



LNCT

Learning Network for
Countries in Transition

Immunization and National Health Insurance

Key immunization functions

Grace Chee, R4D
Helen Saxenian, R4D
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Design issues for the immunization program as national health insurance (NHI) is introduced and expanded

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- V. Do payment methods provide sufficient incentives for service provision?
- VI. Special issues of multiple insurance pools

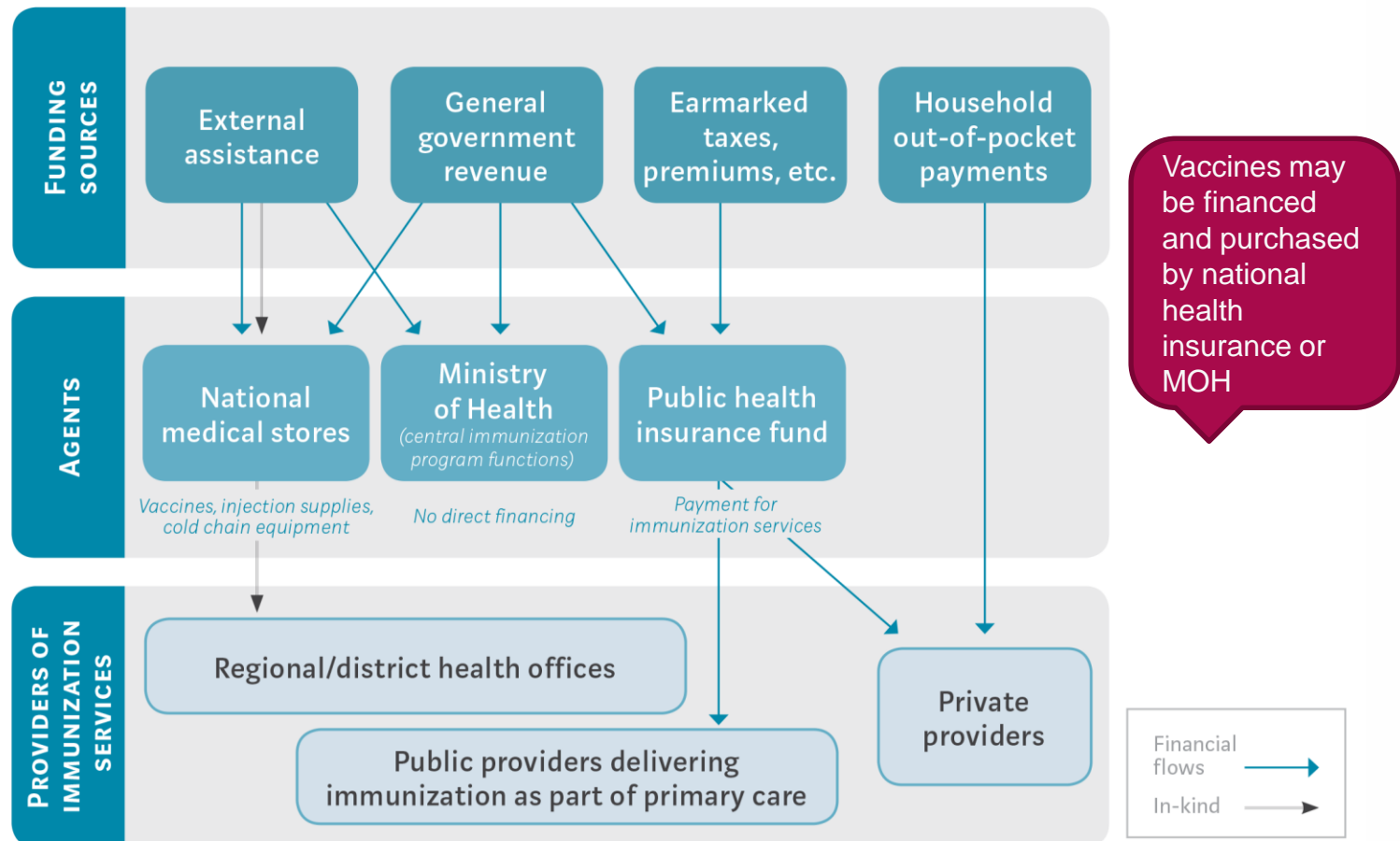
Given broad designs of national health insurance in your country, how might policies be fine tuned to support high immunization coverage, equity, quality and efficiency?

