



RESULTS FOR
DEVELOPMENT

Governance of the Proposed National Health Insurance Fund in South Africa

Models and Lessons from International
Public Sector Experience

Acknowledgments

Results for Development Institute (R4D) is a non-profit organization based in Washington DC. Its mission is to unlock solutions to tough development challenges that prevent people in low- and middle-income countries from realizing their full potential. Using multiple approaches in multiple sectors—including Global Education, Global Health, Governance, and Market Dynamics—R4D supports the discovery and implementation of new ideas for reducing poverty and improving lives around the world.

This report aims to inform the development of National Health Insurance policy in South Africa and documents international experiences and evidence on the organization and governance of large public sector entities for managing health funds and purchasing services. It has been prepared by R4D in consultation with South Africa's National Treasury and with financial support from The Atlantic Philanthropies.

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Acronyms

AIH	Authorization for Hospitalization, type of payment (Brazil)	NHFDO	National Health Financing Development Organization (Thailand)
ANS	National Supplementary Health Agency (Brazil)	NHSB	National Health Security Board (Thailand)
ANVISA	National Health Surveillance Agency (Brazil)	NHSF	National Health Security Fund (Thailand)
AUGE	Universal Access with Explicit Guarantees (Chile)	NHSO	National Health Security Office (Thailand)
BDUA	Single Database of Affiliates (Colombia)	OHIP	Ontario Health Insurance Plan (Canada)
CADTH	Canadian Agency for Drugs and Technologies in Health (Canada)	OOP	Out-of-Pocket
CHT	Canada Health Transfer (Canada)	P&P	Prevention & Promotion
CNS	National Health Council (Brazil)	PCMO	Provincial Chief Medical Officer (Thailand)
CONASEMS	National Council of Municipal Health Secretariats (Brazil)	PHOs	Provincial Health Offices (Thailand)
CONASS	National Council of State Health Secretariats (Brazil)	PHSC	Provincial Health Security Committee (Thailand)
CSMBS	Civil Service Medical Benefit Scheme (Thailand)	POS	Mandatory Health Benefits (Colombia)
CUPs	Contracting Units for Primary Care (Thailand)	PPP	Purchasing Power Parity
DIPRES	Public Budget Office (Chile)	RHSs	Regional Health Services (Chile)
DRG	Diagnosis-Related Groups	SDS	Superintendency of Health (Chile)
EPS	Health Promoting Entity (Colombia)	SE	Executive Secretariat (Brazil)
FCM	Free Choice Modality (Chile)	SFC	Superintendencia Financiera de Colombia (Colombia)
FFS	Fee-for-Service	SGSS	General System for Social Security for Health (Colombia)
FHS	Family Health Strategy (Brazil)	SHI	Social Health Insurance (Chile)
FONASA	Fondo Nacional de Salud (Chile)	SHS	State Health Secretariats (Brazil)
FOSYGA	Solidarity and Guarantee Fund (Colombia)	SIA	Ambulatory Care Information System (Brazil)
GDP	Gross Domestic Product	SIGGES	Integrated Information System for the Management of Explicit Guarantees in Health (Chile)
INAMPS	National Institute for Social Medical Assistance (Brazil)	SIOPS	Public Health Budget Information System (Brazil)
IPSS	Institutional Service Providers (Colombia)	SERMENA	National Medical Service (Chile)
ISAPRES	Instituciones de Salud Previsional (Chile)	SISBEN	System for Selecting Beneficiaries of Social Spending (Colombia)
LHINs	Local Health Integration Networks (Canada)	SNS	National Superintendent of Health (Colombia)
MHS	Municipal Health Secretariats (Brazil)	SNSS	National Health Services System (Chile)
MOHLTC	Ontario Ministry of Health and Long-Term Care (Canada)	SQCB	Standards and Quality Control Board (Thailand)
MOPH	Ministry of Public Health (Thailand)	SSS	Social Security Scheme (Thailand)
MPS	Ministry of Health and Social Protection (Colombia)	SUS	Unified Health System (Brazil)
MS	Ministry of Health (Brazil)	UCS	Universal Coverage Scheme (Thailand)
		UPC	Risk- Adjusted Capitated Payment (Colombia)
		WSIB	Workplace Safety and Insurance Board (Canada)

Foreword

By William Savedoff

If there is one lesson from the history of health reforms over the past 150 years, it is that commitment and persistence matter more than design and forethought. Bismarck proposed a health system for Germany in the 1880s that would be financed and managed by the government, but, facing political opposition, he settled for compulsory insurance administered by existing sickness funds. In 1943, the celebrated Beveridge Report proposed compulsory insurance for Britain and provided the impetus to universalize healthcare after World War II. However, Britain subsequently implemented a plan that created a National Health Service with government financing and publicly managed hospitals.

Every country has such a story in which political commitment to universalizing healthcare provides the energy to move forward while persistence assures that institutions are continually adapted to solve problems as they arise. Those who take up the responsibility to implement health reforms typically look for ideas and encouragement from abroad, but they also rely on domestic institutions and add a strong dose of innovation to make it all happen.

Persistence is important because even when health reforms are successful, they do not cease to have problems. Rather, they solve old problems and then face new ones. This creates a political dilemma for the public sector, which is rarely recognized for improvements relative to a decade ago and regularly criticized for gaps relative to the aspirations of today. Old problems are a sign of failure. New problems should be seen as a sign of success.

South Africa stands today at a critical juncture in its move toward universal healthcare—as other countries have before it. The government has proposed an ambitious healthcare reform which aspires to move away from an inequitable and fragmented system toward one which

is universal, efficient, and fair. The political commitment seems strong, or at least looked that way at the time the 2011 Green Paper was put forward. If South Africa chooses to embrace this commitment, the next question will be to see whether there are enough people willing to persist in creating the institutions, identifying problems, and continuing to solve them in a continual process of adaptation and improvement.

This study is written for South Africans who are committed to universal healthcare and who are looking for ideas to make the governance of a reformed system a reality. The R4D team has identified five countries with features and health systems that make their experiences relevant to South Africa's plan to establish a National Health Insurance Fund: Brazil, Canada, Chile, Colombia, and Thailand. The analysis shows that each country has made remarkable progress in expanding access to healthcare services. It also reveals the diverse institutional arrangements and governance mechanisms used by these countries to promote health system goals. While none of these designs are ideal, they do provide lessons and insights for the choices South Africa needs to make for its vision of national health insurance to move forward.

The R4D team has extracted lessons from these case studies that are most relevant to South Africa and the proposal under discussion in the National Department of Health. These case studies show how other countries have addressed some of the thorniest governance issues facing South Africa, such as: the future role of provinces and medical schemes; ways of engaging private providers; the implications of poor quality in public sector provision; and the need to manage expectations and costs. In this way, it provides a window on experiences in other countries which can serve as sources for ideas and inspiration. With this information in hand, the important thing is to take the next step.

Section 1: Introduction

Introduction

The government of South Africa has proposed to establish a National Health Insurance Fund (NHIF) to act as a single public purchaser of health services nationwide as part of the government's proposed reforms to achieve universal health coverage. Before the government finalizes the structure of the NHIF, it must address in consultation with stakeholders several questions concerning the governance of the NHIF. The National Treasury (NT) has engaged the Results for Development Institute (R4D) to provide information on alternative governance models and to review public arrangements in five countries to pool funds and purchase healthcare services through national health insurance schemes.

This paper presents five case studies of health insurance governance in Brazil, Canada, Chile, Colombia, and Thailand. The analysis focuses on the relevant public agency or agencies responsible for managing health funds and purchasing services, and explains their organizational structures and governance mechanisms. Each case presents information on the country's context and health system and how the relevant health purchaser relates to three key institutions: government, healthcare providers, and other insurers.

In the coming sections, we will outline our methodology and approach, present the five country cases in detail, highlight key themes drawn from a cross-case analysis, and offer recommendations and lessons for NT.

Governance Focus

The South African Department of Health's specifications for the design of the National Health Insurance Fund calls for several features that carry broad implications for its governance. Five of these design elements informed both our selection of appropriate comparison countries and our discussion of the results that we derived from the case analysis. The Department of Health specifies that the NHIF incorporate the following five key system features:

- **A single-payer fund** responsible for pooling public finances and purchasing services from public and private entities;
- **Local management** by local authorities who manage, plan, and coordinate health services;
- **Access to private voluntary insurance** programs that offer voluntary, complementary coverage;
- **Financial arrangements for contracting** with public and private providers;
- **Reimbursement** systems that have evolved over time and use risk-adjusted capitation- or performance-based payments.

Country Selection

To best provide illustrative examples and lessons for South Africa, we chose countries that have public purchasing and pooling agencies, share contextual factors with South Africa, and vary with regard to the above system features. Table 1.1 presents our comparison of contextual factors with South Africa for Brazil, Canada, Chile, Colombia, and Thailand. We group measures into country and health contexts and health outcomes.

Methodology

Unit of Analysis

The unit of analysis in each country is the public agency or agencies responsible for managing health funds and purchasing services. Because there are many different ways of organizing institutional arrangements to provide

universal or near universal health coverage through a public insurance mechanism, we faced two challenges in using this definition. First, the two main functions of interest, managing health funds and purchasing health services, may or may not be carried out within the same institution. Second, these functions (even if carried out within the same institution) are not necessarily centralized—pooling and purchasing can take place at multiple jurisdictional levels within a country. Hence, we have analyzed the pooling and purchasing functions within the system of institutionalized

Table 1.1: Country Context and Health Indicators

Domain	Variable	Country Data						
	Indicator (reporting year)	Brazil	Canada	Chile	Colombia	Thailand	South Africa	
Context	Population (millions) (2013)	200.4	35.2	17.6	48.3	67.0	53.0	
	Country level of income (FY 2015)	UMI*	High	High	UMI	UMI	UMI	
	GDP per Capita (current US\$) (2013)	11,208	51,958	15,732	7,826	5,779	6,618	
	Gini coefficient	51.9 (2005)	32.1 (2005)	52.1 (2009)	55.9 (2010)	39.4 (2010)	63.1 (2005)	
	Basic form of Government (2004)	Federated	Federated	Unitary	Unitary	Unitary	Federated	
	Fiscal Decentralization Indicators (2012)	Revenue	44%	62%	12%	22%	11%	22%
		Expenditure	42%	64%	12%	19%	10%	21%
		Tax	42%	56%	7%	15%	NA	28%
Wages		64%	83%	27%	28%	11%	0%	
Health		NA	NA	NA	NA	NA	NA	
Health Context	Population share financially covered (various years)	Public health insurance**	100%	100%	77%	96%	99.5%	17.9%
		Private health insurance***	23%	67%	16%	NA	2%	16.6%
	Health Market Size (health expenditure per capita x population) in \$Billions (2012)	211.6	202.1	19.4	25.6	14.4	34.2	
	OOP health expenditure: % of total health expenditure (2012)	31.0%	15.0%	32.1%	14.8%	31.1%	7.2%	
	Health expenditure per capita (current \$US) (2012)	1,056	5,741	1,103	530	215	645	
	Health expenditure, total (% of GDP) (2012)	9.3%	10.9%	7.2%	6.8%	3.9%	8.8%	
Health Outcome	Under 5 mortality rate (per 1,000 live births) (2013)	14	5	8	17	13	44	

* UMI is an abbreviation for Upper Middle-Income – A World Bank classification of country income status based on 2014 Gross National Income (GNI) per capita.

** These statistics do not control for differences in the quality or number of health services financially covered. Benefits will vary across countries, for example Brazil and Canada offer basic coverage.

*** The percentage of the population covered by private insurance is not a mutually exclusive category. Those with private insurance coverage may additionally be covered under a public health insurance scheme.

relationships in which they occur, and have focused on the following units of analysis in each case:

Brazil: Our case study examines the shared role of Brazil's Ministry of Health (MS), 26 State Health Secretariats (SHS), and 5560 Municipal Health Secretariats (MHS) in managing health funds and purchasing services for the public healthcare system, the Sistema Unico de Saude (SUS).

Canada: Canada's health system is composed of independent health plans administered at the provincial/territorial level. Our study examines the Ontario Ministry of Health and Long-Term Care (MOHLTC), the agency responsible for administering the Ontario Health Insurance Plan (OHIP).

Chile: Our study considers Chile's Fonasa (Fonda Nacional de Salud), which serves as the national public pooling and purchasing agency for healthcare under the 2005 AUGE reform that introduced 'Universal Access with Explicit Guarantees.'

Thailand: We consider Thailand's National Health Security Office (NHSO). It is a state autonomous agency serving under the authority of the National Health Security Board (NHSB) that administers the National Health Security Fund (NHSF) to provide services under the Universal Coverage Scheme (UCS).

Colombia: We study Colombia's national Solidarity and Guarantee Fund, or FOSYGA (Fondo de Solidaridad y Garantía). It is a welfare trust attached to the Ministry of Health and Social Protection that centrally pools health funds for the General System for Social Security and Health (SGSSS) and transfers the funds to insurers for purchasing health services.

Approach

We developed a structured case protocol consisting of research questions that operationalize the system's history; architecture; key relationships to providers, government, and insurers; and risks.¹ We collected data from official documents and academic literature, informant interviews, and key country and health context indicators. Team members analyzed the data and wrote the case studies according to a standardized outline. The cross-case analysis describes differences and similarities in the design of broad governance features across the cases to derive the report's conclusions and final discussion.

¹ See Appendix 1 for a complete list of the questions in the protocol.

Section 2: Case Studies

Brazil: Sistema Único de Saúde (SUS)

Introduction

Brazil is an upper-middle-income country in South America with a population of 200 million. Brazil's federated government is headed by a president who serves a four-year term. The country's Gini coefficient was 53.1 in 2011, and the percent of GDP spent on healthcare was 9.7 in 2013. With respect to these measures, Brazil closely compares to South Africa, whose Gini coefficient was 65 in 2011 and percent of GDP spent on healthcare was 8.9 in 2013 (World Bank, World Development Indicators). However, total health expenditure per capita in Brazil was US\$1452 PPP in 2013, compared to US\$1121 PPP in South Africa.

We selected Brazil for this report to illustrate how a highly decentralized, multi-payer public healthcare system is governed. In Brazil, the federal Ministry of Health (MS), 26 state health entities (and the Federal District of Brasilia), and approximately 5560 municipal health entities manage and administer the public healthcare system. This public healthcare system, formally known as Sistema Único de Saúde (Unified Health System, SUS) provides a comprehensive benefits package that is free for users at the point of service. The SUS also includes some important provisions for political and civil accountability through civil society and healthcare provider participation in health planning and financing within the National, State, and Municipal Health Councils and the Bipartite and Tripartite Commissions. The case study on Brazil may offer South

How is Brazil's decentralized Unified Health System (SUS) managed?

The Unified and Decentralized Health Systems Act, passed in 1988, empowered state and municipal health entities to carry out financing and policymaking functions that previously were centralized under the Ministry of Health to allow local governments to be more responsive to local health needs.

This health system is unique among our case studies and offers some salient points for South Africa on coordinating planning, pooling, and purchasing between the federal government and numerous subnational agencies.

1. What does it mean for SUS financing and management?

Laws 8080/90 and 8142/90 established cost-sharing mechanisms across the federal, state, and municipal governments to take joint responsibility in the financing of the SUS. While the exact percentages vary from year to year, about 45 percent of SUS financing comes from the Federal Ministry of Health, and 27 and 28 percent come from the state and municipal health entities, respectively.

The Federal Ministry of Health, and state and municipal health entities are responsible for healthcare delivery. They may own and operate health facilities, and additionally contract with private healthcare providers to deliver health services.

These different levels of government are also actively involved with healthcare policy and planning. The Federal Ministry of Health, state and municipal health entities, and civil society are all given input into shaping policy and health programs through collective representation on national and state-level health councils and commissions.

2. What are the consequences of this model?

Joint financing and coordination on policy between the federal, state, and municipal health entities ensures comprehensive representation and mutual accountability in the decision-making process. Civil society is assured a forum in which to discuss the population's needs and implement important health actions. However, the complex bureaucratic processes involved often lead to harmful delays in developing new policies and implementing new programs, and may in fact reduce the responsiveness of local health entities to local health needs.

Sources: Gagnolati et al 2013; La Forgia and Couttolenc 2008

SUS at a Glance

Purchaser: Ministry of Health, State Health Secretariats, and Municipal Health Secretariats

Fund: National Health Fund, State Health Funds, and Municipal Health Funds

Function: The SUS is mandated to follow principles of universality, equity, public financing, decentralization, popular participation, and integrated service provision, and to provide a comprehensive benefits package that is free at the point of service.

Type: Multi-payer

Population insured: Effectively 100 percent; 200 million people

Size: Not available

Budget: Approx. US\$96 billion in government health expenditures in 2012 (World Bank, World Development Indicators)

Finance: Financed through taxation revenues and social contributions at the federal, state, and municipal levels.

Mission: The identification and dissemination of constraints to, and determinants of, health; Health policy formulation designed to promote, in the economic and social fields, compliance with the provisions that “[t]he state’s duty to ensure health is the formulation and implementation of economic and social policies aimed at reducing risk of disease and other health problems and in establishing conditions that ensure universal and equal access to programs and services for its promotion, protection and recovery.”; Care for people through promotion, protection, and recovery of health, with the integrated implementation of healthcare activities and preventive activities. (Translated from Lei n° 8.080, de 19 de setembro de 1990)

Africa some ideas about coordinating health planning and management among public agencies at multiple jurisdictional levels.

The SUS, a tax-financed national health system, was established in 1988 by Laws 8080 and 8142. The percentage of the population covered by health insurance increased from 48 percent in 1988 to 100 percent after its introduction. The reformed health system improved the government’s capacity to deliver services by increasing spending on public healthcare services, decreasing regional disparities in access by decentralizing the planning and purchasing functions to states and municipalities, and strengthening primary healthcare services through an expansion of the Family Health Strategy (Gagnolati et al 2013; Macinko and Lima-Costa 2012).

Since the reform, under-five mortality rates declined from 47 deaths per 1,000 births in 1995 to 14 deaths per 1,000 births in 2013. Out-of-pocket spending as a proportion of total health expenditure decreased from 38.7 percent in 1995 to 30.0 percent in 2013 (World Bank, World Development Indicators). At the same time, government expenditures on health per capita rose from 2.9 percent of GDP to 4.7 percent of GDP between 1995 and 2013 (World Bank, World Development Indicators).

Approximately 25 percent of Brazilians also purchase private insurance in a parallel market for health services. Private insurance holders are eligible to receive services in the universal SUS system, and often do obtain expensive treatments through the SUS because private insurers may restrict their usage of expensive services (Expert Interview

Brazil 2014). This issue raises an important regulatory question regarding whether the SUS should be responsible for financing services for privately insured patients who use SUS facilities. The relationship between the parallel public and private health insurance thus may be of particular interest to South Africa.

Public Agencies Responsible for Managing Health Funds and Purchasing Services

History

Before 1988, under the military regime, social security and medical coverage in Brazil was restricted to formal sector workers (Elias and Cohn 2003). Social Security institutions such as the National Institute for Social Medical Assistance (Instituto Nacional de Assistência Médica da Previdência Social, INAMPS) contracted with private providers to offer medical coverage to these workers, and, consequently, covered about 48 percent of the population. Unemployed, poor, or informal sector workers received care from philanthropic organizations or state-subsidized facilities (Filho and Scorzafave 2009; Elias and Cohn 2003).

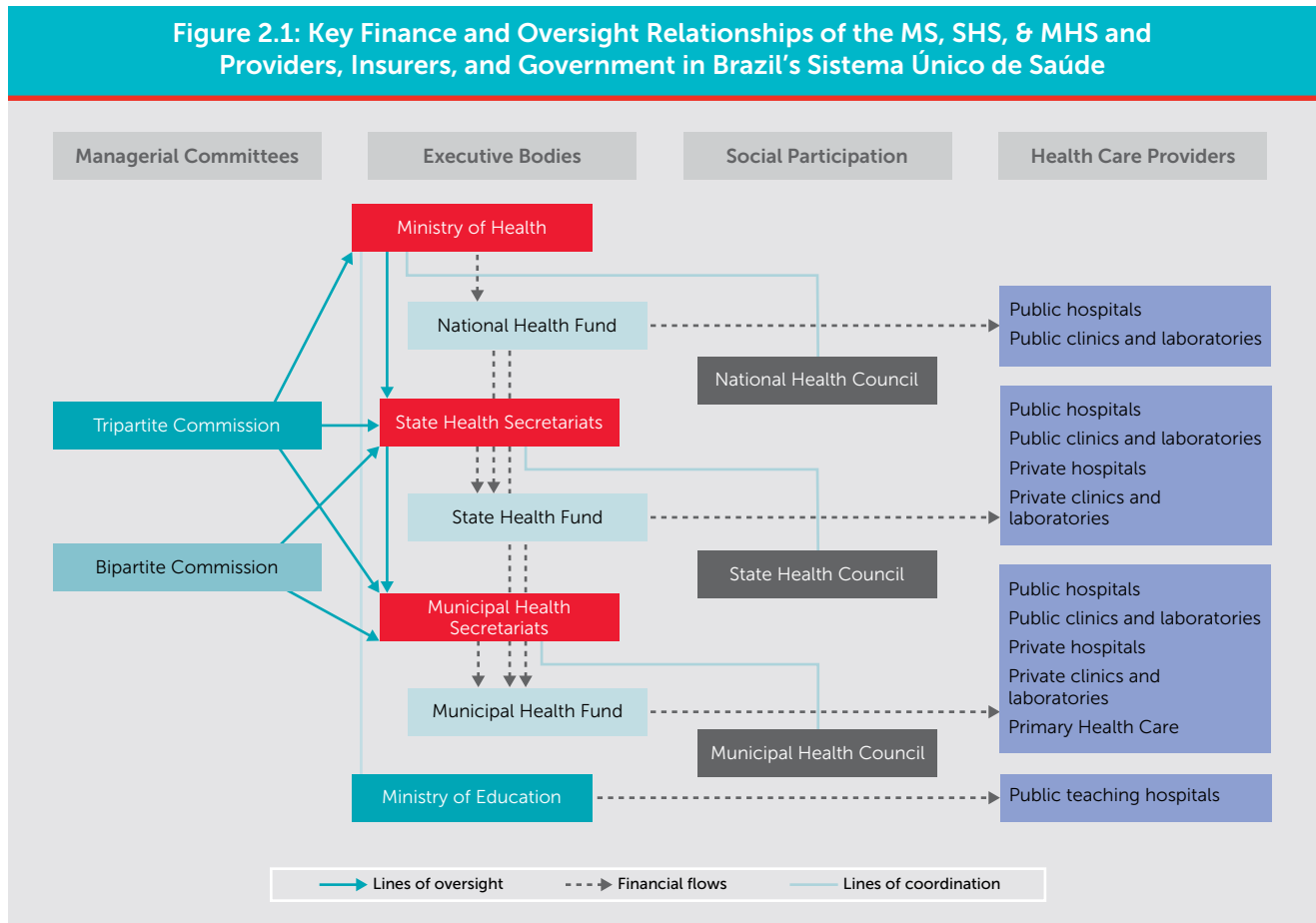
The move to universalize healthcare was a priority of the democratically elected government that took power after the military regime. A new constitution introduced in 1988 proclaimed healthcare as a “right of all and a

duty of the State” (Republica Federativa de Brasil 1988). The 1988 Unified and Decentralized Health Systems Act created the SUS and decentralized health service delivery from the Ministry of Health and INAMPS to state and municipal levels. The SUS, thus, is a national system in which states and municipalities are given formal autonomy over healthcare within the national policy and regulatory framework (Elias and Cohn 2003; Gragnolati et al 2013). The SUS is mandated to follow principles of universality, equity, public financing, decentralization, popular participation, and integrated service provision, and to provide a comprehensive benefits package that is free at the point of service. Brazilian citizens and those living and working in Brazil are eligible for SUS coverage and are not required to qualify or register for the system.

The Federal Ministry of Health (MS) is responsible for the national management of the SUS and controls financial transfers both to providers at federal health facilities and to State and Municipal Health Secretariats. It also formulates and monitors national policies and actions, and defines reimbursement rates for providers. The MS accredits State and Municipal Health Secretariats to provide services at different levels of system responsibility depending on their capacities and competencies (Expert Interview Brazil 2014). In theory, healthcare delivery should be decentralized to the level of the Municipal Health Secretariats (MHS). However, most municipalities are too small to achieve the required technical and financial capacities to offer medium- and high-complexity care, and State Health Secretariats (SHS) must fill the resultant gaps (La Forgia and Couttolenc 2008). The Operational Health Regulations NOAS 01/01 define the accreditation standards for municipalities. Depending on their abilities to meet and document between fourteen and twenty accreditation requirements, municipalities can qualify for full management of primary care services, partial management of the municipal health system (including responsibility for all health units and services), or full management of the municipal health system (World Bank 2007). Apart from the above actors, the Ministry of Education owns and operates a small number of teaching hospitals at the federal level.

System Reporting and Oversight Architecture Description

The figure below highlights the key agencies involved in administering the SUS, as well as the main finance and oversight relationships between government bodies, management committees, healthcare users, and healthcare providers. These relationships are discussed in the sections below.



Source: Authors, adapted from information in World Bank, 2006 and expert interviews.

At the state level, State Health Secretariats (SHS) formulate plans and policies for health (which reflect national plans but include local priorities) and implement the state health plan. Each SHS supports the Municipal Health Secretariats (MHS) and Municipal Health Councils within the state, in conjunction with the State Health Council (which brings civil society participants to health planning, as explained in a later section). In states in which decentralization has not been implemented fully, SHS utilize funds from the pool for hospital care and disease prevention activities, and sometimes operate networks of outpatient clinics.

The MHS are responsible for healthcare delivery and have control over primary healthcare facilities and providers, and where possible, municipal hospitals (Couttolenc and Dmytraczenko 2013). The MHS implement national policies and plans under national and state coordination and support.

The National, State, and Municipal Health Councils operating under the MS, SHS, and MHS encourage civil society participation in policymaking and budget monitoring at their respective levels. The National Health Council (CNS) is made up of forty-eight institutions representing government agencies, SUS entities, and civil society organizations. About half of the members of the CNS are civil society organizations representing SUS users, health professionals, and various social movements. Civil society organizations are similarly afforded input into health policy and planning through the twenty-six State Health Councils and approximately 5,560 Municipal Health Councils.

Finally, the MS, SHS, and MHS approve health policies and programs, set budgets for SUS service coverage, and develop health service reimbursement rates collaboratively through the Tripartite and Bipartite Commissions. Representation from all levels of government is mandated in these Commissions to ensure that health plans are developed and implemented in a cooperative manner. Within each state, officials from the State Health Secretariat and the various MHS are represented on the Bipartite Commission. At the national level, the Tripartite Commission similarly hosts officials from the MS and representatives from national associations of the collective SHS and MHS. The national, state, and municipal health councils also are represented in the Bipartite and Tripartite Commissions and may forward recommendations on behalf of the communities they serve.

Brazil currently does not have a national system, either public or private, for technology assessment or a national plan for the adoption of treatment protocols and guidelines, although it has produced broad policies and guidelines. Some health technology assessment functions are carried out by ANVISA, an autonomous body of five members that serves as the national health surveillance agency. Linked to the MS by a management contract,

ANVISA regulates the production and marketing of drugs, medical devices, and laboratory and hospital services that may affect the health of Brazilians. It coordinates the national health surveillance system; establishes standards for the production and distribution of health products and services; and proposes, monitors, and implements policies and activities in health surveillance (Cerqueira 2010). In addition, drug registration and surveillance is carried out with the support of the technical chamber of drugs (CATEME). CATEME is an advisory body composed of specialists who do not have ties to the pharmaceutical industry, and who are responsible for analyzing the registration process and formulating guidelines for the evaluation process of new drugs (PAHO 2008).

System Financing

The SUS is financed through revenues collected by the MS, SHS, and MHS at the federal, state, and municipal levels. Federal funding for the SUS is collected in a National Health Fund from several revenue sources, including general tax revenues, a tax on financial transactions, and an import tax. State and Municipal Health Secretariats receive a transfer from the National Health Fund, and manage State and Municipal Health Funds that consolidate transferred funds with their own contributions. States must contribute twelve percent of tax revenues from their jurisdictions; municipalities must contribute fifteen percent of tax revenues from their jurisdictions; and the Federal District must contribute twelve percent and fifteen percent from its district-level and thirty-one administrative regions, respectively, to pool funds at the relevant level of government (World Bank 2007; Gragnolati et al 2013).

The federal government contributes the value utilized by the SHS or MHS in the last year, plus any nominal variation to keep up with inflation and changes in GDP. During the early years of the SUS, federal financing accounted for eighty-five percent of total government spending on health. However, since then, the federal share of financing has declined steadily as state and municipal budgets have increased. In 2010, the federal share of financing accounted for forty-five percent of health spending, while state and municipal spending accounted for twenty-seven and twenty-eight percent, respectively (Gragnolati et al 2013).

The 1988 reforms devolved a large number of purchasing functions to the municipal or state level. Federal funds are increasingly transferred to state and municipal health secretariats rather than directly to individual hospitals. The MS makes block transfers to SHS/MHS for basic care, medium- and high-complexity care, health surveillance, and pharmaceuticals based on a global value per capita or the value based on production or coverage (World Bank 2006; World Bank 2007). SHS and MHS can reallocate resources to activities and interventions within each block, but not across blocks, and convert these transfers to

line-item budgets or prospective global budget allocations for public hospitals at the subnational level. The MS also transfers targeted bundles of funds to the SHS and MHS for specialized and high-complexity care provided at private facilities using a formula similar to diagnosis-related groups (World Bank 2006; World Bank 2007). The SHS and/or MHS then oversee contracts and purchasing for public and private hospitals, outpatient units, and primary healthcare.

Information Technology

Information Technology (IT) is a core function of the MS. Within the MS, the SUS Department of Information Technology (DATASUS) and the Information System on Public Health Budgets (SIOPS) are the two main IT systems supporting the SUS, with each handling different responsibilities. DATASUS manages the national health information system. It is a federal-level government agency staffed with approximately fifty people and housed within the MS's Secretariat of Strategic and Participative Management. The MS Executive Secretariat coordinates and oversees the activities of DATASUS, including its branch operations in every state. DATASUS collects information on demographic and health indicators, health system usage, and service delivery information from municipalities and states. DATASUS then analyzes and disseminates this information to help government agencies with their planning and budgeting. SIOPS is the overarching public health budget information system that collects, processes, and organizes data on total revenues and public health expenditures in order to monitor the

utilization of resources by federal, state, and municipal health authorities (PAHO 2008). The MS Executive Secretariat supervises the management of SIOPS.

Agencies' Relationship to Health Providers

Health Providers

Brazil's mix of providers includes public hospitals and health facilities owned and operated by the MS, SHS, and MHS, as well as private healthcare providers. Approximately two-thirds of all health providers in Brazil are private. In 2013, about 67 percent of Brazil's 6875 hospitals were private, 23 percent were municipal, 8 percent were state-owned, and 2 percent were federally-owned by the MS or the Ministry of Education (CNS 2013). The private sector accounts for the vast majority of hospital beds, but the public sector's share has risen from 22 percent in 1988 to 35 percent in 2013 (Graganolati et al 2013). About 70 percent of all hospital beds are contracted under the SUS, while private insurers command the other 30 percent (CNS 2013). The MS, SHS, and MHS also own and operate about 30 percent (70,000) of all primary care, laboratory, and outpatient facilities; municipalities own the overwhelming majority (66,000) of these facilities. Private providers operate another 180,000 laboratory, outpatient, and primary care facilities (CNS 2013).

Brazil's Primary Care Strategy: The Family Health Strategy

The Brazilian government places great emphasis on primary care and has developed targeted access to primary care through the Family Health Strategy (FHS). This strategy establishes a team of health professionals (usually 6 to 10 professionals, including a family health physician, nurse, nursing assistant, community health workers, and maybe a dentist) at a health center who are responsible for a defined population of 1,000 households (or approximately 4,000 people). The primary health team is responsible for first contact comprehensive care and provides referrals to patients for more complex procedures. The team also maintains outreach activities by conducting regular home visits (Couttolenc and Dmytraczenko 2013).

The FHS is financed through federal transfers from the MS to municipalities. The amounts of the transfers are calculated by the MS on the basis of a per-capita fixed amount plus a variable amount that incentivizes expansion activities. The FHS has successfully provided access to and encouraged the use of health services by poor and vulnerable populations by targeting less urban and poorer municipalities, and by expanding in the poorest regions of larger municipalities. The FHS now serves approximately 100 million people in 85 percent of Brazilian municipalities (Couttolenc and Dmytraczenko 2013).

The MS employs a number of mechanisms that contribute to the success of the FHS. First, the MS allows municipalities that implement the program to contract with private management and providers to offer services. Contracting privately alleviates the human-resource constraints that municipalities would face if they had to comply with the complex measures required to expand the civil servant payroll. Second, following from this, the MS, municipalities, and providers sign explicit agreements that identify the roles and responsibilities of all actors, as well as performance indicators and targets. Municipalities continuously monitor these performance indicators and make the results available to the public to hold the health centers accountable. Third, municipalities may receive incentive payments from the MS to expand coverage and services in poorer and more rural areas (Couttolenc and Dmytraczenko 2013).

The SUS generally arranges its contracts to pay public and private facilities through passive *convenios* (World Bank 2007). *Convenios* generally do not specify the functions that the facility must carry out, define outputs, or indicate performance targets in return for funding, but are simply instruments to distribute the budget to private or teaching hospitals linked to the public system. The *convenio* is not used to ensure the accountability, quality, or efficiency of hospital services (La Forgia and Couttolenc 2008). However, the government has tested a number of new, more robust contracting mechanisms with both public and private facilities. For example, a number of public hospitals under autonomous administration now operate under performance-based contracting and financing. These contracts require that public hospitals report on metrics related to the quality, volume, and cost of services they provide, with penalties for not meeting specified service requirements. (La Forgia and Couttolenc 2008).

Provider Accreditation

The SUS does not mandate that providers be accredited to participate in the healthcare network, nor is it a policy priority. Only a small proportion (estimated at less than five percent) of health service providers in Brazil are currently accredited (Paim et al 2011; Gragnolati et al 2013). Still, numerous accreditation systems are in place, such as the National Accreditation Organization, a hospital quality assurance initiative sponsored by the Medical Association of São Paulo, and the Brazilian accreditation initiative supported by the U.S. Joint Commission on Accreditation of Healthcare Organizations (Gragnolati et al 2013). More generally, the MS sets licensing requirements for hospitals that establish minimum quality standards with which a facility must comply to qualify for public funding. However, these requirements are not applied or enforced in many hospitals (La Forgia and Couttolenc 2008).

Payment Mechanisms

The SUS utilizes a number of different mechanisms to pay healthcare providers. Federal hospitals (owned by the MS) and a large percentage of other public hospitals run by SHS or MHS are funded through line-item budget allocations at the level of government at which they are managed. The hospitals have little flexibility to reallocate resources, as the government directly controls their budgets. Budgets are based on the previous years' allocations, adjusted for inflation and/or new programs (La Forgia and Couttolenc 2008). This mechanism of payment is unlinked to performance, which results in SHS/MHS having few incentives to implement or enforce performance metrics into hospital contracts.

Some state and municipal hospitals are paid through a 'prospective global budget' allocation. Hospitals are paid a negotiated global payment allocated monthly or quarterly, contingent on the achievement of specified performance targets for service volume, quality, and others. A hospital's failure to achieve these targets puts a proportion of its budget at risk. Prospective global budget payment allows hospital administrators to have more flexibility over the utilization of funds compared to line-item budget payments.

Public physicians and healthcare workers are paid a fixed salary, allocated at the state and municipal levels, through financial transfers from the MS (La Forgia and Couttolenc 2008).

