ST. JOHN'S COLLOQUIUM

Overcoming the Apartheid Legacy: A South African Case Study on Achieving Social Solidarity in Healthcare Financing

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IPEBLA IACA IAAHS PBSS Canadian Institute of Actuaries Institut canadien des actuaires

Health Systems Context for Actuaries

- Actuaries typically function <u>within</u> healthcare systems
- Actuarial education and discourse tends to lack a health system perspective
- We put forward some key health system concepts
- And use the South African example to illustrate those concepts

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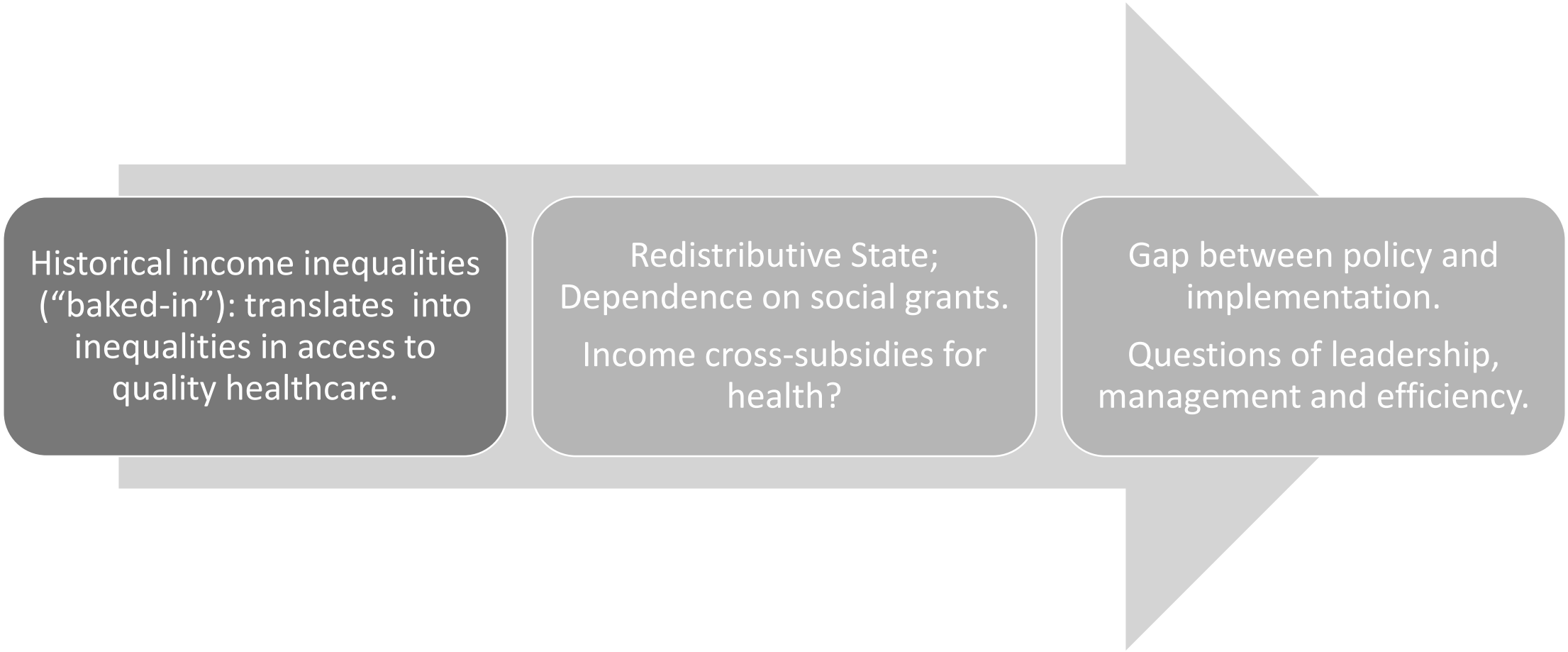
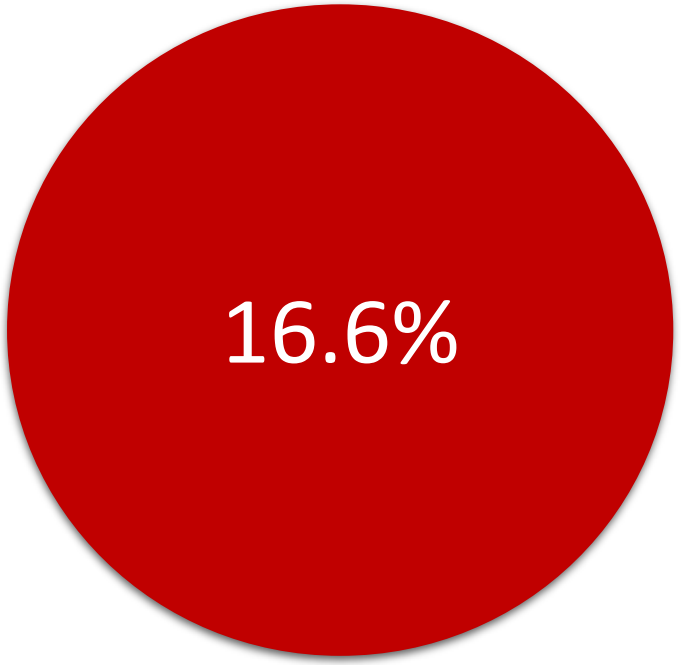
The South African Story: Defined by Apartheid



