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Introduction of a national health insurance scheme

A challenge for social security institutions

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Belize

Over the past decade the Ministry of Health (MOH) of Belize has made considerable progress in reducing basic infectious diseases and improving health status. The shift from infectious to chronic diseases, in addition to the structural problems in the public health system, poses a considerable challenge to the Government of Belize. To address these challenges, the Government of Belize embarked on a process of health sector reform (HSR) that introduced among other things, the separation of functions (purchasing, regulating and delivery of services), with a sustainable financing and purchasing mechanism, a national health insurance (NHI). The proposed system would launch a comprehensive primary health care service for the entire population by using private general practitioners and other existing public and private providers to ensure the highest standards of care. At the hospital level, the NHI would contract with public and private providers to increase the productivity of existing public providers, to increase access to private care and to introduce improvements in quality, user satisfaction and the effectiveness of hospital services.

The traditional health care system – structured around a vertically integrated public system without a clear separation between the regulatory, financing, purchasing and provider functions – led to unacceptable levels of inefficiency, consumer dissatisfaction, poor quality of care, providers that are unresponsive to the population's demand for quality services, and a lack of access to a basic package of services. The advantage in promoting the separation of functions lies in Belize's potential to introduce a new, separate purchasing agency that would consolidate the purchasing function and stimulate the creation of an "internal market" by clearly separating the financing and purchasing functions from the provision of health care services.

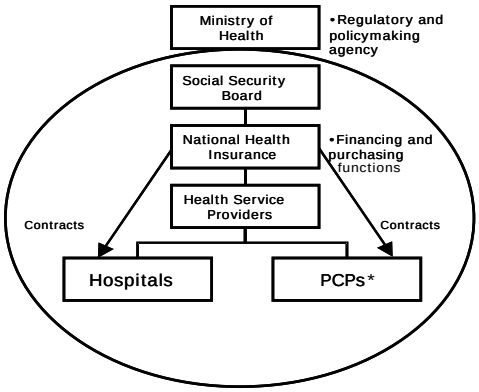
The Health Sector Reform Review Committee, commissioned by the Prime Minister of Belize, approved the overall framework for the system, and the concept of a national health insurance system was outlined in the joint Inter-American Development Bank (IDB)/Government of Belize *aide mémoire* dated 21 October, 1999. The goal of the system, as outlined by the Committee, was to pursue the development of a health care system "…based on equity, affordability, accessibility, quality and sustainability in effective partnership with all levels (sectors) of government and the rest of society in order to develop and maintain lifestyles, behaviors, and environments which are conducive to good health."

The emerging paradigm attempted to combine the advantages of the public system – universal access to a basic package of care and effective control of spending – with the advantages of decentralized systems – less bureaucracy, more consumer satisfaction and increased efficiency in the production of care. This paradigm is based on the separation of functions to make a clear distinction between the regulatory, policymaking function of the Ministry of Health, the purchasing role associated with the insurance function, and the organization of the provider network both public and private.

In April 2001, a National Health Insurance Fund was established in Belize with the purpose of developing a universal health insurance system making quality health care accessible to all Belizeans. As part of the Health Sector Reform Project (HSRP), the Government of Belize defined that the National Health Insurance Fund (NHIF) be established as the primary financing instrument and purchaser of personal health care services, both public and private.[1] The financing and purchasing functions were to be developed within the new NHIF as a separate branch of the Belize Social Security Board.

In order to test the instruments that were developed as part of this model, a pilot project was designed by the Ministry of Health and the Social Security Board (SSB) as the first phase of project implementation. The Prime Minister of Belize officially launched the National Health Insurance Pilot Project on 9 August 2001. As part of the monitoring and evaluation framework, data was collected on a continuous basis in order to track the implementation of the pilot. This has been facilitated by the development and implementation of a comprehensive health planning and purchasing software made specifically for the NHI.

The introduction of the NHI created a new paradigm in the health system, clearly separating the basic functions of the health system: regulation, financing, purchasing and provision of health services. The new model stipulated the creation of a new financing mechanism that would allow health sector financing to increase and would aim to extend access and to improve efficiency and quality. Within this context, the following figure displays a schematic drawing of the system's main actors and their key functions. As displayed in the diagram below, the Ministry of Health has been established as the main regulatory and policymaking agency, while the NHI is responsible for the financing and purchasing functions, and the health services will be provided by different facilities, under contract, in the public and private sector.



[1] Belize Health Sector Reform Programme (BL-0014).

* PCPs = Primary Care Providers.

