

Is there a Sepp Blatter in the house?

Not last year

Not next year

but - some where in between

Kulula.com advert

A year we must never forget

2010

A great year for South Africa

A number we must never forget

R 2010

The amount the DoH has to spend per life per year on health

A number we must never forget

Take about 75% of R 2010

R 1452

What the private industry spends plpa on non healthcare costs

A number we must never forget

Multiply R 2010 by 1000

R 2 010 000

The annual salary of at least 4 principal officers in 2008

A number we must never forget

Multiply R 2010 by 1 000 000

R 2 010 000 000

The annual industry expenditure on managed care

A numbers we must never forget

And then by 5.5

R 11 055 000 000

The annual expenditure on all non health costs

2010

Things we learnt from 2010

We are a “can do” nation

We can work together – the rainbow nation

We can think about things differently

Isn't it time to look at health in this light?



The BHF Annual Southern African Conference – 2010

Deconstructing 28 years of healthcare spend – Symptoms and Solutions

By Dr Andrew Good and Barry Childs



A word for our sponsors



CENTRE FOR DEVELOPMENT AND ENTERPRISE
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a meeting
of minds
The BHF Southern
African Conference
Sun City 22-25 August 2010

Presentation Outline

- *Regulation and Policy*
 - *'Who moved my primary care'*
- *Long term Cost drivers*
- *Is this Market Failure?*
- *What do we do next?*

South African Health System Review

State sector

- Policies good
- Implementation poor
- Resources very limited / not used optimally

Private sector

- Lack of focus on primary care
- Hospital / specialist focus
- Fragmentation of care
- Affordability under pressure
- Resources not used optimally

Primary Health Care – “Now more than ever”

World Health Organisation (WHO) 2008 report details three trends that undermine the delivery of health outcomes

- Hospital centrism – curative focus
- Fragmentation in approach – programmes / delivery
- Uncontrolled Commercialism

Question – Is the Medical Scheme Act good legislation? **Yes!!**

- Introduced community rating (universality)
- Entrenched mutuality of medical schemes
- Improved governance
- Increased independence of trustees
- Improved scheme solvencies
- Eliminated undesirable practices (re-insurance)
- Introduced the concept of minimum benefits

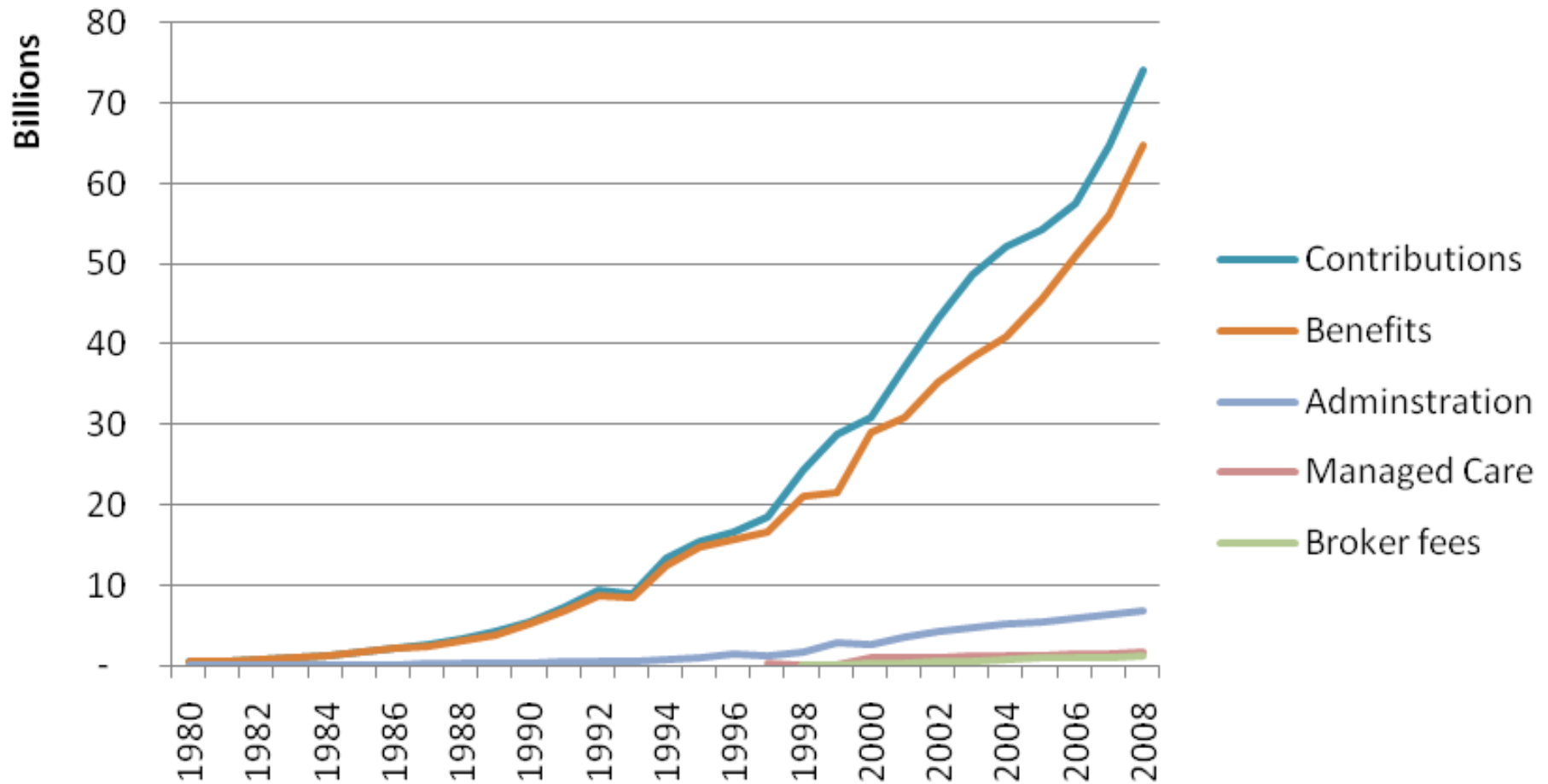
***In summary – Great Legislation except
No mandatory contributions / No income cross
subsidisation / Wrong minimum benefits***

Question – Is the current framework for minimum benefits appropriate? **No**

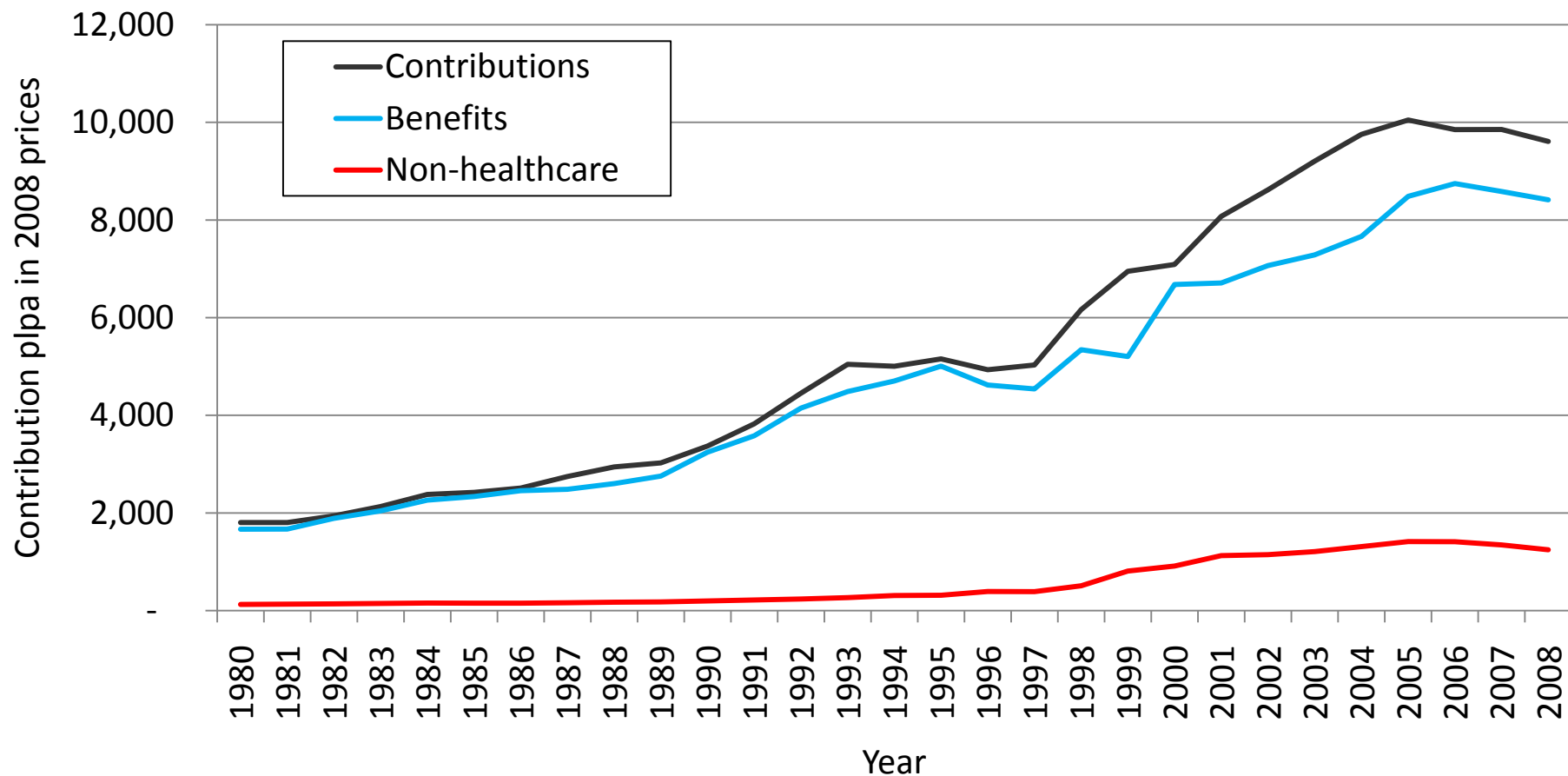
- Not in line with the declaration of Alma-Ata
- Not in line with ANC Health Plan
- Not in line with the National Health Act
- Not is line with WHO's recommendation on Primary Care
- Simply has no focus on Primary Health

