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THE WORLD BANK

Maldives Health Policy Notes 2

September 2011

Public Disclosure Authorized

TRANSITION TO A UNIVERSAL HEALTH INSURANCE SCHEME IN MALDIVES[i]

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Summary

Health insurance -- both voluntary and government-sponsored -- is of relatively recent origin in the Maldives. In September 2011, the President announced an initiative to achieve universal health insurance for all Maldivians from January 2012. An internal analysis of the available resource base for this universal scheme being undertaken by the Government of Maldives (GoM) suggested that the possible revenue sources for the universal scheme would include earmarked payroll taxes on formal sector employers, the existing spending on Madhana (the GoM's current scheme for civil servants, senior citizens, voluntary enrollees and other groups) which would be subsumed under the new scheme, some replacement of the supply-side spending and additional government subsidies to be met from new taxes being introduced. All of these, take together, would still be inadequate to meet the costs of a Madhana-style health insurance scheme for every citizen in the country.

Cost drivers affecting the proposed scheme would include the fee-for-service system which encourages supplier induced demand, use of proprietary drugs with no essential drug lists and no cost controls thereupon, lack of monitoring and IT systems, possible moral hazard, and lack of incentives to contain costs on the part of the insurer, providers and beneficiaries. Possible reforms that could be implemented to contain costs and ensure sustainability include moving away from the fee-for-service model to contain undue escalation in scheme costs. Bundled package rates (moving to Diagnosis Related Groups- DRGs in due course) could be used for secondary and higher care. For outpatient costs, a global budget for each public health corporation (which would cover the cost of providing outpatient services as well as the subsidies required for public health corporations to fill the financial viability gap on account of offering services in sparsely populated and remote areas), moving in due course to *Capitation* (with performance based incentives) could be employed at a *health corporation* level. Systematic costing and appropriate incentive mechanisms being put in place to encourage high productivity and cost containment would be pre-requisites for such provider payment mechanism reform. Another capitation system for preventive care costs through the Ministry of Health and Family (MOHF) and island councils could also be considered, though this would be implemented outside the 'insurance' system. Finally, additional pools of funds could be considered (beyond the insurance system) for specific purposes, such as a safety net which pays for high complexity care and a small pool of funds at the corporation level to cover costs of referral transport.

Continued effort will be required to ensure better targeted subsidies. The country could start with a minimum, essential benefit package which fits in the government's fiscal space. A phased approach needs to be considered, starting with basic service coverage and gradually adding benefits as administrative systems and targeting improve. Considering a legal framework to mandatorily bring in the formal sector employees (possibly along with their family members) under the proposed universal scheme would provide a group which contributes to the scheme's costs, and also brings a large, healthy pool into the scheme, without adverse selection. Policy decision, logistics and modalities around the use of essential drug lists and procurement of these drugs in their generic form with due quality control processes will also need to be made to contain expenditures on drug costs, one of the fastest growing components of costs in the predecessor scheme, Madhana. A strong communication strategy would be required to introduce generic drugs successfully. An effective information management system should be maintained independently from any external entity hired to manage the scheme, with built in reports and business intelligence tools. Changes will also be needed in the proposed bill for Health Insurance in order to support such approaches. Finally, launching the universal scheme entails large and complex reforms, and will need adequate time and resources. On the other hand, implementing the universal health insurance scheme without these reforms would make it ineffective, inefficient and unaffordable.

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Introduction and Background

Health insurance is of relatively recent origin in the Maldives. Both private voluntary health insurance as well as the social health insurance scheme, Madhana[ii], have attained sizeable coverage of the country's population within a short period of time. The voluntary health insurance (VHI) policies offered by two commercial insurers covered a little over 10% of the country's population in 2010. As of March 2011, the social health insurance (SHI) scheme, Madhana, administered by the National Social Protection Agency (NSPA) under the Ministry of Health and Family, covered another 77,500 people, which is about 25% of the country's population, within about two years of its existence.

