Paying Primary Care through National Health Insurance
Strengths and Weaknesses

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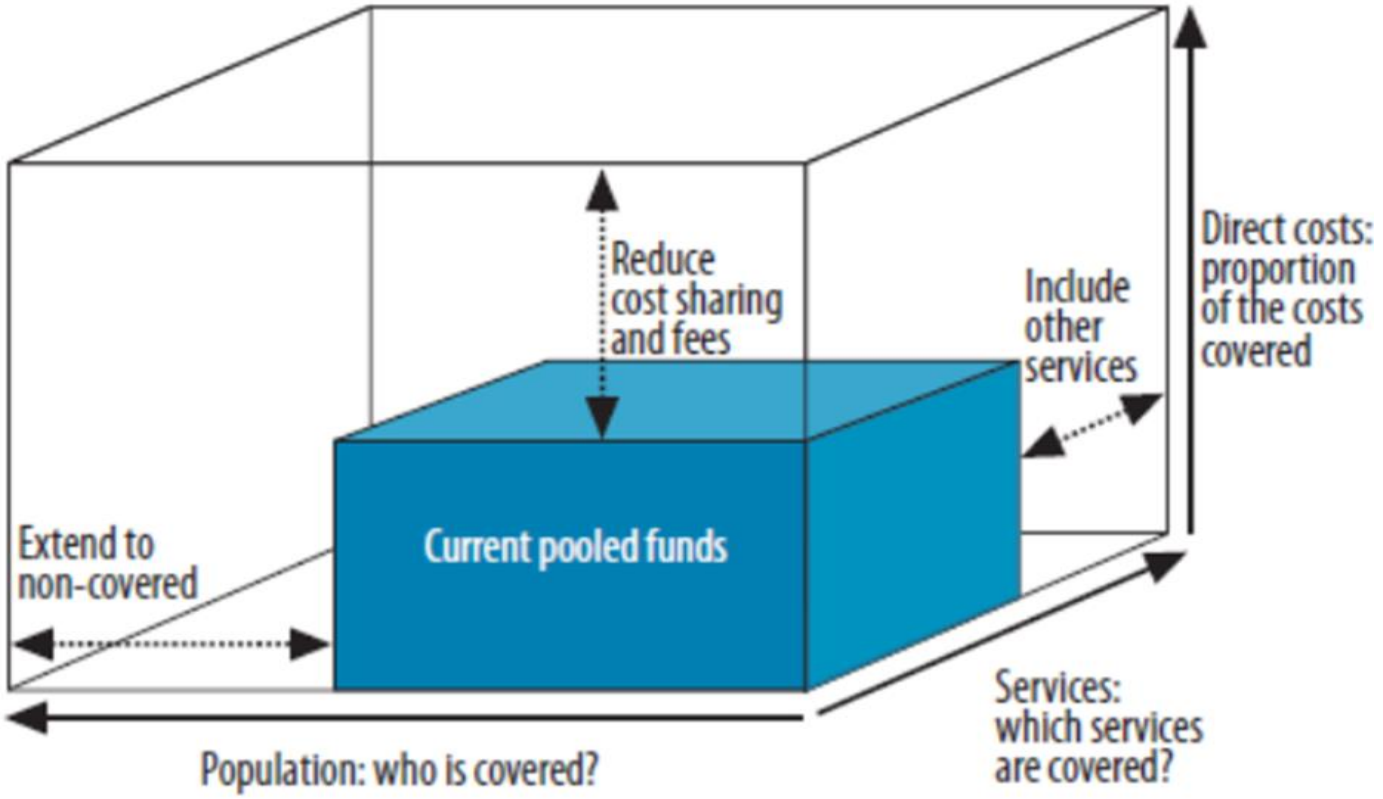
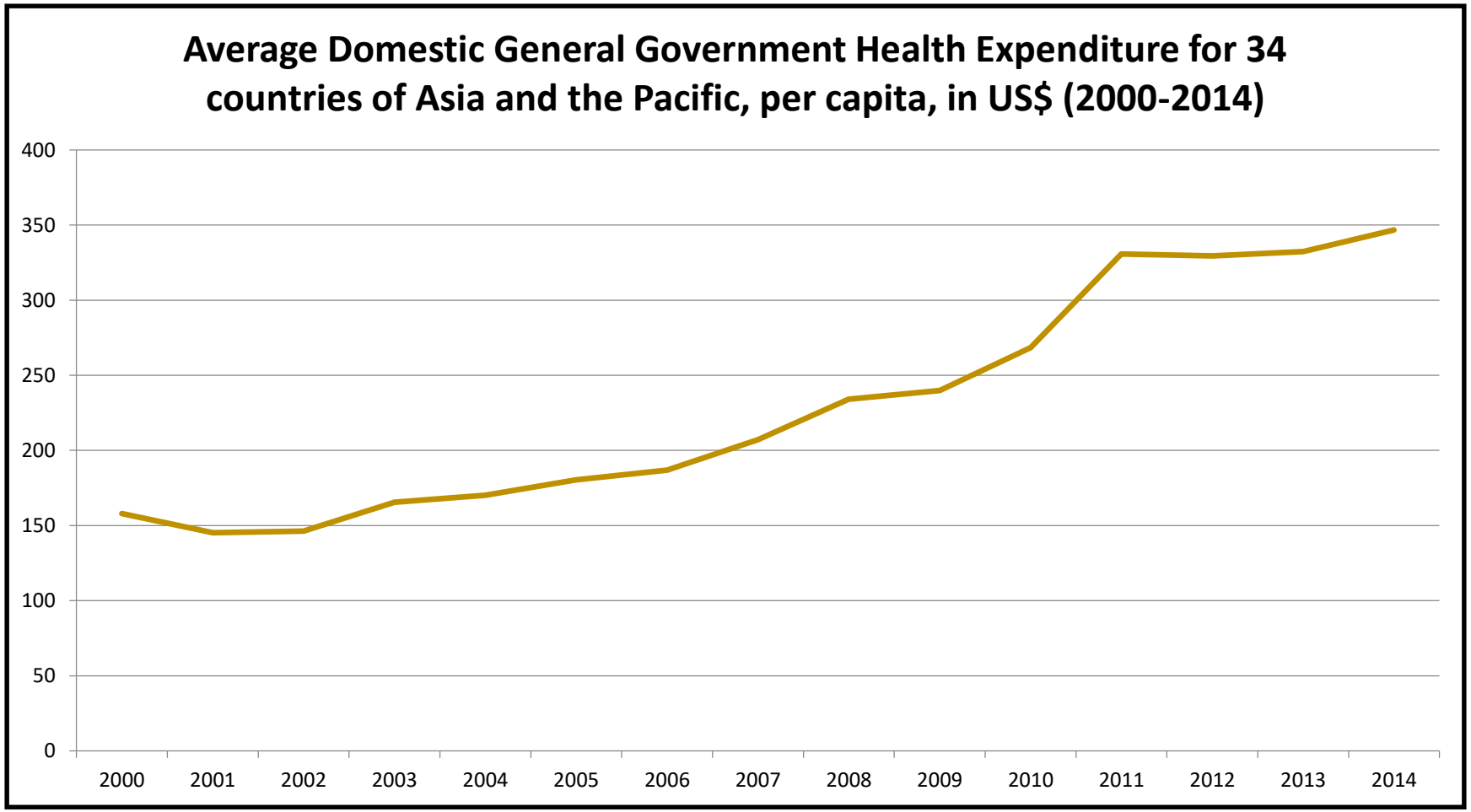
Session Objectives:

