Health Reform

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Agenda

1. Different pathways to Universal Coverage
2. International Trend: NHI vs SHI
3. Four models of healthcare system financing:
   2.1. National Health Insurance (NHI)
   2.2. Bismarck Social Health Insurance Model (SHI) Model
   2.3. Beveridge Model
   2.4. Out of pocket
4. NHI Green paper
Different pathways to universal coverage
Different pathways to universal coverage

- Countries have several options for achieving the ultimate objective of universal coverage.
- Four main health financing system options can be used to achieve universal coverage:
  1. Beveridge Model, which achieves universal coverage immediately
  2. Bismarck Model, where SHI can be viewed as a building block for NHI. A phased implementation approach achieves universal coverage in the long-term.
  3. National Health Insurance, which achieves universal coverage immediately. NHI can be viewed as a mix of the above two options. Under mixed health financing systems, the subsidised population group is partially covered via general tax revenue, and a clearly specified contributory population group is covered by SHI.
  4. A system of private health insurance that is subject to government regulatory powers, especially ensuring a pre-defined benefit package of care.
Different pathways to universal coverage

- National Health Insurance (NHI) Model
- Bismarck Social Health Insurance (SHI) Model
- Beveridge Model
- Out-Of-Pocket Model
2. **International Trend: NHI via SHI**

- SHI is 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 process or 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: SHI vs. NHI

- **NHI** – covers entire population, thereby achieving “universal coverage”
- **Bismarck SHI** – only covers those contributing
Main health models
Main Health Models

- National Health Insurance (NHI) Model
- Bismarck Social Health Insurance (SHI) Model
- Beveridge Model
- Out-Of-Pocket Model
Components

- Purchaser
- Healthcare provision
- Funding
3.1 NHI Model

• Uses an insurance system
• Single State NHI Fund acts as a single funder and single purchaser
• NHI Fund may contract with public and private sector providers i.e. multiple delivery
• Only citizens/employers above a certain income/means threshold contribute into the NHI Fund
• However, the entire population is entitled to benefit from the fund
• The NHI Fund is non-profit.
3.2 Bismarck SHI Model

- Named for the Prussian Chancellor Otto von Bismarck, who invented the welfare state
- 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"
- SHI scheme can be single/multi-funder and single/multi-purchaser
- Funds are usually financed jointly by employers and employees through payroll deduction
- Funds are non-profit
- Typically, SHI scheme contracts with public and private providers i.e. multiple delivery
Compulsory membership under contributory regime

Legislation sets out contribution and benefit rules

Government may fund poor enrollees in subsidised regime

Benefit eligibility once contribution is paid
Mutuality versus Solidarity

- Financial contributions are considered **fair** when health expenditure is distributed according to **ability to pay** rather than according to the **risks** of illness.
- SHI is **based on** the principle of solidarity and not the principle of mutuality.
- The **main distinctions** between mutuality and solidarity are:

<table>
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<th>Mutuality</th>
<th>Solidarity</th>
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<td>Underpins <strong>commercial insurance</strong></td>
<td>Underpins <strong>social insurance</strong></td>
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<td>Characterised by <strong>voluntary membership</strong>, <strong>risk-rating</strong>, and <strong>underwriting</strong></td>
<td>Characterised by <strong>compulsory membership</strong> for <strong>all</strong> or a <strong>defined</strong> group</td>
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Individuals contribute according to **risk**. Applicants contribute to the pool through a premium that is commensurate with their particular risk at the application date. This risk is quantified on the basis of all the underwriting facts that are available and relevant.

Contributions are **not** made in accordance with the risks that each applicant presents to the insurer. Instead, individuals contribute equally or according to **ability to pay**.
3.3 Beveridge Model

- Named after William Beveridge, a social reformer who designed Britain's NHS
- Does not use an insurance system
- Rather, health services are free at the point of treatment
- Health care is provided and financed by the government through tax payments, just like the police force or the public library
- Government is sole payer i.e. single funder model
- Many, but not all, hospitals and clinics are owned by the government
- Some doctors are government employees, but there are also private doctors who collect their fees from the government
- Government directly reimburses providers i.e. single purchaser
- State fund contracts with a network of public and private providers i.e. multiple delivery
3.4 Out-Of-Pocket Model

- Only the **developed** and **industrialised** countries (perhaps 40 of the world's 200 countries) have established health care systems.
- Most nations are too poor and disorganised to provide mass medical care.
- **Basic rule** in such countries is that only the rich get comprehensive medical care.
- **Access** to care is **only** available if the individual:
  - Can pay the bill **out-of-pocket** at the time of treatment, or
  - Is sick enough to be admitted to the **emergency ward** at the public hospital.
Government Share of Cost

