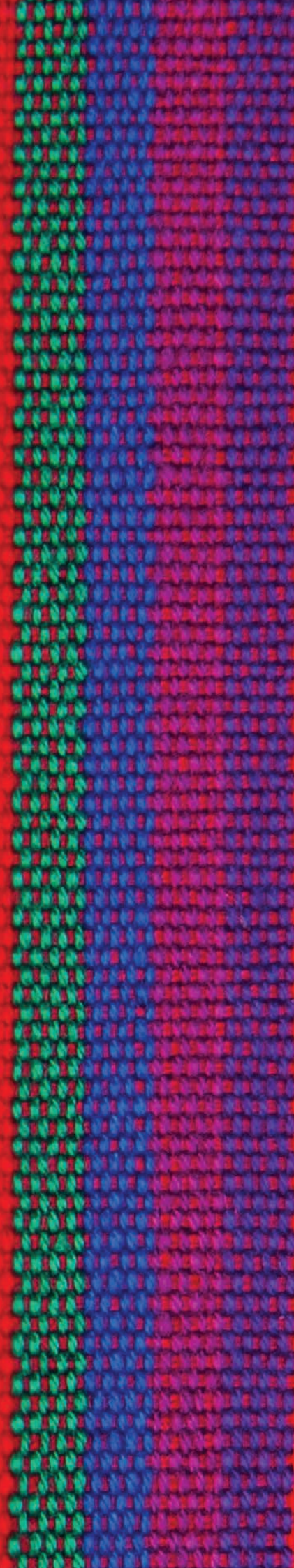




Lessons the world has learnt on the path to Universal Health Coverage



Foreword

There comes a moment in every country's history, where one generation needs to make a choice – an extraordinary choice – for the benefit of the next. This choice is typically made under conditions of uncertainty, high levels of opposition and conflicting views of how the future could play out. And the people who need to make this choice are often criticized, ostracized and unappreciated.

But when the choice involves the greater good – the benefit of the collective – then the decision needs to be made. It needs to be understood. And it needs to be supported. Such is the choice – the brave and bold decision, the hope for our future – that underpins the move towards implementing Universal Health Coverage (UHC) in South Africa.

It is a transition that is feared and opposed because there are very few who can see the end game. Some see the further deterioration in an already broken system of health; some see financial challenges to their existing business models and the state; and some see a continued wastage of limited resources. Many more fear the loss of their dignity; they fear the pain and humiliation; they fear their own preventable death, the loss of loved ones and the inhumane suffering that is the outcome of the lack of access to quality, affordable healthcare. All these views and fears need to be seen and heard, so that we avoid repeating mistakes of the past. The old minds, the divisive voices, the extremists, the populists, the ones who are rooted in their historical successes or are trying to protect their positions of power: those are the ones to be feared because they will sacrifice the future to preserve their interests of the past.

But it's going to be difficult to maintain the status quo, because a step forward has already been taken. Although the details in the framework presented by the 2017 NHI White Paper still need to be fleshed out, the critical elements are there: mandatory enrolment; a breadth then depth strategy for the broad population, with an immediate focus on priority groups; and the standing up of a public insurer. These elements have proven to be successful in other health economies who are successfully moving forwards on the journey towards UHC.

The end game – a modern, sustainable, patient-centric system – is currently only seen by the visionaries, the futurists, the humanitarians and the ones who understand how the process of social evolution takes place. In order to broaden this base of belief and unite all South Africans behind this movement, we will need to bring together the best of our tools and people; speak in a language that can be understood by all of our citizens; and create a common vision of unity, inclusivity and prosperity.



It's time for the healthcare sector to harness its collective capability and build around our people a fortress of UHC – every CEO, insurer, professor, doctor, nurse, patient and person who lives in this country should consider what they can do to contribute, raising their levels of engagement and placing their brick in the wall.

Dr Anuschka Coovadia

KPMG Center for Universal Health Coverage

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Introduction

South Africa's debate on a National Healthcare Insurance scheme has been as vigorous as one could want in a democracy. It is inevitably difficult to plan and implement a change across an entire healthcare system that is as significant as introducing affordable and effective universal health coverage (UHC). As such, drawing on lessons – and heeding warnings – from UHC transitions around the world can be an invaluable source of guidance.

The KPMG Center for Universal Health Coverage has had the benefit of working on major health system projects across many countries and continents; and based on these unique experiences, we have collected together some of our key insights.

This study was undertaken on the basis of a number of assumptions about UHC which we firmly believe in:

Our views on UHC

UHC by 2030 is a goal of almost every country on earth: providing health services of sufficient quality to be effective and available without financial hardship to every member of the population. It is an egalitarian project set in societies which can be highly unequal. UHC can be implemented divisively and ineffectively, or introduced in a way that maximises consensus, stays within budgetary constraints, and ends up benefitting the society and economy far more than it costs. In 2013, a seminal review by a Lancet Commission of leading economists found that around 11% of economic growth in low and middle income countries between 2000 and 2011 was the result of reduced mortality

Designing and implementing UHC policies involve some of the most complex and momentous decisions a society will ever make. Planning for these changes is one of the most difficult and vital tasks any civil servant, administrator, or company board will ever confront. Great will and skill is required to get these policies from droves of documents to the actual doorsteps of patients. Ultimately, the healthcare system that materialises in a country is a reflection of the choices made by its citizens

The creation of universal coverage is a process, not a destination. Its aim is to create and recreate impartial and sustainable institutions that will continue to learn and experiment with promising forms of organisation, new medical technologies, and other challenges. Tools to monitor implementation and a willingness to react flexibly have to be built into the framework of the healthcare system. And people – credible, accountable and motivated people are at the heart of these institutions, behind the utilization of these models and tools and at the forefront of service delivery

The important questions are not simply about funding but about how we spend money better, how we improve long-run outcomes, and how we encourage efficiency alongside humane relationships between healthcare workers and patients. We want to institute a minimum level of equality in healthcare provision that empowers the greatest number of citizens. Some countries much poorer than South Africa do a much better job in caring for their citizens, as do almost all of our peers, often at far lower levels of per capita expenditure

In this document we will first discuss how large-scale societal change can happen in a country, to provide an insight into the types of factors that could promote or prevent sweeping healthcare reforms geared towards UHC. We then explore a selection of UHC implementations in countries around the world, including both successful and unsuccessful reforms. Finally, we look at what we can learn from these successes and failures, and apply these lessons to the South African context.



