helen.suzman.foundation
promoting liberal constitutional democracy

UNIVERSAL HEALTH COVERAGE III – Two Tier: Israel and the Netherlands

The second brief in this series dealt with the insurance mandate systems used by Austria and Germany to finance UHC. This brief reviews the two tier systems of Israel and the Netherlands. Two-tier health care is so named because it involves a publically funded basic health package being provided, with a secondary private tier of additional – and often better quality – services available for those who can afford it.

Currently, South Africa has a two-tier system in place. But unlike Israel and the Netherlands, the difference in quality between the private and public tiers is unacceptable.

News

UNIVERSAL HEALTH COVERAGE III – Two Tier: Israel and the Netherlands
May 11, 2016

UNIVERSAL HEALTH COVERAGE II – Mandated Insurance: Austria and Germany
May 10, 2016

UNIVERSAL HEALTH COVERAGE II – Mandated Insurance: Austria and Germany
May 10, 2016

Who's covered and how?

Israel

Israel introduced UHC in 1995, the penultimate nation in the OECD to do so. The US still has not. Every Israeli citizen is given health care insurance under the National Health Insurance Law, financed by monthly contributions (amounting to around 5% of gross salary).

New immigrants, returning minors, and Israeli citizens born abroad without employment are given one year of free insurance for basic coverage. Soldiers in active duty are exempted as they receive medical care through the army. The government pays for insurance for those without income.

Residents choose from one of four private but non-profit Kupot Cholim (sick funds). These funds are obliged to accept all, regardless of risk or age or pre-existing conditions. The funds must provide a basic basket of services stipulated by law, but can compete on what additional services are provided – such as English language service providers. One can change funds once a year. This creates an element of market style competition that promotes efficiency.

The Netherlands

All Dutch residents are legally obliged to take out basic health insurance. Children under 18 are insured for free, but must be included on one of the parents' policies. The only exceptions are those who object on religious or

'philosophy of life' grounds, as well as members of the armed forces – whose health care is financed and managed by the Ministry of Defence. Those who object on religious/ideological grounds must still pay a general income tax equal to the income-dependent employer contribution. [1]

The contributions are put in non-risk pooled personal accounts that the Health Care Insurance Board then manages. Any health related expenditures are taken directly from the personal account – if this exceeds available credit, the individual pays out of pocket.

Health insurers have to offer the basic benefit package. Citizens are allowed to swap insurers each year. Insurance companies are non-profit, and compete only on service, price and quality of care. [2] There are two types of policy: a benefits-in-kind policy or a restitution policy.

The in-kind policy works by providing care to the insured through providers that are either employed or contracted by the insurer. The insured therefore does not receive a bill for provided care, but the choice of provider is limited. The restitution policy gives the insured free choice of provider, but works by reimbursing the insured who pay out of pocket at point of service. In practice, however, expensive treatments are paid directly by the insurer.

Although basic health insurance is compulsory, about 1% of Dutch citizens are uninsured. [3] These people take out insurance as soon as they need care, but risk a 130% penalty of nominal premiums for the period they were uninsured. In addition, a further 1% default is added every six months onto their premiums. [4] The government provides the insurers with compensation until the debt has been settled.

What's Covered?

Israel

Under the National Health Insurance Law, the basket of basic mandated health services includes: consultations from primary to specialist level and including midwives; prescriptions; hospitalisation and emergency care; laboratory services including blood work; certain medical equipment; diagnostic procedures, including x-rays and scans; rehabilitation. [5] Services not covered include long-term care, psychiatric care, preventative care, public health services and dental care.

All funds offer both supplementary voluntary health insurance (VHI) and health plan VHI: The former supplements the services provided on the basic package

– faster access, greater choice, ability to choose head of department for surgeries, etc. The latter includes supplementary services, but also provides complementary services not covered – such as those listed above, as well as treatment in private hospitals, consultations with private providers, medicines not covered on the basic plan etc. In 2005, about 80% of Israelis took out health plan VHI.

Commercial insurers, regulated by the Ministry of Finance, offer commercial VHI. These insurers can discriminate acceptance on the basis of risk or pre-existing conditions, and can charge higher premiums accordingly. The range of services and the quality provided tends to be higher than that of health plan VHI. The premiums are thus higher, and the demographic who take commercial insurance out tend to be wealthier and in better health.

