Financing the Health System

Finance Technical Task Team
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Strategic goals – identify the *social harms* to be removed

• **Goal 1: Maximise health status** of the population
  – *Reduce preventable mortality and morbidity*

• **Goal 2: Maximise access** to medical care
  – *Remove avoidable impediments*

• **Goal 3: Minimise avoidable reversals** in living standards
  – *Income protection*
Inevitable constraints

• Availability of scarce resources
  – Funding
  – Skills
  – Human resources

• Existing infrastructure

• Pre-existing institutional framework
Where are we today?

- **Right**: Require step-wise adjustment to institutional design, with only incremental change to financing.
- **Wrong**: Require step-wise adjustment to both financing and institutional design.
- **Wrong**: Incremental change to institutions with step-wise adjustment to financing.
- **Right**: Require only incremental change to financing and institutional design.
However...

• It is important to answer this question in relation to the strategic goals

• Different parts of the system focus on distinct goals...
Conceptual framework for prioritising health system interventions in relation to the GOALS

STRATEGIC GOAL:
MAXIMISE HEALTH STATUS

STRATEGIC GOALS:
MAXIMISE ACCESS TO MEDICAL SERVICES AND MINIMISE AVOIDABLE SOCIAL REVERSALS

Low income                                                                                                          High income
Low priority                                                                                                          High priority
Why do health systems differ?

- **Low-income countries**
  - Maximise health status
  - Low priority

- **Middle-income countries**
  - Maximize access to health services
  - Maximize social reversals

- **High-income countries**
  - Low priority

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Income Levels:
- Low income
- Middle income
- High income
Where are the greatest gains in health status achieved?

Diminishing returns for additional expenditure in relation to goal 1

Most gains in health outcomes occur with government health expenditure at levels below US$ 500 per capita.
So what does this show us?

• All countries lie on a continuum in relation to the key priorities
• Systems differ across countries depending on which priorities predominate
• Within countries priorities and their related interventions consistently vary across the income spectrum
MAXIMISE HEALTH STATUS?
Situation analysis

• South Africa’s health outcomes are significantly worse than peer countries
  – Performance appears
    • Unrelated to the levels of public health expenditure (as peer countries with considerably better performance spend equivalent amounts or less)
    • Only partially related to HIV and AIDS (as maternal mortality related to service quality and not infection levels)
South Africa does not perform well compared to its peers...

The peer groups include the ten countries below and above South Africa in terms of GDP per Capita (US$ PPP adjusted)
How well does South Africa perform relative to benchmark countries?

South Africa Compared to Peers (15 above and below per capita GNI in PPP US$): Government Expenditure on Health and Maternal Mortality

Maternal mortality is an indicator of service quality rather than socioeconomic need.
Health districts do not perform well...

WHO Target Cure Rate = 85%

Total TB Cases for 2008 = 307,503
Cases not cured = 133,854 (44%)

Source: Based on data made available by the Health Systems Trust
TB is getting worse because of dysfunctional health districts ...

The failure to effectively treat TB patients within the district health system causes:
1. an increase in preventable mortality
2. Increased (treated) burden of disease
3. Increased unit cost of treatment

Source: Department of Health
General findings to date...

- **Substantial and systemic underfunding** is not the key driver of poor health system performance in relation to health status
- **National strategic policy** linked to resource allocation is decentralised or ad hoc
  - Funds not allocated to where they are most needed
  - Allocated funds are wasted
  - Inconsistent national interrogation of financing requirements
- **Key operational decisions** are centralised (decision-space is severely constrained at the service delivery level)
- **Accountability** is poorly distributed throughout the system (no-one is consistently held responsible for poor performance anywhere in the system)

The impoverished development of practical information systems to aid policy, planning, implementation and operational decisions is symptomatic
MAXIMISE ACCESS TO MEDICAL CARE
Primary responsibility...

• Lies with
  – Government as a
    • Funder and provider
    • Legislator establishing the regulatory architecture
  – Government agents as
    • Regulators - ensuring compliance with the regulatory framework
Situation analysis – government provided services

• Financing unresponsive to need (hospital and district resource allocation)
  – No consideration given to the distinction between demand and supply-driven financial requirements (AIDS and TB treatment is demand driven) (Free State!)

• Quality of the services – no impartial and independent institutionalized arrangement exists to monitor service quality and guarantee service quality

• Referral system is not functional in many areas (system is easily bypassed)
Situation analysis – government provided services

• Optimization of the service configuration has not occurred

• Resource allocation
  – Level and depth of services not linked to a financing plan

• Means test design promotes exclusion rather than inclusion (inefficient targeting)

• System of rationing and service closures are ad hoc and arbitrary

• No independent complaints and adjudication system
Situation analysis – contributory system

- Regulatory architecture of the contributory system is incomplete-
  - Preventable risk-selection retained
  - Preventable anti-selection retained
  - Incomplete benefit framework shifts healthcare expense burden to households
  - No supply-side regime to address systemic cost imbalances
  - Low-income earners unfairly excluded due to configuration of the subsidy framework
  - Regulatory models inconsistent and incomplete
Situation analysis

• Strategic pooling for catastrophic health services is at a minimum (both from a financing and supply perspective)
  – Strategic hospital services
    • Expensive and specialized radiology
    • Trauma services
  – Emergency medical services
    • Emergency transport
    • Motor vehicle accidents
    • Injuries on duty
Summary problem statement

• Public system has a flawed institutional model-
  – Needs new accountability framework
  – Needs altered financing architecture
• Contributory system is partially regulated
  – Needs to maximise pooling
  – Needs to manage pricing and supply decisions
• Strategic pooling opportunities are not taken up
REMOVE AVOIDABLE REVERSALS IN LIVING STANDARDS
Protect people from the financial consequences of ill health

- Income protection short-comings, i.e. no system for
  - Medical expenses protection is incomplete
  - Protection against loss of income due to illness and maternity
  - Post-retirement contribution protection
  - Survivor contribution protection due to the loss of a breadwinner
  - Unemployment contribution protection
PROVISIONAL ASSESSMENT
Where are we today?

Require step-wise adjustment to institutional design, with only incremental change to financing.

 требует ступенчатое корректирование структуры институтов, с только небольшим изменением финансирования.

Require step-wise adjustment to both financing and institutional design.

 требует ступенчатое корректирование как финансирования, так и институтов.

Incremental change to institutions with step-wise adjustment to financing.

 Мало ступенчатого изменения финансирования и институтов.

Access and Income protection.

 Правильное распределение доступа и дохода.

Wrong

Wrong

Right

STRATEGIC INSTITUTIONAL PATHWAY

FINANCIAL PATHWAY
Critical questions?

• What is the future funding requirement?
  – Are levels optimal?
  – Is additional funding required?
  – Are funds available?
  – Where additional funds are required, what is the optimal revenue source and mechanism?
    • Is the tax system optimal?
    • Do we need a dedicated tax?
    • Where are dedicated funding pools appropriate?
Critical questions?

• What changes are required to the public sector institutional framework?
  – Optimise governance of existing model?
  – Introduce purchaser provider split?
    • Public funder to public provider
    • Public funder to private provider (contingent liability?)
Critical questions

• Centralised resource allocation versus fiscal federalism?

• Role of private medical schemes?
  – Actively expand coverage
    • Resolve structural barriers to access
  – No active measures to expand coverage
  – Curtail role to services not covered by the public system