Failure a symptom of fragmentation

GLOBALLY, more than a billion people do not have regular access to affordable and effective healthcare. In addition, about 150 million annually experience severe economic hardship from their expenditures on healthcare, with about 100 million falling below nationally defined poverty lines as a consequence of their health spending.

Figures such as these motivated the World Health Organisation (WHO) to produce the 2010 World Health Report on the theme of Health Systems Financing: the Path to Universal Coverage. The report focused not only on the problem but on the positive experiences of a diverse set of lower-, middle- and upper-income countries in reforming their health financing systems to improve equity in access to care and strengthen their population's protection against the financial consequences of paying for healthcare.

While the goals associated with universal coverage - that those who need services can get them, that the services are of good quality, and that the cost of obtaining care does not cause financial hardship for patients and their families - are shared across most countries, each is at a different starting point and faces different challenges. This does not mean that every country is on its own, however. There are important lessons from international experience, and while there is always a need to tailor the reform agenda to local context, WHO does know something about what has worked, what has not, and how to approach the issues and challenges facing any particular country.

From an international perspective, therefore, it is possible to reflect on SA's National Health Insurance (NHI) reform plan as described in the government's recent Green Paper. In particular, we recommend that countries approach health financing reform by first identifying the main obstacles to universal coverage in their existing system, and then design approaches to address these obstacles (rather than, for example, starting with favoured solutions and then justifying them). The main features of the NHI plan are consistent with our approach.

In SA, the evidence suggests inequalities in coverage and access to care are indeed real problems, and that the way the health financing system currently functions contributes to those problems. The overall level of health spending as a share of GDP is not low by international standards, but the distribution of that spending is highly skewed. Analysis by the Health Economics Unit of UCT shows that about 16 percent of the population is covered by medical schemes. The predominantly upper-income persons with such coverage receive in the range of 4.5 to six times the amount of health spending per capita compared with the rest of the population. Thus, while it would be expected that poorer persons would be, on average, in worse health and need more health resources per person than richer persons, the reverse is the case in SA. So the problem, fundamentally, is that the country's health resources are clearly not distributed according to the population's health needs.

Why does this happen? The problem derives from the way financial flows in the system are fragmented. Health insurance, whether in an explicit form as in Germany or an implicit form as in Britain's National Health Service, is intended to enable redistribution of services and resources from the collective of contributors to those who need them in any particular year. When a system is fragmented, it means that there are barriers to the extent to which this redistribution can occur.

Fragmentation can take many forms and is at the root of inequities and inefficiencies in health systems around the world. In the US, for example, the publicly funded insurance scheme for the poor, Medicaid, operates in parallel to a plethora of private health insurance schemes. Dependent on a mix of central- and state-level funding sources, Medicaid receives less funding per covered person than do most private insurance plans, and as a result, pays providers less to treat its beneficiaries than the private insurers. Increasingly, providers are refusing to accept Medicaid patients because of these low payment rates, and access to care is suffering. It is truly a case of "a programme for the poor being a poor programme". In most other high income countries with explicit forms of health insurance, such as Germany, Japan, the Netherlands, and Switzerland, governments also subsidise health insurance for those too poor to contribute directly. But the key difference with the US is that in these countries, the poor population is part of the same insurance pool as the rest of the population - they are not put in a separate pool but enabled to be in the same "club" as everyone else, regardless of their income.

The nature of fragmentation in SA is different, but the consequences are similar. Because the contributions to medical schemes are pooled only on behalf of scheme members, the actual redistribution from healthy to sick in SA is much less than what would be possible if there were no barriers to the redistribution potential of all prepaid revenues (from taxes and medical scheme contributions) on behalf of the entire population. It is important to recognise that the reason this does not happen now is not the "fault" of any actor in the system. The medical schemes are not doing anything wrong; they are just following the rules of the existing system, in very much the same way private insurance companies do in the US. In both countries, the fault, in terms of equity problems, lies with how the design of these systems has evolved over many years. And indeed, in both countries, to truly address the equity problem requires not merely tinkering at the edges but rather fundamental reform.

What about the planned National Health Insurance reform described in the government's Green Paper? One lesson flowing from the international experience reviewed in WHO's World Health Report is the importance of both increasing the size of the prepaid pool and expand the scope for redistribution that is possible from the prepaid funds. One approach being considered would introduce a new payroll-linked mandatory contribution for NHI, and pool the funds raised from this with allocations from general revenues (allocations that currently flow directly to government health facilities). So indeed, if implemented, the approach would, consistent with international good practice, increase the redistributive capacity of the prepaid funds so that they could better serve the entire population (as compared with the current system where only the tax-funded portion of health spending can be redistributed to this extent).

Because medium and large enterprises are currently paying premiums to medical schemes, the new mandatory contribution would not impose an additional burden, although employers and individuals would still be free to purchase medical scheme coverage on top of the NHI (a similar role for private health insurance is found in many high income countries such as the UK, France, and Slovenia). But the new mechanism would enable at least some of the spending that employers and employees currently devote to medical schemes to flow into the national pool, and together with the general budget transfers, will greatly enhance the scope of the national system to redistribute resources to where they are most needed.

The funding mechanisms proposed for the NHI would thus reduce a major source of fragmentation in the system, and as such are in line with WHO' approach to health financing for universal coverage.

Finally, it is important to note that all countries, rich and poor, struggle to increase coverage, access to new medical technologies, and improve quality of care. It is not just a matter of money; no country can simply spend its way to universal coverage. In the World Health Report we noted that, based on our assessment of health systems around the world, as much as 40 percent of health spending is "wasted", that is, does not produce any health benefits. Close attention needs to be paid, from the beginning, to addressing the main sources of inefficiency in the health system. Without this, progress towards universal coverage cannot be sustained. Here again, the NHI proposal is consistent with this global perspective, as it includes measures to address inefficiencies that currently plague SA's health system.

SA is one of a growing number of countries around the world - among them China, India, Thailand, Kyrgyzstan, Ireland, Ghana, Rwanda, Mexico, and even the US - that are either in the process of designing a reform agenda to promote and sustain universal coverage or has begun implementation.

The specifics of each country's plan differ, as they should, given their different starting points, fiscal and economic contexts, and cultural preferences. But it is fair to say that with the advent of the NHI reform plan, SA is not alone: it is part of a new global movement for universal coverage.

Joseph Kutzin is co-ordinator of Health Financing Policy at the WHO

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