

National Health Policy Past and Future Trajectory

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- Background issues
- Situation analysis
- Reform processes
- Assessment of unfinished business

What is Social Security all About?

- Creating an enabling environment for effective social participation?
- Horizontal equity
- Vertical equity
- Income smoothing
- Risk pooling

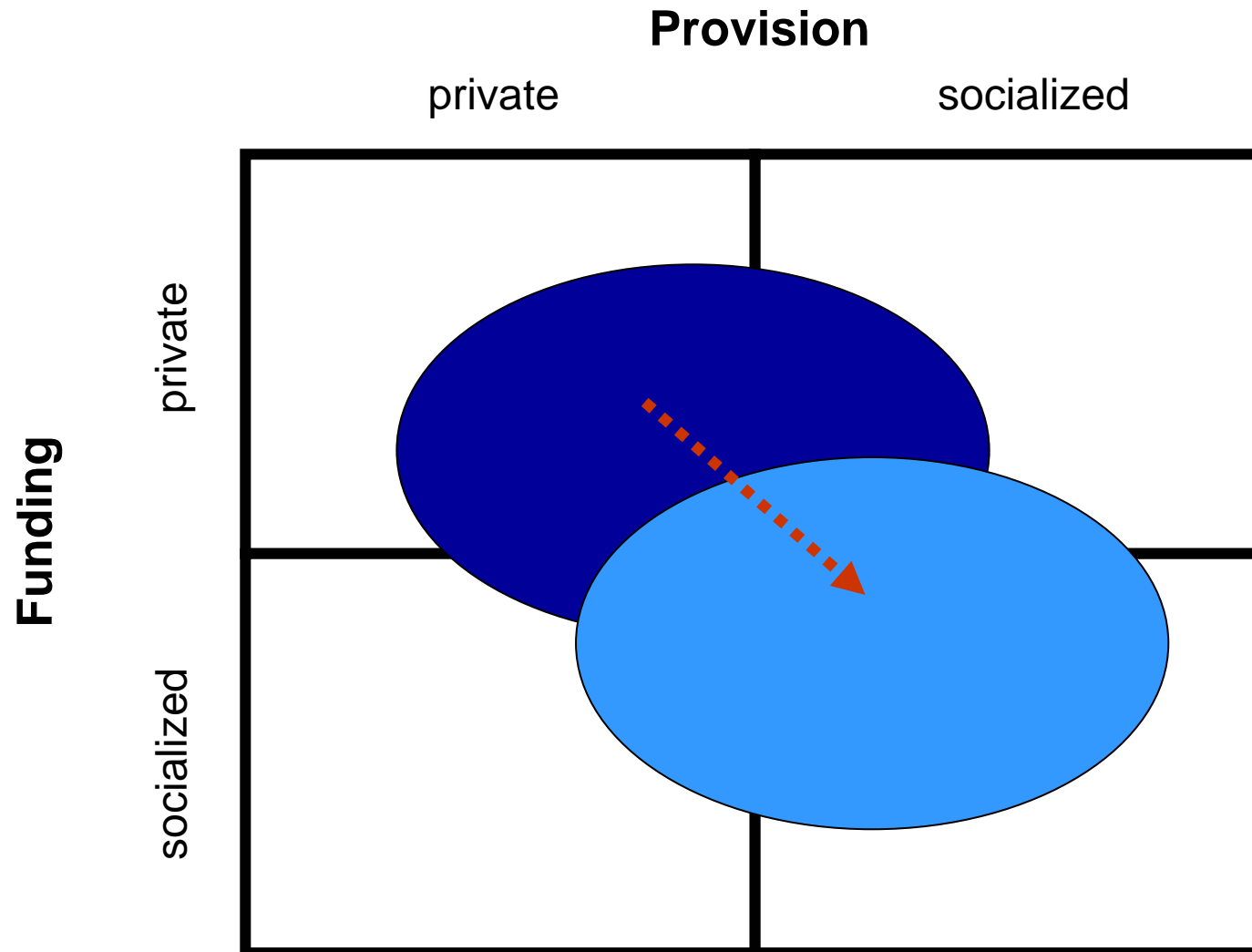
Preliminary Comments

- No magic bullet for health systems reform
- Whatever option chosen requires consideration of:
 - Funding arrangements
 - Institutional framework
 - Provider arrangements
- Internationally views about public/private involvement are regarded as fruitless ideologically loaded discussions

Key Considerations for South Africa – 50-year view

- Formal employment will rise
- Population will become predominantly urban
- Per capita incomes should rise
- Note:
 - it is the view of many informed economists that the existing macroeconomic policy is retarding rather than promoting the above – nevertheless a degree of development is (thankfully) inevitable
 - The failure is attributed to the reduced emphasis on human development as the pivotal supply-side constraint to economic development

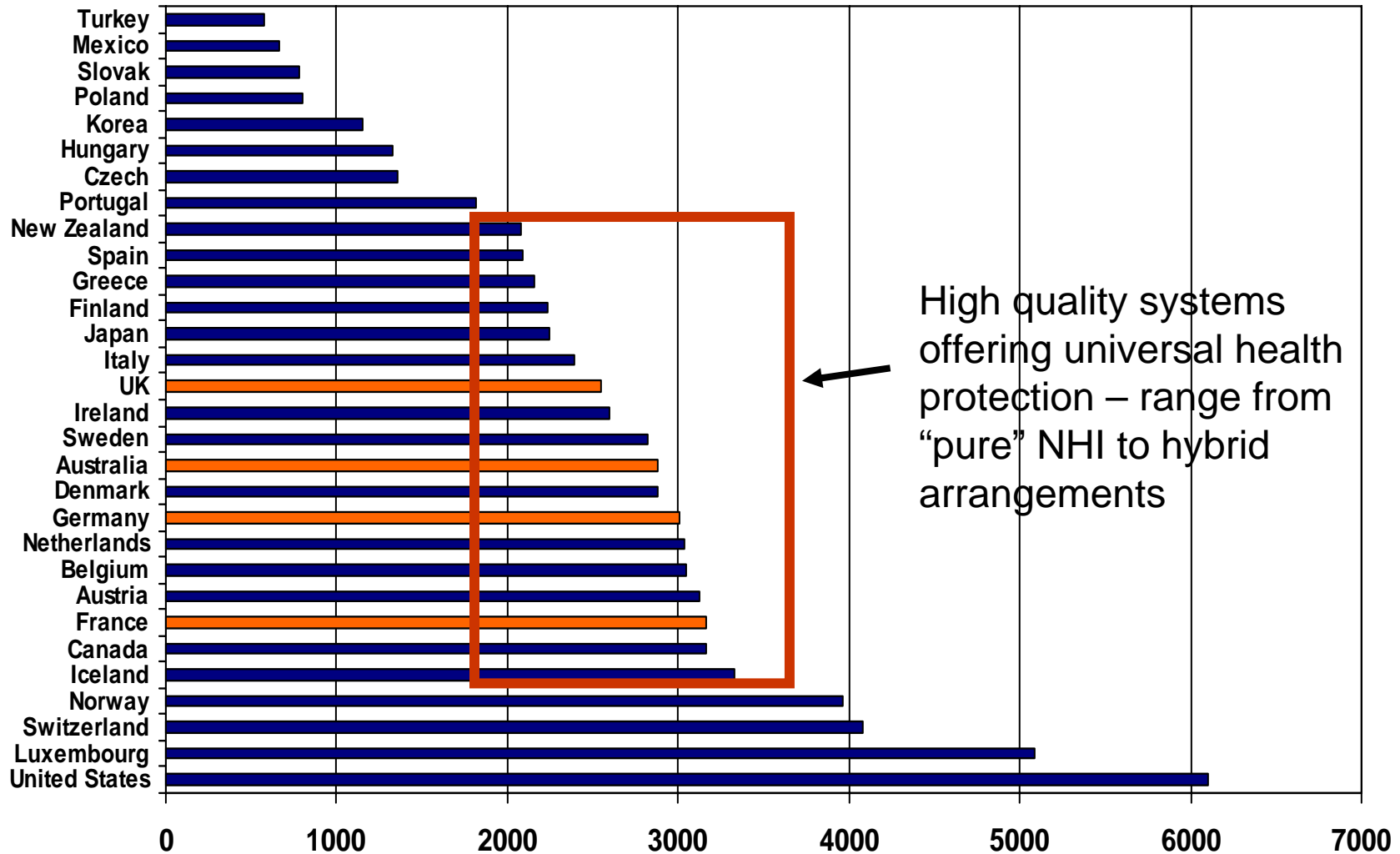
Strategic System Choices



Considerations for the health system

- Organic growth will occur in the contributory health system
- If the contributory health system remains under-developed this growth will be distorted and result in inequity

OECD – per capita health expenditure (2004 or latest)



Germany – an example

- “In Germany, there are two parallel health insurance systems:
 - (a) **State health insurance** is run by German government. Most foreigners (and Germans as well) are obliged to take out state health insurance.
 - (b) **Private health insurance** can be chosen in some specific cases. It generally offers more extensive cover, but is not automatically an advantage for all cases.”

When is state health insurance mandatory?

- “As of January 2004, state health insurance was compulsory the following groups:
 - All employees with an income of up to €40.500 per year
 - Students at state and state-approved universities until completion of the 14th semester or up to 30 years old (with some exemptions).
 - People on work experience (internships) or in secondary education
 - Pensioners who in the latter half of their working life were in a state health insurance scheme for a substantial length of that time or were insured as a family member.
 - Unemployed people receiving benefits from Federal Employment Services (with some exceptions)”

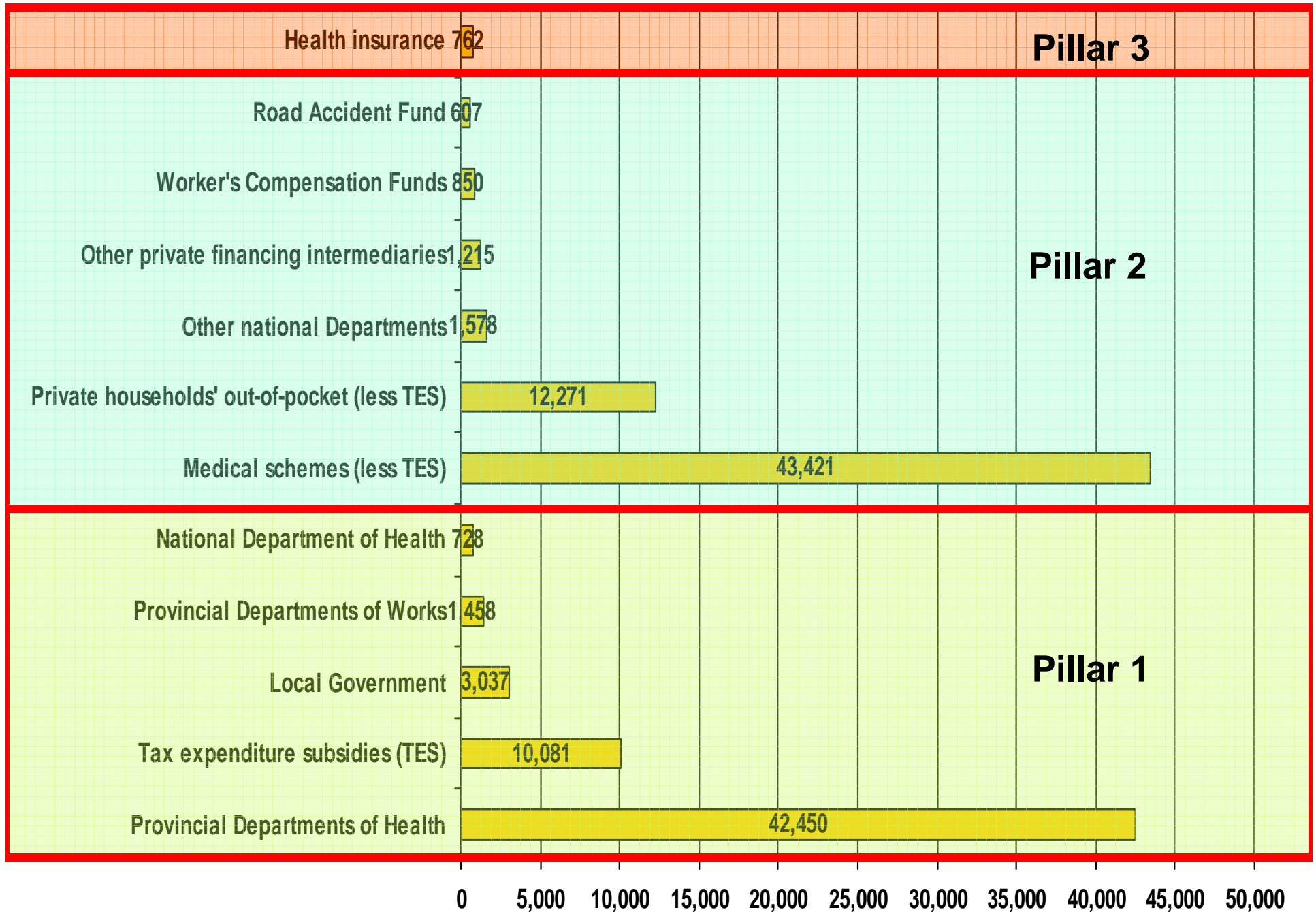
Who can opt for private health insurance?

