for themselves and should be socially guaranteed according to the liberal egalitarian account.

Nonetheless, it is noteworthy that while health insurance helps reduce general disparities in healthcare among various socioeconomic groups by improving availability of services that may otherwise be unaffordable to many, it can also introduce other forms of disparity when those with financial means can purchase private plans that would allow priority or premium access to various types and qualities of care that are unavailable to those without economic means. Higher-income earners, such as those in Germany, can be exempt from supporting the public sickness fund by opting out and purchasing insurance from private insurers. A flourishing market of private insurance may also bid healthcare providers away from publicly funded systems and create shortages in the public sector. Without ongoing financial and political support from the rich and from healthcare providers, there is a worry that the inevitable result will be tiers that are sharply differentiated in terms of both quality and access for those who depend on social insurance and publicly funded services. Moreover, studies in the United Kingdom have shown that health inequalities by class have not been reduced by the presence of universal coverage (Daniels 2013). And as long as private insurance schemes can deny coverage or charge differential premiums for preexisting conditions, financial protection for those in such vulnerable positions may continue to be disadvantaged.

Conclusion

As the global population continues to age and live longer, there will be increasingly more pressure for states to find sustainable ways to ensure that their people are not impoverished by healthcare costs. However, cost is only one of the factors in promoting reliable access to essential services. As many countries, particularly those of lower income, strive to provide universal coverage, there are other calls to

also attend to other infrastructure matters that can help to promote the quality of services that are to be covered and delivered. Health insurance will need to be complemented with supply-side investments to ensure better distribution of facilities, healthcare personnel, functional medical equipment, and computer systems. There will also need to be careful monitoring of various delivery systems to ensure accountability and high performance. Without investments in quality, countries run the risk of wasteful increases in access to unnecessary or poor-quality services (Lagomarsino et al. 2012).

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Cross-References

- ► Access to Health Care
- ► Egalitarianism
- ► Equality and Equity
- ► Justice: Theories of
- ► Resource Allocation
- ► Right to Health

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