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USAID Health Finance and Governance Activity

"Jordan Association For Medical Insurance (Jami) Conference Participants' Opinions On Governance And Financing Issues In Jordan"

Study Report

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ACRONYMS

CIP	Civil Insurance Program
EHSI	Electronic Health Solutions International
GP	General Practitioner
HCAC	Health Care Accreditation Council
HFG	USAID Health Finance and Governance
HIA	Health Insurance Administration
ICT	Information Communication Technology
IT	Information Technology
JAMI	Jordan Association for Medical Insurance
JFDA	Jordan Food and Drug Administration
KADDB	King Abdullah II Design and Development Bureau
MOH	Ministry of Health
NatHealth	National Health Administration Company
PHC	Primary Health Care
RMS	Royal Medical Services
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

USAID Health Finance and Governance Activity (HFG), is a five-year USAID-funded initiative that began in November 2016. HFG aims to support Jordan in strengthening its health sector sustainability and resilience, both of which are highly dependent on sound financing and governance. Among HFG's priority areas are health insurance, universal health coverage (UHC), decentralization, healthcare data, and public-private partnerships. Both UHC and decentralization are longstanding objectives in Jordan's health sector, yet they remain unresolved today.

The HFG team participated in the 2017 Annual Comprehensive Health Insurance Conference held by the Jordan Association for Medical Insurance (JAMI) on May 6 and 7. HFG held an interactive session to assess participants' opinions, reactions, and thinking on 11 health sector governance and financing statements related to advancing UHC in Jordan. The insights gained from the session can help HFG sequence and prioritize work, allocate resources appropriately to tasks, and develop approaches to controversial topics that will maximize the opportunities for success and minimize avoidable roadblocks.
JAMI is a non-profit, nongovernmental association. Among its members are public health insurance organizations, private insurance companies, and self-insured companies. Its main objective is to protect and serve the interests of its members by providing them with logistical, informational, legislative, technological, and legal support inside and outside of Jordan.

One of JAMI's goals is to spread knowledge and awareness about health insurance both nationally and internationally through workshops and conferences. The 2017 conference agenda reflected this goal by emphasizing awareness raising on such topics as the role of reinsurance companies in health insurance, the impact of Information Communication Technology (ICT) on insurance, the role of institutions in health insurance, the global experience of health insurance in small and medium enterprises, and so on. (See the Conference Agenda in **Annex 1**, the Names of Lecturers in **Annex 2**, a List of Attendees in **Annex 3**, and a List of HFG Session Participants in **Annex 4**.)

METHODOLOGY

The session was based on IT-enabled interaction between a facilitator and respondents/participants in the conference. The facilitator presented 11 statements of high relevance to UHC. Each statement was read by the facilitator in Arabic; participants then were given sufficient time to choose their responses from a list of options: (1) strongly agree, (2) agree, (3) neutral, (4) disagree, and (5) strongly disagree. To respond, participants clicked on an electronic device that enabled instant feedback, shown on a screen in a histogram chart format. Each participant received a device.

The vote on each statement was followed by a facilitated discussion in which participants were allowed two minutes to express opinions on the results of the voting. This enabled two to three participants to speak after each vote. At the end of the session, a sheet for comments in Arabic was provided to each participant. It listed the statements and provided space for comments and feedback against each statement. In addition, the sheet asked participants to choose two of the 11 statements they believed were most important. It is important to note that the comments sheet was intended to double as a back-up survey instrument in case the voting technology failed during the session. Copies of the comments sheet in Arabic and English are attached as **Annexes 5** and **6**, respectively**.**

The following statements were presented for voting:

1. Jordan should have a single, public health insurer.
2. Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care.
3. All individuals should be required to participate in a public or private health insurance scheme.
4. All individuals should be required to register with primary care clinics.
5. There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less.
6. Funds used by the Royal Court to pay for healthcare of the uninsured should be used instead to pay to insure the uninsured.
7. The Prince Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals.
8. Ministry of Health primary health clinics should be allowed management autonomy.
9. In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider.
10. The MOH and RMS providing subsidized health insurance to private sector businesses is a model Jordan should expand.
11. It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits.

DATA USED IN THE ANALYSIS

There are four sources of data used in this analysis:

1. Participants' electronic votes/responses to the 11 statements:
   The number of participants' responses for each statement ranged from 53 to 75. The increase from 53 responses on the first statement to 75 for statement 6 is due to an increase in the number of people joining the first conference session that day. Responses for each statement are attached as **Annex 7:** Tabulation of Responses.

2. Oral comments after each vote:
   Participants were given two minutes to provide verbal feedback in response to a comment or question presented by the facilitator after the results from each vote were displayed. Participants who wanted to speak raised their hands and the facilitator gave them the floor. The limited time for responses did not allow everyone who wanted to speak to express their views. For most questions, there was one feedback statement from each of two different participants. For questions related to statements 6, 9, 10, and 11, more than two participants were invited to speak. For the most part, the various participants who gave their feedback to the questions reflected a diversity of thoughts and opinions. A few participants gave their feedback on two statements. For more details from the verbal comments, see **Annex 8:** Oral Feedback and Comments During the Discussion.

3. Participants' written feedback as recorded on the comments sheets:
   A total of 64 comments sheets were collected from participants; the comments on 47 of them were determined to be useful and included in this analysis, whereas 17 sheets merely reflected the participants' responses/votes on the statements. Because these sheets were not meant to be voting sheets—voting was enabled and recorded only through electronic devices—they were excluded to avoid double counting the results. The 17 sheets were not discarded entirely because they contained other important information (see point 4 below). For more details, also see **Annex 9:** Written Comments on the Comments Sheets.

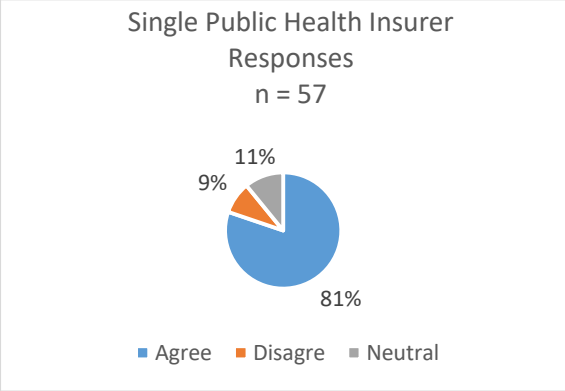
4. The selection of the two most important statements:
   All participants were asked to choose the two statements out of the 11 that they deemed most important. This request was made on the comments sheet. The facilitator guided the participants to that question. A total of 59 participants selected the two most important statements. For more details, see **Annex 10**: Most Important Statements.

ANALYSIS

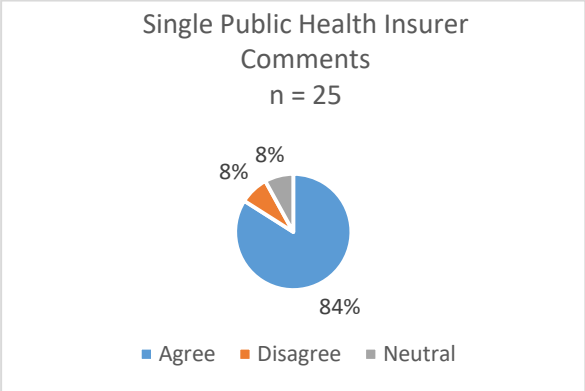
The analysis attempts to balance all four information sources while giving some priority in the discussion to written comments that provided explanations for why some participants voted the way they did. Analysis of the results from the electronic voting is presented separately from those derived from the written comments on the comment sheets. At times the analysis of the written comments expands the options to better capture statements made by some participants who did not entirely understand some statements or felt that an activity needed to be performed and they needed to be informed of its results before they could vote (see Statements 5 and 7). For clarity and completeness, the results from those comment sheets containing actual comments are shown in parallel with those from the voting. Variations between the results from voting and the comments could be due to several causes. Only a subset of participants submitted comments sheets with useful comments, and only these were included in the analysis. Some participants may have changed their opinions after the vote. There were participants who did not vote on all statements electronically but filled out the comments sheets, including for statements on which they did not vote. The analysis of the results from the session participants' choices are grouped as follows: the two choices of "strongly agree" and "agree" were consolidated under "agree"; the choices "strongly disagree" and "disagree" were grouped into "disagree."

Statement 1: Jordan should have a single, public health insurer.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 57 participants voted on this statement, with the choices distributed as follows: 81 percent agree, 9 percent disagree, and 11 percent neutral.
- *From oral comments:* Two participants spoke expressing support for a single insurer managed at a high regulatory level, such as the Prime Ministry, to achieve UHC. One of them suggested having a single public insurer with unified funds, similar to the Turkish experience.
- *From written comments:*
    - 25 participants provided written feedback, with 84 percent agreeing with the statement, 8 percent disagreeing, and 8 percent neutral.

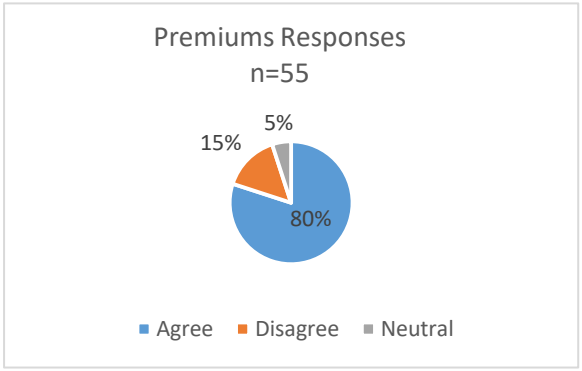
- The comments largely endorsed a single insurer for the public sector and multiple insurers in the private sector, justified by considerations of social justice and preventing duplicative insurance.

Interpretation of Findings:
A majority of participants supported the idea of having a single public health insurer—one that would unify all current public insurers. In their written comments, many participants proposed a single insurer for both the public and private sectors. Such a choice is consistent with mandatory health insurance in Jordan, an option with which all participants agreed in Statement 3.