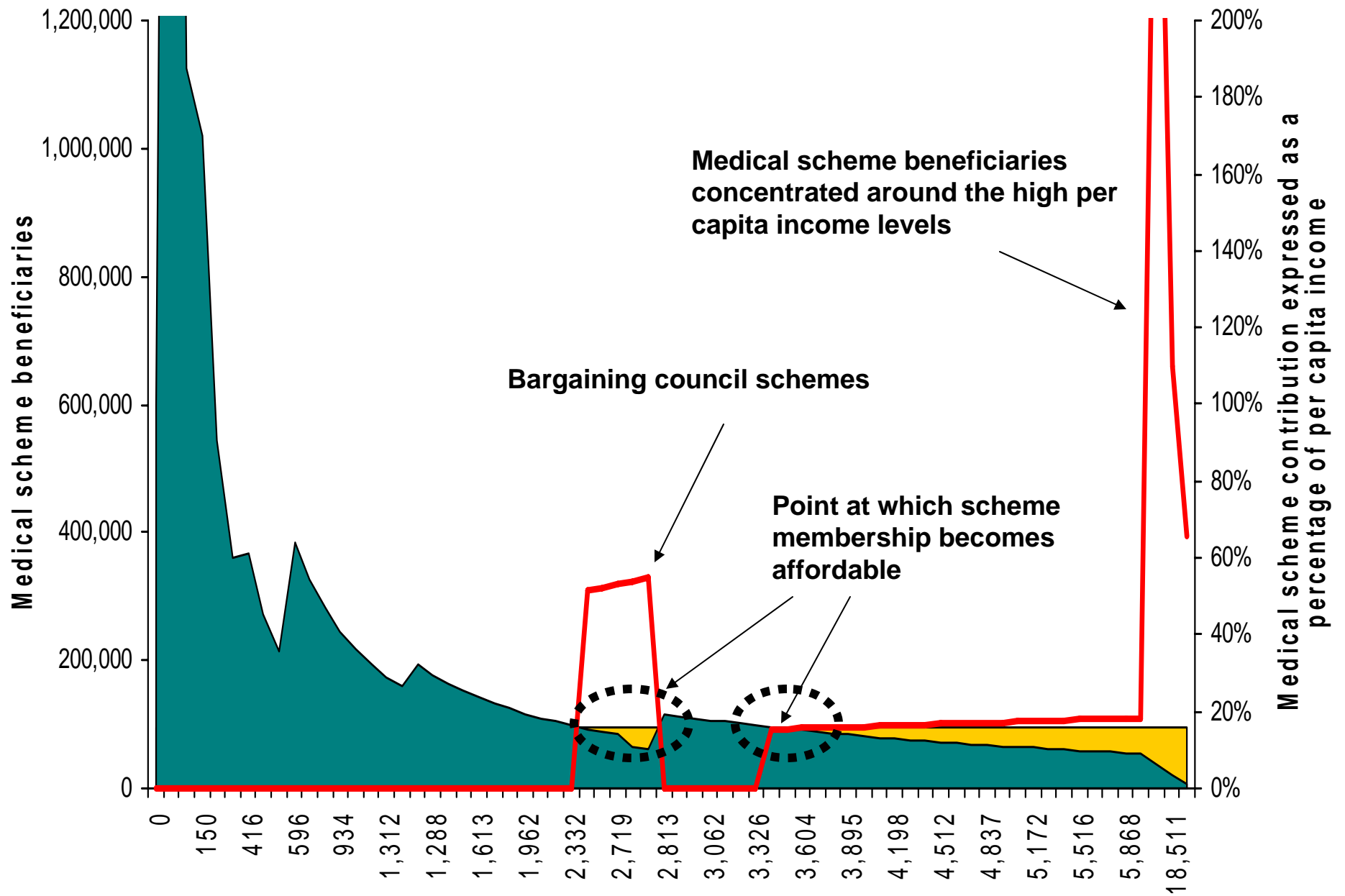
- “In theory, everybody not in the categories above can choose a private insurance scheme”
- “However, once you've opted out of the state insurance scheme, it is almost impossible to go back”
- “Before you make this decision, you should therefore carefully compare the advantages and disadvantages of the two systems”

Advantages disadvantages of state vs private health insurance

- State health insurance contributions are based on your gross income (around 14% with an income cap). If you have a high income, it might therefore be cheaper to opt for a private insurance policy. Students can use a special insurance scheme that offers favourable rates.
- Private health insurance contributions are based on your risk profile, not on your income. For example, women and older people generally pay higher contributions than young men. This is due to a calculation of the average cost for medical treatment for different groups. The older you are, the less attractive it thus becomes to opt for a private insurance.
- Note that contributions are always equally split between employer and employee, independent of whether you are in a private or public scheme.

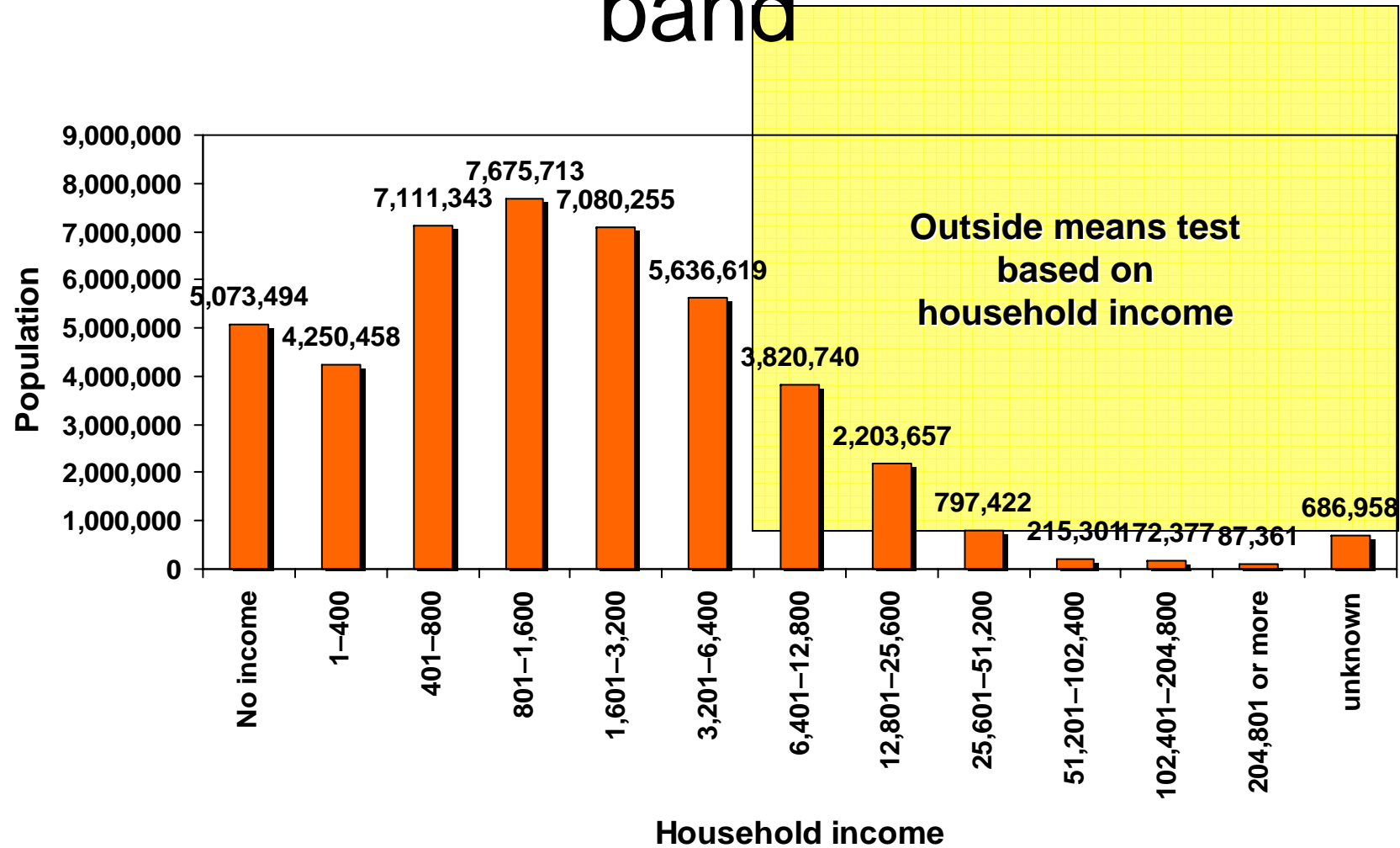
Situation Analysis





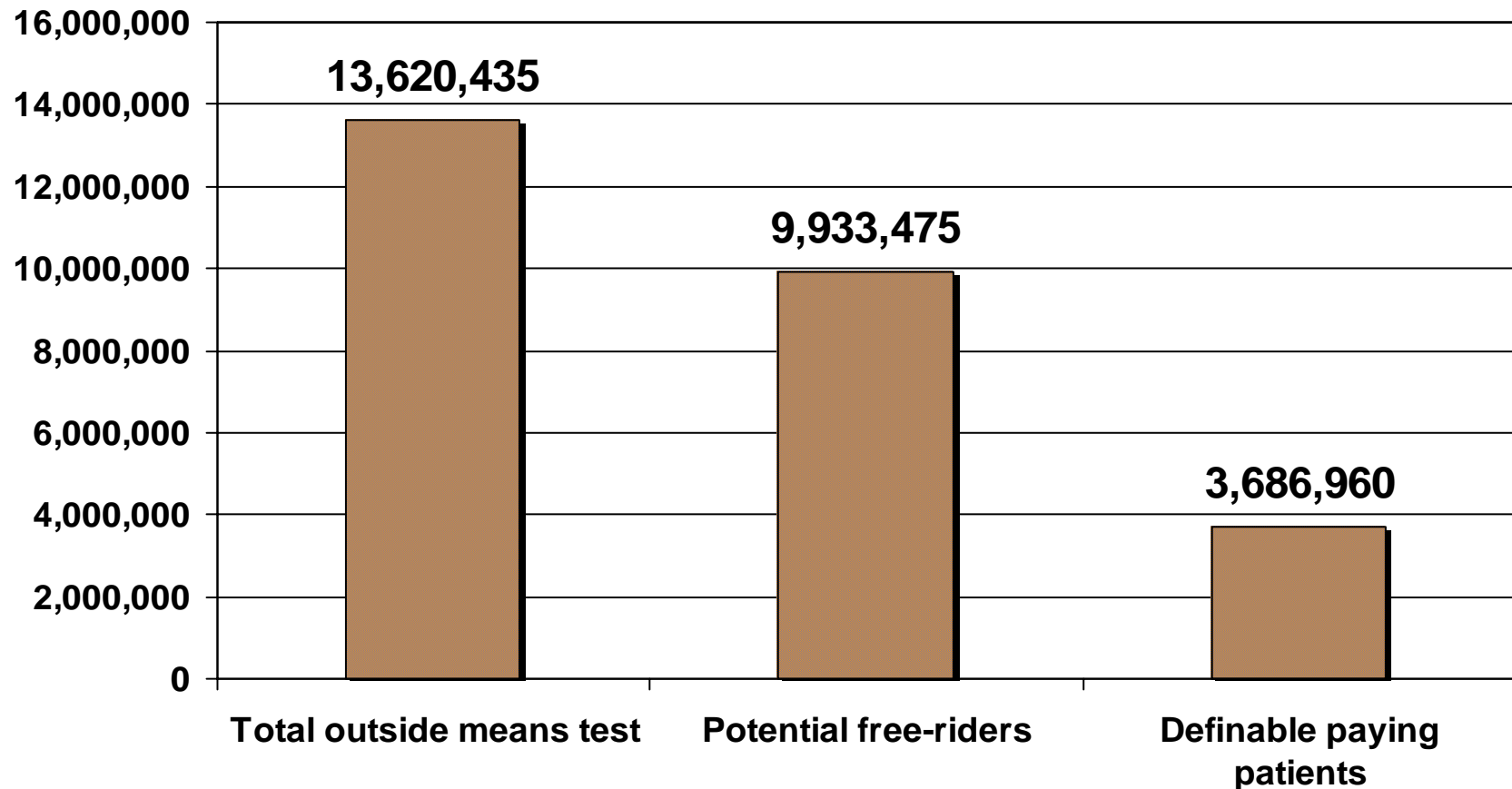
Affordable at 16% of per capita income
 % of scheme contribution
 Medical scheme beneficiaries