- To discuss the role of national health insurance (NHI) in expanding primary care services in a select number of countries in Asia
- To describe the implementation steps needed to enable NHI paying for primary care
- To analyze the bottlenecks and barriers of NHI coverage of primary care, and identify interventions that may address the bottlenecks and barriers
- To determine the appropriateness of NHI paying for primary care

Asia and the Pacific countries are pursuing Universal Health Coverage (UHC)

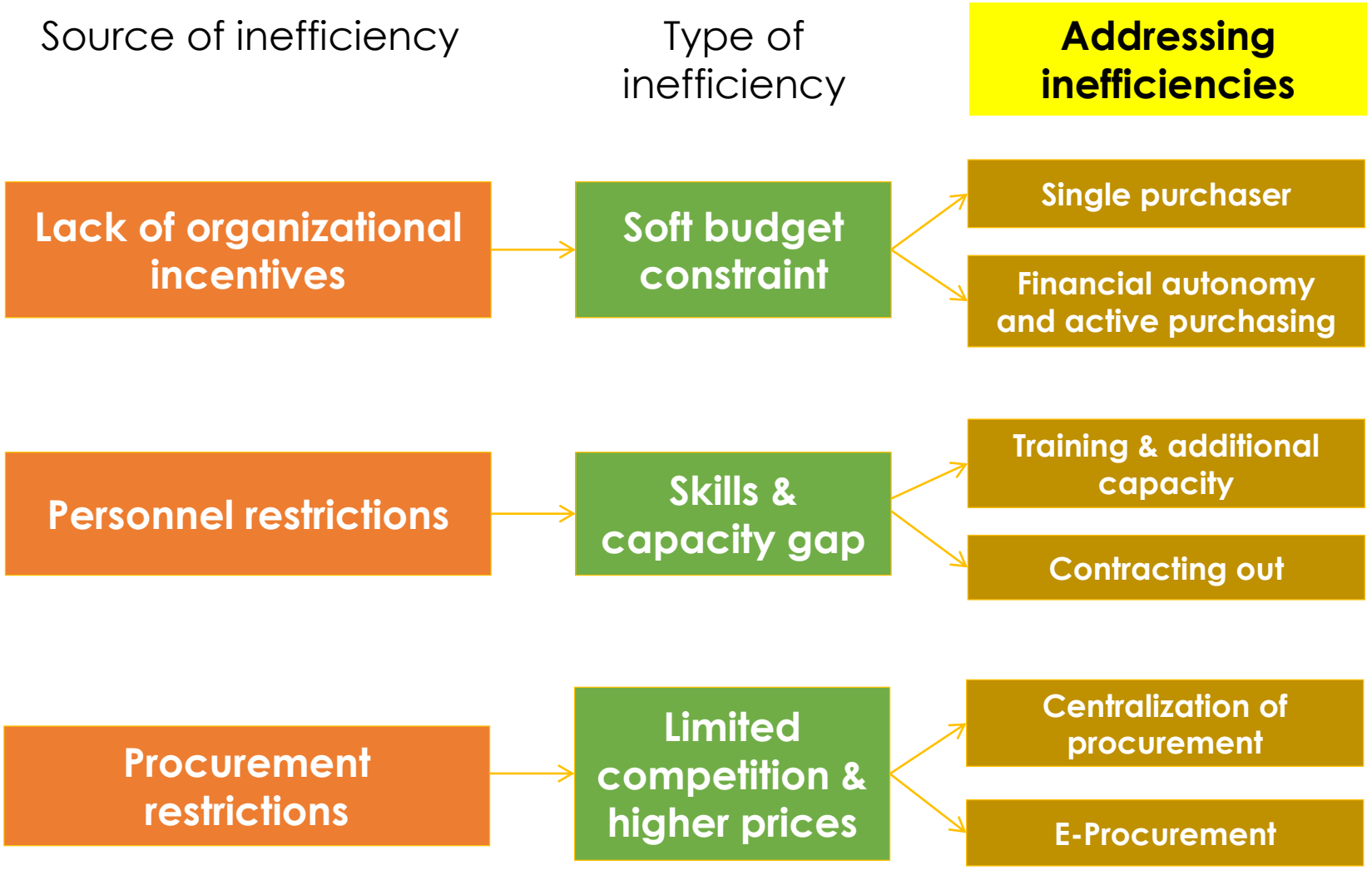


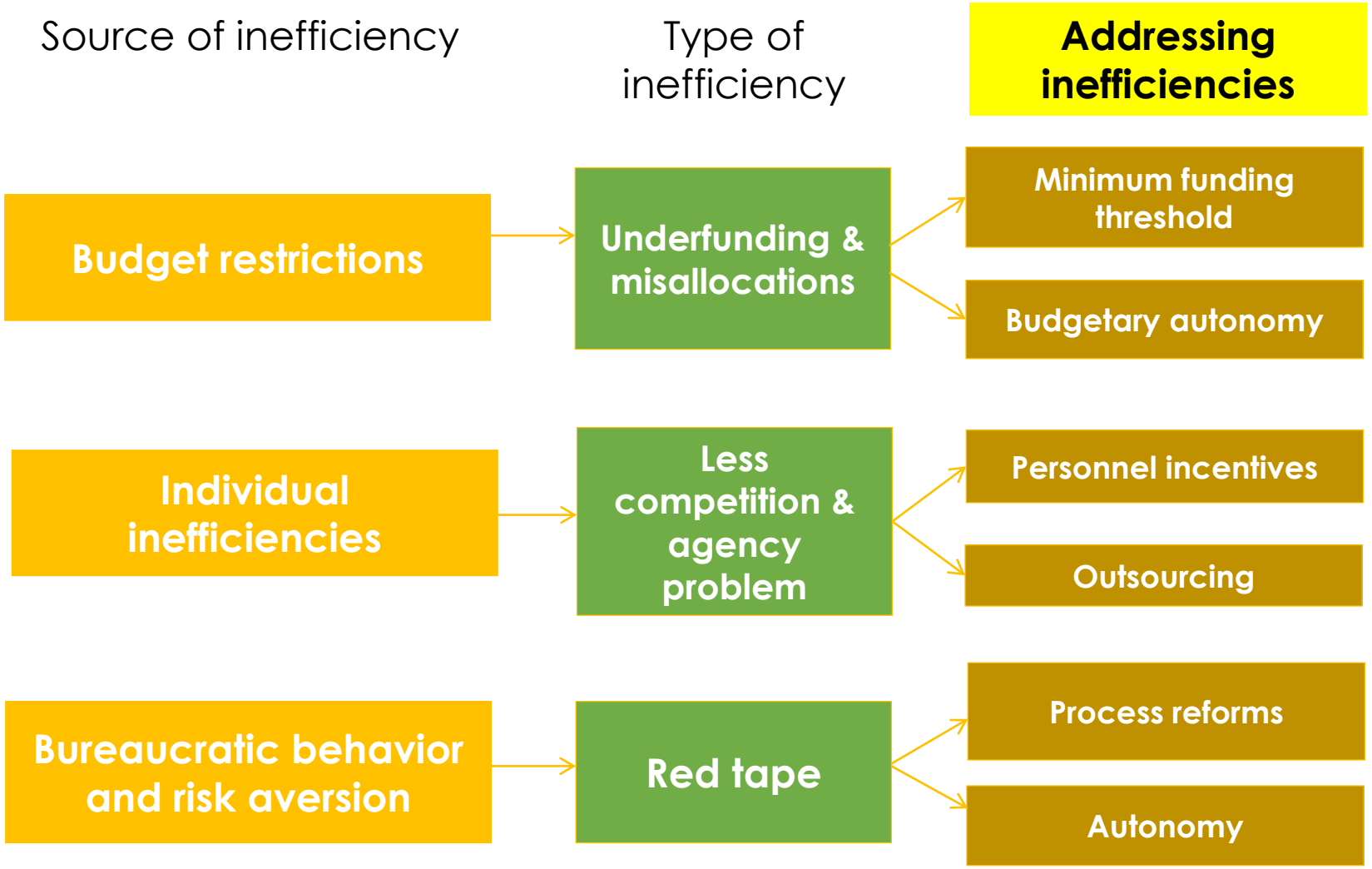
Among the UHC measures are increased increased public sector health spending