Minimum benefits with community rating **are inappropriate** in the absence of mandatory contribution

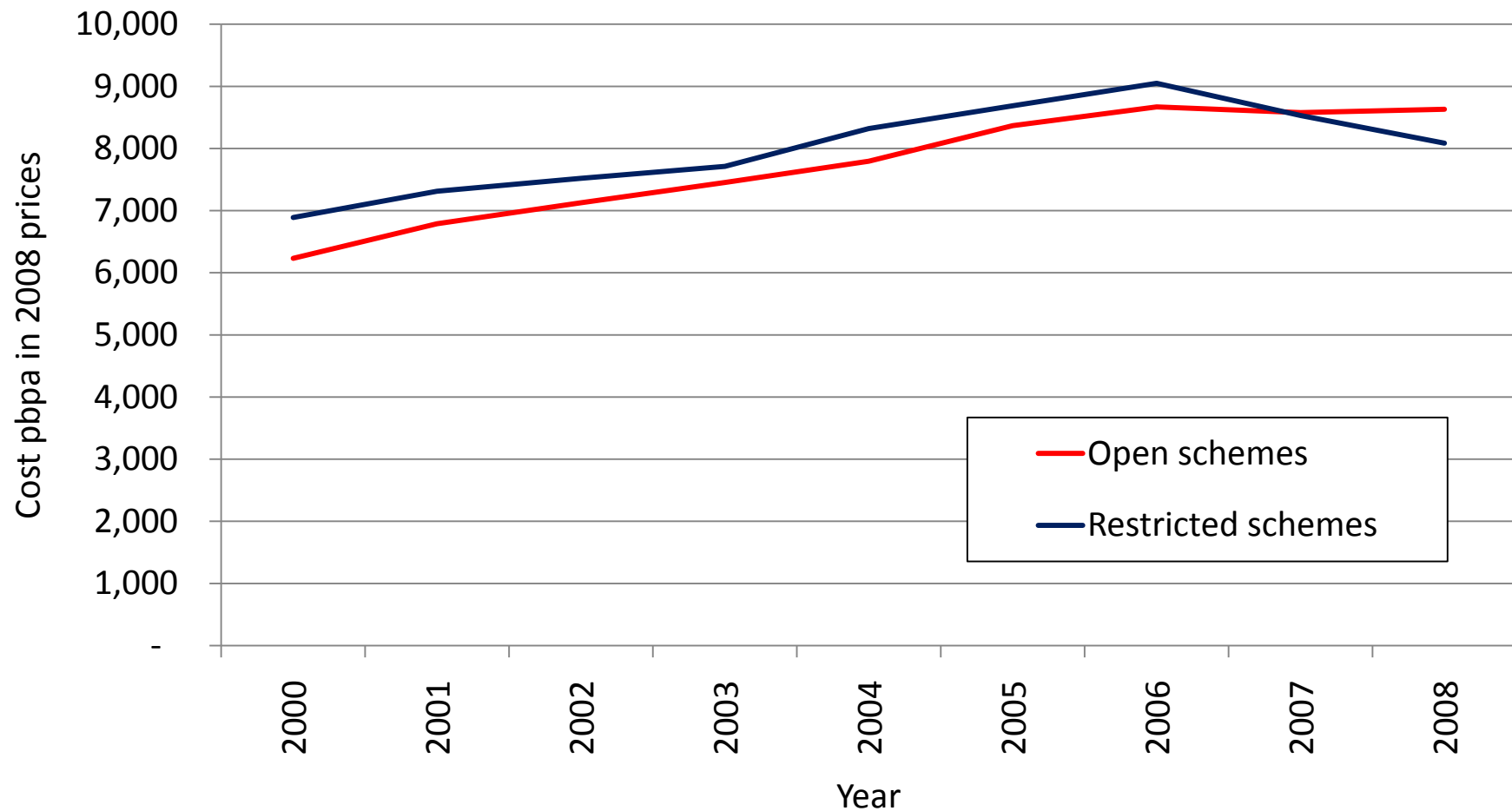
Long term trends - Private healthcare spend in Rand



Long term trends – Medical scheme costs in 2008 prices



Healthcare benefit costs – 2008 prices





SO WHAT ARE THE BIG COST DRIVERS?

Cost Drivers

You!

The good folks in this room

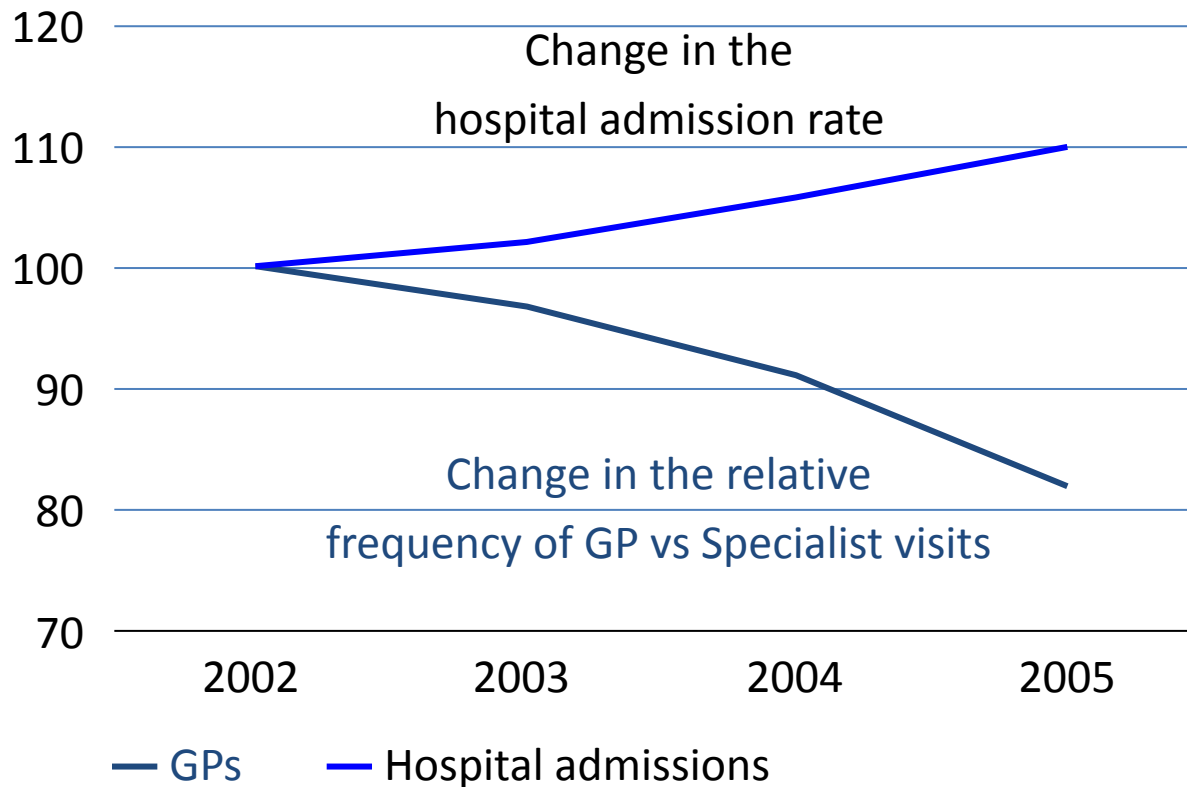
You control the destiny of the industry

You drive the strategies that determine our future

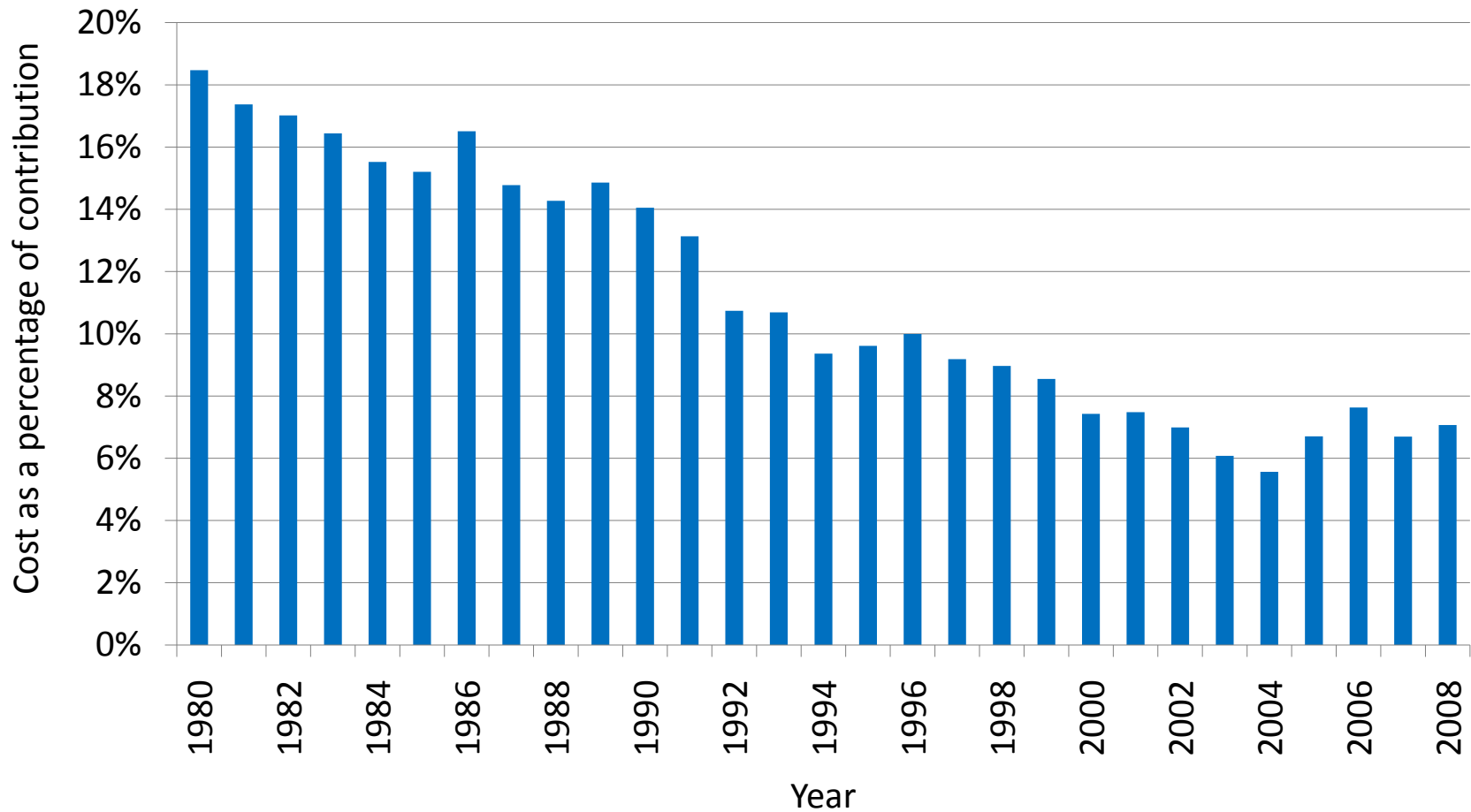
You choose how to respond to the health needs of
South Africa