Population by household income band



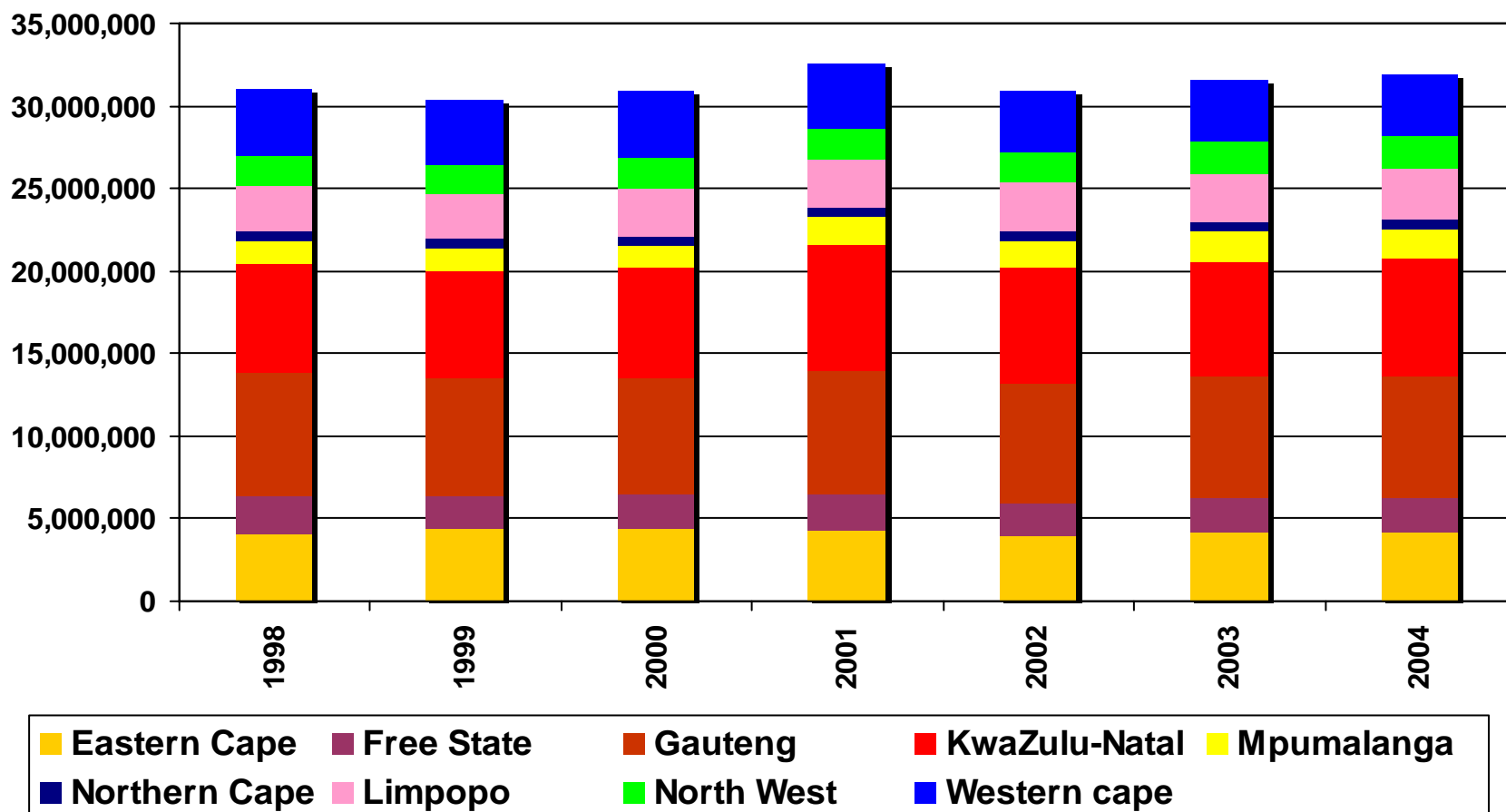
Source data: Census 2001

Assessment of potential contributor population – outside of a reasonable means test

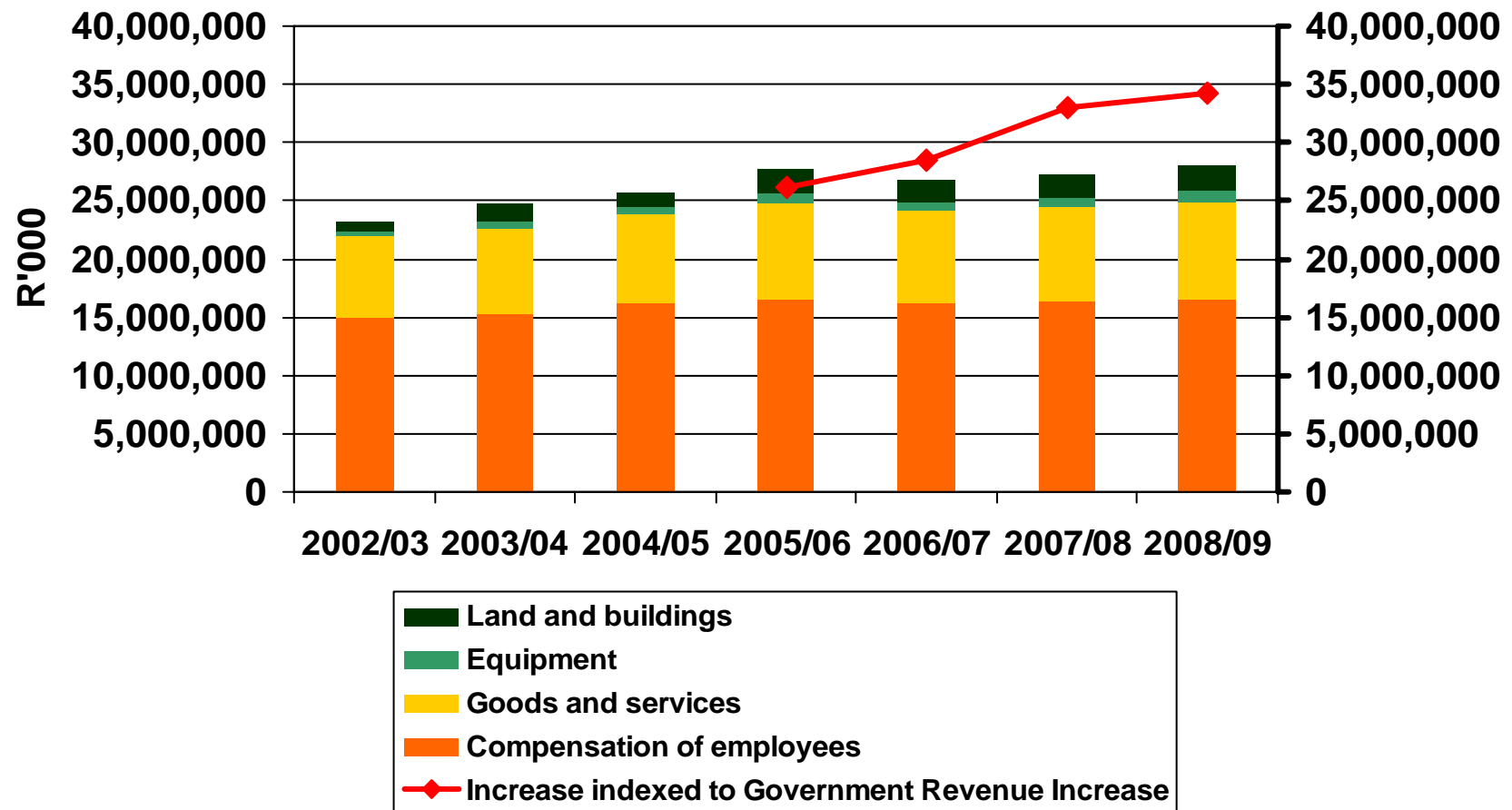


Data source: Census 2001

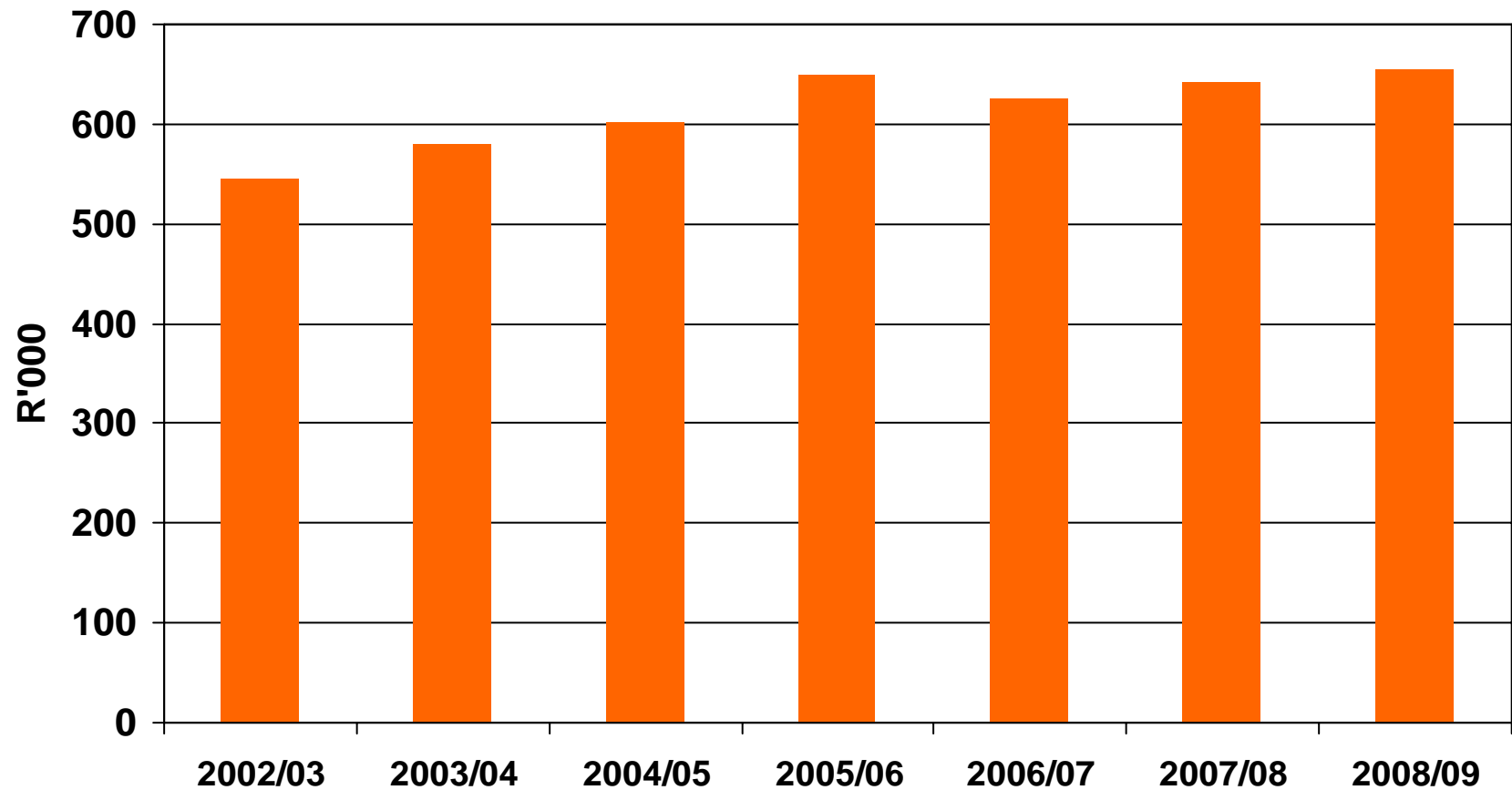
Provincial Health Budgets: including conditional grants; 1998/9 to 2004/5 (constant prices)



Public Hospital Expenditure from 2002/03 to 2008/08, by Standard Cost Item (Constant 2006 prices)



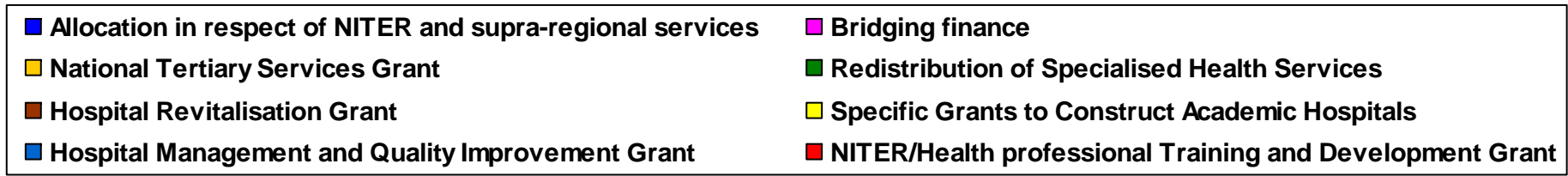
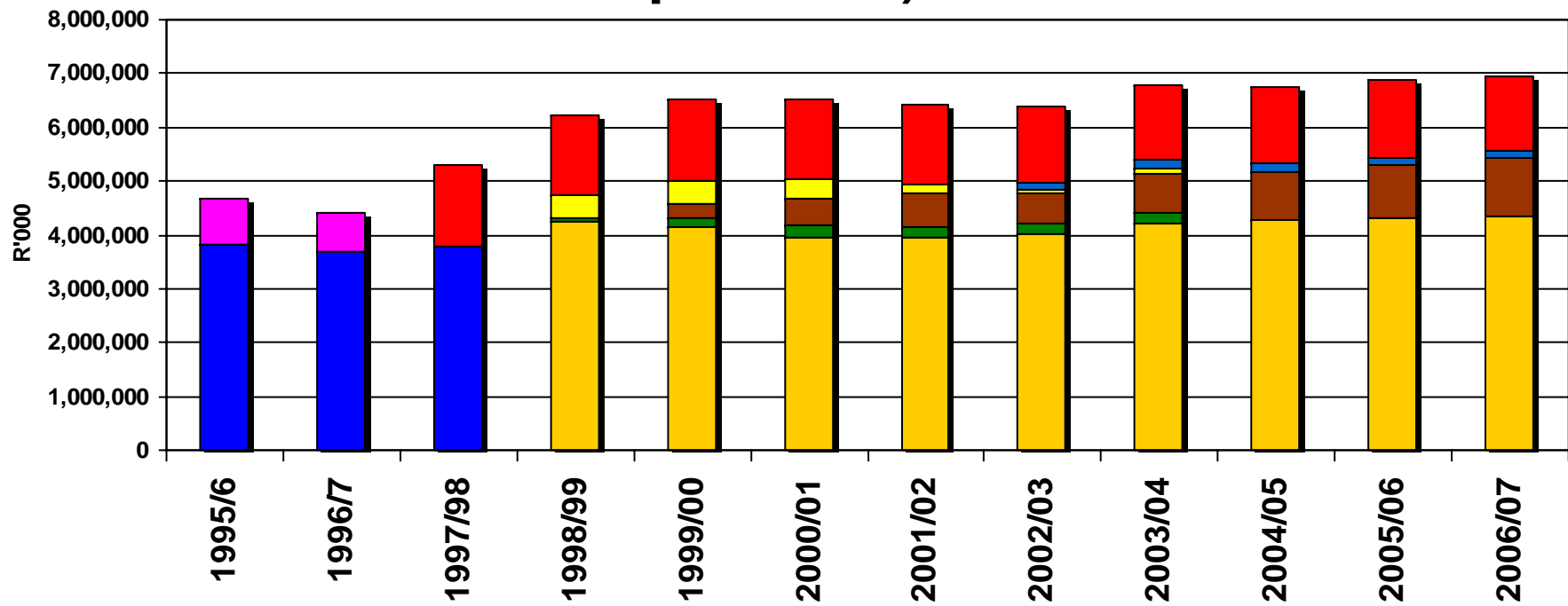
Public Hospital Expenditure from 2002/03 to 2008/08, per capita (Constant 2004 prices)



