DNA Economics
Making economic sense of common problems

Colloquium on National Health Insurance

International experience

1 June 2016

Funding the South African public health system

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Background

- The demand for health care has risen over the past few decades driven by changing demographics, the rise of non-communicable (lifestyle diseases) and the spread of communicable diseases

- Often the demand for health care outstrips the resources available to fund health care costs

- National Health Insurance schemes are a way of pooling funds and spreading risks

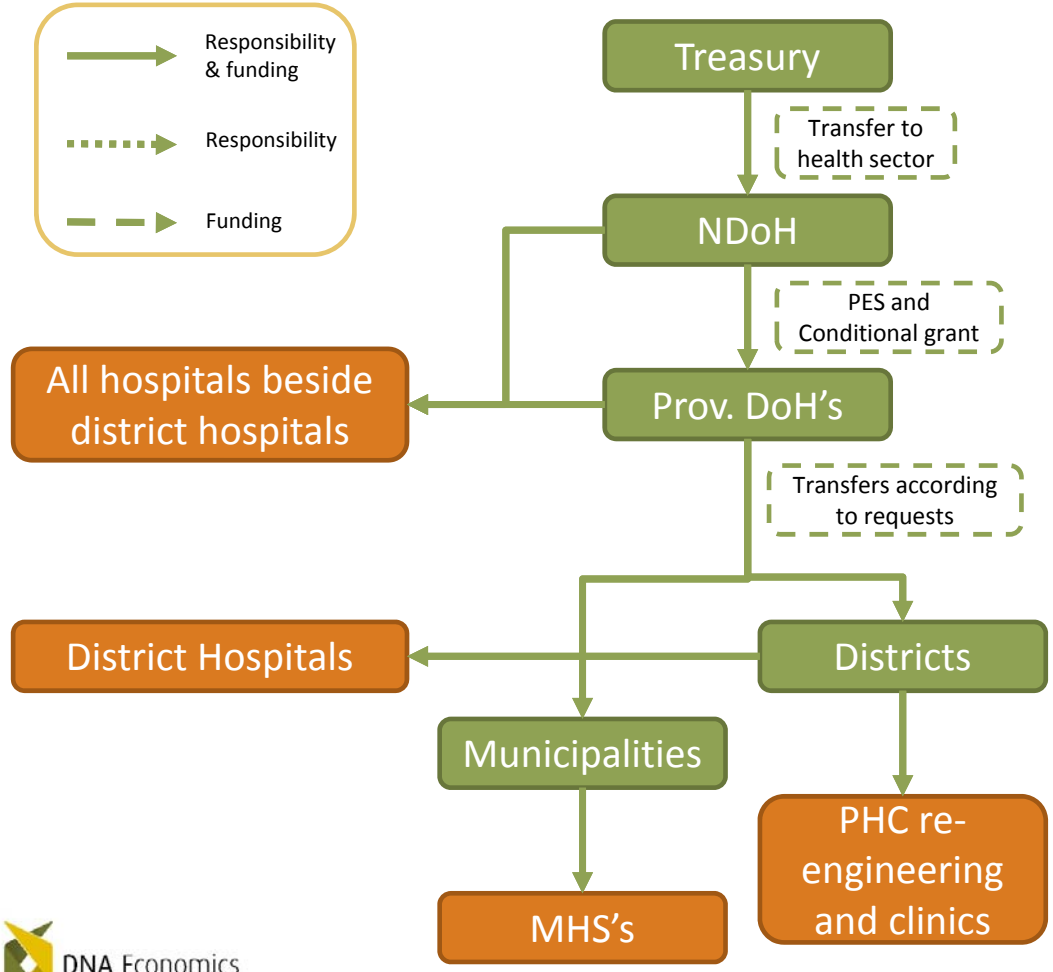
Approach to national health insurance

- National Health Insurance (NHI) is a mandatory insurance scheme that splits the provider from the purchaser and insures all citizens against health care costs
- There are many ways to structure a National Health Insurance scheme:
  - Single payer: A national fund insures all residents and pays for all health expenses; it may require copayment for certain services.
  - Two-tier: The government, through a centralized fund, provides mandatory insurance to all citizens but also allows the purchase of “top-up” health insurance or a “fee for service.”
  - Mandated insurance: The government has no central fund but requires all citizens to enroll in either a public or private health insurance programme

