

## 14 Key Strategic Challenges

### 14.1 Introduction

The strategic challenges facing the South African health system provide the context for reform. They highlight deficiencies from a holistic perspective rather than as problems affecting the public or the private sector. The relationship between the public and private sectors is not neutral with strong feedback effects operating between the two.

### 14.2 Context for Reform

When contrasted with the key reform objectives of a health system, many cannot adequately be met by the current policy framework in South Africa. Important areas raised are summarised below based on views expressed by the World Health Organisation (WHO, 2000).

Many countries are still making inadequate efforts in terms of responsiveness and fairness of health contribution with respect to the provision of health services. The impact is most severe on the poor who are driven deeper into poverty by the lack of financial protection against ill health.

The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society in its stewardship.

The careful and responsible management of the well-being of the population is the very essence of good government. For every country it means establishing the best and fairest health system possible with available resources.

Publicly financed healthcare systems remain the backbone of health care in most countries.

The route of prioritising only primary health care as the route to achieving universal coverage is now under severe criticism. The alternative approach calls for an understanding of "basic" health care which requires the delivery of essential health care, defined mostly by criteria of effectiveness, cost and social acceptance.

Defining "basic" essential health care implies an explicit choice of priorities among interventions, respecting the ethical principle that it may be necessary to ration services, but that it is inadmissible to exclude whole groups of the population.

Health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities.

Oversight and regulation of private sector providers and insurers must be placed high on national policy agendas. At the same time it is crucial to adopt incentives that are sensitive to performance.

Incentives within unregulated private insurance markets for health care are so skewed that the normal rules of competition do not work.

Monopoly power on the part of service providers results in higher prices, lower output, and lower product quality.

When physicians are reimbursed on a fee-for-service basis they are given powerful incentives to provide more services than are necessary.

According to international experience no single payment system is optimal. For this reason most countries adopt mixed systems.

Pre-payment is regarded as the best form of revenue collection for health services, while out-of-pocket payments tend to be regressive and impede access to care.

The main challenge in revenue collection is to expand prepayment, in which public financing or mandatory insurance will play a central role.

In the case of revenue pooling, creating as wide a pool as possible is critical to spreading financial risk for health care, and thus reducing individual risk and the possibility of impoverishment from health expenses.

Achieving greater fairness in financing is only achievable through risk pooling – that is – those who are healthy subsidise those who are sick, and those who are rich subsidise those who are poor.

Insurance schemes designed to expand membership among the poor is an attractive way to channel external assistance to health, alongside governmental revenue.

Governments need to promote community rating (i.e. each member of a community pays the same premium), a common benefit package and portability of benefits among insurance schemes, and public funds could pay for the inclusion of poor people in such schemes.

In middle-income countries the policy route to fair prepaid systems is through strengthening the often substantial mandatory, income-based and risk-based insurance schemes, with increased public funding to include the poor.

Strategic purchasing needs to replace much of the traditional machinery linking budget holders to service providers. Selective contracting and the use of several payment mechanisms are needed to set incentives for better responsiveness and improved health outcomes.

Within insurance environments it also matters how revenues are combined so as to share risks how large they are; whether competition exists between pools; and whether, in the case of competing pools, there are mechanisms to compensate for differences in risk and capacity to pay.

### **14.3 Evaluation of Current Policy Context**

#### **14.3.1 Public sector**

##### *Linkages between policy development and implementation:*

The decentralisation of the health budget within the context of fiscal federalism implies the decentralisation of health policy. Although institutional provision is created for the development of national policy, there is very little direct connection with provincial health systems. As a consequence most national policy implemented at a provincial level only relates to relatively minor issues that can be informally agreed to by all provinces at a national level.

##### *Decentralisation of operational responsibility and accountability:*

The public health system combines a decentralised policy development process with highly centralised levels of operational responsibility. There is clear evidence that this division of responsibility between policy and operational responsibility is perverse and dysfunctional.

##### *Raising revenue from voluntary and mandatory contributions:*

The approach to financing public health services, and hospitals in particular, makes it virtually impossible for effective cost-recovery to occur when services are provided to higher income groups. In order to prevent the under-funding of public health services, when they serve people

not provided for in the general budget, cost-recovery must occur. The current system of public finance makes no provision for efficient cost-recovery options within the public service.

