



MINISTRY OF
**HEALTH &
WELLNESS**

GREEN PAPER ON
**NATIONAL HEALTH INSURANCE
PLAN FOR JAMAICA**



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FOREWORD

Every Government is challenged to finance their public health care system at a level that will guarantee the provision of adequate and effective services. It is therefore important that mechanisms are developed that will reduce the burden of financing borne by the State and individual health seekers.

Since the health financing reform initiated in 2008 with the no user fee policy in public facilities the government is now seeking to introduce its most transformative reform, the National Health Insurance Plan (NHIP) to increase overall resources for the health sector; increase efficiency in the use of available resources; promote sustainable health care financing; and improve the quality and coverage of health services.

NHIP is the strategy for the country's roll out of its Universal Health agenda. We accept that the NHIP is not the total answer for UH but it does advance our progress towards that goal. The NHIP proposal has three central components: focus on funding through pooling of funds, a membership guarantee and entitlement modality, and definition of a basket of services. The equity proposition is also clear where the poor will receive as much as the rich while the needy will receive much more than they can afford to contribute.

The key to UH coverage is the pooling of public and private resources, service provision in public and private facilities and, with a reciprocal commitment between management and membership for accountability and responsiveness.

We encourage everyone to provide the feedback on this Green Paper with the end result that a programme is implemented with an effective and comprehensive package founded on a sustainable financial platform.

OVERVIEW OF CONSULTATION AND DECISION POINTS

AREAS FOR CONSIDERATION	OPTIONS	COMMENTS
Mandatory versus Voluntary Enrolment	<p>Mandatory</p> <ul style="list-style-type: none"> • Administrative / marketing costs much lower • More <i>efficient risk pooling</i>, reduces overall cost / capita of insurance plan • <i>Avoids adverse selection</i> / “insurance death spiral” • Increases enrolment more quickly • Values societal benefit over individual choice • More effective to drive preventive health initiatives to all insured • Increase access by the poor to covered services <p>Voluntary</p> <ul style="list-style-type: none"> • <i>Higher cost to market to individual</i>, voluntary participants. • Higher cost / capita because of <i>higher utilization and risk selection</i>. • Vulnerable to adverse selection and consequential “insurance death spiral” • Slower increases to enrolment, <i>often stalls around 40-50%</i> <p>Values individual choice over societal benefit but at significant costs to society</p>	<p>NHIP Recommendation:</p> <p>The NHIP system will be compulsory (mandatory), and all legal residents will be required to participate.</p> <p>Within mandatory schemes, enforcement becomes a very real challenge</p>
Government Subsidies for Vulnerable Populations	<p>Three different groups are considered in the definition of “vulnerable”:</p> <ul style="list-style-type: none"> (i) PATH beneficiaries and their household members; (ii) Children under the age of 19; and (iii) Elderly members of society over the age of 65. 	
Capitation	<p>Enrolees in the NHIP would have to register with a provider and with restrictions on transfer</p>	

AREAS FOR CONSIDERATION	OPTIONS	COMMENTS
Composition of the Benefit Package	<p>› PHC Access</p> <p>Basic buy”: Preventive Care - Dx Services Focus</p> <ul style="list-style-type: none"> • Allow 1 wellness visit to private MDs and Public Clinics • Allow public MDs to refer for private diagnostic tests • PHC lab + imaging for eligible screening • Pharmacy for 16 conditions covered by NHF › • Additional services for NCDs & communicable diseases • Locum contracting for delivery in public clinics • Private MDs contracted where gaps exist (2 visits; more for infants/AC/NCDs) • Diagnostic services (lab + imaging) 	
Single or Multi-payer	<p>Option 1 - Single-Payer: NHIP is the single fund holder and purchaser of services and PHI can participate by offering voluntary health insurance (VHI); or</p> <p>Option 2 – Multi-payer with Public and Private Payers: NHIP and private insurers can provide the NHIP benefit package in addition to offering VHI.</p>	A single-payer model is recommended at the start
Co-payment	No “balance billing” or limited balance billing (Balance billing is the ability of providers to charge any price above the NHIP agreed rate.	<p>This should not be allowed to present equity of access issues.</p> <p>Proponents of co-payment assert that it is an important price signal that will encourage appropriate utilization of health service</p>
Legislation	Modify the NHF Act or promulgate a new Act.	The use of the existing NHF Act seems to be the most direct way to modify the legal framework.

INTRODUCTION

The health of our nation reflects the level of social and economic development, the choices made by Government and the people to promote and protect health, to manage illness and specific health problems, and to respond adequately to public health emergencies. We have achieved many milestones in health, yet, our central challenge today, is how to ensure that all Jamaicans, regardless of their socio-economic condition, age, and sex, be empowered to achieve their fullest potential in health, leaving no one behind. As a Nation, we have bold decisions and choices to make to respond to the current health needs and safeguard future generations; we need a new paradigm to transform health and health care delivery.

2.1 BACKGROUND

Universal Health imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, effective, and affordable quality medicines, while ensuring that the use of such services does not expose users to financial difficulties, especially groups in conditions of vulnerability.

The drive to Universal Health is a globally recognized goal. Jamaica has been on this quest since the 1970s and has removed out of pocket payment for the population to allow greater access to health care facilities. The establishment of the National Health Fund (NHF) in 2003, which provides social protection for persons with specified chronic conditions by way

of a subsidy for medication, was another step taken to improve access to health care. The Government of Jamaica in 2016 as a policy objective mandated the Ministry of Health & Wellness` to explore the possibility of establishing a National Health Insurance Plan (NHIP).

National Health Insurance (NHI) first appeared on the national agenda in the 1930's during the deliberations of the United Kingdom (UK) - commissioned team on the social riots and protests in Caribbean countries including Jamaica (Table 2.1 below). Since then, NHI has been on and off the agenda of different governments with the 1997 Green Paper on NHI and subsequent NHF legislation representing the most advanced stage reached in the process of development and implementation of NHI plans.