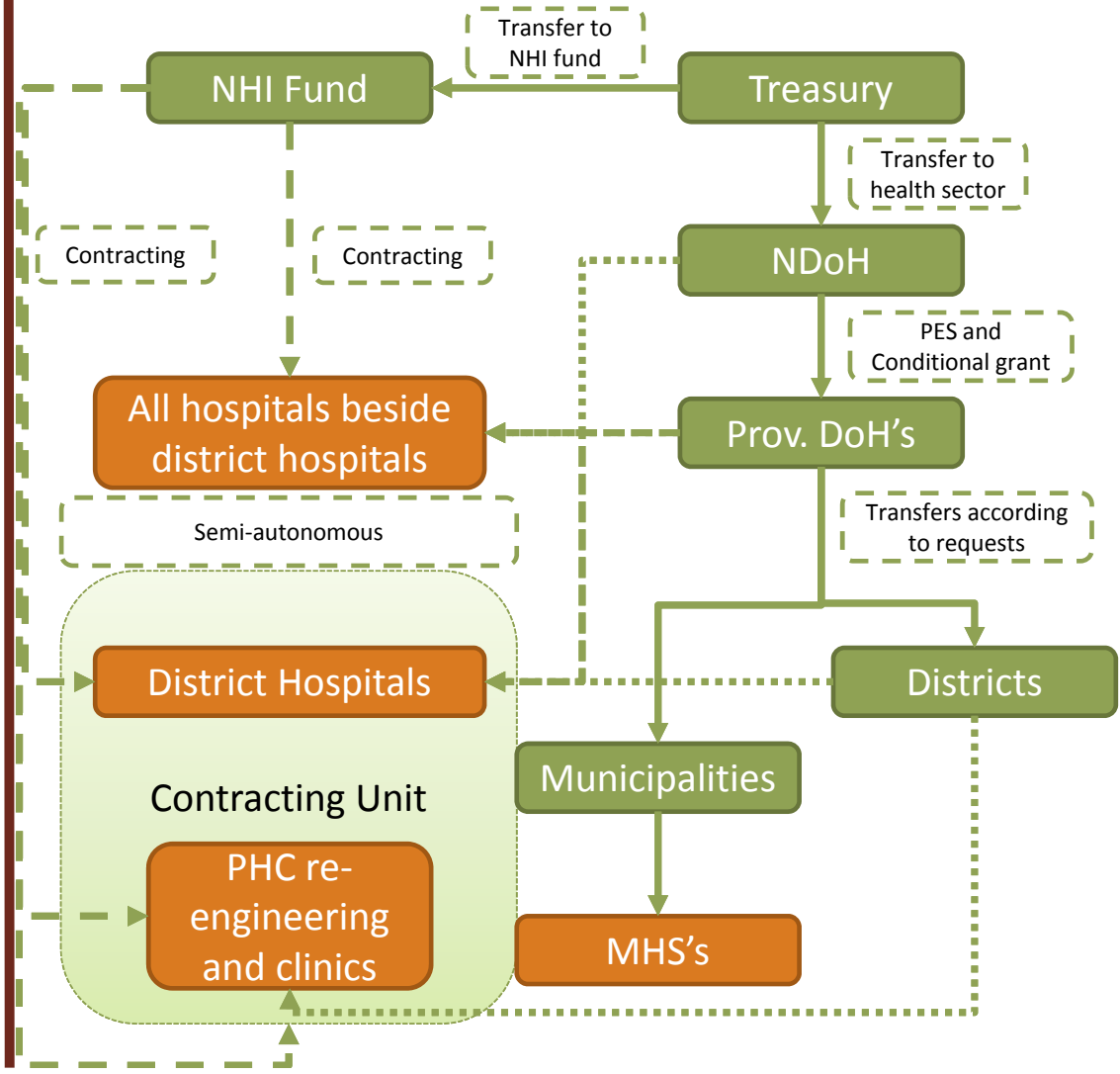
Purchaser-Provider spilt

- In all three cases, health services are provided by public, private or a combination of public and private providers which are all split from the purchaser
- Why split the purchaser from the provider?
  - Could potentially create healthy competition between providers
  - Outcomes, roles and responsibilities can be contractually defined at service provider level
    - This could improve responsiveness to patients
    - Improve accountability
    - Leads to a clear focus on individual responsibility
    - Can improve the management capacity of those in charge

Current health system



Proposed system



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International experience

What can we learn from other countries?

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Research questions

- How is the health system structured in comparator countries?
- How does funding flow from the health insurance fund to public providers?
- On what basis are funds disbursed to public providers?
- How were reforms to the IGFR sequenced in these countries during the implementation of the NHI?
- What are some of the lessons for South Africa?

How were the countries chosen?

- Criteria for the selection of countries
  - A National Health Insurance
  - Emphasis on primary health care
  - Defined functions for sub-national spheres of government
  - A spread across the income spectrum

Vital statistics of comparator countries

	South Africa	South Korea	Thailand	Poland	Australia
Life expectancy at birth	60	82	75.	77	83.
Infant mortality rate (Per thousand liver Births)	36	1	9	2	1
Population	53 969 000	50 474 000	67 726 000	38 017 000	23 219 000
Unemployment rate (%)	24.9	3.5	0.9	9.2	6.0
GDP (US$ per capita)	6 482	27 943	5 519	14 335	64 009
Total Health Expenditure (% of GDP)	8.8	7.4	6.5	6.4	9.4

Australia

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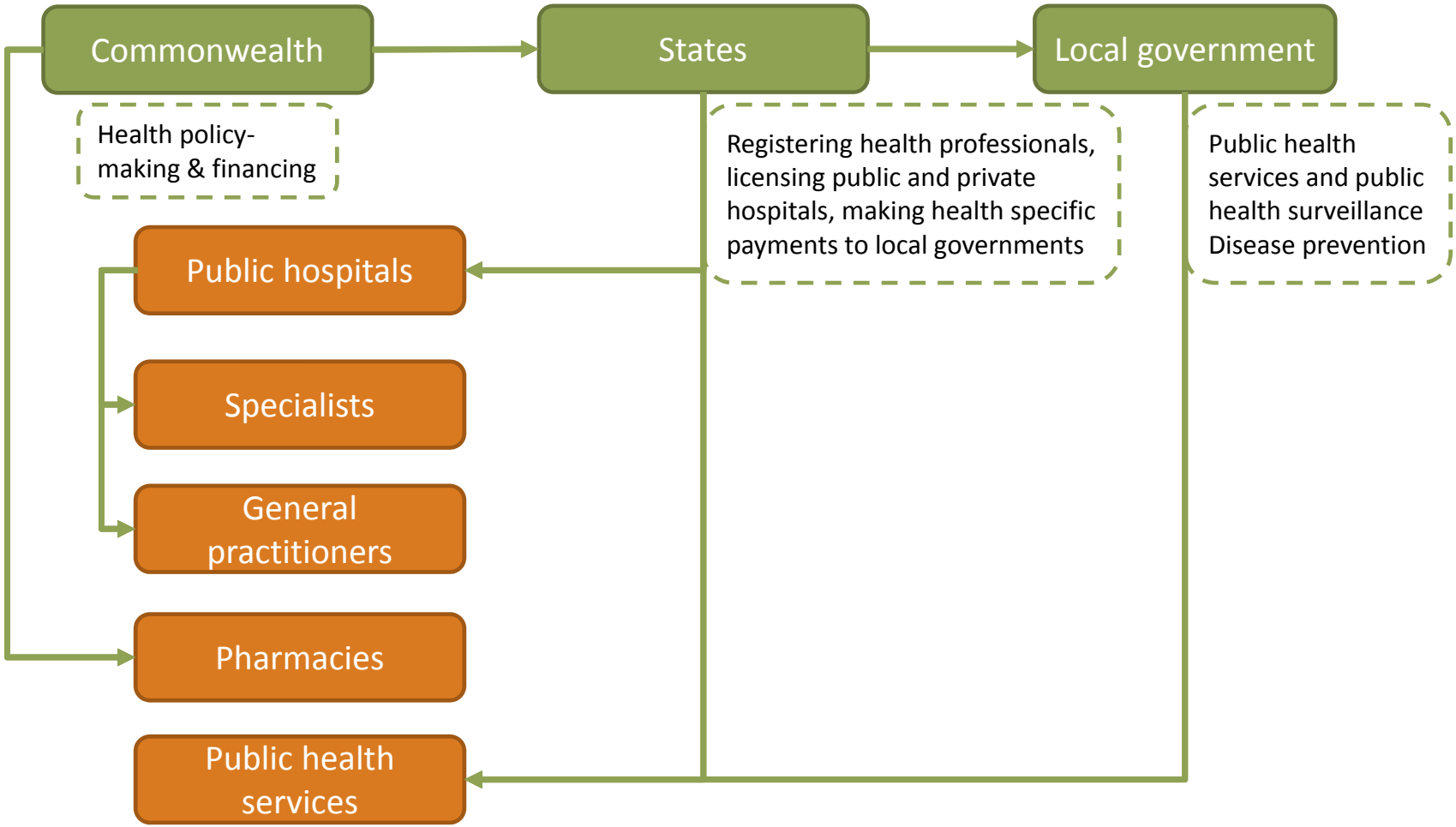
Overview