The SHS and MHS pay for inpatient care at private facilities through the Authorization for Hospitalization (AIH) program, which is similar to a Diagnosis-Related Group (DRG) payment mechanism. AIH payment rates are based on the treatment classification, rather than the diagnosis classification used in DRG schemes. The classification for AIH payments includes about 2,300 medical procedures, grouped in 524 procedure groups and medical specialties. The fees for hospital services (e.g., room and board, operating room fees), drugs and supplies, diagnostic tests and therapeutic procedures, and physician fees are calculated separately. Physician fees are paid directly to the physician, while other fees are paid to the hospital. The MS only plays an indirect role in paying for the AIH through financial transfers to SHS and MHS.

Outpatient or ambulatory care in the private sector is financed similarly through a fee-for-service mechanism known as the Ambulatory Care Information System (SIA). Much like the AIH system, the payments are handled by SHS/MHS and are co-financed by the MS through financial transfers to the SHS/MHS (World Bank 2007; La Forgia and Couttolenc 2008).

MHS make payments to providers serving within the FHS system. MHS receive federal transfers for this purpose, which are determined as a monthly capitation per enrollee plus a variable amount that may finance program expansion activities (Couttolenc and Dmytraczenko 2013).

Private providers generally send claims to the MHS/SHS, according to the level of government at which they are contracted. Auditing units within MHS/SHS conduct a systematic review of claims to check for fraudulent behavior; these units are also in charge of authorizing the use of expensive supplies and high-technology procedures under the SUS. MHS/SHS submit claims to a federal database that is available online through the website of the MS (La Forgia and Couttolenc 2008).

Table 2.1: Provider Payment Mechanisms Utilized in the SUS

Payment Mechanism	Provider	Payer
Line-item budget	Federal hospitals, most state- and municipal-level public hospitals	MS, SHS, MHS
Prospective global budget	Some state- and municipal-level public hospitals	SHS, MHS
Diagnosis-Related Groups	Inpatient care at private hospitals	SHS, MHS
Fee-for-service	Outpatient and ambulatory care at private hospitals; physicians at private hospitals	SHS, MHS
Salary	Physicians at public hospitals	MS, SHS, MHS
Capitation + Incentives	Primary Health Teams under FHS	MHS through federal transfers

Purchasing Agencies' Relationship to Other Government Agencies

In Brazil, the MS at the federal level and the SHS and MHS at state and municipal levels share both financing and purchasing responsibilities. Each level manages a health fund, which consolidates resources from taxation revenues and other government levels. Each level also manages purchasing from various numbers and types of health facilities.

The MS develops the national health policy strategy every four years, which the National Congress approves (PAHO 2008). States and municipalities draw up their own health plans annually, which the appropriate health councils approve. These plans reflect national plans as well as local priorities, as long as the latter do not contradict the national policies set out by the MS (Expert Interview Brazil 2014).

Federal Government

The MS steers the national health system. Within the MS, the Executive Secretariat (SE) supervises and coordinates the activities of five secretariats, including planning and budgeting for federal healthcare, accounting and financial administration, health surveillance and information resources, human resources, and general services (PAHO 2008). The SE also monitors public health expenditures through the Public Health Budget Information System (SIOPS) and the National Health Fund. Moreover, the SE assists states and municipalities with defining and implementing programs (PAHO 2008).

The judicial courts play an additional role in defining the healthcare services available to Brazilians. The Constitution mandates universal coverage of all medically necessary services. Accordingly, the SUS benefits plan is very broad. Many of the benefits conferred by the SUS are implicit and unspecified (Gragnotati et al 2013; World Bank 2007). However, the MS defines a number of services for reimbursement in its published fee schedule; any services that are not included in this list are technically ineligible for reimbursement. This has prompted patients and providers to initiate a number of legal cases against the SUS seeking coverage for rare, expensive, or newly developed treatments. Patients may also bring cases seeking coverage for services that are unavailable in Brazil but have been tested and approved elsewhere. This litigation has prompted the MS to open dialogue with the courts to ensure that judges consider the technical and cost implications of new technologies when ruling on a claim for coverage.

Local Government

The approximately 5560 MHS in Brazil are represented in the National Council of Municipal Health Secretariats (known as CONASEMS), and the 26 SHS are represented in the National Council of State Health Secretariats (known as CONASS). These national councils are corporate private, non-profit organizations responsible for advancing the interests of the SHS and MHS through the Bipartite and Tripartite Commissions.

Within each state there is a State Council of Municipal Health Secretariats (COSEMS) that represents the interests of the MHS within the state and on the respective Bipartite Commission.

Other National, Subnational, and Local Planning Agencies

The Tripartite Commission and Bipartite Commissions are the main forums for the MS, SHS, and MHS to jointly develop health plans, as well as negotiate, approve, or amend policies (Miranda 2007; La Forgia and Couttolenc 2008).

At the state level, the SHS elects delegates to the Bipartite Commission, one of whom will preside over the meetings of the commission, and the State Council of Municipal Health Secretariats (COSEMS) elects an equal number to sit on the Bipartite Commission. This Bipartite Commission must approve municipal and state level plans before they are implemented, and some plans may be further passed up to the national Tripartite Commission for discussion and approval.

The Tripartite Commission coordinates federal health plans, with approval from the various state-level Bipartite Commissions. The MS elects top-level officials to the Tripartite Commission, while the CONASS and CONASEMS elect members to represent the SHS and MHS within the Tripartite Commission. A member from the MS presides over the meetings of the Tripartite Commission (Miranda 2007; La Forgia and Couttolenc 2008; Expert Interview Brazil 2014).

National, State, and Municipal Health Councils serve as public accountability bodies and include representatives from both the government and civil society organizations. These councils are involved in shaping health policies and proposals, inspecting public health accounts and determining where resources should be spent for health, and demanding accountability where needed. Half of the members of each council are civil servants from the MS, SHS, and MHS, while the other half are civil society delegates. Of the civil society delegates, approximately half are health professionals (both public and private). This limits the role of patients and civil society representatives on these councils, which, in some cases, allows for councils to be controlled by the health secretariat (Expert Interview Brazil 2014).

Agencies' Relationship to Other Public and Private Insurers

Insurers

Approximately sixty percent of health expenditures in Brazil are made in the private sector, whether through private insurance or out-of-pocket expenses (Gragnotati et al 2013). The Brazilian government both directly and indirectly subsidizes private spending by families and companies on private healthcare plans, insurance policies, and drug purchases (Paim et al. 2011). Private insurance accounts for twenty-five percent of total health spending, and is mainly purchased by private sector employers (Gragnotati et al 2013). Approximately twenty-five percent of the population chooses to purchase private insurance. This subset of the population generally is younger and has a lower health risk profile and greater purchasing power than the general population (PAHO 2008).

Private insurers purchase services from private providers according to a fee-for-service (FFS) schedule developed by the Brazilian Medical Association (AMB), the national association of physicians in Brazil. In some cases, large public referral facilities may maintain contractual relationships with private health insurers and derive revenues through the FFS payment schedule.

The private insurance system offers services that are also offered within the SUS. However, private insurance is more valuable and more desirable than SUS because of general perceptions that the SUS provides a lower quality of services and patients encounter longer wait times (Expert Interview Brazil, 2014; Gragnolati et al, 2013). Thus, the private insurance market generally caters to the wealthier segments of the population.

Private insurance holders are eligible to receive services in the SUS system if they wish to do so, and often do avail themselves of basic health services as well as high-cost services through the SUS. This is because private insurers may limit access to high-cost treatments while the SUS must provide them for free.

This raises difficult regulatory issues concerning reimbursement between the public and private systems. For example, the SUS can charge insurance companies for services that are delivered to private insurance holders in SUS facilities. The SUS can demand this reimbursement for privately insured individuals even if the private insurance does not cover the provided services, and even though all services are technically covered by the SUS for all citizens and residents (La Forgia and Couttolenc 2008; Gragnolati et al 2013). Rather than use reliable cost information,

private insurers and the SUS negotiate the fee schedule rates that private insurers must pay to reimburse SUS facilities for the cost of treating privately insured patients. These rates are much higher than the AIH payment schedule for private hospitals contracted under the SUS. While many private insurers reimburse the SUS, others have filed cases with the Supreme Court to contest these charges on the grounds that they are unconstitutional (Expert Interview Brazil 2014).

Private insurers are supervised and regulated by the National Supplementary Health Agency (ANS), an independent agency that contracts with the MS. Even so, there is no joint planning or coordination between the public and private systems of care. The ANS monitors private insurance plans' compliance with national legislation that sets minimum criteria for the supply of services, restrictions on stated eligibility criteria and grounds for discontinuing care, and regulations on the amount of premiums charged. The ANS also monitors trends in private plan costs and providers, authorizes corporate mergers and acquisitions, and exchanges information with consumer protection organizations (PAHO 2008; Gragnolati et al 2013).

Key Risks and How They Have Been Addressed

The Implicit Benefits Package and Implications for Financial Sustainability

The SUS reforms established an implicit benefits package with a very generous view of social needs and rights. However, current funding levels are insufficient to meet that expectation, and a growing number of cases petitioning for the coverage of specialized, expensive procedures burden the judicial system and threaten the financial sustainability of SUS (Gragnolati et al 2013; Expert Interview Brazil 2014). Brazil's demographic and epidemiological transitions may further threaten the SUS's financial sustainability, as the demand for chronic disease care increases (Castro 2014).

The MS does not have the authority to limit the benefits package covered under the SUS. It has been able only to exercise limited policy and fiscal options, such as controlling payment schedules, to address rising costs. This has created new systemic issues, discussed below.

Low Reimbursement Rates and Weak Incentives for Private Hospitals

The MS has maintained an outdated, low reimbursement schedule for private hospitals, which has affected the credibility of purchasing agencies under the SUS and their ability to motivate private providers to participate. As they stand, the AIH and FFS reimbursement schedules pay very well for complex care but inadequately for simple procedures. This creates perverse incentives for providers to oversupply complex care. The low payment levels also have driven several private hospitals to lobby states and municipalities for ad hoc bailout payments (La Forgia and Couttolenc 2008; Expert Interview Brazil 2014). Overall, problems related to payment mechanisms and levels discourage private providers, the majority share of providers within the SUS, from wanting to continue operating within the SUS.

The MS also has set volume or financial ceilings on the number of admissions or procedures paid by the SUS in each state or municipality. This strategy could be valuable if executed in a systematic way, but currently the caps are based mostly on historical supply trends, not actual population needs, and, therefore, create and maintain imbalances across geographic areas and socioeconomic groups (La Forgia and Couttolenc 2008; Expert Interview Brazil 2014).

Complex Systems of Governance Coordination

Brazil has established many institutional mechanisms to encourage coordinated planning across municipalities, states, and the federal government, to encourage democratic policymaking, streamlined service delivery, and stronger patient referral systems and medical supply and service management. However, the mandated coordination via Federal, State, and Municipal Health Councils as well as the Bipartite and Tripartite Commissions can often lead to confusion and delays in implementing important programs and reforms (Expert Interview Brazil 2014; World Bank 2007). As such, local health agencies are hindered in their abilities to remain responsive to the needs of the local population.

Discussion and Case Conclusion

Brazil's SUS, a sweeping reform created in 1988 and constructed on the principles of equity and accessibility, expanded healthcare coverage from formal sector workers to all citizens and residents of Brazil. The SUS is not a national health insurance program but rather a national health system financed by general tax revenues that guarantees services for all. The SUS is unique among the cases in this report in that the federal MS and its state- and municipal-level counterparts, the SHS and MHS, all have similar and joint roles in planning, financing, and purchasing health services. The CONASEMS and CONASS—national associations of MHS and SHS, respectively—as well as the Bipartite and Tripartite Commissions determine plans and policies for health at each level. Civil society participation in health planning and financing is encouraged through National, State, and Municipal Health Councils. Each level of the government manages a health fund, which pools tax revenues from the jurisdiction and receives transfers from the health funds at the level(s) above. The MS, SHS, and MHS may own and manage public health providers as well as contract with private providers to provide healthcare services. The MS, SHS, and MHS generally pay providers through budget allocations, DRGs, and FFS mechanisms.

The following lessons that we gleaned from the case on the governance of the SUS are most relevant for South Africa as it determines the design and governance of the NHIF:

- Having an implicit benefits package is creating financial problems for the SUS. Many Brazilian experts have concluded that the SUS should explicitly define a realistic benefit package. In defining its own benefits package, South Africa may want to consider the limitations that an implicit benefits package places on the purchaser's power to control costs. The implicit benefits package in Brazil allows beneficiaries to receive high-cost and resource-intensive treatments and services, depleting the funding and resource pool for other beneficiaries (Gragnotati et al 2013). Purchasers cannot limit the services for which providers claim reimbursements, but only can place caps on payment rates or service volumes. The constitutional guarantee also ties up the judicial system in a stream of complicated cases. Experts in Brazil recommend that emerging health insurance funds be realistic about what can be accomplished in the short term, keeping in mind a clear vision and design for the long term (Expert Interview Brazil 2014). South Africa may initially provide

a smaller benefits package that may be expanded with time as the government evaluates its capacity and potential to offer a wider array of benefits. The private insurance sector may be included in the health service model as a provider of complementary services, or as a top-up system for health services that are not available in the public health system.

- To determine the role of subnational agencies in managing the health system, the MS accredits State and Municipal Health Secretariats as qualified to fully or partially manage the health system under their jurisdictions, according to a set of fourteen to twenty measures of capacity and competence. This ensures that each municipality assumes responsibility only for what it can manage, and the state assumes responsibility for services that the municipality lacks the capacity to manage. South Africa may benefit from defining a similar set of competencies to delegate to District Health Authorities to fully or partially manage the provision of health services. This selective delegation may enhance the effectiveness of local health authorities without overburdening them.
- South Africa may benefit from incorporating some of the provisions for civil society participation that Brazil has succeeded at implementing within the SUS. Half of the members of National, State, and Municipal Health Councils are elected civil society representatives from the healthcare service industry, NGOs, academia, and users of the SUS. By participating in public forums and conferences, the representatives articulate the population's needs and expectations, and provide a user's perspective in identifying and addressing problems.
- Another SUS design feature that may be interesting to South Africa is the primary care outreach strategy that is targeted at neglected populations. The FHS has advanced equity and access to poor and vulnerable populations by providing a clear strategy that is coupled with incentives for municipalities and providers. By directing primary health centers to poorer regions and providing extra payments as incentives to expand health centers and services, Brazil has managed to improve access to primary care from fifty percent to eighty-five percent of municipalities in fifteen years (Couttolenc and Dmytraczenko 2013). The government has made clear its priorities in safeguarding access and quality by showing great flexibility in allowing municipalities to contract with providers on a FFS basis and requiring regular performance monitoring. Such targeted programs could be useful in South Africa, which suffers from similar disparities in wealth and access to healthcare.

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Canada: Ontario Health Insurance Plan (OHIP)

Introduction

Canada is a high-income country in North America with a population of thirty-five million (2013) (World Bank, World Development Indicators). It is a democratic constitutional monarchy: the Prime Minister serves as the head of the parliamentary government, and the Queen, represented by the Governor General of Canada, functions as the head of state. With a Gini coefficient of 33.7 in 2010, Canada fares better in terms of inequality than the other cases in our report. In 2013, Canada spent approximately 11 percent of its GDP, about US\$5,718 (\$4,759 PPP) per capita, on health (World Bank, World Development Indicators). Although Canada's health and economic context differs significantly from South Africa's, its health system shares many similarities with the design of South Africa's proposed NHIF.

Canada's health system, known unofficially as 'Medicare,' is made up of a linked set of health plans administered at the provincial/territorial level. The current federal guidelines for Medicare are set out in the Canada Health Act of 1984. Almost thirty years after the Canada Health Act was introduced, the under-five mortality rate was at 5 deaths per 1,000 births in 2013 (down from 10 deaths per 1,000 births in 1984), while out-of-pocket spending as a percentage of total health spending has remained constant at 15 percent during that same time period (World Bank, World Development Indicators). Medicare covers all Canadian citizens and permanent residents; however, there is important variation in how Medicare is administered across the provinces. For example, while taxes levied at the federal and provincial/territorial levels pay for Medicare, three provinces – British Columbia, Alberta, and Ontario – levy additional health premiums on

How do Ontario's Local Health Integration Networks (LHINs) facilitate local planning and management of the Ontario Health Insurance Plan?

The roles and responsibilities of Ontario's LHINs display many parallels to South Africa's intended role for District Health Authorities (DHAs) under the proposed National Health Insurance Fund.

- LHINs are responsible for planning, coordinating, and managing local health providers.
- The Ministry of Health and Long-Term Care (MOHLTC) transfers funds to LHINs to contract and pay for services from private providers. LHINs do not have active purchasing responsibilities, but simply make budget transfers to providers.
- Collectively, the 14 LHINs in Ontario control about 40 percent, or US\$17.5 billion, of the total health budget.
- LHINs identify and contract with local private providers, including hospitals, long-term care homes, and community health centers.
- LHINs do not have contracting responsibility for physicians and ambulance and laboratory services, which are coordinated directly through the MOHLTC.

How are LHINs governed?

The MOHLTC signs a Memorandum of Understanding and an Accountability Agreement with each LHIN, which is overseen by an LHIN Liaison Branch at the provincial level. LHINs are crown corporations owned by the province but independently managed. Each LHIN has a Board of Directors that determines the strategic direction of the organization.

LHINs are active in developing the provincial plan for health and engaging with the local community on this and other health care issues.

Strengths: The 14 LHINs can identify and contract with providers independently, which enables them to be responsive to local health needs. They bring attention to these needs in developing the provincial health plans.

Weaknesses: The LHINs do not contract for physician, drug, or laboratory services, which makes integration and coordination of services across facilities challenging. LHINs and local hospitals have parallel management structures that may sometimes result in antagonistic policies.

Sources: Osborne Margo 2008; Born and Sullivan 2011; "Local Health System Integration Act, S.O. 2006".

MOHLTC at a Glance

Purchaser: Ontario Ministry of Health and Long-Term Care

Fund: Ontario Health Insurance Plan

Type: Single-payer

Population insured: 100 percent; 13.6 million people (Ontario Ministry of Finance 2014)

Size: Approximately 4000 employees at the MOHLTC and 30 at each LHIN, in 2011 (Born and Sullivan 2011).

Budget: US\$43 billion, including US\$10.5 billion from the Canada Health Transfer (2013-14) (Ontario Ministry of Finance 2013).

Finance: Financed by provincial tax revenues (83 percent), the Employer Health Tax (10.5 percent), and the Ontario Health Premium (6.5 percent) (Ontario Ministry of Finance 2013).

Mission: Champion health promotion in Ontario, and inspire individuals, organizations, communities, and governments to create a culture of health and wellbeing; Provide programs, services, tools, and incentives that will enhance health and wellbeing; Make healthy choices easier; Harness the energy and commitment of other ministries, other levels of government, community partners, the private sector, the media, and the public to promote health and wellbeing for all Ontarians; Make Ontario a leader in health promotion within Canada and internationally (Ministry of Health and Long-Term Care "About the Ministry")

their residents. Moreover, in some provinces Medicare also covers temporary foreign workers and foreign students, whereas in others it does not. Finally, while the Canada Health Act sets guidelines regarding the benefits package, insured services vary among provinces and territories.

Given this variation, we focus this case on the Ontario Health Insurance Plan (OHIP), which is administered by the Ontario Ministry of Health and Long-Term Care (MOHLTC). OHIP illustrates the decentralized administration of health insurance in Canada. Ontario is the most populous province, accounting for approximately forty percent of Canada's population (Ontario Ministry of Finance 2014). The household income per capita in 2014 was approximately US\$30,678, only slightly below the Canadian average (US\$30,882). Public health expenditures in Ontario were approximately US\$3,144 per capita in 2013-2014, which is much lower than the overall Canadian average of US\$4,019 (Ontario Ministry of Finance 2013; Ontario Ministry of Finance 2014).

The governance of Ontario's OHIP offers a successful example of many aspects of South Africa's proposed NHIF: a tax-financed, single-payer system that offers comprehensive health service benefits through contracts with private providers, with the option of private top-up insurance coverage, and decentralized planning and management. We describe in detail below the process and challenges of executing such a system.

Public Agency Responsible for Managing Health Funds and Purchasing Services

History and Overview of the Canada Health Act

The Hospital Insurance and Diagnostic Service Act (1957) and the Medical Care Act (1966) first established a publicly financed health insurance scheme in which Canada's federal government and provinces shared costs. By 1971, all Canadians had free access to hospitals and physicians for medically necessary services. In 1977, cost-sharing formulas were eliminated with the Established Programs Financing Act. This Act introduced federal transfers that were not tied to the costs of the provincial and territorial programs and allowed provinces more latitude over spending on health. As a result, many provinces reduced their health spending in favor of other programs and made up the deficit with extra-billing and out-of-pocket (OOP) charges (Brown 1980).

In Ontario, the level of extra-billing quickly ballooned to about thirty percent of the cost of services (Brown 1980). To address these rising consumer costs in Ontario and other provinces, the federal government replaced previous legislation with the Canada Health Act in 1984. The Canada Health Act established requirements that provinces/territories had to satisfy to receive federal funding, set pan-Canadian standards for hospital, diagnostic, and medical care services, and penalized extra billing and OOP charges for insured services (Canadian

Territorial Formula Financing for Equitable Care across Canada

The sparsely populated and less wealthy Canadian territories – Northwest Territories, Nunavut, and Yukon – receive Territorial Formula Financing in addition to the CHT as an annual unconditional transfer from the Government of Canada to safeguard the health needs of their populations. These funds enable the territories to fund essential health, education, and social services at a level comparable to those offered by provincial governments with larger revenue bases. Each territory's grant is based on the difference between its estimated territorial revenue base and expenditure needs (Department of Finance, 'Territorial Formula Financing').

Institute for Health Information 2005). The five principles of the Canada Health Act are as follows:

- **Administration:** All provincial health insurance must be administered by a public authority on a non-profit basis. The authority is accountable to the province or territory, and its records and accounts are subject to audits.
- **Comprehensiveness:** All necessary health services, including hospitals, physicians, and surgical dentists, must be insured.² Provinces must make every effort to regularly update services and technologies, as well as standards and guidelines, to meet the needs of the population.
- **Universality:** All Canadian citizens and permanent residents are entitled to public health insurance regardless of their ability to pay. Individual provinces and territories may define eligibility standards for other populations (e.g., foreign students).
- **Portability:** A resident who moves to a different province/territory (or leaves the country) is still entitled to coverage from his or her home province.
- **Accessibility:** Health services must be available to all Canadians, with every effort made to reduce financial or other barriers.

Since 2004, the federal contribution to each provincial/territorial health plan has come in the form of the Canada Health Transfer (CHT). Administered by the Federal Department of Finance, the CHT pools general tax revenue and redistributes it to the provinces and territories on an equal per capita basis. The CHT provided approximately US\$24.5 billion to provinces and territories in 2012-13 (Department of Finance, 'Federal Support to Provinces and Territories'). This reflects about eleven cents of every tax dollar received through federal income tax, sales tax, and other taxes levied at the federal level (Department of Finance, 'Your Tax Dollar: 2012-2013 Fiscal Year'). Currently, total CHT levels are set to grow at six percent until 2016-17. Starting in 2017-18, the CHT will grow in line with a three-year moving average of nominal GDP, with funding guaranteed to increase by at least three percent per year (Department of Finance, 'Canada Health Transfer'). The CHT makes up about twenty-one percent

of total provincial/territorial health spending (Levert 2013). Provinces finance the other seventy-nine percent through general tax revenues and health insurance contributions.

Overview of OHIP under the Ontario Ministry of Health and Long-Term Care

In Ontario, the Public Health Act of 1882 instituted the Provincial Board of Health of Ontario, the predecessor to the MOHLTC established in 1999. MOHLTC manages the Ontario Health Insurance Plan (OHIP), determines provincial plans and priorities for health, establishes provider payment schedules and mechanisms, and collects and disburses funds for health (Ministry of Health and Long-Term Care, 'About the Ministry'). OHIP covers all Canadian citizens, permanent residents, work permit holders, and those registered as First Nations or Inuit whose primary residence is in Ontario (that is, those who have spent at least 153 days over a 12-month period in Ontario).

Eligible beneficiaries may register for OHIP at a Service Ontario center, where they are issued a health card. Individuals found ineligible for OHIP may request that the OHIP Eligibility Review Committee, housed within the Negotiations and Accountability Management Division of the MOHLTC, review their case (Ontario Ministry of Health and Long-Term Care 2014). Additionally, if the MOHLTC denies any request for OHIP eligibility, payment for health services, or prior approval for out-of-country medical services, individuals may request a hearing before the provincial Health Services Appeal and Review Board (an independent, adjudicative tribunal appointed by the Lieutenant Governor and Cabinet and including healthcare providers, lawyers, social workers, and others) (Health Services Appeal and Review Board 2014).

The Canada Health Act regulates and MOHLTC defines the services that the OHIP guarantees. The federal government outlines the following basic package of services that OHIP must cover per the Canada Health Act:

- Hospital services that are medically necessary to maintain health, prevent disease, or diagnose and treat an injury, illness, or disability, including accommodation

² This point is explained in greater detail in the next section, titled 'Overview of OHIP under the Ontario Ministry of Health and Long-Term Care'.

and meals, physician and nursing services, drugs, and all medical and surgical equipment and supplies;

- Any medically required services rendered by medical practitioners;
- Any medically or dentally required surgical-dental procedures that can only be properly carried out in a hospital (Madore 2005; Health Canada 2013).

Beyond this, each province/territory may define the specific medical services that it will cover. For example, the OHIP covers inpatient pharmaceuticals but does not cover outpatient prescription drugs for residents unless they are over the age of 65, living in a Long-Term Care Home or enrolled in a Home Care program, or incurring high drug costs relative to their income (these groups may be covered under the supplementary Ontario Drug Benefit Program or Trillium Drug Program) (Ontario Ministry of Health and Long-Term Care 2014). The Federal Department of Health – Health Canada – oversees the provincial/territorial health plan to ensure that it abides by federal standards and the Canada Health Act.

System Financing

OHIP is funded by general tax revenues, including income and sales taxes, as well as specialized health taxes known as the Employer Health Tax and the Ontario Health Premium (Ontario Ministry of Finance 2013). In 2013-14, approximately 40 percent (US\$43 billion) of the US\$112 billion that Ontario spent on provincial programs was allocated to healthcare. This included US\$4.6 billion from the Employer Health Tax, a payroll tax paid by employers on wages paid to employees,³ and US\$2.8 billion from the Ontario Health Premium, an income-based tax paid by Ontario residents specifically earmarked for health services⁴ (Ontario Ministry of Finance 2013; Ministry of Finance, 'Employer Health Tax'; Ministry of Finance, 'Ontario Health Premium'). The budget also included US\$10.5 billion (approximately 24.5 percent of the healthcare budget) from the federal government as part of the Canada Health Transfer (Ontario Ministry of Finance 2013).

System Reporting and Oversight Architecture Description

Figure 2.2 (next page) highlights the key agencies involved in administering the OHIP, as well as the key finance and oversight relationships that the MOHLTC has with the government, independent agencies, and healthcare

providers. We discuss these relationships in the sections below.

The federal government collects and allocates general revenues for health, enforces the Canada Health Act, and sets pan-Canadian standards for health service coverage, food and drug safety, and price regulation for branded drugs (Marchildon 2013). The Department of Finance determines the annual Canada Health Transfer and Territorial Formula Financing Transfer. Health Canada ensures that the Ontario MOHLTC adheres to the regulations set out in the Canada Health Act (Marchildon 2013; Health Canada 2013).

A general manager within the MOHLTC administers the OHIP and determines and verifies beneficiaries' eligibility ('Health Insurance Act' 1990). The general manager of the OHIP is the Associate Deputy Minister for Delivery and Implementation within the MOHLTC (circled in Annex 1). The general manager directly manages the 'Health Systems Accountability and Performance' and 'Negotiations and Accountability Management' branches of the MOHLTC. Other OHIP-related branches of the MOHLTC, such as the Claims Services Branch, are not directly under the general manager's control but do coordinate with him or her (see Annex 1).

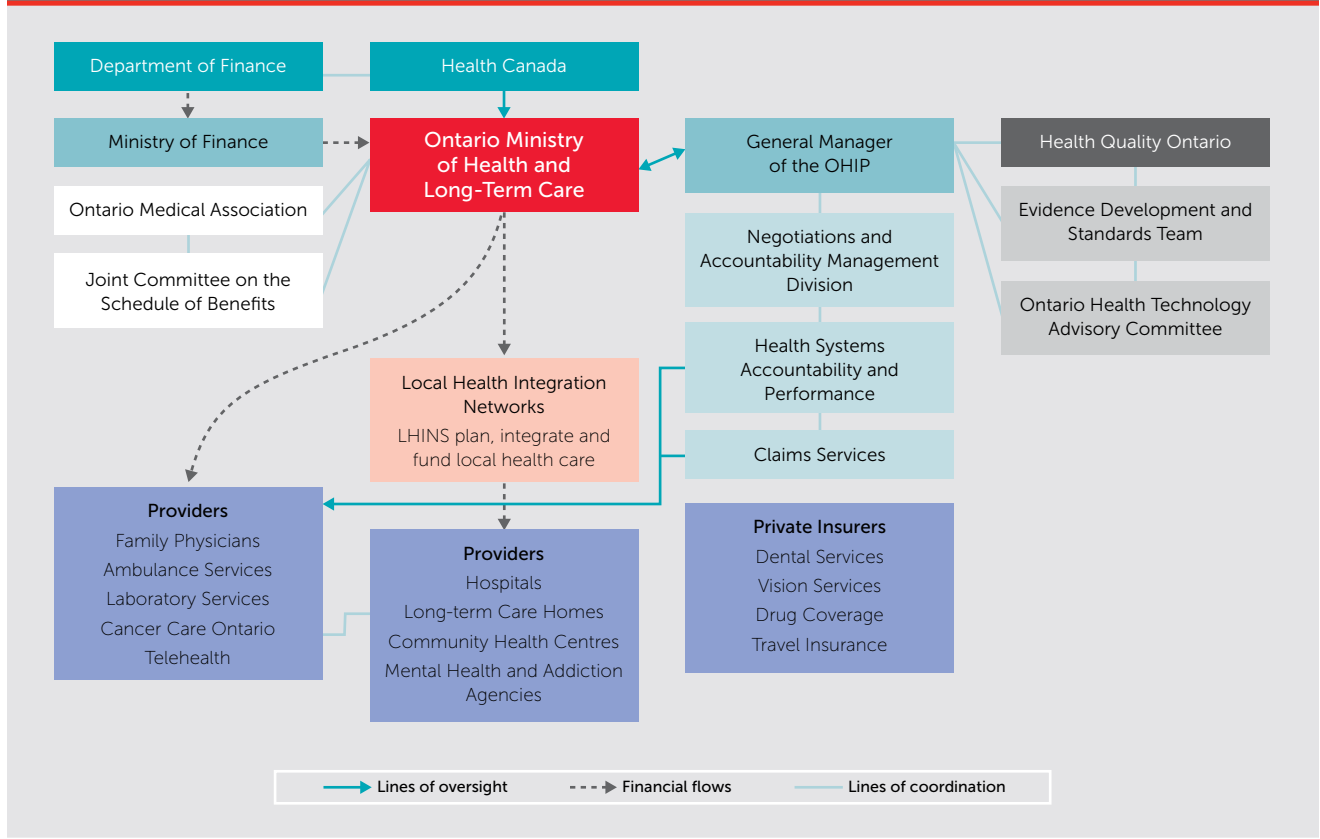
Within the MOHLTC, the Claims Services Branch and the Health Services Branch are responsible for the daily operations of the OHIP (see Annex 1 for the position of these branches within the MOHLTC). The Claims Services Branch registers eligible healthcare providers and pays medical claims for services administered within Ontario, as well as to Ontario residents visiting other provinces and countries. The Claims Services Branch also publishes information about MOHLTC's programs for the public (Auditor General of Ontario 1998; Ministry of Health and Long-Term Care 2014). The Health Services Branch manages more complex claims, approves out-of-country claims, and maintains a registry of all healthcare providers who bill OHIP. It also verifies the veracity and necessity of medical claims and oversees the quality and standards of the medical services provided (Auditor General of Ontario 1998; Ministry of Health and Long-Term Care 2014).

The MOHLTC delegates some important healthcare functions to fourteen sub-provincial agencies known as Local Health Integration Networks (LHINs), which plan for the health needs of the population under their authority in accordance with provincial priorities. LHINs do not provide services directly; instead, they allocate resources among

³ Employers are exempt from paying tax on the first C\$450,000 of payroll for the year. Above the exemption amount, the EHT rates vary from 0.98 percent on Ontario payroll less than C\$200,000, up to 1.95 percent for payroll in excess of C\$400,000. Employers with payroll above C\$5 million are not eligible for the C\$450,000 exemption.

⁴ The Ontario Health Premium tax rates are variable; rates range from C\$0 for taxable income less than C\$20,000, up to C\$450 for taxable income of C\$38,500 (1.2 percent), and down to C\$900 for taxable income more than C\$200,600 (0.45 percent). For the most part, lower income groups pay a greater percentage of their income as Ontario Health Premium than higher income groups.

Figure 2.2: Key Finance and Oversight Relationships of the MOHLTC and Providers, Insurers, and Government in Ontario's health insurance system



Source: Authors, adapted from information in Marchildon, 2013 and Ministry of Health and Long-Term Care, 2014.

hospitals, long-term care homes, Community Care Access Centers, and community mental health and addiction agencies to meet local healthcare needs (Marchildon 2013).

Health technology assessment (HTA) organizations are numerous and operate at both the federal and provincial levels. They may be government agencies or nonprofit private agencies. The Canadian Agency for Drugs and Technologies in Health (CADTH) is the only pan-Canadian HTA agency. It receives funding from federal, provincial, and territorial governments, but remains independent from the government as a nonprofit agency. The CADTH provides evidence-based evaluations of the effectiveness of new health technologies, including prescription drugs, medical devices, procedures, and systems. At the provincial level, the Ontario Health Technology Advisory Committee (OHTAC) of Health Quality Ontario (an arms-length agency of the Ontario government) is funded by the MOHLTC and includes representative from the MOHLTC, LHINS, Ontario Hospital Association, Ontario Medical Association, Council of Academic Hospitals, academia, and industry (Health Quality Ontario, 'Governance'). The OHTAC makes recommendations to the MOHLTC about the uptake, diffusion, distribution, or removal of health interventions in Ontario (Health Quality Ontario, 'About the Health Technology Advisory Committee').

Flow of Data and Information to Support Reporting and Oversight Relationships

Information Technology is handled by the Health Services Information and Information Technology (I&IT) Cluster of the MOHLTC, which is managed by the Chief Information Officer who liaises with the general manager of the OHIP (See Annex 1). Within this cluster the following entities perform specific activities:

- The Health Solutions Delivery branch maintains the IT for the OHIP and associated entities such as the Direct Services division (which includes the Claims Services Branch), the Negotiations and Accountability Management Division (which includes the Health Services Branch), and Service Ontario. The Health Services Delivery branch registers residents into MOHLTC programs, registers healthcare providers, and processes medical claims for payments.
- The Ontario Public Health Integrated Solutions branch provides integrated solutions to help public health professionals efficiently manage cases and outbreaks of infectious diseases, improve delivery and tracking of immunizations, and better manage vaccine inventories (Ministry of Health and Long-Term Care 2014).

Agency Relationship to Health Providers

Health Providers

The MOHLTC uses public funds to contract predominantly with nonprofit, private providers and hospitals. Providers can be either organizations—such as hospitals, long-term care homes, and medical clinics—or independent health professionals. The vast majority of family physicians, family health practices, community health centers, and public health units are professional contractors that are not directly employed/owned by the MOHLTC, creating a clear purchaser-provider split. Services that support primary and acute care, including ambulance, blood, and some laboratory services, as well as food and laundry services, are also private. Most private hospitals and physicians rely on public contracts with the MOHLTC to provide primary care, ambulatory care, and inpatient services because private insurers are legally prohibited from duplicating the coverage of services provided under the OHIP.

