Access to healthcare in South Africa and the proposed NHI plan

Submission to the High Level Panel

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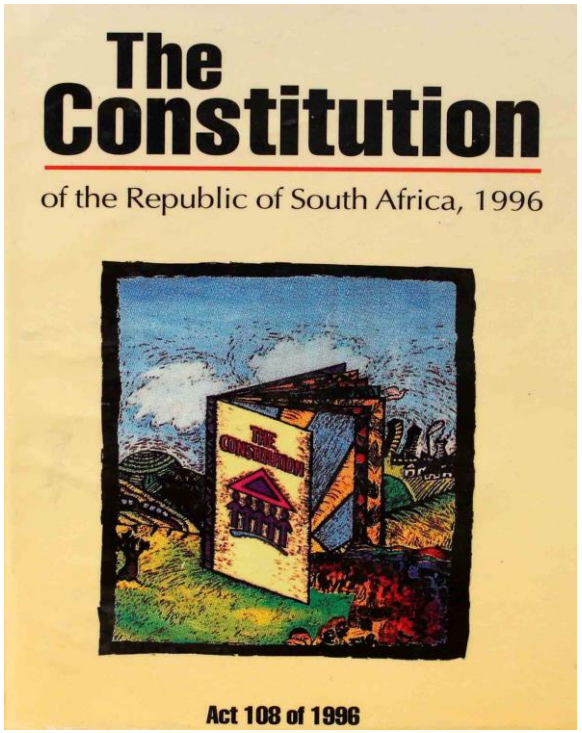
Agenda

1. South African Constitution and Word Health Organisation (WHO) Overview
2. South African Healthcare System - Diagnostics
3. Snapshot – Proposed Hybrid NHI Model
4. White Paper NHI Model (June 2017)
5. Proposed Hybrid NHI model
6. Recommendations
7. Journal References and Academic Articles

SA Constitution & WHO



World Health Organization

Section 27(1):

*Everyone has the **right to have access** to health care services, including reproductive health care…no person may be refused emergency treatment….government must take **reasonable** legislative and other measures, within its **available resources**, to achieve **progressive realisation**…*

All citizens, irrespective of financial status, age and geography, should receive Universal Health Coverage (UHC). It is a human right.

UHC does not mean free coverage for all possible health interventions regardless of cost as no country can provide all services free of charge on a sustainable basis.

Challenges of the Scale and Complexity of SA Healthcare System- Diagnostics

Public / Private disconnect

Inadequate infrastructure

Shortage of health professionals

Poor operational & financial management

Lack of quality data

Public sector

Private sector

Providers

Hospitals

Doctors

Pharma

Medical Schemes

Open

Restricted

Regulatory challenges

High capital adequacy drives up costs

Accountable to patients **and** investors

Rising costs of private cover

47m uninsured

9m beneficiaries

World class care for the rich & poor quality care for the poor

Increasing burden of disease

Little co-ordination of care between doctors

Acute shortage of healthcare professionals

High and rising input costs of healthcare

Difference in access in rural and urban areas

Barriers to access such as rising transport costs

Proposed Model – Hybrid NHI

All South Africans, rich and poor, receive the same package of healthcare services using both private and public sector facilities.

Aims to achieve the same outcomes as the White Paper NHI model but with significantly lower implementation risks.

Key elements of a hybrid NHI Model

- Combines the **key learnings** from the **previous SHI policy process** and the **NHI policy work** to establish **a new NHI Fund** alongside the existing public and private sector funds
- **Co-opts** the well-functioning private sector as a partner, not adversary
- **Mandatory membership** of medical schemes by all employed enables the wealthy and healthy to **cross-subsidise** the poor and sick
- **Focuses** Government funding on the **poor** and **unemployed** in a **new NHI Fund**
- It is **affordable** within the budgetary constraints of the State
- It affords employed citizens their **constitutional right to choose** healthcare they can afford
- It **leverages existing national healthcare assets** to improve supply of services to all
- There is a significantly **lower risk of transition** (and better opportunity to "learn as we go")

White Paper NHI Model – June 2017

Single Fund

- New and largest state entity created **from scratch**
- Funded and managed by **Government**
- All citizens get **same NHI Benefit Package** (NBP)
- **Takes cover away** from **9 million medical aid members** who can afford to pay but become **State-dependent**
- Effective **risk equalisation** is achieved by **pooling all risks** in a single fund

Significant Restructures

- Centralisation of funds **reduces and sidelines** Provincial Health Departments
- **Restructure** of National Department of Health **required to achieve cost savings**
- The role of the **public and private medical aids** is taken over by the new state entity

Strategic Purchasing

- Create **another state entity** to conduct strategic purchasing with the major objective of reduces costs by creating a monopsony
- **Requires capacity and further budget** to build from scratch and to **accredit and monitor** more than **10 000 service providers**

