Finding a model to suit South Africa

Dr Japie du Toit
Healthcare Advisor
PricewaterhouseCoopers

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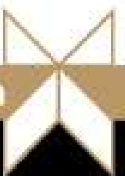
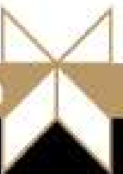


4 models of healthcare systems (T R Reid)

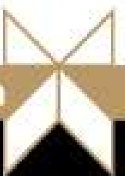
- **The Beveridge model**: Named after William Beveridge, social reformer who designed Britain's NHS. Health care is provided and financed by the government through tax payments, just like the police force or the public library. (UK, Italy, Spain, New Zealand, most of Scandinavia, Cuba)
- **Bismarck model**: Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state -uses an insurance system - the insurers are called "sickness funds" -usually financed jointly by employers and employees through payroll deduction. Universal cover. Providers mostly private. Payers non-for-profit under tight government control. (Germany, Japan, France, Netherlands, Colombia, Switzerland)
- **National Health Insurance**: It uses public or private-sector providers, but payment comes from a single government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler The single payer tends to have considerable market power to negotiate for lower prices, control costs by limiting the medical services they will pay for, or by making patients wait to be treated. (Canada, Taiwan, Korea, Turkey)
- **Out of Pocket** : Developing world Parts of Africa, South-East Asia and Latin America.

Some examples of each



Beveridge - Spain

- Highly decentralized to 17 regions;
- Universal cover (98.7%);
- 12% of population have private insurance as top-up;
- Funding by block grants from federal government to regional authorities supplemented by own regional tax funds;
- Large variation in health resources e.g. Catalonia has more than 4.5 hospital beds per 1,000 population, while Valencia has just 2.8;
- Purchasing agent - regional health authority;
- Patients cannot choose their GP's or specialists - assigned a primary care doctor from a local list – referral within network;
- Co-payment for pharmaceuticals outside hospital, dental & optometry;
- Regions contracts with NHS hospitals, financed through global budgets - case-based payment for hospitals outside the NHS;
- Doctors can be salaried employees, capitation or FFS;



Funding in Spain

Breakdown of the percentage of total expenditure on health in Spain by main contribution mechanisms, 1996 and 2005

%	Tax	Social insurance	Private insurance	OOP payments	Other
1996	57.8	14.6	3.5	23.2	0.9
2005	65.2	5.0	4.7	23.7	1.4

Source: WHO 2007b.

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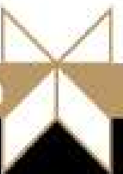
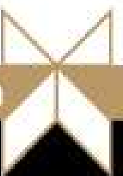
a new dimension
The 10th BHF Southern African Conference
SUN CITY 30.08 - 02.09



Beveridge - UK

- Highly centralised -The government pays directly for health care and finances the system through general tax revenues;
- Universal cover;
- About 12 percent of Britons have private health insurance – through employer or individually;
- National Institute for Health and Clinical Excellence (NICE) issues binding guidelines whether the NHS should provide specific services;
- Co-payment for pharmaceuticals outside hospital, dental & optometry;
- General tax revenues are pooled by the Treasury which negotiates a budget with the Department of Health every three years;
- DOH allocates funding to Primary Care Trusts (PCT) who purchase services from GP's, hospitals (public and private) on "pay by results" mechanism;

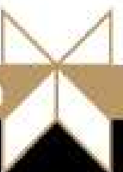


Funding in the UK

Breakdown of the percentage of total expenditure on health in the United Kingdom by main contribution mechanisms, 1996 and 2005

%	Tax	Social insurance	Private insurance	OOP	Other
1996	82.9	0.0	3.3	11.0	2.8
2005	87.1	0.0	1.0	11.9	0.0

Source: WHO 2007b.



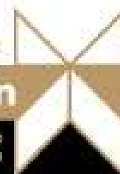
Experiences with Beveridge system

Pro’s

- Good cost control over the longer term
- Simplicity of use for the public
- Low administration cost
- Universal cover

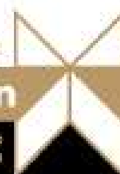
Con’s

- Government funding deficits develop over time
- Service rationing according to available funding
- Major waiting lists – specialist visits, hospital admission, procedures
- Quality issues my develop due to underfunding
- Significant co-payments may develop
- Limited provider choice a common problem
- Private insurance often used to bypass queues by the rich – leading to inequity to access, especially to specialist and hospital care