TABLE 2.1 - TIME-LINE SUMMARY OF NHI PROPOSALS, 1930s - 2003

YEAR	KEY PROPOSAL
1945	British West India (Moyne) Commission Report—Partial Social Health Insurance for Formal Sector Workers (as with NHI in UK at that time)
1960s	Official debates on National Insurance Scheme---Add health component to NIS
1974	Green Paper on National Health System—Integral role for contributory health insurance scheme
1980s	Mixed Proposals largely giving major role to private insurers to manage S/NHI for selected groups
1997	Green Paper on NHI for Jamaica—Mandatory plan for all to be managed by public and private insurers
2003	National Health Fund—as early phase of NHI

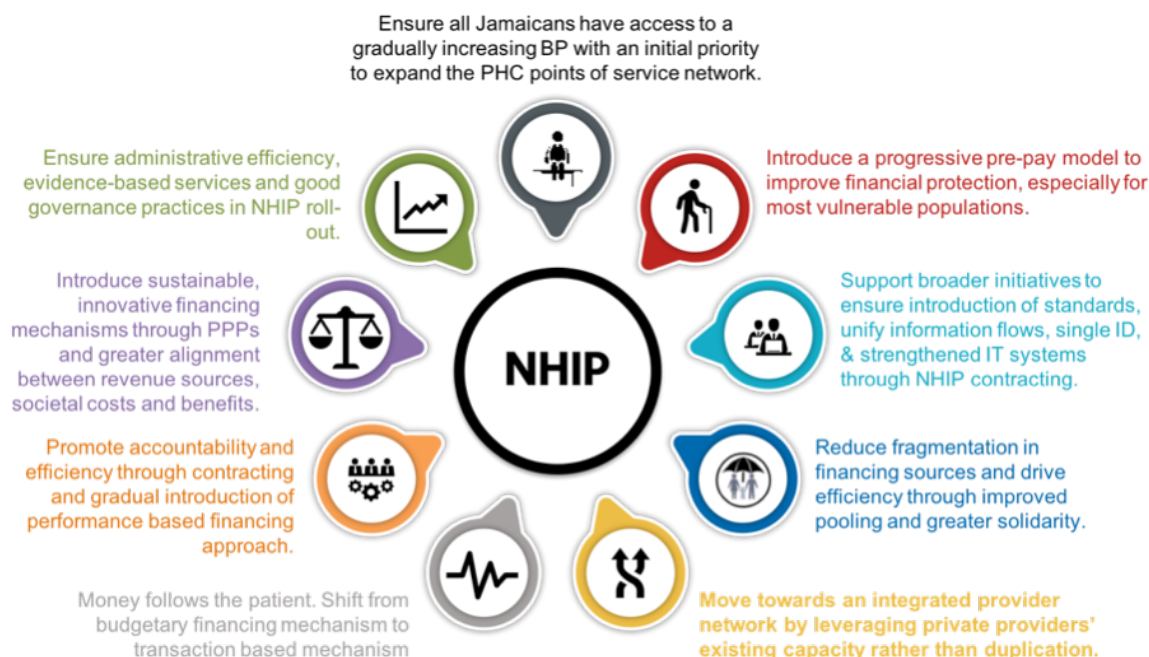
2.2 PURPOSE

The aim of the NHIP will be to provide appropriate levels of access, coverage and financial protection to the population. For consumers and providers of services, the real value of a health insurance plan lies in assurance. For the former, there is assurance that income levels at the time of illness will not hinder access to care; for the latter, there is assurance that money spent in providing care will be reimbursed so that service levels and investments can be sustained.

The NHIP financing recommendations have been designed to fit within the Jamaican strategy to “introduce a programme for sustainable financing of health care” from National Outcome #1 (A Healthy and Stable Population) under Goal 1 (Jamaicans are empowered to achieve their fullest potential) of the Vision 2030: National Development Plan.

There are nine foundational elements that guide the NHIP:

FIGURE 2-1: FOUNDATIONAL ELEMENTS FOR NHIP



2.3 BENEFITS OF A NHIP

In the health sector, national health insurance reforms perform three critical functions:

It is a risk-pooling mechanism offering financial protection against the unpredictable burden of illness so that those needing care can have ready access to services.

It is a payment mechanism offering providers of health services prompt and regular reimbursements.

It is a database providing planners and policymakers with valuable information on patterns of disease, utilisation of services, health expenditure and patient preferences (choices).

2.4 SITUATIONAL ANALYSIS

Ranked eighth in the world by the WHO according to performance in health, the island has achieved much relative to its endowments. However, its ranking plummeted to 115th where fairness of financing is concerned. The Jamaican health system has been challenged by decreasing fiscal space due to low economic growth and a high debt burden. Given the limited fiscal space for health, improving the efficiency and equity of public health expenditures is important.

In Jamaica advances are being made on several fronts which include, inter alia, the removal of out-of-pocket payment, increasing government spending on health insurance coverage, and expanding coverage under the NHF. This all contributes to the view that Jamaica is approaching Universal Health.

A recent World Bank review of health expenditure in Jamaica reveal that, while public health spending is generally pro-poor, and despite the removal of user fees, out-of-pocket expenditures (OOP) remain high at 28 percent and private insurance coverage rates are below 20 percent. Typical of the Caribbean, the island has both a large public health sector and large private health sector. As such out-of-pocket expenditure as a share of total health expenditures continues to be slightly above the median when benchmarked against comparator countries.

Currently, public expenditure in health in Jamaica represents 3.47% of GDP. International experience has shown that a 6% of GDP as public expenditure in health is a useful benchmark and a necessary condition to achieve Universal Health. On the other hand, Out-of-Pocket (OOP) spending in health represents 28% of the total expenditure in health. Although this has been decreasing over the last two decades, it is still at relatively high levels. International experience has shown that when OOP expenditure is above 20%, families are at a greater risk of catastrophic health spending and impoverishment because of an episode of illness.

2.5 SUSTAINABILITY

Needless to say these ideas will need to take into consideration competing social and other spending priorities as well as Jamaica's fiscal and debt sustainability goals. A phased approach may need to be considered. Currently, public expenditure in health in Jamaica represents 3.47% of GDP. International experience has shown that a 6% of GDP as public expenditure in health is a useful benchmark and a necessary condition to achieve Universal Health. On the other hand, Out-of-Pocket (OOP) spending in health represents 28% of the total expenditure in health. Although this has been decreasing over the last two decades, it is still at relatively high levels. International experience has shown that when OOP expenditure is above 20%, families are at a greater risk of catastrophic health spending and impoverishment because of an episode of illness.

Jamaica is experiencing problems also in the way funds are pooled for health with significant segmentation. Approximately 19% of the population has private insurance, while another 25% (approximately 500,000) have disease-specific coverage under the National Health Fund. Enhancing and extending pooling of funds increases equity and efficiency. Health systems with larger and more inclusive pooling mechanisms are more efficient in the distribution of risk and less costly per capita than those with smaller fragmented pools.

