Presentation to the Parliamentary Portfolio Committee on Health

14 July 2021

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4. Medical schemes under NHI
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- Introduction - Simmi Bassudev (Chairperson of HFA)
- Health system imperatives - Lerato Mosiah (CEO of HFA)
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- Medical schemes under NHI - Prof. Roseanne Harris (Technical Advisory Committee, HFA)
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- Key concerns and recommendations - Lerato Mosiah (CEO of HFA)
- Concluding remarks - Lerato Mosiah (CEO of HFA)

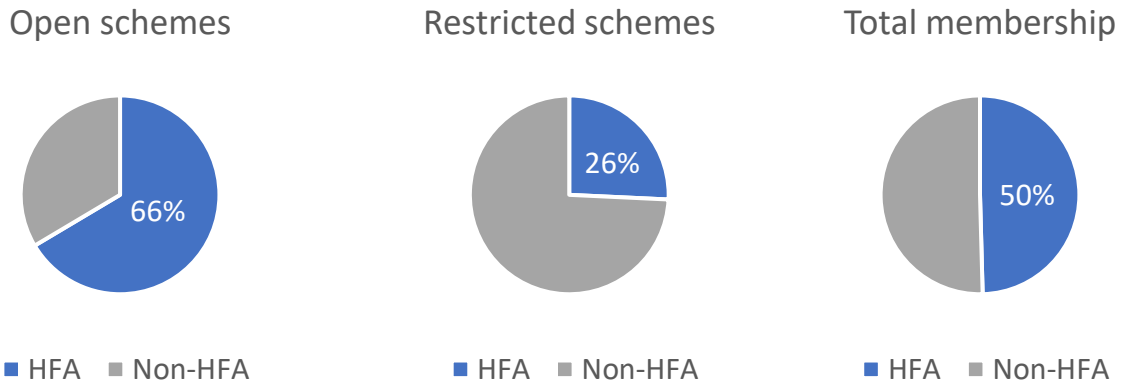
Introduction: Health Funders Association

1. Introduction

- **Health Funders Association**
- Social solidarity underpins South Africa's healthcare policy
- NHI has walked a long road

- The private funding sector comprises of two representative industry bodies, viz:
  - The Health Funders Association HFA) and
  - The Board of Healthcare Funders (BHF)
- HFA (a non-profit organisation) represents Medical Schemes, Administrators and Managed Care Organizations.
- Through its membership, HFA represents 50% of all medical scheme principal members in the country.

HFA Membership: Principal member lives covered by HFA.



Medical Schemes

bestMed

ALLIANCE-MIDMED MEDICAL SCHEME

Bankmed
your good health

Discovery
Health Medical Scheme

LA Health

FEDHEALTH

momentum
health

CAMAF
MEDICAL SCHEME
IN A CLASS OF ITS OWN

GLENCORE
Medical Scheme

MALCOR
MEDICAL AID SCHEME

REMEDI
Administered by Discovery Health

DE BEERS
BENEFIT SOCIETY

PROFMED

SAB
The South African Breweries

sasolmed
medical scheme

AMS
ANGLO
MEDICAL
SCHEME

TSOGO SUN GROUP
Medical Scheme

NASPERS

UNIVERSITY OF KWAZULU-NATAL
MEDICAL SCHEME

TFG

Administrators

pps
HEALTHCARE
ADMINISTRATORS

Momentum
Metropolitan

Discovery
Health

Introduction: Health Funders Association

1. Introduction

- **Health Funders Association**
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- The HFA provides a vehicle for stakeholders involved in the funding of private healthcare to support the long-term sustainability and development of the private healthcare funding industry in South Africa.

- The strategic objectives of HFA include:

  a. Represent the best interests of the industry in an ethical, inclusive, impartial, proactive, effective and efficient way.
  b. Develop and nurture constructive relationships with the beneficiaries of Medical Schemes, the public, policymakers, regulators, and all relevant stakeholders in the healthcare system.
  c. Engage constructively in the policy and regulatory environment.
  d. Create an environment for the industry to engage on specific regulatory and industry matters having regard to all relevant laws, including competition law.

- **The HFA is committed to contributing constructively to health system strengthening and building a sustainable and integrated health system.**

Medical schemes are a vital vehicle for social solidarity in accessing healthcare

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1. Introduction

- Health Funders Association
- **Social solidarity underpins South Africa's healthcare policy**
- NHI has walked a long road