Affordable health care is one of the five key pledges of the Government of Maldives (GoM) and is among the main objectives of the health sector reforms that the GoM is currently undertaking. In September 2011, the President announced an initiative to offer universal health insurance to all Maldivians from January 2012, in order to achieve the following policy objectives:

- Enhance affordability of health care and promote equitable access to health care
- Mitigate health care related financial risks for households and protect the citizens from health care related impoverishment
- Contribute to improved quality and reliability of health care
- Improve the efficiency of health insurance provision via good governance and effective use of fiscal resources
- Ensure long-term fiscal sustainability of health insurance provision through effective designing of the health insurance system in terms of cost containment measure and reforms in the payment mechanismss

Drawing from international experience, the success of Universal Health Insurance programs is highly dependent on certain economic, social, political and administrative factors, which include the following (Gottret and Schieber 2006):

Economic: A large formal sector of labor enabling higher payroll contributions, characterized by increasing urbanization trend.s

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Political: Strength, will and consistency at the highest political level

Administrative: Governance and supervisory capacities to overcome possible market failures such as moral hazard and risk selection as well administrative capacity to manage complex funds, provider payments, contracts and other cost containment measures.

In the current context for the country, though political will to launch the universal health insurance scheme does indeed appear to be very strong, the economic situation and the administrative capacities may pose challenges which will need conscious and planned efforts to surmount.

Design and Institutional Features

A detailed analysis of key design and institutional attributes of a health financing system is necessary before any reform is undertaken. Identifying the strengths, shortcomings and emerging issues of the current scheme could highlight priority areas of reform. The broader features of financing systems to be considered include (Gottret, Schieber and Waters, 2008):

Design Features

Financing: Choices for financing health services could have a huge impact on how evenly the burden of payment is distributed. In order to be a progressive financing system, tools such as tax contribution rates, payroll contribution rates, co-payment mechanisms and subsidies need to be evaluated and implemented in the right mix based on the country context..

Coverage and Benefit Package: Decisions regarding coverage and benefit package are dependent on population need, political demand, available resources (hospitals/staff/equipment), financial sustainability and incremental changes to current schemes,

Consumer Protection: Consumer protection mechanisms are designed to ensure free flow of information and to protect the interests of consumers. Tools to ensure consumer protection may include renewability clauses, transferability of rights, complaints and sanctions.

Provision: The processes of provider empanelment, provider payment and provider accreditation are crucial in devising an insurance program as if actively leveraged, they could deliver better efficiency and quality of care.

Institutional Features

- Institutional and governance structures are fundamental for the success of insurance schemes. Governance arrangements concern accountabilities and relationships established to safeguard stakeholder interests. It broadly entails the composition of the board, selection of board members, rotation of members and associated institutional arrangements (various units, MIS, internal & external audit mechanisms, job description, process maps etc) of the scheme.

Universal Coverage: Resources for Reform

An internal analysis of the available resource base by the Government of Maldives suggests that the possible revenue sources for the universal scheme include the following:

- Government tax revenues
  - Earmarked payroll taxes proposed to be levied on formal sector employers, as applicable to the government itself as the largest formal sector employer in the country
  - Earmarked taxes such as that on tobacco products
  - The existing spending on Madhana which will be subsumed in the new universal health insurance scheme
  - Some replacement of the supply-side spending on health corporations who will now receive demand-side funding from the universal health insurance scheme
  - Additional government subsidies to be met from the new taxes being introduced
- Payroll contributions from the formal sector of labor, which constitute a significant share of the overall labor market may also be looked at. Income rated contributions could be mandated for employers and employees for both public (civil servants) and private sectors. Informal sector contributions, on the other hand, are more difficult to implement and collect administratively. Also from international experience, it has been demonstrated that often contributions from the informal sector have resulted in poor enrolment and adverse selection amongst the members.
- Co-payments and user fee could be considered as an additional (albeit small) source of revenue and a mechanism of cost containment by controlling demand-side moral hazard.

Estimated resource base for 2012

Against this back drop, Table 1 shows the resource envelope estimated by the Ministry of Finance and Treasury (MOFT) that could be generated from each of the above mentioned sources.

