

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...

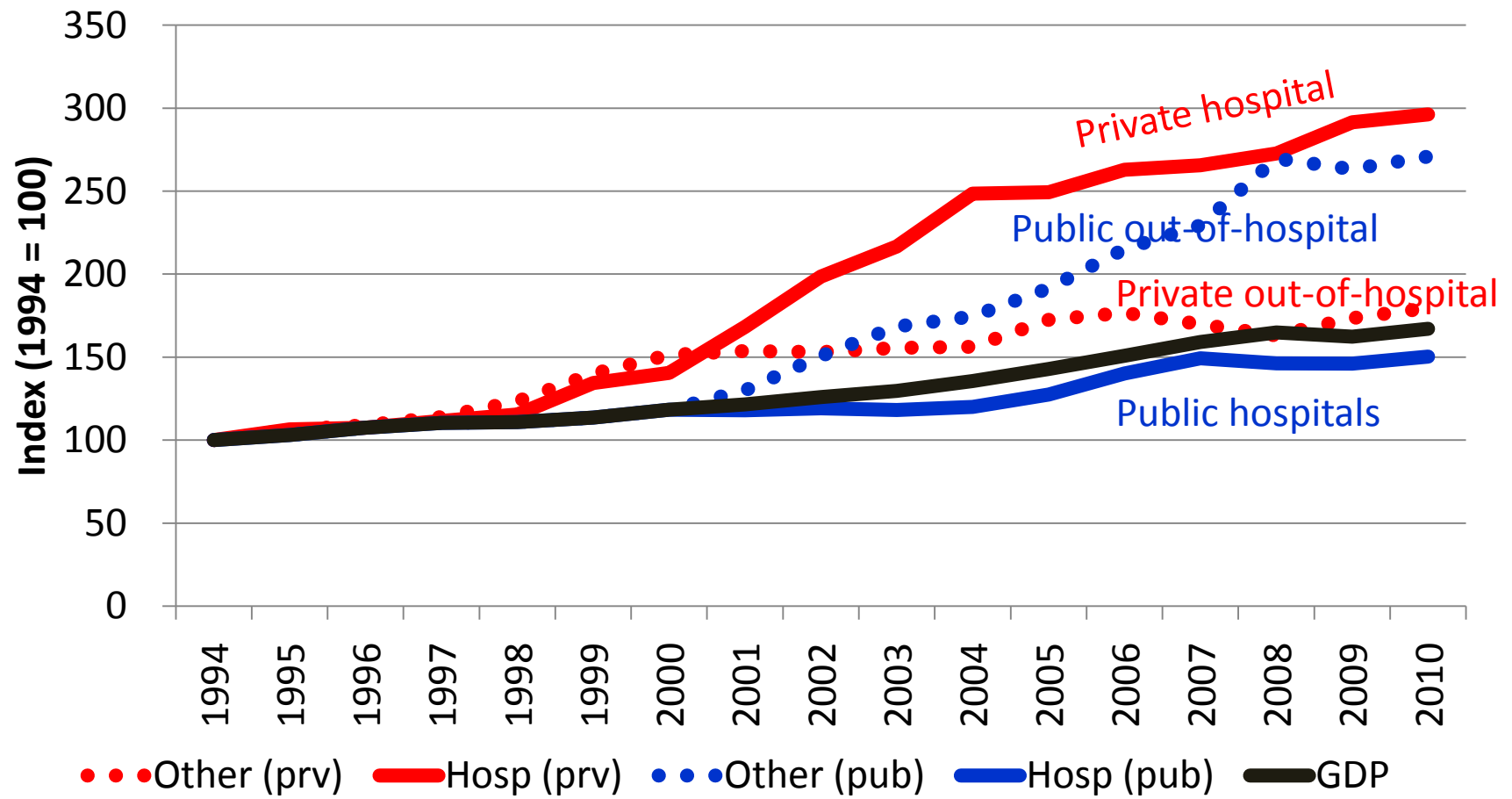
- **Private sector**