INEQUITY OF FINANCIAL RESOURCES

Nearly 50/50

allocation between private and public



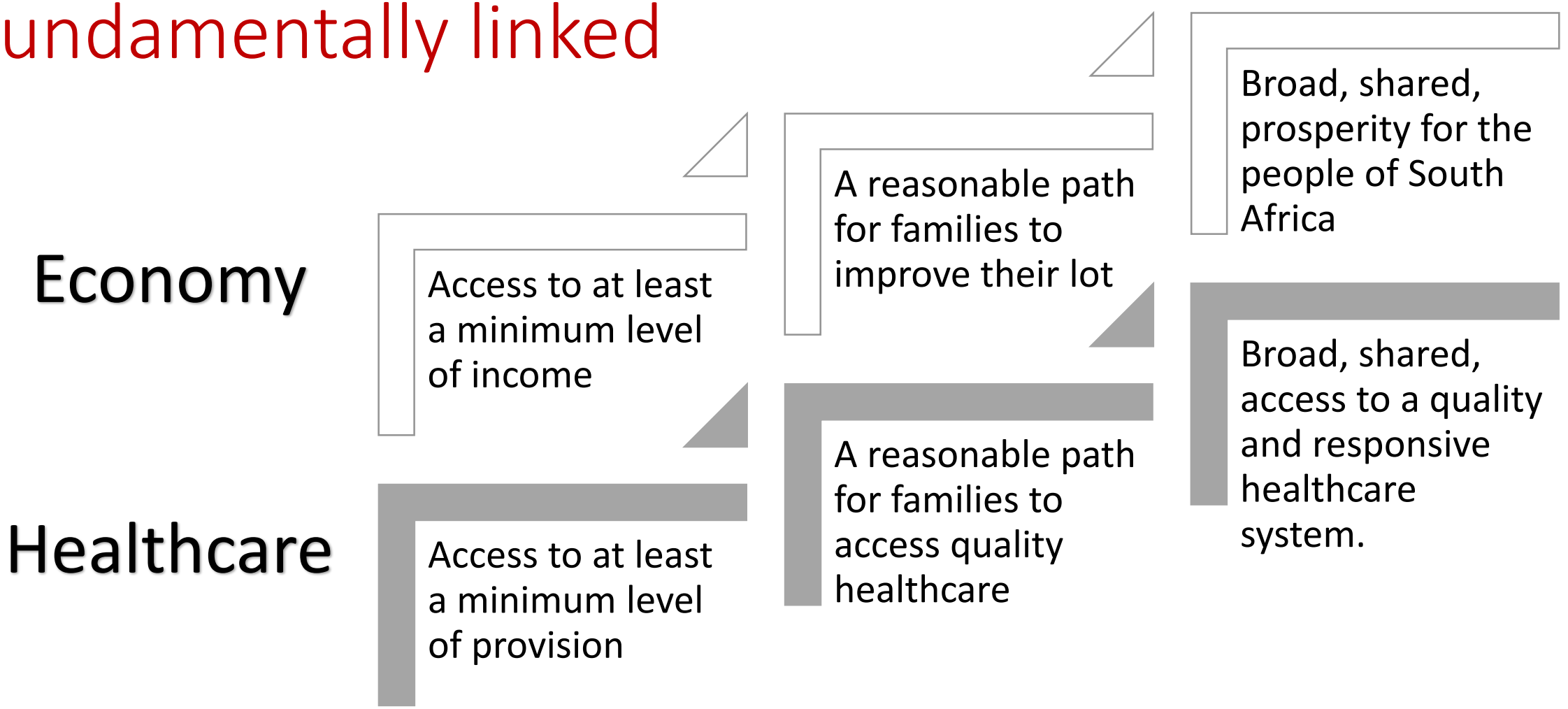
Only 16.6% of the population covered, and coverage is concentrated in the top two income quintiles