There is no one model, workshop will explore positive and negative experiences to draw out lessons

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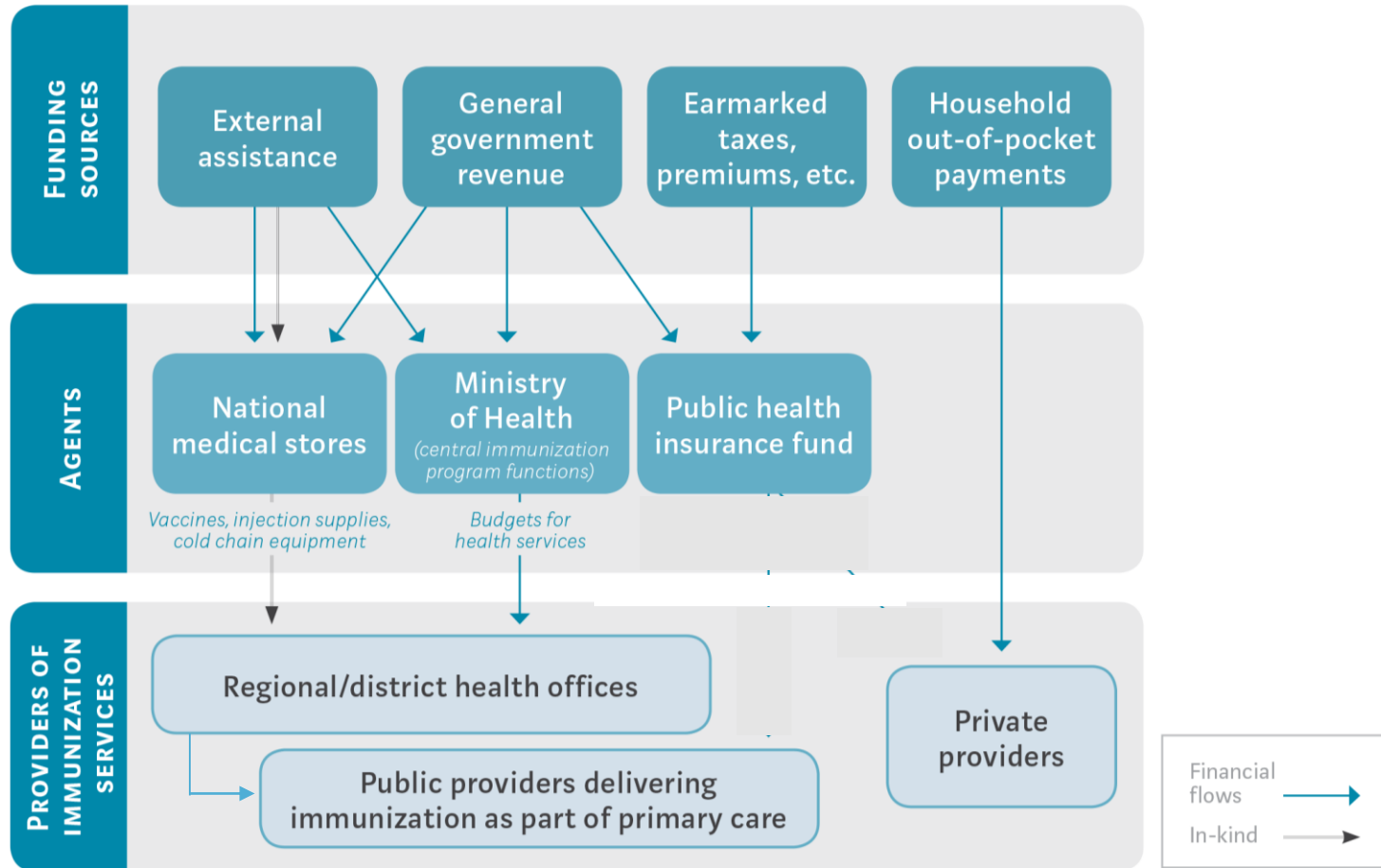
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Immunization in the benefits package; MOH has no role in separately financing services (Georgia, Thailand)