There are approximately 27,100 physicians registered to practice in Ontario, of which 12,600 practice family medicine and 14,500 are specialists (The Ontario Physician Human Resources Data Center 2013). A number of different types of providers offer primary care. Physicians may have an independent practice or form private family practice models such as Family Health Teams or Family Health Organizations. There are 101 private, non-profit Community Health Centers in Ontario that provide primary healthcare and administer health promotion programs. Community Health Centers are staffed by physicians, nurse practitioners, social workers, and community health workers, and often by chiropractors, nutritionists, or dietitians. Private Nurse Practitioner-Led Clinics also offer primary care, including mental healthcare, health promotion, and diagnosis and treatment of episodic and chronic illness. The service teams may include registered nurses, family physicians, dietitians, pharmacists, and social workers, in addition to nurse practitioners. Alongside these facilities, Ontario has thirty-six Public Health Units that administer health promotion and disease prevention programs for the local communities. These Public Health Units are autonomously governed by a board of health elected from the municipal councils of the localities served by each of these units (Ontario Ministry of Health and Long-Term Care, 'Health Services in Your Community').

Ontario has about 155 public (145), private (6), and psychiatric (4) hospitals that operate on approximately 238 sites to deliver inpatient care, emergency care, and surgical procedures, as well as specialized chronic care and rehabilitation. These hospitals generally are not-for-profit entities. Both public and private hospitals are staffed with largely privately-contracted physicians. There

are eleven Public Health Ontario Laboratories that are publicly-owned and provide clinical laboratory services for disease prevention and health promotion (Ontario Ministry of Health and Long-Term Care, 'Health Services in Your Community').

Payment Mechanisms

The MOHLTC identifies eligible in-province services provided by hospitals and physicians, and handles contracting and payments. The MOHLTC usually pays for physicians and specialty services—such as ambulance and laboratory services—in Ontario on a fee-for-service (FFS) scale, or some blended model including salary plus FFS, or capitation (Marchildon 2013). The MOHLTC sets rates of remuneration for physicians, which it renegotiates with the Ontario Medical Association (an association of the province's physicians governed by a member-elected council) every four years. The resulting Ontario Schedule of Benefits lays out the conditions under which more than 180 diagnostic and surgical procedures may be charged to the provincial government and the associated fee schedule (Ministry of Health and Long-Term Care 2014). In the case that any clarifications or amendments must be made to the Schedule of Benefits, the MOHLTC or a physician (with cause) may request the Joint Committee on the Schedule of Benefits, an independent committee composed of physicians elected by the Minister of Health and Long-Term Care, to provide an opinion/recommendation on the Schedule of Benefits (Madore 2005; Ministry of Health and Long-Term Care, Health Insurance Act, 1990).

The FFS model for physician payment is a source of inefficiency in the health system because it creates a financial incentive for physicians to encourage overconsumption of care by rewarding physicians who provide a higher volume of service. To address this, the MOHLTC and the Ontario Medical Association have developed a number of innovative blended payment models that reward family physicians for providing comprehensive care to patients. Physicians may be paid according to one of the following models based on the types of practices and services that they provide: (1) physicians may be paid through a salaried or blended salaried model; (2) they may be paid through a FFS plus incentives model in which they receive monthly capitation payments for all enrolled patients in addition to FFS for preventive care and chronic disease management; or (3) they may be eligible to receive payment through a blended capitation model in which capitation is based on a defined basket of primary care services that physicians provide to enrolled patients based on the age or sex of each patient, and FFS is paid for other services (HealthForceOntario, 'Family Practice Models').

Most hospitals are funded through budget allocations to one of the fourteen LHINs in Ontario.⁵ LHINs are

Table 2.2: Provider Payment Mechanisms Utilized in Ontario

Payment Mechanism	Provider	Payer
Fee-for-service + Incentive/Bonus	Independent Physicians; Family Health Groups	MOHLTC
Blended Capitation Model	Family Health Networks; Family Health Organizations; Family Health Teams	MOHLTC
Salaried Model	Community Health Center Physicians	MOHLTC
Fee-for-service	Ambulance Services; Laboratory Services	MOHLTC
Budget Allocation	Hospitals; Long-term Care Homes; Community Health Centers; and Mental Health and Addiction Centers	LHIN

Source: HealthForceOntario, 'Family Practice Models.'

instituted to plan the local health needs of each of the fourteen unofficially demarcated regions in Ontario. LHINs determine payments on the basis of the previous year's allocation adjusted for any inflation and budget growth, and contract directly with each hospital. LHINs similarly handle payments to long-term care homes, community health centers, and mental health and addiction centers.

Accreditation in Canada is voluntary in some provinces/territories and mandatory in others. In Ontario, community care organizations, specialty health services, and hospitals may voluntarily participate in accreditation programs run by Accreditation Canada, CARF International, and other independent accreditation agencies. These agencies generally set accreditation standards related to governance, risk management, leadership, medication management, prevention and control, and patient safety (Marchildon 2013; Kraetschmer et al 2014).

Purchasing Agency's Relationship to Other Government Agencies

Federal Government

The Department of Finance determines the CHT to be allocated to Ontario, and directly transfers these funds to the MOHLTC on an annual basis. As a stipulation for receiving the CHT, Health Canada ensures that the Ontario MOHLTC adheres to the laws set out in the Canada Health Act (Marchildon 2013; Health Canada 2013).

Provincial Government

At the provincial level, the Cabinet and Lieutenant Governor (the Queen's representative within the province) have significant authority over appointing holders of key positions within the OHIP, including the general manager, the members and board of the LHINs, and the Health Systems Appeal and Review Board. The Ontario Cabinet includes the Minister and (currently) the Associate Minister of Health and Long-Term Care, to whom the general manager of the OHIP is accountable for day-to-day activities; the general manager currently is also an Associate Deputy in the MOHLTC with additional responsibilities.

The MOHLTC of Ontario maintains responsibility for defining the benefits package of the OHIP and the rates of reimbursement to providers. The MOHLTC designs and implements public health programs directly, and handles payments to physicians and family health teams, and for ambulance services, laboratories, and programs such as Telehealth (a free phone service that enables callers to receive health advice or information from a Registered Nurse) and Cancer Care Ontario (Ministry of Health and Long-Term Care 2014).

Other Subnational and Local Planning Agencies

LHINs plan for the health needs of the population under their authority in accordance with provincial priorities, and are responsible for a limited number of funding functions (described in earlier and later sections). The MOHLTC signs a Memorandum of Understanding and an Accountability Agreement with each LHIN. The LHIN Liaison Branch, created by the MOHLTC at the provincial level, is responsible for overseeing the Accountability Agreements and supporting the LHINs and MOHLTC in fulfilling their mutual commitments (Osborne Margo

⁵ A more detailed discussion on LHINs may be found under the next section titled "Government".

2008). The Lieutenant Governor and Cabinet appoint the members and the board of directors of the LHINs. Each LHIN has a board of directors with up to nine members. Board members are appointed for a period of three years, with the possibility of re-appointment for one additional year. Boards have the power to pass by-laws and resolutions, though certain by-laws may require approval by the Minister of Health and Long-Term Care. Boards are required to meet at least four times per year, and meetings generally are open to the public (Bhasin and Williams 2007). LHINs are small organizations, with an average of thirty employees. Collectively, they control approximately 40 percent, or US\$17.5 billion, of the total health budget of Ontario (Born and Sullivan 2011; Osborne Margo 2008).

Beyond funding responsibilities, the aim of LHINs is to plan and integrate the local health system within the broader objectives of the Ontario MOHLTC. LHINs actively identify eligible providers and enter into Service Accountability Agreements that include facility performance measures and quality control standards (Osborne Margo 2008). These Service Accountability Agreements have been instrumental in enabling Ontario to address persistent concerns such as long hospital wait times, by specifying performance standards. LHINs are tasked with participating in the development of the provincial plan for health service provision, engaging the local community, and establishing and monitoring performance standards for health service providers under the network ('Local Health System Integration Act, S.O. 2006').

Agency Relationship to Other Public and Private Insurers

Insurers

In 2013, Ontario spent 11.5 percent of its GDP on health (the Canadian average was eleven percent), of which sixty-eight percent was public (from the federal and provincial government, as well as workers' compensation boards), and the rest was private, either through private insurance or OOP expenditures (Canadian Institute for Health Information 2013). This is similar to Canada as a whole; in 2013, the public sector was responsible for roughly seventy percent of total health expenditures, and the private sector made up the other thirty percent (Marchildon 2013; World Bank, World Development Indicators).

Private health insurance and private physicians that do not hold contracts with the government of Ontario are legally prohibited from competing with the OHIP's services (Marchildon 2013). The majority of private health insurance is employment-based insurance provided by employers for non-OHIP services such as outpatient prescription

drugs, non-medically necessary dental and vision care, and travel health insurance. Other consumers may purchase rehabilitation services or complementary and alternative medicine services in the private market. Private insurance bodies may operate in single or multiple provinces and territories. Currently, approximately sixty-seven percent of Canadians purchase private insurance for additional services that are not covered by Medicare. Canadians who receive or purchase private health insurance are exempt from taxation on those benefits or premiums by the federal government and all provincial governments except that of Quebec.

Within Ontario, the Workplace Safety and Insurance Board (WSIB), an independent trust agency, provides workers with workers' compensation benefits for injuries or diseases that they incur on the job and for which treatment is not covered by OHIP. Employers pay the premium on behalf of their employees, and the WSIB pays workers' compensation benefits.

The federal government is responsible for providing healthcare to First Nations people and Inuit. As per this mandate, Health Canada directly purchases services that are not insured under provincial/territorial plans for eligible recipients. Benefits include outpatient prescription drugs, over-the-counter medication, medical supplies and equipment, non-medically necessary dental and vision care, and medical transportation (Health Canada, 'First Nations and Inuit Health'). These benefits are complementary to the health benefits available to First Nations people and the Inuit through provincial/territorial health insurance plans. Eligible beneficiaries may access these services through providers registered with Express Scripts Canada, a private, for-profit health benefits management service. Providers may then directly bill to the federal government through Express Scripts Canada (Health Canada, 'First Nations and Inuit Health').

The Role of Competitive Market Forces

Ontario has begun a movement to adopt more market-oriented approaches to encourage competition among healthcare providers. The most widely discussed example of this is the competitive bidding process run by Community Care Access Centers to allocate resources for senior-care. The MOHLTC assigns budgets for home-care and long-term care services to a number of regional Community Care Access Centers, which in turn contract out publicly funded services on the basis of "best quality, best price." Both for-profit and nonprofit private providers are encouraged to respond to the request for proposals, leading to a competitive process meant to encourage efficiency and quality (Deber 2003; Randall 2007).

Key Risks and How They Have Been Addressed

Throughout the history of insured health services in Ontario, the MOHLTC has encountered many risks to the sustainability of the system. This section explores some of these risks in detail.

Better Mechanisms for Collecting Premiums

Before 1990, approximately twelve percent of the financing for OHIP (about US\$1.5 billion) was collected through premiums levied on Ontario residents (Helwig 1989). However, the system was ineffective and inequitable for a number of reasons. For example, although residents were required to make contributions, their use of OHIP services was unrelated to whether in fact they had paid (Helwig 1989). Premiums were not automatically deducted from payroll, and residents could not be denied care because they had not made the required payments. As a result, people accessed care without contributing to the cost. In addition, people over sixty-five did not have to pay the premium for themselves, their spouses, or dependents, but all dependents under sixty-five had to start making payments after the demise of the head of household (Helwig 1989).

In 1990, the healthcare premium was replaced by a payroll tax—the Employer Health Tax (discussed earlier)—and employees were no longer personally liable to pay premiums for healthcare. The rising cost of healthcare soon reintroduced the Ontario Health Premium in 2004 as a means to supplement funding for healthcare. The Ontario Health Premium is a payroll tax calculated based on an individual's total taxable income, and levied in addition to the Employer Health Tax paid on their behalf by the employer. The Employer Health Tax and Ontario Health Premium solve some of the problem with evasion and inequities in the original system. Both taxes are deducted at source, allowing very little room for evasion. In addition, the premiums are calculated on an individual basis, not a household basis, exempting only individuals who are above the age of sixty-five and who have incomes below C\$20,000 a year from paying the premium (Ministry of Finance, 'Employer Health Tax'; Ministry of Finance, 'Ontario Health Premium'; Expert Interview Canada 2014).

Rising Cost of Care

More recently, the rising cost of healthcare has become a significant issue in Ontario. Between 2000-01 and 2010-11, the Ontario government's total revenue increased by 4 percent annually, while spending on healthcare rose by an

average of 6.9 percent per year (Drummond et al 2012). In 2012-13, healthcare consumed forty-two cents of every provincial tax dollar in Ontario. The MOHLTC estimates that at the current pace, given population aging and an epidemiological transition to greater chronic disease, health spending will consume seventy percent of the provincial budget by 2025 (Ministry of Health and Long-Term Care, 'Health System Funding Reform'). Ontario has made headway with recognizing its issues in a report by the Commission on the Reform of Ontario's Public Services published in 2012 (Drummond et al 2012). To control costs, the province has begun to transition from a predominantly hospital-based care system to one with more emphasis on primary and preventive care (Drummond et al 2012). The province is also encouraging senior-citizens to receive care through a strong home-based care system with lower costs and greater capacity than more expensive long-term care homes. (Randall 2007).

Inefficiencies in the system may contribute to rising costs. In Ontario, health facilities may provide medical services without strong evidence of their cost-effectiveness. For example, the percentage of caesarean sections and hysterectomies exceeds recommended clinical guidelines (Drummond et al 2012). The MOHLTC regularly mines data to identify falsified or unnecessary claims, but active surveillance is required to stringently monitor the system (Expert Interview Canada 2014). Recommended health systems funding reform will allocate a percentage of funding for Quality-Based Procedures, which will evaluate procedures on an evidence-based, "price x volume" system (Ministry of Health and Long-Term Care, 'Health System Funding Reform').

Friction in Local Management

By design, LHINs are intended to plan for the health needs of the local population as well as set standards and monitor the performance of hospitals, long-term care homes, community health centers, and other healthcare organizations under their control. However, LHINs' abilities to integrate and coordinate local services are challenged by the fact that hospitals and LHINs have parallel management structures. LHINs and hospitals are governed by a board, CEOs, and senior executives, but hospital boards tend to be more powerful and hospitals employ far greater numbers of people than LHINs. Separately, Community Care Access Centers have some contracting responsibilities for home-care and long-term care services. Preserving hospital and Community Care Access Center management arrangements means that LHINs are severely restricted and challenged in their abilities to integrate care across providers and across the region (Born and Sullivan 2011; Buist 2011). This system is unique to Ontario, as Regional Health Authorities in many other provinces have eliminated the various competing boards in favor of a single board, a CEO in charge of overall health planning,

and vice-presidents who have control over financing, human resources, hospital services, and more. This restructuring requires valuable time and political capital.

Discussion and Case Conclusion

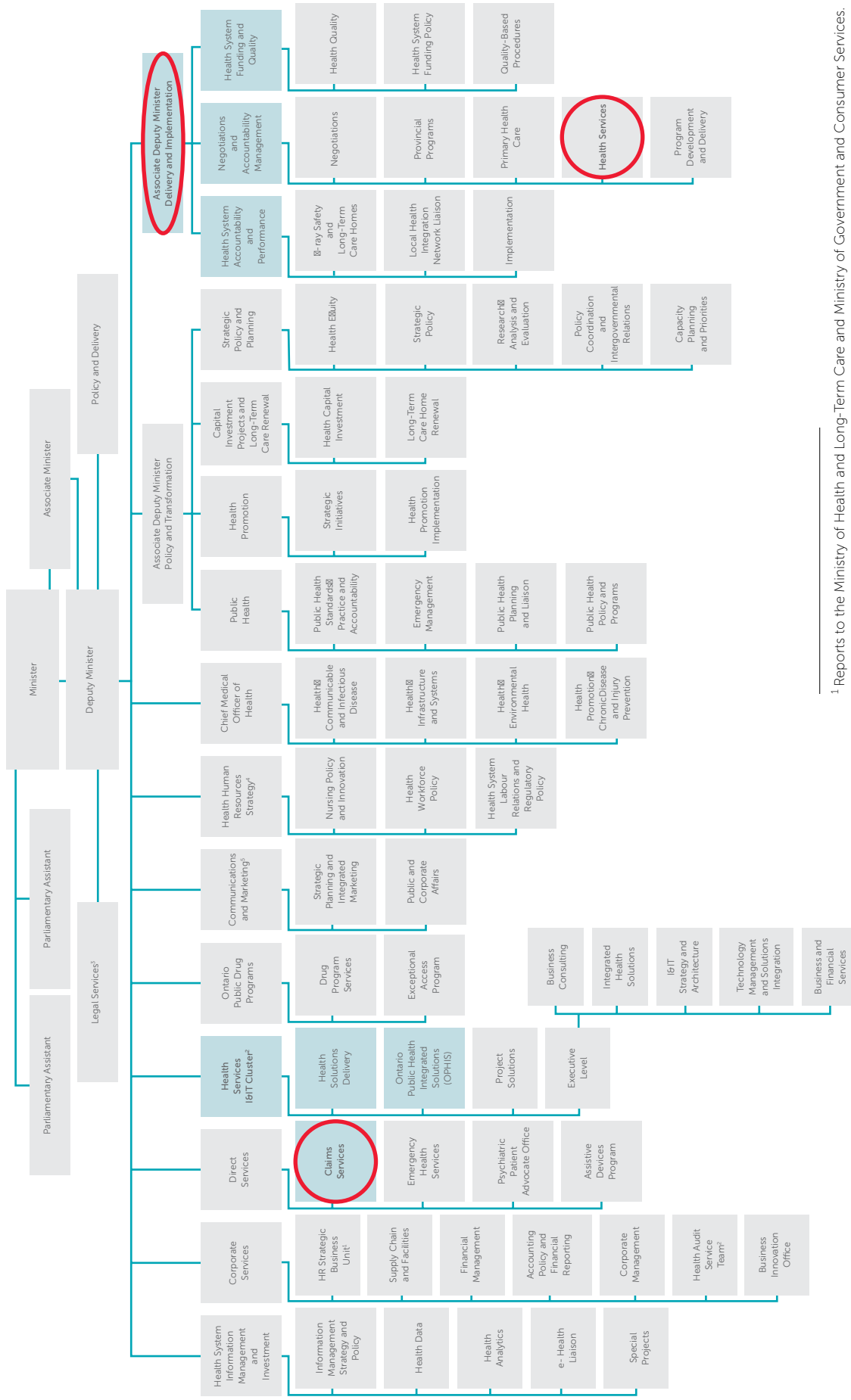
Canada's healthcare system is one of the earliest examples of universal health coverage, and also provides an example of a well-functioning health system close to the ideal of South Africa's NHIF—albeit with much heavier reliance on private sector provision of healthcare. Canada's division of responsibility between federal and provincial governments is also the best aligned among our cases with South Africa's constitutional divisions for healthcare provision. The Canadian federal government collects and allocates general revenues for health (through the Canada Health Transfer), enforces the Canada Health Act, and sets pan-Canadian standards for health service coverage, food and drug safety, and price regulation for branded drugs. Provincial/territorial government agencies, such as the Ontario MOHLTC, manage healthcare for their residents, determine the services to be provided (in accordance with guidelines set by the Canada Health Act), and set rates of remuneration for hospital and physician care in collaboration with provincial medical associations. LHINs plan and integrate the local health system within the broader objectives of the Ontario MOHLTC.

In Ontario, the OHIP provides universal coverage for medically necessary services (except outpatient prescription drugs) to all Ontario residents at no cost to the patient at the point of service. Residents may purchase coverage for services that OHIP does not cover on the private health insurance market, and approximately two-thirds of Ontarians do purchase supplementary private insurance. The OHIP has been successful in ensuring universal access to healthcare, as healthcare is funded from general revenues and is available to all residents at no cost. It is effective in its goal to financially protect citizens against high-cost hospital and physician services. However, OHIP must address some prominent gaps in coverage, most notably the exclusion of prescription drugs, and inequities in the utilization of services, such as a pro-rich bias in the use of specialist physician services (Marchildon 2013).

The following features regarding the governance of the MOHLTC and OHIP are most relevant to South Africa as it determines the design and governance of NHIF:

- The Canada Health Transfer contributes to reducing inequities in health financing among provinces by redistributing revenues collected on a national basis to the provinces on an equal per capita basis. This enables provinces with lower tax bases to benefit from revenues collected from wealthier provinces.
- Ontario has implemented a strong tax enforcement system that ensures an adequate revenue base for health insurance. The taxation system is largely income-based, which is progressive and, thus, essentially equitable. In addition, the province collects employer and employee premiums for health insurance through payroll taxes deducted at source. This curbs evasion that is common among monthly contribution schemes.
- The Health Services Branch of the MOHLTC conducts routine algorithmic mining of health claims data to find falsified or unnecessary claims and to prevent such claims by checking them early and often.
- The MOHLTC updates rates of remuneration for physician and hospital services with the Ontario Medical Association every four years, ensuring that MOHLTC coordinates with service providers and maintains rates that are competitive in current markets.
- The MOHLTC plays a significant role in defining and assessing the cost of the benefits package. The MOHLTC can control costs by exercising this authority. The MOHLTC publishes an updated Schedule of Benefits every four years, which is monitored by the Joint Committee on the Schedule of Benefits.
- The absence of competition from private insurers—since they are not legally allowed to cover services covered under the OHIP—prevents the duplication of services and creates efficiencies in the allocation of healthcare resources, including workforce, technologies, and infrastructure. It also enables the MOHLTC, as a single-payer, to control the cost of labor and services in the private market more easily.
- The complete purchaser-provider split in Ontario supports mechanisms by which the MOHLTC and LHINs may manage provider performance. LHINs draw up service accountability agreements with each facility in their regions, specifying performance provisions that govern quality, equity, and access. This has helped Ontario to reduce hospital waiting times and improve cost-efficiency.
- The LHIN system in Ontario has decentralized planning and purchasing for healthcare, allowing local agencies to plan and contract for the specific health needs of the communities they serve. However, the decentralization is not complete, and the MOHLTC still retains control over contracting and purchasing physician and laboratory services. This incomplete decentralization limits the ability of the MOHLTC to integrate systems and coordinate services across the province, and also diminishes the abilities of the LHINs to effectively manage local health services provision.

Annex 1: Organization Chart of the Ontario Ministry of Health and Long-Term Care



¹ Reports to the Ministry of Health and Long-Term Care and Ministry of Government and Consumer Services.
² Reports to the Ministry of Health and Long-Term Care and Treasury Board Secretariat.
³ Reports to the Ministry of Health and Long-Term Care and Ministry of Attorney General.
⁴ Reports to the Ministry of Health and Long-Term Care and Ministry of Training, Colleges and Universities.
⁵ Reports to the Ministry of Health and Long-Term Care and Cabinet Office.

Source: Reproduced by the authors from the MOHLTC organization chart. Accessed from www.health.gov.on.ca/en/common/ministry/orgchart.pdf

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Chile: Fondo Nacional de Salud (Fonasa)

Introduction

Chile is a high income country in Latin America with a population of 17.5 million. It is a democratic unitary state headed by a president elected as both head of state and government by popular vote for a single four-year term. Both Chile and South Africa have high rates of income inequality (a Gini coefficient of 50.8 in Chile compared to 65 for South Africa in 2011)⁶ and similar proportions of the population that exclusively access public providers for healthcare.⁷ Although per capita GDP and health expenditures in 2012 were much higher in Chile than in South Africa—at US\$9,440 and US\$1,606 compared to US\$6,003 and US\$982⁸—total health expenditure as a percentage of GDP in 2012 was in fact lower in Chile than in South Africa at 7.2 percent compared to 8.8 percent (World Bank, World Development Indicators).

Despite being a unitary state, Chile has a persisting legacy of administrative decentralization,⁹ economic liberalization, and social sector reform from seventeen years of military rule that began in 1973 (Posner 2008). In fact, the 2005 universal health coverage reform known as AUGE

(Universal Access with Explicit Guarantees) built on public institutions established in the 1950s and 1960s along with private purchasing institutions established in the late 1970s. Chile's system of mandatory social health insurance (SHI), as designed under the AUGE reform, delivers health services and insurance to more than seventeen million people. About seventy-seven percent of Chileans (13.5 million) are enrolled in a large government-run and nonprofit public health insurer called Fondo Nacional de Salud (Fonasa). Another sixteen percent choose from a number of for-profit private health insurers created in 1981 and known as Instituciones de Salud Previsional (Isapres) (DIPRES 2013). The entire system is financed by a combination of payroll taxes (28 percent), government revenue (30 %), out-of-pocket payments (38 percent), and voluntary insurance premiums (4 percent).¹⁰

We include Chile in this report because available evidence suggests its SHI reform has markedly improved equity and access to healthcare by establishing enforceable guarantees for a set of explicit benefits (Frenz, Delgado, Kaufman, and Harper 2013). Following the enactment of AUGE, the rates of inequity in healthcare access in Chile have declined (Frenz et al. 2013); almost four-fifths of the beneficiaries are now served

How did Chile build its public health insurance regime?

Public health insurance in Chile builds on existing infrastructure to purchase and provide health services, combines regulation for all (public and private) insurers and providers under a single institution, and provides a blueprint for how a single-payer public healthcare system may coexist with duplicative private insurance.

Chile is an example of a country that achieved universal health coverage through incremental reform. The 2005 AUGE law relied on a pre-existing purchaser-provider split between a long-established public health provision system and (public and private) purchasers created in the late-1970s and early-1980s to specify and deliver a set of minimum benefits to all Chileans. Beneficiaries who are enrolled with the public purchaser, Fonasa, receive these benefits with the additional guarantees of timely, equitable, affordable, and quality health services through state-owned providers.

The healthcare regime in Chile combines regulation of both public and private purchasers and providers under the Superintendency of Health within the Ministry of Health. The unification of oversight has helped to allay concerns about the uniformity of healthcare and health insurance regulations across agents working in Chile's health sector and to ensure fair and equal treatment of beneficiaries for all health insurers.

Through joint regulation, common minimum benefits, and consumer choice regarding enrollment in one type of insurer or the other, Chile also provides a model for how a single-payer public health insurance system may coexist with competing private insurers that typically deliver more expensive health plans to higher-income enrollees.

⁶ World Bank, World Development Indicators.

⁷ Sixty-eight percent for public providers for both Chile (Eduardo Missoni and Giorgio Solimano, "Towards Universal Health Coverage: The Chilean Experience," *World health report* 2010) and South Africa (HEU Information Sheet, University of Cape Town).

⁸ World Bank, World Development Indicators. PPP; constant 2005 \$.

⁹ Policy formation and implementation remains top-down, however, given Chile's unitary structure

¹⁰ *Fonasa 2011*, quoted in *Supporting the Development of National Health Insurance in South Africa: a Review of Benefits Policy and Active Purchasing Reform in Chile*—Results for Development Institute, 2014.

Fonasa at a Glance

Purchaser: Fondo Nacional de Salud (Fonasa)

Function: Serves as the national public purchaser for healthcare under Chile's 2005 AUGE health reform.

Type: Single-payer for the public sector under AUGE, covering more than three-fourths of the national population.

Size: 1,137 staff in 2011 (DIPRES 2013).

Budget: Fonasa spends about ninety-six percent of its budget on purchasing services for beneficiaries from public and private sector providers, and incurs less than five percent in administrative spending. According to 2011 data, eighty-five percent of healthcare spending was directed at public (institutional) providers while about fifteen percent was spent on care through the private sector under the 'Free Choice Modality.'

Expenditure: Fonasa incurred about 2,938 billion Chilean pesos in spending on institutional (public) and private care for its beneficiaries in 2011 (about US\$5.66 billion) (DIPRES 2013).

Finance: Financed by a seven percent mandatory payroll contribution and transfers from general government revenue.

Mission: Fonasa is tasked with a) providing health insurance at the national level by delivering financial coverage for health services in the public and private sectors through an appropriate health plan that improves the satisfaction of the insured and complies with legal obligations and guarantees, and b) efficiently managing public sector financial resources for health by efficient collection, recovery, and audit to improve the quality of care for the insured (DIPRES 2013).

through the public sector; citizen satisfaction with Fonasa is quite high (2011 and 2012 Adimark-GfK surveys); and Isapres' membership had dropped to about sixteen percent in 2009 (DIPRES 2013) from twenty-six percent in 1995 (Unger, De Paepe, Cantuarias, & Herrera 2008). Moreover, Chile's public health insurer, Fonasa, shares many institutional features and responsibilities with the proposed NHIF in South Africa. Fonasa was established to institute a purchaser-provider split in Chile's public healthcare system and is now responsible for national pooling of healthcare funds from public and private sources to guarantee the provision of a minimum set of benefits to its beneficiaries. It also contracts with public and private providers, negotiates prices for health services, determines the budget, makes fee-for-service and capitation payments, and competes with the private health insurers, Isapres.

Public Agency Responsible for Managing Health Funds and Purchasing Services

History

The military regime of General Pinochet sought to reverse the populist fiscal and political pressure on the state in

the 1970s (Posner 2008): Fonasa was formed to replace the National Medical Service (SERMENA) in 1979¹¹ to make the provision of healthcare more market-oriented and to introduce competition and institute a purchaser-provider split across the entire system. It offered coverage to all Chileans, financed by workers' mandatory income contributions and subsidies from the ministry of finance¹² to cover both poor and retired individuals and to co-finance services for all beneficiaries (Unger et al. 2008). Follow-up reforms in 1981 also created the Isapres as competitors to Fonasa, providing individuals with a choice between Fonasa and an Isapres to receive their mandatory contribution.¹³

However, this transfer of social insurance funding to private insurers reinforced the disparities endemic to Chile's labor market (Posner 2008) and exacerbated inefficiencies in healthcare provision, necessitating the AUGE reform of 2005 under President Lagos. For instance, the private Isapres could exclude beneficiaries on the basis of health problems, risks, and ability to pay. As a result, low risk and high income groups migrated to private insurers, which relegated the majority of Chileans to the inadequately resourced and underperforming public health sector.¹⁴ By 1990, Isapres covered less than fifteen percent of the population but accounted for almost forty percent of benefits expenditures in the health system. By the late 1990s, Isapres received two-thirds of all payroll contributions but provided coverage

¹¹ Decree 2763 of 1979. (DIPRES, "Evaluación Del Gasto Institucional Fondo Nacional De Salud, December 2013," DIPRES. Ministry of Finance, Chile. 2013).

¹² Public revenue includes earmarked levies for health introduced under the 2005 AUGE reform. Missoni and Solimano, "Towards Universal Health Coverage: The Chilean Experience."

¹³ The mandatory contribution was initially three percent, but the government raised it to seven percent in 1986 because of a fiscal deficit in the system caused by a reduction in state subsidies and migration of higher income beneficiaries to private insurers. Paul W Posner, *State, Market, and Democracy in Chile: The Constraint of Popular Participation* (Palgrave Macmillan, 2008).

¹⁴ *Supporting the Development of National Health Insurance in South Africa: a Review of Benefits Policy and Active Purchasing Reform in Chile—Results for Development Institute*, 2014.

to only twenty percent of the population (Posner 2008). Also, while Fonasa was regulated by the government, the government did not regulate Isapres until the early 1990s when an agency formed to oversee the Isapres first began to function. It quickly expanded to cover issues like quality of services, solvency, benefits, access, and consumer care and to protect the interests of Isapres' beneficiaries (Savedoff and Gottret 2008). Similar regulations did not apply to Fonasa, which raised concerns about the fair and equal treatment of beneficiaries of the two types of health insurers. A benefits floor established by law for members of both Fonasa and Isapres currently covers eighty health problems identified for their frequency, severity, and cost.

Among other steps, the 2005 reform remodeled governance arrangements and coverage responsibilities of Fonasa and Isapres to mitigate the inequities caused by these disparities. The reform guaranteed a consistent benefits floor for all Chileans regardless of whether they were Fonasa or Isapres affiliates.¹⁵ In addition, it introduced changes meant to improve the quality and accessibility of services by Fonasa, and combined the regulation of both Fonasa and Isapres (as well as all health providers) under a single agency. Fonasa is now regulated by the Superintendency of Health (SDS) and undertakes to cover an explicit set of minimum benefits (the mandatory benefits floor), including primary and emergency care and targeted conditions defined according to their epidemiological burden (Bitran and Urcullo 2008). It also provides guarantees of access, timeliness, financial protection, and quality for service provision for these benefits through public providers organized under the National Health Services System (SNSS), and offers access to private sector services for beneficiaries through a Free Choice Modality (FCM; against higher copayments), and vouchers (when service through SNSS is unavailable for some reason). Fonasa also continues to cover services that are not included in the set of minimum benefits, as before; that is, without the AUGE guarantees being applicable.

System Architecture

The figure on the following page maps Fonasa's financing and provision relationships within Chile's social health insurance system. Solid lines illustrate key oversight and accountability relationships between entities, while dotted arrows trace the flow of funding between various actors to finance the system. The illustration is followed by a brief description.

Fonasa and Isapres cover all workers in the formal sector who legally are required to pay a flat seven percent payroll contribution for health coverage. Fonasa beneficiaries are classified into four groups (A, B, C, & D) depending on their socioeconomic status and monthly income. Those who are formally classified as indigent through a means test belong to Group A and are exempt, along with retired and legally unemployed workers, from payroll contributions as well as copayments to healthcare providers. The remaining Fonasa beneficiaries generally comprise middle to lower income workers and their families. The Ministry of Finance supplements Fonasa's funding pool with subsidies that cover both AUGE and non-AUGE services for non-contributing members (Group A), as well as co-finance AUGE benefits for all beneficiaries. It also transfers resources to the Ministry of Health, which is responsible, through its sub-secretariats of Public Health and Healthcare Networks, for health-related policy making and public goods and for delivering health services through a network of twenty-nine Regional Health Services (RHSSs).

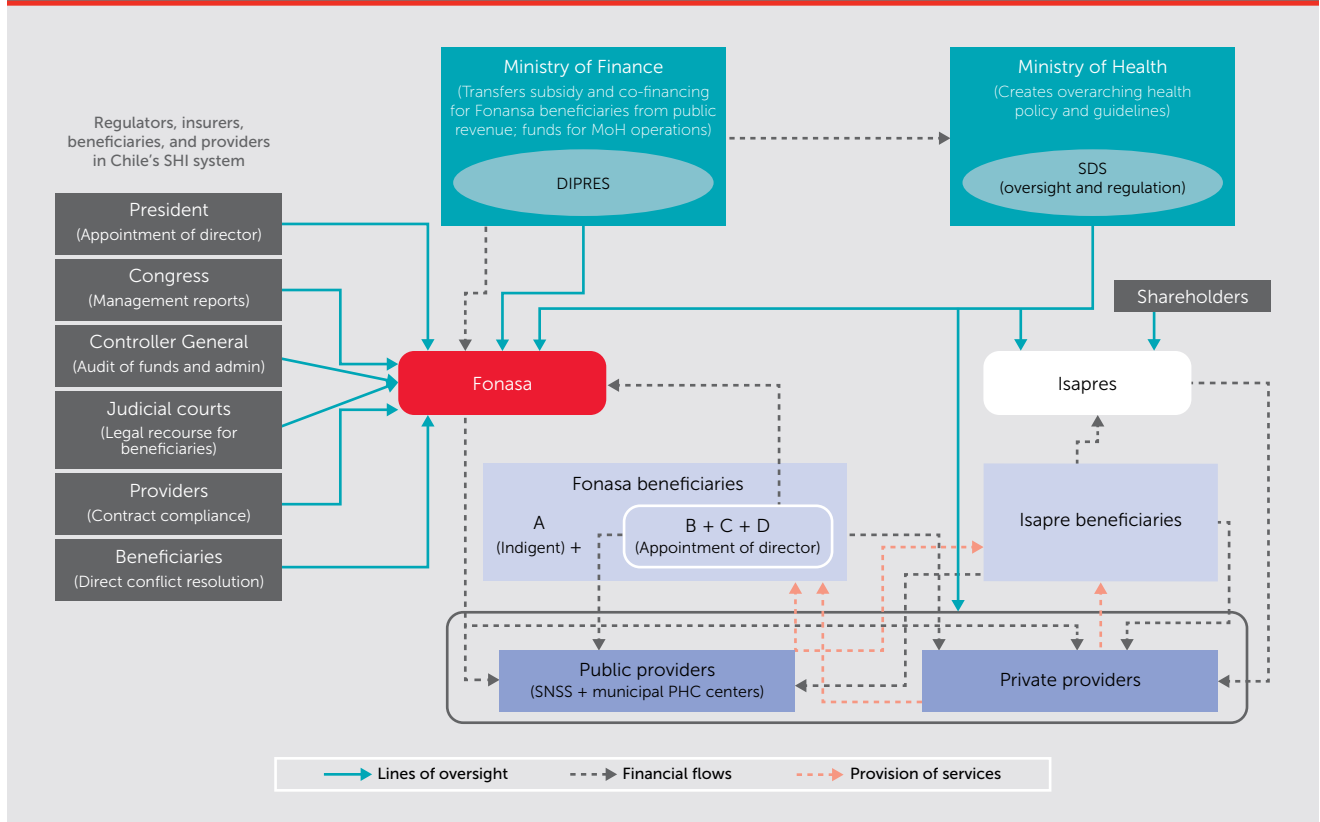
All Fonasa beneficiaries can access the explicitly defined set of AUGE benefits through public providers under mandatory service guarantees of access, timeliness, financial protection, and quality, as enforced by the SDS (discussed later). Fonasa beneficiaries can still obtain services that are not explicitly guaranteed from public municipal health centers without paying at the point of service, or obtain secondary and tertiary care in public hospitals for a copayment. Importantly, they can also opt to receive services from private providers under Fonasa's *Free Choice Modality* in exchange for paying higher copayments, or they can access private services through AUGE vouchers if guaranteed benefits are not available from the public system, mostly for reasons of capacity constraints.