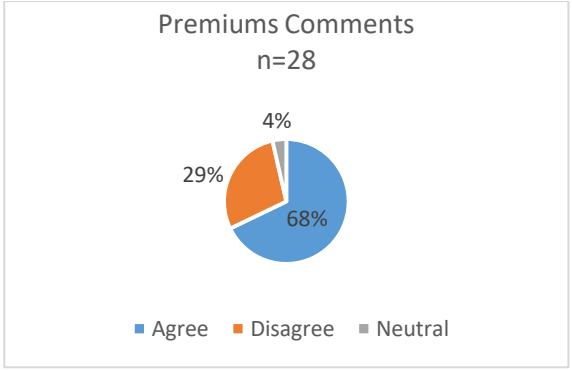
Recommendations:
There is an opportunity to explore key health financing and insurance concepts with Jordan's health sector leaders to develop a better understanding of many policy alternatives.

Statement 2: Public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 55 participants voted, with 80 percent agreeing, 15 percent disagreeing, and 5 percent neutral.
- *From oral comments:* Two participants spoke, expressing the opinions that the poor should not pay any premiums and that premium levels should be correlated with income.
- *From written comments:* 28 participants provided written feedback, of whom:
  - 68 percent agreed that premiums should increase with higher income levels, although with a few caveats: that increased premiums should rise in parallel with increased quality of healthcare services and better benefit packages.
  - 29 percent disagreed with having the rich subsidize the poor, feeling that the government should be responsible for covering them.

Interpretation of Findings:

Many participants seemed to not understand the concept of the health insurance solidarity principle, under which the rich subsidize the poor, the healthy subsidize the sick, men subsidize women, urban dwellers subsidize rural dwellers, and so on.
Participants insisted that if premiums are increased, benefits must be enlarged and the quality of services improved. They did not seem to acknowledge that very low levels of premiums are among the causes of the current financial and quality problems in the system.

Similarly, there was no acknowledgement that the cost of current benefits under public insurance is much higher than the premiums collected from members. If participants recognized this fact, presumably they would not ask for more benefits with an increase in premiums. Currently, the premiums in public insurance are meaninglessly low compared to the benefits they supposedly cover. Although not seemingly apparent to most participants in the context of this statement, in other statements they showed great awareness that the prices of healthcare services in Jordan are high (see the next statement).

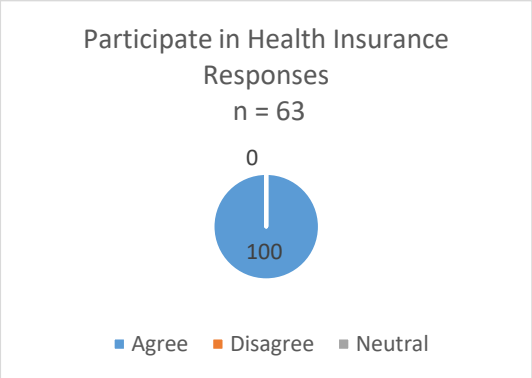
The participants who disagreed by expressing the opinion that wealthy people should not subsidize poor ones, and that the poor are the responsibility of the government, may be unaware of the solidarity principles of both taxation and health insurance, under which the rich subsidize the poor either through taxes or insurance.

Recommendations:

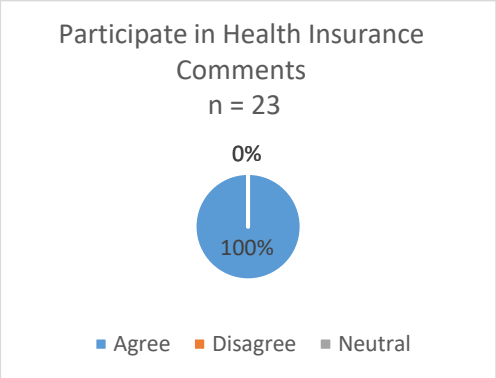
Greater awareness raising and education are needed regarding the fundamentals of insurance—the aggregation of risks/risk pooling, solidarity/subsidization in insurance, and the relationship between the cost of care and premiums. Also, further discussion is needed about the purpose of premiums in Jordan, given they are so low. A discussion is needed about whether premiums should be considered a revenue source or not.

Statement 3: All individuals should be required to participate in a public or private health insurance scheme.

Results from voting:



Results from written comments:



Findings:

- *From voting:* All 63 participants agreed with this statement.
- *From oral comments:* One participant provided verbal feedback in agreement with the statement, emphasizing the need to balance between revenues and the services provided; the feedback was that initially the target population should be the uninsured Jordanians who can afford to pay for insurance and a minimum benefit package. If they need more upgraded services, then they must pay higher premiums.
- *From written comments:*
    - 100 percent of the 23 participants who provided feedback agreed that such an approach would improve the social protection of Jordanians and non-Jordanians—much needed given the high cost (or prices) of health services in Jordan.
    - Participants also emphasized the importance of offering a low-cost benefit package to the noninsured and increasing the number and quality of health services in the public sector.

Interpretation of Findings:

All participants agreed on the need for health insurance across the whole population, and that designing a minimum benefit package to support the currently noninsured is an acceptable method.

There is consensus on the need to include the entire population of Jordan with health insurance, but that would not mean everyone receiving the same benefits. Many participants suggested having different packages at different costs; e.g., the uninsured should receive a low-cost package. What is a low-cost package, however? For instance, should a package be judged by the premiums that public employees pay for their entitlements under the Civil Insurance Program (CIP) or the Royal Medical Services (RMS)? These are already very low-cost products, not because the cost of the benefit is low but because the state covers the lion's share of the costs. Thus, the cost of this package is low for the consumer but high for the state. Tax revenues subsidize those who may need subsidization least. In contrast, the costs to the consumer for a similar or smaller benefit package offered by a private insurer could be much higher than in the public sector.

Recommendations:

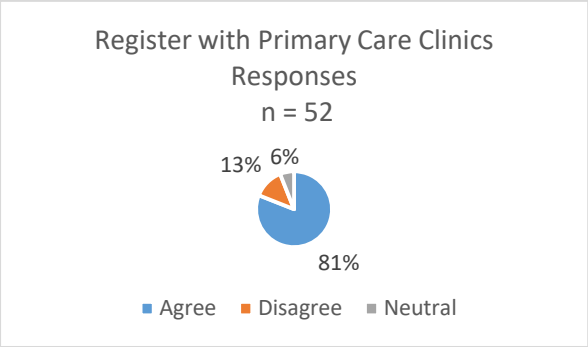
Raising awareness and strengthening knowledge in various areas is needed. These questions need to be posed: What constitutes health insurance, and which "insurers" in Jordan are really insuring? What is the cost of healthcare services in different subsectors, who incurs them, and in what proportion (premium vs. tax financed)? Insurance coverage may carry a low premium because the true cost of services is subsidized or the benefit package is small or provided by less costly providers, or both. Should the poor receive inferior benefits or care to keep costs low? Should there be a minimum benefits package, and what would be its impact on premiums?

There should be a discussion about whether the same entitlement received by public employees should be offered to the uninsured at the same prices/premiums, particularly given that the investment and operating costs of the public healthcare delivery systems serving the entitled population under the CIP and RMS insurance (Ministry of Health [MOH]

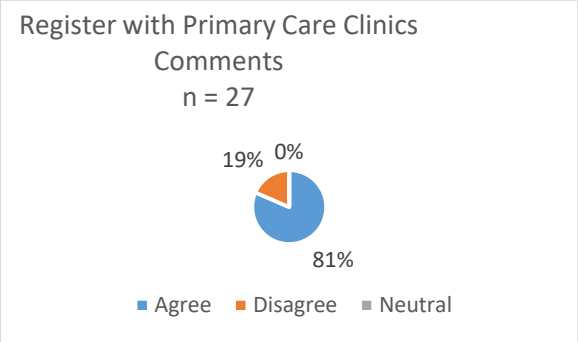
and RMS facilities) are financed entirely by national budget funds rather than the premiums collected from beneficiaries.

Statement 4: All individuals should be required to register with primary care clinics.

Results from voting:



Results from written comments:



Findings:

- *From voting:* Of 52 voters, 81 percent agreed with the statement, 13% disagreed, and 6% were neutral.
- *From oral comments:* Two participants commented on the results of the voting. They stated the following:
    - There are not enough resources to support primary health clinics (PHCs).
    - The population will resist such a concept unless the quality of PHCs improves.
    - This approach was tried in Jordan before (1989) and, although successful, it was abolished.
- *From written comments:* 27 participants provided written feedback:
    - 81 percent agreed with the statement, provided that the PHC network is increased, especially in rural areas; has qualified staff; improves the quality of its services; and general practitioners' (GPs') and family doctors' roles are strengthened. In addition, PHC providers should be held accountable for unnecessary referrals that lead to the unjustified use of costlier services at higher levels of care. Implementing all of these changes requires a political decision.
    - 19 percent disagreed, stating that there is no need to oblige patients to go through PHCs to access the healthcare system.

Interpretation of Findings:

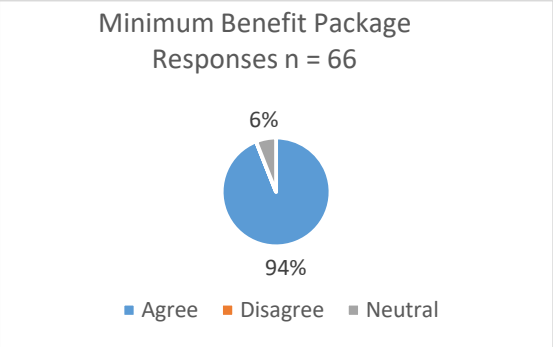
There is strong support for making PHCs the gatekeepers of the healthcare system under the preconditions of improved PHC services and political support. There is an understanding that PHCs add value to the system when their services are solid and recognized by the population, as shown by an increased demand for services and higher levels of customer satisfaction. Only then will PHCs become a desired alternative to hospital care and a welcome point of entry to the healthcare system. Lessons from Jordan's previous experience with PHC gatekeeping could help predict potential obstacles to improvements.