- 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

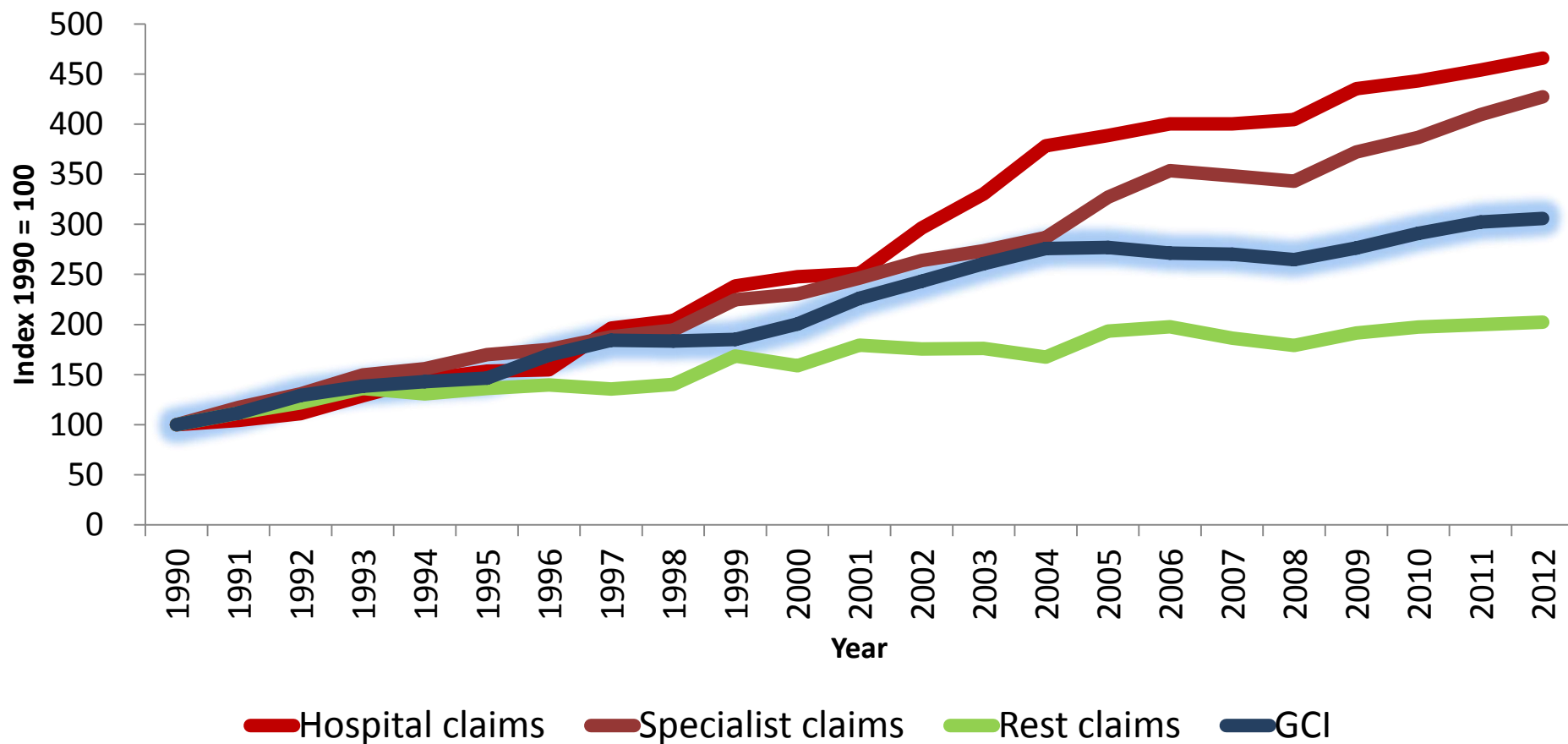
- Characterised by excessive cost increases

