Health Financing for Universal Health Coverage: Messages for South Africa?

World Health Organization

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Overview

Operationalizing UHC

WHO's approach to health financing

Some lessons from experience with potential relevance to South Africa

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UHC and public policy

UHC, defined

Enable all people to use the health services that they need (including prevention, promotion, treatment, palliation and rehabilitation) of sufficient quality to be effective;

Ensure that the use of these services does not expose the user to financial hardship

- World Health Report 2010, p.6

Making it operational: a direction, not a destination

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"Moving towards UHC" means progress on one/ some/all of the following (progressive realization)

- Reducing gap between need and use (equity in use)
- Improving quality
- Improving financial protection

Offers practical orientation for policy reforms

- Approach relevant to all countries
- What are the ways that we are under-achieving on these goals? What obstacles to progress must be addressed?
- Reform needs to be about solving problems, not picking a model

UHC changed (or should have) the basis for public policy on health coverage (1)

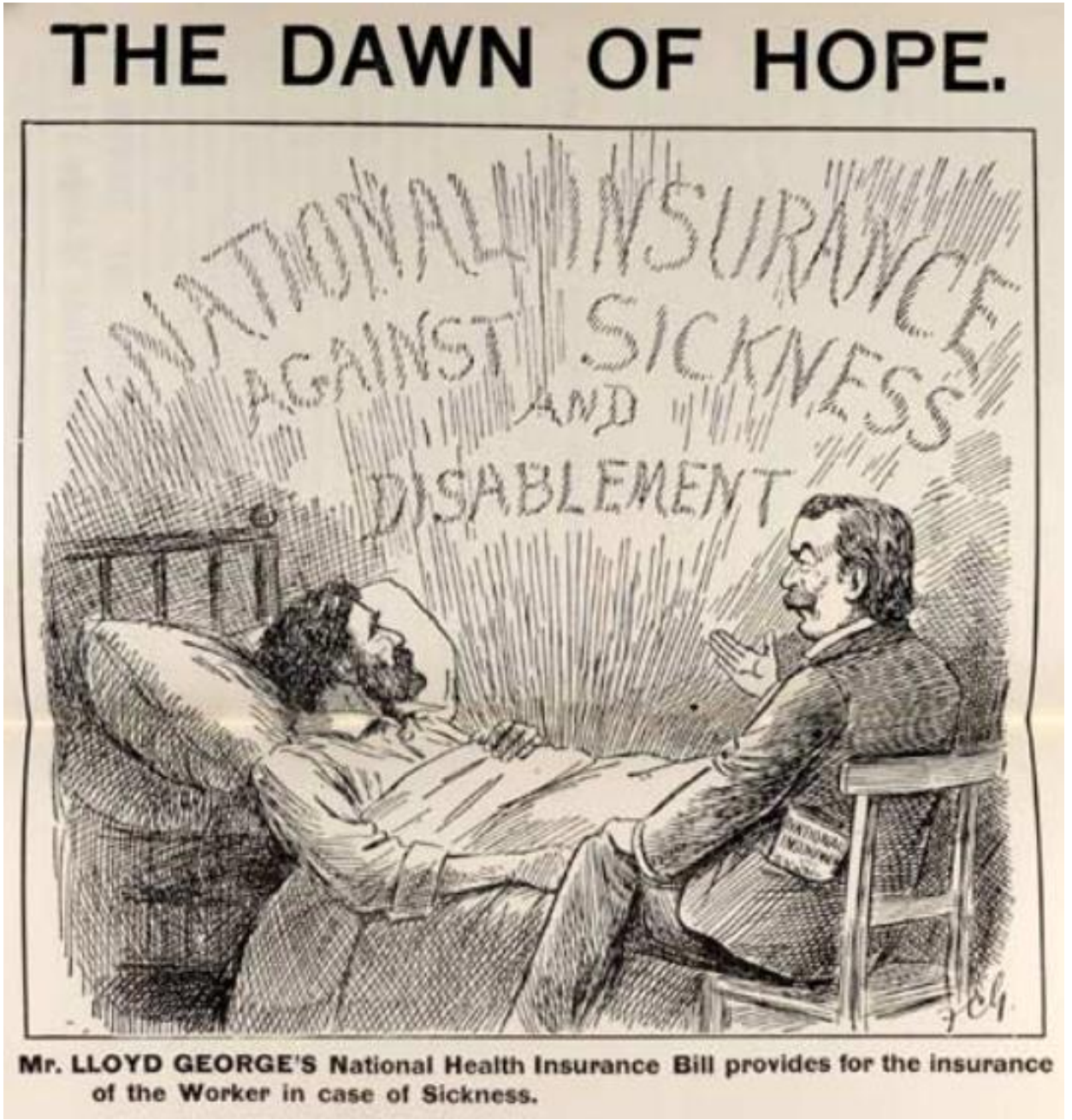
Coverage as a "right" (of citizenship, residence) rather than as just an employee benefit

