Universal Health Coverage- Strategic institutional choices, a discussion on the competing options

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Policy Approach

- Policy changes *should* flow from an **accurate diagnosis** of problems detectable within a pre-existing context and reflect a **substantive social consensus** on the way forward
  - To date there has been no official diagnostic from which policy proposals can be developed
  - Policy proposals have been developed without reference to a formal publicly available diagnostic
  - There has also been no real attempt to generate a substantive social consensus at a technical level

Distinguishing between values, objectives and policy choices

- **Values**
  - Every resident should have access to a **generally accepted** package of health services developed through a consultative process **consistent with the requirements of an open democratic society**

- **Objectives**
  - Every resident
    - *Will have* access to a **defined set of services (or package)** without facing an **unfair financial barrier** to access
    - Financing the package *will be* **fairly distributed across income groups** taking account of their **ability to pay**

- **Objectives – continued…**
  - Access to services *will be* **guaranteed as a right** and apply to all *residents* while fairly including *non-residents,* and will be **justiciable** through an accessible judicial system (quasi or actual)
  - The system of guarantees *will be* made available in a **sustainable** manner

- **Policy choices**
  - Involve **design options** required to realise the *values* and *objectives* recognising that*:*
    - They must take account of the policy context
    - There are technically superior and inferior choices
    - There may be more than one solution
  - The policy process will influence the quality of the policy options chosen

Understanding Universal Coverage as a Right

FORMAL social protection

- Legislated system of guaranteed protections
  - Publicly delivered
  - Social insurance
  - Regulated private delivery
- Redistributive transfers
  - Vertical – via the tax system
  - Horizontal
    - Tax system
    - Insurance
- **Protection is a right**

INFORMAL social protection

- Inter- and intra-household transfers
- Private contracts
  - Employees/employers
  - Individual
- Redistributive transfers
  - Vertical – almost nil
  - Horizontal – limited to insurable risk and income group
- **Protection is not a right**

Therefore,

- Achieving universal health coverage requires careful consideration of the configuration of mechanisms required to achieve a…

