ERSA Research Brief

May 2014

Panel: Health financing and regulatory reforms[1]

On 6 February 2014 ERSA hosted a symposium in Stellenbosch on *Critical Choices Regarding Universal Health Coverage (UHC)*. The symposium included a panel discussion on 'Health financing and regulatory reforms'.

The panel was chaired by Andrew Donaldson (National Treasury) and four panellists participated:

- Mark Blecher (National Treasury)
- Nicola Theron (Econex)
- Alex van den Heever (University of the Witwatersrand)
- Brian Ruff (Discovery Health)

The objective of this brief is to encourage public discussion amongst practitioners, policy makers, academics and NGOs on the broad process of health system reform in South Africa.

The brief captures the most important points raised by the panellists during the discussion. It summarises the themes that emerged from their responses to the Chair's questions. Since the same themes came up in answers to different questions, a thematic rather than question-based summary is offered. The range of questions discussed included the impact of a single-payer health financing system, the future of prescribed minimum benefits in a single-payer system, avenues to curtail private sector cost increases and a wish list of health sector reforms for the next decade.

Themes identified

1. **South Africa lacks the rigorous and detailed evidence-base required to guide large-scale health system reform**

As South Africa embarks on a large-scale health system reform process, questions are being asked about whether there is sufficiently detailed microeconomic evidence about the problems with the current public and private sector financing and delivery systems. Such evidence will be needed to guide the process. Without robust evidence, it is unlikely that system reforms will yield the expected improvements in 10 to 15 years' time. It should therefore be a national priority to invest in and develop the necessary information systems and data collection and analysis capacity to guide the reform.

2. **South Africa can learn about broad reform directions from other countries**

One of the panellists proposed that South Africa has much to learn from the health reform experiences of Thailand and Chile and other relevant countries and suggested that there are a number of potential reform outcomes which different countries demonstrate for South Africa.

The Thai approach has achieved universal coverage through the development of a strong Universal Coverage (UC) scheme which covers a large section of the population. The country has invested strongly in capacity development to guide the Fund, in benefit selection and other areas. The Thai UC

[1] Report on panel discussion compiled by Anja Smith (University of Stellenbosch).

system has managed to build quality in the public health system which is used and trusted by many Thais, but does contract with private providers for various services. Despite a desire to consolidate schemes, the civil servant scheme and social security scheme still operate as separate schemes, but there have been various steps to benefit harmonisation.

In Chile, UHC was pursued by defining a basic benefit package for both the public (FONASA) and private insurance (ISAPRE) markets. Chilean families can choose between the public fund and private funds with respect to their contributions and the public subsidy. A prioritised benefit package was developed through the AUGE reforms.

Taiwan, Turkey, Malaysia, Brazil and South Korea all provide interesting reform choices. In countries like Taiwan and South Korea the public fund(s) contract extensively with competing private as well as public providers. In contrast, in a National Health Service option like in the United Kingdom much of the provision is public, although general practitioners are independent contractors.

3. Primary care services must be expanded and improved

The question of change must be considered from supply and demand perspectives, and public and private sector perspectives.

On the demand side, it will be essential to improve the quality of public sector healthcare to the point where the choice between using public or private health services becomes a real one and using public services will not be the worse option.

On the supply side, the most important reform will be to ensure that there is a good primary healthcare system in both the public and the private sector. Every citizen must have a link to a primary care provider and this must be the entry point into the South African health system. A strong referral system will be needed. . A system where families could choose to use general practitioner services as part of a publicly funded NHI would be a big improvement on the current system.

4. Private sector costs must be curbed to ensure sustainability and improve access

The current health financing arrangements mainly meet the needs of the low-income (public sector) and high-income (private sector) markets. Those who fall in the middle must be taken into account – the so-called ‘gap market’ or middle-income market. This will require reform on both the supply side (lower cost, higher value services) and the demand side (moving away from fee-for-service as the payment mechanism in contracting with suppliers; and through carefully targeted insurance subsidies).

One of the biggest cost drivers of private health services is the hospital- and specialist-centric nature of the South African private sector. The private sector needs to return to a strong triage or referral system. It is evident from the lack of clear data on costs within the supply side of the system that cost containment has not been the main focus area of the private sector. However, certain approaches such as formulary led purchasing and hospital alternative reimbursement contracts are helping to decrease prices.

An extreme outcome of the Competition Commission’s current enquiry into the private health sector could be price regulation. But this will not necessarily follow. The enquiry aims to first establish an evidence base before providing recommendations to rectify market failures. The point is first to identify the market failures. Price regulation would be the least desirable outcome of this process since South African regulators have a history of getting prices wrong (e.g. pharmaceutical price regulation) and this could have serious negative consequences for the market. Instead, it is hoped that the Commission will form a view on what could make the system work better and will suggest remedies such as new regulatory agencies, research bodies and regulations aimed at enhancing its performance. The pending recommendations from the current OECD review on health prices could also be useful in thinking about private sector health costs in South Africa.

5. A well-defined benefit package is essential to make NHI work for all

One panellist said that the current concept of what a minimum benefit package should look like in the NHI system seems to have largely been shaped by the existing 'prescribed minimum benefits' (PMBs) in the private health financing sector. The development of an acceptable and affordable benefit package will be central to the success of the reform process. The panellist added that the current private sector PMB scope is simply too broad, i.e. it covers too many conditions, to be affordable for South Africa as the basic benefit package in the NHI system. Ultimately the benefit package will have to be rationed. Such rationing would not be unique to South Africa.

Another panellist argued that the current private sector PMB framework can be experienced as an open-ended liability, which it was never intended to be. It was intended to be mainly focused on catastrophic medical expenses. Medical schemes have chosen to interpret PMBs as hospital-focused and have largely ignored preventative care. The panellist said that the introduction of the PMBs has made it even more urgent to establish a risk equalisation fund to stabilise expenditure by medical schemes, given the high expenditure requirements associated with PMBs.

It was pointed out that the role of PMBs depends on the future role of medical schemes in the system. The quality level at which public services are provided within the NHI will be central to the success of the NHI and the future role of medical schemes. It was argued that unless quality in the public sector improves sufficiently, medical schemes will retain their substitutive role and the PMBs currently in place in the private sector will remain relevant. It is also useful to consider the South American approach to prioritising benefits such as the AUGE reforms in Chile and Plan Nacer in Argentina.

6. Prudent health reform requires gradualism and working within the boundaries of the existing health systems in South Africa

Panellists were in agreement that successful reform requires organic, gradual change and path dependencies. Some panellists argued further that this implies that a complete health system overhaul is not a prudent approach. They were concerned that replacing the financing platforms of either (or both) the public or private systems would be too drastic and that initially the focus should be on dealing with existing problems in both systems, using a gradual reform process, and aiming for an eventual convergence of the two systems in 15 years' time. An additional tactic may be to explicitly focus on the development of a market for insurance cover for the 'gap market'.