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Health Reform: Unpacked

Ashleigh Theophanides
Deloitte South Africa

Deloitte.

Agenda

- *Different Delivery Systems*
  - Healthcare models
  - International literature and country experience
- *Namibian Case Study: Interaction of Health Reform and Social Security*
  - Policy objectives
  - Purchasing of healthcare services

Providing Healthcare to Citizens: Challenges Faced by Different Governments

Challenges Faced by Governments

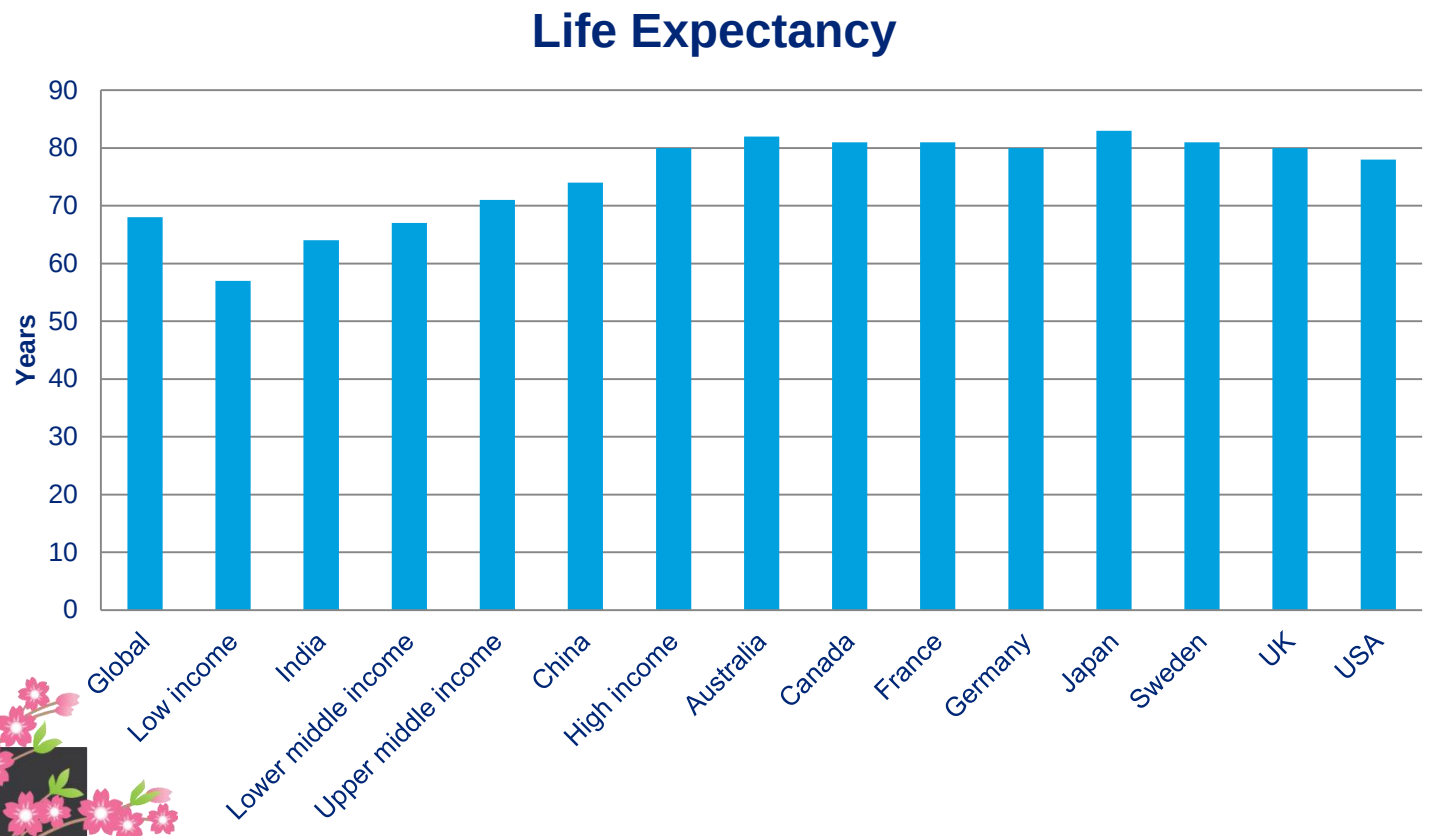
- Ensuring that all citizens have access to care, and not just emergency care but prevention services and care for chronic conditions;
- Bringing costs under control; and
- Maintaining or improving quality of care.

This depends on equitable access to a health system that delivers high quality services

