National Health Insurance Systems

Key Concepts and Issues

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The overarching goal: Universal Health Coverage

According to the World Health Organization

- Provide all people with access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective;
- Ensure that the use of these services does not expose the user to financial hardship

This definition of UHC embodies three related objectives:
- Equity
- Quality
- Financial protection

What functions does the system need for UHC?

- Provision of services
- Purchasing of services
- Pooling of funds
- Raising of revenues

- Cost sharing/user fees
- Access to providers
- Entitlement-based?
- Taxes and contributions

What functions does the system need for UHC?

- **Provision of services**
- **Purchasing of services**
- **Coverage schemes**
- **Raising of revenues**

**Governance, regulation, information**

**People**

- **Health service benefits**
- **Cost sharing/user fees**
- **Access to providers**
- **Entitlement-based?**
- **Taxes and contributions**
- **Choice?**

Pooling of funds

Universal—not entitlement-based

Provision of services

Often cost sharing/user fees

Supply-side rationing

Purchasing of services

May not have choice of provider, including private providers

People

Pooling of funds

Universal—not entitlement-based

Raising of revenues

Income and other taxes

MOH budget

Line-item budgets; public facilities only

Often not clearly defined

General taxes

In a traditional budget-funded health system

- MOH budget
- Line-item budgets; public facilities only
- Often not clearly defined
- General taxes
- Provision of services
- Purchasing of services
- Pooling of funds
- Raising of revenues
- Income and other taxes
- People
- Supply-side rationing
- Often cost sharing/user fees
Why we are not discussing budget-funded systems today

- Budget-funded systems can be an effective way to finance UHC.
- The focus of this meeting is national health insurance
  - All countries in the room have moved toward these mixed systems
- Our objective today is to discuss and learn how to make mixed NHI-budget systems work better for immunization
Terms and definitions for this meeting

- **National health insurance**
  A national health insurance system is a way of organizing health financing that:
  - relies completely (or mostly) on public sources of funds (e.g. payroll tax, general tax revenues, VAT, mandatory contributions)
  - defines specific entitlements in terms of benefits and financial protection
  - involves separation of the functions of purchasing and service provision

- **Related terms**
  - **Coverage schemes**—generic term used to describe different kinds of programs to provide access to services with financial protection (e.g. national health insurance, community-based insurance scheme, etc.)
  - **Public health insurance program**—another way to refer to a national health insurance system, but the use of “public health” sometimes causes confusion
  - **Social health insurance**—traditionally tied to employment
  - **Private voluntary health insurance**—does not rely on mandatory participation and contribution; managed by a private entity; typically charges premiums related to health risk and have less regulated (or unregulated) benefits packages
National health insurance

**Raising of revenues**
- Dedicated tax, general revenues, and/or premium contributions

**Pooling of funds**
- National insurance fund(s) or agency
- Contracting; multiple provider payment systems

**Purchasing of services**
- Provision of services
- Access to contracted providers
- Choice?
- Entitlement-based

**Benefits package**
- Cost sharing/user fees

**People**
- Entitlement-based
- Choice?
- Income and other taxes; premiums
Why do countries introduce NHI?

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>Challenges in Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hope of increased funding for the health sector</td>
<td>Funding allocation is often changed <em>within</em> the health sector not <em>to</em> the health sector</td>
</tr>
<tr>
<td>Creating a dedicated funding stream for the health sector</td>
<td>Earmarked funds often offset by reductions in other parts of the health budget</td>
</tr>
<tr>
<td>Explicit commitments to the population in terms of service entitlements</td>
<td>Even with explicit service entitlements, supply side constraints may limit access to services</td>
</tr>
<tr>
<td>Introducing a purchaser-provider split</td>
<td>A large share of funds often continues to flow through the supply-side budget</td>
</tr>
<tr>
<td>Increasing the flexibility in the use of funds, including new provider payment systems</td>
<td>Public financial management systems may limit the autonomy of providers to respond to new incentives</td>
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</tbody>
</table>
So there can be unintended consequences

Especially when there is a mixed model (NHI on top of budget system)

- Fragmentation in financing
- Confusing payment incentives for providers
- Over-emphasis on curative services, and crowding-out of health promotion and prevention
- Some people, services, and functions “falling through the cracks”

*Careful policy choices are needed to get the potential benefits of NHI and avoid the unintended consequences*

*This is particularly true for immunization*
How significant is NHI in the overall health financing landscape?

Countries in the room today

Source: WHO Health Expenditure Database; United Nations, Department of Economic and Social Affairs, Population Division (2019)
At your table

How are the functions carried out in your country’s NHI scheme?

Which services are in the benefits package?

How are providers paid to deliver covered services?

Where are the funds for the scheme(s) pooled?

What are the sources of revenue for the scheme(s)?

Provision of services

Purchasing of services

Pooling of funds

Raising of revenues

Is everyone entitled to the same services?.....

Is there cost-sharing?

Which providers can people access through the scheme? Is there free choice?

Do you have to register for the scheme or is everyone automatically covered? If there is more than one scheme do people have choice?

