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Private Voluntary Health Insurance under NHI

In this note we explore the possible future role of private voluntary health insurance in South Africa (SA) under the proposed system of National Health Insurance (NHI). In examining its role in a selection of developed and developing countries, we find that private VHI plays a vital role not only in countries which have not yet achieved universal health coverage, but importantly also in countries which have already done so. We also consider the benefit packages offered by private health insurers in countries with universal care. Finally, these lessons are applied to the South African context.

1 Introduction

The proposed National Health Insurance (NHI) system will entail mandatory health insurance, with all eligible people having to contribute to a central NHI Fund (see Econex NHI Note 1). This move towards mandatory contributions to the NHI fund will have certain implications for the current providers of private voluntary health insurance (VHI), i.e. medical schemes.

In the current NHI discussions there is no certainty regarding the role of private VHI providers under such a system. Although official policy documents have explicitly stated that voluntary health insurers would continue to exist after the implementation of the proposed NHI, questions arise regarding the exact future role that these providers would play.

In this research note these issues are explored by examining the role of VHI providers in comparable countries with universal coverage schemes and applying these lessons to SA.

2 Defining Private VHI

Voluntary health insurance can be defined as any health insurance that is not mandatory, but bought out of free choice and funded by voluntary contributions. Voluntary health insurance can thus be distinguished from national health systems and social insurance financing models, which are both characterised by mandatory payments.[1]

In reality, most private health insurance markets are voluntary. However, there are excep-

This research note forms part of a series of notes dealing with issues of health reform in South Africa. In the interest of constructively contributing to the NHI debate, the Hospital Association of South Africa (HASA) has commissioned this series of research notes which can be accessed on the Econex website: www.econex.co.za.

1. *OECD (Organisation for Economic Co-operation and Development) (2004), Private Health Insurance in OECD Countries. N. Tapay and F. Colombo, co-authors. Paris.*

tions. For example, Switzerland is an exception among OECD member countries in mandating the purchase of private health insurance by citizens. Uruguay requires persons in certain income bands ($600–$1,800 annually) to purchase private coverage, and Saudi Arabia is in the process of introducing compulsory private health insurance for expatriates.[2] This is already the case in the Netherlands.[3]

It is important to note that South Africa's medical scheme environment was in the process of becoming a social health insurance environment. The Department of Health has introduced three of the five reform pillars (i.e. open enrolment, community rating and PMBs), but have not as yet introduced mandatory membership and a risk equalisation fund (REF). The system is therefore voluntary, but also has design features of SHI systems.

The poor quality of care in the public sector also leads to many employers forcing employees to have medical aid – it is therefore in a sense quasi-mandatory.

Private health insurance plays an important role in countries where public health insurance is not sufficient. This insufficiency could refer to either the quality or quantity of care, and it is important to note that the definition (or expectation) of "sufficiency" does differ between socio-economic groups within a country. Skewed income distributions, present in a large number of developing countries, result in a narrow and often smaller tax base, which yields insufficient funding to provide services at a level which would satisfy both the poor and the rich. It is also important to note that private health insurance continues to be important even in countries where universal coverage has been attained. For the purposes of this note we will examine developed and developing countries where some level of universal coverage has been achieved in order to determine what role private VHI plays in these countries.

A number of definitions exist describing the type of insurance supplied by private providers in addition to that provided by public coverage (see Table 1).

Private health insurance offers *complementary* insurance to cover residual health costs, for example where copayments are required. If an individual receives treatment from a public hospital, and is required to pay a portion of the cost of her treatment, she would be able to claim this additional cost from her private insurer.

With *supplementary* insurance, private insurance pays for prescription drugs and treatments that are not publically reimbursed.

Table 1: Classification of voluntary health insurance

Insurance type	Covers	Example
Complementary	Cost sharing in the social-security system	Insurance for statutory user charges
Supplementary	Services excluded from the public system	Insurance for certain prescription drugs and dental care not publicly reimbursed
Duplicative	Faster access and better quality services than those available publicly	In countries with long waiting times or poor quality public care

Source: OECD 2009[4]

2. *The World Bank (2006), Health Financing Revisited: A Practioner's Guide.*
3. *http://www.privatehealth.co.uk/healthinsurance/expatriate-health-insurance/by-country/.*
4. *OECD (2009), Health at a Glance 2009: OECD Indicators.*

For example in many countries dental care is not covered through the public system and a person visiting a dentist would fund this visit through a private insurer or out of pocket cash payments.

Duplicative insurance provides private sector access in the case of waiting times in public systems or significant qualitative differences between public and private care and in the case of less comprehensive services in the public system. If, for example, a person would prefer to visit a private clinic to undergo an operation, as opposed to a public hospital, he would pay for this through private insurance or through out of pocket cash payments.

