Review Article

Global directions for reforming health systems and expanding insurance

What is suitable for the Arab Gulf countries?

Samir N. Banoob, *MD, PhD.*

ABSTRACT

Most countries are exploring and implementing reforms of their health care systems. The Arab countries in the Gulf are no exception after establishing modern governmental health care systems accessible to all and free of charge. Current problems of the Arab systems include financial, managerial and quality issues. The private sector in these countries has no defined national role and is gowing abruptly and unplanned. The paper presents the major global health reform directions, analyzing the current activities in the Arab Gulf countries and proposing certain practical relevant approaches for health reform, and expansion of insurance in these activites.

Keywords: Health reform, health insurance, medical care.

Saudi Med J 2001; Vol. 22 (9): 743-748

Most countries, including the richest ones in the industrial world, are facing major challenges in coping with the escalating cost of health care, and at the same time are seeking to preserve their commitment to universal coverage of their populations and maintaining a high quality level of services provided. This rising cost of care results from at least 3 factors 1. Advancement in health and medical technology, where costly procedures for diagnosis, treatment, and surgery that were not available in the past became a demand by the consumers and by the health care providers, and are being widely used. 2. The medical care inflation rate is always rising higher and is sometimes double the general inflation rate in most countries. 3. Aging of populations where the percentage and numbers of persons 65 years and over are increasing due to better health care and improved nutrition and environment. Normally, the elderly require 2-3 times more health services than the non-elderly.[1] For this reason, countries are looking for the best ways of raising the efficiency and effectiveness of their health systems through aggressive national reforms. Countries with governmental systems similar to many Arab countries, where the government owns, finances and manages its medical care facilities are changing to health insurance schemes, leaving medical care to public and private independent providers (hospital, physicians). In doing so, ministries of health in these countries are focusing on establishing health policies, regulations, monitoring the quality of care, controlling cost, and providing public health services. Examples of these countries are the United Kingdom (UK), Ireland, Spain, and all the Eastern/ Central European countries. On the other hand, countries with predominantly private insurance schemes such as the United States of America (USA) are considering mandating insurance through public insurance schemes and managed care models. Health insurance or security appears to be the

From the College of Public Health, University of South Florida, Tampa, Florida, United States of America.

Address correspondence and reprint request to: Dr. Samir N. Banoob, College of Public Health, University of South Florida, 13201 Bruce B. Downs Blvd., MDC 56, Tampa, Florida, 33612-3805, United States of America. Tel. +1 813 974 5131. Fax. +1 813 974 6741.

ultimate solution in the long range. It has been proven all over the world that a medical care system totally owned, financed and operated by governments is less efficient and less effective. Apart from Eastern and Central European countries, which are moving to health insurance and privatization, the UK, which is known by its public central national services is departing from its classic model to 1. Contracting groups of general practitioners for the total care of individuals, and those practitioners contract hospitals to provide hospital care and acting as fund holders for their patients. 2. Allowing the district health authorities to contract public or private hospitals to provide care creating competition on cost and quality. 3. Converting large regional and teaching hospitals to become autonomous organizations that contract the district or the private insurance organizations to provide care. These changes aim at more choices for the beneficiaries. At the same time, it is gradually introducing privatization and the build-up of a public-private mix that can compete for contracts, and the only way for competition is to save costs by becoming more efficient, and to provide better quality of care. It is apparent that such a scheme may be suitable for many Arab countries. In this respect it should be noted that 1. Although the study of the most prevailing systems in the world is very useful, it is clear that copying one system and transplanting it in another community is never successful. This was further proven by experiments and experiences of Eastern and Central European countries that rushed into copying some western systems between 1989 and 1992. Naturally the concepts and principles from other countries can be used only to design a system that is custom tailored to the country, and is relevant to its social cultural, political and economic patterns of both the health care users and providers. 2. The most prevailing systems are those using job related insurance with employer-employee contributions under an acceptable national policy. 3. Implementation of national health insurance or a health security scheme does not mean turning the governmental system to the profit-making insurance companies, nor does it suggest selling hospitals and health facilities to the private sector. On the contrary, the majority of hospitals in Western countries are still public, and most of the health insurance organizations are public or private not-for-profit organizations. The American model is the exception to that, and this is why the system is difficult to change. Although the needed changes are well known, the major problem in the absence of a national health policy is that the special interest groups have became politically powerful so that they almost run the system and abort any radical change. The USA model is useful to learn with regards to issues that should be avoided rather than a model to be imitated.[2] 4. There are many insurance models in the world. Policy makers in many countries may find it necessary to use different models in the same country in response to regional differences or certain types of beneficiaries. 5. Many Arab countries have strong ingredients and potential to introduce a national system for health security or insurance in the long range due to the following: (a) The presence of a social security system that can be expanded to cover health security (b) Many insurance companies are already selling health insurance policies. The coverage and benefits of such policies and the number of persons covered by comprehensive care by private insurance needs to be determined (c) A general attitude of concern regarding the current health system where most people including the policy makers feel the need for its change and reform (d) Many governments are adopting policies of economic reform and privatization. This can be clearly applied to health care by introducing health insurance (e) The move towards health security or social health insurance that is prevailing in most industrial and developing countries is creating a wealth of information on the types, experiences, and lessons of success and failure, which, if studied carefully, can assist in designing a relevant system for the Arab world.

