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The moral hazards of mandatory private health insurance in Arabian Gulf countries

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About the author

The author of this paper has 33 years' experience across all forms of insurance, including health insurance, in many countries. His last 10 years have been specifically focused on health system financing in developing countries in the Middle East and Africa. The author's work has included working for a "Big 4" advisory firm, a GCC government and providing *pro bono* advice to other regulators in the Middle East and Africa. He has also provided advisory and consulting services in health system financing and regulation to clients of global consulting companies.

Why this paper?

The reason for this paper comes from the author's observations of how mandatory private health insurance in some Arabian Gulf countries has provided access to healthcare to many who previously lacked such access but with adverse effects including:

- Many insurance companies losing money on their health insurance portfolios
- Over-utilisation by insured members
- Alleged abuse by physicians and healthcare providers
- A lack of incentives for insurers to invest in preventive initiatives
- Dubious or unsubstantiated claims rejections and delayed claims payments

Limitations on scope

This paper focuses primarily on the health insurance market of the United Arab Emirates (UAE), the most competitive market of the countries that form the Arabian Gulf Cooperation Council (GCC). It also focuses only on the moral hazards that accompany mandatory private health insurance, yet many of the issues can be found to varying degrees in other GCC countries that operate systems of mandatory private health insurance.

Context

This paper should be read against the economic and political background that exists in several GCC countries. This includes hereditary rule largely by single families although on occasions we do see some form of elected bodies with limited powers. Families, not just the ruling families, also play a large part in the corporate world, often owning conglomerates covering many sectors. Sometimes, those in positions of political and economic authority also have interests in the commercial world.

All views expressed and statements made in this paper (unless otherwise specifically referenced) are those of its author.

Why have some GCC countries adopted mandatory private health insurance?

Demographics

Even before its founding in 1971 with the union of seven emirates under a federal institution, the UAE has attracted foreign workers. After the union the rate of growth increased significantly in some emirates, particularly Dubai and Sharjah. Whilst many came primarily for work, some were driven by conflicts or “unfriendly” regimes in their home countries causing them to seek a more stable and secure environment. Indeed, this continues even today with an example being the hundreds of thousands who arrived from Russia after the extension of conscription for the war in Ukraine.

Whatever the reason, better economic prospects or stability and security, foreigners came to the extent that it is estimated that the foreign population (known as “residents”) accounts for around 88% of the entire UAE population. The nationalities are diverse with more than 130 countries represented. Of the total population the biggest representations are Indians (38%), Pakistanis (17%), Filipinos (7%) and Egyptians (4%)[1]. Other Arabs, Bangladeshis, Nepalis, Iranians, Africans and western Europeans make up around 23%.

Personal taxation

An attraction of the UAE has always been its perception as a “no tax” environment. Whilst this perception is not strictly true, nevertheless, the prospect of earning a salary with no income tax or other personal taxes to pay was very attractive. In early years, and still somewhat true today, wages were also higher than what could be found in home countries as demand for labour and expertise was high in order to fuel growth.

The reality is that there are “taxes” such as

- Value Added Tax (currently 5%)
- Municipality tax such as on restaurant and other services
- Road tolls
- Knowledge fees (added to certain government transactions)
- Housing fees (5% of annual rent in Dubai)

Whilst in the early days, workers arrived with the intention to stay perhaps just 2 or 3 years, accumulate savings from their tax-free wages and then return home, this trend changed as residents began to stay much longer. (The author himself has been a resident for 18 years and has many acquaintances with similar lengths of stay). As will be seen later, this has an impact on health system financing in the UAE.

Corporate taxation

Until recently, there was no corporation tax in the UAE. This is gradually changing with taxation now being levied on companies with profits above a certain size. It is clear that this will be extended in terms of scope and reach, not least to move towards the OECD Global Minimum Corporate Tax Rate of 15% agreed in 2021 by 136 countries (including all GCC countries).

The effect on health system financing

The combination of limited personal taxation, no corporate tax and a high foreign population meant that there was a huge number of people and companies not contributing to government coffers to allow them to finance government provided healthcare facilities to everyone.

