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THE RELATIONSHIP BETWEEN THE OPERATIONS OF HEALTH INSURANCES VERSES THE QUALITY OF HEALTHCARE OUTCOMES

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Abstract: **The paper seeks to analyze the free health care policies, health insurances and the effect they have on the quality of healthcare. The research question is "Do the exemption of health user fees affect the quality of care among populations". Health systems act as the buffer between the citizens and the bills, maintain the health of individuals and communities, and should treat those who need medical attention or aid. There are three main theoretical models of modern health care that are linked to health economics and management. The department of health has a vast and huge responsibility to manage chronic conditions, sick visits, physical accidents, preexisting conditions and acute occurrences. There are three models that are underpinning the study, including the Beveridge model, the Bismarck model and the National health insurance model. These three models have dominated the healthcare system and have diverse impact depending on the specificity of implementation angle. The findings reveal that countries like the United Kingdom, Spain, and New Zealand mostly use Beveridge model for the government's fend for their citizens. On the other hand, the Bismack model is widely used in Japan, Germany, Switzerland and Belgium as this model demands that workers who contribute to the national economy should benefit more regarding health care. The third model is the national health insurance which demands that citizens should contribute to their health management minimally per month or per year then receive care as per agreement of packages. Studies however show that combining these models have a positive impact and are more cost effective on a country than singling out on one model. Most of the literature supports that even most African countries are agreeing to the fact that health is expensive and so to be cost effective and deliver quality care, demands an understanding of the setup, work on supply chain and incorporate all the three models without compromising on quality health care delivery and coverage.**

Keywords: **Cost effectiveness, Value based health care, Health insurance and coverage.**

1. INTRODUCTION

Health economics is the aspect of public health that deals with the systematic review and management of health problems by applying economic theories. (Mills, 2021) This involves how well we attend to aspects of consumers, productions, social choices of individuals, behaviors both in private and public organizations. This essay seeks to address the implementation of free health services, the existence of health insurances and how they affect the quality of health care among populations.

Worldwide, the issues of economics have a bearing on quality of life and management of medical resources. Public health has an interest in ensuring that benchmarks in cost effectiveness are well looked after for the benefit of prioritizing the building blocks for health care. Important aspects of equitable action in ensuring quality care, economical evaluation of new technology, prioritizing prices and optimal private investments are some of the aspects that come with this vital subject.

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ABOLISHMENT OF USER FEES FOR RURAL HEALTH FACILITIES OF ZAMBIA

The aspect of user fees has been practiced in Zambia for many years. Depending on political preferences, sometimes it was emphasized and sometimes not. Removal of user fees may either be on all health services or in part, to the primary care level, to selected population groups, to selected services for everyone, or to selected services for specific population groups characterized by medical or economic vulnerability. The particular services are usually picked to provide safety to population groups that are considered to be most vulnerable, particularly low-income groups.

The health financing, user fees were abolished in rural areas in April 2006, peri-urban areas in mid-2007 and the entire Primary healthcare level in January 2012. (WHO,2019).

Primary Health Care Zambia includes health posts, health centers, and district hospitals. All services provided under these facilities are provided free of charge. Further, patients referred from the primary health care (PHC) facilities to secondary and tertiary level hospitals are supposed to be treated free of charge in line with the user fees removal guidelines (Ministry of Health, 2007). A bypass fee is defined as a fee that puts on a client that comes from the lower level facility to a higher one without any form of referral unless that person was for an emergency case. (Miyanda,2009) As an exception, secondary- and tertiary-level hospitals (and some district hospitals in a few districts) are allowed to generate revenue from patients who want express services or better outpatient or in-patient services are granted for free at all (low-cost) sections of the hospital.

Additionally, according to Byford et al (2016) some hospitals operate on schemes which allow employers or companies, households, and individuals to make contributions in order to have a predefined package of health services. However, there are no guidelines on how much should be charged to patients across the board.

Further, Raftery (2021) argues that although revenues are deemed, there seems to be no legislature in support of this practice. The way forward hinges more on. “Cost-effectiveness analysis”

Researchers continue to investigate the cost-effectiveness of various healthcare interventions, treatments, and policies. The study also explores some principles surrounding cost effectiveness to help decision-makers allocate limited healthcare resources efficiently. (Ministry of Health 2007)

2. COST-EFFECTIVE ANALYSIS

According to Dookeran et al (2020) post-effective analysis is a method used to evaluate the costs and benefits of different interventions or strategies. It helps in determining which option provides the most value for the resources invested. Here are the key steps involved in conducting a cost-effective analysis:

Measure Costs: Identify and measure all relevant costs associated with each alternative. These costs may include direct costs (such as equipment, labor, and supplies), indirect costs (such as overheads), and any other relevant costs (such as training or implementation costs).

