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Roles & obligations between public care and the private insurance sector

Substitution vs. supplementary models

Panel discussion Georgian – German Health Care Symposium
Tbilisi July 7th, 2014 - *Wolfgang Wand, Managing Partner*

Introduction

1 Thesis

- Any government faces the obligation to ensure the proviso of a MINIMUM standard of Health Care for its citizens, the unrestricted access to the same and the supervision of defined quality standards

2 Thesis

- Central and UNILATERAL proviso foster bureaucracy, hinder efficiency, block innovation and leads to increased costing – competition is vital

3 Thesis

- Any country needs a functioning private insurance sector as an integral and fundamental pillar of its financial market – health insurance is an important component of any insurance industry

Fundament

With the introduction of UHC Georgia is well on the way to provide a basic, all-encompassing health care delivery system to the countries citizens

QUESTIONS

Is the private insurance sector fit for the particular challenges of PHI?

Should private insurance compete with the centrally funded UHC or co- exist?

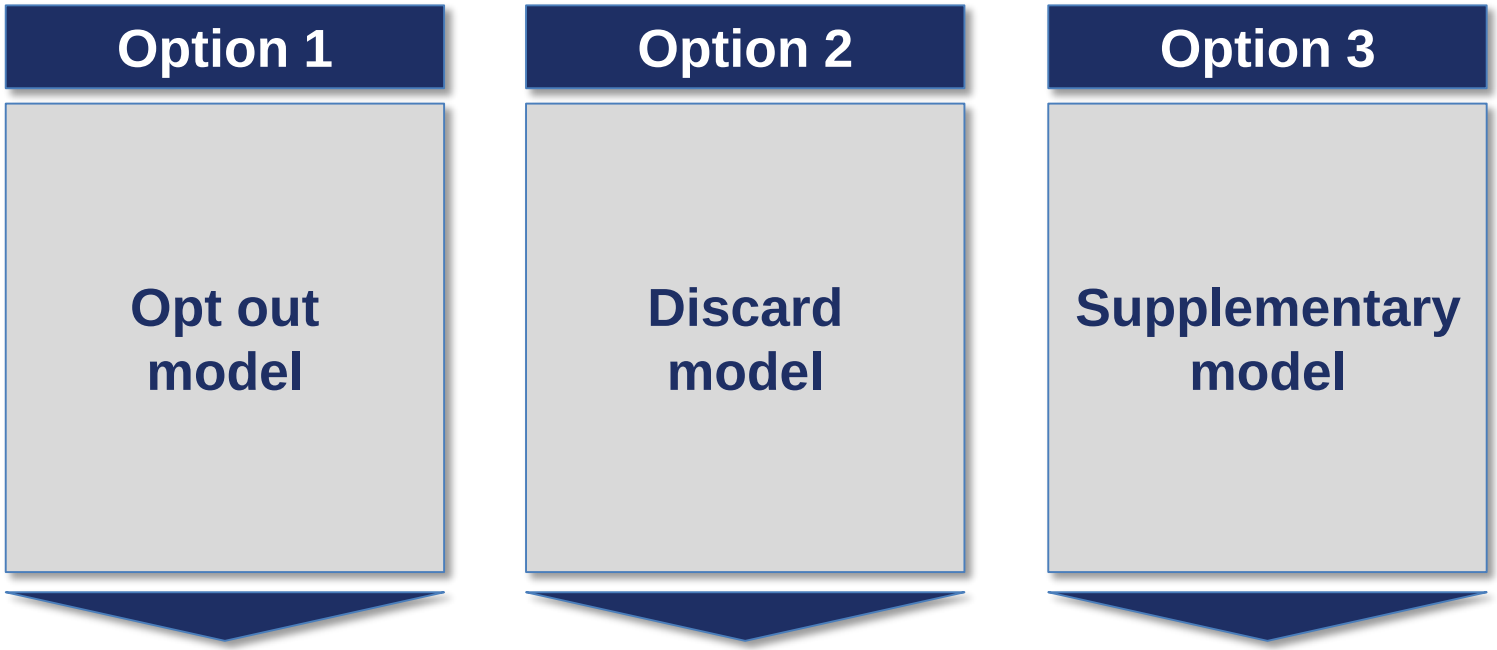
Should private insurance substitute or complement UHC?

Political statements of missionary quality:

Left to socialist:	equal care for everyone, no privileges for the “better- offs”
Liberal:	full competition between the public and private sector
Conservative to right:	from “who pays shall be entitled to better services” to “it’s the individual’s obligation and choice to look after his/her health”

Let us address options, models and scenarios without any “missionary” eagerness!