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[1] United Arab Emirates Population Statistics 2024: Global Media Insight

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Initially, a resident could arrive at a government hospital, receive treatment and possibly not be asked to pay. But as the numbers of residents rose, this was clearly unsustainable for government. The solution was to be found in mandatory private health insurance funded by employers.

The rationale for health insurance to be paid by insurers was quite simple: they were paying no corporation tax yet were employing huge numbers of foreign workers (who often came with family members) who might require healthcare which the government felt was not its responsibility to finance in the absence of any contribution by employers.

Thus the concept of mandatory private health insurance paid for by employers of foreign residents was born. Its phased introduction began in the emirate of Abu Dhabi from 2006 and in Dubai from 2013. From 2025, a national scheme for the other 5 emirates is set to be introduced.

Regarding other GCC countries, Saudi Arabia began implementation of its scheme for residents and nationals working in the private sector in 2006. Meanwhile, Qatar made a number of attempts but currently does not have a scheme in place. Bahrain began discussing the options in 2005 but has yet to have a private health insurance scheme in place. Oman is in the long process of implementation and Kuwait does not yet have a scheme in place.

What has been the approach in scheme design?

A two-tier system

Both the Abu Dhabi and Dubai schemes feature a two-tier system. Under this system, workers earning low salaries (known as Lower Salary Band workers in Dubai) were to be provided with a level of minimum benefits (essential benefits plans). However, these benefits were indeed low with an aggregate annual maximum coverage limit in Abu Dhabi of 250,000 Dirhams (AED) and in Dubai of 150,000 AED (equivalent to 68,000 USD and 41,000 USD respectively). Pharmacy benefit minimum limits were 3,000 AED in Abu Dhabi and 1,500 AED in Dubai (816 USD and 408 USD respectively).

For all workers, employers could provide benefits up to whatever limits they wished based upon what was available from the private health insurance market but obviously at increased costs. In all cases, the plans must cover the specified “essential benefits”. Most plans for lower salary workers cover only the minimum benefits.

What was the thinking behind this approach?

A zero corporate tax environment was a strong attraction for foreign companies and governments did not want to see employer funded private health insurance as a tax on employment. Consequently, the cost of the insured benefits had to be set at a reasonable rate for those employing large numbers of lower salary band workers.

On the other hand, many employees of multinational corporations had expectations of healthcare benefits that mirrored the benefits available in their home country. Hence the establishment and availability of the so-called “enhanced” plans.

The moral hazards of employer funded private health insurance

No incentive for responsible utilisation

The law prohibits employers from asking employees to fund their health insurance plans (although employees can pay for family members to join who are otherwise not eligible if the employer provides such an option). In such a situation, the employee has no incentive to keep utilisation at a low level.

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There are options to counter this, for example the requirement for co-payments (employees pay a fixed percentage of the overall service costs) and deductibles, a fixed payment towards a service rendered.

The effects of little or no employee contribution at point of service

The clearest effect is that insured members can seek treatment as often as they like and at whichever facility they choose. Often, they will choose the most expensive facility available to them based on the network of providers accessible under their specific plan.

A second effect is that if an insured member is not happy with the advice or service provided at one facility, they can simply seek another opinion at another facility (known as "doctor shopping").

A third effect is that, in the absence of any significant co-payment, the insured member will generally not challenge the tests, treatments and prescriptions recommended by a physician which they might otherwise question if they were paying from their own pocket.

The effects of no scheme member contribution

Employers are not allowed to ask employees to make a contribution to their health insurance plan (other than for optional benefits or adding non-eligible family members). This has the same effects as listed above when it comes to utilisation patterns.

However, there is another effect in that employees have no incentive to take steps to improve their lifestyle behaviour such as more exercise, healthier diets, reduced alcohol consumption or smoking cessation.

The moral hazards of direct access to specialists and consultants

The lack of a "gatekeeper" approach

The extremely competitive environment for health insurance in the UAE (almost 50 companies offering health insurance for a population of around 10 million) means that insurers will often try to outcompete not just on price but service access.

