Basic Health Insurance (BHI) Curaçao 2013-2018

EVALUATION OBJECTIVES,

LESSONS OF IMPLEMENTATION

AND EXPERIENCED 'BEST'(?) PRACTICES

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General Facts - Curaçao

Capital	Willemstad
Location	Southern Caribbean sea, 65 km N of Venezuela
Official languages	**Papiamentu** (Native) & **Dutch** (Government) English & Spanish (commonly spoken)
Area	444 km²
Highest point	372 m (Mount St. Christopher)
Population / econ.:	**160'012** (January 1st, 2018), 100+ nationalities**, LTE 76 (M) – 81 (W),** GDP/cap ca. **USD 20K**, Unempl. rate 14%, GDP -1.7%, CPI 1.6% (all data 2017).
Brief History:	
1499	Native inhabitants: **Arowaks** 'Discovered' by Alonso de Ojeda**. Spaniards** settle
1634	**Dutch** conquer Curaçao from Spain **Dutch Colony (1791). 'Curacao and its Dependencies' (& Surinam).**
1800-03 / 1807-16	**British** occupations
1954	Part of **Netherlands Antilles** (with Aruba, Bonaire, St. Maarten, Statia, Saba) **internal autonomy within Kingdom** (except *'Defense'* & *'For. Affairs'*) Aruba leaves constellation in 1986 (autonomous within Kingdom)
2010 ('10-10-10')	**Autonomous state within Kingdom**, a similar status Aruba & St. Maarten, the smaller islands Bonaire, Statia & Saba become Dutch municipalities
Government	Unitary **parliamentary** representative **democracy** (under constitutional monarchy)

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Topics BHI - Curaçao

- Prior to Implementation (< 2013)
- Objectives
- **Evaluation Objectives (2013-2018)**
- **Lessons of Implementation**
- ‘Best’ (?) Practices Care Purchase
- Future Developments

Prior to 2013: 6 public health funds

'Patchwork of systems, funding and coverages'

	Private Sector (< USD 35'000)	**Low Income Grp** (< USD 7'000)	**Civil Servants** (> USD 20'000)	**Civil Servants** (< USD 20'000)	**Pensioners** (Government)	**Pensioners** (Semi-Gov.)
n = 128'000*:	**70'000**	**29'000**	**14'500**	**1'000**	**12'000**	**1'500**
model:	***'Bismarck'***	***'Beveridge'***	***'Bismarck'***	***'Bismarck'***	***'Dual'***	***'Dual'***
Employer	8.3%**	0.0%	7.9%	8.5%	0.7%	0.0%
Employee	2.1%	0.0%	3.1%	2.5%	10.0%	12.5%
Government	2.1%	100% expenses	gov = employer	gov = employer	only deficits	only deficits
PREMIUM**	**12.5%**	**0.0%**	**11.0%**	**11.0%**	**10.7%**	**12.5%**
Co-payment	n.a.	n.a.	10% expenses	n.a.	10% expenses	n.a.
COVERAGE	**+**	**++**	**+++**	**+++**	**++**	**++**
Hospital Class	3	3	1 or 2	3	2 or 3	3
Tariffs providers	LOW	LOW	HIGH	HIGH	MID	MID

*excluded population not covered by 6 public funds (ca 25'000)
**premium % on average and rounded

