ANNEX

INTERFACE AND RESOURCE BODIES (IRB)

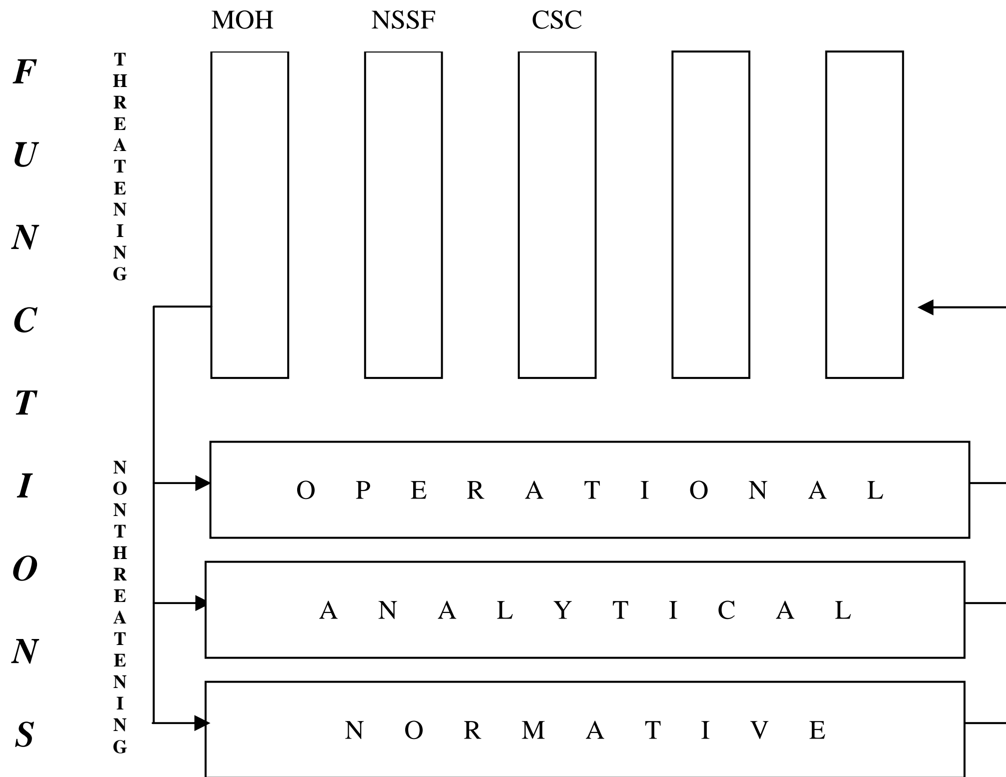
The IRB option is a variant of the Third Party Administrator (TPA) model. It bets on upgrading the performance of public funds by providing them with pertinent information, credible technical assistance and a common approach in dealing with providers.

MISSION

This option considers that for any solution to be implemented, it has to be administratively and politically feasible and thus has to carefully respect the autonomy of each fund. Therefore, creating interface and resource bodies (IRB) assisting these public funds and executing on their behalf some technical tasks would be a feasible alternative, on condition that IRBs prerogatives do not englobe functions which might threaten the identity of the existing funding agencies.

Accordingly public financing functions were split into two important groups: "*threatening*" and "*non-threatening*" functions.

Fig 1: IRB alternative: vertical integration of threatening functions and horizontal integration of non-threatening functions



Threatening functions include policy making, conceptional and major decisions on: entitlement, benefits package, contribution rates, waivering policies, and contracting with providers. These issues that are critical for the identity and autonomy of the funding agency will be kept in its hand, but related decisions would be based on pertinent information, unavailable for them under the existing conditions. Providing the same accurate and timely information by the IRB for all concerned agencies is crucial to guide their policies, and to enable them for making evidence-based and most likely similar decisions.

Non threatening functions are of 3 types:

1- O*perational tasks* such as: establishing a unified database on beneficiaries, issuing a standardized health card, providing prior authorization, ensuring control at the point of service delivery and processing claims.

2- A*nalytical work* such as: cost analysis and actuarial studies.

3- *Normative functions* such as: accreditation of providers and case management protocols.

The same type of functions could be delegated by all public funds to one independent body (IRB), in order to overcome fragmentation, ensure technical support, generate needed

Table 1: Comparison between the classical TPA model & IRB mission and functions

	TPA	***IRB***
Deciding on entitlement	Risk selection (underwriting processing)	-
Deciding on benefits package	Limitations & exclusions	Provide evidence and recommend
Setting contribution rates	Risk based premiums	Provide evidence and recommend
Collection of contributions	-	+/-
Conducting actuarial studies	+	+
Selecting providers & services	+	Provide evidence and recommend
Contracting out	+	-
Contract termination	+	Provide evidence and recommend
Client services	-	+
Issuing prior authorizations	+	+
Tarification and payment mechanisms	+	+
Reimbursement of providers	+	+
Claims processing & auditing	+	+
Bills deductions	+	+
Utilization patterns assessment	+/-	+
Case management	-	+
Quality assurance	-	+
Accreditation	-	+

information, and increase the efficiency of public financing. The nature and the legal status of the IRB may vary for each type. For example, operational and analytical functions could be executed by a private firm, whereas normative functions would better be delegated to a body that includes representatives of both providers and financers as consensus building should be sought.

This option intends mostly to rationalize health care financing, increase the efficiency of funding and provision of health services, and allow better regulation, quality assurance and consumer empowerment.

Entitlement, coverage and benefit packages may remain the same, for each funding agency. However, in order to increase accessibility to health services especially of the poor, the MOH should strengthen the primary health care system. This would compensate for not covering ambulatory care for the uninsured and would allow shifting money for more cost effective means.

