Who’s paying for your healthcare?

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As we progress further into the millennium, populations continue to grow, and healthcare challenges continue to burden our populations, the economic means and models for meeting the healthcare requirements of our community come under ever closer scrutiny and analysis.

Today, even the most evolved and established economies and healthcare systems such as those of the U.S. and the United Kingdom continue to see convulsions in healthcare delivery and cost and experience a need for healthcare financing reform.

The United Kingdom with its National Health Scheme has become established as a flagship for decentralised healthcare delivery, with its focus on general practitioners (GP) as its core together with high quality specialised tertiary services working in a sort of hub and spoke model, administered in different regions by the NHS Trusts.

The trouble is that while there is no out-of-pocket expense for the consumer, and GP services are relatively easily obtainable, the specialised or referral services (think joint replacement) come with a long wait period, due to the cost involved, to the point where UK citizens embark upon long voyages to countries such as India or Thailand where the same procedure can be obtained at a fraction of cost and in a short time frame.

Nationalised systems similar to the UK exist in France and Canada, both of which boast an exceptional quality of medical care, with physicians who can function without attention to volume – driven incentives, proving that nationalised healthcare can work.

In the United States, the healthcare system is overburdened by costs related primarily to end-of-life issues including intensive care and long-term support of the chronically ill, also raising ethical and legal dilemmas. So much so that training on end-of-life issues has become a mandatory part of continuing medical education. However, the factors governing healthcare costs, and reimbursement, go far beyond the competence or even the ethics of the individual medical practitioner.The medical insurance model favors those with private insurance, that in turn provides the consumer with greater patient choice in provider selection.

The Federal healthcare programs namely Medicare and Medicaid, designed for the elderly and indigent have become deficit – ridden and nonviable, resulting in cap-based schemes such as the DRA or Deficit Reduction Act, which reduce provider margins to razor thin or nonexistent levels. Emergency services are largely supported by Good Samaritan laws that require that all citizens be provided emergency services without being pre-charged. The unfortunate fallout of all this is that emergency services (including imaging) tend to be abused even in situations where the condition is chronic.

In our teleradiology practice, we have had the opportunity to witness the overutilisation of emergency medical imaging, driven in large part by the fear of malpractice litigation. For example the ordering of CT angiography scans of the brain in patients with headache to

exclude the remote possibility of an aneurysm, even in the absence of other supporting evidence.

Further, in keeping with its capitalist nature the U.S. has a largely incentive and procedure driven financing model, one in which the most highly reimbursed physicians are the most productive, especially the ones who perform specialised procedures (for example, a cardiac surgeon is reimbursed at an order of magnitude higher than a pediatrician).

In the Scandinavian countries, healthcare is both free and high quality, related to higher taxation and a significantly higher percentage of GDP investment by the Baltic nations into their citizens' healthcare, and this is arguably the best certainly the most universal and equitable model in existence.

Asia represents a melting pot of healthcare systems and models. It has some of the world' s most advanced nations such as Japan, which provide a startling insight into the direction in which healthcare expenses and funding are ultimately heading across the globe. An interesting statistic is that Japan has among the highest life expectancies in the world together with the world's oldest population. While its healthcare expenditure is a relatively modest 7.8% of GDP (as of 2010), there are two significant implications of this trend, namely, as the fraction of the population over 65 increases, the fraction of individuals who pay taxes and premiums that finance the system decreases.

At the same time the older segment of the population consumes a larger section of the cost of healthcare, which represents a debilitating double whammy to which all developed economies are prone, regardless of their geographic location. Developed Asian economies such as South Korea, Singapore and Taiwan are prone to similar trends.

At the same time, Asia is also home to large and heavily populated countries such as Indonesia, Bangladesh, Pakistan and India. The common trend within these economies is a) the relatively low percentage of GDP spent on healthcare (2% for Pakistan, 2.2% for Indonesia in 2006, 1.2% for India) b) the relative role distinction wherein the state provides for primary care and private entities are largely taking over tertiary care provision c) the growing role of nongovernmental organisations in healthcare.

The recent introduction of large schemes such as India's Ayushman Bharat which provides healthcare insurance to lower socioeconomic groups and simultaneously assigns caps in fees for private providers, is a reflection of the realisation of the state of its inability to provide healthcare at the tertiary level to its citizens and its ensuing efforts to share its responsibilities with private providers of the same.A similar scheme was launched in Indonesia titled Jamkesmas, short for Jaminan Kesehatan Masyarakat (Health Insurance Scheme for the Population) in 2008 with similar goals, extending the range of coverage from "poor to near poor".

The WHO Alma Ata Declaration of 1978 mandated universal access to public primary care. While sadly, even this goal has not been substantially met in many parts of the globe, the rapid improvements in medical technology and the consequent healthcare aspirations of a growing middle class have resulted in the launching of populist healthcare schemes that seek to cater to a large sector of the population than Alma Ata sought to provide for. In any discussion or debate on healthcare the question of who should pay, and how much, inevitably arises. The answer has sociological, ethical and political overtones.

Today technology enters the discussion as well. Three aspects of modern day healthcare technology have the potential to transform healthcare delivery and costs. The first is Telemedicine. By improving access to quality healthcare from even the most remote location, this technology has the potential to bridge vast healthcare gaps that exist in our system and create a flat – world model for healthcare delivery.

The second phenomenon is that of online education which addresses physician shortages and quality of care. While both of these are essentially temporising measures, most recently Deep Learning/Artificial Intelligence, which also address physician shortages, has the potential to transform healthcare economics altogether and permanently. One would hope that once AI is an established part of healthcare delivery, we will see some of the inequities and deprivations of healthcare finance finally addressed and resolved.

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