ޔައުމިއްޔާ

އިޖްތިމާޢީ ކޮމިޓީގެ 8 ވަނަ ބައްދަލުވުން. (26.04.2010)

<u>ރިޔާސަތުން ވާހަކަދެއްކެވުން:</u>

ކޮމިޓީގެ އަދި ވަނަ ބައްދަލުވުމަށް ވަޑައިގެންދެއްވި އިއްޒަތްތެރި މެންބަރުންނަށް މަރުޙަބާ ދަންނަވަން. މިއަދު އަޅުގަނޑުމެން މި ބައްދަލުވުމަކީ ބައިގަޑިއިރާއިރުގެ ދިގު މިންގެ ބައްދަލުވުމެއް. މި ބައްދަލުވުމުގައި އަޅުގަނޑުމެން މިއަދު އެޖެންޑާކޮށްފައި މި ވަނީ މިނިސްޓްރީ އޮފް ހެލްތް އެންޑް ފެމިލީން ދައުވަތު ދެއްވައިގެން މި ކޮމިޓީ ވަޑައިގެން ތިއްބެވި ޑަބްލިއު.އެޗް.އޯ ގެ އެކްސްޕާޓުންގެ ޓީމަކާ ބައްދަލުކުރުން. އާދެ، ހެލްތު މިނިސްޓްރީން ފަންޑުކުރާގޮތާ ސިޔާސަތު އިޖުތިމާޢީ ކޮމިޓީއާ ހަވާލުކޮށްދިނުމުގައި ވާނެ. އެގޮތުން ކުރިޔަށް ދާއިރު ހުރި ކަންތައް މި ބައްދަލުވުމަށް ވޮކޭޝަނަލް ވަޑައިގެންނެވި ބައްދަލުވުންކުރީމު. ދެން މި ބައްދަލުވުމުގައި ހެލްތު ކެއަރ ފައިނޭންސް އަދި ހެލްތު އިންޝުއަރެންސް މޮޑަލިޓީޒްގެ މި ސަރުކާރުގެ އަށްވާ ސިޔާސަތުތަކާ ބެހޭގޮތުން ކަމަށް ވާތީ މި ބައްދަލުވުން މާލޭގައި ތިއްބެވި މަސްލަހަތުގެ ބޭނުން ހިތަށްއެރީ އިޖުތިމާޢީ ކޮމިޓީއާ އެކު ބައްދަލުކުރުމަށް އެދިވަޑައިގަތީ. ދެން ކޮމިޓީގެ މެމްބަރުން އިހުން ތަޢާރުފުކޮށްދެނީ މިހާރު އަޅުގަނޑުމެން ދަންނަވާލަން ބޭނުންވަނީ. އެގޮތުން އިޖުތިމާޢީ ކޮމިޓީގެ މެންބަރުން ވަޑައިގެންނެވި ހަމަޖެހިފައި މަރުޙަބާ ދަންނަވަމުން އަޅުގަނޑުމެން މިހާރު އެ ބައްދަލުވުން ދަންނަވާލާނަން ވަޑައިގެން ތިއްބެވި އިޙްތިރާމްކުރާ. (ވަގުތުކޮޅެއް ހޭދަވެ).

<u>Chair Person:</u>

Good morning honorable members and invited guests. We have with us today a team from WHO. We understand from Ministry of Health and Family that the team is here to conduct a workshop and Ministry of Health would like to take this opportunity to enable the social affairs committee of the Peoples' Majilis to meet with this experts. These experts are rather consultants are you know experts on health care, finance and the health insurance modalities. So at the outset let me first a fall very warm welcome to visiting WHO team on behalf of the Social Affairs Committee. Before I proceed further I would like to introduce the members of Social Affairs Committee. We have 11 members, total 11 members in committee. But today the plenary is still in session. You can see over there the TV. Some members are waiting for their slot to speak in the plenary. On my right we have Honorable Abdul Azeez Jamal Aboobakuru, on my left here Honorable Hamidh, Honorable Makhloof, Honorable Ahmed Rasheedh, Honorable Afrashim Ali, Honorable Rugiyya Mohamed. And once again on the behalf of all members of the Social affairs committee I would like to offer you a very warm welcome. We have a short period of time available. Because we have some other

engagements program for the day. So without any further comments I would like to offer the flow to the team to proceed from here. Thank you very much.