Source: Immunization Financing Resource Guide, p.25

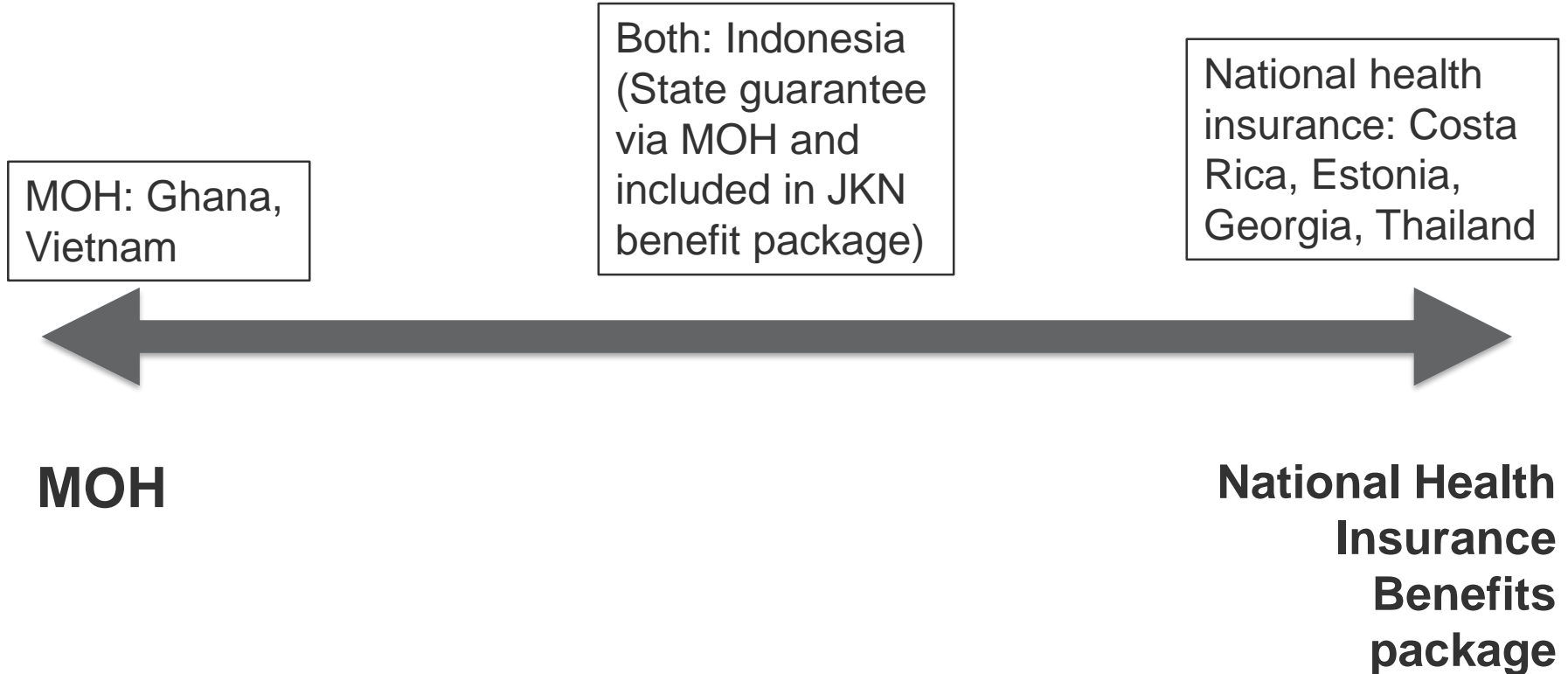
MOH continues to fund services; immunization not in benefits package (Ghana, Vietnam)



Source: adapted from Immunization Financing Resource Guide, p.24

Immunization services: financed and supplied by MOH or financed in benefits package or both?