- A major but often unrecognized shift in the logic that prevailed prior to WW-2
- Critically important implications for choices on revenue sources and the basis for entitlement

NHI in the UK, 1911

Risk covered by "health insurance" was loss of wages when ill and unable to work (protection for workers, not entire population)

This rationale no longer applies!



Source of slide: Sarah Thomson, WHO Barcelona Office

What UHC implies for revenue sources and entitlement

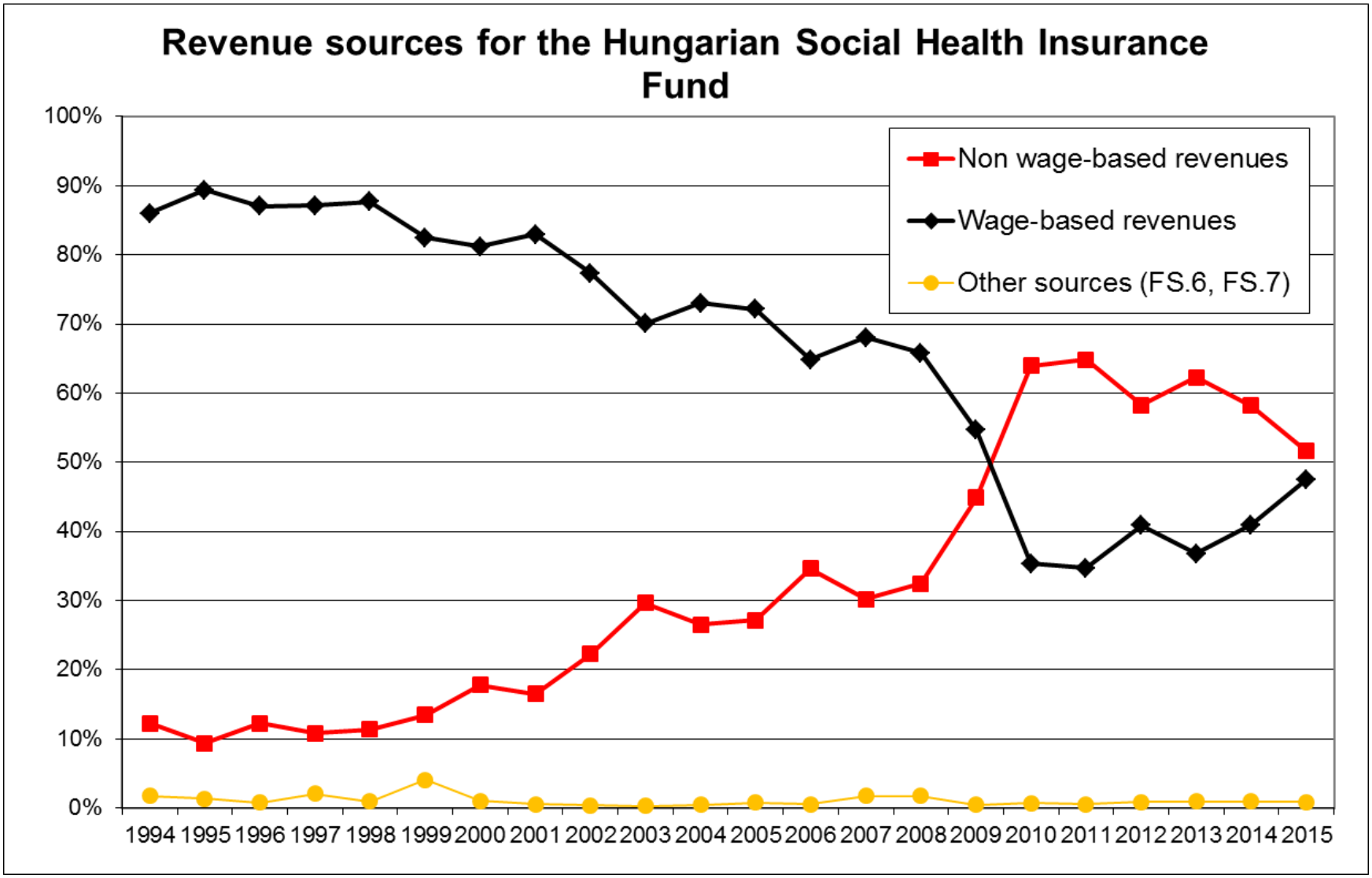
Progressive de-linkage of health coverage from employment status