Source: Department of Health - Annual Report 2012

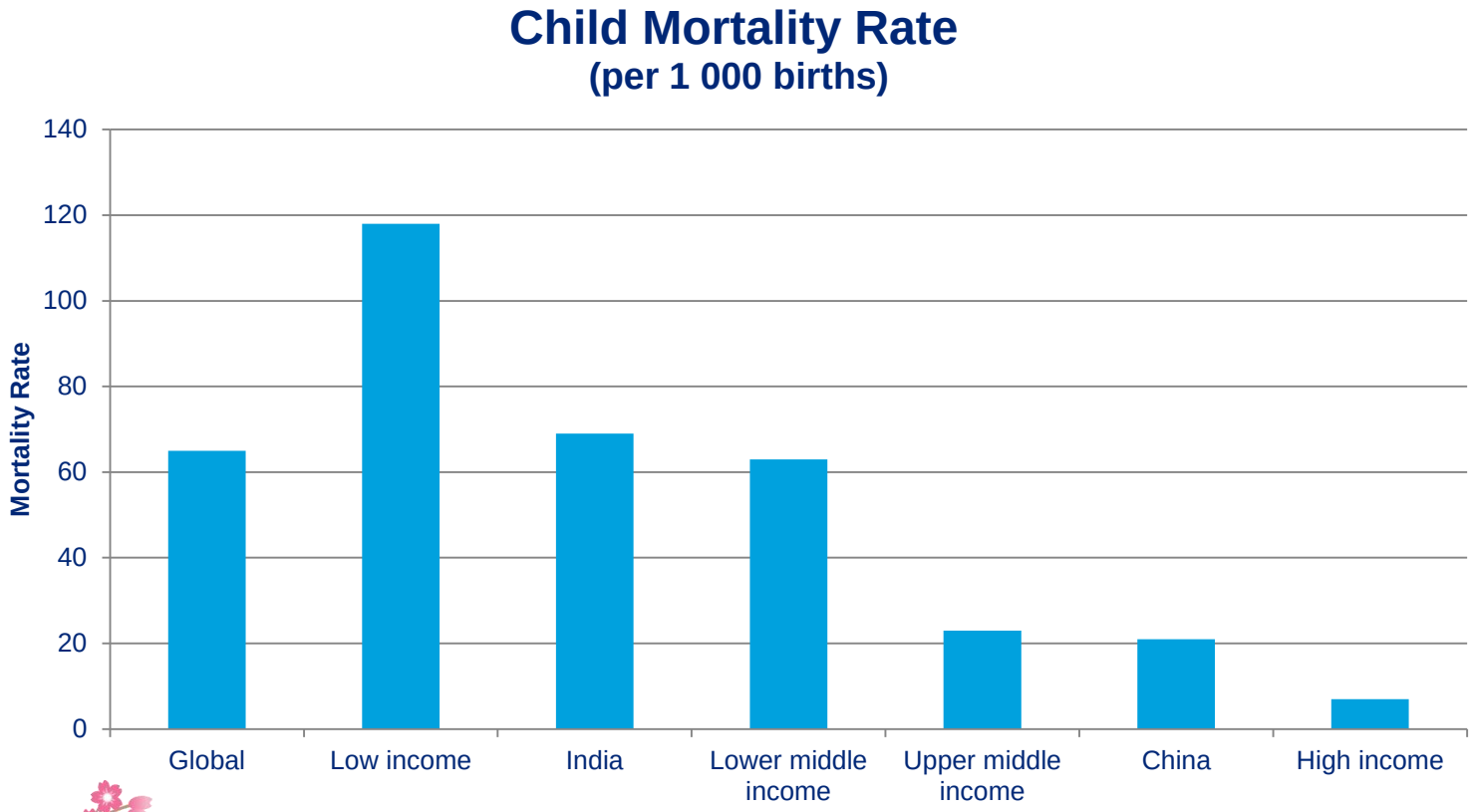
Challenges and Contradictions

Predictably, wealthier nations have better life expectancy:



Source: World Health Statistics 2010 report, WHO

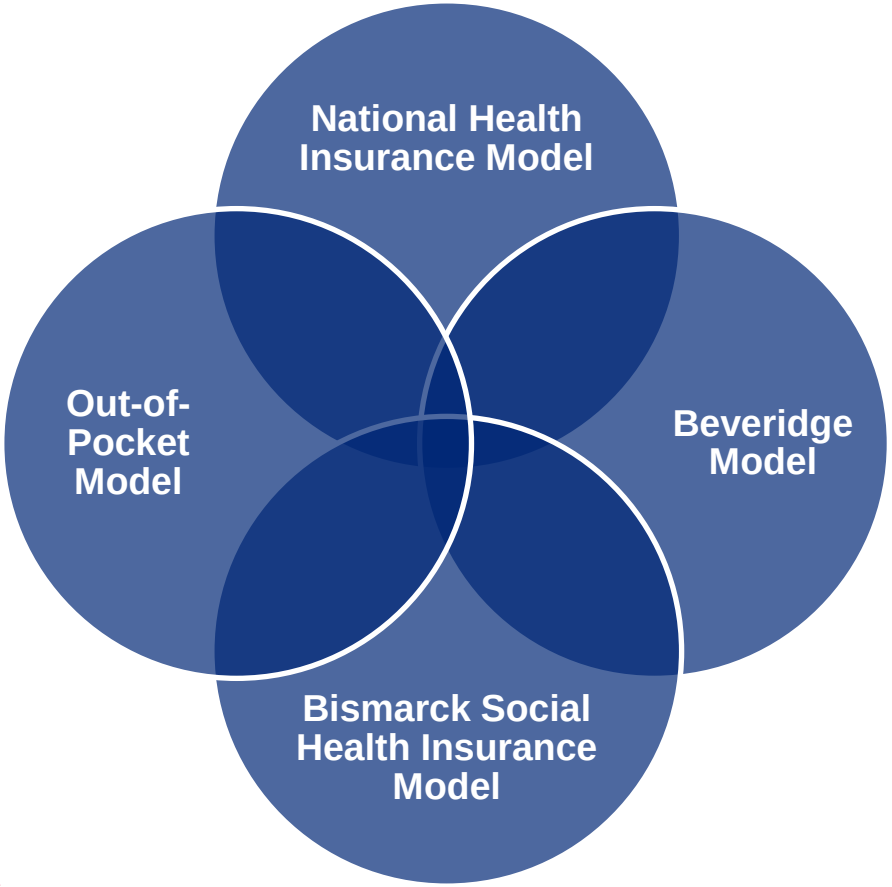
Challenges and Contradictions



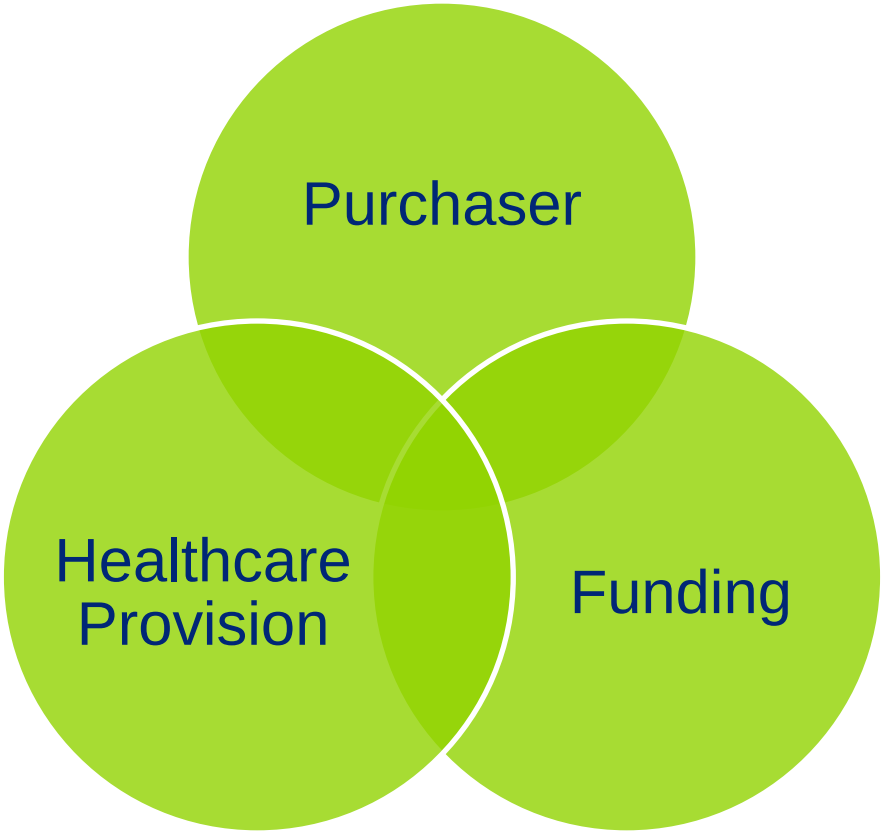
Source: World Health Statistics 2010 report, WHO

Different Delivery Systems

Main Healthcare Models



Components

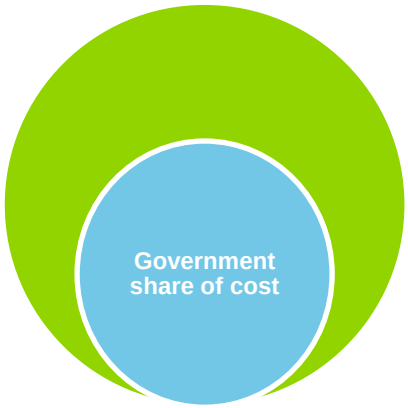


Features of Main Healthcare Models

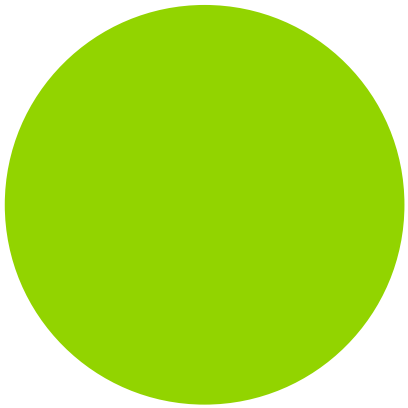
Policymakers must keep in perspective the options for financing their health system.