Source: authors

BUT need to address public sector inefficiencies


Source of inefficiency
Type of inefficiency
Addressing inefficiencies
Lack of organizational incentives
Soft budget constraint
Single purchaser
Financial autonomy and active purchasing
Personnel restrictions
Skills & capacity gap
Training & additional capacity
Contracting out
Procurement restrictions
Limited competition & higher prices
Centralization of procurement
E-Procurement


Source of inefficiency
Type of inefficiency
Addressing inefficiencies
Budget restrictions
Underfunding & misallocations
Minimum funding threshold
Budgetary autonomy
Individual inefficiencies
Less competition & agency problem
Personnel incentives
Outsourcing
Bureaucratic behavior and risk aversion
Red tape
Process reforms
Autonomy

National Health Insurance (NHI) Systems help address these inefficiencies and maximize value for money

From Korea and Thailand to…

- PRC
- Philippines
- Indonesia
- Viet Nam
- Laos
- Nepal
- Mongolia
- India
- Pakistan
- Armenia
- Other DMCss

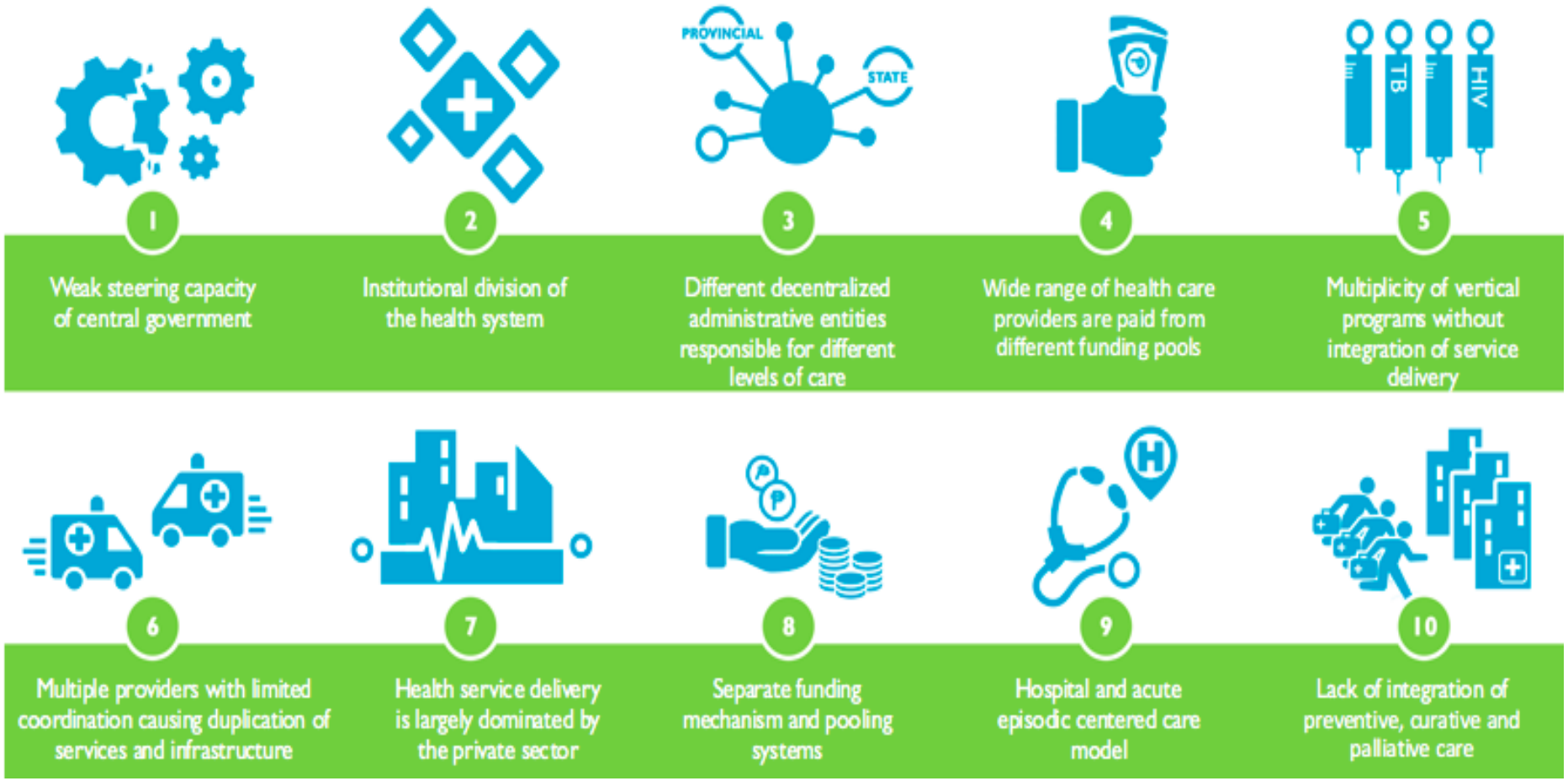
NHI

- Common features in Asia:
  - ✓ **A national agency or body serves with more or less autonomy from the state, sometimes even as a legal entity apart from the government**
  - ✓ **This organization operationalizes health financing functions by ensuring citizens' financial protection, and purchasing health services and goods on behalf of a population.**
  - ✓ **Potential to carry a stewardship function for the whole health system, and provide an opportunity for efficiency gains in each sub-function that is beyond operations by the public sector**.
- Often referred to **national health insurance, national health service, national hybrid health insurance, national health fund, national social security fund** …

