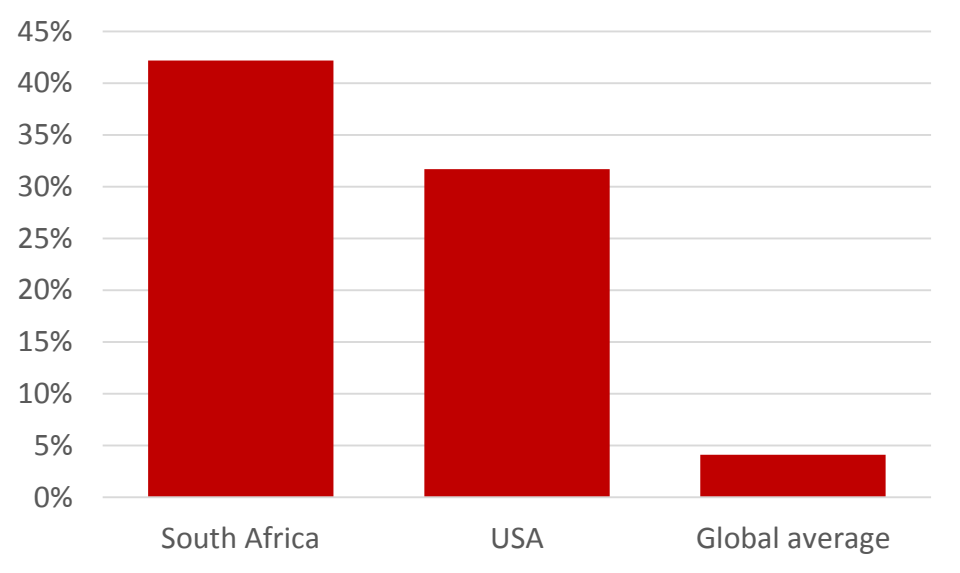
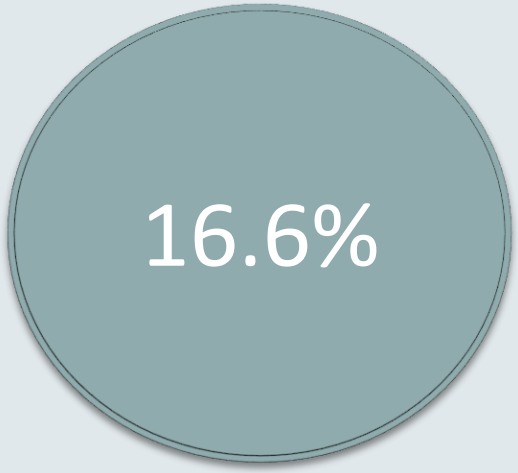
Pluralistic Approaches to Universal Health Coverage

PLURALITY OF PROVISION & FINANCING

Context

Inequity of financial resources





SA is an outlier: voluntary health insurance as a percentage of total health spend

Only 16.6% of the population covered, and coverage is concentrated in the top two income quintiles

Source: OECD, Council for Medical Schemes, StatsSA

Relatively well-resourced private delivery

300 hospitals and 34,000 beds

7,500 doctors & 6,700 specialists

77,500 nurses

3,000 pharmacists

Source: Econex (2014)

Goals of Reform: Quality of Delivery

- Van der Berg: dissatisfaction with the current national health system is dissatisfaction with the quality of the care provided in the public sector
- Econex: poorest households, who are eligible for free public healthcare, pay considerable sums for private healthcare. User dissatisfaction in the public sector stemmed mainly from long waiting times, unavailable medicines and rude staff, while in the private sector dissatisfaction was mainly attributed to the price of the service.
- A comparative study of the quality of health systems in 48 developed and developing countries undertaken by the Monitor Group in 2008 found that the public sector ranked 8th from the bottom, while the private sector ranked 6th from the top