Some have tried to market plans that require a visit to a family physician first, to then possibly referred to a specialist. However, employers and employees were not keen on this restriction and simply sought cover from insurers who did not make this a requirement. Having said that, there is evidence that some employers are insisting on a gatekeeper approach to contain premium costs.

There is no strictly enforced requirement for insured members to seek advice from a family physician (general practitioner) before seeking advice from a specialist. Given that there is little to no cost for the insured member, understandably they tend towards booking consultations with specialists who charge more than a family physician.

The effects of direct access

Clearly, one effect is that the ability to consult directly with a specialist leads to higher consultation fees to be paid for by the insurer.

A consultation with a family physician may identify a simple cause of symptoms with an equally simple and inexpensive remedy. Not having a gatekeeper system in place exposes the insured member to a specialist who not only charges more for a consultation but is often incentivized to order several expensive tests without following accepted clinical guidelines. This is a contested point with many specialists saying that they would not do this and always follow clinical guidelines, ordering whatever tests are necessary and waiting for the results to determine if further tests are required.

A third effect of not having a gatekeeper system is the danger that unnecessary tests are recommended which may be harmful to some patients, multiple x-rays being one example.

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A fourth effect is that individuals may simply seek advice from an inappropriate specialist based upon their personal assessment of the cause of their symptoms. This can result in unnecessary costs.

A summary of the regulatory regime in the UAE

A system with multiple regulators

As a federation of 7 emirates, the UAE has regulators at both federal level and at emirate level. Essentially, emirates must follow federal regulatory authorities. However, where there are no federal level regulations on a particular matter, emirates can develop their own regulations.

The area of health insurance is also complicated further by the fact that health insurance is a financial services product which are generally regulated by a financial regulator such as a Central Bank or an authority appointed by a Central Bank or government to regulate financial services. However, health system financing (of which private health insurance is one financing tool) is also of concern to healthcare regulators. These may be at the federal level such as the Ministry of Health and Prevention (MOHAP) or at the emirate level such as Department of Health Abu Dhabi (DOH), Dubai Health Insurance Corporation (a part of Dubai Health Authority (DHA)) or Sharjah Health Authority (other emirates do not have their own health authorities).

All of the above has resulted in a complex regulatory environment. In the absence of federally mandated private health insurance, DOH and DHA developed their own laws to introduce it. However, at the same time, insurance companies were subject to regulation by the Federal Insurance Authority. (The latter was subsumed in 2022 into the Central Bank of the UAE (CBUAE)).

Sharjah (despite having a health authority) and the other emirates will be following a MOHAP initiated federal private health insurance system from January 2025.

Prudential vs market conduct regulation

Many countries operate the regulation of their financial services under what is known as a “two peaks” model. One example is the United Kingdom where the Prudential Regulation Authority (PRA) manages the financial stability and activities of banks and insurance companies while the Financial Conduct Authority (FCA) manages the way that banks and insurance companies conduct themselves, particularly in relation to customers and policyholders.

How does the “twin peaks” model apply in UAE?

The answer to this question is that it does not in relation to private health insurance in particular. The CBUAE provides prudential regulation over insurance companies including monitoring solvency, licensing entities and influencing premiums for motor insurance but it does not regulate the level of health insurance premiums. CBUAE also has a light touch in terms of market conduct regulation for banks but virtually no impact on market conduct of insurance companies when it comes to health insurance.

For health insurance, DOH and DHIC have no involvement in prudential regulation of insurers who offer private health insurance. However, they both have a heavy influence on market conduct including defining minimum benefits to be offered, consumer complaints handling procedures, licensing health insurers, third party administrators and brokers to operate within their own emirates, setting premiums for essential benefits plans, mandating the use of centralised electronic claims systems, specifying time frames for claims settlements, the use of international coding systems such as ICD and others.

Consequences of the regulatory environment in UAE

The complex nature of regulation of health insurance in UAE as described above is that market participants and employers need to account for different rules in different emirates.

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Another consequence is that the system provides no control over private health insurance premium levels (other than the Abu Dhabi Basic Plan and the Dubai Essential Benefits Plan for lower salary band workers).