GUARANTEED level of social protection

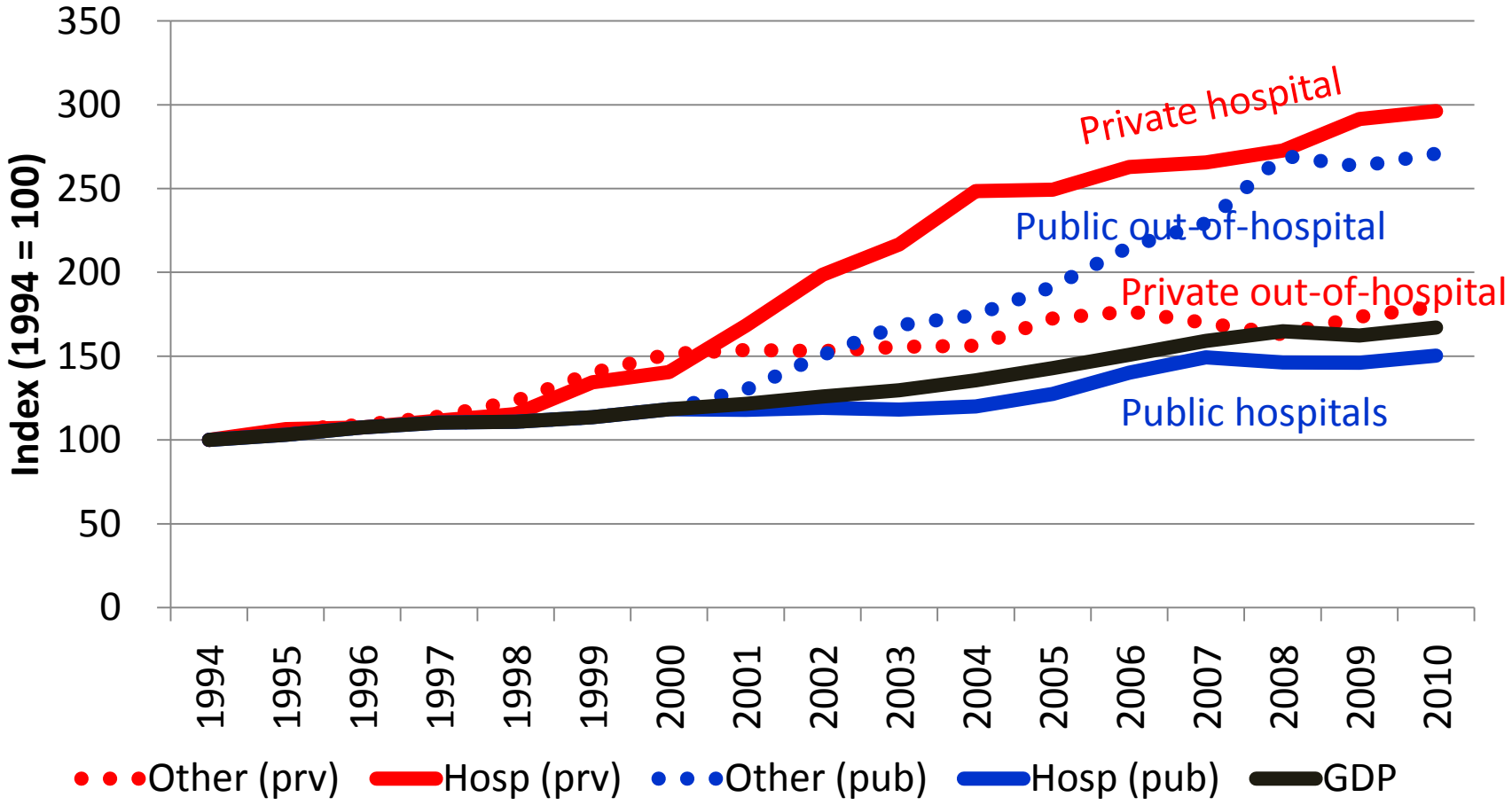
Context

- **Public sector**
  - Provincialized service delivery
  - National focus on policy and resource allocation
  - Characterised by systemic corruption and performance failures due to the system of political appointments into the administrations, hospitals, and other services

Continued…

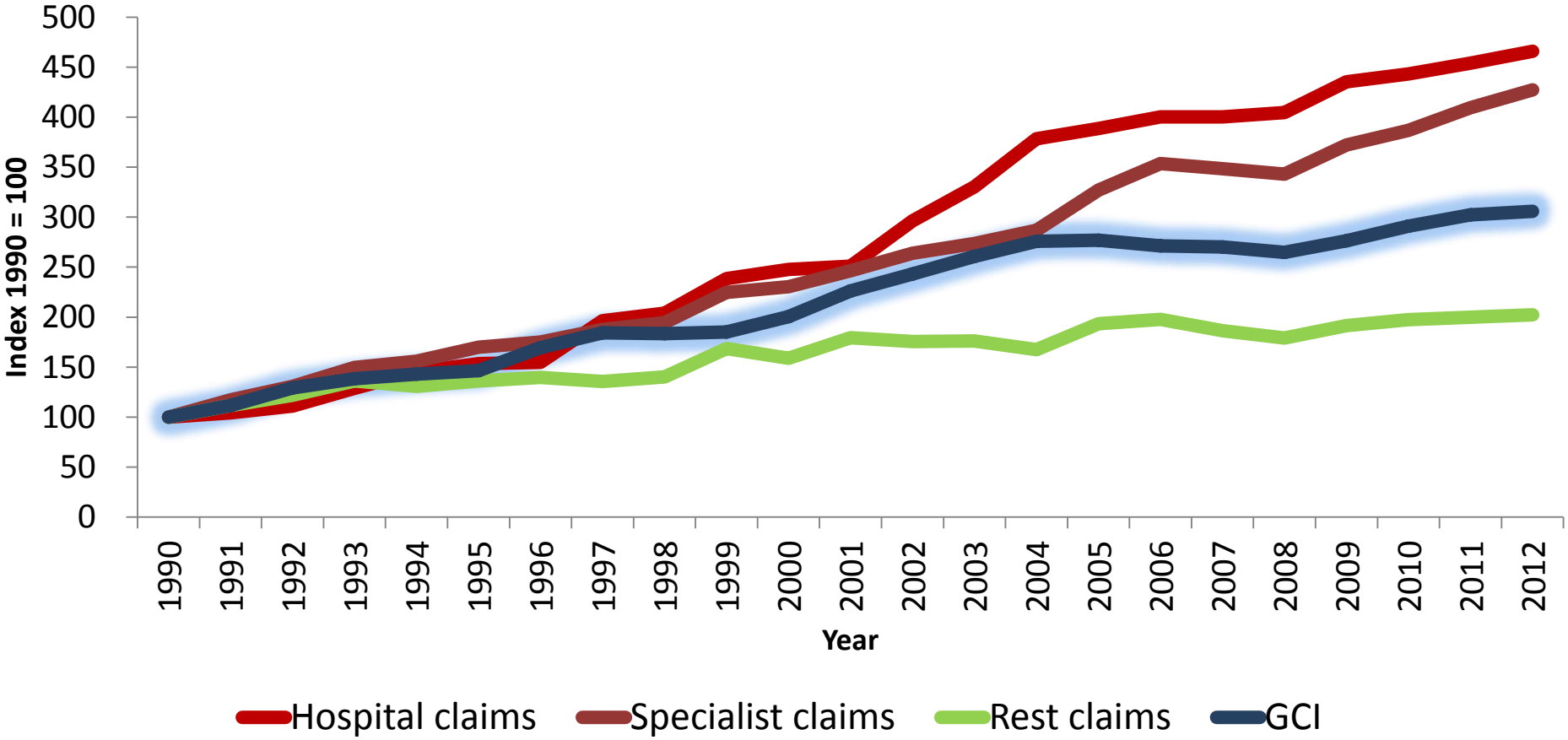
- **Private sector**
  - Regulated voluntary medical scheme system with certain protections in place
    - Contributions cannot be determined in accordance with health status
    - Mandatory minimum benefits
    - Open enrolment
    - Protected access persons with pre-existing conditions
  - Characterised by excessive cost increases

