Discovery
NATIONAL HEALTH INSURANCE BILL
Commentary by Discovery Health (Pty) Ltd
25 January 2022

Overview

Discovery Health (DH) is entirely in support of the aspirations of the NHI Bill which encompass broader access to equitable health care for all South Africans.

Covid-19 has demonstrated the importance of having a resilient health system and the opportunity for public-private collaboration in delivery of health care.

We are concerned that there are risks in the technical design of the system which will adversely affect the achievement of the objectives.

We suggest a collaborative approach that leverages off the extensive expertise in the health sector based on an aligned commitment to the policy principles.

Discovery believes there are challenges facing both the private and public sector and we fully support the principle of integrated national health system reform for public benefit

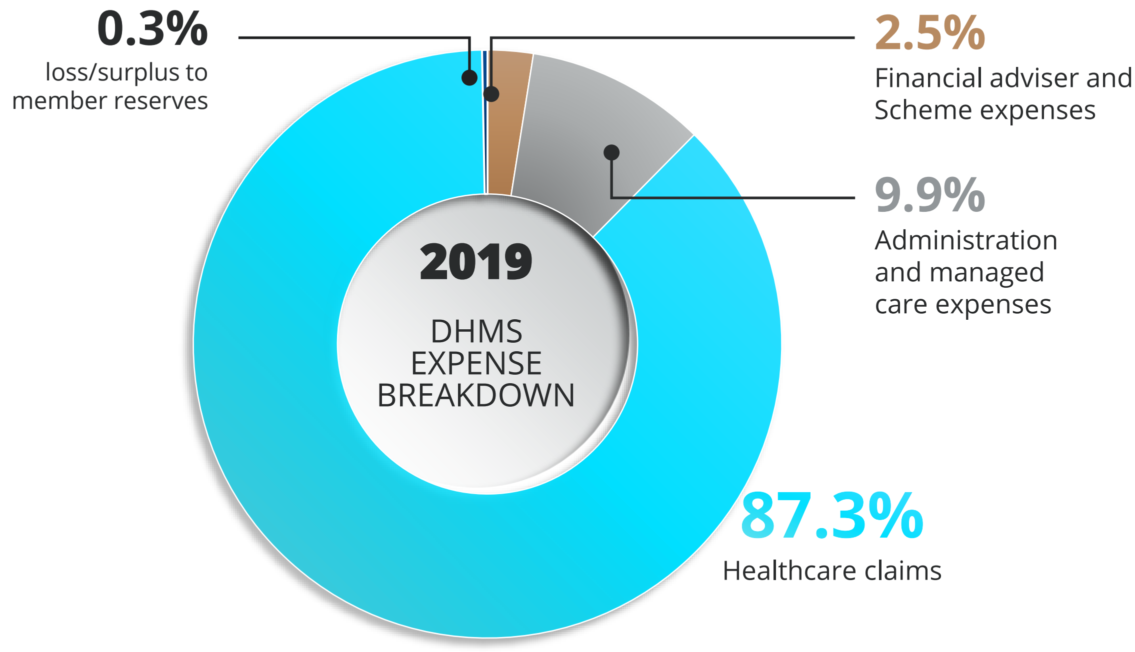
Introduction

- DH **embraces** our Government's policy direction towards achieving **Universal Health Coverage (UHC)** and intends to continue playing a **constructive partnership** role in SA's health policy reform process.
- The **private sector** plays a meaningful role in the overall performance of the SA health system, while simultaneously making a **significant contribution** to our economy through its direct contribution to the fiscus, employment and attraction of investments.
- Our health reforms in SA should ensure that the private sector **continues** to play this **meaningful** role by co-opting it as a partner and integral part of the health policy transition, consistent with other nations.
- DH has been an **active** participant and **partner** for social change, contributing to socio-economic development and health system strengthening initiatives in SA over the past two decades.
- DH believes that there is a **workable** operational model that fits within the **NDoH policy** framework, drawing on the key learnings of previous policy development processes to ensure:

1. All South Africans receive the **same minimum** package of healthcare services, leveraging all available healthcare skills and assets in the country
2. The private sector **shares** the State's load in terms of **funding and provision** of healthcare services in the context of SA's resource constraints
3. Phased implementation that is **affordable and sustainable** within the budgetary constraints of the State, in the short and long term with significantly lower transitional risks

Overview of medical schemes

Medical schemes are not-for-profit entities



- **Income** is derived only from member contributions (97.5%) and investment returns (2.5%)
- **Administrator fee is fixed** each year. Not linked to any contribution savings or claims paid.

Medical schemes operate on the basis of social solidarity

Open enrolment
Everyone must be accepted with only limited underwriting in specific circumstances.