Cost Drivers – Diminishing focus on primary care

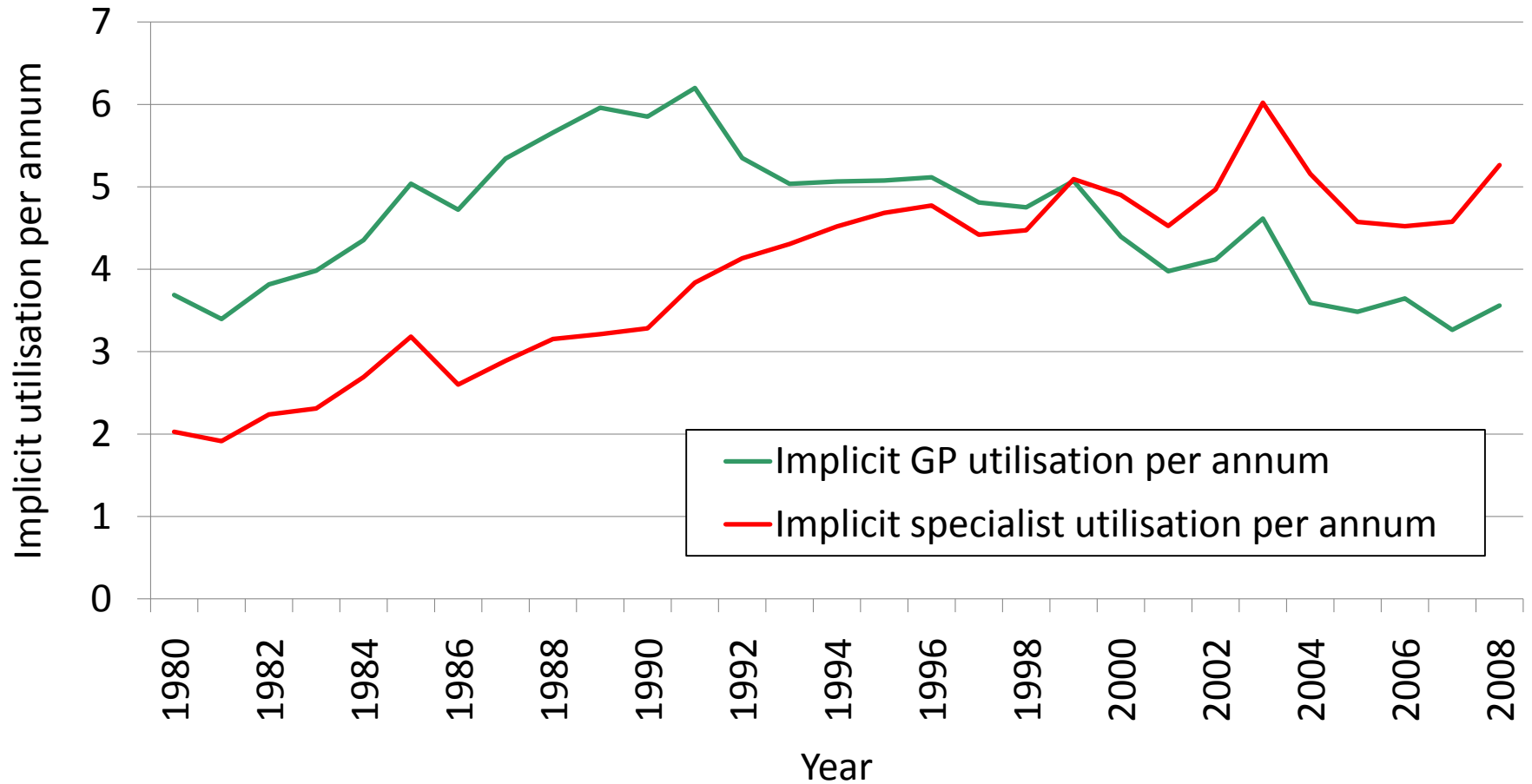
From Discovery interim results 2006



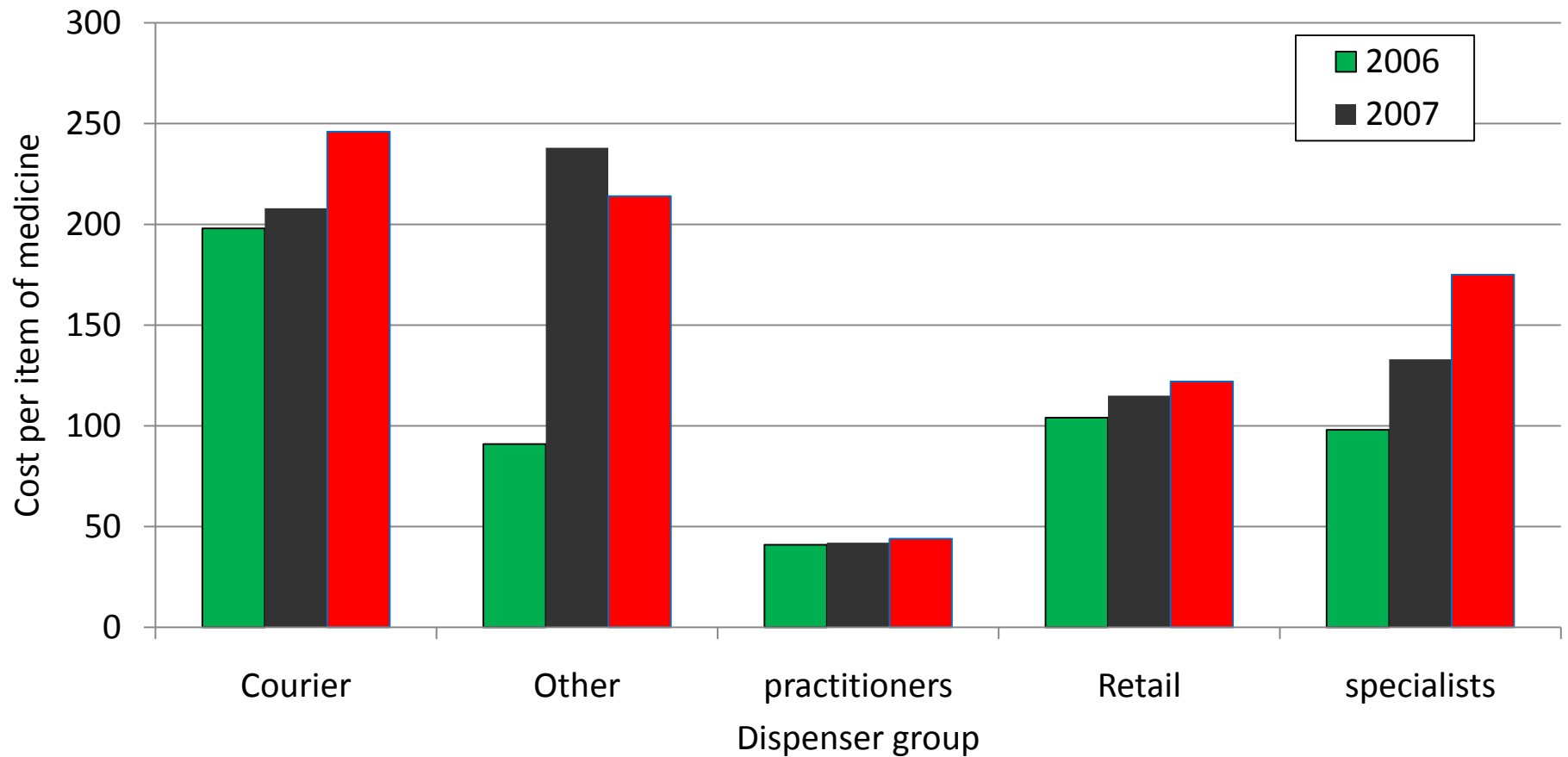
Cost Drivers – Diminishing focus on primary care



