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ILLNESS TO WELLNESS: A COMPARATIVE STUDY ON INSURANCE SCHEME APPROACHES IN SAUDI ARABIA AND SUDAN

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ABSTRACT

Purpose: Private health insurance is growing in Sudan. The National Health Insurance Fund (NHIF) announced the'Road map to Universal Coverage' goal in 2015, inferring political direction to increase the insured population. This paper aims to compare the different roles played by private insurance in chronic diseases care between Sudan and Saudi Arabia (SA).

Design/Approach: A descriptive comparative study of:

1. Observations and process analysis of models used in SA private insurance; 'Wellness Model' and 'Extended Care Model'.

In-depth interviews and desk reviews exploring Sudanese private insurance approaches.

Findings: Primary results shows high focus from Sudanese schemes on illness management, compared to 'healthcare partner' vision in SA.

Originality: The paper illustrates gaps in the Sudanese vision regarding insurance roles, namely considering (Healthcare Partner) approach instead of (Health Services Buyer) approach. This is potentially important for increasing health coverage and insurance effectiveness.

Keywords: health insurance; healthcare; public health; chronic disease; health innovation; mobile health (mHealth).

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INTRODUCTION

Financing health services and the cost of chronic/non-communicable disease is troublesome in Sudan, like most of the countries in the area. According to World Health Organization (WHO) Surveillance Strategy report, the increase in NDC in 2020 is estimated to pass 60% in developing and newly industrialised countries as reported by Mufunda et al. (2006). It is believed that urbanisation and increased life expectancy can partially explain the increasing prevalence of non-communicable disease, An example would be the warning of the 'diabetes epidemic' that has been raised, with an estimation of 366 millions to suffer from Diabetes mellitus (DM) worldwide by the year 2030 (Wild et al., 2000).

Similarly, researches raised many warnings regarding DM in Sudan. It has been linked it to increased urbanisation and a sedentary lifestyle, along with dietary habits and social beliefs about obesity. However, only a few multidisciplinary DM public-care centres are available in Khartoum, the Capital: (Ahmad and Ahmed, 2001) reported only two such centres. The main cause of diabetes-related morbidity and mortality is Diabetic Ketoacidosis. This occurs mainly due to a lack of compliance and failure to recognise important symptoms. Furthermore, the high cost and lack of facilities and a multidisciplinary approach are also among the main issues reported (Ahmad and Ahmed, 2001). The high cost will have a far worse effect in low socioeconomic settings, where health awareness is less rooted. Balla et al. (2013) estimated the prevalence of DM in rural areas by 11.2%, and described the level of knowledge and awareness as 'low'. This will have a great impact on the development of those communities, where physical strength is vital for an individual's income and for the economy in general.

As a result of this burden, increasing access to health services, especially to this under developed communities, became crucial, and health insurance has an important role to play here. A secondary analysis of the Sudan Health Utilization and Expenditure Household Survey, 2009 named health insurance as one way to increase access to the services (SHUEHS 2009) (Baloul and Dahlui, 2014a,b) In fact, today's policy directions in Sudan is for universal health insurance coverage by year 2020, as announced by the director of National Health Insurance Fund (NHIF). However, from the inception of the NHIF up till today, it has only managed to cover 35% of the total population (Alintibaha Journal interview, 2015/2/3). Most of the insured are formal sector employees. This emphasises the disparities in healthcare services utilisation for chronic disease between different socioeconomic and demographic groups, as was reported after the secondary analysis of SHUEHS 2009 (Baloul and Dahlui, 2014a,b).

Thus, another supporting arm became a necessity in Sudan if insurance coverage was to reach its targets. Private insurance became the possible partner to achieve this goal. This study is an attempt to compare the private insurance approaches used in Sudan and Saudi Arabia (SA).