INEQUITY OF DISTRIBUTION OF HEALTHCARE RESOURCES

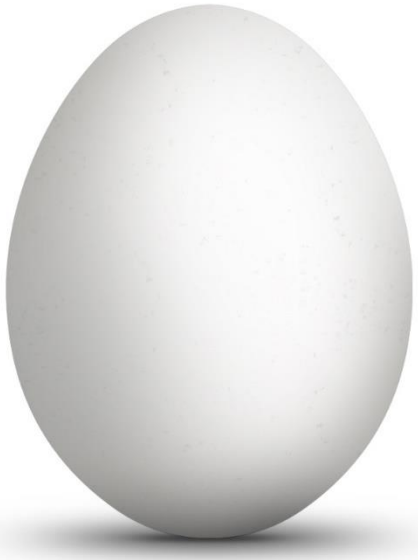
	DOCTORS	SPECIALISTS	HOSPITALS	BEDS
PUBLIC	13 656	4 986	410	85 362
PRIVATE	8 119	7 588	357	36 200

Econex *Updated GP and Specialist Numbers for SA*. Econex Health Reform Notes, 2010. **Note 7**.
Econex and Quantec Research, *The contribution of HASA member hospitals to the South African economy*. 2011.

Economy and Healthcare system are fundamentally linked



CHICKEN OR EGG?



Investment in health bolsters economic growth and development

Investment in health is too expensive & threatens economic sustainability

A few key principles

Market Failure in Healthcare

The market under provides for public goods

- Healthcare is in some ways is a public good (non-excludable; though not non-rivalrous)
- Particularly in low-income segments

Information asymmetry, the presence of desperation and third-party payer effects mean that market dynamics break down

- Doctors and patients cannot be construed as equal, rational market participants.
- Doctors act as agents for patients, yet have perverse incentives to maximize income that do not always align with patient wellbeing.
- Doctor's have a professional monopoly (like actuaries!) which is good for standards, but bad for institutional competition

MUTUALITY AND SOLIDARITY

Mutuality: Pooling of risks after risks are assessed – contributions paid according to the assessed risk

Solidarity: Risks pooled but contributions assessed on a non-risk based measure – typically ability to pay

