QATAR'S NATIONAL HEALTH INSURANCE COMPANY (NHIC): WHAT HAPPENED, AND WHAT SHALL BE DONE TO DEVELOP THE CURRENT SOCIAL HEALTH INSURANCE LAW

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ABSTRACT

A health insurance contract is a private contract between individual entities (usually an insurance company and an individual). A health insurance company is needed to manage risks, and it accounts for them by placing insured individuals in the risk pool. In this way, individuals do not suffer the full economic consequences of their purchasing behaviour and are able to shift the uncertain but potentially costly burden to all policyholders. However, healthcare is a public concern, as it is a constitutional right in Qatar, but no government, no matter how wealthy, can alone finance healthcare. Health insurance is a financing mechanism for healthcare, and therefore, Qatar's government established the National Health Insurance Company (NHIC). The story of the NHIC did not end well, as the company was dissolved. What happened, and what shall be done? To improve Qatar's health insurance scheme, the state must make a rational economic choice and shift the scheme to the private health insurance market with government intervention through regulations.

Keywords: Health Insurance, National Health Insurance Company (NHIC), Universal Health Insurance (UHI), Qatar Civil Code (QCC), Law and Economics.

INTRODUCTION

This article critically examines how Qatari legislators incorporate appropriate national laws to meet public health needs and concerns, particularly access to quality healthcare. The law has been and will continue to be a fundamental tool for solving critical health problems in national and local communities. In any debate on health reform, a foreseeable set of complex policy, management, economic, and legal issues is likely to be raised. This article aims to identify practical, workable solutions to the legal issues that may arise in introducing universal health insurance (UHI) in Qatar. In particular, the article demonstrates how economics must be taken into account when constructing national policy.

Since this article focuses on legal issues, some attention to policy issues is unavoidable because the law is the realization of policy. Section 2 will provide brief background information on Qatar's first attempt to establish the National Health Insurance Company (NHIC). This company stopped providing services and was dissolved. How and why did it fail? What can be learned from history to address the contemporary policy challenges in Qatar's UHI system? One result of Qatar's public financing of healthcare is that the government has become involved in the medical (and hospital) income determination process in a significant way. However, doing so has

led to a cost explosion, as we will see in the section. Furthermore, this section presents the objectives, and the organization of the article. Mainly the article tries to develop the current Social Health Insurance Law through reforming legislation.

This article is a constructive attempt to pave the way towards an improved health insurance scheme for the nation based on a legal and economic analysis of health insurance. However, it does not try to create consensus solutions for the problems identified, nor does it attempt to provide a unified theory of how to provide health insurance in Qatar. Furthermore, this brief article does not attempt to select among the presently opposing proposals or make recommendations among them. Instead, it is a project that aims to provide policymakers with a concise analysis of some complicated legal issues faced by the government's path to health reform and a clear articulation of the range of solutions available to resolve two questions: why did the NHIC fail? Who shall provide the health insurance to the public, the public sector or the private sector? Section 3 will demonstrate the need for the participation of private insurers because insurance companies have sufficient actuarial information and better risk management.

Ultimately, this article aims to provide a practical, applied guide to improving health insurance through a new health insurance policy based on health and economics reasoning. Health economics provides a market-oriented view in which health insurance pays for healthcare. It also suggests the main objective of health insurance policy, which is to encourage health insurance when the costs of such insurance justify the benefits (also known as *"optimization", "efficiency", or "cost-effectiveness"*) (Lieberthal, 2016). Nonetheless, this article will not analyse in depth the efficiency of the current system, as it has proven its inefficiency; rather, it seeks an efficient substitute. The examples provided by other countries are not considered blind references for the legislative guidance of best practices because Qatar is different from most countries. Healthcare is a constitutional right. Therefore, Section 4 will illustrate the need for government intervention in regulating health insurance. Questions about the role of government are particularly crucial in health insurance (Lieberthal, 2016). Moreover, as the COVID-19 pandemic has shown us, disease outbreaks are real and recurrent. Resources of the public health sector funded and managed pandemic emergencies. How the private health sector helped the public sector during the pandemic will be explained in section 5.

Health insurance has a specific role: paying for risky future healthcare costs (Lieberthal, 2016). Therefore, insurance means relinquishing more essential goods in good times to purchase less vital goods in bad times. Health economics also explains why and how markets might fail and how public policy can address these market failures (Lieberthal, 2016). The fact that health insurance is not provided for all populations (uninsured individuals) can be considered a type of market failure (Lieberthal, 2016). Any proposal to fix the health system must reflect that the healthcare system’s primary goal is to provide patients with access to necessary healthcare services (Wendt, 2014). Consequently, Section 6 will explain that the recommendations for the privatization of health insurance do not mean that the state will abandon its role in providing health insurance. Section 7 will conclude.

LITERATURE REVIEW

Legislations that protect the population's health may be organized and administered quite differently in different countries, depending on historical and constitutional factors and the specific health challenges that each country has faced in the past. Therefore, it is crucial to

provide the historical background of Qatar's health industry to understand how vital it is to the state. This wealthy state included the development of healthcare in Qatar as fundamental to meeting the goals for the country outlined in QNV **2030 (NV, 2020**). Healthcare is considered to be a constitutional right to all citizens according to the Qatari constitution. Qatar's spending in the last few years and the establishment of new health colleges show the high care of the state. Nevertheless, the most vital step was the establishment of the NHIC.