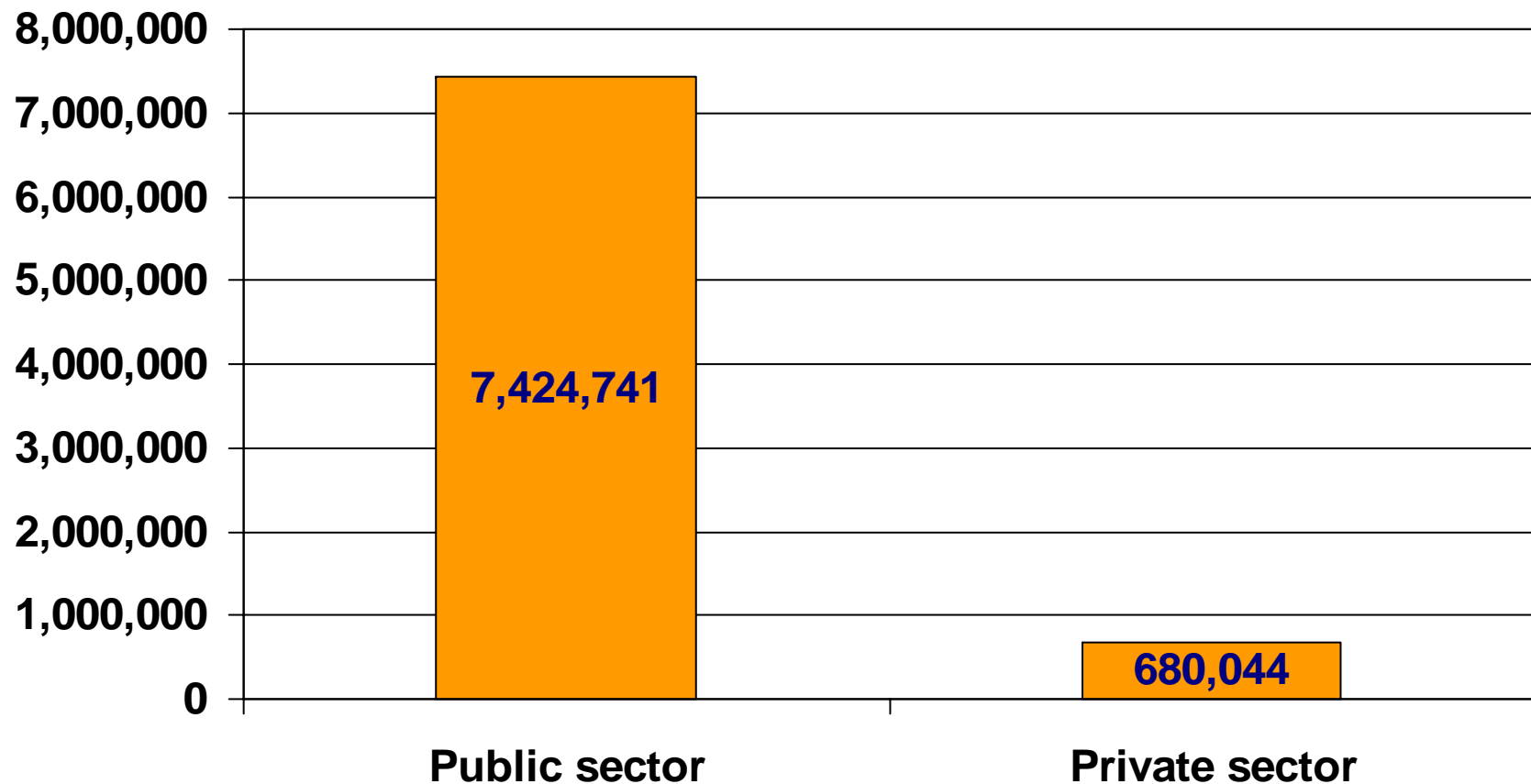
Expenditure increases in the public and private hospital sectors (2005 prices)

- Public sector (includes doctors and specialists)
 - 2002 to 2005: R4.2 billion
 - R1.6 billion capital
 - R1.4 billion staff
 - 2005 to 2008: R200 million
- Private sector (excludes doctors and specialist fees)
 - 1997 to 2005: R7.7 billion
 - 2002 to 2005: R3.4 billion

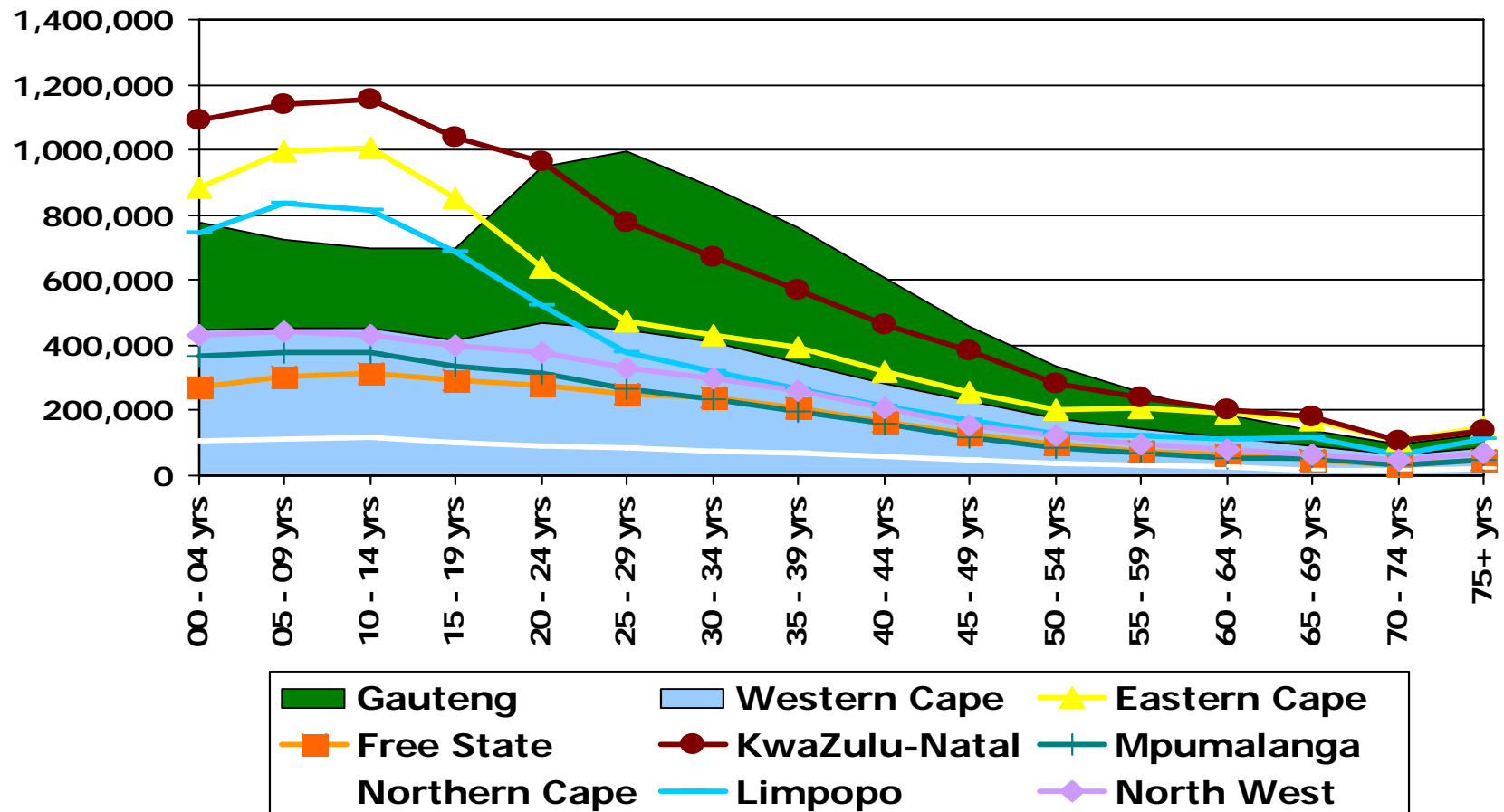
Conditional grants from 1995/6 to 2006/7: NTSG and HPDTG (2004/5 prices)



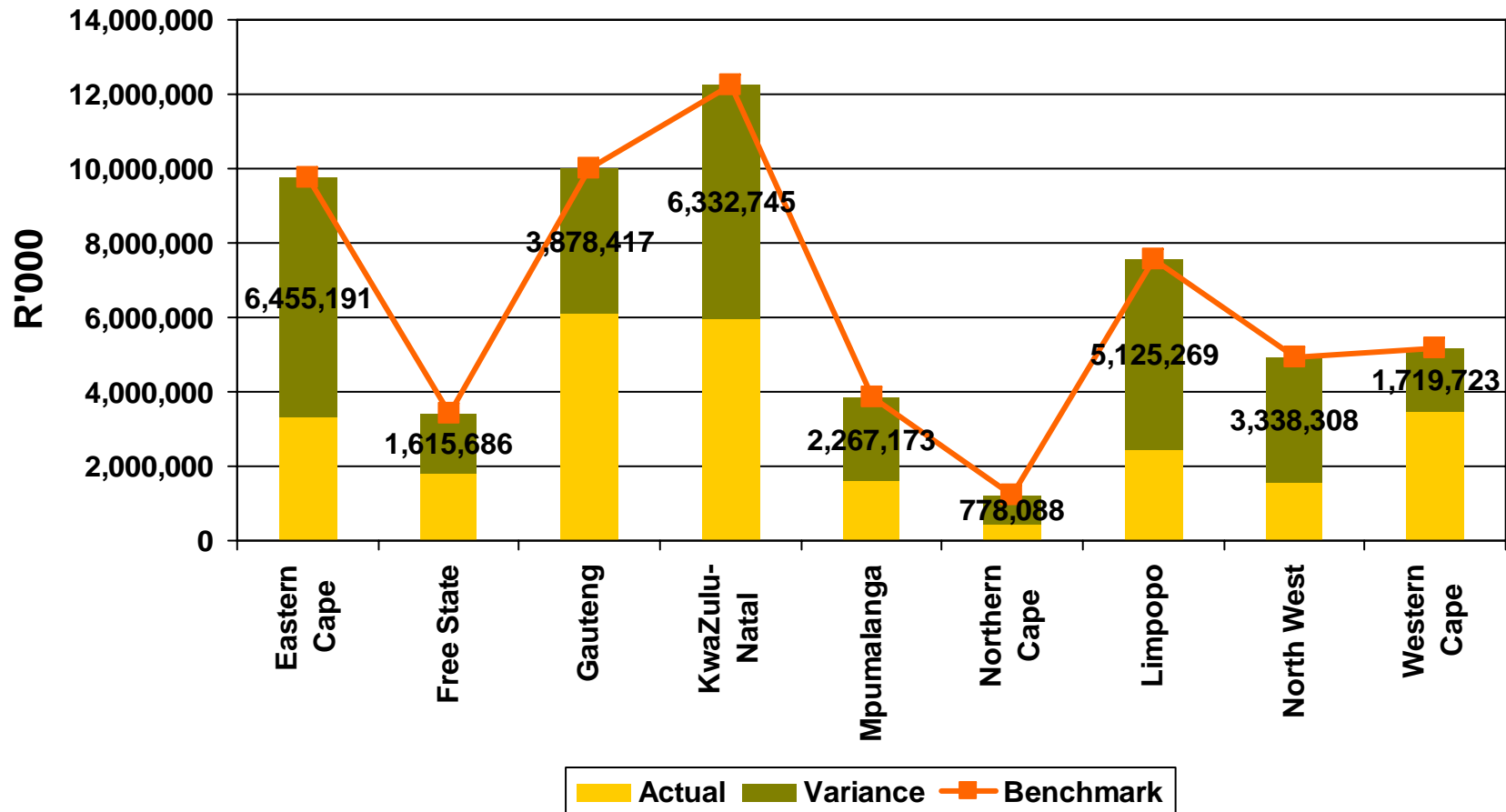
Change in population served by the public and private sector from 2000 to 2010



Population: by age, by province (est. 2005)



Variance from benchmark by province (Constant 2006 prices)



Assessment

- Budget system removes the determination of the national health budget from sight
 - Impacts on budget bidding process
 - Removes political accountability for the national allocation
- National health budget has largely “flat-lined” and is not planned taking account of
 - Population changes (including immigration)
 - Changes in morbidity
 - Movement toward the realization of appropriate access to healthcare
 - *The budget allocations are an outcome of the budget process rather than any explicit policy or plan*