A person speaking from WHO team:

Thank you honorable delegate members of Social Affairs committee of the Majlis of Maldives. On behalf of the team I wish to offer you some comments and thoughts on how the country which universal coverage. Where the system is so important which able to contribute efficiencies and equity outcomes of people of Maldives. The guiding principal may look like a foreign to provide financial risk protection and access to health care by all citizen and work force here refer to both local and expatriate work force in Maldives. Which are affordable and sustainable. At first the society health system of solidarity across different population with poor and high and low income young and old. To provide financial risk protection with a minimum level of our pocket payment but how saw which can be capacity fee and imperating the household. To achieve efficiency by low level of administrative cost, using of resources and proper system to achieve society equity. This can be achieve in term of contribution best on capacity to pay and use of services base of health needs and also achieve this quantity of care been provided . We have 3 functions revenue collection risk pooling and strategic purchasing. Allow me to start first with revenue collection. The goal is to achieve solidarity and…. …refer to rich contribute pay more and poor pay less or exempt from the payment. And then is the government solider that financial burden for poor. In achieving such goal can contribute on space capacity on pay. Income related contribution by all public and private employee in Maldives and co payment on service of so which to introduce out to maintain to be best in capacity to pay by the Patient. Not by use level of uses of services. On sources of finance we classify a population into broadly into three groups. The formers of the sector of employee, the poor and informer Allow me to go with informer employee first. It should be income in related contributions by employers and employees. Which reach of 1 to 1 or 2 to 1 or 1 to 0. The case of current *Madhana* Program for the civil servant the government pay the whole amount which is 1 to 0 for the employ for the private sector employ you may consider 1 to 2 or 1 to 1 or 2 to 1. Is the cost of Philippin they use employer pay one part employ pay one part. The Vietnam and many others the employ pay two parts and employee pay other part. We need to address the floor and ceiling of income for access contribution. Is should be progressive. And progressive it depends on the society viewers on the solidarity of the countries. For example in Philippines the cap between riches and poor are 7 and half tons. The current Maldives contest of RF2000 and RF1000 is two terms different. So the cap is quiet close. Then the government may

wish to expand to have a more progressive gap between rich and poor contributor. So that mean the employer by law has to deduct employee monthly pay roles and contributes its obligation is part by chance while transfer to the fund currently managed by NSPA. Where by penalty is should be applied to the none complains in the law. Second gap is for the poor the senior citizen and retayary after switching this is fully funded by the government revenue as it is currently practice in NSPA. The informal sector which is the most difficult part. The policy and which stage the application where as banned of contribution with poor subsidies by government revenue in favor of poor. Finally treatment not available in Maldives now the current regional contribution is RF1500 per year. And finance by members except by poor which is show by the government. We have the view that the treatment abroad not available in country should be a major technical discussion further assessment on these sub components is so important this recommended. The fund is managed by NSPA the National Social Protection Agencies. This as foreign function by NSPA giving collection from contributory members from employ sector and from the non-employ. In for more sector the most difficult to fast as affect by many other countries. For example in Vietnam and Philippines enforcing the informal sector to contribute is quite difficult and very costly to admin premium collections. NSPA may need to submit but not yet request to government for those commence is responsible to subsidies. For example the poor the retire and the senior citizen and some part of the informal sector. NSPA to should be subject to external audit by the government auditor general or its equitant bodies. By load of fund should be allowed to achieved and balance to the foreign gears. And not to limit rather unspent amount back to the checker to treasurer. The fund investment to generate profits is govern by the rules and procedure led by governing by the of NSPA. In such case then Maldives Monitory Authority and Finance ministry should be members of governing by the NSPA. It is very commonly practice in many other countries the social security fund is allowed to invest in govern by in pension etc. To generate profit and to consolidate the fund size. On risk pooling it is recommend that monthly universal coverage to Maldivian citizens and our expert work force in Maldives for which Insure large pools of contribution and solidarities and large group of risk pooling across the whole population including the excepts something around 80 thousand or two hundred or one to two hundred thousand people. The coverage of expert worker is justifying best on foreign accruement that natural image on equitable label protection and it able to various conventions as four members of ILO. We need to insure solidarity across the group of the 3 group of population. For example the employee sector should cross subsidies at the population group means employer sector may in monitory term contribute more than the informal group and the poor population.