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



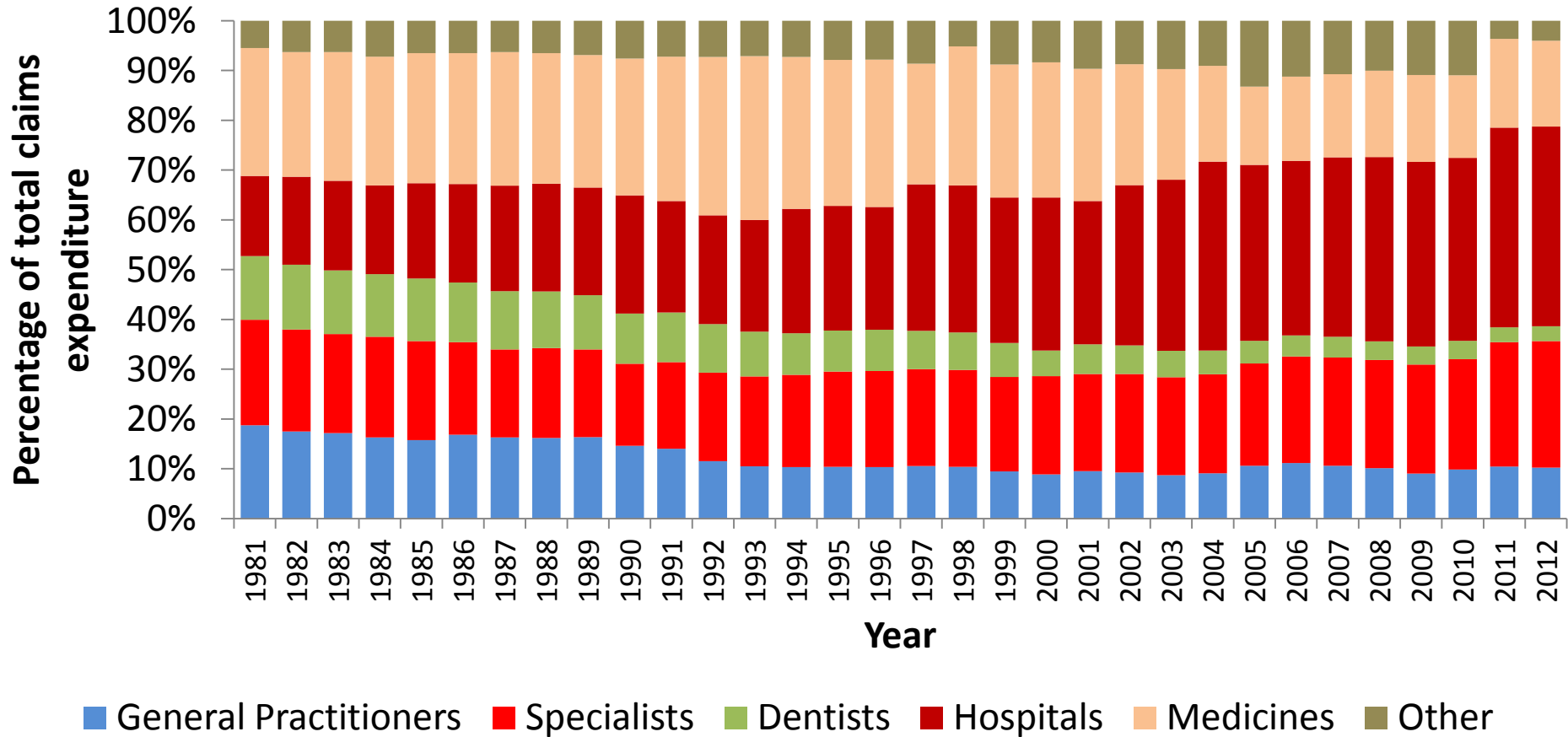
Sources: Council for Medical Schemes Annual Report, Provincial Budget Statements, Statistics South Africa