“Increased public spending on healthcare is an investment in the wealth as well as the health of a country. KPMG’s recent economic analysis of The Bahamas’ new National Health Insurance system showed it will generate seven times its cost in terms of increased GDP, through improved productivity and population health. It often has a multiplier too – well targeted government spending gives the private health sector confidence to invest as well.”

Dr Mark Britnell, Chairman, KPMG Global Health Practice

Based on our experiences, across the world, with the design, costing, analysis and implementation of UHC projects, we have identified the critical components of UHC Implementation.

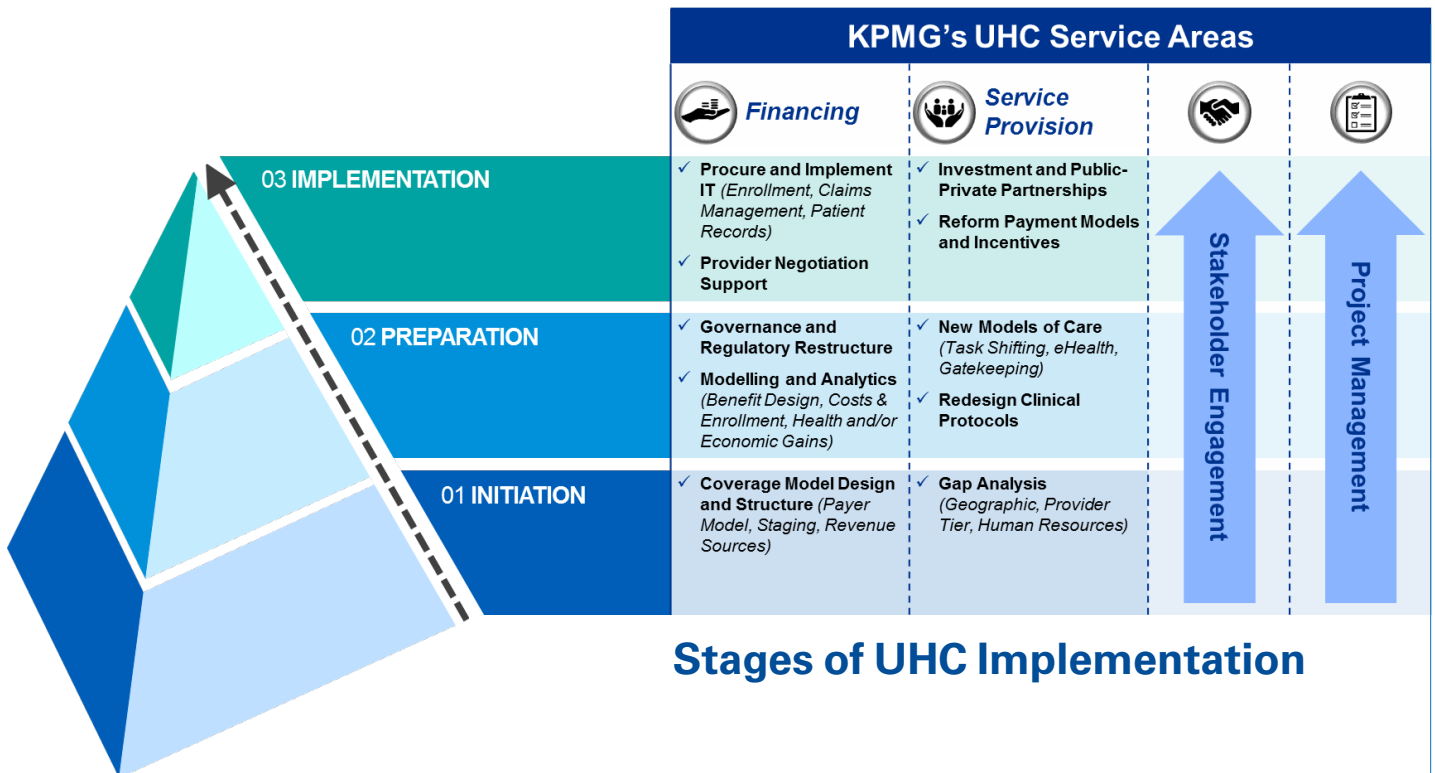


Figure 1: KPMG service offerings directly supporting the implementation of UHC

From the diagram above, the key streams of initiation, preparation and implementation can be seen to have a series of critical links and interdependencies. In order to optimise the roll-out, each service area needs to be progressed in a controlled, coordinated, sequential manner. The importance of Project Management and Stakeholder Engagement are often underestimated and under-funded; however these streams are the glue that ultimately holds the entire project together.

How change happens

"The transition to UHC is a sensitive time when decisions carry unusual weight for a country many decades or even generations into the future."

Under normal circumstances institutions evolve slowly. Only during periods of exceptional social upheaval—such as in response to natural disasters, wars, or financial crisis—do major changes occur. Political windows of opportunity interact with these events, creating unforeseen consequences of great significance. Antonia Maioni, for example, argues that the Social Security reforms in the 1930s in the United States established a model of contributory social insurance for one deserving group, the elderly, which paved the way for establishing Medicare but may have impeded the universal expansion of coverage. The U.K.'s NHS grew out of the Wartime Emergency Service. Germany's open medical insurance system today is a direct descendent of Otto von Bismarck's Health Insurance Bill of 1893 to grow the country's military might.