And it is recommended as it is in dice international precedent not allowed to up out from the monitory enrollment. The one three private insurance is allow for at u know benefit package. Which is not cover by NSPA. For example service package not cover by NSPA. On straight purchasing on benefit package designed. It is so why the public health function should be remain as a legitimate responsibility and full fund that government free approximate all citizens. For example humanization, family planning etc. These are the principle apply in the desire of the benefit package. For example use of cost effectiveness evidence. The country may apply execution less principle. For example surgical intervention should be excluded. It should be comprehensive enough. For example include outpatient service, accident, emergency etc. This is called deapth of coverage. However the level of the depth of coverage should be strike against the physical capacity of the NSPA to the finance in a sustainable way. Then it is recommend to have a regular assessment to take balance which is between availability of fund and the demand of resources to spend. It is not necessary in law to. Stimulate such detail of benefit package. But law may empowered NSPA to apply this principle in there benefit package design. On provider we should include public and private providers in Maldives that of acceptable quality standard. Being license and license by MOHF and being accredited by future accreditation bodies to be develop in the future. Because most countries have developed accreditation bodies, either the independent body under the MOHF depends on future evolutions. But the quality of goals we need to ensure to provider its offer good standard of care. On provider payment method it is the most vital component of the system desire to insure that, that is long term sustainable. The crane method to be forced has a high potential for supply and demands high administrative costs and less affective to check supplier individuals demands. Should this be amended and to what tax should be crafted that in the law Subject to further scrutinization and technical work out. The prefer choice in best in International experience many over city country stay away. From conventional services or FIFA service and a mix mode of provider payment should be adopted and mix part should be pre dominant by capitation plus outpatient and inpatient. And to medicate of the capitation FIFA service can be apply for some services that capitation does not provide adequate services. We have to access the view point of providers. They may not like cross in provider payment. However health care provider in Maldives is predominate by public nonprofit providers. Which is not for outpatient visit where by the private clinic or private hospitals also pay quite significant draw, If capitation is adopted there is a need to register the members to a prefer provider without ensuring that proper referencing is there. The average of outpatient capitation and inpatient is that when we require members to be register which a provider network there is a lack of family care

there is continuity care conical and non conical diseases. And we can achieve efficiency through administrative cost is much lower administrative is more simple and there is no need to outsource the help for the review compare to the current FIFA service more goods And also we can prevent better prevent suppliers demand because provider has no incentive to over prescribe and over dispense service. There for the cost condimental capacity of the capitation is very good. The down side is an in adequate some service that we can improve correct this advantage by providing FIFA service for some services. The down side is if there is creeping by falls providing falls that know stick at the original diagnosis so, that diagnosis going up and provider can get more resources. There is a need for technical development of Maldivian system if which is in the country. The objective of core payment is to prevent pro assets behavior by patient. It cannot core payment cannot prevent supplier more assert. To supplier introduce demand. Because of imperfect emergent because of the information is symmetry. There for some international evidence it found that provider payment methods send a strong signal prescriber behavior and capitation has more advantage from service in term of coping with the supplies individual demand in efficiencies. If cross and payment is adopted copayment might not be necessary. And maximum ceiling of reimbursement is not necessary. A few more slicer on governance and governance is to ensure accountability by all concern parties. And the spiriting roll of the purchaser and providers to overcome interest which is generally accepted that by international precedent. Now NSPA become the purchaser it is fund manager who purchase service on behalf of all members. It can be a autonomous public body govern by manageable science of medistic holders, boards, members plus some ex office your. Ensure the Ministry of Health and Family. The health service corporation now you have 8 health service corporations can be health care provider network. In state of contract in state of doing business in it help central hospitals can make with it of health service corporation recently developed in country. We need to hope NSPA to whole employer and the whole government accountable to each other. We need perhaps in the law fins for employers for the non comprehence to contribute falls importing of the number of members and there parlors. In some country in the law they have some impressments for those who have a force importing non- comprehence to the law. Like Thailand ve have imprisonments but enforcement never been implemented. So they use collapse instead of stick. But perhaps both should be strict in the law. Government to provide adequate and no budget to subsidies the poor the senior citizens and retiree, and also NSPA should be subjected to external performance which audits. It should have a monthly important to the requirement to the parliament to you sir. Of it’s no performance and public in performance which is interested to the general public. All

this the instrument to the whole every key partner accountable and discussing and responding we have to provide accountable to its member as well. Finally we need to monitor and evaluate the outcomes of this policy. And it is legitimate responsibility of the MOHF to monitored outcome of this UC. Universal Coverage policy. We need to monitor worker activity of financial contributions. The financial risk protection in term of incidental of capacity fit health spending by the household and encouragement we need to modern equity in terms of utilization and equity in public subsidies and also regular monitor consumer satisfaction as well. On behalf of team I thanks very much for your time sir.