BUT…

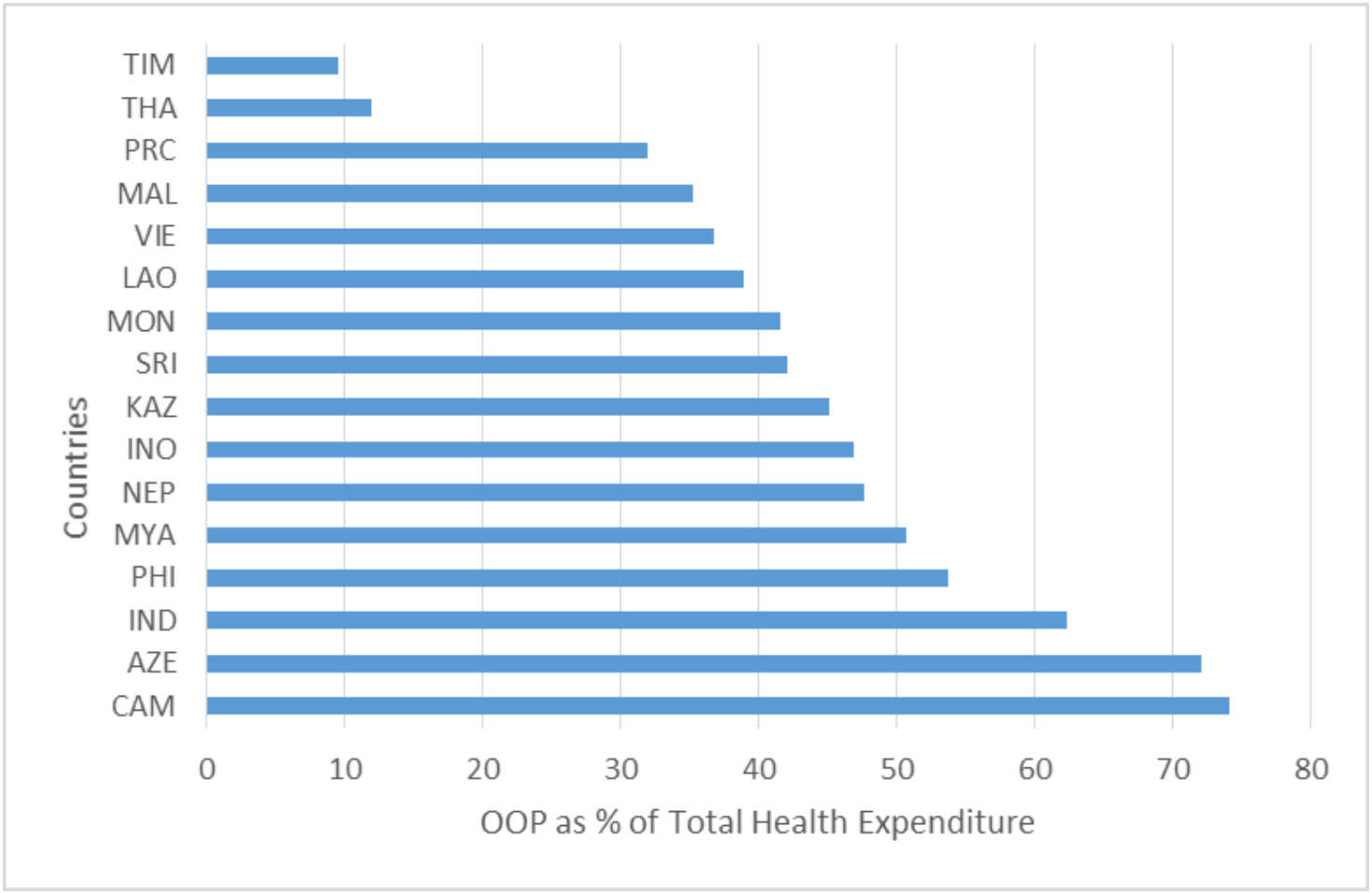
NHI may aggravate Fragmentation

10 CAUSES OF FRAGMENTATION



NHI is not automatically equivalent to Strategic purchasing

High Out of Pocket (OOP) spending continue to persist in a number of countries in Asia and the Pacific



Source: WHO Global Health Observatory, 2014

Need to build up ”new” health system skills and capacities

- Contracting/ Managing health care providers and sub-national
- Costing/ financial management
- Digital health
- Determining and measuring quantity an quality of care
- Managing capitation, case rate, pay for performance and other payment systems which is not line-item budget, salary and unregulated fee for services
- Making financial autonomy work in hospitals and health care providers
- Management/governance of a separate health fund

Is NHI an appropriate way to pay for primary care?

Gaps in Primary Care Service Coverage

Country	Skilled Birth Attendance	Antenatal Care Services - at least four visits (%)	Married or in-union women of reproductive age who have their need for family planning satisfied with modern methods (%)	DTP3 coverage (%)	Estimated ART coverage among people with HIV (%)	Tuberculosis Treatment Coverage (%)	Population using improved drinking-water sources (%); Urban and Rural total	Population using improved sanitation facilities (%); Urban and Rural Total
	Latest Available Year	*Latest Available Year*	*Latest Available year*	2016	2016	2015	2015	2015
Azerbaijan	99.9	66.1	21.5	97	30 (22-40)	81 (67-98)	87	89.3
Cambodia	89	75.6	56.4	90	80 (70-92)	59 (42-92)	75.5	42.4
India	81.1	49.7	63.9	88	49 (40-61)	59 (36-110)	94.1	39.6
Indonesia	87.4	83.5	78.8	79	13 (11-15)	32 (23-50)	87.4	60.8
Kazakhstan	100	87	79.6	82	31 (27-37)	89 (81-99)	92.9	97.5
Lao, People Democratic Republic	40.1	36.9	61.3	82	41 (36-47)	37 (26-57)	75.7	70.9
Malaysia	99	-	-	98	37 (34-41)	87 (75-100)	98.2	96
Mongolia	98.9	89.6	68.3	99	33 (31-39)	37 (23-72)	64.4	59.7
Myanmar	60.2	73.4	58.5	90	55 (48-63)	70 (54-96)	80.6	79.6
Nepal	55.6	59.5	56	87	40 (35-47)	75 (66-85)	91.6	45.8
People's Republic of China	99.9	-	96.6	99	-	87 (75-100)	95.5	76.5
Philippines	72.8	84.3	51.5	86	32 (29-35)	85 (74-99)	91.8	73.9
Sri-Lanka	98.6	92.5	69.4	99	27 (18-39)	69 (52-96)	95.6	95.1
Thailand	99.6	93.4	89.2	99	69 (60-79)	53 (35-89)	97.8	93
Timor-Leste	29.3	55.1	38.3	85	-	57 (40-87)	71.9	40.6
Viet Nam	93.8	73.6	69.7	96	47 (41-53)	79 (65-98)	97.6	78

Source: WHO Global Health Observatory; Accessed October 16, 2017

Country experiences

Social Health Security Program

(Health Insurance)

Dr. Bhuwan Paudel
Senior Public Health Administrator
Health Insurance Board,
Government of Nepal