SOCIAL SECURITY PILLARS

Pillar 1

Universal basic benefit

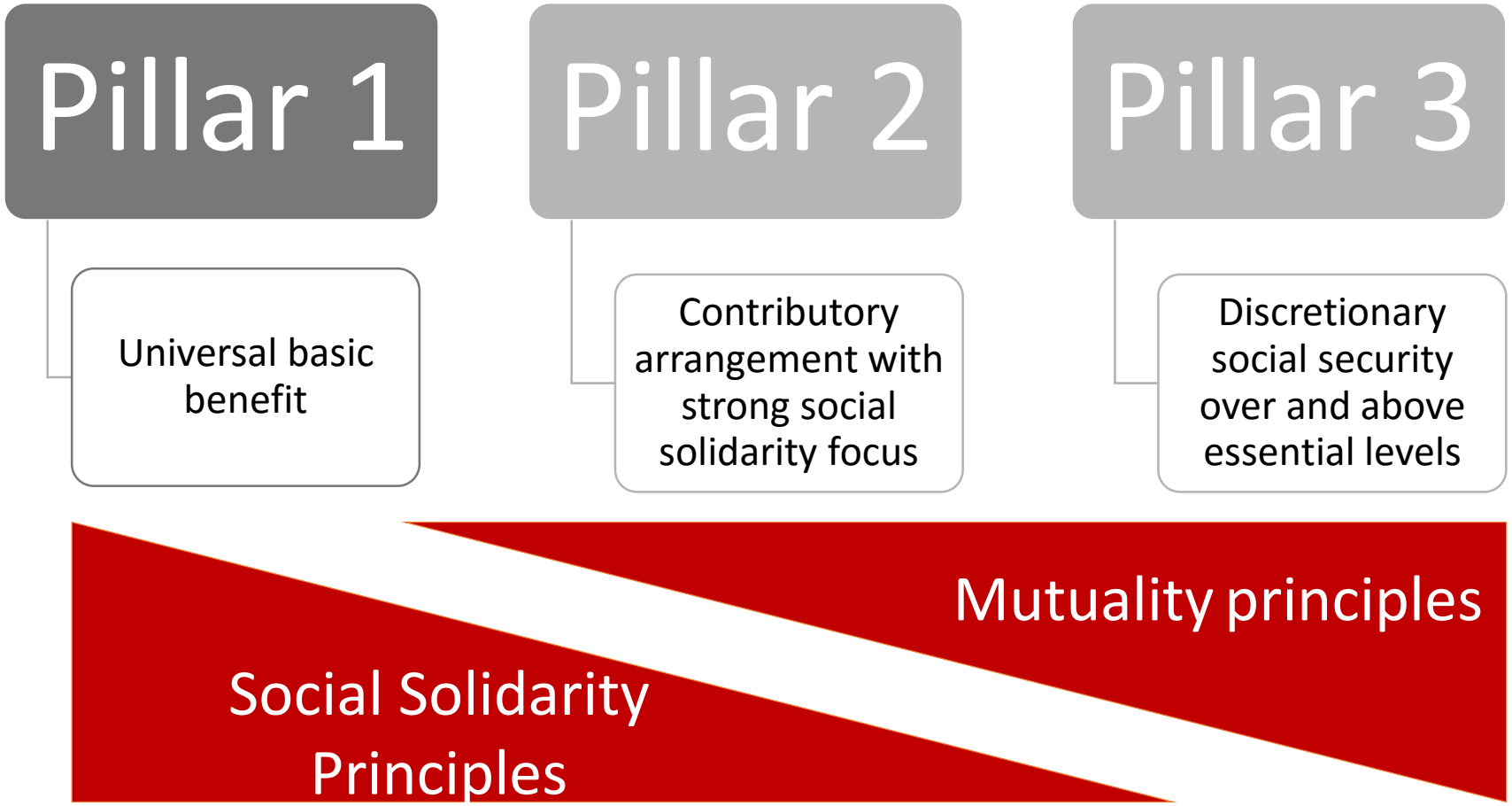
Pillar 2

Contributory arrangement with strong social solidarity focus

Pillar 3

Discretionary social security over and above essential levels

SOCIAL SECURITY PILLARS



Where South Africa Fits in

SOCIAL SECURITY PILLARS

Pillar 1