Quality

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	SA
Percentage of users of private health services highly satisfied with the service received										
2009 GHS	95.1	92.4	91.2	94.7	92.2	87.8	95.6	94.2	92.5	92.5
2010 GHS	95.1	91.0	91.2	88.5	96.1	91.3	90.8	92.7	94.9	92.1
2011 GHS	98.6	95.3	92.4	85.9	97.2	94.8	89.9	89.9	92.0	92.9
Percentage of users of public health services highly satisfied with the service received										
2009 GHS	56.0	41.8	52.9	53.7	67.4	46.8	65.8	44.8	58.1	54.5
2010 GHS	52.7	55.8	52.4	48.9	75.4	57.4	64.1	50.5	60.4	55.9
2011 GHS	67.0	68.4	57.6	51.5	78.1	62.2	54.5	52.0	65.6	61.9

Source: Day & Gray (2013)

Proposed Solutions

- Articulated in the NHI Green Paper (2011)
- Wide-ranging and ambitious healthcare sector reforms
- Aim of universal coverage (increased social solidarity)
- Aim to decrease inequality and inefficiency
- Relatively long-term implementation time line
  - Theoretically 14 years from 2011 (2025) but likely much longer
- Strong emphasis on primary and preventative care
- Single-payer solution
- Insurance solution (as opposed to just a purchaser/provider split)
- Emphasis on a single tier

Pluralistic Approaches to Financing

Medical Schemes 101

Primary financing mechanism for private healthcare in South Africa

Not-for-profit entities owned by their members

Social solidarity principles:
open enrolment, community rating and prescribed minimum benefits

Medical Schemes and NHI

Current

- Criticisms of medical schemes
- Insufficient regulatory attention paid to the current stability, sustainability and affordability of medical schemes

Pre-NHI

- Concern that NHI preparations may be compromised by increased instability of medical schemes
- Pathway to manage transition to NHI

NHI

- Uncertainty over role of medical schemes

Does the current system achieve solidarity?

Fragmentation (323 benefit options → 323 different risk pools?)

Incentives to cherry pick members

Voluntary environment → anti-selection

Limited extension of cover, buy down and deregistering of beneficiaries

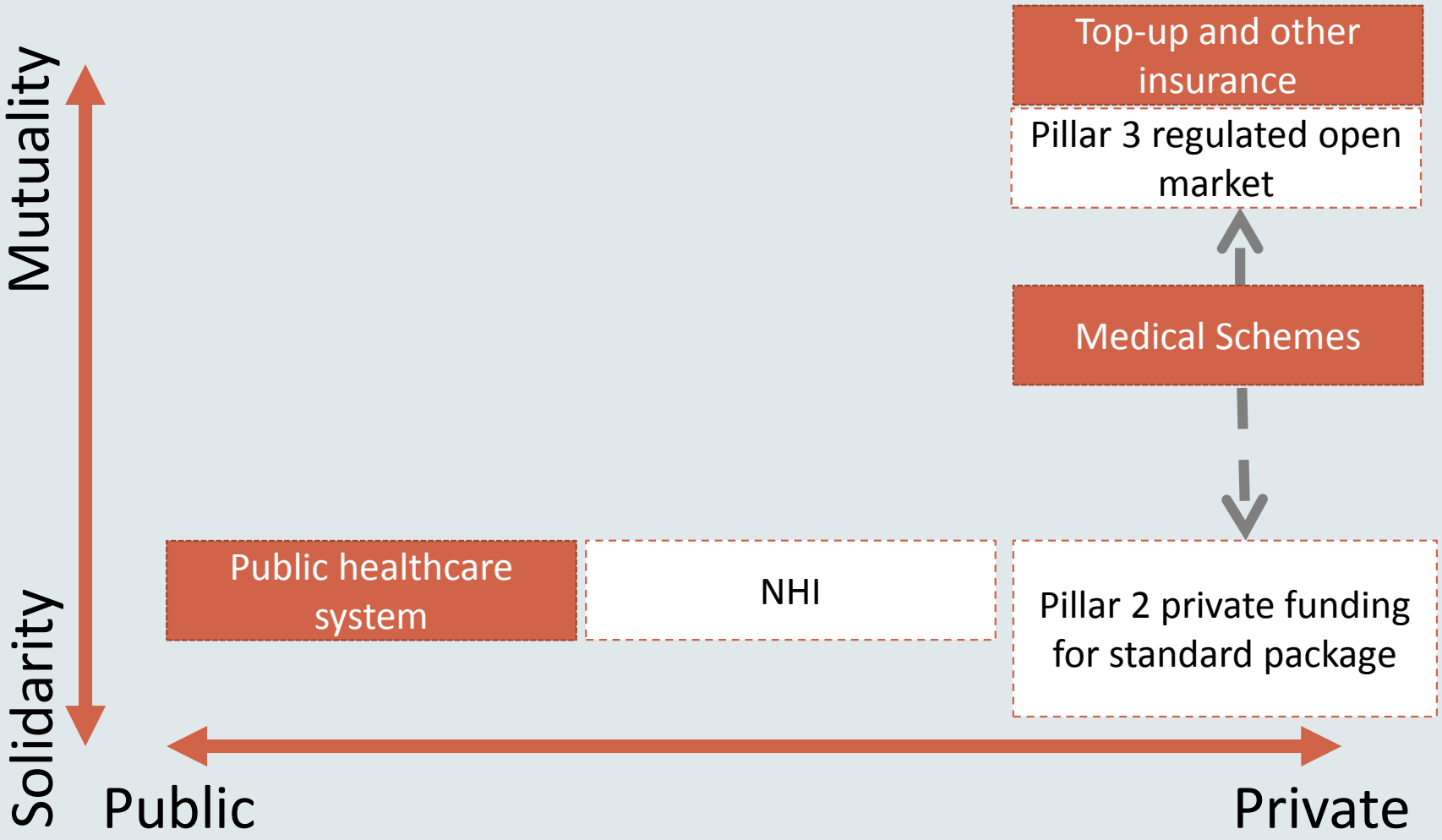
Limited income cross subsidies – below tax threshold?