Milestones

- **2015/16 : mentioned in the new constitution.**
  :Health insurance policy and regulation
  : Program Started in one district
- **2016/17 – Expanded to eight districts.**
- **2017/18 – Health insurance Act.**
  - **Program reached up to 40 districts (till now)**
- **2018/19 – Planned to cover entire nation (77 districts)**
- **Population Coverage : up to 1 Million till date**

(~3.5% of Total Population and approx. 8% at the district level)

- **Out of total insuree 15% are ultra-poor- premium is paid by government)**

Paying Primary Health Care Facilities

- Basic health service packages : stage of approval and government commitment to provide free of cost
  (Not implemented now)

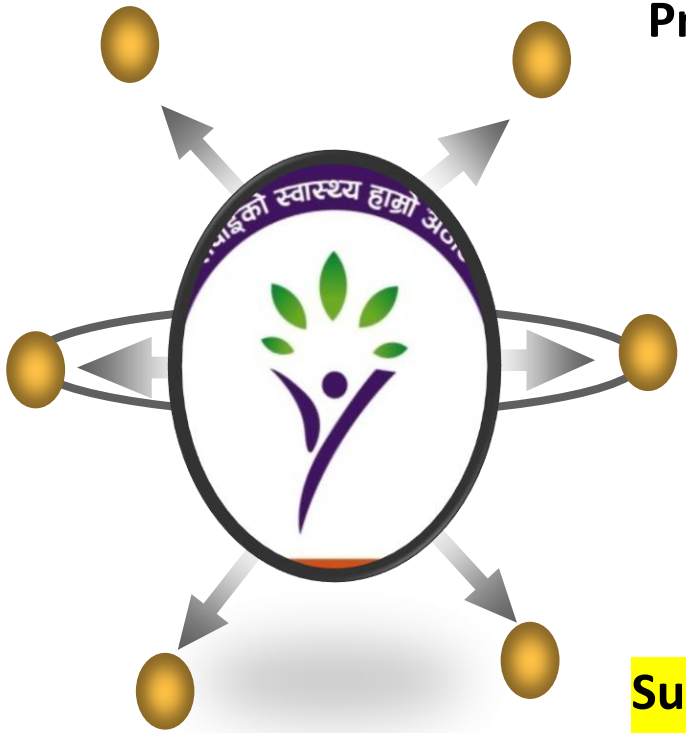
- According to HI Act : Health insurance pay for the service not covered by BHS.

- Health insurance is Paying for the service where people have to pay including Primary health facilities.

Features of Health Insurance in Nepal

Contributory/Family Based

Purchaser and Provider Split



Cash-less and (Upper Cap)

IT based (IMIS)

Subsidy to Poor and Targeted Population

Public and Private Providers

Service started from Primary health center

Enrollment

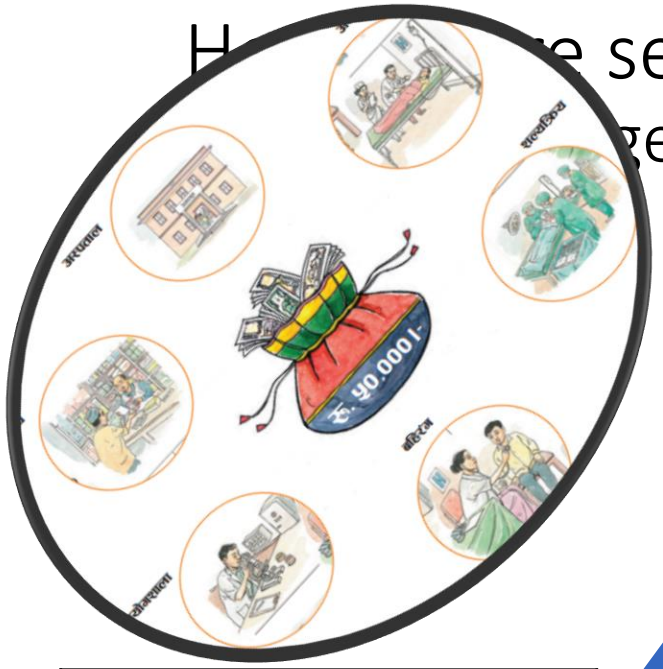
- Voluntary
- People from all ages
- Family as a Unit,,
- By Enrollment Assistant (EA)

Premium

Rs 2500/family(5 mem)/year

Rs 425 /added member /year

H e services
ge)



1) Free Drugs

2) Free care services.

3) Targeted free care service

Rs 50,000/year/5 member
Rs 10,000/added member/yr maximum Rs 100,000

Services

1) **OPD**
2) Emergency
3) Inpatient, Drugs
4) Procedure Operations

Negative List

1) Cosmetic surgery
3) Equipment like artificial organ, reading glass not more than 1000 once in a year, hearing machine less than 5000
4) Artificial insemination services, organ transformation, Sex transformation etc.
5) Injuries treatment cost due to personal warfare
6) Accident related treatment due to alcoholic and drug use
7) In the case of dental treatment, modern dental implant, root canalling, etc.

1. A. General OPD & Emergency Services

OPD Package (NPR. 200 for hospital/ patient, PHC 100/patient)
Diagnostic tests covered under OPD package
•Consultation/ Medical examination
•TC/DC/Hb
•Stool RE, Urine ME/RE
•Blood Sugar (up to 2 times)
Emergency Package (NPR. 400 for hospital/ patient for patients getting discharged from emergency)
Diagnostic tests covered under Emergency package
•Consultation/Medical examination
•TC/DC /Hb
•Urine ME/RE
•Blood Sugar (one time)
•S. Creatinine
•ECG

If member comes to referral center without referral slip, (exception emergency):member has to bear all the treatment cost

Reimbursement Process of Primary Health Care Providers:

- Service providers lodge the claims for services provided through IMIS software (Daily basis).
- The software auto-reviews the submitted claims (first level audit based on filters set), software passed claims reach to reviewers.
- The Claim Review Team at Health Insurance Board reviews the claims and uploaded supporting documents. Approved claims are processed for reimbursement.
- A number of claims are also reviewed by the Quality Control & Monitoring (Claim Review) Committee at HIB. Committee reviews submitted documents and may request for any additional documents if required.
- Approved claims are processed for release of payment.

PRIMARY HEALTH CARE FINANCING

REPUBLIC OF ARMENIA

Background

- GNI per capita is US$4,020
- Life expectancy is 75 years
- Maternal mortality ratio of 25 per 100,000 live births
- Neonatal mortality rate of 7 per 1,000 live births
- Under-five mortality of 14 per 1,000 live births
- Total health expenditure per capita around US$162, about 4.5% of GDP