Bismarck - Netherlands

- One of most market-oriented national health care systems in Europe;
- Major reform in 2006 – now 98.5% cover;
- All citizens purchase a basic health insurance plan from one of 41 private insurance companies set at an average rate of €1050 p.a.;
- Government provides ‘health care allowances’ for low income citizens if the average flat-rate premium exceeds 5% of their household income on a sliding scale;
- Employers generally pay half of insurance premiums, the individuals the other half. Individual premiums are tax deductible;
- Insurance must cover a comprehensive package including GPs, specialists, hospitals, dentistry for <18y, medicines, EMS and therapists;
- Additional cover can be purchased at an unregulated price;
- Insured patients >18y must pay the first €150 in a given year;
- Insurers negotiate quality, quantity, and price with providers;
- Insurers may provide care directly, with own staff and facilities, e.g. primary care centres and pharmacies or contract a network with DRG type payments for hospitals, capped FFS or salaries for specialists and capitation for GP’s.

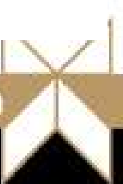


Funding in the Netherlands – pre 2006

Breakdown of the percentage of total expenditure on health in the Netherlands by main contribution mechanisms, 1996 and 2005

%	Tax	Social insurance	Private insurance	OOP payments	Other
1996	4.2	62.0	19.5	8.1	6.2
2005	2.8	62.8	20.1	8.0	6.3

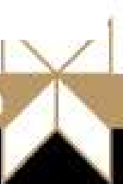
Source: WHO 2007b.



Funding in the Netherlands – post- 2006

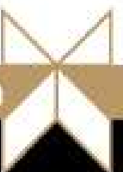
Breakdown of the percentage of total expenditure on health in the Netherlands by main contribution mechanisms, 1996 and **2007**

%	Tax	Social insurance	Private insurance	OOP payments	Other
1996	4.2			8.1	6.2
2007	2.8		83	8.0	6.3



Bismarck - Colombia

- Compulsory insurance system that is supposed to provide universal coverage through two types of affiliation (2003 reforms);
  - The **contributory system** covers those can pay. The employed contributes 12% of their salary (2/3 is paid by employer) while self-employed pays 12% of their declared income (70% of members);
  - The **subsidized system** cares for the indigents. They are entitled to a minimal package initially providing 50% of contributory system benefits - gradually to be increased to 100% by 2010 -30%;
- Subsidized system is partly funded by contributory system – 8.33% of collections of the contributory regime goes to subsidized regime;
- Insurers (EPS) are now competing for contributors and private providers compete for patients;
- State assumes the role of regulator, provides subsidies for the poor and, through a highly decentralized system, takes care of the 'collective' health needs – public and preventative health – delivered by local government;
- Universal health care coverage not achieved - permanent economic crisis, armed conflict, official unemployment rate of 20%, and a continuous deficit on government budget – deficit on subsidised system
- By 2003 58% coverage achieved.



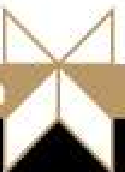
Experiences with Bismarck system

Pros

- Increased competition drives down cost;
- Universal cover possible;
- Uniform and comprehensive package of benefits possible;
- Good quality measures in place for private providers and driven by competition;
- Separation of finance and provision.

Cons

- The community rating requirement may result in steep increases in premiums for younger workers;
- Potential oversupply of services by private providers;
- Difficult to police compulsory contributions and self –employed may stay out or under-report income;
- Strong regulatory control needed;
- High administration cost.



National Health Insurance - Taiwan

- Introduced in 1995 when only 57 % was covered by 3 SHI programs called Labour, Government Employees, Farmers insurance. (96% cover achieved by end 1996)
- NHI had 2 objectives: equal access to all and controlling spending;
- NHI provides universal access to a comprehensive benefit package covering preventive and medical services, prescription drugs, dental services, Chinese medicine, and home nurse visits;
- Patients have the right to freely choose their providers and for hospitals and physicians to freely choose their practice.
- Preventative services free. Co-payment of US$8 for hospital OPD and US$5 for clinic visits and 10% co-insurance for inpatient hospital cost capped at 10% of average national income. Poor exempted.
- OOP fell from 48% of total spent on health in 1993 to 30% in 2000.
- Hospitals are publicly (35%) and privately (65%) owned (5.7/1000) paid on DRG's;
- 63% percent of doctors employed by hospitals are salaried plus bonus
- based on productivity - remainder are fee-for-service private practitioners;
- Most workers are employed in formal sector, so a compulsory NHI can effectively collect premiums through employers. (4% unemployed)