Table 1 : Estimated resource base for the universal health insurance scheme in 2012

	Contribution Rate	Total Revenue
Private Formal Sector		
Employers	3%	131m MRF
Employees	1.5%	66m MRF
(capped at a particular level, if required- say 1000 MRF per month)		
Public Sector		
Employers - Government	3%	60m MRF
Employees - Civil Servants	1.5%	

New non-government resources from formal sector contributions	**260m MRF**
Additional resources for the scheme (as indicated by MOFT)	**200-300m MRF**
Estimated expenditure in 2012 for existing Madhana coverage	**250m MRF** or More
Existing supply side expenditure budget in 2011 (some part of which may be converted into demand side financing)	**850m MRF**

Source: Ministry of Finance and Treasury, Government of Maldives, September 2011

Is Universal Coverage feasible with the Fee-for-Service Madhana Model?

The aggregate expenditure for the Madhana scheme in 2010 was 165 million MRF, which is more than double the expenditure in 2009 (76 million MRF). Despite the introduction of mid-stream corrective measures, average costs per beneficiary have steadily escalated since the launch of the scheme from 1,500 MRF in 2009 to 2,500 MRF in 2011.

At this pace, a model similar to Madhana cover may cost 1billion MRF (or more) in 2012 to cover all citizens (3,000 MRF * 330,000) and would presumably rapidly rise further, as compared to the 600m- 700m MRF resource envelope indicated from the calculations above.

It is crucial to understand key factors contributing to this level of cost escalation, in order to account for them in the new reformed scheme. These drivers include the following:

- Fee for service system and supplier induced demand, as discussed later in this note
- Proprietary drugs with no essential drug lists and no cost controls thereupon
- Lack of monitoring and information systems, due to potential fraud and leakages, and the absence of timely information to take mid-course corrective action
- Adverse selection[iii] and moral hazard[iv]
- No incentives to contain costs on part of insurer (as there is no risk transfer to them, and they could actually earn more service fee if there are more claims), providers (who again do not bear any risk and are free to set prices) and beneficiaries (as higher claim costs for Madhana do not directly translate into higher contributions or curtailment of services for them)

Cost containment and sustainability of reforms

Considering the escalating costs of the existing health insurance system and the limited resource envelopes, possible reforms that could be implemented to contain costs and ensure sustainability are discussed below.

A. Provider Payment Systems:

At present, the Maldivian health care system is based on a fee-for-service payment mechanism i.e. service providers charge fees individually for each service delivered. Empirical evidence shows that this model incentivizes the supplier to create artificial demand (i.e., supplier induced demand) and leads to escalating health care costs (Langenbrunner et al 2009). Therefore, international experience strongly suggests moving away from the fee-for-service model to contain undue escalation in scheme costs. This is particularly important for Maldives when scaling up to universal health insurance, as a large proportion of the country's healthcare costs would continue to be borne by the

exchequer. In consultation with the GoM team working on universal health insurance, the following provider payment mechanism is proposed for the new universal scheme.

1. Bundled package rates (moving to Diagnosis Related Groups- DRGs in due course) would be used for secondary and higher care, for a limited set of defined packages and probably not for all types of hospitalization. Covered inpatient services would be bundled into packages and there would be a corresponding, aggregate fee for each package. The packages would be uniform and no variations due to higher or lower use of services would be permissible.
2. A global budget from the exchequer to each public health corporation (and private hospitals, if mechanisms to calculate a global budget can be worked out and mutually agreed) which would cover the following
    a. Cost of providing outpatient services to all scheme beneficiaries, including preventive and primary care services, essential drugs and an identified list of diagnostics.
    b. Subsidies required for public health corporations to fill the financial viability gap associated with offering services in sparsely populated and remote areas.

Eventually, the GOM might consider shifting to *Capitation*[v] (with performance based incentives) to be employed at a health corporation level, after taking into account the different situations in which each corporation is placed in terms of population base served, the geographical context and other factors. Continued subsidies will generally be required to be given to public health corporations to fill the financial viability gap as described above, as the recoveries from insurance may not be sufficient to recover the high fixed costs of making services available in such locations.