Health insurance is a reasonable response to the vastly variable need for healthcare (Segal, 2004). It is an insurance product produced by health insurance companies and covers the medical and surgical expenses of an insured individual. Health insurance reimburses the costs incurred due to injury or illness, or it pays the care provider of the insured individual directly. Health insurance companies are entities that organize the market for health insurance by connecting businesses and individuals into large pools that distribute the risk for individuals while facilitating the accessibility, choice, and purchase of private health insurance for uninsured individuals (Jost, 2009).

In Qatari law, health insurance is the insurance of persons. There is another type of insurance: insurance against damages. Article 791 of the Qatar Civil Code (QCC) provides that *"In insurance against damage, the insurer shall commit to indemnify the insured against damage arising from the occurrence of the insured risk, provided that such indemnity does not exceed the insurance amount"*. Health insurance is different than other forms of insurance. In general, consumers purchase insurance to protect their financial assets. Although health insurance can also protect consumers' finances, consumers purchase health insurance to access healthcare services (Custer, 2020). In other words, health insurance is not about just waiting for risk to materialize; it also pays for different services such as free preventive care, for example, vaccines, screenings, and certain check-ups. It is not about damages; it allows people to shift the risk of their health expenses to a third party, the insurer.

Even though health insurance appears to be a private contract between individual entities, legislators have paid attention to the contract. The QCC consists of 1182 articles, most of which are non-mandatory clauses. This non-mandatory status is not the case for the insurance articles (QCC Articles 771 to 807 cover the insurance contract); these articles are mostly mandatory. For example, paragraph 1 of Article 801 provides that *"No agreement may be concluded in violation of the provisions of this Chapter, or that amends these provisions other than in the best interest of the insured or the beneficiary"*. Here, legislation has intervened because of the power held by insurer in regard to negotiation. All insurers are large corporations that manage and draft insurance contracts (Elbarrawy, 2017), which is another reason the Qatari government intervened by establishing the NHIC.

Qatar established the NHIC, which managed and operated *SEHA. SEHA* incorporated the NHIC as a Qatari joint-stock firm wholly owned by the State of Qatar, and its mission was to oversee the Social Health Insurance Scheme, including its phased implementation and ongoing management. According to its mission statement, the NHIC aimed *"To run the National Health Insurance Scheme providing access to quality and reliable healthcare for all people in Qatar in a cost-effective manner"*. It was estimated that the Social Health Insurance Scheme would be introduced in five stages starting in July 2013 and ending in 2015. The Social Health Insurance Law mandated that all residents and visitors would access basic healthcare services over the phased timetable.

In a sudden shock move, the Qatari government shut down the national health insurance scheme at the end of 2015, telling citizens to purchase private care or private health insurance. The government decided to stop the health insurance service provided through the NHIC starting on 31 December 2015 and entrust all healthcare services to private insurance companies. The government did not provide any reason for suddenly shutting down the NHIC. One might wonder what exactly happened.

The NHIC provided mandatory health insurance coverage through a network of public and private clinics and hospitals. Qatari citizens could access medical treatment at a range of private hospitals, clinics, health centres, opticians, and other service providers across the state that had signed on to participate in the system. The government picked up the bill for its citizens. With medical treatment given more than one million times under SEHA and an estimated Qatari population of approximately three hundred thousand, this rate of usage amounts to more than three visits per person. In the fifteen months from August 2013, SEHA paid out Q.R.1.3 billion (US$ 357 million) for healthcare. Before SEHA, Qataris could have free healthcare services at only a limited number of state-run clinics and hospitals.

The main reason for the problems faced by the NHIC was that health service providers saw it as a cash cow for overcharging and fraud. Many went to private clinics and hospitals under SEHA (IMTJ News, 2016). Consequently, the injection of public money into the private medical market provided what appeared to be limitless revenues for physicians and private hospitals to order more services and products for their patients, finance new capital investments, and raise their prices. Moreover, similar to other countries in the Middle East, falling oil prices appeared to take a toll on Qatar's economy, which may have caused the service interruption and the government's decision to withdraw SEHA.

Health funding is a critical component since all health system functions depend upon adequate and sustainable financing (Magnusson, 2017). The suspension of *SEHA* activities indicates that the government intends for the private sector to play a significant role in offsetting its expenditure. Moving to private insurance companies may help in achieving better management of medical insurance programmes and plans and in avoiding the increasing abuse of such programmes by private hospitals and clinics that seems to have taken place. Furthermore, although the region may now be facing economic challenges, the development of healthcare in Qatar continues to be essential for the country to meet its goals outlined in QNV 2030 (Singh, 2016).

The 2015 Gulf Cooperation Council (GCC) Healthcare Industry Report predicted that in 2020, spending in healthcare in Qatar would double and reach $8.8 billion, reflecting a compound yearly growth rate of 12.7% and placing Qatar in the middle of the table in terms of healthcare expenditure forecasts for the region (Keane, 2016). Historically, Qatar's government has paid for 80% of its total healthcare spending, with the remainder met by the private sector (Keane, 2016). However, the health services in the country are sound; the high costs associated with operating the NHIC system came at a high financial cost for the Qatari government (Oxford Business Group). A fundamental, interrelated problem that restricts countries from moving closer to universal coverage is resource availability. No matter how wealthy, no country has been able to ensure that everybody has access to every technology and intervention of healthcare services (World Health Organization, 2010).

