Introduction to Health Economics and Systems

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A distillation of the NHI proposals

- Essentially the proposals come down to two big ideas and a range of subordinate ones
- I will focus on the big ideas – as these are most likely to impact on the strategic coherence of the health system and are-
  - Introduce a centralised “purchaser” within the first tier of government (proposed by the ANC in September 2010)
  - Increase public health expenditure from around 3.5% of GDP to 8% of GDP over 15 years, with a doubling of public expenditure in 5 years (proposed by the ANC in September 2010)

The centralised “purchaser” would…

- Operate in parallel to the existing public health system with the public system becoming a “contractor” to the “central purchaser”
- This is motivated on the basis of that this monopsony purchaser of both public and private services will enhance efficiencies

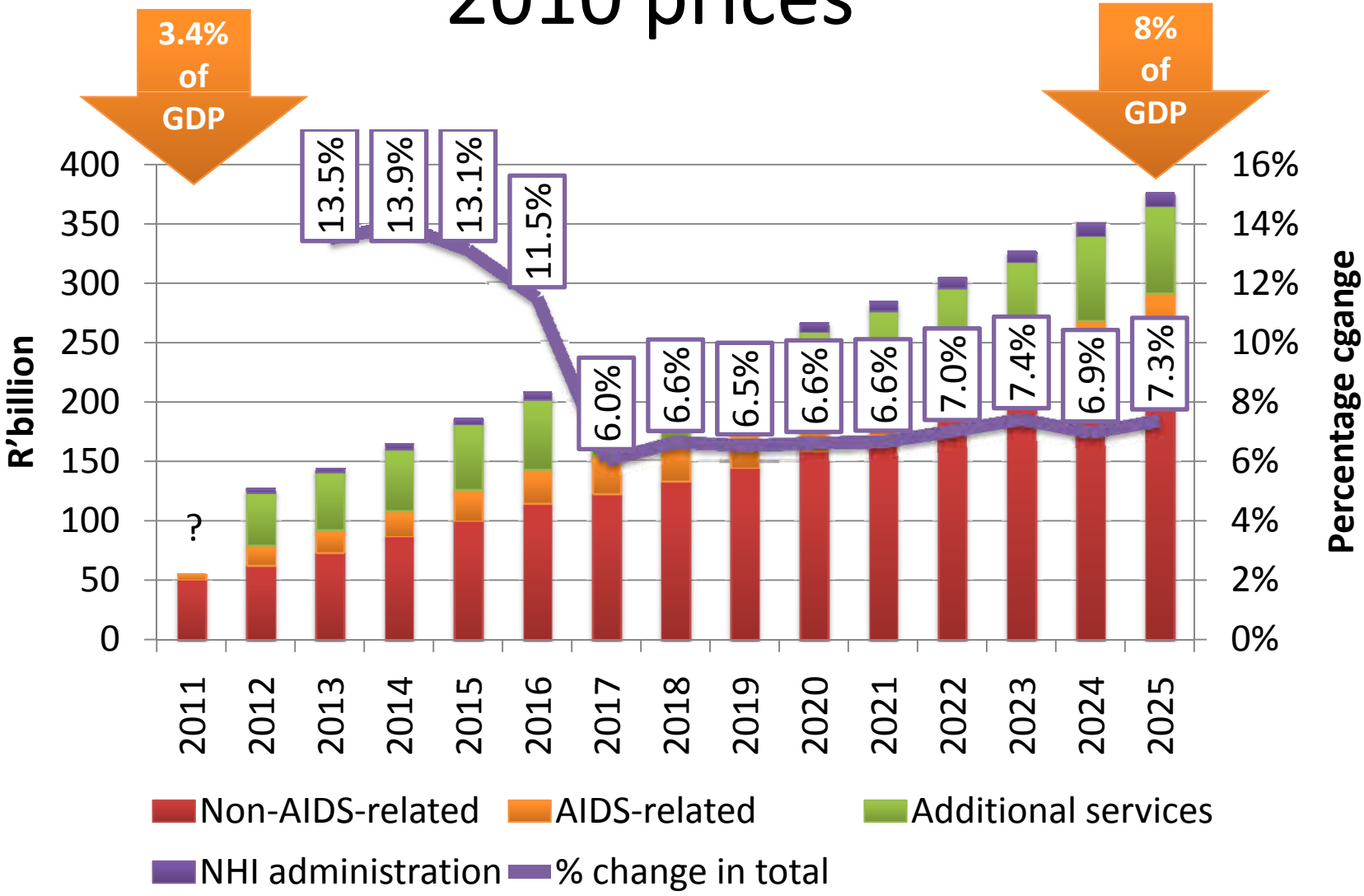
The corporate governance structure is remarkably feeble…

- Minister of Health is to appoint the CEO
- This essentially exposes the “central purchaser” to inevitable capture by special interests as has become common practice in South Africa
- Funds proposed to flow through the fund would ultimately be around 4 times the existing public health budget of around

Concerns with this proposal…

- The public health system is already failing due to a compromised accountability framework
- The “central purchaser” will split the authority for regional planning and service delivery, confusing an already weak system
- Too much money will be placed in the hands of too few people, who are meant to contract with every single health supplier in the country
- No domestic or international precedent supports this approach as the valid response to South Africa’s institutional framework

Proposed "NHI" budget in constant 2010 prices



Source: Based on numbers produced by Di McIntyre for the ANC, NHI Discussion Document, 2010

Minister of Health…

"Having said so honourable speaker, this 4 pandemics are occurring in the face of a reasonable amount of health expenditure as a proportion of the GDP. Available evidence indicates that we spend 8,7 % of our GDP on health (the bulk of which, as is commonly known, is unfairly spent in the private sector). This expenditure is significantly more than any other country on the African continent and in some instances even outside our continent. A serious anomaly here is that our health outcomes are much worse than those of countries spending much less than us. Evidently, there is a very serious underlying problem here that needs our attention. The effects of our burden of disease are clearly aggravated by inequitable distribution of human and financial resources between public and private sector whereby resources are seriously skewed in favour of the private sector, whilst it is serving only 16% of the population, in contrast the public sector which serves a whopping 84% of the population."

Health Budget Vote Speech to Parliament, June 2011

2. The two-tier health care system

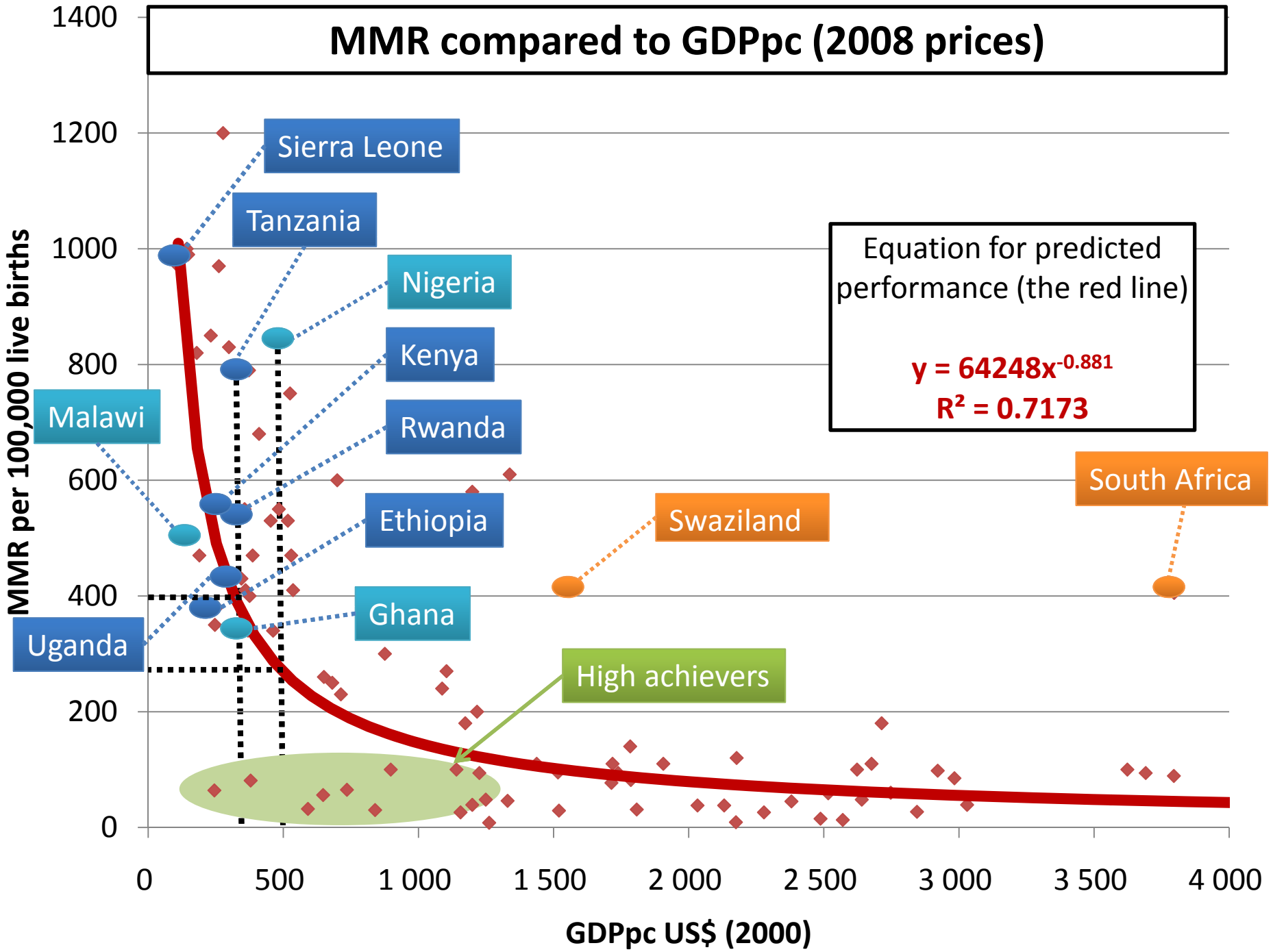
- SA spend R135-billion on health (or 7% of GDP) in 2008.
  - This could be enough to provide health care for all South Africans.
  - Countries with NHI provide less than we pay
- But despite these resources, poor infant and child, low life expectancy rate prevail

WHY?