Index changes in real medical schemes expenditure, public health expenditure and GDP 1994-2010



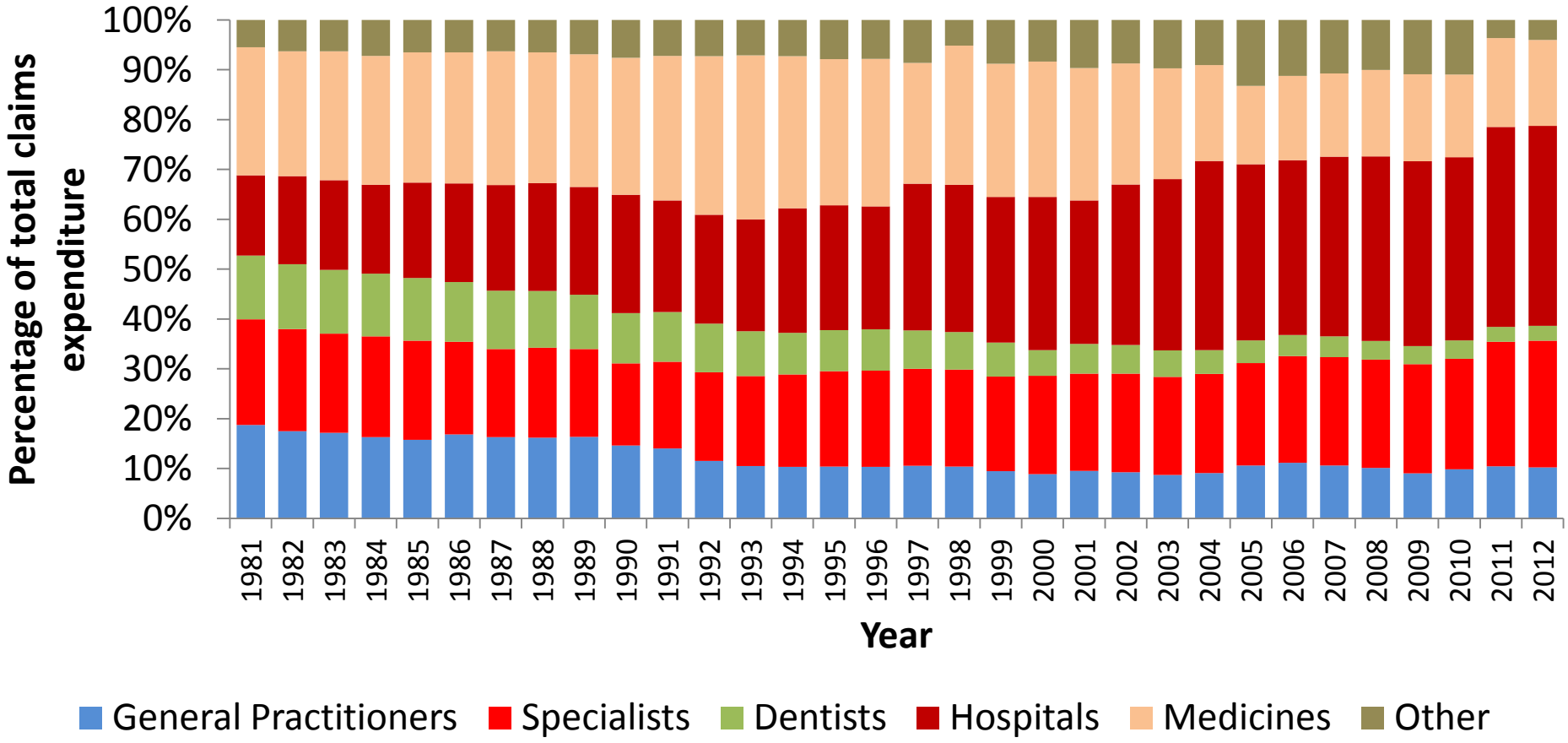
Sources: Council for Medical Schemes Annual Report, Provincial Budget Statements, Statistics South Africa