Universal basic benefit

Pillar 2

Contributory arrangement with strong social solidarity focus

Pillar 3

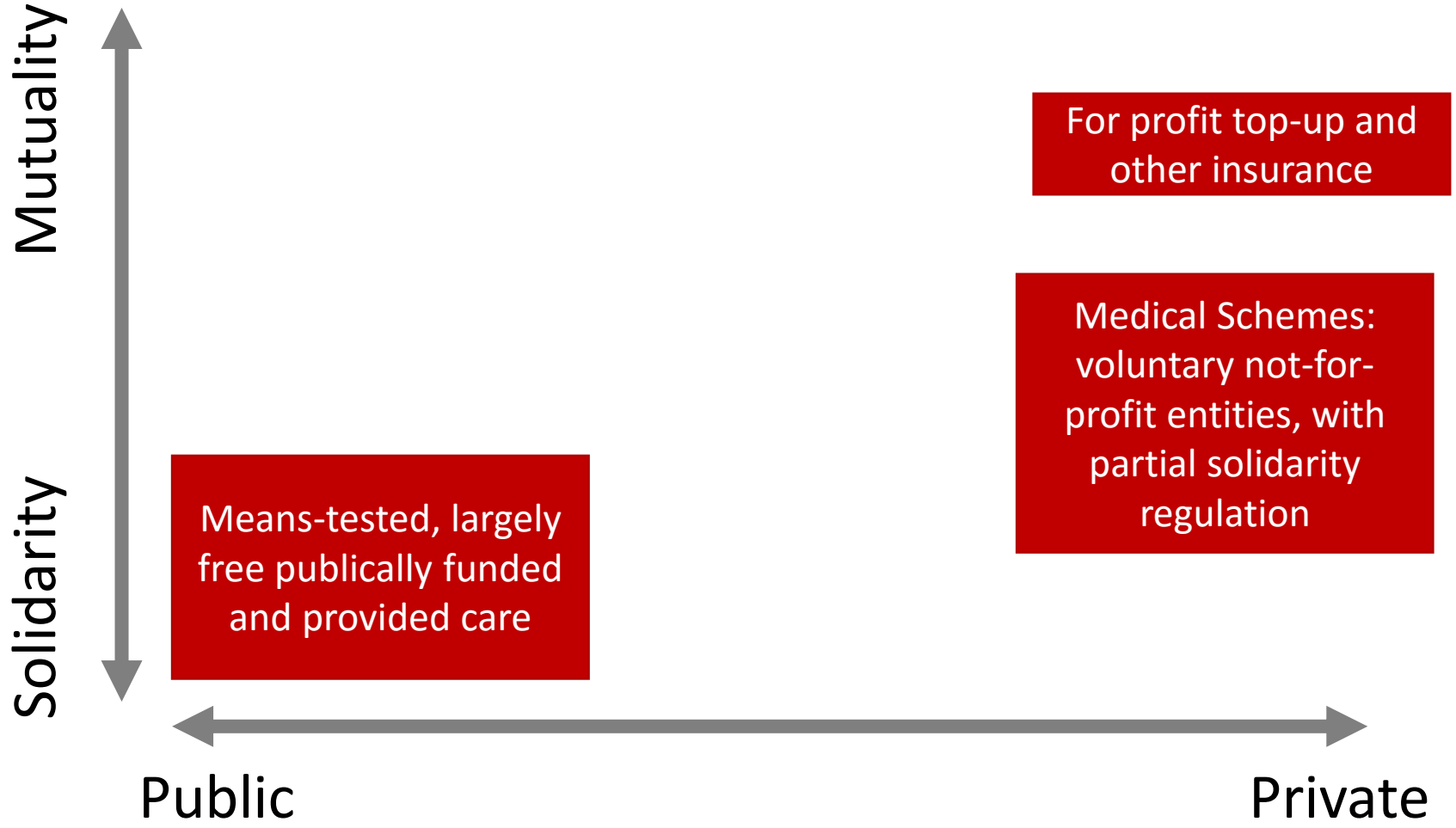
Discretionary social security over and above essential levels

Medical Schemes

Public healthcare provision

Top-up and other insurance

MUTUALITY AND SOLIDARITY



DOES THE CURRENT SYSTEM ACHIEVE SOLIDARITY?