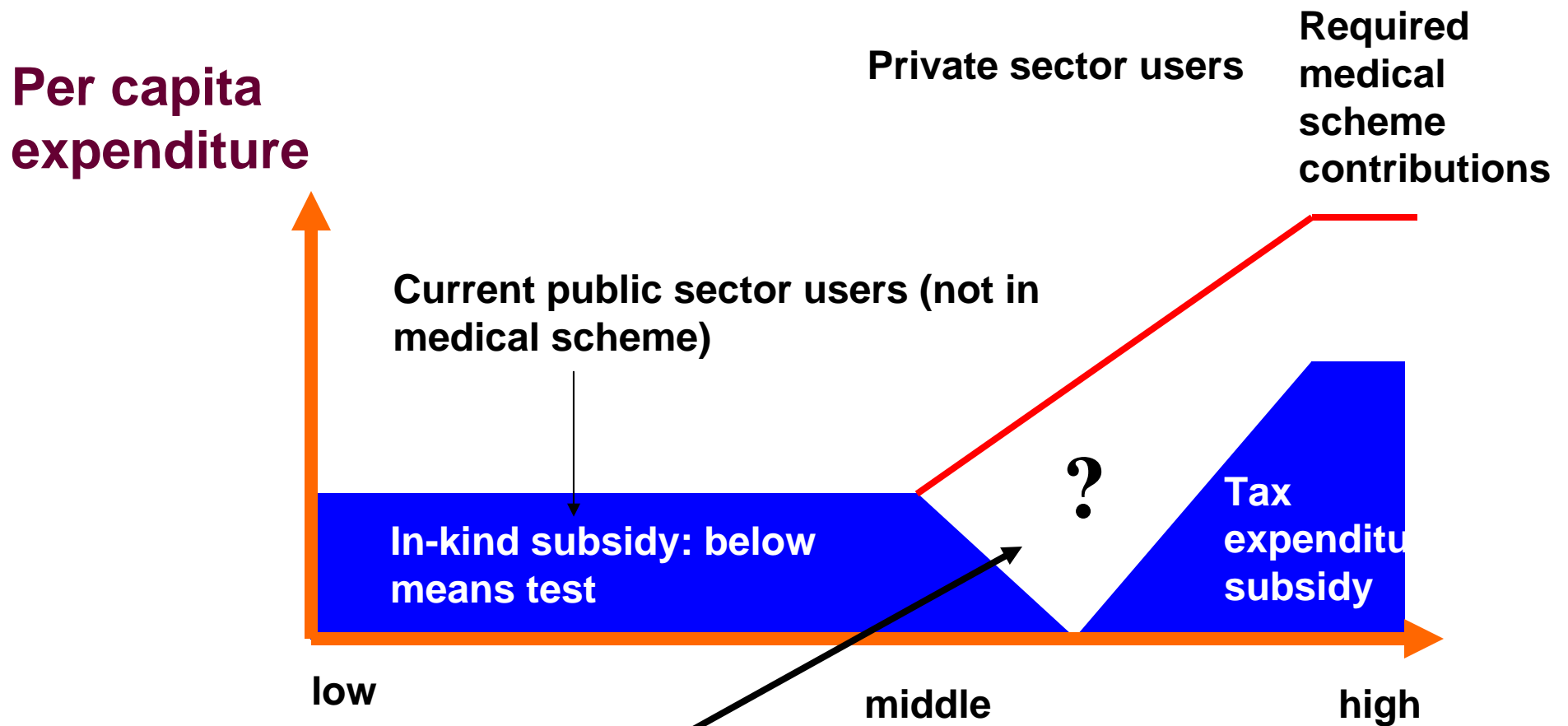
Assessment

- There are improvements in expenditure, but quite limited and off a low base-line (many years of stagnation)
- There is no specification of the minimum level of service required to ensure appropriate access to healthcare
- It appears there is no strategic progressive realization framework
- Public health system levels and quality determined implicitly

Assessment

- Capital budget decisions have been separated from current budget planning
- District system incomplete
 - Lacks a financing framework
 - Lacks a coherent governance arrangement
- Provincial governments license private hospitals without due consideration to fixed medium-term pool of human resources
- Not clear that the public health system has the correct mix of governance arrangements (hospitals, regional structures) – generates inflexibility and insensitivity to served population
- Tax Expenditure Subsidy provided to medical scheme members lacks a coherent rationale within the context of the poor resourcing of the public health system

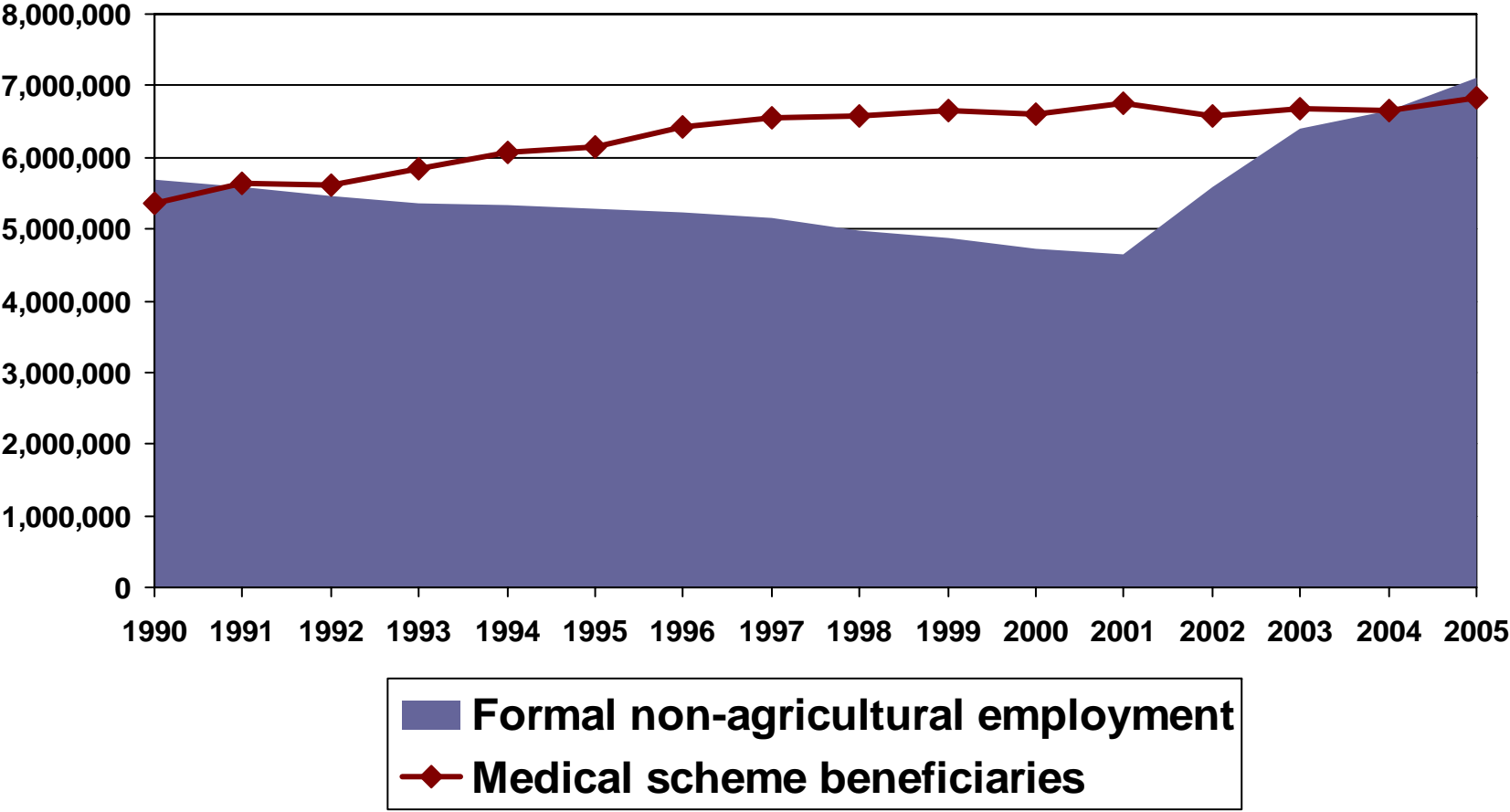
Current Health Subsidy Framework



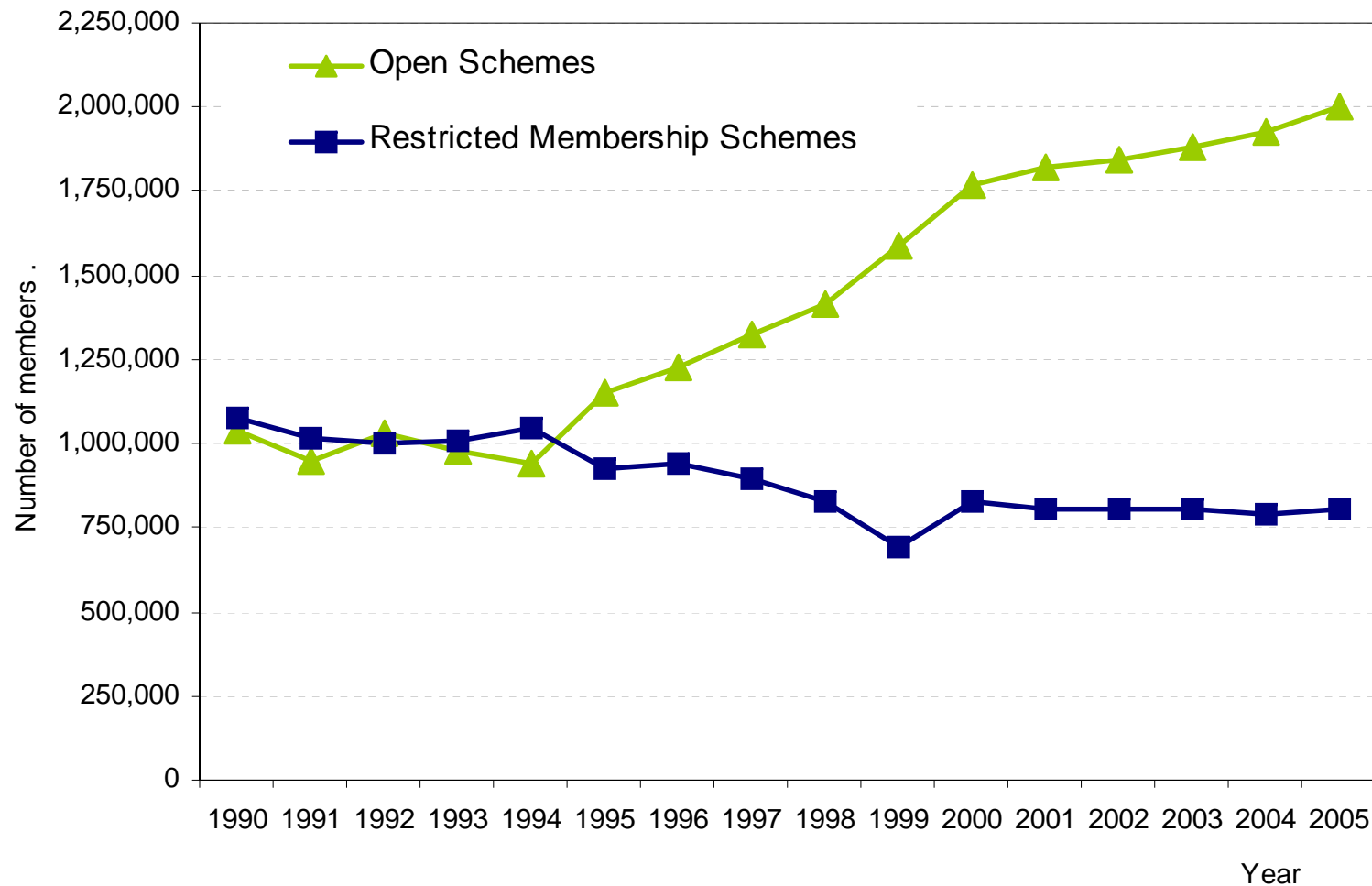
Low income groups are forced to pay for public and private services without reasonable access to a subsidy or to risk pooling via a medical scheme

Income level

Change in Medical Scheme Membership 1990-2005 compared to formal non- agricultural employment

