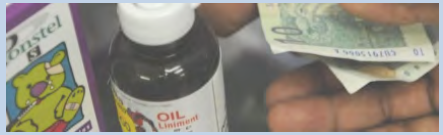


(Dis)agreements in South African health system reform debates

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Symposium on Health Reform
1 July 2011, Stellenbosch

HEALTH ECONOMICS UNIT

Introduction

- My expectations from symposium:
  - Identify areas of agreement in current debates and areas of disagreement:
    - Some relate to what the underlying problems are
    - Most relate to what is the most appropriate way to address these problems
  - Come up with ***real options*** for health system ***improvements*** to debate

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Declaration of interest

- Goal: A universal health system:
  - Two key elements:
    - Financial protection for all
    - Access to *needed* health care for all
  - To achieve this:
    - Contributions to funding of health care according to ability-to-pay
    - Benefit from health care according to need
    - ➢ Income and risk cross-subsidies
- Strategy: Reduce health system inequalities

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Public sector

- Agreement that there are major challenges:
  - Allocative and technical efficiency
  - Management, accountability and governance
  - Access:
    - Availability (especially drugs)
    - Affordability (transport costs; time costs)
    - Acceptability (staff attitudes)
- Lack of agreement on (in)adequacy of resources (human, financial, equipment etc.) relative to size and BoD of population served

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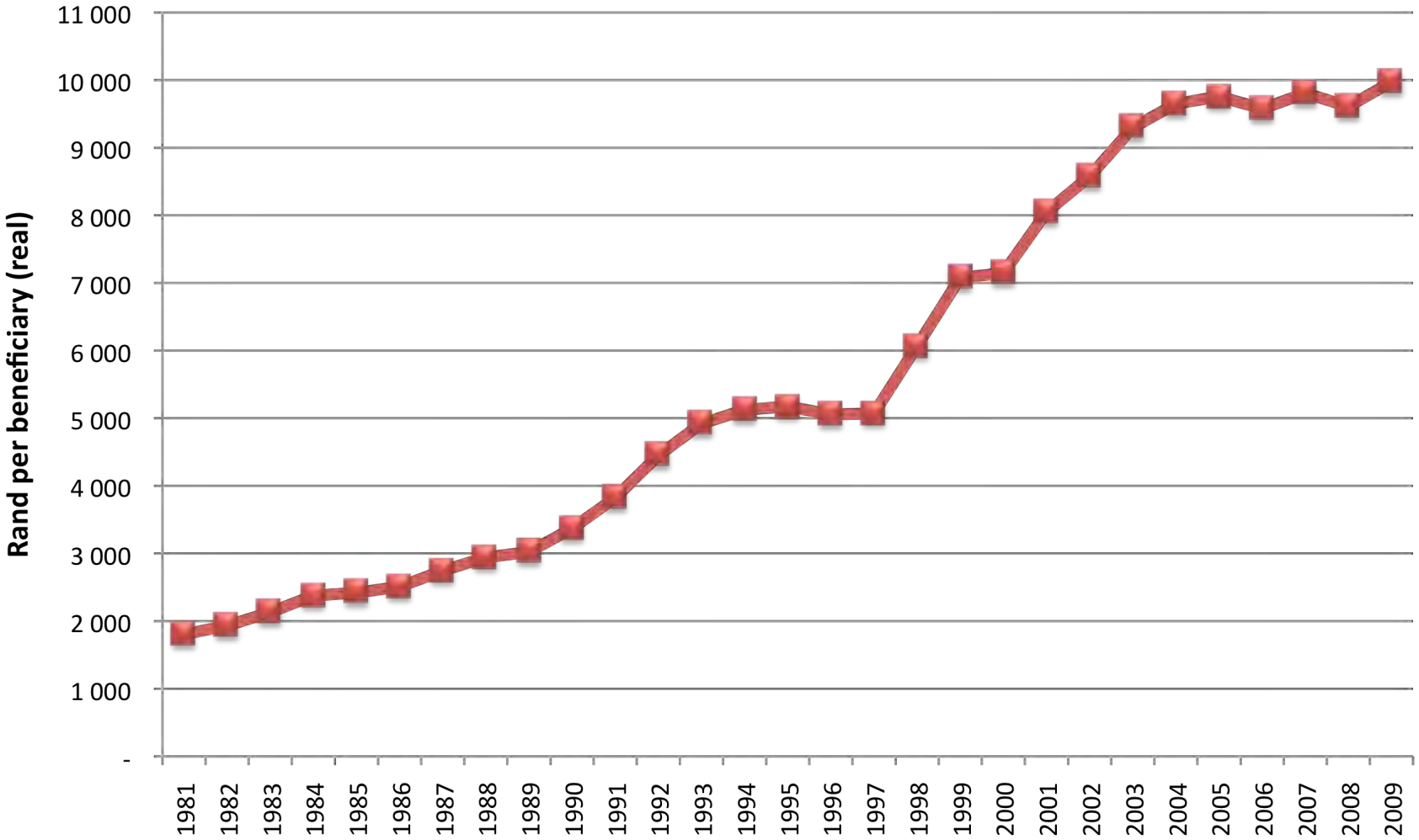
Affordability of schemes?