Recommendations:

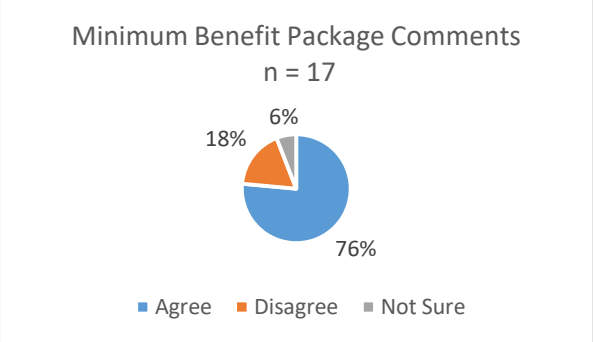
- Strengthen PHCs and monitor patient use/demand for and satisfaction with PHC services
- Set targets for demand and satisfaction levels which, when met, will trigger instituting PHCs as gatekeepers
- Learn from successful PHC practices in Jordan
- Create a model and run a pilot
- Monitor performance
- Allocate increasing amounts of healthcare resources to the PHC system upon improved results/performance

Statement 5: There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less.

Results from voting:



Results from written comments:



Findings:

- *From voting*: 66 participants voted, with 94 percent agreeing and 6 percent neutral.
- *From oral comments:* One participant commented on the results of the vote, stating that all current packages are similar but inadequate.
- *From written comments:* 17 participants provided comments:
    - 76 percent agreed, emphasizing the need for comprehensive insurance for inpatient care, improved quality of services, and different packages with different premiums.
    - 18 percent were against a minimum package, as they believed it could result in a monopoly and not meet the needs of the poor for certain services, such as surgeries.
    - 6 percent were unsure.

Interpretation of Findings:

Most participants agreed on the need for a minimum benefit package, given an improvement in the quality of services. It is a misperception, however, that a minimum benefit package is related to quality of services—a minimum benefit as a concept is independent of quality of services. Yet the perception is that quality from public providers is low across the board. (This begs the question: Does this perception mean that no services should be offered?)

Another misconception is that the minimum benefit package is a single/individual product with its own premium. The minimum package is a standard requirement, not a product. Indeed, some public or private insurers in countries that enforce it create products that match that standard. Nevertheless, the standard and the product are two different things. A product offering only the minimum benefit package from the least expensive providers (presuming these are quality providers) could be presumed to be the lowest-cost product.

A product based on the minimum package does not automatically imply an affordable premium. Affordability is subjective. Thus, lavish benefits for RMS employees and their families could cost a few dinars per month for members. Increasing them by several thousands of percentages could be viewed as unaffordable, yet it still would be a tiny premium, given the value of the benefits. Would such an increase be considered affordable or not?

It would not be possible to derive a single cost for a minimum benefit package in Jordan. The cost of the package would depend on many aspects related to the design of the package, such as the costs of the network that delivers the services to the beneficiary, options for out-of-network service delivery, co-payments, deductible, co-insurance, dependents, and so on. As a simple example, the same package designed to be delivered by a higher-cost (and possibly higher-quality) network would come with higher premiums than those accessing lower-cost networks if all other design factors were the same across packages offered by multiple insurers. An additional (albeit temporary) impediment to determining the proper cost of benefits and actuarial premiums is the absence of true cost data in the public sector.

Many participants insisted on including inpatient services in the minimum benefit package. In the context of the responses to Statement 6 below, this concept would imply including treatments for some noncommunicable diseases, such as cancer, in the minimum benefit.

Although some participants insisted that premiums should be affordable, they recognized that noncommunicable diseases, the main disease burden in Jordan, require long-term, often expensive care. Should they be excluded from the minimum benefit package if they may make it "unaffordable," or should they be included to ensure against financial ruin in cases of disease, with the government subsidizing the cost?

It appears that for many participants, it is difficult to understand the links among the economics of healthcare costs, the function of how care is delivered, and financial protection related to how care is financed.

The cost of care is distinct from how care is financed. There are ways to reduce the cost of care by making it more efficient. The efficient delivery of care is one of the primary goals of knowledgeable and responsible public or private insurers/payers.

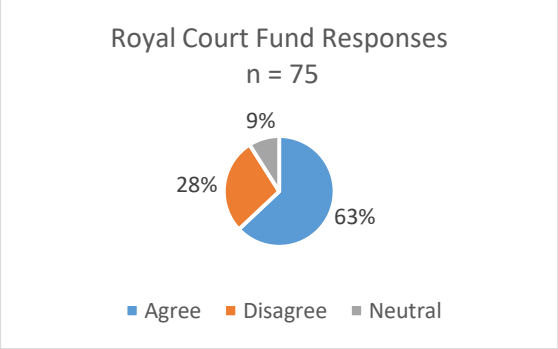
A standard benefit package should contain cost-effective clinical services, include health prevention and promotion and some outpatient drugs, and provide financial protection against costly diseases. How affordable that would be and for whom it is intended, would be based on a combination of the quality of the delivery system (better quality is usually less costly); the risk of the pool of insured (frequency and type of services used); and the levels of cost and risk sharing among the individuals, employers, providers, insurers, and the state.

Recommendations:

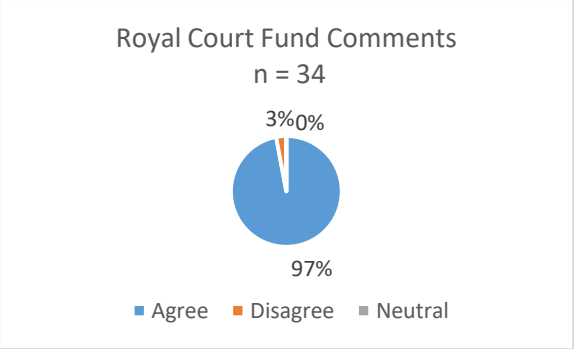
- Educate healthcare leaders and technical experts about the concept of a minimum benefit package and its "benefits," as well as some of the methods to design it
- Conduct a workshop for policymakers and key technical experts on the minimum package
- Create a technical group of experts to design and propose a package for approval by policymakers

Statement 6: Funds used by the Royal Court to pay for healthcare of the uninsured should be used instead to pay to insure the uninsured.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 75 participants voted; 63 percent agreed with the statement, 28 percent disagreed, and 9 percent were neutral.
- *From oral comments:* Four participants expressed opinions. They criticized the statement and suggested the money should be used not for all uninsured, but only for the uninsured poor. Some pointed out that the Royal Court fund was initially intended to serve the poor, but more recently has been used by the non-poor as well.
- *From written comments:* 34 participants provided comments, 97 percent of whom supported the statement, with the caveat that the Royal Court funds should target the poor (based on income level) and not be used by the uninsured non-poor, help reduce the system's deficit, and be used to pay for the high cost of disease for the poor and non-poor alike.

Interpretation of Findings:

Participants largely agreed with the statement. The written comments make it clear that some agreed with the statement only under certain conditions, such as when they are purchasing insurance for the poor only and covering the cost of treatments of costly cases, such as cancer, for all uninsured. Many participants did not seem to understand the value of healthcare insurance as a mechanism for healthcare financing, compared to paying the cost of care as or when the need to use services arises.

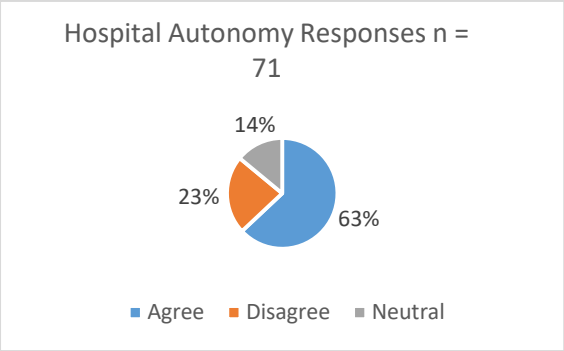
These participants essentially recommended that Royal Court funds be split into two segments—one to cover insurance for the poor and the other to be available to meet the cost of treatment for certain costly illnesses for all of the uninsured (and perhaps the insured whose insurance does not cover these illnesses).
Many participants appeared to be unaware that the Health Insurance Administration of the MOH already covers the poor at no cost to them.

Recommendations:

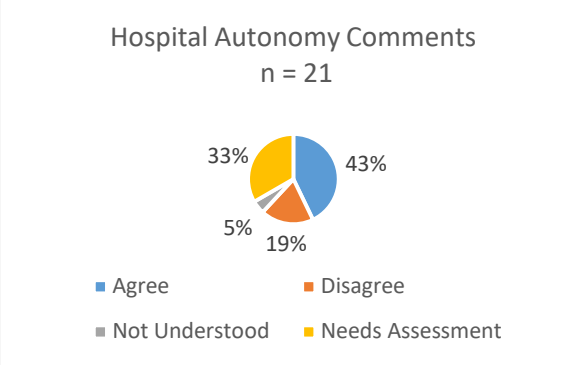
- Step 1 (short term): Shift the Royal Court mandate to providing insurance for the poor and coverage of costly treatments associated with key noncommunicable diseases.
- Step 2 (medium term): Include the main burden of treating noncommunicable diseases, such as cancer, diabetes, cardiovascular disease, renal disease, and others, through a minimum-benefit package; impose and enforce mandatory health insurance coverage in Jordan; and focus the Royal Court charity on providing health insurance to the poor.

Statement 7: The Prince Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 71 participants voted, with 63 percent agreeing, 23% disagreeing, and 14 percent neutral.
- *From oral comments:* Two participants shared the view that the concept of autonomy is sound and the experience of Jordan with autonomy has shown promising results; however, the Hamza experience must be evaluated before deciding how to proceed further.
  From written comments: 21 participants provided written comments, with the following results:
  - 43 percent agreed with the statement, recommending administrative and financial autonomy, a board of directors separate from the MOH, expanding the experiment to teaching hospitals only, and ensuring full transparency in the process.
  - 33 percent indicated that the experience at Prince Hamza Hospital should be assessed in a holistic manner, both financially and administratively, and as to beneficiaries' satisfaction.

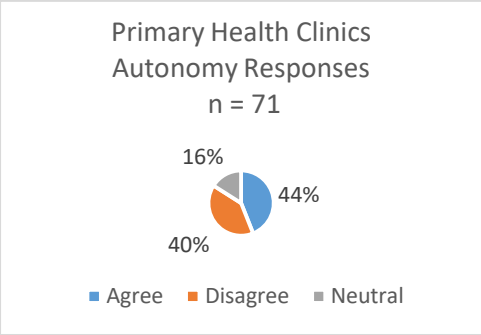
- 19 percent disagreed, e.g., favored no hospital autonomy.
- 5 percent did not understand the statement or its subject well—their comments both disagreed and agreed with autonomy.