METHODOLOGY

This is a descriptive and comparative study, that aims to compare the approaches followed in private insurance companies in Sudan and SA, targeting insurance members suffering from chronic diseases (e.g. Diabetes mellitus, Hypertension, Dyslipidemia, etc.). Two models of private insurance were examined during April 2015. The example taken from SA was Bupa Arabia; owning the largest health insurance market share in year 2014 (36%, while the next two competitors achieved 25% and 18%, respectively) as stated in the Saudi Stock Exchange (Tadawul) (2nd issue of Bupa world, Bupa Arabia, winter 2015). Bupa focuses on health insurance (i.e. no other forms of insurance is provided through Bupa Arabia); this made it the best candidate for this study. Bupa had recently adopted the 'healthcare partner' approach in accordance with the company vision of 'healthier, happier and longer lives'. Observations and disk review of some of the relevant documents of the 'healthcare partner' approach was conducted in the first half of April 2015.

On the other hand,semi-structured interviews were conducted either on-phone or face-to-face – with medical personnel (i.e. doctors), who are currently working or used to work until recently,in the one of Sudan's private medical insurance

institutions (either directly or as a Third Party Administrator (TPA)) in four private insurance firms (Islamic Insurance, Blue Nile, Middle East Insurance and United Insurance). Due to the lack of data about the size and market share of private insurance firms in Sudan, we aimed for this purposive sampling to enhance the scope of this study. Moreover, thought these four selected companies are considered to be some of the biggest companies in Sudan,none of them provided solely medical insurance; all four were providing health services as part of wider package of comprehensive insurance plans, either directly or through a TPA.

As the governmental regulatory role was very apparent in the SA example, inspecting the government perspective in Sudan was vital in order to provide a holistic picture in the comparative study. Hence, another interview was conducted with the former director of the NHIF to evaluate the combined role of Private-Public health insurance in achieving the universal coverage goal, and other forms of coordination regarding chronic disease management.

Also, desk reviews of NHIF law (2001), newspaper interviews and the NIHF official website and Facebook page were done.

All qualitative data obtained from interviews was recorded and reported in written form, then cross-checked for analysis. After obtaining data from the desk review, the data was combined and analysed using qualitative thematic analysis.

This study faced many limitations: shortage of researchers, a tight schedule and scarcity of online data and relevant literature (especially on Sudan), which limited the review done in this study and highlighted the need for more research in Sudan focusing on this issue.

Themes covered in the interview were: general overview, type of services provided, population and governmental interaction and relations with healthcare service providers.

RESULTS AND DISCUSSION

General picture and coverage

All local private Health Insurance providers in Sudan were found to deliver health services consistently as part of larger insurance packages (i.e. none of them provided only health insurance). In fact, health insurance had been perceived as a necessary loss in order to attract clients to purchase the insurance policy, according to one of the interviewees.

However, there are TPAs who provide health insurance; this is akin to an outsourcing deal made by the insurance company to the TPA to run their medical business operations such as claims, providers issues approvals, etc.

According to one of the interviewees, private insurance covers only about 200,000 members, hence the private insurance sector's influence on the universal coverage plan 'is marginal'.

Type of services provided

Chronic disease management in the SA example has many features that developed over time, but the main features detected were as follow:

1. medical and nutrition consultation hotline
2. maternity follow up
3. medications refill services
4. home-based lab investigation
5. result interpretation service
6. health blog (in progress)
7. outbound checkup calls
8. automatic drug interaction and overdose alerts
9. outbound checkup calls
10. automatic drug interaction and overdose alerts
11. 'Most trusted doctor' recommendation
12. mental health and stress assessments (Firm-based)
13. smoking cessation efforts (planned campaigns)
14. public lectures and
15. inpatient service reviews.

In Sudan, some companies have introduced the medication refill as a way to facilitate obtaining monthly medication for their members (which will also cut some costs for both the company and the member), but no other activities in the healthcare partner role were reported. Some private insurance companies tried unsuccessfully to increase their members' access to services by buying services from NHIF health centres. On the hand, private health insurance provides access to quality services that is hard to find in public hospitals.