Why Shall the State Not be the Sole Insurer?

Even high-income countries now understand that they must continually re-evaluate how they move forward in the face of rising costs and expectations (World Health Organization, 2010). Health services cost money. Currently, the global annual expenditure on health is approximately US$ 5.3 trillion (World Health Organization, 2010). For example, the member's state of the Organisation for Economic Co-operation and Development (OECD) represent merely 18% of the world population but account for 86% of the world's health spending; a few OECD countries spend less than US$ 2900 per individual each year (World Health Organization, 2010). Comparatively, in 2016, Qatar had the highest health expenditure per capita in the GCC at US$ 1827. Similarly, Qatar allocated 3.1% of GDP to health expenditure in 2016, below the global average of 10%. Additionally, the most recent health indicators and statistics found that in 2018, there were nearly 3535 hospital beds in Qatar, up from 3011 in 2017 and 2627 in 2016. Even though this increase is sizable, it equates to a ratio of 13 beds per 10,000 people, which is still much lower than the OECD average of 47.9 beds per 10,000 people (Keane, 2016).

If Qatar aims to introduce universal health coverage (UHC) for all residents, more resources are needed to fund such a programme. The path to UHC, at least on paper, is relatively simple. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services and improve efficiency and equity (World Health Organization, 2010, executive summary). Health financing is much more than a matter of increasing or allocating money for health. It is also a matter of who pays the bill, when the payment is due, and how the money is spent (World Health Organization, 2010). Consequently, the Qatar Cabinet of Ministers has publicly confirmed that it aims to support the private sector in a far more comprehensive manner by permitting private healthcare insurance companies to provide healthcare insurance coverage for all residents (Keane, 2016). One could conclude that Qatar has decided to move away from universal free access to a model based on purchasing insurance. In fact, to many experts in medicine, economics, and sociology, it has become clear that the only way to spread the cost burden around is to adopt some form of health insurance (Rushing, 1986).

Insurance requires capital because of the need to pay the costs for producing insurance and providing a cushion against statistical outliers, meaning people whose healthcare costs are much more than expected (Lieberthal, 2016). In the case of third-party payment (such as under SEHA), capital could be used to create or purchase a system for structuring insurance contracts, conducting claims verification, and constructing a claims pay-out system (Lieberthal, 2016). On the other hand, insurers who take on health risk management utilize more capital than insurers who only serve as third-party payers because health insurers employ a mix of capital and labour to produce health insurance (Lieberthal, 2016).

Capital is a key input in health insurance because health insurers supply economic risk management by applying the law of large numbers (Lieberthal, 2016). The application of the law of large numbers to healthcare claims for health insurance implies that the larger the risk pool is, the more definite the insurer can be of its average claims (Lieberthal, 2016). The law of large numbers makes risk management easier and cheaper by converting a risky variable, individual healthcare spending, into a less risky variable, the average healthcare spending for a large group (Lieberthal, 2016). Health insurance companies then profit based on the difference between premiums and the cost of providing health insurance (Lieberthal, 2016). Here, profits refer to

what insurance companies charge in addition to paying for covered benefits to profit from the sale of insurance (Lieberthal, 2016).

To ensure profit, the health insurer takes responsibility for deciding how much to pay a doctor for a routine visit, how much to pay a pharmacy for a drug, and so on, given the employer's willingness to pay for healthcare services (Lieberthal, 2016). These arrangements were not made when SEHA was introduced, and hospitals and doctors saw it as a cash cow for overcharging. Health insurance companies play a crucial role in the financial intermediation of healthcare payments, defining what is paid for under health insurance, adjudicating, and making payments (Lieberthal, 2016). Moreover, health insurance companies will fulfil the demand to finance healthcare spending (Lieberthal, 2016). Health finance puts a price on this complex service, and it is the role of health insurance companies to arrange and make payments related to the cost of care (Lieberthal, 2016). Health finance is a way for providers to transform an uncertain flow of revenue based on a patient population into a certain flow of revenue (Lieberthal, 2016).

Could We Leave the Responsibility for Health Insurance to Private Insurance Companies?

Insurance companies have a number of standardized contracts that they offer on the nongroup market, as well as premiums for each type of insurance. There are a variety of contracts, but each is *"take it or leave it"*—an individual cannot negotiate changes to health insurance contracts on the nongroup market. Nongroup health insurance is a *"contract of adhesion"*, which means that a contract is written by the insurance company for sale to individuals. Nongroup insurance is, on average, actuarially unfair because of the lack of negotiation (Lieberthal, 2016). In general, individuals pay for the nongroup health insurer to negotiate the scope of benefits and the cost of health shocks. Uninsured individuals must accept the prices for healthcare as given. Negotiating prices on behalf of individuals on the nongroup health insurance market allows for a more *"reasonable"* premium, meaning something that is within individual budget sets (Lieberthal, 2016). Individuals often seek nongroup insurance only when they are ineligible for employer-sponsored or government coverage. This insurance is called group demand.