Beveridge Model
•Government is sole payer i.e. single funder model
•Network of public and contracted private providers i.e. multiple delivery
•Government directly reimburses providers i.e. single purchaser

NHI Model
•Uses an insurance system
•State fund acts as a single funder and single purchaser
•Uses private sector providers i.e. multiple delivery



Bismarck SHI Model
•Uses an insurance system
•A Bismarck SHI scheme can either be made up of multiple risk pools/funds, or a single risk pool/fund
•The insurers are called "sickness funds" i.e. multi-funder and multi-purchaser
•Funds are usually financed jointly by employers and employees through payroll deduction
•Funds are non-profit
•Typically private providers i.e. multiple delivery



Out-of-Pocket Model
Access to care available if:
•one can pay the bill out-of-pocket at the time of treatment, or
•one is sick enough to be admitted to the emergency ward at the public hospital

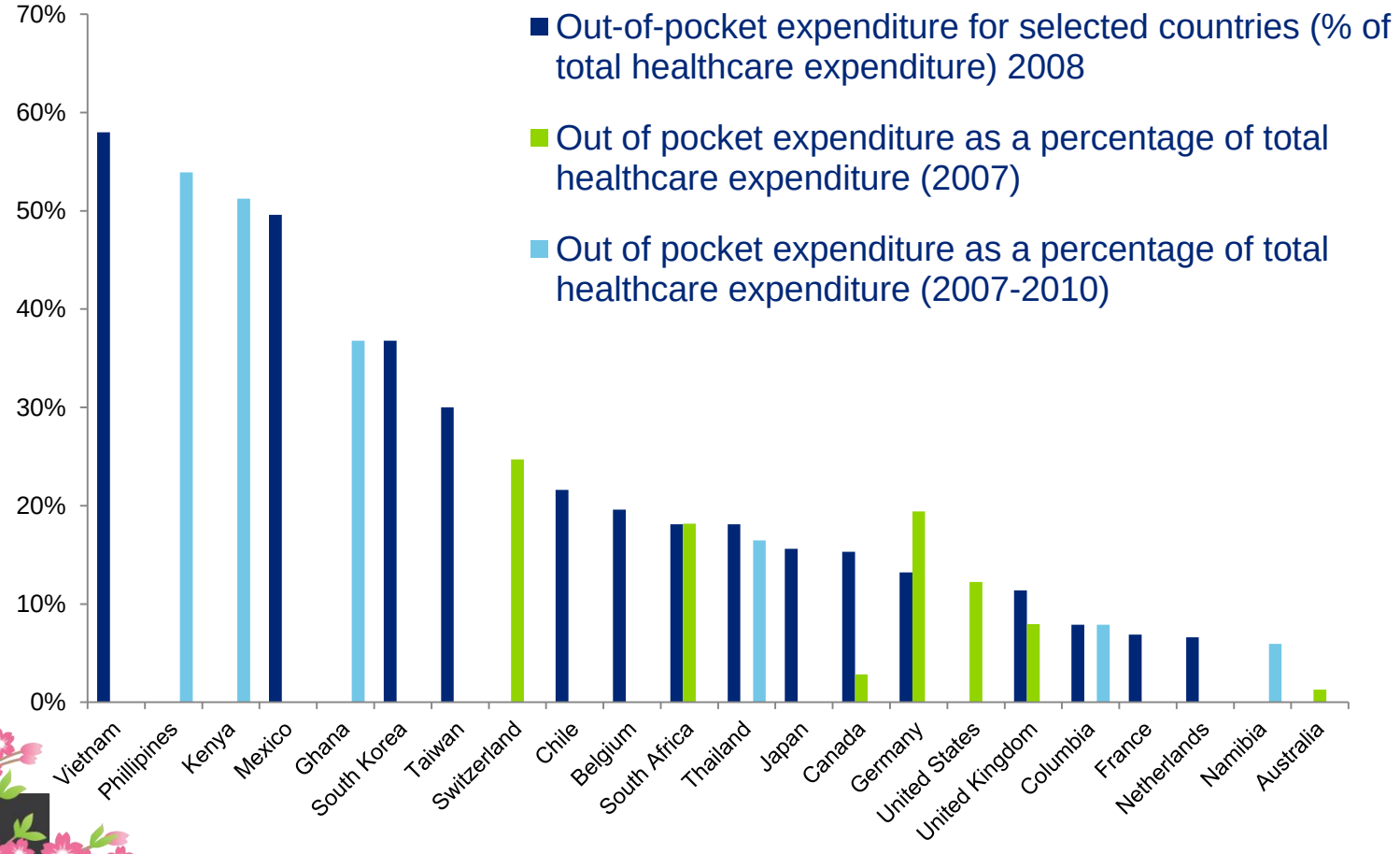
International Trend: NHI via SHI

- SHI is a one of the main funding models used for healthcare financing
- Many SHI initiatives have taken place in Africa, Asia, and Latin America.
- A total of **twenty seven** countries have introduced the overriding principle of universal coverage **via** SHI
- This is because it is difficult to move to universal coverage overnight, we therefore need a **phased approach**:
    1. Start with **occupational/employee groups**
    2. Then **expand coverage**, where government plays role in subsidising the rest of the population
- **Advantages** of this two-step approach:
    - More **financially stable** (once the **contributory regime** is solvent and well performing, the **subsidised regime** can then be established)
    - More **buy-in** from contributors i.e. more acceptable to people who pay SHI/NHI contributions in Step 1. This is because contributors are provided an unambiguous **value proposition**.

Key Distinction: NHI vs. SHI

- NHI – covers entire population, thereby achieving “universal coverage”
- Bismarck SHI – only covers those contributing