Moreover, the allocation of funding faces challenges. Allocation of resources should reflect health systems priorities and goals, and payment mechanisms should be conducive to incentivizing the provision of services that are prioritized by the country. Currently, the allocation of resources across the health regions does not seem to reflect defined technical criteria. With respect to levels of care, the prioritization of the first level of care has decreased, with all regions well below the originally agreed 25% allocation. Furthermore, allocation through historical global budgets is predominant within the public sector, with low incentives towards improving efficiency and quality.

Nevertheless, Jamaica has made important strides in attempting to reduce segmentation, extend coverage and ensure equity. However, a large percentage is still left behind in matters of access, quality of care and equity. There is a national consensus on the need and possibilities of a national insurance scheme that improves equity for all Jamaicans. Finding the right arrangements is the urgent task.

Jamaica achieved an important milestone to remove financial barriers to accessing health services and provide financial protection for health in 2008 by removing user fees at the point of care in public health services. To maintain this significant achievement and address current and future health needs of the population, it is necessary to secure sustainable financing.

“ Out-of-Pocket (OOP) spending in health represents 28% of the total expenditure in health. Although this has been decreasing over the last two decades, it is still at relatively high levels. ”

PROPOSED BASIC PACKAGE OF SERVICES FOR NHIP

A NHIP benefit package (BP) can be defined as the services that have been established as the minimum requirement of healthcare services that should be available to a defined population under specific conditions and with defined financial limitations.

The aims for a basic benefits package are:

- Improve efficiency in the allocation of resources;
- Guarantee target population coverage;
- Focus resources to specific groups (e.g. vulnerable populations);
- Rationalize public expenditure;
- Improve horizontal equity: persons with equal needs receive the same benefits.

The following four dimensions were used to frame the benefit package's design:

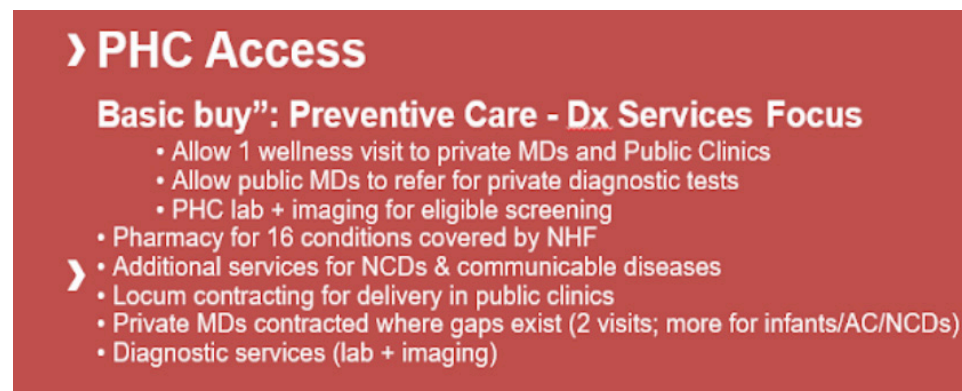
- Population health needs based on the existing patterns of demand and gaps in coverage showing particular emphasis on non-communicable diseases and maternal and child health (MCH) services and large gaps in imaging and laboratory;
- Services to be provided / funded directly by public health system, either on a universal basis or on the basis of clear eligibility criteria but not initially covered by NHIP;
- Services to be provided on a universal basis and funded via the future national health insurance system;
- Services not covered by NHIP or the public system and thereby available either in the private sector through PHI or out of pocket payments.

Additionally, further consideration will be given to how those services can evolve over time.

3.1 BENEFIT PACKAGE OPTION

Under this option, the population would receive a comprehensive package of primary care services that would serve to expand access to key services and to provide better coverage for PHC. The high level summary is provided in figure 3-1.

FIGURE 3.1: SUMMARY OF BENEFITS PACKAGE



Source: Sanigest Internacional

Some of the additional benefits under this plan include:

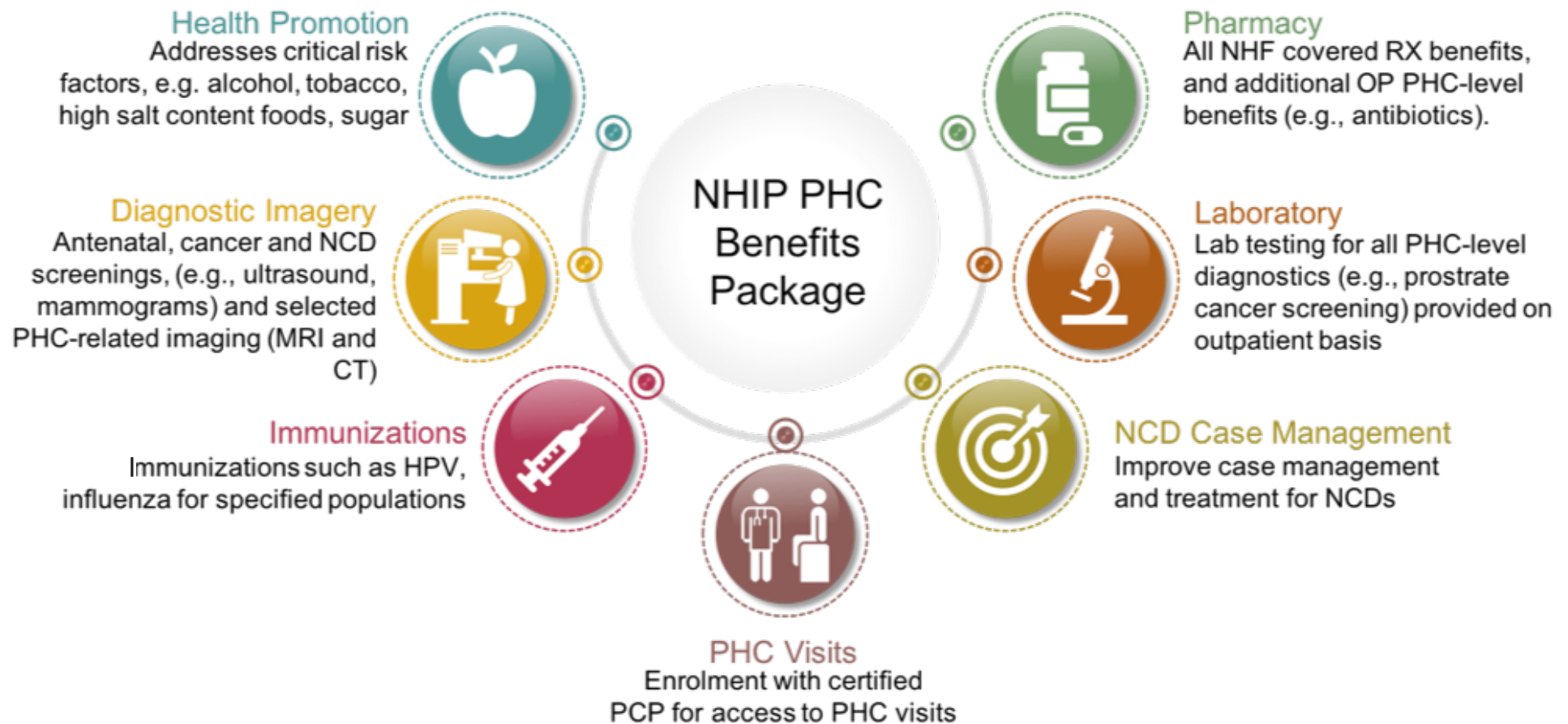
- Expanded package of health promotion to address critical risk factors in the population, e.g. alcohol, tobacco, high salt content foods, sugar, etc.
- Expanded screenings for antenatal, cancer and NCDs. Coverage for diagnostics required for screening programmes including ultrasound, mammograms, selected imaging (MRI and CT), colorectal and lung cancer screening.
- Selected immunizations such as HPV, influenza for persons aged 65 years and over.
- Improve case management and treatment for NCDs including: Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and