NHI White Paper Model – Red Flags

- **Unions will have to agree** to significant restructures and downsizing of provincial HDs. Mass retrenchments inevitable otherwise costs duplicated, not saved
- **Affordability challenges** will continue to exclude lower income earners as the private sector funds are squeezed out (likely to lead to **overall loss of cover**)
- A **substantial increase** in out of pocket payments which will prejudice the poor
- On supply side: service providers may **opt out, which will exacerbate inequality**
- On demand side: Wealthy members may be **serviced by providers who opted out** which will **exacerbate inequality**
- **Political risk** from significant shift required in how **Government allocates budgets** to Provincial departments
- **Difficulty building institutional infrastructure and managerial capabilities from scratch** that will be required to run what will be the biggest Government department in SA
- **Monopsony** has same negatives as **monopoly – it stifles innovation and competition and limits freedom of choice.** It also runs the risk of **increasing inefficiency and corruption.**

Flawed Assumptions of the NHI White Paper

1. State will be able to spend **full 8.9%** of GDP on healthcare
2. Government has **fiscal resources** to implement White Paper
3. Single Payer NHI model is the **only available model** to achieve universal health coverage (UHC)
4. Implementation of **Single Payer NHI required to improve access** to and **quality** of public healthcare
5. Implementation of Single Payer NHI is **required to reduce costs of private healthcare** services
6. **Private Sector is opposed** to universal access to healthcare and NHI objectives

Flawed Assumption 1: Funds Available for NHI

	2016/7 Rm*	% of GDP
Government expenditure	**190 600**	4.3%
Provincial	*166 400*	
NDoH	*4 500*	
Other	*19 700*	
Private Sector	**198 400**	4.4%
Medical schemes	164 300	
Out Of Pocket (OOP)	27 200	
Other	6 900	
Donors	**9 300**	0.2%
Total	**398 300**	8.9%

* As per White Paper June 2017

Available for reallocation or redistribution

Discretionary and voluntary

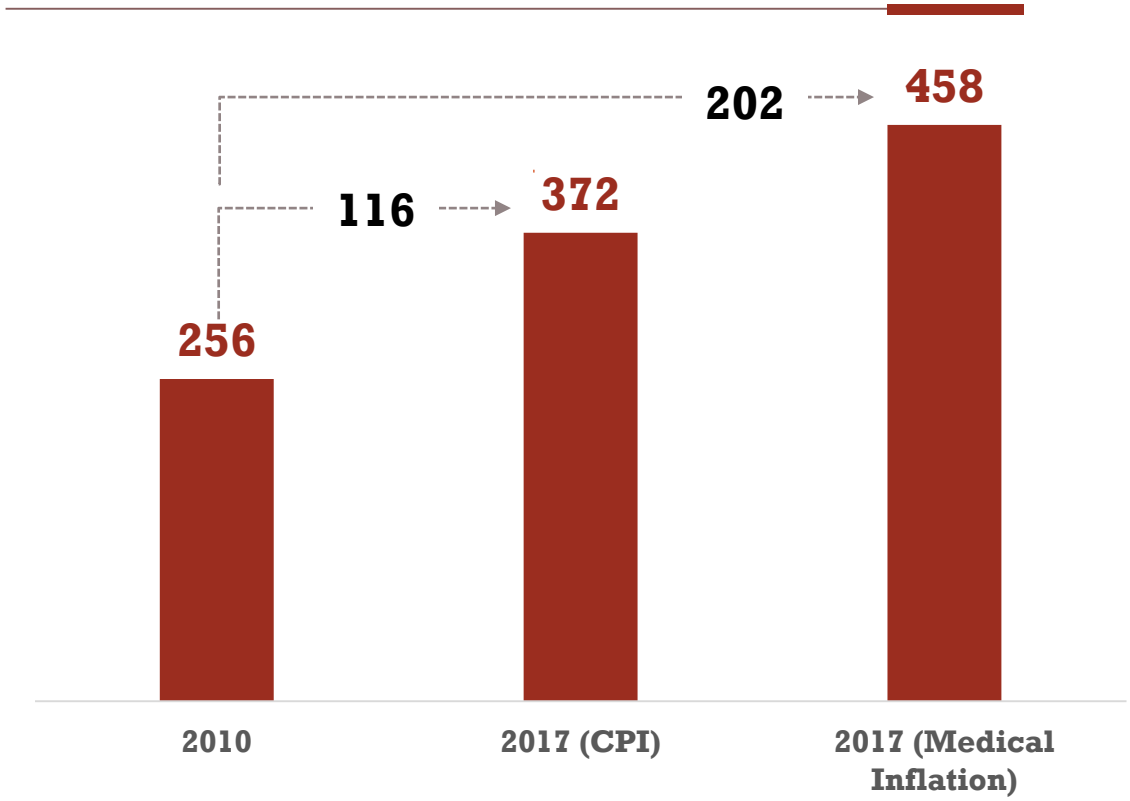
Medical scheme **contributions are discretionary** (mainly after tax) expenditure by approximately 16% of population

Out of pocket (OOP) is from household budgets **(catastrophic for the poor)** by a further 20-30% of the population

Private Expenditure is not available to be allocated by the NHI.
Only 4.3% of GDP is available – balance comes from voluntary payments by individuals

Flawed Assumption 2: Government Has Sufficient Fiscal Resources

Cost estimates in White Paper based on **2011 assumptions** and have not been properly adjusted subsequently. **Price inflation, GDP growth**, disease burden changes and population growth need to be accounted for.