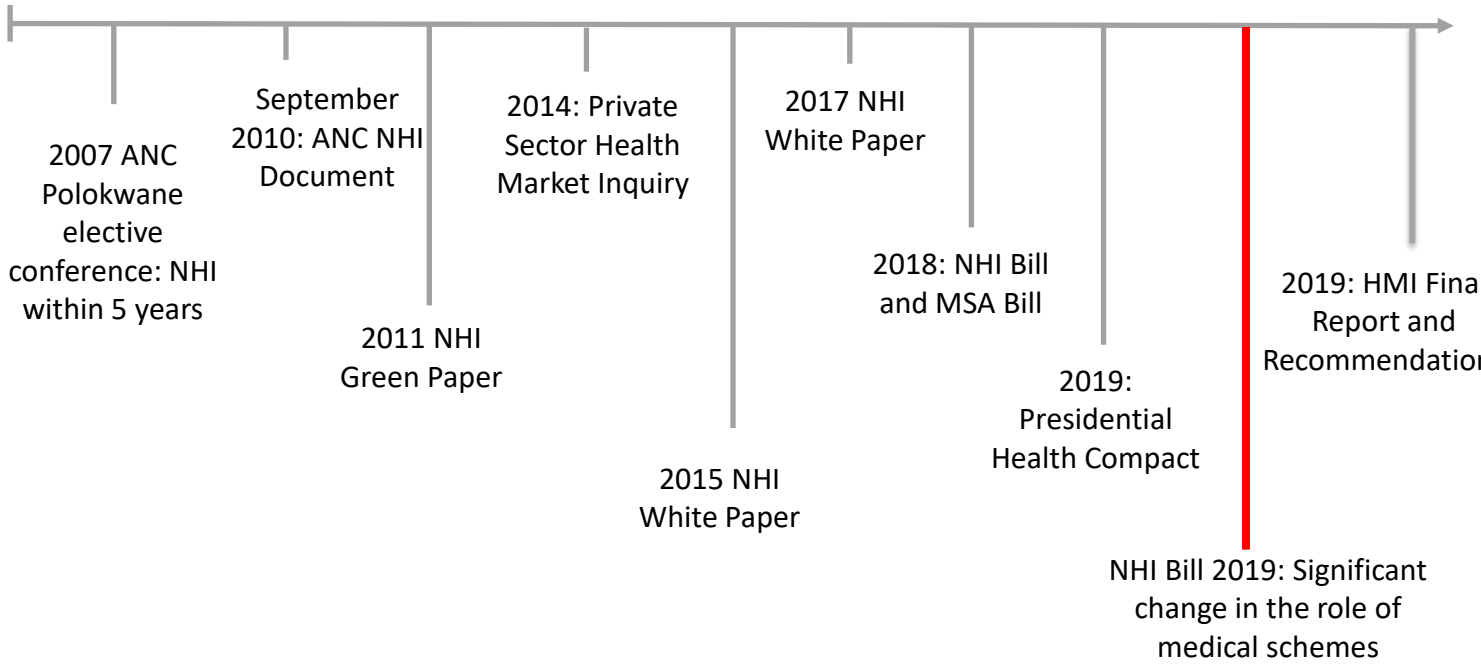
- **South Africa's healthcare policy since 1994 has been grounded in the principle of social solidarity**
- Medical schemes and the Medical Schemes Act (of 1998) form part of that framework by providing a vehicle by which those who can afford to pay for their own healthcare (through discretionary, private expenditure) can do so.
- An environment that ensures social solidarity has 4 key characteristics, in addition to risk equalisation:
  i. Open enrolment
  ii. Community rating
  iii. Statutorily defined package of benefits (implemented as PMBs)
  iv. Mandatory membership (not yet in place in South Africa)

- **Health system reform has a strong path dependence;** Successful reform to achieve UHC is more feasible and likely to succeed within the framework for social solidarity via medical schemes that already exists. Dismantling this system by limiting schemes in favour of single-payer system is not a requirement to achieve equitable access to quality healthcare. The HFA supports amendments to the current multi-payer framework to achieve UHC

Brief history of NHI in South Africa

1. Introduction

- Health Funders Association
- Social solidarity underpins South Africa's healthcare policy
- **NHI has walked a long road**



Medical schemes have participated and engaged in all of the phases of this complex process.

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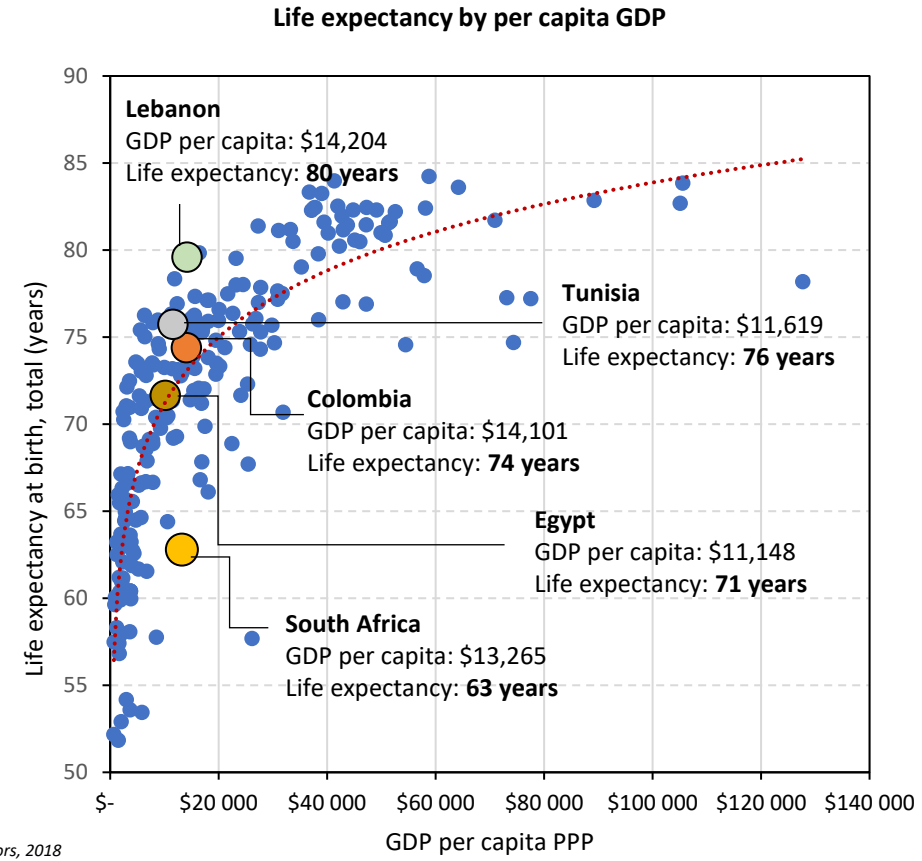
Health system imperatives

