To the Editors:

Private health insurance profits: the need to take a closer look

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Sri Lanka has invested in a free health care service and a free education system even before independence. The free health care service extends from preventive to curative sectors encompassing even tertiary health care throughout the whole country. The free health care system has become a major burden to the country over the years with development of new technologies and the increase in people's aspirations and needs. During the last two decades, a number of reports have addressed this issue [1].

One method of financing health care is through health insurance, a method of risk sharing focussing mainly on reducing the economic burden during a catastrophic illness. Risk-sharing through insurance is most worthwhile when the event insured against is largely unpredictable, infrequent, costly, unwanted, unplanned and uncontrollable by the insured.

Voluntary private indemnity health insurance is provided through employers, mutual societies, cooperatives or directly by companies; these generally cover hospital and physician services, but the benefits are limited or non-existent for preventive services, primary care, or outpatient drugs. In Sri Lanka, private health insurance is the most rapidly increasing source of health care financing which has increased from <1% in 1990 to 3% in 2006.

The purpose of this investigation is to describe some important characteristics of private health insurance schemes available to consumers in the country. Three insurance companies were contacted and details of health insurance plans were obtained. The benefits of some health insurance plans currently available are given in Table 1.

The benefits are dependent on the type of plan and there is upper limit for the number of days an enrolee can make claims. All plans have a benefit for patients admitted to government hospitals in which services are provided free of charge. In Sri Lanka, the share of the public sector for inpatient care is 72%; and for outpatient care it is 35%. In 2006, except in Malaysia (26.2%) and Hong Kong (16.5%), private health insurance accounted for less than 10% of the total health expenditure for countries in the South and Southeast Asian region [2].

Based on plans of company 1 (Table 1) for the private sector, assuming if only room charges are accounted for, a patient will be paid upto 40 days per event. If the same patient stays in a government hospital, he has benefits for 50 days. In plan 1 of company 1, the benefits for staying 50 days in a government hospital is Rs 250.00 × 50 which is Rs 12,500.00 as compared to Rs 40,000.00 for staying 40 days in a private hospital. Likewise, in plan 2 of company 1, the benefits for staying 50 days in a government hospital is Rs 20,000.00 as compared to Rs 64,000.00 for staying 40 days in a private hospital. Likewise, in plan 3 of company 1, the benefits for staying 50 days in a government hospital is Rs 25,000.00 as compared to Rs 80,000.00 for staying 40 days in a private hospital.

In the plans of company 2, the number of days of benefits for hospitalisation per event is variable. In plan 5 of company 2, the benefits for staying 15 days in a government hospital is Rs 1,000.00 × 15 which is Rs 15,000.00 as compared to Rs 120,000.00 for staying 40 days in a private hospital. Similar benefits are provided by company 3 in all its plans.

It is seen that insurance companies can have profits ranging from Rs. 37,500.00 to Rs 105,000.00 by promoting patients to seek treatment in government hospitals as opposed to seeking care in private hospitals. In other words, the benefit given to patients seeking treatment from government hospitals is like being paid to be sick.

Providing two methods of benefits for hospitalisation in public and private sector hospitals is not only defrauding the enrolee but also morally unacceptable. These health insurance plans and insurance companies in a sense are avoiding their corporate social responsibilities by further burdening the public sector health care services. We strongly recommend that the government should bring legislation, so that, when a patient with health insurance is admitted to a government hospital, it should be able to obtain the full benefits that the patient would obtain if (s) he were admitted to a private hospital. This is one way of recovering public health expenditure, however small that component may be, that could be utilised for upgrading the services provided by the government hospitals at no extra burden to the consumer.

Table 1. **Benefits of some health insurance plans available in the country**

Insurance company	1			2					3				
Plan	1	2	3	1	2	3	4	5	1	2	3	4	5
Annual limit	50,000	80,000	100,000	35,000	55,000	85,000	100,000	150,000	35,000	55,000	85,000	100,000	150,000
Maximum limit per event	40,000	64,000	80,000	30,000	48,000	75,000	80,000	120,000	30,000	48,000	75,000	80,000	120,000
In private sector													
Room charges (per day)	1000	1600	2000	1,250	1,250	2,000	2,500	3,000	1,250	1,250	2,000	2,500	3,000
Admission	17,500	28,000	35,000	12,250	19,250	29,750	35,000	52,500	12,250	19,250	29,750	35,000	52,500
Doctors charges	25,000	40,000	50,000	18,000	28,000	42,500	50,000	75,000	17,500	27,500	42,500	50,000	75,000
Investigations	7,500	12,000	15,000	2,000	2,500	2,500	5,000	5,000	4,000	6,000	10,000	11,000	14,000
OPD				1,200	1,500	1,500	4,000	5,000	3,200	4,000	5,000	9,000	10,000
In government hospital													
Amount paid (per day)	250	400	500	300	400	500	750	1,000	300	400	500	750	1,000
Maximum number of days	50	50	50	15	15	15	15	15	15	15	15	15	15
Charges for drugs taken from outside									4,000	6,000	10,000	11,000	14,000
Co - payment									20%	20%	20%	20%	20%

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