Isapres beneficiaries primarily comprise upper-middle- and high-income individuals and their families. Their seven percent mandatory contribution may be large enough to cover the cost of private insurance premiums, which individuals can supplement with an additional voluntary premium. Depending on how much they pay, Isapres beneficiaries can get access to insurance plans that offer higher benefits. Isapres beneficiaries make copayments to private providers and can also obtain services at public hospitals on a fee-for-service (FFS) basis.

The remaining population (about three to four percent) includes members of the armed forces who have their own insurance plan, or people who lack formal insurance coverage (PAHO 2012).

¹⁵ These benefits currently cover 80 health problems identified for their frequency, severity, and cost (Antonio Infante, "The Post Military Government Reforms to the Chilean Health System." *Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health*. 2007.), with associated treatment protocols and clinical practice guidelines developed by the ministry of health and used for costing benefits (Estanislao Gacitúa-Marió, Andrew Norton, and Sophia V Georgieva, "Building Equality and Opportunity through Social Guarantees: New Approaches to Public Policy and the Realization of Rights." World Bank Publications. 2009).

Figure 2.3: Key Finance and Oversight Relationships of Fonasa and Providers, Insurers, and Government in Chile's health insurance system



Reporting and Oversight Arrangements

Figure 2.3 shows the various oversight and accountability relationships within which Fonasa is embedded. Fonasa is an autonomous public institution without a board of directors or any direct governance by contributors, patients, or providers. Instead, it is directly governed by all three branches of the government. Specifically, Fonasa is accountable to the president of the republic, Congress, the Ministry of Finance, the Ministry of Health,¹⁶ the Controller-General's Office, the Superintendency of Health (SDS), and, more generally, the courts, healthcare providers, and beneficiaries (Bitran, Munoz, Escobar, and Farah 2008). As explained later in this section, Fonasa also has its own internal accountability mechanisms. Isapres, by contrast, are directly accountable to shareholders and to the SDS.

Chile's president retains the exclusive prerogative of appointing or removing Fonasa's director, whose tenure typically coincides with each president's term. The Chilean National Congress also holds Fonasa accountable by reviewing its annual Management Report, which contains quantitative performance indicators that the Congress evaluates on the basis of goals set in the preceding year through management improvement plans. The

Management Report also includes a report on Fonasa's sources and uses of funds, financial management results, and the degree to which it achieved its commitments.

The Ministries of Finance and Health exercise more routine control over Fonasa (Bitran et al 2008). The Ministry of Finance sets guidelines for and approves Fonasa's Management Report and management improvement plans through its Public Budget Office (*Dirección de Presupuestos* or DIPRES). To minimize any inconsistencies, DIPRES exclusively outlines performance indicators and goals for Fonasa's fiscal year. DIPRES can also offer Fonasa incentives to encourage better performance, such as performance bonuses of up to eighteen percent of annual salary for Fonasa's management and staff, which may be cut if goals are not reached. The Ministry of Finance also can partially restrict Fonasa's monthly budgets if it fails to comply with budget law regulations. The Controller-General's Office, an authoritative and independent entity headed by a director appointed to a tenure position by the president and Congress, audits Fonasa's administrative procedures and funds. The Office has its own monitoring bureau located inside Fonasa's premises to facilitate oversight. The Office can request that Fonasa or the Ministry of Health internally investigate irregularities, or it can launch its own investigation

¹⁶ For broader AUGÉ policy guidelines issued by The AUGÉ Advisory Council based on recommendations from the Technical Secretariat of the AUGÉ.

on large-scale anomalies. While the Controller-General's Office is in charge of monitoring Fonasa's administrative processes and accounts and the Ministry of Finance monitors Fonasa's performance at the macro level, the Ministry of Health is ultimately responsible for overseeing Fonasa and conducts much closer oversight through the SDS.

Until 2005, Fonasa was not subject to explicit regulation even though the Superintendencia de Isapres, created in 1990, was regulating private insurers. After the 2005 AUGE reform, Chile unified health insurance regulation under the newly created SDS, which subjects Fonasa to formal regulation for the first time.¹⁷ SDS ensures that the rights of Fonasa's beneficiaries are safeguarded, monitors Fonasa's compliance with its responsibilities under AUGE, and can call for the Ministry of Health to investigate and even sanction Fonasa's directors and staff. Specifically, the SDS monitors Fonasa's calculation of reimbursements and copayments, authorization of health loans for beneficiaries, compliance with AUGE, and beneficiary satisfaction through opinion surveys. SDS also monitors any formal (out of court) arbitration of disputes between Fonasa and its beneficiaries. Beneficiaries, in turn, can hold Fonasa accountable through three channels, which beneficiaries generally utilize in the following order: direct complaints to Fonasa, consumer protection through the SDS, and legal appeal to a court of law (Bitran et al 2008).

Finally, Fonasa's internal governance consists of a director and a group of subordinate departments. Most decisions are made in three progressively larger committees (Bitran et al 2008): the Executive Committee consisting of the director and the department heads; the Extended Executive Committee consisting of the director, the department heads, and fifteen regional directors; and a committee consisting of the director, the department heads, the regional directors, and the sub-department heads. Although departments exercise varying influence over each of the decisions in their respective areas, there is no voting in these committees and the director has the final say. An important sub-department is that of Management and Processes Control (part of Fonasa's Strategic Planning Department). Once the Extended Executive Committee defines an annual plan with goals and performance indicators, including DIPRES's management improvement plan as one of its components, it is handed over to the Management and Processes Control sub-department for follow-up. The sub-department is empowered to request data and reports from Fonasa's staff, and has access to all internal Fonasa documents. It reports its monitoring activities to the Extended Executive Committee (Bitran et al 2008). Finally, Fonasa also has fourteen user committees—participatory bodies of patient associations and beneficiaries—which act as advisers to the director. Although they have no power to impose or vote on decisions, they have prompted some initiatives, such as the Mobile Fonasa

program in 1997 (an outreach program for remote locations with no Fonasa office) (Bitran et al 2008).

Flow of data and information to support reporting and oversight relationships

Other than the records for certifying, accrediting, and registering providers, the most important data management tool is SIGGES, or the Integrated Information System for the Management of Explicit Guarantees in Health (Gacitúa-Marió et al. 2009). SIGGES is maintained by the SDS as part of the supervision and control mechanisms to help with regulating Fonasa and Isapres. It contains online information for each AUGE patient, and helps to monitor the services that are provided to each beneficiary, including documenting waiting times and cataloging other medical data. Doctors, nurses, and other health professionals are responsible for keeping this database up-to-date. The system thus enables providers to monitor and follow-up on the waiting lists, and also features alerts when waiting deadlines are about to be reached so that timely actions may be taken. In addition, the system supports financial management and evaluation of the post-AUGE health system (Gacitúa-Marió et al. 2009).

Agency Relationship to Health Providers

Health Providers

The cost of purchasing health services for beneficiaries accounts for nearly ninety-six percent of Fonasa's spending, while administrative costs make up less than five percent.¹⁸ Fonasa primarily purchases services from the public health delivery network (the twenty-nine RHSs of the SNSS), which is distributed throughout the country and includes most hospital beds in the country. This public health delivery network comprises 192 hospitals (63 tertiary, 24 medium complexity, and 105 low complexity) and 17 specialty care ambulatory centers. However, primary healthcare, delivered through 1,870 health centers, is distinct from the SNSS and decentralized to the 346 municipalities (WHO 2012). These health centers "provide preventive and curative services, but complex interventions including childbirth are referred to secondary care," with funding coming mostly from the central government and complemented by municipal resources (Vargas and Wasem 2006). Fonasa also makes about fifteen percent of its health-related payments to private providers (DIPRES, 2013).

¹⁷ See description of SDS mandate: <http://www.supersalud.gob.cl/568/w3-article-6487.html>

¹⁸ *Supporting the Development of National Health Insurance in South Africa: a Review of Benefits Policy and Active Purchasing Reform in Chile—Results for Development Institute*, 2014.

How Providers are Paid

Fonasa purchases services from the SNSS using a mix of budget support and fee-for-service (FFS) payments to all twenty-nine geographically-decentralized regional health services (RHS), which are themselves managed by the Ministry of Health. Fonasa negotiates prices with the RHSs after conducting cost studies in public hospitals.¹⁹ The prices are published in Fonasa's public price list. The RHSs in turn allocate funding as budget support and FFS payments to individual hospitals and specialty care centers. To purchase primary care from locally-managed municipal health centers, Fonasa determines and administers capitation and program-based payments that it bases on the direct and indirect costs of service provision and the number of Fonasa beneficiaries registered with each primary care center.²⁰ Fonasa makes payments to SNSS and PHC pursuant to management contracts negotiated with RHSs and municipalities.

Fonasa also makes FFS payments to private providers for routine and emergency care. Fonasa's beneficiaries may access private doctors' offices and hospitals for primary, secondary, and tertiary care but they are required to pay higher copayments under the *Free Choice Modality*.²¹ Fonasa may also enter into various types of agreements with private providers (framework agreements, open bids, and direct contracts) to purchase services using FFS if benefits availability, capacity, or access issues arise in the public sector. Beneficiaries may be given AUGE vouchers to use in such cases. Additionally, emergency care (until stabilization) through the private sector is available to all beneficiaries. Overall, these private sector payments make up about fifteen percent of Fonasa's total health spending, with the remaining going to public providers (DIPRES 2013).

Purchasing Agency's Relationship to Other Government Agencies

National Government

Chile is a presidential democracy with a unitary state. It currently comprises 15 regions that are subdivided further into 54 provinces and 346 communes or municipal

governments. Although political authority remains highly centralized, reforms in the mid-1970s devolved greater administrative responsibility to regional governments. However, despite administrative decentralization, the national Chilean government has not handed down significant political autonomy. Regions and provinces are headed by intendants and governors appointed by the president and advised by unelected bodies, with each taking instructions from the chief executive one level above. Hence, Chile has an institutional structure that facilitates the policies and priorities of the national government to be implemented by the regional, provincial, and local governments (Posner 2008).

Local or Regional Governments

Subnational governments do not appear to play any significant role in Fonasa's contracting with and payment to regional health services, municipal health centers, or private providers. The regional governments' most important fiscal function is to prepare a ranking of feasible regional investments projects. This ranking is meant to reflect local preferences about new public infrastructure and selected projects that are funded through various decentralized funds made available by the central government (Letelier 2011).²² Notwithstanding this ranking function, each region has limited fiscal and programming autonomy.

Each region does have its own regional health authority that represents the central MOH in the regional ministerial secretariats (SEREMIs). Instead of autonomous subnational government bodies, regional representatives of national health institutions are responsible for coordinating and managing the national system locally. These regional representatives include: Fonasa's 4 regional offices for managing contracts with public and private providers and its 103 customer service branches distributed along the national territory; the 15 regional offices of the SDS; regional health services comprising the overall SNSS; and regional health authorities representing the central MOH.

Fonasa does make capitation and program-based payments to municipal health centers, which are distinct from the SNSS and run by local governments. Fonasa's main purpose in making these payments seems to be cost control instead of encouraging improved quality and output through active purchasing mechanisms.

¹⁹ *Supporting the Development of National Health Insurance in South Africa: a Review of Benefits Policy and Active Purchasing Reform in Chile—Results for Development Institute*, 2014.

²⁰ These PHC networks also serve as gatekeepers to the SNSS through "Referral Health Centers" or CRS (*Supporting the Development of National Health Insurance in South Africa: a Review of Benefits Policy and Active Purchasing Reform in Chile—Results for Development Institute*, 2014). The municipalities also receive grant funds for PHC from the national budget. The grant funds comprise a population-based component and a supplement for idiosyncratic health characteristics of each municipal area Leonardo E Letelier S, "Theory and Evidence of Municipal Borrowing in Chile," *Public Choice* 146 (2011).

²¹ A little more than seventy percent of the FCM financing is now provided by Fonasa.

²² Education and health represent about 62% of all grants.

Agency Relationship to Other Public and Private Insurers

Insurers

Isapres, as described, operate independently and competitively alongside Fonasa, and are subject to a separate set of SDS regulations regarding establishment, operations, and solvency (Bitran et al 2008). There does not seem to be any direct relationship between Fonasa and these Isapres, except in the sense that both are mandated to cover a minimum set of AUGE-defined benefits,²³ regulated by the same agency for performance against this mandate, and Fonasa's beneficiaries can access private providers—usually catering to members of Isapres—under certain mechanisms (as discussed in the sections on system architecture and payments to providers). Thus, formal coordination between “the public and private health subsystems in Chile” has not been instituted as an explicit means by which to achieve the health system's objectives (Missoni and Solimano 2010). However, there are other salient ways in which competition with private health insurers can impact the public purchaser's performance. For instance, private insurers have a profit motive to work hard to attract members by offering diverse insurance plans, investing in attractive infrastructure and medical technologies, and advertising heavily. All of this influences the public's expectations regarding what medical care should be covered and what constitutes good quality medical care. In Chile, as mentioned earlier in the discussion of the FCM and AUGE vouchers, Fonasa's beneficiaries can use private providers under certain circumstances. Privately insured individuals can also use public providers. For example, Isapres members may use SNSS hospitals to receive the most advanced critical treatments that the private hospitals may not offer.

The Role of Competitive Market Forces

Chile created Fonasa and Isapres with the theory that encouraging competition between the insurers would result in more efficient administration, lower prices, and higher-quality healthcare. This competition may have contributed to a number of changes. In 1998, Fonasa started a catastrophic health insurance plan and in 2000, Isapres responded by voluntarily including high-cost services in their plans. Isapres also lowered its administrative spending to increase sales and marketing and began to make bulk purchases from providers to contain costs. Both Fonasa and Isapres also increasingly automated

their processes to improve administrative efficiency and simplify reimbursement to their members (Bitran et al 2008). However, while not a stated objective under AUGE, competitive pressure has not resulted in creating a private alternative to Fonasa for low income or high risk individuals, as Isapres remain quite expensive. Similarly, Isapres' beneficiaries can still lose mobility across insurers if they develop expensive health conditions. The competition between insurers has also meant that individuals may have difficulties understanding and comparing competitive insurance plans, and that Isapres may underemphasize personal prevention activities because of uncertainty about returns since subscribers with better health can easily switch insurers (Bitran et al 2008). Because of duplicative coverage obligations and competitive pressures, the number of people who enroll in Isapres is not just an indicator of socioeconomic status but also may reflect Fonasa's performance in terms of beneficiaries' satisfaction with care, making the drop in the number of individuals covered by Isapres from twenty-six percent in 1995 to just sixteen percent in 2009 particularly meaningful. Hence, we assume that the existence of Isapres helps Chile because it pushes Fonasa to perform better and gives more affluent Chileans access to a publicly regulated and constrained set of insurers.

Key Risks and How They Have Been Addressed

As the discussion above shows, risks to Fonasa's operations include the following significant exogenous limitations that affect its performance:

Active purchasing: Limited capacity for active purchasing restricts Fonasa's insurance function

Fonasa is tasked with the dual mandate of ensuring insurance coverage for its beneficiaries as well as efficiently managing public finances for health. Almost one-third of the eighty-five percent of Fonasa's total spending on public providers, however, takes the form of transfers to support historic budgets and does not purchase specified benefits. Overall, only a quarter of all of Fonasa's payments are in the form of FFS; the rest are hospital budget transfers, FCM and vouchers to private providers, and capitation payments (PHC). This mix of payment mechanisms limits the scope for more active purchasing and has remained mostly unchanged since the AUGE reform, which itself did not significantly impact Fonasa's payment mechanisms and therefore its capacity for active purchasing.

²³ Isapres' beneficiaries are not subject to AUGE guarantees in benefits provision, however.

While this points to a need to “deepen” Fonasa’s insurance function (DIPRES 2013), Fonasa has limited choice but to continue with these transfers given its inability to influence large scale administrative and systemic changes in the public provision system. Mitigating this issue would involve enabling Fonasa to better inform public investment in the RSHs to improve their capacity and/or enable them to perform more services on FFS basis.

Rising costs: *Inadequate capacity in the public sector leads to reliance on costly private providers*

Fonasa has to bear the high costs of vouchers for private provision of healthcare because of inadequate capacity in the public sector to deliver minimum benefits as guaranteed. Data suggest that transfer of AUGE patients who are not treated in a timely manner from the public to the private sector more than doubles costs or halves the number of services that could be provided (Bitran and Escobar 2014). This is against the backdrop of the high overall cost of expanding AUGE services: by 2012, Fonasa’s spending per beneficiary had increased by more than seventy-five percent above 2002 levels (Bitran, Debrott, & Arpon 2013).

Continuing to invest in strengthening the public health sector’s capacity to provide at least the AUGE benefits floor as guaranteed will be important to managing this dimension of Fonasa’s performance in the future.

Limited policy levers: *Fonasa cannot manipulate key policy levers to improve its sustainability*

Fonasa is unable, given restrictions by the AUGE law and SDS, to alter affiliation and coverage conditions, decide the level of mandatory contributions, and emulate the Isapres in accepting higher premiums for top-up coverage. Since Fonasa is also not involved in regularly and systematically defining and assessing the costs of minimum benefits for affordability—that seems to occur entirely between the Ministries of Finance and Health—it is unable to directly manipulate the major policy levers that shape its financial and statutory obligations.

In the early 1980s, one major crisis occurred in the form of the growing fiscal deficit because of reduced public subsidies and migration of higher income individuals to Isapres. To respond, the government increased the mandatory contribution from three percent to seven percent of beneficiary income in 1986 (Posner 2008). Giving Fonasa a more active policy role should enable it to better plan its financial liabilities.

Discussion and Case Conclusion

Fonasa is a dominant part of Chile’s multi-payer public health system, funded by a seven percent payroll contribution and subsidies from public tax revenue. Its core responsibility under Chile’s 2005 AUGE reform is to purchase explicitly defined minimum benefits from the public health system under legally mandated guarantees of access, timeliness, financial protection, and quality. In addition, it continues to implicitly cover all other health services as before. Within Chile’s unitary government, it is regulated by the Superintendency of Health in the Ministry of Health, which also regulates its private sector competitors, the Isapres. Fonasa is strategically managed by DIPRES in the Ministry of Finance. Finally, it primarily purchases (secondary and tertiary) services from the geographically decentralized public health system—the SNSS—but, like the Isapres, may reimburse private providers under a *Free Choice Modality* or through contracts and vouchers. It also administers capitation and program-based payments to locally run municipal health centers for primary healthcare.

Fonasa came out of reforms in the late-1970s to improve quality and efficiency in the health sector in Chile by consolidating public insurance agencies and introducing competition between public and private entities. It has provided the institutional basis to improve equity in healthcare, a process which was strengthened through the 2005 AUGE reform. Fonasa’s success is reflected in the fact that it now serves about seventy-seven percent of Chile’s population, maintains quite high levels of citizen satisfaction as measured by surveys, and incurs fairly low administrative costs (less than five percent). By helping to operationalize benefits reform, it has also enhanced equity and stemmed the tide of adverse selection (Frenz et al 2013; Unger et al 2008; DIPRES 2013). Statutory reviews of Fonasa’s performance indicators have found broad alignment in its mission, goals, and activities, concluding that Fonasa continues to successfully fulfill its mandate of guaranteeing access, timeliness, financial protection, and quality in healthcare for its beneficiaries (DIPRES 2013). It has helped achieve near-universal coverage in Chile by providing indiscriminate access to various health services that beneficiaries need, particularly among populations like the elderly, women, and members of lower income groups.

However, in addition to key risks above, areas for further reform of Fonasa’s performance have also been identified in reviews (DIPRES 2013). For example, it is crucial that Fonasa gathers enhanced and more targeted data going forward. Although an effective surveillance system like SIGGES can help Fonasa to ensure that it uses its resources efficiently and identifies adverse trends before they affect financial sustainability, Fonasa still needs to improve its production of data for more granular measurement of standard

performance indicators,²⁴ particularly those for quality, efficiency, equity, and financial protection of enrollees. For these reasons, and to combat fraud and abuse, Fonasa needs a mechanism to collect data, especially during the period of incremental expansions of benefits. Better data would also help Fonasa address residual equity concerns: for instance, data on patient consultations shows that geographic disparities still exist, which points to a possible avenue to improve health equity.

Apart from the overview of Fonasa's performance, the following considerations may inform policy proposal on developing the NHIF in South Africa:

- **Unification of healthcare regulation:** The 2005 AUGE reform consolidated overall oversight and regulation of Fonasa, Isapres, as well as public and private providers in the SDS within the Ministry of Health. The government previously regulated Fonasa directly, but began to regulate the Isapres separately from Fonasa in the early 1990s. As such, prior to 2005, regulations applicable to Isapres regarding quality of services, financial solvency, benefits, indiscriminate access, and consumer care did not apply to Fonasa, which raised concerns about fair and equal treatment of beneficiaries across health insurers (Savedoff and Gottret 2008). The unification of oversight has helped to allay concerns about the uniformity of healthcare and health insurance regulations across agents working in Chile's health sector, although the specific rules and mechanisms concerning the governance of Fonasa and Isapres differ and the entities continue to operate entirely independently. This contrasts with the earlier situation in which Isapres could more freely exclude low income-high risk beneficiaries.

If South Africa considers instituting the proposed NHIF, it should consider the benefits of unified regulation to avoid the type of concerns raised in Chile. Moreover, it will be important for South Africa to determine how statutory regulatory agencies like the NHI Commission (to oversee the NHIF), the Office of Health Standards Compliance (to monitor providers), and the Council for Medical Schemes might relate to each other. Although not addressed in this case study, this will be particularly important in light of Chile's experience overseeing the Isapres before 2005 and then instituting reforms to bring them into the fold of a universal mandatory health insurance system, regulating them through the SDS, and requiring them to cover a set of minimum benefits so that their functions would better align with public policy goals. Given the likely continued role of medical schemes in South Africa, it will be useful for the government to engage in targeted learning and

consultation to clarify early on how regulation might evolve, such as in the form of changes to the Medical Schemes Act of 1998.

- **Role of private providers:** Another key consideration for South Africa based on Chile's experience concerns the continued role of private providers in supplying services to Fonasa beneficiaries. The gains that Fonasa made in providing AUGE services came at a significant cost. Per capita spending on beneficiaries by Fonasa increased by more than seventy-five percent between 2002 and 2012 in the aftermath of the reform (Bitran et al 2013). The cost of providing vouchers for private sector services (which are necessary because of the public system's capacity constraints that limit its ability to deliver guaranteed benefits) is an important component of this rising spending on beneficiaries. When the AUGE law was passed, the costs were financed through an increase in the consumer tax (VAT) from 18 to 19 percent; a tobacco tax; customs revenues; and proceeds from the sale of the state's minority shares in public health enterprises. Chile's Ministry of Healthcarefully estimates the cost of additional benefits to ensure that Fonasa's benefits continue to be affordable, but as the consumption of health services by Fonasa beneficiaries continues to increase²⁵ and as new benefits are added, Chile will need to add additional resources and/or invest in increasing the capacity of public health providers.

As South Africa institutes healthcare obligations and contracting mechanisms as part of the NHI reform, it will need to carefully and realistically estimate the capacity of the public health sector and analyze the demand that may need to be satisfied by private providers. Already, private providers have begun to indicate in interviews their serious concerns about "remuneration, state control, increased workload, clinical autonomy and diminished quality of care, and working conditions," (Surender, Van Niekerk, Hannah, Allan, & Shung-King 2014) suggesting that policymakers may need to revisit their assumptions about excess capacity and interest in the private sector.

- **Unitary versus federated context:** Finally, an important caveat for South Africa is that Fonasa functions within Chile's top-down unitary structure, in which the priorities and policies of the national government are consistently iterated down the administrative chain of command within public organizations. Fonasa's ability to pool and deploy resources across the national territory, coordinate with public providers (SNSS and municipal facilities), streamline data collection, and implement policy in a consistent manner derives significantly from this centralized context. For South Africa's proposed

²⁴ As outlined in the World Bank's *Health insurance handbook: how to make it work* (Hong Wang et al., *Health Insurance Handbook: How to Make It Work*, vol. 219. World Bank Publications, 2012).

²⁵ In the fifteen-year period from 1997 to 2012, the volume of services used by Fonasa beneficiaries, particularly through expensive channels like the Free Choice Modality, nearly tripled (*Supporting the Development of National Health Insurance in South Africa: A Review of Benefits Policy and Active Purchasing Reform in Chile*- Results for Development Institute, 2014.).

NHIF to work broadly in a similar manner in the country's federated context (in particular to institute national-level pooling of resources), the government must change the functional and financial roles of provinces and districts.

In conclusion, the health financing system in Chile is quite progressive (Savedoff 2000). Fonasa and the SNSS facilitate the transfer of funds from wealthier segments of the population to the less wealthy to provide for their healthcare needs. Although Fonasa is not a "health solidarity fund," in that it does not facilitate "the transfer of funds from the private to the public health system," (Missoni and Solimano 2010) it is financed in part from transfers from the Ministry of Finance out of general public revenues. Similarly, while there is continued stratification in available healthcare benefits and quality by income groups in Chile, public health expenditures since 2005 have increased in absolute terms and as a share of both total health expenditures and total public spending (Missoni and Solimano 2010). At the same time, private spending on health has decreased as a share of total health expenditures and the proportion of out-of-pocket spending in private health expenditures has also begun to level off (Missoni and Solimano 2010). These indicators suggest that the Chilean population is protected from health-related financial shocks. But, as elsewhere, the long-term sustainability of the system is tied to the public sector's ability to deploy additional funds and to the performance of Chile's economy.

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Colombia: Fondo de Solidaridad y Garantía (FOSYGA)

Introduction

Colombia is an upper-middle income country of 48.3 million in Latin America.²⁶ In 2012, Colombia's per capita GDP was US\$4,252, total per capita health expenditure was US\$723.3 (PPP), total health expenditure was 6.8 percent of GDP, and GINI coefficient was 53.5.²⁷ Before 1993, Colombia had a fragmented system of public, private, and social security health coverage, and only twenty-four percent of the population was covered by health insurance (Giedion and Uribe 2009). A major health reform in 1993 ('Law 100') reorganized Colombian health coverage, financing, and pooling under a single national system called the General System for Social Security for Health or SGSSS (*Sistema General de Seguridad Social en Salud*). By 2012, the reform had raised personal health insurance coverage in Colombia to almost universal levels (Vargas-Zea, Castro, Rodríguez-Páez, Téllez, and Salazar-Arias 2012).

The SGSSS is a public system managed by the Ministry of Health and Social Protection (MPS or *Ministerio de Salud y Protección Social*) that centrally pools health funds for all Colombians in a national Solidarity and Guarantee Fund, or FOSYGA (*Fondo de Solidaridad y Garantía*), and organizes cross subsidies among beneficiaries. It also regulates a network of insurance companies called the EPSs (*Entidad Promotora de Salud*, or health promoting entity) that are responsible for affiliating members, collecting payroll

contributions, and purchasing services from public and private providers. In addition to this health insurance component, the SGSSS also encompasses a system of intergovernmental transfers for health, which is used to finance a set of population-level public health interventions at the subnational level.

Colombia is a unitary democratic state headed by a president elected by popular vote for up to two four-year terms.²⁸ At the subnational level, Colombia comprises a capital district as well as 1,119 municipalities overseen by mayors and grouped into 32 'departments' headed by governors. Both mayors and governors are elected by popular vote. However, these subnational governments have limited autonomy. The SGSSS and decentralization reforms in the last two decades have created schemes by which the government transfers national funds and capacity for administering its personal and public health policies to the municipalities and departments.

Rationale

Despite possible parallels with South Africa regarding the decentralization of funding for public health, Colombia has a unique system of regulated market competition among health insurance companies responsible for enrolling beneficiaries and purchasing services, and public and private providers vying to sell services to insurers. The

How is Colombia's General System for Social Security for Health (SGSSS) organized?

The SGSSS creates national pooling and income solidarity, regulates market competition among insurers and providers, and institutes a regime of intergovernmental transfers for health to subnational governments for (non-insurance) public health services.

The SGSSS pools funds to finance health insurance services for the population at the national level through a trust fund—FOSYGA—attached to the Ministry of Health and Social Protection. FOSYGA pools payroll contributions from contributing SGSSS enrollees, as well as transfers from general public revenue, and makes capitation-based payments to insurers that enroll both paying and non-paying beneficiaries.

Insurers under SGSSS compete to enroll members, collect and pass up payroll contributions from (paying) beneficiaries, and receive capitation transfers from FOSYGA to purchase healthcare services from competing public and private providers.

In parallel, subnational governments—departments (regions) and municipalities with limited autonomy—receive transfers from Colombia's national government to finance the programming and delivery of public health services.

²⁶ World Development Indicators: Population Dynamics (The World Bank). 2013 information.

²⁷ World Development Indicators; in constant 2005\$ for 2012.

²⁸ CIA: The World Factbook

FOSYGA at a Glance

Pooling fund: *Fondo de Solidaridad y Garantía* (FOSYGA).

Function: Serves as the national pooling mechanism for health insurance under Colombia's 1993 General System for Social Security for Health (SGSSS) reform.

Type: A welfare trust attached to the MPS and managed by trustees on behalf of the MPS pools funds for health insurance services for more than ninety-eight percent of the country's population.

Finance: Financed by a 12.5 percent mandatory payroll contribution from contributing beneficiaries and transfers from the general government revenue.

Mission: Under SGSSS, health insurance funds for all Colombians are pooled in FOSYGA; the 12.5 percent payroll contributions from contributing enrollees by insurance companies (EPSs) are paid into the fund, as are government transfers. FOSYGA helps to establish cross subsidies (income solidarity) among paying and non-paying beneficiaries and facilitates capitation-based payments to EPSs so that they can purchase services for their beneficiaries.

features of Colombia's unique system limit the extent to which we can compare it with the NHIF in South Africa. Currently, NHIF is proposed as a single-payer public fund responsible for both pooling and purchasing, with likely voluntary top-up private insurance and a significant policy role for local governments.²⁹

However, we include Colombia here as an interesting, partial case study because FOSYGA may offer possible lessons to South Africa regarding organizing sustainable and centralized pooling of health insurance funds through public channels. FOSYGA also provides a counterexample to large healthcare pooling and purchasing organizations in other countries³⁰ in that it is a welfare fund (an account) managed by trustees on behalf of the MPS.³¹ Therefore, this case study focuses only on describing the national public arrangements to pool SGSSS funds and the governance thereof. Beyond providing an overview of the overall system, we do not delve into describing the EPSs and related purchasing and governance mechanisms, the providers of specified SGSSS insurance benefits, or the interface of the personal care system with subnational governments. We do, however, describe Colombia's regime of intergovernmental transfers of funds from the national government to the municipalities and departments to finance population-level health services, because this regime offers takeaways for South Africa.

Public System of Managing Health Funds and Purchasing Services

System Architecture

The figure on the following page shows the organization of financing and delivery in Colombia's personal health insurance system as overseen by the MPS. We discuss the salient functions of the MPS in the next subsection.

As shown in Figure 2.4, the SGSSS is financed primarily by transfers from general government revenue and payroll contributions from employers and workers, all of which are pooled by the national Solidarity and Guarantee Fund (FOSYGA).³² Colombia requires that all Colombians be affiliated with one of two types of insurance companies—EPS-C or EPS-S—which cover a standardized set of mandatory benefits called the POS (*Plan Obligatorio de Salud*).³³ EPS-C affiliates and families are part of the contributory regime of SGSSS and comprise formal workers and those earning above a monthly threshold. EPS-C affiliates must contribute 12.5 percent of income for health coverage.³⁴ EPS-S beneficiaries and their families are part of a subsidized regime for poorer affiliates who are exempt from making payroll contributions or provider copayments. EPS-S affiliation is determined by municipalities in Colombia through a proxy means testing instrument used to target

²⁹ Draft policy proposals (R4D memo to the National Treasury; September 01, 2014)

³⁰ Such as Fonasa in Chile or the NHSO in Thailand.

³¹ Discussed later in more detail.

³² Other funding sources include municipality rents and taxes and co-payments to providers.