Shift in revenue mix from specific contributions for health insurance to general government revenues

LMICs – all recent coverage expansions reflect this approach

- India, Indonesia, Gabon, Thailand, Mexico, Peru, China, Philippines, Ghana…

Many HICs also moving towards "tax-funded health insurance"



Source: Szigeti et al (forthcoming). WHO/Hungary Country Office

UHC changed (or should have) the basis for public policy on health coverage (2)

Unit of Analysis: system, not scheme

- Effects of a "scheme" or a "program" is not of interest per se; what matters is the effect on UHC goals considered at level of the entire system and population
- Assess goals embedded in UHC at the population level…
- …because a scheme can make its members better off at the expense of everyone else

UHC is an explicitly political agenda, because it requires redistribution

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WHO's approach to health financing

The functional approach

Regardless of label, all health financing arrangements involve

- Revenue raising
- Pooling of funds
- Purchasing of services (allocation to providers)
- Policy (explicit or implicit) on benefit entitlements and rationing

It is not the case that the Germans are "more insured" than the British just because their system carries the label "insurance"

What we care (and don't care) about

We care about how well financing arrangements "insure" their populations

- Promoting use in relation to need, financial protection, and quality
- Countries need to tailor their financing arrangements to their context, guided by these objectives
- Almost certainly, South Africa's NHI will not conform to traditional notions of "insurance" – you have choices

We don't care what you call it – whatever works to communicate effectively with your people

- Think/plan with functions, sell with labels

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Health financing for UHC: some lessons from experience with potential relevance to South Africa

Messages/lessons for the transitional implementation

Build foundations for more equitable, efficient, transparent, and adaptable health system

- Choices made for implementation steps should reflect this
- Avoid “locking in” inequalities and inefficiencies that will be hard to undo in the future
- There is no magic to NHI or UHC; it will take hard work (reflected in the proposed Commissions)

Some criteria/principles to guide implementation

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1. Accountability and public reporting

2. Design in equity and universality from the beginning

3. Address areas of potential conflict of interest

4. One health system per country

5. Combine central guidance with managerial flexibility (results, not “compliance” and control), to move towards a data-driven, thinking health system

1. Accountability, transparency, reporting

Reducing fragmentation and strengthening purchasing power is the great potential advantage of single payer arrangements