The type of insurance (complementary, supplementary or duplicative) which is primarily supplied by private insurers is thus to a large extent a function of the workings of the public and private health systems in each respective country. Where co-payments are material, the need arises for complementary insurance to aid in covering these costs. Where a number of treatments sought by patients are excluded from public care, supplementary insurance may be used to obtain these treatments from private providers. Where large qualitative differences between public and private health care exist, the need arises for duplicative insurance, so that care may be obtained from the private system. In some cases, government regulation plays a role in determining what type of voluntary cover may be provided by private insurers.

3 The role of private VHI in countries offering universal access

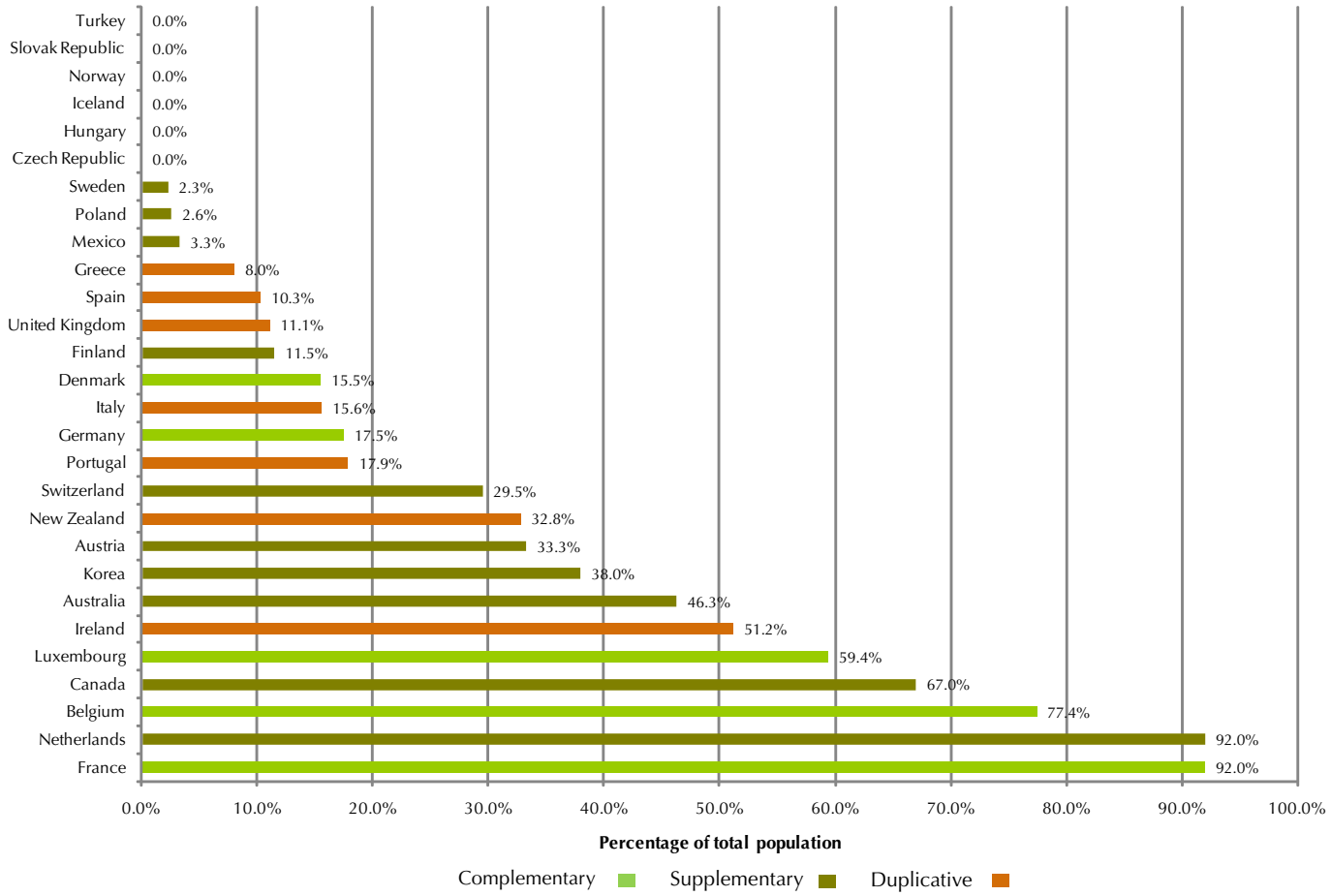
3.1 Developed countries

In the majority of the developed world the population is covered by a system of universal medical care. Nevertheless, private health insurance continues to play a vital role in many of these systems. Most often, private health insurance supplies both complementary and supplementary coverage (i.e. coverage of additional fees charged by providers, and of benefits not included in the basic benefit packages). However, in a few countries, private health insurers are not allowed to cover cost-sharing but only to cover additional benefits (thus only supplementary insurance). This is the case in Australia, the Netherlands and Switzerland, where 46.3%, 92.0% and 29.5% respectively of the population is covered by supplementary insurance (Figure 1). Duplicative VHI is often limited to specific population groups in a smaller number of countries. In developed countries, with fairly advanced public healthcare systems, it is