Group demand generally refers to employers and the government's demand for health insurance provided to groups of employees or beneficiaries through risk pools (the rule of large number) (Lieberthal, 2016). Health insurance provided by an employer or the government brings together large groups of individuals, making for a natural insurance risk pool (Cutler & Zeckhauser, 2000). Health insurance mandates for employers will increase employer demand for health insurance (Lieberthal, 2016), and this employer mandate is a necessary step in Qatar, as more than 2 million migrant labourers are working and living in Qatar. Many of those immigrants are unable to use all healthcare facilities. They do not access emergency services through hospital accident and emergency departments (AEDs). Although over 8% of Qatar’s GDP is spent on healthcare each year, uninsured labourers do not utilize such services (Bener, 2017). In fact, almost 80% of migrant workers have no medical insurance (Bener, 2017).

Not having health insurance raises the cost of all healthcare services and uninsured individuals respond by consuming fewer of these services (Lieberthal, 2016). One of the main consequences of uninsured individuals for society at large is so-called *"spillover effects"*, also known as *"externalities"* in economics. Spill over effects mean that when a large percentage of

one's community is uninsured, it is harmful to those with health insurance (Pauly & Pagán, 2007). Therefore, there must be a rule to require large employers to provide health insurance to employees or pay a penalty. This mandate has the effect of raising the cost of not providing insurance, and while the mandate operates as a tax on employers that do not offer insurance, economists generally view the employer mandate as a tax on employment in practice. Health insurance is not valued as highly as cash compensation since money is fungible, while health insurance can be used only to pay for healthcare. Health insurance can help an employer attract employees; consequently, the employer is motivated to demand health insurance. Employers may also have a specific interest in health insurance as a benefit because health insurance can help an employer maintain a healthy workforce (Lieberthal, 2016).

When health insurance helps to keep an employee healthy, the employer benefits through that employee's productivity at work. Migrant workers in Qatar have suffered from medical conditions and health problems such as back pain; headache; cardiopulmonary issues such as heart and respiratory diseases; gastrointestinal (GI) and abdominal issues such as diarrhoea and peptic ulcer; pseudo-neurologic issues such as fatigue, depression, anxiety, and stress; diabetes; hypertension; and asthma and allergic diseases. Meanwhile, the most common occupational accidents are falling, slipping, and being struck by an object. Health insurance should be provided to all migrant workers during their working contracts (Bener, 2017). From an economic perspective, employees will be motivated to address most illnesses or injuries that will make them less productive, both to maintain the ability to be employed and because they value their own health (Lieberthal, 2016).

What should be done in the case of people who are not part of the workforce, such as elderly people, children, unemployed individuals, and low-income people? Similarly, an entirely private system will tend to price high-risk individuals, elderly people and sick people out of health insurance, denying them access to healthcare (Segal, 2004). Many countries provide health insurance on a national basis or some other basis not related to employment or risk-related factors (Lieberthal, 2016). Social insurance refers to insurance programmes given by the government to citizens and residents as a public good (Lieberthal, 2016). Government health insurers offer eligible individuals the chance to obtain health insurance coverage, and social health insurance is generally provided on an individual basis. One must conclude that no health insurance scheme can endure financially sustainable if a culture of inappropriate billing practices established among health service providers or if additional fees are excavating from members in ways that drive needy and low-income persons away from the scheme (Magnusson, 2017). The most appealing suggestion could be a government social insurance that coexists with private insurance. In fact, the Covid-19 pandemic has provided useful lessons.

What Lessons can we Learn from the Covid-19 Pandemic?

The most frightening kind of health emergencies may become manifest in the event of an emerging infectious disease for which available medical treatments is inadequate. For many of the pathogens most likely to be deployed as bioweapons, effective treatments and prophylactics either do not exist or cannot be produced quickly enough and in sufficient quantity to protect the population immediately. Similarly, if a naturally occurring virus produces a pandemic disease, the availability of health responses will lag significantly behind the transmission curve (Hunter, 2007). As the COVID-19 pandemic has shown us, disease outbreaks are real and recurrent

events, but how they are conceptualized in government policy is changing. *"Health emergency"* is becoming a powerful frame, a funding magnet for programmatic initiatives, and a rapidly enlarging subfield of knowledge within public health (Hunter, 2007).

What can we learn from the current pandemic? This remain to be seen. The first case in Qatar was confirmed on February 29, 2020 (The Peninsula Online, 2020). As of March 16, 2021, there were a total of 171,212 confirmed cases, and a total of 1,635,175 people had been tested in the country. Looking at the numbers and comparing to the population, 6.1% of the population was infected with the disease, ranking Qatar 32nd in the world. On the other hand, the number of people tested is relatively low at 1.6 million, ranking Qatar 77th globally.

Not surprisingly, the public sector took the lead in confronting the pandemic. It was not until June 20, 2020, that the State allowed private healthcare facilities in Qatar to carry out swabbing for COVID-19 testing. Private clinics are still asked to send the swabs to Hamad Medical Corporation laboratories for testing (The Peninsula Online, 2020). No data on each hospital's share of daily tests are available. However, some numbers provide indications for proper assumptions. The total number of tests before June 20th was 317, 694 in a total of 113 days. Figure 1 below shows the numbers of tests in the first 113 days and thereafter, once private clinics were allowed to conduct the tests. Figure 2 illustrates the daily average of tests of citizens before and after private clinics were allowed to carry out the tests (Our World in Data, 2021).