Chair person:

Thank you very much for most comprehensive presentation and if you would like to add any more remarks to that. Otherwise I will open floor to the honorable members if they have any clarification. Ok you have the floor now.

A person speaking from WHO team:

So just to add to what Doctor have just mentioned. If you look at the health finance system in Maldives the government has been investing the lot of resources in the health of the population and it is one of the few countries in the region and one of the middle income country is which have such a excellent demonstration of government commitment to health of citizens with a 80% of health expenditure coming from the government as also a large share of the government budget been committed to the health sector. That something which country willing to be complimented for demonstrating that commitment to health of its citizens. If you look at the share amount of the expenditure which is done and also not only the highest south Asia region all the countries in south Asia region by capital. It also, more than what other country of similar income levels of spend of the health of the population that's something again creditable. If you also compare that to the outcomes for example changing enphant mortality in Maldives has been biggest in terms of reduction enphant mortality in South Asia region has happened in Maldives as compare to 1990 level it almost one forth of that level and that is now at the same level in Sri Lanka which had much better enphant mortality when in 1990. So lot of gains has been made in that. And this now needs to be this momentum needs to be taken forward as we embark in new system using NSPA for Social Protection using medical corporation for delivery of health services and it's important that we ensure that the money that is committed by the people of Maldives to the government of the Maldives health sector is utilize in most efficient way. And a sustainable because the current health system increasing the rapidly needs costs and the

system of paying what we call FIFA service has its own limitation. It is not able to control the cost. One effective way to be able to pool the money being spending health financing is to through the NSPA and we have excellent opportunity in terms of propose bill and it is now been frame for the social protection and this entered discussion wasn't that contest that if you could give some inputs and workshop that we are organizing also that contest. That any inputs that given from global experience which could help planet in a way sustainable gives the right health outcomes and it is equitable and protect honorable section of the population. Thank you sir.

Chair person:

Thank you very much. We have very little time for further discussions. So we have a clock over there so at 11:45 there about we will try to conclude this session. So I now open the floor for honorable members to raise any questions or seek any further clarifications on presentation or any matter related matter.

Medu henveyry constituency MP Mr. Hamidh Abdul Ghafoor:

I guess the concept is new to us the concept of NSPA. My question is just I mean what is your observation. Sum other issues that which we have. Is people are still not that aver of the benefits. So it's very casually people don't register. They only register only when they fall ill. And then NSPA says we got a three month down time for this. The question is, is there any system where suddenly everybody is in.

A person speaking from WHO team:

Its I believe that if the law is pass by you. And before it is passed you need to have a public awareness creation a big campaign to our citizen this is entitlement at the some obligations as well. So active public relation is very important to prepare along with the line of legislative process. That's our experience is Thailand, in Vietnam and also in the Philippines.

A person speaking from WHO team:

Just to add most countries in the world which is most emergent social health insurance particularly lower and middle income. Start with mandating the large formal sector. To be part of the social security system. So as now if you look at the beneficiaries of NSPA they predominately the government employees, senior citizens are pensioners, the *zarooree*, poor and largely groups which are paid by the government. Number which have been voluntary contributions from individuals. And voluntary contributions from individual may not happen at a very large number because it's a young and healthy

population. Largely young population they may not realized the need. To pay for health today because they may not have much health expenditure. And most countries manage that by some form of mandating, some basic coverage which is the responsibility of the employer at least the large employers and their employees to coming the pool. And when they coming the pool. Their family coming the pool large share of the population is in the formal sector employment and that along with their families if through the Bill brought under the health insurance it will improve solidarity improve the pooling and lead to a much more sustainable and vibrant health insurance system.

Maavah constituency MP Mr. Abdul Azeez Jamal Aboobakuru:

Thank you. I just take this opportunity to thank the consultant team for the presenting this informative presentation. Because this will help us to in our committee when we debate certain bills. So once again I in behalf of our comity I would like to covey our hearties to thank, thank you.

Chair person:

I think the presentation is so comprehensive that there doesn't arise any questions. Now for the sake of other members also if possible we would like to have a copy of the presentation in hard copy or soft copy it does not a matter which ever form it is. So that we can distribute to other members for their benefit and for the larger parliamentary purposes and I think that will do clock is now ticking 11:45 so once again thank you very much for this presentation and we are very privilege to have opportunity to meet with you and gain such information and I' m sure this will be beneficial to *Peoples Majlis* and the all the members at large. And I thank also like to offer our thanks to Ministry of Health for organizing this meeting and WHO also for initiating this kind of exercises in Maldives thank you very much.

———————