. Measure Outcomes: Identify and measure the outcomes associated with each alternative. These outcomes should capture the benefits or changes resulting from the interventions. They can be expressed in physical units (e.g., number of lives saved) or monetary units (e.g., cost savings). Calculate the Cost-Effectiveness Ratio: Calculate the cost-effectiveness ratio for each alternative by dividing the total costs by the total outcomes. This provides a measure of how much it costs to achieve a particular outcome with each alternative. (Bodrogi,2010)

Compare Alternatives: Compare the cost-effectiveness ratios of the different alternatives. Identify the alternative(s) that provide the most favorable. Cost-effectiveness ratio. These alternatives are considered more cost-effective than others.

Sensitivity Analysis: Perform sensitivity analysis to assess the robustness of the results. Vary key inputs and assumptions to see how they impact the cost-effectiveness results. This helps to identify the factors that have the most significant influence on the findings.

It's important to note that cost-effective analysis is just one tool for decision-making, and other factors should be considered alongside cost-effectiveness, such as clinical effectiveness, patient preferences, and ethical considerations. (Bodrogi,2010)

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VALUE-BASED HEALTHCARE

According to Brown et al (2010) Value-based healthcare (VBHC) is a healthcare delivery model that focuses on optimizing the value of healthcare services provided to patients. It emphasizes achieving the best possible health outcomes for patients relative to the costs incurred. However, there are other aspects of the health sector that have not received equal attention, not least is the inequitable distribution of health services among different geographical and socio-economic groups. There is still a big margin disparity in the health services available for people living rural and those living urban areas, for people from privileged families, and those from marginalized ones, and for people from various age and gender associations. (Byford and Raftery,2020).

According to Barber et al (2020) In traditional healthcare models, the volume of services provided often takes precedence over the actual outcomes achieved. It shifts the focus to patient outcomes and the overall value delivered. It seeks to improve patient outcomes while controlling costs by aligning incentives, promoting quality, efficiency, and enhancing patient-centered care.

In another study by Boom G. and Standing H. entitled 'Pluralism and marketization in health sector 'elaborated some of the key principles of value-based healthcare include: It was reported in this study that more than 60 % of developing countries still put a cost or expenses on the client receiving the treatment either indirectly or directly. In their laid down principles, they upheld human rights, quality health care effectiveness in outcomes of patients and collaboration. This concept exposes a patient to a lot of options in treatment than just giving what is available. (Danzel, 2012)

HEALTH INSURANCE PROCESSES

According to Mills (2021**)** health insurance is a contract between an individual or a group and an insurance company, where the insurer agrees to provide financial coverage for medical expenses in exchange for regular premium payments. It is designed to protect individuals and families from the high costs of healthcare services.

Health insurance plans come in different types, such as employer-sponsored plans, individual plans, government programs like Medicare and Medicaid, and group plans through organizations or associations. Each plan has its own set of benefits, coverage limitations, and costs. Premiums: Health insurance requires individuals to pay regular premiums, which are typically monthly payments. The premium amount varies based on factors like the type of plan, coverage level, age, location, and the number of people covered.

Deductibles: A deductible is the amount that individuals must pay out of pocket for covered medical expenses before the insurance coverage begins. For example, if the deductible is $1,000, the insured individual is responsible for paying the first $1,000 of their medical expenses, and then the insurance coverage kicks in.Copayments and Coinsurance: Copayments (or copays) and coinsurance are the portions of the medical costs that individuals are responsible for paying even after meeting the deductible.(Mills, 2021)

Copayments are fixed amounts (e.g., $20 for a doctor's visit), while coinsurance is a percentage of the cost (e.g., 20% of the total bill).

Peterson et al (2016) highlighted some African countries which were analyzed in a study entitled "the future of universal health coverage in Africa ``Uje Okeke at el in 2017, reported that Rwanda had health insurance (HI) coverage of approximately 87%, spent 2.26% of GDP on health compared to Nigeria whose HI coverage was only 3% and its health expenditure 0.53%. South Africa, Kenya, and Tanzania in 2017 had an HI coverage rate of 17%, 10%, 3% respectively while their health expenditure was 4.35%, 2.05%, and 1.58% respectively.