non-fatal cardiovascular event in the next 10 years. For example preventive interventions using acetylsalicylic acid and statins for diabetics.

- Treatment of new cases of acute myocardial infarction with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis.
- Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level.
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum.
- Iron supplementation for anaemia in women and children.
- Select pharmaceutical services, for the 16 conditions currently covered by NHF. Expansion of health promotion initiatives outlined in the “Basic Buy” (see Annex A).

- Enrolment with a certified NHIP primary care provider for access to two (2) primary care visits per year. For specific populations (pregnant mothers, NCD patients, infants) additional visits are covered, to ensure appropriate levels of co-ordinated care are received.
- Laboratory and imaging PHC-level diagnostics (e.g., HbA1C testing for diabetics, mammograms) provided on an outpatient basis through private and public providers.
- All NHF covered pharmaceutical benefits, along with additional outpatient PHC-level pharmacy benefits (e.g., antibiotics).
- Dental care for children aged less than 18 years old, covering one (1) cleaning and two (2) fillings per year.

FIGURE 3-2: NHIP PHC BENEFITS PACKAGE



3.2 EXCLUSIONS AND LIMITATIONS (SERVICES NOT COVERED BY THE NHIP)

The BP option will not cover all health care expenses and include limitations and exclusions. The following is a partial list of services and supplies that are generally not covered (see Annex B for the entire listing).

- Substance abuse & dependency
- Curative home care
- Inpatient/outpatient and home-based rehabilitation
- Electronic mobility device
- Chronic mental illness
- Interventional dentistry
- Non-covered reconstructive surgery
- Weight loss treatment including but not limited to gastric reservoir reduction surgery

The expectation is that the private sector can develop new private health insurance packages that offer coverage for those gaps at lower costs than existing more comprehensive plans. The following figure outlines the differences in coverage between a possible NHIP PHC focused plan and the existing private health insurance plans.

FIGURE 3-3: COMPARISON OF NHIP PHC BP, MOHW AND SAMPLE PHI PLANS

	Insurer / MoHW				
	NHIP PHC Focused		Guardian	Sagicor	MoHW
	Public Provider	Private Provider	Security Guards #3	GEASO	No User Fee
PHC OP visits	Covered by NHIP. (No user fee policy remains).	Up to 2 visits / year (more for maternity, NCDs, infants). Capped co-pay for visits*. No deductible.	Up to \$1,000 6 visits / year	Up to \$1,500 up to 10 visits	No User Fee Policy continues.
OP Spec Visits	Not covered by NHIP. (No user fee policy remains).	Not included beyond ObGyn / Paed / Internal Med visits (inc. in 2 above). Capped co-pay for visits.	80% up to \$15,000 +MM. Up to \$2,000 for referred (4 visits) or \$1000 for unreferred (4 vis)	Up to \$2,500 (per visit, 2 visits per disability, 6 visits per year or 8 for specialists)	No User Fee Policy continues.
Clinical Lab	Not covered by NHIP. (No user fee policy remains).	Included with referral and copay*	80% up to \$6,000 + MM	Up to \$10,000 + MM	No User Fee Policy continues.
Dx Imaging	Not covered by NHIP. (No user fee policy remains).	Included with referral and copay*	80% of UCR	80% of GEASO schedule	No User Fee Policy continues.
Maternity	Visits covered by NHIP. (No user fee policy remains).	Antenatal / postnatal visits / scans / labs with capped co-pays.	Not covered at this level (begins at option 4)	Normal (1st) \$52,500; (2nd) \$47,500; C-section \$65,280; Miscarriage \$41,300	No User Fee Policy continues.
Rx Drugs	Not covered by NHIP. (No user fee policy remains).	No co-pay for generic OP PHC-level drugs. Capped co-pay for others.	80% of cost up to \$6,000	20% co-payment up to \$40,00 for individual, \$80,000 per family for combined Rx, Dental and Vision	No User Fee Policy continues.
Dental	Not covered by NHIP. (No user fee policy remains).	Dental care for children <18 (1 cleaning and 2 fillings per year)	Not covered		No User Fee Policy continues.
Vision	Not covered by NHIP. (No user fee policy remains).	Medium term, add Cataract surgery for >60 year olds with co-pay for non-exempt patients	Ophthalmologist (1 visit / year) up to \$2000		No User Fee Policy continues.

