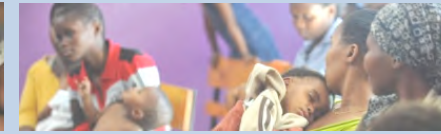
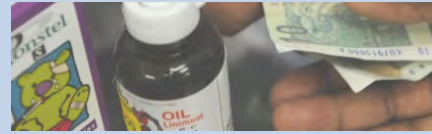




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(Dis)agreements in South African health system reform debates

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Symposium on Health Reform
1 July 2011, Stellenbosch



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



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

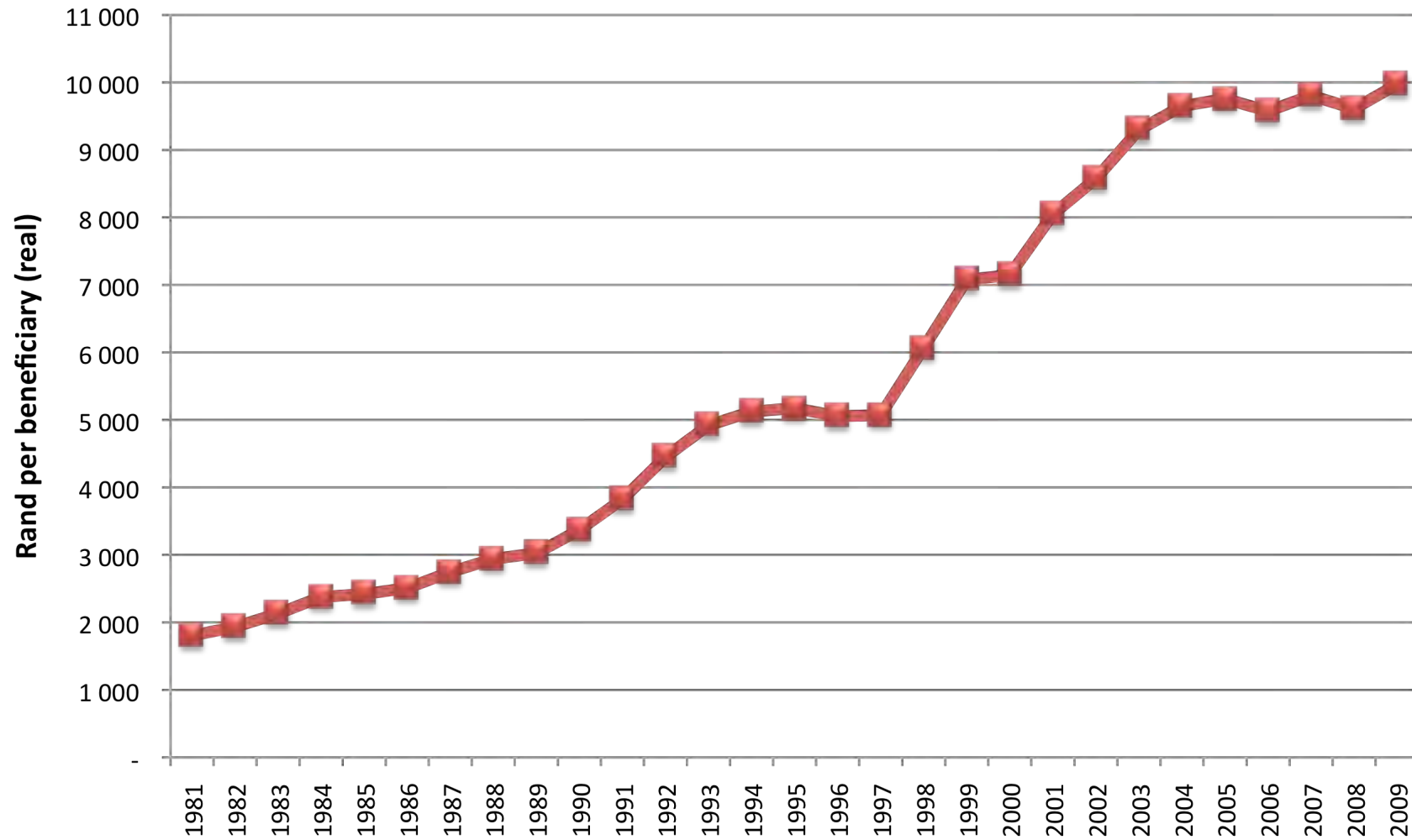


Public sector

- 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

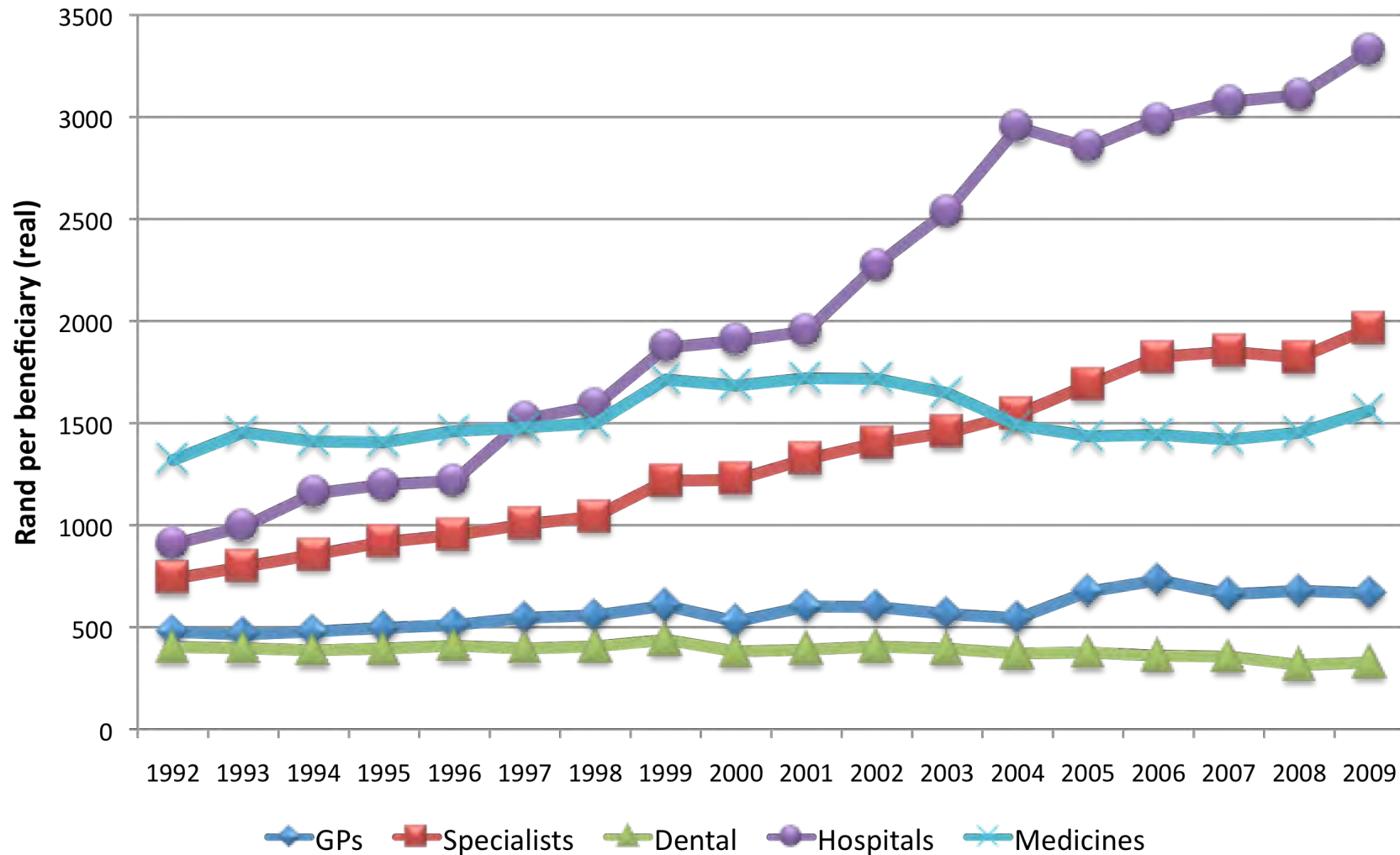


Affordability of schemes?