We often see that a country is ripe for change when faced by mounting desperation, the widespread loss of hope, a disruption of the status quo and increasing levels of civil unrest, which tends to result from the unmet expectations of the majority. When a situation arises that is conducive to change it is important that the change be guided in the right direction early. Path dependence is a well-established phenomenon in social reform: when a civil movement or an economic process or policy has started down a track it can be very expensive and difficult to change course.



"Processes that take countries towards UHC are inherently political because it requires the state to compel healthy and wealthy members of society to subsidize health services for the sick and the poor. This results in a much greater role for compulsory public financing mechanisms (tax financing and social insurance) over voluntary private mechanisms (user fees and private insurance). This health financing transition tends to be very popular with people on average and low incomes who gain greater access to expensive health services. It is less welcomed by people on higher wages, who are required to pay higher taxes. However despite this political opposition, with the notable exception of the US, all high-income countries have now made this transition because their governments have responded to the demand of the majority of the population to switch to a publicly financed health system."

Robert Yates, Project Director, UHC Policy Forum, Centre on Global Health Security, Chatham House

The single most important factor for success is genuine and sustained political leadership at the most senior levels of government. Over the last few years, we have seen that **Healthcare can be a major force in deciding elections.** In most cases, the head of state leads the reform personally and secures support for it in his or her electoral platform. An unsuccessful or non-consensual reform process can be highly divisive. In a majority of American elections since 1992 the provision of healthcare has been a primary element of contention. From Tony Blair in the U.K. to Barack Obama in the U.S., political success in advanced economies has often flowed from securing public trust in the ability to improve healthcare delivery to the nation. In Indonesia, President Joko Widodo (Jokowi), was elected Governor of Jakarta in part on the strength of his commitment to healthcare, between 2012 to 2014—he soon introduced the Jakarta Health Card. He successfully used the platform to get elected to President and has since been pursuing an ambitious plan to achieve full population coverage by 2019.

Public support is also vital and often assured by effective leadership and policy design. For this reason policymakers should ensure that the “missing middle,” often a majority of voters who may be too poor to afford private coverage but too well off to be satisfied with state coverage, see their interests reflected in the new system.

We have found that strong communication, transparency and ongoing community engagement are required to bring the people along – **‘leave no one behind’** is the fundamental principle behind these reforms, so the process needs to be inclusive from the very beginning. The design also needs to start with the end-user in mind, in order to provide services that are relevant, valued and acceptable.

What citizens want...

Most Healthcare reforms fail to address the primary cause and symptom of Health System underperformance:



“

I want access to trusted doctors and healthcare professionals that listen to me

I want the facilities to be clean and accessible

I don't want to wait to get investigations and treatment

I want to be able to get world class treatment and surgery

I don't want to face uncertainty around finances to pay for healthcare

”

“ Access to the best possible care without fear of the costs delivered by a system I trust”

Key success factors include:

- Pursuing models driven by public finance and based on the principle of being free at the point of use (UK)
- Investing in lean care models and community empowerment (Brazil)
- Supporting strong institutions, especially a robust purchasing function (China)
- Planning for impartial and effective governance (Netherlands)
- Monitoring implementation so that corrections and improvements can be made (China: Sanming)
- Designing payment mechanisms that provide appropriate incentives (Singapore)
- Commitment to the path of reform across political cycles (Thailand)

Common stumbling blocks include:

- A state that is unable to act as an effective decision-maker (Nigeria)
- Ambitious national strategies without the region-level governance to ensure they are enacted (Mexico)
- Existing special interests which require accommodation (United States in 1993, 2009)
- Adverse economic cycle (United States in 1974, South Africa in 2017)
- Inadequate human and physical infrastructure to make new entitlements meaningful or effective (India)
- Investment overly focussed on tertiary care (Philippines)



UHC Implementation around the World

Throughout this document we have provided summary insights from previous UHC implementations around the world. We explore both what success looks like and what can failure teach us, and ask questions such as “what does it take to implement UHC?” Here we start with China, and specifically Sanming Province in China.



“Every country is approaching the challenge of UHC from a different place, but that doesn’t mean there isn’t a great deal to be learned from different stories of success and failure around the world.”

Sir David Nicholson, Senior Advisor, KPMG Center for Universal Health Coverage



China



*Coverage	97%
*Health Care Spending	5.5% of GDP
*Life Expectancy	76

Starting from almost no insurance coverage for its rural population before 2003, China has achieved remarkable progress towards UHC. A three tiered system of basic medical insurance (BMI) – for rural residents, urban residents and urban employees – now covers virtually the entire population (~97 percent). These three insurance schemes will be integrated to improve efficiency. Commercial supplementary health insurance is rapidly expanding although from a low base.

China aims to increase its health spending to 7 percent of GDP by 2020, which would roughly add an additional US\$150 billion (1.5 percent of total GDP) per year.

Depth of coverage and supply remain low by OECD standards. Rural and poor provinces are significantly underserved.

The primary care workforce is being strengthened. A hierarchical provider structure is being implemented for the sake of efficiency: patients must seek care from lower tiered facilities or primary care before being referred to a top-tier hospital. Public hospital reform—improving operations, incentives, and management—has proven to be the most difficult part of the transition.

China has experimented at the local level to find effective models for reform:

In 2014, the city of Sanming introduced a reform package intended as a pilot for national reform. An economically middling city facing industrial decline and an ageing population, inequality between countryside and city, and drug commissions to doctors in public hospitals. Its municipal medical insurance confronted a substantial deficit: 14.4% in 2011.

In 2016 the city was promoted as the leading reform model for hospitals around China. A reform package realigned the entire provider system. Drug mark-ups were banned and a ‘two invoices’ system streamlined supply chains, cut down on fraud, and exposed over-prescribing practices.

The annual growth rate of total healthcare expenditure has fallen by more than a third. Reimbursement is over the national average, reducing out of pocket payments for patients. Drug prices were reduced by 30% and overall use of drugs by 20%, meaning that the proportion of spending going to drugs almost halved. A mixture of economic growth and efficiency improvements have seen the wages of health workers and administrators doubling over this period.