Examples from LNCT countries and other middle income countries around the world.....more of a continuum than a strict dichotomy



Key questions when immunization included in NHI benefits package?

- Is the entire population covered by NHI? If not, are subgroups outside of NHI scheme at risk of lower coverage?
- Might NHI financing offer more flexibility and scope for immunization requirements? (Costa Rica, influenza vaccine), or is the NHI budget already overstretched?
- How will new vaccine introductions be evaluated against competing priorities in the benefits package? (Thailand, robust decision-making process)
- Will provider payment methods provide sufficient incentives for immunization? Or are purchasers more interested in acute care?
- Will providers understand what their responsibilities are?
- If multiple NHI funds, is the overall system fragmented and inefficient with different coverage levels across beneficiary populations?

Key questions when immunization remains the responsibility of MOH

- What will happen to MOH budget as NHI grows? May be at risk of budget cuts as NHI financing needs increase (Ghana).
- Might immunization services be “crowded out” by NHI-reimbursed services at public facilities? (Ghana)
- Will population understand where they are entitled to immunization services? Is the system putting an extra burden on them to seek services at different locations?

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Vaccine procurement: who finances and who carries it out?

| Country | Vaccine procurement carried out/financed by | Comments |
|------------|---|---|
| Costa Rica | Social Security finances certain vaccines (70-85% of total costs); MOH finances remainder (15-30%). Both agencies carry out procurement separately. | <ul style="list-style-type: none"> • Divided up, historically, by vaccines. • Debate over which entity is then responsible for new vaccine introductions. • Vaccines are in the Social Security's pharmaceuticals budget, without a separate line item. Some concerns initially that this might pose a risk to vaccine financing, but has not been a problem to date. When need to unexpected purchases of influenza vaccine arose, Social Security drew on larger budget. |
| Estonia | Estonia Health Insurance Fund finances and carries out procurement | |
| Georgia | NCDC finances and carries out procurement | |
| Ghana | MOH/Gavi? Or now NHIS? | |
| Indonesia | MOH | |
| Thailand | UCS (National Health Security Office) | Some discussion about bringing it back to MOPH. |
| Vietnam | MOH | |

Regardless of who handles, international experience shows that vaccine financing and procurement, in most cases, should be a national function

- Vaccine procurement almost always remains national in LICs and MICs
 - Specialized knowledge required
 - Need for pooled resources
 - Accurate forecasting and budgeting
 - Economies of scale generated
- National level can handle tenders, with subnational levels then financing purchases.
- Under decentralization, Kenya shifted vaccine financing and procurement to its 47 counties.
 - Commitment to immunization, and understanding of vaccine procurement, was not equally strong across all counties.
 - Funding gaps and capacity issues led to procurement delays and shortages of vaccines and supplies
 - Financing and procurement then recentralized.
- Pakistan has decentralized vaccine financing to provinces. Federal level has to collect money from provinces to meet Gavi co-financing commitments.

Pros and cons of who handles vaccine procurement? MOH or Insurance entity?

- No one answer
- Ideally centralized at the national level, unless strong argument for another approach
- Entity must have the specialize skills for vaccine procurement
- Some experience that national insurance can add budget more flexibly for urgent vaccine procurement requirements