Out of Pocket Expenditure by Country



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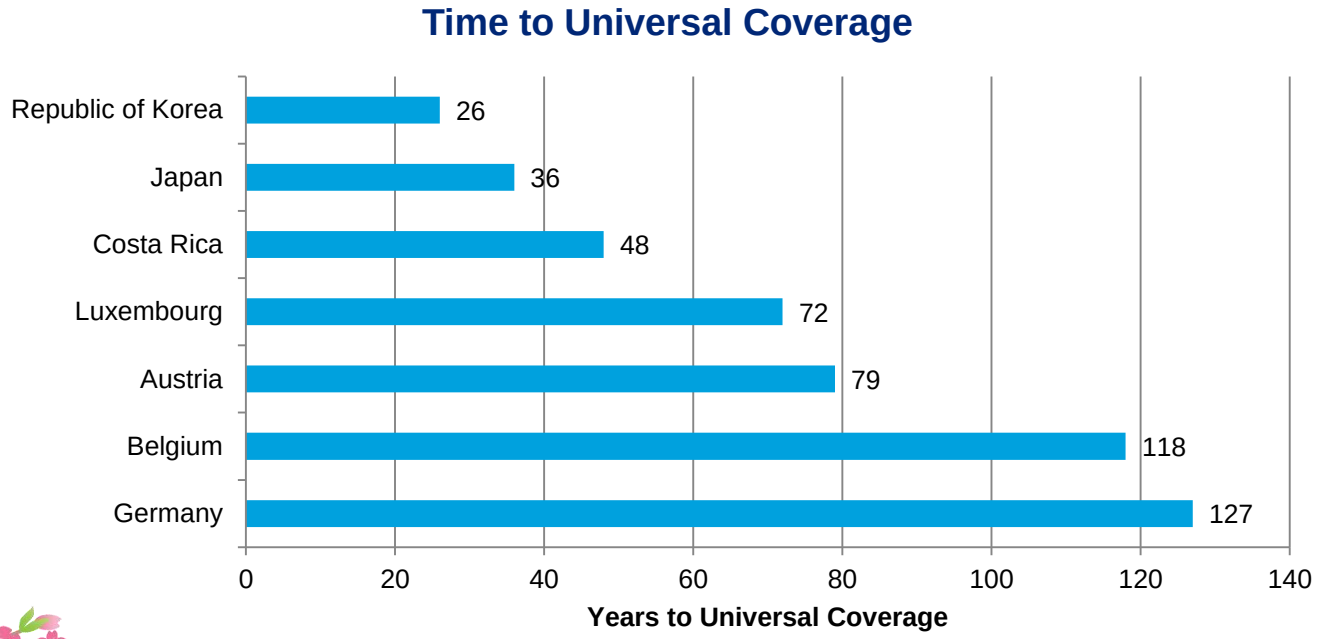
Achieving Universal Coverage

A Lengthy Process

Due to the difficulty of moving to universal coverage overnight, a process or phased approach is needed:

1. Start with occupational/employee groups
2. Expand coverage, where the government plays a role in subsidising the rest of the population



Source: WHO. (2004). Reaching universal coverage via social health insurance: key design features in the transition period, Discussion Paper, Number 2

Country Case Studies

Country Characteristics

	Population (millions)	Per Capita GDP (US $)	Population Below Poverty Line (%)	Population Living in Urban Areas (%)	Unemployment Rate (%)	Private Health Expenditure (% of THE)	OOP Health Expenditure (% of THE)	Total Dependency Ratio
Year	2010	2010	2003 - 2009	2010	2008 - 2010	2010	2010	2010
Source	World Bank	World Bank	UN data	UNICEF	Nation Master	WHO	WHO	WHO
Kenya	40.5	775	45.9 (2005)	22	40.0 (2008)	55.7	42.7	82.2
Ghana	24.4	1283	28.5 (2006)	51	11.0 (2000)	40.5	26.9	73.6
Philippines	93.3	2140	26.5 (2009)	49	7.3 (2010)	64.7	54.1	64.1
Colombia	46.3	6225	45.5 (2009)	75	11.8 (2010)	27.3	19.5	52.3
Thaliand	69.1	4608	8.1 (2009)	34	1.2 (2010)	25	14	41.7
Namibia	**2.3**	**5330**	**38 (2003)**	**38**	**51.2 (2008)**	**41.6**	**7.4**	**66.9**

Source: Hsiao, W. C., & Shaw, P. R. (2006) - Social Health Insurance for Developing Nations

Namibian Case Study: Interaction of Health Reform and Social Security

Social Security Funds in Namibia

Social Security Act 34 of 1994 paves the way for four social security funds:

Maternity, Sick leave and Death Benefit Fund

Subject to provisions the fund provides maternity benefits to females, sick leave benefits to everyone and death benefits to dependants of every employee

National Pension Fund

Provide pension benefits to every employee subject to the rules of the fund.

Development Fund

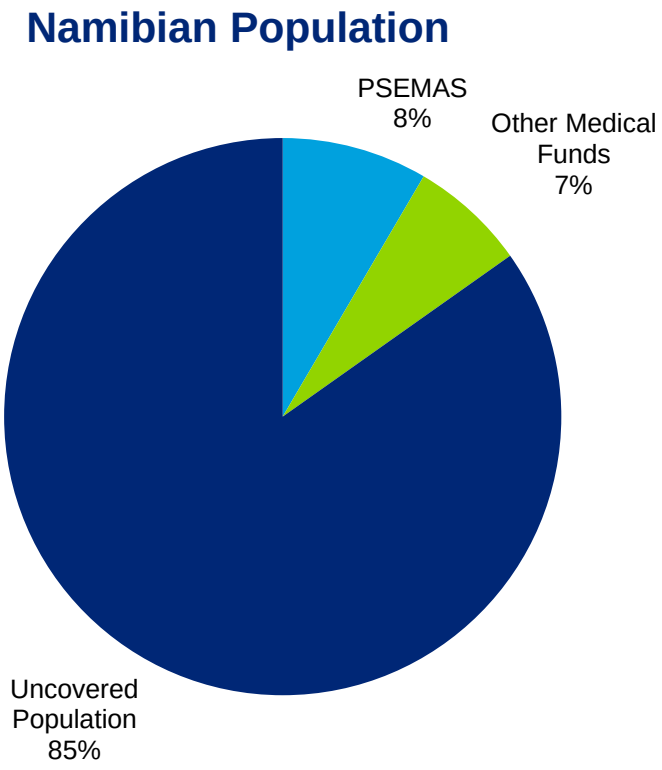
Training and employment schemes for disadvantaged, bursaries and other forms of financial aid.

National Medical Benefit Fund

The Social Security Commission currently administers the Maternity, Sick leave and Death Benefit Fund, as well as the Development Fund.

Healthcare Environment in Namibia

10% of the highest income households accounting for over 90% of total household income therefore posing a serious health care funding challenge.



Source: NPC. (2005) - Namibia Household Income & Expenditure Survey. Windhoek: Central bureau of statistics.

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Healthcare Environment in Namibia