Achieving UHC is an urgent priority in South Africa. Given our level of economic development, health outcomes are poor. South Africa's high, complex and shifting burden of disease requires an agile approach to healthcare provision.

South Africa has poor health outcomes relative to economic peers

2. Health system imperatives

- **Social gradient in health outcomes**
- South Africa's high burden of disease



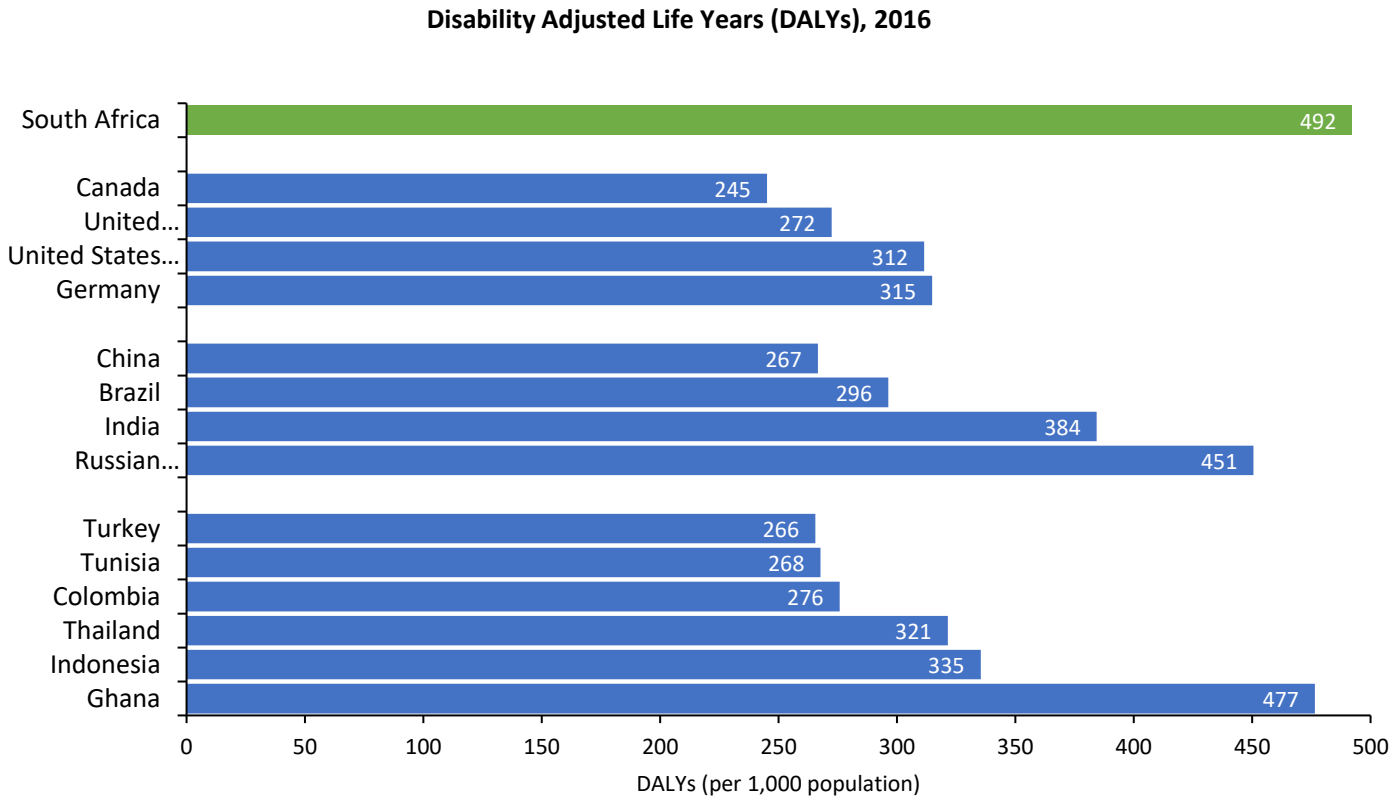
Source: World Development Indicators, 2018