Who pays for the scheme(s)?
Example of Ghana’s National Health Insurance Scheme

- **Pooling of funds**
  - Earmarked VAT and social security payroll tax; small amount of premiums

- **Provision of services**
  - Provision of services
  - NHIS benefits package

- **Purchasing of services**
  - Ghana DRG payment; fee-for-service; public and private providers
  - No formal cost-sharing

- **People**
  - Access to all contracted providers (public and private)
  - Free choice of provider
  - Entitlement-based (must have NHIS card)
  - Single scheme—no choice

- **Raising of revenues**
  - VAT; social security payroll; premiums
Specifying the benefits package

Opportunity to explicitly prioritize

- Cost-effective services
- Services that meet most of the health needs of the population, especially vulnerable groups
- Services that create high financial burden

In practice, benefits are often defined based on political process
Promising more than can be delivered?

Source: WHO Advanced Course on Health Financing (Matthew Jowett, Benefit Design and Rationing)
Challenges

- Benefits overly general—unclear what’s in and what’s out
- Benefits promise more than the system can deliver
- Unclear entitlements
- No clear policy on cost-sharing and “balance billing”
- Fragmentation between preventive/promotive and curative services
- Challenge of bringing in donor-funded priority programs
  - How to ensure resources are available
  - Protecting coverage in the transition to universality
  - Parallel systems for procurement, supply chain, health workers and training
Benefits package in Ghana’s National Health Insurance Scheme

### NHIS Benefits Package

**Comprehensive:**
Estimated to cover 95% of health conditions affecting the population of Ghana

- Most necessary outpatient diagnostic and curative services
- Inpatient services and emergency care
- Maternity care
- Oral health
- Medicines according to the published list

**Preventive services (including immunization) excluded and covered for free by MOH.**

**Other excluded services:** not medically necessary (e.g. cosmetic treatments); some high-cost services (e.g. most cancer treatments and organ transplant)

**Full financial protection:** No cost-sharing

**Equitable:** same for all population groups
Purchasing of services

The opportunity to be strategic

Passive

Limited information used to allocate funds and pay providers, e.g.:

- Payment to providers based on inputs not linked to services
- Little/no selectivity of providers
- Little/no quality monitoring

Strategic

Deliberate decisions about what to buy, from whom to buy, and how to buy services:

- Clear service packages and service delivery standards
- Selective contracting
- Output-based payment systems that create deliberate incentives
- Manage overall costs in the system
Incentives

An incentive is a signal with positive or negative consequences that directs individuals or organizations toward self-interested behavior.

Types of “signals”

- Financial reward or penalty
  - Payment
  - Financial authority or power
  - Opportunity for future financial gain
- Non-financial reward or penalty
  - Satisfaction
  - Recognition
  - Reputation
- Others?

The way health providers are paid to deliver covered services will create incentives for them that will affect which patients they prioritize, which services the deliver and how they deliver them.
## Incentives in provider payment systems

**Providers have the incentive to:**

<table>
<thead>
<tr>
<th>Unit of payment</th>
<th>Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliver more of the unit of payment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Line item budget</strong></td>
<td>Inputs</td>
</tr>
<tr>
<td><strong>Fee for service</strong></td>
<td>Each individual service</td>
</tr>
<tr>
<td><strong>Capitation</strong></td>
<td>Each enrolled person</td>
</tr>
</tbody>
</table>

**And to minimize their internal cost per unit**
When providers are paid in multiple ways that are uncoordinated

Multiple payment streams… each with its own requirements

- Out-of-pocket payments
- Drugs and supplies
- Salaries
- Vertical program funds
- Performance-based payments
- Local government funds
- Health insurance fund payments

Health facility receives noisy or no signals about who to serve, what to provide, and quality

- Limited flexibility to use funds to respond to patient needs
- Accountable for $ more than outcomes
- Risk aversion—penalized for using funds in innovative ways
- Under-execution of funds
Coordinated PHC payment in Estonia

**EVOLUTION OF ESTONIA’S PHC CAPITATION PAYMENT SYSTEM (2003–2017)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>Capitation</td>
<td>74.3%</td>
</tr>
<tr>
<td></td>
<td>Basic allowance</td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td>Investigation fund</td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td>Distance fee</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Second nurse fee</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Activity fund</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Therapeutic fund</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Quality bonus</td>
<td>-</td>
</tr>
<tr>
<td>2017</td>
<td>Capitation</td>
<td>55.0%</td>
</tr>
<tr>
<td></td>
<td>Basic allowance</td>
<td>14.1%</td>
</tr>
<tr>
<td></td>
<td>Investigation fund</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>Distance fee</td>
<td>0.8%</td>
</tr>
<tr>
<td></td>
<td>Second nurse fee</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td>Activity fund</td>
<td>0.7%</td>
</tr>
<tr>
<td></td>
<td>Therapeutic fund</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>Quality bonus</td>
<td>2.7%</td>
</tr>
<tr>
<td></td>
<td>Out-of-office hours</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Source: JLN 2017
Main messages

- NHI is one way to organize health system functions to achieve UHC
- Countries introduce NHI for many reasons, but whether these objectives will be met depend on many factors
- It is also possible that NHI will bring unintended consequences--including for immunization and other priority public health programs
- An evidence-based policy process with clear objectives, stakeholder engagement, and accountability is necessary to get the potential benefits from NHI while avoiding unintended consequences.
- Need to be a learning system to catch unintended consequences, monitor, adjust