GOVERNANCE ARRANGEMENTS

4.1 GOVERNANCE OF THE SYSTEM

The Ministry of Health and Wellness (MoHW) would be tasked with stewardship of the system including the tasks of 'formulating strategic policy directions, ensuring good regulation and appropriate tools for implementing it, and fostering the necessary intelligence on the health system's performance to ensure accountability and transparency. Currently the MoHW does provide a stewardship role, but also purchases services through the Regional Health Authorities (RHAs), and is responsible for the provision of services at Bellevue Hospital. Ideally, the MoHW would be less involved in the purchase / provision and more focused on overseeing the entire system. The purchasing of services would then sit with insurers, either public or private. A single-payer model will be pursued at the start for the purchasing of services, that is, the body will pool the resources from non-contributory and contributory sources and function as the purchaser (i.e., the NHF). The MoHW would provide the supporting services that are outside of NHIP package. As well, PHI would continue to receive funds and contract services under complementary or supplementary plans that are beyond the PHC benefit package under NHIP.

5.2 ORGANIZATIONAL STRUCTURE AND ADMINISTRATION

The following table summarized the distribution of some of the main functions under the MoHW and the NHIP administrative institution.

TABLE 5.1 - DISTRIBUTION OF FUNCTIONS

	MOHW	NHIP ADMINISTRATION
Heath Policy formulation and establishment of national priorities	✓	
NHI policy and plan		✓
Definition of health care standards	✓	
Review and definition of benefit package	✓	✓
Facility certification and licensing	✓	✓
Review and definition of reimbursement rates		✓
Pharmaceutical rate negotiation		✓
Medical benefits and drug reimbursement		✓

ELIGIBILITY FOR MEMBERSHIP

5.1 GROUPS ELIGIBLE FOR MEMBERSHIP

Compulsory Enrolment

The NHIP system will be compulsory, and all legal residents will be required to participate. An individual's membership status will be linked to a contribution, either from Government or through a direct contribution. This includes the employed, self-employed, unemployed, non-economically active, retirees and children.

Citizens Who Reside in Jamaica

All Jamaican citizens who are currently residing (or "ordinarily resident") in Jamaica will be eligible to enrol in the NHIP. Further, all babies with Jamaican citizenship born in Jamaica will be enrolled in the programme from the day they receive their National Identification number and birth certificate.

A definition of "ordinarily resident" will need to be adopted (i.e., if a Jamaican citizen moves from Jamaica, after what period of time are they no longer considered resident? If a Jamaican has a dwelling in another country, what is the minimum amount number of days they must reside in Jamaica in order to be considered currently resident?)

Legal Residents of Jamaica (non-citizens)

All legal residents of Jamaica will be eligible to enrol in the National Health Insurance Plan within the first three months of year one. Moving forward, all babies born in Jamaica to legal Jamaican residents will be enrolled in NHIP from the day they receive their National ID number and birth certificate. However, based on the type of residency permit, there may be different requirements to be met, as follows:

Legal residents with Work Permits

Residents whose status is based upon them having a work permit will be required to make a financial contribution. It is proposed that the cost of an average NHIP beneficiary be added onto the annual work permit fee and be payable by the employer requesting the permit.

Residents whose status is based upon them being married to a Jamaican citizen or legal resident (for example, a foreigner with a work permit as described above) have no additional requirements for enrolling in NHIP.

Legal residents with Spousal Permits

Residents whose status is based upon them being married to a Jamaican citizen or legal resident (for example, a foreigner with a work permit as described above) have no additional requirements for enrolling in NHIP.

Legal residents with Other Residency Permits

Residents whose status is based upon any reason other than being a dependent of a Jamaican citizen or a work-permit holder will be required to make a financial contribution to be an eligible beneficiary.

Children born in Jamaica to undocumented migrants

Babies born in Jamaica to undocumented migrants (UDM) are a special category as they are not considered "illegal", but do not have legal status until they turn 18 and they are permitted to apply for legal status. Therefore, all babies with Jamaican birth certificates should be eligible for membership, regardless of the status of their parents.

Jamaican students 18-25 studying abroad

Jamaican students (defined as Jamaican citizens studying at an educational institution approved by the Ministry of Education and Youth, and who also hold a valid student ID and are under 25 years of age) will be eligible for the same membership benefits as all other members (i.e., coverage abroad).

Foreigners Studying in Jamaica (college / university level)

There are a number of foreign students studying in Jamaica, and it is anticipated that number will increase in the future. All foreign students will be eligible for membership. However, it is to be determined if, foreign students should be mandatory members of the plan, without exception, or if foreign students who can demonstrate that they have comparable coverage from their home country or private health insurance plan will not be required to participate. If it is not compulsory, there will be an added administrative process of periodically determining that the student still has the insurance coverage they arrived with.

Inmates of the correctional facilities

Inmates will remain the responsibility of the State and are automatically enrolled/re-enrolled in NHIP as part of their release.

6.2 GROUPS NOT ELIGIBLE FOR MEMBERSHIP

Temporary Visitors

Temporary visitors (tourists) will be ineligible for membership.

Undocumented Migrants

Undocumented Migrants will not be eligible for membership in the NHIP. They will receive health benefits, as required, through the public health system (to ensure public health safety) in the same way they do now.

Transient Workers

Workers who are on temporary work-permits (less than three months), will be ineligible for NHIP membership. This is recommended as it has been seen in other countries that individuals may intentionally try and gain access to a health care system through applying to be a temporary worker, and receive health care services which they require. Additionally, the government may have to consider a policy that requires all foreign workers with temporary contracts to have the sponsor (employer) show either proof of private insurance, or willingness to pay any health bills incurred by the employee within Jamaica.

Jamaican citizens (non-college students) living and/or working abroad
All Jamaican citizens who live abroad and are not legally considered residents of Jamaica are ineligible for NHIP membership. Nevertheless,

when a Jamaican who has been a member of the NHIP leaves the country, they will be eligible for benefits for a period of up to three months. However, all the requirements that exist for other members would also be in place for them, along with one additional, as follows:

- they would only be eligible for care in Jamaica;
- transportation costs to Jamaica for care would not be covered.

Individuals working abroad for specified Jamaican Government ministries or corporations

As indicated above, Jamaicans who are not legally resident in Jamaica will not be eligible for NHIP membership. However, individuals who have been working for specified entities, such as the Ministry of Tourism, upon their transfer back to Jamaica, will not be subject to a waiting period (should one be adopted) before becoming eligible for benefits.

Individuals working for specified international organisations and foreign embassies

Certain international organisations, such as the Pan American Health Organisation, and foreign embassies, are generally not required to contribute to the NIS, and are not considered as members of the national social security system. The same policy will be implemented for the NHIP.