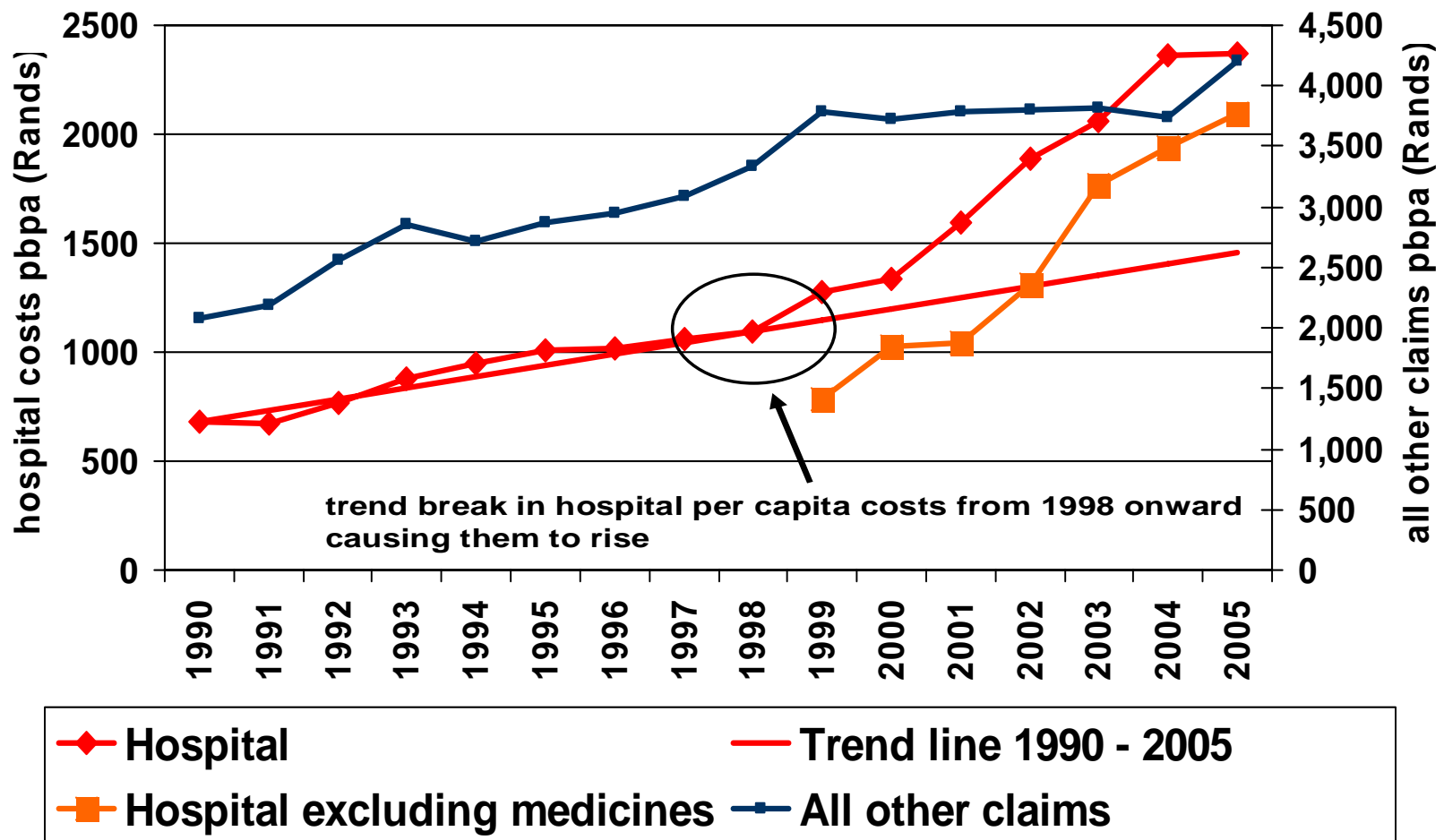


Medical Scheme Beneficiary Changes 1990 to 2005

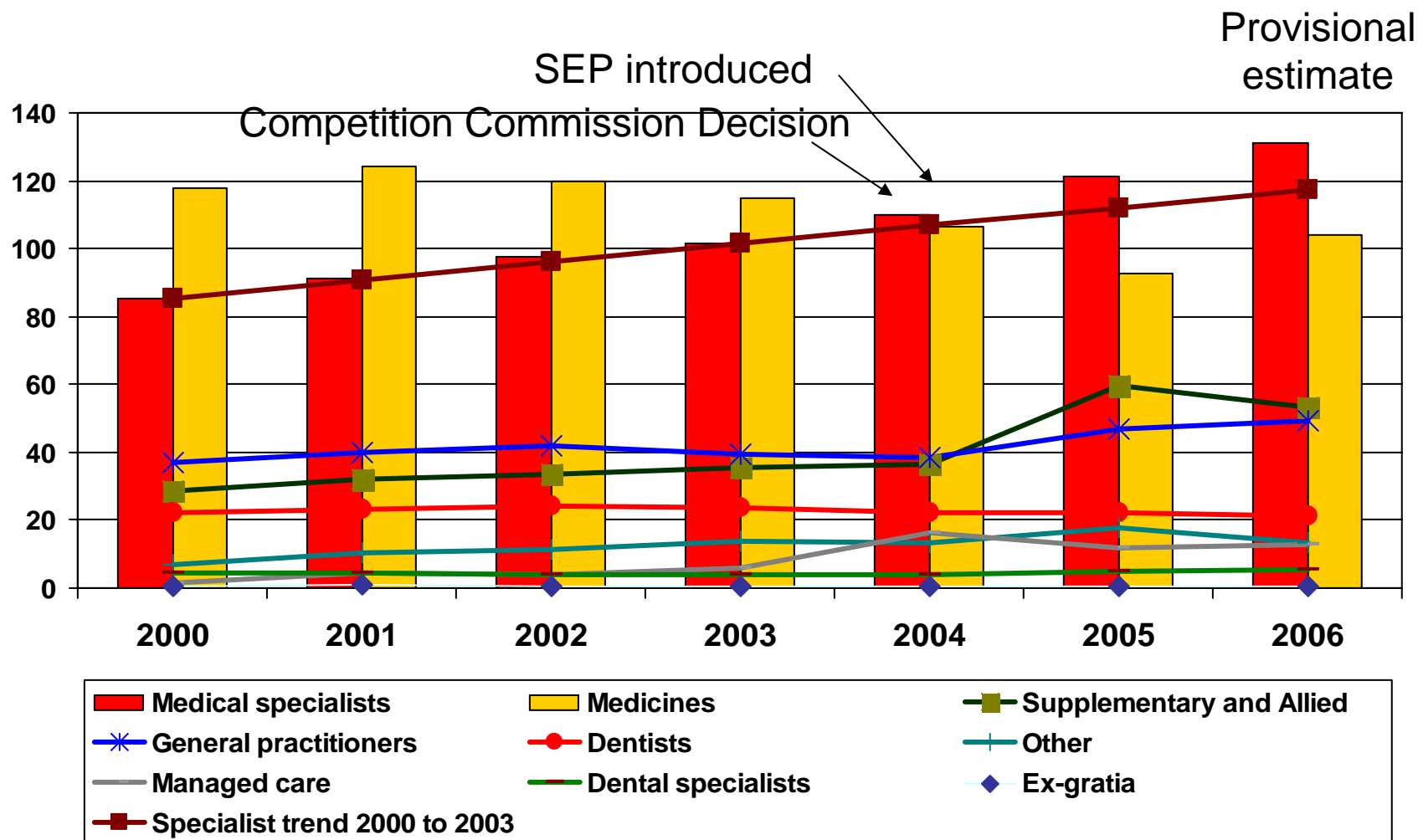


Source: Council for Medical Schemes

Hospital cost trends from 1990 to 2005, Rands per beneficiary per annum (Constant 2005 prices)

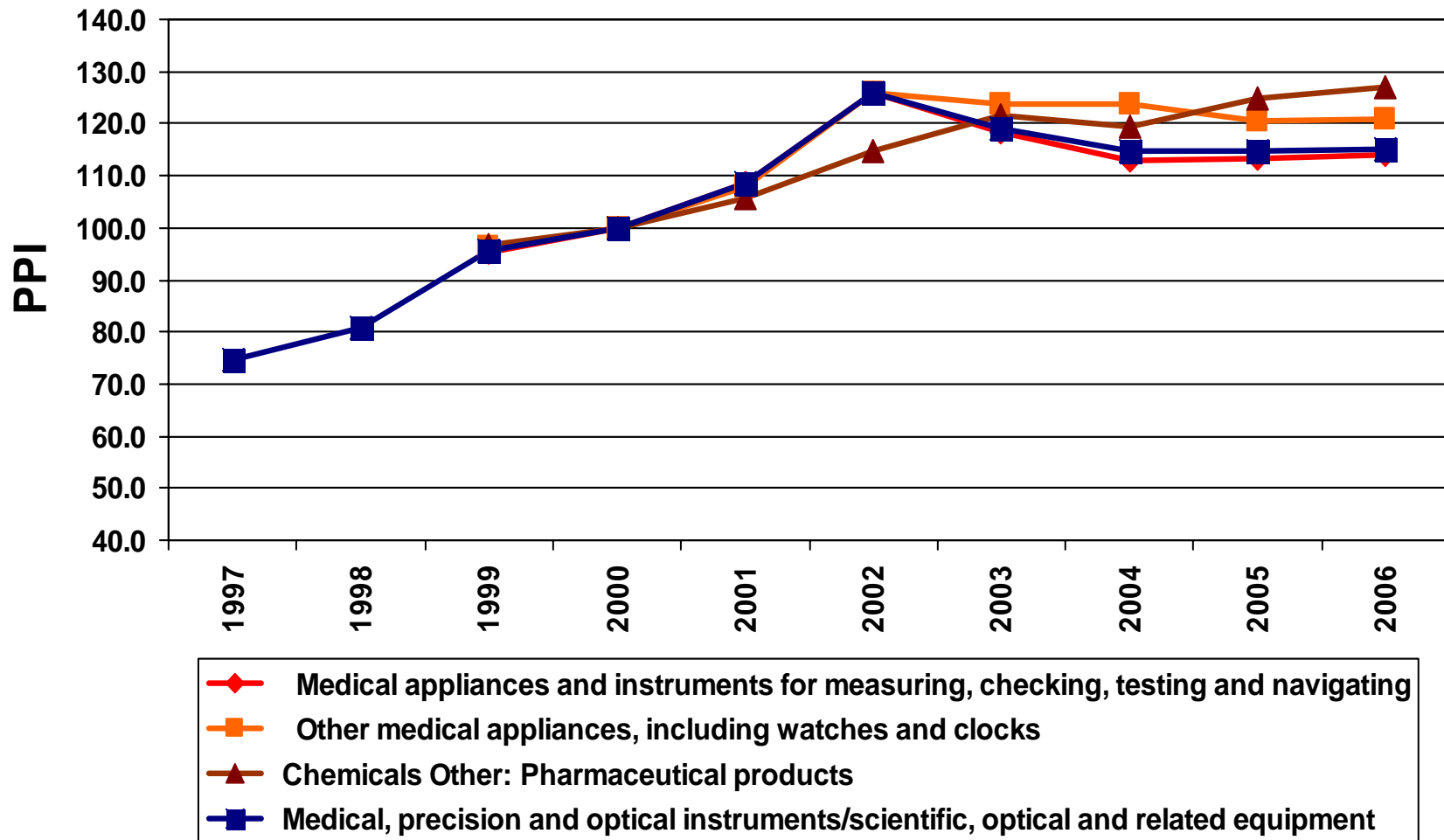


Out-of-hospital cost pabpa from 2000 to 2006 (constant 2006 prices)



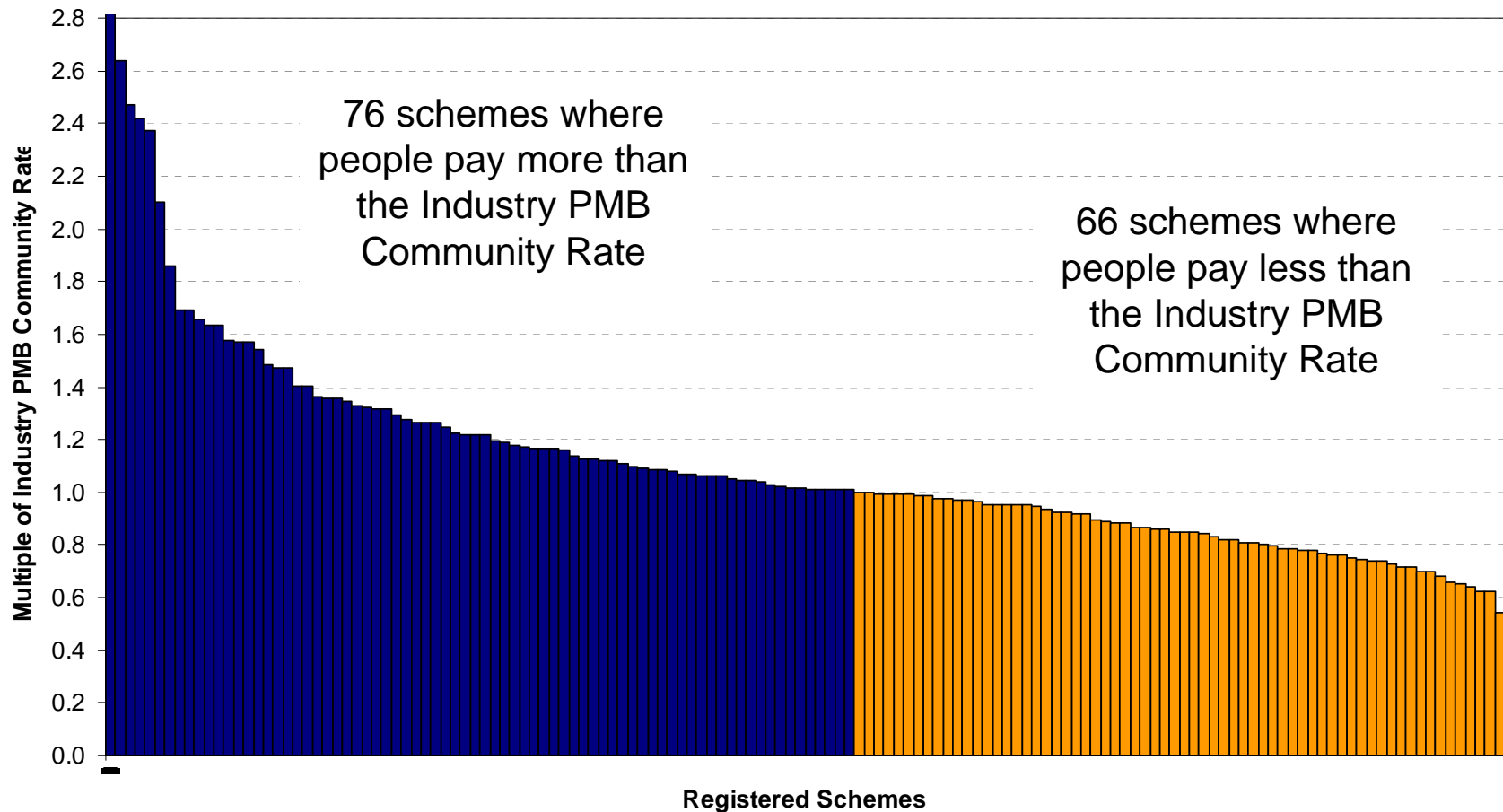
Source: Council for Medical Schemes

Producer Price Index 1997 to 2006



Effect of Age on the Scheme Community Rate for PMBs

1 scheme at multiple of 4.1



Source: Formula Consultative Task Team, 2003

Finance Committee

November 2004

Option 1

- *“The first provides for primary care cover only to the whole population using private sector providers where available and the public sector institutions where not. It cannot be implemented without a major injection of funds. There will be a delay in bringing equitable care to the most disadvantaged portion of the population until there are many more adequately trained nurses, and a redistribution of doctors. Implementation will take at least two years.”*

Option 2

- *“The second option also provides for universal primary health care coverage, but provides for contributors (the employed) to receive private sector care where available, while non-contributing people will make use of public sector institutions, which will be expanded and developed on receipt of per capita funding. The level of per capita funding to the public sector will be lower than that to the private sector, but the employed will cross-subsidize non-contributors very significantly. This can be seen as an interim step towards universal access to the private sector. Again implementation will be a long process.”*

Option 2 (cont.)