Real per capita changes in medical scheme expenditure and GCI (2012 prices)



Source: Council for Medical Schemes data from scheme audited financial statements 1990 – 2012 (adjusted for CPI)

Changes in the structure of medical schemes expenditure on benefits (1981-2012)



Source: Council for Medical Schemes data from scheme audited financial statements 1981 - 2012

Strategic Choices

Option 1

- Build system of formal guarantees through both the **public and private systems**

- Requires **addressing systemic failures** in both the public and private systems

Option 2

- Build system of formal guarantees exclusively around **public sector** delivery

- Requires **replacing the entire system of public and private "purchasing"**

Public sector reform

Option 1

- Introduce **national-level resource allocation**
- Retain provincial system and nationally regulate for
  - Governance and accountability frameworks (removing political conflicts of interest)
  - Decentralisation – autonomous District Health Authorities, hospitals, EMS

Option 1

- Establish a **national fund** to act as a **purchaser** of both public and private services
  - Budget for the entire system at a national level
  - With regional and district structures (District Health Authorities)
  - Contract with both public and private providers
  - Provinces to operate merely as a provincial service option for contracting

Continued…

Option 1

- Gradually introduce purchaser provider split within the provincial system
  - Provinces and District Health Authorities to contract with both public and private services
- ICT framework - legislated nationally – with conditional grants and compliance framework to ensure implementation provincially

Option 2

- Introduce a purchaser provider split
  - National fund and District Health Authorities to contract with both public and private providers
- ICT framework - system designed, procured and implemented by national government for all parts of the system

Public sector guaranteed benefits

Option 1

- Legislated norms and standards
  - Service configurations
  - Supply norms
  - Protocols
  - Essential drugs
  - Service standards
  - Performance standards

Option 2

- Legislated norms and standards
  - Service configurations
  - Supply norms
  - Protocols
  - Essential drugs
  - Service standards
  - Performance standards

Public sector governance and accountability

Option 1

- Implementation of independent boards of supervision which appoint and remove the CEOs of hospitals and District Health Authorities
- **All points of purchasing de-politicised**

Option 2

- Officially proposals are to retain political appointments to all parts of the system, including the national fund, hospitals, and District Health Authorities
- Only change is for national rather than provincial political appointments – **the system therefore remains exposed to systemic corruption**

Public sector access entitlements

Option 1

- **Universally free** (remove means test) at point-of-service, with **medical scheme beneficiaries required to pay** for public sector benefits from insured benefits

Option 2

- **Universally free** (remove means test) at point-of-service, with **medical scheme beneficiaries not required to pay** for public services

Public sector financing

Option 1

- General tax funded

Option 2

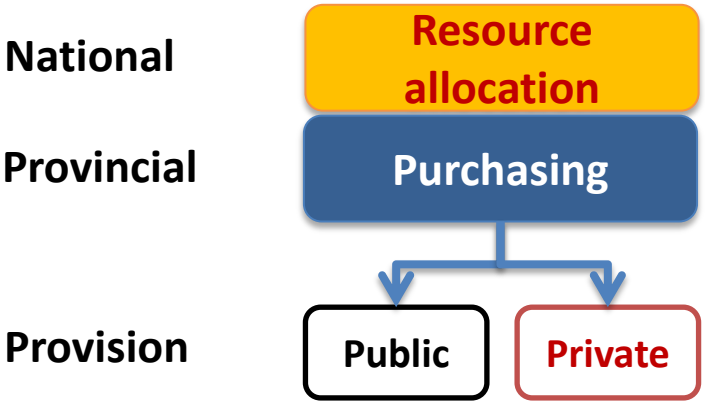
- General tax funded

As universal benefits are being provided – general tax revenue remains the most stable and fairest source of revenue

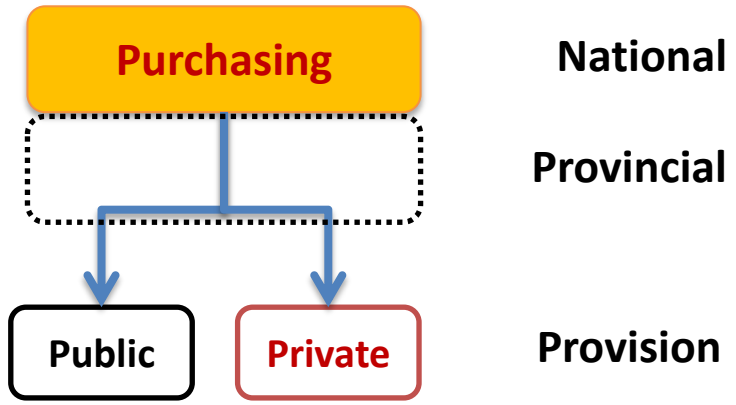
Supplementing a general budget allocation with a payroll (or some other for of earmarked) tax will not alter the discretionary nature of the public health budget