Result: Inequal accessibility and contribution

Prior to 2013: 6 public health funds

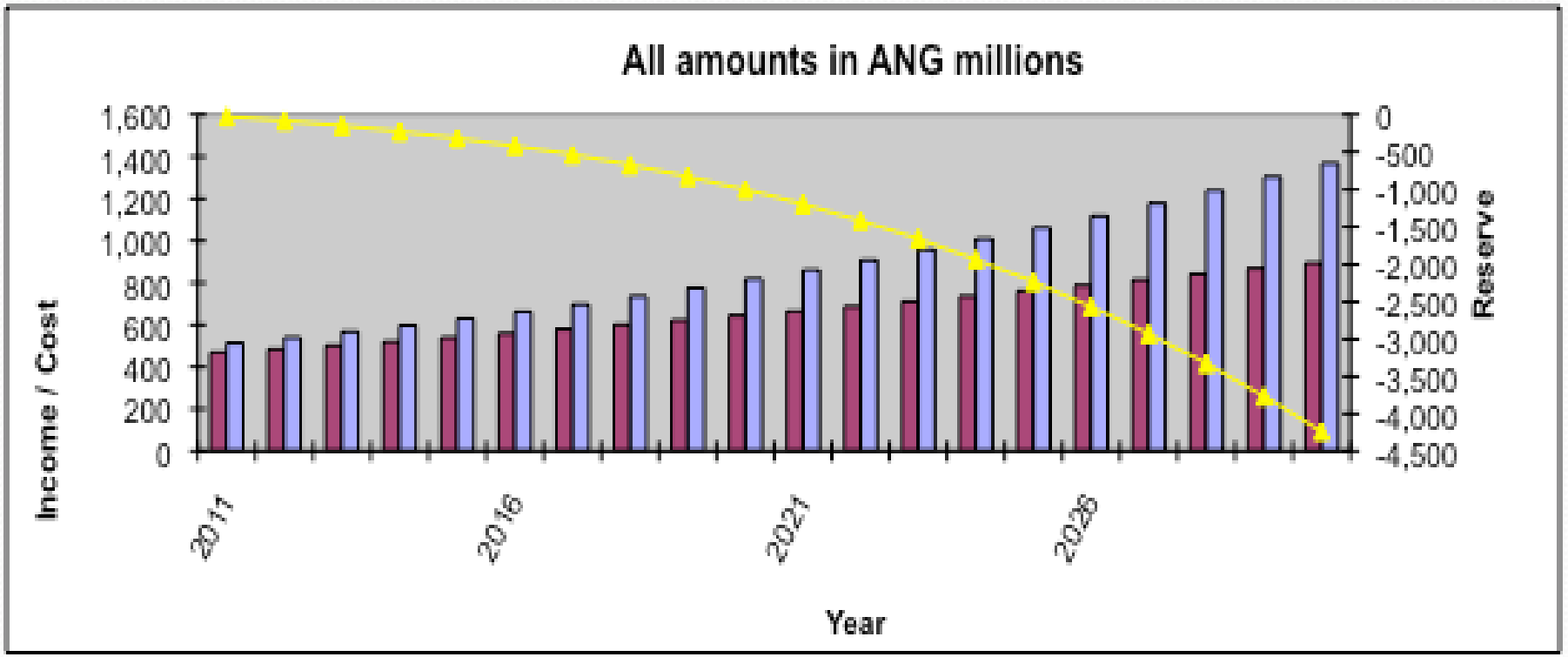
HEALTH INSURANCE SYSTEM CURACAO BEFORE BHI (DATA 2012)

	CURE				**CARE**	
	USD 314M				**USD 35M**	
	6 PUBLIC FUNDS	VARIOUS PRIVATE INSURERS	O-O-P AND/OR UNINSURED		1 PUBLIC FUND 'AVBZ'	
	84%	16%			100%	
	128,000	>25,000*			153,000	
	USD 257M	**USD 35M**	**USD 22M**		**USD 35M**	

Source: Nat Health Accts & SVB
*estimate SVB, includes add-on insurances

Prior to 2013

Unchanged Policy: 'No-Go - Unsustainable'



Result: Deficits, growing / accumulating by the years

Objectives

Intro: Feb 2013 ***Lv Basisverzekering Ziektekosten (BHI)***

(preparations as of 2011)

- Main Objectives:

I.	Raise Accessibility	=> Legislation: **'Landsbesluit Verzekerdenkring'**
II.	Uniform Coverage (& Tariffs)	=> Legislation: **'Landsbesluit Verstrekkingen'**
III.	Harmonize Premium %	=> Legislation: **'Landsbesluit Premieheffing'**
IV.	Improve Financial Sustainability	=> Government & Executive Body (SVB)
v.	**Raise Level & Quality Care**	=> Executive Body (SVB) & Health Care Providers

Objective I: Raise Accessibility

- **Legislation: Landsbesluit Verzekerdenkring**

Base:	Population 6 public funds (mandatory)
Opt-in:	**Private insured (individuals / collectives);**
	'Own-risk' companies (e.g. refinery / hospital)
	Condition 'opt-in': Residency
	Condition 'stay-out': Comparable Coverage Plan
Mandatory:	'New' Citizens
	- Immigrants (documented)
	- Newborns
No opt-out:	**'Once-in-never-out'.**

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Evaluation Objective I (2013 => 2018)

Raise Acccesibility:

- Feb 2013: Insured **128'000** of 153'000 population CUR
- Aug 2018: Insured **150'000** of 160'000 population CUR
- Insured (n): + 22'000 (+17%)
- Participation Rate: **84%** => **94%**

Adjustments 'on-the-road':

- *2014 'Repair Legislation':* ***New Immigrants (temp. permits) no longer admitted***
- *2015 'Repair Legislation':* ***Inclusion Civil Servants (& Empl. Government Entities)***

CONCLUSION: RISEN ACCESSIBILITY ACCOMPLISHED

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As from 2013: 1 public health fund

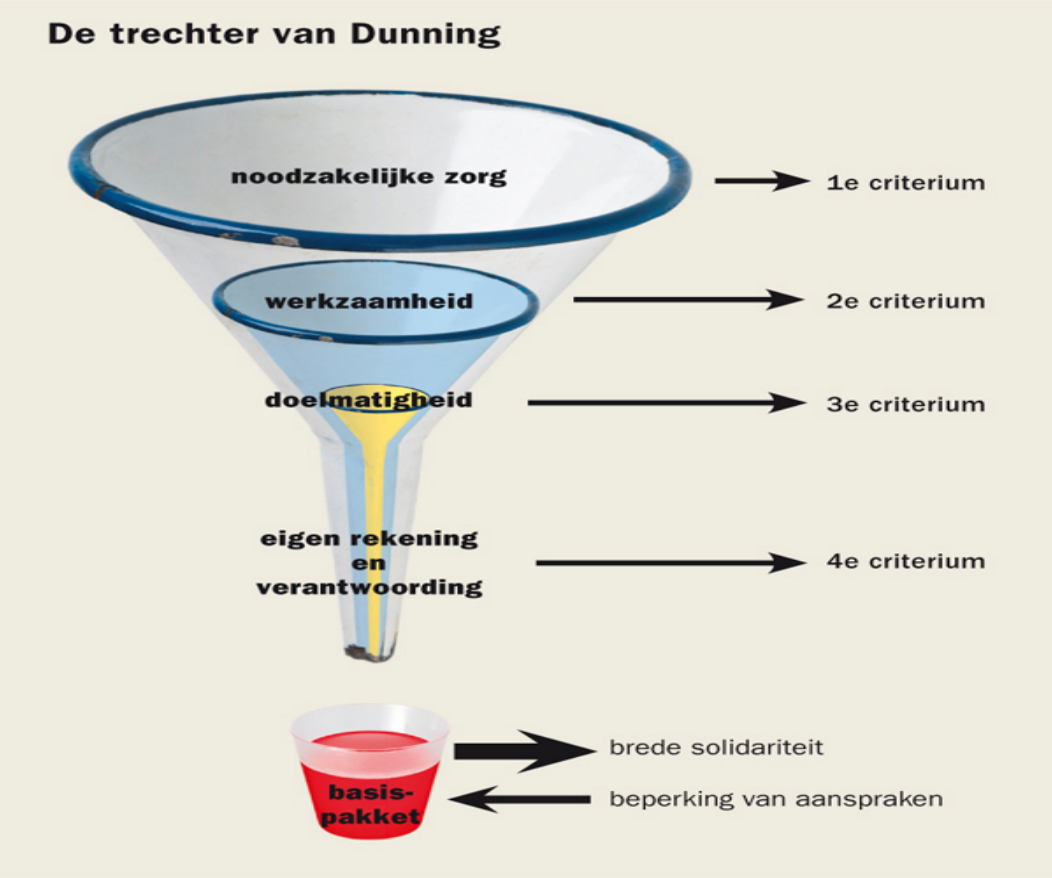
HEALTH INSURANCE SYSTEM CURACAO AFTER BHI (DATA 2018)