For a more in-depth analysis on health reforms in Sanming search for “Sanming: The real story of grass-roots healthcare transformation in China”

Reform governance

- Establish a single, city-wide integrated management team to replace the weak, fragmented existing leadership
- Establish a performance management system for hospitals, then make this data fully transparent to the public
- Give control of surpluses and hospital savings to central team to reinvest across the reform program



Reform drug procurement

- Centralize procurement for all public hospitals and make purchasing open price-competitive
- Implement 'two invoices' system to reduce fraud and eliminate drug mark-ups by providers
- Monitor and reduce drug usage, especially of antibiotics and drugs with low clinical outcomes and high commissions

Reform medical insurance

- Merge two of the three medical insurance funds and 'level up' the benefits of the least generous one
- Centralise management of the funds from country to city level, thereby reducing the number of risk pools from 15 to 2
- Move commissioning arrangement to payment by disease-type and limit the reimbursement price on imported drugs

Reform provider incentives

- Shift incentives from prescribing to medical services, and introduce a salary cap to disincentivize over-treatment
- Increase salary payment to staff and eliminate drug commissions and illegal 'red envelope' income by staff with an increased 'sunshine salary' payment
- Establish annual salary packages for hospital CEO's, with a comprehensive KPI performance management system (6 categories and 40 indicators)



Mexico



*Coverage	91%
*Health Care Spending	6.3% of GDP
*Life Expectancy	77

During the last decade, Mexico has made progress in broadening Universal Health Coverage (UHC) mainly due to the introduction of Seguro Popular (SP) in 2004, a public health insurance scheme aimed at covering the self-employed, unemployed and informal sector. SP succeeded in increasing the percentage of the population with public healthcare coverage from 51% in 2002 to 91% by 2014 (OECD 2007, OECD 2015).

Yet because of vested interests and a lack of forceful leadership, the result has been an unsustainable, underfunded and fragmented health system in which doctors work for the state.

Costs are high, and tariffs are set too low. Mexico's administrative costs are also extremely high (8.9%—two to four times the typical costs for the OECD; the U.S. is considered high at 7%). The system is extremely uneven. Some states exceed the OECD average. Others perform at the level of a sub-Saharan nation. Dr. Nelly Aguilera, Chief of the Economic Analysis department in the Ministry of Health, claims that the main reasons behind high administrative costs are powerful unions and an excess of secretaries, drivers and unnecessary staff in government and the insurers. Mexico's human and infrastructure resources appear to be underutilized. Mexico has one of the lowest consultations per doctor among OECD countries, with around 1,000 consultations per doctor compared to 2,500 in OECD. (Mexico has 500 patients per doctor = 2 annual visits.)

Observers note that a lack of clear leadership from the Ministry of Health and a resultant fragmentation of the different networks for healthcare provision. The original goal was to decentralize expenditures to states, but there was not a strong enforcement or follow up from the federal government, nor was there much accountability or transparency on the part of the states. This has resulted in a high level of variation in how much SP funding was actually spent on healthcare, and to what extent it was used efficiently and effectively to improve populations' health.



India



*Coverage	37%
*Health Care Spending	4.7% of GDP
*Life Expectancy	68

India has made only modest progress towards UHC although the possibility of rapid change is shown by state-level experimentation. Spending on healthcare is around 4% of GDP, small in absolute terms, while the government itself spends only a quarter of that on health (\$15 per capita). Its poor health outcomes, and lack of other investments in infrastructure, are generally regarded as hobbling its attempts to increase its growth rate and to establish middle-income status within a generation.

While 407 million people are now covered by public insurance schemes, and around 53-58 million by private ones, the majority of India's population (some 63%) have little or no coverage.

As well as health financing problems, the country has enormous human and physical infrastructure problems. India is 4.5 million beds short of the OECD average, and there are only 2 nurses for every 1000 Indians. Mistrust over the quality of public health services is a major barrier to people seeking care, with underqualified, overstretched staff, medicine stock-outs, absenteeism and corruption among the chief concerns.

India has fallen into several of the traps that have been noted earlier in this document. For example, the government has focused primarily on getting health cover only for the very poor, rather than trying to cover everyone equally. This has been a significant factor in the low coverage levels still seen in India, primarily among the 'missing middle'.

India also assigns little political importance to healthcare – it has rarely been a significant talking point during elections, and therefore the political will to improve healthcare has remained low.

India has some reasons to be positive, however. The private sector has consistently invested strongly in the creation of healthcare infrastructure. India is well known for having some of the most innovative private healthcare providers in the world, and these have grown significantly in recent years. However, despite rapid expansion private insurance will likely reach no more than a third of the population in the next twenty years, and so most Indians will still have trouble accessing private care.

Rather than progress being uniformly slow, performance against key health outcome indicators has shown enormous inter and intra- state variation, with states like Assam, Madhya Pradesh and Jharkhand dragging the national averages down, while others have seen much greater success.



“Historically, India has been one of the slowest of the large emerging economies to make large public investments in health – jobs, infrastructure and education have come first. This is changing now and the federal government is beginning to make some big commitments to double health spending over the next five years. Still, in such a large country the challenge is always implementation, as some states have a much better track record than others at health system change”

Dr Niti Pall Medical Director, KPMG Center for Universal Health Coverage

Netherlands



*Coverage	100%
*Health Care Spending	10.9% of GDP
*Life Expectancy	82

In the Netherlands an expensive but well-regarded system nevertheless involves extensive state regulation of the private market. Government healthcare subsidies follow the patient and the patient is tracked in and out of hospital by a care supervisor in tandem with social services, which allows the private sector to function effectively in an essentially public system. Regulatory interventions in the Dutch healthcare system are structural rather than continuous, which has created a well-coordinated system. Integration means that each patient receives care in appropriate settings, and has his or her case managed, while the system as a whole can implement efficient and rational policies for different kinds of cases and adjust its provisioning of resources at a macro level.



“UHC has made a broad package of high quality healthcare available for all Dutch citizens. Whereas a lot of issues might be under political debate in the Netherlands, UHC is not one of them and it is widely seen as a valuable asset for Dutch society.