National Health insurance Taiwan

Insurance Coverage Expansion In Taiwan, Insured People As Percentage Of Population, 1950–2000

Percent

100

80

60

40

20

0

Labor Insurance (LI), 1950

Government Employee Insurance (GEI), 1958

Farmers Insurance (FI) Demonstration, 1985

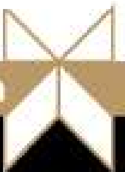
FI, 1989

Before NHI implementation, 1995

1950 1960 1970 1980 1990 2000

SOURCES: For 1950–1994, J.R. Lu and C.R. Hsieh, "The National Health Insurance Program in Taiwan," in *Health Economics* (Taipei: Pro-Ed Publishing Company, August 2000), chap. 14, 401; for data after 1995, Taiwan Bureau of National Health Insurance.

NOTE: Taiwan's National Health Insurance (NHI) was implemented in 1995.

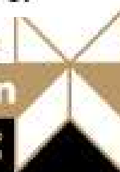


- 7 years after the NHI's implementation, the program began to run a deficit, and the government raised contribution rate from 4.25 % to 4.55 % of annual income in 2002;
- Government has the revenue to subsidize the coverage of the poor, veterans, and farmers.
- Taiwan has the skills and human resources to manage the NHI.

Health Spending And Health Status Indicators In Selected OECD Countries, 1999

Country	Total health spending as percent of GDP	Total health spending per person (US$ PPP)	Life expectancy at birth (years)	Infant mortality rate (deaths per 1,000 live births)
Taiwan	6.0%	$ 686	74.9	6.5
Japan	7.4	1,852	80.6	3.4
Democratic Republic of Korea	5.6	758	75.5	7.7
Canada	9.2	2,616	79.0	5.3
Germany	10.7	2,428	77.8	4.5
United Kingdom	7.1	1,666	77.4	5.8
United States	13.0	4,373	76.7	7.1

SOURCE: Organization for Economic Cooperation and Development, *OECD Health Data 2002* (Paris: OECD, 2002); and J.R. Lu and W.C. Hsiao, "Development of Taiwan's National Health Account," *Taiwan Economic Review* 29, no. 4 (2001): 547–576.