- Health outcomes and mortality are correlated with economic development
- **Compared to countries at similar levels of economic development, South Africa has poor health outcomes**
- This places tremendous pressure on health systems and provides impetus to address UHC in South Africa

High and complex burden of disease contributes to poor health outcomes

2. Health system imperatives

- Social gradient in health outcomes
- **South Africa's high burden of disease**



Source: World Health Organisation (WHO), 2018; FTI calculations

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South Africa’s fiscal reality

Achieving UHC in a recession means that government may need to leverage existing capacity to improve access to healthcare services

There is limited scope to increase tax rates in South Africa

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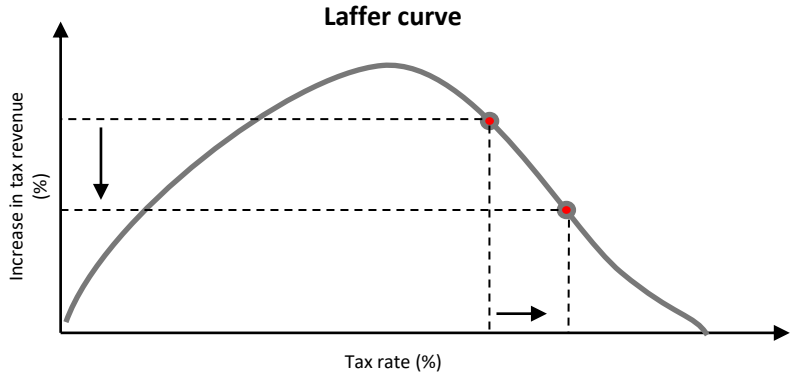
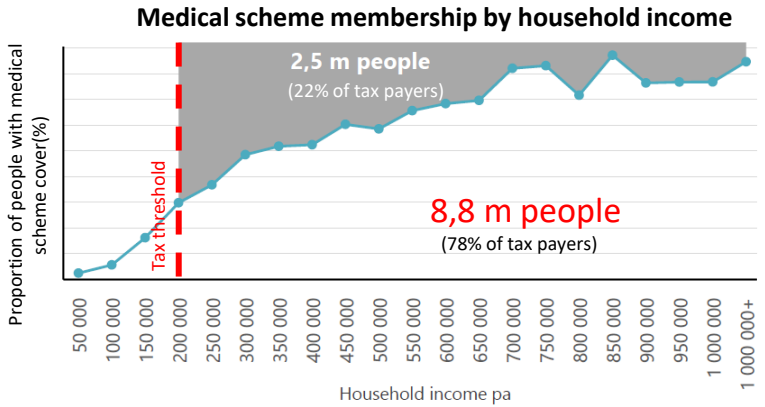
3. South Africa's fiscal reality

- **Limited scope to increase tax rates**
- Health system framework exists to alleviate pressure on public finances

- **Private, discretionary expenditure on medical scheme premiums cannot be redirected towards payment for health services provided by NHI**
- Additional funding for NHI can therefore only be raised via taxation
- South Africa is on the downward sloping part of the Laffer curve: **increasing tax rate will lead to decreased tax revenue. Removing medical scheme tax credit amounts to raising the tax rate**
- Capacity to generate revenue for NHI via taxation (i.e. higher tax rates) is limited
- More than 20% of tax payers in South Africa do not belong to medical schemes and rely on the public health system – This is South Africa's "**missing middle**"
- Including the missing middle in medical schemes in pursuit of social solidarity lowers the burden on the public sector and improves medical scheme affordability
- **This limits the need to raise additional revenue to achieve UHC**



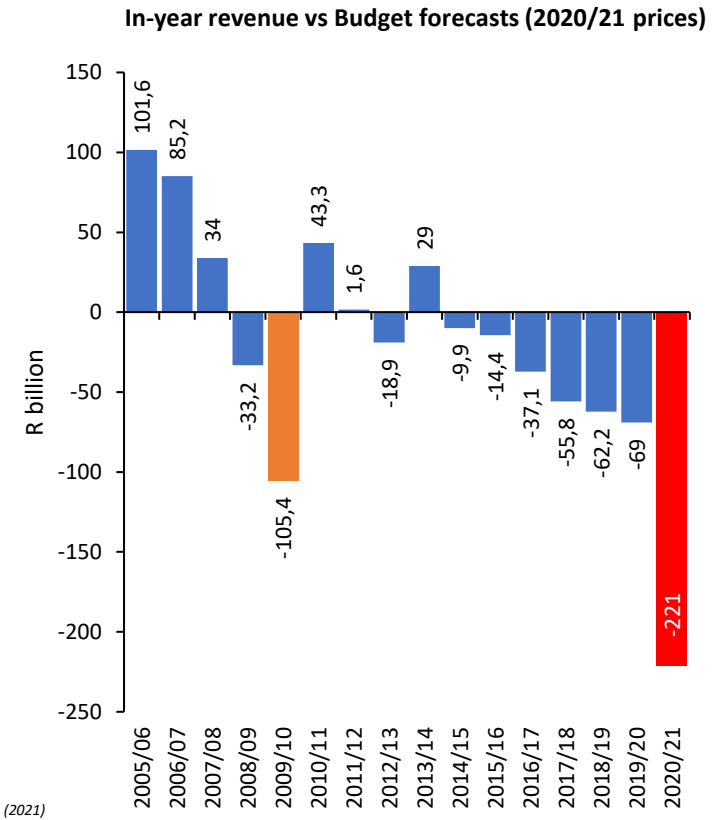


Source: Raath (2019). "What if we found a way to achieve universal health coverage." Foresight Dialogues presented by Insight Actuaries and Consultants