	CURE			CARE
		USD 324M		**USD 44M**
	1 PUBLIC FUND 'BHI'	VARIOUS PRIVATE INSURERS	O-O-P AND/OR UNINSURED	1 PUBLIC FUND 'AVBZ'
	94%	6%		100%
	150,000	>10,000*		160,000
	USD 289M	**USD 15M***	**USD 20M***	**USD 44M**

Source: Nat Health Accts & SVB
*estimates SVB, includes add-on insurances

Objective II: Uniform Coverage

- **<u>Legislation</u>: Landsbesluit Verstrekkingen**



<u>THEORY:</u>

CRITERIA (TOP -> DOWN),
IS PROVIDED CARE:

1. NECESSARY?

2. EFFECTIVE?

3. EFFICIENT?

4. PUBLIC RESPONSIBILITY?

ALL CONFIRMATIVE? =>
IN BHI COVERAGE PLAN

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Evaluation Objective II (2013 => 2018)

- **Uniform Basic Coverage:**

  - Feb 2013: Prevention, GP, Dental Care **(<18 yr)**, Paramedic, Maternity, Mental Health, Hospital (3rd class) & Specialist Care, Referrals Abroad, Lab, Pharmacies, Glasses Provisions **(<18 yr),** Medical Aids & Devices, Revalidation, District Nursing & Home Care and Medical Transport.

Adjustments 'on-the-road':

- *2014 'Repair Legislation': Addition **Dental Care & Glasses Provisions >60 yr / low inc***
  *Expansion criteria **non-urgent Medical Transport***
- *2015 'Repair Legislation': Inclusion of Civil servants **(+ limited additional coverage)***
  'Inevitable / unforeseen' medical expenses abroad

CONCLUSION: UNIFORMITY COVERAGE ALMOST FULLY ACCOMPLISHED

(IF NOT: POLICY CHOICE)

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Objective III: Harmonize Premium

- **<u>Legislation:</u> Landsbesluit Premieheffing (> 18 yr)**

  - Feb 2013:

Employer:	9.0% of gross income
Employee:	3.0%
Premium free inc:	**USD 6’700 year (0%)**
Insured:	nominal fee USD 46 / yr
Pensioners:	**10.0%**
Income ceiling:	**USD 56’000**
Own contribution:	USD 0.55 (Naf 1.00) per prescription line

  - 2015 ‘Repair Legislation’: **main goal**: **diminish inequality pensioners**

Employer:	9.3% of gross income ↑
Employee:	4.3% ↑
Premium free inc.:	**Rising scale USD 6’700-10’000 year (0%-4.3%)**
Insured:	**no nominal fee ↓**
Pensioners:	**6.5% ↓**
Income ceiling:	USD 84’000 ↑

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Evaluation Objective III (2013 => 2018)

- **Harmonize Premiums:**

  - **Minors for free**
  - **Less wealthy pay lower % (< USD 10'000)**
  - **Pensioners pay higher % than active labor force (gap down from 7 to 2.2%)**

Adjustments 'on-the-road':