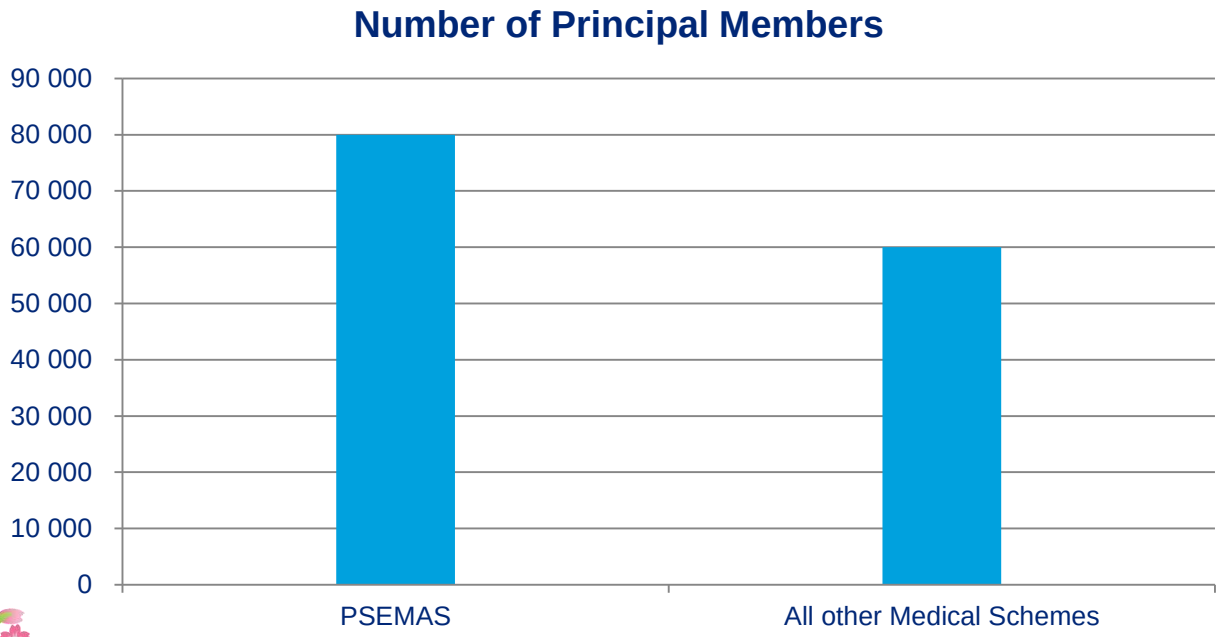
- Health professionals are attracted to the private sector, further exacerbating poverty dis-equilibriums
- The health workforce density figures for Namibia are consistently below the WHO benchmarks for the period of 2000 to 2010 across several disciplines

Health Workforce 2000 - 2010			
	Number	Density (per 10 000 population)	Benchmark Density (per 10 000 population)
Physicians	774	3.7	22.4
Nursing and midwifery personnel	5 750	27.8	44.5
Dentistry personnel	90	0.4	6.5
Pharmaceutical personnel	376	1.8	3.7
Environment and public health workers	198	1	4.7
Infrastructure			
Hospital beds (2000 – 2009)	-	2.7	36
Radiotherapy units (2010)	-	0.005	.014

Source: World Health Statistics 2011, World Health Organization

Healthcare Environment in Namibia

- Public Service Employee Medical Aid Scheme (PSEMAS) is open to civil servants only
- Accounts for over 50% of medical scheme principal member population
- It is heavily subsidised by the Ministry of Finance and may not be sustainable going forward



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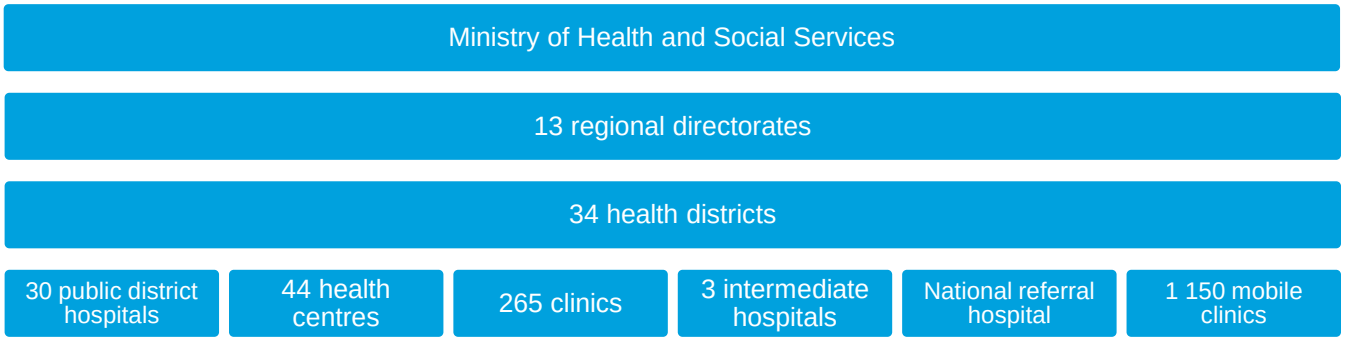
Public & Private Sectors

Public Sector

Managed at two levels:

- The Ministry of Health and Social Services (MoHSS)
- The regional level

MoHSS: formulates policy, strategic planning, setting legislation & regulation, and co-ordinating functions



Mission facilities which are subsidised by government also play a significant role

Private Sector

- Largely restricted to urban areas
- 13 medium sized hospitals, 75 primary healthcare clinics, 8 health care centres, 557 medical practitioners and 75 pharmacies

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Absorption of PSEMAS Membership into NMBF

Advantages:

- PSEMAS is currently unsustainable
- Will align objectives with MoHSS
- Ministry of Finance funding can be shared in a more transparent and consistent manner
- Data set and membership of PSEMAS can be used to inform NMBF
- PSEMAS's administration systems can be leveraged
- Contributory regime from a much larger NMBF risk pool will be more financially stable
- Help align and give impetus to the many debates that are ensuing in the health sector e.g. equitable resource allocation and expected future donor funding

Disadvantages:

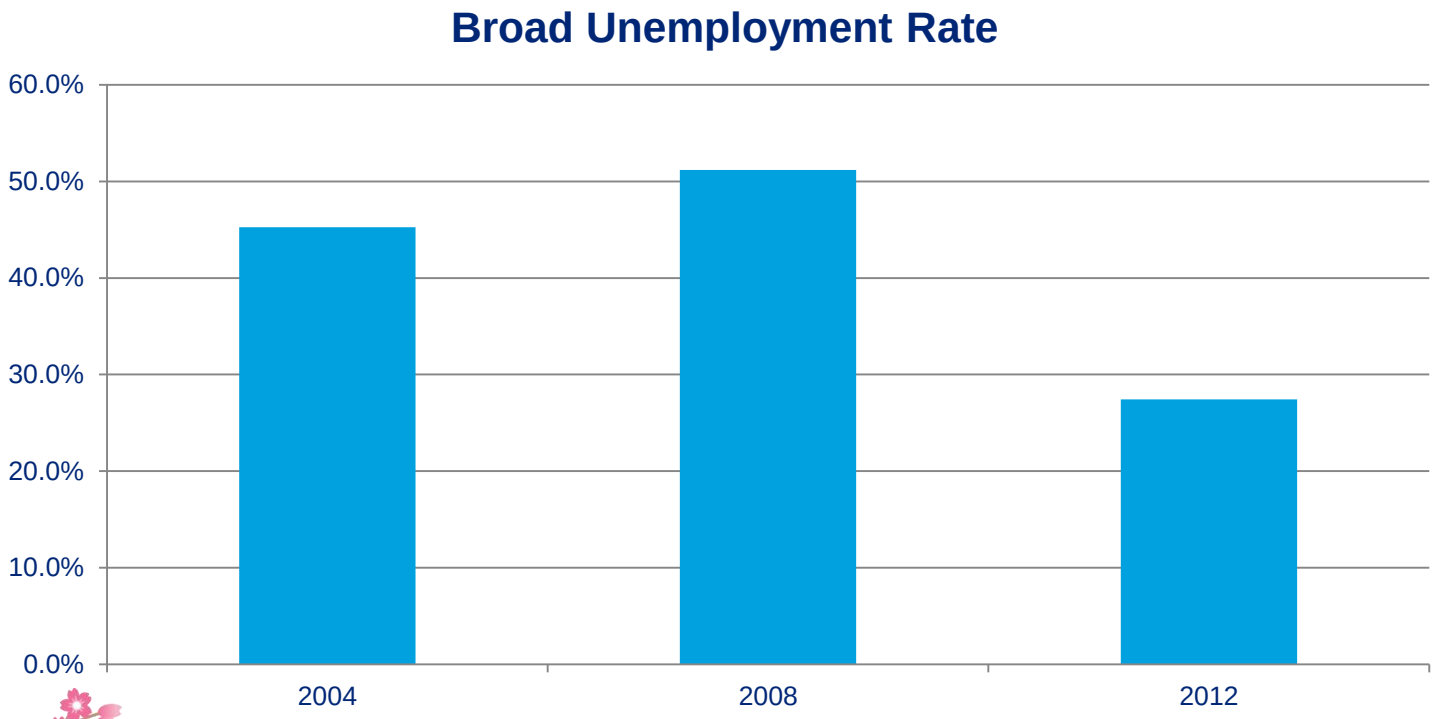
- Removal or downgrading PSEMAS benefits is likely to face resistance from unions
- Government approval is still required
- Legislation must be updated