Population and governmental interaction

In SA, the Council of Cooperative Health Insurance (CCHI) is the overseeing and governing body of all health insurance companies. It is responsible for the following – among other tasks:

- Determining the specification of insurance policies; where it sets the basic level of services (what should be covered for each policy). However, each company can widen the spectrum of its services according to the premium and size of the insured group.
- Accrediting the health insurance companies.
- Accrediting the service providers that offer health services for the insured population.

Another interesting observation is that within the Saudi system, the issuing of residency permits (Iqama) for non-citizens of SA is not done unless the appliers have presented proof of medical insurance, (private insurance is sought in most of the cases). On the other hand Saudi citizens working in private and semi-private firms are also covered by their companies' polices. This is particularly significant as most of working force in Saudi are foreigners and a very small proportion have the right to be treated in the public hospitals for free.

According to 2001 NHIF Act; all firms in Sudan were obliged to enroll their employees in the NHIF. Yet some entities were granted exemption from the obligation to cover their employee through the national insurance as they were providing healthcare to their employee through other forms of funding (i.e. having their own care provider, private insurance, etc.). Some companies, and even governmental entities, utilise private insurance services to avail better services 'that could fulfill their employees needs'.

When it comes to interaction with governmental bodies, little,if any, coordination was reported from the employers of private insurance companies. Although some private entities had trials to buy services from the NHIF, they were not successful.

Guidelines and relations with healthcare services providers

Companies in both countries faced challenges in applying the guidelines they proposed for their members' care. Saudi Arabia has the upper hand (in some sense) as all procedures that exceeds the preauthorised limit (i.e. the monetary limit assigned to each class in the policy accordingly) needs authorisation from the company. Hence, if the procedure is not compliant with guidelines (mainly American) it will not be approved (e.g. if no significant symptoms are reported or gold standard investigations were not used). In Saudi Arabia, however, as all service providers have to use the International Statistical Classification of Diseases and Related Health Problems (ICD), 10th Revision – Australian Modification (AM), Australian Refined, Diagnosis-related Group (ICD10 AM/AR – DRG), the same code is used in the ministry of health hospitals. This makes it easier to establish national registries and other prevalence studies. Both sides have no recorded role in developing evidence of healthcare or health impact measurement.

On the other hand, TPAs in Sudan were mainly following up with hospitals on the approvals and claims, but no other forms of interaction with care givers were reported.

CONCLUSION AND RECOMMENDATION

Health Insurance practices in Sudan are focused greatly health services buyers, although in a few of the examples used, some features of Disease Management Programs were identified. However, no strategic orientation towards a clear health partner role (versus services provider role) was reported. As stated earlier, the health insurance market is still growing – both social and for-profit, and firms should be able to adopt policies that are both evidence-based and context-friendly to reach the wider coverage targeted, (vertically and horizontally).

The Wellness Model, Healthcare partner and Disease Management Programs are some of the many examples of policy approaches actively practiced in other parts of the world. However, the high cost of healthcare services demands a more innovative integration between public and private insurance to complement each other. Although private insurance is profit-oriented, where demand and competition urge it to satisfy its customers, we can still enhance the quality and cost-effectiveness of healthcare delivery and avail the adoption of advanced techniques, even if on a smaller scale.

Private insurance is tightly linked to the local market with all its ups and downs. However, on very primitive notion, as private and public health services were rendered to foreigners travelling to Sudan for treatment purposes on individual bases, it should be also feasible to sell such services via insurance or other business forms outside of Sudan. Widening coverage for Social Insurance could be achieved theoretically in collaboration with NHIF.

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BIOGRAPHICAL NOTES

Abdelrahman Khalifa is a registrar of Community Medicine and Healthcare Operation Manager in Bupa Arabia-Saudi Arabia, he worked for the Public Health Institute – Sudan for four years as Monitoring and Evaluation Coordinator, during his undergraduate years he was passionate about community service and he established an NGO (Takaful-IUA). This passion continued after graduation in many other initiatives including Nafeer initiative during 2013 Khartoum floods, such experiences made him interested in Healthcare innovation to develop practical solution for the Sudanese context.