PANEL ON THE ASSESSMENT OF KEY LEGISLATION

EMBARGOED

until

21 NOVEMBER 2017 – 17H00

A hybrid model to achieve universal healthcare coverage

While there is consensus amongst all stakeholders regarding the vision and objectives of the NHI as set out in the White Paper, there are differences in how the NHI should be implemented. The Panel received a presentation of what was referred to as the Hybrid Model, that proposes a three-tier model of private schemes, government schemes and a new NHI scheme. Broad details of the proposal are as follows (please see the powerpoint presentation for more details).

The proposal seeks to take the best out of current and previous policies and legislation to recommend an alternative approach to the implementation of an NHI model that they believe will be more likely to deliver on the objectives of the White Paper and achieve the constitutional and WHO objectives of universal health coverage (UHC) for all in South Africa.

The Private Sector presenters of the Hybrid NHI model maintain that it is more feasible and far less risky to implement, will create less political resistance, and takes advantage of the existing infrastructure, skills and systems within the current health care system. This approach suggests that the employed and wealthy continue to fund themselves with minimal support from the tax payer. It therefore directs more funding to the poor and unemployed.It is less risky and quicker to operationally implement and co-opts and places obligations on the well-functioning private sector – all in pursuit of the identical constitutional and World Health Organisation objectives of UHC for all South Africans as the White Paper. The presentation in the Annexure also highlights the risks that the NHI Model and White Paper will exacerbate inequality and lead to even worse disparities than the current system as wealthy people will opt out.

A broad outline of the proposals with supporting data, references and comparisons with the White Paper is set out in the powerpoint presentation. Salient details are as follows:

- It combines the learnings and best parts of the White Paper and previous policies (including Social Health Insurance) to create a new NHI Fund in a three-tier model alongside the existing public and private sector funds.

- The healthy and young are introduced into the risk pool by mandatory medical scheme membership to all employed people and used to subsidise the NHI. The wealthy, young and healthy therefore subsidise the poor, old and sick.

- Scarce funds are directed at the poor and unemployed and the wealthy fund themselves largely out of after-tax earnings. The model is therefore much more affordable to the taxpayer than the model in the White Paper.

- The private sector is co-opted and given obligations to become part of the solution rather than being side-lined by a new mega government department (which would dwarf other entities like Eskom, South African Social Security Agency, Road Accident Fund and others).

- It leverages existing national healthcare assets in the public and private sector to improve services to all. No low to middle-income country has successfully implemented a single-payer model. The successful low to middle-income countries predominantly have features of the Hybrid Model.

- It provides significantly low transitional and implementation risks and focusses on building the physical infrastructure and institutional infrastructure of the country.

The model contemplates a 3-tier system consisting of the private medical schemes with mandatory membership funded by the employed; the existing public sector schemes; and a new NHI fund for the unemployed and low-income employed funded by the state. All three pillars will provide the identical package of Prescribed Minimum Benefits (PMB). Motivations for the recommendations are as follows:

- This option results in cheaper premiums for the employed poor as it is expected to reduce the cost of cover by as much as 23%.
- This will also make it cheaper to provide for the balance of the population as the government can allocate the additional resources to the poor.
- It will lead to a transition to UHC which is far less risky as the cost of any over-runs in the employed population, due to the expected continuation of high utilisation levels and better access to facilities, will not be borne by the state.
- A regulated private medical scheme mechanism is likely to reduce levels of inequality as risk and income equalisation mechanisms can be applied. A single fund approach with the wealthy purchasing care directly and via private health insurance operating as a completely separate pool will create much greater levels of inequality. This has been evident in other markets with high levels of income disparity.
- The wealthy are likely to make more claims due to factors such as access and expectations. The Hybrid Model is structured on the basis that they pay for this additional cost rather than drawing from the central pool. Higher utilisation levels mean that there is a risk that the wealthy will squeeze out the poor in terms of benefits.
- Members that are currently comfortable with the services offered by their schemes will not only have significant cost reduction but also have security of being able to stay with their schemes rather than being forced to join an untested and yet-to-be established single fund controlled by a huge government department. This should address resistance to cross-subsidies as well as continuing to provide an element of choice of cover.

In summary, the employed are compelled to pay for themselves and subsidise the poor while the proposed NHI Fund can focus on the poor. This is consistent with the proposed implementation framework that focuses on vulnerable groups (women, children, the elderly and disabled). This will speed up the achievement of UHC for all. The speed of expanding cover can be accelerated by also enabling medical schemes to simultaneously expand access affordably.