In the coming years the focus of our system will be on transparency, such as the publication of outcome measures, and regional cooperation between different tiers of providers.”

Dr Anna van Poucke, Partner & Head of Healthcare, KPMG in the Netherlands



Nigeria



*Coverage	<10%
*Health Care Spending	3.7% of GDP
*Life Expectancy	53

The Nigerian constitution prescribes that primary healthcare be implemented by local government; secondary care by state government, and tertiary care by the federal government. This public healthcare is largely free of charge, but suffers from chronic resource shortages such as a lack of doctor. Some estimates show that as many as half of all Nigeria doctors work abroad, largely in the United States and Europe.

There is also a small private healthcare provider sector, but this is also relatively under-developed. The best hospitals operate at no more than an advanced secondary care level, hence the higher-income population (the approximately 30 million people with annual income over USD 5 000) has typically patronized medical tourism in countries and regions such as India, South Africa, the Middle East and Europe.

The majority of the population does not have private healthcare coverage, and so they place reliance on the public healthcare system. However, Nigeria does have a National Health Insurance Scheme (NHIS) which has been in existence for more than 10 years. It only has 6 million members, comprising mainly private sector & federal government workers.

The 36 states in Nigeria have not participated in this scheme, and to date around three states have passed their own UHC legislation with support from the federal government. A number of other states are likely to pass their own UHC legislation later this year.

Vested interests (and lack of political will to tackle them) and economic troubles have so far blocked serious attempts at reform. The cost of care is high while private customers don't always get good quality due to over-servicing and under-regulation. Some public care facilities offer better preventive care than private, but overall there is a lack of incentives for people to stay healthy.



“Currently Nigeria is experiencing a recession for the first time in 25 years, and this has resulted in a new prevailing view that Nigeria has to grow its economy in spite of a low oil price regime. As such there has to be a prioritisation of healthcare for government spending if Nigeria is to develop a sustainable UHC framework. Investments in UHC must be pitched as a way to path to growing Nigeria's economy to have the best chance of being prioritised, and this can be done as there are many economic benefits that healthcare investment would bring. One opportunity being pursued, for example, is investment in private, high-quality healthcare provision to capture the market of Nigerian patients who ordinarily go abroad for treatment.”

Kunle Elebute, National Senior Partner, KPMG Nigeria

Rwanda



*Coverage	97%
*Health Care Spending	7.5% of GDP (3.2% in 1996)
*Life Expectancy	65

Rwanda is a vital example for countries without a great deal of public resources for healthcare. Health insurance has been mandatory since 2008 and 45% of the resources came from premiums, which stand at around \$2 per year. Rwanda implemented a community-based health insurance scheme: residents of an area pay into the local health fund and draw from it when necessary. They are assessed on a sliding scale: the poorest pay nothing while the rich may be responsible for co-payments. It has enjoyed the benefits of an effective and determined state which, despite criticism of its human rights record, has pursued reform in the healthcare sector pragmatically and forcefully.





Lessons from comparative global experience:

While every country has its own unique set of resources and constraints, and will necessarily move to UHC on its own path, it is possible to set out a list of lessons from recent experience that may help to improve the chances of successful, decisive, and consensual implementation.

UHC means integration:

of the public and private sectors, of healthcare training and service delivery, of the community and the hospital. In the Netherlands the system is centered on the citizen and the social network. A care coordinator tracks the patient, weaving together home-care and social services, rather than focusing only on his or her time in the hospital under the supervision of a G.P. The Dutch system permits entrepreneurship in a contained environment, making it suitable for the difficulties in implementation experienced in South Africa.

Partnerships are vital:

It is clear that value can be unlocked when we are able to align incentives and work across the healthcare continuum; bearing in mind that patient information is confidential and privacy needs to be protected. Coordination between different parts of the system is therefore difficult but necessary. Mexico is an example of a system lacking effective coordination, caused by an absence of strong leadership and inadequate data sharing/transparency. Singapore and the Netherlands, on the other hand, are positive examples of highly partnered and coordinated systems. Singapore's Personal Data Protection Act simultaneously ensures confidentiality and distributes patient information, anonymised where necessary, to the relevant financial and medical points. A large investment in health informatics in Singapore is driving efficient allocation of resources and better management of chronic conditions (through, for example, allocating field visits to poorly controlled diabetics who would otherwise call on emergency resources).

Harness the power of transparency:

Simply making data on the performance of healthcare providers more transparent can have a dramatic impact on their behaviour, as well as equipping doctors, patients, and administrators to jointly tackle corruption. KPMG recently published a study called Through the Looking Glass on the transparency of health systems around the world, finding that five of the world's best health systems – Denmark, Finland, Sweden, Norway and the UK – also had the five highest transparency scores.

Money can be a challenge, whether there is too little of it or too much. Build on success:

Money alone doesn't create capacity nor does it improve equity. It shouldn't be spent only on immediate needs. Free healthcare doesn't work if the services aren't available; a good example is Tanzania where a heavy burden of disease and an ambitious plan for expanding coverage, without adequate resources or planning, has led to low morale and less effective provision than would have been possible with a more measured approach. Often the question in poor countries or low-middle income countries (like South Africa) isn't how much Treasury gives the health sector. It's about how the health service spends the money it already has ("not more money for health, more health for the money.") Rwanda shows that an inexpensive system can be fair and (relatively) effective. The United States shows that a wealthy system can be unfair and unevenly effective (but with some excellent aspects).

Alignment can be improved via intelligent payment mechanisms:

There is no consensus on a preferred payment mechanism, as the suitability of any method is highly contextual and its impact is strongly influenced by the governance and institutional arrangements to regulate and enforce payment systems that exist in a country. There are many different ways to classify health system but four broad types can be constructed, each with large variations in real life:

- the Beveridge model (like the UK’s NHS where the state owns and operates facilities out of general taxes),
- the Bismarck model (non-profit social insurance co-funded by government and employers),
- the National Health Insurance model (single-payer national health insurance like Canada),
- the voluntary private health insurance model (like the US before the introduction of the Affordable Care Act).