Key expenditure increases



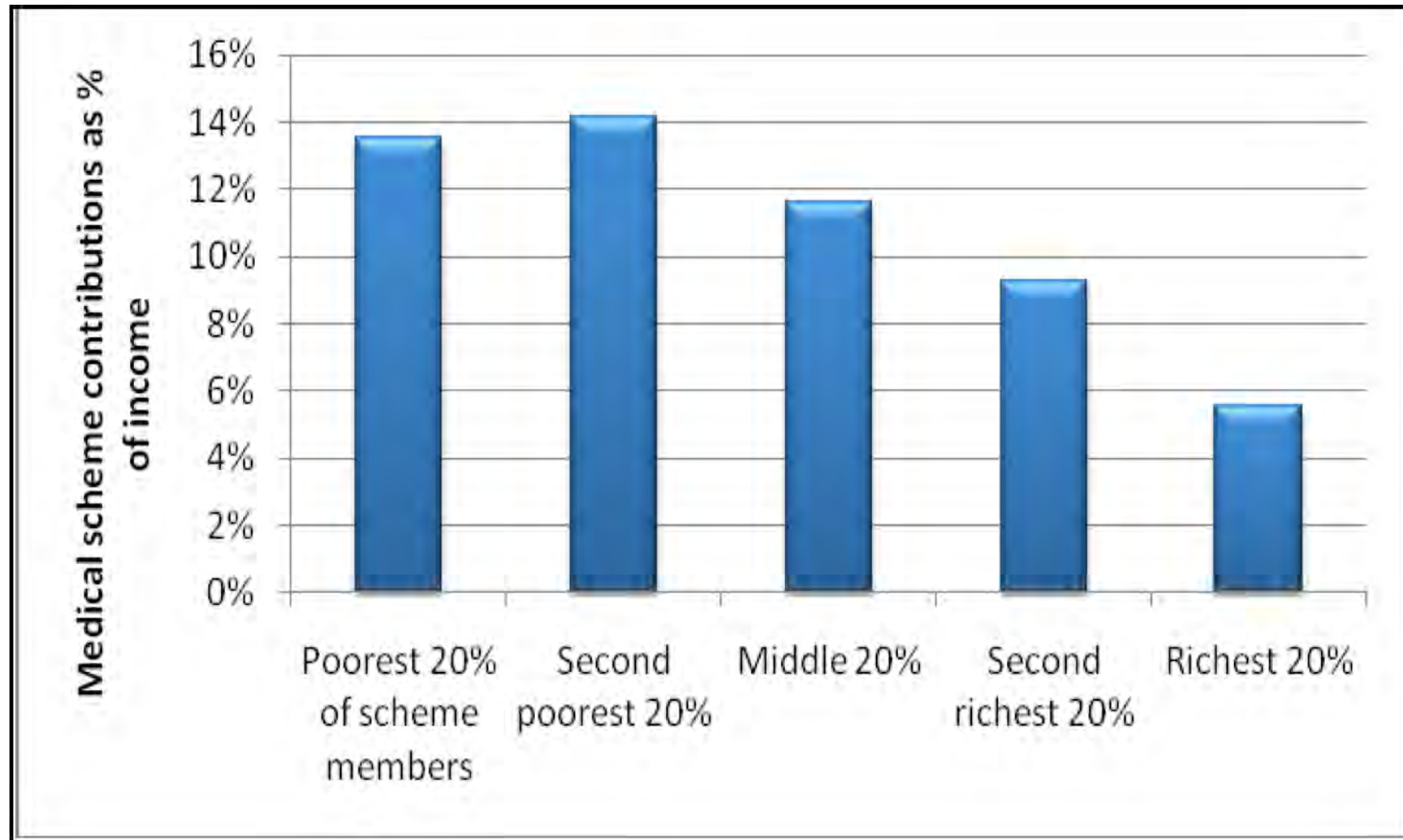


Key issues

- 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



Funding distribution across scheme members





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



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.