With the fiscus under pressure, health reform must be incremental

3. South Africa's fiscal reality

- Limited scope to increase tax rates
- **Health system framework exists to alleviate pressure on public finances**



Source: National Treasury and SARS (2021)

- In an already fiscally constrained environment, the global recession in 2020 puts public finances are under severe pressure
- Prioritisation of spending will be important in order to stabilise South Africa's public finances
- An **incremental approach** to achieving health reform is possible and advisable. This avoids significant expenditure from a constrained budget
- **Relying on elements of the existing health system** to achieve universal access to quality healthcare is necessary to avoid the numerous consequences of implementing NHI as a single-payer system. This approach is followed globally where private health systems are already in place

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Medical schemes under NHI

Limitation on the role for medical schemes will adversely affect access and cost of cover

Section 33 curtails the role of medical schemes significantly

4. Medical schemes under NHI

- **Section 33 curtails schemes**
- Consequences of limiting medical schemes
- Apparent motivation for limitation of schemes
- Limited evidence for apparent motivation
- Medical schemes offer considerable value to South Africa's healthcare landscape

*"Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer **complementary cover** to services not reimbursable by the **Fund**."*

- Significant departure from 2018 version of the Bill: "*a user may purchase healthcare services not reimbursed by the Fund through any other private health insurance scheme*"
- **No document or discussion motivating the change in stance; no technical analysis; no assessment of consequences**
- SEIAS framework is in place specifically to "*minimise unintended consequences from policy initiatives, regulations and legislation; to anticipate implementation risks and encourage measures to mitigate them.*"
- It would be more useful to use the establishment of the NHI framework as an opportunity to improve the way that medical schemes function and to create an integrated medical schemes system capable of supporting the NHI Fund in facilitating access to quality healthcare for all.

There are numerous consequences to restricting medical schemes

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4. Medical schemes under NHI

- Section 33 curtails schemes
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Limiting medical schemes in favour of a single-payer will have far-reaching consequences:

i. **Increases the burden on the public sector**: approximately 9 million lives previously covered by medical schemes (through discretionary contributions of members' premiums) will need to be covered by NHI

ii. **Reduces cover substantially**: Given budgetary constraints, NHI is likely to cover a much narrower range of services than what is currently provided by medical schemes

iii. **Expenditure per person will decrease**: even if taxes were increased by enough to collect current medical scheme contributions as tax revenue, and per capita expenditure increased, expenditure will remain significantly lower than medical scheme contributions per person per month

iv. **Exacerbates shortage of healthcare providers**: curtailing the ability of medical schemes to pay for services creates significant uncertainty amongst service providers, and may discourage them from practising in South Africa. Likewise for facilities, uncertainty regarding health system structure discourages investment

v. **Discourages innovation in healthcare provision**: single-payer system or monopsony buying power disincentivises research and development which often requires significant financial investment. A constrained budget precludes such expenditure

Impact of limiting the scope of medical scheme cover

4. Medical schemes under NHI

- Section 33 curtails schemes
- **Consequences of limiting medical schemes**
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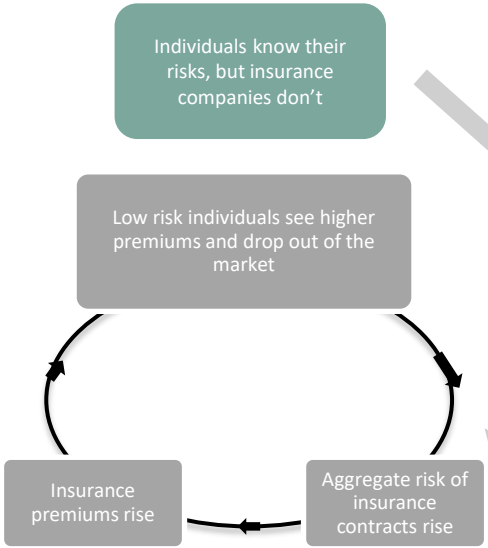
Legislated limitations on the extent of benefits increases anti-selection risk and destabilizes the risk pool driving up the cost of cover for everyone.