- With a simple CPI adjustment, the **cost increases** to **R372bn** in 2017 terms and as much as **R458bn** with medical inflation included
- This is almost **double** current **state expenditure** on **healthcare**
- This would make the NHI Fund the **single largest state entity**
- The White Paper calculates the funding shortfall on scenarios of 2%, 3.5% and 5% growth.
- Shortfall on **2% growth scenario** is **R108bn** in 2010 rands, but increases to **R193bn** in 2017 terms including CPI and medical inflation - would **be additional R193bn** with current growth rates.
- Average GDP growth is 2.05% since 2010 and **1.1%** in the **last 3 years**

Note: Values derived from White Paper / Green Paper and CPI and medical inflation adjusted in 2010 terms

Flawed Assumption 2: Government Has Sufficient Fiscal Resources

GDP Growth	• Current GDP growth is around **1%**, well **below the levels used to project** the available funds from 2011 **(3.5% was assumed)**
Large Entity	• Can the **SA economy sustain** the introduction of a **state entity larger than Eskom** without proper fiscal planning?
Funding Shortfall	• Allowing for **CPI only**, the **cost in 2017 terms over R368bn** and the **shortfall in excess of R150bn** (assuming 3.5% growth) – significant risk that these numbers could increase.
Cost Ambiguity	• ***"Not useful to focus on getting the exact number indicating the estimated costs….."*** *(Para. 200 White Paper)* • **Detailed costing needed.** Proceeding without a detailed costing and funding plan signed off by National Treasury is **fiscally irresponsible**
Undefined Benefits	• Projected **costs do not specify** what will be **covered** **or** **methodology** used.
Financial Risks	• The **systemic risk to the economy** of the proposed **model is far too large** to take the **risk of not understanding the costs**. • **Fiscal responsibility** suggests the need to **understand short, medium** and **long term cost drivers, risks** and **exposure**
Competing Priorities	• Budgetary requirement must be **balanced with other priorities**: Education, unemployment, poverty alleviation (social determinants of health)

Flawed Assumption 3: Single Payer NHI is Only Available Model

Single Payer Model*

Canada

- Current expenditure is close to 11% of GDP >$6 000 per capita (12x SA)
- Canada is a single payer with exclusion of private funding.

Taiwan

Ireland

Failed Attempts

Alternative Models

Thailand

- Publicly funded UHC fund
- Public and private sector funds for the employed

Chile

- Central fund for the poor
- Employed covered by private insurers
- Common benefit package pooled across all citizens

Brazil

- Publicly funded central fund
- Private sector offers supplementary cover

40+ Western European countries

- **Single payer with parallel private funding is the dominant UHC model in the world today**

Flawed Assumption 3: Single Payer NHI is Only Available Model

Alternative Models

Obamacare

- Compulsory cover for the formally employed
- Purchased from competing insurers
- Community rating principles including rating bands, catastrophe pooling
- State funds (Medicare and Medicaid) focus on elderly and unemployed

NHS

- Funded from general tax revenue
- Gatekeeper model to manage utilisation
- Public and private sector providers
- Private insurance operates on a supplementary and complementary basis e.g. BUPA

Flawed Assumption 4: Single Payer NHI Required to Improve Access, Quality of Public Sector Care…There are Other Alternatives

Focus on building and enhancing infrastructure

- **Low hanging fruit:** build and revitalise clinics & hospitals
- **Increase hospital beds** (constant since 1976 despite population doubling)
- **Institutional infrastructure** including governance and management skills

