PRIVATE PREPAID HEALTH FINANCING SCHEMES' ROLE IN HEALTH SYSTEM

Jan Mertl

Abstract

One of main obstacles with private financing of health care is the dependency of common insurance product on medical underwriting and pre-existing conditions. In countries like Czechia, where universal health care system exists, this ensures necessary solidarity between healthy and sick citizens and financing objectively needed health care. Suggesting private coinsurance to supplement this system may work for some scenarios but many clients and life situations will be excluded from real possibilities to use it. Therefore, we discuss possible role for prepaid schemes that are independent of health status at the time of buying and provide flexible options for clients that want to allocate their private resources for care above the universally needed and available standard. Although they are not able to cover up for classic insurance scenarios – covering random insurance events usually with high costs, they are able to provide treatment programs that will supplement standard therapeutic and preventive care.

Key words: prepaid programs, health insurance, health system

JEL Code: I13, H20, H51

Introduction

Health systems today face dilemmas that emerge from increased expectations of all stakeholders and changing the health system governance practices (Jakubowski & Saltman, 2013). Doctors want to be paid well and provide state of the art medicine, patients need treatment for huge spectrum of diseases and some of them want additional services, insurance companies want to remain relevant and take their part in organizing and effective financing of health system, and the relationship to their clients. At the same time, it is highly important to keep the objectively needed health care universally available, both because of solidarity reasons and as a prerequisite for possible voluntary schemes that will be discussed in this paper.

A number of fragmented voluntary private health expenditure schemes exist in OECD (Sagan & Thomson, 2016). Some of them utilize a principle of private health insurance (usually long-term or even life-long like in Germany), utilize non-profit principle (like in France

"mutuelles") and their role in the system is determined also by historic, institutional and cultural preferences in a nation (Brouland & Priesolová, 2016). A principle of health savings account or medical savings account has been tried in a number of health systems worldwide as a part or option in the universal part of the system, e.g. in USA (Baicker, Dow, & Wolfson, 2006) or Singapore (Medisave). The issues with these schemes when utilized in universal part of the system include limited options for patient and public policy when the individual account gets empty for some reason, problems when people get older and the health expenditure curve goes up and the situation of sick and poor people who cannot accumulate enough resources for the needed care at all (Hanvoravongchai, 2002). We are aware of these issues and therefore discuss private prepaid schemes whose position and character strives for minimizing the associated known risks.

In this context, this paper seeks for scientific determination of private prepaid scheme's position in the health system that is backed by universally available health care provision financed from public resources.

Methodologically we use standard approaches of health economics and health policy analysis. We work with three categories of health care and focus on those that are truly voluntary in demand function, thus suitable for allocation of private resources. We do not discuss where is the border between universally (compulsory) and voluntary health care financing, because this is determined in time and based on evidence-based medicine approaches, therefore out of scope of this economic analysis. However, we know that such a border always empirically exists, even if it is sometimes a little bit blurry or changes as medicine or diseases develop.

1 Typology of health care

Because of socio-economic properties of health care and the two independent dimensions of solidarity in health (health status and income), we should not try in health policy to focus only on the public part of health care financing that must exist (at the level determined by medicine and public choice), and let the market decide about the rest (Krebs, 2015). The market will just decide in such a way, that it will very problematically measure the health future of the patient and try to make an insurance plan for it. That will not work well in many cases. Moreover, it will prevent any sharing of the burden of disease; locking many of people out of the possibility of spend their money in order to gain required health utility. We have to look deeper, and while differentiation by previous health issues is discouraged, differentiation by

wealth (income) seems more acceptable, especially in the connection with gaining private health utility.

If we look at the categories of demand for health care, we can thus divide them as follows (Mertl, 2017a):

- what a patient must have,
- what a patient wants to have,
- what a patient can have.

Financing care of the 'must have' type has to be financed by public resources – optimally and typically regardless of both income and health condition. This results in financing from general or earmarked taxation (Mertl, 2017b). We see it as a prerequisite to voluntary consumption of certain types of health care that we describe further.

Financing care of the 'can have' type is the good field for regulated private financing schemes, optimally differentiated according to income, but not by the (initial) state of health at the time of the contract or even worse, medical history. If other insurance techniques are not applicable, also the simpler prepaid schemes could be used which overcome the problem of health risks selection by not utilizing them at all and relying on paying in advance and then consuming predefined packages of health care. In this type of care is maintained condition of objective medical indications and recommendations, but without the existence of an objective need for particular method of treatment. Such schemes will increase the individual benefit of the patient, while simultaneously regulation of the products will prevent or reduce the incidence of market failure in terms of categorizing patients according to their individual health risk, which is undesirable as stated before.

Financing care of the 'wants to have' type could use direct payments, but it can also connect with schemes of previous type ('can have'). Especially when taking into consideration that the real decision-making capabilities of most patients on the health market are limited and it is more efficient to purchase this care collectively (by third party). Given the limitations of private health insurance, prepaid schemes can accumulate resources and provide guaranteed purchasing power for creating the programs responding to individual patient's wants.