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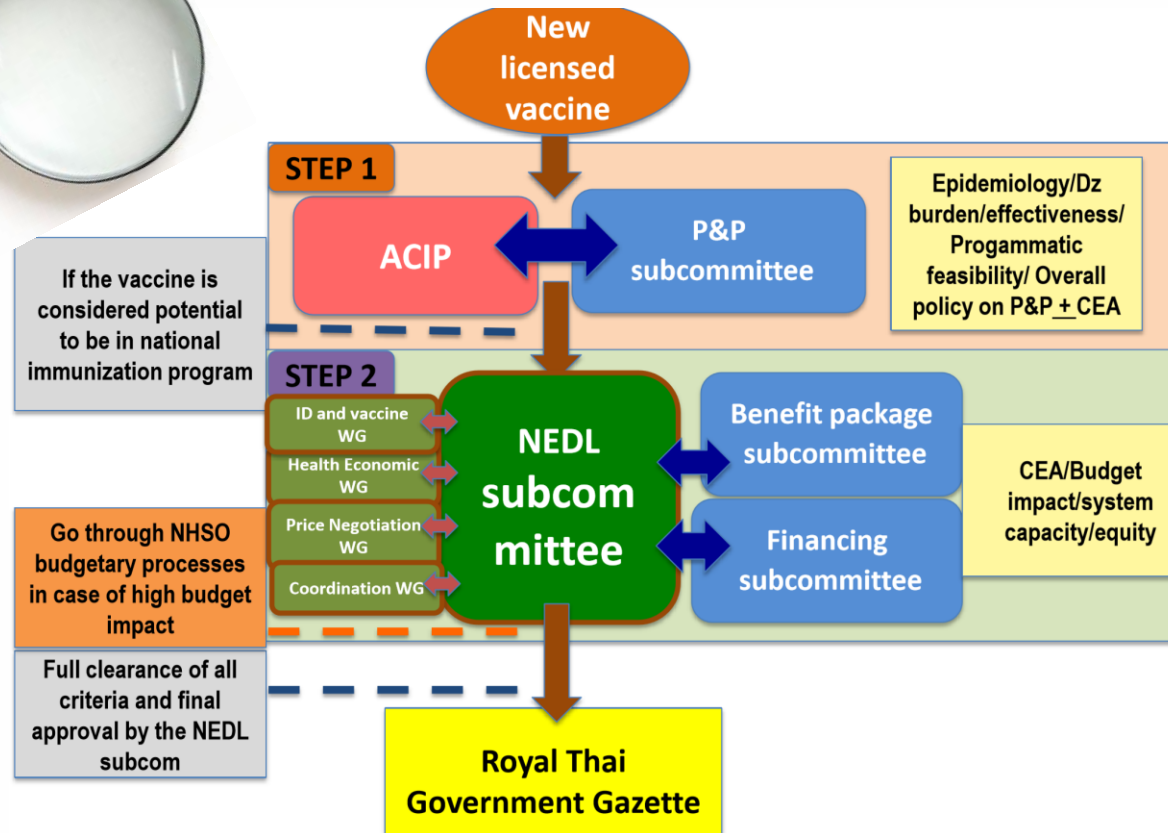
Non-Procurement Functions – with MOH or NHI? at national or subnational level?

| Key Functions | Including (non-exhaustive list) |
|----------------------|---|
| Policy setting | <ul style="list-style-type: none">• Issuing policies, guidelines, regulations (including NVI)• Strategy setting• Budget advocacy |
| Provider quality | <ul style="list-style-type: none">• Supervision• Providing training• Monitoring, reporting |
| Public health | <ul style="list-style-type: none">• Surveillance• AEFI response• Outbreak response• Monitoring and evaluation• Reaching underserved |

Policy setting (Issuing policies, guidelines, regulations, strategy setting, budget advocacy)

| Within MOH or NHI | With separation of purchasing and provision |
|---|--|
| <ul style="list-style-type: none">• How would NHI be consulted for policies with budget impact?• Is the NHI agency authorized to set policy?• Would MOH hold greater commitment to public health?• Is there potential conflict of interest to advocate for policies and budgets? | <ul style="list-style-type: none">• Do policies, regulations, and strategies, cover both public and private providers?• Are guidelines disseminated to all providers (including private providers)? |
| In collaboration with effective NITAG | |

Thailand: policy process for considering new vaccine introductions evaluated against entire benefits package and UCS funding