Rationale – to achieve MDGs

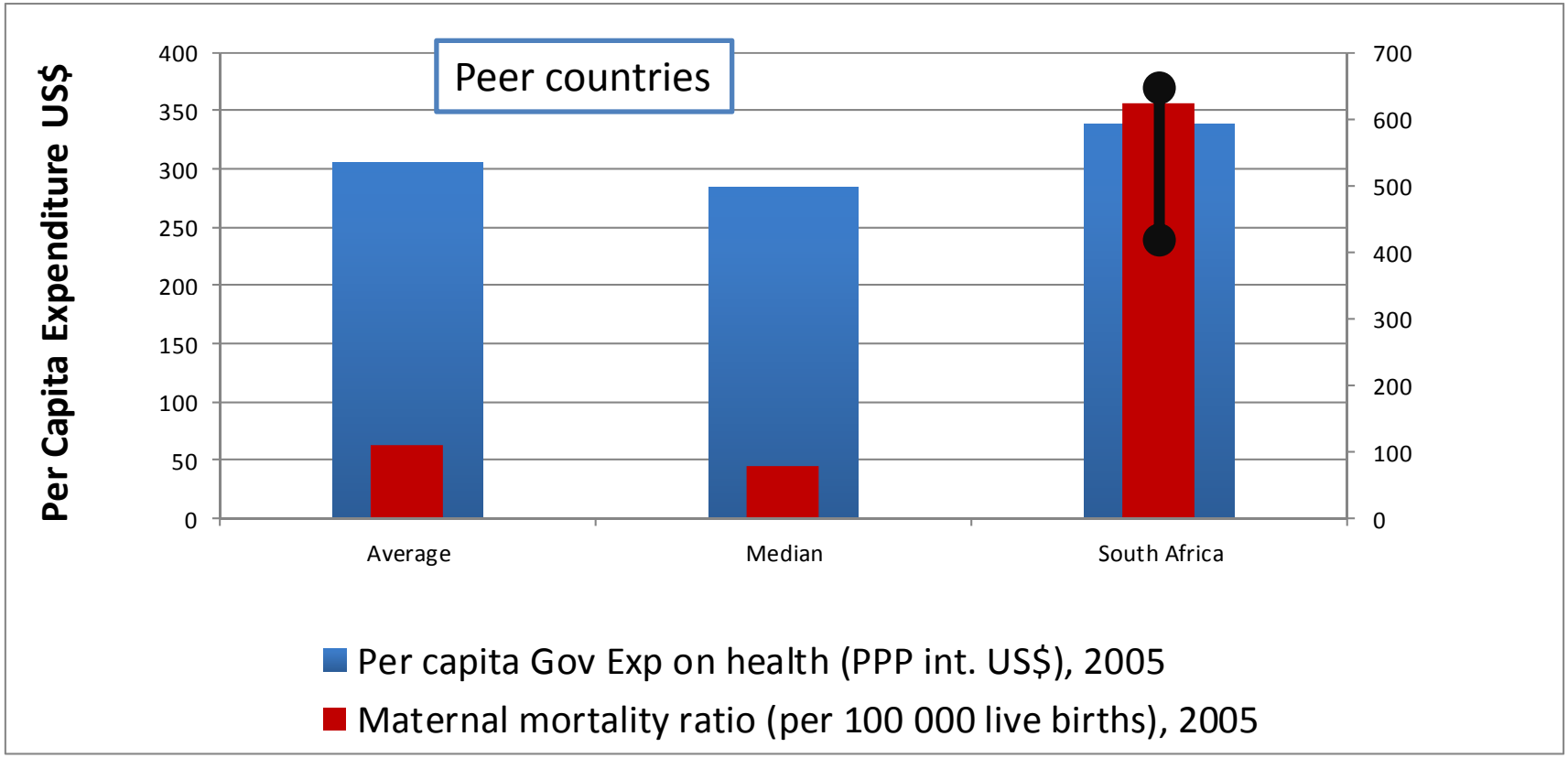
"43. The case for change in health care financing in South Africa through the introduction of mandatory NHI health is both strong and urgent. The case for change should also be considered in the light of the lack of achievement of the Millennium Development Goals (MDGs) for health, and the stagnation and even deterioration in mortality rates and life expectancy."

ANC, Report to the NEC, July 2009


MMR compared to GDPpc (2008 prices)
MMR per 100,000 live births
GDPpc US$ (2000)
1400
1200
1000
800
600
400
200
0
0
500
1 000
1 500
2 000
2 500
3 000
3 500
4 000
Sierra Leone
Tanzania
Nigeria
Kenya
Malawi
Rwanda
Ethiopia
Ghana
Uganda
Swaziland
South Africa
High achievers
Equation for predicted performance (the red line)
y = 64248x-0.881
R² = 0.7173

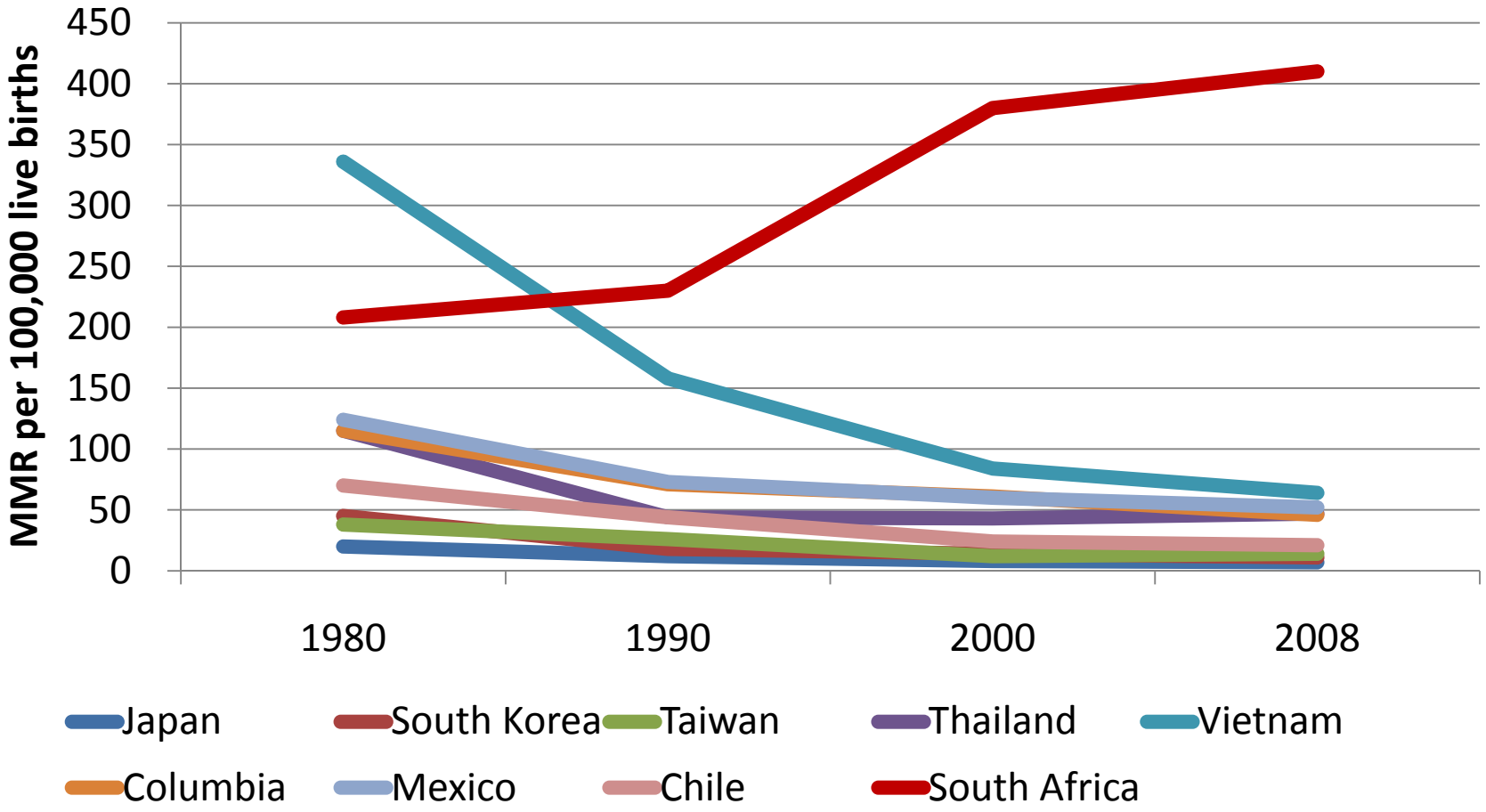
Outcomes compared

South Africa Compared to Peers (15 above and below per capita GNI in PPP US$): Government Expenditure on Health and Maternal Mortality



Maternal mortality is an indicator of service quality rather than socioeconomic need – and can't be blamed on HIV and AIDS

Multi-payer and mixed systems have been successful in improving health outcomes at normal levels of public expenditure (Maternal Mortality Rates per 100,000 live births – 1980 to 2008)



Source: World Health Organization

Maternal and child mortality problem is however framed entirely as an HIV and AIDS issue…

"High Maternal and Child Mortality

A lot has been said about the high maternal and child mortality in our country. You have noted honourable members, that most of our interventions in HIV and AIDS are directed at pregnant women and children. We will work hard to reduce the mortalities of these targeted groups. Remember that maternal mortality is not just death of a woman; it is death of a woman, because she dare fell pregnant! She becomes vulnerable to death because she is trying to bring new life to earth. We know that even the mortality brought upon by HIV and AIDS is disproportionally affecting young women of childbearing age more than the men. This can't be right."

Health Budget Vote Speech to Parliament, June 2011

SA failing to keep tots alive

“A damning report, the "South African Child Gauge for 2009/2010", released by the University of Cape Town's Children's Institute, blames the crumbling public health system for much of our children's woes.

“South Africa holds the dishonorable distinction of being one of only 12 countries - including war-torn Afghanistan - to have failed to reduce child mortality since 1990.

“It ranks in the company of the Democratic Republic of Congo and Burundi.