COUNTRY	HEALTH INSURANCE PERCENTAGE COVERAGE
Rwanda	87%
South Africa	17%
Kenya	10%
Nigeria	3%
Tanzania	3%

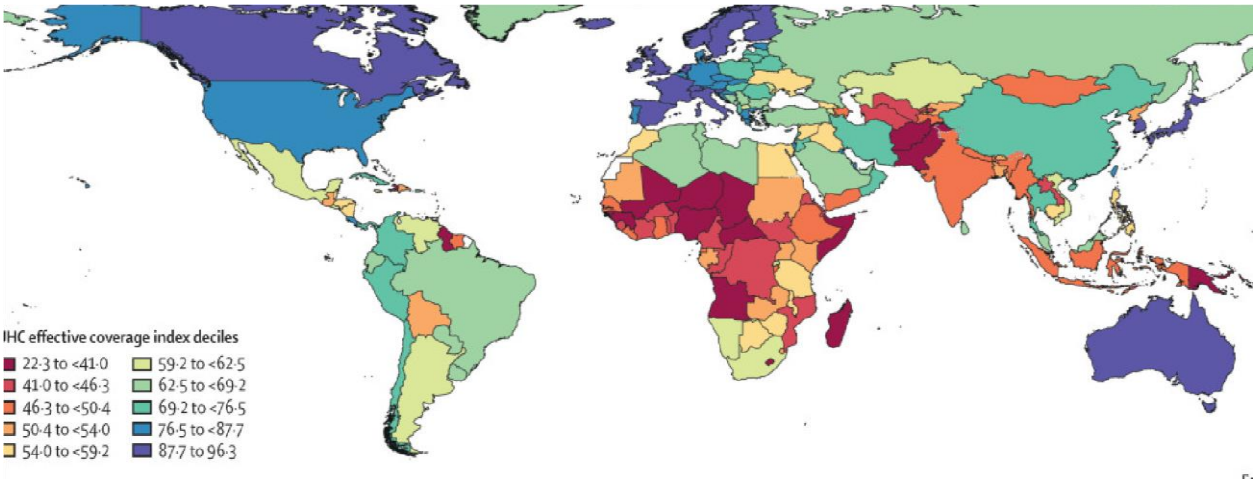
The table shows how countries like Rwanda have managed to implement the policy of universal coverage. Utibe et al (2021) stated that Rwanda uses Community based health insurance (CBI) to get to where they are today. In the same study on the other hand, South Africa was reported to have the largest private insurances and medical schemes. (Fejiro,2021) The studies show that South Africa has utilized private insurance to improve the low cost or services for poor people and refugees or foreigners in transit.

Peterson et al (2016) highlighted that in most African countries, plans often have a network of healthcare providers with whom they have negotiated discounted rates. When individuals receive care from in-network providers, the insurance company covers a higher portion of the costs. Out-of-network providers may result in higher out-of-pocket costs or may not be covered at all, depending on the plan. (Marck,2009)

Covered Services: Health insurance plans typically cover a range of services, including preventive care, doctor visits, hospital stays, emergency care, prescription drugs, and sometimes dental and vision care. However, the specific coverage and limitations vary by plan, and some services may require preauthorization or meet certain criteria for coverage. (Harmar, 2010) Exclusions and Limitations: Health insurance plans may have certain services or conditions that are not covered, known as exclusions. Additionally, they may have limitations on the number of visits, treatment duration, or coverage for certain procedures or treatments.

In another study conducted in 2019 by the World Health Organization entitled “Effective Coverage performance reported that Sub Saharan Africa had the widest of the universal coverage in 2019 as shown by the map below. (Mcpack and Bennett, 2019)

Insurance health coverage index : (Bennett S. and Mcpack B.2019)



Health insurance typically has designated open enrollment periods during which individuals can enroll, renew, or make changes to their coverage. Special enrollment periods may be available outside of the open enrollment period for qualifying life events like job loss, marriage, birth, or adoption.

Berker et al (2022) Health Insurance Marketplace: In some countries, there are online health insurance marketplaces where individuals can compare and purchase health insurance plans. These marketplaces often provide subsidies or tax credits to help make insurance more affordable for eligible individuals.

Insurance Benefits and Explanation of Benefits (EOB): Insurance benefits outline what is covered, the cost-sharing amounts, and any limitations. An Explanation of Benefits (EOB) is a statement sent by the insurance company after a medical service, detailing the billed charges, the portion covered by insurance, and the patient's responsibility.

Berker et al (2022) states that many people today are lured into insurance without a deeper understanding of the outcomes especially in African countries. Many loose money for lack of comprehensive information on what insurance coverage is. Berker highlights that understanding the specifics of health insurance coverage is crucial for individuals to make informed decisions about their healthcare and manage their out-of-pocket expenses. Studies say that It is important to review plan details, network providers, coverage limitations, and costs before selecting a health insurance plan.