Interpretation of Findings:
The results from the voting show that a majority favored hospital autonomy, whereas the written comments demonstrate that some attendees would support hospital autonomy only if the results from the assessment of the Prince Hamza Hospital pilot are positive. Indeed, an assessment can demonstrate success and justify rolling out management autonomy to other hospitals. However, there did not seem to be a clear realization of a very important fact: there is no alternative to hospital management autonomy in a modern healthcare system. Therefore, a potential poor result from the assessment of Prince Hamza Hospital should not close the door to hospital autonomy.

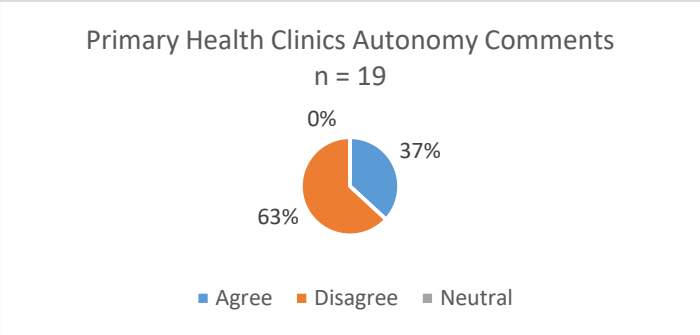
Recommendations:
Assess the experience at Prince Hamza Hospital and recommend amendments to the pilot, if needed, or roll out the concept to more hospitals if the pilot is deemed successful.

Statement 8: Ministry of Health primary health clinics should be allowed management autonomy.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 71 participants voted, with 44 percent agreeing with the statement, 40 percent disagreeing, and 16 percent neutral.
- *From oral comments:* Two participants expressed opinions; one agreed with autonomy if it were done in accordance with the government's vision for decentralization, whereas the other disagreed, asserting that PHCs have a very basic routine set of tasks, so autonomy is not needed at that level of service.
- *From written comments:* 19 participants filled out the comments sheets, indicating the following:
  - 63% disagreed with the statement because most of the clinics/centers do not provide quality services.
  - 37% agreed with the statement, provided that autonomy is subject to control, staff are trained, and management is effective.

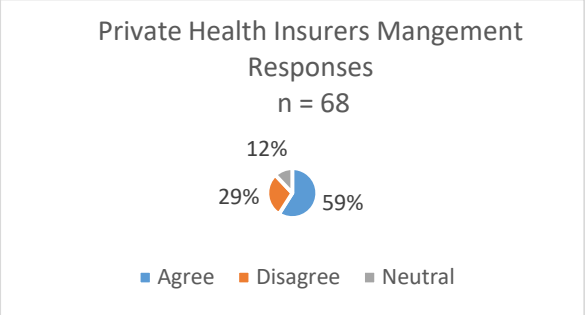
Interpretation of Findings:
Opinions were split. Opponents to PCH autonomy highlighted that the level of PHC staff qualifications and experience is a major concern that does not warrant the delegation of increased management responsibilities to PHCs. Proponents see PHC autonomy as connected to the pursuit of decentralization and want to move forward with it. There is little awareness regarding the high correlation between efficient operations, effective clinical management, and the degree of provider management autonomy. Management autonomy is the driver for improved PHC services, not vice versa. Also, respondents did not seem to make the connection that current PCH non-autonomy has not resulted in good management or quality care—problems often cited in opinions about previous statements.

Recommendations:
Although the split in opinions is understandable to a degree, there seemingly was no knowledge of the international experience, in which, as in the case of hospital management autonomy, the autonomy of PHCs is unconditional and essential for advancing a healthcare system's quality and efficiency by funding providers based on outcomes rather than capacity.

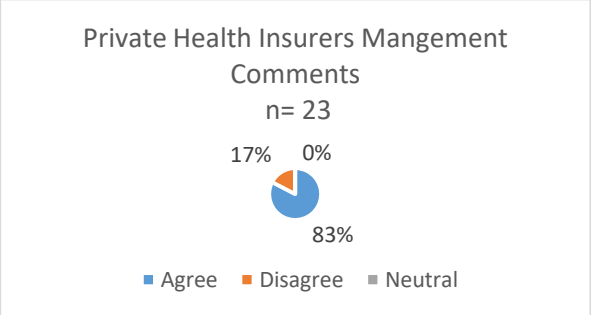
It is essential to educate participants about why autonomy is imperative and how other countries have worked to put it in place.

Statement 9: In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 68 participants voted, with 59 percent agreeing, 29 percent disagreeing, and 12 percent neutral.
- *From oral discussion:* Five participants expressed opinions. The comments of those who agreed centered on the need to evaluate other countries' experiences, including Dubai, which is considered to have had a good experience. Others disagreed with the statement, feeling that the drive for profits in the private sector would affect the poor negatively.
- *From written comments:* 23 participants provided comments, with the following results:
    - 83 percent agreed with the statement because the private sector is more efficient and its management might lead to a reduction in prices; at the same time, insurers should have a clear role and responsibility as managers, and the whole arrangement should be controlled by the government.

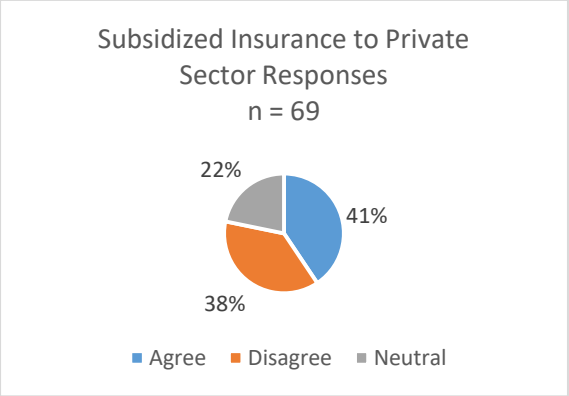
- 17 percent disagreed with the statement, feeling it would be very expensive, and that Jordan is not ready for such a model.

Interpretations of Findings:
Most voters agreed with the statement. Many voted "neutral" because they were not familiar with such arrangements. Some voters appeared to see making a profit as a negative thing. At the same time, many felt that the private sector is recognized as "the more capable manager" compared to the public sector. Some appeared to be unaware of the relationship between the possibility of profit making and efficiency.

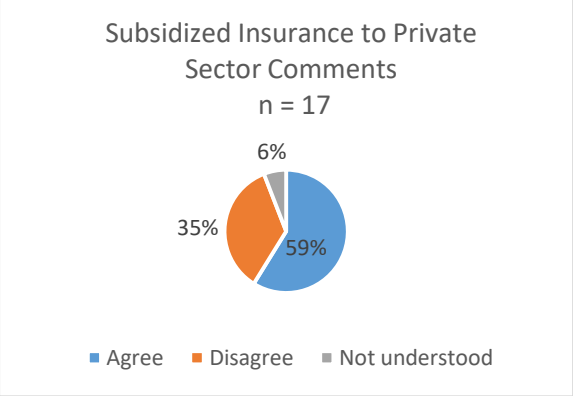
Recommendations:
Raise awareness among participants about the experience of other countries, where private insurers manage public healthcare funds. This increased awareness should enable them to consider this option along with other, more familiar ones on the way toward improved use of public health resources.

Statement 10: The MOH and RMS providing subsidized health insurance to private sector business is a model Jordan should expand.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 69 participants voted, with 41 percent agreeing, 38% disagreeing, and 22% neutral.
- *From oral statements:* Three participants expressed opinions.
  - Two stated that the available public sector healthcare infrastructure and services must be improved for those who are already insured before considering offering/selling insurance to more companies.
  - One confirmed that such an arrangement would be very beneficial to people who live in rural areas, where private sector providers are usually unavailable.
- *From written statements:* 17 participants wrote comments as follows:
  - 59 percent agreed with the statement, given that the quality of services would be improved, premiums would not increase, and the benefits would be managed by the Health Insurance Administration.

- 35 percent disagreed, as they considered the two public insurers unable to provide quality services to their current members; thus, adding more would not drive improvement.
- 6 percent did not understand the statement.

Interpretation of Findings:

The quality of services was almost the only concern of participants in this statement. Whether the premium paid by private employers is adequate or too low to cover the benefits their employees receive—thus needing to be subsidized by the government—seemed to be of no concern to participants. Possibly they had little awareness of this issue.

This gap in knowledge is consistent with comments on other statements that showed only a weak awareness of the link between cost of care, premiums, and quality of service. The quality of service in the public health system certainly is of no concern to the companies that insure their employees with the CIP or RMS. Otherwise, they would take their business elsewhere. Some participants think that adding insureds from the private sector to the publicly funded system would make quality improvements more difficult.

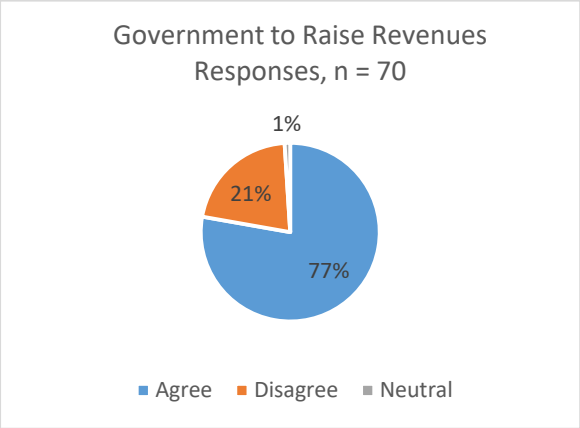
However, it is important to highlight that the government regularly expands the CIP program to hundreds of thousands of individuals (elderly, school age children, etc.) thus adding far more people to the system than those possibly coming from the private sector.