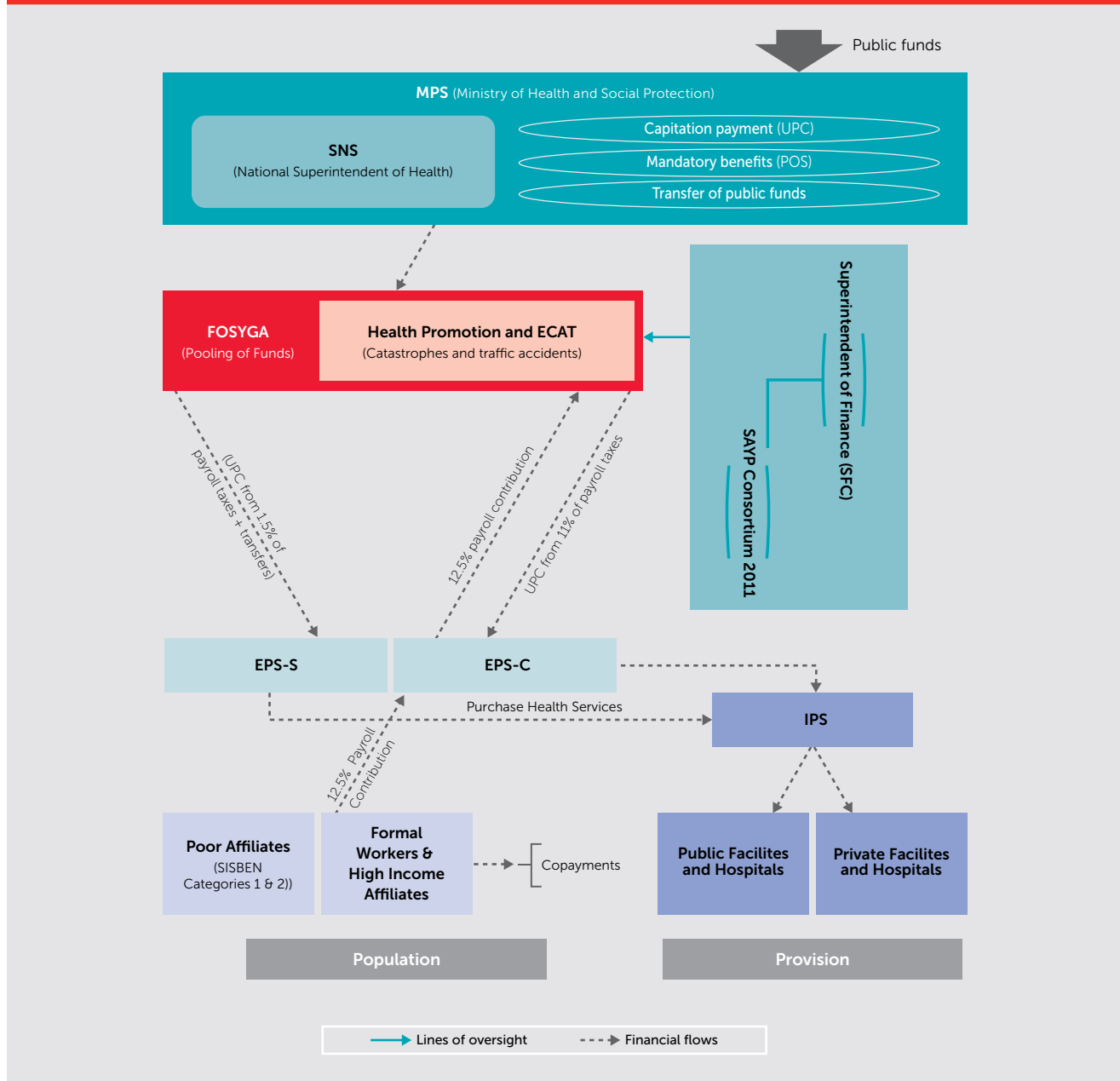
³³ A wide ranging package including general primary, secondary, and tertiary services; emergency, dental, obstetric, and neonatal care; specialist consultation, medicines, some surgeries, and rehabilitation; and some high cost services (HIV/AIDS, cancer treatment, etc.) as well as maternity and disability assistance Ursula Giedion and Manuela Villar Uribe, "Colombia's Universal Health Insurance System," *Health Affairs* 28, no. 3 (2009).

³⁴ Split between employer (8 percent) and employee (4.5 percent) for salaried workers. Informal workers and pensioners must pay their 12.5 percent contribution in full. Lorena Mesa Melgarejo, "Determinants of Healthcare Expenditure: The Colombian Case," *APUNTES DEL CENES* 30, no. 52 (2013).

public social sector spending known as SISBEN (System for Selecting Beneficiaries of Social Spending) (Castaneda and Fernandez 2003). Only beneficiaries that fall in SISBEN categories 1 and 2 are eligible for EPS-S insurers.³⁵ To cover health services for affiliates, EPS-S insurers receive FOSYGA funding from general public funds and a solidarity transfer of 1.5 percent out of the 12.5 percent contributed by

EPS-C affiliates. Outside of SGSSS, Colombians employed in certain specified sectors may be enrolled in “Special Regimes” for the military, police, the state oil company, the judicial system, etc. Overall, by 2012, about forty percent of SGSSS enrollees (formal sector workers) were covered by the EPS-Cs and the rest were covered by the EPS-Ss (Webster 2012).³⁶

Figure 2.4: Key Finance and Oversight Relationships of FOSYGA and Providers, Insurers, and Government in Colombia’s General System for Social Security for Health



³⁵ However, this system may have been *de facto* abandoned as the national government accelerated enrollment for informal workers through the EPS-Ss (Fernando Montenegro Torres and Oscar Bernal Acevedo, “Colombia Case Study: The Subsidized Regime of Colombia’s National Health Insurance System,” in *Universal Health Coverage Studies Series (UNICO)*. Washington DC: The World Bank, 2013).

³⁶ Up from about fifty percent covered by EPS-Ss in 2009 (Susan Powers Sparkes and William C. Hsiao, “Comparison of the Health Systems of Brazil, Chile, Colombia and Mexico,” Kaiser Family Foundation, 2010.). Percentage enrollment in SGSSS, and likely EPS-S, has since risen further.

EPSs affiliate members, collect payroll contributions on behalf of FOSYGA, and guarantee access for their members to the POS benefits. They receive a risk-adjusted capitated payment, called the UPC, back from FOSYGA and manage those resources to finance the POS for their beneficiaries by purchasing services from competing public and private providers. EPSs are expected to help expand coverage to the previously uninsured, enroll anyone who applies according to the law, organize their members' access to POS-covered care throughout the country, and provide FOSYGA with all necessary information³⁷ related to affiliates and their dependents (Giedion and Uribe 2009; Glassman, Escobar, Giuffrida, and Giedion 2009). The EPSs purchase services by entering into contracts with Institutional Service Providers (IPS), which are a mix of public and private entities competing to serve patients (Guerrero, Gallego, Becerril-Montekio, and Vásquez 2011).

System Reporting and Oversight Architecture

The Ministry of Health and Social Protection (MPS) takes precedence as the lead regulator and policymaker in implementing and overseeing health insurance under the SGSSS. The MPS defines the mandatory SGSSS benefits package (the POS), determines the capitated payment (UPC) paid to the insurance companies (the EPSs), sets copayment rates for providers, evaluates the SGSSS, and recommends policy changes to the legislature (Torres and Acevedo, 2013).³⁸ The National Superintendent of Health (SNS), a quasi-autonomous agency attached to the MPS, leads the SGSSS's System of Inspection, Surveillance, and Control (Torres and Acevedo 2013). It monitors and inspects the EPSs, IPS, and other entities that manage health funds to purchase services, and also has the authority to judge and resolve conflicts between actors in the SGSSS.³⁹ However, Colombia's Superintendent of Finance (SFC) evaluates the financial governance of FOSYGA funds.

Intergovernmental Transfers for Health in Colombia

As mentioned above, under SGSSS, FOSYGA finances health insurance benefits—the POS—for individuals. But Colombia also has a system of intergovernmental transfers for health that is used to finance a set of population-level public health interventions called the Plan *Básico de*

Salud (PBS). The PBS is intended to cover interventions with collective benefits or high externalities, and includes immunization and maternal and child health services, as well as control of epidemics and communicable diseases, including TB, leprosy, malaria, and STDs (Glassman et al. 2009). Both POS and PBS, “along with protocols and standards of care as of 2000, were explicitly established in laws, norms, and guidelines, thus creating a financing and expenditure benchmark for public health and a legal entitlement for the respective target populations” (Glassman et al. 2009).

The PBS is delivered at the subnational level through federal transfers to departments and municipalities. The interventions were initiated after both health policy and decentralization reforms in Colombia redistributed public health responsibilities. Before the 1993 SGSSS reform, it was hard to isolate a source of financing for public health interventions because health budgets were transferred in lump sum from the MPS. There was, in fact, an inequitable emphasis on curative care, spending on which increased from fifty percent to seventy percent of health expenditures between 1970 and 1990 (Glassman et al. 2009). After administrative decentralization in the mid-1980s, further constitutional reform and Law 60 of 1993 allowed population-based allocation rules and fiscal decentralization. However, even after decentralization and the SGSSS reforms, municipalities and departments had complaints about the parameters used under Colombia's *Sistema General de Participaciones* (SGP) regime to transfer national government resources to regional and local levels. Subnational governments also complained about the disparity between responsibilities and capacity at the departmental and municipal levels, and the volatility in financial resources earmarked for social investment given variable government income (Clavijo and Torrente 2008). Law 715 of 2001 clarified public health functions and responsibilities at each level of government to mitigate the formerly slow progress in meeting fiscal decentralization goals, and extended the SGP (Glassman et al. 2009). The Law reset the level of national transfers for health—basing them on subnational indicators of equity and efficiency—and redefined the responsibilities of subnational governments to be more in accordance with their capacity.

Within Colombia, the central government concentrates primarily on policy design, regulation, and public finance. Departmental governments assume regional planning, management, and financial responsibilities, and provide some services and articulation of local and national

³⁷ As managed through the BDU, the Single Database of Affiliates maintained by the MPS. The BDU is introduced later in the section titled Pooling and Payment.

³⁸ Prior to December 2012, a special administrative unit with substantial autonomy established in 2007 within the MPS, called the Health Regulation Commission (CRES), managed these functions. CRES was abolished in December 2012 to “streamline the institutional arrangements of the health sector” Torres and Acevedo, “Colombia Case Study: The Subsidized Regime of Colombia's National Health Insurance System.”

³⁹ Diana Pinto and Ana Lucia Muñoz, “Colombia: Sistema General De Seguridad Social En Salud,” *Estrategia del BID* 2014 (2011).

levels, while municipal governments implement actual policy and provide public services. Hence, in fiscal terms, municipalities are considerably more important than departments even though the latter are responsible for programming the two most expensive subnational public services—health and education. Currently, eighty-five percent of SGP transfers to subnational governments are reserved for education, healthcare, and infrastructure spending (Brosio and Jimenez 2012). Of these funds, sixty percent are dedicated to education, twenty-five percent to healthcare, and the remaining fifteen percent to the sector (likely infrastructure) with the more urgent needs (Clavijo and Torrente 2008). These transfers are in addition to the more general transfers to municipalities (*participaciones municipales*). Importantly, although health and education policies have been decentralized administratively, they have not been “devolved” to departments and municipalities in Colombia. In fact, the national government in Colombia has seldom been happy with how the subnational recipients spend fiscal transfers and has constantly attempted to control—through legislation and constitutional amendments—how departments and municipalities use funds.

Overall, Colombia’s health and decentralization reforms not only increased resources for public health but also earmarked them exclusively for POS or PBS purposes. Consequently, the resources available for public health measures increased by thirty percent between 1995 and 2004 and became more predictable (Glassman et al. 2009). In addition, from 1990 to 1993, the national government established administrative procedures to certify local governments as “decentralized.” To become certified, local governments must satisfy several requirements, one of which mandates the creation of local health directorates to assume public health responsibilities. After the local governments meet the requirements and are certified, the national government can shift authority, responsibility, and budgetary control of the public health resources to departments and municipalities. At present, the main role of this system is to permit the decertification of those territorial entities that have obvious capacity problems (increasingly) assessed on the basis of an ex-post assessment of service results (Bird 2012). Thus, the national government under SGP now routinely evaluates departmental and municipal uptake of PBS interventions.

Pooling and Payment

Management of the FOSYGA Pool

As mentioned above, SGSSS resources pooled in FOSYGA to finance the POS benefits are sourced from public revenue transferred from the MPS, as well as from payroll contributions from affiliates collected and transmitted by the EPSs. By law,⁴⁰ FOSYGA is attached to the MPS as a welfare trust to manage earmarked resources for investment in health. Until 2011, however, “there was virtually no financial supervision of health plans, which were supposed to be monitored by the Health Superintendence” (Torres and Acevedo 2013). Because the SNS did not have the staff, resources, and skills to provide the requisite financial supervision of FOSYGA, this oversight function was transferred to the Superintendencia Financiera de Colombia (SFC).⁴¹

The ‘SAYP Consortium 2011’ regularly administers the FOSYGA portfolio under a contract with the MPS.⁴² The consortium comprises fiduciaries (trustees) Fiduprevisora and Fiducoldex. The fiduciary consortium managing FOSYGA resources must strictly adhere to regulations issued by the SFC regarding the governance of trusteeships.⁴³ In general, trusts (*carteras colectivas*) in Colombia are “subject to a full complement of requirements relative to disclosure, authorization, and operation,” including a “review of the organizational capacity, governance, and resources” of the managers (IMF 2013). The consortium manages FOSYGA funds, which are organized into the following subaccounts: compensation for the contributory regime; subsidized regime of health solidarity; health promotion; and catastrophic risk insurance and traffic accidents (ECAT). The consortium manages dedicated resources independently within each subaccount as separate investment portfolios, with interest and other income reverting to the respective sub-pool of funds under applicable budgetary rules.⁴⁴ The consortium is responsible for investing FOSYGA resources pursuant to the explicit criteria of safety, liquidity, and profitability as set out in a Unified Operational Proposal (*Propuesta Operativa Unificada*), which contains guidelines and conditions agreed to with the MPS. A portfolio coordination mechanism established by the SNS within the SAYP consortium ensures that the consortium adheres to these guidelines and conditions consistently and produces reports on the monitoring and management of these portfolios regularly.

⁴⁰ Law 100 of 1993, Decree 1283 of 1996 governing FOSYGA operations, and Decree 2280 of 2004. <http://www.fosyga.gov.co/>

⁴¹ Superintendent of Finance; a Colombian government agency responsible for regulating the overall banking and securities markets and protecting depositors and policyholders.

⁴² Contract 467 of 2011. <http://www.fosyga.gov.co/>

⁴³ Available at: <http://www.fosyga.gov.co/AcercadelFOSYGA/MarcoNormativo/OtrosDocumentos/tabid/312/Default.aspx>

⁴⁴ <http://www.fosyga.gov.co/>

Payments to Insurers

FOSYGA transfers funds as risk-adjusted capitation payments to the EPSs from resources received from public sources and payroll contributions. MPS determines the capitation payment unit (UPC) annually as the appropriate value to cover the mandatory benefits. Hence, the UPC is the most salient variable that MPS takes into account in making financing decisions within the SGSSS (Melgarejo 2013) to effectively guarantee the “right to health” and access to healthcare (part of the broader mandate of the MPS).

MPS’s calculation of the UPC incorporates population characteristics that determine health spending,⁴⁵ actuarial techniques for assessing risk, and statistical models (Melgarejo 2013). The risk assessment of the UPC is based on the following variables: the cost of the mandatory benefits according to information from the EPSs; resource need estimates for any new procedures; the net premium (the cost of providing services and the risk of the total population in each regime); the commercial premium (administrative and utility costs); insurance estimates of unreported losses; past trends in the utilization and cost of POS services; and a final risk adjustment.⁴⁶

The UPC is the “necessary premium” to cover the cost of health insurance (Melgarejo 2013). However, the MPS has only recently standardized the POS across the contributory and subsidized regimes. Before 2012, the EPS-S affiliates could, generally, access only a limited mandatory benefits package, POS-S.⁴⁷ In 2008, the Constitutional Court ordered a “Health Bill of Rights” established for all Colombians and directed the government to immediately work to standardize the POS-S and POS-C for those under eighteen years of age and work to unify the POS for both regimes (Torres and Acevedo 2013). The government first unified POS for those under eighteen first, then for those sixty and older in 2011. Finally, the government unified POS for all EPS-C and EPS-S affiliates on July 1, 2012.⁴⁸ The government’s process of standardizing the POS across all affiliates was slow, as it required the EPSs to adjust contracts with the providers in their networks. Hence, for 2012, the capitated payment in the contributory regime was estimated at about US\$310 while the UPC for the subsidized regime was about US\$200.⁴⁹ The difference in UPC between the two regimes may have resulted from the fact that as of 2012 the benefits of the two regimes were not yet fully standardized and because the health

profiles of the respective beneficiaries differed. Importantly, when the UPC is insufficient to cover the POS, the EPSs bill FOSYGA for overages as “recoveries” (recobros). Information on how these recoveries are determined and their financial impact is not publicly available (Melgarejo 2013).

Flow of Data and Information to Support Financing and Reporting Relationships

BDUA, the Single Database of Affiliates (Base de Datos Única de Afiliados), serves as MPS’s main instrument to manage and regulate the SGSSS and properly control the flow of resources. The EPSs populate the database with information about enrollment and beneficiaries’ characteristics. The BDUA Directorate within MPS provides MPS and the trustees of FOSYGA with vital information on resource needs and affiliates. For instance, the MPS determines EPS-S’s membership based on information from the BDUA supplied by insurers in the subsidized regime. However, the MPS has expressed concerns about duplicated, incomplete, or fraudulent information in the BDUA (MPS).⁵⁰

Salient Issues and Lessons from Colombia

Over the last two decades, health insurance coverage under the SGSSS has increased from less than a quarter of the population to near-universal levels. Data from 1995–2009 show that per capita out-of-pocket health payments declined sharply as comparable health spending from pooled sources increased, thereby enhancing financial protection for the population as a whole (Fan and Savedoff 2014). Lower income groups have gained unprecedented access to an expansive set of publicly ensured services through the subsidized (POS) regime of the SGSSS, and because benefits packages have been standardized for all beneficiaries.

We have identified some issues that require further reform. First, there is “wide consensus on the need to improve capitation as a mechanism to pay for health plans” but no agreement on the means to do so (Torres and Acevedo 2013). The level of the capitated payment to the EPSs

⁴⁵ Only age, sex, and geographical area are included in the case of Colombia.

⁴⁶ MPS calculates the approximate risk by multivariate statistical techniques. Melgarejo, “Determinants of Healthcare Expenditure: The Colombian Case.”

⁴⁷ Covering only basic PHC services and some high-cost (catastrophic) ones

⁴⁸ <http://www.minsalud.gov.co/Paginas/default.aspx>

⁴⁹ Quoted in Torres and Acevedo, 2013. The Constitutional Court ruled in November 2012 that the base level of capitations for the same package of mandatory benefits should be the same. Hence, calculations of the capitation need to be refined.

⁵⁰ The government launched a major investigation in 2011 into suspected irregularities in the processing of POS claims involving EPSs; discovering fraudulent use of identities, falsified enrolments, “payments in cases of false diagnosis, and fake documentation to simulate provision of services rendered” Torres and Acevedo, “Colombia Case Study: The Subsidized Regime of Colombia’s National Health Insurance System.”

from FOSYGA (the UPC) is the chief determinant of health expenditures in Colombia⁵¹ and is shaped by the risk profile of the benefits (POS). Unlike in countries in which benefits are determined (at least partially) on the basis of epidemiological profile and health status, there is little evidence to suggest that the POS captures such concerns (Melgarejo, 2013).⁵² Because the POS was not determined to explicitly target the health status of the population, the UPC primarily functions as a tool for risk adjustment instead of one for population welfare. This is true particularly when the process for establishing it is less than fully insulated from political pressures by stakeholders (Melgarejo 2013) like the EPSs. The mandatory standardization of the POS also means that it is unclear what levers the government will have available going forward for controlling health expenditure. The standardization would require more public subsidies for EPS-S beneficiaries whose numbers have swelled in the last decade.⁵³ Proposed reforms include reducing the payroll contribution level and drawing more financing from corporate taxes, as well as identifying and removing large numbers of non-poor beneficiaries from the EPS-S rolls (Torres and Acevedo 2013).

Similarly, because only recently has the POS been integrated for both SGSSS regimes, the UPC for EPS-S beneficiaries is lower than for EPS-C affiliates, leading to continuing equity problems in access to healthcare. Although recent research has noted improvements in equitable access to healthcare, it is not clear if the expansion of the subsidized regime played a role, and “concern about the slow pace of progress on the right to healthcare and equity” has continued to dominate public debate (Torres and Acevedo 2013). Public actors who have applied pressure in this regard have included Colombia’s Ombudsman, the General Comptroller, the General Attorney, and, significantly, Constitutional Court Magistrates.

Colombia’s cost and equity issues connected to the segmentation of insurance are significant for South Africa. South Africa too may end up with a similarly segmented population of insurance beneficiaries if medical schemes offering duplicative (minimum benefits) coverage continue to operate alongside a future NHIF. In such an eventuality, the NHIF, as currently envisioned in draft policy proposals by the Department of Health, will be similar to Colombia’s EPS-Ss in the sense that the NHIF will be responsible for purchasing subsidized health services for lower income enrollees in the system. Meanwhile the medical schemes that enroll contributing members will cater to more affluent beneficiaries who have more expensive, and likely more expansive, health services—similar to the EPS-Cs

in Colombia. Hence, Colombia’s situation shows that financial and equity challenges in healthcare may continue to persist. But Colombia also shows how a country can create cross-subsidies among beneficiaries in the presence of multiple insurers. Joint pooling for all beneficiaries under FOSYGA serves to transfer part of the 12.5 percent payroll contribution—passed up from EPS-C enrollees—to pay for health services for EPS-S members. If medical schemes and the NHIF continue to coexist in South Africa under the future NHI, an overarching cross-subsidy mechanism—such as FOSYGA or, more simply, a tax on medical scheme contributions—may be instituted to redistribute funds from insurance plans with lower needs and higher revenues to those with higher needs and lower revenues, creating greater income solidarity and mitigating some of the pressure on public resources to finance NHIF services.

Within its federated context, South Africa may also consider studying and adapting Colombia’s system of dedicated intergovernmental transfers of financing for (non-insurance) public health spending to complement the expansion of personal insurance coverage through the NHIF. As detailed in this case study, Colombia controls and finances both education and health services centrally, but subnational authorities administer these services using transfers from the national government under Colombia’s SGP regime. These transfers primarily comprise earmarked funds to pay the salaries of employees in the health and education sectors. South Africa may also consider broadening or reprogramming the transfer of (conditional) development funds to subnational governments as it institutes a nationally-pooled, single-payer health insurance system.

Colombia’s case also illustrates that such an arrangement may not be without frustrations. Attempts by Colombia’s national government to decentralize expenditures but retain control of how funds are spent have resulted in considerable policy flux and several iterations of legal and constitutional reforms. The government has attempted to correct the so-called “vertical fiscal imbalance” whereby national authorities collect more tax revenue but subnational governments may be directly responsible for delivering more services than they can finance. Through the latest (2011) set of constitutional amendments and legislation, Colombia continues to try to accomplish the following: rationalize the flow of resources to subnational governments to address this vertical imbalance; reduce regional divergence by evening out the flow of national funds among recipients (the “horizontal fiscal imbalance”); and earmark and control how SGP funds are spent, mainly by adding additional conditions and layers of approval that the subnational governments must satisfy before

⁵¹ As opposed to income elasticity or demographics

⁵² As an aside, this may also help explain the lower per capita health expenditure in Colombia.

⁵³ Subsidized coverage for the poor reached ninety eight percent by 2010. Torres and Acevedo, “Colombia Case Study: The Subsidized Regime of Colombia’s National Health Insurance System.”

being able to spend national funds. For South Africa to similarly closely monitor and control subnational spending on health would require legal changes that would be complicated, given the country's federal structure compared to Colombia's unitary one. However, South Africa may be able to leverage its extensive experience with making conditional grants to subnational entities for greater earmarked spending on public health and other development programs.

We identify the following additional issues regarding FOSYGA and Colombia's health system that South Africa should consider:

- As mentioned in the section on payments to insurers in Colombia, "recoveries" for expenses on mandatory benefits over and above the UPC by EPSs constitute an additional outflow of resources from FOSYGA. However, the government's process of determining the amount of these recoveries is not fully transparent. Reports of corruption (in 2008, 2010, and 2011) have charged that EPSs may have inflated medicine costs by "50 % or 100 % over the real market value" or "registered medicines of the POS as not-POS," (Melgarejo 2013) pointing to a need for better control.
- Because FOSYGA is managed as a trust fund, it is vulnerable to market risks on its investments. There have been reports of significant losses in the past.⁵⁴
- Finally, it is also not clear if Colombia's healthcare reform, including financing and cross-subsidy arrangements, can be convincingly tied to improved health outcomes. Studies have documented overall improvements in beneficiaries' health status over the last decade, but it is not clear if these can be linked to expanded coverage under the subsidized regime (Torres and Acevedo 2013). Another recent review of the SGSSS's impact on health status variables in Colombia DHS surveys also did not find any conclusive evidence of health impact (Giedion and Uribe 2009).

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⁵⁴ As part of overall investments by social security funds. <http://www.eltiempo.com/archivo/documento/MAM-3918376>

Thailand: National Health Security Office (NHSO)

Introduction

Case, Rationale, and Key Context

Thailand is an upper-middle-income country with a population of 67 million located in South-east Asia. Thailand's unitary government is based on a constitutional monarchy: a Prime Minister serves as the head of the parliamentary government, and a hereditary King functions as the head of state. Thailand has seventy-six provinces and two special governed districts, Bangkok and Pattaya. Provinces are composed of districts and sub-districts called Tambons. Income inequality in Thailand is relatively low at 39.4 in 2010 compared to the global average inequality index estimated at 38.5 in 2005, and very low compared to South Africa's Gini coefficient of 63.1 in 2005. In 2012, Thailand's annual health expenditure per capita was \$385 PPP; this rate of spending was well below the other cases that we discuss in this report (World Bank, World Development Indicators 2012).

We selected Thailand for case analysis because it is widely recognized for having achieved universal coverage at a relatively low cost by adopting a universal coverage scheme (UCS) in 2002 (Walaiporn et al. 2011; Balabanova, McKee, and Mills 2011; Health Insurance System Research Office 2012; Hanvoravongchai 2013). The scheme offers a comprehensive benefits package that is free at the point of service and focuses on primary healthcare (Health Insurance System Research Office 2012, 37). The UCS is financed by tax revenue and has a fixed annual budget and a cap on provider payments.

Launched in 2002, Thailand's UCS reform, the National Health Security Act, extended health coverage to an additional twenty-five percent of the population by merging several, but not all, preexisting insurance schemes (Limwattananon et al. 2013). Two years after it was introduced, the insured population reached 95.5 percent (Hughes and Leethongdee 2007). Eight years after that, under-five infant mortality rates were at 14 deaths per 1,000 births (down from 21 deaths per 1,000 births in 2002), out-of-pocket spending had decreased from 76.9 percent to 55.8 percent, while the insured population reached 99 percent.

How Did Thailand Successfully Rollout UCS?

Overall lesson is one of adequate system capacity to absorb changes

Decades-long investment in public primary and rural healthcare infrastructure laid groundwork for the policy rollout.

- **Building Public Hospitals:** The Ministry of Public Health (MOPH) accelerated development of provincial and district public hospitals in the mid-sixties so that by 1990, all Thais had access.
- **Mandatory Rural Service:** Starting in the 1970s, newly-trained nurses, doctors and para-professionals served a mandatory three year term in the public health system. This resulted in providing the rural poor with greater access to well-trained health professionals.
- **Focus on Child and Maternal Health:** Free antenatal care, skilled birth attendance, family planning, and immunizations funded and provided by the Thai government reached universal coverage by the 1990s.

Leadership, opportunity, and learning from past large scale insurance schemes enabled reformers to successfully act on a policy opportunity.

- **Pragmatic Leadership:** Generations of charismatic and influential leaders both within and outside of the MOPH were committed to implementing pro-poor, pro-rural health policies.
- **Learning from Experience:** Lessons on health financing infrastructure and know-how were developed from the numerous large-scale insurance programs introduced in piecemeal fashion over many years, including the 1975 Medical Welfare Scheme, the Civil Service Medical Benefit Scheme (1980), the Social Security Scheme (1992), and several failed voluntary programs that extended benefits to informal populations, and provided lessons on adverse selection and moral hazard.
- **Policy Window:** UHC reformers in the MOPH and the Health Systems Research Institute, an independent quasi-public institution linked to the MOPH, recognized the window of opportunity in the run up to the 2001 election and took action.

Sources: (Walaiporn et al. 2011; Hanvoravongchai 2013)

NHSO at a Glance

Purchaser: National Health Security Office (NHSO).

Function: Manages the Universal Coverage Scheme.

Type: Multi-payer system. The UCS is the largest of Thailand's three public health insurance funds.

Coverage: About seventy-five percent of the Thai population, or forty-eight million individuals not covered by the CSMBS or the SSS, or by private voluntary insurance.

Size: 824 staff in 2013

Budget: Administrative budget 1.29 percent (note that the NHSO has no administrative responsibility to generate revenue or collect premiums from UCS members) (Health Insurance System Research Office 2012, 71)).

Expenditure: THB 89,836 million (2011) in total expenditures (NHSO 2012; Hanvoravongchai 2013, 4), or approximately USD\$2,973 million 2011 (R4D).

Finance: General tax-financed.

Mission: *Promote and develop a quality health care system with public confidence and provider satisfaction. Promote the participation of civil society and local administrative organizations in health security development. Promote and protect people's right to health security, as well as reinforce the public's learning process in realizing their rights and duties. Manage the health security funding and the utilization of the fund in the manner of sufficiency and efficiency. Establish a high quality organizational management system and promote continuous development towards a learning organization. (nhs.go.th)*

Public Agency Responsible for Managing Health Funds and Purchasing Services

The 2002 UCS reform, entitled the National Health Security Act, established the National Health Security Office (NHSO) as a state autonomous agency under the authority of the National Health Security Board (NHSB) (*National Health Security Act B.E. 2545 2002*). The NHSO was designed to administer the National Health Security Fund (NHSF), register beneficiaries and service providers, and pay claims according to the NHSB's regulations (Hanvoravongchai 2013, 2).

The UCS is tax-financed with a fixed annual budget and a cap on provider payments. The reform extended health coverage to an additional twenty-five percent of the population that previously were uninsured by merging several, but not all preexisting insurance schemes (Limwattananon et al. 2013).

The UCS scheme offers a comprehensive benefits package that is free at the point of service and focuses on primary healthcare (Health Insurance System Research Office 2012, 37). Two years after it was introduced, the UCS financially covered 75 percent of the population, while the insured population reached 95.5 percent nationally, including those under the two other public schemes discussed later (Hughes and Leethongdee 2007). Twelve years after that, Thailand's per capita health expenditure was four percent of GDP, \$385 PPP (2012) and ninety-nine percent of the population was insured.

The UCS reform made significant progress in meeting its goals to improve equitable access to quality health

services, reduce OOP household spending on health services, and help prevent the impoverishment of families by reducing catastrophic medical spending (Health Insurance System Research Office 2012). Utilization increased after the reform both in the number of outpatient visits per year (by 31 percent, from 2.45 in 2003 to 3.22 in 2010) and in the number of hospital admissions (by 22 percent from 0.094 in 2003 to 0.116 in 2010); and among UCS members in the lowest income quintile, the incidence of OOP payments for healthcare exceeding 10 percent of total household consumption expenditure fell from 6.8 percent in 1996 to 2.8 percent in 2008. After the government introduced the reform, impoverishment as a result of catastrophic health expenditures fell significantly in both outpatient and inpatient groups (Health Insurance System Research Office 2012, 76–79).

History

When it was introduced in 2002, the UCS replaced the 30-Baht policy, and consolidated several existing insurance schemes (Limwattananon et al. 2013). Importantly, the 2001 30-Baht policy laid the institutional groundwork for the UCS reform by establishing a capitation-based provider payment system while it split the purchaser and provider functions. The policy, which required a co-payment of THB30 (about USD\$0.76) per visit or admission, was discontinued in 2006 after the gradual introduction of the UCS reform ended and the NHSO assumed full responsibility for the purchasing function in place of the Ministry of Public Health (MOPH) (Hughes, Leethongdee, and Osiri 2010). The 30-baht co-payment was reintroduced for prescription medicines only in 2012, with exemptions for emergency treatment and P&P care (Hanvoravongchai 2013).

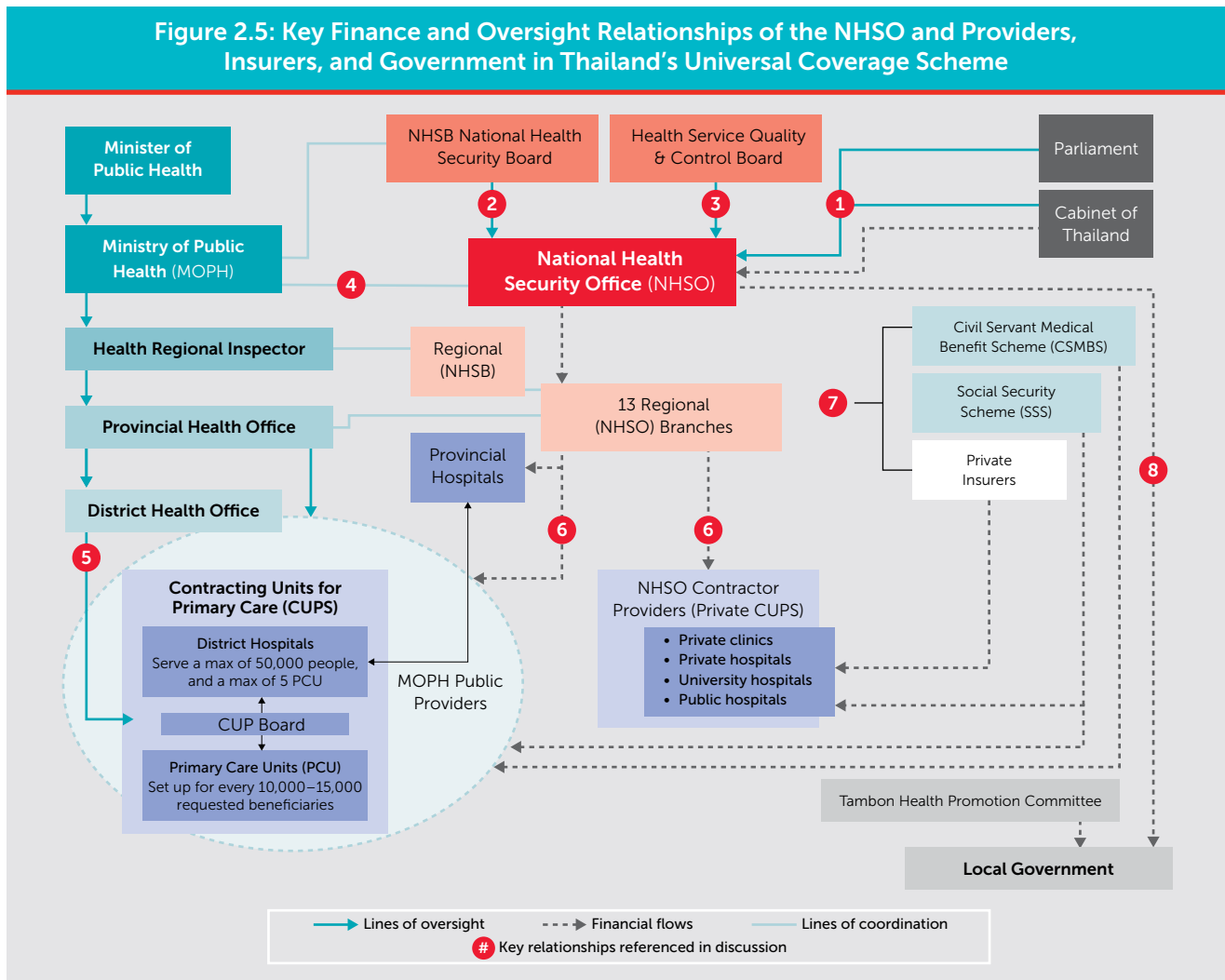
Prior to the UCS, about thirty percent of Thais were uninsured⁵⁵ and the government had difficulties administering the existing financial protections that had been introduced in piecemeal fashion. Approximately twenty percent of the population were covered under the Civil Servant Medical Benefit Scheme (CSMBS), most of whom were civil servants and workers, and the Social Security Scheme (SSS); and about fifty percent received coverage from one of two public programs, the Medical Welfare and Voluntary Health Card schemes (Health Insurance System Research Office 2012, 26). Roughly one-third of those who were publicly-insured received minimal benefits (Hughes and Leethongdee 2007, 1000).

UCS reformers intended to merge all three major public schemes, the CSMBS, SSS and UCS, into a single-purchasing agency under the NHSO. However, this ambitious proposal was substantially modified during the parliamentary process of drafting the National Health Security Act. As

a result, today, each of the three public schemes has its own legal framework, governing board, and management structure (Srihamrongsawat 2014; Health Insurance System Research Office 2012). The UCS, which superseded the Medical Welfare and Voluntary Health Card schemes, is the largest, covering seventy-five percent of the population, while the SSS and CSMBS cover sixteen and nine percent, respectively. About 2.2 percent of the population purchases additional voluntary private health insurance ("Thailand Health Financing Review 2010" 2010, 14).

System Reporting and Oversight Architecture Description

Figure 2.5, below, presents a picture of the key finance and oversight relationships of the NHSO with providers, insurers, and government.