- Predominantly a tax-financed system – services subsidized through the National Health Insurance Scheme
- Health insurance scheme is called Medicare
  - Offers patients access to doctor of choice for out-of-hospital care, free public hospital care and subsidised pharmaceuticals
  - Contributes funds to the states to run public hospitals
- Introduced in 1984 to provide free or subsidised treatment by health professionals
- Aim was to give all Australians access to adequate, affordable health care, irrespective of their personal circumstances.

Health system



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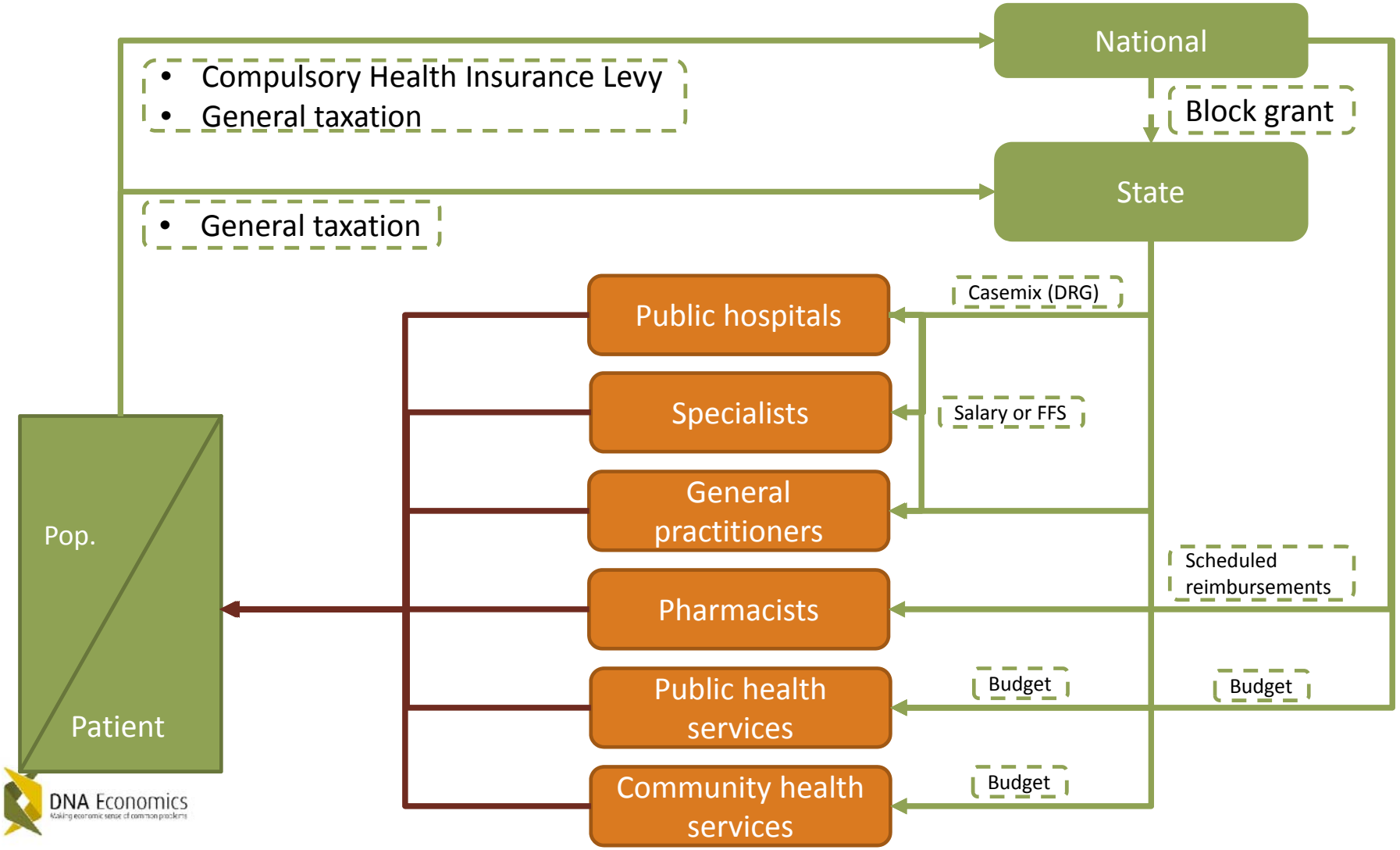
Health System Funding and Financing