2 Prepaid schemes' characteristics

The principle of prepaid health schemes is quite simple in pure economic point of view. For a given amount paid for given period, client receives services of certain value. Their significance for health policy lies in the incentives they provide and position in health system they have. At first, they support free choice of patient, since he can decide how much money

he can (backed by universal coverage) annually allocate for his health services. This of course depends on his income, if he is working or retired, etc. Secondly, they overcome the problem of health risk selection by providing the benefits of value equal to the annual payment that the patient has decided.

We can give an example how the prepaid scheme can look like.

Assume that a patient is able to allocate 500 CZK for his health services monthly, e.g. 6 000 CZK annually (can be lower/higher amount in practice according to the individual budget limitation or willingness to pay). Therefore, he can buy a prepaid scheme for this price.

He then is offered, according to his preference and/or health status, a package of health services that he can consume for that money during a year. It can be offered purely according to his demonstrated preference, or he can get advice from a doctor according to his health status, which services he would the most benefit from. When he is still healthy, he will mainly utilize prevention and better lifestyle benefits, such as:

- 1 000 CZK for services of nutrition advisor
- 2 000 CZK for lifestyle activities and programs (exercise, relaxation)
- 1 000 CZK for better services at general practitioner (email/callback/SMS), additional preventative consultations/screening
- 2 000 CZK for vitamins, vaccination and reimbursement of regulation expenditures if introduced/expanded in universal part of the system

When he is already sick, e.g. has cardiovascular disease, the structure of benefits can change:

- 1 500 CZK for better services at cardiologist, lower copayments for advanced drugs that he takes regularly
- 500 CZK for vitamins and dietary supplements
- 1 000 CZK contribution for a home cardio monitoring device
- 1 000 CZK for better services at general practitioner (email/callback/SMS), regular monitoring of health status
- 2 000 CZK for lifestyle activities and programs (exercise, relaxation)

It is clear, that the structure of benefits can differ according to the status of the patient and is highly dependent on the creativity of the scheme providers. In addition, we can imagine that the employers will provide partial or full financing of those packages as a specific employment benefit. Thus, it can serve also as the factor of market differentiation and market choice. Theoretically, special prepaid schemes can be created for e.g. dental and eye care.

We can summarize a SWOT analysis of those prepaid schemes in the following table.

Table 1: **SWOT analysis of prepaid schemes**

Strengths	**Opportunities**
Synergic effect with universal health coverage, while keeping public and private resources separated Non-discriminatory approach according to the health status of a client Patient has choice about the character and volume of provided services Lowering transactional costs and increasing economies of scale compared to situation when the patient buys the services individually – creating "health packages"	Possibilities of truly voluntary allocation of private resources for health care Possibility of individual or group aiming of those schemes, e.g. at young people, employees of certain branches, the elderly people Options for health providers and health insurance companies to be creative about the content of those packages Transparency for client about the allocation of his resources
Weaknesses	**Threats**
Construction and consumption of the package might be perceived as not necessary for healthy and not enough for sick The amount of resources that individual can allocate might be too low for scheme to be useful Does not cover bigger expenditures nor provides full coverage for listed situations (as insurance does) Requires to be backed up by universal system (property, not weakness in Czechia)	Those who can utilize it the most (sick/poor) could not afford to buy it Some medical branches can offer more into packages than the others Character of competition and regulation on the market Unclear influence on the overall health system effectiveness

Source: (Mertl, 2017a).

From the SWOT analysis it is clear which position those prepaid schemes have. Of course, if they were introduced in the universal part of the system or without universal system baseline, they would quickly fail, because large social groups would not get suitable coverage and treatment within them.

The role of health insurance companies and health providers is important for those prepaid schemes to work. It depends on their creativity and professional level what they can offer to the clients. When they also provide advisory services when choosing those programs, they can tailor the schemes' content to individual needs if desired. Alternatively, a client can compare different general offers that he is able to buy for a given amount of money.

Because one of the disadvantages of health savings accounts is the "pressure to save" (Avera, 2017) – e.g. not to consume too much services in order to save money put there – suggested prepaid schemes are not intended to provide saving capabilities. When a person cannot consume all the services that he/she paid for in a given period, he/she can take their money back or can buy a scheme for the next period for that money. The content of package can differ between periods in case that the client's health status or preferences change.

We can imagine that existence of these prepaid schemes can in the end stimulate the development of services that can be included in them as they can mobilize resources for additional health services. This can be a factor of socioeconomic and regional development, since the people usually consume those services within their home location, and therefore support employment and overall economic growth.

Conclusion

As a possible alternative to private health insurance, which has strong limitations caused especially by individual health risk evaluation necessity (medical underwriting), prepaid schemes can be considered. Systemically in the form of health savings accounts, they also have disadvantages that become highly prominent if they are not supported by solid universal system – then they quickly fail with poorer or sicker population, or when the clients get older and demand more expensive care.