The moral hazards created by a complex yet incomplete regulatory system

Lack of premium regulation and its consequences

Apart from as mentioned previously, there is no control in the UAE over the level of health insurance premiums or the way they are calculated. In a highly competitive environment, this means that insurance companies can price to win business at technically loss-making levels. This is evidenced by the fact that all but possibly 5 of the 28 locally listed insurers lose money on their health insurance business.

Consequences for healthcare providers

In the face of a loss-making line of business, insurers can either subsidise these losses by making profits on other business lines or seek to reduce claims costs. This results in many healthcare providers claiming that they are subjected to unjustifiable claims denials or reductions in claims amount paid. Insurance companies of course deny this.

Consequences for insured members

A lack of premium regulation means that insurers can not only price group business at technically unsound levels but they can also inflate premiums for individuals funding their own policies (admittedly this is a small proportion of the population) and also for very small family businesses. This manifests itself by insurers simply adding the amount of any significant claim in one year to the renewal premium for the following year. Given that previous medical history is disregarded by underwriters only for schemes of 10 or more insured members, this makes it impossible for an individual or family business to switch to another insurer.

Consequences for improving population health

In a highly competitive market with little or no premium regulation, employers continually ask their insurance broker to find ways to reduce their premiums. There are only two options:

- Reduce benefits
- Switch to another insurer offering a cheaper price

Reducing benefits may of course lead to a decline in an individual's health. Switching insurer, in a highly competitive environment means that insurers see little point in investing in preventive benefits to improve population health in the medium to long term, their argument being "Why should I do this when the insured members will not be with me possibly even next year? I will never see the benefit".

Frankly, this is a short sighted approach by the very nature of insurance being seen as a short-term, annual contract. Instead, insurers should realise that if they all invested in preventive measures population health in general will improve so that all insurers will eventually benefit from reduced claims costs.

Lack of a transparent healthcare provider rating system

Unless a regulator implements a provider rating system based upon quality of care outcomes, consumers have no way of identifying where they might receive the best treatment in relation to the cover available to them under their plan. The effect of this has been that insured members make their choice on the "price equals quality" myth. As a consequence, people believe that the more expensive a healthcare provider is the better treatment it provides. This in turn leads to some of the most expensive providers receiving a level of footfall not justified by the quality of care they deliver. Conversely, providers which charge less in order to attract business are seen as possibly providing an inferior level of care.

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Some might argue that the solution here is simply for insurers to reduce access to the most expensive hospitals or remove them completely from their networks. But this approach denies access for insured members to hospitals that may well be able to justify their prices with proven better quality of care outcomes.

In a system where all health insurance claims must pass through a centralised electronic claims (e-claims) system, regulators have much of the data to be able to determine quality of care outcomes such as length of stay, readmission rates and complications rates. In addition, there are commercial solutions in the form of surveys known as patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). Regulators can also use consumer complaints in their assessment.

One word of caution in developing a quality of care outcomes "index" as a means of assessing the quality of care and outcomes provided by healthcare facilities is that the results must be "risk-adjusted". This adjustment should take account of the typical severity of conditions treated by a specific healthcare provider. Put simply, those that are known to take on the most difficult of cases should have their results adjusted to take account of this. Risk adjustment can also include geographic location of the facility, for example is it next to a large school or university or is it in an area with an abnormally high population of elderly?

Recommendations to remove or reduce the moral hazards

The employer funding issue

Recommendation 1 - Introduce a minimum co-payment

In the interests of consumer protection, regulators sometimes set a maximum co-payment on out-patient visits. This provides insurers with the option of offering plans with zero co-payment. This removes completely any inclination on the part of the insured member to think twice about the number of visits they make. It also means they have no reason not to visit a more expensive facility or seek a consultation from a specialist rather than a family physician.

Instead, regulators should require that policies have a minimum co-payment rather than specify a maximum. Some might argue that this gives insurers freedom to set punitive levels of co-payment but in reality this would not happen in a competitive marketplace where policyholders would simply avoid insurers who set co-payments at too high a level.