Employee Taxation

- 6.0% of the population pay taxes (Namibian Minister of Finance)
- Tax room may only exist with employers in the private sector
- This tax group however may already be facing tax increase in the near future due to:
  - the new Education Act: the taxation system proposed is that 2% of company profit must be paid
  - Other Acts such as the Child Protection Bill are sound in principle but require costing investigations
- Thus, it can probably be answered that it is *not* advisable to impose further charges at this stage, at least without due consideration. Rather, a better approach might be to adopt fiscal discipline and move away from a welfare state (to avoid sovereign bankruptcy like countries are experiencing in the EU, and to attract foreign investment in Namibia).

Unemployment

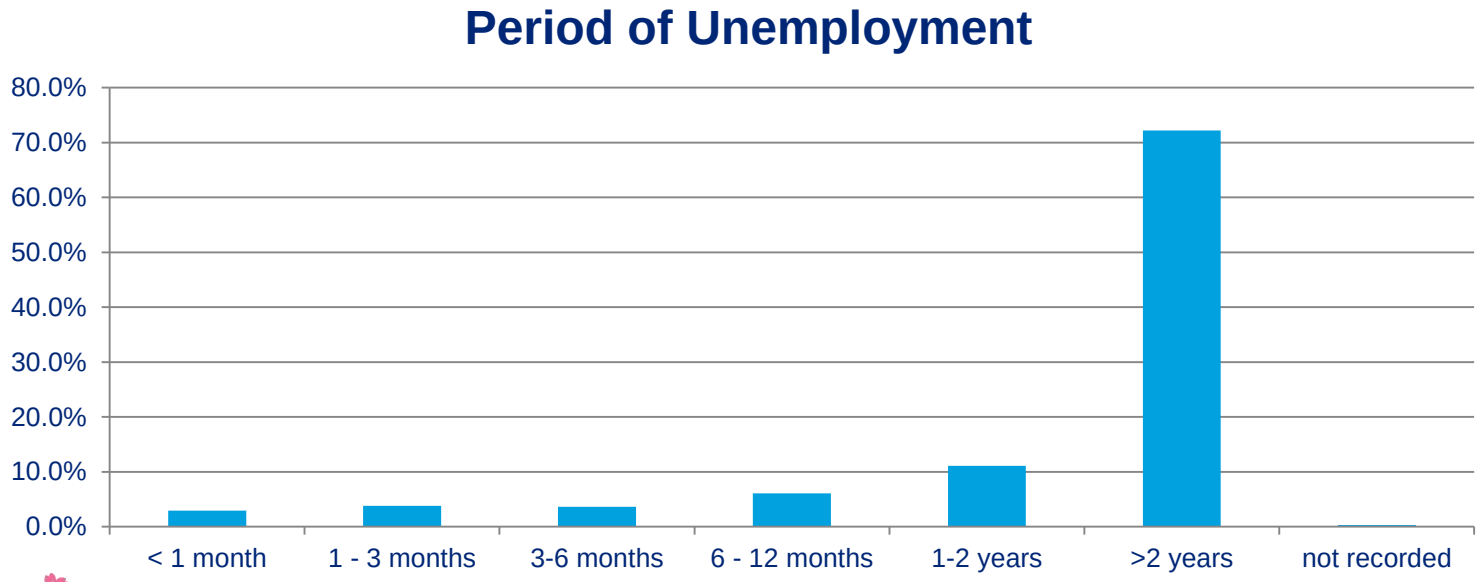
The broad unemployment rate changed as follows from 2004 – 2012:



Source: Namibian Labour Force Survey

Unemployment

- Unemployment is much higher at younger ages
- The unemployment is of a long term nature, with 72.2% of unemployed having been out of work for more than 2 years



Source: Namibian Labour Force Survey

Unemployment

- Unemployment is much higher at younger ages
- The current unemployment is not conducive for the SHI
- Job creation and health care must be considered simultaneously

Ensuring the health of the population can contribute positively to productivity, GDP growth, and hence job creation

Labour Market Structure

- SHI typically funded by a deduction from income
- However, income from informal sector and self-employed is difficult to assess because:
  - income tends to be variable
  - difficult to know when a cost has been incurred by the individual or business
  - strong incentives for people to understate income.
- About 60% of population operate in informal sector, particularly in subsistence farming:
  - Agriculture and fishing employees make up 29.9% of total employment
  - Agriculture, primarily livestock, is a substantial contributor to the economy, but is particularly prone to fluctuations due to weather extremes, suffering from both drought and flood.
- So, it can probably be answered that the formal sector is not large relative to the informal sector, and it may be difficult and expensive to collect SHI contributions from the informal sector.

- Because of mining, tourism, and large commercial farms, the formal sector of the economy is proportionately larger than in many African countries.

Source: Ministry of Labour and Social Welfare, 2010

Burning Health Priorities

Rank	Main Causes of Morbidity	Number	Percentage
1	Other respiratory disease	472,734	22.9
2	Musculo-skeletal system disorder	287,959	13.9
3	Skin Diseases	205,393	9.9
4	Common cold	199,084	9.6
5	Trauma	180,007	8.6
6	Diarrhoea without blood	176,608	8.5
7	Nose and throat diseases	175,743	8.5
8	Other Syndrome	171,486	8.3
9	Other Gastro Intestinal diseases	122,570	5.9
10	Contraception, gynaecology, pregnancy and obstetric	80,907	3.9
Grand Total		2,072,491	100

Source: MoHSS – Health Information System

Burning Health Priorities

Rank	Main Causes of Mortality	Number	Percentage
1	HIV/AIDS	1,811	20.4
2	Diarrhoea, gastroenteritis, presumed infectious	1,578	17.8
3	Pneumonia	1,483	16.7
4	Pulmonary tuberculosis	1,453	16.4
5	Heart failure including CCF	587	6.6
6	Anaemia	549	6.2
7	Malnutrition	410	4.6
8	Hypertension, essential primary	345	3.9
9	Other respiratory system diseases, pneumoconiosis, lung abscess, etc.	336	3.8
10	Stroke, intracranial haemorrhage, cerebral infarction, CVA	319	3.6
Grand Total		8,871	100