- *“Both schemes provide for primary health care only and leave voluntary private insurance to cover other levels of care. Medical schemes will be prohibited from providing primary care.”*
- *“Both make full use of private sector providers, who are remunerated on a capitation basis.”*

Option 3

- *“The third option approaches universal cover by improving cover for the employed who are obliged to contribute to a social health insurance scheme. Contributions are pooled and used to provide for all levels of care. The idea is that this scheme will be expanded progressively until a switch to a universal NHI scheme can be achieved.”*

Assessment

- Of the three the *third* option was regarded as the most feasible. This option accepted the view that a massive overnight shift in the system was not feasible. It also recognized the need to cover both primary care and higher level services. The Committee however did not attempt to provide any serious detail to the nature of the recommended proposal.
- The proposal that the system progressively advance to a full NHI suggests that a social health insurance (SHI) proposal was actually being made as a key step toward an NHI.

NHI Committee

2005

Contributory System

- A new regulatory system for Medical Schemes to include:
 - A single Act to govern all funds doing the business of a medical scheme
 - Community rating
 - Prescribed minimum benefits
 - Open enrolment for open schemes
 - A capping of the tax expenditure subsidy for medical scheme contributions by individuals and employers
- A risk equalization fund to include:
 - A risk equalization mechanism between medical schemes
 - An income-based contribution system
- Employer mandates on medical scheme membership

Primary Care

- Proposed a systematic expansion in public sector funding for primary care, with the adoption of a private contracting framework
- Report appeared to recommend a universal primary care system funded entirely through general tax
- No specific funding mechanism was identified by the report to realize this objective

Assessment

- The NHI Committee did not support medium-term consideration of an NHI on the grounds of feasibility
- This confirmed the position taken by the Finance Committee Report of 1994
- This position has been supported in all subsequent reviews and Committees of Inquiry
- However, all the reports from this period see NHI as emerging ultimately as the medium-term reforms mature

Medical Schemes Act

Legislative framework

- The revised regulatory environment for medical schemes represented the first phase in the movement toward SHI, as recommended, and was implemented via new legislation passed in 1998. This included:
 - A single Act to govern all funds doing the business of a medical scheme;
 - Community rating;
 - Prescribed minimum benefits;
 - Open enrolment for open schemes; and
 - An expanded regulatory authority, the Council for Medical Schemes, reporting to the Minister of Health.
- No revision to the tax or income-based cross-subsidy framework was implemented at this stage. This was left to the process for implementing a SHI which required the implementation of the revised regulatory environment for medical schemes as a prerequisite.

Taylor Committee

Focus of the Committee

- Identified systemic short-comings of the health system
- Specified a long-term vision identified as “National Health Insurance”
- Specified medium-term proposals consistent with the long-term vision
 - Structural changes required to build social solidarity into the contributory system
 - Structural changes in the “single-payer” public system required to achieve integration with the ultimate vision
 - The structural framework was prioritised rather than any specification of a “level of funding”, i.e. the changes could be implemented without any changes to the budget constraint

Vertical equity considerations

- *“The redesign of the income tax subsidy represents the only viable short- to medium-term measure for achieving minimum required income-based cross-subsidies across the entire health system, both public and private.”* (Department of Health, May 2002, p.44).
- *“Income-based cross-subsidies can however be achieved through allocations from an earmarked or general tax into a risk equalization fund. The risk-equalization fund therefore allocates both income- and risk-based cross-subsidies. An earmarked tax for this fund is more appropriate than a general tax contribution, as it establishes a clear link between a shared risk-pool and the contributory environment.”* (Department of Health, May 2002, p.74).
- *“The subsidy should ultimately be raised as part of the revenue obtained from a universal mandatory contribution toward a national health insurance fund. Both the collection and distribution of funds would become incorporated within an integrated framework.”* (Department of Health, May 2002).

Health

Phase 1: Development of Enabling Environment

- Preparation of Public Sector Budget System
- Preparation of Public Sector Hospital System
- Consolidation of Medical Schemes Reforms
- Development of integrated subsidy system
- Implementation of measures to contain private sector cost increases

Phase 2: Implement Preparatory Reforms

- Risk equalisation Fund for medical schemes
- Risk-adjusted subsidy to medical schemes
- State sponsored medical scheme
- Mandatory environment for civil servants

Phase 3: Implement Statutory Mandates

- Mandate medical scheme membership for
 - Medium to large employers
 - High-income earners
- Voluntary contributory environment for low-income groups
 - State sponsored scheme
 - Public Sector Contributory Fund

Phase 4: National Health Insurance Implemented

- Central Equity Fund
- Public Sector Contributory Fund

2002

2003

2004

2005

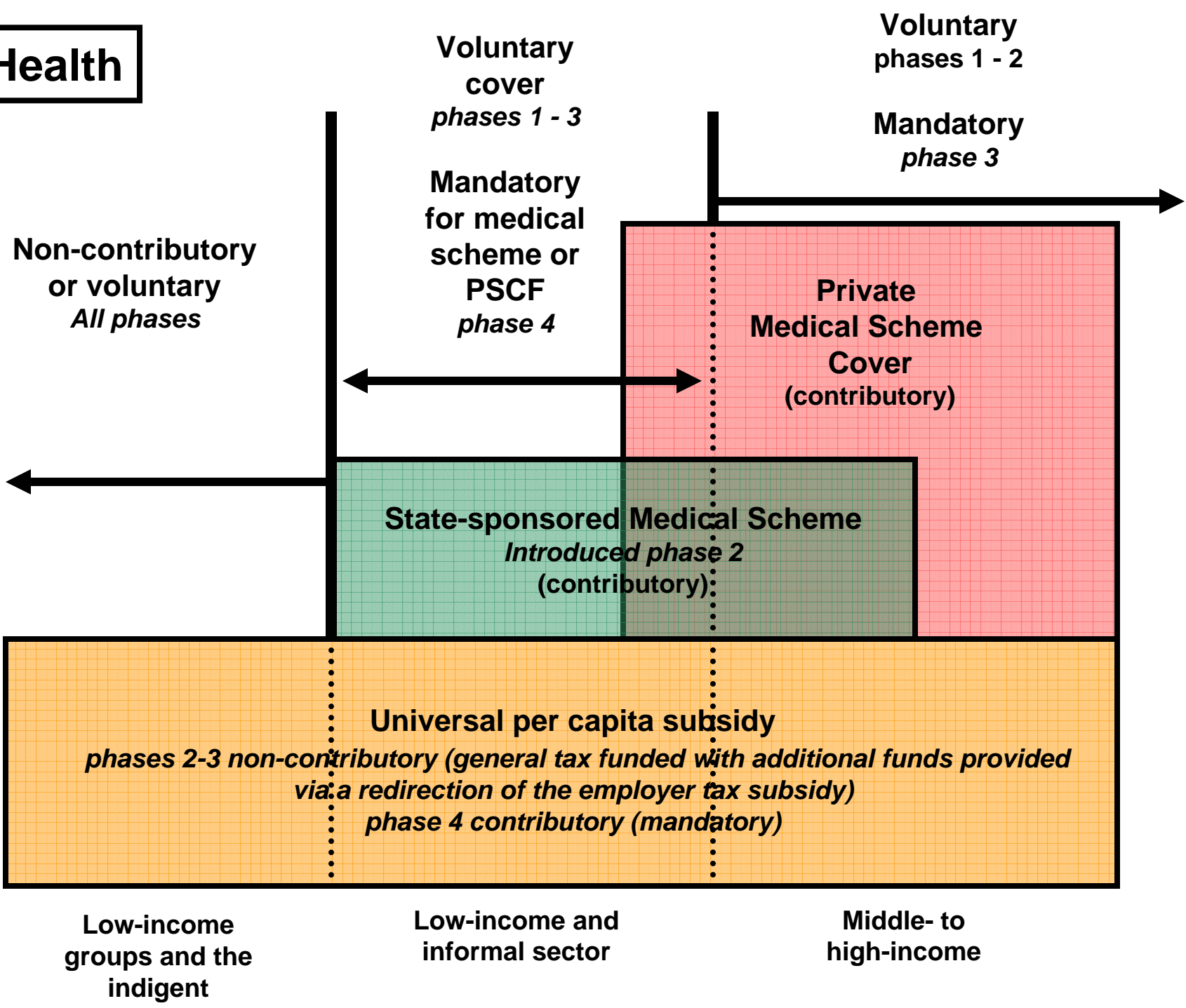
2006

2007

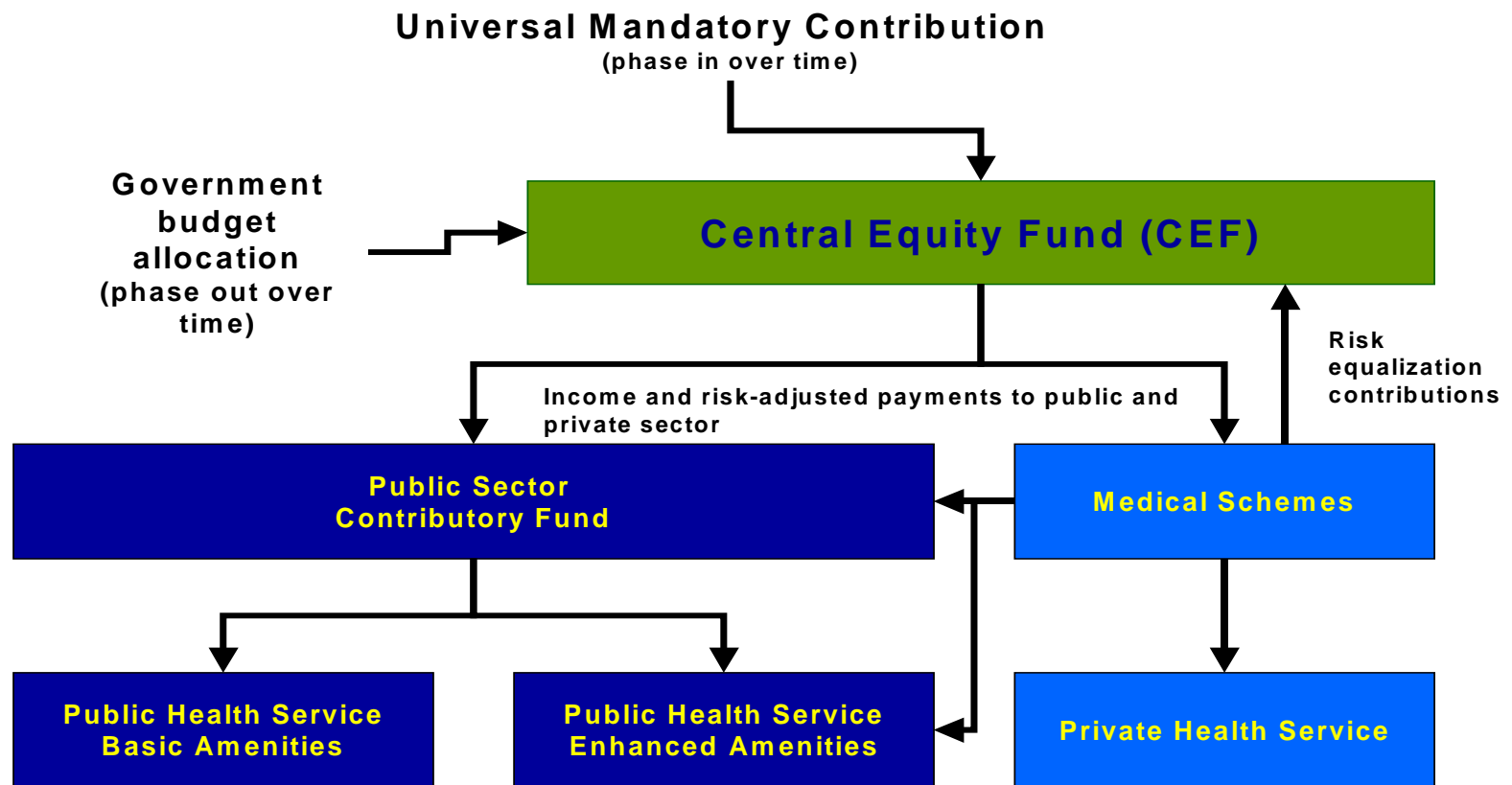
2008



Health



Phase 4



Medical schemes can pre-pay or reimburse the public sector contributory fund for public sector services. They can also directly contract with the hospital.