Recommendations:

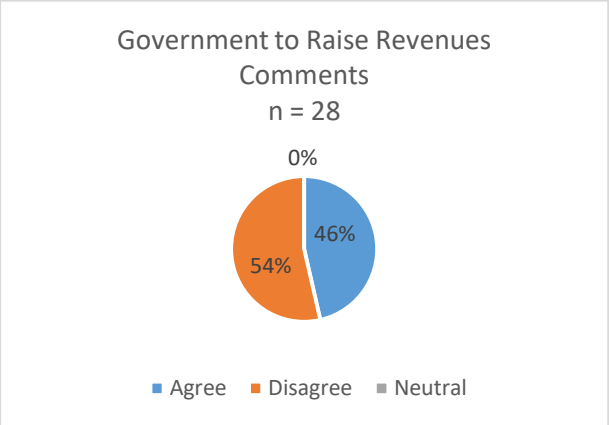
More awareness raising and capacity strengthening on health insurance fundamentals is needed. Before offering insurance to private companies, public insurers may want to consider costing the benefits they offer to private parties, using actuarial methods and the actual cost-of-services data. Actuarially sound premiums, if established, could ensure that no health insurance subsidy would be provided to private companies by the government. Such premium setting will likely affect the demand for public insurance from private parties. One sizeable problem is that microdata on the use and cost of services are absent from the public system. Much more investment in health information systems like Hakeem is needed to make such data available.

Statement 11: It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits.

Results from voting:



Results from written comments:



Findings:

- *From voting:* 70 participants voted; with 77 percent agreeing, 21 percent disagreeing, and 1 percent neutral.
- *From oral comments:* Four participants expressed opinions emphasizing the need to use available resources efficiently and update the policies and regulations for the health sector.
- *From written comments:* 28 participants provided written feedback.
    - 46 percent agree with the statement if it did not entail increasing existing or imposing new taxes, except for those on tobacco and alcohol ("sin taxes"). Such revenues could be used to improve the infrastructure and the quality of services, and allow more people from the private sector to receive services from the public sector.
    - 54 percent indicated that an efficient use of available resources, reducing waste, and instituting good health policies would cover the health sector deficit.

Interpretation of Findings:

There was no definite yes or no answer; many participants agreed on increasing sin taxes, whereas others emphasized the efficient management of available resources. There was some naivete shown in voters believing that efficient management costs the same as inefficient management. Also, there were serious contradictions in the statements of some participants. Some stated that additional revenue should be used to improve the healthcare infrastructure and quality of services, rather than on arrears. They thought that some of the revenue should be used to attract private sector participants to the public sector; yet in previous statements, they overwhelmingly recognized that public sector services are poor and the private sector offers better alternatives. Statements from many participants proposed addressing deficits by making the system more efficient. However, they showed a shortage of knowledge of the prerequisites for efficiency. One prerequisite is the autonomy of healthcare providers, to which many participants were opposed in one form or another. The other prerequisite is the availability of micro-level data linking costs to patients and their use of specific services at specific providers.

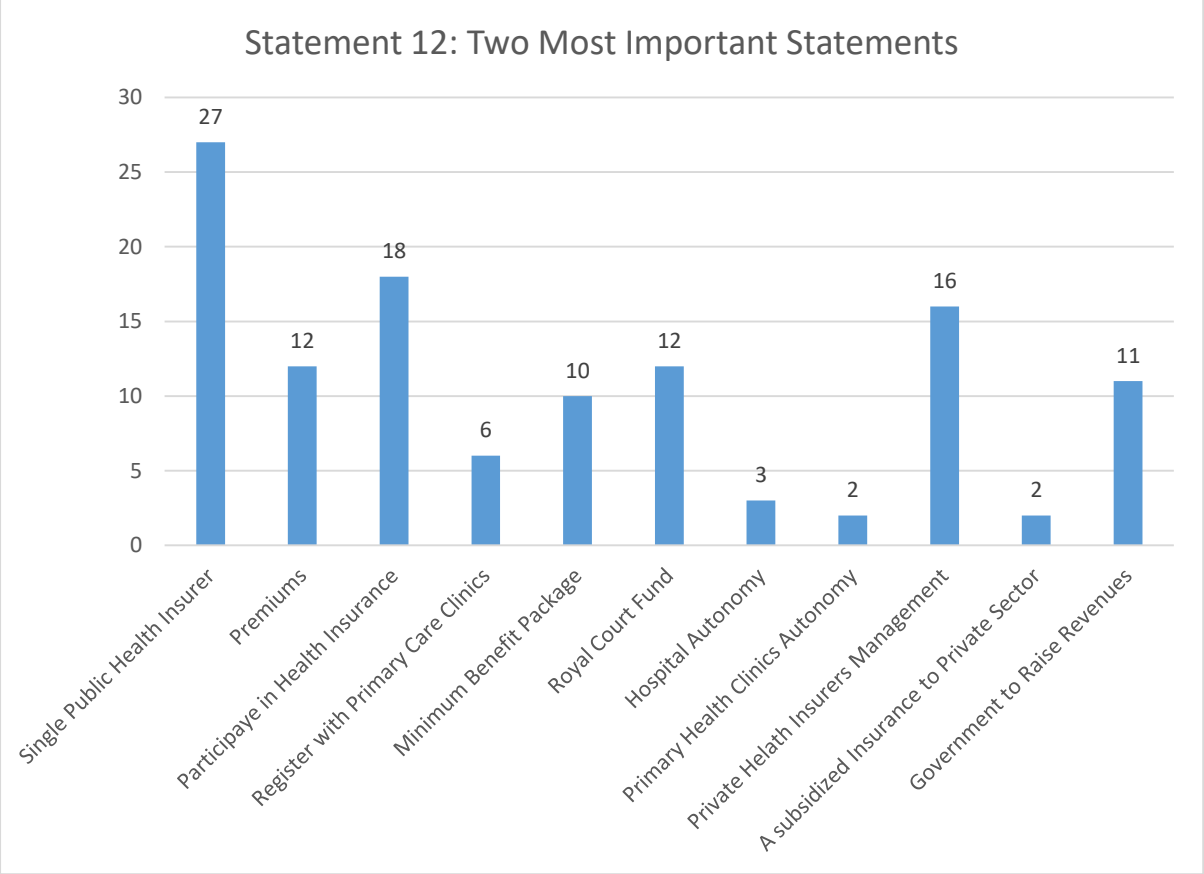
Recommendations:

The recommendation is to both increase revenues to pay arrears and improve the efficient use and management of available resources. Revenues in the system can also be increased by raising insurance premiums in the public sector, thus reflecting more accurately the true cost of care than do current premiums.

Deciding in favor of provider management autonomy is a prerequisite for the efficient management of available resources. Once autonomy is allowed, healthcare providers' staff can be prepared to assume increased responsibilities through capacity building and technology.

Finally, the need for targeted, sufficient, and timely investments in data systems to accelerate the availability of micro-level data in the healthcare system cannot be overemphasized.

Statement 12: Participants were requested to choose the two most important statements.



A total of 59 participants chose the most important of the 11 statements as follows: 27 chose "Jordan should have a single, public health insurer"; and 18 chose "All individuals should be required to participate in a public or private health insurance scheme."

CONCLUSION

The participants attending the HFG-led session at the JAMI Annual Conference are important stakeholders in the health sector. The session's approach placed them in an environment of anonymity, enabling them to vote honestly and use their own personal or professional opinions as a guide.

The main conclusion from this session is that there are two statements on which there was overwhelming agreement—the need to unite all public schemes into a single public health insurer, and that all people in Jordan should be required to have health insurance. Both statements are hugely important and concern the fundamentals: the design of a healthcare system that would fit the attainment of its main objective. In Jordan, the core objective is reaching universal health coverage. The means to do so is through a sustainable and resilient healthcare system, and having a single public insurer and mandatory insurance are significant steps to attain it.

These two issues have been ripe for solution in Jordan, and their solutions are now obvious. The consensus on the two issues warrant a timely response from the leadership of the health system, which is not simply the MOH and RMS. A natural next step would be for the leadership of the system to invite professionals to discuss the details of implementation of a single public insurer and mandatory insurance. Moving forward on these two issues would be a giant step toward establishing the right conditions for reaching universal health coverage.

There is overwhelming level of concern about the quality of services in the public health sector. This conclusion was manifested in the comments on nearly every statement. The quality of services is a function of the available mix of enforceable rules, accountability, incentives, and disincentives. There are significant system-wide issues with all four of these. Setting the stage for a new single payer/insurer in the public health system with new provider payment rules, incentives, and disincentives offers a unique chance to make significant strides toward improving the quality of healthcare services in the public system.

Another important factor for success is provider management autonomy. Although many resist this concept, it is the cradle upon which the engine of the provider payment systems of a single insurer need to rest.

Creating a single public insurer is an opportunity to split the payer from the providers, who are currently united under each public provider-payer (MOH, RMS, University).
The public sector should move forward in providing a minimum benefit package. In more than one way, this action is a prerequisite for mandatory health insurance open to the participation of both public and private insurers while guaranteeing or setting a standard for "minimum product specifications" in health insurance.

The public sector has much to learn from the private sector on how to manage available resources efficiently and improve services. Although this fact is recognized, there is some concern that the private sector cannot be trusted to work with the public sector, including in managing resources on behalf of the public sector, since the former operates for profit.

This opinion is not supported by international and perhaps Jordanian experience, where the private sector alone or private-public partnerships deliver high-quality, valuable services at competitive prices to the population.

There is a recognized need to reprogram all or part of Royal Court funds to provide health insurance to the uninsured poor. Because the poor are already insured through the Health Insurance Administration, the target should shift to the remaining uninsured.

There is a great deal of confusion about insurance concepts; participants revealed many inconsistencies, arguing in favor of or against the same concept in different contexts. This fact demonstrates the apparent need to enhance knowledge and understanding through various types of capacity strengthening.