The Gulf Region directions. The Arab Gulf States' governments have financed, and are financing their health care systems especially during the past 3 decades. This is natural, and was associated with the oil revenues that facilitated generous funding of all services including health care. With the expansion of its developmental projects and the decline in oil revenues, these countries are carefully planning for cost sharing of services by their users, and rationalizing health spending which used to be unlimited. These directions can be illustrated by the following: 1. As early as 1980, the "Kuwait Health Plan to the year 2000" concluded clearly the need for converting the national governmental system to a health insurance scheme in the long term. This plan (directed by the writer) was based on extensive studies and analysis of demographic projections, cost and utilization of health services for the long range. 2. In 1985, the Gulf Ministers of Health conducted a conference on "Health Economics and alternatives of health care financing".[5] This conference, attended by approximately 35 senior participants from all the Arab gulf countries recommended health insurance as the only viable solution for the member countries in the future. 3. Most of the Arab Gulf states began to introduce in the early 80's a system of cost sharing and collecting fees for services at least from expatriate populations. At the same time, many countries are beginning to explore some type of health insurance/security suitable for its needs. Recently, the writer conducted the following studies or organized the following conferences, or both: A study on introducing National Health Security in United Arab Emirates (UAE) (1995), Conference for

Table 1 - Health systems and reform policies in select western countries.

Country	Insurance/Coverage	Health care financing	Main reform policies
1. Belgium	Five not for profit sickness funds (mutualities) and one public covers 85% of population and 15% for major risks (4% of wages by employers and 2.5% by employees).	- 46% social secutiry contributions to sickness funds. - 39% government - 12% out of pocket - 3% voluntary insurance	- Fixed global budget for health - Global budgeting for hospitals (1982) - Reducing hospital bed capacity and converting some to nursing homes - Improving hospital management - Limiting budget of laboratary testing and pharmaceuticals
2. France	- 99% statutory health insurance through social security - Not-for- profit and for-profit supplementary voluntary insurance (80%)	- 70% social security - 4% government - 6% non-profit supplementary insurance - 2% private insurance	- Controlling growth in social security contribution to growth of GDP - Global budgeting for publich hospitals (1984) Controlling fees for ambulatory physicians Control of health technology and pharmaceuticals Capping on private hospital reimbursement
3. Germany	- 91% 1241 statutory public sickness funds - 9% private (upper income)	- 60% sickness funds equally between employers and employees as 12% of wages - 22% government - 11% out of pocket - 7% private insurance	- Strengthening global budgeting for office based physicians and hospitals - Introducing sickness funds in former East Germany - Creating competition among sickness funds and choices between funds - Considering a capitation payment for general practitioners (currrently on fee for service controlled by physician associations)
4. United Kingdom	- 100% under National Health Service (regional health authorities for hospitals and community services and organized general practitioners) - 11% private supplementary insurance	- 72% general taxation - 16% national insurance contribution of 1% of wages by employee and 1% by employer - 12% out of pocket and private supplementary insurance	- Allowing public hospitals to become self governing trusts district health authorites to contract hospital and general practitioner sevices - All hospitals to contract services of catering, laundry and maintenance - Creating large general practices to be fund-holders contracted by district health authorities.
5. Canada	- 100% through provinicial health plans	- 40% Federal funds - 34% Provincial funds - 26% Out of pocket	- Lowering the administrative cost through a single-payer system - Caps on hospital and health spending - Utilization and over billing review - Considering managed care models - Increased numbers of the general/family practitioners - Technology constraint on hospitals