The "Death Spiral" of adverse selection



Limits on the scope of medical scheme cover

- **Only those who are likely to claim join cover**

Increasing tax burden

- **Fewer lives can afford additional cover**

Higher cost and smaller risk pool

- **Lower viability of cover and limited ability to offer cover for high cost treatments**

Less access to additional cover for everyone

Source: David A. Asch, MD, MBA

Apparent motivations for limiting the role of medical schemes

4. Medical schemes under NHI

- Section 33 curtails schemes
- Consequences of limiting medical schemes
- **Apparent motivation for limitation of schemes**
- Limited evidence for apparent motivation
- Medical schemes offer considerable value to South Africa's healthcare landscape

In the absence of official motivation for limiting medical schemes, we highlight concerns with the apparent the motivations put forward in various forums to establish a single purchaser system :

i. The distribution of resources between the public and the private sector (NHI White Paper 2017, Par. 58; SEIAS NHI Bill 2019: pp. 2-3, p. 7)
ii. The racial profile of medical scheme beneficiaries (Dr Olive Shisana, 2019)
iii. Inequality spending between public and private sectors (SEIAS - NHI Bill 2019: p. 2, p. 8)
iv. Improved financial risk protection for medical scheme beneficiaries (NHI White Paper 2017, Par. 67)

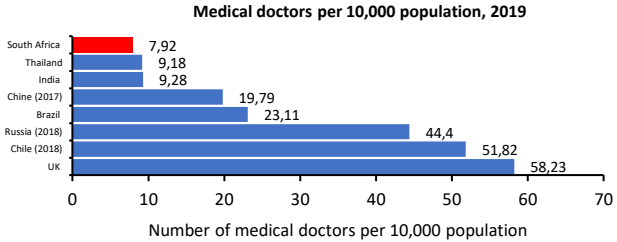
Very limited evidence to support limitation of medical schemes

4. Medical schemes under NHI

- Section 33 curtails schemes
- Consequences of limiting medical schemes
- Apparent motivation for limitation of schemes
- **Limited evidence for apparent motivation**
- Medical schemes offer considerable value to South Africa's healthcare landscape

Claim: Skewed distribution of resources in the public and private sector

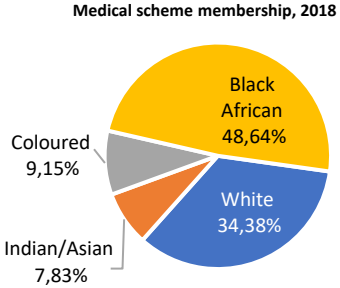
- Even if all personnel worked in the public sector, total HRH (public + private) in South Africa lags peer countries
- South Africa has significant shortage of healthcare personnel
- Single payer system does not remedy this shortage



Claim: Inequality in spend between public and private sector

- Inequality in health spend is acknowledged; HFA supports policies to address this inequality with urgency
- Even if it were possible to redirect private after-tax expenditure from medical schemes to public health expenditure (which it is not; this is private disposable income) per capita public health expenditure will be significantly lower than current medical scheme per capita premium expenditure
- It will be impossible to purchase comprehensive package of services equivalent to care currently available to medical schemes members; increase demand for private services on OOP basis, in line with what is observed in other African countries (Nigeria, Ghana and Kenya where OOP comprises 75%, 38% and 28% respectively in 2016)

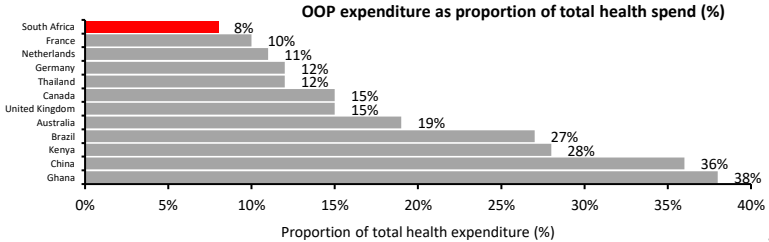
Claim: Medical schemes serve predominantly white members



- Black Africans comprise largest groups of medical scheme members (48.64%)
- Whites beneficiaries are the second largest group, with slightly more than a third of total membership (34.38%)
- Rhetoric is divisive and factually incorrect

Claim: medical scheme beneficiaries face large out-of-pocket payments

- By international standards, OOP payments are low in South Africa
- OOP payments are discretionary in nature paid when funds are exhausted
- OOP payment are highest for allied services which are unlikely to be covered by NHI; therefore will not lower OOP spend for scheme members



Medical schemes have required expertise to achieve UHC in South Africa

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4. Medical schemes under NHI

- Section 33 curtails schemes
- Consequences of limiting medical schemes
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- Limited evidence for apparent motivation
- **Medical schemes offer considerable value to South Africa's healthcare landscape**

- In addressing South Africa's urgent need for universal access to **quality** healthcare, medical schemes provide robust infrastructure on which to build a framework based on social solidarity.