ATTACHMENTS:

Annex 1: Conference Agenda
Annex 2: Names of Lecturers
Annex 3: List of Attendees
Annex 4: List of HFG Session Participants
Annex 5: Comments Sheet – Arabic
Annex 6: Comments Sheet – English
Annex 7: Tabulation of Responses
Annex 8: Oral Feedback and Comments During the Discussion
Annex 9: Written Comments on the Comments Sheets
Annex 10: Most Important Statements

Annex 1: Conference Agenda

Conference Agenda	
Session 1:	Public- Private Partnership
Session 2:	Reality and Legislative Regulation of Health Insurance
Session 3:	Professional errors and error/ malpractice under normal medical responsibility
Session 4:	The Modern Medical Tourism Industry
Session 5:	Opinions on Governance and Financing Issues in Jordan
Session 6:	Computerization of comprehensive Health Insurance/ ICT
Session 7:	Health Insurance in the light of experiences of Arab and International markets
Session 8:	Latest Scientific developments

Annex 2: Names of Lecturers

Name of Lecturer in Arabic	Name of Lecturer in English	Email
المهندس فارس قموه	Engineer Fares Gamouh	faris.gammoh@jiig.com
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الدكتور طاهر الشخشير	Dr. Taher Shakhsheer	taher.shakhshir@ods.com.jo
عطوفة اللواء الطبيب معين الحباشنة	Major General Dr. Maeen Habashneh	Gdrms@jrms.gov.jo
عطوفة النائب الدكتور إبراهيم بني هاني	Dr. Ibrahim Bani Hani Member of Parliament	
سعادة العين نائل الكباريتي	His Excellency Nael Kabariti	chairman@jocc.org.jo
سعادة العين عيسى مراد	His Excellency Eissa Murad	issa.murad@hmg.jo.com
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سعادة الدكتور عوض مطرية	His Excellency Awad Matreyeh	
سعادة السيد عدنان أبو الراغب	His Excellency Adnan Abu Al Ragheb	
سعادة الدكتور محمود الكيلاني	His Excellency Mahmoud Al Kilani	kilanioffice@yahoo.com
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الدكتور مؤمن الحديدي	Dr. Moa'men Al Hadidi	moh.nifm@gmail.com
الدكتور إبراهيم الطراونة	Dr. Ibrahim Al Tarawneh	drtarawneh@hotmail.com
الدكتور فوزي الحموري	Dr.Fawzi Al Hamouri	fhammouri@gmail.com
الدكتور نائل زيدان	Dr. Na'el Zaidan	info@essrahospital.com
الدكتور عبد الله البشير	Dr. Abdullah Al Basheer	info@jordan-hospital.com
الدكتور هايل عبيدات	Dr. Hayel Obeidat	hayel.obeidat@jsda.jo
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السيد غسان اللحام	Dr. Ghassan Al Laham	ghassan@ehs-int.com
الأنسة لارا طلال كعوش	Ms Lara Talal Kaoush	
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الدكتور محمد قيسية	Dr. Muhammed Qaiseyeh	mohammad.q@arabpotash.com

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الدكتور محمود سرحان	Dr. Mahmoud Sarhan	sarhan1954@gmail.com
الدكتورة سناء السخن	Dr Sanaa Al Sukhon	salsukhun@yahoo.com

Annex 3: List of Attendees

List of Attendees	
1	Jordan Association for Medical Insurance
2	MOH
3	RMS
4	Health Committee/ Senates
5	Health Committee/ Parliament
6	Private Hospital Association
7	Jordan Doctors Association
8	Jordan Dentists Association
9	Dawacom
10	Hakeem
11	HCAC
12	Central Bank of Jordan
13	Amman Chamber of Commerce
14	Amman Chamber of Council
15	Jordan Nursing Council
16	WHO
17	King Hussein Cancer Center
18	The National Society of Consumer Protection
19	Health Alliance for Patient Protection
20	Health Finance and Governance
21	Health Finance in Dubai Health
22	High Health Council

Annex 4: List of HFG Session Participants

List of HFG Session Participants					
No.	**Name**	**Agency**	**Position**	**Mob No.**	**Email**
1	Umaymah Nassar	HCAC	Standards Development Specialist	079 639 77 36	om2380@yahoo.com
2	Dr. Mahmoud Al Kilani	Attorney	Attorney	079 56 33 509	Kilanioffice@yahoo.com
3	Wissam Adnan	Al Arabiyah Insurance	Health Insurance Manager Assistant	0777 66 74 88	wissamamero@yahoo.com
4	Dr. Mohammed Alqam	Occupational Health Directorate	Manager	079 50 53 069	mohammedalqam191@yahoo.com
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6	Majed Al Ma'yatah	Arab Potash Company	Senior HR officer	077 84 03 204	not provided
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9	Khaled Abu Hudeib	HIA	HIA Director	079 61 00 621	hudeibkhaled@hotmail.com
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11	Reema Khalil Daoud	Euro Arab Insurance Group	Head of Customer Care	079 60 41 020	staryland@yahoo.com
12	Ghassan Al Laham	EHSI- Hakeem	Executive Director	not provided	not provided
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14	Alaa' Shaqdan	Jordan Central Bank	Executive Director Assistant	079 85 08 482	alaa.shaqdan@cbj.gov.jo
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17	Wasef Haddad	Orange Jordan Telecom Group	HR Manager	077 73 74 441	wassef.haddad@orange.com
18	Eyad Al Attari	NatHealth	Executive Vice President	077 99 57 070	iyad_attari@nathealth.net
19	Abd Al Fattah Al Kilani	Director of a Private Lab	Director of a Private Lab	079 99 58 059	dr. alkilani@yahoo.com
20	Ahmed Mishal	King Hussein Cancer Foundation	Director of Business Development Department	079 85 20 052	Ahmad.mishal@khcf.jo
21	Ra'ed Al Mousa	King Hussein Cancer Foundation	Manager	079 65 05 7747	rmousa@khcf.jo
22	Subhi Al Etari	Arab Jordanian Insurance Group	Director of the Internal Audit Department	079 52 88 733	subhi_++2@yahoo.com
23	Dr.Ayman Al Azza	NatHealth	Head of Approvals Section	077 57 85 388	a.azzeh@nathealth.net

List of HFG Session Participants					
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24	Saher Wasfi	Health Systems/ Private Contractor		not provided	Saher@jhu.edu
25	Hala Mahadeen	Medexa	Development Manager	079 76 03 279	mahadeen.hala@2yahoo.com
26	Abeer Hadidi	HIA	General Budget Department	079 54 85 050	
27	Dr.Fadya Attari	Arab Union International Insurance Company	Manager of Health Insurance Department	079 99 94 682	fadia.attari@auii-jo.com
28	Dr. Fadya Samara	Health Alliance for Patient Protection	Secretary General	not provided	not provided
29	Rawan Al Hayari	JFDA	Head of Good Governance for Medicine	079 90 54 529	awhyari@gmail.com
30	Dr. Yaseen Al Husban	Private Sector	Former Minister of Health	077 90 09 001	ymss5@hotmail.com
31	Majd Abu Taha	Medexa		not provided	majd_abutaha90@gamd.com
32	Mo'men Al Hadidi		Senior Consultant in Forensic Medicine	079 90 50 300	moh.nifm@gmail.com
33	Maisa Al Saket	Health Alliance for Patient Protection	Board Member	079 90 54 000	maisasakit@gmail.com
34	Sawsan Al Majali	Senate	Senator	079 68 77 033	Sawsanmajali@gmail.com
35	Fares Gamoh	Newton	CEO	077 75 91 001	fgammoh@newtoninsurance.com
36	Mohammed Abu Jeih	Dawacom		not provided	abujeih@hotmail.com
37	Bilal Al Swelat	Potash Company	Timesheet supervisor	079 78 50 805	not provided
38	Ahmed Al Kayed	The Housing Bank		079 44 16 428	not provided
39	Yaser Ghanam	The Housing Bank	Insurance Manager	not provided	not provided
40	Safwan Tbaishat	The Arabian Jordanian Group	Deputy Manager	079 55 60 422	stbaishat@hotmail.com
41	Mohammed Abu Tahoun	Dawacom	Director of Public Relations and Media	078 06 66 832	m.abwtahoun@edawacom.com
42	Ahmed Al Hayari	Royal Court	Not provided	079 90 50 228	
43	Ahmed Al Tijani	NatHealth	CEO	077 93 44 000	Ahmad_tijani@nathealth.net
44	Dr. Adnan Al Dmoor	Al Esraa' Hospital	Medical Director	079 90 30 207	admoor2009@yahoo.com
45	Abd Al Majeed Zaa'tar	KADDB	Insurance Supervisor	077 47 14 073	azaater@kaddbinvest.com
46	Waleed Al Qetati	Arab International Insurance Federation	General Manager	079 90 80 116	waleed.q@auii-jo.com

Annex 5: Comments Sheet – Arabic

البيانات الشخصية التالية تعبأ اختيارياً:

الاسم:.....
جهة العمل:.....
المسمى الوظيفي:.....
رقم الخلوي:.....
البريد الالكتروني:.....

آراء المشاركين حول أهم القضايا المتعلقة بالتمويل الصحي والحوكمة في الاردن
مؤتمر السياسات الصحية / التأمين الصحي الشامل 7 أيار 2017

الرقم	الموضوع	ملاحظات
1	يجب أن يكون لدى الأردن تأمين صحي موحد للقطاع العام	
2	يجب أن يكون لدى برامج التأمين الصحي في القطاع العام أقساط تامين متصاعدة لحماية الفقراء والزام ذوي الدخل المرتفع بدفع مبالغ مالية أكثر تتناسب مع التكلفة الحقيقية للخدمات الصحية	
3	يجب على جميع الافراد الاشتراك بتأمين صحي حكومي أو خاص	
4	يجب الزام جميع الافراد بالتسجيل في مراكز وعيادات الرعاية الصحية الأولية	
5	يجب توفرحزمة منافع تأمينية موحدة بحد ادنى لدى الجهات التامينية في القطاعين العام والخاص. على أن لا تقل الخدمات المقدمة عن حدها الادنى مع امكانية أن تزيد	
6	الأموال المستخدمة من قبل الديوان الملكي العامر لتغطية المعالجات الطبية يجب استخدامها لتأمين غير المؤمنين	
7	يجب تعميم نموذج مستشفى الأمير حمزة باعطاء بعض الاستقلالية الادارية لمستشفيات أخرى لتحسين الأداء	
8	يجب اعطاء مراكز الرعاية الصحية الأولية التابعة لوزارة الصحة استقلالية ادارية	
9	في كثير من الدول، يتم ادارة أموال الرعاية الصحية في القطاع العام من قبل شركات التأمين في القطاع الخاص. هذا نموذج يجب أن يأخذه الأردن بعين الاعتبار	
10	تقوم وزارة الصحة والخدمات الطبية بتوفير التأمين الصحي المدعوم لشركات القطاع الخاص. هل يجب على الأردن التوسع في تطبيق هذا النموذج	
11	من الضروري ان تجد الحكومة طرق لزيادة الايرادات لتغطية العجز المتزايد في القطاع الصحي العام	

يرجى تحديد أهم موضوعين من المواضيع السابقة حسب رأيك:

- **الموضوع الاول يحمل الرقم: ----------**
- **الموضوع الثاني يحمل الرقم: ----------**

ملاحظة مهمة:

ان المواضيع المقترحة لا تعبر عن أو تعكس مواقف أي من الوكالة الأمريكية للتنمية الدولية (USAID) أو مشروع التمويل الصحي والحوكمة (HFG) أو شركة بلاديوم المنفذة للمشروع.