Options – How to structure a Private Health Insurance system



…and combinations thereof

Opt out version

- The individual may opt out of the UHC service and seeks COMPARABLE or better care from the private sector
- Per capita cost otherwise attributable to the individual from the state budget are either paid to the individual or his/her private insurance company

THUS

Public and Private compete on equal terms and prices for the same or a better level of care.
Differentiation criteria:

- "purchasing ability"
- Quality of customer service [customer centrism]

Considerations

- May everyone opt out?
- Only certain segments of the population (in excess of income level, self- employed…)?
- Discrimination prohibited otherwise potential anti- selection at the decrement of the public system
- Way of no return?

Discard model

- **Though eligible for UHC benefits an individual purchases full private medical insurance**
- **Cost may be expected to be – subject to age and gender –substantially higher than per capita expenditure of the state budgeted**
- **If I want to drive Mercedes and pay for it, I am entitled to the benefits such as**
  - wider benefits
  - better treatment (?)
  - better inpatient accommodation
  - jumping the queue

Considerations

- Should the private insurer (or the individual) be entitled to partial payment compensation under UHC (principle: cost otherwise payable by UHC)?
- Ethical obligations of the private insurance sector (see separate folio)
- Individual and/or corporate business

Supplementary model

- **Private insurance covers co- insurance obligations under UHC**
- **May provide top- up to higher limits on a per diagnosis / ailment basis**
- **May pay higher fees for treatment in order to achieve “better” treatment**
- **May pay for single bed accommodation**
- **May pay for out-of area treatment**
- **May pay for diseases otherwise excluded under UHC**

Considerations

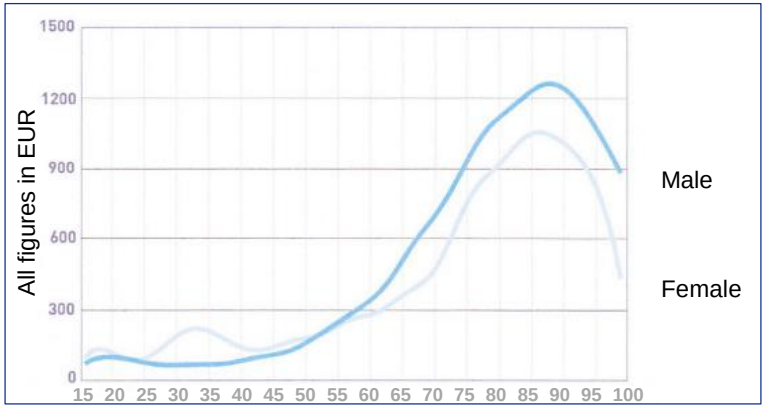
- Individual and/or corporate business
- Discrimination might be a necessity
- Ethical obligations of the private insurance sector (see separate folio)

PHI – contracting parties, collective or the individual?

Fundamentals

- „Eastern Europe“ health care insurance markets so far are prone to collective (group insurance) schemes, individual business has no strong history as yet – tendency gradually changing, albeit slowly
- “Old European” markets have a strong tradition in individual insurance
- “Group” affords bundling of diverging risks into a homogenous group thus balancing the risk amongst a collective – downside: a common “sponsor”, usually the employer, is necessary
- Individual business requires individual underwriting (discrimination) as to gender, age, pre- existing conditions, occupational exposure et al

Age correlation of expenditure, in- patient 2011[1)]



Key issues

- Guaranteed renewability –an insured may not be penalized if he/she encounters a serious illness
- How to cope with the aging issue? Adjustment or age reserves?
- An industry bail- out fund might be necessary in case of insolvency of a health insurer

1) source: PKV- Verband (German Association of Private Health Insurers)
All values standardized to the value of a 43 male

Governance – thus regulation – required!

Do you concur with the theses?

1. Any government faces the obligation to ensure the proviso of a MINIMUM standard of Health Care for its citizens, the unrestricted access to the same and the supervision of defined quality standards
2. Central and UNILATERAL proviso foster bureaucracy, hinder efficiency, block innovation and leads to increased costing – competition is vital
3. Any country needs a functioning private insurance sector as an integral and fundamental pillar of its financial market – health insurance is an important component of any insurance industry

Your opinion?

1. Is the private insurance sector fit for the particular challenges of PHI?
2. Should private insurance compete with the centrally funded UHC or co- exist?
3. Should private insurance substitute or complement UHC?

Panel discussion opened – looking forward to your considerations!