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

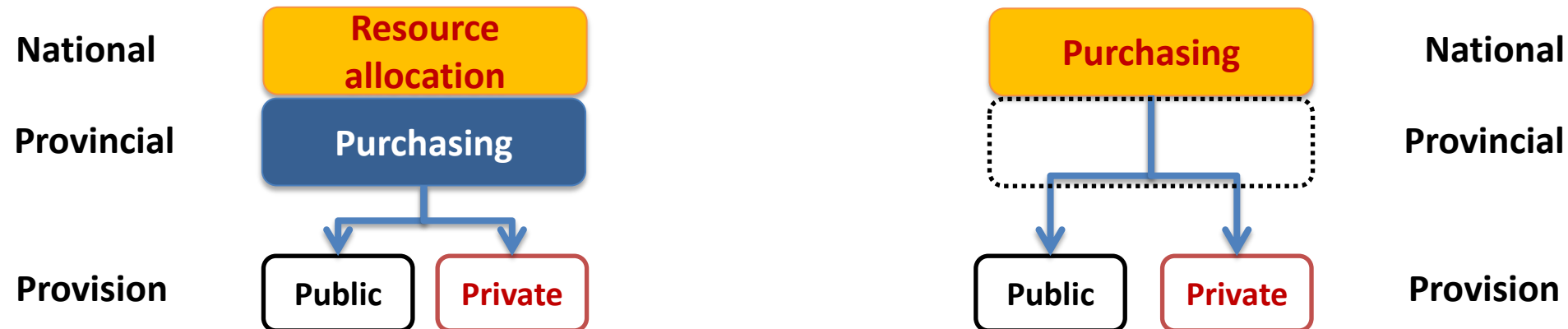
As universal benefits are being provided – general tax revenue remains the most stable and fairest source of revenue

Supplementing a general budget allocation with a payroll (or some other form 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