POPULATION COVERAGE

6.1 UNIT OF SUBSCRIPTION

The unit of subscription for the NHIP will be at the family / household level as opposed to at the individual level. This is in keeping with many international NHI plans where the unit of subscription is the family / household as there are documented improved health benefits associated with a Primary Care Provider having a whole family under their care.

Additionally, household / family enrolment allows for more rapid growth of the fund pool (i.e., instead of only signing up a NHF member as one person, NHIP would sign up the NHF member, their spouse and two children). Finally, household / family level subscription can reduce biases that may otherwise occur. For example, a single mother might choose to just sign up her child, but not herself in order to save money – depending on how contribution levels are finally determined.

6.2 DEFINITION OF DEPENDENTS

Dependents are defined as additional members under NHIP and everyone should have an explicit contribution made by them, or for them. However, the details of how that might work will require further elaboration. For example – will children be considered the dependents of one / both parents or will they be considered to be covered through a government contribution made on their behalf? Non-working

spouses could be considered a dependent of their working spouse, and require a specific contribution made by their spouse, and have their eligibility tied to the spouse's contributory status. However, if there are two working spouses both would be required to contribute.

If it is decided that children are also considered dependents who require a contribution made for them by the primary household contributor (i.e., government is not contributing on their behalf), a firm decision has to be made on whether they also have their eligibility tied to that individual's contribution status. In this case, as a child may have parents/guardians in two different households, a decision should be made on whether either parent can make contributions for the child, or if there should be a designated contributor that needs to be up-to-date (rather than both or simply either of the two) is sufficient for eligibility purposes.

6.3 IDENTIFICATION OF MEMBERS

It is recommended that all members be provided with insurance cards. These cards should be presented at the point-of-service for validation of the member's current status within NHIP. Initially a unique ID can be assigned but eventually the individual's unique national identification number can be used.

Dependents are defined as additional members under NHIP and everyone should have an explicit contribution made by them, or for them.

OTHER POLICY CONSIDERATIONS

Provider Network Requirements

Credentialing standards for the NHIP will have to be developed and applied to ensure that all beneficiaries have access to quality health care providers, high quality, accessible and patient-centred care.

All health establishments, intending to become a provider under the NHIP will be inspected and certified by an Office of Provider Compliance (OPC) to be established. The OPC will also verify that the health professionals are licensed by respective council bodies and the health care providers are complying with criteria for any Ministry of Health regulations regarding accreditation in readiness for contracting with the NHIP. The NHIP standards for credentialing may exceed the minimal standards that are set by MoHW for facility licensing to ensure that international best practice standards are followed.

Provider Certification Process

The certification process will aim to promote delivery of services that are:

- People-centred
- Comprehensive
- Coordinated
- Accessible
- Committed to quality and safety
- Committed to patient satisfaction

Objectives of the Certification Process

The objectives are as follows:

- Provide list of standards for the delivery of quality services that must be met;
- Establish a benchmark against which health establishments can be assessed, gaps identified, and strengths recognized; and
- Provide evidence of compliance with certification requirements.

Becoming a Provider

- Becoming an NHIP provider is voluntary for each facility;
- Certification is mandatory to becoming a NHIP provider;
- This process does not replace or exclude the current Licensing requirement;
- Such facilities will still need to comply with those requirements as a pre-requisite to be certified as a Certified Provider.

7.1 PROVIDER PAYMENT MECHANISMS

A provider payment method may be defined simply as the mechanism used to transfer funds from the purchaser of health care services (or fund-holder) to the providers, and a provider payment system may be defined as the payment method combined with all supporting systems, such as management information systems and accountability mechanisms that accompany the payment method.

The contract between the NHIP payer and providers would be executed on an individual basis, with each provider. In the context of either public or private providers, the provider organization could also include a network of providers, such as a Regional Health Authority or private clinic group; but at minimum all providers must:

- be expected to meet the minimum conditions in the contract;
- achieve satisfactory certification as described above;
- be subject to fines and blacklisting for non-compliance.

The provider payment mechanism will be guided by the following principles:

- Payment will be tied to a defined patient population, i.e. the money follows the patient and all claims are transaction based;
- Care is prepaid at a predetermined rate, either under capitation where the prospective provider reimbursement per member per month is set or for fee based schedules;
- The prices negotiated by NHIP should be as close to full price as possible with either no “balance billing” or limited balance billing fixed at a multiple. Balance billing is the ability of providers to charge any price above the NHIP agreed rate. This will not be allowed to prevent equity of access issues;
- Financial risk will be somehow transferred to providers on a limited basis and with clear rules;
- Target terms and contract negotiation should be fully transparent and standardized;
- Some risk adjustment may be required to take account for differences in a providers’ population’s underlying risk – e.g. the elderly may cost more and require more care and thus might be more heavily reimbursed. Geographic disparities also may be adjusted for in payment formulas as well as adjustments for vulnerable populations that are also often estimated to consume more care.

7.2 PHARMACEUTICAL PROVISION UNDER NHIP

The NHIP will establish a reference-based pricing reimbursement model for pharmaceuticals.

The proposed process would include the organisation of a periodic (1-3 years) price tender based on the pharmacy formulary for NHIP. During the price tender, NHIP will publish the estimated volumes for each product and other terms for the participation in the tender, e.g. certification of origin and other requirements. Based on the tender results, a reference price would be established for each drug, which would be based on the CIF price plus wholesaler margin and retail pharmacy margin. Pharmacy margins could either be based on a fixed percentage, such as 15% or a sliding scale whereby low priced drugs have a higher margin than high cost drugs. In addition, an agreed upon dispensing fee would be added depending on the type of pharmacy.

The wholesalers would supply the drugs to the retail pharmacies based on the agreed reference price and wholesaler mark-up. Pharmacies would then be entitled to claim from NHIP for the full cost of the drug, including margins but no additional costs could be passed on to the customers. The pharmacies would then pay the wholesalers based on the agreed payment terms. Monitoring of the ordering patterns versus the claims processed would be done to ensure compliance with the terms of the agreement.

7.3 PROPOSED BUSINESS RULES FOR THE NHIP AGENCY

The following section describes some of the initial business rules for the information system for the NHIP with emphasis on Planning and Purchasing of Health Services cycle.