Infrastructure Maintenance

- Maintain Buildings
- Maintain Equipment
- Facilities Management

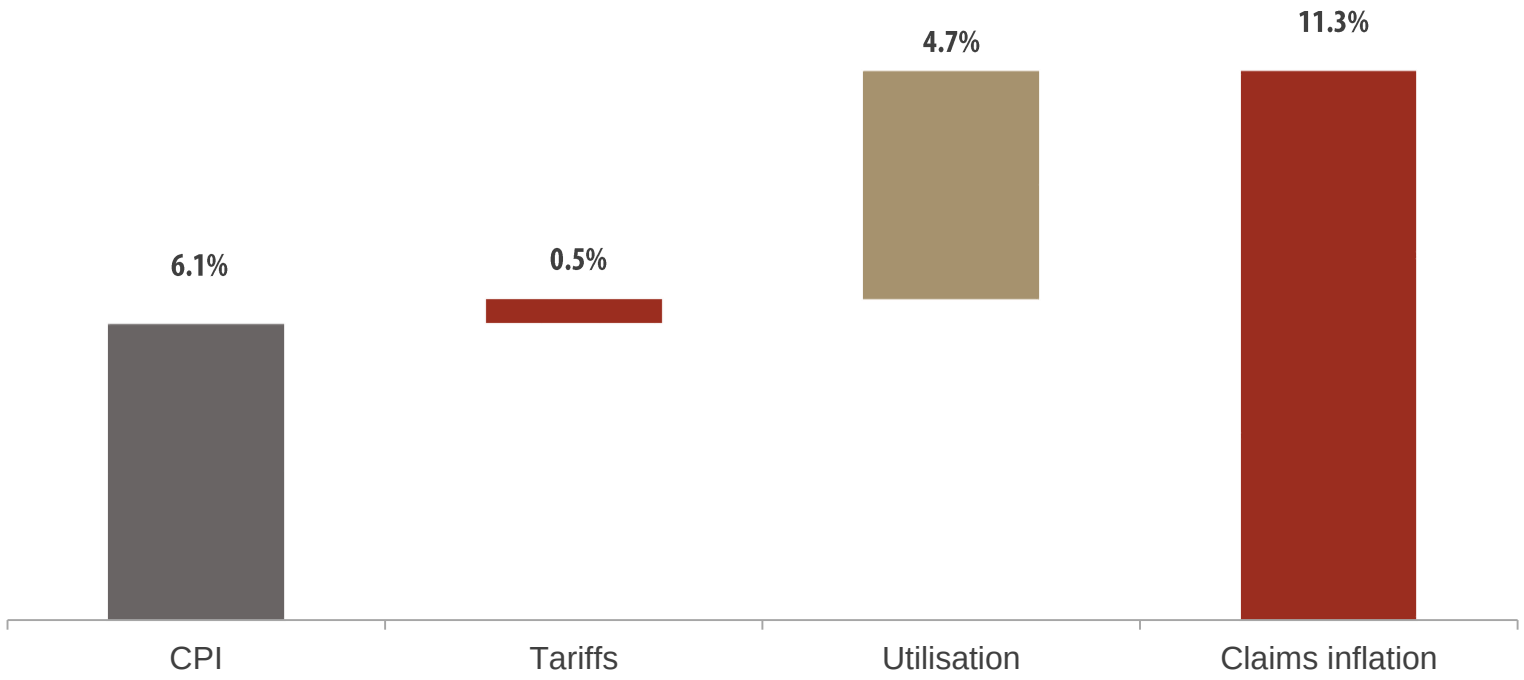
Staff Development

- **Retain** the current staff through revitalization
- Invest in **reskilling** and **upskilling** existing staff
- Invest in **training** using both public and private facilities
- **Take up existing offers of training assistance by private sector**

Building and Improving Physical & Institutional Infrastructure does not Require White Paper's NHI Model

Flawed Assumption 5: Single Payer NHI Required to Reduce Costs in Private Sector

Causes of Medical Scheme Claims Inflation (2008-2016)



If tariffs had been kept constant since 2008 premiums would only be **2.8% lower**

If utilisation was constant since 2008, premiums would be **27% lower**

Drivers of utilisation include ageing, increasing disease burden, adverse selection, new technology, new hospitals, fee for service

Health Market Inquiry Analysis:

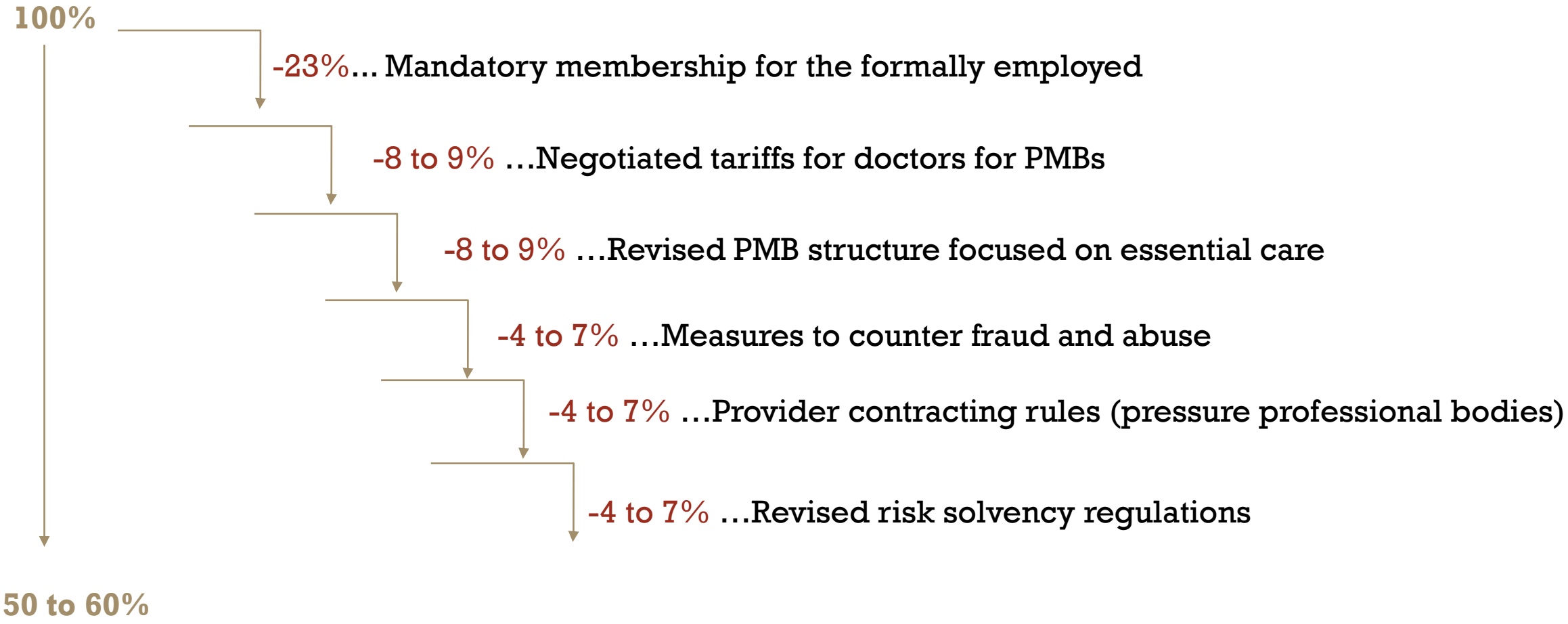
Utilisation of services is the **major driver** of the gap between CPI and claims inflation as tariffs closely track CPI.

competitioncommission south africa

Therefore, a single payer and price regulation **will NOT necessarily address cost inflation.**

Flawed Assumption 5: Single Payer NHI is Required to Reduce Costs in Private Sector

Other interventions that can be used to reduce costs



Regulatory interventions that can be implemented in the short term can reduce costs by up to 40%

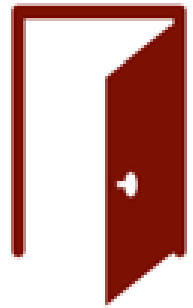
Flawed Assumption 6: Private Sector does not Support UHC and NHI Objectives

Support from Private Sector

- **The private sector should be co-opted as part of the solution, not the problem**
- Constant **support** for principle of **expanding access** to **quality healthcare** services to all South Africans
- Prepared to **commit skills** and other **assets**
- **Industry work** on LIMS, REF, ITAP, LCBOs etc. has **stalled**
- Strong **commitment** to **improving access** to poor and vulnerable
- Requires **detailed consultation** and **involvement**
- Provide private sector with **active role** in development process

Expertise available from Private Sector

- Benefit design
- Clinical risk management
- Provider contracting incorporating international best practice
- Data collection and management
- Data analytics
- Economic evaluation
- Forecasting
- Risk factor analysis
- Costing of benefit package
- Actuarial expertise



White Paper NHI: Implementation Risks and Political Hot Potatoes of NHI White Paper

Citizens

- Loss of tax subsidy **reduces affordability** for low income scheme members. Will **increase burden** on public sector
- Existing medical scheme members **lose cover during transition** but expected to pay taxes
- Wealthy **can buy** supplementary cover and pay co-payments to bypass referrals – **higher inequality**

Fiscal

- Massive strain on **tax burden** (ratio to GDP)
- Major risk that existing **costing is understated**

Unions

- **Significant reduction of jobs** in provincial DoHs **or costs will be duplicated**
- **Redeployment** in National DoH
- **Loss of medical scheme coverage** by union members
- Loss of tax subsidy **affects low income** earners the most

Public Sector

- **Inadequate training** of medical personnel
- **Resistance** from employees to loss of medical scheme coverage **e.g. Parmed, GEMS, Polmed**

Private Sector

- **May be unwilling** to **contract** at regulated NHI Prices
- Will **opt out** and sell services for cash to wealthy citizens
- **Majority** of population **worse off** than before.

Central Strategic Purchasing…3 Ways to Reduce Costs

Reduce Doctors' Fees

- Create **pressure** to see more patients in limited timeframe
- Patients get **poor quality of care**
- **Less** pre-emptive intervention
- Doctors **cannot** work harder than they are doing at present
- **Skills leave** the industry and the country
- Significant **political resistance** from **organised health professions**