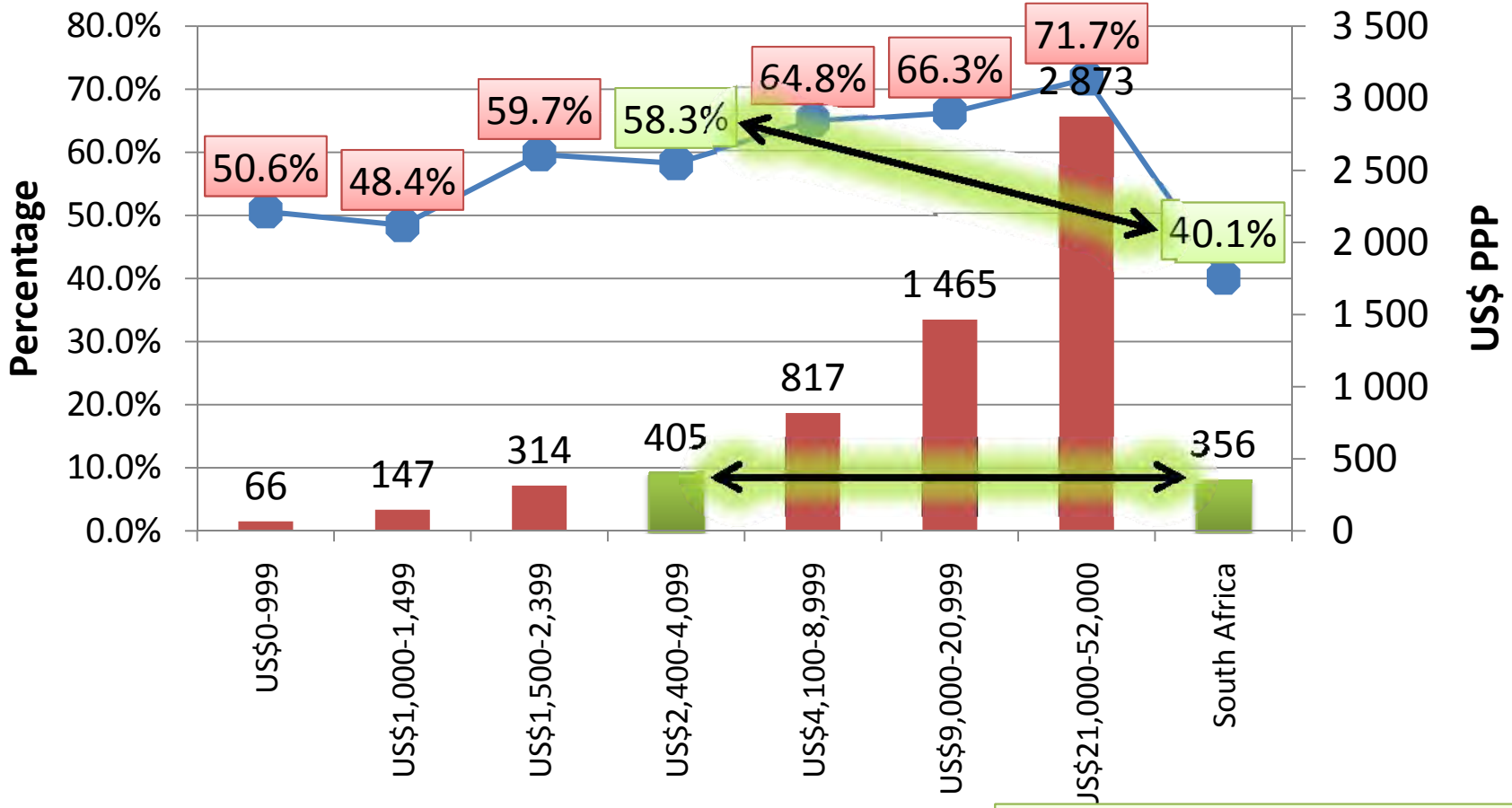
South African child deaths have risen from 56 deaths per 1000 births in 1990 to 67 deaths per 1000 births in 2008, according to Unicef.

“This is despite South Africa's high GDP and the billions of rands pumped into providing public health services.

“Unicef's deputy representative in South Africa, Malathi Pillai, said the recent spate of infant deaths at the Charlotte Maxeke Academic Hospital, in Johannesburg, was shocking.”

Jul 27, 2010 10:09 PM By PHILANI NOMBEMBE (The Times)

Government health allocation as: a % of total health spend; and per capita (2009)



South Africa:

- 17% crude gap

However,

- Excludes tax subsidy
- Increases since 2009

South Africa:

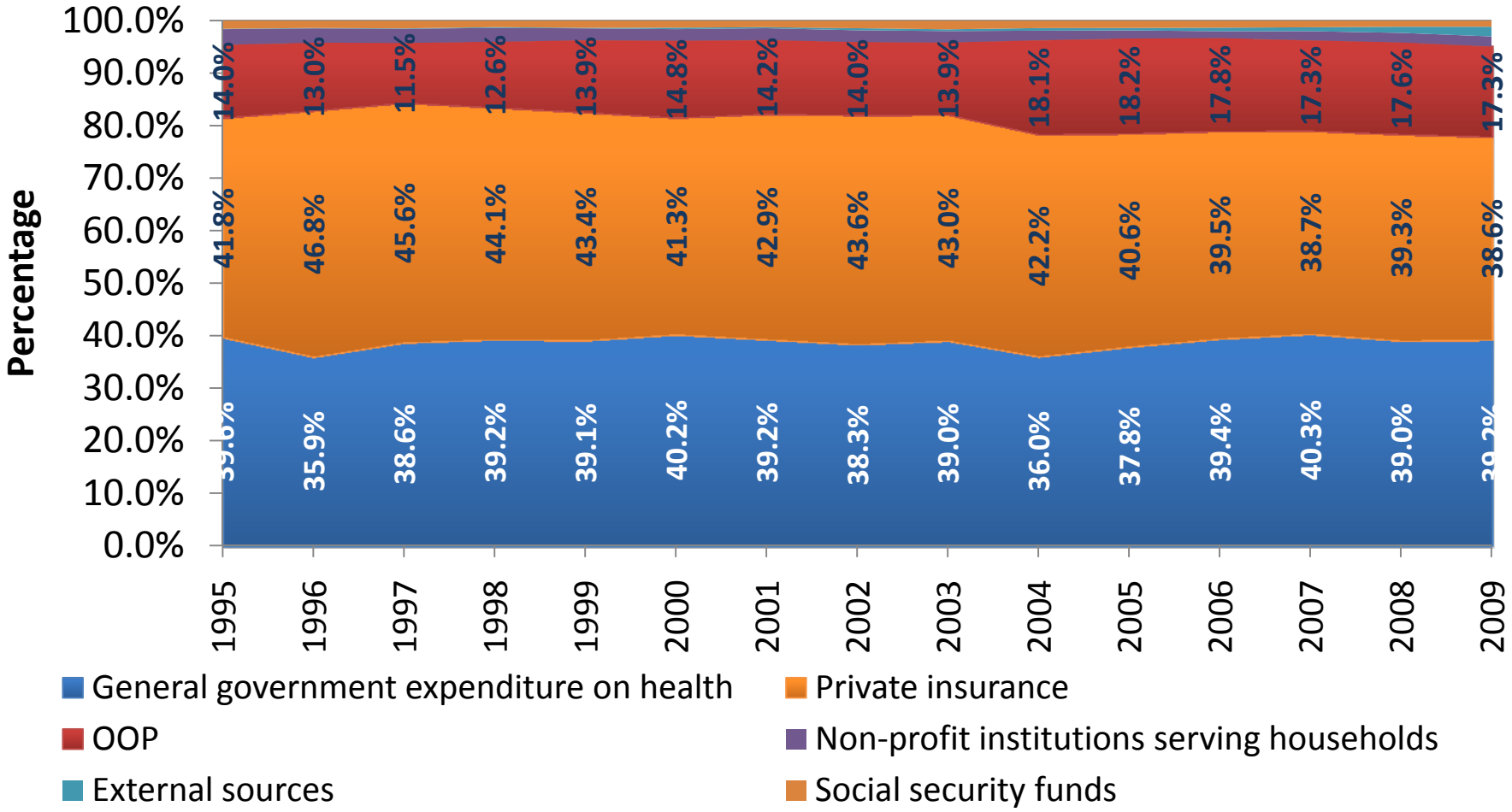
- Low percentage distorted by high private expenditure rather than low public expenditure

Government and medical scheme expenditure…

"Government expenditure on health care per person dependent on the public sector has barely kept pace with inflation, while real medical scheme expenditure per beneficiary has doubled in the past decade, with excessive cost increases in key parts of the health sector."

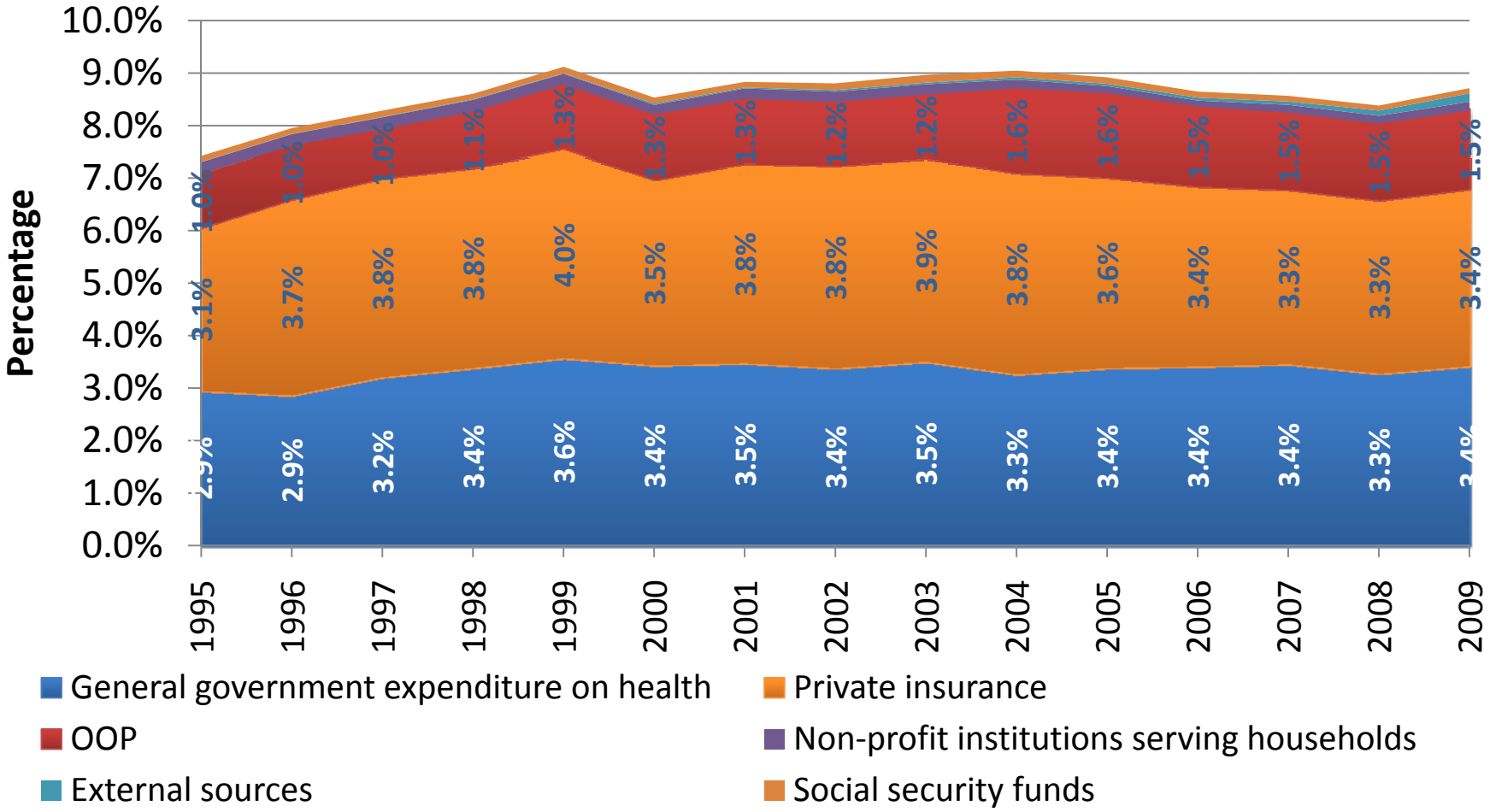
ANC, NHI Discussion Paper, September 2010