usually purchased by those who are excluded from participating in some or all aspects of the statutory health insurance scheme (high-earners in the Netherlands and self-employed people in Belgium and Germany) and those who are exempt from contributing to the statutory health insurance scheme because they are allowed to opt out of it (high-earning employees in Germany and some self-employed people in Austria).[5]

Figure 1 shows the percentage of the total population covered by voluntary private non-primary[6] health insurance in selected OECD countries and also shows whether this cover is chiefly complementary, supplementary or duplicative. In most OECD countries the rate of healthcare coverage is 100% or very near to this target. Examining Figure 1, one can see, for example, that in New Zealand 32.8% of the population has private VHI and this is chiefly of a duplicative nature – in other words, used to cover services already covered by the public system, but rendered

5. *Elias Mossialos and Sarah Thomson (2004), Voluntary health insurance in the European Union, European Observatory on Health Systems and Policies and LSE Health and Social Care, London School of Economics and Political Science.*
6. *"Primary" in this case refers to the principal source of insurance cover.*

Figure 1: Population covered by private non-primary VHI (by type) in selected OECD countries, 2007 or latest year available



Source: OECD 2009

Note: VHI can be both duplicative and supplementary in Australia; and can be both complementary and supplementary in Denmark and France.

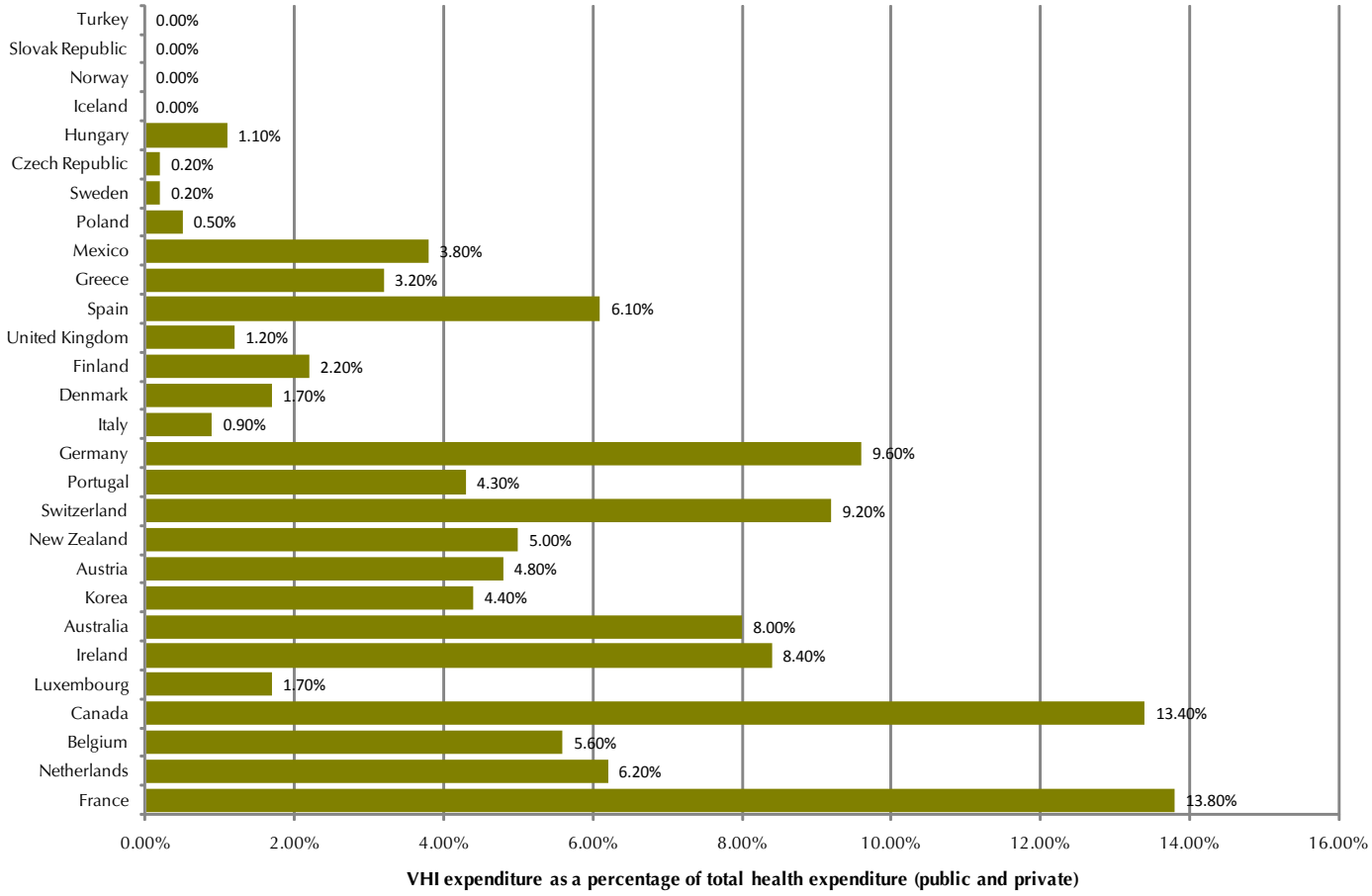
in private clinics instead of public hospitals. This is done because of perceived differences in the quality of healthcare provided between the public and private system, with individuals willing to pay a premium for better quality care provided in private clinics.