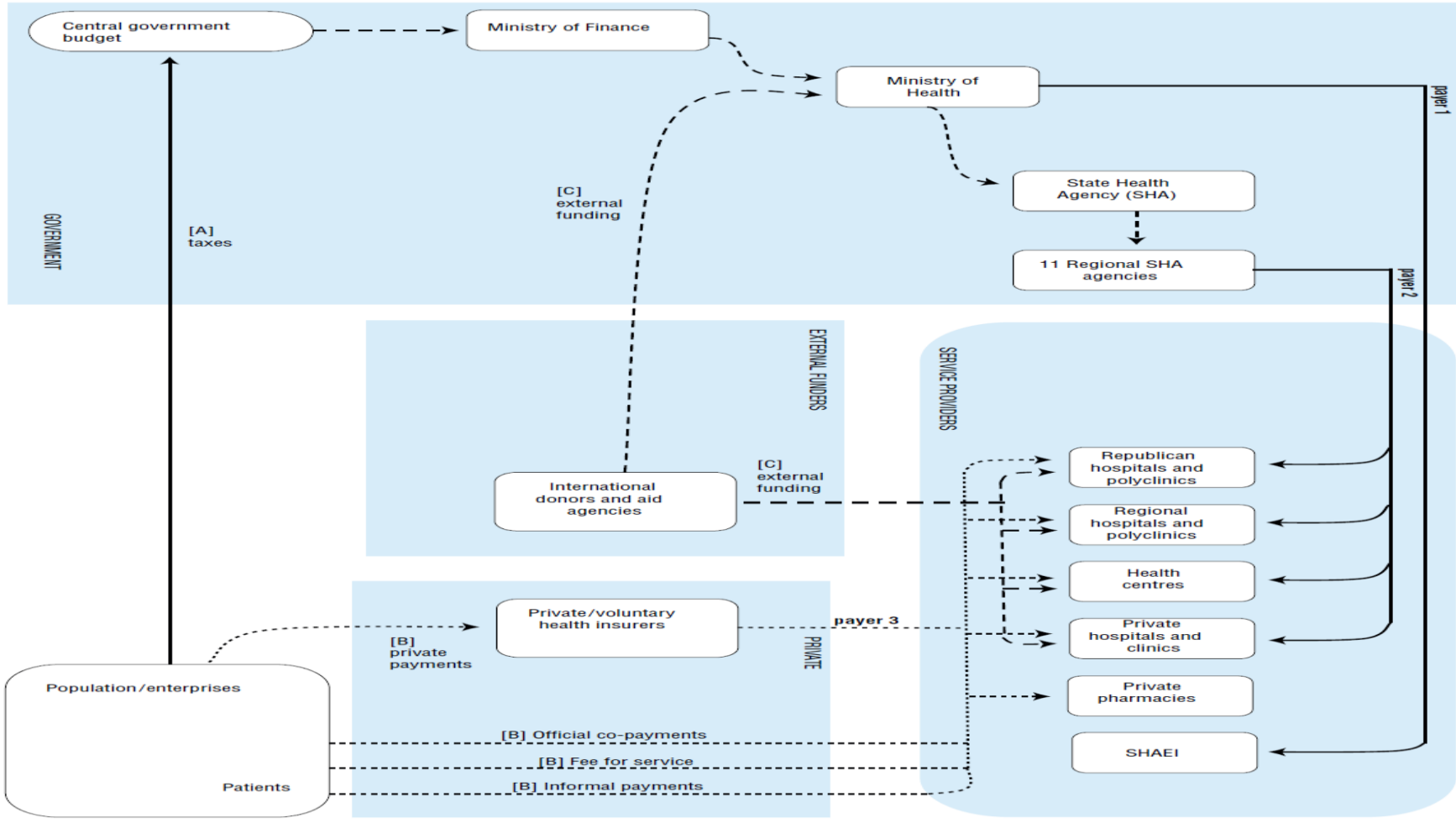
STATE HEALTH AGENCY (SHA)

- Establishment in 1997
- Objective:
  - to separate the public purchasing function from the public provider function, which were both under the MoH.
  - to contract both public and private providers to deliver BBP, monitor and pay the health providers and to become a strategic purchaser.

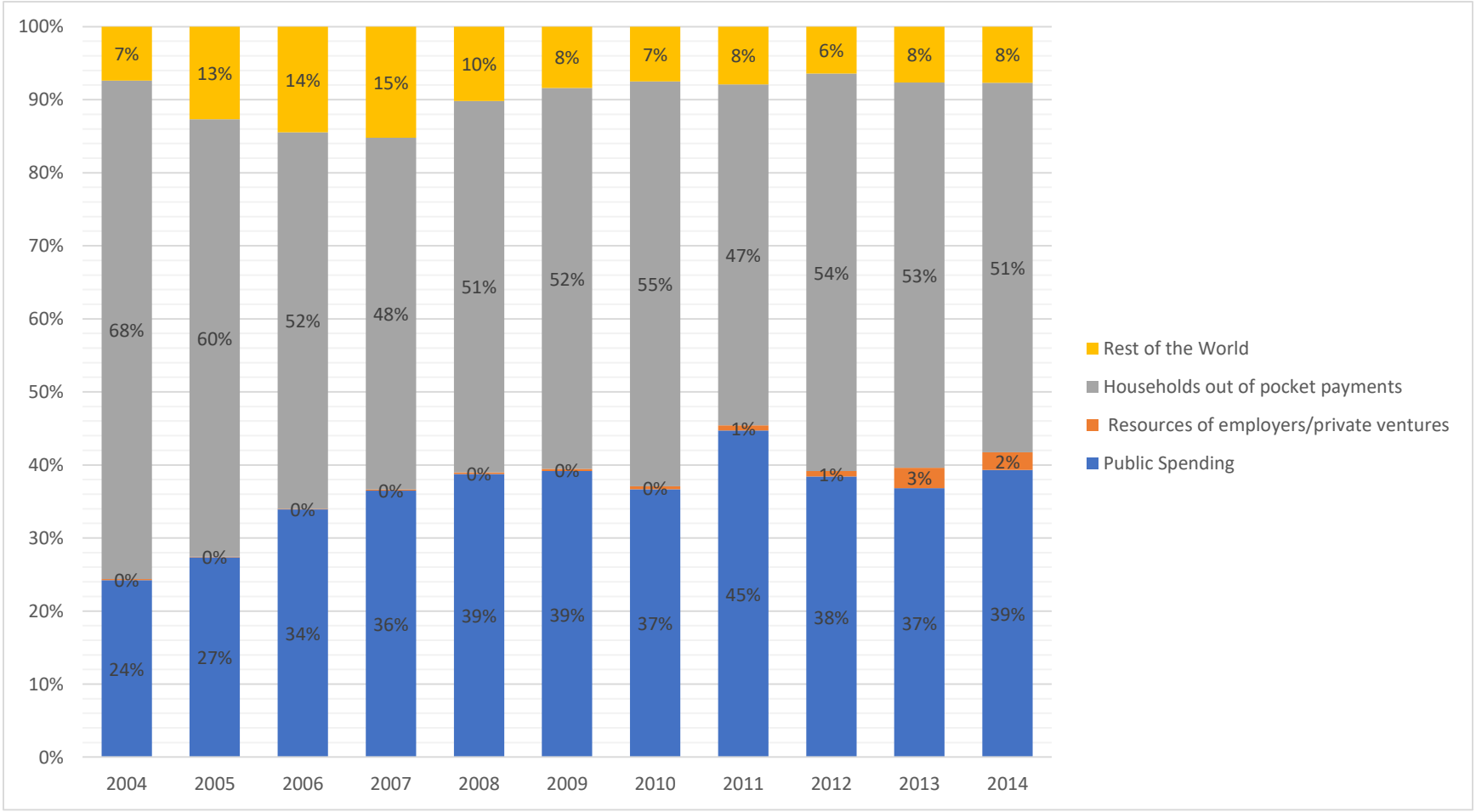
- The SHA retained its status of a semi-independent purchasing agency until 2002 on the same level as other ministries, then it was incorporated within MoH structure.