The development of the new system is an integral part of the Belize Health Sector Reform, whose objectives are focused on developing strong capabilities within the system, reducing health care costs for both the government and the population, and improving patient care.[2] The implementation of the NHI was designed specifically to address the problem of inefficiency and inequity in health sector expenditure. The general objectives of the NHI are:

- introduce managed competition via creating a single purchaser of services and parallel stimulation of the private sector;
- achieving an equitable and sustainable system of sector financing.[3]

In line with the overall objectives of the Health Sector Reform Project, specific objectives were set forth in terms of capabilities to be developed, efficiency gains to be achieved and improvements for patients. The key objectives in each area are detailed in the following points:

Capabilities

- The strong regulatory and policymaking function of the Ministry of Health as the conductor of the health care system.
- Decentralization of responsibility and accountability from the center to the level at which management can best respond to consumer needs.
- Development of internal market mechanisms to ensure that resources follow the patients, rather than the other way around.
- Ensure a high degree of flexibility to allow for variations at the District level to take into account the specific local needs, to test alternative models of financing and provision, and to change strategies throughout the reform process.

Costs

- A clear separation of financing and delivery, as a key element in the introduction of competition, transparency and accountability to the health insurance system.
- Gradual introduction of competition (in quality and efficiency), among private providers and between MOH providers and private providers, to allow a diversity of services to members while standardizing service fees.

Patient care

- Greater accountability to patients.
- The pursuit of the highest level of care, quality, and value with the resources available in the system.

The pilot focused on the Belize South Side sector, a geographical definition within the boundaries of Belize District. This region was selected because it represents an area with limited infrastructure prior to the pilot project, it has urban and rural population, and the population is at high risk of illness due to its socioeconomic characteristics.

[2] Technical note, the Introduction of National Health Insurance: *The Way Forward*.

[3] NHI operational manual.

Importance of the Ministry of Health as a regulatory agency

The role of the Ministry of Health in the new system becomes increasingly important as a regulatory body to ensure access to the population. Once the provision of care is decentralized, the MOH will have additional budgetary resources to pursue the highest standards of regulation and policy-making.

The basic functions of the Ministry of Health should be focused on establishing national health sector priorities and national health policy, including the establishment of the legal and regulatory framework in pursuit of these objectives. To carry out this function, the MOH should continue to strengthen guidelines for:

- establishing national health priorities based on the population's health needs;
- using the national health priorities to develop a comprehensive national health plan;
- establishing a unified system for reporting and statistics;
- ensuring uniform technological policy with regard to pharmaceutical and medical equipment;
- certification and licensing professionals, medicines, drugs, equipment, and technology in general;
- developing uniform criteria and national programs for training medical professionals as defined by the national government;
- establishing and enforcing quality standards of medical care;
- establishing licensing procedures for medical, laboratory, radiological and pharmaceutical activities;
- financing and coordinating medical research;
- organizing sanitary and epidemiological services;
- disaster relief.

Financing mechanism

The design of the NHI depends heavily on the introduction of a new provider payment mechanism, designed to better align the providers' incentives with the purchasers' desire to achieve the highest value-for-money. To this extent, several innovations were introduced as part of the pilot project. The main changes introduced in the system were:

- At the primary care level, allocations were made on a per capita basis, compensating the PCPs in accordance with the actual number of members that enrolled with the given PCP. The capitated budget allows the PCP greater flexibility in assigning resources and to achieving the desire results.

- At the hospital level, a case based payment system was developed and prices were negotiated with hospitals to include all the required services to produce a specific hospital discharge. Rather than pay for each item, or activity, related to a hospital stay, the case base purchasing system transfers part of the risk from purchaser to provider and sets clear limits on the expenditure for a given case.

- For pharmacy, laboratory, and imaging/radiological services, a fee-for-service system was established whereby the NHI and the providers negotiated a specific list of products that would be purchased and the price of these products. Through the negotiation, the NHI realized cost savings of up to 50 per cent over prices previously used by SSB for employment injury.

- Performance bonuses were established for PCPs and hospitals to create a variable remuneration that would encourage the providers to achieve the results desired by the NHI. Performance bonus ranged from 10 to 15 per cent of the total amount billed by providers and were allocated based on the compliance with pre-established targets.

- An automatic billing system was established between the providers and the NHI. This system allows the providers to report electronically the activity billed for the NHI members and then the NHI makes an electronic transfer to the bank account of the providers. The system is state-of-the-art and includes numerous controls to reduce fraud and over-billing.

- Benchmarking: Once information was obtained and analyzed from the pilot (as well as using international figures), benchmarks were set for referrals in the areas of laboratory, imaging and pharmaceuticals. These were then incorporated into an incentive scheme that had financial penalties to providers each month for not meeting defined targets.

Management of the purchasing function

The goal of the purchasing agency is to obtain the highest value-for-money with the funds collected by the National Health Insurance Fund. The purchasing function has been developed as a specialized department within the structure of the Social Security Board. This will ensure the separation of functions between the Regulatory/Policy making functions of the Ministry of Health, the Provider function to be gradually decentralized from the MOH to the Regional Health Authorities/Hospital Boards and private providers, and the Purchasing function to be managed by the NHI within SSB.