Cost Drivers – Diminishing focus on primary care

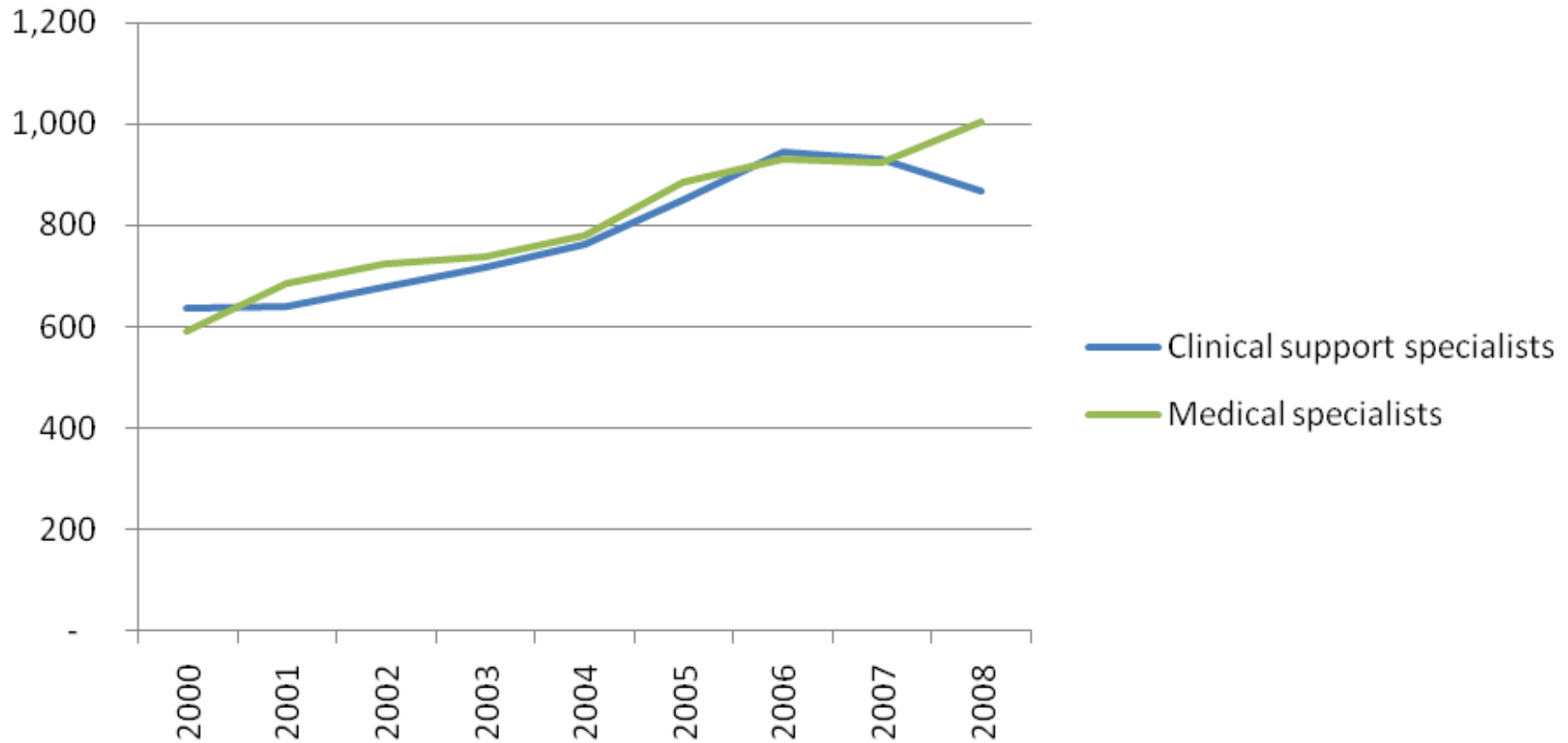


Cost Drivers – Diminishing focus on primary care



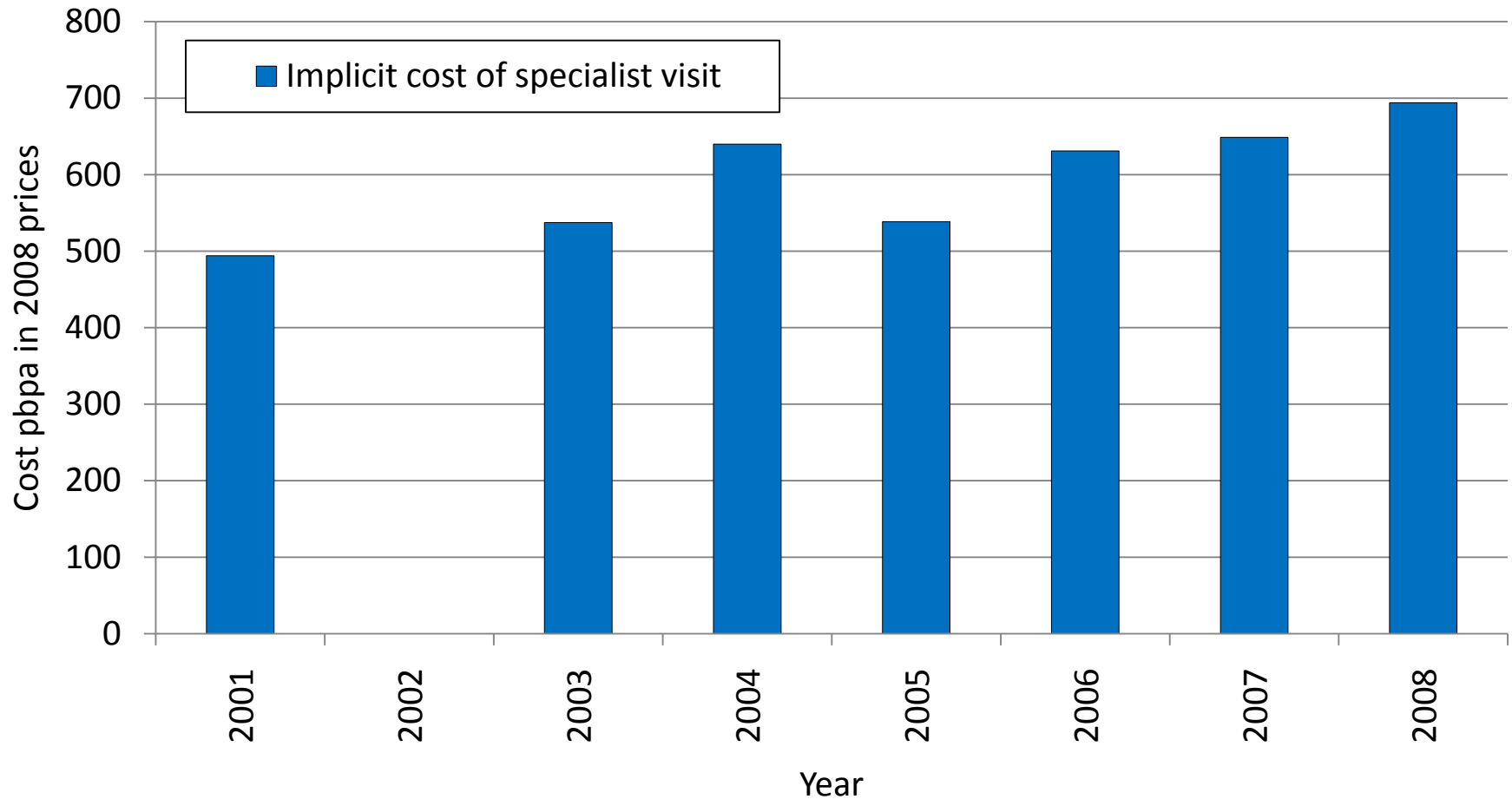
Source: Mediscor survey