For all the above options aimed at reforming provider payment mechanisms in the country, in order to achieve efficiency gains, the pre-requisite would be a systematic costing exercise and the provider payment mechanisms will need appropriate incentive mechanisms to encourage both high productivity and cost containment.

In addition to the insurance system, another capitation system for preventive care costs through MOHF and local government councils could also be considered, though this would be implemented outside the insurance system.

Finally, additional pools of funds could be considered (beyond the insurance system) for specific purposes:

- A safety net through a separate pool of funds which pays for defined types of high complexity care required from outside the country, which is not covered by the existing insurance system. This would be aimed at financial protection for poorer patients unable to afford such treatment, evaluated and granted on a case-to-case basis, until uniform and objective targeting criteria for this coverage are worked out.
- A small pool of funds at the corporation level to cover costs of referral transport, partly to ensure that legitimate needs for referral transport to a regional hospital or to Male' are not compromised, and since the amount will be limited, also to ensure that there is no over-referral

B. Other Health Systems and Health Policy Considerations for Introducing Universal Health Coverage

Coverage: Designing an enrolment or pricing strategy which encourages enrolment of family members, rather than only individual coverage, would enable better enrolment and spread of risk, especially if the formal sector is expected to be self-sustaining and manage without public subsidies. Continued effort will be required to ensure better targeted subsidies for deeper coverage (such as cover for treatment outside Maldives for high complexity treatment not available in-country), especially as more informal sector and lower-income groups are now being brought under the scheme. A policy decision to be taken is whether the scheme would cover only the citizens of Maldives or even expatriates.

Benefit Package: When contemplating a move to universal coverage, the scheme may need to identify the maximum essential benefits package which can be offered within the government's fiscal space. A phased approach should be considered, starting with basic coverage and gradually adding benefits as administrative systems and targeting improve. Items of high public health importance and known cost-effective interventions could be prioritized.

Financing: Considering a legal framework to mandatorily bring in all formal sector employees (possibly along with their family members) under the proposed universal scheme would provide a group which contributes to the scheme's costs, and also brings a large, healthy pool into the scheme, without adverse selection. This larger pool with the inclusion of healthier people could also contribute to achieving smaller premiums compared to the current requirements. Income rated contributions could be mandated for employers (3%) and employees (1.5%) for both public (civil servants) and private sectors.

Essential Drug Lists and Drug Logistics: Policy decisions, logistics and modalities around the use of essential drug lists and procurement of these drugs in their generic form with due quality control processes will also need to be made. This will be particularly important in order to contain the expenditure on drug costs, which has been one of the fastest growing components of the costs in the predecessor scheme, Madhana. To achieve the greatest economies of scale, generic drugs would need to be procured centrally in bulk and distributed to health service providers. The existing health facilities may need to create capacities to directly provide such drugs to the patients rather than directing patients to standalone pharmacies. The required quality assurance mechanisms and regulatory systems will also need to be put in place before generic drugs are introduced. Furthermore, as this is going to be a major change, a strong communication strategy would be required to introduce generic drugs successfully to patients and providers.

Institutional: Decisions are required on the institutional structure of the governing body for the scheme, including decision on board nominees, their terms of employment and applicability of civil service commission rules to them, whether there will be any risk-transfer (i.e., whether the insurance risk is retained in the NSPA or transferred to an insurer) and if risk continues to be retained by the NSPA, then on the modalities for claim administration (whether this will be performed in-house or outsourced to a third party administrator).

Quality and Standards: In order to ensure patient safety and appropriate quality of services, the scheme may also want to lay down standards and quality criteria for the services provided to its beneficiaries by its network of providers upfront.

Information Systems: Effective management of the proposed universal health insurance scheme would require a sophisticated and effective health information management system which should be maintained independently from any external entity hired to manage the scheme, because depending on the same external entity will limit the relevance, timeliness and availability of the data, as also affect the monitoring of the hired intermediary itself. The system should ideally be linked to all the agents involved in the operation of the scheme and data should flow from all service delivery points into the system, with built-in reports and business intelligence tools[vi].