Reduce Hospital Fees

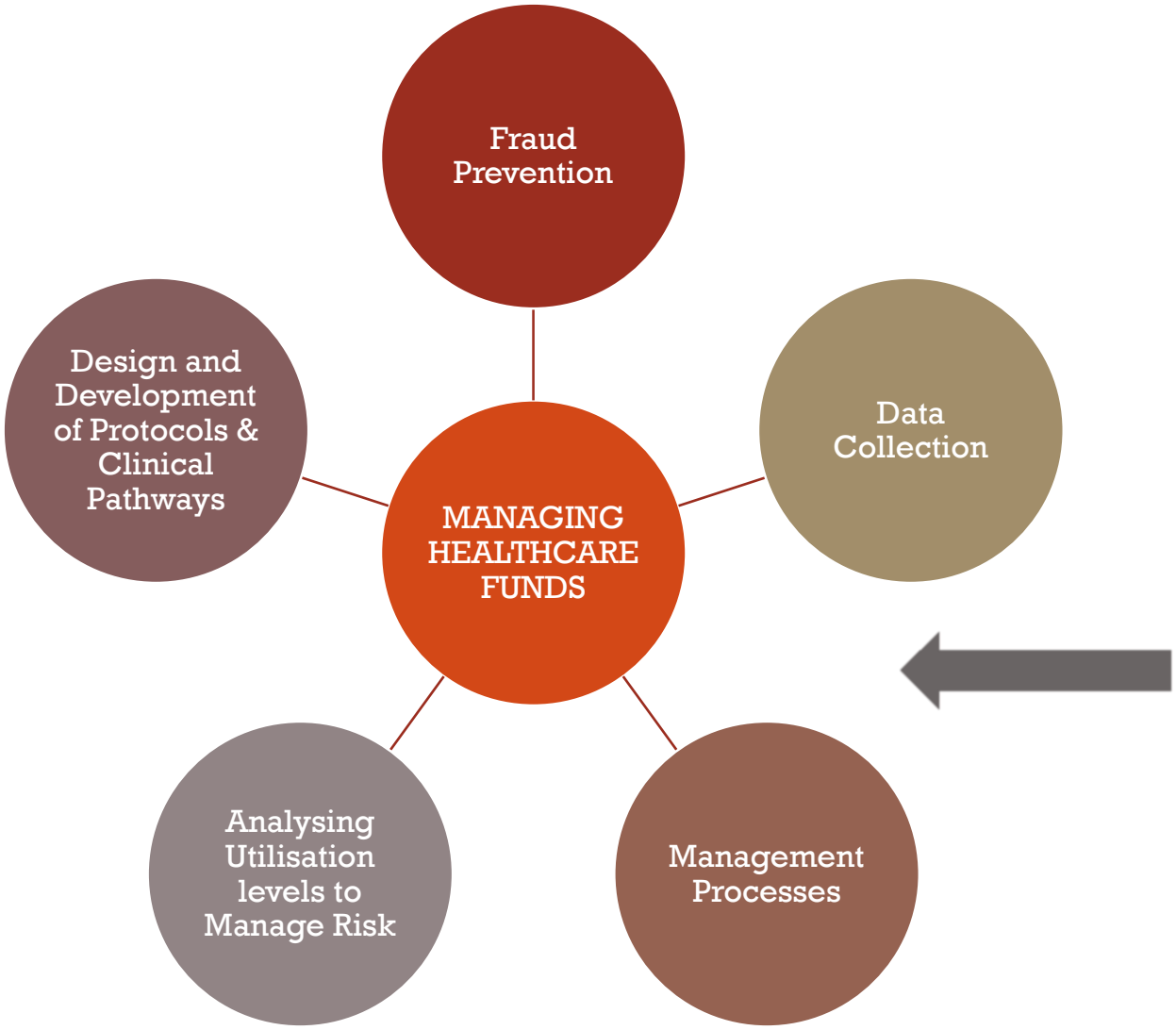
- **Lower service** delivery in all hospitals
- **Investor uncertainty** and reduced investment into well functioning hospitals
- **No capacity** to leverage well functioning facilities to assist the poor
- Significant **resistance** from **hospital groups** and their **employees**

Reduce Drug Costs

- Already regulated so **little scope** for negotiation
- Private sector **already subsidises** public sector
- One bucket model **eliminates cross subsidies** of public by private sector. Will **increase** public sector **costs**

Monopsony = monopoly + collusion with all disadvantages in an environment where dominant players are being penalised.
Unlikely to significantly reduce costs.