National Health Programs and Primary Health Care Services would be delivered in collaboration with NGOs and municipalities nation-wide. This would be based on the MOH-NGOs experience starting from the network of already contracted health centers.

An adequate referral system would help rationalizing services utilization; whereby the PHC centers constitute an entry point into the system, public hospitals function as "frontline hospitals", while reliance for tertiary care will remain essentially on the private sector.

DISCUSSION

This IRB option developed in 1997[1,2] is found to be in accordance with the "guidelines for developing a viable proposal" brought out later on by Kahn CN 3rd and Pollack RF[3], particularly in maintaining current coverage levels, building on existing structures and maximizing public funds.

The fragmentation of health financing has its negative impact on both cost and quality of health services. The weak bargaining position of public funds that are dealing separately with providers is responsible for the existing imbalanced relation with the powerful Private Hospitals Syndicate and Physicians Orders. Managing contracts with providers by institutionally weak public funds in the absence of pertinent information, leads to abuse and uncontrolled over-consumption of below average quality of services. On the other hand, the inexistence of a database on beneficiaries and ill-defined eligibilities, together with the multiplicity of benefit packages, are leading to overlapping and duplications of coverage.

Equal accessibility to health care, and regaining balance in financing by using tax money to cover the poor are strengths that might be compromised by a drastic change.

Regarding the SHIP proposal (option III), and besides overcoming financing fragmentation, the purpose of creating one compulsory public insurance, is to ensure equity in risk protection by having every citizen contributing in generating necessary funds. This is too ambitious considering the ill-organized administrative and fiscal system. It will raise an endless debate around contributions setting, and would require a cumbersome collection system.

On the other hand, financing health services that are unaffordable by the poor by using taxes (MOH budget) remains essential for ensuring fairness in financing and equitable access. The MOH contribution counterbalances the inequity in risk protection, resulting from having more than half of the population uninsured. Being not enrolled with an insurance scheme necessitates complicated administrative authorization procedures in the MOH. This should not necessarily hinder the accessibility to expensive services that are worth the effort. Those complicated procedures unexpectedly resulted in reducing (over) utilization of the services, as is demonstrated by the much lower hospitalization rate (8.4%) among those eligible to the MOH coverage, compared

to other public funds. Nevertheless, the MOH hospitalization rate should be interpreted with caution. It is calculated by dividing the number of MOH-covered admissions over the total number of eligible. This total includes eligible persons who are not aware of their rights or who choose not to seek Ministry's coverage.

Table 2: Strengths and weaknesses of the fragmented system model, the merger of funds model and the third party administrator model (IRB).

	Fragmented System	Merger of Funds	IRB
Sources of Funding:	(Balanced)	(Not Clear)	(Balanced)
Contributions Vs	+ +	+ + +	+ +
Taxes	+ +	+ ?	+ +
Risk Pooling	+	+ + +	+ +
Economies of Scale	+	+ + +	+ +
Evidence-Based Decisions	-	+ ?	+ + +
Efficiency	+	+ ?	+ + +
EQUITY			
In financing	+ +	+ ?	+ + +
In access	+ +	+ + +	+ + +
In risk protection	+	+ + +	+ +
Competitiveness	+	- (Monopoly)	+ + +
Bargaining Power	-	+ + +	+ +
Impact on Quality	-	+	+ + +
Political Feasibility	+ +	+	+ + +
Position of Stakeholders	+ +	+	+ + +
Consumer Protection	+	+ +	+ + +
Identification of Eligibility	-	+ + +	+ + +
Legislative Reform Needed for Implementation	-	+ + +	+
Power	Powerless	Great Power	Decentralized Power
Systems' Ability to Adapt with Financial Crisis	Flexible but passive	Rigid	Flexible and alert

Besides the doubtful feasibility of merging public funds, merger would lead to the creation of a great monopoly preventing competition among financers. It also necessitates a major legislative reform and leads to a heavy bureaucracy. However, the merger model allows avoiding duplications and overlapping, provides a powerful bargaining position and insures an optimal

risk pooling. Many important issues such as setting and collecting contributions and benefiting from government's subsidies remain undefined. Most importantly, there is no guarantee that once merged, the arising public fund would be better managed and more efficient than the average public administration.

Merger of funds is the rational choice to achieve economies of scale. Yet, the very low administrative cost (1.6%) for the MOH, makes this issue less important. The same argument is valid when considering the bargaining power with regard to getting better prices, where the cost per eligible person per year for the MOH (80 USD) seems difficult to lower. However, the issue of bargaining power becomes more relevant when talking of cost effectiveness in a large sense i.e. improving the value for money disbursed, especially in terms of quality of services provided. This seems to be the major deficiency in the current system, yet the IRB alternative remains the best choice.

The IRB model maintains balanced sources of funding and respects the independent entity of each fund allowing competitiveness. It strengthens each fund while the resulting power remains decentralized, provides technical assistance, enhances evidence-based decisions, and creates a framework for regulation and quality assurance.

With regard to risk pooling, the issue should be looked at from the source of financing standpoint. The NSSF, which is financed mainly by contributions, is pooling 713,000 beneficiaries. The other public funds are mainly financed by taxes and are pooling 505,000 beneficiaries, whereas the MOH budget covers 1.9 million entitled persons. Grouping similar functions of all public funds including the MOH, and delegating them to one agency would allow achieving economies of scale.

In conclusion, the IRB alternative seems to preserve best the acquired benefits mainly in terms of maintaining universal access. It allows for enhancing efficiency and assuring quality

without overloading the system. And most importantly, this option seems politically, socially and administratively quite feasible.

REFERENCES

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