In this paper, we introduced the prepaid schemes as an extension to well-covering universal health care system and without special incentives to save money there, overcoming those disadvantages largely.

As seen from SWOT analysis, they have some unique properties that are lower transaction costs and high economies of scale, non-discriminatory approach to the health status of clients and voluntary allocation of money for health services' package chosen individually with possible medical advice.

We do not want to pretend that prepaid schemes are a miracle that can resolve the issues with lower private health expenditure share in Czechia. The analysis shows also their weaknesses and threats and for some scenarios, other financing schemes can be more appropriate. Especially for random rare events with higher costs (like injury or inpatient care) private health insurance can be highly suitable. However, we suggest that prepaid schemes should be seriously considered as an option especially in the form of voluntary extension of universal system for specific health packages consumption and financing. There they could help to obtain individual utility in health better than simple fee-for-service or private health insurance approach, especially for the people that want to invest in their health and continuously maintain it with the help of the social and health services sector.

What we must avoid at all costs is to gradually diminish the universally available care in order to create more and more space for individual (even prepaid) expenditure schemes. The opposite approach is correct, e.g. given the rapid development possibilities of today's medicine

and allied services, create new voluntary schemes of health care and make them available for those that want to and can pay for them. This way we ensure that they provide additional value over the universally available standard and ensure the quality and safety of care for those who do not want to or cannot pay more than they are legally obliged (including ordinary health insurance payments).

If we want to respond to the demand for "above-standard" care and possibility of health providers to supply it, it should be done if desired by introducing more equivalent financial schemes above the current levels (OECD, 2016) not decreasing the volume of public expenditure that currently flows into the system. This way can in the long run the ratio between public and private expenditure change slightly more in favour of private one, but the public part will be able to cover the necessary care without diminishing its quality or accessibility. Considering the private expenditure or simply "solidarity changing", we have to distinguish what we want to achieve. Whether we want to regulate the system by introducing co-payments (effectively forcing the people pay for the care they need with some regulative effect), or if we want to create schemes that provide additional (private) utility in health for those who demand it and want to pay for it. For sure, current medicine in majority of branches can offer voluntarily available care and services above the universally needed range and this could bring benefits to those people who can afford them. However, we have to recognize that by nature, even prepaid schemes can be socially selective and thus the equity issues can arise again, especially until the Czech wages (incomes) stay at current level.

Acknowledgements

The article has been prepared within the project "Current trends in development of financial markets", supported by the institutional support for long-term strategic development of research organization at the University of Finance and Administration in the year 2017.

References

1. Avera. (2017). Avera health plans. Retrieved 1.3.2017, from Health Savings Account (HSA) Qualified: https://www.averahealthplans.com/app/files/public/57113/avera-health-plans-hsa-explanation.pdf
2. Baicker, K., Dow, W., & Wolfson, J. (2006). Health Savings Accounts: Implications for Health Spending. *National Tax Journal,* 59(3), pp. 463-475.

3. Brouland, P., & Priesolová, J. (2016). Doplňkové zdravotní pojištění, institut "mutuelle" a jeho terminologie. *Acta Oeconomica Pragensia*, 24(6), pp. 69-77.
4. Hanvoravongchai, P. (2002). *Medical savings accounts: lessons learned from limited international experience.* Geneva: WHO. [Online.] Retrieved 1.9.2017, from <http://www.who.int/health_financing/documents/dp_e_02_3-med_savings_accounts.pdf>
5. Jakubowski, E., Saltman, R. B. (2013). *The Changing National Role in Health System Governance: A Case-based Study of 11 European Countries and Australia*. Denmark: WHO. [Online.] Retrieved 1. 9. 2017, from: < http://www.euro.who.int/en/publications/abstracts/changing-national-role-in-health-system-governance-the.-a-case-based-study-of-11-european-countries-and-australia-2013 >.
6. Krebs, V. et al. (2015). *Sociální politika*. Praha: Wolters Kluwer.
7. Mertl, J. (2017a). *Prepaid schemes in Czech health care system.* In XXII. International conference – Theoretical and practical aspects of public finance. Praha: VŠE (in print).
8. Mertl, J. (2017b). The Possibilities of Transition from Health Insurance Contributions to Earmarked Health Tax in the Czech Republic. *Ekonomický časopis*, Vol. 65, No. 7.
9. OECD. (2016). *OECD Health Data Statistics*. OECD ILibrary: OECD.
10. Sagan, A., & Thomson, S. (2016). *Voluntary health insurance in Europe: country experience.* Brussels: European Observatory on Health Systems and Policies.

Contact

Ing. Jan Mertl, Ph.D.
Katedra financí VŠFS
Estonská 500
101 00 Praha 10
Email: jan.mertl@outlook.com