Income rating in 20% of open options

A pluralistic approach makes sense

- Advocated by the ILO as a mechanism for achieving universal coverage
- Achieve both solidarity and subsidiarity goals
- Private health insurance is part of multipronged approach
- Not a simple replacement for NHI
- Allows us to use what we already have

But clarification of roles is required



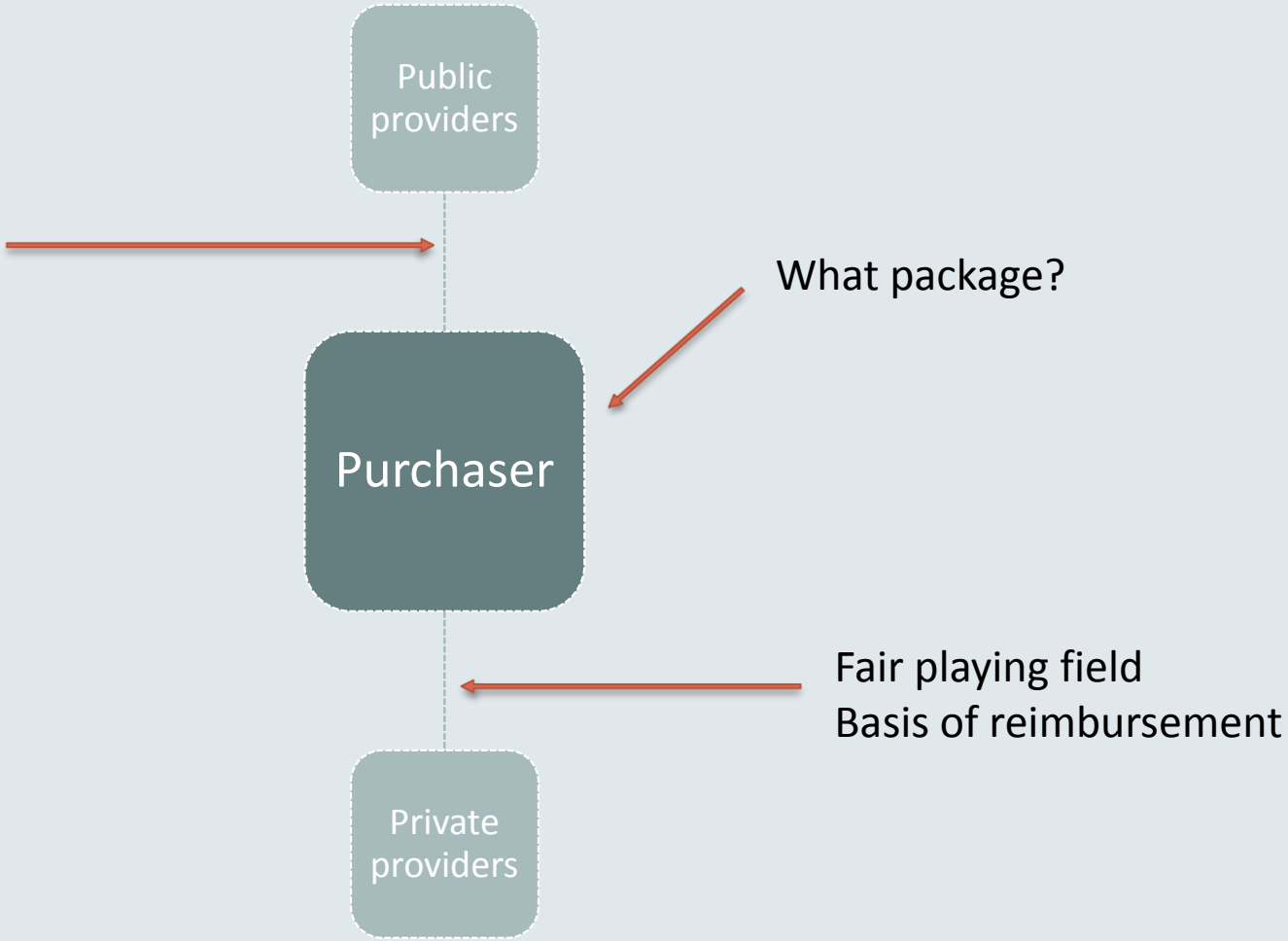
Take the wheel

- Strengthened solidarity for pillar 2
  - REF will reduce fragmentation by creating a virtual pool
  - Schemes share the risk and no longer compete on the basis of risk profile
  - Focus on efficiency, value proposition and price
  - Will require a common benefit package (revised PMBs)
  - Income cross subsidisation that is congruent with NHI vision
  - Compulsory contributions for upper-income households to limit anti-selection
- Critical in (at least) the interim period before NHI implementation

Plurality of Provision

The purchaser/provider split and plurality of provision

Purchaser/ provider split has implications for the purchaser, but also for the provider



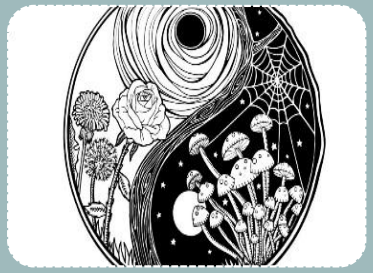
Delivery challenges

- Human resource constraints
  - Movement between sectors
  - Scope for collaboration on training
- Issues of efficiency
- Urgent need to strengthen public-sector delivery (focus of first 5 years of “NHI”)
- The private health sector acknowledges the difficulties associated with the current fee-for-service model, exacerbated by third-party payment

Comparison of Public and Private Hospitals

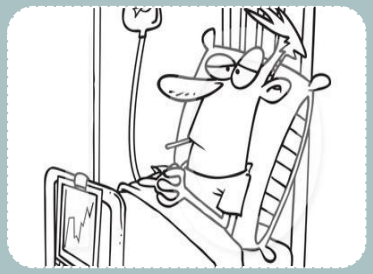
Structural differences in costs

- Taxation, cost of capital, preferential purchasing, staffing arrangements



Differences in “nature”