Provider quality (Supervision, training, reporting)

| Within MOH or NHI | With separation of purchasing and provision |
|---|---|
| <ul style="list-style-type: none">• Would supervision and training be funded from national or subnational budgets?• Does the NHI agency have capacity to conduct training or supervision?• Would NHI follow up on delayed reporting?• Would reporting be linked with vaccine supply or provider payment?• Would the NHI analyze data and be responsible for response? | <ul style="list-style-type: none">• Are private providers reporting on doses administered?• Who accredits and supervises private providers? Are they following the national immunization schedule, using WHO or country approved cold chain equipment? |

Georgia: National Center for Disease Control and Public Health (NCDC) engages closely with private providers given roles they play in immunization

In Georgia, Social Security Agency contracts health facilities (largely private) to provide immunization

- National Center for Disease Control and Public Health (NCDC):
 - ✓ Supplies vaccines and injection supplies
 - ✓ Provides training for introduction of new vaccines
 - ✓ Supervises both state supplied and commercially obtained vaccines
 - ✓ Supplies about half of cold chain to facilities
- However, some facilities:
 - May not be using cold chain that meets WHO standards
 - Are not reporting, especially on commercial vaccines

Source: Abt Associates. The Role of Private Sector Providers in Georgia National Immunization Program, 2018.

Public Health (Surveillance, AEFI & outbreak response, evaluation, reaching underserved)

| Within MOH or NHI | With separation of purchasing and provision |
|---|--|
| <ul style="list-style-type: none">• Does the MOH have unique capabilities related to outbreak response and surveillance?• Does the public expect government responsibility for AEFI?• Might the NHI have better financing options for reaching the underserved?• Are the underserved covered by NHI?• Does the NHI agency have incentives and capacity to develop/implement strategies to target the underserved? | <ul style="list-style-type: none">• Are private providers reporting on AEFI, VPDs? |

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Roles and responsibilities for immunization need to be clearly defined to prevent “falling through cracks”



Indonesia: Immunization in JKN capitated payments? Some providers not aware

- Individuals and providers are sometimes unclear on entitlements and funding sources for immunization services for insured vs uninsured, which could affect access for the uninsured.
- Funds for immunization services are part of the capitation payment to primary care providers under JKN (including immunization) but confusion among local governments and providers can result in capitation payments being used only for curative care, and private providers uncertain whether to provide services.



Ghana: Immunization falling through cracks

- Lack of clear delineation of roles and responsibilities between MoH and NHIA for budgeting, planning, and procurement of vaccines
- Little discretionary budget remaining to finance operational costs (99% to human resources)
- Reduced funding for cold chain, outreach, etc. means missed opportunities to increase coverage and equity

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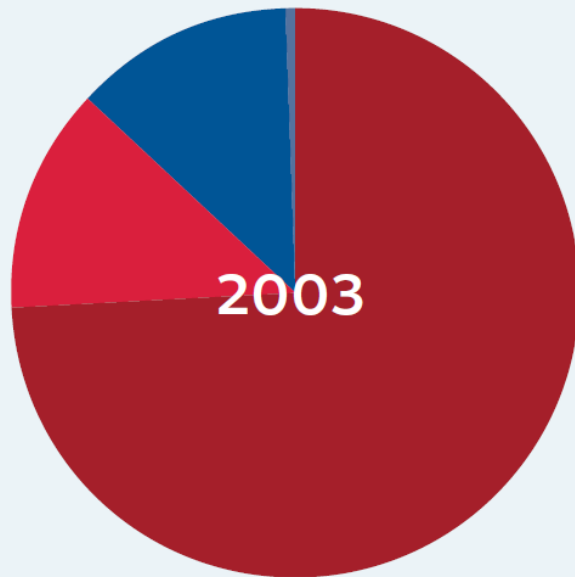
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Payments and incentives for immunization when financing and provision are separated