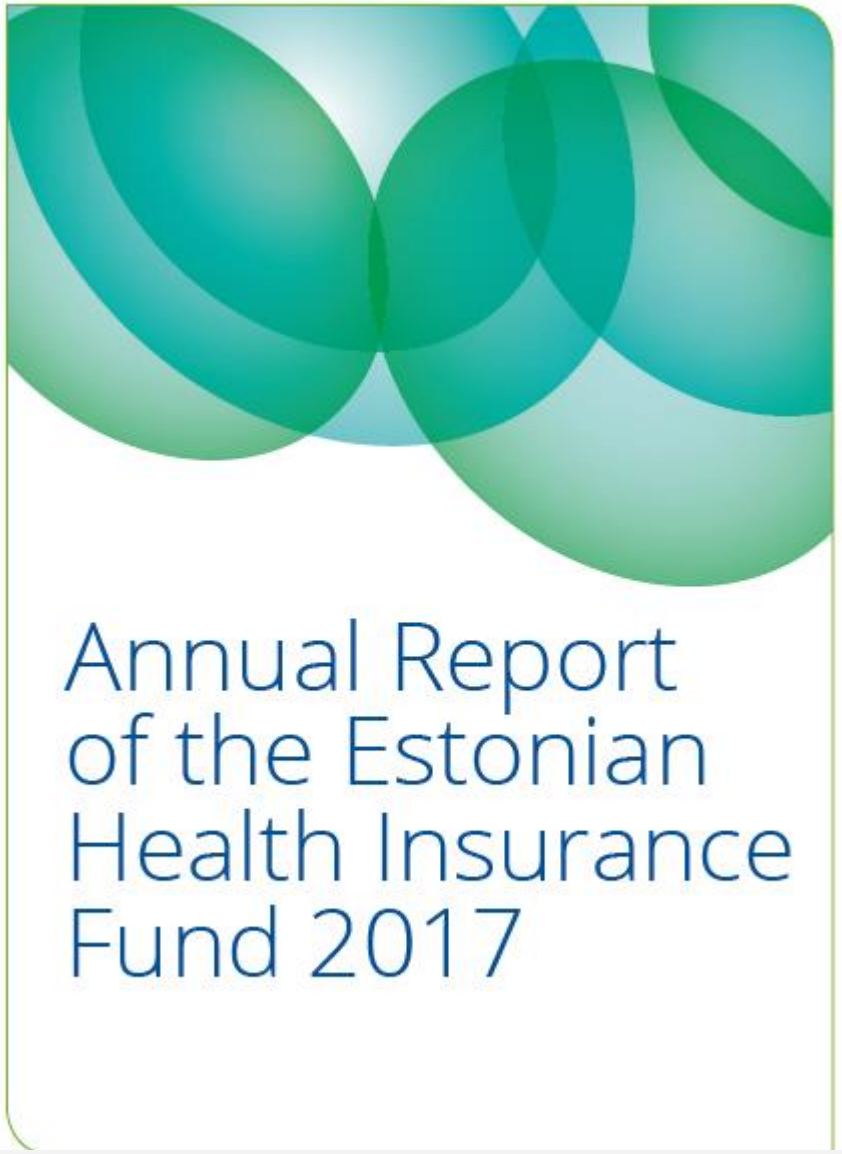
- Many good examples (Costa Rica, Estonia, Turkey, Hungary, Lithuania, Kyrgyzstan, Moldova, Philippines, and most recently Indonesia)

But putting all the money in one place is also a risk (Kazakhstan's experience in late 1990s)

This is non-negotiable

Mandatory public reporting on the use of funds and results achieved by the new NHI agency

There are good (great) examples from which to learn



https://www.haigekassa.ee/en/organisation#tab-annual-reports

2. Design universal, pro-poor approach into early implementation

If you start with the formal sector using contributory-based entitlement, you will "lock in" segmentation

- Vested interests block unified approach including informal sector and poor
- Even the reformers in Mexico and Thailand could not fully overcome the legacy of the historical link of health coverage to employment

Avoid separate public schemes/pools for different population groups – that's a recipe for long-term inequity and inefficiency

Practical steps to lay foundation for a universal system

Unify information platform on patient activity, regardless of insurance affiliation status

- Technical foundation for universal system (Kyrgyzstan, Korea, Maryland/US)

Get diversity in the pool and common benefits at first stage (e.g. formal and poor, formal and informal), even if you can't get everyone in immediately – set the precedent (Moldova, Kyrgyzstan, Indonesia)

3. Address conflict of interest…NOW

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This is a fundamental governance responsibility for those leading the health system

Conflict of interest is a source of inefficiency and potentially "bad medicine"

- USA: physician owners/investors of hospitals and diagnostic centres to which they refer (a poor county on Texas-Mexico border has highest Medicare costs in the country as a result of this)

Chinese public hospitals: incentives aligned to induce unnecessary tests

Source of slide: Prof. Winnie Yip

All staff of the hospital are investors in the CT scanner with objective to maximize its use

More generally: why you can't just spend your way to UHC

China vs Thailand during 2000s

- Both greatly increased public spending and affiliation to health insurance programs
- In Thailand, service use and financial protection improved due to coherent, closed end provider payment policies that managed spending growth.
- NOT the case in China: open-ended fee-for-service with percentage co-payments shifted money to providers, and burden to patients

Conflict of interest in South Africa?