- Stakeholders (ownership, management, funding)
- Objectives & incentives



Differences in patient case-mix

- Dual healthcare system
- Activity mix

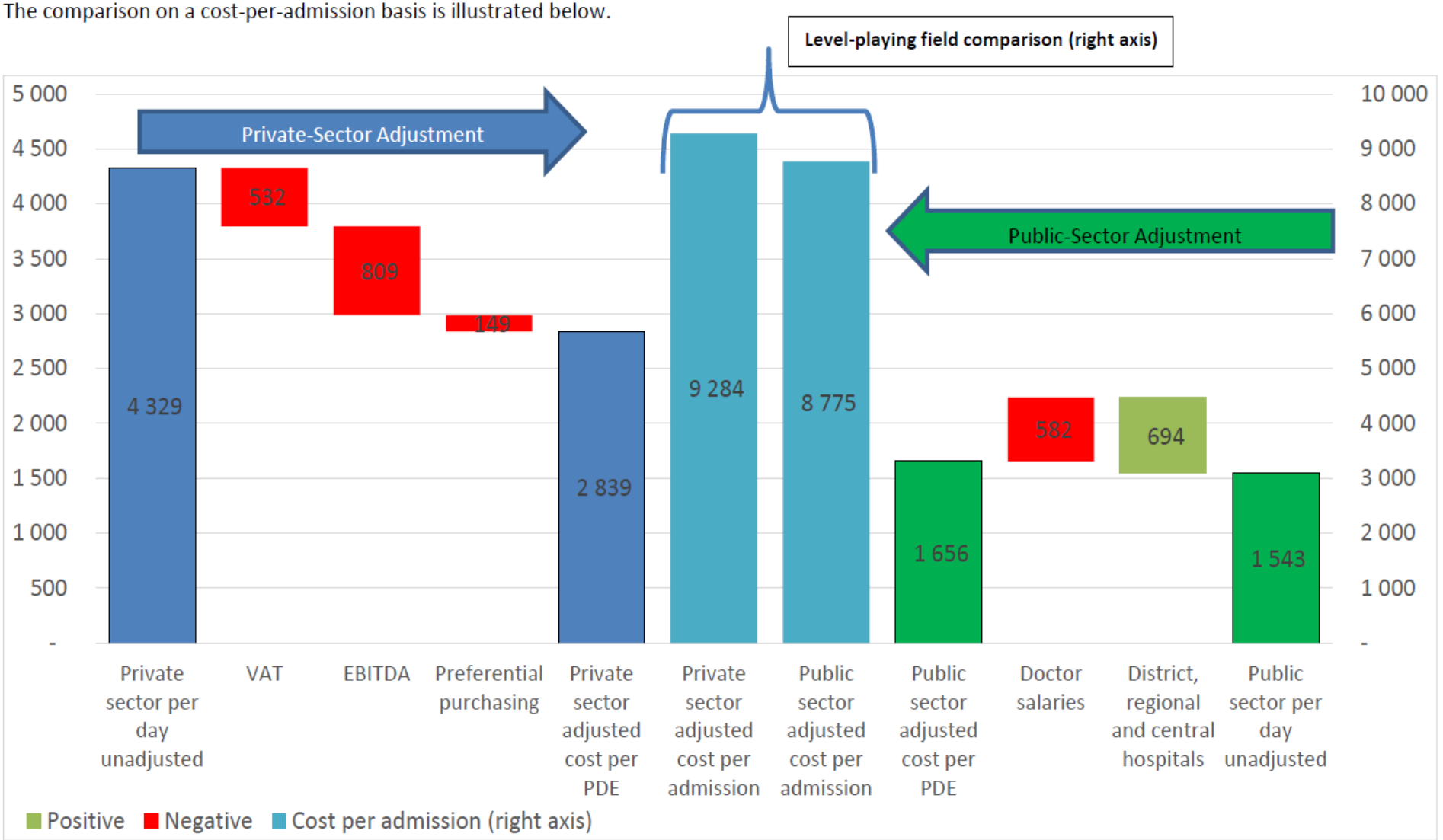
Differences in quality

- Difficult to measure
- Various components (e.g. structure, process, outcomes)

