NATIONAL AUDIT OFFICE OF LITHUANIA
• BRINGING BENEFITS •

ASSESSMENT OF REGULARITY OF 2018 SETS OF CONSOLIDATED FINANCIAL AND BUDGET EXECUTION REPORTS AND LEGALITY OF MANAGEMENT, USE AND DISPOSAL OF FUNDS AND PROPERTY OF THE COMPULSORY HEALTH INSURANCE FUND

30 September 2019

No. FA-7

SUMMARY

The Objective and Scope of the Audit

Pursuant to the Law on National Audit Office [1], and the Law on Public Sector Accountability[2], we have conducted the audit of the assessment of regularity of 2018 sets of consolidated financial and budget execution reports and legality of management, use and disposal of funds and property of the Compulsory Health Insurance Fund.

The audit was conducted in accordance with the Public Auditing Requirements, International Standards on Auditing and International Standards of Supreme Audit Institutions. The audit report contains only the items performed and identified during the audit and the independent opinion on the consolidated financial and budget execution reports is presented in the audit conclusion. The scope and methods of the audit are described in greater detail in Annex 2, Audit Scope and Methods (pages 26-29).

[1] Law on National Audit Office, Article 9 (1)(5)
[2] Law on Public Sector Accountability, Article 30

The main results of the Audit

1. There were no material misstatements or compilation discrepancies in the consolidated financial and budget execution reports for 2018

Consolidated financial and budget execution reports data for 2018 of the Compulsory Health Insurance Fund in all material aspects are prepared and presented in accordance with the requirements concerning them and give a true and fair view (Section 1, page 11).

2. There is a lack of consistency in the financing of public health care in the area of contracts with medical institutions

The activities of the five territorial health insurance funds do not guarantee equal conditions both for the population and the health care institutions

A resident may not receive treatment for which the fund pays, at any of the treatment facilities of his or her choice, i.e. he/she is able to receive the same services in one institution and is unable to receive (or pay for) them in another. A health care institution that has contracts with all territorial health insurance funds can provide paid services to all residents, and an institution that has a contract with one territorial health insurance fund is only for residents of that area.

A single contract with a health insurance fund is not sufficient for medical institutions seeking to provide paid services to the entire population. They must enter into five contracts with all territorial health insurance funds. This increases the administrative costs of both the fund and the treatment facilities. Territorial health insurance funds for personal health care services has concluded 1 494 contracts with 893 medical institutions at the beginning of 2018, of which 200 healthcare institutions have concluded contracts with more than one territorial health insurance fund.

Healthcare institutions have unequal competitive conditions and may receive different amounts of financing from the funds for the same service depending on the specific territorial health insurance funds. At the same time, a resident, depending on the area of the territorial health insurance fund he is related to, has greater or lesser access to personal health care, compared to a resident of another area, although contributions are paid on equal terms.

When concluding contracts with health care institutions, five territorial health insurance funds act according to different principles due to the lack of proper procedures (for medicines and healthcare measures) to be established by the Minister, differently applied unclear and/or inaccurate provisions (in paying for nursing, inpatient and outpatient services, including the process of negotiations) or failure to apply them (in paying for nursery, inpatient, medical rehabilitation and sanatorium treatment services). For example, the four territorial health insurance funds calculated amounts for 132 healthcare institutions that are greater by EUR 1,078.89 thousand, whereas other 60 healthcare institutions were calculated amounts that were by EUR 1 815.09 thousand lesser, for payment for inpatient services; healthcare institution nursery services can be allocated with more or less funds, since the territorial health insurance funds allocate such funds to institutions by applying different indicators.

Thus, the differences identified in this audit with regard to the award of contracts between individual territorial health insurance funds and medical institutions demonstrate the need to optimize the funds management structure, so that all residents of the country could have equal access to personal health care and operate on an equal footing.

Already, during the previous audit, we noted that the division of fund administrators, i.e. territorial health insurance funds, into separate legal entities - generates unnecessary costs in the administration of the fund, that generates no added value, therefore, we recommended merging six fund administration institutions into a single legal entity, to optimize the funds activities and make its management system more simple (section 2.1, pages 12-17).

Contract negotiation creates a non-transparent environment

Territorial health insurance funds may change the annual amount of funding for treatment facilities during the negotiations. Today's economic relationship is hard to imagine without negotiation, a way of communicating where the parties try to find a mutually satisfactory solution to their different goals and positions. However, in the case at hand, the health institutions and the health insurance funds must pursue common goals: one to provide quality services and the other pay for it fairly. We have found that the negotiation process is opaque because decisions to change the project contract amounts are made without clear criteria and motives set out in the procedures. Up to 26 percent of all medical institutions have participated in such negotiation processes in 2018. Taking this into account, we believe, that the circumstances determining the amount of the contract should be assessed prior to the submission of the draft contract to the medical institution and that negotiations should take place only in exceptional, rare circumstances (section 2.1.3, pages 18-19).