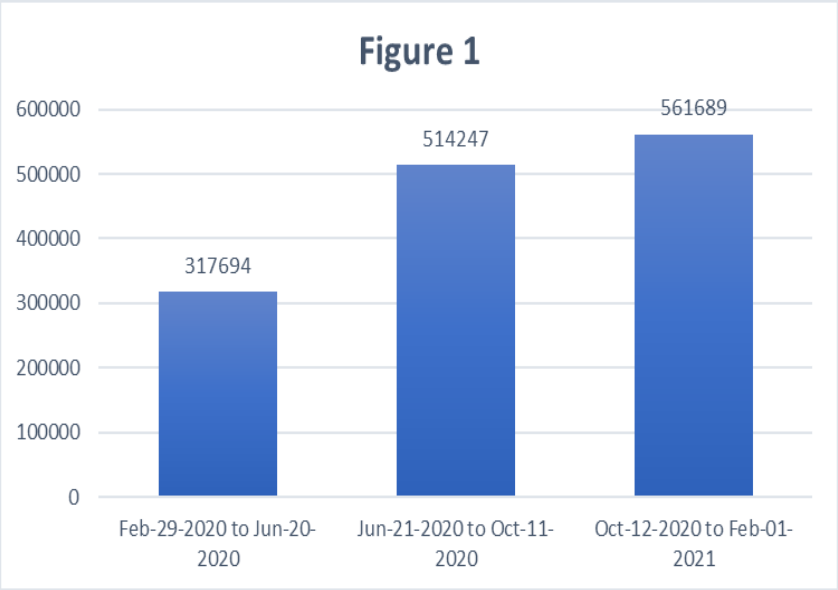

FIGURE 1
ILLUSTRATES THAT THE NUMBER OF TESTS HAS INCREASED COMPARED WITH THE FIRST 113 DAYS.

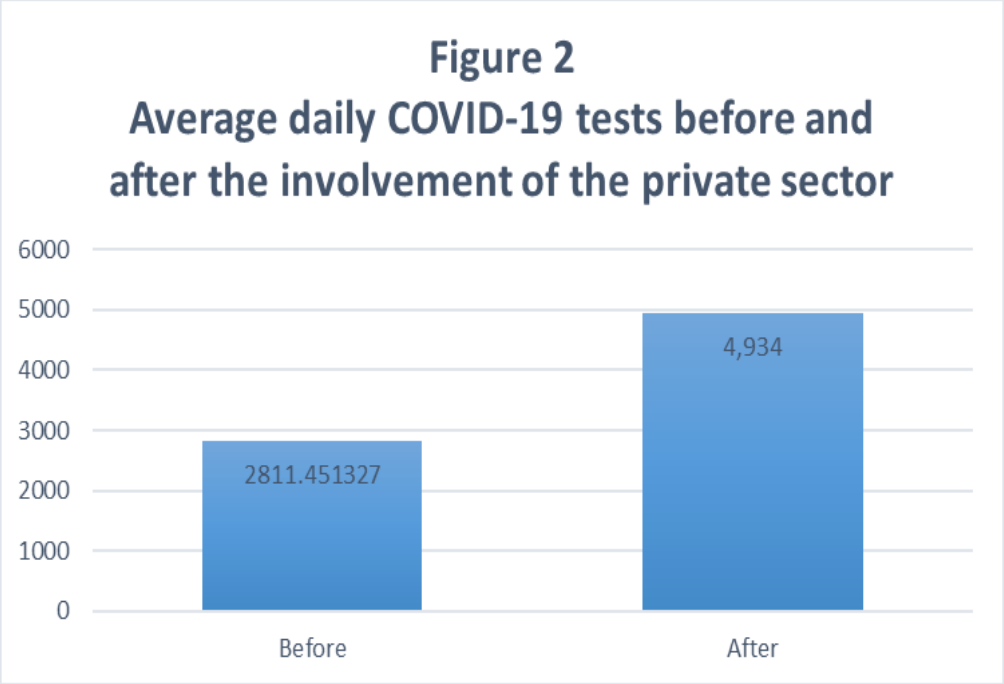

FIGURE 2
DEMONSTRATES THAT THE DAILY AVERAGE NUMBER OF TESTS INCREASED 175% AFTER PRIVATE SECTOR INVOLVEMENT.

The above figures illustrate the need for collaborative public and private efforts to address public health issues. Policymakers must call for the private sector's participation in the public health system. One could assume that some people may be at increased personal risk during a pandemic because of limited access to health care services. Risk reduction planning for such people should be the trend and will be essential in situations in which society and the public and private sectors confront an infectious disease outbreak with adequate pharmaceutical resources for vaccinations or treatments to curb transmission.