Health reforms (1)

- The idea of a NHI scheme was introduced in Australia in the early 1970s
- Faced strong opposition from the private sector and opposition parties
- The proposed legislation was rejected due to a parliamentary deadlock
- Eventually agreement was reached and Medibank was introduced in 1975.
  - Mandatory health insurance

Health reforms (2)

- Between 1975 and 1983, a series of changes were made.
  - individuals could opt out of Medibank and purchase private health insurance or
  - Pay a levy of 2.5% of taxable income to remain in the scheme; i.e. Voluntary Insurance
  - By 1981, many people had dropped out
    - Decreased the size of the pool and left a lot of people uninsured
- In 1984, the fund was re-established as a tax-funded health insurance system (Renamed to Medicare)
- The lesson: Allowing for voluntary membership can have a large impact on the size of the pool. Not only does it affect those that choose to be uninsured, but increases the risks of those that remain in the fund due to a decrease in the funding available for health care.

Poland

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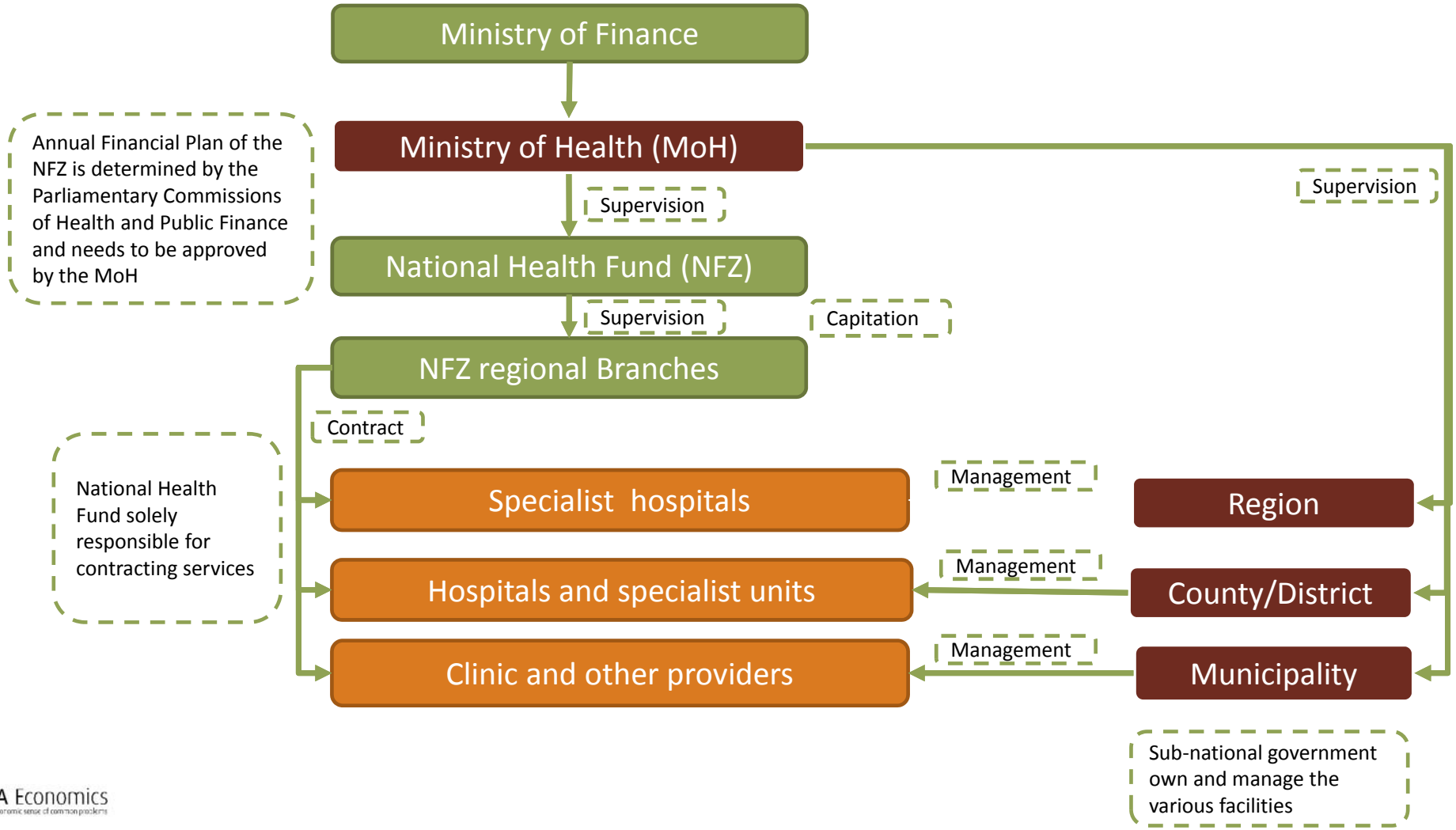
Overview

- All citizens, regardless of their financial circumstances, have the right to equal *access* to health services
- Ministry of Health is the key policy-maker and regulator in the system
- National Health Fund (NHF) – Established in 2003
  - Negotiates and signs contracts with service providers
  - Monitors the fulfilment of contractual terms
  - In charge of contract accounting
  - Health promotion such as the publication of information in the area of health promotion and awareness