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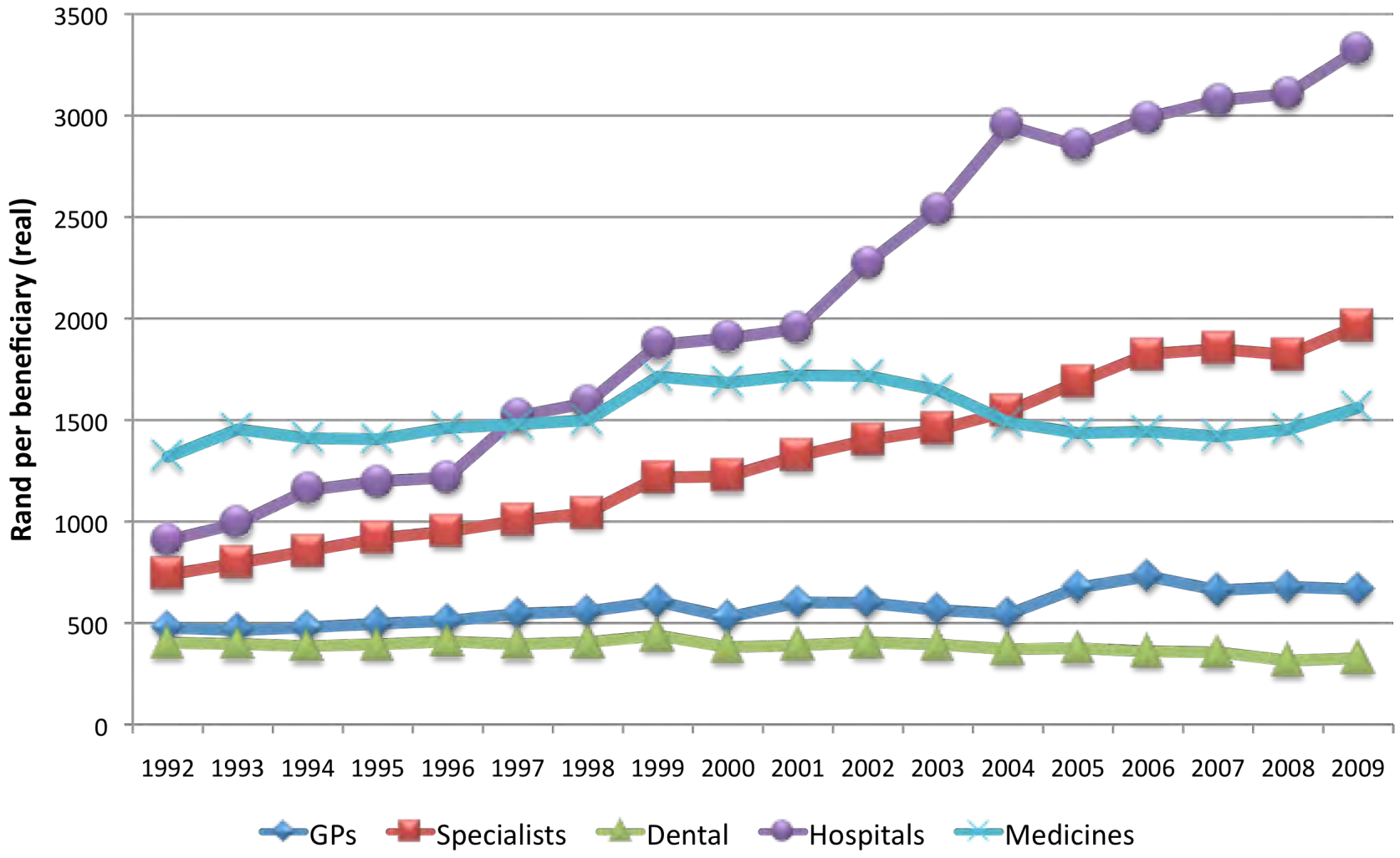
Key expenditure increases