- SHA is responsible for the allocation of financial resources, based on annual contracting mechanisms with health care provider organizations and monitoring the quantity and quality of services provided.

Financial flows in Health System Armenia



Distribution of Financing Sources



Structure of Financing of Outpatient Care (including primary care)

Financing of Outpatient Care is carried out based on the volume of the reports on performed activities, but not more then the Contractual Price, is following:

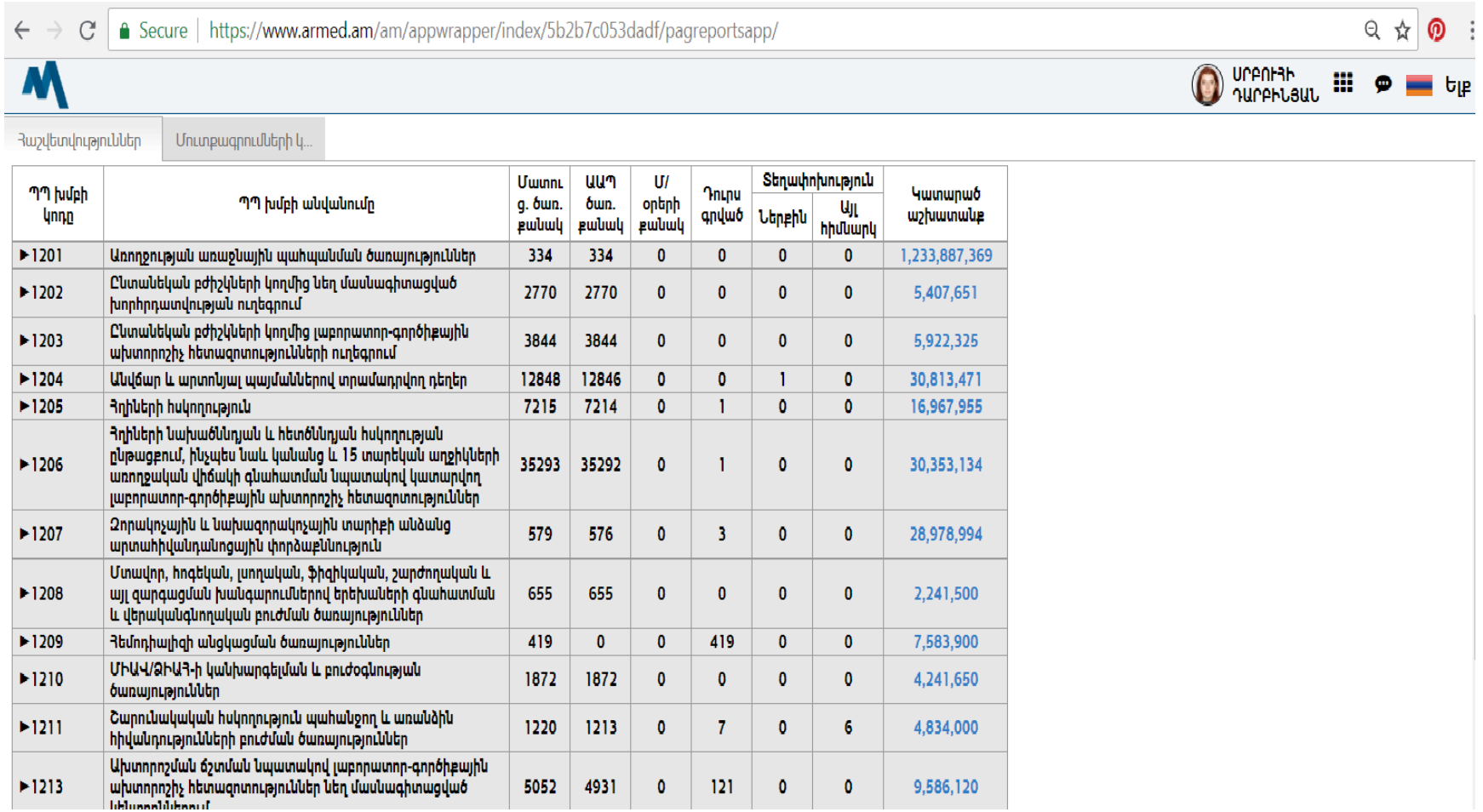
- Payment of physicians and nurses, as well as laboratory-instrumental examinations - on per-capita basis (including general practitioners, family physicians, pediatricians, OBG-s of women consultations, narrow specialists, school nurses).
- Financing of medicine provision - based on the number of population (special groups/ vulnerable).
- Financing for antenatal care (the number of registered pregnant women per-month).

Basic Benefit Program (BBP)

- BBP covers
  - PHC services, and emergency services for 100% of population, with co-payment schedule for some services (no co-payment for poor/vulnerable);
  - inpatient services for poor, vulnerable and special categories (with exception of high-tech health care services) and group of diseases by 100%.
- BBP law is called State Health Targeting Program (AL-139) which was enacted on December 2000 and became effective January 2001.