One might wonder how much the government has spent facing the pandemic. There is no source with an exact number; however, the State's yearly allocations for health can provide an indication. Figure 3 depicts health allocations since 2016. Qatar's budget for 2016 allocated QR 20.9 billion for health out of an estimated expenditure of QR 202.5 billion (Gulf Times, 2015). The amount increased in 2017, when 24.5 billion was allocated to the health sector, representing 12.3% of the total estimated State expenditure of QR 198.4 billion (Gulf Times, 2015). In 2018, the allocation for the health sector was QR 22.7 billion, representing 11.2% of the total expected expenditure of QR 203.2 billion (The Peninsula Online, 2017). In 2019, the allocation for the health sector was set at QR 22.7 billion or 11% of the total budget estimate, which pegged revenues at QR 211 billion and expenditure at QR 206.7 billion (Gulf Times, 2018). Finally, in 2020, the allocation for the healthcare sector was 22.6 billion, representing approximately 11% of the total expenditure (Gulf Times, 2020).

FIGURE 3
THE PERCENTAGE OF TOTAL EXPENDITURE IN HEALTH CARE

Provides strong support for the notion that no matter how wealthy a country is, the State cannot do it alone. The percentage of total expenditure in health care has, in fact, decreased from 2017. In 2021, the allocation for healthcare amounted to QR 16.5 billion out of an estimated expenditure of QR 194.7 billion (Ministry of Finance, 2021). These allocations show a decrease in both the percentage and the amount even though we are facing a pandemic. Private health actors are needed as a matter of fact. As the reader may now be aware, this article is about government-centric rule in the health sector. Still, the private sector must play a role in providing health services. The article aims not to establish ongoing public-private partnerships but to show the importance of the private health sector's role. In sum, the analysis reveals a paradox: ensuring the effectiveness of the private sector's role in achieving health goals will require more funds through health insurance. Private health insurance will be necessary to smooth financial shocks caused by the public health crisis and responses thereto and to make a greater number of health providers available to the population.

Welfare State vs. Law and Economics Analysis: Towards Balanced Recommendations

One could conclude that the private health sector is needed to add to the available resources of public hospitals, but we still need a public provider. Here, we are not suggesting reintroducing SEHA or another state-run health insurance scheme for multiple reasons. First, the article previously recommended requiring large employers to provide health insurance to their employees. In fact, Qatar's revised overall economic participation rate was 88%, with 96% for males and 59% for females. On average, nine out of every ten working-age persons participate in

the labour force (Planning and Statistics Authority, 2019). Therefore, we are talking about a tiny number of people here, and an employer mandate insurance scheme will cover the majority. The US provides a positive example, as 61% of the non-elderly population there (totalling 260 million people) receive health coverage through an employer (Hyman, 2008). Therefore, Articles 7 and 10 of Law No. 7 of 2013 governing Social Health Insurance shall be amended. Currently, the articles require employers to purchase governmental insurance. The recommendation is to mandate employers to purchase insurance through private insurance companies.

Second, social government insurance will purchase insurance coverage from the market. In short, the public system of financing and regulation was designed to fill the gaps left by private health insurance. In other words, the government will not act as a single payer but, rather, as the purchaser of insurance coverages on behalf of individuals eligible for government social health insurance. Therefore, this article suggests amending Article 2 of Law No. 7 of 2013 governing Social Health Insurance. The new article will provide *that "The health insurance system shall be mandatory to ensure the provision, in accordance with this Law and the Bylaw, of basic health services to all Qatari citizens, GCC citizens, residents of the State and visitors who are not covered by their employers".*

As a purchaser, the government could select insurance on behalf of individuals and improve their welfare by ensuring that all plans are of high quality and that people are not overwhelmed with choice, which is also known as *"managed competition"* (Enthoven, 1993). This governmental purchasing of insurance would reduce the uninsured population by extending the programme to unemployed individuals. In fact, social insurance has two primary purposes: broad targeting and redistribution. Notably, in the US, many government-provided health insurance programmes use a form of outsourcing to provide health insurance benefits. For example, a large portion of the population with Medicare and Medicaid insurance receives insurance from a privately managed care company (Lieberthal, 2016).

A government interested in its citizens' health capital as part of their *"general welfare"* views health maintenance as a significant factor in determining societal utility (Lieberthal, 2016). Furthermore, healthcare is considered a fundamental human right in many countries, such as Qatar, where this right is written into the constitution. The country's constitutional commitment to providing healthcare made healthcare a fundamental right. Nevertheless, recognition of the constitutional right does not require the government to become the sole provider of all health services. However, it does commit the government to pursue those intermediate objectives that help achieve the broader goal of UHC (Magnusson, 2017). Furthermore, as explained above, the state's ability as a single payer to bear and share risks related to health implies that the optimal quantity of risk management is finite (Lieberthal, 2016).

In health insurance, as in the economy as a whole, the rationale for considering the allocation problem is that resources are limited (Lieberthal, 2016). The *"fundamental theorems of welfare economics"* explain the importance of equilibrium for determining an optimal allocation of economic resources, and the theorems are fundamental because they *"…describe the efficiency properties of a competitive equilibrium".* They apply to the study of *"welfare economics"* in the sense that they describe the conditions under which human welfare is maximized. Here, welfare is the overall benefit obtained by society from economic transactions in the market. These theorems also define the scope of the gains from trade. In the case of health insurance, individuals and institutions use markets to *"trade"* health insurance (Lieberthal, 2016). Moreover, state-run health insurance has disadvantages in that it cannot be tailored to an

individual's health in the same way that healthcare can be. Therefore, it may be less efficient and amount to a *"deadweight loss"* of money used to finance public health programmes (Lieberthal, 2016).