What needs to be done?

Restructure public finance arrangements

- (Existing modality is opaque, inequitable and fragments policy and planning)
- Allocative efficiency requirements
 - Centralize decisions on the determination of national health allocations (otherwise there is no single-payer) – allocations are then set at the level at which national policy parameters are established
 - Provincial governments
 - Districts
 - A resource allocation mechanism needs to be established which makes technical decisions on allocations based on transparent policy determinations
- Horizontal equity requirements
 - Regional service access must be achieved

Restructure governance and administrative arrangements

- Lower tiers of government should have operational autonomy within clear policy parameters
- Hospitals – need to become fully autonomous
- District system – needs to have clear autonomous and accountable executive structures

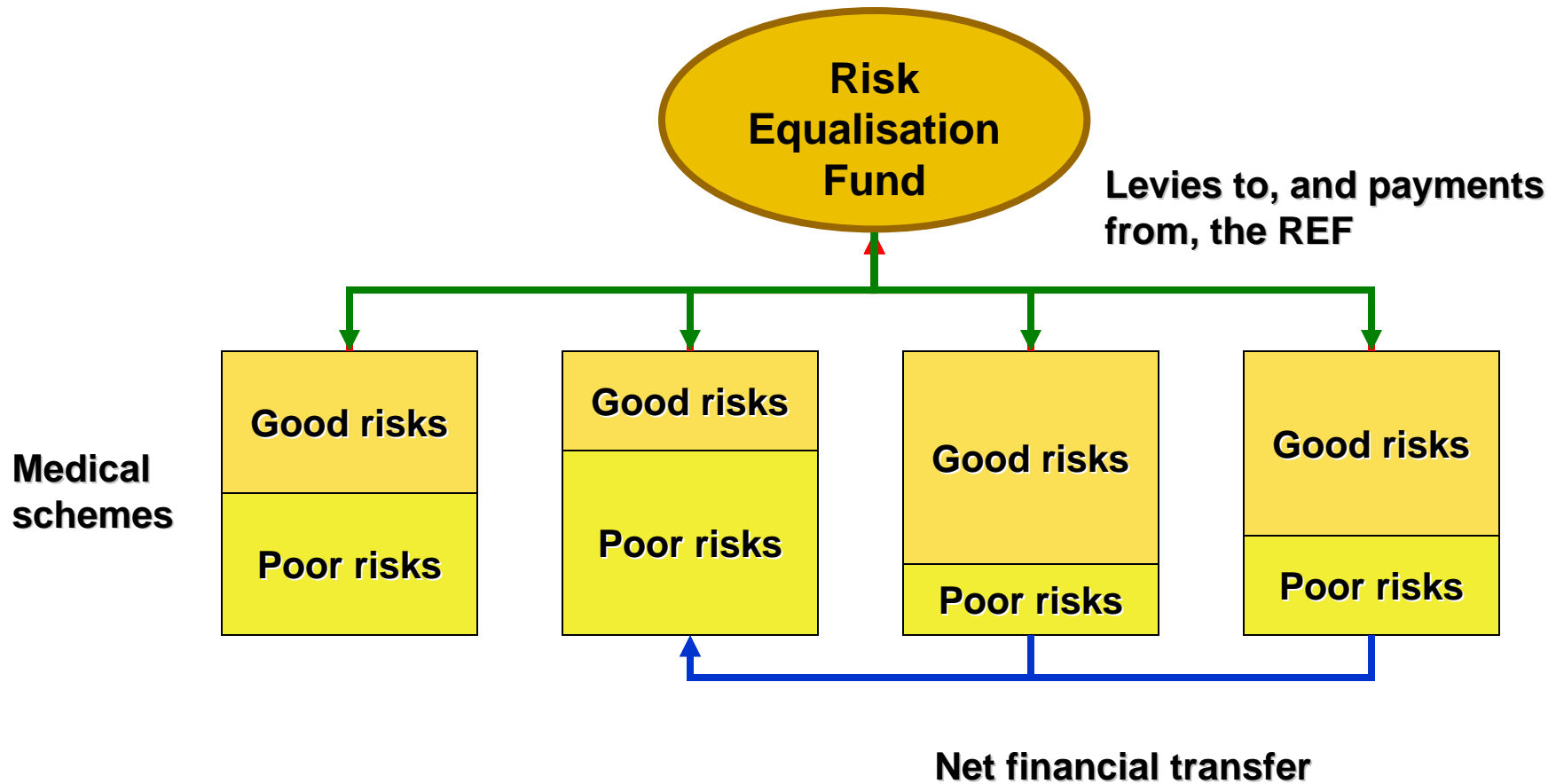
Minimum Package

- Health service targets must be formally established (developing country requires that targets adjust constantly)
- Human resource planning in relation to service targets is required – including supportive funding model
- Means test should be removed – ultimately mandating medical scheme cover would replace the “means test” targeting mechanism

Contributory System

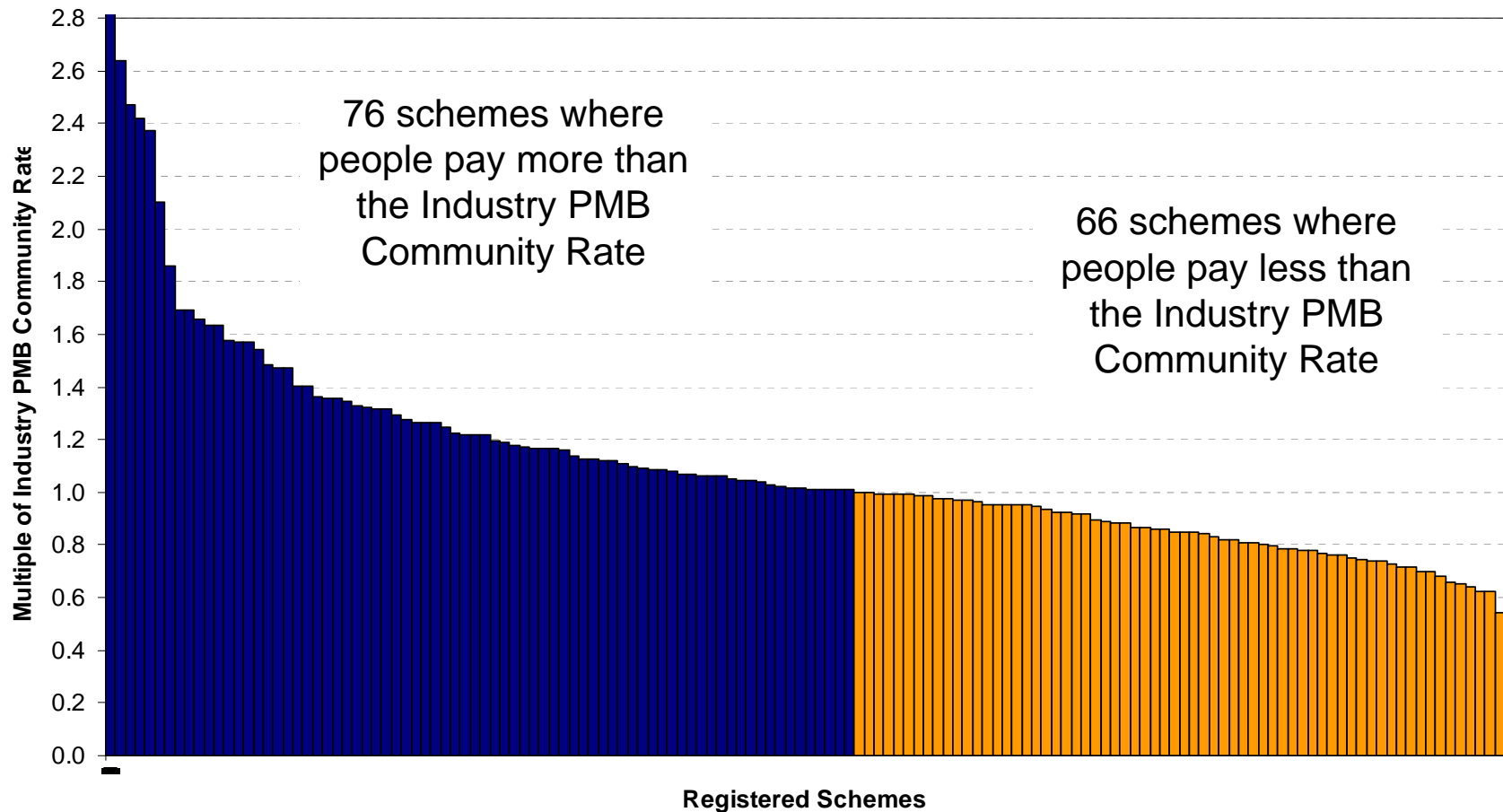
- Social solidarity framework must be fully implemented
- Supply-side requires a coherent regulatory framework
 - Price/cost determination
 - Conduct regulation

Risk Equalization: what is it?

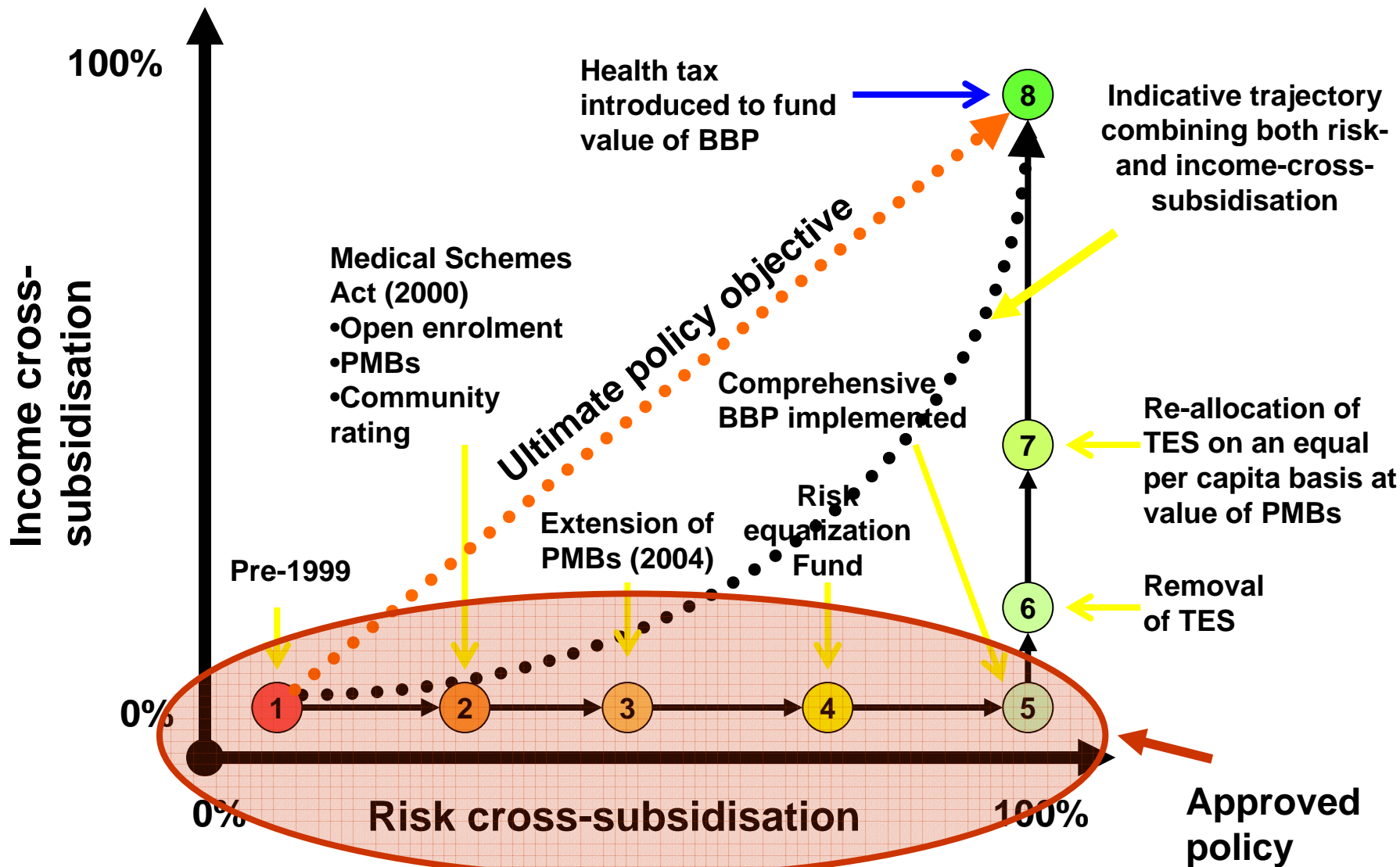


Effect of Age on the Scheme Community Rate for PMBs

1 scheme at multiple of 4.1



Source: Formula Consultative Task Team, 2003



BBP = Basic Benefit Package (i.e. a comprehensive essential package of healthcare benefits)

TES = Tax Expenditure Subsidies (both employer and individual subsidies)

PMBs = Prescribed Minimum Benefits (current legal requirement, which is not fully comprehensive)

End