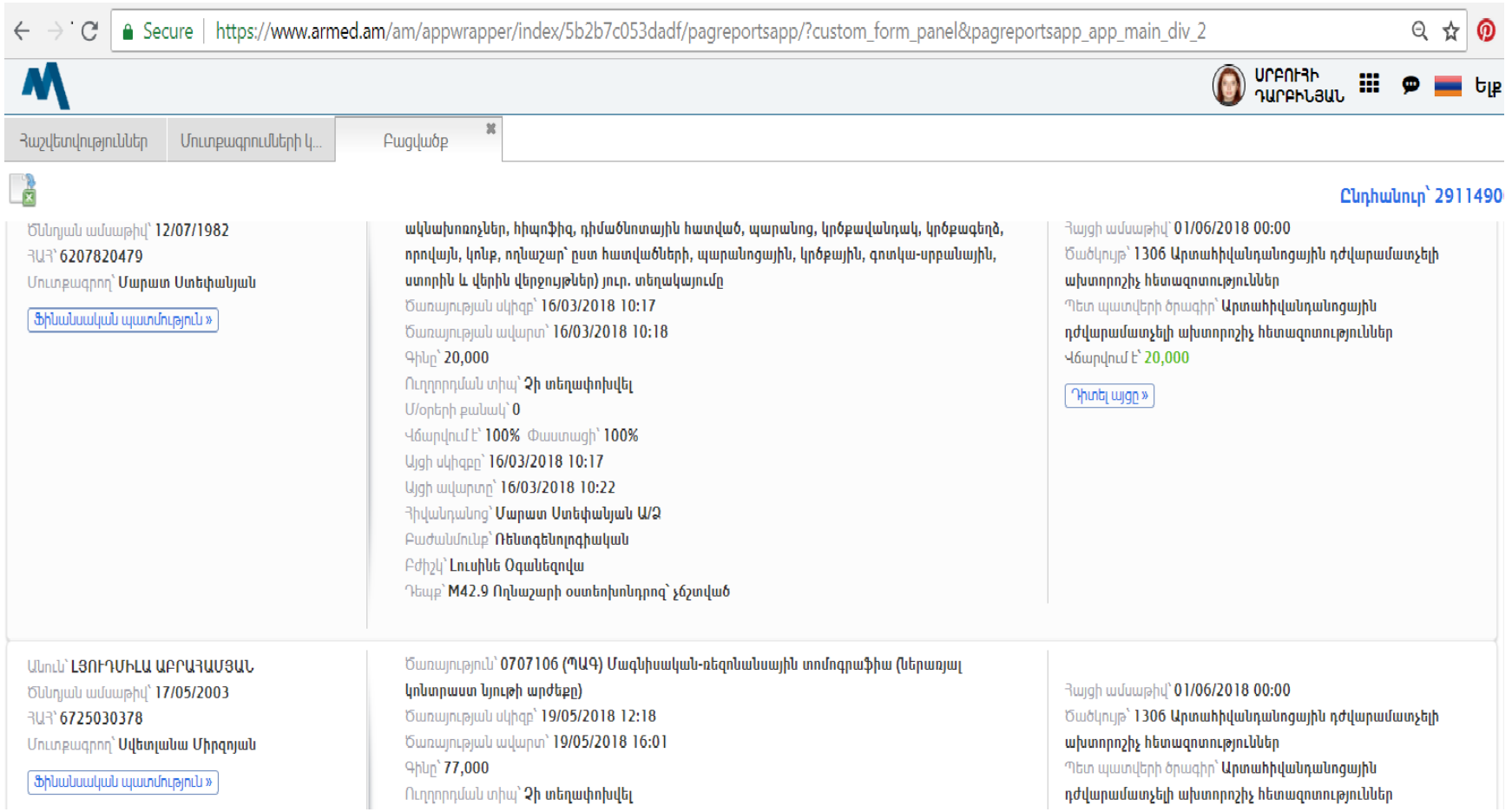
- MoH contracts all health facilities through SHA which in turn pays the facilities, and monitors facilities' reports. SHA purchases BBP from almost all public and private providers in Armenia.

E-health



ՊՊ խմբի կոդը	ՊՊ խմբի անվանումը	Մատուց. ծառ. քանակ	ԱԱՊ ծառ. քանակ	Մ/օրերի քանակ	Դուրս գրված	Տեղափոխություն		Կատարած աշխատանք
						Ներքին	Այլ հիմնարկ	
▶1201	Առողջության առաջնային պահպանման ծառայություններ	334	334	0	0	0	0	1,233,887,369
▶1202	Ընտանեկան բժիշկների կողմից նեղ մասնագիտացված խորհրդատվության ուղեգրում	2770	2770	0	0	0	0	5,407,651
▶1203	Ընտանեկան բժիշկների կողմից լաբորատոր-գործիքային ախտորոշիչ հետազոտությունների ուղեգրում	3844	3844	0	0	0	0	5,922,325
▶1204	Անվճար և արտոնյալ պայմաններով տրամադրվող դեղեր	12848	12846	0	0	1	0	30,813,471
▶1205	Հղիների հսկողություն	7215	7214	0	1	0	0	16,967,955
▶1206	Հղիների նախածննդյան և հետծննդյան հսկողության ընթացքում, ինչպես նաև կանանց և 15 տարեկան աղջիկների առողջական վիճակի գնահատման նպատակով կատարվող լաբորատոր-գործիքային ախտորոշիչ հետազոտություններ	35293	35292	0	1	0	0	30,353,134
▶1207	Զորակոչային և նախազորակոչային տարիքի անձանց արտահիվանդանոցային փորձաքննություն	579	576	0	3	0	0	28,978,994
▶1208	Մտավոր, հոգեկան, լսողական, ֆիզիկական, շարժողական և այլ զարգացման խանգարումներով երեխաների գնահատման և վերականգնողական բուժման ծառայություններ	655	655	0	0	0	0	2,241,500
▶1209	Հեմոդիալիզի անցկացման ծառայություններ	419	0	0	419	0	0	7,583,900
▶1210	ՄԻԱՎ/ՁԻԱՀ-ի կանխարգելման և բուժօգնության ծառայություններ	1872	1872	0	0	0	0	4,241,650
▶1211	Շարունակական հսկողություն պահանջող և առանձին հիվանդությունների բուժման ծառայություններ	1220	1213	0	7	0	6	4,834,000
▶1213	Ախտորոշման ճշտման նպատակով լաբորատոր-գործիքային ախտորոշիչ հետազոտություններ նեղ մասնագիտացված	5052	4931	0	121	0	0	9,586,120

E-health system



Performance Based Financing

- Implemented since 2011 with 10 performance indicators.
- Initiated by MoH to supplement existing per-capita payment mechanism for PHC providers with incentive scheme.
- Government-funded, no external support (except for technical assistance and trainings)
- Covers ALL PHC providers nationwide (~ 350 facilities)

PBF Scheme

- Increased up to 30 indicators in 2012

Before 2015

- Payment frequency – annual (second quarter of next year)
- Bonus payments substituted 5 to 7 percent of providers' annual income
- Indicators cover:
  - Disease prevention (6 indicators)
  - Control of chronic diseases (7 indicators)
  - Maternal and Reproductive Health (3 indicators)
  - Child Care (7 indicators)
  - TB detection (1 indicator)
  - Maintaining Electronic Registers of Patients with certain Diseases (6 indicators).

PBF Scheme

- Since 2015 the payment of incentives is done semi-annually in accordance with the level of achievement of 28 performance indicators
- Each visit to PHC provider is registered with special form, then entered into electronic HIM system
- For 2018 PBF scheme and list of indicators is under revision.

Social Package (SP)

- In 2012, the government introduced a new initiative called the Social Package for the Government, covering civil servants and public employees working in education, culture and social protection sectors.
- Each employee received a voucher for 132 thousand AMD and mandatory 52 thousand should be spent for health insurance, also it was allowed to spend the remaining amount to cover more comprehensive health insurance plans.
- Since year 2015 also for above mentioned category of employees was introduced an annual cheek up program.
- Starting 2017 medical care and service for the Beneficiaries is organized and financed through health insurance contracts concluded between the MOH and the private health insurance provider companies.

Challenges for Armenia

- The current and further reforms of healthcare system financing mechanisms in Armenia should be directed towards:
  - reduction of shadow turnover,
  - increase of health budget allocation to PHC,
  - further improvement of financing mechanisms, including introduction of new targeted PBF scheme,
  - introduction and implementation of quality assurance mechanisms.

Summary

- Many countries in Asia and Pacific are establishing and/or expanding national health insurance as part of their efforts to pursue and achieve universal health coverage

- NHI is also being adopted for it helps address government health sector inefficiencies, enable access to needed health care services including primary care services, and allows the harnessing and aligning of the private health sector to support government objectives.

- Several Asian countries has used their NHI to introduce and/or broader primary care services. However, several countries have not fully integrated primary care services into their NHIs.

- NHI has great potential to widen primary care services and addressing the bottlenecks and barriers to NHI coverage would be crucial in ensuring that this potential is met.