Expenditure as a percentage of total



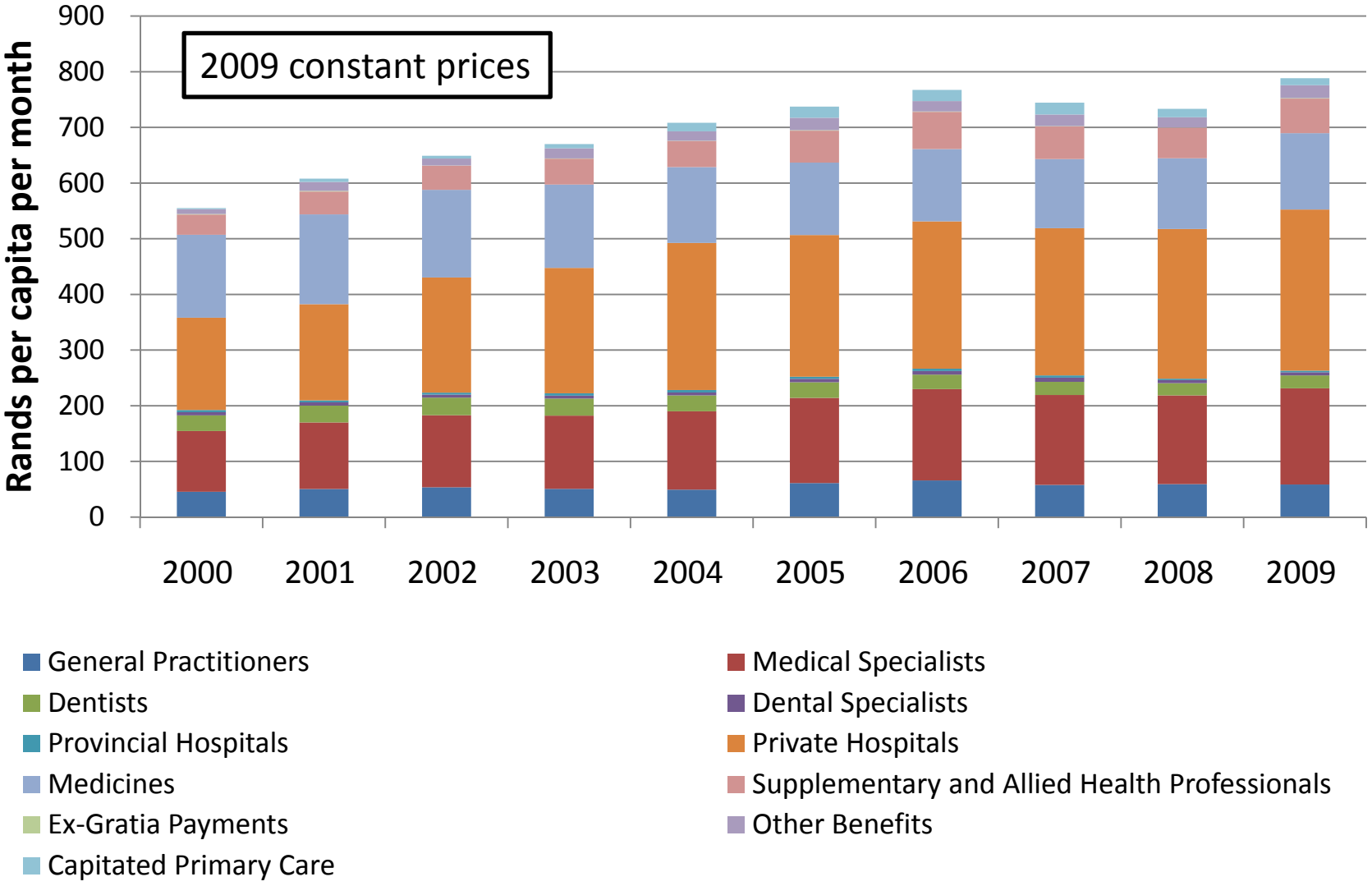
Source for data: WHO, 2011, http://www.who.int/nha/country/zaf/en/

South Africa: Health expenditure as a percentage of GDP



Source for data: WHO, 2011, http://www.who.int/nha/country/zaf/en/

Medical schemes claims costs over the past decade have not doubled…



Source: Council for Medical Schemes, Annual Report 2009

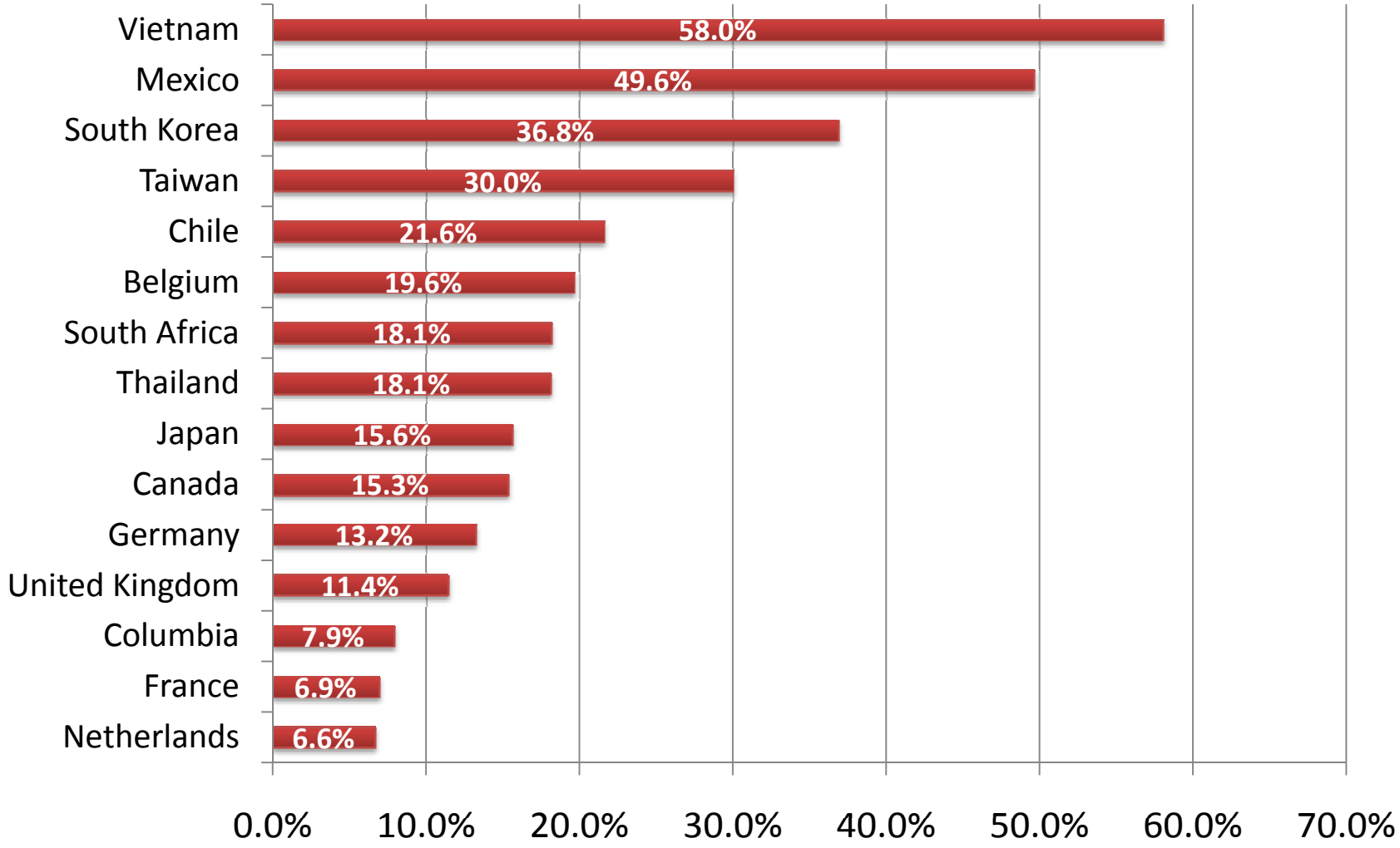
Are co-payments South Africa's biggest health problem?

- "*For example, in South Africa, 57% of health spending flowed via private health insurance contributions (44%) and out of pocket spending (13%). If the poor did not have to spend this 13% on out of pocket expenditure, they would either save it or spend it on other goods and services*." [underline added] ANC, NHI Discussion Document, 2010, p.22.

- "*Over 60% of out-of-pocket payments are made by medical scheme members. This highlights the extent to which medical scheme members are not fully protected from the costs of health care*." (McIntyre, SAHR, 2010)

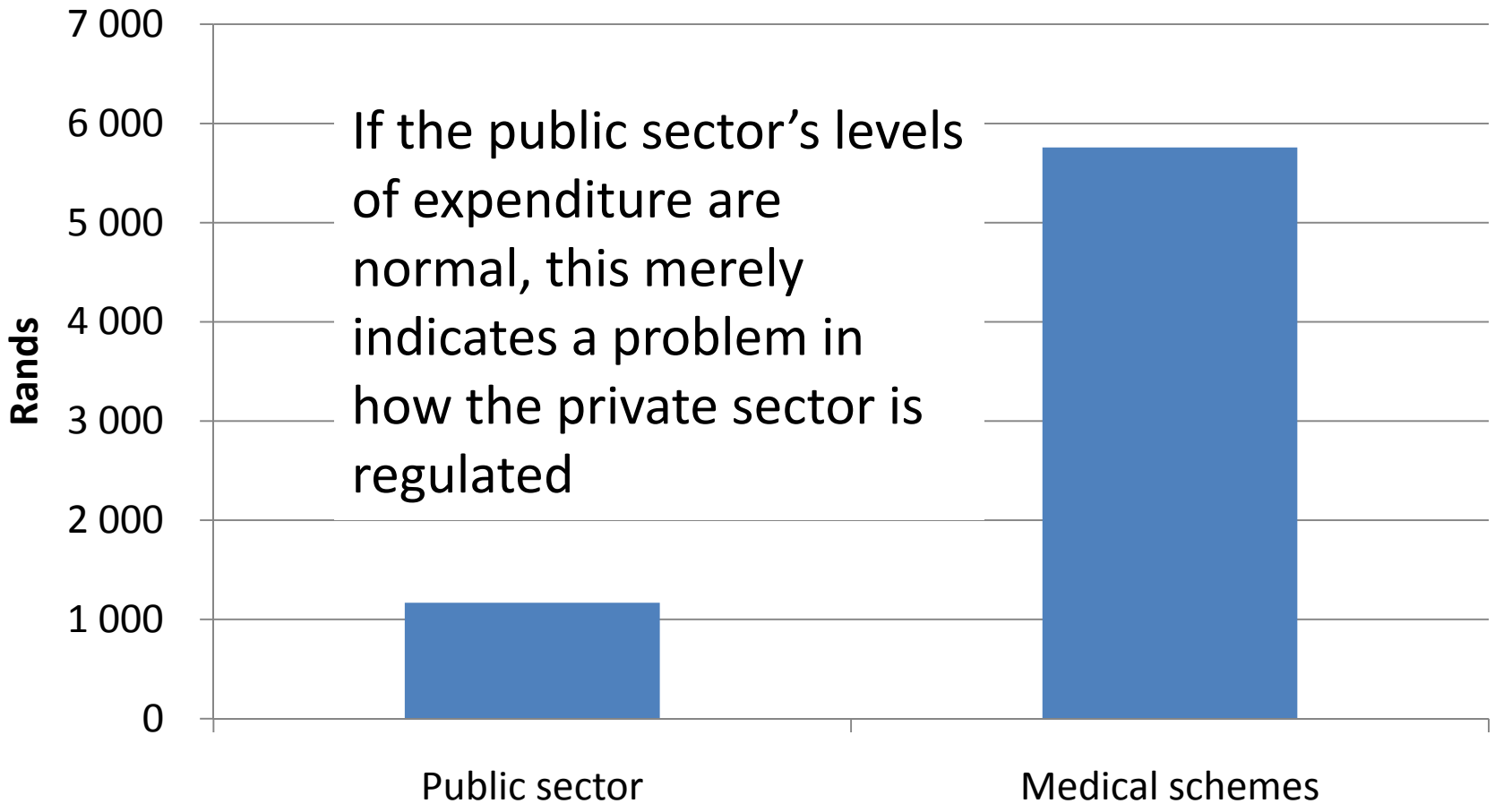
- **Aside from the evident contradiction – some case about out-of-pocket payments is being made**

Out-of-pocket expenditure for selected countries (% of total health expenditure) 2008



Source: WHO, 2010 download

Per capita expenditure (2009 prices) Rands – what does this really show?