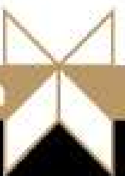


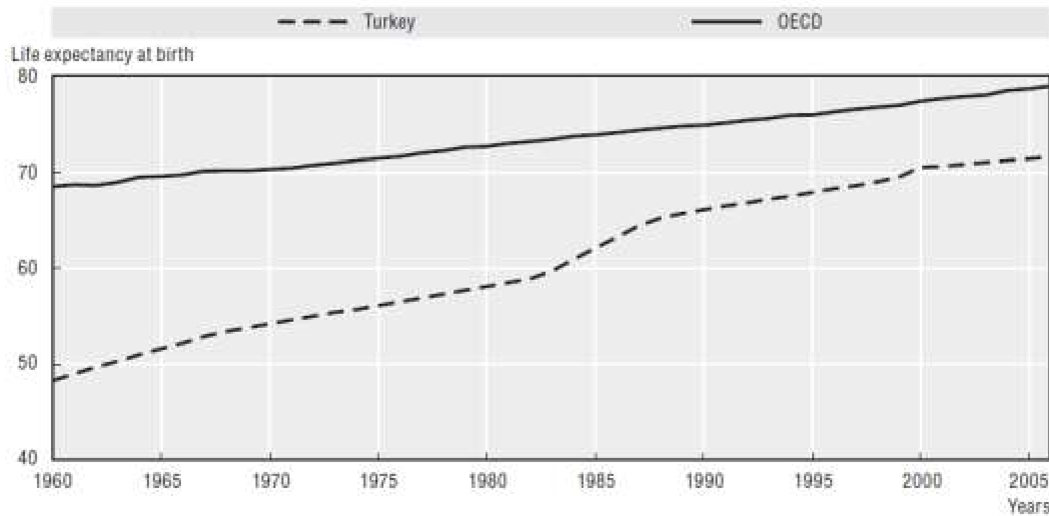
National Health Insurance - Turkey

- Before 2003there were 3 health insurance funds covering formally employed, self-employed and active and retired civil servants. A government-financed programme covered the low-income uninsured (the Green Card programme). Informal-sector workers account for about 25% of the population and only some of these were covered as dependents.(85% coverage)
- Ministry of Health (MoH) operated a very large network of preventive and primary health-care centres and hospitals, while one of the social security agencies managed its own network of facilities. Private facilities were not effectively regulated. (60% of spending was public)
- 10 year health transformation plan of 2003-2013 established the MoH as a planning and supervising authority; implementing Universal Health Insurance (UHI) uniting all citizens of Turkey under a single Social Security Institute (SSI);
  - expanding delivery, increasing access, improving the motivation, knowledge and skills of personnel.
  - Set up educational and scientific institutions to support the system;
  - securing quality and accreditation systems to encourage effective and quality health-care services;
  - providing access to effective information for decision making, through the establishment of an effective Health Information System.

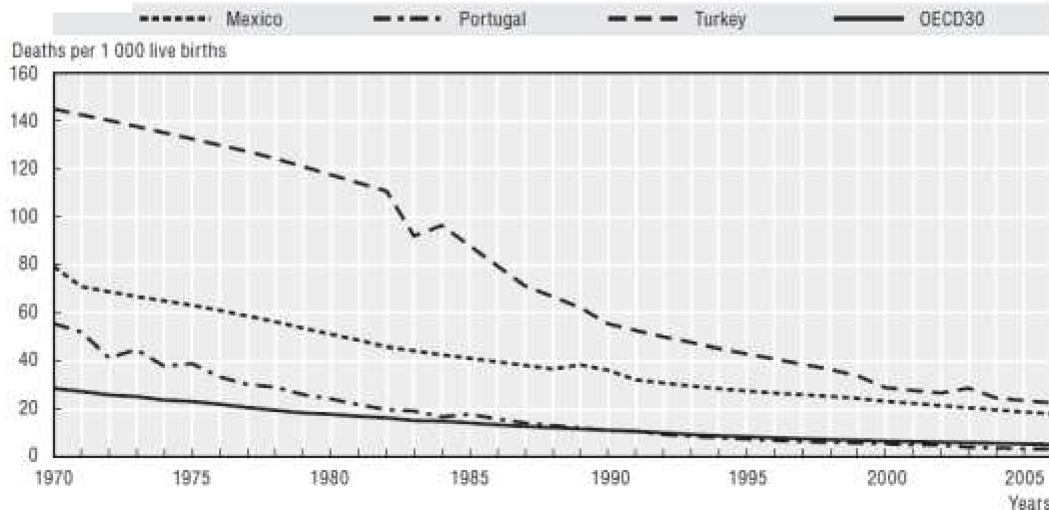
National Health Insurance - Turkey

- Public hospitals in Turkey, including those previously managed by a social security institute, were consolidated under the DOH;
- Hospital reimbursement moving to DRG's for all hospitals – private hospitals may charge 30% more than SSI rates funded through co-payment;
- in October 2008, a single-payer system has been established for public patients as a Social Security Institute with a single claims and utilisation management system;
- Contributory scheme -12.5% of income of all employees in the public and private sectors, and the self-employed will be collected-employer contributes 7.5%. Means testing for reduced premium;
- Non-contributory – for the poor – government contributes reduced rate;
- 10% unemployment rate;
- Average 2.3 beds per 1000 population with large regional variation.

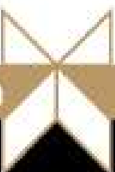




Turkey: 71.6



Turkey: 22.6



Experiences with National Health Insurance

Pros

- Previously uninsured increased their use of health services – access;
- The single-payer system provides tools to manage spending more effectively (unified fees, lower administration - 2% of total cost), patient & provider data used in management;
- Increased equity and universal cover;
- NHI can be introduced without using more resources if there is a functioning existing system and unemployment is low - increases can be offset by savings.

Cons

- Duplication of provider facilities possible;
- NHI may struggle to keep up with patient demands for more benefits;
- Resources can go to services that deliver minimal health returns;
- Heavy commitment of resources to short-term care and comprehensive coverage for acute care undermines funding for public health;
- Significant organizational ability and human resources are required to manage a NHI.