Source: MoHSS – Health Information System

Burning Health Priorities

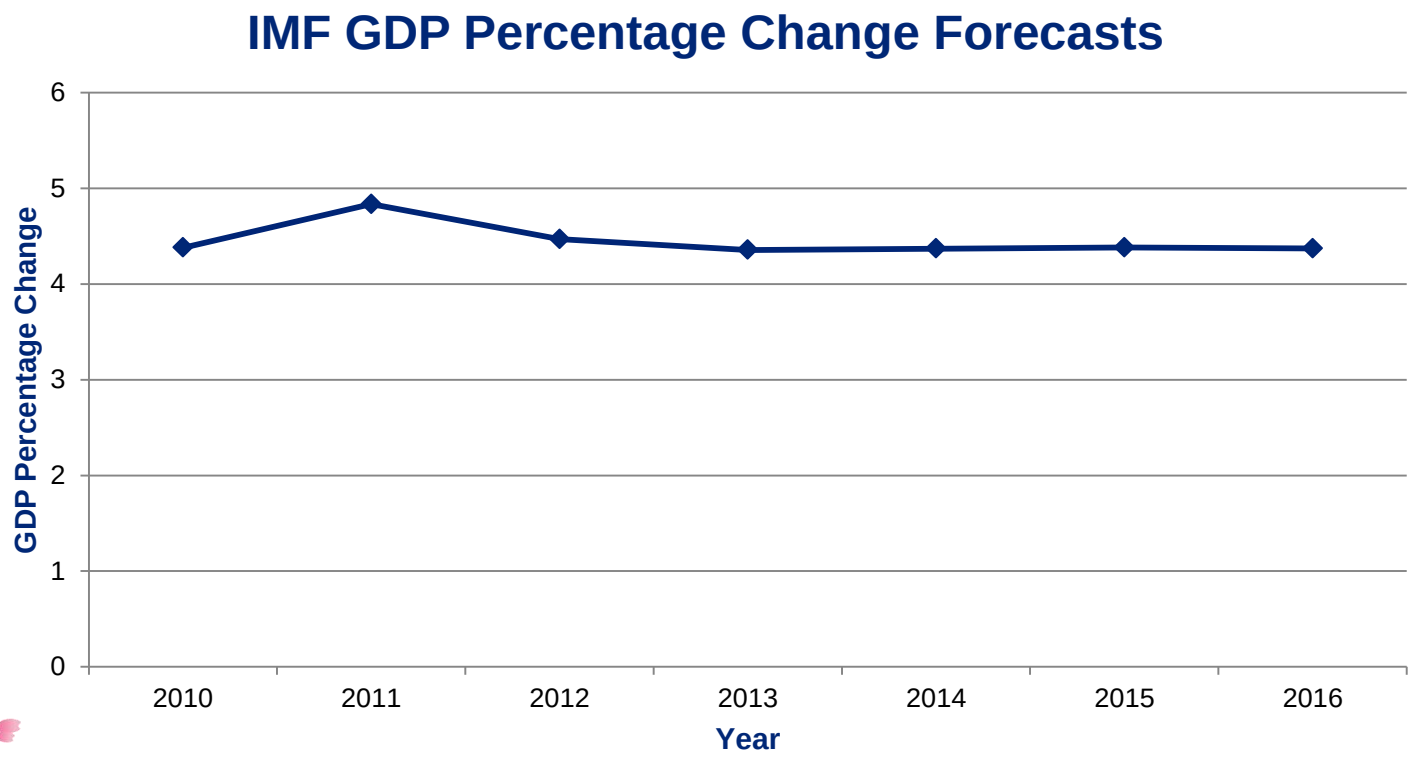
- Data suggests that Namibia's key health needs are preventable.

For example, effective preventable measures (against largely preventable conditions such as HIV/AIDS, Diarrhoea and Gastroenteritis, Malaria, Pulmonary tuberculosis, Pneumonia, Malnutrition, other respiratory diseases, Heart Failure, and Stroke) can help reduce or avoid downstream (and hence more expensive) health costs.

- A large part of the health needs of the population will be met by the continued introduction of preventative care.
- However, academic literature and international experience suggest that SHI works best for curative care due to the greater perceived value proposition – access to treatment is guaranteed in the event of illness.
- SHI is not likely to successfully fund basic preventative care and health promotion nor expand primary health care among scattered rural populations which is focused on prevention and health promotion.
- SHI will be useful if the a residual part of the health needs of the population will be met with an NMBF benefits package that is based on curative care.
    - This will help reduce downstream, more expensive hospitalisation costs.

Projected GDP growth

The table below illustrates the IMF's GDP growth forecasts for Namibia (Ndjavera, 2011):



Projected GDP growth

- An important enabler of the SHI is economic growth
- Economy contracted by 0.8% in 2009 due to sharp drop in diamond production
- April 2011 projections prior to Euro-zone double dip recession fears showed expectations of relatively constant , yet low growth over the next 4 years
- Growth will be insufficient to fund the introduction of the NMBF
- Remember however to consider job creation in line with health decisions

Policy Objectives of the NMBF

Policy Objectives of the NMBF

• **Accessibility**: Not just entry access into the health care system but also ability to move within its different levels

• **Financial Accessibility**: Extent to which people are able to pay for care

• **Geographical Accessibility**: Extent to which services are available and accessible to the population. Also covers the actual offering of the services at these facilities

• **Universal Access to Healthcare**: ALL people having an EQUAL opportunity to gain entry to a quality accredited health facility for diagnosis and therapy

• **Universal Coverage**: Physical and financial access to necessary health care of good quality for all persons in society

• **Equity in Healthcare**: "Everyone should have equal opportunities to maximise their health status…incidence of health care financing should be distributed according to ability to pay and benefits should be distributed according to need."

Policy Objectives of the NMBF

• **Equity in Health Financing:** wealthier groups contribute a greater proportion of their income to the overall financing of the healthcare than poorer groups

• **Equity in Resource Allocation**: resources should be distributed in such a way that gives greater preference to those that have a greater need for healthcare

• **Quality in Healthcare**: delivery of safe care that is consistent with current medical knowledge and customer-specific values and expectations

• **Responsiveness in Healthcare**: reflection of individual's actual experience with a health system: autonomy, information, confidentiality, dignity, prompt attention, quality of basic care, access to social support network and choice of providers

• **Sustainability**: ability of the health system to adequately generate resources for the provision of good quality health care today and in the future

• **Protect the Nation's Health**: government aims to safeguard a healthy and productive workforce which will in turn improve the GDP

Source: IMSA. (2009a). Glossary of Healthcare Financing Terms. Retrieved from IMSA National Health Insurance Policy Brief Series: http://www.imsa.org.za/national-health-insurance/policy-briefs/

Purchasing of Healthcare Services

Purchasing of Health Services

Benefit Package

The benefit package's specification should aim to:

- Be as comprehensive as possible, given the budget constraints of the SHI scheme.
- Ensure members receive the health benefits that they need.
- There should be no under-provision or over-provision of health care. Therefore, regular monitoring is a necessary task of the SHI administration.
- Account for society's preferences regarding efficiency and equity, so that resources are used optimally.