About half of those with commercial VHI, however, are on group policies – that is, covered by their employers or unions who purchase insurance en masse at equitable rates. In 2005, about one third of Israelis had commercial VHI. There is therefore clearly significant dual membership with health plan VHI. The reason is thought to be a lack of awareness and understanding of how similar the services provided are. [6]

The Netherlands

In 2008, under the Health Insurance Act (Zvw) the basic health insurance benefit package included: medical care, from primary to specialist level and including midwives; hospital stay; dental care until age 22; medical aids and devices; pharmaceutical care; ambulance transportation; mental health care including eight sessions with a psychologist, and one year in patient care if needed (after that, long-term in-patient mental care is covered by the Exceptional Medical Expenses Act (AWBZ)). [7]

VHI is complementary – it covers services not included by the statutory health insurance (SHI) schemes under Zvw and AWBZ. The latest data from 2009 shows that 91% of insured took out complementary VHI. [8] Insurers are allowed to refuse applicants on the basis of medical risk. Most provide free VHI cover for the children of VHI policy holders. VHI covers services like: dental care above the age of 22, reading glasses and contact lenses, and physiotherapy. It may also include services that are not evidence-based, such as chiropractic.

Financing

Israel

In 2012, total health expenditure amounted to roughly $18.8 billion, or 7.3% of GDP. This placed Israel well below the 9.3% average of OECD countries. 60% of total expenditure was covered by public sources, which is also well below the average of 72% in OECD countries. [9]

Public financing is split between two main sources: health contributions and general tax revenue. [10] Individuals pay 3.1% on wages up to half the average national wage for their health contributions, and 4.8% on any income that exceeds that. Failure to pay does not impact on the right to NHI, but does result in legal recovery of payment.

General tax revenue accounts for the different between funds available from health contributions and the determined level of NHI funding needed. "The system therefore lies somewhere between a social health insurance system and a tax-financed system". [11]

5% of NHI funds are allocated for individuals with rare and very expensive illnesses, with the remaining 95% being split up by a capitation formula based only on age. [12] Many worry this does not do enough to prevent creaming and reduce equity, as it does not take any other risk factors into account. However, there has not been any evidence to suggest that this is the case yet. With regards to pooling, it is the health plans themselves that pool rather than the NII.

The Netherlands

In 2012, total health expenditure amounted to roughly €98 billion, or 11.8% of GDP. This is second only to the United States (16.9%) among OECD countries. [13] Around 86% was accounted for by public sources. Of this, SHI contributions and premiums made up 67% (36% for Zvw and 31% for AWBZ) whilst government accounted for 19%. This is well above the OECD average of 72%. Private sources account for the remainder – 4% from VHI and 10% from out-of-pocket payments (including those that will be reimbursed in restitution policies).

The average nominal premium was €1100 per year in 2008, which amounts to approx 6% of a net 'modal income'. [14] Each insurer sets this premium. Premiums are paid directly to insurers. The compulsory income-dependent contribution is collected as a tax from salary. The contribution amounts to 6.9% of income – with a ceiling of €2233 per year. For the self-employed, it is based on a tax assessment, and they contribute 4.8%. [15] The aim is for contributions and premiums each to count for 50% of total SHI expenditure.

Insurers are funded by the Health Insurance Fund, which pools premiums and contributions. The allocations to insurers are based on risk profiles of their insured. This means that health insurers receive compensation for accepting those persons with unfavourable risk profiles – something which they are obliged to do (at the basic SHI level). [16]

The risk-adjustment contribution is based on: age/gender, socio-economic status, region (regions vary in health indicators of overall quality of life), consumption of pharmaceuticals, and chronic conditions. Efficient risk-pooled insurers will generate surpluses. This enables them to reduce their premium rate and attract customers from less efficient plans. Competition makes UHC efficient.

Conclusion

Israel and the Netherlands represent two different benchmarks for how two-tier health care could be both efficient and comparatively equitable in South Africa. Rather than pursue the extravagant and highly ambitious single payer scheme envisaged in the NHI White Paper, currently before the SA public, attention could be focussed on consolidating the public tier, possibly with mandated intervention from the private sector, in order to improve efficiency and quality of service.

In the next brief, I shall review Canada's single payer system.

Andrew Barlow
Researcher
andrew@hsf.org.za

Bibliography:

[1] http://www.hspm.org/countries/netherlands25062012/livinghit.aspx?Section=3.3%20Revenue%20collection/sources%20of%20funds&Type=Section
[2] ibid.
[3] ibid.
[4] ibid.
[5] http://www.moia.gov.il/Publications/health_en.pdf
[6] ibid.
[7] ibid.
[8] ibid.
[9] http://www.oecd.org/els/health-systems/Briefing-Note-ISRAEL-2014.pdf
[10] http://www.hspm.org/countries/israel25062012/livinghit.aspx?Section=3.4%20Pooling%20of%20funds&Type=Section
[11] ibid.
[12] http://www.hspm.org/countries/israel25062012/livinghit.aspx?Section=3.4%20Pooling%20of%20funds&Type=Section
[13] http://www.oecd.org/els/health-systems/Briefing-Note-NETHERLANDS-2014.pdf

[14] http://www.hspm.org/countries/netherlands25062012/livinghit.aspx?Section=3.3%20Revenue%20collection/sources%20of%20funds&Type=Section
[15] ibid.
[16] ibid.