⁵⁵ Note (Hughes, Leethongdee, and Osiri 2010, 448) report that the insured population was forty percent in 2001, prior to the reform. This figure contrasts sharply with the seventy percent figure cited in (Health Insurance System Research Office 2012, 26). Wibulpolprasert and Thaiprayoon (2012) report that approximately seventy-one percent of the population were insured in 2001.

The NHSO receives an approved UCS budget from the government (see Figure 2.5, relationship 1). The UCS budget is the sum of capitation, based on analysis of unit and services costs, multiplied by the number of beneficiaries and the estimated annual operating cost (Hanvoravongchai 2013, 2).

The NHSO carries out the purchasing function centrally. The capitation budget is passed through contracting units for primary care (CUPS) to the provider facilities, as shown in relationship 6 in Figure 2.5, above. A citizen registration database and a housing database enable planners to calculate the population that each CUP will serve.

Thai nationals who are not already covered under the CSMBS or SSS are automatically enrolled in the UCS. They are assigned to the CUP linked to their local district hospital based on their registered residence in the housing database. To use UCS system services, however, they must register at a district office if they live in a major metropolitan area, or any health center, public hospital or provincial health office if they live outside of the metropolitan area (Hanvoravongchai 2013, 4). Thais who work away from home may register at CUPS near their workplaces without changing their house registration information (Srithamrongsawat et al. 2012, 26).

Flow of Data and Information to Support Reporting and Oversight Relationships

A substantial administrative database supports the UCS system. The database tracks 150 million outpatient, and 5 to 5.5 million inpatient transactions every year and any prevention and promotion (P&P) payments and services for the purposes of reimbursement (Hitachi Data Systems 2012). The system is integrated with Thailand's Civil Registration and Vital Statistics (CRVS) for reporting purposes and has some limited integration with SSS's and CSMBS's registration systems. The three main public funders share their beneficiary databases to enable members to transfer between the schemes (Aljunid et al. 2012).

To date, the NHSO IT system has not been used for monitoring and evaluation because of the cost of analyzing data and NHSO's staff's limited capacity to do so (Srithamrongsawat et al. 2012, 24). While we do not know the exact size of the system or the number of staff who run it, the NHSO requested a budget of THB60 million (approximately US\$1.8 million) for the whole IT system in its latest annual budget request (Expert Interview Thailand 2014).

Agency Relationship to Health Providers

Health Providers

A majority of health providers under the UCS belong to the MOPH network. MOPH units make up seventy-three percent of the contracting units for primary care (CUPS), seventy-nine percent of secondary or tertiary care hospitals, and ninety-five percent of the primary care units with which the UCS contracts (Srithamrongsawat 2014, 13). Two-thirds of Thailand's hospitals and hospital beds at the regional, provincial, general, and district levels and within national centers of excellence are MOPH institutions. The MOPH primary care network includes 10,000 health centers covering all villages and sub-districts throughout the country. Several hundred thousand public health workers and clinicians staff MOPH facilities and about one million village health volunteers support village health activities (Hanvoravongchai 2013, 17).

One reason for the prevalence of MOPH facilities is the Thai government's requirement that all public hospitals participate as UCS providers (Srithamrongsawat et al. 2012, 14). The MOPH is additionally responsible for promoting health and overseeing the control and treatment of diseases (see relationship 5, in Figure 2.5). Outside of the MOPH network are private sector and other public providers; for example, the Defense and Education Ministries have a few public facilities.

NHSO-accredited private providers also participate in the UCS network. In 2011, Thailand had 300 private hospitals, 17,000 private clinics, and 11,000 private pharmacies, which were located primarily in urban areas. For example, more than half of the UCS members in Bangkok were registered with private clinics and hospitals, compared to just less than six percent nationally (Hanvoravongchai 2013, 18).

The MOPH delegates contracting authority to Contracting Units for Primary Care (CUP), which serve as the NHSO's main contracting vehicle. The CUPS act as "fund holders" on the provider side. CUPS receive capitation funding and pay local service units to provide outpatient services (Bates and Annear 2013). The gatekeeping system in the district hospitals of the UCS system refers critical and severely ill patients to regional hospitals for more intensive medical care (Hanvoravongchai, 2013, 18).

Public MOPH CUPS typically consist of a district hospital serving around 50,000 beneficiaries, and as many as five primary care units (PCU), one for every 10,000-15,000 registered beneficiaries, as required by the NHSO. The NHSO also contracts with private CUPS. These are likewise

set up with a primary care unit (PCU) for every 10,000 to 15,000 registered members.

Contractual agreements between the NHSO and public CUPS consist of “soft” payment arrangements, rather than detailed, legally binding documents that specify provider outputs and quality standards. These contracts are set up to transfer payments between institutions within the unified system and typically lack penalties if institutions engage in adverse behavior. For example, the NHSO has not required public or private hospitals that made false or inappropriate claims to pay penalties for their infractions, rather they were required only to return the additional monies paid to them (Srithamrongsawat et al. 2012, 24). The NHSO infrequently monitors contracts and only has audited the claims for a few high cost-services.

Some network providers contract individually with the NHSO. For example, the NHSO contracts with public specialist centers and private hospitals under different arrangements called Contracting Units for Secondary Care (CUS) and Contracting Units for Tertiary Care (CUT). In urban settings, the NHSO contracts with accredited private clinics (Srithamrongsawat et al. 2012, 23).

How Providers are Paid

Under the UCS system, NHSO pays primarily for outpatient and prevention and promotion (P&P) services using capitation, while it reimburses inpatient care at provincial and tertiary hospitals using weighted Diagnosis Related Groups (DRG) under a global budget.

The NHSO manages the following contractual arrangements:⁵⁶

- **Outpatient services:** NHSO calculates capitation by multiplying the age-adjusted capitation rate by the number of beneficiaries registered with a CUP and disbursed at the beginning of each budget year. In MOPH facilities, specific expenses such as staff salary may be deducted at the central or provincial level depending on negotiated arrangements (see staff salaries, below for more detail).
- **Inpatient services:** Arranged using a case-based payment method following DRGs with a global budget ceiling.
- **Prevention and Promotion (P&P) activities:** Three channels are used: 1) a national program purchases bulk vaccines, 2) community health funds match local government commitments, and 3) direct payments are made to primary care providers (Expert Interview Thailand 2014).

- **High costs case:** A pre-assigned fee schedule determines payment for cases of “myocardial infarction, stroke, hemophilia, or selected diseases that require specific instruments” (Hanvoravongchai 2013, 3).
- **Priority services:** Fee schedule payments for cataract surgery and kidney stone treatments are made to increase access of beneficiaries to these key services.
- **Special incentive payments:** This mechanism is used to encourage the early detection of chronic diseases such as diabetes or hypertension.
- **Special funds:** The Antiretroviral Fund and Renal Replacement Therapy Fund pay according to a predefined fee schedule for HIV/AIDS patient treatment (including ARV drugs), renal replacement therapy for end-stage renal disease patients, and replacement for providers’ capital depreciation.
- **Staff salaries:** Although the UCS capitation rate includes the full cost of an average members’ annual services (i.e., includes labor, materials and depreciation), the salary component is not disbursed directly through UC budgets. Over the years, some portion of MOPH public employee salaries (100 percent in 2002-03; 79 percent in 2004-06; and 60 percent starting in 2007) has been subtracted from the UCS capitation budget, either at the CUP or the provincial level. This deduction is made because the salaries of public employees are protected under Thailand’s Public Salaries Act. Civil service salaries are made in a separate allocation, via the provincial treasury offices, that cannot be re-purposed (Srithamrongsawat et al. 2012, 40).

A challenge for the NHSO is that capitation methods which are used to pay for outpatient services, offer incentives that can undermine the quality of services beneficiaries receive. To deal with this, the UCS provides a hotline for patient complaints, a no-fault compensation fund to reimburse patients or personnel in the event of medical error, and hospital accreditation regulations to protect beneficiaries (Srithamrongsawat et al. 2012, 23).

Alternate providers have few opportunities to compete because of the dominant role that MOPH facilities play in providing healthcare and the Thai government’s requirement that all public hospitals participate in UCS. This is particularly so in the primary care setting, in which ninety-five percent of the UCS contracts are with MOPH units. Thus, the UCS has somewhat limited purchasing power and its scope for active purchasing is confined to targeted services (Srithamrongsawat et al. 2012, 34).

There is evidence of active purchasing in targeted services at the tertiary care level. The payment scale for targeted

⁵⁶ Information contained in the payments section closely follows (Hanvoravongchai 2013, 3).

services such as “haemophilia drugs, chemotherapy for cancers, leukemia and lymphoma, renal stones, asthma, stroke fast-track services, thrombolytic agents for ST-elevated myocardial infarction, and high-cost drugs” (Srithamrongsawat et al. 2012, 19) is separately managed and more attractive. The number of targeted services with separate payment arrangements has increased over the life of the UCS reform. Some high-cost and accident and emergency services, and a few prevention and promotion services with separately-managed payment arrangements, have been added over time.

Agency Relationship to Government

National Government

As an independent public agency, the NHSO is accountable to the National Health Security Board (NHSB), as shown in relationship 2 of Figure 2.5. The Minister of Public Health chairs the NHSB whose thirty members include technical experts and representatives from public organizations, local government, civic groups, and professional organizations (Srithamrongsawat et al. 2012).

The NHSB sets policy, develops the benefits package, sets the standards to be met for health services delivery and criteria for fund management, manages the no-fault compensation fund, and sets up the regulatory framework for contracting providers. NHSB subcommittees in finance, benefits package development, and civic and local government involvement and other areas undertake specific management responsibilities (*National Health Security Act B.E. 2545* 2002, 12; Srithamrongsawat et al. 2012; *NHSO Annual Report Fiscal Year 2013 2014*).

As shown in relationship 4 of Figure 2.5, no formal agency, board, or committee coordinates the activities of the MOPH and the NHSO. Other than positions held by top MOPH officials on the NHSB, the MOPH has no direct policy setting or finance function with respect to UCS healthcare finances.

A second board, the Standards and Quality Control Board (SQCB), is responsible for quality control. The MOPH Director General of the Department of Medical Services, the Secretary General of the Food and Drug Administration, and the Director of the Division of Medical Registration all sit on the SQCB, which is chaired by an elected member (Hanvoravongchai 2013, 4–5). Additional SQCB members include technical experts and representatives from public organizations, professional organizations, local administrative units, non-governmental organizations, and professional groups (Srithamrongsawat et al. 2012, 11).

NHSB is chaired by the Minister of Public Health and has 30 members:

- (9) Public organizations
- (4) Local government
- (5) Civic groups
- (5) Professional bodies
- (7) Technical experts

SQCB is chaired by an elected member with 34 members:

- (4) Public organizations
- (5) Professional councils
- (4) Local administration organizations
- (5) NGOs
- (10) Professional groups
- (6) Technical experts

(Srithamrongsawat et al. 2012, 12).

Local Government

Subnational governmental entities do not appear to play a substantial role in purchasing health services for the fund, despite the enactment of a decentralization reform in 1999. When the UCS was first created, its designers wanted MOPH healthcare facilities to come under the control of local governments or local area health boards. These plans never materialized, however, and only a single pilot was ever carried out (Health Insurance System Research Office 2012, 54).

The NHSO disburses a small amount of P&P funding to local level government bodies through a sub-district or local health fund created in 2006. This fund matches NHSO contributions with those of local governments to improve the alignment of P&P activities with local needs (Srithamrongsawat et al. 2012, 14). In 2010, the NHSO allocated THB40 per capita to the fund and communities matched 20, 30, or 50 percent, depending on their size (Srithamrongsawat et al. 2012, 14). Local Tambon Health Promotion Committees comprised of local government heads, and senior community and civil society leaders decide how to distribute the funds locally (Expert Interview Thailand 2014).

Other Subnational and Local Planning Agencies

At the sub-regional level, the MOPH Provincial Health Offices (PHOs) coordinate with NHSO regional branch offices to decide on the assignment of beneficiaries to each

hospital. The director of the health insurance division of the PHO acts as secretary of the Provincial Health Security Committee (PHSC), which is chaired by the Provincial Chief Medical Officer (PCMO). The PHSC develops appropriate guidelines for how the UCS budget will be allocated within the province (Pitayarangsarit et al. 2008). The members of the PHSC include representatives from provincial and district hospitals, health centers, private hospitals and non-MOPH public hospitals, as well as district health officers, local officials, civil society groups, and medical professionals (Srithamrongsawat et al. 2012, 14).

Coordination between the NHSO and local providers is carried out at the regional level where there is also room for civil society members to participate in the system. Regional Officers of the NHSO link to the Regional Health Security Boards (RHSB) to oversee relations with local providers, perform strategic planning, and undertake performance management. A local elected board member (perhaps a retired health administrator) chairs the RHSB whose members include the Provincial Chief Medical Officers, representatives of local administrative units, civil society group members, experts, and the regional office director. The MOPH's Health Regional Inspector acts as an advisory member of the regional board while the regional office acts as the RHSB's administrative office (Srithamrongsawat et al. 2012, 14).

Agency Relationship to Other Public and Private Insurers

Insurers

In addition to the UCS, Thailand has two other separately managed public insurers, the CSMBS and the SSS, and a small number of voluntary private insurance entities that primarily serve the population in Bangkok. As depicted in relationship 7 of Figure 2.5, the CSMBS, SSS, and private insurers carry out their own contracting relationship to providers, independent of the UCS.

The CSMBS insures civil servants and their families, is financed through general tax revenue, and reimburses beneficiaries directly using fee-for-service, and DRG for inpatient care. Public facilities are the main providers for CSMBS's beneficiaries. The SSS insures private-sector employees, and is financed through a combination of contributions from employees, the government, and employers. Its mode of provider payment is "inclusive capitation for outpatient and inpatient services plus additional adjusted payments for accident and emergency and high cost care, utilization percentile and high risk adjustment" ("Thailand Health Financing Review 2010" 2010, 12). SSS providers include both public and private contracted hospitals and their networks (Srithamrongsawat 2014).

To date, the three public schemes continue to be managed separately, even though Articles 9 and 10 of the National Health Security Act provide a legal basis for integrating them. Observers have noted that the schemes will not be harmonized until they agree on many aspects of administration and management (Srithamrongsawat 2014).

Private health insurance is separately administered and managed. Individuals or households pay voluntary premiums. Private insurers pay by retrospective reimbursement, and beneficiaries exercise free choice of either public or private healthcare providers.

The Role of Competitive Market Forces

Competitive market forces do not play a role in beneficiaries' selection of providers in rural areas; however, beneficiaries have some choice in urban markets. The UCS system serves individuals who are not otherwise registered beneficiaries of the CSMBS or SSS systems (i.e., who are civil servants or the family members of civil servants, or private employees). Within the UCS system beneficiaries are assigned to a CUP based on their place of residence or work. Even though beneficiaries are free to change their registered CUP up to four times per year, those who reside in rural areas have little alternative because the UCS is the dominant provider. This is because there are fewer providers in the rural areas of Thailand. In contrast, beneficiaries who reside in urban areas have more choices because a larger number of private and non-MOPH providers operate in cities.

Key Risks and How They Have Been Addressed

The following discussion of risks to the Thai system is divided into two parts: risks that Thailand observed during the early stages of reform, i.e., during implementation, and risks that are likely to affect the evolution of the system in the future.

Implementation Risk

Big Bang Reform: The Thai experience with UCS is widely seen as a "Big Bang" reform because it quickly provided basic health insurance coverage to an additional twenty-five percent of the population. Yet, two issues hampered the reform's implementation. First, the new system of capitation started to pay (and empower) community hospitals that began to allocate their funds according to their priorities. For example, community hospitals held on

to the capitation budget rather than refer beneficiaries to secondary and tertiary hospitals as they were supposed to do. Second, the NHSO controlled the disbursement of funds but not civil staff salaries. As a result, the NHSO could not quickly reassign MOPH civil servant staff to meet new demands in the highest need facilities. As a result, the reforms took much longer to implement than reformers had anticipated (Hughes, Leethongdee, and Osiri 2010; Hughes and Leethongdee 2007).

- A big bang reform compresses implementation steps and may not leave sufficient time for different elements of the system to adapt to change.
- Thai reformers now recognize the limitation of using capitation on its own to redistribute financial resources throughout the system. More consideration of how the financial reform would mesh with the existing tiered organization of the MOPH system might have helped Thailand to avoid these implementation problems.
- Thai reformers have noted they underestimated institutional and structural features of the reform and professional opposition. Thailand may have benefitted from more outreach to the front-line health workers, staff, medical professionals, and administrators to win their commitment during the process of reform.

Purchaser-Provider Split: The NHSO initially tasked the Provincial Health Offices, an administrative tier of the MOPH, with the purchasing function. However, this created a conflict of interest by combining purchasing and provider functions in single office that reported to both the MOPH and the NHSO.

- The NHSO's ability to implement institutional change has been an important means to resolve systemic conflicts. For example, between 2001 and 2005, the NHSO created thirteen regional level branch offices and in 2006 transferred the purchasing role to them. These branch offices now liaise with the PHOs to oversee performance management and set strategy, but still retain the purchasing function.

Present and Future Risk

Rising Costs are Unsustainable: The costs associated with healthcare are increasing. In 2013, Hanvoravongchai (2013, 15) reported that healthcare spending constituted fifteen percent of general government expenditures and had become a major concern.

- To contain costs, the purchaser should have the authority to take corrective action with regard to benefits, revenues, and/or payments to ensure financial sustainability (Savedoff and Gottret 2008, 54). The NHSB has the authority to evaluate and change the capitation rate and the schedule of reimbursable services on an annual basis. Therefore, if revenues

authorized by the government do not increase, the NHSB can manage higher demand for services by squeezing providers who will have to accept less income or find ways to increase productivity.

- If Thailand is going to meet growing demand for more and better healthcare services, it will have to raise more revenues through collecting premiums or expanding government revenues through tax reform. The UCS also is considering cost-sharing, drug supply management, and cash flow management to help manage costs (Hanvoravongchai 2013, 15).

Finance Reform Leads to Inter-institutional Conflict:

The 2002 UCS scheme separated the purchaser and provider functions, upending existing budgetary and power relationships throughout the health system. For example, the MOPH became a large public network manager, but lost systemic budget control and its role as the overall health system manager. Whereas the MOPH used to channel funds to its administrative tiers and service units, the UCS reform rearranged these operations. Now the NHSO is authorized to contract with and pay providers. Whereas conservative MOPH leaders strongly opposed and fought this split, sought to undo the reform, and slowed implementation, reformists sought to implement the plan as quickly and comprehensively as possible.

- To address this conflict, the NHSO and the MOPH shared responsibilities for a limited period of time. Specifically, the MOPH managed the pooled funds from the start of the reform in 2002 until 2006-07 when the NHSO assumed full financial power.
- Although the MOPH and NHSO continue to navigate the UCS reform, unresolved rifts resulting from the introduction of the purchaser-provider split are a source of conflict and institutional adjustment to this day. For example, observers point to Thai news reports in 2014 of debates between the NHSO and MOPH over which institution should guide the country's health policy, as both are mandated to do so (Expert Interview Thailand 2014).

Lack of Harmonization in the Three Schemes: The UCS reformers intended to harmonize the three existing public health insurance schemes to create a larger pool of funds that could be flexibly redistributed to address geographic and income inequalities (Hughes, Leethongdee, and Osiri 2010, 448). However, civil service and labor unions resisted this plan and the government decided instead to create three separately-managed schemes. Evidence suggests that differences in the benefits packages, reimbursement methods, rates, and availability of high cost services and drugs in each scheme have perpetuated inequitable access of individuals to services of the same quality. Civil society organizations and interest groups are pressing for changes that would reduce these disparities (Hanvoravongchai 2013, 15).

- To address harmonization, the NHSO set up a coordination committee in 2004 to discuss standardizing and sharing registration data across the schemes, developing a common audit system, and supporting data exchange to enable monitoring and evaluation activities. Although none of these goals were met explicitly, the committee reported improvements, for example in establishing a joint audit system and in sharing and regularly updating beneficiary databases between the schemes (Health Insurance System Research Office 2012, 63).
- In 2010 the Thai government moved to set up a new temporary organization to oversee the three insurance schemes called the National Healthcare Financing Development Organization (NHFDO). NHFDO was given three years to establish a plan and road map to harmonize the three schemes. NHFDO works under the National Healthcare Financing Development Committee whose chair is the Prime Minister; and whose Vice Chairs are the ministers of Finance, Public Health, and Labor.
- To date the government has made little progress harmonizing the three schemes even with the work of the 2004 and 2010 committees referenced above.

Equitable Distribution of Resources: Like many countries, Thailand suffers from an unequal distribution of well-trained staff between urban and rural areas. Reformers wanted to use the UCS to reduce this inequality; however, to do this, planners must be able to match the budget for staff salaries to the locations in which staff services are most needed. Since Thailand's Public Salaries Act requires that civil service salaries be made in a separate government allocation that cannot be re-purposed, it is difficult to make an optimal match of MOPH staff to hospitals and clinics.

- After ten years of UCS finance reform, the concentration of staff and hospitals is still highest in the central region while remote regions suffer staff shortages (Hanvoravongchai 2013, 15). Because staff salaries are determined by the MOPH, protected by law, and paid to individual staff members, hospitals and clinics in the central region receive a larger proportion of funds than do facilities that employ fewer staff members.
- Since 2007, the NHSO has deducted salaries at the provincial level; however, because the NHSO has no ability to alter the salary allocation determined by the MOPH, it compensates for these differences by manipulating the non-salary operating budgets of hospitals and clinics at the provincial level. The NHSO calculates full capitation for each province such that those with high salary allocations receive less funding under non-salary operating budget (Srithamrongsawat et al. 2012, 19–21)

- The salary subtraction arrangement is an ongoing issue. In the 2011 financial year the NHSO imposed a floor and ceiling on the salary deduction so that it was not greater or less than average salary \pm 1 standard deviation.

Discussion and Case Conclusion

Thailand's big bang UCS financial reform enabled the population to achieve nearly universal access to health insurance coverage in a very short period of time. The reform successfully carried out a purchaser-provider split and enabled Thailand to reach universal coverage by extending health insurance to an additional twenty-five percent of the population. At the same time, the reform shifted financial, governance, organizational, and management arrangements as the NHSO became the purchaser on behalf of UCS beneficiaries. Thailand's success was due to several factors: a deep bench of committed reformers both inside and outside the MOPH who pushed through many ambitious ideas to create a more progressive and equitable health system; years of infrastructure investment by the MOPH, which built hospitals and provided access to individuals in rural areas; longstanding investments in primary healthcare; lessons learned from the experiences of other large-scale health system reforms; and the analytic capability of the Health Systems Research Institute (Health Insurance System Research Office 2012).

As discussed in the section on risks, several of the large issues that remain unresolved in Thailand, including the harmonization of the three public insurance schemes, institutional conflict between the MOPH and the NHSO, and ways of addressing staffing shortages in high-need areas, may offer important lessons to South Africa as it undertakes its own reform. In addition, Thailand may offer South Africa several ideas regarding the design of a health insurance system.

Institutional Conflict

Creating the NHSO and introducing the purchaser provider split reshuffled power relationships in the health system with particular consequences for the MOPH as it lost provider payment authority. While Thailand did not set up a coordinating mechanism between the two institutions, it is worth considering whether more formal coordination would be beneficial in South Africa. It is also worth noting in the examples described here that the NHSO's flexible response has led it to implement incremental solutions over time. For example, the NHSO eliminated the conflict of interest that existed because Provincial Health Offices

of the MOPH had authority over both budgets and providers by separating the functions when it created the thirteen regional NHSO offices. This separation allowed the system to retain the purchaser provider split at a lower jurisdictional level.

Harmonization of Existing Schemes

South Africa should consider laws or policies that will enable existing schemes to be harmonized either as the reform is carried out or at some point in the future. The Thai reform created the legal basis to integrate the three public health insurance schemes, even though they operate separately in practice. Establishing a legal basis for harmonization has the advantage of creating the opportunity to integrate schemes in the future if conditions change. Without the legal basis, chances of future integration would be much lower. This raises implications for how South Africa handles its own government insurer.

Matching Staff with Areas of High Need

South Africa should pay attention to and remove barriers that impede the optimal match of health staff to areas of high patient demand. South Africa should treat this as a priority, especially if it seeks to address inequalities in the population's access to healthcare. The Thai example demonstrates how the Public Salaries Act, and other rigidities in the ways that the MOPH allocates staff to hospitals and clinics, prevented a more flexible distribution of staff. The UCS system still suffers from staff shortages in rural areas despite the NHSO's efforts to allocate compensatory non-salary budget to understaffed hospitals and clinics, and despite mandatory service in rural areas.

System Design Features

In closing, Thailand offers several ideas for system design that may be of interest to South Africa. First, Thailand uses mechanisms at several levels to ensure that stakeholders are represented effectively in the decisions and governance of the insurance scheme. For example, as a state autonomous agency, the NHSO is governed independently by a powerful board whose representatives are drawn from across the health system.

Second, the design of Thailand's contracting units for primary care (CUPs), and the relationship of the CUPs to provincial and regional MOPH and NHSO offices may offer South Africa ideas about how to structure similar district-level institutions if the proposed NHIF reform calls for them.

Finally, in terms of system complexity and evolution, Thailand offers two lessons. First, its success in introducing capitation rested on the existing house registration

system and a well-established patient-tracking IT system. Without such large-scale data systems, it would have been very difficult to introduce capitation at the reform's start. Second, Thailand introduced active purchasing only after capitation, and initially only for a limited number of services. Thus, the complexity of the payment system continues to evolve over time.

These examples illustrate some of the ways in which the Thai system has improved incrementally over time as its leaders learned from experience. South Africa will contend with a final question as to whether incremental institutional development will be feasible or whether participants will resist further expansion or change after the government implements major health insurance reforms.

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Section 3: Case Study Comparisons

In this section, we describe how the cases vary along nine dimensions: models; basic governance architecture; history and scope of reforms; relationship to providers, insurers, and other government entities; risks; civil society participation; and operations.

Models

How Systems are Typically Classified

Researchers typically classify health insurance systems by the number of payers (i.e., single or multiple) and the provider mix (i.e., mostly public or mostly private).

Table 3.1: Models

		Provider Mix	
		Mostly Public	Mostly Private
Public Payer Type	Single-payer		
	Multi-payer		

The cases that we selected for this study do not fit easily into these categories, which demonstrates that institutional variation is the norm.

- Chile typically is characterized as a multiple payer system with private insurance. However, the public pooling and purchasing agency covers seventy-seven percent of the Chilean population, which is a larger percent than is covered by the public payers in several countries that are characterized as single payers.”
- Brazilian public policy intends to offer a single unified public health system with public provision through federal, state and municipal services. However, in practice the private sector continues to play a large role. Approximately two thirds of healthcare service providers under the SUS are private providers. About one quarter of the population purchased private voluntary health insurance.
- Thailand might qualify as a multiple payer system with its three major public pooling and purchasing agencies. Yet, that was not the goal of the 2002 reform, which enacted laws to merge them under a universal single-payer system. In practice, all three public insurers continue to be managed and administered separately.

Each mainly purchases health services from a large, well-established public health service network.

- Canada is typically described as a single payer system, yet the federal government’s role in policy setting and administering a national cross subsidy is minimal and Canada’s provincial purchasing and pooling agencies operate with near autonomy and great discretion. Furthermore, the prominent role of private providers is not well known. In Ontario, the MOHLTC sets the benefits package, negotiates remuneration, and purchases services from the province’s predominantly private providers.
- Colombia clearly has a multiple payer system, but it pools risk across insurers and includes a mix of public and private providers. The public pooling agency only manages a centralized pool of funds and disburses payments to competing private and public insurance companies. In turn, these multiple insurers purchase services from competing public and private health service providers.

Case Models

Since the public agency or agencies responsible for pooling funds and purchasing health services do not adhere to the traditional models, this section briefly describes each of them in turn. We discuss the system’s basic architecture, the mix of healthcare providers from which they mainly purchase services, and how cross subsidies are carried out.

Brazil

In Brazil, multiple public payers purchase services from a provider mix that is mainly private. Brazil implemented a sweeping health reform in 1988 that expanded healthcare coverage from formal sector workers to all citizens and residents of Brazil. The SUS is not a national health insurance program but rather a national health system that guarantees services for all and is financed by general tax revenues. The system is highly decentralized: the federal ministry of health and its state and municipal counterparts (the MS, SHS, and MHS) jointly plan, finance, and purchase health services. Each level of the government manages a health fund, which pools tax revenues from the jurisdiction and receives transfers from the health funds at the level(s) above. The MS, SHS, and MHS may own and manage public health providers as well as contract with private providers to provide services.

Canada

In Ontario, a single public insurer purchases services from mostly private providers. Canada's federal government sets national standards for health services and products and administers the Canada Health Transfer, a national cross subsidy. Canada's provincial governments act as single payers, exercising a great deal of autonomy to pool funds and purchase health services on behalf of their provincial beneficiaries. For example, Ontario's MOHLTC purchases healthcare services for its residents, determines the benefits package, and negotiates provider remuneration with other stakeholders. All residents have access to universal coverage for medically necessary services that are funded from general revenues and provided free at the point of service. The MOHLTC exercises monopoly power in its negotiations with mainly private providers.

Chile

In Chile, a single public insurer, Fonasa, purchases services from mostly public providers. Fonasa must purchase explicitly-defined minimum benefits (AUGE benefits) for seventy-seven percent of the Chilean population with funding from payroll contributions and public subsidies. Fonasa operates alongside a number of for-profit private health insurers known as Instituciones de Salud Provisional (Isapres). Both types of insurers are legally mandated to guarantee the same access, timeliness, financial protection, and quality of service. The care of indigent, retired, or legally unemployed beneficiaries is subsidized with funds from general revenues, payroll taxes on Fonasa contributors, and copayments from wealthier Fonasa beneficiaries. Fonasa primarily purchases services from the public health delivery network, which is distributed throughout the country and owns most hospital beds.

Colombia

Colombia has a unique system of regulated market competition among both health insurance companies responsible for enrolling beneficiaries and purchasing services, and public and private providers vying to sell services to insurers. The system was created under the General System for Social Security for Health (SGSSS) reform in 1993. The system is financed primarily by transfers from general government revenue and payroll contributions from employers and workers, all of which are pooled by the national Solidarity and Guarantee Fund (FOSYGA). FOSYGA operates as a welfare trust whose trustees manage a pool of funds to pay for mandatory health insurance services covering ninety-eight percent of the country's population. All Colombians are required to affiliate with one of the competing insurance companies that cover prescribed benefits packages. SGSSS administers a cross subsidy whereby a portion of the

payroll contributions of wealthier workers pays for poorer affiliates who are exempt from payroll contributions or provider copayments. The insurance companies receive a risk-adjusted capitated payment back from FOSYGA, which they use to purchase services from a mix of public and private entities that compete to serve patients.

Thailand

In Thailand, the three public insurers purchase services from providers that are mostly public. The main public insurer is the National Health Security Office (NHSO), which is financed by general government tax revenues and covers approximately seventy-six percent of Thais. The Universal Coverage System under the NHSO serves individuals who are not otherwise registered beneficiaries of the other two public insurers, i.e., who are not civil servants or the family members of civil servants covered by the CSMBS, or private employees covered by the SSS. The three public insurers are managed and administered separately: each separately negotiates contracts with the national health ministry's network of public providers constituting roughly three-quarters of all providers in Thailand.

Basic Governance Architecture

The basic governance architecture of the public pooling and purchasing agencies in the five cases we examined varies considerably. Brazil and Canada carry out pooling and purchasing operations in their subnational jurisdictions. In contrast pooling and purchasing operations in Chile, Colombia, and Thailand are centralized. Oversight of the respective pooling and purchasing agencies in Brazil, Canada, and Colombia is carried out by their respective health ministries. In comparison, oversight in Thailand is carried out by an independent board, and Chile's Fonasa is held to account by all three branches of the national government.

The public agencies we examined in the cases operate at different jurisdictional levels. Brazil's SUS is a national health system carried out by health entities at the national, state, and municipal levels. Canada's MOHLTC is a provincial health ministry. The agencies in Chile, Colombia, and Thailand all operate at the national level, but each is constituted differently within the country's health system architecture. Chile's Fonasa is an autonomous public institution and serves as the funding arm of Chile's health ministry. Colombia's FOSYGA is a welfare fund managed by fiduciaries on behalf of the Ministry of Health and Social Protection. Thailand's NHSO is a state autonomous agency serving under the authority of an independent board, the National Health Security Board.

The national health ministries in Brazil, Canada, and Colombia provide oversight of the respective purchasing and pooling agencies in those countries. The federal Ministry of Health (MS) manages Brazil's SUS following plans approved by the National Congress. The SHS and MHS are accountable to the MS, but all three also work collaboratively through Tripartite and Bipartite Commissions to set budgets for SUS service coverage and determine health service reimbursement rates. Canada's Federal Department of Health (Health Canada) oversees the MOHLTC's health plans to ensure its compliance with federal standards and the Canada Health Act. A general manager within Ontario's provincial health ministry administers the health insurance fund, OHIP. In Colombia, the Ministry of Health and Social Protection (MPS) oversees health insurance policy and regulation under the SGSSS. Colombia's Superintendent of Finance (SFC) evaluates the financial governance of FOSYGA funds.

In contrast, Chile's Fonasa has direct accountability to all three government branches. Most directly, Chile's President has the discretion to appoint a director to lead Fonasa. The agency is accountable to the Superintendent of Health in the Ministry of Health for coverage and service delivery obligations, and to the Public Budget Office (DIPRES) in the Ministry of Finance for efficient and effective financial management. Chile's Isapres, by contrast, are directly accountable to shareholders. In Thailand, the NHSO is constituted as an independent public agency accountable to the National Health Security Board (NHSB). The Minister of Public Health chairs the 30-member NHSB. Members of the NHSB include technical experts and representatives from public organizations, local government, civic groups, and professional organizations.

History and Scope of Reforms

The government reforms that established pooling and purchasing agencies often leveraged existing institutions, but varied in the scope of activities that they carried out. In three of five case countries—Thailand, Chile, and Canada—reforms for universal health coverage built on existing institutions and remodeled their responsibilities, as well as authority and financing relationships. In Colombia and Brazil, however, the government replaced existing paradigms of healthcare financing and provision through sweeping reforms.

Thailand's 2002 reform leveraged the country's earlier investments in rural and primary health infrastructure but upended existing financial and reporting relationships. The NHSO reform expanded health insurance coverage to an additional twenty-five percent of the population that previously had been uninsured and unified several existing health insurance schemes. At the same time, it introduced a new purchaser-provider split, which replaced the health

ministry's power with the new financing and regulation provisions of the NHSO.

In Chile, the purchasing institutions and purchaser-provider split were established by sweeping reforms in the 1970s and 1980s. The country's current regime governing Fonasa, described in the chapter on Chile, was implemented by the 2005 AUGE reform for universal health coverage. AUGE unified the health supervision of public and private insurers and providers, and defined an explicit benefits floor for all beneficiaries with legal guarantees related to delivery for Fonasa enrollees.

Reforms in Canada were more incremental than those in other countries. A series of legal reforms established publicly financed health insurance in the 1950s and 1960s. These initial reforms were followed by financing reforms in the 1970s and an overarching national healthcare framework was established in the 1980s.

Both Colombia and Brazil, unlike Canada, implemented sweeping reforms. Colombia's Law 100 in 1993 completely reorganized health coverage, financing, and pooling. The law also introduced cross subsidies and a new system of regulated market competition among both insurance companies competing to enroll beneficiaries, and public and private providers vying to sell services to insurers.

Brazil introduced a Constitutional reform in 1988 that redefined the public sector's healthcare commitments and responsibilities by declaring health as a "right of all and a duty of the State." The reform also decentralized health service delivery to the state and municipal levels, established local health funds, and instituted a system of intergovernmental transfers to finance health.

Providers

Data on the mix of providers in the cases show that one type of provider, i.e., either public or private, dominates in each country even though all systems have a combination of both types.