- *2015 'Repair Legislation': **Premium pensioners down from 10% to 6.5%***

CONCLUSION: HARMONIZATION / SOLIDARITY ALMOST FULLY ACCOMPLISHED

(IF NOT: POLICY CHOICE)

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Objective IV: Improve Financial Sustainability

- **<u>Improve Financial Sustainability</u> (dual, Bismarck/Beverage)**

• 2013:	Expenses:	USD 255M
	Premium income:	USD 124M (43% of total)
	Government contribution:	USD 163M (57%)
	Expenses per capita:	USD 1'798
• 2018 (proj.):	Expenses:	USD 289M
	Premium income:	**USD 158M (51%)** ⇧
	Government contribution:	**USD 153M (49%)** ⇩
	Net result (after overhead):	**USD 12M**
	Expenses per capita:	**USD 1'926 (trend +1.4% per yr)**

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Objective IV: Improve Financial Sustainability

- **Expenditures per health sector per capita (USD):**

	2018 (proj.)	2013	trend p/y
Hospitals	577	604	**- 1%**
Pharmacies	396	402	**- 0%**
Specialists	264	225	+ 3%
Labs	172	127	**+ 6%**
GPs / Dentists	146	127	+ 3%
Medical Referrals Abroad	140	142	**- 0%**
Paramedics	59	41	**+ 8%**
Mental Health	54	37	**+ 7%**
Home Care / District Nursing	39	40	**- 0%**
Other / miscellaneous	79	53	
PER CAPITA (USD)	**1'926**	**1'798**	**trend 1.4% p/y**

Evaluation Objective IV (2013 => 2018)

- **Improve Financial Sustainability**

  - **Less Government Contributions**
  - **Higher Premium Incomes**
  - **Positive Fund Results**
  - **Expenditures per Capita: Growth = Relatively Low (1.4%)**

Global	**2.5%**
LatAm & Carib	**2.5%**
USA	2.0%
Netherlands	**1.5%**

Source: IHME (2010-2015)

CONCLUSION: FINANCIAL SUSTAINABILITY FAIRLY ACCOMPLISHED (so far...)

Objective V: Raise Level & Quality of Care

Care Contracts, Protocols etc.

Quality Goals (2013):

- Quality & Production Protocols providers
  - o mandatory (accreditated) refreshment courses
  - o introduction treatment protocols
  - o maintain minimal/maximum production levels
  - o diminish waiting lists
- Implementation policy docs and vision papers health care providers
- Patients inscription with 1 GP, 1 pharmacy and 1 dentist (of choice)

Level Goals (2013):

- Expansion local care, substituting medical referrals
  - o set up catheterization laboratory and neurosurgery unit:
  - o expansion dialysis units
  - o expansion quantity of medical specialists

Evaluation Objective V (2013 => 2018)

Raise Level & Quality of Care

Quality Goals (status 2018):

- mandatory (accreditated) refreshment courses:
  introduced for GPs, medical specialists, dieticians, speech therapists, remedial therapists
- intro treatment protocols:
  received from psychologists, physiotherapists, speech ther., dieticians and chiropractors
- maintain minimal/maximum production levels: min = 30-50% & max = 150% of production standard
  introduced for GPs, medical specialists, psychologists and dieticians
- diminish waiting lists:
  in progress
- implementation policy docs and vision papers health care providers:
  in progress
- patients registration with 1 GP, 1 pharmacy and 1 dentist (of choice)
  introduced for GPs and dentists, **in progress for pharmacies**

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Evaluation Objective V (2013 => 2018)

Raise Level & Quality of Care

Level Goals (status 2018):

- expansion local care => less medical referrals: **diminish expenses referrals (growth 0%)**

  o set up **cathlab** (a.o. angioplasty) and **neurosurgery** unit:

  cathlab in place 2014: **referrals cardio n=293 (‘13) => n=44 (‘15)**
  neurosurgery unit in place 2017: **referrals neurosurgery n=182 (‘15) => n<50 (proj. ‘18)**

  o raise capacity **dialysis units**:

  Private Clinic and Hospital: in place (no more referrals in ‘18)

  o raise quantity of **medical specialists** (new specialists mandatory on payroll):

  from 92 to 103 specialists
  - on payroll and Poli in Hospital **42 (was 8 in ‘13)**
  - billing, private Poli outside Hospital **61 (was 84 in ‘13)**

CONCLUSION: QUALITY & LEVEL GOALS PARTLY ACCOMPLISHED

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Lessons of Implementation towards a BHI (policy choices)

- Use One Executive Body
- Take Implementation Time (Publication Law 30 Jan, Implementation 1 Feb...)
- No Nominal Premiums
- Don't start too Broad (coverage plan)
- Avoid Exceptions / Exonerations (in entitlement, coverage plan, premiums)
- Attend Undocumented Population
- Attend Unforeseen Medical Costs when Abroad (holidays etc.)
- Concentrate Patient Registration (1 GP – 1 dentist – 1 pharmacy)
- Invest in Quality & Prevention: reduces (growth of) costs in long run

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'Best'(?) Practices Care Purchase on Curaçao

- GPs:
  - Mandatory Registration (by 1 GP of choice)
  - Stipulate standard of income (salary + cost of private office)
  - Fee per capita per year
  - Quality Registration (accreditated courses)
  - **Minimal and maximal size of medical offices (measured in pats.)**
  - Mirror info (pharma, **lab, referrals to med. spec**.)
- Dentists:
  - Mandatory Registration (by 1 dentist of choice)
- Paramedics:
  - Quality Registration (courses, protocols)
  - Stipulate standard of income (salary + cost of office)
  - Minimal and maximal size of billing (measured in amount USD)
- Medical Specialists:
  - **Mandatory Contract Integrated within Hospital**
  - Stipulate standard of income (salary)
  - Quality Registration ('BIG', courses, protocols)
  - Mirror info 'peers' (**pharma, lab, referrals back to GP**)
- Hospital/institutions:
  - Budgetting on meso-level (20+ productgroups)
- Pharmacies:
  - Stipulate standard of income (salaries + cost of offices)
  - Fixed gross margin fee per prescription line
  - Mandatory generics

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Best (?) Practices Care Purchase on Curaçao

- **Points of Attention, side effects containment measures:**
  - **3 pharmacies stopped services (out of 32)**
  - **budgetted institutions in some financial distress (level of efficiency)**
  - **budgetted institutions incline to diminish non-urgent (elective) production**
  - **budgetted institutions have less incentive to invest, innovate & diversify**
  - **medical specialists on payroll incline to work less hours than billing spec.**
  - **waiting lists elective care for some groups of specialists**

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Future Developments => 2019/2020

- **Transition Process to New Central Hospital Q3/Q4-2019: 300 beds**

Future Developments => 2019/2020

- **Transition Process to New Central Hospital Q3/Q4-2019: 300 beds**
  - **Develop 'Functional Differentation' between Central Hospital & Clinic**
  - **Stipulate Capacity Planning for medical specialists**
  - **'Billing/Integration Legislation' for Medical Specialists (centralized, payroll Hospital?)**
  - **Implement multidisciplinary chronic care groups in '1½ line' (GP+paramed+med spec)**
  - **Implement 'Care/Clinical Pathways' (Diabetes, CVRM)**
- **Digitalize & interconnect health providers (e.g. 30 pharmacies, 6 laboratories)**
  - **Use BIG DATA in general, transform to ICD-10 codes**
- **Implement (more) quality convenants with more groups of caregivers**
  - Minimum / maximum production levels
  - Mandatory accreditated training and refreshment courses
- **Expand prevention programs (prostate screening, wellness, eating habits)**

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GRAN TANGI !!!