Source - Organization of Economic Cooperation and Development "1994"[3]
- World Health Organization 2000 (An update on reform directions)[4,6]

the Arab League (21 countries) on Alternatives of health care financing (1995)[7] Proposal for applying national health insurance in Kuwait (1995 & 1997), Consultancy on resource mobilization and health financing in Oman (1996), Conference on health management and financing and social insurance, Najran, Kingdom of Saudi Arabia (1996).[8] Therefore, there are clear indications that the Arab governments are moving with variable paces towards application of health reforms including health insurance schemes, privatization, decentralization, and the introduction of managed care models. Particularly, most of the Arab Gulf countries are moving towards expanding health insurance. This approach, although natural can be harmful to the national health systems if it is created without careful planning. To be successful, health insurance systems should: Introduce and enforce strict regulations and careful monitoring of quality in the private sector; prevent any restrictions on insurance policies such as

Table 2 - Health expenditures in select countries, 1997.

Countries	Total Expenditure as % of GDP[1]	Public Expenditure as % of Total Health Expenditure	Private Expenditure as % of Total Expenditure	Total Expenditure in International $	Public Expenditure in International $	Out of pocket Expenditure in International $
Industrial Countries						
USA (28,020)	14	44	56	3,724	1,643	619
Canada (19,020)	9	72	28	1,836	1,322	313
UK (19,600)	6	97	3	1,193	1,156	37
Germany ($28,870)	10.5	77.5	27	2,365	1,832	267
France ($26,270)	10	77	23	2,125	1,634	433
Sweden ($25,710)	9	78	22	1.943	1,516	427
Australia ($20,090)	8	72	28	1,601	1,152	266
Middle Income Countries						
Mexico ($3,620)	6	41	59	421	172	222
Brazil ($4,400)	6.5	49	52	428	208	195
South Africa ($3,520)	7	46.5	53.5	396	184	183
Hungary ($$4,340)	5	85	15	372	316	56
Poland ($3,230)	6	72	28	392	281	111
Thailand ($2,460)	6	33	67	327	108	214
Turkey ($2,830)	4	74	26	231	171	54

Source: World Health Organization, World Health Report 2000,[9] World Health Organization Eastern Mediterranean office. "The work of WHO EMRO, 1994, Alexandria,[10] Egypt 1995
Seven countries from each category were chosen with comparable GDP to the Arab Gulf states. GDP = Gross Domestic Product in international $

exclusion of pre-existing conditions or putting caps on expenditure or refusal of insurance such as using risk rating; Instead, the best encouraged insurance is group insurance of large numbers such as community rating. Many countries have this model as a public not-for-profit fund and not necessarily private; encouraging job-related managed care models with prospective payments by employers and employees; avoid any financial barriers such as high fees or co-payments especially at the primary care level; provide public insurance for categories that are not covered under employment-based insurance such as the elderly, the poor and the unemployed.

In this respect, the gulf countries should avoid the creation of health insurance as a private sector provided by private physicians and private hospitals. Instead, at least large national hospitals should contract and provide care for the public or the private insured on a cost-plus basis. Countries should be careful that creating 2 separate systems could lead to: 1. Excess capacity of hospital beds that will increase the national health care cost, 2. Creating a 2 tier system, one public and another private and 3. Deterioration of the public sector which will be receiving mainly the uninsured, and the complex advanced or terminal patients that the private sector can not handle or avoid handling since it is not making a profit. In fact, studies of the writer in certain gulf countries recently concluded that nationals are the most users of the private sector although they pay on a fee for service basis and not under insurance plans.