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Key issues

- Purchasing power imbalance between schemes and providers (hospitals & specialists)
- Provider fee increases
- Over-capitalisation
- Over-servicing/supplier-induced demand
- Combined cost of administration, broker and 'managed care' costs
- Fee-for-service & range of perverse incentives

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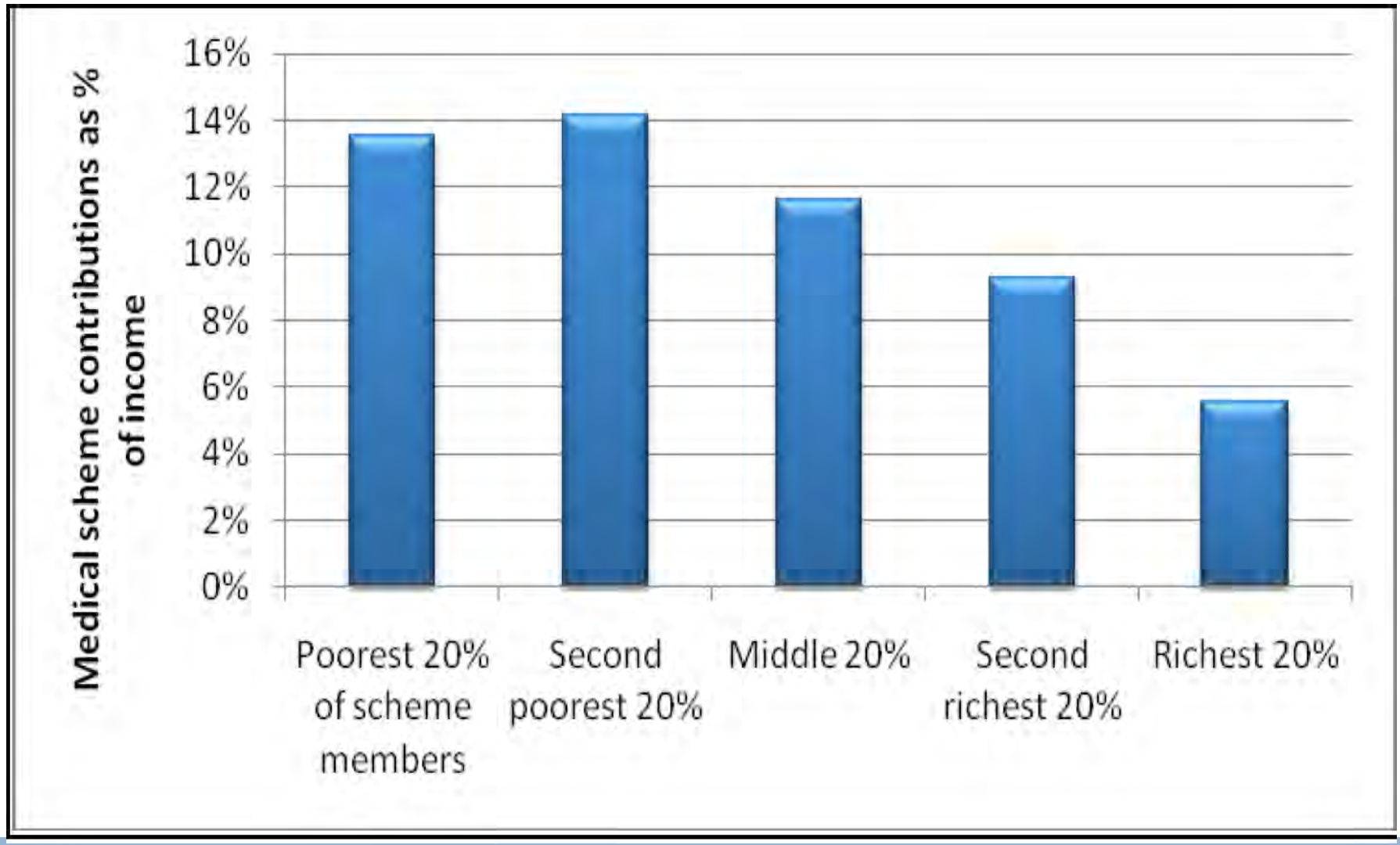
Funding distribution across scheme members