There are other reasons for government intervention, such as the pursuit of fairness and justice. Nevertheless, this article aims to pursue economic efficiency—that is, the goal of obtaining the highest level of well-being of members of society from a given level of resource endowments. Therefore, if private insurance companies are more cost-effective than the government in providing insurance services, then it would be more efficient for the government to purchase insurance rather than produce it directly (Lieberthal, 2016). If properly implemented, as envisioned, the governmental purchasing of insurance will provide the means of ensuring that everyone will have access to the quality health services they need, without suffering financial hardship due to operational mismanagement.

In a sense, health capital a mix of private goods and public goods (Lieberthal, 2016). If health is an individual concern, then why does an insurer pool individual together as a group to write health insurance? Health insurance is ultimately a third party, intermediating between individuals seeking care and providers who must be paid for delivering that care (Lieberthal, 2016). Health insurance has a *"loading cost"* other than the cost of claims, which is the cost of designing and administering the insurance plan. All health insurance producers incur cost for the production of health insurance. Therefore, healthcare is best considered as having high effectiveness and a high cost for improving health. Health insurance is intended to address health risks on a case-by-case basis by financing healthcare (Lieberthal, 2016).

Health insurance is now a large and vital part of the healthcare industry. Health insurers around the world finance a much larger proportion of healthcare than they did one hundred or even fifty years ago (Lieberthal, 2016). All health insurance companies have a common primary purpose, which is the production and sale of health insurance (Lieberthal, 2016). UHI per se, however, does not automatically lead to UHC. Therefore, to reach universal health care, and within the universal health insurance implementation process, Qatar has to make concrete implementation decisions that align with the overall objectives of UHC. These decisions cover the operationalization of various health system functions, including health system financing, governance arrangements, health service delivery, health information systems, the health workforce, and access to essential medicines. The preparatory phase for health insurance implementation is critical and requires a broader multi-stakeholder collaboration to address several potential bottlenecks and challenges (Mathauer et al., 2019).

The government contracts with the private insurer to provide health insurance directly to the beneficiaries, and pay all or part of the cost of the health insurance plan (Newhouse et al., 2015). When outsourcing these types of services to private companies that specialize in providing health insurance (Lieberthal, 2016), the government’s rationale is efficiency. However, this article argues that a single-payer system is not the most useful category in comparative health policy analysis and that the experiences of some countries provide valuable lessons. A single-payer programme would put for-profit private insurers out of the business of selling basic coverage; would almost surely pay less for the services of physicians, hospitals, and drug producers; and would entail sizable new taxes, a positive share of which would likely fall on the business community (Brown, 2019).

The private financing of healthcare directly increases the resources devoted to health without putting pressure on public finances. Private funding is also supported by the arguments

that public financing results in fewer healthcare provision choices and results in less responsive systems (Chen, 2013). Most research points to improvements in healthcare technology as the impetus for the growth in healthcare costs worldwide. All healthcare systems must cope with this rapid acceleration in the strategies available to treat patients (Glied, 2009). The public sector cannot do so alone, and therefore, it converges on a hybrid system in response to the expected pressure to increase the efficiency of healthcare systems. In other words, the growing pressure on the public finance of contemporary welfare states has led to the increased importance of market mechanisms in healthcare systems around the world (Łyszczarz, 2016). When viewed from this perspective, private insurance plays a role in social policy even though the insurer aims to make a profit (Rushing, 1986). In the present analysis, private health insurance is viewed as producing positive social consequences.

Privatization processes, the introduction of managed care and the domestic market, and increasing private healthcare financing are the global trend (Łyszczarz, 2016). A positive example is the Netherlands, which is traditionally classified as a social health insurance system with strong regulation on access to medical care. In 2006, the responsibility for financing healthcare was transferred to private insurance companies, which has been understood by some authors as a privatization of the Dutch healthcare system. However, private plans in the Netherlands are strictly regulated and, therefore, do not represent a private health insurance model (Wendt, 2014). The government intervention is essential; otherwise, an entirely private system would tend to price high-risk individuals, elderly people and sick individuals out of health insurance, denying them access to all or some healthcare services (Segal, 2004). Moreover, Qatar's underdeveloped private health insurance sector may have only a limited capacity to acquire information and capital, absent a working financial market; therefore, the role of the government is essential. Total legislation focusing on the privatization of all health insurance could be more effective in the later stages of economic development when private health insurance companies have acquired institutional financial strength and experience (Lee, 2017).

The proposed government intervention in healthcare is minimal and effective. The regulatory mechanism might be later left to negotiations between fundholders and providers with some control by the government (Chen, 2013). The government can act through an agent, and legislation may be needed to establish a health insurance commission to manage a national health insurance scheme, including registering members, accrediting health service providers, processing claims, and managing a national health insurance fund. All of this combined; the involvement of state actors, non-governmental actors, and the market with the dimensions of *"financing", "service provision", and "regulation",* with these three dimensions being *"ideal types"* (Wendt, 2014).