Cost Drivers – Increasing focus on specialist care

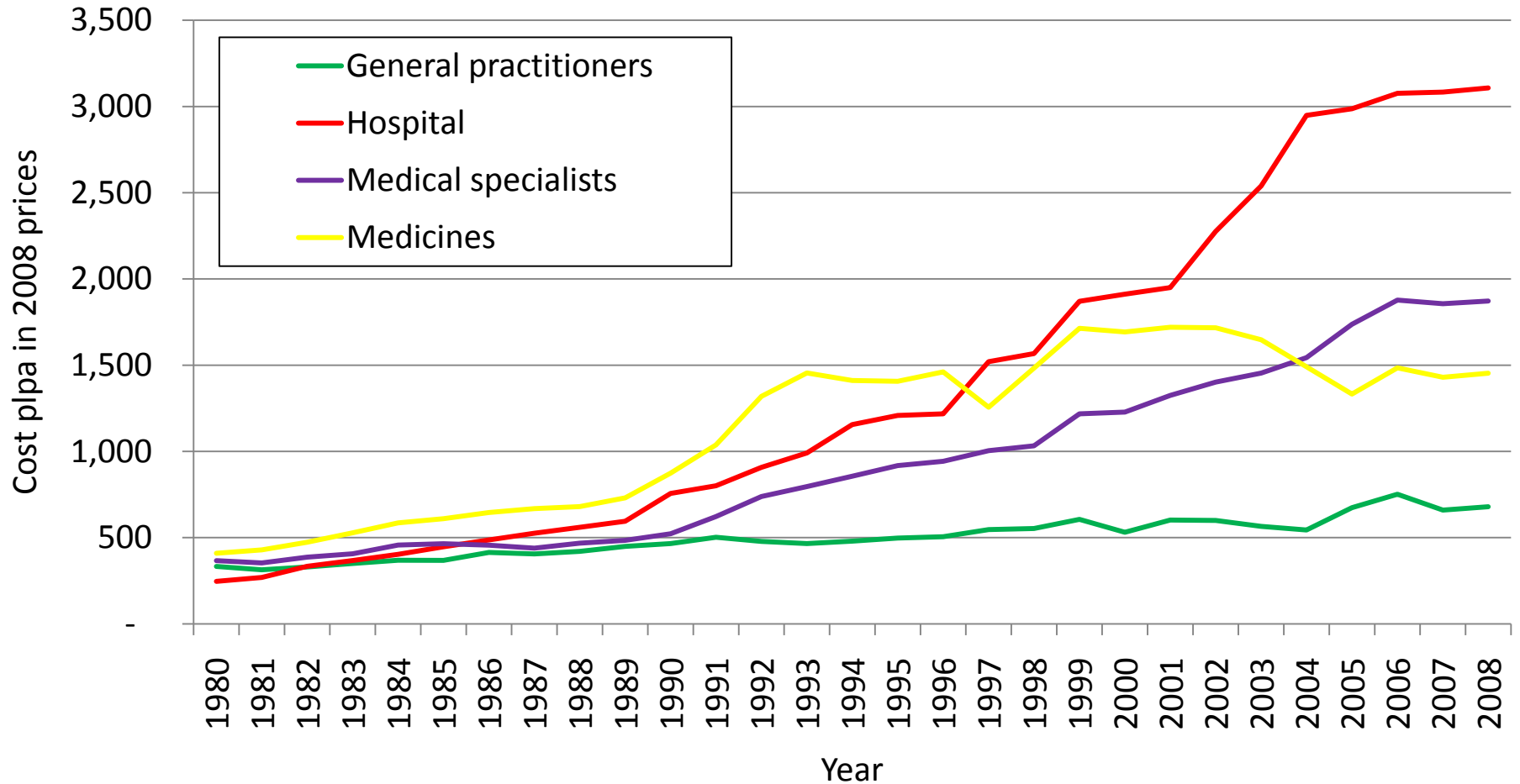


Costs plpa in 2008 prices

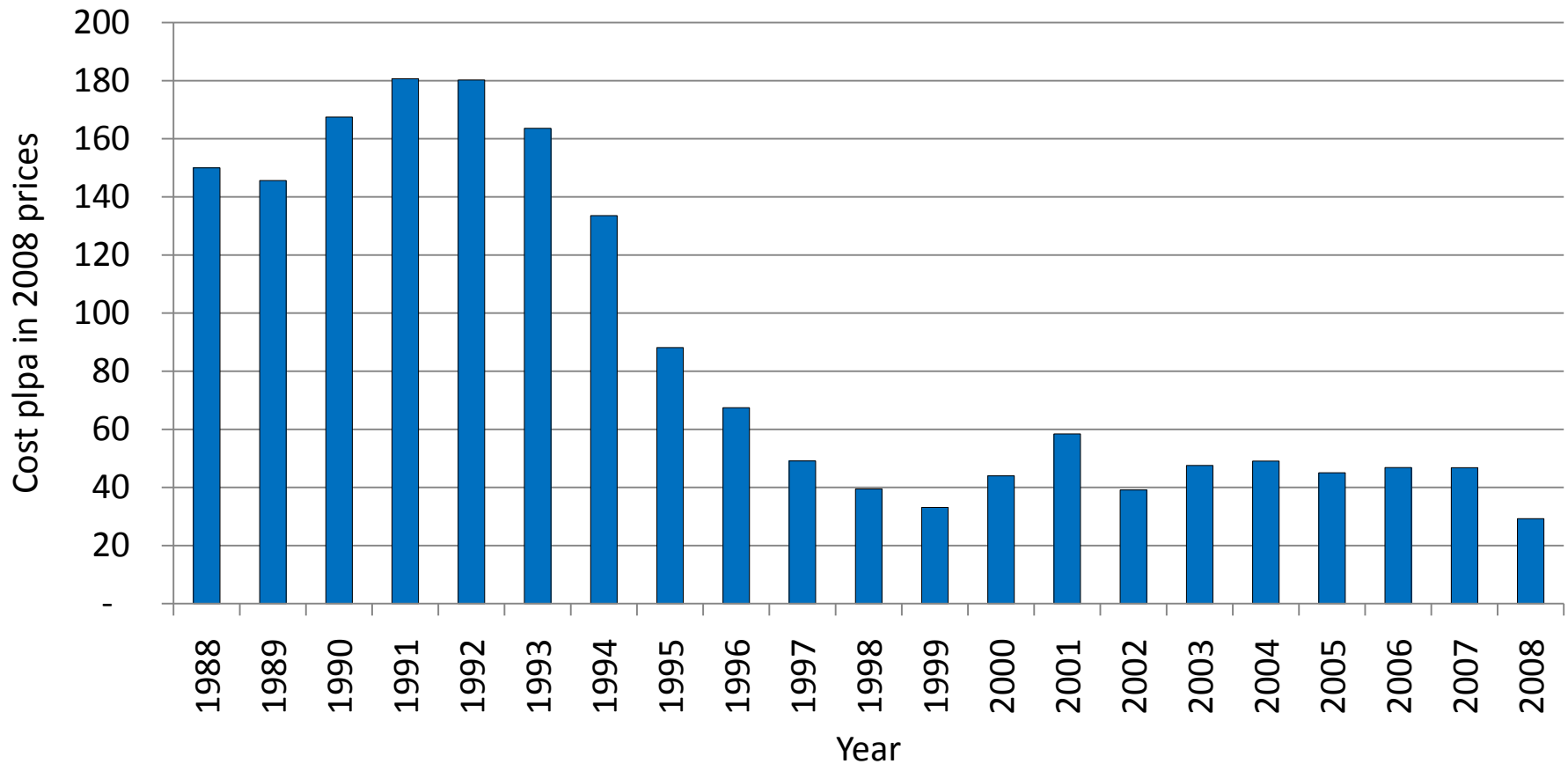
Cost Drivers – Increasing focus on specialist care