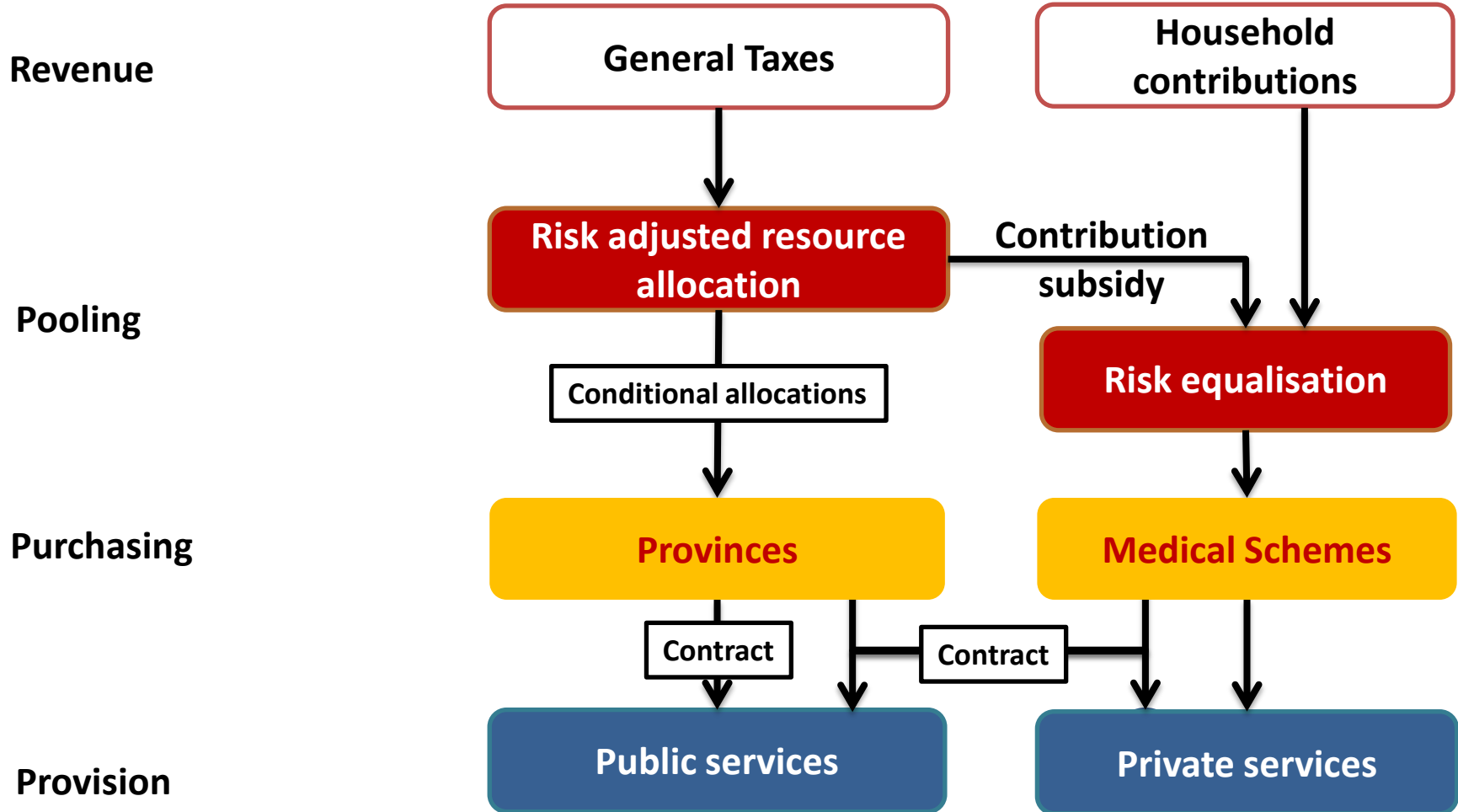
Option 1

- 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

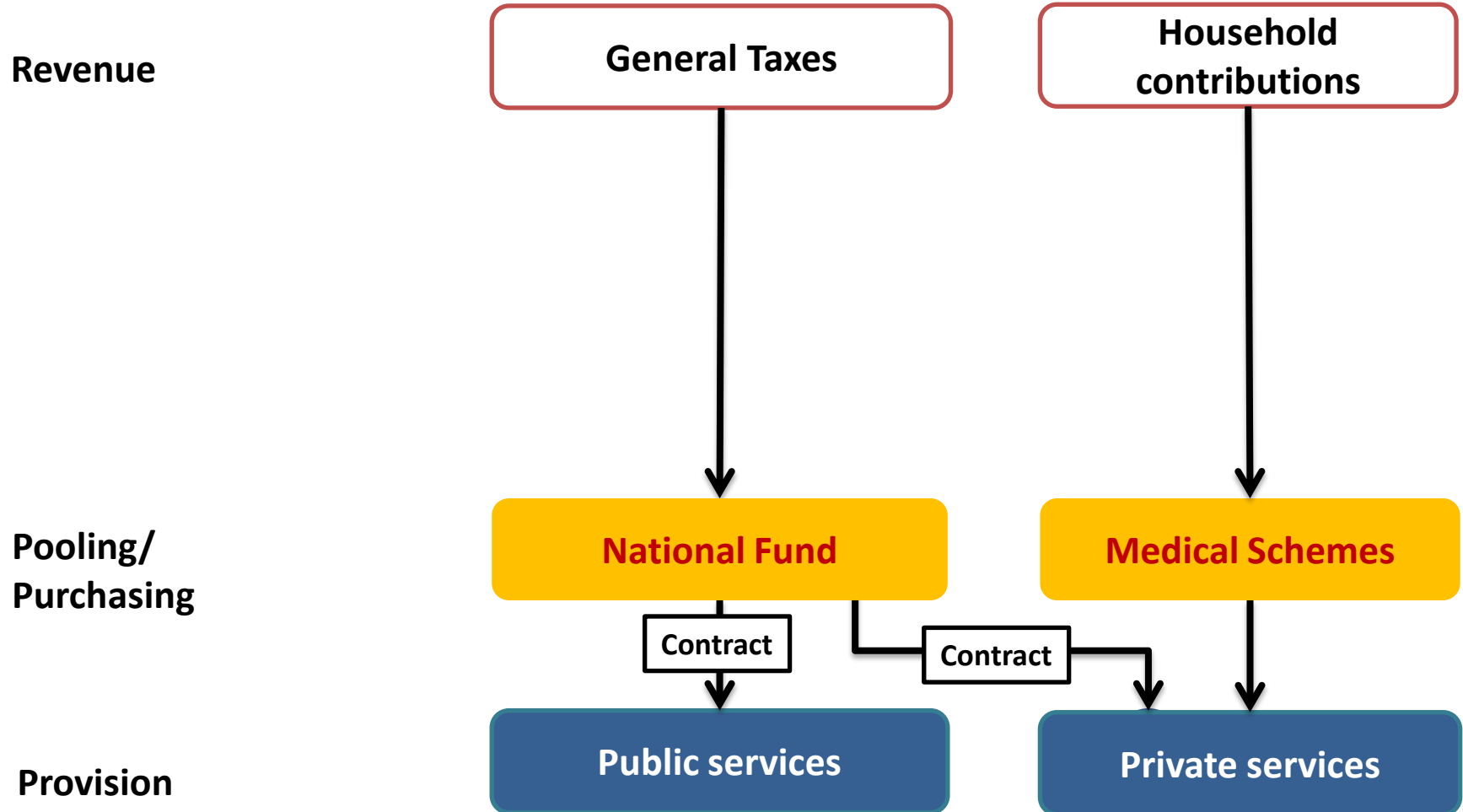