Health System



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AJ43
AJ44
AJ46

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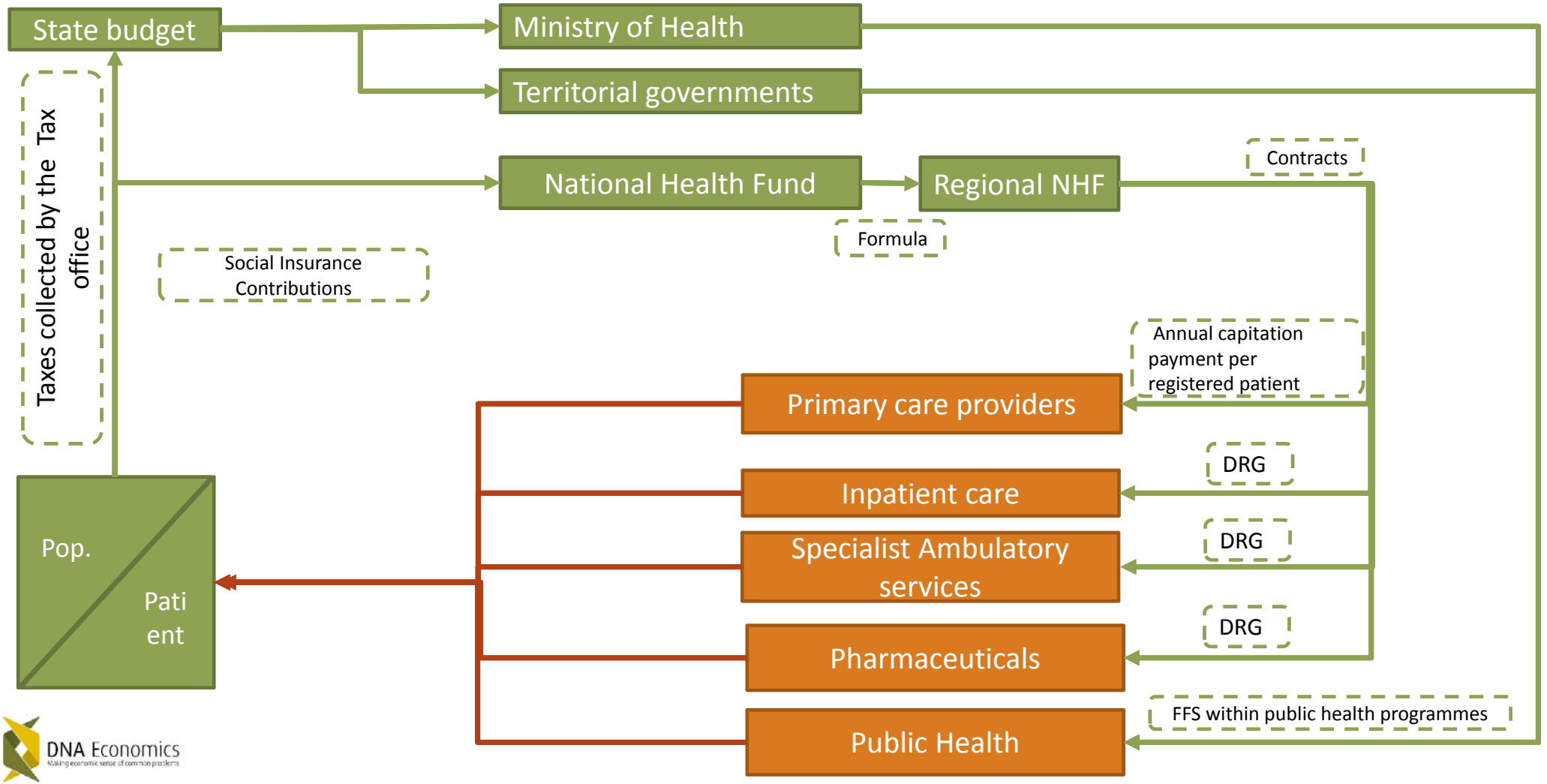

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Slide 20

AJ43 I would say funding and financial flows
Amanda Jitsing, 2016/05/31

AJ44 Don't use acroynms, like everyone will know and understad t.
Amanda Jitsing, 2016/05/31

AJ46 I think you need to explain clearly what goes to the Health Fund versus other types of expenditure that go to the MOH, Other Ministeries and Territories
Amanda Jitsing, 2016/05/31

Health reforms (1)

- Post –soviet reform (1991- 1998) focussed on health care decentralization
  - Authority over public health care was transferred from the Ministry of Health down to the regions and, to a lesser extent, to the *municipalities*
- Universal Health Insurance commenced in 1999 with the creation of 16 sickness funds in each region
  - Lack of a unified strategy and contracting principles
  - Application of different payment mechanisms for contracted services
  - Infringed the “equity” rule prescribed in the Constitution
- Sickness funds were replaced by a single central insurance (NFZ) in 2002

Health Reforms (2)

- 2003 Law on the Universal Health Insurance
- Declared unconstitutional
  - imprecise formulation could lead to discretionary decision-making in the system
  - no precise definition of guaranteed services
  - lack of mechanisms to control NFZ's finances by the treasury, parliament and the insured population
  - lack of definition of the relationship between the NFZ and the state's budget, which could potentially imply the state's responsibility over NFZ's debts; and
  - overlapping competencies of the NFZ and the Ministry of Health and lack of precisely delineated supervisory powers of the Ministry of Health
- Replaced by the 2004 Law on Health Care Services Financed from Public Sources.