Workforce...

"There is a serious mal-distribution of health workers in the country, with 60% of the nurses and 40% of the doctors serving 85% of the population using the public sector"

ANC, NHI Discussion Document, September 2010

Provider distributions between public, private, and medical schemes

Provider	Public	Private	Total
Nurses	120 730	57 000	**177 730**
GPs	11 942	7 298	**19 240**
Specialists	4 413	5 177	**9 590**
Total doctors	16 355	12 475	**28 830**
Total	**137 085**	**69 475**	**206 560**
Nurses	68%	32%	**100%**
GPs	62%	38%	**100%**
Specialists	46%	54%	**100%**
Total doctors	57%	43%	**100%**
Total	**72%**	**28%**	**100%**
Catchment populations			
By provider	77%	23%	**100%**
Medical scheme	84%	16%	**100%**

Sources: Persal, PCNS adjusted for actual medical scheme claims, GHS 2006 (StatsSA)

To achieve “equity” in doctors and nurses you would require…

GHS catchment populations

- Nurses 16 122
- GPs 2 873
- Specialists 2 971

- **Total 21 966**

- Cost = **R7.5 billion pa**

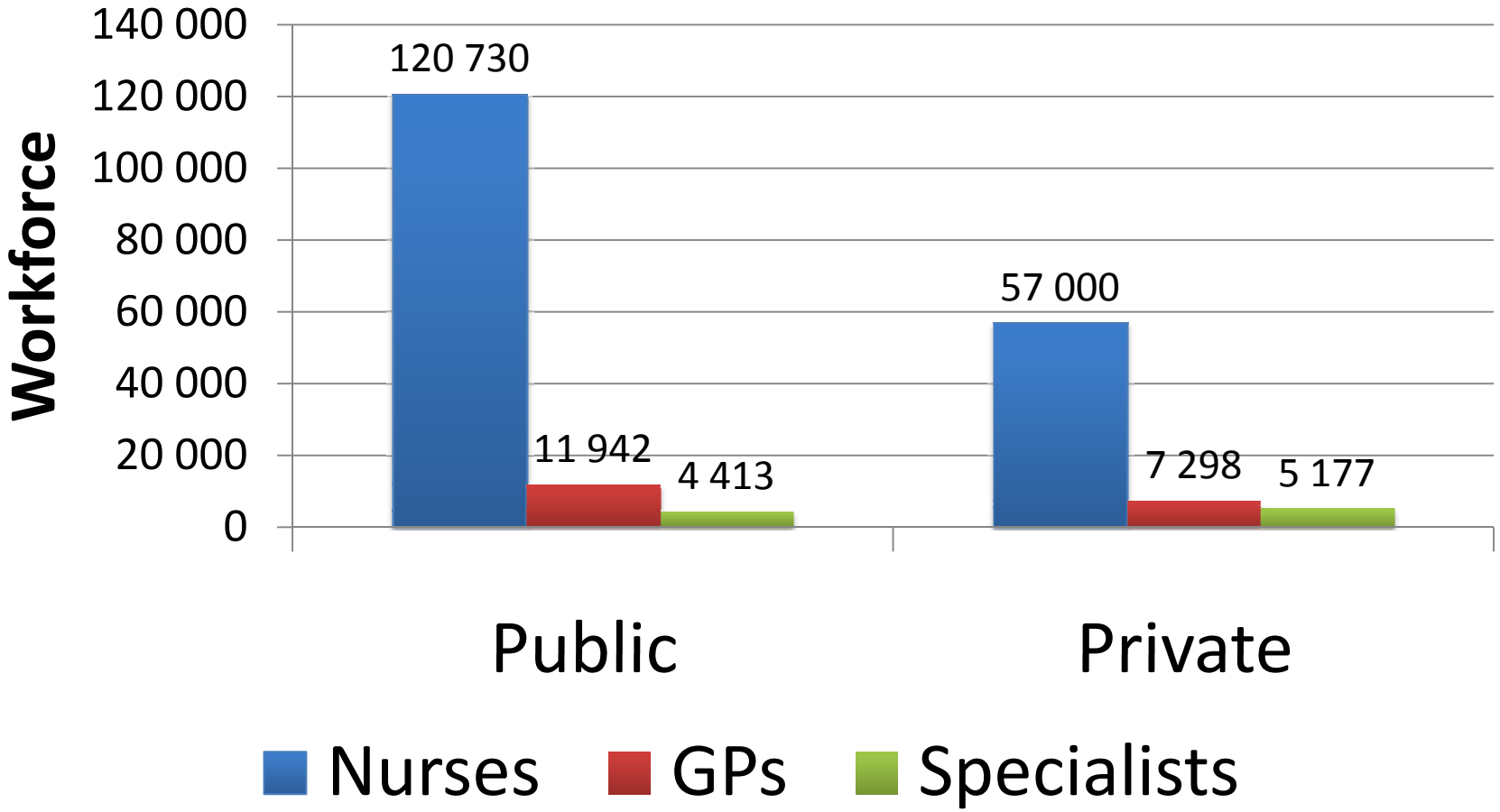
Medical scheme catchment population