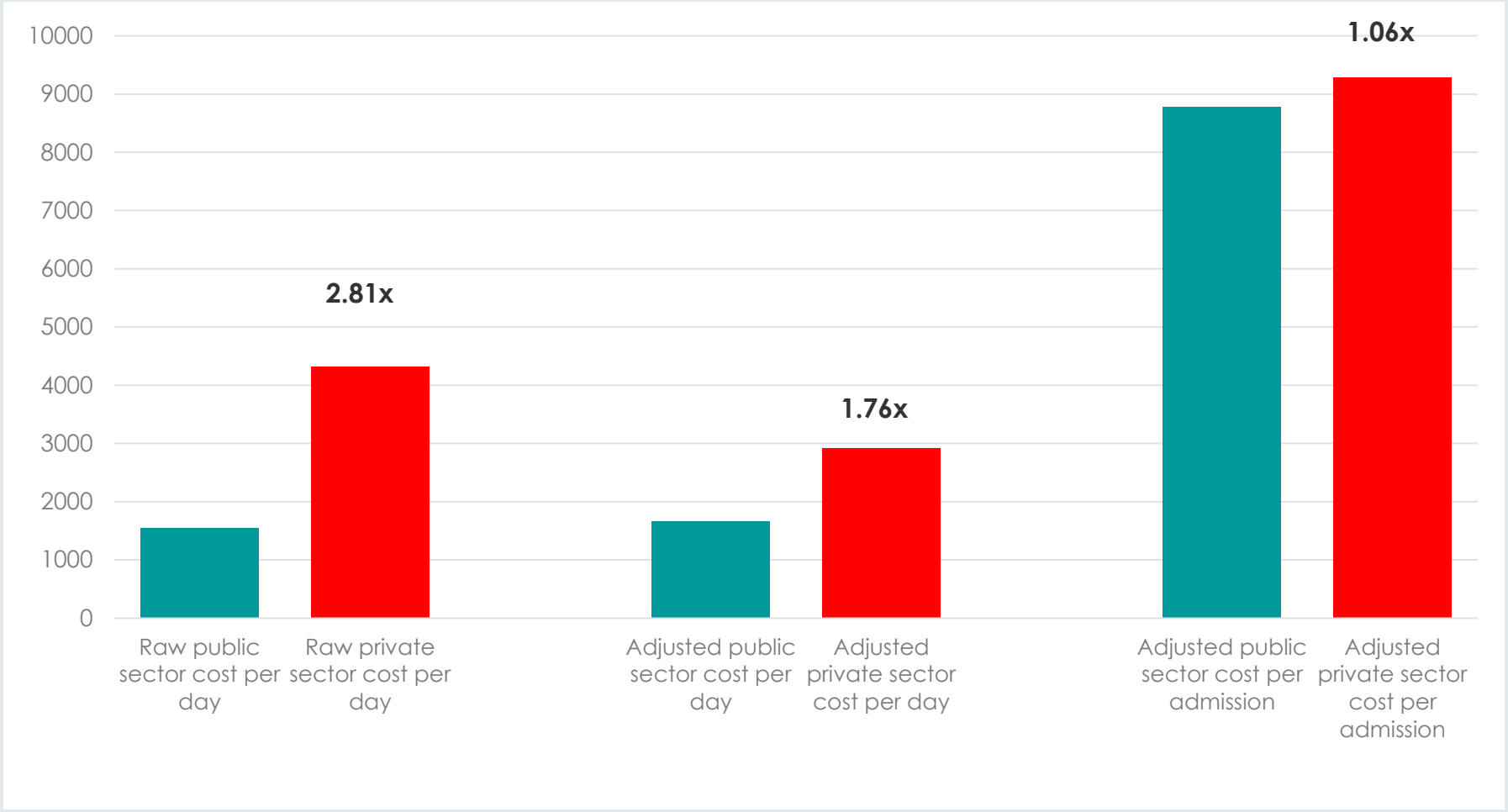
Why bother?

- Informal comparisons already exist
  - Perceptions of cost differentials can drive policy decisions
  - Threat of regulatory intervention in the private sector that is predicated on perceptions of inefficiency (for example, price regulation for the private sector)
- Doing a comparison can reveal a lot
  - Inadequacies of available data
  - Deeper understanding of structural differences between the two sectors
  - Greater awareness of the pitfalls of simplistic comparisons
  - Highlighting the extent to which there is not a level playing field

The comparison on a cost-per-admission basis is illustrated below.



Base scenario results



Discussion

- Results indicate a far smaller differential in the costs of delivery than implied by current rhetoric.
  - Plurality of provision is a policy option that requires serious consideration.
  - Worth noting that rhetoric often based on “per capita per annum” costs, which introduces further distortions (for example, protocols, access, waiting lists and denied care)
- Clear need for rigorous comparisons of the private and public hospital sectors in South Africa
  - Risk of policy decisions being made on the basis of polarised perceptions and broad characterisations of the two sectors.
  - Necessity of ensuring that comparisons adjust appropriately for structural differences between the sectors