The NHIP will be based on key principles for access which are outlined below:

- The system is enrolment based and linked to contributions from either government or self-pay;
- Access to the benefit packages requires enrolment with a primary care physician;
- Accessing outpatient benefits, beyond the PHC level, requires a verified referral from a NHIP physician.

Membership rules

- Every legal Jamaican resident must register for NHIP using their TRN, NHF, JADEP, GOJ or PATH card.
- A person can only register with a provider if he/she has a valid NHIP card.
- Registration will be allowed with one primary care provider (PCP) at any one time. Members can change providers once per year unless they have a legitimate grievance or justification for transfer, e.g. moved from one parish to another. The provider can be a general practitioner (GP), paediatrician or ObGyn.

Provider Payment

Prices will be standardized by type of provider; however, adjustments may be made based on geographic differences, incentive mechanisms or other negotiated terms between NHIP and the providers.

7.4 SERVICES REQUIRING PRIOR AUTHORISATION

In order to ensure proper execution of medical guidelines and patient pathways, the NHIP should reserve the right to reimburse a limited list of services (especially in the PHC+ BP) that can result in either very high expenditures or are subject to inappropriate and unnecessary medical care if the protocols are not closely followed. These services could require pre-authorization by the NHIP and may be subject to specific access conditions as set out by the NHIP.

CONCLUSION

The Ministry through the consultation process seeks your opinion on the following decision points:

1. The enrolment options: mandatory versus voluntary
2. Most suitable benefit package
3. Single-payer or multi-payer options
4. Role of private health insurers
5. Participation of private service providers
6. Membership eligibility

Your comments on any additional areas of interest regarding the management, administration and implementation of a NHIP are welcome.

In taking these ideas forward the GOJ will require consideration of competing spending priorities including other social spending. It will also need to be undertaken in a way that does not undermine fiscal sustainability nor medium term targets. We will therefore need a comprehensive approach that considers all factors and a likely phasing of implementation that allows achievement of these and other objectives.

Consequently, the Ministry of Health & Wellness invites consultation and discussion on the Green Paper: National Health Insurance Plan for Jamaica.

Email:

JNHIPGreenPaper@moh.gov.jm

Mail:

Ministry of Health and Wellness,
10-16 Grenada Way, Kingston 5

ANNEX A Benefit Package

PROMOTION

- **Tobacco cessation interventions**
- **Harmful alcohol interventions**
- **Healthy living**

Reduce salt intake through the reformulation of food products to contain less salt and the setting of target levels for the amount of salt in foods and meals

Reduce salt intake through the establishment of a supportive environment in public institutions such as hospitals, schools, workplaces and nursing homes, to enable lower sodium options to be provided

Reduce salt intake through a behaviour change communication and mass media campaign

Reduce salt intake through the implementation of front-of-pack labelling Eliminate industrial trans-fats through the development of legislation to ban their use in the food chain

Reduce sugar consumption through effective taxation on sugar-sweetened beverages and sugar in food chain

Promote and support exclusive breastfeeding for the first 6 months of life, including promotion of breastfeeding

Implement subsidies to increase the intake of fruits and vegetables

Replace trans-fats and saturated fats with unsaturated fats through reformulation, labelling, social policies or agricultural policies

Limiting portion and package size to reduce energy intake and the risk of overweight/obesity

Implement nutrition education and counselling in different settings (for example, in preschools, schools, workplaces and hospitals) to increase the intake of fruits and vegetables

Implement mass media campaign on healthy diets, including social marketing to reduce the intake of total fat, saturated fats, sugars and salt, and promote the intake of fruits and vegetables

PREVENTION

- **Vaccination against human papillomavirus (2 doses) of 9–13 year old girls**
- **Prevention of cervical cancer by screening women aged 21–65 years, either through:**

Visual inspection with acetic acid linked with timely treatment of pre-cancerous lesions¹

Pap smear (cervical cytology) every 3–5 years linked with timely treatment of pre-cancerous lesions

- **Human papillomavirus test every 5 years linked with timely treatment of pre-cancerous lesions**
- **Screening with mammography (once every 2 years for women aged 50-69 years) linked with timely diagnosis and treatment of breast cancer unless previous family history**
- **Diabetic retinopathy screening**
- **Population-based colorectal cancer screening, including through a faecal occult blood test, as appropriate, at age >50 years, linked with timely treatment**
- **HIV screening**
- **STD screening**
- **Lipid disorder screening**
- **Diabetes screening upon suspicion**
- **Screening for Gestational Diabetes Mellitus**
- **Screening for Hepatitis B Virus Infection in Pregnancy**
- **Screening for lung cancer adults 55-80 who have a 30 pack/year smoking history currently smoke or have quite in past 15 years. CT scan annually until clear for 15 years.**

- Influenza vaccination for patients >65, population with diabetes, COPD and CVD
- Preconception care among women of reproductive age who have diabetes including patient education and intensive glucose management
- Screening of people with diabetes for proteinuria and treatment with angiotensin-converting enzyme inhibitor for the prevention and delay of renal disease
- Prevention of liver cancer through hepatitis B immunization
- Cost-effective interventions to prevent occupational lung diseases, for example, from exposure to silica, asbestos
- Ultrasound screening for pregnant women
- Secondary prevention of rheumatic fever and rheumatic heart disease by developing a register of patients who receive regular prophylactic penicillin
- Screening for Asymptomatic Bacteriuria in pregnant women
- Screening women whose family history may be associated with an increased risk for potentially harmful BRCA mutations. Women with positive screening results should receive genetic counselling and, if indicated after counselling, BRCA testing.
- Anaemia
- Screening for Sickle Cell Disease in Newborns
- Abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
- Falls prevention in adults >65

TREATMENT

- Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk* approach) and counselling to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and non-fatal cardiovascular event in the next 10 years. Examples preventive intervention with acetylsalicylic acid, statins for diabetics.
- Treatment of new cases of acute myocardial infarction** with either: acetylsalicylic acid, or acetylsalicylic acid and clopidogrel, or thrombolysis
- Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Primary prevention of rheumatic fever and rheumatic heart diseases by increasing appropriate treatment of streptococcal pharyngitis at the primary care level
- Folic acid supplementation
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum
- Iron supplementation for Anaemia in women and children
- Select pharmaceutical services, for the 16 conditions currently covered by NHF:
 - Select pharmaceutical services, for the 16 conditions currently covered by NHF:
 - Arthritis
 - Asthma
 - Benign Prostatic Hyperplasia
 - Breast Cancer
 - Diabetes