Option 2

- 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

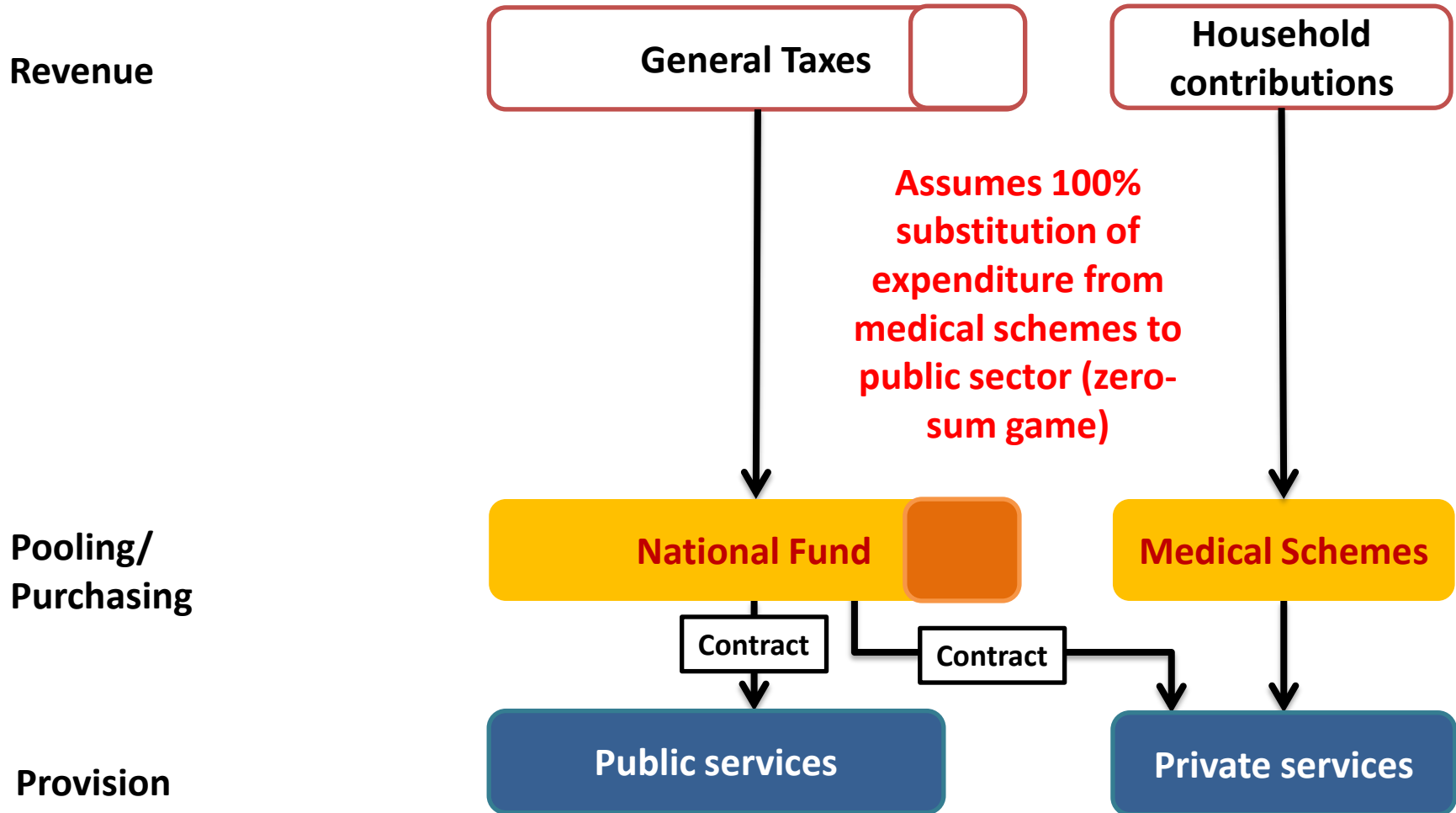
Option 1