The key issues related to the development of the purchasing function include:

- Design of objectives and targets based on the population's health needs rather than on the supply of service. The purchasing function flips the logic of the system from a traditional supply-basis (how many doctors, beds or clinics) to a population basis (how many people, what are the priority health needs and how can the NHI best meet those needs). This change in logic tends to produce important gains in outcomes as resources are better directed where they are most needed.

- Development of performance contracts between the NHI and all providers. The contracts clearly lay out the objectives, the rights and responsibilities of the NHI and the providers, the sanctions, indicators and payment mechanisms.

- Design and Implementation of a comprehensive health planning and purchasing information system that automates nearly 100 per cent of the processes associated with the NHI. The system will allow the NHI to maintain administrative expenses at a minimum and to ensure adequate controls throughout the implementation of the NHI.

Design of the health care provider model

The main characteristics of the provider model are:

- The package developed under the pilot project provides for comprehensive services for primary care, including some deliveries at hospital level, as well as all required support services (laboratory, pharmacy, imaging/radiological).

- The basic level of primary health care is based on a population-based contract with General Practitioners (GPs). Under the NHI, general physicians have organized Group Practices to assume full responsibility for the primary health care of population that range from 3,000 to 12,000. The estimated parameter is 1 GP for every 4,000 members.

- The GPs serve as a gatekeeper to the system. All support services as well as hospital and specialist services must be referred by the GP.

- Competition has been encouraged among several providers to allow the NHIF to obtain the highest value-for-money and to allow consumers more choice in the selection of providers.

- Providers are guided by the contracts that were established with public and private hospitals to provide increased levels of production, quality and user satisfaction at the hospital level.

Changes in governance

The new structure includes an NHI Committee, similar to the Investment Committee of the SSB that oversees the operation of the NHI. The NHI Committee includes participation from the Ministry of Health, the SSB, the Ministry of Finance and other seats to represent civil society, employers, unions, religion, and other major stakeholders.

Changes in legislation

Enabling legislation was approved to enact the National Health Insurance Fund and to introduce the structural changes required within SSB. The enabling legislation provides for the possibility of establishing a permanent financing mechanism for the NHI to facilitate national implementation.

Challenges

The health care model developed initially as a pilot project in the South Side of Belize has experienced important transformations. These have taken place as a result of a myriad of factors which can be categorized as: financial, political and technical. Throughout this process there are some significant lessons learned which are being presented here as important challenges:

- **"New kid on the block" syndrome**: This is a normal process that occurs when an entity/institution/person intrudes on someone else's territory. The movement of Social Security as an important stakeholder and decision maker, into the field of medical

care previously monopolized by the Ministry of Health, was a violent political process. This is time-dependent and needs to be managed intelligently and with patience.

- **Perception of privatization:** Certainly this issue was introduced as an argument to increase the resistance towards Social Security's involvement. However, it is an important perception that needs to be dispelled from the very inception. There was, and continues to be, a lack of understanding of the private sector's role in this new model of health care.

- **Public information (PI) campaign:** There was always the argument that a PI campaign could not start without all the relevant policy decisions having been made. There was also a perennial fear of releasing information that could be used to "criticize" and "add fuel to the fire". In essence, the effect of the "New kid on the block" syndrome was to negate the potential positive result of a good PI campaign. It is important that an effective PI campaign be started early and that information transparency be adhered to. This is an important key to eliminating or reducing resistance.

- **Acquiring the technical capability:** There is a particular challenge in acquiring the technical expertise within a small economy. Many times it will require the "buying out" of the human resource from the Ministry of Health, which becomes another sore point of contention. However, it is important that in the planning stages, due consideration be given to the preparation of personnel for proper health care management positions.

- **Monitoring and evaluation:** Efficient, effective and sustainable systems need to be developed for the purposes of collection of information and management of the model. Without the computerized NHI system of "activity registration", billing, contract management, incentive scheme management, it would be almost impossible to benchmark and impose financial incentive processes.

- **Leadership:** The adage "Actions speak louder than words" is an important element to keep in mind. Social Security **must** be prepared to take a leadership role. This is inherently linked to the development of technical capability and may become an area where "resistance" could result in the very slow development of the reform process. Areas such as accreditation/registration of providers and medical audits; while they are, strictly speaking, the domain of the regulatory body (MOH), the lack of tradition in these areas certainly becomes an impediment in the implementation and someone must jump-start the process. In the case of Belize, the SSB conducted the first Patient Satisfaction surveys, medical audits, facility inspections, and provider registration.

- **Political advocacy:** It is important to allocate enough time and effort to convince all Cabinet Ministers and back-benchers (the executive and the legislative). Having the support of the Minister responsible for the SSB is not enough, particularly for an endeavor of National proportions.

- **Window of opportunity!** Finally, all of the above must be considered within the context of "windows of opportunity". In the case of Belize, the political decision on financial source/sustainability missed this window and we are still suffering the consequences, waiting for another "opportunity".