The federalisation of health funding and policy creates a potentially fatal disjuncture preventing the serious consideration of mandatory contributory options (i.e. social or national insurance) designed around the use of public sector services. By their nature such systems would require centralised institutions which raise the funding and reimburse health services. Without a unified system allocating the health budget to provinces, the required centralisation of the contributory system would clash irreconcilably with the fiscal federal system.

As provinces would receive the money conditionally from the contributory system, but have discretion over the funding from general taxes, differences will occur between basic services and enhanced services provided through the contributory environment. Without resolving this issue a contributory system dedicated to the public sector will prove discriminatory and serve very few public policy objectives.

*User fees:*

The application of means tested user fees for hospital services to uninsured patients using public hospitals is both discriminatory and operationally flawed. Apart from the fundamental inability of public hospitals to apply the exclusion principle, which is a prerequisite for any system of user fees; and to do means test assessments at point-of-service, which no systems reform could make work. The sheer volume of patients seen makes individual billing of uninsured patients in all settings (public or private) administratively impossible.

The introduction of a revised policy on hospital tariffs (the uniform patient fee system or UPFS) although an improvement upon previous tariff systems is a palliative measure and will achieve little in the way of cost-recovery for the public hospital system and public policy in general. The tariffs do serve some purpose in charging medical schemes, or social insurance funds such as the Road Accident Fund (RAF). However, public hospitals themselves will see very little of the increased revenue, and structural flaws relating to billing out-of-pocket patients, the application of the exclusion principle, and the application of the means test cannot be overcome merely through adjusting the tariffs.

*Budget Allocations:*

The allocation to the health service is declining in real terms on a per capita basis. This results in staff reductions and capacity problems. The reduced quality of service available in the public sector creates a privatisation by default, with only the private health system as an alternative. The

absence of any real choice of sector for higher income groups results in the monopoly pricing of both medical services and medical scheme contributions. Public sector budget cuts appear to be one of the most significant contributors to increases in overall health spending.

*Equity:*

The achievement of equity on an inter-provincial basis is virtually impossible due to the existence of the fiscal federal system. Furthermore, the strict division between the public and private sector disallow any coherent subsidy framework that can span both systems in a coherent fashion.

*Human Resources:*

The rigidity of the centralised system of human resource regulation has resulted in a significant deterioration in morale and capacity within all elements of the public sector. This has had a more severe impact on the health system which is already complex and multi-disciplinary. Staff retention in critical areas of the health service is now difficult both as a consequence of inadequate budget, remuneration and career opportunities. Options that allow staff to work in both environments simultaneously are currently very difficult to operationalise and control.

### **14.3.2 Private Sector**

*Cost increases:*

The private sector is characterised by chronic cost increases linked to the fee-for-service reimbursement of providers, an oligopolistic service provider market (which prevents cost containment resulting from competition between service suppliers). Recent trends also show that people are in a weak bargaining position relative to open medical schemes. As a consequence consumers face an inelastic demand for medical scheme cover, which is abused. This takes the form of over-charging administration fees, the extraction of underwriting surpluses from schemes using quota share reinsurance agreements, and the paying of excessive commissions to brokers in competition for market share.

*Links to the public sector:*

It is likely that a market for lower cost public sector services would develop, given cost pressures driven by over charging in the private sector. However, the inability to contract due to public sector inflexibility is a key constraint despite a willing market for public hospitals.

*Low-cost contributory environment:*

The development of a low-cost market for medical scheme cover is hindered by the following:

- (a) An oligopolistic provider market;

- (b) The inability of medical schemes to formulate contracts for improved amenities at public hospitals, or for other relevant public health services, due to public sector inflexibility; and
- (c) The existing tax subsidy which only serves to reduce the cost of cover for higher income groups.

*Risk-Selection:*

There is evidence that a significant degree of residual risk-selection continues to exist in the medical schemes market. In the absence of any system of risk-equalisation, this will result in instability between medical schemes.

*Tax Subsidy:*

The value of the tax subsidy toward the private health system is substantial and is estimated at R7,8 billion. It currently lacks a clear public policy objectives with associated identifiable positive outcomes. The subsidy therefore needs to be reconsidered within a broader subsidy reform framework.