Cost Drivers – Resulting hospital admissions

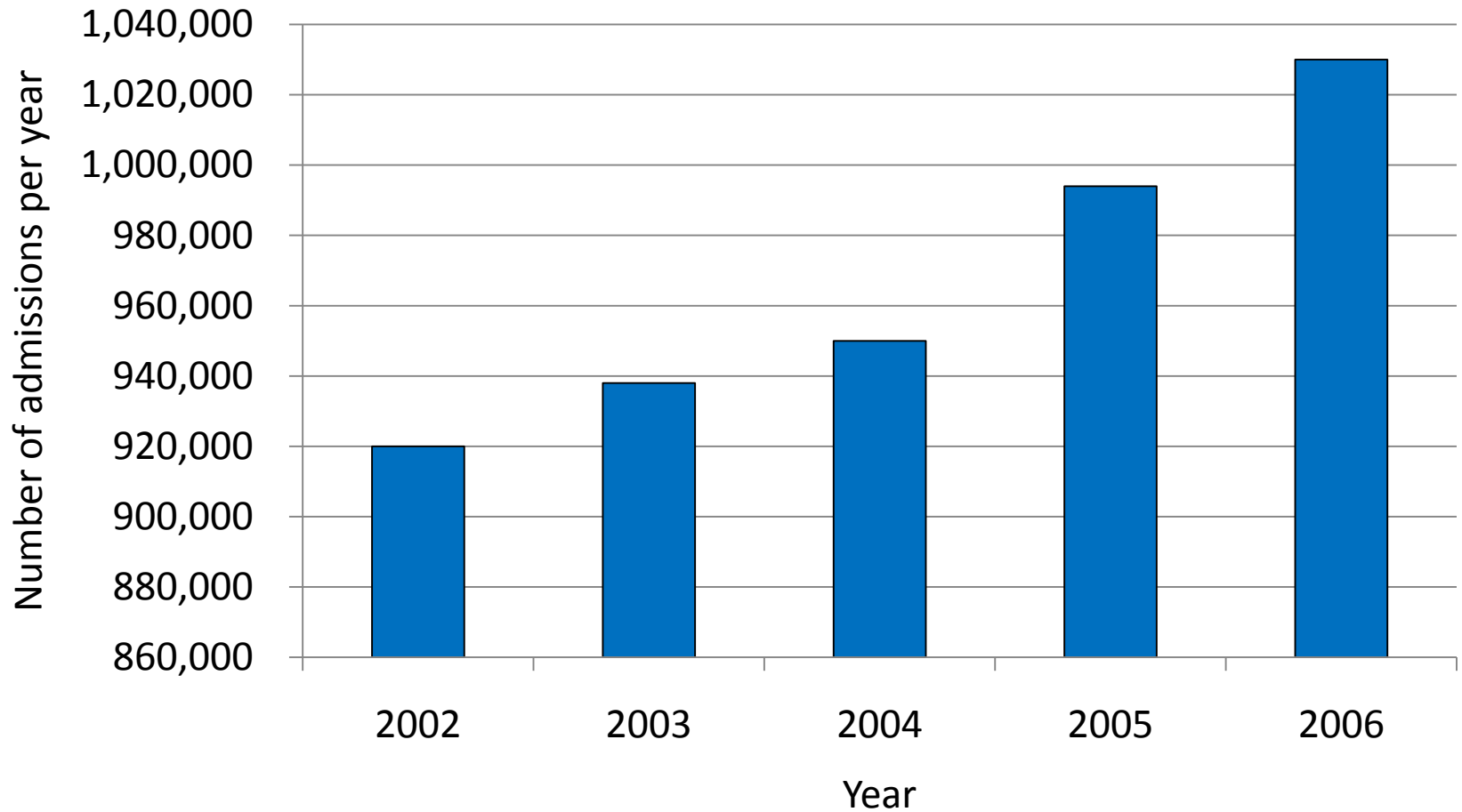


Cost Drivers – Resulting hospital admissions

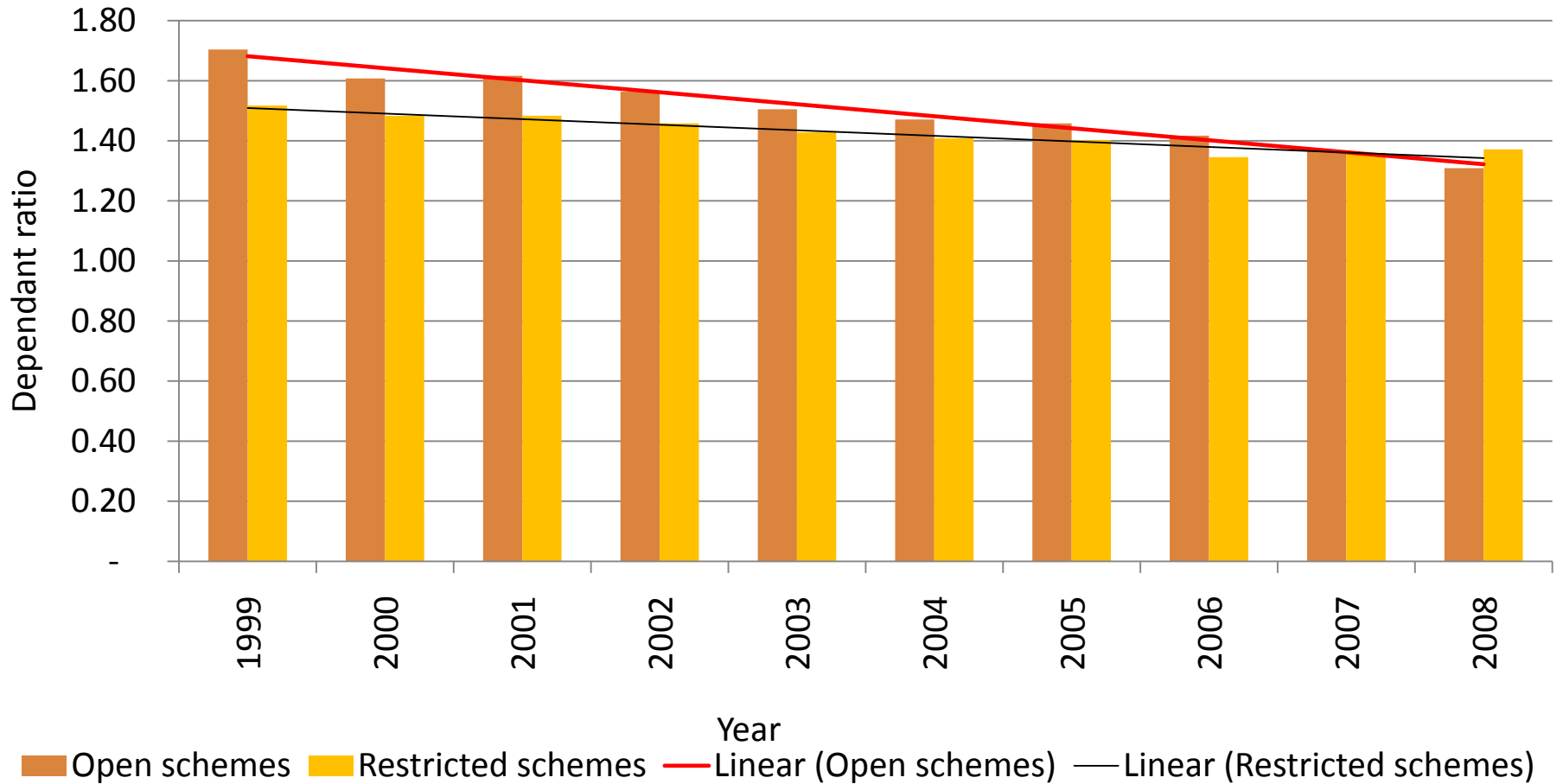


Scheme expenditure on state hospitals

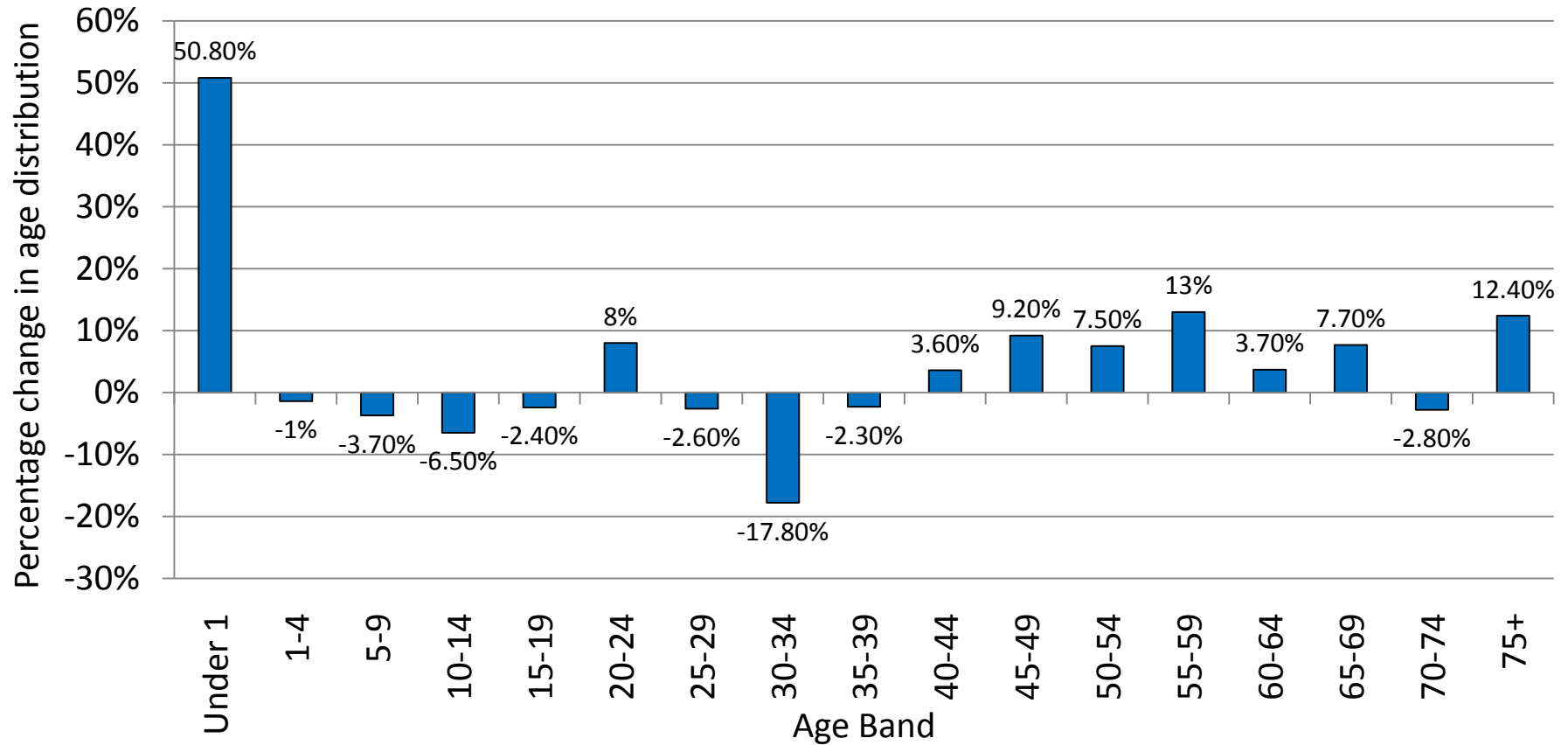
Cost Drivers – Resulting hospital admissions