- Nurses 28 563
- GPs 4 220
- Specialists 3 643

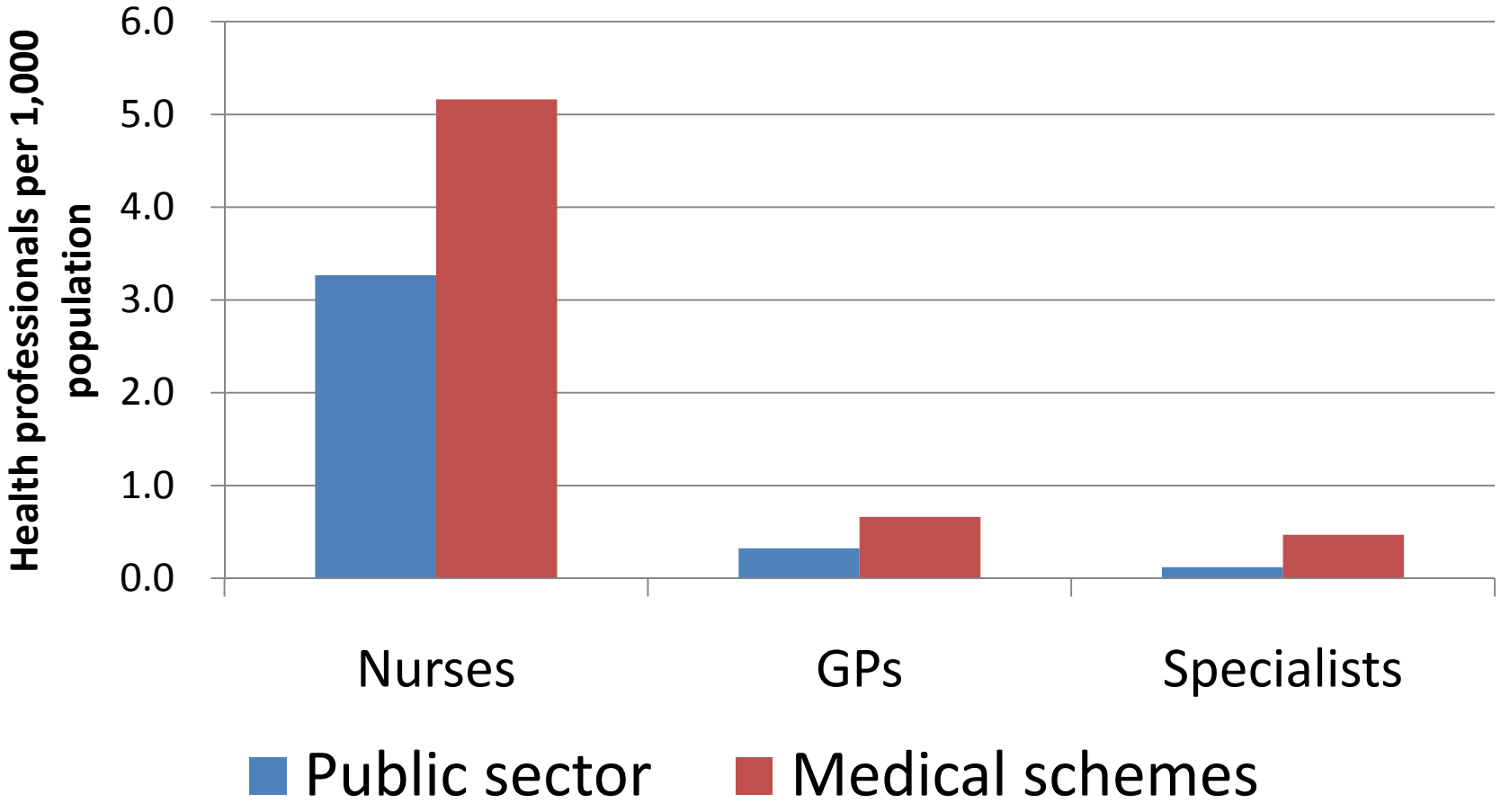
- **Total 36 425**

- Cost = **R11.8 billion pa**

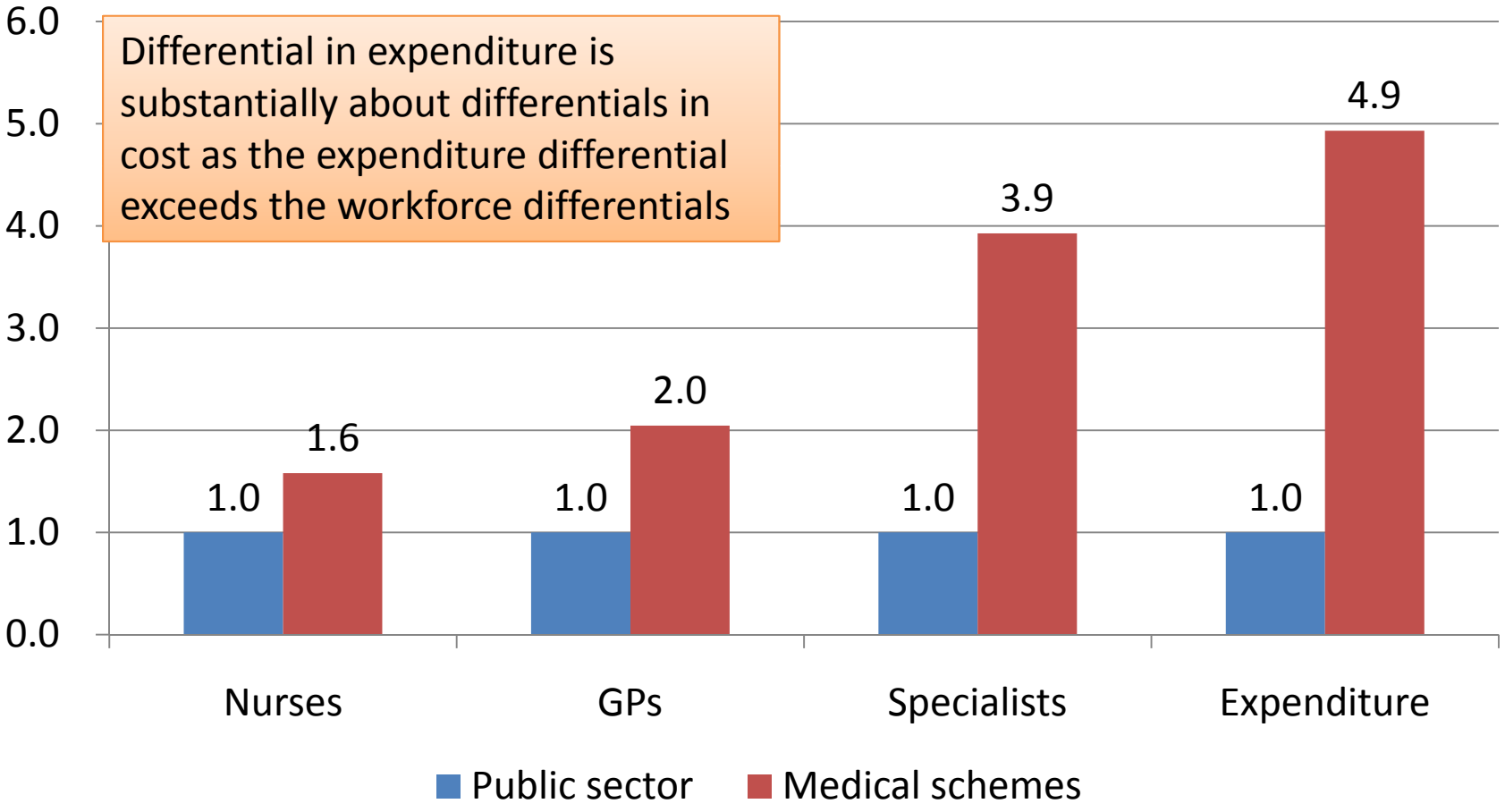
Providers in the public and private sector



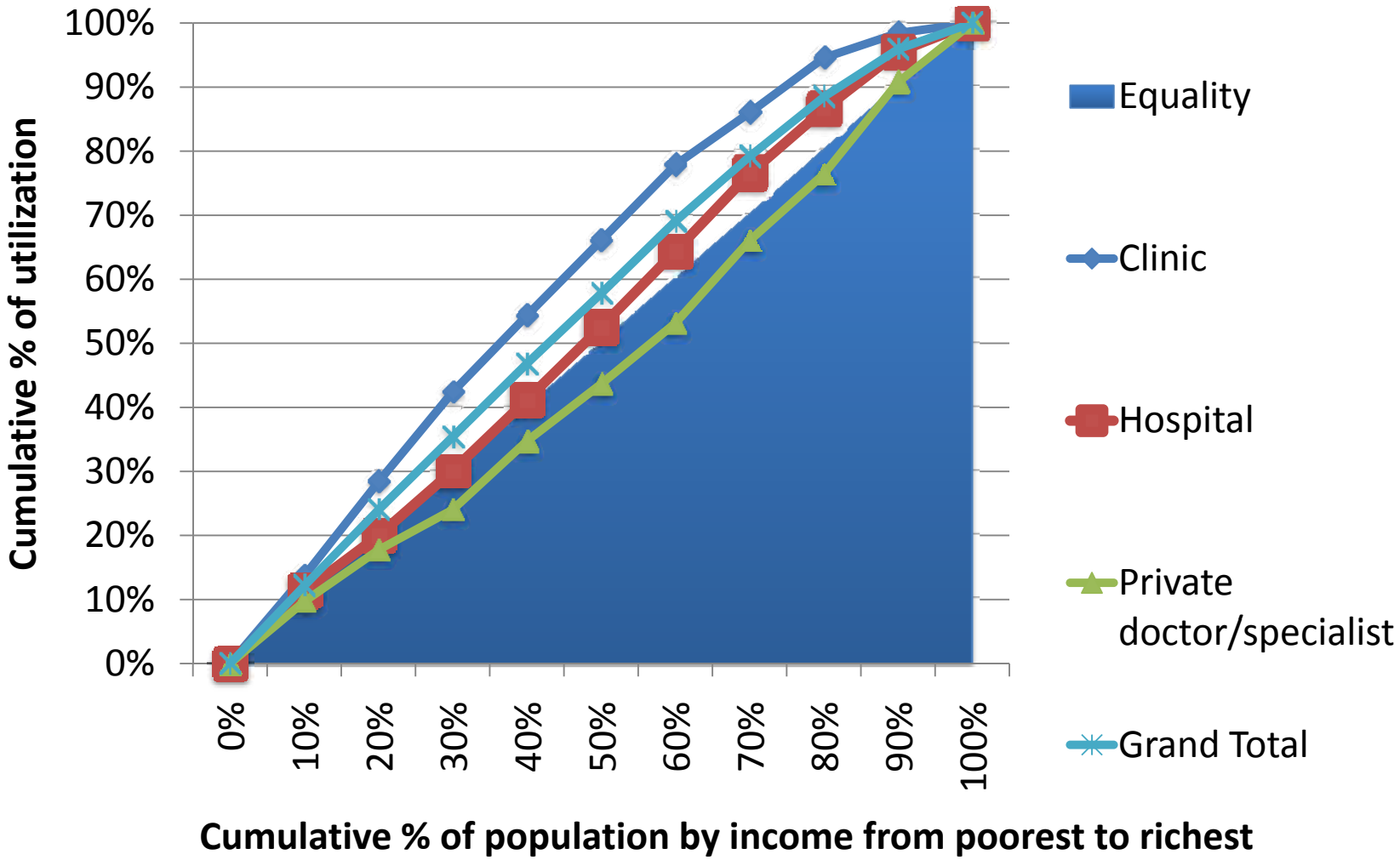
Workforce differentials (health professional per 1,000)



Per capita expenditure differentials, expressed as a ratio to the public sector, substantially exceed relevant staff to population ratios also expressed as a ratio to the public sector

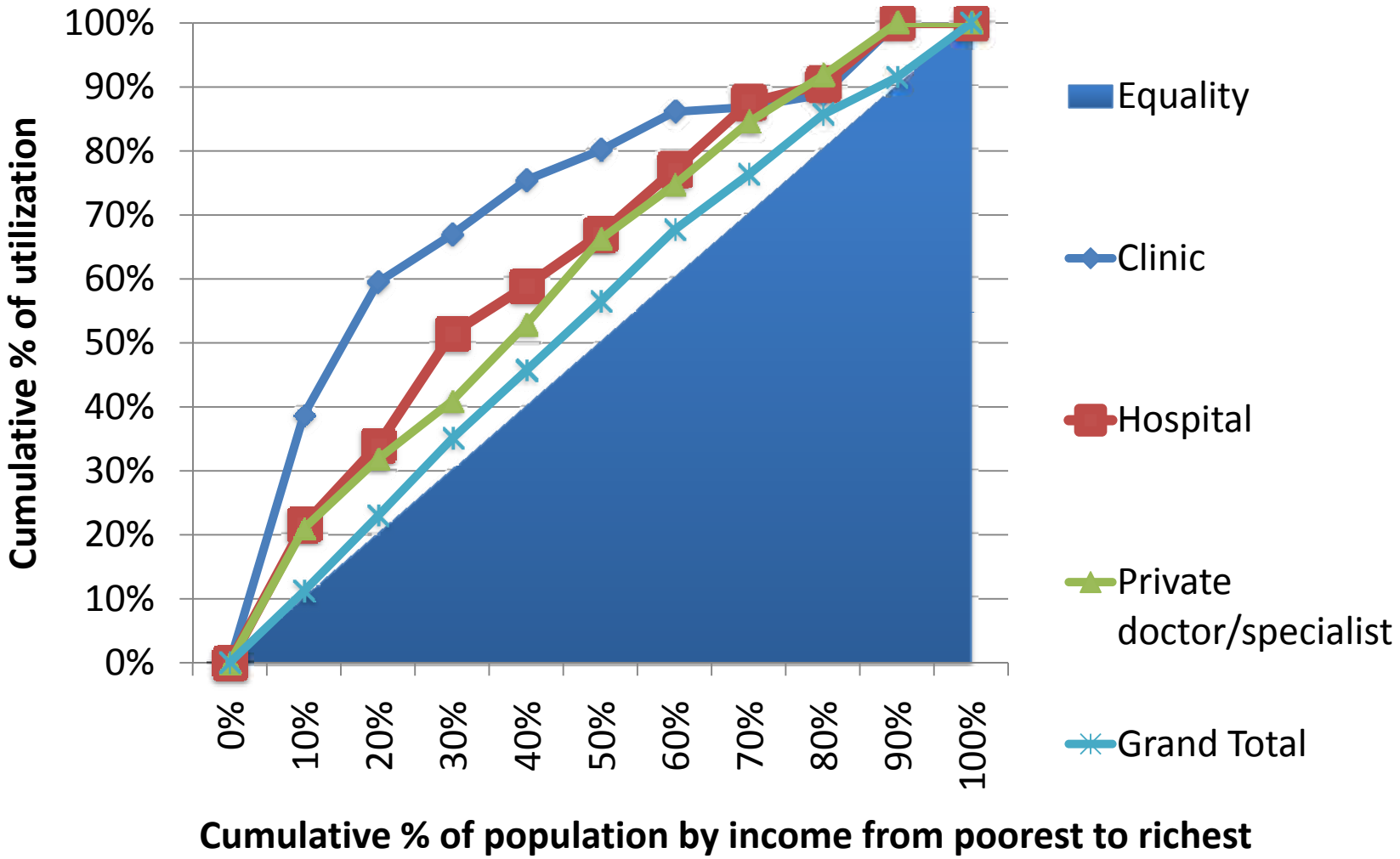


Service Use: National (Non-medical scheme population)



van den Heever, 2009

Service Use: National (Medical Scheme population)



van den Heever, 2009

On Universal Cover in South Africa

- Need to distinguish between UC as an objective and UC as a mechanism
- Initial references to NHI also confused mechanisms with objectives

- South Africa already has UC, achieved through several instruments of policy
  - Public delivery system
  - Regulated insurance
  - Categorical public insurers (CF, RAF)

What have people been costing?