Policy makers need to decide the relative importance of different efficiency and equity criteria, such as:

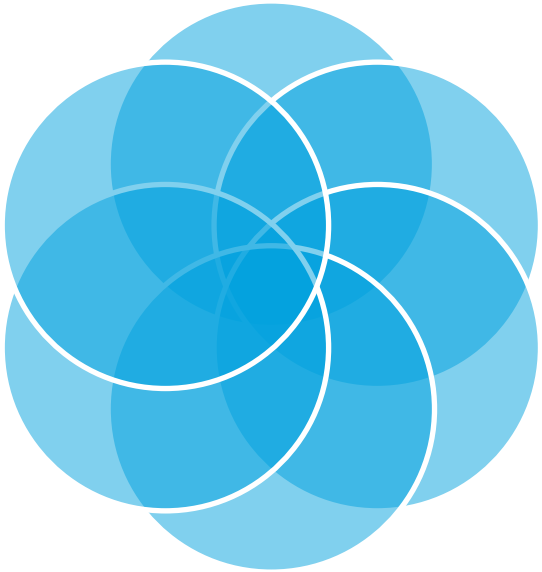
- Cost-effectiveness
- Significant positive impact on an individual's health or severe health conditions
- Equality in health over a lifetime
- Poverty reduction
- Horizontal equity, defined as "equal treatment for equal need"
- Collective versus individual responsibility

Purchasing of Health Services

Reimbursement Methods

Capitation

Fee-for-Service



Per diem

Salaries

Diagnosis Related Groups (DRGs)

Budgets

Purchasing of Health Services

Reimbursement methods: Appropriate incentives

Choice of reimbursement method → Provider's incentives to over-provide or under-provide → Cost and quality of care i.e. resource use

The incentives of each provider is a key consideration when designing the overall mix of reimbursement methods

Provider behaviour is often a natural consequence of the reimbursement method used
(Actuarial Report on the Design of the NMBF – Final draft : Deloitte)

When actual past provider behaviour is monitored, the behaviour is often in line with the provider behaviour that one would have expected at outset when the reimbursement system was designed

The success of any reimbursement system should be measured by both:

- The system's accuracy and lack of bias
- The extent to which the reimbursement system incentivises provider behaviour in line with social objectives

Purchasing of Health Services

Reimbursement methods: Promotion of optimal resource allocation

Reimbursement method	Likely level of provision	Key design remedies
Fee-for-service	Over-provision	Combine with budgets Adjust fees when specified quantity is exceeded
Capitation	Under-provision	Integrated referral system
Daily payment	Over-provision	Decrease daily payment as length of stay increases
DRGs	Over-provision	Clearly defined diagnostic groups
Budgets	Under-provision	Strict budgets that are not based on historical cost allocations Integrated referral system
Salaries	Under-provision	Link salaries to performance

Source: Actuarial Report on the Design of the NMBF – Final draft : Deloitte

Delivery of Health Services

There are five main strategies to promote the efficiency and quality of health care under SHI :

1. Create competition
   - At insurance level
   - At provider level
2. Use a mix of rational payment methods
   - Impacts provider incentives and hence the volume, quality, and cost-effectiveness of health services
3. Strategic provider selection and contracting
   - The SHI agency should be a collective purchaser versus passive payer
   - Set minimum quality standards and certify providers
4. Define and regulate the essential drug list
   - Almost all SHI programs have specified a drug list
5. Reduce the supply-side subsidy
   - Avoid double-paying public facilities with income from government budgets and insurance plans

Source: Actuarial Report on the Design of the NMBF – Final draft : Deloitte

Governance

The structure and processes of the control mechanisms used to hold the SHI agency accountable to beneficiaries and funders (that is, the government and employers) of the scheme

The following critical choices have to be made in relation to SHI governance:

- Ownership of the SHI agency e.g. public, quasi-public, or private-non-profit
- Organisational structure, with emphasis on the composition, election, and accountability of board
- Management structure, which must be given discretion in financial and personnel decisions
- Government supervision, with emphasis on society's interests, original objectives, and funding

One of two existing ministries may be responsible for SHI, and each structure has potential problems:

Ministry	Challenge
Ministry of Health	• Medical Professionals on board are more concerned about the welfare of the supply side than of the demand side • The additional revenues generated by the SHI often largely benefit providers
Ministry of Labour and Social Security	• Insurance viewed simply as a payment mechanism, rather than as a prudent, organised purchaser for the insured

Alternatively, a new independent ministry – the SHI agency – can be established.

Financing sources

Principles:

- Funding should be progressive
- Funding accommodates Treasury's preference to have control over funds
- Funding source limits the degree of supplementation from other sources

Financing Source	Merit
Earmarked tax	•Typically not progressive •Cedes control to other government departments •Always needs supplementation by general income tax
VAT	•Regressive and hence not appropriate •Cedes control to other government departments
Standard personal income tax	•Probably the most progressive, and hence the most appropriate

Source: Actuarial Report on the Design of the NMBF – Final draft : Deloitte

Tax Collection System in Namibia

Country	World Ranking			
	Ease of Paying Taxes	Tax Payments	Time to Comply	Total Tax Rate
Namibia	99	123	149	4
UK	16	15	23	76
Germany	88	53	84	128
Taiwan	87	56	108	100
South Africa	24	24	75	43
Kenya	162	133	153	135
Ghana	78	109	90	53
Philippines	124	149	70	118
Colombia	118	71	80	171
Thailand	91	83	106	78

Source: www.pwc.com/payingtaxes

Tax Collection System in Namibia

- This is an option for funding the NMBF
- The system is seen to be equitable and transparent
- Individuals may be required to contribute a percentage of their salaries to the fund subject to a maximum amount, much like the current social security contributions
- A self-assessment tax system is used with penalties for late submissions
- The total tax rate in Namibia is the 4th lowest in the world and much lower than in other countries that have successfully implemented NHI/SHI schemes
- Investigation into tax rate or tax budget may be required if tax will be the main source of NMBF funding

Current Collection Methods by Medical Aid Schemes

Currently:

- The Namibian Association of Medical Aid Funds (NAMAF) is the representative of the healthcare funding industry
- Medical scheme contributions are monthly in advance
- Subscriptions in arrears result in suspension of benefits
- Employed individuals pay via employer
- Self-employed pay via debit order
- However, only 28% of population have bank accounts (FinScope, 2011)
- Not compulsory
- Default common during months of hardship to provide relief.
- Benefits reinstated when premium is paid but does not require past premiums be made up.

Recommendations:

- All employed individuals must have medical cover
- Continue collecting via employers and debit orders
- Ensure premiums are made up in full after a default

Conclusion

Conclusion

Characteristics of a good Health system

- Leadership and governance
- Health information systems
- Health financing
- Essential medical products and Technologies
- Human resources for health
- Service delivery

Source: http://www.who.int/healthsystems/EN_HSSkeycomponents.pdf

Questions?

Ashleigh Theophanides
Tel: +2711-209-8112
atheophanides@deloitte.co.za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