Figure 2 shows private VHI expenditure[7] (expressed as a percentage of total health expenditure) in the same selection of OECD countries. In the Netherlands, although 92% of the population is covered by private VHI, this form of expenditure comprises only 6.2% of total health expenditure.

Real and perceived quality gaps in public coverage and delivery systems serve as an impetus for VHI purchases in some countries. Waiting times, increasing demand for choice, and perceptions of inadequacy of public systems are leading motivations in Ireland, New Zealand, Spain, and the United Kingdom. Increased waiting times and perceptions of inadequate public systems encourage the purchase of duplicative insurance, so that faster and better care may be obtained in private hospitals. Where public cover is

7. *This value excludes all out-of-pocket expenditure. Expenditure on VHI along with out-of-pocket expenditure sum to form total private expenditure on health. Mandatory health insurance covering the entire population is reported in OECD Health Data as public coverage, although it is a borderline case.*

Figure 2: Expenditure on private VHI in OECD countries, 2007 or latest year available



Source: OECD 2009

not provided, primary VHI policies are purchased mainly to minimise the financial risks associated with illness. Cultural factors and differences in risk aversion across national contexts may account for a higher inclination to buy private cover in some countries. For example, nearly all those ineligible to social sickness fund insurance buy a primary VHI policy in the Netherlands, and over 90% of the socially covered population, buys supplementary insurance.[8] While France has a universal public health insurance system, the coverage it provides is incomplete and the vast majority of the French population has private complementary health insurance. In France, the co-payments required by the public system are higher than those in comparable countries. Furthermore, certain services are poorly covered by the public system, most notably dental and optical care. As a result of these factors, private VHI in France is thus of a complementary and supplementary nature.[9] This private coverage accounts for 13.8% of total health spending and roughly 92% of the population is covered.

In Taiwan NHI coverage was instituted in March 1995. Congru-

8. *Francesca Colombo and Nicole Tapay (2004), Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems, OECD Health Working Papers No.15.*
9. *OECD Health Working Papers No.12, Private Health Insurance in France (2004).*

ent with these changes, rapid growth occurred in the Taiwanese demand for private health insurance.[10] Between 1996 and 2007, premiums paid by the general public for private health insurance increased more than sevenfold, from NT$23.9 billion to NT$171.4 billion, while premiums for NHI doubled from NT$65.5 billion to NT$142.9 billion. The NHI provides basic health insurance coverage to guarantee all citizens access to healthcare. Despite this, a substantial financial burden may still result in the case of a serious illness or other health catastrophe. Thus, there is an incentive for individuals to purchase private health insurance to avoid catastrophic health expenses. Based on this situation, most private health insurers in Taiwan provide insurance plans only covering inpatient care. This also ensures that these individuals are able to receive medical treatment at private hospitals not associated with the NHI, cutting down on waiting times and receiving a higher standard of treatment than is the norm. The market for VHI in Taiwan is therefore both complementary and duplicative, in the sense that the additional out-of-pocket expenses related to health catastrophes are covered, as well as medical treatments at private hospitals offering the same services as that in the public system, but of a better quality.