Governance Issues and Risks

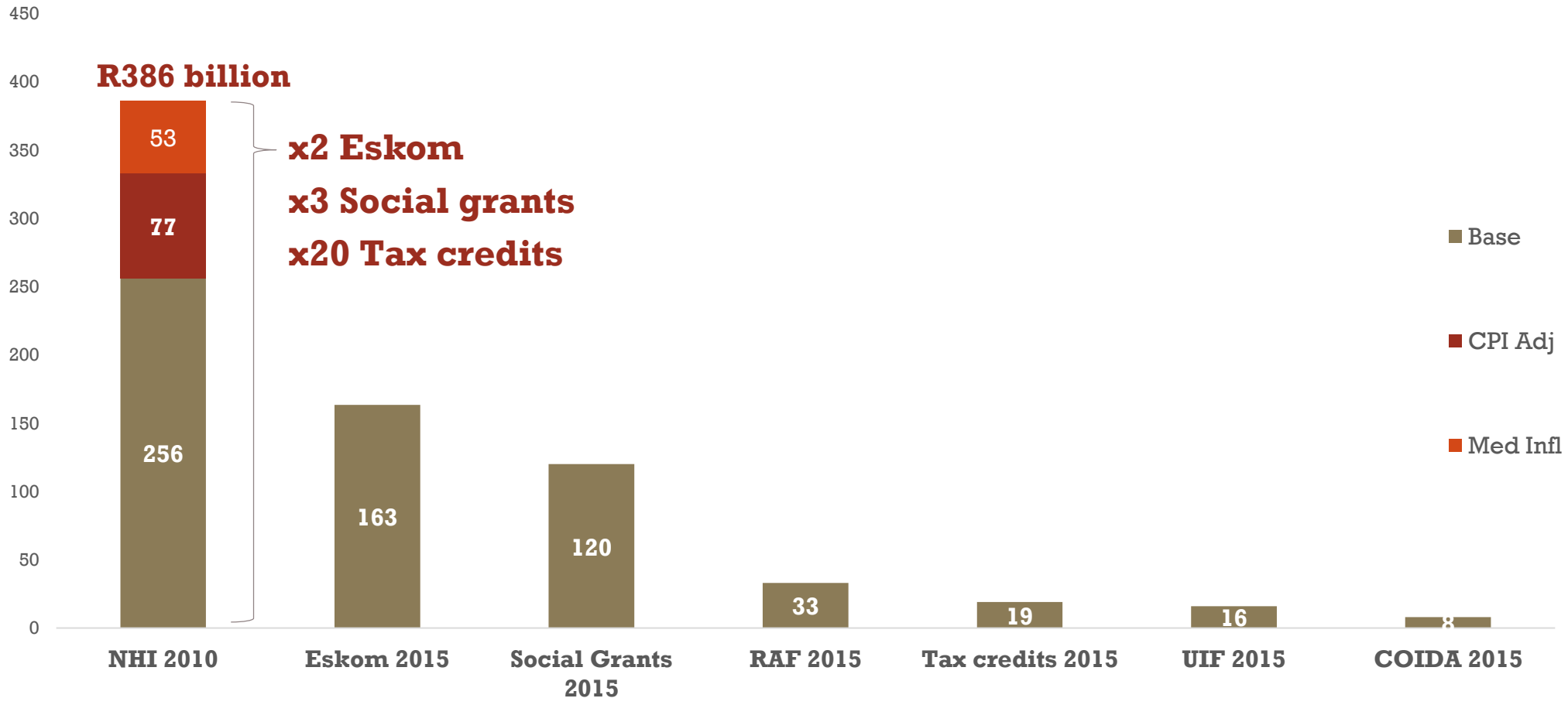


Key Considerations

- White Paper envisages a **massive scale operation**
- Current comparator organisations are functioning poorly (RAF, COIDA, SASSA) – even though **much smaller** and **simpler** than proposed NHI Fund
- **Single largest state entity** would have to be created
- Significant **complexity** in **managing healthcare funds**
- Significant **risk of corruption** and failure – **poses systemic risk** to **economy**
- **Physical centralisation of funds** is a **risk**
- **Centralisation** of **funds** in a **single entity** is a **big risk**

Financial Requirements (2015 Rands)

Annual amount in perspective – R'bn



NHI spend will be significantly higher than any other government spend

Note: CPI adjustments based on 2015 terms

Hybrid NHI Model – Three Fund Types Including New NHI Fund

1

Private Sector Medical Aid Schemes

Est. 20m members

Members:
- Formally employed & dependents
- Anyone else willing to join

Funded by:
- Tax credits
- Employer contributions
- Employee contributions

Voluntary additional cover

2

Public Sector Medical Aid Schemes

Est. 5.5m members

Members:
- Civil servants and dependents

Funded by:
- Tax credits
- Employee contributions

Voluntary additional cover

3

New NHI Fund

Est. 30 m members

Members:
- Informal sector (who have elected not to join private medical aid)
- Unemployed

Funded by:
- Allocations from general taxation

Mandatory NHI Benefit Package: Virtual Pooling of Cost Across All Funds

Public and Private Providers Leveraged to Support NHI Fund

Private Sector Medical Schemes

1. As a minimum, **all schemes** must **offer** the **NHI Benefit Package**

2. **Compulsory membership** for **all employed people**. This increases the risk pool and introduces the young and healthy to subsidise the old and sick

3. Membership administered by corporates
   - Members (employees) select medical scheme/s for all employees in entity. **White Paper** NHI model provides **no choice to members**
   - **Corporates subsidise, administer** and take on **compliance role**
   - **Hybrid NHI** model **promotes innovation** through **competition and choice individually and collectively**
   - Medical schemes **regulated** on social solidarity basis with **risk equalisation**

4. Medical schemes can provide members with parallel and with **top-up/additional benefit** packages **paid for by members**

5. **Only burden** on tax funding is via a **capped tax subsidy** (which should be targeted to low income earners). Otherwise **members** and their **employers pay for themselves**.