- Majority Public: Chile, Thailand
- Majority Private: Brazil, Canada, Colombia

Most providers in Chile and Thailand are public entities. Chile's Fonasa primarily purchases services from the public health delivery network of 192 hospitals and 17 specialty care ambulatory centers. Primary healthcare is delivered through 1,870 public municipal health centers. In Thailand, seventy-three percent of the CUPs (catchment areas, each of which cover approximately 50,000 registered beneficiaries) are operated by the MOPH. About seventy-nine percent of secondary or tertiary care hospitals are public as are about ninety-five percent of the primary care

units. Two-thirds of Thailand's hospitals and hospital beds at the regional, provincial, general, and district levels and within national centers of excellence are public, MOPH institutions.

In contrast, providers in Brazil, Colombia, and Canada are mostly private. In 2013, 67 percent of Brazil's 6875 hospitals were private, while the rest were a mix of municipal, state, and federal hospitals. In primary care, the government owns and operates about thirty-three percent of facilities and the remaining sixty-seven percent are private. A majority of Colombia's providers are thought to be private although the IPS's are a mix of public and private entities that compete for patients. In Ontario, the MOHLTC contracts almost exclusively with private hospitals, long-term care homes, medical clinics, independent health professionals, and family physicians.

Provider Accreditation

In Ontario and Brazil public and private health providers are accredited by independent, third-party agencies. Provider accreditation is voluntary in Brazil. However, in Ontario, accreditation is a prerequisite for a provider to qualify for reimbursement from OHIP. In Chile, Colombia and Thailand, government agencies carry out provider accreditation. In Chile, the SDS (national Ministry of Health superintendent) accredits providers; the SNS accredits providers in Colombia, and the Healthcare Accreditation Institute located within the Ministry of Public Health accredits providers in Thailand. Accreditation is required for hospitals participating in the UCS scheme but is voluntary for other public and private providers in Thailand.

Changing the Provider Mix

At the point of system design, the mix of public and private providers is a factor to be taken as given. Yet case evidence suggests that policymakers can introduce policies to change the provider mix over time. For example, in Thailand, heavy government investment in public sector health infrastructure dating from the 1960s led to the development of a robust public provider network that covers rural areas reasonably well.

In Chile and Brazil, healthcare reform policies prioritized public sector development by design. Chile's Fonasa overwhelmingly has paid public providers since its formation in 1979. After the 2005 AUGE reform, four-fifths of the beneficiaries are now served through the public sector and enrollment with private insurers that offer services through private providers dropped from twenty-six percent in 1995 to sixteen percent in 2009. Today, eighty-five percent of all of Fonasa's spending is in the public sector in part because public providers are given budget support in exchange for their participation in

AUGE. Similarly, before Brazil's SUS reform, public social security institutions contracted with private providers to cover formal sector workers. Subsequently, Brazil's heavy public infrastructure investments helped increase the share of public providers from twenty-two percent in 1988 to thirty-three percent in 2013. In contrast, Canada's approach always favored private sector providers, with the government investing mostly in regulation and quality assurance programs rather than in public infrastructure.

Provider Contracts

The nature of contracting relationships seems to depend somewhat on the mix of provider type, but not entirely. For example, we see the NHSO using "soft" payments to contract with the mainly public providers in Thailand; by comparison, the Brazilian MS, SHS, and MHS use passive distribution mechanisms to contract with public and private providers in Brazil. Thailand's payment arrangements with the public CUPS act to transfer funds within the unified system. These arrangements typically lack penalties for adverse behavior by contractors. For example, in Thailand hospitals that make false or inappropriate claims have been required only to return the additional monies paid to them, rather than pay penalties.

In Brazil, the MS, SHS, and MHS use passive *convenios* to pay private hospitals or teaching hospitals linked to the public system, but performance-based contracting seems to be coming online. *Convenios* are not used to ensure accountability, quality, or efficiency of hospital services. More recently, Brazil has started experimenting with performance-based contracting. The contracts specify production, quality, and cost targets, as well as performance indicators and reporting requirements.

Contracts used by Ontario's MOHLTC specify clear performance outcomes, and the LHINs enter into 'Service Accountability Agreements' that include facility performance measures and quality standards.

In Chile, Fonasa negotiates 'management contracts' with the twenty-nine Regional Health Services to provide budget support to public hospitals, and to set FFS prices. It also may contract with private providers using framework agreements, open bids, or direct contracts. Currently, about half of the payments to the RHSs are in the form of FFS and the remaining are budget transfers. However, Fonasa pays for the prioritized AUGE services fully in FFS to incentivize provision. But these do not contain caps on volume or reporting on quality; the latter are enforced by the health system regulator SDS as one of the four explicit guarantees of AUGE. Our knowledge of Colombia's contracts is limited because the case focused on Colombia's innovative pooling mechanism.

In sum, case evidence from Thailand and Brazil suggests that purchasing contracts in both countries do not necessarily specify performance requirements or impose penalties. In contrast, available evidence from Ontario finds that MOHLTC contracts specify clear performance outcomes. In comparison, Chile's Fonasa and Colombia's EPSs are allowed a great deal of discretion in negotiating contracts and so their contracts vary widely in the use of performance criteria.

Provider Payment Arrangements

FFS payment mechanisms cover the largest components of healthcare in Brazil, Canada, and Chile. FFS is used to pay for outpatient care and physicians at private hospitals in Brazil; primary healthcare, laboratory, and ambulance services in Canada; and inpatient and outpatient services (fifty percent of payments) from the public sector, and all inpatient and outpatient services for private providers in Chile. In contrast, FFS is used to pay for a smaller number of specific health services in Thailand and Colombia. Canada, Chile, and Colombia use capitation to pay for primary healthcare services. Colombia additionally pays inpatient and outpatient services using capitation. In Brazil, capitation is used to pay for the Family Health Strategy, a primary care program serving about 100 million people. Last, Thailand's NHSO pays an age-adjusted capitation rate for all outpatient services, inclusive of primary healthcare services.

Brazil uses AIHs (similar to DRGs but classified by treatment rather than diagnosis groups) to pay for inpatient care at private hospitals whereas in Thailand DRGs pay for all inpatient services under an enforced global budget ceiling.

Brazil, Canada, and Chile all use global budgets. In Brazil, a global budget pays for care provided in public hospitals. In Canada, global budgets pay for inpatient and outpatient care at both private and public hospitals, and in Chile, global budgets support inpatient and outpatient services for public providers, which amount to about half of all inpatient and outpatient care.

Payment methods do not appear to have changed much in Chile and Colombia, but we find some evidence of experimentation in Thailand and substantial changes with new programs introduced in Brazil and Canada. Thailand's NHSO has used capitation from the start of the UCS reform in 2002. More recently, Thailand introduced Prevention and Promotion (P&P) payments to support specific activities and separately introduced more favorable scales to pay for high-cost services in a few areas of tertiary care. Ontario recently replaced its FFS payments for physicians with two alternative blended payment models designed to incentivize comprehensive care provision. Finally, Brazil introduced capitation plus incentive-based payments when it initiated a new program, the Family Health Strategy in the late 1990s.

The Scope for Active Purchasing

Evidence of active purchasing—to monitor how providers and beneficiaries respond to the pricing system, and adjust rates and contractual terms to improve the value of purchased services—is limited. Efforts to increase active purchasing in Thailand, Chile, and Canada have been hampered by the governments' limited abilities to improve contract and payment arrangements, or to implement them widely and systematically. For instance, in Thailand, there are limited opportunities for provider competition because a majority of providers are public and mandated to participate in the UCS (about ninety-five percent of the UCS contracts are with MOPH units). The NHSO uses active purchasing for a few targeted services in tertiary care where it has arranged more favorable FFS payment scales and incentives.

Neither Canada nor Chile do much active purchasing despite having FFS payment systems in place. In Chile, although a quarter of Fonasa's overall payments (to both public and private providers) use FFS, Fonasa lacks the ability and authority to adjust rates and contractual terms and scale the use of them to improve the value of purchased services. This is because Chile's Regional Health Services—networks of public providers—primarily utilize budget financing to pay providers. Fonasa is unable to alter the provider's incentives under AUGÉ, the country's healthcare regime. Hence, Fonasa payments mainly comprise hospital budget transfers (about fifty percent for public providers and a little more than one quarter of overall payments), contract and voucher payments to private providers, and capitation (for PHC).

Despite Ontario's technical capacity and authority to adjust the FFS payment system, the MOHLTC does not seem to adjust its rates and contractual terms to improve the value of purchased services either. Instead, Canada's extensive use of FFS creates incentives for the overconsumption of care. The MOHLTC pays 60 percent of physicians using innovative blended payment models designed to incentivize them to provide more comprehensive care. However, Ontario does not adjust rates based on evidence derived from monitoring the use of services.

We see very little evidence that Brazil uses active purchasing mechanisms. Rather, Brazil uses mostly line-item budget allocations and an Authorization for Hospitalization (AIH) program, which is similar to a Diagnosis Related Group (DRG) for inpatient care. In general, FFS is used for outpatient care. Some state and municipal hospitals are paid through a 'prospective global budget' allocation, which ties meeting service volume and quality performance targets to the budget payment, but that seems to be the extent of evidence that active purchasing is being used.

Overall, the cases present little evidence that active purchasing is widely and systematically used. Instead, implementing active purchasing is a challenge in multiple contexts.

Insurers

Other Public Insurers

Brazil, Canada, Colombia and Thailand have more than one public insurer. Only Chile acts as a single payer in the public sector. Brazil is known for its multi-payer public system of health insurance managed under the MS. Less well known is Canada’s system in which its ten provinces have set up and independently managed their own public health insurance schemes. In Brazil and Canada, affiliation is determined by the jurisdiction where one resides. In comparison, Thailand has several large public insurers whose membership is determined by occupation. The CSMBS and the SSS are managed and governed separately from the UCS and provide coverage to affiliated civil servants and private sector workers.

A single agency in Brazil and Canada regulates their respective public insurers. The Executive Secretariat and five secretariats of the MS works together to regulate Brazil’s public insurance. In Canada, provincial public insurers are regulated by Health Canada at the national level. In Thailand, the NHSB regulates the UCS, but other government entities regulate the CSMBS and the SSS.

Private Insurers

Each of the five countries have private insurers. Private insurers are regulated by separate, independent entities in Brazil (National Supplementary Health Agency (ANS)) and Thailand (Office of Insurance Commission (OIC)), an independent commission supervised by the Thai Ministry of Finance). In contrast, regulation of public and private insurers in Chile and Colombia is unified under a single

authority in both countries. In Canada, Health Canada and the provincial health ministries regulate different aspects of private insurance. The Canada Health Act sets out some regulations for private health financing and insurance, limits the conditions under which privately-purchased services may be subsidized under the public scheme, and allocates some responsibility for this to provincial governments as well. The MOHLTC has some responsibilities for overseeing private insurance within Ontario.

The five cases vary significantly in terms of the size of the private insurance market and the extent of competition. Insurers don’t compete in Brazil, Canada, and Thailand because a beneficiary’s affiliation with any of the public insurers is determined by one’s jurisdictional residence. Finally, Chile and Colombia’s systems of managed competition are the only systems in which regulation of the public and private insurance market is unified under the same authority.

Of the five cases, Canada is structured in a way that is very similar to policy proposals for South Africa (i.e., a single-payer fund, local management, and access to private voluntary insurance for complementary coverage) except that Canada relies predominantly on private provision. Brazil’s federated structure with decentralized responsibilities and emphasis on public provision shares important similarities with policy proposals in South Africa but lacks the financial arrangement of a national health insurance fund. Despite the presence of competing private insurers, Chile’s system may actually have more in common with the South African proposals because Fonasa acts as a single payer for more than three-quarters of the population as a public fund that reimburses mostly public providers with some options for reimbursement of private providers.

Table 3.2: Extent of Insurer Competition and Regulation in the Private Insurance Market

	Population Share Covered by Private Insurance	Public Subsidies for Private Insurance	Private Insurance Services Allowed	Extent of Insurer Competition	Private and Public Insurance Regulated by the Same Authorities
Brazil - MS, SHS, MHS	25%	Yes	Duplicative	Low	Mix of Unified and Separate Public and Private Oversight
Canada - MOHLTC	67%	Yes	Supplementary	Low	Mix of public entities
Chile - Fonasa	16%	No	Duplicative	Managed competition	Unified oversight
Colombia - FOSYGA	4.7%	N/A	Duplicative	Managed competition	Unified oversight
Thailand - NHSO	2.2%	No	Duplicative	Low	Separate public and private oversight

The share of the population covered by private insurance varies considerably across the five case countries. In Canada, 67 percent of the population is covered by private health insurance whereas 25 percent is covered in Brazil, 16 percent in Chile, and 2.2 percent in Thailand. It is difficult to develop a comparable indicator for Colombia because although more than two-thirds of the EPSs are private, FOSYGA covers all Colombians.

Of the five cases, only Canada restricts private provider services to supplementary services such as medicines, and dental and cosmetic procedures. In contrast, private insurers offer the same services as the public insurer in Brazil, Chile, Colombia, and Thailand.

Canada's public and private insurers are not competitors. Private insurers are mandated to offer supplementary health services by law and, therefore, do not compete with the public insurers. Provincial public purchasers may serve only their own residents and, therefore, do not compete with the other provincial public insurers. A mixed set of public entities regulates Canada's public and private insurers. The Canada Health Act guides all public and private plans, sets the limit for the public subsidy of private premiums, and determines the scope of regulations that the provinces will cover. Ontario's MOHLTC defines the private insurers' benefits packages, but is regulated by other provincial departments (health and finance).

In Brazil, twenty-five percent of the population purchases duplicative private health insurance. Brazil gives tax exemptions to households and employees to purchase private health insurance. Although everyone is entitled to have healthcare paid for by the public system, which is financed through various taxes, the private insurance market generally caters to the wealthier and employed population segments. In comparison to the underfunded public health system, private insurers offer services of superior quality and shorter waits to see providers. An independent agency called the ANS is contracted by the MS to regulate private insurers. However, since SUS is structured to be the single universal health system, the public and private insurers are separately regulated. Brazil's SUS does not officially coordinate with private insurers, even though it may charge private insurers if it provides services to patients who have private coverage for those services. Formal coordination in Brazil could help alleviate rising costs because private insurers sometimes refuse to reimburse the SUS for these services.

In Thailand, about 2.2 percent of the population purchases private voluntary health insurance from competing insurers that operate mainly in Bangkok. Thailand's private and public insurers offer the same services, but do not appear to compete very much given the private market's limited size. Private health insurance is administered, managed, and regulated by an independent commission supervised

by the Thai Ministry of Finance. This commission is entirely separate from any of the regulators that oversee the public insurers. Despite legal provisions to integrate them, Thailand's three public insurers, the UCS, CSMBS, and SSS remain separately managed and administered. Likewise, an independent government agency separately administers and manages private insurers.

In contrast, Chile's Isapres (for-profit, private insurers) directly compete with the public insurer Fonasa. The Chilean government subsidizes the cost of private insurance but guarantees that both public and private insurers provide the same package of services at the same level of access, timeliness, financial protection, and quality. Beneficiaries direct their seven percent mandatory payroll contribution to either Fonasa or Isapres, but Isapres' beneficiaries may pay an additional voluntary premium to participate in plans with higher benefits. A single entity regulates Chile's independent and competitive Isapres and Fonasa. Both the Isapres and Fonasa must provide the 80 mandatory AUGE services, however the regulations pertaining to the Isapres' and Fonasa's financial solvency and risk are distinctive.

Colombia presents an alternative scenario in which the multi-payer system also is used to implement a cross subsidy. Part of the payroll contributions channeled to FOSYGA from plans with lower risk and higher revenues (EPS-Cs) is redistributed to the plans with higher risk and lower revenues (EPS-Ss). By law, both EPS-Ss and EPS-Cs are mandated to cover the same benefits; although, the standardization of benefits packages across these two types of plans is still in process. EPS-S beneficiaries generally have access to fewer and lower quality services. Since the government determines both prices (payroll contributions or subsidy) and benefits, the EPSs only compete on the basis of quality and customer service. The SNS in Colombia regulates and monitors all the public and private EPSs.

The case evidence suggests that the presence of multiple payers does not necessarily translate into more consumer choices. Evidence from Brazil and Thailand demonstrates that despite the presence of multiple public payers, wealthier and employed consumers are more likely to have options from which to choose an insurer. The single payer systems in Canada and Chile do not fare much better in terms of presenting consumers with choices. In Canada, consumers have no choice of a public insurer because affiliation is determined by provincial residence. Canadian consumers, however, can select their private insurer as long as they can afford to pay the voluntary premium.

Government

Purchasing Responsibilities

Chile's Fonasa and Thailand's NHSO carry out a majority of their purchasing centrally. Even though both entities pay local municipalities to provide services, the amount differs greatly. Fonasa mainly contracts with the regional health services of the national health system. However, about 23.8 percent of all Fonasa's spending is used to pay municipalities through a mix of capitation and program funding to run primary healthcare centers. The NHSO directly pays contracting units for primary care (CUPs) across Thailand. It also disburses a small amount of matched funding to local government bodies called Tambon Health Promotion Committees to pay for P&P activities.

In contrast, purchasing is carried out at multiple jurisdictional levels in Brazil and Canada. Brazil's MS purchases health services from federal hospitals; the SHS purchase services from public and private hospitals, clinics, and physicians; and the MHS purchase primary care services in addition to the same services purchased at the state level. Canada's Health Canada purchases services not covered under the OHIP for First Nations people and Inuit. In Ontario, the MOHLTC directly controls about 60 percent of the budget to purchase physician, laboratory, and ambulance services, while the remaining 40 percent

is transferred to Local Health Integration Networks (LHINs) to purchase services from hospitals, community health centers, and long-term care homes.

In Colombia more than 70 decentralized EPS's purchase medical care for their affiliated beneficiaries. The EPS's compete for beneficiaries on quality and are not associated with state or municipal jurisdictions as a rule. However, some EPS's correspond to municipal councils. In addition, departments and municipalities in Colombia implement and partly finance a public health services package called the PBS, which delivers non-insurance services.

Responsibilities for mobilizing revenues, pooling, purchasing and providing care are distributed differently across these five countries. Brazil's and Canada's purchasing and pooling agencies carry out their operations at the subnational level, which is consistent with more decentralized patterns of governance in federated contexts. Among the unitary states of Chile and Thailand, subnational governmental entities primarily work to implement national policy priorities and lack significant policy autonomy. Colombia presents a more mixed picture.

Decentralized purchasing decisions may be more responsive to the beneficiary population, but place an increased demand on subnational actors to carry out complex administrative and management tasks. Upward reporting requirements add to this complexity, especially when they involve reporting to multiple agencies.

Table 3.3: Decentralization and Complexity in Payment and Financial Accountability

	Placement	How many vertical funding transfers are there between the purchasing and pooling agency, and the providers?	Atomized vs. aggregated providers	Administrative Complexity of Payment Methods	Lines of Financial Accountability
Brazil	Subnational	One or two or three (MS > providers; MS > SHS/MHS > providers; (MS > SHS > MHS > providers).	Atomized—individual providers	Medium to High (Mostly DRG and FFS for inpatient and outpatient care at private hospitals (67%); budget support to public hospitals (33%); some capitation payments for primary healthcare through FHS)	Concentrated
Canada (Ontario)	Subnational	One or two (MOHLTC > providers for physician, ambulance and laboratory services; MOHLTC > LHIN > providers for hospitals, community health centers, and long-term care homes).	Atomized—individual providers	High (mainly FFS to physicians (27100, organized as individuals or teams), ambulance and laboratories (11); some capitation payments to primary health teams; and budget support to hospitals (154) and community health centers (101))	Concentrated
Chile	National	Two or less (Fonasa > RHSs > public providers; Fonasa > private providers)	Aggregated — 29 RHSs	Medium (mainly budget transfers; also FFS and capitation payments)	Diffuse
Colombia	National	Two (FOSYGA > EPSs > providers)	Atomized (IPS)	Low (capitation payments)	Concentrated
Thailand	National	One, NHSO branches > CUPS	Aggregated — CUPS	Medium (mainly capitation and DRG, but also FFS for specialized services.	Concentrated

Brazil's MS, SHS, and MHS manage funds and carry out purchasing at the federal, state, and municipal levels. States and municipalities have formal autonomy over healthcare within a national policy framework. Canada's health system is made up of a linked set of health plans administered at the provincial/territorial level under a 'hands-off' national policy framework.

Consistent with their federated forms of governance, both Brazil and Canada evidence the highest fiscal decentralization levels⁵⁷ of the five countries. Forty-four percent of all revenue in Brazil and sixty-two percent of all revenue in Canada is collected at the state or provincial level. In the unitary states, Chile, Colombia, and Thailand comparable figures are twelve, twenty-two, and eleven percent, respectively. While limited to a small number of cases, this evidence suggests that decentralization of key health responsibilities and management of fiscal resources, e.g., tax revenue collection, go hand in hand.

Brazil's purchasing and pooling agencies process a high volume of payments because they pay a large number of highly atomized providers directly. Brazil also uses administratively intense methods for a majority of its payments. For instance, it pays for inpatient and outpatient care at two-thirds of all facilities (private hospitals) using DRG and FFS payments. In contrast to its intensive payment processing, Brazil's upward financial reporting and accountability is relatively simplified in that it is centralized in the Ministry of Health.

Canada's MOHLTC pays physicians, ambulances, and laboratory services directly, but adds another step for hospitals, community health centers, and long-term care homes, which are paid through the LHINs. The MOHLTC uses FFS to pay roughly 27,000 providers. The MOHLTC additionally makes some capitation payments to primary health teams, and makes budget payments to the LHINs, which in turn support 154 hospitals and 101 community health centers. Upward financial reporting is made to a single agent, the Auditor General, which is an independent office of Ontario's Legislative Assembly.

In Chile, policy control is highly centralized and the institutional structure works to reflect the priorities of the national government. Each of the country's fifteen administrative regions has its own regional health authority representing the central MOH in the regional ministerial secretariats (SEREMIs). The regional authorities coordinate and manage the local health system but have limited fiscal and programming autonomy. One of their main tasks is to report local preferences in the ranking of new public infrastructure investments.

Similarly, in Thailand, subnational governmental entities do not appear to play a substantial role in purchasing health services. Instead, the infrastructure for the purchasing and delivery of health services is vertically integrated. The MOPH Provincial Health Offices (PHOs) and the NHSO's regional branch offices coordinate to assign enrollees to hospitals. The PHOs also organize Provincial Health Security Committees (PHSCs), which develop guidelines for the use of UCS's budget locally. Regional Officers of the NHSO also work with Regional Health Security Boards (RHSBs) to oversee relations with local providers.

In Colombia, health and decentralization reforms since the early 1990s have helped increase and earmark resources for collective health services. Nevertheless, the central government remains responsible for policy design, regulation, and public finance. It sets the direction for public health and other social policies and transfers funds to regional governments so that they can carry out planning, management, and financing responsibilities. The national government directly funds municipal governments to implement health policies and provide health services. Even so, Colombia has gone through a series of reforms to enhance national control over how subnational recipients spend national funds.

In theory, fiscal decentralization improves health outcomes by aligning purchaser discretion with the local population's health needs. However, absent local capacity to manage devolved resources and authority, fiscal decentralization can have the opposite effect. Our review of evidence from the five cases suggests that the administrative complexities associated with making payments in Brazil and Canada is fairly high. In Colombia, the unitary national government struggles to retain control over how regional and municipal entities spend their funds. These results collectively elevate the importance to South Africa of assessing the subnational governments' administrative capacities to carry out similar and related tasks in South Africa.

Risks

This section discusses some of the common risks of establishing a public agency or group of agencies to manage health funds and purchase services. The discussion is based on our analysis of the case studies.

Rising Costs

Rising costs are a problem in every country, and public insurers may lack the authority to change either the benefits

⁵⁷ Please see Table 1.1 in the report's introduction, Country Context and Health Indicators

package, or adjust revenues or payments to manage them. The largest single factor contributing to increasing health costs is rising incomes and the associated increases in effective demand for healthcare services. Other factors that contribute to increasing healthcare costs are advances in technology, medical inflation, the aging of the population, and changes in the financing and management of healthcare (Chernew & Newhouse 2012; Fan & Savedoff 2014; Garibaldi, Martins, & van Ours, 2010; Hall & Jones, 2007; OECD, 2006). When countries undertake health reforms, the biggest immediate cost increases largely result from expanding coverage to new population groups (Savedoff et al 2012). Insurance arrangements generally are more expensive than public health systems but some countries seem to have kept control of overall costs while expanding coverage (e.g., Colombia) (Chernew and Newhouse 2012; Fan and Savedoff 2014; W. D. Savedoff et al. 2012; Mosca 2007; OECD 2006; Hall and Jones 2007; Garibaldi, Martins, and van Ours 2010).

Evidence from Brazil suggests it lacks sufficient funds for two main reasons. First, SUS offers a comprehensive, open-ended benefits package, which the MS is not authorized to limit. The MS has authority only to control payment schedules. Second, beneficiaries' use of the judicial system to redress lapses or gaps in coverage is driving up costs.

In both Chile and Colombia, guaranteed benefits and the public insurers' limited abilities to alter affiliation or coverage conditions are driving up costs. In Chile, Fonasa cannot change mandatory contribution levels, accept higher premiums for top-up coverage, or alter affiliation and coverage conditions. As a result, Fonasa purchased more costly private sector services to guarantee delivery of the legally defined benefits floor, which increased per capita beneficiary spending by more than seventy-five percent between 2002 and 2012. In Colombia, the courts ordered FOSYGA to standardize the benefits package across the subsidized and contributory insurance schemes, which has driven up costs. At the same time, rising enrolment in the health insurance plans that do not require contributions (i.e., the 'subsidized regime') increases demand for services and increases costs, without bringing in additional revenue."

In Thailand, rising costs seem to result from the expansion of coverage to a new population group under the UCS, the abolition of user fees from 2006-2011 (the co-payment was reinstated in 2012), a comprehensive benefits package, and limited scope to introduce provider competition or active purchasing to increase efficiency. Thailand's NHSB does in fact have the authority to evaluate and change the capitation rate and the schedule of reimbursable services on an annual basis. Therefore, if revenues authorized by the government do not increase, the NHSB can manage higher demand for services, but only by squeezing providers who will have to accept less income or find ways to increase their productivity.

In Canada, Ontario's MOHLTC estimates that by 2025 health spending will consume seventy percent of the provincial budget because of demographic and epidemiological shifts. Although the MOHLTC has the authority to change all of the cost-related parameters, systemic inefficiencies present the biggest challenges in addition to rising demand. The following are among the known inefficiencies: FFS, the main instrument used to pay providers, provides incentives for providers to perform unnecessary procedures; strong cost-effectiveness evidence is not always used to decide what to cover; and experts have identified the need for more active surveillance of unnecessary or falsified claims.

Jurisdictional Conflicts and Mixed Roles

Jurisdictional conflicts in Canada's and Brazil's federated systems, and the problem of managing the split role of the public health ministry and the public insurer in Thailand, highlight a common challenge facing governments: how to coordinate multiple responsible agencies.

In Canada, hospitals and the LHINs, which plan and regulate health provision at the local level, have parallel management structures even though they are meant to work together to integrate and coordinate service delivery in Ontario. Though both entities are governed by boards and have similarly organized executive management structures, hospitals retain disproportionate power because of their more powerful boards and larger employee base. This limits the LHINs' ability to integrate services by providers and region. Ontario is unique in still facing this challenge. Other Canadian provinces have already eliminated these parallel structures in favor of joint local planning and delivery arrangements.

Brazil institutionalized coordinated planning across municipalities, states, and the federal government, to encourage democratic policymaking, streamlined service delivery, and stronger patient referral systems and medical supply and service management. However, the mandated coordination via Federal, State, and Municipal Health Councils as well as the Bipartite and Tripartite Commissions can often lead to confusion and delays in implementing important local programs and reforms. The amount of coordination required amongst these entities has caused local health agencies to be less responsive to the local population's needs.

Both Canada and Brazil exemplify the importance of paying attention to the design of vertical and horizontal coordination mechanisms in federated systems to ensure that delivery is efficient and advances the national health system's objectives.

In Thailand's unitary system, the UCS health reform established the NHSO and instituted a purchaser-provider split that stripped the MOPH of its authority to pay providers and manage the overall health system. At

the time, MOPH leaders actively sought to undermine the reform. As a result, Thailand implemented the split incrementally over several years in order to neutralize the conflict. However, no formal coordination mechanism was established to carry out future negotiation with the MOPH, and coordination has been carried out only on an as-needed basis. Whereas NHSO has now implemented the purchaser-provider split down to the subnational level, conflict still erupts between the two institutions. This may indicate the limitations of an incremental approach to reform in addressing upended power relationships. While it may be an unavoidable fact in some negotiations, there is no evidence from Thailand to suggest that formal purchaser-provider coordination in the public health system would be a worse alternative.

Civil Society Participation

This section describes the mechanisms used by countries to make their purchasing and managing agencies accountable to beneficiaries.

Public policies in Canada, Chile, Colombia, and Thailand all define an explicit benefits package. In contrast, Brazil's benefits package is implicit. The benefits packages in Colombia and Chile are mandated to cover an explicit set of benefits. Canada and Thailand review and update benefits annually.

Case evidence suggests that civil society members often participate in benefits package decision-making but that the intensity and structure of their participation varies. At one end of the spectrum, neither Colombia nor Chile evidences a direct, decision-making role for beneficiaries or civil society members. For instance, in Colombia, government actors influence policy decisions about the benefits package. Any challenges from the public to change the benefits package are generally routed through Colombia's Ombudsman, the General Comptroller, the General Attorney, and, significantly, Constitutional Court Magistrates.

Fourteen beneficiary and patient association committees advise Fonasa's director, providing a direct—although not

authoritative—point of influence on the system. Some civil society inputs to benefits package decision-making are handled prospectively. For example, the AUGGE Technical Secretariat in Chile's Ministry of Health researches social preferences to include benefits in the minimum benefits package. Other inputs are handled retrospectively, for instance Fonasa regularly fields opinion surveys to assess whether customers' experiences indicate that Fonasa's services have satisfied the legal guarantees. Beneficiaries may also lodge complaints with Fonasa or with SDS, or challenge their benefits coverage in a court of law.

Although the Canadian government regularly redefines benefits and reimbursement rates, beneficiaries have no official or direct role in this process. Instead, beneficiaries are able to influence the government's decisions about benefits through three channels: voting in provincial and national elections, consumer choice to select providers, and an active civil society. Because nearly all Canadian providers are private, a consumer's decision to use one provider instead of another can affect a provider's size and scope and, therefore, its power to influence prices and reimbursement rates in stakeholder negotiations. Finally, members of Canada's civil society have petitioned the government or called media attention to problems such as long wait times and inadequate services for older populations.

The situation in Canada contrasts with those in Brazil and Thailand in which civil society participation is formalized. In Brazil, civil society members are guaranteed half of the seats on municipal, state, and national health councils. The national health councils are responsible for shaping health policy and planning, inspecting public accounts, determining spending allocations, and demanding accountability. In Thailand, civil society members hold about ten of the thirty seats on the NHSO board, which is ultimately responsible for deciding the benefits package. In addition, a complaints hotline, which is available 24/7, allows patients and providers to give feedback on service quality and coverage. NHSO policy states that complaints to the hotline must be addressed by the system within one month of their receipt, otherwise, they will be re-routed (and escalated) to the Standards Quality Control Board.

Table 3.4: Main ways of regulating quality/Degree of civil participation in each system

	Civil society participation in benefits package decision-making	Civil society participation in quality
Brazil	Indirect, retrospective	Institutionalized
Canada	Indirect, retrospective	No formal role
Chile	Indirect, mix of prospective and retrospective	No formal role, advisory to director
Colombia	Indirect, retrospective	No formal role, litigation
Thailand	Direct, prospective	Institutionalized

Operations

Size and Scope

The four health financing institutions that reported on the size of their staff vary widely in this respect. For example, Colombia's FOSYGA employs few, if any, staff directly, whereas Canada's MOHLTC employs more than 4,000 individuals. Staff numbers do not seem related to the size of the insured population. For example, as shown in Table 3.5, agencies in Colombia and Thailand both serve around 48 million people. FOSYGA operates as a welfare trust under contract to the director-general of finance at Colombia's Ministry of Social Protection and has no direct employees. In contrast, the NHSO employs 824 executive,

managerial, operational and sub-contracted staff to carry out a wide range of national and regional operations. Therefore, it is likely that the differences in the scope of the institutions' activities account for variations in staffing, although we do not have information for Brazil.

We were unable to obtain a breakdown of staff numbers by functional area. That information would have enabled us to test this hypothesis. Instead, Table 3.6 presents case evidence on the agencies' key activities, i.e., 'Collects Premiums' or 'Manages Funding Pool'.

Colombia's FOSYGA reports no or few staff and a very limited scope since a board of trustees manages the fund on behalf of the Ministry of Health and Social Protection (MPS). FOSYGA does not collect premiums or enroll beneficiaries, rather it

Table 3.5: Staff Size

Country	Public Purchasing and Pooling Agency	Staff Size	Public Purchaser's Insured Population
Brazil	Sistema Único de Saúde (SUS)	N/A, but there are up to 5587 purchasing agencies/offices of healthcare under the SUS.	200 million
Canada	Ontario Ministry of Health and Long-Term Care (MOHLTC)	4,000 within the MOHLTC 420 employees at the 14 LHINs (est.)	13.6 million
Chile	Fondo Nacional de Salud (Fonasa)	1,137	13.5 million
Colombia	Fondo de Solidaridad y Garantía (FOSYGA)	0	48.3 million
Thailand	National Health Security Organization (NHSO)	824	48 million

Table 3.6: Scope of Activities

Activities	Brazil - MS, SHS, MHS	Canada - MOHLTC	Chile - Fonasa	Colombia - FOSYGA	Thailand - NHSO
Collects Premiums	N/A	No	Yes	No	No
Manages Funding Pool	Yes	Yes	Yes	Yes	N/A
Identifies Beneficiaries	N/A	N/A	Yes	No	N/A
Registers Eligible Beneficiaries	No	Yes	Yes	No	No
Benefits Package Definition (setting & revising)	N/A	Yes	No	No	Yes
Accredits Providers	No	No	No	No	No
Sets Regulation and Policy	Yes; Other entities	Yes	No	No	Yes
Processes Routine Health Claims, and Monitors Data Collection	Yes	Yes	Yes	No	Yes
Manages Routine IT	Yes	Yes	No	No	Yes
Carries Out Health Technology Assessment	No	No	N/A	No	No
Carries Out Disease Surveillance	Yes, Other entities	Yes	No	No	No

Note: Information in the cells indicates "Yes" if the purchasing and pooling agency carries out the activity; "No" if it does not; and N/A if the activity does not apply. We note "other entities" in several cells for Brazil in which responsibility was shared with an outside agency.

simply receives premium payments collected from separate health promoting entities that enroll beneficiaries. FOSYGA pools all health funds centrally and uses a simple mechanism to pay the health promoting entities that in turn pay providers.

In contrast, Thailand's NHSO carries out four main activities: it sets and revises the benefits package, sets regulation and policy, processes health claims, and carries out routine IT. A factor that limits the NHSO's size is that the NHSO does not generate revenue or collect premiums, instead it receives its general tax-financed budget from the Thai government.

Chile's Fonasa has a staff of approximately 1137. Its main activities include collecting premiums, managing the funding pool, identifying and registering beneficiaries, and processing routine health claims.

Information on the number of staff collectively working under Brazil's MS, SHS, and MHS was not available. Each of Brazil's up to 5587 pooling and purchasing agencies manage funding pools, process health claims, monitor data collection, perform disease surveillance, and set policy. The pooling and purchasing agencies share disease surveillance and policy setting activities with external actors.

The MOHLTC in Ontario reports the broadest scope and largest number of staff: 4,000 employees. The MOHLTC manages the funding pool, registers beneficiaries, sets and defines the benefits package, defines the strategic direction of healthcare in the province, decides policies and regulations, manages IT, and conducts disease surveillance activities.