SA: US$8900/869, Colombia: US$6130/626, Taiwan:US$16111/686
Turkey: US$10771/609

GDP per capita and health expenditure per capita, OECD countries, 2006

Health expenditure per capita (USD PPP)

$y = 0.100x - 376.9$
$R^2 = 0.737$

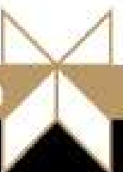
USA
CHE
ISL
NOR
LUX
AUT
CAN
BEL
FRA
NLD
DEU
SWE
DNK
IRL
ITA
AUS
NZL
FIN
JPN
ESP
GRC
PRT
CZE
HUN
KOR
SVK
SA
MEX
POL
TAIW
TUR
COL

7 000
6 000
5 000
4 000
3 000
2 000
1 000
0

0
10 000
20 000
30 000
40 000
50 000
60 000
70 000

GDP per capita (USD PPP)

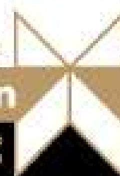
Source: OECD Health Data 2008.



Lessons in finding a model for South Africa

Policy development

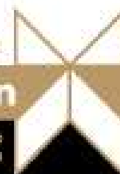
- Enabling factors for heath reform:
  - Strong and sustained economic growth;
  - Long-term political stability and sustained political commitment;
  - Strong institutional and policy environment;
  - Increased levels of population education;
  - Commitment to equity, social cohesion and solidarity;
  - Health coverage and financing mandates;
  - Financial resources committed to health, including private financing
  - Consolidation of risk pools;
  - Limits to decentralisation;
  - Primary care focus, especially millennium development goals;
- Reform should be initiated though development of rational, evidence based policies leading to sustainable transformation;
- Universal coverage and a comprehensive benefit package to all of its residents should the objective of all health reform initiatives;



Lessons in finding a model for South Africa

Policy development

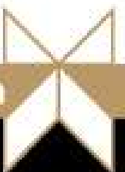
- Attention to national history, values, and culture to help each country define the appropriate approach to reforms;
- Have sufficient information and strong analytical tools and skills to define the most pressing problems and to develop and monitor solutions that are appropriate for the country;
- Significant body of evidence in healthcare reform is available globally and useful reform tools were developed internationally.
- Separate purchasing and delivery of healthcare;
- Public health issues across ministries e.g. sanitation, human settlement and education;
- Incorporate market mechanisms such as competition, cost-consciousness, market prices, and consumer choice;



Lessons in finding a model for South Africa

Policy implementation

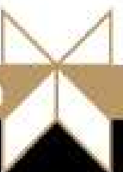
- Good information systems and evidence-based decision-making;
- Strong stakeholder support;
- Efficiency gains and co-payments used as financing mechanisms;
- Flexibility and mid-course corrections;
- “The devil is in the detail”;
- Involvement of higher education and vocational training institutions;
- Improving transparency and accountability of the system.



Lessons in finding a model for South Africa

Provider

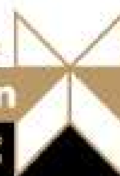
- Taiwan set a reasonable volume standard for outpatient visit coupled with a sliding fee schedule for visits above the volume standard. This discouraged induced demand and reduced the number of visits per person.
- Performance-related pay to raise providers' productivity;
- Payment should be performance based for both public and private facilities;
- Public providers should have a fair amount of autonomy and be kept accountable;
- Hospital based doctors (including specialists) should be salaried by hospital;
- Reimbursement should be based on capitation and DRG systems that share risk with providers;
- Rewarding good quality care and providing incentives for efficiency in service organization and delivery;
- Family practice as primary care portal.



Lessons in finding a model for South Africa

Funder

- Universal health care led to cost containment, not cost explosion;
- Single payer or very few payers are better positioned to control cost and reduce overheads globally mergers occurred on a large scale;
- Single payment technology interface saves costs for providers and funding pool;
- Promoting administrative efficiency by minimizing duplication and minimizing costs that do not contribute to achieving system goals;
- Supplementary rather that substitutive private insurance had better results in NHI;
- Centralizing collection lead to less fragmentation of national pool and contribute to sustainability because a fewer pools means less need for risk adjustment less resistance to it.



Lessons in finding a model for South Africa

Government

- Strong stewardship role;
- Ultimately less involvement in provider functions with some level of autonomy of health delivery facilities;
- Strengthening health surveillance/disease control;
- Health regulation including financing and provision over all sectors;
- Create planning and management capacity;
- Monitoring and evaluation;
- Health promotion, social participation in health, promotion of equitable access;
- Quality assurance, human resources training, research in public health and control and disaster prevention;
- Develop capacity to undertake health technology assessment HTA (including economic evaluation).

Thank you.
Questions?

Contact details:
japie.du-toit@za.pwc.com