For in-patient treatment, there should also be a minimum co-payment but limiting the overall insured's liability to a reasonably affordable maximum monetary amount. This would again mean that insured members would think more carefully about using the most expensive hospitals whilst at the same time protecting them against the prospect of having to contribute a fixed percentage of what could be a huge bill without any limitation.

Recommendation 2 - Introduce member contributions

Though possibly controversial, this would be a clear incentive for employees to understand that their utilisation patterns have an influence on employer premiums. Certain protections would need to be in place to protect the lowest wage-earners such as a *de minimis* limit of income below member contributions would not be required. Protection should also be provided for those with children covered under the employer's scheme.

Recommendation 3 - Reward improvements in lifestyle behaviour

This can be done at either the employer scheme level or at the individual level. However, measurement can be complicated and there are questions of equity between individuals.

At the scheme level, employers could benefit from a reduction in premiums based upon the overall improvement in the health of its workforce. This improvement could be based upon biometrics such as HBA1C results, levels of hypertension, cholesterol or body mass index levels. Although somewhat crude, it would

provide the employer with an incentive to offer "wellness" days in conjunction with healthcare providers in order to record the indicators as well as provide an opportunity for health education for its employees.

Such a scheme would of course need health insurance underwriters and employers to agree on the parameters and the improvement levels to be achieved in order to produce a premium reduction.

At the individual level and in the absence of employee contributions to premiums the situation is more complicated. Where there is no employee contribution, the employer must consider other incentives to encourage and reward lifestyle behavioural change. This could be in the form of gift vouchers, bonuses or other rewards. It is also essential that any incentives are based upon the *improvement* in health status and not the *absolute* level of health.

However, measurement and equity are two problems. Whilst biometrics can help show someone has taken steps to improve their health, other measurements such as alcohol consumption reduction or smoking cessation would have to be self-reported which would make them unreliable. Yes, there are tests available to determine these measures but this becomes an intrusive exercise. The problem of equity is that some individuals may simply be unable to make such improvements in their health through behavioural change and would therefore not be able to benefit from the rewards available.

Where there is an employee contribution, clearly the incentive towards improving health through lifestyle behavioural change is greater but again, there are issues in measurement and equity as described above.

Therefore, in reality, the most workable option would be an arrangement at the scheme level which uses biometrics as the measure for improvement and a reduction in overall scheme premium for the employer who now has a quantifiable incentive to encourage improvements in health status of its employees.

The issue of direct access to specialists

Recommendation 4 - Introduction of a mandatory gatekeeping system

Authorities should introduce regulations requiring insured members to seek advice from a family physician (general practitioner) before seeking the advice of a specialist.

However, given the structure of the UAE physician network, there may simply not be enough family physicians to cope with the demand which would result in delays and potential patient harm. To a large extent, the introduction of teleconsultations over recent years can assist here in terms of both accessibility, efficiency and cost-saving.

There would also need to be exemptions but there would also need to be some safeguards to avoid insured members simply attending an emergency room facility.

Another solution to this "volume" problem could be that insurers offer cheaper premiums for policyholders who voluntarily choose a plan which requires them to seek initial advice from a family physician.

Overall, the implementation of such a system would result in significant cost savings but would require careful thought and prior analysis to prevent any unintended consequences.

Dealing with gaps in the regulatory framework

Recommendation 5 - Introduce a system of premium regulation

Many insurers dislike the prospect of a system of premium regulation. However, this is largely due to the ill-thought through methodology applied in motor insurance where often a tariff system is imposed or restrictions on discounts are applied periodically. This approach provides insurers with very little flexibility to underwrite and price based upon the risks they face or their appetite for market share.

The author's proposal for premium regulation offers a system which provides underwriters with the flexibility to price within certain lower and upper parameters set by the regulator. This system is used in many of the states of the United States of America is based on a "banding" system.

Briefly, this system places upper and lower limits on how underwriters price for individual risks presented (age, gender, health and others), on plan related risks such as level of provider network and also on additional benefits such as maternity, optical and dental. The system is fully explained in the Author's earlier paper "The case for health insurance premium regulation in the United Arab Emirates".