6. **Members exercise** their **constitutional right** to **choose the provider** and package they can **afford** to **pay for** themselves. There is a significant **risk of litigation and political resistance if citizens are denied this right.**

Public Sector Medical Schemes

1. **Implement same suggestions** as proposed for **private sector**
2. Because members are public employees the **tax funding effectively funds these members**
3. **Public sector schemes** can **continue to exist** as **separate entities** (GEMS, Parmed etc.)
4. **Public sector employees** continue to have the **opportunity to select additional cover**
5. The cost of cover is **shared** with employees

New NHI Fund

1. A **new medical NHI fund** created for the unemployed and informally employed

2. **Funded by:**
   a) **The Government** and directed at the **poor and unemployed**.
   b) **Low income** earners assisted through a **tax subsidy**
   c) **Risk subsidies** from public and private funds with low risk profiles through risk equalisation

3. **Provides NHI Benefit Package on same basis** as private funds and public sector funds

4. **Benefits from common pooling** for NHI Benefit Package from cross subsidy

5. Consider **leveraging existing medical scheme administrators** to take advantage of **capacity** and **expertise** (as per GEMS model)

A Virtual Fund Achieves Risk Equalization Without the Large Fund Risk

Virtual Fund: all schemes retain independence but risk subsidies are paid by low risk funds to high risk funds to achieve risk equalisation without physical of cash.

Physical Fund: All funds pooled to achieve risk equalisation.

✓ Benefits of a Virtual Single Fund

- Achieves same **risk equalization** as single fund by **sharing risk across funds**
- Healthy and wealthy **cross subsidise poor and sick**
- Better **accountability** and **transparency**
- More **autonomy** and **incentives** for funds to innovate and deliver high quality services
- **Addresses resistance** from **stakeholders concerned by large state entity** and **associated governance**
- **Eliminate implementation risk** and **systemic risk** of corruption and failure of Single Payer NHI Fund

✘ Risks of a Physical Single Payer NHI Fund

- Funding **risk is borne entirely** by the **State**
- **No direct responsibility** for **cost containment**
- Major **inefficiencies** in central funding
- Risk of **corruption** and **inefficiency** (SASSA, RAF, SABC, Eskom, PRASA) leading to **failure of system** and **systemic risk**
- **Not necessary** to **achieve UHC goals**
- **Risk** of **significant resistance** from **many stakeholders.** Is existing capital that has been built up by members paid into the central fund? Is this confiscation? Litigation a certainty.

Hybrid NHI vs White Paper NHI

Deliverable	White Paper	Hybrid Model
Provide UHC	✓	✓
Provide universal and standardised benefit package	✓	✓
Access to all doctors and hospitals – public and private	✗ • Private providers not obliged to contract with NHI and may opt out. Citizens may choose to bypass NHI gatekeeper, or seek care and pay OOP	✓ • Each fund will contract with private providers on their own terms, but private providers not obliged. Citizens will have more choice, but will not be able to bypass the system
Differentiation of access	• Citizens may bypass NHI referrals or purchase care OOP	• All citizens receive mandatory NHI Package
Freedom of choice funder	✗ • Single funder – no choice	✓ • All citizens have greater freedom of choice
Freedom of choice provider	✗ • NHI will stipulate providers available based on their willingness to contract	✓ • Funders will have freedom of choice to contract with providers on own terms
Incentive for competition, innovation and efficiency in the funder and provider markets	✗	✓
Financial burden on state	✗ • Any under estimation of costs needs to be covered by tax revenue • Systemic risk of failure • Political resistance	✓ • State's obligation is limited to those belonging to NHI fund. Employed funded by contributions which need to cover costs (risk transferred) and cross subsidy of NHI package (risk shared)
Decentralisation of hospital management	• Under NDoH	• Hospitals compete based on efficiency (first tested at provincial level)
Risk of transition	• Only vulnerable groups covered in first phase, affordability challenges will continue to exclude lower income earners as the private sector funds are squeezed out. Likely to lead to overall loss of cover.	• Parallel process of introducing NHI Fund for vulnerable groups AND expanding access to cover to lower income earners in partnership with private sector. More likely to lead to broader affordable cover.
	Unaffordable and higher risk	**Affordable and lower risk**

Recommendations

1. Consider a **hybrid NHI model as a less risky, more affordable** NHI model

2. **Collaborate** with all players and **National Treasury** to **define budget implications** of all models under consideration

3. Continue to **accelerate public revitalisation** programmes in an effort to **improve efficiencies** and as part of an **operational readiness assessment**

4. Co-opt **private sector** as **part of solution.** E.g. training doctors in private sector and leverage private sector for admin, for partnership to conduct readiness assessment

5. Consider short term **regulatory interventions** in healthcare sector to **improve affordability and efficiency**

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