Changes that may be needed in the present bill for Health Insurance

In order to implement the proposed reforms, the following changes might be needed in the proposed bill for Health Insurance (as of September 2011).

- The bill should define applicability for coverage – whether it applies to all residents of Maldives or only to citizens
- The present bill allows 'opting out' for better coverage- this will affect an income rated model[vii] and thus should to be reconsidered
- It allows expansion of the benefits package (through 'exemptions' to coverage exclusions) by the Board, and also gives the minister-in-charge some over-riding rights to make changes to Board suggestions. These discretions may be counter-productive and may lead to unsustainable commitments, and so need reconsideration and possibly deletion
- The bill in its current form requires health insurance cards- which may not be necessary if the citizen ID cards can be used for this purpose.
- The bill requires the entity managing the health insurance scheme to meet all requirements similar to commercial insurance providers in Maldives- this may create regulatory and compliance conflicts as the functions of this agency may not be similar to a health insurance company which does retail, voluntary business.
- The current bill also requires the agency to take up any social protection service asked by the President- which needs to be made more specific so that the agency is not required to go beyond its mandate.

Next Steps

Decisions such as the introduction of generic drugs, improving service delivery capacity, establishing strong regulatory frameworks and moving away from the fee-for-service payment mechanism are large and complex reforms. Hence these tasks need to be phased out and the time-line for the implementation of the universal health insurance scheme needs to be more realistic. Tasks which we recommend be undertaken in the near future are:.

- Amend the health insurance bill on the lines suggested above
- Develop a communication strategy for the proposed reforms
- Define an action plan for phased implementation
- Provider payment systems to be agreed upon, costed and calculated
- Finalization of essential drug list and the logistics for procuring and distributing generic drugs
- Clarify transition arrangements for existing formal sector insurance policies and existing Madhana beneficiaries

- Work to develop the MIS for the insurance scheme needs to commence immediately
- Efforts being made to improve targeting of beneficiaries, some of which are already being undertaken by NSPA, should move ahead steadily

Universal health coverage is a desirable goal, but it will require considerable time and resources to implement the required financing, governance and service delivery reforms successfully. On the other hand, it is also worth emphasizing that implementing the universal health insurance scheme without these reforms could make it ineffective, inefficient and unaffordable.

[i] This policy brief reflects the discussions and contextual situation in September 2011, when this brief was drafted, before the universal health insurance scheme, Asandha, was launched in January 2012.
[ii] See policy note 1 of this set for a detailed discussion of the Madhana scheme.
[iii] Adverse selection, also called antiselection, is a term commonly used in the voluntary health insurance context and reflects the problem of asymmetric information that affects the operation of the insurance market, resulting in an inequitable transaction. The insured, knowing the likelihood of events, chooses to insure against only those that pose a strong risk. The insurer, having less information (in this case, about the health status of the prospective insured), accepts the contract at terms designed for lower risk situations. Adverse selection in the health insurance context could be exemplified by persons joining health insurance schemes only at the time when they need medical services.
[iv] Moral hazard is an insurance-prompted change in behavior that aggravates the probability of an insured event in order to access benefits, for example, an insured's demanding medical services or diagnostic tests not substantiated on medical grounds (demand-side moral hazard). Provider-induced moral hazards include overservicing such as providing more consultations, diagnostic tests or other services than are medically necessary (supply-side moral hazard).
[v] Under a capitation payment, the provider receives a fixed fee per individual per time period (month or year, for example) to provide all covered services, regardless of how many services are provided to any of the individuals covered.
[vi] Business intelligence tools are advanced software applications used to identify data patterns and otherwise analyze, interpret, report and present data.
[vii] When contributions are determined as a percent of income, higher contributions will be required from higher income groups. This may incentivize them to remain outside the health insurance system and thus will significantly reduce the resources mobilized from the formal sector contribution into the system.

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