Lessons from Poland

- Market power of the lone purchaser:
  - The NFZ has often been criticized by health care providers on the grounds of its abuse of market power
  - Reform proposals to split the fund into competing funds have been put forward
  - However, this goes against one of the important reasons for a single payer system – containment of costs
- Mechanisms should be in place to regulate or manage the NHI Fund's finances
- The relationship between the state's budget and the NHI fund should be clearly defined
  - Who is ultimately responsible for the NHI Fund's debt?
- Caution should be taken to ensure that the functions of the NHI and the respective spheres of government do not overlap (Especially in terms of monitoring outputs and outcomes)
- In Poland each level of territorial self-government is independent with its own organizational units and responsibilities.
  - Makes coordination of activities in the health sector difficult
  - Coordination of health service provision could potentially be a primary function of provinces

South Korea

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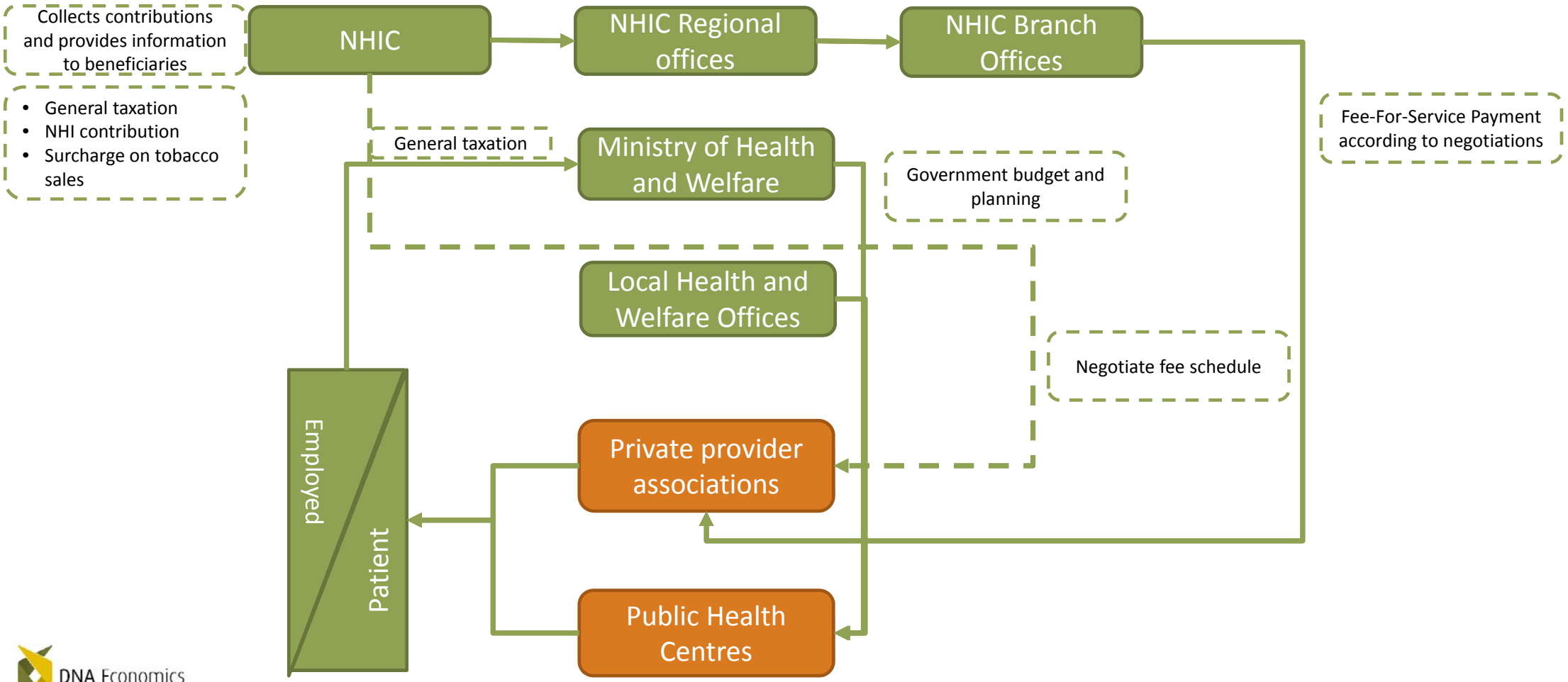
Overview

- South Korea has a unique NHI system with a single insurer (The National Health Insurance Corporation) covering almost the entire population.
- Headquarters in the capital carries out functions through 6 regional headquarters and 178 branch offices nationwide
- Health services predominantly provided by private sector providers
- Paid through fees established through negotiations between the NHIC and the various provider associations.
- Covers nearly entire population – only a small portion covered by the Medical Aid Programme (A programme specifically for the poor)

Health system



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Health reforms (1)

- South Korea adopted a step-by-step approach to incrementally achieve universal health insurance coverage
- 1977: Employees working in large companies (>500 employees) were enrolled
  - Government did not subsidise the health insurance scheme and it therefore had to be self-sustain; hence employees at large companies
  - Government saw this as a pilot study to gauge the probability of success of a NHI scheme
- Beginning 1979: Cover extended to civil servants and private school teachers
- Middle 1979: Coverage extended to employees at medium sized (300 – 500 employees) companies
- 1981: Coverage extends to small companies (100 – 299) employees
- 1983: Coverage extends to smaller companies (16 – 99 employees)
- Also, during the 1980s, all first and second-line dependents of employees were also included.
- 1989: Universal Insurance coverage for all major population groups

Health reforms (2)

- However,
  - All these population groups were in different funding pools
- Under this multi-fund system, the bargaining power of individual insurers was weak - likely to lead to increasing medical costs
- Consequently, in 2000, the funds were integrated into a single fund
- Some of the advantages of this was reform include
  - Greater leverage during negotiations
  - Enlarged risk pooling
  - Reinforced income redistribution at national level.
  - Improved administrative efficiency

