# Pricing the national health insurance scheme in Qatar – opportunities and challenges

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# National Health Strategy

- Outlines the vision for the future healthcare system outlined in Qatar National Vision 2030
- It maintains that a healthy population is a fundamental basis for a successful nation
- The Strategy proposed changes across the entire healthcare system, one of which is the development of a social health insurance scheme that enables choice, allowing people to use healthcare services from both the public and private providers while ensuring high quality, efficient and affordable healthcare.

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# Seha

- Aims to enhance the wellness of the people of Qatar through the provision of full health insurance coverage to the entire population
- Stage 1 was introduced in July 2013
  - Covered females 12 years and over for women's health and maternity services.
- Stage 2 was launched in 2014, with coverage for all Qatari nationals and people of similar status for a much broader range of services
- Future stages 3 and 4 of the scheme will extend coverage to all non-Qatari residents within the country and visitors

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# National Health Insurance Company (NHIC)

- Manages Seha
- Established in July 2013
- Owned by the government and managed by an executive team, reporting to a board of directors
- The board comprises of representatives from the Supreme Council of Health (SCH), the Ministries of Finance, Labour, Interior, the Central Municipality Council and members from the private business sector

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# Aims of this presentation

- Outline the approach to pricing for Stage 2 of Seha
- Reflect on the challenges of bundled payment system
- List the next steps for pricing for Seha for the next financial year and beyond

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# The beginning…

- A range of steps were taken in the public sector in preparation for the launch of Seha:
  - ICD-10-AM coding of inpatient data was progressively implemented throughout 2012, as a mandate by SCH
  - Australian Refined Diagnosis Related Groups (AR-DRGs) were adopted for grouping acute inpatient data
  - Clinical costing was implemented

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# Stage 1

- Decision to use a bundled payment method for health care services to the extent possible. Therefore:
  - AR-DRGs used for pricing acute inpatient care (using 76 AR-DRGs relevant for women and maternity services)
  - A modification of the Australian Tier 2 classification was adopted for specialist medical services using 9 classes relevant to women's health
  - A primary health classification was adopted based on 4 levels of complexity (minimal, low, moderate and high)
  - MRI and mammography were unbundled from the specialist and primary care service, but other imaging, laboratory and pharmacy services were bundled into the price

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# Stage 1

- Although not included in Stage 1, previous work had also recommended the adoption of Urgency Related Groups (URGs) classification for emergency care
- Stage 1 was implemented with a limited network of hospitals

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# Challenges for Stage 2

- Pricing a much wider range of services than had been priced in Stage 1
- Expanding the scheme to a wider range of providers, including ‘standalone’ providers (i.e. those without the capacity to provide ancillary services)
- Limited availability of activity and cost information for the private sector

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# How Stage 2 was approached

- Consultations with both public and private providers, particularly relating to their experiences with Stage 1
- Benchmarking of international prices to understand the extent to which prices and relativities aligned with other countries within the region and more widely around the world
- Compilation and analysis of activity and cost data
- Development of prices
- Exploration of various policy options and decisions (e.g. unbundling pharmacy costs from specialist and GP prices)
- Launch of Seha, including communicating key features of the scheme to prospective providers

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# Stage 2 fee schedule:

- Prices developed for:
  - Inpatient services (acute and sub- and non-acute)
  - Emergency services
  - Specialty medical consultation clinics
  - Primary health care
  - Allied health and nurse-led clinics
  - Home based modalities
  - Dental
  - Diagnostic imaging

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# Issues encountered

- Greatest challenges were in pricing dental services and diagnostic imaging
- Non-admitted service classification is also problematic
- The issues are as follows:
- Dental
  - Challenging to adhere to the principle of bundling
  - No system from around the world was identified that had successfully bundled dental services in a similar way to which inpatient services are bundled using DRGs for payment purposes
  - Therefore, the resulting classification and payment systems are largely itemised

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# Issues encountered

- Diagnostic imaging and laboratory:
  - Largely bundled with admitted or non-admitted medical services for ‘integrated’ providers (i.e. those with the capacity to provide ancillary services along with medical, allied health and nurse consultations)
  - However, a system for paying for ancillary services sourced from standalone providers was needed to accommodate clinical service providers that do not have access to ancillary services as part of the same organization (i.e. ‘standalone’ medical providers), and also, standalone ancillary service providers wishing to be part of the scheme

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# Issues encountered

- Diagnostic imaging:
  - Prices were developed for selected imaging tests from the Australian Classification for Health Intervention (ACHI) codes (part of the ICD-10-AM suite)
- Non-admitted service classification:
  - It is provider rather than patient based
  - Classes are not resource homogenous
  - However, providers have been submitting diagnoses and procedures for non-admitted patients as part of the claims process, and therefore, a rich data source will be available for selecting an alternative system

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# Gaps

- The two major gaps in establishing prices are laboratory and home care
- Laboratory:
  - Unified prices yet to be developed
  - Currently exploring options, potentially using the Logical Observation Identifiers Names and Codes (LOINC) system for reporting laboratory services
- Home care:
  - Includes episodic and continuous care
  - Although the price schedule includes pricing for some home based modalities (e.g. dialysis), a more sophisticated system for both episodic and continuous home nursing is currently being developed.

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# Conclusions

- Bundled payment system underpinning Seha ambitious, especially for non-admitted services
- Balance required between a bundled system and granular information to allow for analysis of utilization of services and morbidity patterns (for decision support in the implementation of the National Health Strategy)
- Some challenges already addressed in Stage 2:
  - Unbundling of pharmacy
  - Design of referrals from standalone facilities

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# Next steps

- Generate insight from claims data:
  - Fraud and abuse prevention
  - Assessment of clinical quality
  - Evaluation of cost-efficiency
- Ensure a provider structure that is based on a sustainable model of payment allowing providers to sustain their business model and payers to avoid unsustainable cost increases over time
- Leverage on the specific opportunity of a young payment system in being able to introduce innovative new models of payments and incentives especially with regards to bundled payments for outpatient services

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