High-level architecture of the public system

Option 1



Option 2



Both options envisage the development of a **purchaser provider split**, but *option 1* proposes to achieve this by building on the existing provincial platform rather than replacing it with totally new regional structures with the same functional responsibilities

Private sector - financing

Option 1

- Ensure system of guaranteed protections are sustained and expanded
  - Mandate coverage for higher-income groups
  - Contribution subsidy for lower income groups replaces current tax subsidy
  - Risk equalisation
  - Mandatory minimum benefits
  - Supplementary benefits
  - Open enrolment

Option 2

- Deregulate private funding
  - Remove all contribution subsidies
  - Remove open enrolment
  - Remove mandatory minimum benefit
  - Permit for-profit insurance
  - Permit unlimited risk-rating and risk-selection

Private sector - provision

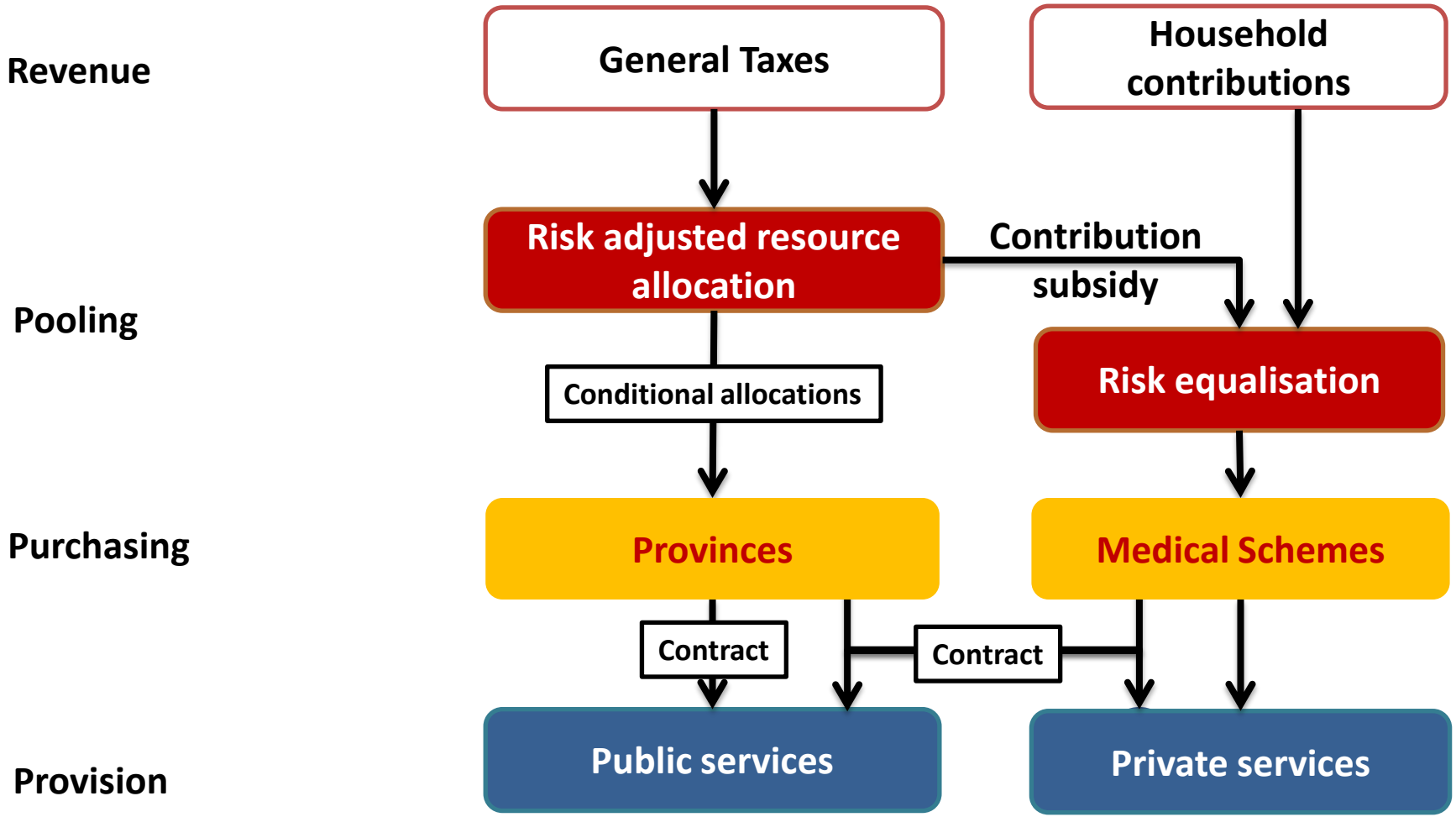
Option 1

- Implement regime to manage inappropriate price and cost increases
  - Deal with systemic conflicts of interest
  - Deal with excessive market concentration
  - Deal with collusive practices and other problematic market conduct