Nearly all countries will run a combination of these variations on these models. Even if a broad health system type is chosen, though, there are many different reimbursement methods and contract types that each have their own unique pros and cons. The key lesson is that misaligned incentives can be tackled: Reforming flawed payment models can have a tangible and significant impact on how and what healthcare is delivered. (Sanming)



“Countries underplay the importance of transparency to successfully executed UHC programs. Like any large-scale reform, proper governance is paramount to ensure meaningful change happens in practice and not just paper. This is especially important in healthcare as people don’t use services they don’t trust, and transparency is one of the most important ways of fostering that public confidence.”

Jonty Roland, Program Director, KPMG Centre for Universal Health Coverage

Pros and cons of four traditional currencies

Payment methods	Provider behaviour			
	Prevent health problems	Deliver services and solve health problems	Respond to people's legitimate expectations	Contain healthcare and transaction costs
Global budget (and salary)	++	--	+/-	+++
Capitation (and salary)	+++	--	++	+++
Diagnostic-related payment	+/-	++	++	++
Fee-for-service	+/-	+++	+++	---

Source: Reforming payment for health care in Europe to achieve better value, Nuffield Trust and KPMG 2012 - table adapted from WHO 2000, p106 by Hurst and Charlesworth.

Public financing is necessary: Countries such as Chile, Brazil, Mexico, Turkey, Thailand and China have used compulsory public financing mechanisms to close coverage gaps, and have improved health outcomes, lowered inequality and raised levels of financial protection compared to their peers. Households in the informal sector do not tend to buy health insurance unless it is heavily subsidized using public funding, and so many people do not benefit from poorly planned implementations of UHC without significant public financing. Mexico is a good example of an under-resourced system. So is Tanzania.

Universal entitlement is preferable to means testing. Many countries have largely abandoned trying to differentiate between the poor and the non-poor and instead have been providing a universal entitlement. As well as rapidly increasing coverage, one of the major advantages of this approach is that it eliminates the need to undertake costly means-testing exercises among the population. It also avoids the problem of adverse selection where people with lower perceived health needs do not tend to join. Additionally there is good evidence that these systems tend to be more equitable, as in the case of Sri Lanka, which offers free universal healthcare to every citizen, regardless of means, and show health outcomes competitive with far more developed economies.

Capacity-building is essential. Increasingly, there is recognition that one barrier to UHC is the weak capacity of healthcare providers in low-income countries. No amount of insurance coverage can provide effective care when health systems lack functioning infrastructure. Such health system resources include a sufficient number of doctors, nurses, and community health workers, who have access to reliable supplies of medicines and surgical equipment and logistical routes of providing care. In South Africa, the government attempted to expand public infrastructure during the transition to democracy after 1994, but after a few years it was recognised that deprived geographic regions could not absorb resources effectively. The government returned to a policy of emphasizing health system development in urban centres, as part of an economic growth strategy. (Nigeria is a problem case, China is the opposite.)

Vertical programmes need to be scaled and incubated into sys-wide benefits. Too often do health systems – especially in the developing world – focus on treating specific diseases in isolation, rather than understanding how these diseases could be treated as part of a more holistic health system. Of course, occasionally dealing with a particular disease is so overwhelmingly urgent that it simply must take immediate priority over all else, but then later on these vertical programmes would still benefit from becoming more integrated into the wider health system.

Adverse conditions, and low levels of economic development, may still allow effective implementation. There exist models of expanding healthcare access to universality in lower-income countries, even those with legacies of conflict and social (especially ethnic) inequality. One very good example is Rwanda. Sanming's story shows that even low-spending health systems can generate substantial efficiencies to be reinvested into improved services and financial protection.

Radical reform is easier if tied to new investment: Transformation faced far less resistance in Sanming because most of the key stakeholders stood to benefit financially from the changes.

Consider the merits of an assurance model (versus insurance). Under assurance, as in the UK's NHS, entitlements are specific and free and can be progressively provided as economic growth allows. You don't pay premiums and many services are free; the basket of free services can be expanded as economic growth allows. This can forestall the inefficiencies of a pricing system although it is hard to create interfaces with the private sector. The insurance model is more familiar and tracks individual patients to suppress usage and collect premiums.



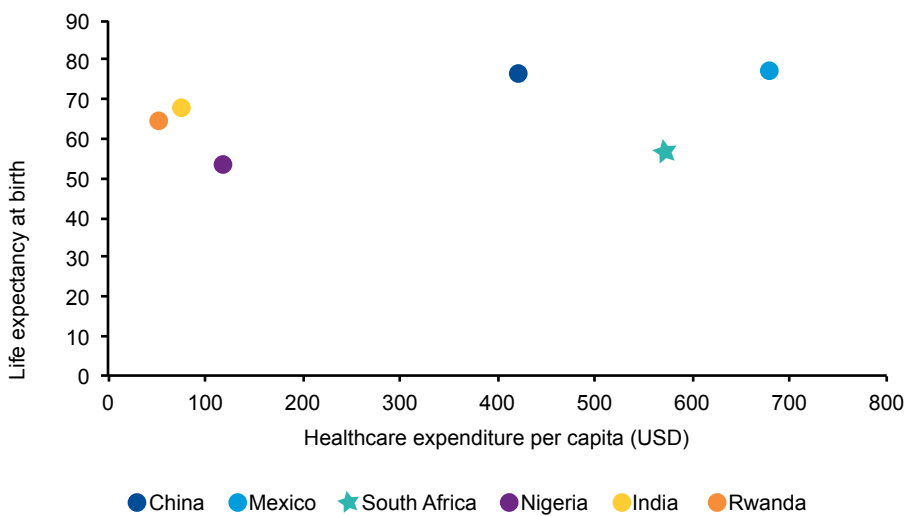
The State of Play in South Africa











South Africa's debate on a National Health Insurance scheme has been as vigorous as one could want in a democracy.