Fragmentation

Incentives to cherry pick members

Anti-selection

Limited extension of cover

Limited income cross subsidies

DOES THE CURRENT SYSTEM ACHIEVE SUBSIDIARITY?

Price inelastic

Latent demand

Limitations on competition

Market (non)responsiveness

Purchasing failures

Governance and incentive failures

Neither Here nor There

Social solidarity reforms not fully implemented (no income cross-subsidy, no risk equalisation, no mandatory membership)

No managed open-market competition, no incentives for innovation or growth, an administration industry which is prone to incumbency

Uncomfortable middle ground and cover that is increasingly unaffordable and unsustainable, with regulatory grey areas for low-cost insurance products

National Health Insurance Reforms

- Universal Health Coverage
- Large-scale & long-term reforms
- Complex set of reforms
- Questions of sequencing & planning
- Changes to financing, purchasing & delivery of care

UNIVERSAL HEALTH COVERAGE: 3 KEY DIMENSIONS

Universal population coverage

Universal financial protection

Universal access

MEDICAL SCHEMES AND HEALTH REFORM

Current

- Criticisms of medical schemes
- Insufficient regulatory attention paid to the current stability, sustainability and affordability of medical schemes

Pre-NHI

- Concern that NHI preparations may be compromised by increased instability of medical schemes
- Pathway to manage transition to NHI

NHI

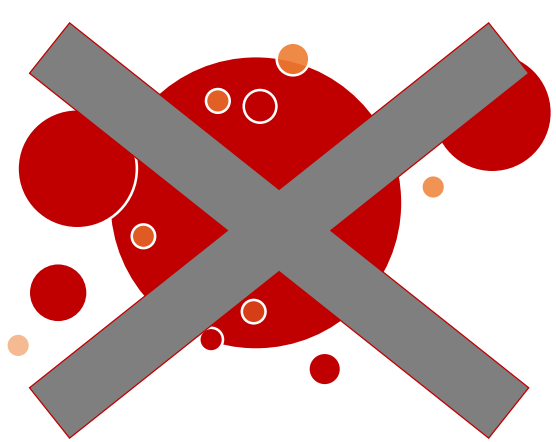
- Uncertainty over role of medical schemes