- Because the various ANC documents, and some external papers, proposed NHI as a mechanism, it was costed as a mechanism

- Essentially – some set of entitlements and institutional arrangements were proposed – which if taken at their face value resulted in 20 or so World Cups a year…

The rational approach is to…

- Identify priority interventions and service rationalisations within a gradually improving fiscal envelope

- Sort of like the way its done in the rest of government…

Another rationale: policies involving the preservation of medical schemes…

- "May" permanently entrench a 2-tier system – "as has occurred in Latin America"

- However…
  - Multi-tier arrangements are expected on the trajectory to UC as well as after UC has been met
  - Predominantly single tier systems exist only in countries with high per capita GDPs and high employment – it is for this reason that developing countries have plural systems and not because they are trapped within an institutional design

Some international evidence... ?

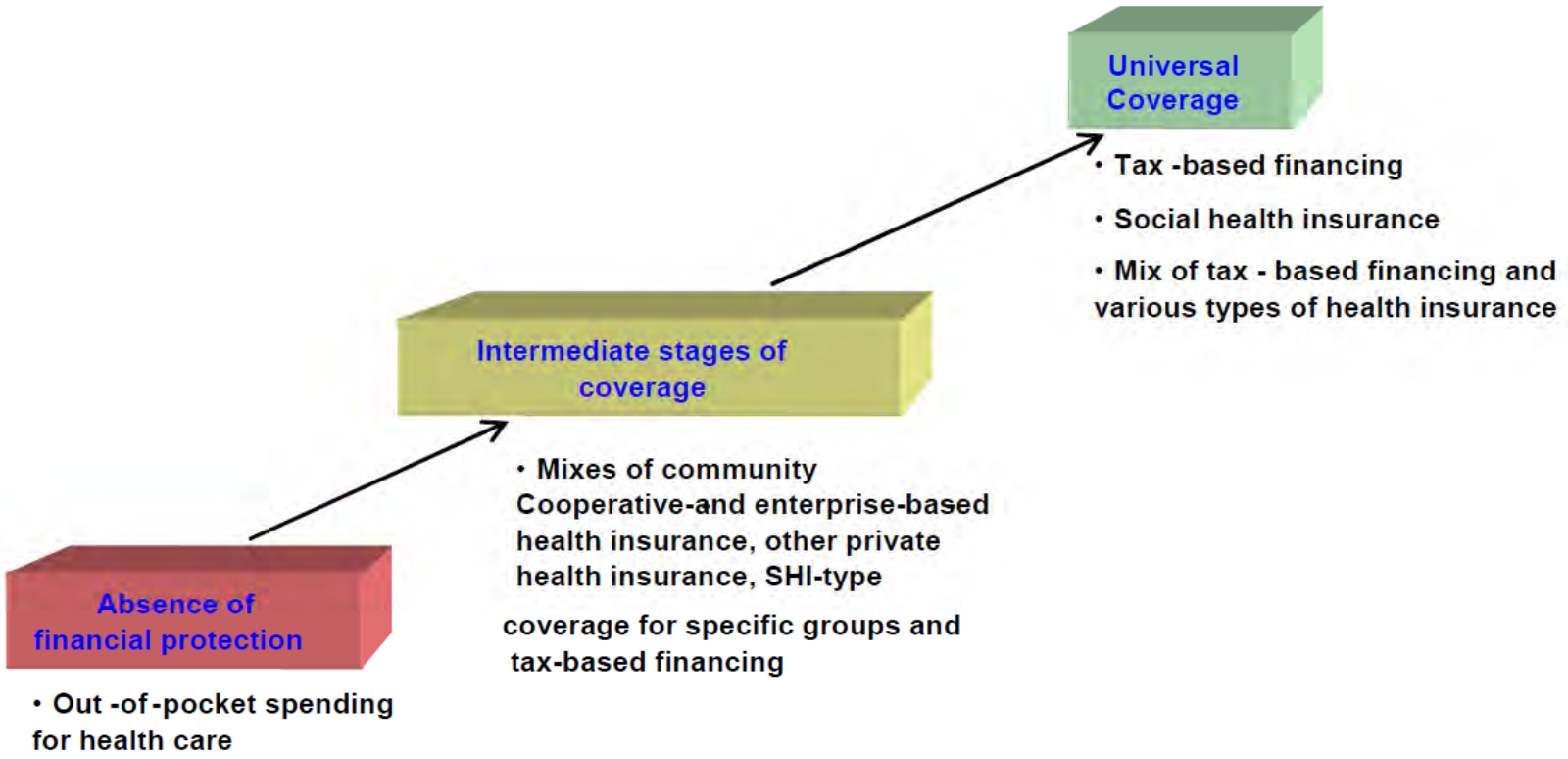
"NHI has been adopted by a number of middle-income countries including Taiwan (China), the Republic of Korea, Mexico, Thailand and more recently Vietnam and Columbia." ANC, NHI Discussion Document, September 2010

However…

- Only Taiwan and Korea have single-payer NHI systems, and both are around 3 times SA's per capita GDP, both with co-payment levels that substantially exceed that of SA
- According to this information the "multi-tiered" Latin American health systems are NHI systems ???

World Health Organisation's view of transitions to UC

Figure 1: The transition to universal coverage



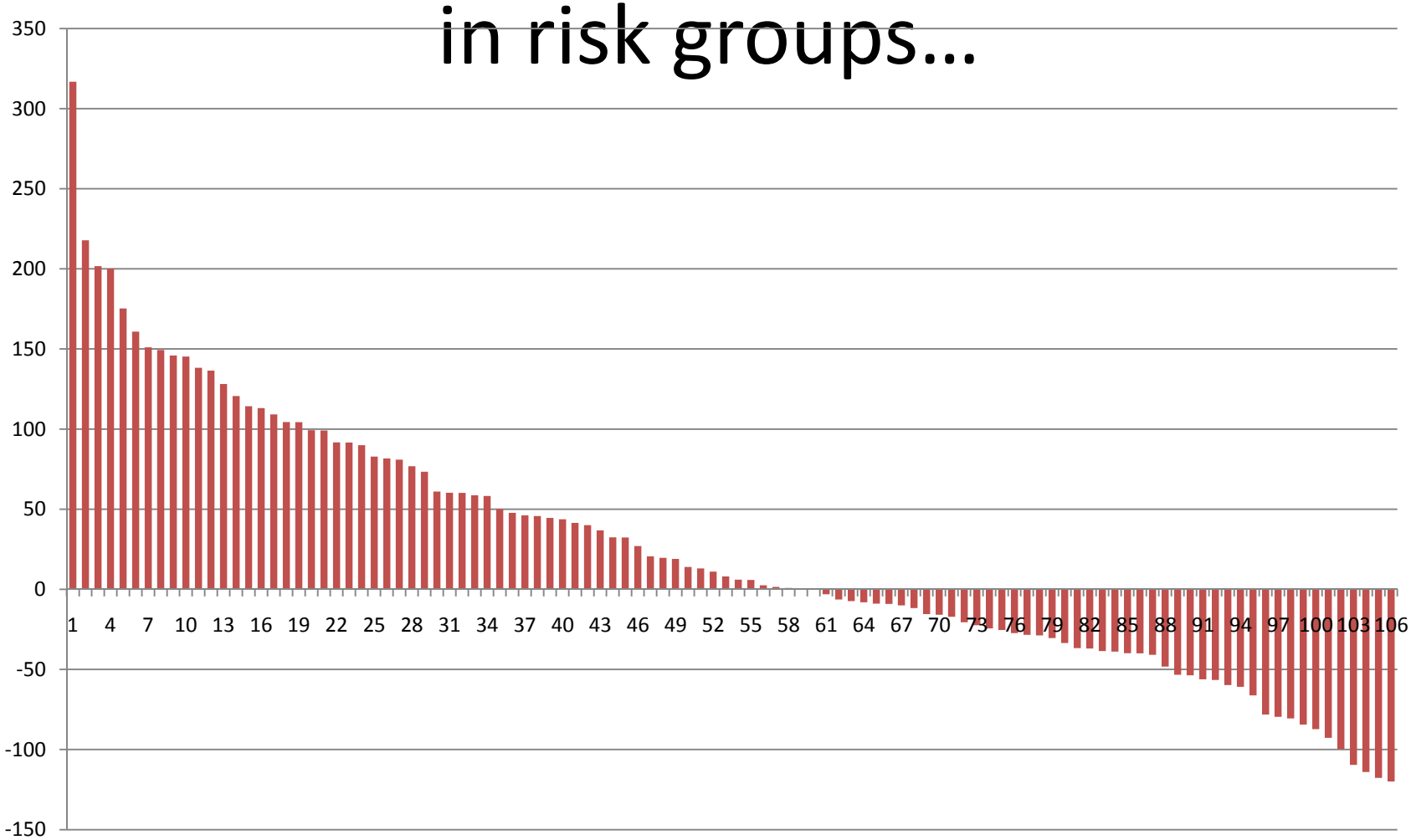
World Health Organisation, Achieving Universal Health Coverage: developing the health financing system, 2005, p.2.