*Demographic Structure of Medical Schemes:*

The demographic structure of medical schemes imply a differently structured health system to that of the general population. This creates concerns about the resulting efficiency of the health system as a whole given the substantial resource allocation bias in favour of the medical scheme market.

*Intermediaries:*

Intermediaries do not always act in the best interests of scheme members and the public at large. This includes instances where administrators abuse their influence over schemes under their management; where brokers blackmail administrators into paying kickbacks to retain members; and where managed care arrangements are merely structured to extract additional fees from schemes. The shift of members between schemes is largely induced by broker activity, rather than active decisions of members. Thus schemes are incurring substantial increased costs for no added value to the environment. Overall non-medical expense related expenditure, which includes administrative expenditure and broker fees, is the fastest growing cost-driver in the private health market.

*Unfair Discrimination:*

There is evidence of significant discrimination against people with chronic conditions in open medical schemes. Currently the prescribed minimum benefits do not protect members from this

form of abuse. As most people who suffer from chronic conditions are in older age cohorts this amounts to unfair discrimination on the basis of age.

### **14.3.3 Mandatory Contributory System**

The introduction of a mandatory contributory environment in addition to the non-contributory tax funded public health system has been the ultimate objective of health policy since 1995. Such a contributory system can take the form of dedicated social health insurance (SHI) fund for contributors only. It could also take the form of national health insurance (NHI) where both contributors and non-contributors benefit from a universal system.

#### *National Health Insurance versus Social Health Insurance:*

From an organisational point of view the implicit and explicit subsidies required within the overall health system remain identical irrespective of whether the regulated contributory and non-contributory systems remain separate.

National health insurance is not an option that emerges overnight as an alternative to social health insurance. Instead it becomes feasible within market economies where formal employment levels are high. Prior to this mixed systems are inevitable.

#### *Future Paths for South Africa:*

Regulated private insurance coupled with various social health insurance options and government subsidies represent the middle-income country route toward building a universal system.

National health insurance, or the complete nationalisation of the private sector, cannot be seriously considered as reasonable options for South Africa.

National health systems and insurance can be based upon single or multiple payer systems. The choice of system largely depends on historical developments and local conditions. Whichever system prevails makes little difference to the underlying equity principles and objectives.

### **14.4 Concluding Remarks**

Although many of the elements of a unified and integrated health system exist in South Africa, at present they do not result in a functional and integrated framework. If these deficiencies are not addressed, the health system as a whole will continue to increase in cost, while simultaneously reducing and becoming increasingly unfair in the allocation of cover.

## 14.5 Role and scope of government involvement

The ultimate responsibility for the overall performance of a country's health system lies with government, which in turn should involve all sectors of society. A government has the responsibility for establishing the best and fairest health system possible with available resources. Health policy and strategies need to cover the private provision of services and private financing, as well as state funding and activities. The oversight and regulation of private sectors has to form part of the overall government response and must be high on the policy agenda.

### *Central Objectives*

- o *Increased risk pooling:* Risk pooling needs to be encouraged through the use of a combination of instruments. These would include the tax system, subsidies to private regulated insurers, the creation of risk-equalisation mechanisms within both public and private sectors, government mandates, and the reinforcement of community rating.
- o *Finance:* Government policy needs to ensure that a universal minimum financial allocation is made available for all people resident in South Africa. It should however be possible to top-up this minimum allocation with medical scheme contributions.
- o *Benefits:* Government policy needs to provide a framework that results in cover for a minimum level of essential services, irrespective of whether it is provided in the public or the private sectors.
- o *Service provision:* Ensuring that a sustainable universally available service provider system is in place must underpin government's strategy with respect to healthcare. Central to this strategy must be the strengthening of the public sector owned and controlled network of services.
- o *Efficiency:* Given the existence of perverse incentives in unregulated markets for health care, any regulation must pay careful attention to the incentives generated. The use of mixed systems for covering and providing health care combined with the correct elements of choice is the best approach to balancing health care objectives with the need for operational efficiency.

## 14.6 Role of the Public Sector

The public sector system must remain the backbone of the overall health system and should be protected from chronic under-funding.

## 14.7 Role of the Private Sector

The private sector can provide an effective environment for achieving increased levels of funding over and above tax-based allocations. However, as the private market for health care suffers from

chronic market imperfections, public sector involvement is required to ensure that funding levels are socially optimal and not merely what the market will bear.