PLURALISTIC VS. MONOLITHIC APPROACHES

Schemes

Reduce fragmentation and extend down the income spectrum

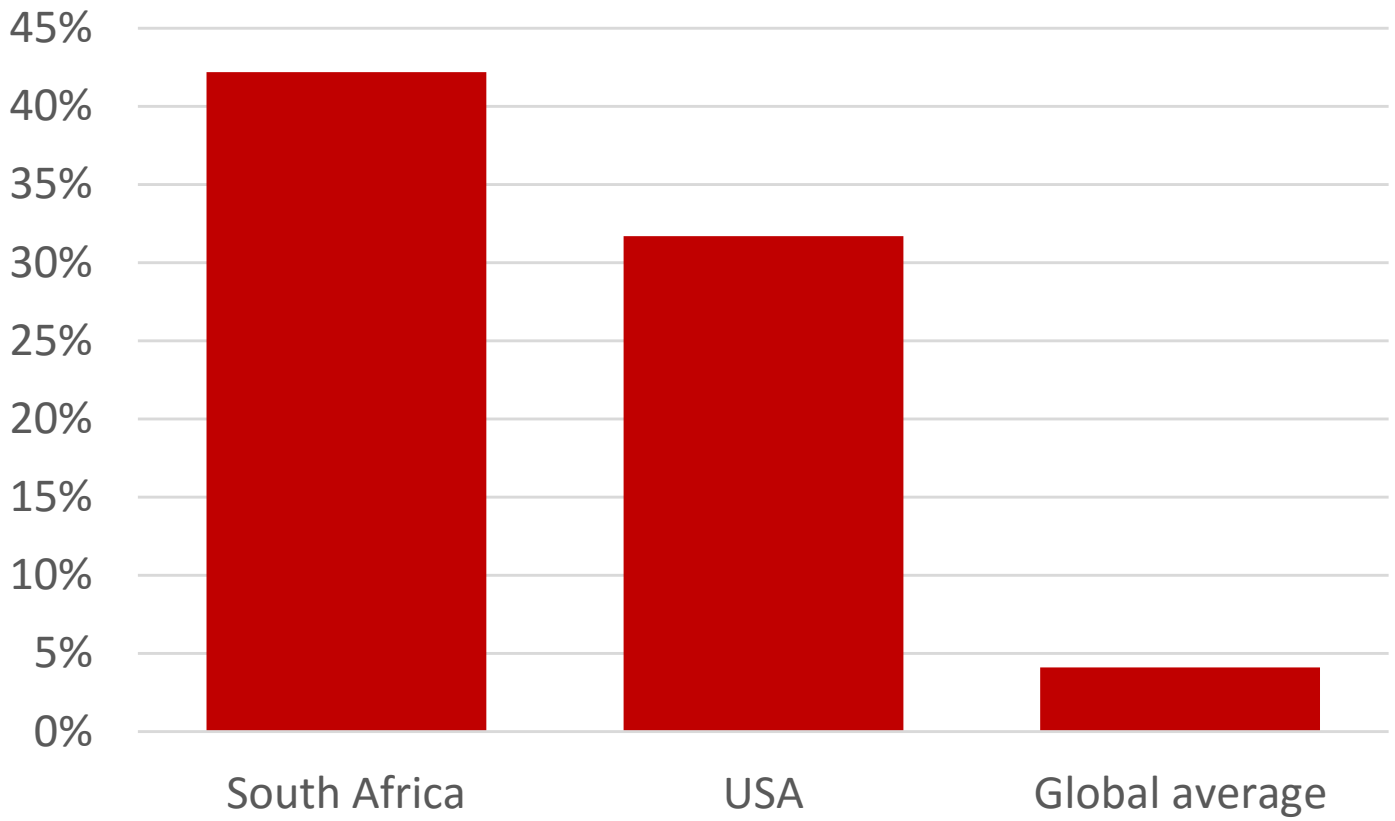
NHI



A pluralistic approach makes sense

- Advocated by the ILO as a mechanism for achieving universal coverage
- Ensures institutional diversification and responsiveness
- Achieve both solidarity and subsidiarity goals
- Private health insurance is part of multipronged approach
- Not a simple replacement for NHI
- Allows us to use what we already have