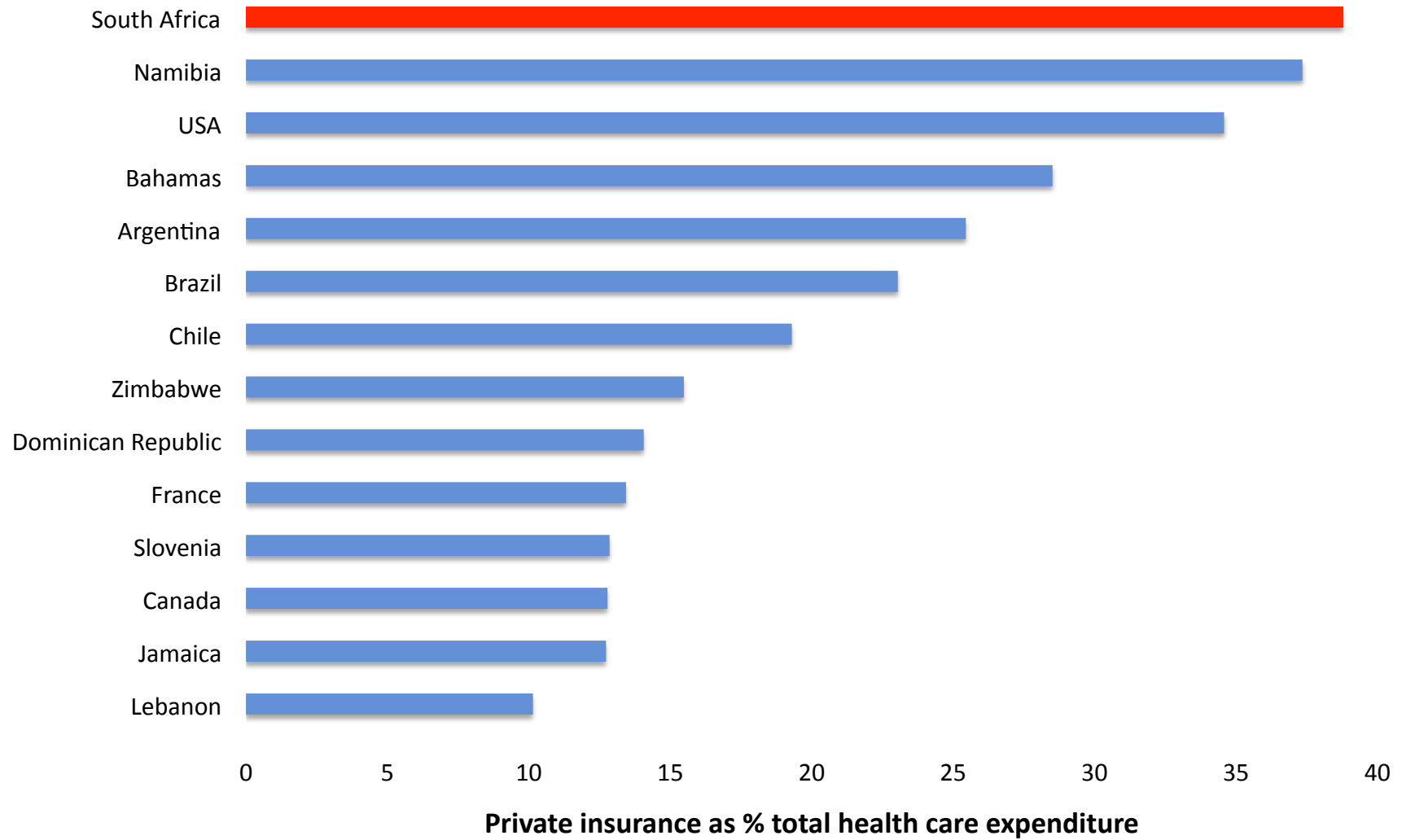


Public-private mix

- 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

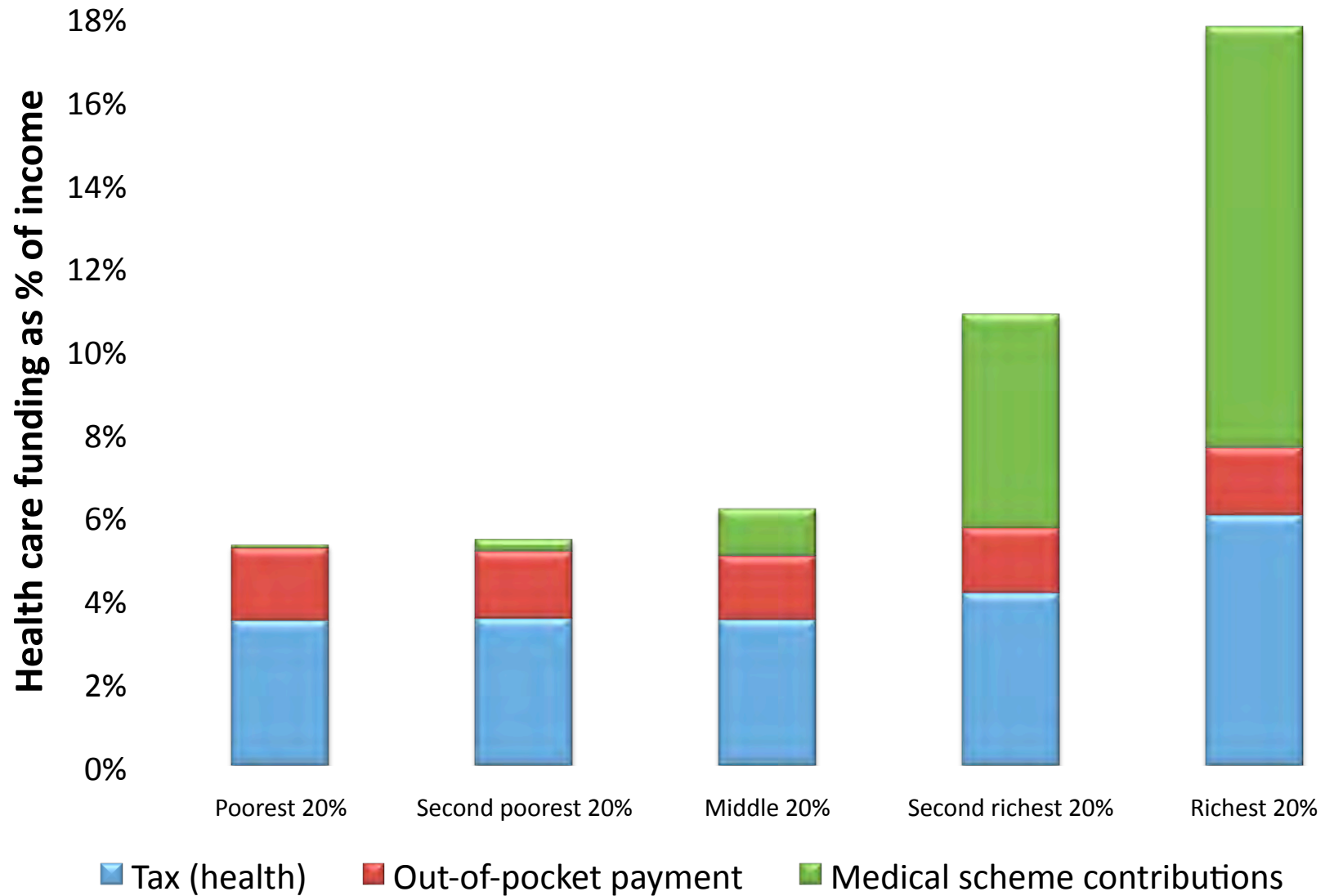


Relative share of PHI



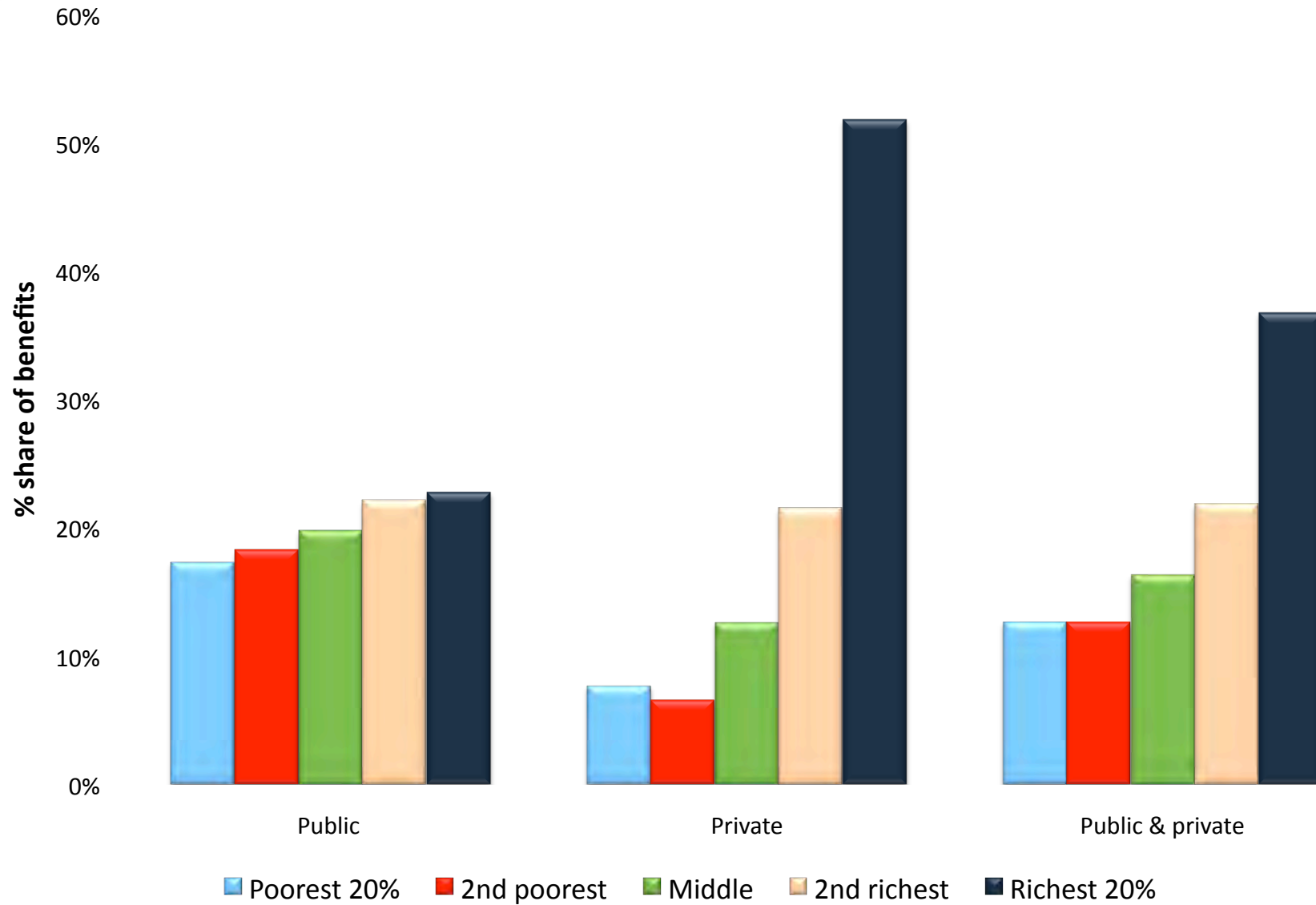