According to proponents of NHI, Risk equalisation will undermine “NHI”

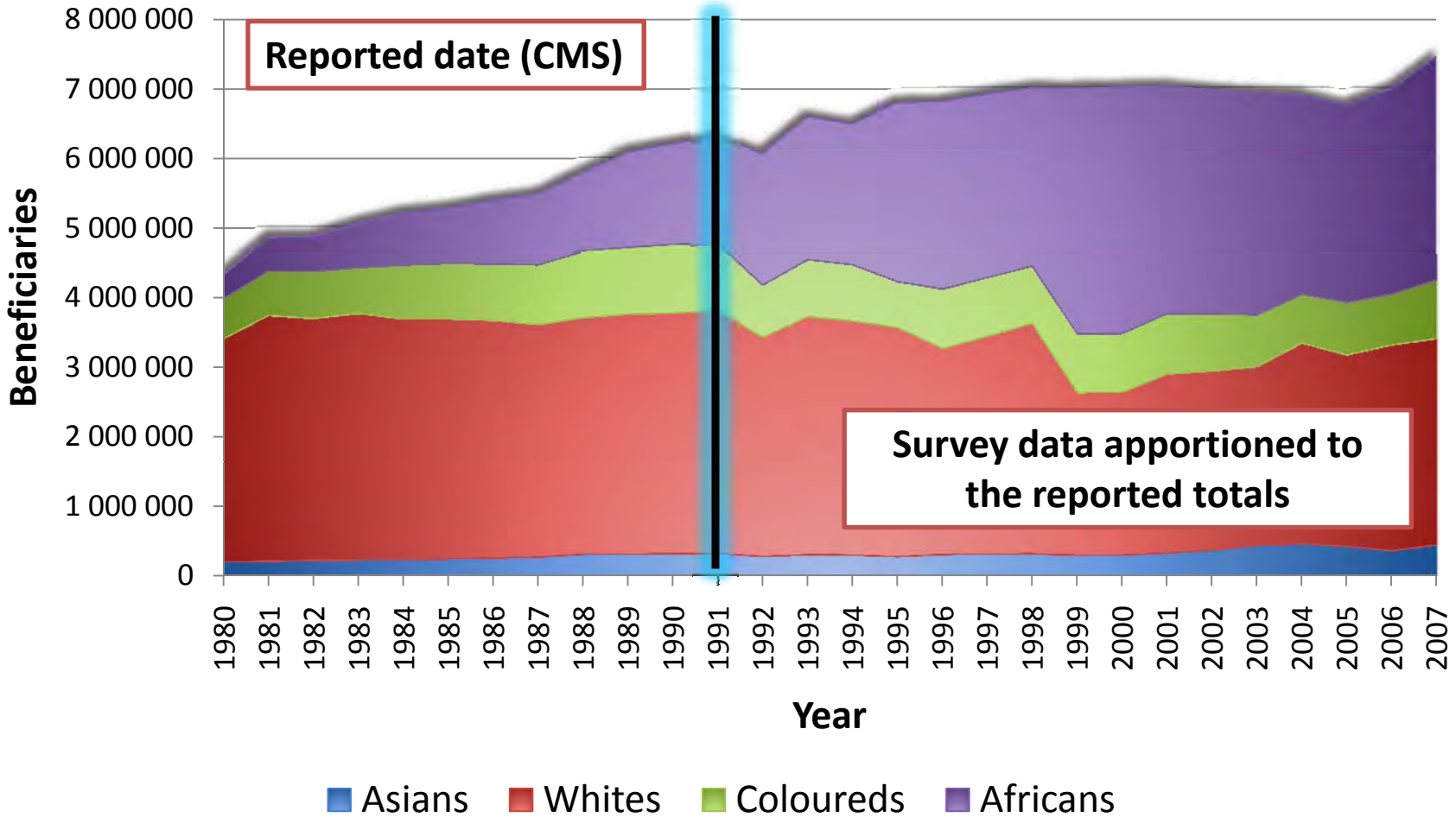
- As a consequence legislation proposing to stabilise and properly regulate medical schemes involving governance reforms and risk equalisation (after a full process running from 2003)in 2008 was blocked

- This probably sets an international precedent for stupidity…

…large differences between the costs of medical schemes due to variations in risk groups…

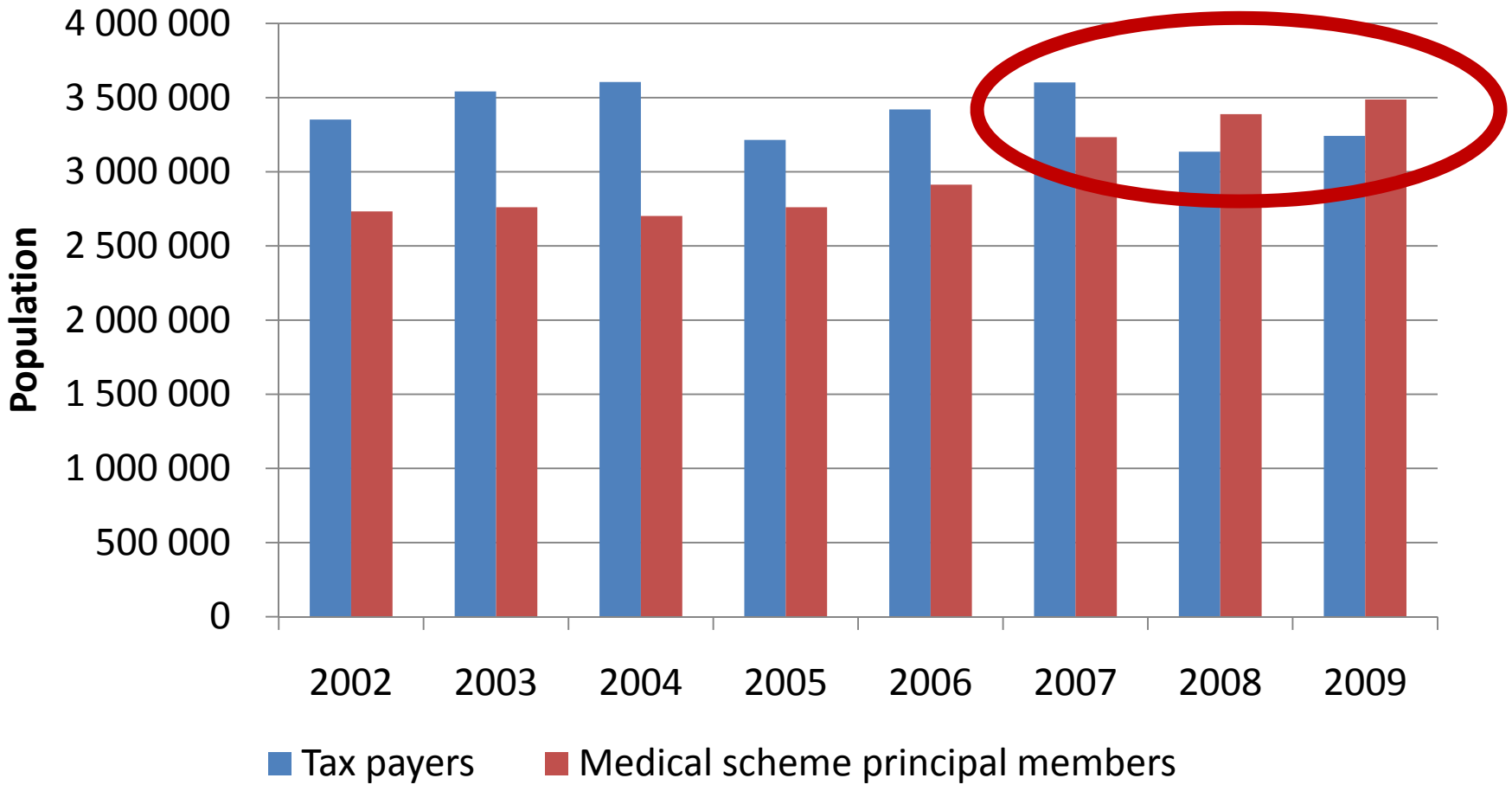


Do medical schemes preserve apartheid?



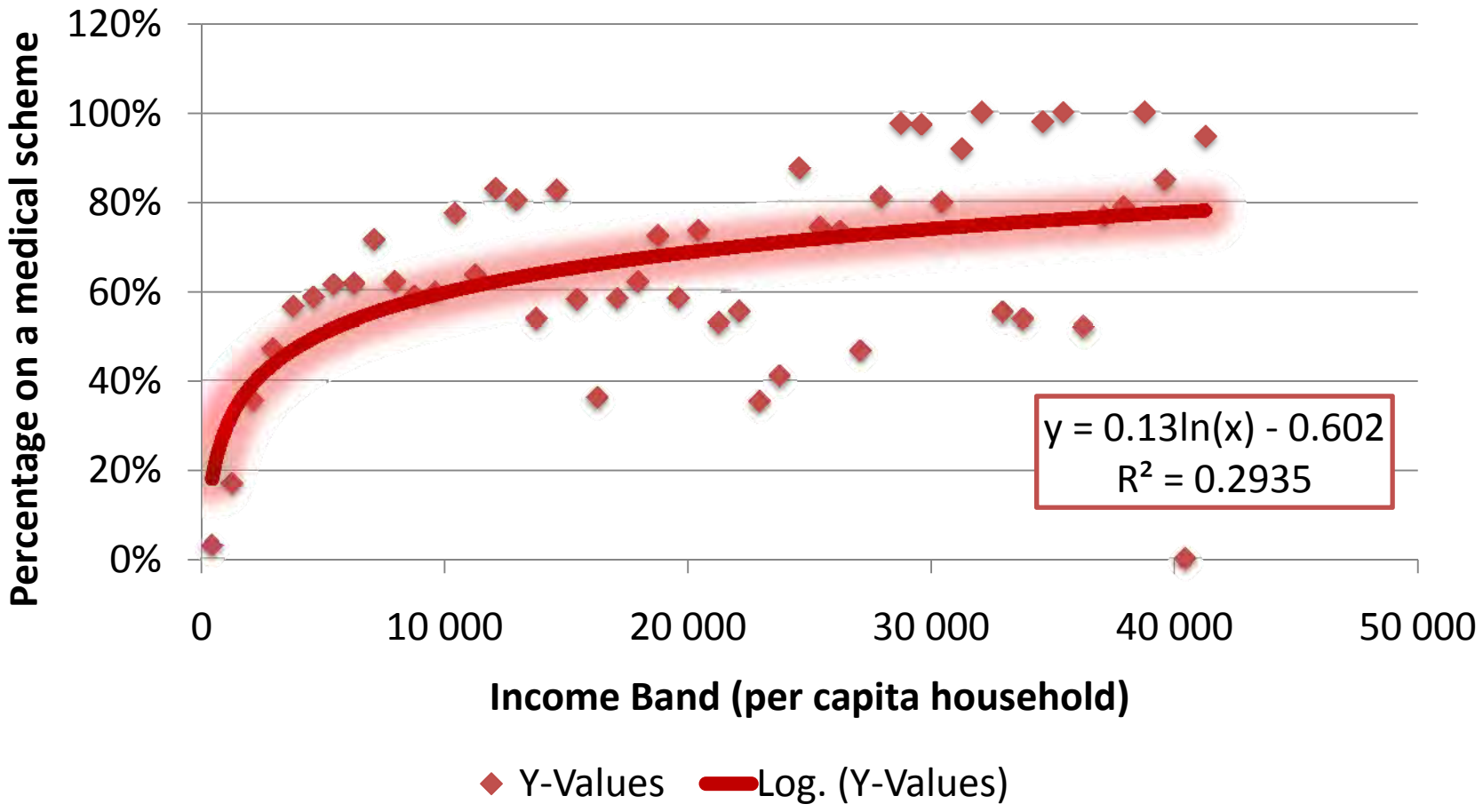
Sources: Council for Medical Schemes Annual Reports to 1999 and OHS, GHS and LFS

Tax payers versus principal medical scheme members



Sources: Council for Medical Schemes; SARS

Medical Scheme Participation



Source for data: GHS2006

In Conclusion

- The technical basis for the proposals made thus far are weak and in many cases disingenuous
- South Africa's reform trajectory requires effective policy leadership – which cannot occur in such a climate
- Far from requiring radical fiscal upscaling, or the implementation of high-risk institutional interventions, more conventional and common-sense reforms are required