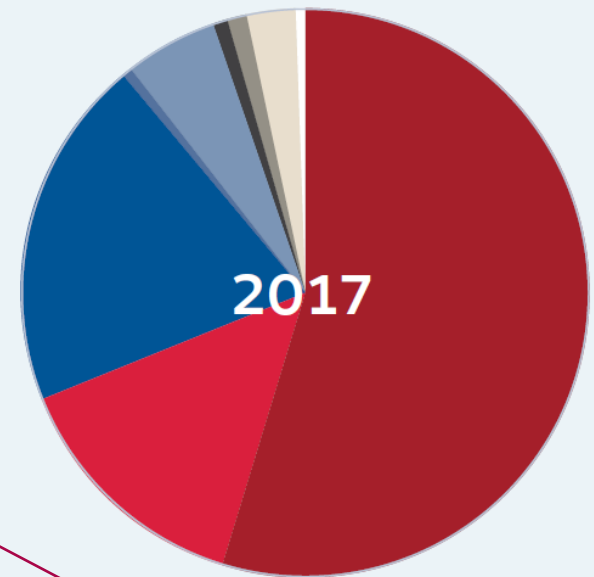
1. Provide vaccines and supplies directly, include other costs in capitated payments to providers
2. Provide vaccines and supplies directly, pay fee-for-service for vaccinations
3. Combination of (1) and (2)
4. Need for additional performance rewards?

Countries are experimenting with performance rewards for immunization: coordinated PHC payment in Estonia

EVOLUTION OF ESTONIA'S PHC CAPITATION PAYMENT SYSTEM (2003-2017)



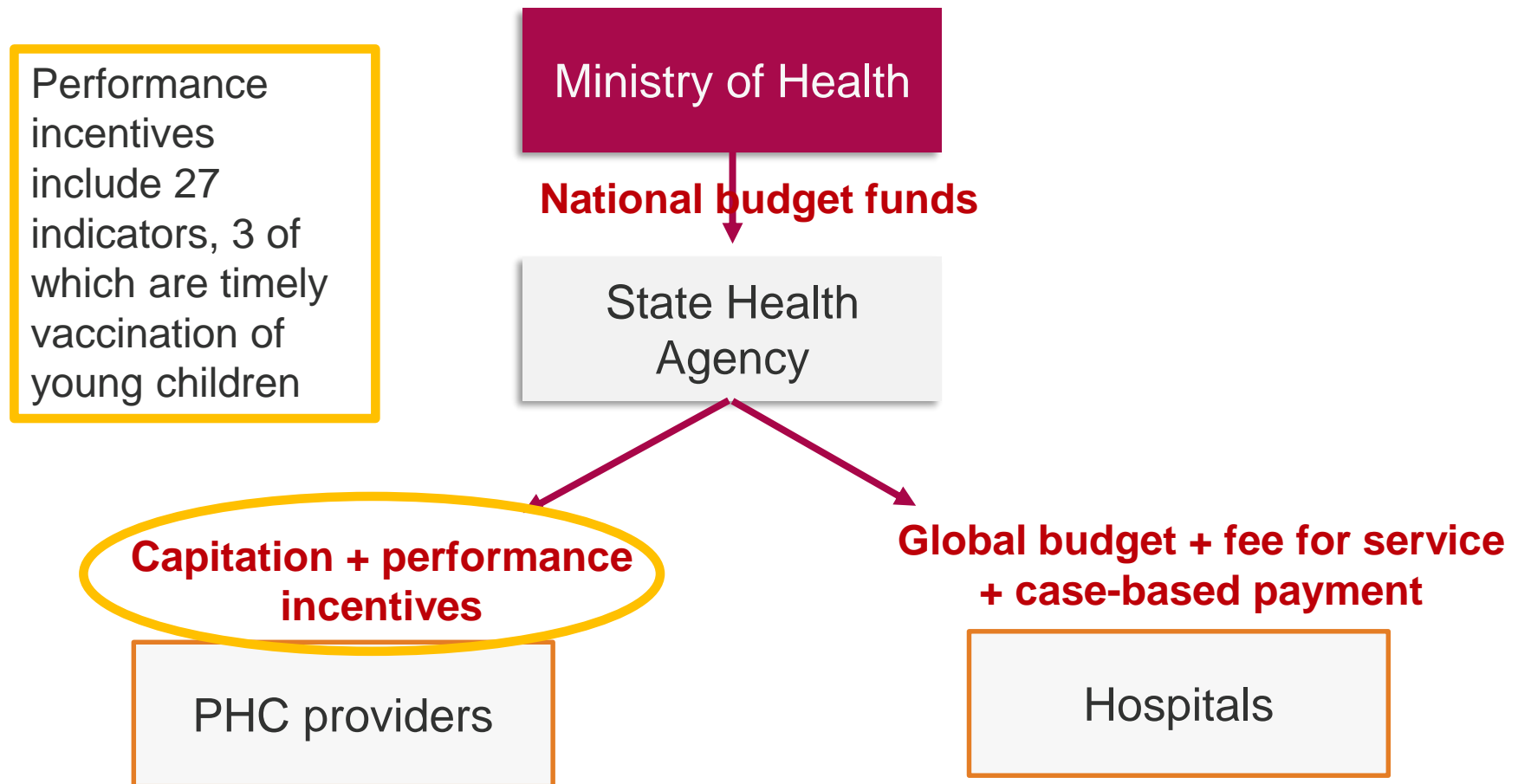
| 2003 | PAYMENT | 2017 |
|-------|-------------------------|-------|
| 74.3% | Capitation | 55.0% |
| 12.6% | Basic allowance | 14.1% |
| 12.6% | Investigation fund | 20.0% |
| 0.4% | Distance fee | 0.8% |
| - | Second nurse fee | 5.2% |
| - | Activity fund | 0.7% |
| - | Therapeutic fund | 1.3% |
| - | Quality bonus | 2.7% |
| - | Out-of-office hours pay | 0.4% |