On the one hand voices of caution point to poor economic growth, and a poor record of delivery, as limitations on coverage. On the other hand longstanding commitments to equity and inclusion point to a much broader effort to overhaul the parallel systems of private and public healthcare provision including mandated coverage, provider re-organisation, and the creation of a single fund for civil servants.

Below we compare South Africa's performance against the lessons learnt in the previous sections. Firstly we discuss South Africa's position with regards to the key drivers behind societal change as a whole, and then with regards to health sector-specific factors. South Africa currently has a two-tiered health system and so, where appropriate, each is assessed separately.

Health expenditure per capita versus life expectancy



Lesson	South African healthcare's performance	
	Public sector healthcare	Private sector healthcare
The single most important factor for success is genuine and sustained political leadership	Whilst the position of the President – and by extension the entire cabinet – is somewhat precarious, the Minister of Health is passionate about driving the implementation of UHC in South Africa and bringing quality healthcare to all South Africans regardless of their ability to pay. However, he is still dependent on support from the treasury, and they have many competing priorities.	
Public support is vital	There is a view that patience with the poor public health system is wearing thin, and that public support for healthcare reform is therefore high. Whilst many users of the private healthcare system fear any change which may disrupt their own access to quality care, even they are generally strongly in favour of reform to tackle the rising costs, and of good quality healthcare for all.	
Integration and partnerships are vital	Much of the care that is delivered in the public sector is done so through vertical programmes, and different parts of the public system is run by different levels of government (national/provincial/district) 	There is no clear gatekeeper function and care is fragmented, with many doctors working as sole traders 
Harness the power of transparency	Neither sector does a good job of publishing quality data on healthcare services, nor patient experience data, which robs providers of a very powerful incentive to improve care. In addition, the flow of patient data between providers is generally manual or absent. South Africa does benefit from a strong policy for safeguarding patients' data privacy, but it remains to be seen how effective enforcement will be. The Minister has also stated that he intends for there to be a national electronic patient record system, which could bode well for increased transparency if the inevitable security and privacy concerns can be addressed. KPMG recently published a healthcare transparency study, which ranked South Africa as 30th out of 32 countries analysed. For the full report search "Through the looking glass: A practical path to improving healthcare through transparency".	
Money can be a challenge, whether there is too little of it or too much.	South Africa's public health system certainly manages to treat a large number of patients with few resources (though the quality of this care is often questionable), and South Africa's ART programme is often hailed as a huge success in this regard. However, little has changed in the public health system in recent years as regulatory change has stalled and the OHSC has remained under-resourced. 	In South Africa's private sector this challenge has largely been ignored. Costs have spiralled upwards and cost-saving initiatives that would also improve quality – such as increasing the use of primary health services and preventative care – have not been prioritized. 
Alignment can be improved via intelligent payment mechanisms	The NHI White Paper has made it clear that public tertiary hospitals will be centralised and ran at a national level, whilst public hospitals will be delegated greater powers. This could lead to improvements in alignment in what is currently a very fragmented system, and the introduction of a National Health Insurance can also help to improve alignment. 	Whilst there is no single payment mechanism that can be said to be the best one, or the correct one, it is almost certain that the preponderance of fee-for-service reimbursement in the private health system has driven up costs without leading to a focus on clinical outcomes. 
Public financing is necessary	In South Africa, 8.8% of GDP is spent on healthcare. The government spends 14.2% of its budget on healthcare, though, which is close to the 15% agreed upon by African countries in the Abuja declaration. 	The government does provide tax refunds for private medical expenses, which is a policy which can encourage people to purchase health insurance. However, the NHI White Paper has made it clear that these tax credits will be phased out in the coming years. 

Lesson	South African healthcare's performance	
	Public sector healthcare	Private sector healthcare
Universal entitlement is preferable to means testing.	Whilst officially free public care is only available based on means testing, there are many reports that in practice little means testing is done. The NHI will scrap means testing at the point of care in the future, however. 	In the private health system there is a form of means testing: only those able to pay high fees are able to access care. This excludes the majority of the population. 
Capacity-building is essential	The public health system is often seen as heavily under-resourced, with far too few healthcare workers, too little money and inadequate infrastructure. There are examples of great success in the public healthcare system, though, which implies that management and leadership capacity could be a factor behind the sector's uneven effectiveness. Clinical associates are being trained to help reduce the workloads of doctors, but as yet have not been effectively deployed as posts don't exist to employ them in. 	The private sector generally has more resources than are needed to treat its patients, as evidenced by estimates that 30-40% of private healthcare spend is due to over-servicing. However, there are still shortages of many specialists, and the private sector is not allowed to train new doctors and has restrictions on training nurses. 
Vertical programmes need to be scaled and incubated into system-wide benefits	South Africa has the largest and most successful antiretroviral therapy programme in the world. However, it is still rather 'vertical' in nature, being run from its own programme in the Department of Health, separately from the PHC programme. 	Vertical programmes are less of a feature in the private sector, though it could be argued that many doctors are individual 'vertical programmes' in and of themselves as few work as part of multi-disciplinary teams.
Adverse conditions, and low levels of economic development, may still allow effective implementation	This is especially relevant to South Africa now that the country has fallen into a recession. Relative to its healthcare spend, South Africa's life expectancy is extremely low and, whilst much of this is due to the HIV/AIDS epidemic, much is also due to the highly unequal distribution of healthcare spending.	
Radical reform is easier if tied to new investment	With the economic problems South Africa is facing, very little new money is being made available by the government for healthcare. However, the NHI white paper has suggested a number of options for increasing the public healthcare funds available, such as by eliminating tax rebates for private medical expenditure. 	Since GEMS brought a large number of civil servants into South Africa's insured population, the number of members of medical schemes has remained static. This, covered with high medical inflation, means that little new money is being made available for investment in private healthcare in South Africa. If the public sector becomes more open to PPPs, and if the NHI is able to effectively contract with private providers, this could create significant new income for private providers to invest in reform. 
Consider the merits of an assurance model (versus insurance)	More than half of people using primary care do so because service is free at the point of care. In the private sector, this is true for less than 5% of people. This raises the question of whether low cost, or affordable, services may be appropriate for the remainder of patients. People delaying medical care in the poorest households totalled 21%. The most common reason for this is high transport costs to and from facilities. An assurance model, along with local clinics or assured transportation, may reduce self-imposed delays and improve health outcomes just by virtue of timely interventions. 	