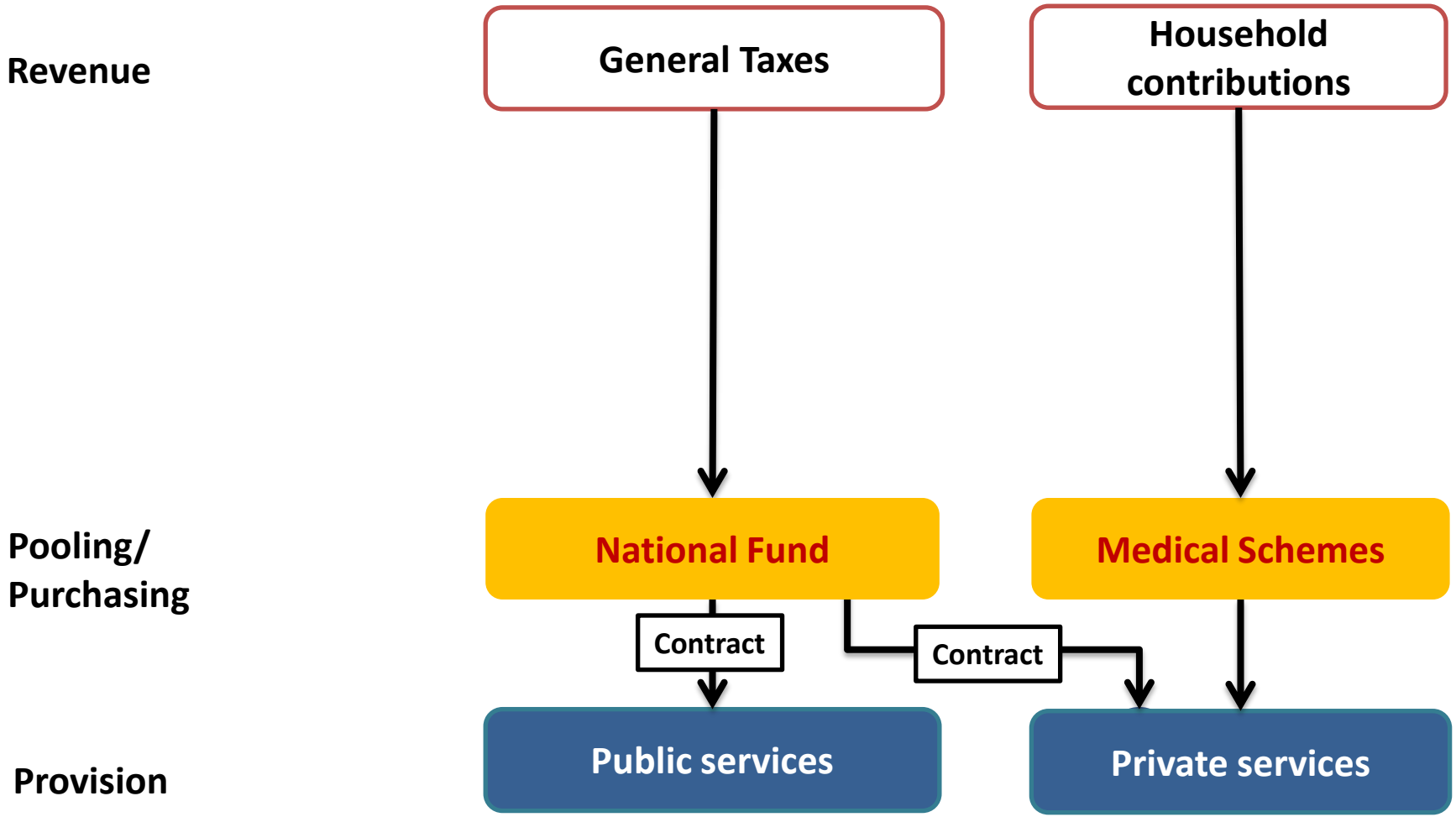
Option 2

- Ignore provider cost increases as private providers will be regulated by way of contract with the public sector –at some distant point in the future