Practical approach. A practical approach to all countries could be: 1. Introduction and expansion of insurance slowly and avoiding rushing a system that can face political and financial problems 2. The system must be planned to cover the citizens and not only the expatriates 3. In preparation for that, the major hospitals of government should be transformed into public-not-for-profit independent authorities. This will facilitate its efficient management and its ability to contract the private sector without the need to use or build new private hospitals. 4. In all situations, management training of nationals and planning for preparing a suitable and trained national cader of administrators and providers is a prerequisite for a successful system. This includes training physicians on cost consciousness and full understanding of economic concepts in health care. Physicians should learn how to form group practices and to manage managed care contracts. 5. It should be noted that the introduction and application of health insurance or health security schemes will not lower the cost, and may not relieve the government from its current financial burdens. Health care cost is increasing in all countries with national health insurance schemes, and the Arab Gulf Countries will not be an exception to that. The health security scheme is expected to ensure better quality, efficiency, effectiveness, equality and consumer satisfaction. The government will continue to have the solid role of establishing the national health policies in collaboration with employers, beneficiaries and providers. Its financial contribution

Table 3 - Health systems in the Gulf countries.

Indicator	Oman	Saudi Arabia	Kuwait	UAE	Qatar	Bahrain
I *Resources*						
1. Population (million), 1998	2.40	19.49	1.73	2.31	0.57	0.58
2. GNP/Capita (US$), 1998	4,820	7,040	17,730	17,400	11,600	7,840
3. Health Expenditures as % of GNP, 1997	3.9	3.5	3.3	4.2	6.5	4.4
4. Physicians/1000	1.18	1.60	1.82	1.74	1.43	1.17
5. Nurses/1000	3.01	3.25.00	4.89	3.78	3.54	2.74
6. Dentists/1000	0.08	0.14	0.26	0.24	0.21	0.12
7. Hospital Beds/1000	2.28	2.50	3.22	3.12	2.00	3.14
8. Health Centers/10000	0.60	1.00	0.40	0.90	0.60	0.40
II *Services*						
% Coverage	95	94	100	90	100	100
% Safe Water	68	93	100	98	100	100
% Sanitary Facility	79	86	100	95	100	100
% Prenatal Care	95	65	100	90	100	95
% Immunization						
- Polio	98	95	100	90	91	98
- Measles	98	95	100	90	91	98
- BCG	97	93	98	90	86	93
III *Indicators*						
1. Low birth weight %	8	6	9	6	8	7
2. Infant Mortality/1000 Live Births	25	24	15	15	17	18
3. Under 5 Mortality/1000 Live Births	31	28	15	18	23	20
4. Maternal Mortality/10,000 Live Births	2.00	1.70	2.70	0.10	0.00	2.00
5. Life Expectancy at Birth (Years)	71	74	76	77	72	73
6. Crude Birth Rate/1000	38	35	24	21	21	23
7. Crude Death Rate/1000	7	6.8	4.9	5.5	10	6.2

1. Most of the data on human resources and services represent EMRO report 1997.
2. GNP (Gross National Product) was compiled from Population Reference bureau in 1997.
3.Indicators should be interpreted with care since some of the data may be calculated for the whole population and some for the Nationals only with a wide variation in % of expatriate residents in the 6 countries.
4. Ministy of Health expenditures on health in United Arab Emirates may be excluding expenditure by the individual Emirates, and in Saudi Arabia is excluding the other Governmental sectors. These expenditures in both countries are very significant. All other countries' expenditures represent Ministry of Health expenditures only.
BCG=Bacille Calmette-Guerin; UAE - United Arab Emirates

will at least cover the poor, the elderly, the disabled and the unemployed. Also, the government will have the responsibility of providing public health services and of regulation of practices, licensing of providers and health facilities, and quality monitoring of all services provided.