Australia and Ireland explicitly encourage private health insurance as a strategy to complement public financing and share the burden of providing health services to all. In this way, a well-functioning VHI system is used to benefit health outcomes as a whole. Historically, both countries used private insurance to provide principal coverage for significant segments of their population and it is now used to relieve pressures on the public system. As a result of targeted interventions, 46.3% and 51.2% respectively of the population in these countries purchase private insurance.[11]

Understanding the role that VHI plays in those countries with the most advanced universal coverage systems is vitally important. It seems clear that even in countries where the public health system is highly advanced, the need still arises for some form of private health insurance, the nature of which is determined by unique factors related to the health system of the country in question. However, it is also important to understand the role of VHI in the developing world, and especially in those developing countries that have initiated some form of universal healthcare. This is discussed below.

3.2 Developing countries

Many developing countries have initiated steps towards achieving universal health coverage. We examine the role of VHI in

10. *Tsai-Ching Liu & Chin-Shyan Chen (2002), An analysis of private health insurance purchasing decisions with national health insurance in Taiwan, Social Science & Medicine 55 (2002) 755–774.*
11. *World Health Organisation (2004), Private Health Insurance: Implications for Developing Countries, Discussion Paper Number 3 – 2004.*

Thailand, Brazil and Mexico, three countries in the developing world which have made significant progress in this regard.

Brazil's private health insurance market has grown despite public policies aimed at establishing a universal, publicly financed healthcare system. The latest figures indicate that expenditure on private health insurance is approximately 21% of total health expenditure.[12] Private health insurance covers 45 million people in Brazil (or more than 20% of the population), which makes it one of the largest markets in the world.[13] Due to the poor condition of the public healthcare system, there has been an enormous increase in private health insurance in the last two decades. Brazil's VHI providers are primarily established to provide duplicative cover in order to gain access to private healthcare of a better quality than that provided in the public system.

Thailand introduced universal coverage reforms in 2001, becoming one of only a handful of lower-middle income countries to do so. Approximately 16% of the population is covered by social health insurance.[14] Means-tested healthcare for low income households was replaced by a new and more comprehensive insurance scheme, originally known as the "30 Baht Scheme", in line with the small copayment charged for treatment. While this copayment did not reflect the marginal cost of interventions, it did prevent overuse. However, the 30 Baht copayment was abolished in 2006 for political reasons.

The universal coverage benefits package is a comprehensive package of care, including both curative and preventive care. However, certain organ transplants, cosmetic surgery and infertility treatments are excluded.[15] At present, less than 2% of the population is covered by voluntary private health insurance. The benefit package for private insurance depends on the premium payable, with more generous packages related to higher premiums.[16] Private insurance in Thailand is thus chiefly of a supplementary nature, covering those treatments not supplied by the public system.

Mexico has initiated reforms with the aim of achieving universal health coverage by the end of 2011.[17] At present, public social security schemes cover all the population working in the private formal sector and government workers, i.e. excluding independent self-employed workers, informal sector workers and unemployed people. From 2004, the System of Social Protection in Health offers a new public health insurance scheme that has been implemented to provide voluntary public health insurance to the population previously excluded from social security. Individuals paying for private care generally prefer to do so out of pocket, and therefore private health insurance, if at all, is taken in case of emergencies, where hospitalisation may be required. The nature of the health insurance is thus complementary, covering additional expenses related to hospitalisation, and duplicative to the extent that these hospital treatments are obtained in private clinics. Private insurance still plays a small role in Mexico, with only 3.3% (or approximately 3 million) of the population covered.[18]

12. *Neelan Sekhri & William Savedoff (2005), Private Health Insurance: Implications for Developing Countries, Bulletin of the World Health Organisation.*
13. *Bernard Coutotolenc & Alexandre Nicolella (2007), Private Health Insurance in Brazil: Features and Impact on Access and Utilization (Abstract).*
14. *http://www.crehs.lshtm.ac.uk/downloads/publications/Thailand_policy_brief.pdf.*
15. *Available at: http://www.jointlearningnetwork.org/content/thailand-universal-coverage-scheme.*
16. *Available at: http://www.equitap.org/publications/profiles/hsp_tha.pdf.*
17. *Available at: http://www.presidencia.gob.mx/en/press/?contenido=42321.*
18. *See footnote 22.*

4 Main factors influencing the role of VHI

Having examined the role that VHI plays in both developed and developing countries, it becomes clear that certain factors exist which influence the type of role that VHI plays in these countries. A very strong relationship exists between per capital health expenditures and gross domestic product (GDP) per capita.[19] Higher income levels broaden the tax base, making more resources available to the public health system. This leads to increased access to low-cost health care of an improved quality, reducing the need for voluntary health insurance. However, even in high-income countries VHI still does play a role, as the public sector cannot attend to all the needs of consumers.