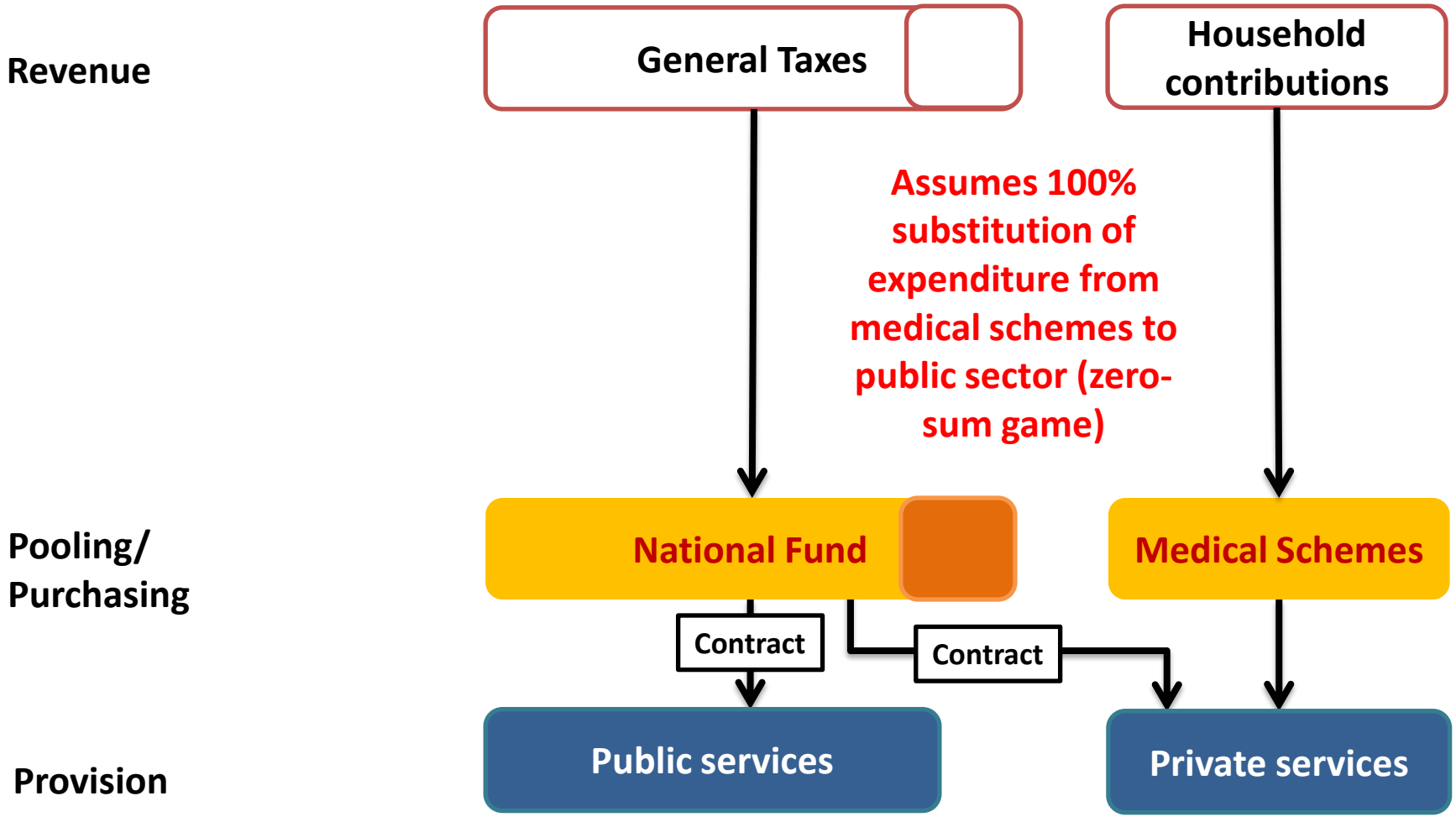
Option 1


Revenue
Pooling
Purchasing
Provision
General Taxes
Household contributions
Risk adjusted resource allocation
Contribution subsidy
Conditional allocations
Risk equalisation
Provinces
Medical Schemes
Contract
Contract
Public services
Private services