The effect is that underwriters can retain the principles of technical underwriting whilst giving insurers some flexibility to adjust pricing to fit their business acquisition strategy. However, it prevents insurers from discounting to technically unsustainable and loss-making levels and also addresses the practice of insurers pricing cynically at renewal of individual or family paid policies by simply adding the value (or a proportion) of previous year claims.

Such a system would also reduce the pressure on insurers to deny claims made by healthcare providers as their pricing would be technically sound with a greater likelihood of profits being made.

It would also reduce the "churn" from one insurer to another at renewal. This latter effect would in turn create more of an incentive for insurers to invest in preventive measures as member portfolios would be less likely to move to another "cheaper" insurer which is simply buying business at technically unsound levels of premium. The introduction of more preventive benefits would improve population health in turn leading to better insurance company performance. This becomes a "virtuous" circle.

However, a system of premium regulation needs to be supported by the regulatory authorities which in turn requires the political will to achieve this. The latter the Author has not seen in the UAE in the last decade apart from during his tenure at Dubai Health Authority when he first proposed a workable system. In addition, the fragmentation of the regulatory regime described earlier would need to be addressed such that one system applied to the whole UAE thereby ensuring that insurers could not indulge in arbitrage due to different rules in each emirate.

Recommendation 6 - Develop and publish a quality of care index of healthcare providers

As described earlier, the claims data is available, commercial PROMs and PREMs are available to survey patient opinion and the regulators' complaints data could also be used. To determine provider ratings. There are also methodologies to "risk adjust" the rating scores to reflect the different casemix from one provider to another.

Such an index would assist in three ways:

- It would replace the "price equals quality" myth described earlier
- It would place pressure on providers to focus on outcomes and not "fee for service" based revenue which is just one prerequisite for moving to a system of Value-based Healthcare (VBHC)
- It would also support the overhaul of the current "price-based" provider network system applied by the dominant TPAs and insurers who administer claims internally (see the Author's separate paper entitled "Reasons why the private health insurance provider network system needs reform")

So why, if the data and methodologies are available, do we not see such an index? The Author believes with good reason that there are some parties with vested interests who do not wish to see such transparency. The UAE seeks to attract foreign direct investment (FDI) in many commercial sectors. One of these is healthcare. Indeed, there are several examples of foreign hospital groups having a presence in UAE. The question to be addressed is therefore to what extent would such transparency adversely affect the profitability of some healthcare groups and hence their willingness to retain their UAE operations?

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Some thoughts on the position in other GCC countries

Kingdom of Saudi Arabia

KSA has seen remarkable progress in its regulation of the healthcare financing system and of the healthcare sector itself. In terms of the former, there has been greater coordination between regulators and some amalgamation and in terms of the latter the Vision 2030 objective to separate the regulation and operation of healthcare providers is progressing. The establishment of clusters, the accountable care organisation approach, the move towards corporatization with the ultimate goal of privatization is a well laid out plan. All of this also facilitates the move to VBHC in which KSA is the leader in the region.

Having said that, most of the Author's recommendations still apply to KSA. The exception possibly being in relation to premium regulation, an area in which KSA has for several years now had some regulations in place.

Sultanate of Oman, Kingdom of Bahrain, State of Kuwait and State of Qatar

Oman is moving forward with its implementation of mandatory private health insurance and has technology partners assisting with connecting the various stakeholders. However, the Author believes that all 6 of his recommendations be considered in order to reduce or remove the moral hazards detailed in this paper.

Kingdom of Bahrain, State of Kuwait and State of Qatar

These smaller states (by population) have had a mix of schemes over many years, including fixed fee payments required to enable expatriate workers to access healthcare services at government hospitals. However, progress has either been slow (Bahrain), schemes have been withdrawn (Qatar) or are still in development (Kuwait).

Regardless of the above statement, if these countries are to use private health insurance as a health financing tool, they need to consider all 6 of the Author's recommendations to reduce or remove the moral hazards.

Further advice

If any healthcare market practitioner, health insurer, healthcare provider, investor in healthcare or regulator or any company considering a GCC market entry would like to discuss any of the matters raised in this paper please contact the Author by email to robin.ali@consilient.ie

--- *Robin Ali*