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Private sector

- No agreement:
  - Everything fine, just:
    - Get regulatory framework right
    - Collective bargaining on fees
    - Promote competition/reduce market concentration (hospitals)
    - Reduce conflicts of interest
  - Quite serious problems that regulation has had limited success in addressing

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Tiered health system

- 16% covered by schemes:
  - Average spending of R11,390 p.c. via schemes and OOP by scheme members
- Further 16% use private PHC on OOP basis and public sector for specialist & inpatient:
  - Average spending of R2,806 p.c. (OOP for private PHC and tax funded for hospital & specialist)
- 68% entirely dependent on public services:
  - Average tax funded spending of R1,880 p.c.

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Public-private mix

- No agreement:
  - Not an issue:
    - Richer groups are entitled to choose to spend more on health care
    - All countries have private insurance
    - Doesn't impact on the public sector
  - Is a big issue:
    - Tax funds shouldn't be used to subsidise or purchase private insurance for an elite
    - Contributes to skewed distribution of scarce HR across sectors relative to populations served

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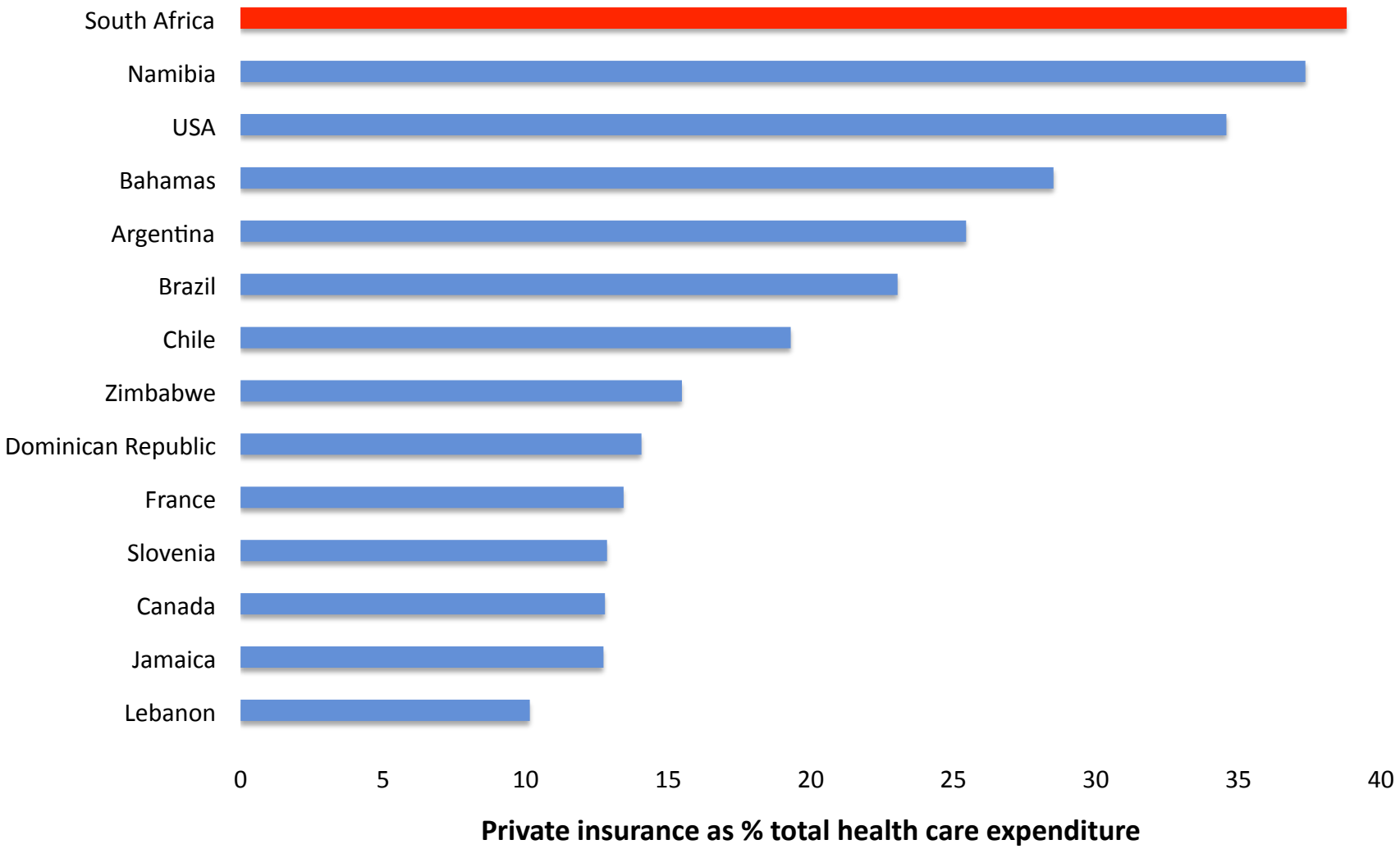
Relative share of PHI