Proposed feasibility studies. Before entering into insurance planning, applications and regulations, a scientific feasibility study should be made in each country. The general goal of such study is to analyze the current health care system in terms of service utilization, cost and funding of services for the different population groups, and to present recommendations on the best alternatives of health care organization and financing under a national health security scheme. It should be noted that most of the data available does not include private utilization and expenditures. The specific objectives of the study should include analysis of the feasibility and application of expanding the national security scheme that should enable the use of the most efficient model or models of providing health care as part of the social security benefits for citizens and their dependents. The system(s) should eliminate duplication of service utilization, allow for competition among providers, and improve the consumers' satisfaction giving them more choices and a positive role in cost-sharing, planning, and management of health services. The expected outcome of such a feasibility study is to present the main options of the schemes to be considered in the country in terms of its organization, provider funding sources and projected costs, at least for the next 10 years and the methods of payment. It should specifically describe beneficiaries, benefits, and expected sources of funding for the following categories 1. Government employees and their dependents (citizens and non-citizens). 2. Public

sector employees and their dependents (citizens and non-citizens) 3. Private sector employees (citizens and non-citizens) 4. Citizens not in the workforce (unemployed, retired, housewives, disabled, and in long-term care) 5. Non-citizens who are self-employed and their dependents 6. Non-citizens who are working in households (servants, maids, cooks, drivers, guards, gardeners.) 7. Treatment of work-related accidents and diseases and compensations. 8. Treatment of visitors from the G.C.C. and other foreign visitors. The study should also address the organizational changes and the new role of the Ministry of Health.

The role of the private sector. Given the policy directions in health care, the private sector should prepare itself for a new role and different strategic planning from the current ad hoc short-term approaches, namely: 1. The concept of fee-for-service is disappearing, and can no longer survive in the long-term. The private sector should be prepared to utilize capitation and managed care models. 2. More regulation and monitoring of quality of care is to be expected since the governments in turning a large market share to the private sector, will be more obligated to monitor the quality of care provided by this sector. 3. Managed care requires large systems that can cover comprehensive care. Therefore, small medical organizations should have plans to expand, integrate with other small organizations, or at least collaborate with other private and public organizations through contracting and partnership if merging is not feasible. The goal should be the formation of large, financially viable health systems. 4. The success of a private corporation will depend on price and quality. Therefore effective scientific management of health agencies is the only solution for the efficient use of resources and control of expenditure without compromising on quality. Therefore, the choice of specialized trained health management consultants and administrators is never a waste, but an essential ingredient for success. Likewise, training of administrators and heads of technical services should be central to the success of private organizations. 5. New systems can not be imported but can be designed and adjusted to each situation. This applies specifically to: a. Hospital and comprehensive health insurance management, b. Quality assurance/improvement/management c. Management Information systems.

References

1. Banoob S. Privatization of health Systems with Care: a message to East Europe from Western Systems. Zeitchsiftfur Gesundheitswissenschaften (German Journal of Public Health), 1993; 2 V1: 130-136.
2. Banoob S. Private and Public Financing: health Care reform in Eastern and Central Europe. World Health Organization 1994; 15: 329-334.
3. Organization of Economic Cooperation and Development, The Reform of Health Care: a Comparative Analysis of Seven OECD Countries": Health Studies No. 2. OECD. Paris: 1992; 131-134.
4. Murray Lopez A. In: Global Comparative Assessment in the Health Sector. Geneva; World Health Organization: 1994. p. 153-155.
5. Arab Gulf Health Secretariat. Health Economics and alternatives of Health Care Financing. Kuwait; Arab Gulf Health Secretariat: 1985.
6. World Health Report. Health Systems: Improving performance. Geneva: World Health Organization; 2000. p. 184-186.
7. The Arab League conference on Alternatives of Health Care Financing: Cairo (Egypt); 1995.
8. Najran Health Region, Ministry of Health, Kingdom of Saudi Arabia. International Conference on Health Administration. Najran (KSA): MOH; 1996.
9. World Health Organization. Eastern Mediterranean Region. The Work of WHO in EMRO; 1994
10. Population Reference Bureau. World Population Data Sheet. Washington DC (USA); 1997.