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As medical scheme expenditure increases, so do the earnings of Administrators

- No incentive to control cost growth
- No incentive to see a 70% c-section rate as a problem
- No incentive to move away from open-ended fee-for-service reimbursement

So premiums rise and benefits shrink – consequences of this inefficiency are shifted to patients (and employers, including government)

Is there a way to alter these incentives so that they are aligned with public policy concerns?

4. One country, one system

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Technical perspective

- The public and private delivery and financing arrangements in the country, like any country, have interactions and spillovers

Political perspective

- The core foundation for NHI is a recognition that the financing and delivery "architecture" of the health system has not changed much since 1994

Globally, South Africa is an extreme outlier: do we care?

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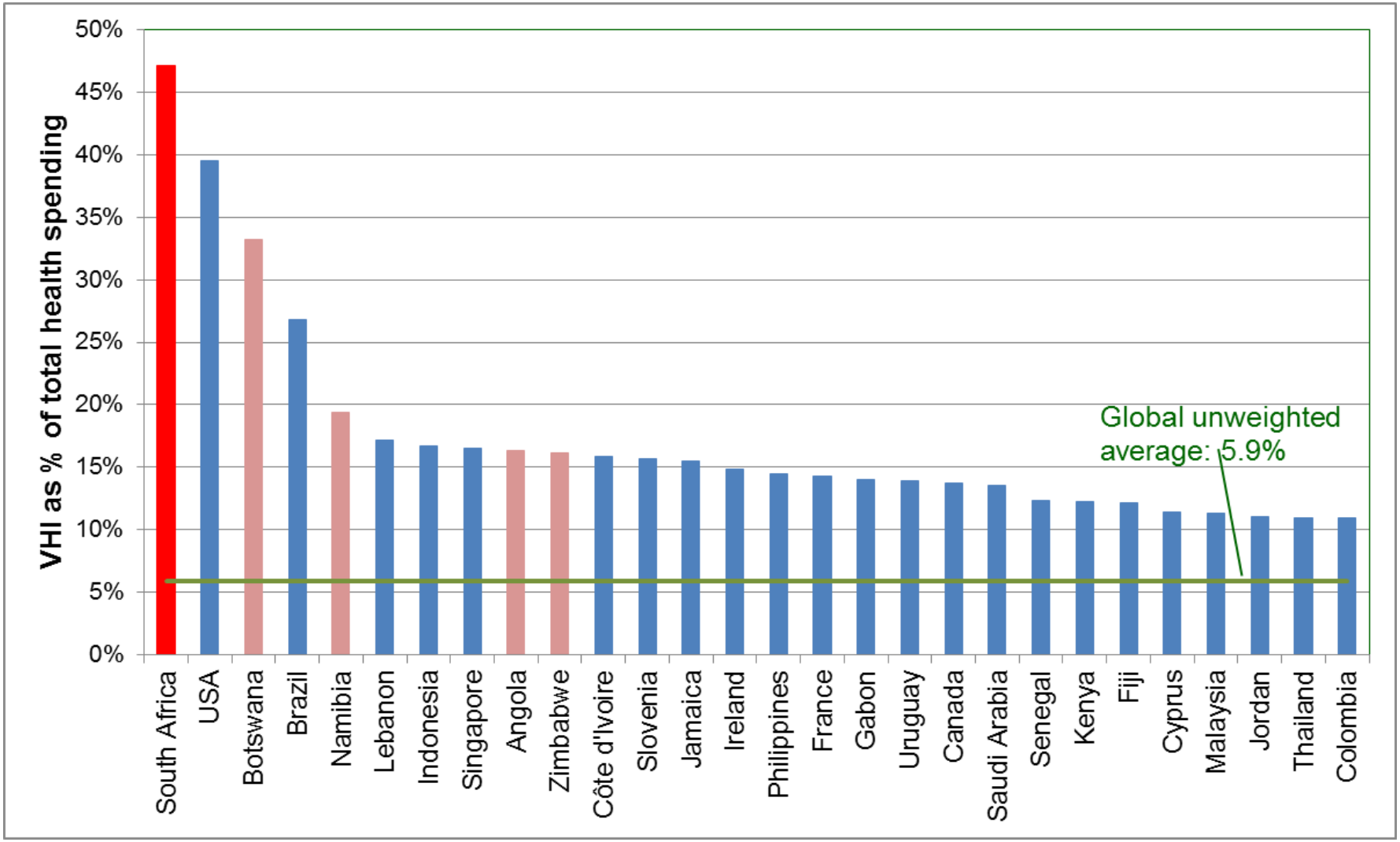