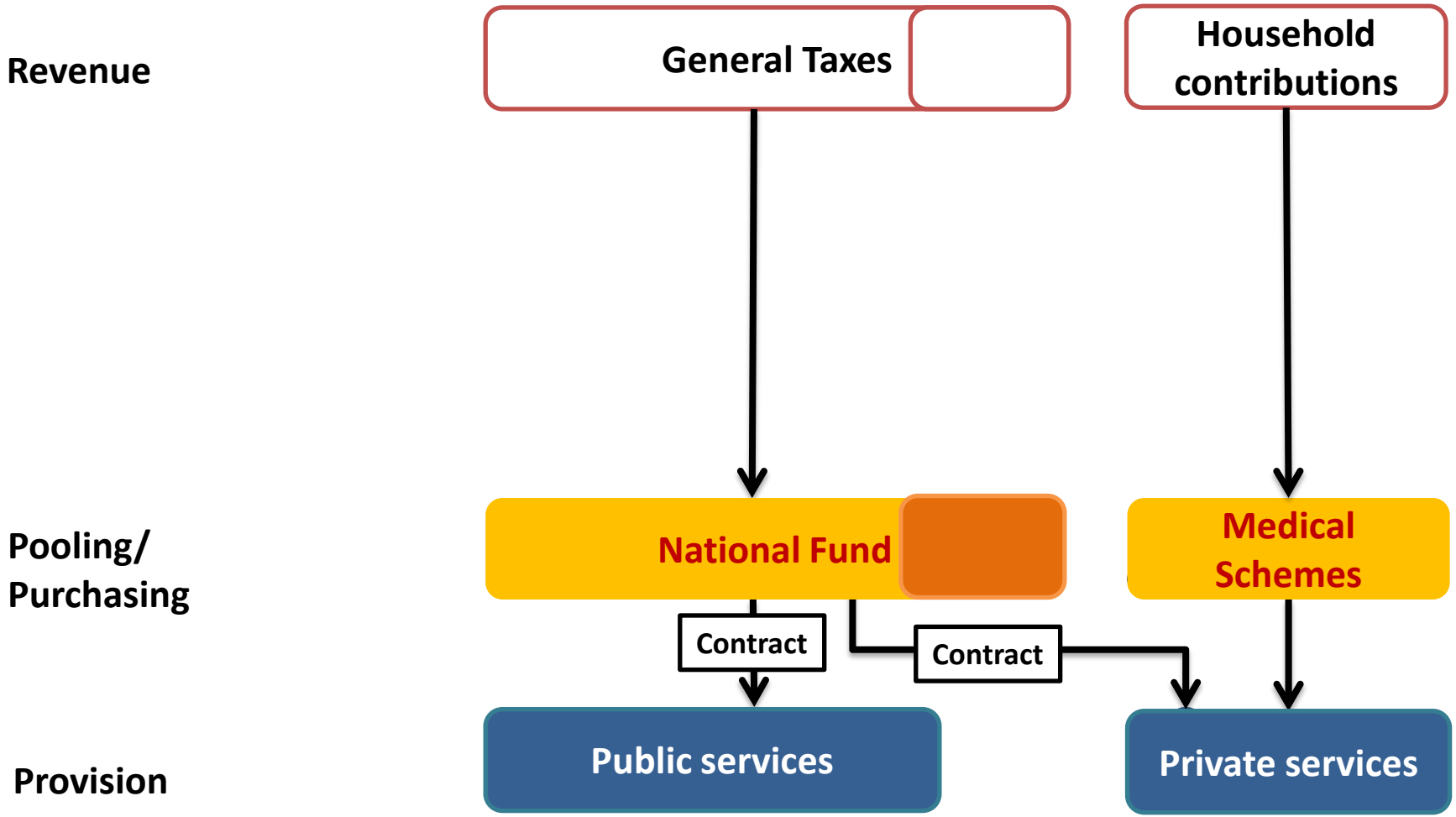
Option 2


Revenue
General Taxes
Household contributions
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

Option 2


Revenue
General Taxes
Household contributions
Assumes 100% substitution of expenditure from medical schemes to public sector (zero-sum game)
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

Option 2


Revenue
General Taxes
Household contributions
Pooling/ Purchasing
National Fund
Medical Schemes
Contract
Contract
Provision
Public services
Private services

Risk assessment

Option 1

- Low-risk
  - Prioritises systemic failures while retaining the broad architecture of the current system
  - Builds on existing platforms to deepen coverage
  - Does not damage existing public and private platforms as part of the reform trajectory

Option 2

- High risk
  - Identifies and addresses no systemic failures for reform (although they could be incorporated into this option)
  - Success of this option requires perfect achievement of all assumptions
  - Allows the current platforms and systems of guarantees to degrade on the assumption that the new platforms will perform better

Conclusion

- Whereas **option 1** recognises flaws in both systems and tries to address them to deepen coverage and system-sustainability, **option 2** ignores all systemic flaws in the current system (public and private) on the assumption that the new and unproven system will replace everything and work better

Option 2 therefore runs the entirely plausible risk that existing protection (formal and informal) in both the public and private systems systematically deteriorate, while no new system ever emerges

END