Share of funding burden



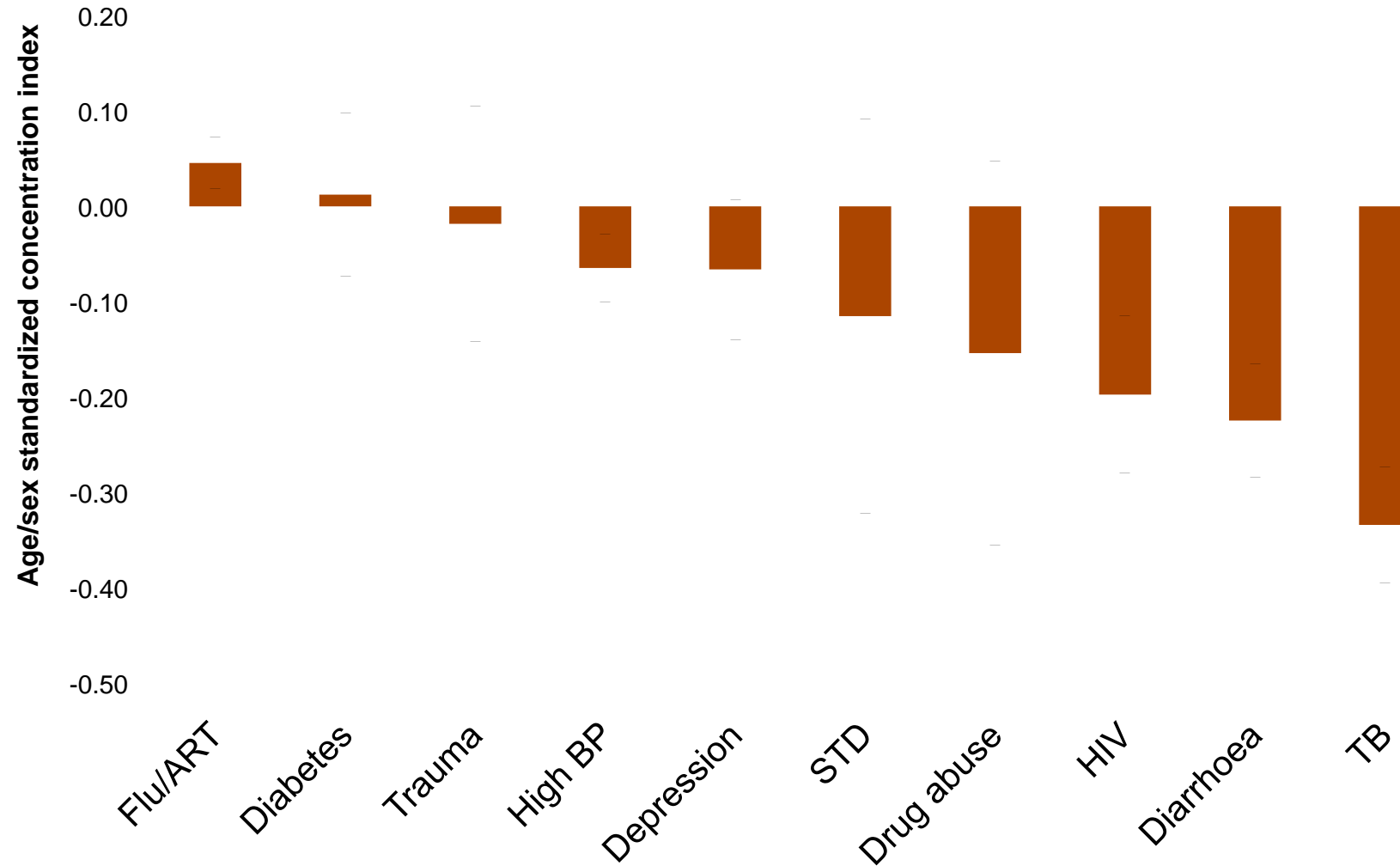


Share of benefits





Distribution of illness





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



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’



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



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)



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

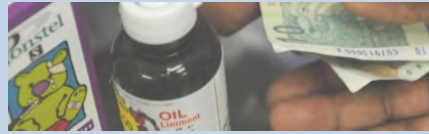


Bottom line

- 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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Thank you
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