- Medical schemes have considerable expertise in the following areas, all of which are necessary to improve delivery, ultimately, access to quality healthcare to a wider part of the South African population:
  - **i. Proven administrative capacity**: Currently paying in excess of 50,000 practices in South Africa, and paying more than 500,000 claims each day
  - **ii. Development of treatment protocol and formularies**: facilitating the establishment of treatment pathways to manage cost and utilisation, with a focus on primary and preventive care;
  - **iii. Benefit modelling and pricing**: allowing for reliable, accurate costing of healthcare services, improving predictability and planning capacity
  - **iv. Provider contracting**: increasing focus on value-based contracting to encourage efficiency and cost management
  - **v. Health service monitoring**: capacity to monitor quality and detect fraud, waste and abuse
  - **vi. Health data analysis**: improves patient care and experience and allows for the establishment of efficient care pathways

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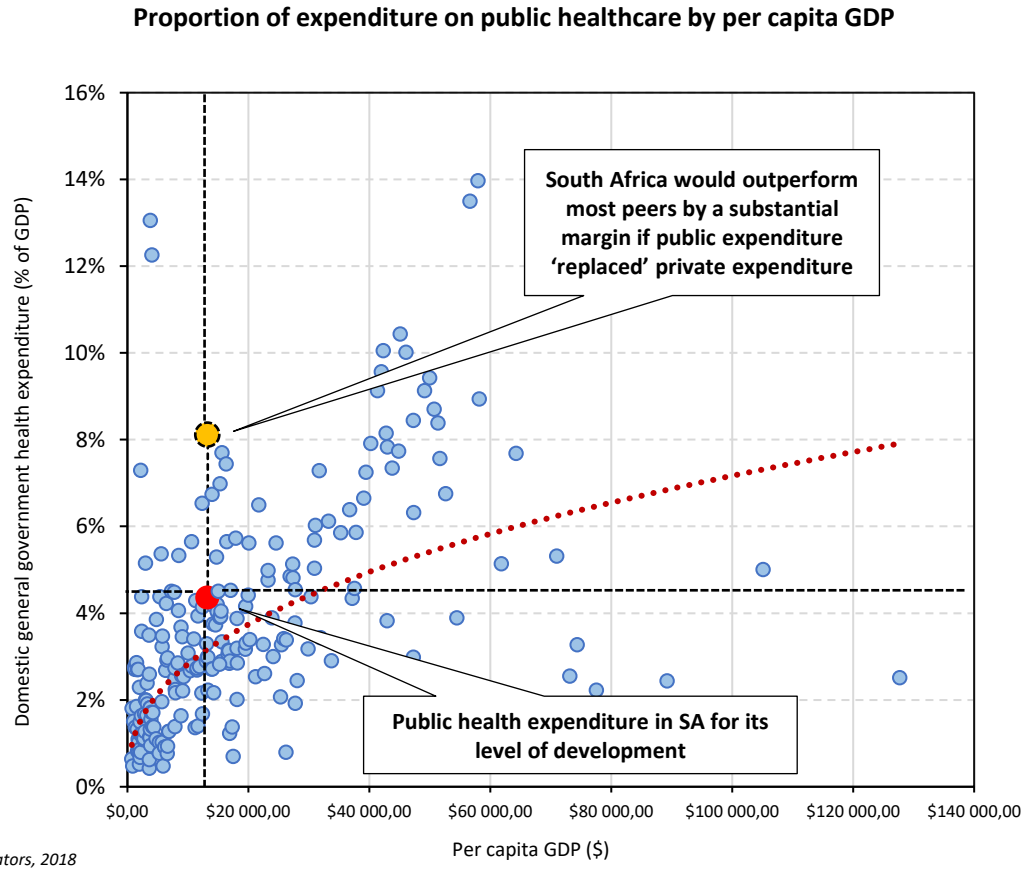
Pathways to UHC

Achieving UHC need not restrict private insurance; on the contrary by collecting private contributions, the financial burden of provision on the state is reduced. Risk pooling does not require a single-payer system, and monopsony buying power is not an economically efficient market structure

A single-payer system is not the only way to achieve UHC

3. Pathways to UHC

- **NHI is not the only route to UHC**
- Tenuous motivation for single-payer system
- HMI proposes various changes



Source: World Development Indicators, 2018

- Relative to economic peers, South Africa spends a large proportion of GDP on healthcare
- Various models exist to achieve UHC; do not require restrictions on private health insurance
- Public health expenditure will not replace private expenditure; in reality, limiting medical schemes will result in increased out-of-pocket expenditure

Various pathways to achieving the objectives sought with a single-payer system

3. Pathways to UHC

- NHI is not the only route to UHC
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From a functional perspective, the motivation for a single-payer system includes:

i. Achievement of **risk pooling** across the entire South African population

ii. Need to establish **monopsony buying power** for the NHI Fund as the only purchaser of healthcare services

- **Risk pooling** across the population does not require a single-purchaser of healthcare
  - Hybrid model can achieve risk pooling: leverage existing risk-adjustment mechanisms
  - These are described in detail in the Health Market Inquiry's final report as well as in various other forums
  - Virtual risk pools established by a risk adjustment mechanism provides the benefits of a single risk pool while retaining a multi-payer system, but avoid pitfalls of single-payer system

- **Monopsony buying power will not result unequivocally in lower prices**
  - Risk of inappropriate prices threaten equilibrium of demand and supply of services
  - Significant cross-subsidisation in sectors servicing the public and the private sector (e.g. pharmaceuticals); single-payer **may well increase prices** faced by public sector
  - Significantly large team required to administer such a fund, with considerable know-how and technical capacity to manage such an entity