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SOME POTENTIAL IMPACTS OF REMOVAL OF USER FEES IN HEALTHCARE

Bareford et al (2020) stated that removing user fees can make healthcare more affordable and accessible to a larger portion of the population with improved access: This can lead to increased utilization of healthcare services and early detection of illnesses, resulting in better health outcomes and preventive care: Without user fees, people may be more likely to seek preventive care and regular check-ups, leading to the early detection and management of diseases. This can reduce the burden of advanced and costly treatments and improve overall health. User fees can act as a barrier, particularly for low-income individuals or those without insurance. Removing user fees can promote equity in access to healthcare by ensuring that everyone, regardless of their financial status, can receive necessary medical care. Negative effects.

However, Jiang (2015) argued that removing user fees may result in a surge in demand for healthcare services, potentially overwhelming healthcare providers and leading to longer wait times for treatment. This can negatively impact the quality of care; as healthcare professionals may have limited medical resources to spend on each patient.

According to Howe and Camargo (2014) If user fees were a significant source of revenue for healthcare facilities, their removal could create financial challenges. The loss of revenue might limit the availability of resources, equipment, and medical supplies necessary for providing high-quality care. Without user fees, alternative funding sources must be identified to sustain healthcare systems. If adequate financial resources are not available, it could lead to underfunding and strained healthcare systems, which can ultimately affect the quality of care provided. Therefore, the researchers concluded that it was important to consider alternative financing mechanisms and ensure that healthcare systems receive adequate funding to maintain and improve the quality of care while removing user fees.

3. FINDINGS

The objectives of a health insurance company should be to cushion people's burden of spending so much money when a health crisis strikes. Berker et al (2022) stated that many people today are lured into insurance without a deeper understanding of the outcomes especially in African countries. Many loose money for lack of comprehensive information on what insurance coverage is. Berker(2021) highlights that understanding the specifics of health insurance coverage is crucial for individuals to make informed decisions about their healthcare and manage their out-of-pocket expenses. It is therefore important to review plan details, network providers, coverage limitations, and costs before selecting a health insurance plan.

Danzel et al (2012) said that the vital part is to ensure that patients are protected in developing countries as still some health departments put a cost or expenses on the citizens receiving the treatment either indirectly or directly. In their laid down principles, they upheld human rights, quality health care effectiveness in outcomes of patients and collaboration. This concept exposes a patient to a lot of options in treatment than just giving what is available.

Mcpack and Bennett (2019) reported that there is still a big margin disparity in the health services available for people living rural and those living urban areas, for people from privileged families, and those from marginalized ones, and for people from various age and gender associations. (Byford and Raftery,2020).

Literature findings indicate that worldwide, the issues of economics have a bearing on quality of life and management of medical resources. Important aspects of equitable action in ensuring quality care, economical evaluation of new technology no longer matter in some countries.

On the other hand, studies have shown that removing user fees can promote equity in access to healthcare by ensuring that everyone, regardless of their financial status, can receive necessary medical care.

However, Jiang (2015) advised governments to be quotious as removal of user fees may result in a surge in demand for healthcare services, potentially overwhelming healthcare providers and leading to longer wait times for treatment. Studies have shown that doing away with user fees has a potential to negatively impact the quality of care, as healthcare professionals may have limited resources to spend on each patient.

According to Howe and Camargo (2014) User fees are a significant source of revenue for healthcare facilities, their removal could create financial challenges. The loss of revenue might limit the availability of resources, equipment, and medical supplies necessary for providing high-quality care.

Mills et al (2020) stated that there is a growing emphasis on value-based healthcare, which focuses on improving patient outcomes while considering the costs of care. Researchers are exploring ways to measure and enhance value in healthcare delivery.

Robertson (2020) emphasized that it is vital for health departments to Promote collaboration among healthcare providers, organizations, and stakeholders to deliver coordinated and integrated care. This involves breaking down silos, improving care transitions, and fostering care continuity across different settings.

4. CONCLUSION

Governments can establish robust regulatory frameworks and oversight mechanisms to monitor the operations of private health insurance companies. This includes setting clear guidelines for insurance practices, ensuring transparency in pricing and coverage, and enforcing compliance with regulations. Governments should not relent to invest in and strengthen public healthcare systems to provide high-quality services to citizens.

Issues of education and transparency are crucial, governments have a mandate to promote health literacy among citizens by providing information about health insurance options, coverage terms, and consumer rights. Transparent communication and public awareness campaigns can empower individuals to make informed decisions and protect themselves from exploitation.

By focusing on value, healthcare systems can strive for better outcomes, reduced costs, and improved patient experiences. Governments protect the public on health price control, quality pharmaceuticals, bring in control in insurance and health coverage, and finally they should not completely remove user fees if they have no sustainable plans for quality health care.

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