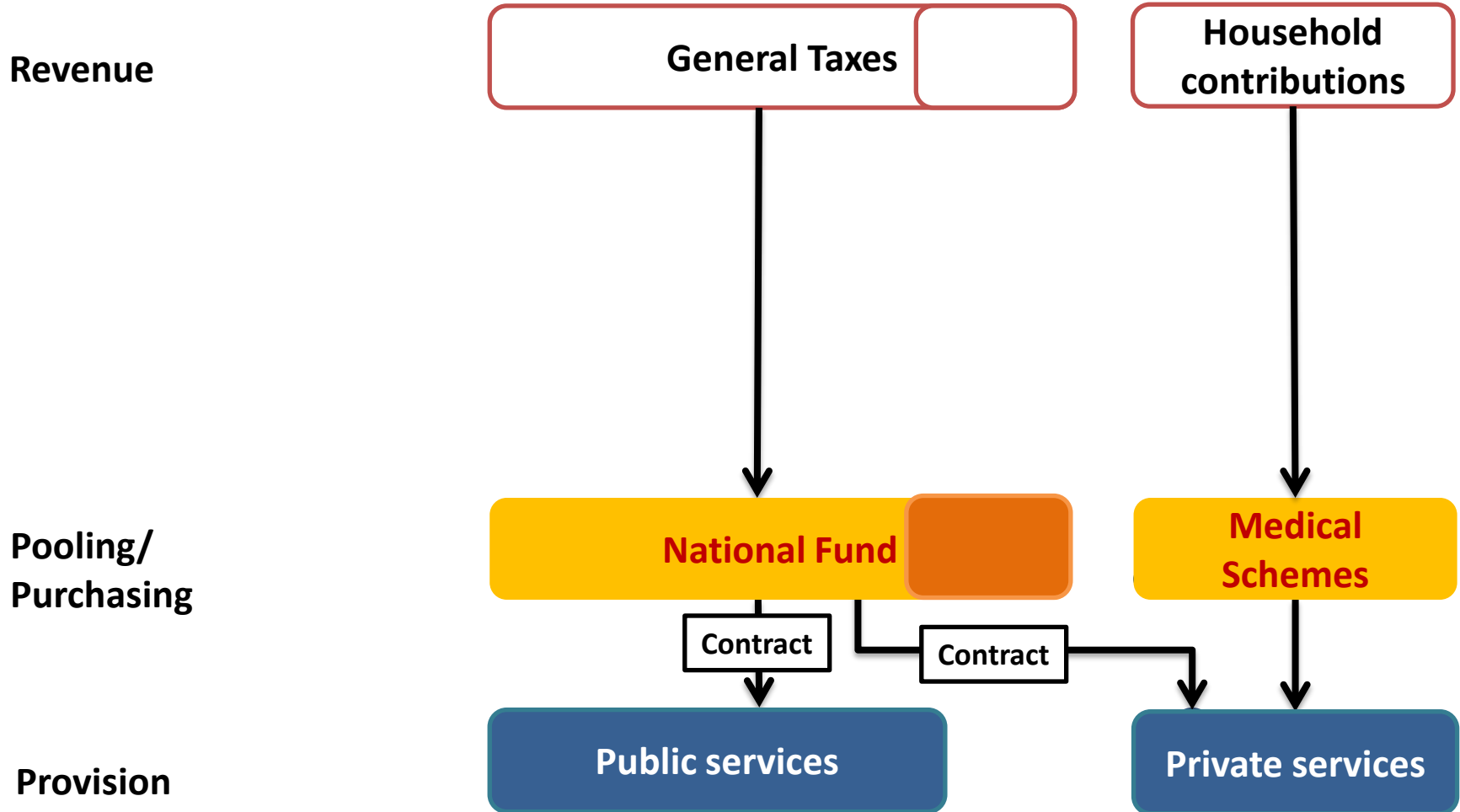
Option 2



Option 2



Option 2



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