HMI recommendations canvas various interventions to improve access

3. Pathways to UHC

- NHI is not the only route to UHC
- Tenuous motivation for single-payer system
- **HMI proposes various changes**

- It is possible to achieve UHC without diminishing private health insurance; given the fiscal pressure facing government, it is important to consider various avenues to UHC
- HMI's report and recommendation aim to ready the private sector to operate as part of NHI; to capacitate the private sector to integrate into that system
- Recommendations allow for a greater degree of cross-subsidisation: those who are able to, pay for themselves, allowing most vulnerable to rely on state
- Addressing cost and efficiency issues improves the affordability and accessibility of private healthcare; creates an environment in which the private sector can play a greater role in healthcare provision, alleviating the public sector

- Recommendations will go some way to progress the private sector's capacity to contract with government. Some examples:
  - **Changes to the HPCSA regulations**: Allowing doctors to form multidisciplinary practices, simplifying contracting and moving towards a more integrated model of healthcare provision
  - **Greater emphasis on primary and preventive healthcare in benefit design:** Utilisation for the appropriate level of care will reduce the cost of healthcare provision, resulting ultimately in improved affordability, accessibility and sustainability of healthcare provision
  - **Greater reliance on alternative reimbursement mechanisms (ARMs):** Moving away from a fee-for-service (FFS) model is an important step in lowering cost. Change to the HPCSA regulations will facilitate this. Medical schemes are well-equipped to assist with this
  - **Risk adjustment:** enables greater degree of cross-subsidisation; widely used internationally and locally (equitable share formula)

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Key concerns and recommendations

Key concerns arising from the 2019 NHI Bill

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4. Concerns and recommendations
   - **Key concerns**
   - Recommendations
   - Concluding remarks

- **Drafting language may cause confusion**: Definitions of key concepts are absent. For example, "*fully implemented", "not reimbursable", "semi autonomous entity" have not been defined*
- **Constitutionality of the Bill**: potentially open to Constitutional challenges regarding the rights of medical scheme members to access healthcare via medical schemes
- **Governance issues**: concentration of powers with the Minister for the selection of board members gives rise to significant governance concerns, given the fiscal significance of a schedule 3A entity
- **Flow of funding**: National Treasury has not released a paper on NHI funding; Large financial allocations are to be made to providers who are not legal entities (such as the Contracting Units for Primary Healthcare - CUPs) is problematic; Medical schemes do not receive tax credits, these accrue to members and constitute "uncollected" taxes. Tax credits are not a revenue pool available to be redirected.
- **Role of provinces and local government**: unclear what the function of provinces and local government will be in healthcare provision under a single-purchaser system; Unclear how District Health Management Offices and CUPs align with the 3-tier government structure. It is unclear who the contracting party will be
- **Maintenance of purchaser provider split**: It is unclear how the establishment of the NHI Fund will successfully establish and maintain a purchaser-provider split, given the current arrangement of healthcare provision in provinces.

Recommendations for the 2019 NHI Bill

4. Concerns and recommendations
   - Key concerns
   - **Recommendations**
   - Concluding remarks

The HFA wholeheartedly supports health reform to achieve UHC. We recommend the following amendments:

- Amendments to Section 33 allowing the **role of medical schemes to evolve as the NHI Fund is implemented and access to quality care is achieved**. Specifically, the following amendments are suggested:

  33. Medical schemes may offer benefits to users in respect of relevant health services, as defined in the Medical Schemes Act, in accordance with the Medical Schemes Act, notwithstanding that such benefits may be reimbursable by the Fund in accordance with this Act.

- **Removal of provisions to amend the Medical Schemes Act as per Section 57 of the Bill**. Such amendments should be dealt with at the appropriate time and via the parliamentary process for the Medical Schemes Amendment Bill, not within the framework of the NHI Bill
- Amendments to **governance** provisions to entrench principles of transparency, independence and accountability: Ministerial selection and appointment of boards leaves them vulnerable to undue influence. Measures must be taken to ensure competence and accountability to communities served, not solely to the Minister. The role of Parliament in these provisions is important.
- **Implementation of phases** to be defined with reference to the achievement of **milestones** (which are quantifiable, and independently and transparently measured)

Concluding remarks

4. Concerns and recommendations
   - Key concerns
   - Recommendations
   - **Concluding remarks**

- The HFA **supports the policy objective to achieve the progressive realisation of the right of access to quality personal healthcare services, and to make progress towards achieving UHC**. The HFA recognises the urgent need to address inequality in access to healthcare.

- The HFA support a **collaborative approach to strengthening the health sector** with reference to, and aligned with the **Presidential Health Compact.** The importance of a public/private partnership in the delivery of healthcare in South Africa cannot be emphasised enough. Partnerships with private stakeholders in the areas of human resources development, management skills, liability management and priority project delivery have been highlighted as fruitful areas for partnership. Medical schemes are particularly well-placed to assist the Fund in establishing and developing these and other areas.

- Careful consideration of the findings and **recommendations of the HMI** with regards to improving the efficiency in the private sector. This assures the **sustainability of the health system as whole.**

THANK YOU