WHO National Health Accounts database

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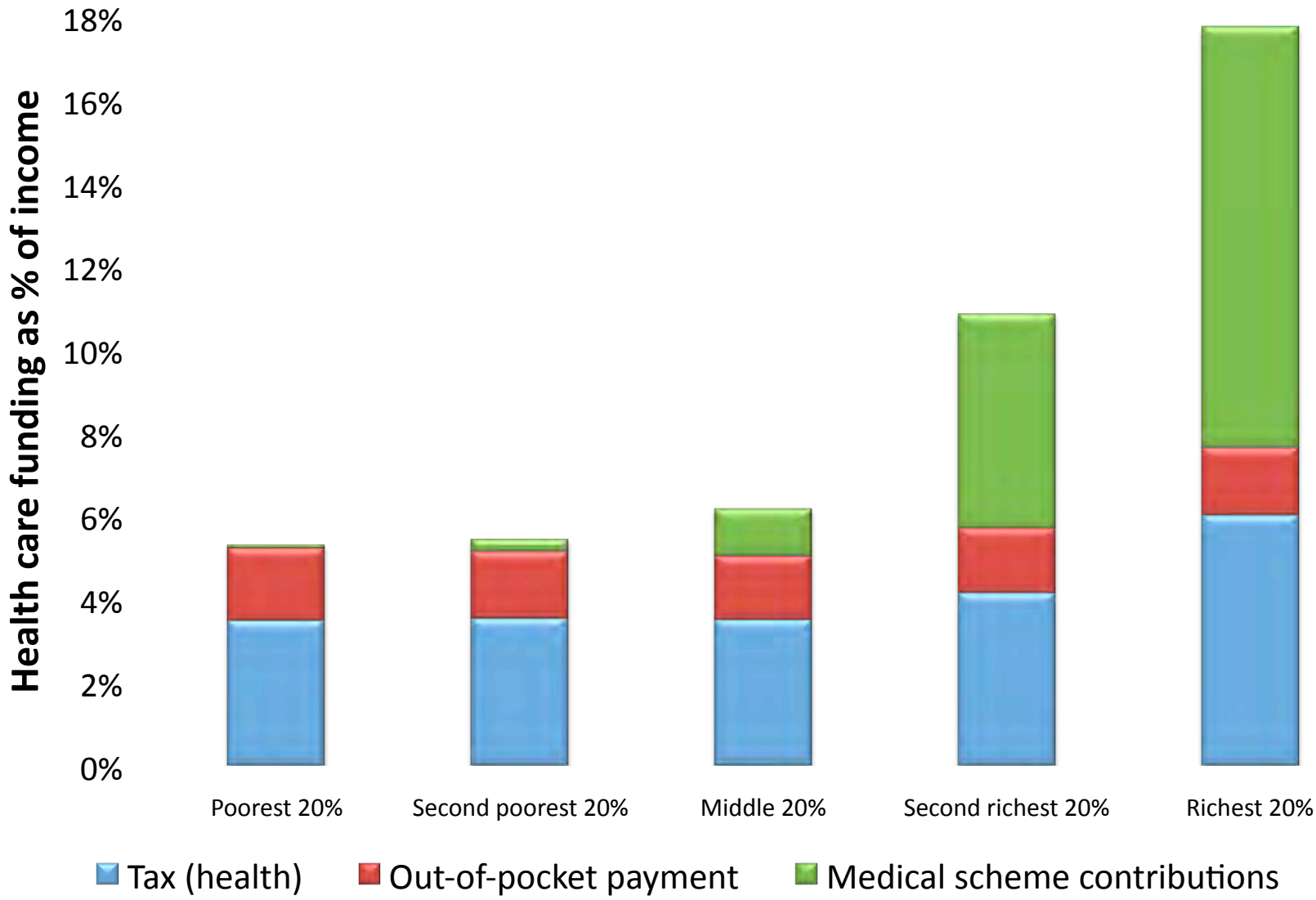
Share of funding burden



Ataguba & McIntyre (SHIELD WP2&3 report)