The strong role of the state can be used for controlling healthcare costs and for reducing inequalities (Wendt, 2014). Governance should have specific arrangements for setting up and aligning with other support mechanisms that strengthen accountability and performance (e.g., accreditation and contracting, including selective contracting). The main goal of the government's agents will be to reconcile the tension between a competitive insurance market exerting pressure for selective underwriting and actuarially fair premiums and an upcoming welfare state exerting pressure for universal access and socially reasonable premiums. The adoption of essential elements of the welfare state logic will enhance the ongoing integration of

the commercial health insurance industry into a more extensive system of healthcare financing (Vonk & Schut, 2019).

Insurance has long been a heavily regulated industry, and constitutional challenges to requirements imposed on exchange through regulation or negotiation are unlikely to succeed unless the requirements are wholly rational and applicable. However, it remains true that the government shall retain considerable discretion in regulating a wide range of insurer behaviour (Jost, 2009). The state could consider applying uniform regulation of underwriting, premiums, and benefits to avoid exposing individuals to adverse selection or limiting insurers' ability to compete in selling insurance. Alternatively, the state could only purchase insurance through the exchange in specific markets for individuals or small groups that fall beyond the scope of the employer mandate scheme (Jost, 2009).

CONCLUSION

A review of existing laws was required to ensure that they adequately support a multi-insurer framework. In this article, privately purchasing health insurance has been proposed as a possible substitute for only one major company. As evident, this paper, like all legal solution papers, does not purport to provide a concrete proposal on how the processes of private health insurance companies should be organized. Instead, it merely attempts to describe the legal issues that control of the market by private health insurance raises and to propose alternative solutions to legal problems were useful. Specifically, it analyses and offers alternative solutions to the legal issues raised by proposals to establish an insurance scheme with cooperation from the government and private entities.

This article makes the case that the government's lack of success should draw attention to understanding how events have come to pass. The inefficient and perverse regulation and administration of the NHIC led to huge costs borne by the government. Given that economic resources are finite, private health insurance is needed to compete with any government programme (Lieberthal, 2016). The state must take a hard look at the aggregate cost, and certainly by now, it must recognize that the wrong decision will result in the loss of a sizable amount of revenue. If the state desires to regulate inefficiently, it should bear the costs of its inefficiency. Broader markets for health insurance will make life easier for the population, be less costly to the state, and make regulating the market more challenging.

The concept of the government as an actor that can intervene in markets is central to the notion of economic policy-a government (or social planner*)* may be able to implement policies that lead to *"better"* equilibria (Lieberthal, 2016). Market supervision allows the government to maintain its traditional consumer protection efforts to ensure that health insurers do not misbehave. In countries where publicly funded UHI does not exist, a combination of private and public sources makes health insurance almost universal, as in the United States (Rushing, 1986). Private health insurance schemes will coexist with the public systems that are the vehicles used by the government to scale up coverage. The government will regulate a wide range of matters in regard to private insurers, including registration, advertising, competition, premiums, adverse selection, and reporting requirements (Magnusson, 2017). Undoubtedly, the state improves health insurance regulations, but it should not ignore the similar pathologies that prevail in healthcare delivery regulations.

However, these issues are subject for other articles. As evident, this article discusses some critical factors, mainly the necessity of private health insurance involvement. Nevertheless, it does not address all relevant social, political, cultural, and economic issues in depth. An in-depth discussion of these issues falls beyond the scope of this brief article but should be explored in future studies. Qatar constitutes a significant and informative case study for other countries with similar categories. More importantly, Qatar's second National Development Strategy (2018-2022) is expected to focus on healthcare (Health Needs Assessment 2019, Strategy Planning and Health Intelligence Department, Ministry of Health, State of Qatar). This article is an initial attempt to suggest a better strategy for UHI to avoid what happened when Qatar promoted the NHIC. This study illustrates that to combine health insurance funds, operational challenges in the following areas should be taken into account: financing mechanisms, population coverage, a benefits package, provider engagement, organizational structure, health service delivery, and operational processes. Of course, any consideration of these issues should be accompanied by the necessary legislations and regulations.

Any further studies should have adequate cogent reasons to justify the consolidation process in the given context. When moving towards combining health insurance funds, policymakers must ensure that the health insurance system is allied with the broader policies and stewardship of the healthcare system. Enacting major reforms in a health system with fragmented insurance schemes with different target populations, prepayment structures, benefits packages, and development histories is inherently difficult. Addressing the differences and operational challenges in the main areas of the health insurance system generated in this study may provide an initial platform for designing and implementing the merging process of UHI schemes in Qatar and other countries with similar situations.

In conclusion, the lessons derived from the present paper can be informative for policymakers from Qatar and other countries, especially those with similar situations, trying to merge existing health insurance schemes to strengthen risk pooling. As discussed throughout the article, Qatar's experience shows that it is challenging to reduce fragmentation in a disintegrated health financing system due to the many operational obstacles that exist in different areas of the health insurance system. The public and private sectors must operate together in parallel in the health insurance market, supervised by the state government. Moreover, the current health crisis could open a new chapter in approaching collaborative frameworks and incentivizing greater participation of the private sector in the health market.

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