The lower the quality of care in the public health system, the more the incentive exists for alternative care provided by the private sector. This creates the possibility of a market for duplicative health insurance. Thus, the presence of and extent of the quality gap between the public system and services offered through VHI is a large determinant of the role of VHI. Where the range of services offered by the public sector is limited, the need for supplementary VHI arises, in order to cater to the needs of consumers who require a broader range of services. Finally, where co-payments are required in the public system, the need arises for complementary VHI which will assist individuals in paying for treatment. The more widespread, and larger the co-payments are, the more likely it will be that members of the public would be willing to pay for such coverage. High levels of out-of-pocket expenditure thus stimulate demand for complementary VHI.

5 Application to SA

After examining the role of VHI in both the developed and developing world, we are able to apply this information to SA. As in other developing countries, large perceived quality differences between public and private care currently exist, and as such private VHI is primarily of a duplicative nature, enabling individuals to seek better quality treatment in private clinics and hospitals than they would be able to obtain at minimal cost from public providers. At present, the number of beneficiaries covered by medical schemes in SA is around 8.1 million.[20] The exact impact that the introduction of NHI would have on the market for private VHI is not certain and, given the importance of this, further research in this area is certainly required. Nevertheless, we can look at some of the implications of a NHI for the future role of private VHI in SA.

Quality differences between public and private care are expected to continue for a while even after the introduction of NHI, and if this is the case it may be expected that the future role of private VHI in SA would continue to be most-

19. *Jacques van der Gaag, Health Care for the World's Poorest: Is Voluntary (Private) Health Insurance an Option? December 2007.*
20. *Included in this figure are approximately 1 million individuals covered by the Government Employees Medical Scheme (GEMS). There is uncertainty as to how this scheme will position itself with the introduction of NHI.*

ly duplicative. However, official policy documents indicate that the NHI scheme may be financed through the removal of tax subsidies for medical scheme contributions, a surcharge on taxable income, a mandatory NHI payroll contribution, an increase in VAT and allocations from general taxation.[21] These measures would reduce the income that individuals have at their disposal to purchase private insurance, which may make this form of insurance unaffordable for many South Africans. It is important to note that these measures would also reduce the disposable income available for all purchases, not only VHI. It seems likely that individuals would reprioritise all spending as the NHI tax will be deemed a general tax, as opposed to something that has been offset against medical scheme contributions. If the NHI scheme is implemented it may be that many individuals, for financial reasons, would be forced to forfeit membership of private medical schemes and rely solely on NHI. This will be explored further below.

5.1 Possible changes to benefit packages

The type of insurance offered by private health insurers to a large extent determines the benefit packages which are covered in their plans. For example, duplicative private insurance includes benefits already offered by the public system. Supplementary insurance, by contrast, focuses on those benefits which are specifically excluded from the public system. The benefit package offered by insurers is thus an important component of the discussion on types of private VHI.

All medical schemes operating in SA are required by the Medical Schemes Act to grant access to a set of prescribed minimum benefits (PMBs). Although protecting patients/consumers, the presence of PMBs drives up the cost of supplying medical insurance, resulting in higher prices which reduce access. The introduction of a NHI implies that everyone, regardless of medical scheme membership, will have access to PMBs which will effectively be unrationed. It is unclear whether medical aid schemes will still be required to supply plans which include PMBs. It thus makes sense to examine the regulation regarding benefit packages from VHIs in some of the countries with multiple private health insurance funds in the presence of universal health cover.

As one might expect, there are significant differences in the regulatory environments governing private health insurers in countries with universal health coverage.[22] Countries have adopted regulation mechanisms either to ensure uniform contribution rates and benefits to the whole

Table 2: Regulation of health insurance markets in countries with universal healthcare, multiple insurers and consumer choice

Country	Insurers allowed to change benefits	Insurers allowed to change coverage levels	Insurers allowed to change premiums	System of risk equalisation
France	no	no	no	yes
Germany	yes	no	yes	yes
Netherlands	yes	no	yes	yes
Switzerland	no	yes	yes	yes

Source: OECD Survey on health system characteristics 2008-2009.

21. *ANC National General Council 2010, Additional Discussion Documents. Released September 2010, pages 25-26.*
22. *Valerie Paris, Marion Devaux and Lihan Wei (2010), Health Systems Institutional Characteristics: A Survey of 29 OECD Countries, OECD Health Working Papers No.50.*