- Epilepsy
- Glaucoma
- High Cholesterol
- Hypertension
- Ischemic Heart Disease
- Major Depression
- Prostate Cancer
- Psychosis
- Rheumatic Heart Disease
- Sickle Cell
- Vascular Disease

ANNEX B

Benefit Package Limitations and Exclusions

- For the PHC+ BP: Additional costs due to semi private (less than 4 patients per room) or private accommodation at the patient's choice.
- Any examinations or procedures requested by third parties such as purposes of employment, insurance, criminal or civil proceedings or emigration.
- Immunizations to prevent disease except as specifically provided by name in the BP
- Cosmetic or plastic procedures except as Medically Necessary
- Prosthetic devices
- Orthoptic training (eye muscle exercises)
- Sleep lab
- Alcohol or chemical dependency treatments
- Restrictions on allied services such as limitations on: chiropractors, occupational therapists, and audiologists. Included are also paramedical mental health and substance abuse therapy, and speech therapy.
- Dental care. Exclusions may include, but are not limited to:
 - Corrective treatment on or to the teeth
 - Dental prosthetics
 - Extraction of teeth, including bony impacted wisdom teeth
 - Treatment of dental abscess or granuloma
 - Placement, removal or replacement of implants of the teeth and alveolar ridge including preparatory oral and maxillofacial surgery (bone grafts)
- Treatment of periodontal disease and abscess
- Root canal
- Treatment required for, or as a result of, biting or chewing - orthodontics
- Braces, retainers, bite plates, snore guards or any appliance or device which is fitted to the mouth
- **Treatment for chronic mental disease. Examples of chronicity include, but are not limited to, the following:**
 - Treatment for mental diseases or illnesses which, according to generally accepted professional standards, are not usually amenable to favourable modification.
 - Hypnosis and psychoanalysis on inpatient or outpatient basis.
 - Treatment for mental illnesses which have not responded positively to reasonable treatment procedures. Three criteria will be used to review response to treatment:
 - » number of psychiatric/ substance abuse hospitalizations;
 - » degree of disability as indicated by comparison to standard established criteria; and
 - » Subscriber's degree of cooperation and compliance with treatment plans

- Weight loss treatment including but not limited to gastric reservoir reduction surgery, gastric stapling, by-pass or diversion and any other weight reduction programs.
- Dietary or nutritional supplements for gaining or maintaining weight are excluded, except for charges for non-milk or non-soy formula required to treat diagnosed diseases and disorders of amino acid or organic acid metabolism, protein sensitivity resulting severe chronic diarrhoea, and severe malabsorption syndrome resulting in malnutrition, provided the formula is prescribed by a Participating Physician, and the Physician furnishes supporting documentation to Health Plan. The benefits will be limited to those conditions where the formula is the primary source of nutrition as certified by the treating physician by diagnosis.
- Refractive eye surgery including radial keratotomy, LASIK and implantable corrective lens (except for lens following cataract surgery), Orthoptic (vision) training.
- Custodial care; personal comfort items such as wheelchairs, televisions, telephone, private rooms (except as Medically Necessary) in a hospital or skilled nursing facility; housekeeping services and meal services as a part of Home Health Care.
- Experimental medical, surgical, or other health procedures including experimental drugs.
- Trimming of corns, calluses and nails except for diabetic conditions approved in advance.
- In vitro fertilization (IVF), embryo transplant services (GIFT, ZIFT), reversal of voluntary sterilization, and outpatient self-administered infertility prescription drugs. Infertility injections or medications normally self-administered will not be covered.
- Abortions and any related procedures, unless Medically Necessary.
- Transsexual surgery and related services.
- Speech therapy except as provided in Section II-B-2 of this Attachment.
- Experimental organ transplants
- Private duty nursing.
- Contact and corrective lenses
- Growth hormones or steroids used for growth and development.
- Counselling for marital or relationship conflicts, employment counselling and vocational rehabilitation counselling services.
- Sclerotherapy for spider angiomas.
- Breast augmentation and/or reduction surgery.
- Hearing aids.
- Penile implants and erectile devices.
- Services rendered primarily for the convenience of a Member in the absence of a specific clinical requirement.
- Charges for completion of forms and reports other than for the patient's medical record.
- Surrogate and/or gestational pregnancy and any related procedures
- Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer, or as necessary to safeguard a Member's health due to a non-dental physiological impairment. Surgery for the treatment of the temporomandibular joint, which is dental in nature.
- Staged procedures or surgeries when performed in preparation of a non-covered reconstructive surgery.
- Alternative medicine/therapy including but not limited to: non-prescription drugs or medicines, vitamins, nutrients, food supplements, biofeedback training, neurofeedback training, hypnosis, acupuncture, acupressure, massage therapy, aromatherapy, Chelation therapy, rolfing and related diagnostic tests.
- Laser treatment including Candela, V-beam and photodynamic therapy for rosacea, port wine stains and other skin disorders.
- Extra Corporeal Shock Wave Therapy (ESWT) for conditions of the feet elbows and shoulders.
- Removal of skin tags.
- Electronic mobility devices such as electric scooters, wheelchairs etc.

GLOSSARY

BP	Benefit Package
BPH	Benign prostatic hyperplasia
CIF	Cost Insurance and Freight
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
Dx	Diagnostic
ESWT	Extra Corporeal Shock Wave Therapy
FFS	Fee for Service
GDP	Gross Domestic Product
GOJ	Government of Jamaica
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HSS	Health System Strengthening
IVF	in Vitro Fertilization
JADEP	Jamaica Drugs for the Elderly Programme
MDs	Medical Doctors
MoHW	Ministry of Health and Wellness
NCDs	Non-Communicable Diseases
NHF	National Health Fund
NHI	National Health Insurance
NHIP	National Health Insurance Plan
NHT	National Housing Trust
OOP	Out-Of-Pocket
OPC	Office of Provider Compliance
PATH	Programme for Advancement through Health and Education
PCP	Primary Care Provider
PHC	Primary Health Care
PHI	Private Health Insurance
PPP	Public Private Partnership
RHA	Regional Health Authority
Rx	Pharmaceutical
S/NHI	Social/National Health Insurance
STD	Sexually Transmitted Diseases
TEF	Tourism Enhancement Fund
TRN	Tax Registration Number
UDM	undocumented migrants
VHI	Voluntary Health Insurance

NOTES



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