Annex 6: Comments Sheet – English

The personal data is optional:
Name:……..
Organization:……..
Position:……...
Mobile no.:……..
Email:……..

Participants' Opinions on Main Governance and Financing Issues in Jordan
Health Policy Symposium/ Universal Health Coverage
May 7th, 2017

No.	Subject	Notes
1.	Jordan should have a single, public health insurer	
2.	Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care	
3.	All individuals should be required to participate in a public or private health insurance scheme	
4.	All individuals should be required to register with primary care clinics	
5.	There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less	
6.	Funds used by the Royal Court to pay for health care of the uninsured should be used instead to pay to insure the uninsured	
7.	The Prince Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals	
8.	Ministry of Health Primary health clinics should be allowed management autonomy	
9.	In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider	
10.	The MOH and RMS providing subsidized health insurance to private sector businesses is a model Jordan should expand	
11.	It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits	

Please select the most important statements in your opinion:

- **Statement no.:**
- **Statement no.:**

Important Note:
The statements proposed for voting do not express or reflect positions of USAID, HFG and The Palladium Group.

Annex 7: Tabulation of Responses

Tabulation of Responses																					
		Actual responses						Actual responses from a total of 75 responses						Summary for the actual no. of responders				Summary of responses out of 75			
No.	Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N: total Number	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Missing	Agree	Disagree	Neutral	N: total Number	Agree	Disagree	Neutral	Missing
		38	8	6	1	4	57	38	8	6	1	4	18	46	5	6	57	46	5	6	18
1	Jordan should have a single, public health insurer:	67%	14%	11%	2%	7%		51%	11%	8%	1%	5%	24%	81%	9%	11%		61%	7%	8%	24%
	Existing public health insurance schemes should have premiums that protect the poor and require	32	12	3	6	2	55	32	12	3	6	2	20	44	8	3	55	44	8	3	20
2	those with higher incomes to pay higher amounts that more closely reflect the real costs of care:	58%	22%	5%	11%	4%		43%	16%	4%	8%	3%	27%	80%	15%	5%		59%	11%	4%	27%
	All individuals should be required to participate in a	50	13	0	0	0	63	50	13	0	0	0	12	63	0	0	63	63	0	0	12
3	public or private health insurance scheme:	79%	21%	0%	0%	0%		67%	17%	0%	0%	0%	16%	100%	0%	0%		84%	0%	0%	16%
	All individuals should be required to register with	33	10	3	4	3	53	33	10	3	4	3	22	43	7	3	53	43	7	3	22
4	primary care clinics:	62%	19%	6%	8%	6%		44%	13%	4%	5%	4%	29%	81%	13%	6%		57%	9%	4%	29%
	There should be a common, minimum benefit package all public and private health insurers must	42	20	4	0	0	66	42	20	4	0	0	9	62	0	4	66	62	0	4	9
5	cover. This means benefits offered by insurers could be more than the minimum but not less:	64%	30%	6%	0%	0%		56%	27%	5%	0%	0%	12%	94%	0%	6%		83%	0%	5%	12%
	Funds used by the Royal Court to pay for health care of the uninsured should be used instead to pay	38	9	7	6	15	75	38	9	7	6	15	0	47	21	7	75	47	21	7	0
6	to insure the uninsured:	51%	12%	9%	8%	20%		51%	12%	9%	8%	20%	0%	63%	28%	9%		63%	28%	9%	0%
	The price Hamza Hospital model of allowing some management autonomy to enhance performance	32	13	10	3	13	71	32	13	10	3	13	4	45	16	10	71	45	16	10	4
7	should be expanded to more hospitals:	45%	18%	14%	4%	18%		43%	17%	13%	4%	17%	5%	63%	23%	14%		60%	21%	13%	5%
	Ministry of Health Primary health clinics should be	19	13	12	10	19	73	19	13	12	10	19	2	32	29	12	73	32	29	12	2
8	allowed management autonomy:	26%	18%	16%	14%	26%		25%	17%	16%	13%	25%	3%	44%	40%	16%		43%	39%	16%	3%
	In many countries, public monies for healthcare are managed by private health insurers. This is a model	27	13	8	2	18	68	27	13	8	2	18	7	40	20	8	68	40	20	8	7
9	Jordan should consider:	40%	19%	12%	3%	26%		36%	17%	11%	3%	24%	9%	59%	29%	12%		53%	27%	11%	9%
	The MOH and RMS providing subsidized health insurance to private sector business is a model	13	15	15	6	20	69	13	15	15	6	20	6	28	26	15	69	28	26	15	6
10	Jordan should expand:	19%	22%	22%	9%	29%		17%	20%	20%	8%	27%	8%	41%	38%	22%		37%	35%	20%	8%
	It is urgent the government finds ways to raise revenue to cover the growing public health sector	48	6	1	5	10	70	48	6	1	5	10	5	54	15	1	70	54	15	1	5
11	deficits:	69%	9%	1%	7%	14%		64%	8%	1%	7%	13%	7%	77%	21%	1%		72%	20%	1%	7%

Annex 8: Oral feedback and Comments During The Discussion

Oral Feedback and Comments During the Discussion		
No.	**Statement**	**Comments by Participants**
1	Jordan should have a single, public health insurer:	1. Have Universal Health coverage under one single insurer, managed by the Prime Ministry, that regulates and manages all different Health insurance programs
		2. UHC will never be achieved unless there is unified single insurer, with unified funds similar to the turkish experience.
2	Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care:	Poor people should be excluded from paying any premiums, as they are the government's responsibility. Premiums need to be increased based on income.
		Private Sector, Public Sector, RMS, universities all have to join togethere to have a reform . Premiums have to be based on income, and provided services.
3	All individuals should be required to participate in a public or private health insurance scheme:	A balance between revenues and provided services have to be taken into consideration. Initially start with the uninsured capable Jordanians, and provide them with a minimum beneift package.
4	All individuals should be required to register with primary care clinics:	There is not available resources to implement the concept, and the population will be resistant.
		Can be implemented, if primary health centers were qualified and enough.
5	There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less:	Minimum packages in the sector are similar; however, the ones provided by the public sector are inadequate
6	Funds used by the Royal Court to pay for health care of the uninsured should be used instead to pay to insure the uninsured:	The budget used by the Royal Court is huge, and needs to be used to insure the poor non-inusred
		Exemptions were created to support the poor, but needs to have regulations
		If poor patients were covered with health coverage then there is no need for exemptions
		The statement needs to include the poor uninsured.
		exemptions are not used by the poor, but misused by rich people
7	The price Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals:	Concept is great, but hard to implement. However previous experiences showed promising results.
		An evaluation has to be done to Prince Hamza prior to expanding to other hospitals

Oral Feedback and Comments During the Discussion		
No.	**Statement**	**Comments by Participants**
8	Ministry of Health Primary health clinics should be allowed management autonomy:	Decentralization is accordance with the governments' vision, having qualified management to support it.
		PHC centers have routine work without receiving complicated issues or cases, and there is no need for decentralization at this level
9	In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider:	Profit factor at the private sector level will affect the uninsured poor.
		Feedback from countries that have tried this approach must be evaluated.
		Pool of funds should be managed by a neutral entity
		All statements are related and linked together to provide guidance on achieving UHC
		Dubai experience is a successful example on such statement. The Government should provide guidance and regulations, while other entities who have developed services cn provide good quality of services.
10	The MOH and RMS providing subsidized health insurance to private sector business is a model Jordan should expand:	Public sector should provide services to the insured ones and improve the available services
		Due to the lack of distribution of private sector all over Jordan, coordination between both sectors need to take place to serve all the population
		Infra structure and services need to be improved to have social justice
11	It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits:	increase revenues is not needed, what is needed is an efficient management for the available resources.
		GDB amount spent on HS is 8%, which is a good amount, but there is high waste and ineffeciency in using the available resources
		Regulations and policies at the health sector needs to be changed for better usage of resources.
		Use the available resources and reduce the waste

Annex 9: Written Comments on the Comments Sheets

Annex 9: Written Comments on The Comments Sheet				
	1	2	3	4
Statement	**Jordan should have a single, public health insurer:**	**Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care:**	**All individuals should be required to participate in a public or private health insurance scheme:**	**All individuals should be required to register with primary care clinics:**
R1				
R2	Yes. We seek a single insurance coverage.	Provided that the service provided for citizens is		Each citizen should register with the
R3		Yes. I strongly agree since many people of the		I agree providing the specialized medical
R4		Yes, but the services should be fairly distributed	Yes, some government employees and their	Yes, but it is difficult due to the lack of
R5	I strongly agree provided that all sectors	Yes, but there are diseases that are not affordable		
R6				
R7				
R8			Single health insurance	There is MOH white card system which is
R9	Not only for the public sector –	Insurance by wealth segments to pay for the poor.	Compulsory health insurance	since it is the entry point to health care
R10		Payment should depend on the provided service		
R11	Single for both public and private sectors	I agree provided that it is commensurate with age/	I agree, by establishing a minimum single	
R12	I strongly agree. As the premiums		I strongly agree due to the high cost of	
R13				
R14				
R15	The insurance should identify the	Provided that providing the service in a timely	This is necessary	In order to provide good services, private
R16				
R17				
R18		It is difficult to identify the income resources by		This is difficult to be achieved
R19	Yes. one form for all with no	I strongly agree for the continuation of the	Yes, reduce the greed of doctors	No, it is part of the people's culture not
R20	Single for public and private sectors but		Compulsory subscription	These clinics are not qualified
R21	Neutral. We have a third health			Strongly agree (the White Card)
R22		This insurance will be inefficient as it will be based		
R23				