AJ17

Thailand

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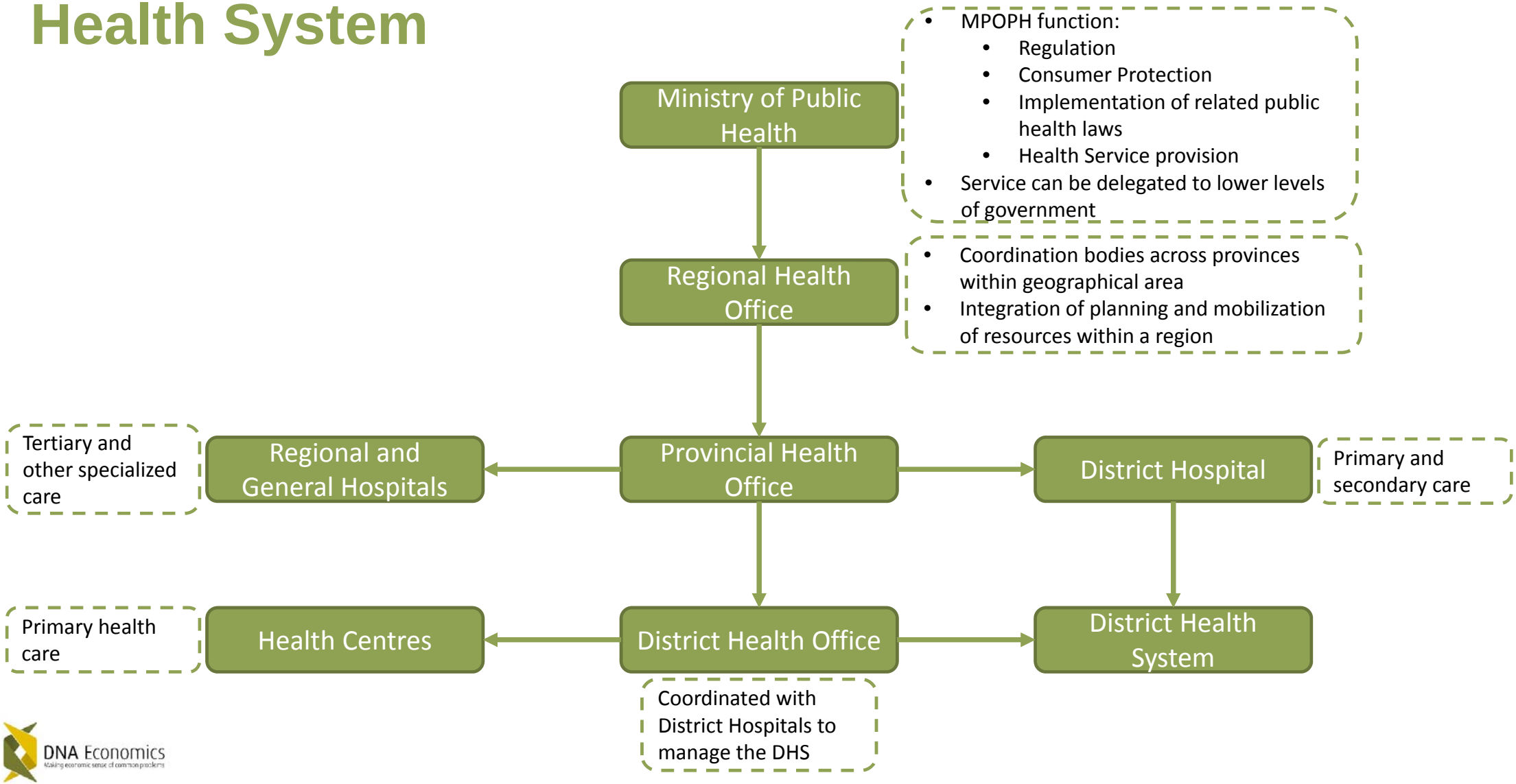
Slide 29

AJ17 I think you need to go back to your country by country structure. It is quite difficult to do this thematically.
Amanda Jitsing, 2016/05/30

Overview

- The Ministry of Public Health is the national authority responsible for formulating and implementing health policy
- By 2002, the entire Thai population was covered by three public insurance schemes:
  - Civil Servant Medical Benefit Scheme (CSMBS) – Covers 6 million civil servants
  - Social Health Insurance Scheme (SHI) – Covers 9 million private sector employees
  - Universal Coverage Scheme (UCS) – Covers the rest of the population (47 million)
- The implementation of UCS in 2002 completed the split between provider and purchaser – this part of the presentation will therefore focus on the UCS.