As this analysis shows, the South African healthcare sector is not currently ideally placed for a successful UHC implementation. However, the need for large-scale reform has become so acute that South Africa must do everything it can to persevere along the path to UHC. Potentially the largest challenge may be securing strong political leadership for this change, but the public support for some form of healthcare reform and the passion and experience of the current Minister of Health make this a challenge that can be surmounted.

In fact, all of these issues that would stand in the way of a successful UHC implementation can be addressed, and so with the right will and expertise there is every chance that South Africa can have high quality healthcare for all.



Recommendations

We strongly believe that the potential to provide quality healthcare for all exists in South Africa, and in this section we put forward some ideas to put South Africa in a stronger position to be successful in its UHC implementation.

Success factor	Recommendation for South Africa
The single most important factor for success is genuine and sustained political leadership	If handled correctly, the creation of an effective health service – whether at the national or provincial level – can have an enormous impact for politicians, political parties and citizens. If nothing else, this needs to drive the country’s next President politics and give him or her the strength to see healthcare reform through to its conclusion.
Public support is vital	Public support for UHC is already largely present in South Africa. More can be done to educate current medical scheme members on how healthcare reform could also benefit them, such as with lower premiums and more integrated care experiences. Public support must also lead to increasing patient engagement. More engaged patients routinely have improved healthcare outcomes, and more vocal patients can be a driver for increasing quality of care.
Integration and partnerships are vital	Regulatory blockages must be cleared, and for this to happen strong political drive is required. In the meantime, however, payers and providers of care can use their own initiative to create partnerships and integrated systems of care that work for all. An example of this is PPO Serve – a private company which was started up with the aim of enabling closer integration of healthcare providers.
Harness the power of transparency	Steps have been taken in this regard with the creation of the Office of Health Standards Compliance. However, requirements could be put in place to mandate healthcare providers to publish a selection of quality indicators, which even in an unaudited form would help to drive performance.
Money can be a challenge, whether there is too little of it or too much	It must be accepted that South Africa does not have the financial resources to provide all South Africans with the same care that medical scheme members currently have. Once this has been accepted, the conversation can move on to thinking of innovative ways to provide the best healthcare possible for what money is available. This includes improving coordination, introducing task-shifting, rolling out mhealth and telehealth initiatives, pushing care out into communities and introducing a gatekeeping function.
Alignment can be improved via intelligent payment mechanisms	Innovative payment mechanisms are currently not widespread in the public healthcare sector. The NHI will make public providers compete with private providers, and so public providers will have to form effective care and referral networks in order to provide low cost care to many people. Currently fee-for-service payment is predominant in the private sector. Medical Schemes, however, have the power to change this. Even without significant regulatory change they can improve their managed care services, their quality monitoring and – enabled by these changes – the payment incentives of healthcare providers.
Public financing is necessary	Once again, this is largely dependent on political support. The South African government currently spends significantly on healthcare, but greater health spending can be used as a platform for gaining greater political support from the public.
Universal entitlement is preferable to means testing.	Whilst the public sector already does little means testing, the private sector can work to make ‘means’ less of an issue by focusing on improving affordability. Steps to achieve this include greater promotion of primary healthcare and creating business models based on high-volume, low-cost care provision, such as the Aravind Eye Clinic in India. In the private sector, regulations such as the prohibition of hospitals employing doctors and the PMBs make these steps a challenge to achieve, however.

Success factor	Recommendation for South Africa
Capacity-building is essential	The government needs to continue its efforts in improving both public and private healthcare services, and providing the OHSC with a greater budget and more 'teeth' may help to achieve this. If the OHSC can hold underperforming providers to account, as well as support them in their improvement, healthcare provision as a whole will improve.
Vertical programmes need to be scaled and incubated into system-wide benefits	One challenge with integrating vertical systems is that they are often partly donor-funded. Aligning donor's goals can be difficult, but new approaches for cooperating with donors must be developed. In South Sudan the government requires that all donors work through a single entity fund the Health Pooled Fund. This has led to improvements in the coordination of care with the wider system, and an improved take on this approach could be used in South Africa.
Adverse conditions, and low levels of economic development, may still allow effective implementation	Any investment in a poor economic climate is difficult, but the case for investing in healthcare is both economically and societally strong. A recent KPMG study into the impact of the National Health Insurance scheme in the Bahamas has projected that primary care phase alone will lead to an economy that is 3.7% larger by 2035. Framing this case in terms of economics can help to secure investment funding to improve healthcare.
Radical reform is easier if tied to new investment	There is significant interest, both domestically and abroad, in investing in South African healthcare. South Africa can improve how it supports such investment, however.
Consider the merits of an assurance model (versus insurance)	The government or Medical Schemes could pilot providing certain healthcare services on an assurance basis. This would work best for those services whose consumption should be encouraged – for example preventative care such as vaccinations.

Perhaps most importantly, however, is to have patience. As vital as it is to provide quality healthcare as soon as possible, change of this magnitude takes time. South Korea implemented a UHC system in 12 years, but for most countries a twenty year time horizon may be more realistic, though economic growth and global technological change could reduce this. Having patience does not mean taking your foot off the accelerator, or accepting a lack of progress. It means understanding that this is a large and daunting task and that we must all work together to see it through successfully.

"It is time to walk the talk and the whole world is asking for that - health as a rights issue, an end in itself, and also health as a means to development. All roads should lead to universal health coverage..."

– Dr Tedros Adhanom Ghebreyesus,
Director-General of the World
Health Organization



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