In sum, comparing the activities undertaken by purchasing and pooling agencies in Canada, Chile, Colombia, and Thailand suggests that staff size increases with the scope of agency's activities. With no independent staff, Colombia's FOSYGA has the least expansive scope; it serves only as a pooling mechanism. Chile, Thailand, and Canada differ from Colombia in that the agencies in question all process payments. However, while Canada and Chile also register beneficiaries and collect premiums, Thailand does not, which may help explain why it operates with such a relatively lean staff. Finally, the factors that appear to differentiate Canada from Chile relate to the MOHLTC's health policy and IT management role, which extends well beyond core activities.

IT Infrastructure

The IT infrastructures underlying the public purchasing and pooling agencies in all five countries are extensive. Case evidence suggests that purchasers use a mix of in-house and external capacity to carry out some or all of the following activities: enroll beneficiaries, process routine payments, track patients or collect data for policy planning and management.

Brazil's national health information system is managed by the MS. The SUS Department of Information Technology (DATASUS) is housed within the MS's Secretariat of Strategic and Participative Management. DATASUS collects, analyses, and disseminates state and municipal health system usage as well as service delivery and claims data to inform planning and budgeting activities. DATASUS also collects information on demographic and health indicators, and epidemiological and morbidity information. The MS Secretariat also manages the public health budget information system, SIOPS, which collects, processes, and organizes data on total revenues and public health expenditures.

Much of Ontario's IT infrastructure is managed in-house by the MOHLTC's Health Services I&IT Cluster. This cluster manages OHIP's IT services, registers residents into MOHLTC programs, registers healthcare providers, and processes medical claims and payments. The Ontario Public Health Integrated Solutions Branch separately provides integrated solutions to help manage cases and outbreaks of infectious diseases, improve immunization delivery and tracking, and manage vaccine inventories (Ministry of Health and Long-Term Care, 2014).

In Chile, the Integrated Information System for the Management of Explicit Guarantees in Health (SIGGES) contains online information for each AUGE patient. SIGGES captures medical data that is used by the SDS to supervise and control AUGE, support financial management and evaluation of the health system, and by doctors, nurses, and other health professionals to monitor services and address wait times in real-time.

In Colombia, a single database, the *Base de Datos Única de Afiliados* (BDUA) is used to enroll beneficiaries and monitor finances. The EPSs enter enrollment and beneficiary information, which is used by the MPS's BDUA Directorate and FOSYGA's trustees to track resource needs and to determine EPS's membership. Following a major investigation it launched in 2011, the Colombian government raised concerns about duplicate, incomplete, or fraudulent information found in the BDUA (MPS) (Torres & Acevedo, 2013).

In Thailand, the NHSO's Bureau of Insurance Information Technology manages a database that tracks 150 million outpatient, and 5 to 5.5 million inpatient transactions every year, as well as any prevention and promotion (P&P) payments and services for the purposes of reimbursement (Hitachi Data Systems 2012). The system integrates with Thailand's Civil Registration and Vital Statistics (CRVS) for reporting purposes and with the SSS and CSMB registration systems to enable members to transfer between the public schemes. The IT system is supported by a budget of approximately THB60 million (roughly US\$1.8 million).

Section 4: Discussion

Origins, Scope, and Evolution of National Health Insurance Funds

The systems and entities that govern health insurance funds in the case countries vary substantially in scope and emerged from reforms that were both sweeping and incremental. In each of the case countries, the reforms were built upon previous investments and existing institutions and continue to evolve.

The sweeping reforms that resulted in significant new institutions for UHC in Brazil, Chile, and Colombia were followed by periods of incremental change and adaptation. For example, Chile's sweeping reforms in 1979 and 1981 unified all public and formal insurers under a single public insurer, Fonasa, and created the private Isapres to compete with it. Nearly a quarter century later, in 2005, Chile introduced the more incremental AUGE reform. AUGE changed the governance arrangements and coverage responsibilities of the public insurers to address social inequalities that emerged long after Fonasa and Isapres were implemented.

The governing entities that we examined in Thailand and Canada also experienced significant shifts towards UHC, but the respective governments introduced these changes by remodeling the responsibilities, authority, and financing of existing institutions. For example, Thailand created a new insurance agency for those without coverage without eliminating or fusing the old public schemes. In the 1980s, Canada built on the publicly financed health insurance scheme established in the 1960s and 1970s by creating federal funding regulations and policies for the provincial health authorities.

Successful reforms start with ambitious goals that require the establishment of new institutions and funding instruments to achieve them. After governments enact or adopt reforms, they spend the subsequent years implementing, adapting, and then responding to problems that emerge in their implementation. For example, Thailand's ambitious 2002 reform sought to create the NHSO as a new single payer structure that would unify the three existing public insurance schemes. Ultimately, the National Security Act established a purchaser provider split and output-based payment mechanisms. However, it was not politically feasible for the Thai government to harmonize the three public schemes during the Parliamentary debates leading up to the new law. Instead,

reformers secured language in the Act that would facilitate its harmonization in the future. Thus, the Act laid important groundwork to support the reform's ongoing evolution.

Stakeholders' discussions of the major goals and principles for the NHIF—e.g., whether the NHIF will be constituted as a single or multi-payer, rely on local management, or allow duplicative private voluntary health insurance—are likely to take place within a changing landscape. After five years of transition, the landscape will be different. Stakeholders may then decide to discard some principles while retaining others.

Since reform is an ongoing process, NT may want to prioritize its goals and principles first and then map the legal and policy steps required to implement them. That way, even if the ultimate goal (e.g., single payer) is not feasible in the near term, NT can reduce or eliminate any barriers that might prevent its key goals and principles from being adopted in the future.

Basic Governance Architecture

The cases that we studied illustrate that there are multiple ways for South Africa to structure the broad governance architecture of the NHIF.

In Brazil, Canada, and Colombia the public pooling and purchasing agencies are all placed within their respective health ministries. Chile's Fonasa is also located within the health ministry. However, it is constituted as an autonomous institution that serves as the health ministry's funding arm. In comparison Thailand constituted the NHSO as a state autonomous agency, which serves under the authority of an independent board, the NHSB. Thailand's Minister of Public Health (MOPH) is responsible for overall stewardship of the health system, and chairs the NHSB, although he is one of thirty members. This architecture institutionalizes an arms-length relationship between the major purchaser and major provider. Even so, the process of instituting the purchaser provider split in Thailand has led to deep, persistent rifts between the NHSO and MOPH. Thailand slowed the implementation process to deal with this rift, but Thailand has not set up an official agency to coordinate between the NHSO and MOPH. Instead, the Thai government has assembled coordinating commissions to address specific issues in the short run on an ad hoc basis.

The major operations of the pooling and purchasing agencies we examined in the cases are carried out at different jurisdictional levels within their respective governments. Purchasing and pooling operations are mainly carried out at the national level in the unitary states of Chile, Colombia, and Thailand, and at subnational levels in the federated states of Brazil and Canada.

Finally, the pooling and purchasing agencies we examined in the cases differ as to what government agency holds them accountable. In Brazil, Canada, and Colombia, pooling and purchasing agencies are accountable to their respective health ministries. In Chile, Fonasa is directly accountable to all three government branches. Thailand's NHSO is accountable to the NHSB, which ultimately is accountable to the Thai Cabinet and the Thai Parliament.

If South Africa chooses to constitute the NHIF as an autonomous public agency that will be held accountable to an oversight Commission, it can look to Thailand as a model. Accordingly, South Africa should look closely at Thailand's experience of implementing the NHSO to learn from its conflicts and pitfalls.

Size and Scope

The size and type of staff governing national health insurance funds correspond to the particular scope of the entity(ies), and those scopes vary considerably.

Staff size appears to vary in relation to each agency's scope of activities among the four agencies that provided staff size information. If South Africa wants to establish a system of universal health coverage with an NHIF that separates financing from the provision of services, it will have to collect revenues, select which providers to reimburse, and establish payment terms.

The number of staff required by the NHIF will depend on which functions it carries out and which it assigns or delegates to other agencies. Thus, South Africa will have some ability to choose the size of the NHIF depending on its scope. The cases that we examined offer South Africa a wide range of alternatives to consider.

If South Africa configures the NHIF as a fund that receives revenue from the tax service and disburses funds to provincial insurance agencies, its staffing would be quite minimal, as is Colombia's FOSYGA.

If, however, the NHIF receives revenue from the South African tax service but takes responsibility for administering beneficiaries and processing payments to providers, then it must be larger, similar to Thailand's NHSO. The NHSO reported 824 staff in 2013.

If the NHIF collects premiums, administers beneficiaries, processes payments to providers and engages in pooling across the divide with medical schemes, it will require even more staffing, more in line with Chile. Chile's Fonasa reported 1,137 staff.

Finally, if the NHIF also uses its funding and payment mechanisms to monitor and regulate the supply of healthcare services (e.g., accreditation, incentive for quality provision) and carry out routine management of IT, then it will require significantly more staffing, along the lines of Ontario, Canada which reported more than 4,000 staff.

South Africa will need to consider existing institutional and staff capacity and various alternatives for consolidating, sharing, or developing new capacity for the future NHI system. The government will need to first agree to the scope of activities that the NHIF will carry out in-house; determine other institutions that may assume responsibility for functions outside of the NHIF's scope; and plan for how the NHIF will administer and govern its relationship to those non-NHIF institutions.

Role of the Provinces

National health insurance funds are governed through decentralized, subnational authorities in the two federated case countries. In the three unitary states, the funds are governed through centralized national funds that reimburse health providers directly or regulate private insurers.

In the federated contexts of Brazil and Canada, subnational government entities manage the funding pools, set regulation and policy, and process routine health claims. In the unitary states of Chile and Thailand, national funds are channeled through regional and local units. In Colombia, a unitary context, a central fund flows to private insurers under managed competition in a system that likely is least applicable to South Africa's vision for the NHIF.

South Africa has several options for how to channel funds to providers. Two prominent options are to establish provincial funds, largely in line with its federated governance structure, or to bypass the provinces with at least some funds channeled directly to the proposed District Health Authorities (DHAs). If the NHIF decides to route funds to the provinces, it might allow them to set up their own health insurance funds with which to purchase services from public and private providers as is done in Canada. South Africa could allow provinces a great deal of discretion to work with the proposed DHAs. In Ontario, the provincial health ministry transfers about forty percent of its total health budget to a Local Health Integration Network (LHIN). Like the role proposed for the

DHAs in South Africa, Ontario's LHINs plan, coordinate, and manage local health providers and contract with local private providers for certain types of care.

If South Africa follows this approach, South Africa's provinces would be required to manage an insurance system. However, the provinces currently have low levels of fiscal management relative to those of Canada's provinces. Therefore, any proposed plan must consider how the provinces will develop or improve the skills needed to carry out cost accounting, payment processing, and other financial tasks. It may be feasible for South Africa to build the capacities of the provinces, as both Chile and Colombia extensively reformed their respective public health services to make them capable of receiving payments from insurers. However, it will be critical for South Africa to pilot and test such a model before implementing such a plan across the country.

If South Africa bypasses the provinces with some proportion of NHI funding, the NHIF instead would need to pay DHAs, hospitals, and private providers directly. Thailand manages its universal coverage system in this way. Thailand's Minister of Public Health (MOPH) delegates its contracting authority to contracting units for primary care (CUPs). The NHSO transfers capitation funding to the CUPs, which act as "fund holders" on the provider side. CUPs pay local service units to provide outpatient services and pay for referrals for inpatient care. Chile, similarly, delegates contracting and purchasing authority to Regional Health Service (RHS). The RHSs comprise the public health delivery network of specialized and non-specialized hospitals.

South Africa must consider that the systems in Chile and Thailand function in a top-down, centralized unitary structure, which is unlike South Africa's federated structure. If South Africa were to bypass the provinces in such a way, it would be forced to create a stronger, single-payer-like NHIF, and implement substantial (possibly constitutional) changes in governmental relations. Such changes would be needed for the government to transfer non-earmarked provincial funds into a national health insurance fund, bypass the provinces, and reimburse local district health authorities and private providers directly.

Under South Africa's federated structure, its provinces today receive eighty-eight percent of all public health sector expenditures. Beyond determining what legal authority is required to change the mix of provincial healthcare funding and responsibility, South Africa will also need to weigh the costs and benefits of reallocating labor, administrative and managerial expertise, civil servant salaries, and institutional knowledge from the provinces to another level of authority.

Role of Medical Schemes in Relation to the NHIF

Of the five cases that we examined, only Canada restricts private insurers to offer supplementary (non-duplicative) health coverage. Private insurers in Brazil, Chile, Colombia, and Thailand are allowed to offer duplicative services.

The portions of the population covered by private insurance vary considerably across the five case countries, from 67 percent in Canada (supplementary coverage) to 25 percent in Brazil, 16 percent in Chile, and 2.2 percent in Thailand.

If South Africa intends to create a single payer system in which its medical schemes offer voluntary supplementary coverage, it must figure out a temporary role for the medical schemes during the NHIF's expansion. The challenge is to find ways to improve the public sector's quality and access so that people want to use the public system rather than pay for private insurance.

South Africa also must decide which services to allow the medical schemes to cover in a single payer system. It will also need to determine whether to place any restrictions or conditions on premiums and services that medical schemes are allowed to offer. Canada insists on universal public insurance for a comprehensive package and restricts voluntary private health insurance to cover only care that is not publicly insured, such as outpatient medicines, dental services, and cosmetic procedures.

South Africa could allow multiple payers during the transition period. If it does, it would need to either let existing medical schemes compete with public insurers to provide a basic or comprehensive package of services (Brazil), or insist on a new form of health insurer (e.g., EPSs in Colombia, Isapres in Chile).

Brazil allows existing medical schemes to compete with public insurers to provide a basic or comprehensive package of services in a parallel system. Starting from a small base of public provision, Brazil expanded the share of hospital beds in the public sector from 22 percent in 1988 to 35 percent in 2013 through its heavy public infrastructure investments after SUS. However, the services available through Brazil's public insurance system are widely viewed as being of inferior quality to those available through private insurance. Beneficiaries of Brazil's public system suffer long wait times. As a result, the size of the private insurance sector has not diminished despite heavy public investment to create more public health services. About 25 percent of Brazil's (mostly) higher income groups have continued to purchase private insurance to supplement the insurance coverage they receive through the SUS since the late 1990s.

Chile insisted on creating a new form of health insurer, which overwhelmingly has paid public providers since its formation in 1979. Today, 85 percent of all of Fonasa's spending is in the public sector and Fonasa gives public providers budget support in exchange for their participation in AUGE. Yet, Chile created the private Isapres in 1981 to compete with Fonasa and allowed Fonasa's beneficiaries to direct their mandatory payroll contributions towards purchasing voluntary private insurance under them. Chile also guarantees that public and private insurance packages and quality are the same. Under these conditions, private insurance enrollments in Chile dropped from 26 percent in 1995 to 16 percent of the population in 2009.

A path toward a single payer system would require that South Africa:

- Improve public sector quality and access so that people increasingly want to seek care from public providers rather than pay for medical scheme coverage.
- Regulate the private supply of healthcare services (e.g., restrict excessive technology) and prices of private healthcare services to limit input cost pressures on the public system.
- Create incentives for medical schemes so that the schemes eventually prefer providing complementary packages to basic or comprehensive packages.
- Avoid or gradually eliminate government incentives that encourage the purchase of private insurance (even at the margin).

South Africa will need to determine what policy instruments it has to accomplish the first two goals and begin moving through the transition.

Role of Private Providers

NHI funds that are intended to increase access to care by engaging private providers must have price levels sufficient to attract private providers' participation and mechanisms that control cost escalation.

South Africa may be able to increase the population's access to healthcare by engaging private providers in UHC, and may attract such providers by offering the prospect of greater patient volume under UHC. South Africa, however, will have to balance private participation and cost escalation, which has been a major struggle elsewhere. Chile pays private sector providers (at higher rates) to ensure that the country meets the guaranteed level of medical care promised under AUGE. However, this approach has been costly. Despite significant increases in

public capacity, in the ten years after AUGE (from 2002-2012) Chile's per capita spending on Fonasa increased by more than seventy-five percent in part due to rising spending on private providers.

In Brazil, public reimbursement rates for complex care in private hospitals are favorable from providers' perspectives, but are inadequate for simple procedures. This creates perverse incentives for providers to oversupply complex care. The low payment levels also have driven several private hospitals to lobby states and municipalities for ad hoc bailout payments. Overall, problems related to payment mechanisms and levels discourage private providers, the majority share of providers within the SUS, from wanting to continue operating within the SUS.

Thailand has successfully attracted private hospitals to participate selectively in the UCS by offering more attractive payment scales for targeted tertiary services. For example, in 2008 the NHSO addressed the long waitlist for cataract surgery by unbundling the procedure from the IP DRG system. The NHSO began to pay hospitals a fixed fee per case and paid surgeons a special fee to perform cataract surgeries. The number of cataract lens replacements subsequently doubled in 4 years from around 70,000 lenses replaced to more than 140,000. However, Thailand's success in cataracts did not carry over when it applied a similar payment method to primary healthcare. This was partly because data recording, entry, and monitoring requirements overburdened the understaffed health centers that tried to implement the payment method. Careful monitoring of new payment mechanisms introduced by public insurers is needed to make sure they are effective in different settings.

If South Africa chooses to proceed with a universal plan that includes private provision, it must improve its understanding of the private healthcare market and utilize a full range of instruments to improve healthcare access while containing costs. Such instruments include mechanisms to negotiate the prices reimbursed to private providers by the NHIF as well as by medical schemes, control the adoption of technologies that are not cost-effective, and set conditions for physicians to have access to public hospital facilities, among others.

South Africa may be able to develop its system through experimentation and learning. For example, South Africa could reimburse a small number of private providers in a few places for a limited package of services. Using experimentation, the government can learn under what conditions public payment/reimbursement will attract private providers and be manageable to implement at the same time. It can use this information to develop appropriate payment mechanisms, rates and feasible negotiating mechanisms incrementally.

South Africa will need to carefully review the current costs and cost drivers of private services and compare those to revenues and payment approaches likely to be available under NHI. It will then need to create feasible incentives to induce private providers to participate. In addition, South Africa should look for opportunities to run experiments and pilots to test and evaluate the instruments it identifies.

Payment Systems

Most countries have mixed payment systems that are increasingly designed to improve value for money.

We find little evidence that the case countries use active purchasing systematically (i.e., monitoring how providers and beneficiaries respond to the pricing system, and adjusting rates and contractual terms to improve the value of purchased services). For example, Thailand's use of active purchasing is limited to a few targeted services in tertiary care which it has introduced incrementally over time. In Brazil, some state and municipal hospitals are paid through a 'prospective global budget' allocation, which ties meeting service volume and quality performance targets to the budget payment. Canada has introduced innovative payment mechanisms to incentivize comprehensive care, but its extensive use of FFS results in the overprovision and overconsumption of care.

Instead, most of the case countries use a mix of FFS, capitation, and global budgets that improve value for money but fall short of active purchasing. For example, Thailand's NHI uses capitation to pay for outpatient care and DRGs in combination with a global budget cap for inpatient services. Both payment mechanisms encourage cost containment, optimal service, and efficiency over FFS, but lack the active monitoring and price adjustment that Thailand applies to its targeted tertiary services.

Payment mechanisms introduced through UCS reforms in Colombia and Chile do not appear to have changed

substantially after the reform's implementation. In comparison, Thailand has introduced new active purchasing mechanisms to pay for selected tertiary services and devised new ways of paying for village-level P&P services. Canada and Brazil each added significant new programs that used new mechanisms in place of FFS. Brazil introduced the Family Health Strategy in the late 1990s which used capitation plus incentive-based payments to pay for comprehensive primary care services in rural and poor regions of Brazil. Canada began to pay physicians using capitation under the Family Health Network and Family Health Organization models which it introduced in the early 2000s.

Thailand's ability to successfully introduce new capitation and DRG mechanisms with the UCS reform resulted from its previous experience implementing large scale public insurance schemes. Thailand had a well-established citizen registry database which allowed it to calculate population service areas for capitation and a previously developed DRG system that was ready for the NHI to use.

South Africa has the opportunity to adopt state of the art payment mechanisms when it institutionalizes the NHI. To do so, South Africa's public health sector will need to make significant public financial management changes in order to receive payments on the basis of DRGs, FFS, capitation, or other payment mechanisms—and to adapt to changes over time.

South Africa would also benefit from policy dialogue on the extent to which it wants to implement active purchasing from the onset of reform. Active purchasing requires extensive capacity to set and update rates, monitor performance, and respond to evidence of rationing or excessive utilization. South Africa should consider whether it has an existing office or institution that can carry out work to promote active purchasing; and whether it has certain provinces or providers that might be willing to participate in active purchasing experiments.

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Appendix 1: Data Collection Instruments

Data Collection

R4D collected data from four main sources:

1. Official documents of the public agency or agencies responsible for managing health funds and purchasing services—such as laws, notifications, regulations, organizational structure charts, annual reports, and diagrams;
2. Relevant academic and grey literature identified using keyword searches in major academic databases;

3. Interviews with country health system experts; and
4. Key country and health context indicators from widely-available data series such as those published by the World Bank and the International Monetary Fund.

R4D developed two instruments to collect comparable data on the governance of large public pooling and purchasing funds in comparison countries, a structured case study protocol, and an interview protocol:

Instrument A.1: Structured Case Study Protocol

No.	Question	Data	Data Source
1	Name of author (person completing the questionnaire)		
2	Country name		
3	Name of the purchasing & pooling agency that is the main focus of this case study (What is the institution responsible for transferring pooled funds to healthcare providers under UHC?)		
4	Function		
5	Who are all the financial agents of UHC? (Insert new rows to list all the financial agents by name and acronym). Also describe affiliation, e.g. central government agency, regional or local government, social security, autonomous governmental institution, philanthropic, private). ** Note "financial agents" are all flow-through agencies that incur expenditures for UHC and include 'fund holders', 'pooling agents', 'purchaser', 'payer'. It does not include "sources of funding or providers of care".		
6	What is the responsibility of the purchasing & pooling agency?		
7	Primary insurance fund (name of the primary fund of pooled resources)		
8	Year the fund was launched		
9	Key legislation that established the fund		
10	How is the fund financed?		
11	Purchasing & pooling agency vision		
12	Purchasing & pooling agency mission		
13	Purchasing & pooling agency goals		
14	What services are purchased from the funding pool?		
15	Is the benefits package "comprehensive" or limited? (A comprehensive benefits package is presented in the Benefit Package tab of this workbook. If the literature does not classify the system, or does not agree, you can refer to the benefits package list to determine 'comprehensiveness')		
16	How is the fund's budget determined?		

Instrument A.1: Structured Case Study Protocol (continued)

No.	Question	Data	Data Source
<i>Size and scope of the purchasing & pooling agency</i>			
17	What is the functional scope of the purchasing & pooling agency?		
18	Number of employees (in the purchasing & pooling agency)		
19	Number of FTE		
20	Wages Paid to FTE		
21	Annual budget		
22	Annual expenditure		
23	Number of staff in the year the fund was founded		
24	Percentage of the population financially covered (at the start of the fund, and currently)		
<i>Architecture of the purchasing & pooling agency</i>			
25	How is the purchasing & pooling agency of the fund situated within the national government (i.e. in the MoH)? Or is it autonomous?		
26	List all of the governing bodies with responsibility for the purchasing & pooling agency? What role(s) do they play (i.e. does the purchasing & pooling agency report to these bodies?).		
27	If the governing body is constituted as an independent board (or boards), describe who serves on these boards and how they are appointed		
28	What is the role of the Ministry of Health in relation to the purchasing agency? (E.g. policy setting, financing delivery, monitoring, other?)		
29	What agency is in charge of enrolling beneficiaries for UHC? The purchasing agency? A separate agency? Local governments?		
30	What entity is responsible for defining the benefits package(s)?		
31	What are the mechanisms for the monitoring, revision and re-setting of the benefit package? What actors are involved?		
32	What regional or local offices administer and monitor the fund at the local level?		
<i>Payment systems</i>			
33	Who sets prices/rates?		
34	Does the price/rate setter have autonomy and market power to set prices, or is it a price taker?		
<i>Health providers</i>			
35	Briefly describe the mix of public and private providers, if possible, by level (primary, secondary, and tertiary)		
36	Who are the healthcare providers that the Purchasing Agency (e.g. in Thailand, the NHSO) contracts with to provide health services for its beneficiaries? For each level, primary, secondary and tertiary, are the providers private, philanthropic, or public?		
37	Do providers need to be approved or accredited to participate in UHC?		
38	What entity accredits health providers?		
39	How are health services delivered locally?		
40	What mechanisms does the fund use to channel funds to the contracted providers for outpatient care?		
41	What mechanisms does the fund use to channel funds to the contracted providers for inpatient care?		

Instrument A.1: Structured Case Study Protocol (continued)

No.	Question	Data	Data Source
42	What mechanisms does the fund use to channel funds to the contracted providers for other types of care? For example, for disease prevention and health promotion activities?		
43	Does the purchasing & pooling agency provide additional incentives for desired provider behaviors, e.g. quality improvement, data reporting, etc.?		
44	Is there evidence of active purchasing? (i.e. monitoring how providers and beneficiaries respond to the pricing system, and adjusting rates and contractual terms to improve the value of purchased services)		
45	How is 'active purchasing' carried out? Who are the actors and what information is needed to inform their decisions?		
Local purchaser			
46	What (if any) subnational purchaser is responsible for making local purchasing arrangements?		
47	How is funding channeled to this purchaser?		
Lower levels of government			
48	How does the fund relate to lower levels of government?		
Classification			
49	Classify the type of insurance fund entity (e.g. direct provision, single payer, corporatist, regulated market) and double check with interviewee that this classification is correct (apply classification used in Savedoff & Gottret, 2008).		
Insurance market			
50	What is the market for health insurance in country x?		
51	How does the fund relate to other (public and private) insurers?		
Evolution over time			
52	List in separate rows, the year / time of KEY policy changes and what those changes were		
53	Any indicators of the policy changes documented above (e.g. KEY changes in the share of the population covered by ins; number of insurer staff, etc.)		
Functions			
54	What functions does the purchasing & pooling agency in country x undertake? Who carries it out (e.g. the purchasing & pooling agency or another agency? If another agency, what is that agency?		
	Collect Premiums		
	Manage Funding Pool		
	Identify Beneficiaries		
	Register Eligible Beneficiaries		
	Benefits Package Definition (setting & revising)		
	Accredit Providers		
	Set Regulation and Policy		
	Process Routine Health Claims, and Monitors Data Collection		
	Manage Routine IT		
	Health Technology Assessment		
Disease Surveillance			

Instrument A.1: Structured Case Study Protocol (continued)

No.	Question	Data	Data Source
<i>Information System</i>			
55	Is there a system that tracks use of healthcare by HCP enrollees? Is this used to improve the care they received in any way? If so, please explain.		
56	Does the information system track: beneficiaries (i.e. demographics, health status)		
57	Does the information system track providers? (I.e. infrastructure, quality reporting, provider performance, cost information?)		
58	Does the information system track internal processes? (I.e. utilization per beneficiary, or provider, payments and accounting info, grievance status?)		
59	What information is made publicly available?		
<i>Risks</i>			
60	What institution is charged with ensuring the financial sustainability of the system?		
61	What are the top three risks to financial sustainability? How are these being addressed?		
62	Does the institution have appropriate authority to take corrective action to ensure financial sustainability? This would be defined as the ability to change at least one of the parameters on which financial sustainability depends, such as the conditions of affiliation, the contribution rate, benefits package, ability to act as a strategic purchaser, or tariffs? (See Savedoff & Gottret, p. 54)		

Instrument A.2: Interview Protocol

Interviewer	
Interviewee	
Title	
Organization	
Area of Expertise	
Email	
Tel/Skype	
Interview Date	

Insurance System and Governance

- Illustration of system architecture, along with a basic description of providers, insurers, and government.
- Explain the purpose of illustration/figure in email, and request assistance with validating it over phone/skype. The main questions are: are the right institutions represented in the picture (purchasers, insurers, government) and does it portray the basic relationships correctly?

Evolution/Change Over Time

- Staff, size and functions

Request information (or any time-trends documentation) about what the fund was like when it started as compared to today, in terms of:

- | | |
|--|--|
| <ol style="list-style-type: none"> Number of staff <ol style="list-style-type: none"> Number of staff at the fund's start [YEAR: _____] Number of staff today Size of the fund <ol style="list-style-type: none"> Fund budget/expenditure at the start [YEAR: _____] Fund budget/expenditure today | <ol style="list-style-type: none"> Functions <ol style="list-style-type: none"> Number of functions at the start [YEAR: _____] Number of functions today |
|--|--|

- Contracts

What kinds of contracts/payment mechanisms to healthcare providers did the fund use originally? (Select any from the list, below) or match to inpatient, outpatient, P&P, special funds (e.g. for HIV/AIDS, dialysis). Below is a list of payment types from McIntyre, 2007 based on: Carrin and Hanvoravongchai, 2002; and Kutzin, 2001.

Contracts/Payment Mechanisms for Healthcare Providers	Check all payment mechanisms that were originally used by the fund?	Which of these were the dominant forms (select up to two)?
Salary		
Capitation		
Fee for Service		
Budget allocation		
Per diem		
Case-based (includes diagnostic related groups (DRGs))		

- Of the two most dominant forms of payment indicated in the table above, in what year did the fund switch to a different kind of contract?
- What type of contract was that?

Complementary Functions

- List South Africa's complementary functions and explain that South Africa wants to compile a complete list of "complementary" functions carried out by National Funds in other countries.
- Please ask the interviewee to evaluate the list for any missing functions, and to provide any knowledge they have of the assigned responsibility for the function (i.e. is it assigned to a division within the fund or outsourced to a contractor, another agency, etc.?)

Proposed Complementary Functions for NHIF in South Africa	Country X National fund has this function? (Yes/No)	Carried out in-house, or outsourced? (If outsourced, to whom/what?)
Develop appropriate processes for complaints and appeals from the general public and healthcare providers		
Definition and monitoring of the benefits package: Make decisions to change services, payment rates to providers		
Oversee management and operation of the National Health Information System (NHIS)		
Data collection and quality assurance		
Accreditation of providers		
Collect routine submission of clinical and patient information from providers		
Translate coded information (i.e. Translate coded information into DRG payments, case mix system adapted to South African context)		
Monitor provider performance		

Human Capital by Division/Unit

- Table listing the purchaser's units, offices or divisions, along with columns for staff skill sets and number of staff.
- Complete as much information as possible and request the interviewee to input any missing data; or forward the request to someone in human resources who can provide a breakdown of the division by skill set and number of staff (example table, below is for Thailand. Please delete these entries and insert appropriate units/divisions for your case).

Unit/Division	Staff Skill Sets	Number of Staff
General Administration		
Financial Administration		
HR and Change Management		
Legal Affairs		
Internal Audit		
Benefit Administration		
Specific Benefit Management		
Claim and Medical Audit		
Service Quality Development		
Claim Administration		
Disease Management		
PR and Client Relations		
Civil and Society Movement		
Insurance Information		
Technology		

IT Requirements

- a. What can you say about the size and scope of the IT infrastructure supporting the fund? Specifically, what functional health system domain areas does it cover?

Evolving health system domain reference model, (PATH 2012, vi)				
<i>Functional Domain</i>	<i>Sample Processes</i>	<i>Sample Task Leader</i>	<i>Covers this Domain (Y/N)</i>	<i>In-house (1) / Outsource (0)</i>
Community Services	Patient registration Patient case management	Healthcare worker Supervisor		
Facility services	Patient registration Birth registration	Healthcare worker Surveillance officer		
Laboratory services	Specimen collection Results reporting	Healthcare worker Laboratory tech		
Human resources	Create new position Transfer employee	Human resource officer District manager		
Supply chain	Order medicines Store medicines	District manager Storekeeper		
Finance and insurance	Enroll members Verify coverage	Registration clerk Receptionist		
Management and planning	Produced monitoring and evaluation indicator reports Create operating plan	District manager Nat'l monitoring and evaluation manager		
Environmental services	Map water quality and access Map sanitation resources and access	District manager Surveillance officer		
Knowledge & information	Create care-delivery protocols Access research and protocols	Program manager District health officer		
Infrastructure management	Manage cold chain equipment Create facility construction plan	Immunization manager Program manager		

Appendix 2: Standardized Case Outline

Material collected using the data collection instruments was used to draft five stand-alone case studies of public sector pooling-purchasing mechanisms in Brazil, Canada, Chile, Colombia, and Thailand. The case material was organized using a standardized case outline as follows:

Country introduction

- a. 1-2 paragraphs providing an introduction to the country/pooling & purchasing agency studied, why it was selected, and what features of its health insurance system make it uniquely interesting to South Africa.
- b. Pooling & purchasing agency of focus (unit of analysis)
 - i. 1-2 paragraphs giving a brief history of the purchasing agency: motivations, precursors, issues when started, and how it evolved.
 - ii. Create a box with key information about the purchaser of focus for the study: size, and scope (number of employees, budget, expenditure, mission, and goals etc.).

System Architecture

- a. Draw an illustration of the financing and oversight relationships between the purchasing agency and healthcare providers, insurers, and government.
 - i. Use lines/arrows to show the direction of financial flows between the purchaser and the other institutions.
 - ii. Use lines/arrows to show the reporting/oversight / accountability relationships between the purchasing agency and insurers, providers, and government institutions.
 - Note the flow of data and information between institutions – i.e. who collects data, and who reports data/information to whom, including consumer complaint systems, beneficiary monitoring, or patient referral information.
 - Note the flow of data and information to support reporting and oversight relationships, i.e. how one or more IT systems is used to enable active purchasing decisions, enable the reporting of consumer complaints and concerns, and to develop system user statistics.

Providers

- a. Brief description of providers in the country and how the purchasing agency relates to them (flows of funds and oversight/reporting, as depicted above)
 - i. Which entities (providers) ultimately get paid by the fund to deliver health services? (Regardless of whether these payments are made directly to the provider or via another insurer (subcontract)).
 - ii. How are payments to these entities made? (Describe the mechanisms, i.e. how the national fund pays providers).

Government

- a. How does the purchasing agency relate to national and local governments?
 - i. Brief description of national and local levels of government in the country and how the purchasing agency relates to them (flows of funds and authority, as depicted in system architecture).
 - ii. Relationships/division of responsibilities between the fund, provinces, and districts (any overlaps with purchasing?). More specifically, do subnational government entities play a role in purchasing health services for the fund? Do the subnational governments play a part in active purchasing, if so, what is that part?

Insurers

- a. What relationship does the national fund have to other public and private insurers?
 - i. Describe the other public and private insurers.
 - ii. How do they relate to the purchaser (flows of funds and authority, as depicted in system architecture)?
 - iii. What role, if any, do competitive market forces play in the system?

Risks

- a. What are the three most important problems that the fund has faced? How did each arise; how could each have been avoided?
- b. Based on experience of each country, are there any suggestions for South Africa on avoiding similar problems?
- c. Specific Concerns for South Africa:
 - South Africa is concerned about tax evasion by high earners who may under-report their income – is this a problem in the respective country under review? If so, how is it addressed?
 - South Africa is concerned about false claims by healthcare providers – is this a problem in the respective country under review and how is it addressed?
 - South Africa is concerned that the NHIF will end up covering the poor and middle class while rich people continue to get insurance coverage from medical schemes and create a two-tier system. Is this a problem in the respective country under review and how have you addressed it?

Case Conclusion

- a. Three to four paragraphs summarizing the main results or learning from the individual case analysis that is relevant to South Africa.
 - i. Summarize the salient features of the fund's governance structure in light of the detail presented in the case. How is it funded? Is it a public/private/autonomous institution? How does it relate to providers, other insurers, and government?
 - ii. Did some features work especially well in relation to what the country hoped to accomplish?
 - iii. What are the big issues that remain unresolved in the respective country?
 - iv. What lessons from the respective country are most relevant for South Africa?



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