Annex 9: Written Comments on The Comments Sheet				
	1	2	3	4
Statement	**Jordan should have a single, public health insurer:**	**Existing public health insurance schemes should have premiums that protect the poor and require those with higher incomes to pay higher amounts that more closely reflect the real costs of care:**	**All individuals should be required to participate in a public or private health insurance scheme:**	**All individuals should be required to register with primary care clinics:**
R24		I think that the government is responsible for all	Health insurance is a necessity and none is	At first, these clinics must be improved,
R25	Disagree.	Will the high income persons pay extra amounts	Service should be commensurate with	I strongly agree. Activating the role of
R26		I agree provided that the percentage is identified		
R27	Why? Where is the competition? There	I disagree. This is unfair. Why does not the State	I agree, but under fair conditions for citizens.	Incomprehensible question. This was
R28	Yes. In order to reduce waste in the	The premium is related to service	Yes. insurance is important for the	Yes, but it is very difficult. This should be
R29	It should be for Jordan and for all	This should be applied on both public and private	Yes. Jordanians and non-Jordanians	Yes, provided that they are public and
R30	It is necessary to make accurate			This requires availability of competent
R31			Yes. it is very necessary	This is top priority. Patients should be
R32	There should be a single insurance		In order to treat the symptoms before	I agree, but qualifications and equipment
R33	Yes, yes, yes, yes, to achieve social justice		This is a popular demand and a political	There should be a political decision stating
R34	There should be a single insurance	Yes, and also concerning the service provided or		Qualification of staff
R35	It is very necessary in order to prevent	This is the principle of collaboration, taking		It was applied previously and was positive
R36		Please identify those with higher incomes since a	Yes, because costs are rising	Yes, to limit the regions in order to
R37	I support this idea. Each patient can	This a good contribution to cover all patients	Comprehensive health insurance and this is	For more organization and distribution of
R38	Yes. And the private sector			Performance and services should be
R39	For the public sector and all citizens		I agree on raising health services in the	
R40		No. insurance is not a tax. There is income tax		
R41			I strongly agree due to the importance of	
R42	With emphasis on social justice in terms	With removing nepotism		
R43	It is preferable	Good suggestion	Important	Important to reduce costs
R44		Insurance premiums should be linked with the		
R45	So that all citizens of all categories can	I think the poor should not pay any fees and the	I agree, and so all categories of the society	After organization of such clinics and
R46	I agree on connecting them centrally to	There should be progressive insurance categories	I agree to increase subscriptions and cover	Not necessarily as long as there are
R47		I disagree – health insurance is a right for citizens		

Annex 9: Written Comments on The Comments Sheet				
	5	6	7	8
Statement	**There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less:**	**Funds used by the Royal Court to pay for health care of the uninsured should be used instead to pay to insure the uninsured:**	**The price Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals:**	**Ministry of Health Primary health clinics should be allowed management autonomy:**
R1				
R2		Yes. The poor.	We should firstly know the outcomes of	Through the directorates
R3		For sure since a lot of the poor do not		Yes provided that management
R4		Yes, because they are mostly given to the		
R5	Yes. The quality of the service insured should be	For the poor only, with exemptions for	Prince Hamza Hospital experience should	An experimental sample from the clinics
R6				
R7		For the poor and the persons who are		
R8				
R9	minimum service packages	For the poor who cannot afford	Yes if this means administrative autonomy	Administrative autonomy without
R10		The uncovered whether poor or rich.	There is no competent administrative staff	There is no competent administrative
R11	Which increase? Premium?	Comprehensive insurance for all		
R12				
R13			Yes, but in a different way.	
R14			We can only judge this through or after	
R15	Not only accessibility even if too late but also the	The disease should be considered in this		
R16		Covering the poor who have no		
R17		There should be insurance coverage for a		
R18		I agree for the treatment of the poor		
R19	Yes, and in case a beneficiary wants to add	For particular cases. Cases such as		
R20	I support availability of several packages	The funds should be provided for the		I disagree since they are unqualified
R21	A comprehensive health insurance should be		Disagree. Decentralization is better	Decentralization achieves the goal
R22		Individuals are often insured by cancer		
R23		Funds spent from the Royal Court		MOH clinics suffer from administrative

Annex 9: Written Comments on The Comments Sheet				
Statement	5	6	7	8
	There should be a common, minimum benefit package all public and private health insurers must cover. This means benefits offered by insurers could be more than the minimum but not less:	**Funds used by the Royal Court to pay for health care of the uninsured should be used instead to pay to insure the uninsured:**	**The price Hamza Hospital model of allowing some management autonomy to enhance performance should be expanded to more hospitals:**	**Ministry of Health Primary health clinics should be allowed management autonomy:**
R24	At first, this package should be agreed upon. It	Exemptions should be organized	The reality of Prince Hamza Hospital	There is no need for this
R25	I strongly agree provided that efficiency of	Reconsidering exemptions and linking	I agree.	I disagree. They should be affiliated to
R26		Medical and social conditions should be		
R27	I disagree. I am against any monopoly.	I disagree. There are many uninsured	Why? Doctors should have a certain	
R28	Yes. Decent coverage for decent living	Yes. Reduction of misuse.		Autonomy/ governance and
R29		If the comprehensive health insurance is	This experience should be assessed in a	If enough staff and training, effective
R30		With modifying the question to be for		
R31			The idea is correct but the application is	Centralization in policies and following
R32	I agree. It should cover all diseases	When insurance is compulsory, there is	I agree but with no nepotism and control	
R33		Funds from the Royal Court are Royal	This experience needs consideration to	I disagree. Health directorates should
R34				
R35		To cover the poor who are not insured	Only for major teaching hospitals	For health directorates in the
R36	What is the meaning of the second part in defining	There are diseases requiring large		
R37		This is the main objective of covering the	This is a good idea	
R38		There is no social justice in covering		There may be nepotism
R39			In case of success at Prince Hamza	
R40		The patient is the same whether rich or	No due to nepotism	No due to nepotism and lack of
R41		I strongly agree since there is a segment		
R42	The minimum does not meet the needs of the			
R43	For sure	In case of applying the comprehensive	For sure	
R44				
R45	I think all categories of the society should receive	The poor should be covered by such	Generalization of the decision to	I disagree since health clinics are fully
R46	I agree as illustrated in (3)	There should be a clear scale to identify	There should be central connection to	I disagree due to the poor service
R47				

Annex 9: Written Comments on The Comments Sheet			
	9	10	11
Statement	**In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider:**	**The MOH and RMS providing subsidized health insurance to private sector business is a model Jordan should expand:**	**It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits:**
R1		For some special cases.	Develop the electronic systems in a
R2	No. it will change into commercial		
R3	Yes provided that the private sector		
R4	Yes, but it should be subject to control	Yes because there are some skillful	
R5	Yes, because this is part of good	If we realize social justice and the	After evaluation of expenditures to
R6	Seeking profits and benefits will appear		
R7	There must be a mutual independent		Resources should be redirected
R8		Yes, but under specific conditions	Yes. Increasing revenues, controlling
R9	Public and private partnership is	This model can be applied for	Not the revenues, but the health
R10	The private sector is more flexible than		
R11		No. the prices of the military	Ways to find investment financial
R12			
R13			
R14			Yes. in my personal opinion, this can
R15		Necessary, especially for the remote	Simultaneous with raising the
R16			
R17			
R18	I agree due to their ability to manage		I agree for increasing the
R19			
R20		I believe the opposite	There is no need to increase
R21			
R22			Finding new revenues does not
R23	We may focus on partnership in	This can be applied if capacity and	Focus should be on the effective

Annex 9: Written Comments on The Comments Sheet			
	9	10	11
Statement	**In many countries, public monies for healthcare are managed by private health insurers. This is a model Jordan should consider:**	**The MOH and RMS providing subsidized health insurance to private sector business is a model Jordan should expand:**	**It is urgent the government finds ways to raise revenue to cover the growing public health sector deficits:**
R24	Engagement of the private sector in	I think these service institutions	Yes. resources should be raised and
R25	I strongly agree, for the purpose of	I reservedly agree	Changing the financial management
R26	I agree on participation not only in the	The question is incomprehensible.	I agree on the management of the
R27			I strongly disagree.
R28	The private sector is better due to		
R29	This is possible but the meaning of	This depends on availability of staff,	Focus should be on the effective use,
R30	Cooperation with the private sector in	Not in this stage due to the great	
R31			Improvement of management and
R32	Management by private insurers makes		This is realized by managing expenses
R33	There should be one insurance	MOH and RMS cannot provide the	We spend 1.9 billion on the health
R34	There could be conflict of interests, so		Good governance is required to
R35	I think Jordan is not ready for this	The experience of civil insurance to	Provided that no new taxes are
R36			Provided that revenues are not
R37			
R38	* More efficiency		Dealing with resources should be
R39			Provided that no new taxes are
R40	Yes because the private sector is more	No due to nepotism	Yes to stop wasting resources
R41			
R42			
R43	This will be so expensive		For sure.
R44			
R45			The most important sector in any
R46			
R47			

Annex 10: Most Important Statements

Annex 10: Most Important Statements											
Statement	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
V1	x		x								
V2	x				x						
V3	x		x								
V4		x	x								
V5			x	x							
V6					x				x		
V7	x					x					
V8	x		x								
V9	x	x									
V10			x			x					
V11	x		x								
V12							x		x		
V13	x							x			
V14			x			x					
V15									x	x	
V16			x		x						
V17		x		x							
V18	x	x									
V19	x	x									
V20		x	x								

Annex 10: Most Important Statements											
Statement	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
V21							x	x			x
V22	x				x						
V23				x		x					
V24	x								x		
V25									x		x
V26						x			x		
V27	x					x					
V28									x		x
V29	x			x							
V30	x										x
V31	x			x							
V32	x		x								
V33	x			x							
V34	x	x									
V35	x		x								
V36			x						x		
V37		x				x					
V38									x		x
V39	x				x						
V40	x		x								