Source: WHO Global Health Expenditure Database

VHI is not necessarily a problem, but here in SA, it's a driver of system inequity and inefficiency

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Population coverage with VHI compared to percent of health spending via VHI

Country	Voluntary health insurance		
	Population coverage	Share of health spending	Role
France	90%	14%	Complementary
Slovenia	84%	16%	Complementary
UK	9%	4%	Supplementary
Kenya	1-2%	12%	Duplicative
South Africa	16-17%	47%	Duplicative

Source of European VHI population coverage data: Sagan and Thomson 2016; data for latest available year

Why the private medical sector is a public policy concern

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Spillover effects

- diversion of scarce (especially human) resources to serve the insured, at expense of the poorer population
- High prices also push up input costs across system
- Fiscal impact – premium increases for civil servants

Harming patients

- Some of the high costs are due to dangerous practices (e.g. 70% c-section rate for privately insured)

What is South Africa, and what do you want it to be?

- Since 1994, public policy based on this being one country

5. From "command and control" to local problem solving within clear policy framework

Focus on accountability for results, not control of inputs or just executing budget line items

Central planning is good for setting high-level objectives, but not for responding to diverse needs of a large country in a timely manner

Many countries have had success with "managed autonomy" as well as harnessing the brainpower of local managers

For example

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Ghana in the 1990s

- Each Regional Directors of Health Services was encouraged to establish an Operations Research Unit to investigate and develop local solutions to local problems
- Empowered District Health Teams (which formed part of the Unit)

In Mexico's decentralized system

- Annual meeting of State Health Departments to review comparative performance data and share experience with changes introduced

A specific health financing issue

The gains from "strategic purchasing" can only be realized if managed have some degree of autonomy to manage their internal resources

- Partial autonomy over reimbursements from single payer agency in Kyrgyzstan enabled hospital managers to make large efficiency gains in 2001 that translated into lower informal payments for patients
- Autonomy was not a "giveaway", and is not "all-or-nothing"; providers still had to report on the use of funds and had some limits on their spending decisions