3. We have a reserve for the Compulsory Health Insurance Fund only at the end of the year

On 31 December 2018 the Fund's reserve has collected EUR 145.28 million of which EUR 26.46 million Is the main and EUR 118.82 million Is the risk management part. The main part is intended to cover exceptional circumstances and its usage should be approved by the Government, while the risk management part is used to reimburse the costs of compulsory health insurance, to balance income and expenditure, and to cover income shortfalls according to the resolution of the Minister. In 2018, EUR 80.00 million of the risk management part of the reserve was used to cover current expenditure. Both the circumstances surrounding the use of the deserved risk management part of the reserve, described by the legal acts, and the fact that it is being used even during economic growth confirm our previous audit[3] opinion, that we can only consider the main part of the reserve as a fiscal, sustainable reserve of EUR 26.46 million. We note that this part of the reserve is not accumulated and will decrease in size as the fund's income is reduced.

The legislation specifies the transfer of reserve funds to the Fund's reserve account by the end of the current budget year, i.e. it does not set requirements for the formation of reserve parts throughout the year. There were no funds in the reserve account for more than half a year. In our view, the legislation must set out very clear requirements for the

[3] Public audit report "Assessment of the 2017 national set of financial statements and public debt data and its management"2018-10-01 No. FA-2018-P-60-3-4-1

safe-keeping of the reserve to ensure that such funds are used in the statutory circumstances (Section 2.2, page 20).

4. The administration of municipal funded health services needs to be improved

The State Health Insurance Fund and its subordinate territorial health insurance funds are institutions maintained from the Fund's budget and performing the functions assigned to them in the implementation of the Fund's budget, however the Vilnius territorial health insurance fund's desk also administrated the budget finances of one of the municipalities, intended to provide teeth prosthetic services. The Fund's budget did not receive any additional revenue for the provision of these services and the administration costs of the services to the residents of the municipality were covered from the Fund's budget.

The Supreme Audit Institution welcomes the contribution of municipalities to health care financing, but sees the need to improve this process. The distribution of municipal funds not to all, but to a limited number of medical facilities capable of providing funded services carries the risk that municipal budgets may be allocated in a non-transparent manner and without a proper competitive environment. In addition, consumers are not provided with aggregated information on how much taxpayers' money is spent on health care, when the same services are paid for from different sources of funding and in different ways. Thus, there is a need to improve the legal framework in order to ensure the transparent provision and financing of such services on an equal basis (section 2.3, pages 21-22).

Recommendations

To the Ministry of Health Care

1. In order for the health care institutions to operate in an equal competitive environment, and to reduce the administrative burden - centralize the process of concluding contracts with medical institutions (2nd main audit result).

2. In order to ensure that the Fund's budget funding, allocated to pay for personal healthcare services costs would be planned according to the same principles and in for them to be clearly distributed to healthcare institutions - improve the legal regulation (sizes of unallocated funds, use of the bed functionality indicator, funding specified in contracts, etc., including allocation of funds for medicines and medical aid measures and the negotiation process (2nd main audit result).

3. In order to ensure the Compulsory Health Insurance Fund reserve accumulation, determine clear requirements for reserve protection in legal acts (3rd main audit result).

4. Improve the legal regulation of the personal healthcare services, paid with the funds finances and additionally by municipal funds, so that the provision and financing of such services would be transparent and based according to the same principles (4th main audit result).

Measures and deadlines for the implementation of recommendations are given in the "Recommendation implementation plan" (page 23).

In order to transfer to the objective cost-based, periodically recalculated personal health care rates, to optimize fund activities, make the purpose of contributions to the Fund clear and clearly set the volume and scope of services, paid for by the Fund, it is important to implement the recommendations, provided in previous audits (the Fund's public audit reports: 2018-10-01 No. FA-2018-P-6-3-7-1; 2017-09-29 No. FA-2017-P-10-10-4-1):

1. After implementing the recommendations of previous audits and knowing the Fund's clear financial capabilities, transfer to an objective cost-based personal health care service price, that is periodically recalculated according to established criteria.

2. Ensure that all parts of the payment for personal health care are in compliance with the provisions of the law.

3. Regulate the inclusion and exclusion of personal health care services from the list of fund-compensated services in accordance with criteria provided for by laws, taking into account the prices of the provision of services and objectively assessed possibilities of the fund. Determine the frequency of updating and reviewing the list of compensated services.

4. In order to optimize the performance of the fund and to simplify its management structure, combine the six existing bodies administering the fund into one legal entity.

5. Improve the legal regulation - by establishing a clear scope (volume) of personal health services paid from the (health insurance premiums) and to provide that only those costs, that meet the purpose of the insurance and are not covered by state funds, should be covered by health insurance contributions.

6. Initiate a discussion with the institutions responsible for social assistance policy to assess the greater volume of provided healthcare services for socially vulnerable groups, its relevance to the content of social assistance, and initiate changes in legal regulation to finance such social assistance with funds other than compulsory health insurance contributions.