Cost Drivers – The absence of mandatory cover

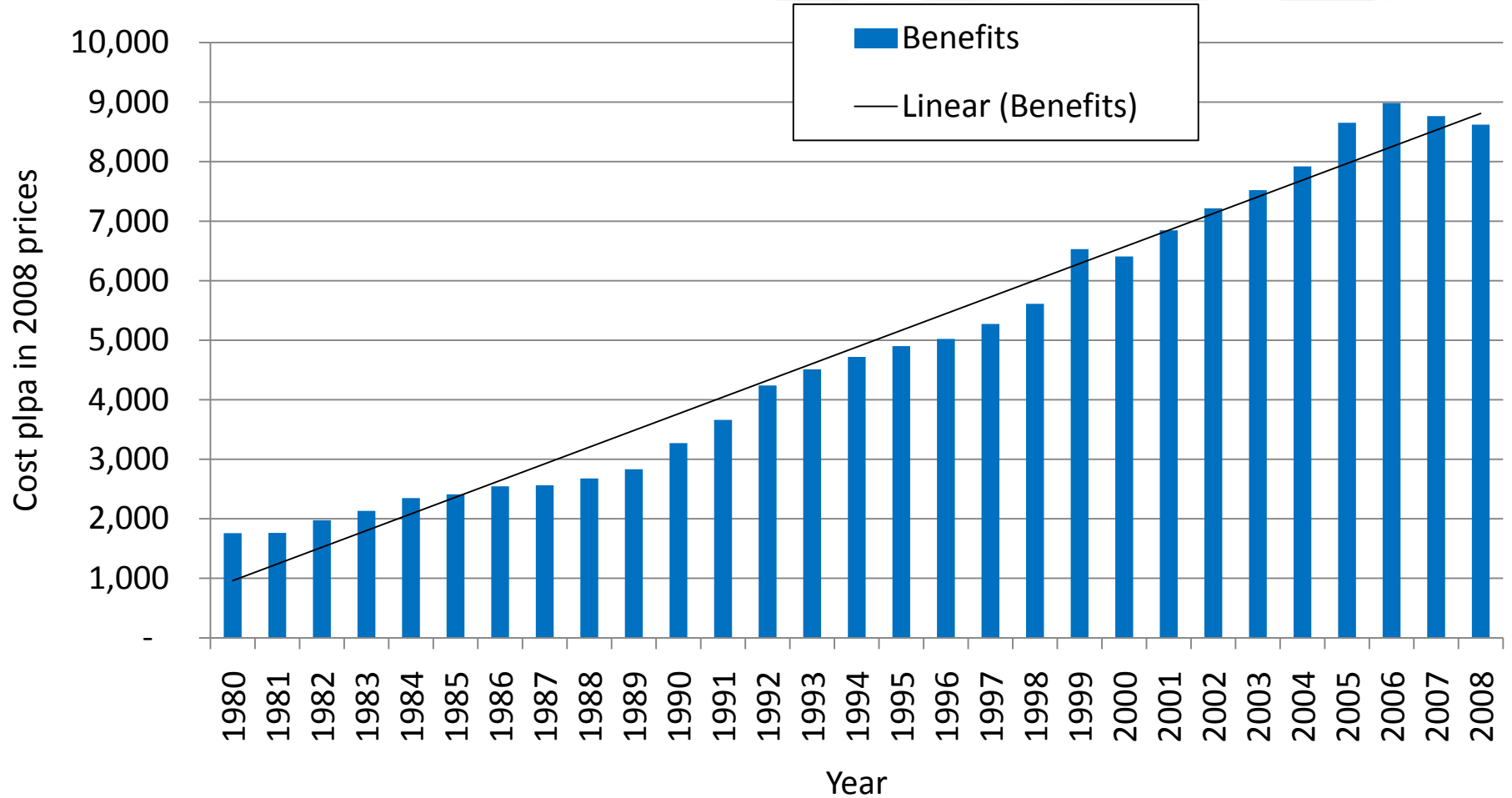


Cost drivers – The absence of mandatory cover

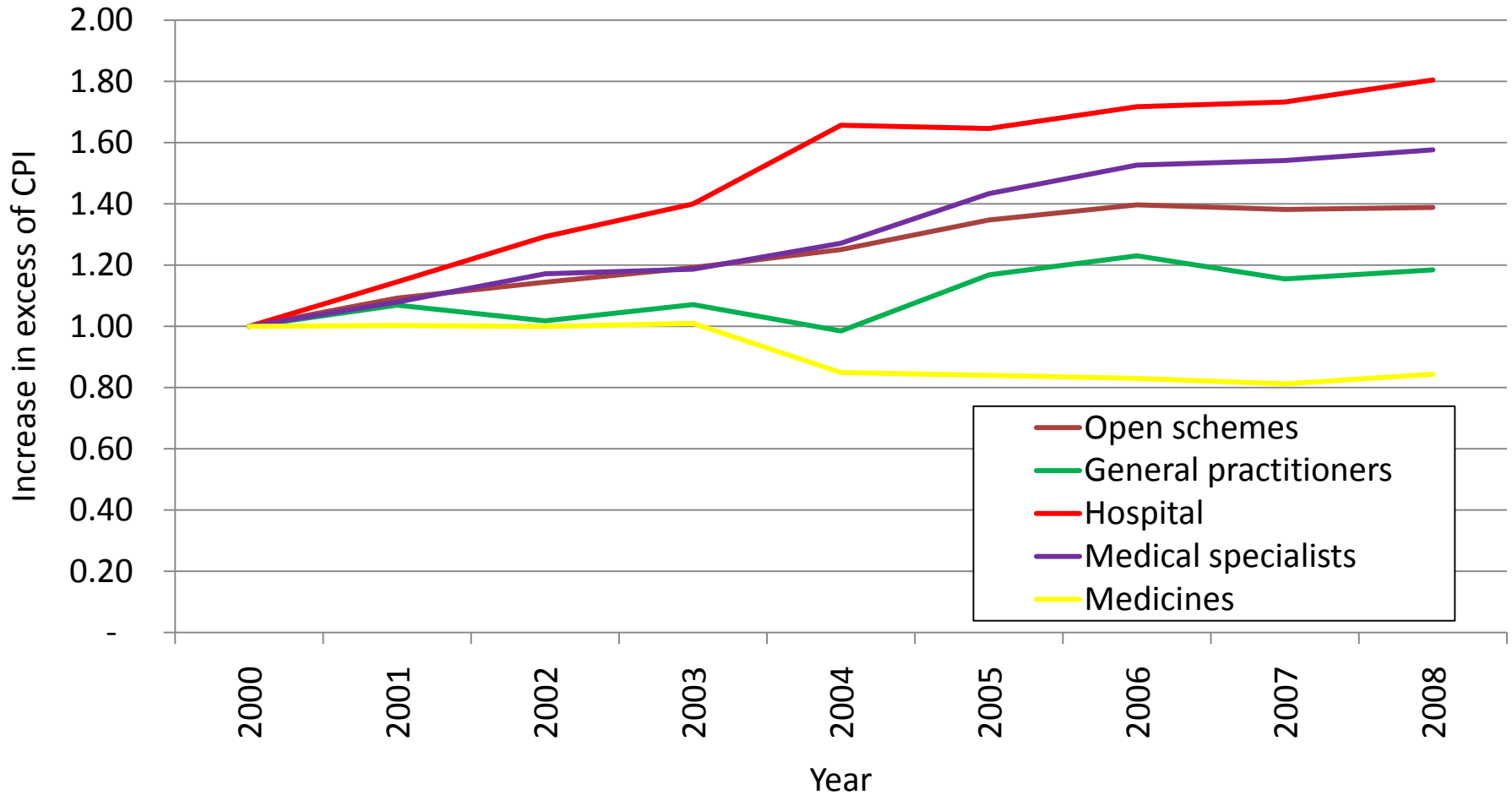


Source: HASA

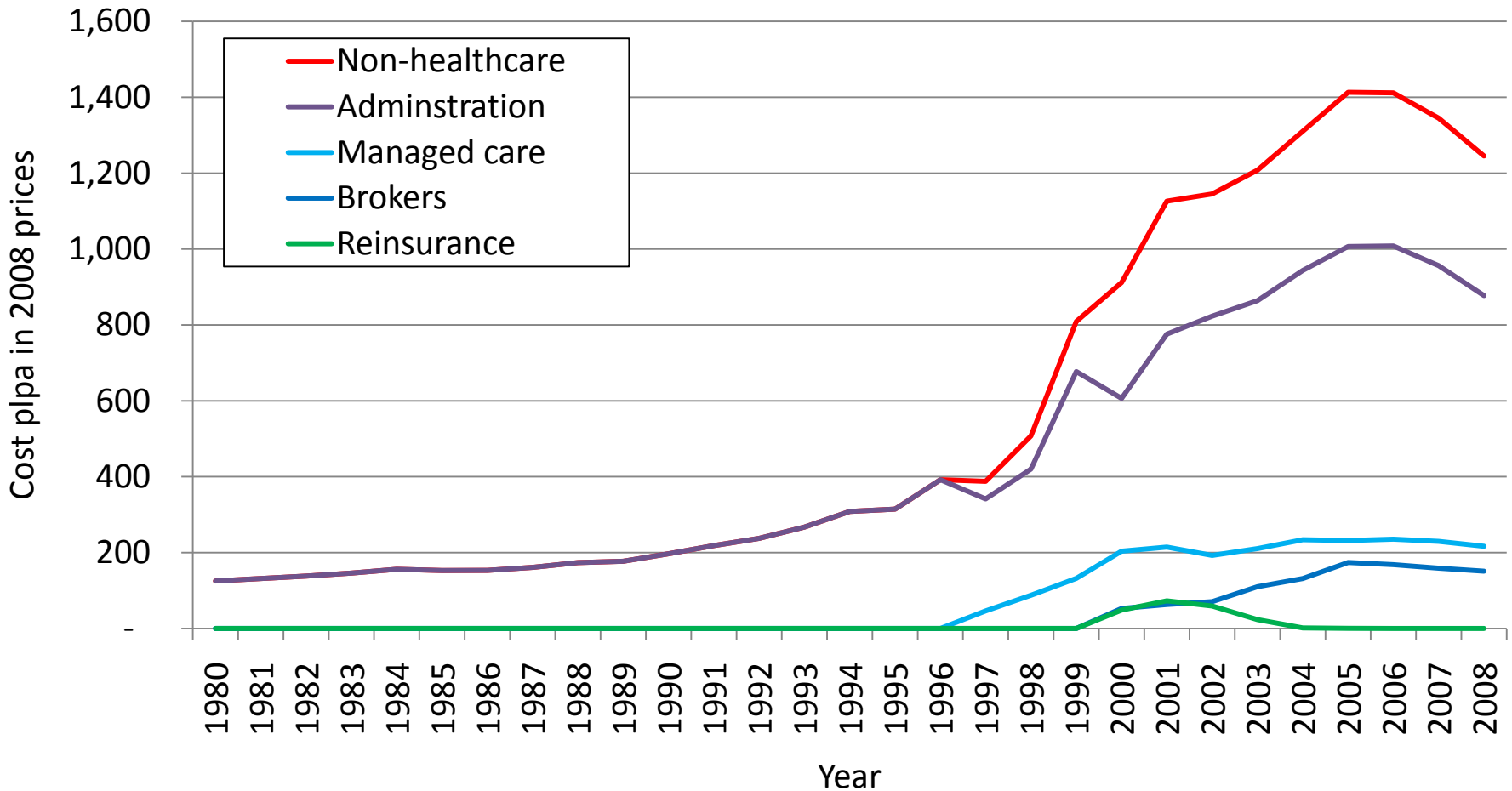
Cost drivers – PMB's



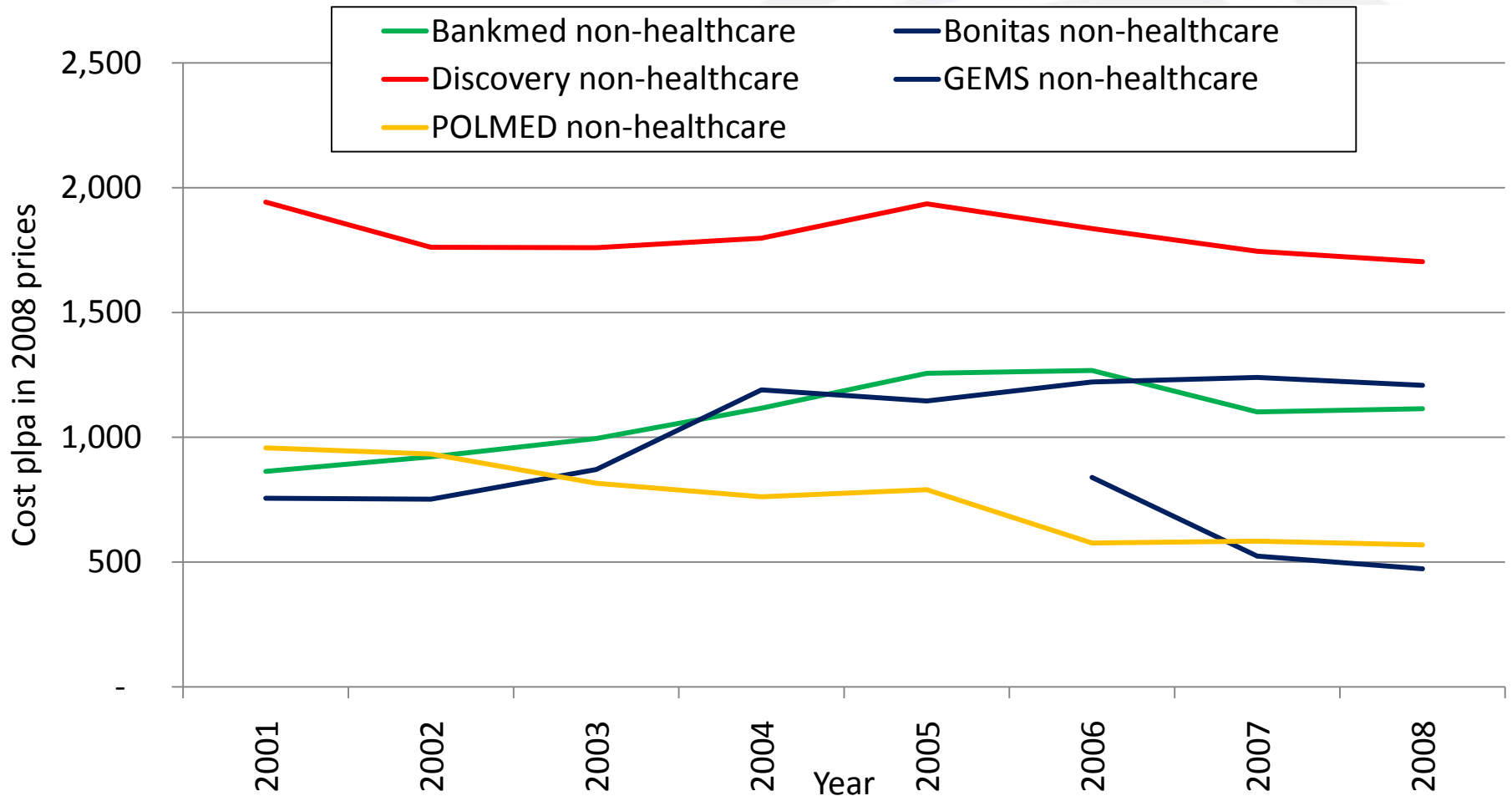
Cost drivers - PMB's



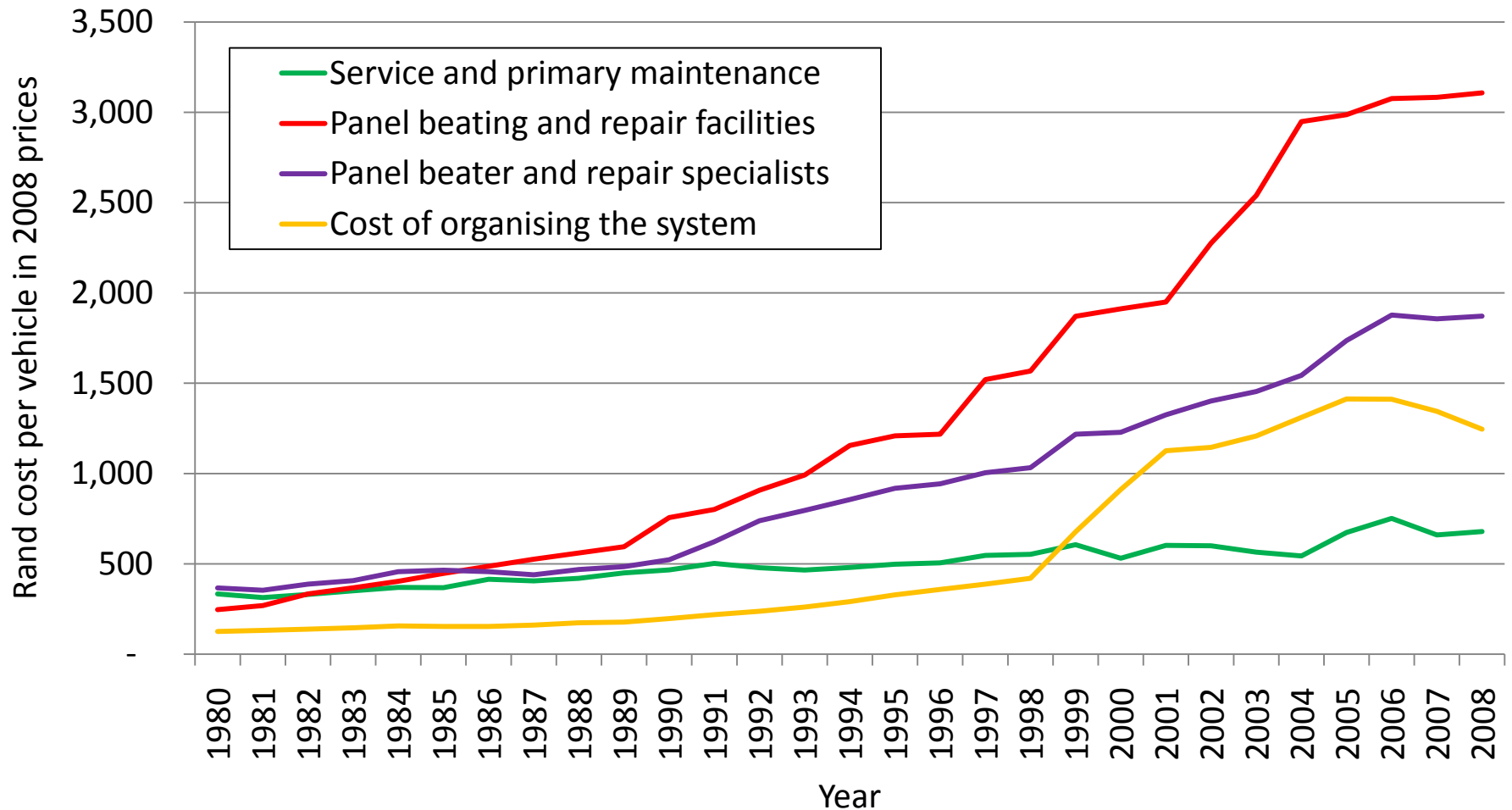
Cost Drivers – Non-healthcare costs



Cost Drivers - Non-healthcare costs (some examples)



Market failure or System Design?





DOES ALL THIS IMPLY MARKET FAILURE?

Market failure or System Design?

Some questions to ask:

- What are the aims of our market?
- What are the operating conditions of the market?

Will address two topics:

- Efficiency
- Equity

What are our Market Aims?

- The best – equipment, facilities, best benefits, best scheme, best doctor. We don't want to settle for less.
- Freedom of choice
- Lower premiums
- Providers want a reasonable income and return
- Regulators want improved equity and access (and compliance)

*These forces act in opposition
We cannot have them all*

Operating conditions

- Regulations have improved sub system equity (within the private market only), but also contributed to increases in health care costs
- Voluntary risk pooling has resulted in significant anti selection – increasing individual participation in the market

Operating conditions

- Health care reimbursement systems reward the best most luxurious care
- Prices for services should be fair
- Derivations of prices can be based on what services cost to deliver, and should be supplemented with a layer that chooses what should be paid for.
- Purchasing functions should be based on value
- However the market has not evolved sufficiently to date

Operating conditions

- Extremely fragmented supply side structures
- Little or no co-ordination of care
- Little or no involvement of Primary care
- General short supply of resources doesn't help
- Third party purchasing function significantly dampens normal market mechanisms
- Managed care rationing mechanisms act alone against all other market forces

Market Impediments and Solutions

| <i>Market Impediment:</i> | <i>Workable Solution:</i> |
|--|---|
| No scheme comparability | Publish benefits in a standardized template |
| Curative focused PMBs | Include much stronger primary care focus in medical scheme funding policy and benefit design. |
| Fragmented care continuum | Promotion of team based care and information sharing |
| Lack of co-operation between public and private sector | Increased engagement, trust building and open discussions of issues |
| Lack of measurement and reporting | Increase publicly available data for independent analysis |