Creation of outpatient drug package in Kyrgyzstan

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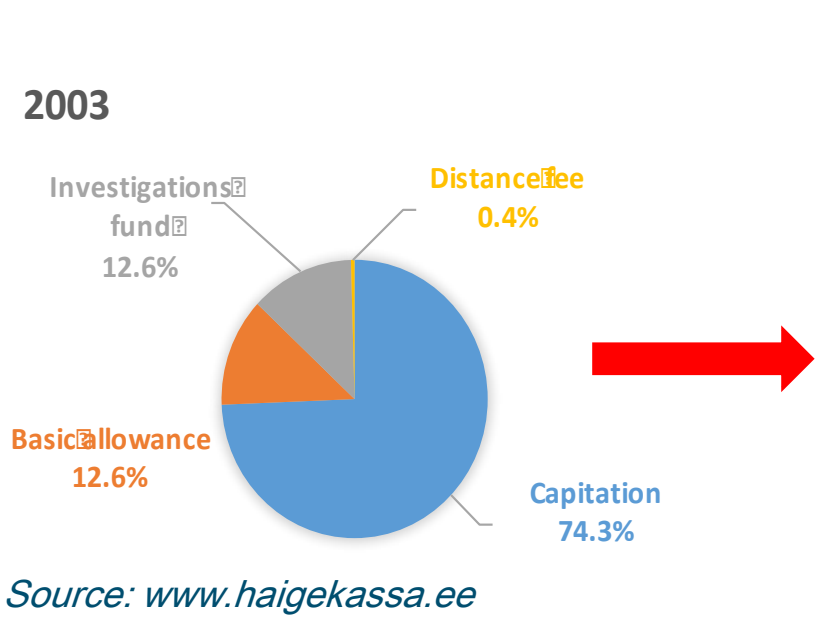
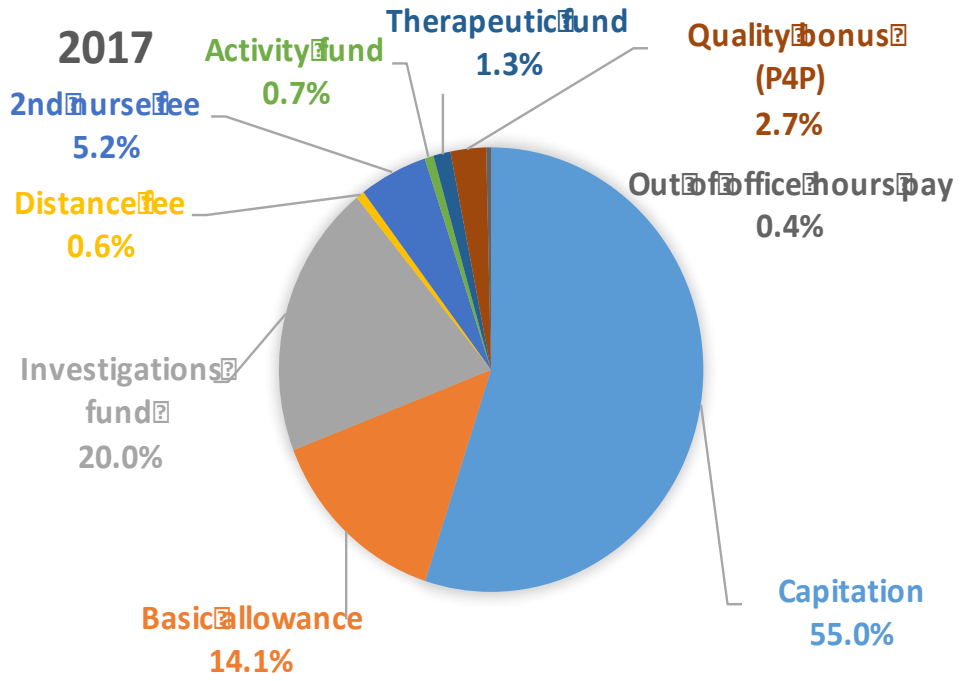
Inpatient database showed high number of cases for PHC-sensitive conditions

Led MHIF and MOH to develop reform

- Outpatient drug package targeted at four conditions (e.g. hypertension)
- Dissemination and monitoring of implementation of new clinical guidelines for these conditions
- Ongoing monitoring and adjustment over the years

Estonia changed its PHC payment system in response to new challenges and more/better data





Source: www.haigekassa.ee

- **All costs** are covered through these different payments
- Over time the role of **capitation** has **decreased**
- **Fee for service** (mostly with cap) part **increases** continuously enabling family doctors to take more role over patient care
- **New incentives**: P4P, out of office hours fee, 2nd nurse fee

Implement, evaluate, learn and adapt

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Need good plan, but recognize that "s_ _t happens"

- Not everything can be anticipated
- Circumstances vary around the country
- Circumstances and needs change over time

Move towards a data-driven, adaptive system

- Unified national provider payment database is a tremendous potential resource
- So is the excellent applied research capacity that exists in South Africa

Government needs to steer these to a common purpose

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Final reflections

Reminder

Financing can't do it alone; it takes a system

The proposed Commissions recognize this – completely agree

The different pieces have to be aligned while not "over-designing" from the central level

- More art than science, but can approach it systematically

Minister's sound principles to guide implementation of NHI in South Africa

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Improve quality in the public sector

Manage cost growth in the private sector

[He says it better than I do, and certainly more concisely]

Summary messages

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Guide specific implementa-tion steps by clear criteria

Design in universality from the beginning (UHC=unified)

Commit to transparency and public accountability

Don't be constrained by traditional notions of insurance

Put in place foundations for equity and efficiency

Implement, evaluate, learn and adapt: ensure space for flexibility