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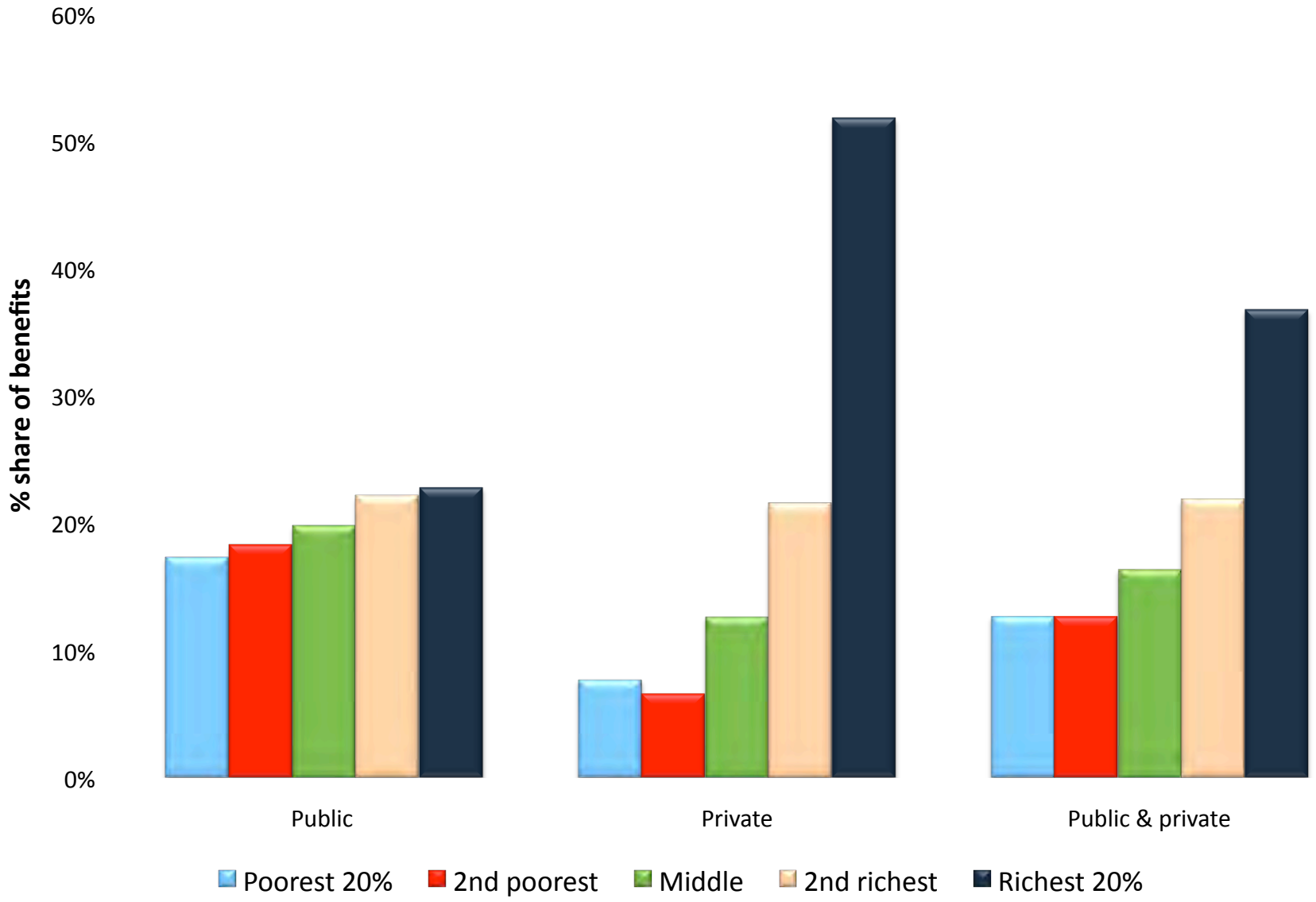
Share of benefits