Beveridge Model

NHI Model

Contributory Regime

Government share of cost – Subsidised Regime

Bismarck SHI Model

Government share of cost – Subsidised Regime

Out-of-Pocket Model
Healthcare Models by Country

**Beveridge Model**
- Great Britain
- Spain
- Scandinavia
- New Zealand
- Hong Kong
- Cuba

**NHI Model**
- Canada
- Taiwan
- South Korea

**Bismarck Model**
- Germany
- Switzerland
- France
- Belgium
- Netherlands
- Japan
- Latin America

**Out-of-Pocket Model**
- Rural regions of:
  - Africa
  - India
  - China
  - South America
Experiences with NHI

Disadvantages

• Substantial organisational skill and HR are required to manage and administer NHI

• Because the NHI Fund and not household income becomes the budget constraint, it may be difficult for supply to keep up with patient demand for more and more health benefits, thus resulting in high medical inflation
Experiences with NHI

Advantages

• Potential to be cheaper and much simpler administratively than for-profit private insurance since there is no need for marketing & no profit objective and hence no financial motive to manage/assess claims
• The single payer tends to have considerable market/bargaining power to negotiate for lower prices
• Cost control through benefit limits, or by making patients wait to be treated
• Increases access, since previously uninsured increase their utilisation of services
• Increases equity
• Universal coverage ultimately achieved
• Single-payer system allows more effective cost containment (unified fees, lower administration, patient and provider data used in management)
• If the unemployment rate is low and there is a functioning existing health system, then NHI can be phased in potentially without using more resources (increases in claims cost can be offset by savings due to economies of scale and risk pooling)
Experiences with Bismarck SHI system

Disadvantages

• Contributions are **community-rated** (i.e. contributions do not depend on risk, but on ability to pay), which results in significant increases in contributions for **young and/or healthy employees**

• Enforcing **compulsory contributions** under contributory regime is challenging

• The **self-employed** may not enrol or they may understate their income

• Significant **administration expenses**

• Significant **regulatory control** is required

• Because the SHI Scheme and not household income becomes the **budget constraint**, it may be difficult for supply to keep up with **patient demand** for more and more health benefits, thus resulting in high **medical inflation**

• Need to enforce **community vs. risk rating** otherwise high risk lives burden State (Chile)

• If multiple funds & community rating, then **REF** is required and REF is difficult to implement with poor **information systems** (Netherlands)

• Continual **depletion/degradation of benefits** under subsidised regimes (Colombia)

• **Fee-for-service reimbursement** is expensive such that SHI fund starts to short-pay providers, who then charge OOP payments (Ghana)
Experiences with Bismarck SHI system

Advantages

• Comprehensive and uniform benefits package is possible
• Universal cover possible in long-term, although challenging
• Funding and provision of services functions are separated
• Increased competition contains cost
• Competition between private providers drives quality
Experiences with Beveridge system

Disadvantages

- **Deficits** in government finances develop over time
- **Quality** problems may become prevalent because of deficits
- Substantial **copayments** may develop because of deficits
- Significant **waiting lists** for e.g. surgical procedures, in-hospital, specialists
- **Restricted** provider choice
- Private health insurance typically used to obtain “higher level of care” by the rich e.g. bypass waiting lists, luxury accommodation, increased doctor choice, access to local hospital, increased standards. However, this results in **inequitable access** e.g. for specialist and in-hospital treatment
Objectives and Principles of NHI in South Africa
Objectives of NHI

The NHI will have the following 4 key objectives:

1. To provide **improved access to quality health services for all South Africans** irrespective of whether they are employed or not.

2. To **pool risks and funds so that equity and social solidarity** will be achieved through the creation of a **single fund**.

3. To **procure services on behalf of the entire population and efficiently mobilize and control key financial resources**. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of some of the medical schemes resulting in spiralling costs.

4. To **strengthen the under-resourced and strained public sector** so as to improve health systems performance.
NHI will be guided by the following principles

The Right to Access
- The Constitution states that everyone has a right of access to healthcare services.

Effectiveness
- Better performance of the healthcare system that will result in improved life expectancy for the entire population.

 Appropriateness
- The adoption of new and innovative health service delivery models that take account of the local context and needs.

Equity
- Those with the greatest health need are provided with timely access to health services.
NHI will be guided by the following principles

Social Solidarity
• The creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick.

Affordability
• Services will be procured at reasonable costs that recognise health as not just an ordinary commodity of trade but as a public good.

Efficiency
• The key will be to ensure that minimal resources are spent on the administrative structures of the NHI and that value-for-money is achieved in the translation of resources into actual health service delivery.
Questions

THANK YOU