Includes measure of fully immunized children

Source: JLN 2017

Experience with payment innovations: Armenia



UK: NHS payments to GPs are attentive to incentives for immunization

- GP practices receive a global capitation payment
- Directly receive vaccines and injection supplies
- If the GP opts out of immunization, the capitated payment is reduced by 1-2%
- Fee for service payments per vaccine delivered
- Payments for timely vaccination (if patient received vaccine within 3 months of eligibility)
- Some additional payments for reaching specified level of immunization coverage

Source: Tim Crocker-Buque, Kitty Mohan, Mary Ramsay, Michael Edelstein & Sandra Mounier-Jack (2019) What is the cost of delivering routine vaccinations at GP practices in England? A comparative time-driven activity-based costing analysis, Human Vaccines & Immunotherapeutics, DOI: [10.1080/21645515.2019.1619403](https://doi.org/10.1080/21645515.2019.1619403)

Provider payment for immunization: final thoughts

Performance rewards may be quite data intensive. Get underlying payment systems right (adequate funding of capitation and/or fee for service), then provide monitoring and feedback to providers as nudges?

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Special issues of multiple insurance pools

Thailand example: 3 insurance pools but only one is responsible for immunization

- Universal Coverage Scheme (UCS), 75% of population, funded by general taxation. Managed by National health Security Office (NHSO).
- Civil Servant Medical Benefit Scheme, 8% of population, civil servants, general taxation)
- Social Health Insurance, 16% of population, formal sector workers, employer/employee contributions and government
- UCS takes on responsibility for immunization

Mexico example (will learn more this afternoon)

- Six+ insurance pools, uneven immunization coverage across pools
- Coordination issues, fragmentation

Summary

- No one “perfect” model
- Higher level insurance design decisions likely a given; work to design policies that make sense for immunization
- Keep national functions at the national level
- Clarity is needed on who funds and who carries out what immunization functions; likewise population must know where it can get services
- Some immunization program functions may need to adapt to new actors, new ways of working (e.g. supervising, reporting, monitoring private as well as public providers)
- Temporary problems can arise from transition to new system versus more structural flaws in design: monitor and be in a learning mode to detect problems and adjust policies