Health System



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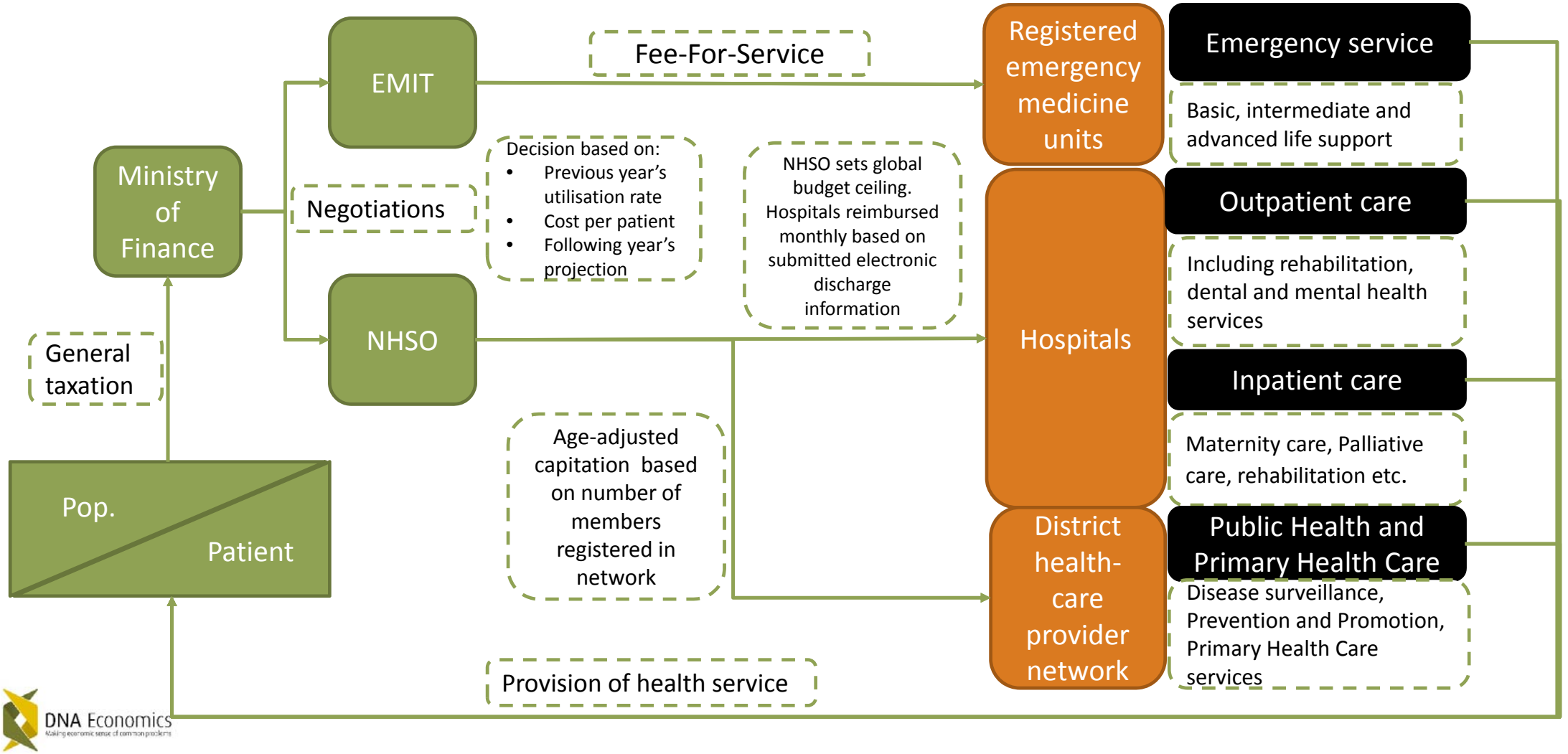
Health System Funding and Financing



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Health reforms (1)

- 1999: Decentralisation Act promulgated
  - All public services held by central ministries, including health should be gradually devolved to Provinces, Districts and Municipalities.
- First Decentralisation Action Plan focussed on the transfer of all public health-care facilities to provinces
- All health devolution suspended in late 2002 due to changes in leadership and government policy and the implementation of the Universal Coverage Scheme through the establishment of the National Health Security Organisation (NHSA)
- From 2008 onwards, second Decentralisation Action Plan was implemented.
  - Focussed on devolving all Health Centres (Primary Health Clinics) to Sub-Districts
  - District and Provincial Hospitals could be devolved to either Province or Municipality

Health reforms (2)

- Slow progress was still a problem; mostly due to stringent criteria for readiness of Sub-Districts to assume responsibilities for Health Centres.
- Those that were devolved reported positive results:
  - Increased management flexibility
  - Greater responsiveness to community and patients
  - Increased community participation.
- No progress was made with proposed plans to scale up the devolution of Health Centres to Sub-Districts
- Third Decentralisation Action Plan approved in 2012
  - Not much changed from the Third

Slide 34

AJ52 Very good!
Amanda Jitsing, 2016/05/31

Lessons from Thailand

- Lessons:
  - Gradual implementation of decentralisation can be challenging
    - Change in leadership or context could slow down or negate past progress
  - The gradual implementation was enforced by the strict criteria for assuming management responsibilities
    - Weaker criteria could lead to responsibilities being handed to institutions that aren't ready
    - Can leader to major losses and inefficiencies
  - Spreading ownership across different levels of care could lead to fragmentation of the health system
    - A coordinating mechanism between facilities providing different levels of care is extremely important when the system is decentralised; specifically to facility level, as proposed in the NHI White Paper

Lessons for South Africa

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Options for structuring the NHI

- Although primary decision-making power predominantly lies at a Central NHI Fund, many countries opt to decentralise some administrative function to regional branches
  - Contracts and their negotiations happens between the regional funds and the local service providers
  - Regional branches allow for efficient access for the providers to the fund
  - Although the regional funds have limited functions, they are still complex institutions and will require competent and specialised human resources to function efficiently
- The relationship between the State's budget and the NHI Fund will have to be very clearly defined

Reforms to the IGR system (1)

- One of the major issues of the NHI proposal is the shift in the function especially in terms of management and financial flows
- At the beginning stages of NHI implementation, all facilities will be ready to become semi-autonomous
- Provinces therefore have a major role to play during the transition period
- And once facilities assume all their assigned responsibility, provinces, districts and municipalities will still have a major role to play in enhancing the efficiency of the Health System

Reforms to the IGR system (2)

- In the already established systems discussed these functions include but are not limited to:
  - Licensing of practitioners and facilities (Coordinating with the work of the OHSC)
  - Funding and providing of community and public health services
  - Environmental health services (SA Municipalities)
  - Primary Health Care (Care not provided by the District Hospitals and their contracting units)
  - Identification of population health needs
  - In some instances, they own public facilities
  - Coordination between different levels of care (This is very important to prevent the fragmentation of the system due to decentralisation)
- Decentralisation of services will have to be managed very carefully

Funding and financing flows

- The NHI White Paper proposes a direct contracting relationship between the NHI Fund and the service providers (Contracting Units)
- This can be done by other a Fee-for-Service Approach or a Capitation Approach
- For Public and Primary Health Care, a Capitation Approach is mostly used, while a Fee-for-Service Approach is most often used for inpatient and ambulatory services.
- A Single fund has immense market power in negotiating these rates
  - Is massively instrumental in containing health sector costs
  - Have to balance this power with the need for health care providers (They need incentive to stay)

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