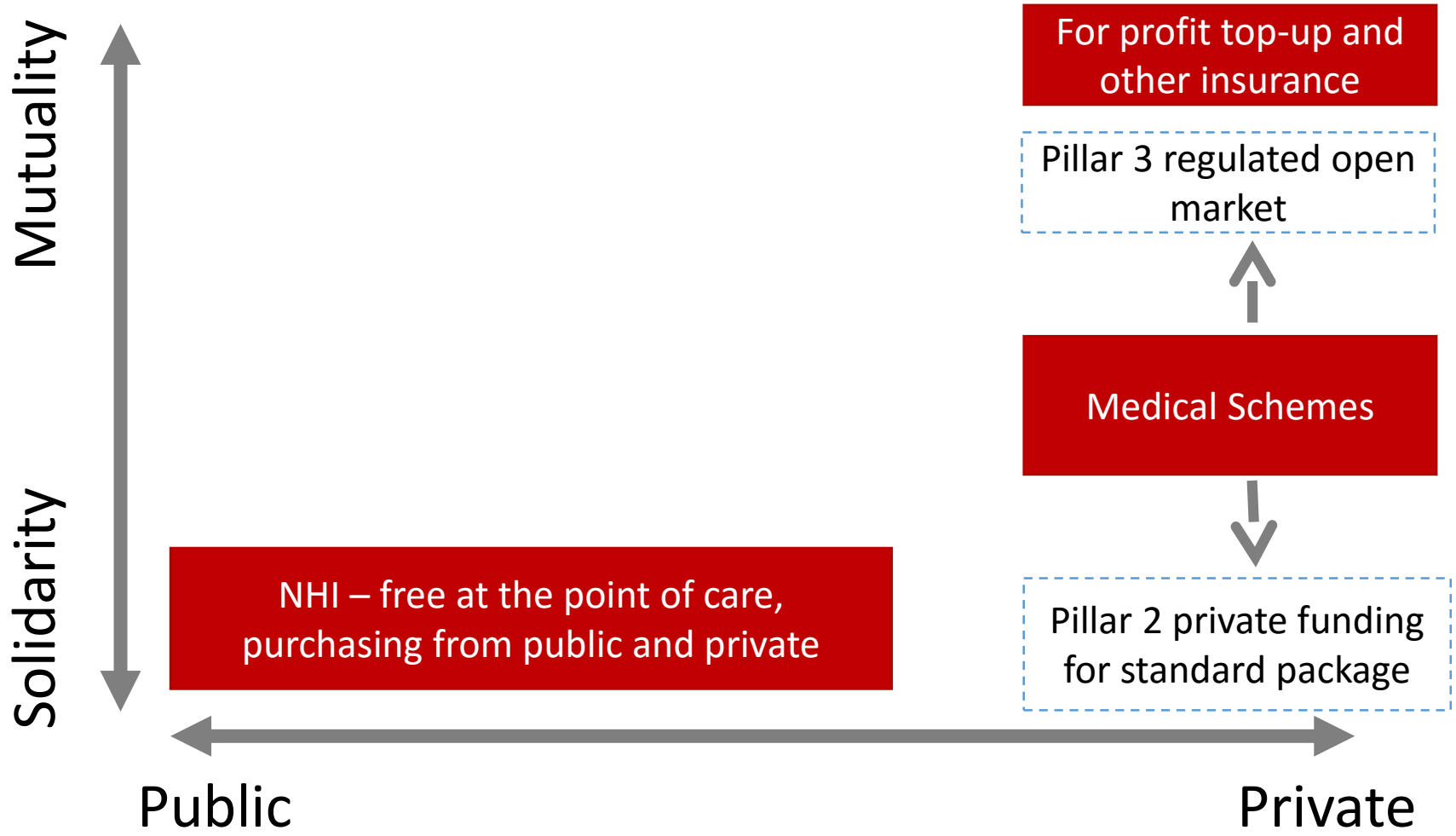
WHY A PLURALISTIC APPROACH TO UNIVERSAL HEALTH COVERAGE MAKES SENSE FOR SOUTH AFRICA



SA is an outlier: voluntary private health insurance as a percentage of total health spend

OECD.
http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

BUT CLARIFICATION OF ROLES IS REQUIRED



Considerations for other health systems

- You cannot consider the healthcare system in a vacuum. Economic prosperity is the biggest driver behind broad healthcare outcomes.
- All health systems are dynamic, and face complex trade-offs between subsets of the population
- Even where there is agreement on the outcomes, there are multiple potential reform pathways
- Actuaries can contribute by articulating and costing policy options
- And can assist with building the mechanisms to enable an efficient health system (risk equalization, risk-adjusted reimbursement, quality measurement etc.)