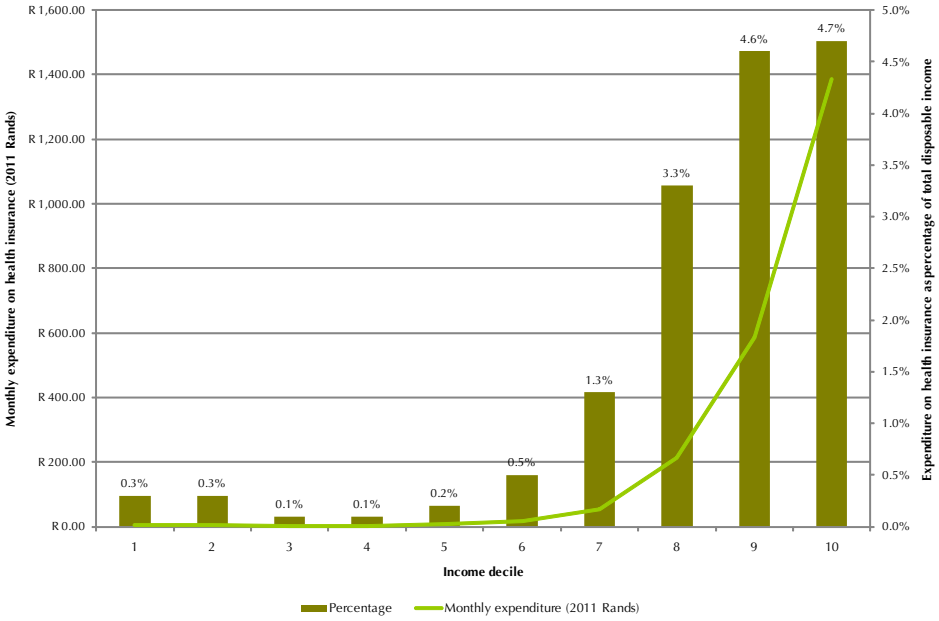
population, or in the alternative, to allow insurance funds to differentiate their products (see Table 2). In France, for example, contributions and benefits are uniform across health funds. In Switzerland, a uniform benefit basket is defined and insurers are not allowed to modulate it. In the Netherlands, insurers are allowed to modulate the benefit basket only upwards. The basic insurance package is set by the national government; insurers cannot fall below this level of coverage.

A wide range of health insurance market regulation exists in countries with universal healthcare access and multiple private health insurance funds. The ability of insurers to change the benefit packages they provide is constrained in some countries but not in others. Thus, it is not clear that any definite guidance can be given on the subject for SA, except to say that internationally it appears each country chooses its own system.

5.2 Role of duplicative vs. supplementary insurance

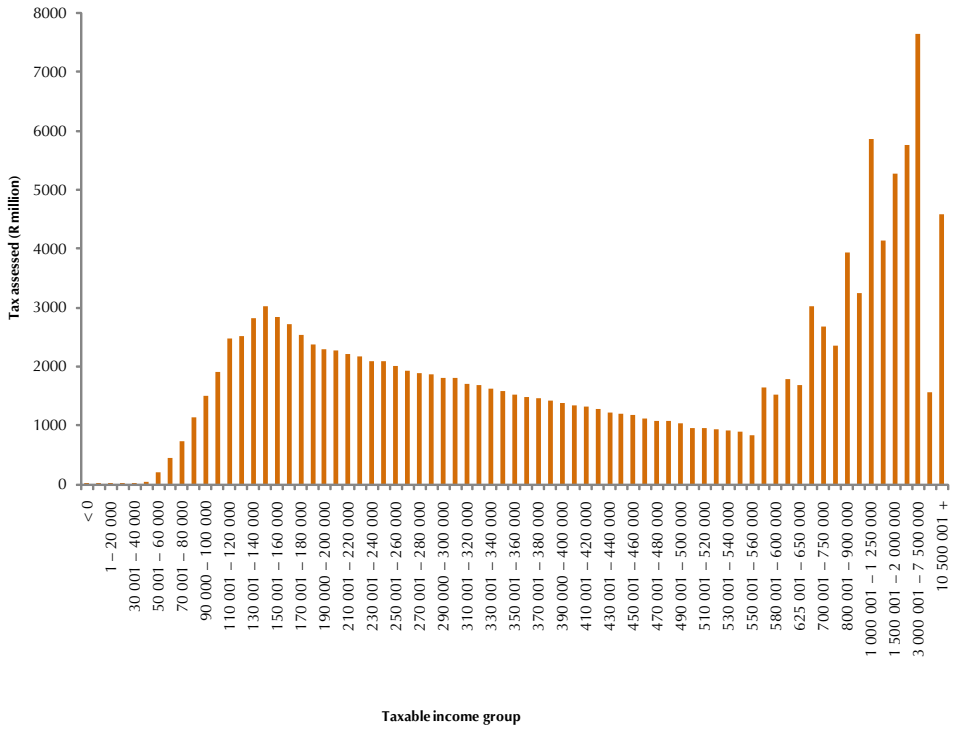
In SA, VHI plays an important role in granting access to private healthcare of a better quality than that currently provided by the public system. Given the proposed financing mechanisms of NHI in SA, the affordability of this duplicative insurance may decrease with its introduction, making it less likely that private citizens would be willing to incur this expense. At present the upper income deciles spend up to 4.7% of their disposable income on health insurance. In 2009, the number of principal members to medical schemes was 3.5 million,