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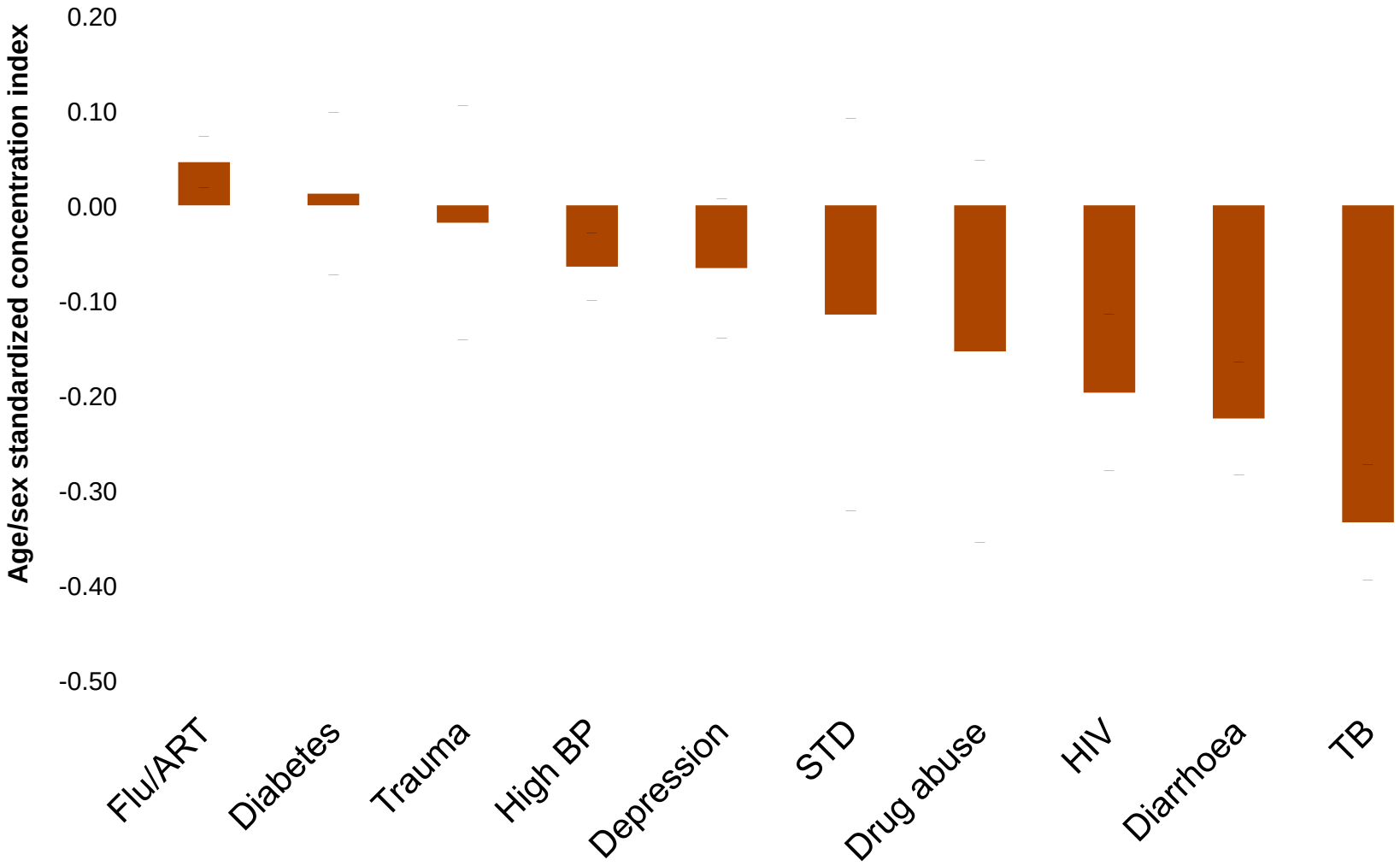
Distribution of illness



Ataguba, Akazili & McIntyre (forthcoming): GHS 2008 data

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Reform perspectives

- Leave the private sector largely alone (just improve regulations) and focus on getting the public sector 'right'

- Need overall health system reform:
  - Focusing only on public sector will not address the public-private mix challenges
  - Nor will it address the challenges in the private sector

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Private sector

- Will different regulation work better?
- Can provider fee increases be addressed?
- Willingness within sector to transform (LIMS)?
  - Conclusion – affordability greatest barrier
  - Solution – formalise a three-tier system
  - Pharmaceutical companies – cheaper for LIMS (*voluntary* basis and *limited time*)
  - Private hospitals – lower cost for LIMS
  - Medical schemes – prevent 'buying-down'

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Public sector

- Is it possible to improve efficiency, equity and accountability within the current institutional arrangements?

- Key issue is active purchasing - identifying needs of population and ensuring appropriate and good quality services are available where and when needed

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Larger, separate public funding pool

- International evidence shows private crowds-out public health spending (& vice versa)
  - Restore some public-private funding mix balance
- Enables purchasing of services from private providers
  - Restore some public-private HR mix balance
- Purchasing power (carrots) more effective than regulation (stick)
  - Address provider fee increases (to the benefit of universal entitlements and schemes)

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Larger, separate public funding pool

- Different institutional environment provides opportunity for:
  - Fast-tracking delegations to hospitals and districts
  - Active purchasing (different set of skills)
  - Improved governance and accountability
  - Changing provider payment mechanisms
- Real entitlements & providers have to deliver
- Improves income and risk cross-subsidies in overall system
- Improve health system information

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Bottom line

- Open to persuasion
- Heard plenty about the problems (quite a bit of agreement)
- Heard very little about possible solutions and mechanisms through which key health system objectives can be achieved

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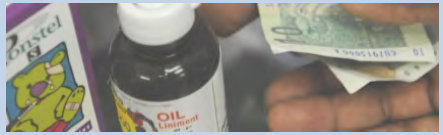


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Thank you

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