| Fee for service cost based reimbursement | Funder and Providers should both strive for mutually acceptable payment reform |
| Lack of value based competition | Increase publicly available data on price and quality |

Solutions – in practice

- Focus on Primary Care
 - Patients should all nominate a GP, who should be empowered with information and be proactive in care co-ordination
- Transparency of costs for comparability
 - Data by provider should be publically available for independent analysis
 - Benefits per scheme should be comparable in a standard industry benefit template

Solutions – in practice

- Regulation
 - Should focus on mechanisms that overcome poor market conditions, such as information
- Benefit design, administration and managed care must restructure care delivery with providers, to work as one system , not pockets of care

But what about equity?

- All these issues while relevant, do not address larger equity issue – those without cover
- Improved market mechanisms in private health system will not address equity (and neither will private sector regulation)
- Even if medical scheme costs were to reduce significantly, access would not improve dramatically

A controversial proposal...

- Consider GEMS Sapphire...
 - PMB compliant network based low income option
 - Private primary care, medicine, radiology, pathology, auxiliaries
 - Public hospital care + Private hospital maternity
- Analysis of CMS 2008 report shows costs roughly R115 plpm (including admin)
(recall LIMS was estimated in 2006 to be R108, but without hospital cover)

A controversial proposal...

- Now consider Tax Expenditure Subsidy
 - Estimated at R12bn pa
 - Purpose was to incentivise scheme membership, but highlights inequity in larger system (tax benefit to the rich)
- We could buy PMB compliant cover for almost 9 million new people with the TES, right now.
- Perhaps members could be asked to pay a token amount per month to belong – say R10 plpm

A controversial proposal...

- Does the right things from a policy point of view
 - Reduces inequity
 - Maintains focus on primary care
 - Alleviates pressure on the public sector
 - Provides additional funds to public sector
- There are issues to work out – people on the margin will be affected by the removal of the TES
- There are also risk related issues to be worked out, but compulsory membership of some kind will sort most risk issues out.
- Should be the first step toward universality

A controversial proposal...

- Any objections?

Next Steps

- *Not last year*
- *Not next year*
- *but - some where in between*

'Who moved my primary care'

We must make a choice about health

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