Figure 3: Health insurance expenditure per income decile, 2011 Rands



Source: Stats SA, Econex calculations

Figure 4: Tax assessed per income category, 2008



Source: South African Revenue Service

supporting another 4.6 million beneficiaries. In 2008 the number of assessed taxpayers was also 3.5 million, while the total number of registered taxpayers was 5.9 million. Examining Figures 3 and 4, one can clearly see that those in the upper income deciles, spending the highest percentage of their disposable income on health insurance, are also those who contribute a large proportion to the total personal income tax received by government and are those that will in all likelihood be most severely taxed through the NHI financing mechanisms.

The 3.5 million principal members to medical schemes, who currently support an additional 4.6 million beneficiaries, will thus be placed in a position where they, along with the other 2.4 million taxpayers, are now required to support approximately 50 million individuals, the entire population of South Africa.

If we assume that the implementation of NHI will result in a doubling of this health insurance cost, it means that almost 10% of disposable income (of the higher income groups) will be spent on health insurance. Other work by Econex[23] has shown that the price elasticity of demand is very low for health insurance, indicating that it is considered an essential good. Because it is considered essential, it seems likely that individuals would prefer to continue their medical scheme membership and instead cut back on other non-essential expenses.

As long as material qualitative differences exist between care in the public and private sector, individuals would in all likelihood prefer to continue the purchase of duplicative insurance. However, any improvement in the quality of care offered in the public system would most likely result in a shift away from duplicative insurance to supplementary insurance. Increases in tax may make duplicative insurance increasingly unaffordable, once again resulting in a shift away from duplicative insurance to supplementary insurance.

Given international evidence it seems very likely that private VHI in SA will continue to play a duplicative role, as long as material quality differences remain between private and public care. It may however be that the importance of duplicative insurance could decrease in SA as this form of cover becomes less affordable. On the other hand, private supplementary VHI may play an increasingly important role in order to cover treatments and prescription drugs not available through public coverage. More research is required to determine the exact impact in terms of medical scheme memberships and type of insurance in the market for private VHI in SA.

6 Conclusion

Examining the situation in other countries, it is clear that the role of private health insurance cannot be ignored. In both the developed and developing world the provision of private healthcare insurance plays some role, whether small or large. The high levels of private VHI expenditure in some of the countries with advanced universal care systems indicate that individuals are often willing to pay for additional insurance, alleviating pressures on the public system for services which are unaffordable to offer publicly, but still sought after.

In its study[24] of OECD countries' markets for private health insurance, the OECD concluded that, on balance, private insurance makes a number of positive contributions including affording financial protection (compared

23. *Dr. Nicola Theron, Linette Ellis & Johann van Eeden, Medi-Clinic report on determinants of medical scheme participation, November 2008.*
24. *OECD (Organisation for Economic Co-operation and Development) (2004), Private Health Insurance in OECD Countries. N. Tapay and F. Colombo, coauthors. Paris.*

with out-of-pocket expenditure), enhancing access to health services (when mandated financing is incomplete), increasing service capacity and promoting innovation as well as helping to finance health care services not covered publicly, in the case of supplementary private health insurance.

In the developing world the popularity of VHI continues to increase, even as these countries move towards systems of universal coverage. The role of private VHI is an important one and it can be harnessed to serve the public interest if governments implement effective regulation and focus public funds on programmes for those who are poor and vulnerable. Private health insurance has the advantages of not relying on coercive taxes that distort the economy and providing greater flexibility in choice of insurance than the usual "one size fits all" public system. The private sector might also relieve servicing pressures on the public sector so can be viewed as complementary in some instances.

In South Africa, government would be well advised to recognise the positive role that private VHI can play, especially in alleviating pressure on the public sector. Choice has become increasingly important in healthcare and people would be willing to pay for such a choice between the private and the public sectors. This is especially true in countries like South Africa with large quality differences between the private and the public sectors. While the details of the proposed funding mechanisms of the NHI will determine to what extent people will still be able to afford private VHI, it is clear that the burden on current medical aid members and tax payers will have to increase substantially if quality care is to be extended to the total population. With such a small tax base, the burden will have to increase significantly in order to provide for all. If people cannot afford to continue their current private VHI, they might choose to buy supplementary rather than duplicative cover, but the need for voluntary VHI will most likely persist, even in a world of universal coverage.

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