Community rating
Everyone pays the same rate per option regardless of age, health status or any other factor

Strict solvency Regulations ensure financial resilience

Over **300 Prescribed Minimum Benefits** must be covered in full which means comprehensive cover is guaranteed

The role of Discovery Health as an accredited administrator

Medical schemes are regulated by the CMS and governed by an independent, majority member-elected Board of Trustees

Robust regulation and governance

All contributions are pooled to fund members' claims, and any surplus funds remain in reserves for the security and benefit of members

Discovery Health administers 20 medical schemes (1 open and 19 restricted)

CMS
Council for Medical Schemes

Regulates

Members

elect

belong

Board of Trustees

governs

Appoints / outsources to

Discovery Health Medical Scheme

Medical Schemes

LAHealth

Bankmed

services

Discovery Health

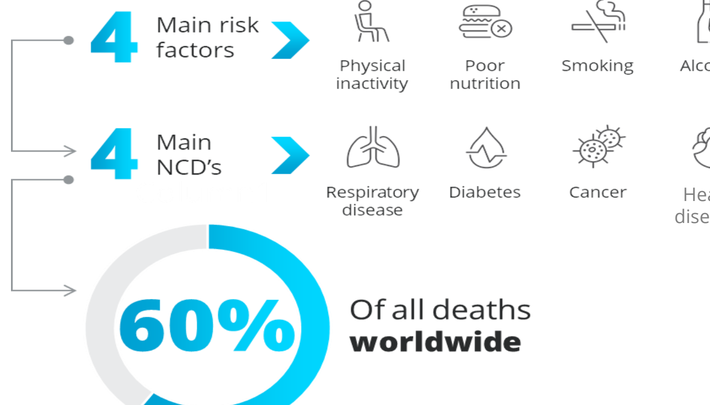
Administrator and managed care provider

Discovery Health is an accredited administrator and managed care provider subject to regulation by the Council for Medical Schemes

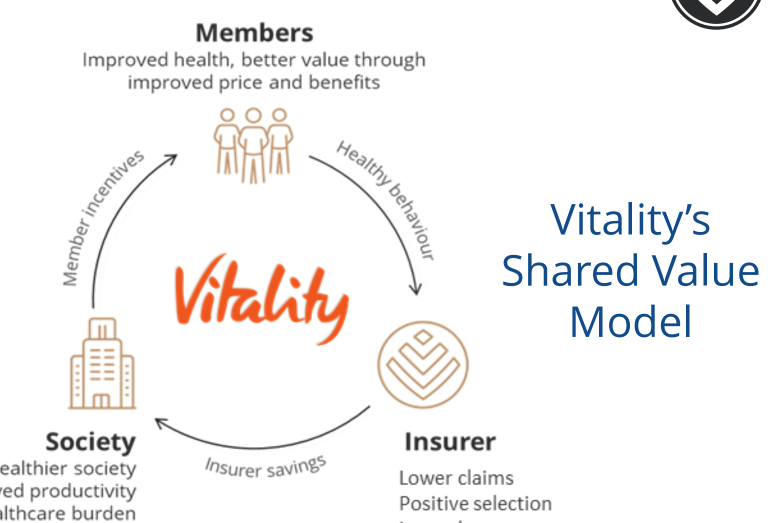
The role of Vitality in behavioural change

Value of achieving population behaviour change

The nature of risk is behavioural



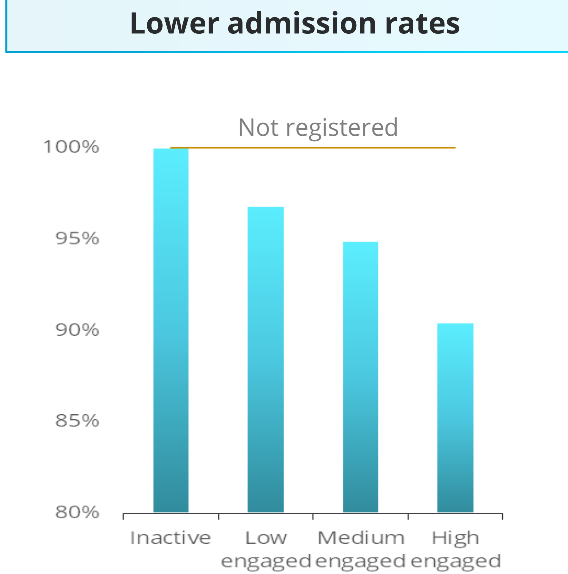
"An investment of as $1 - $3 in preventative health per person per year could substantially reduce morbidity and mortality attributed to NCDs," WHO



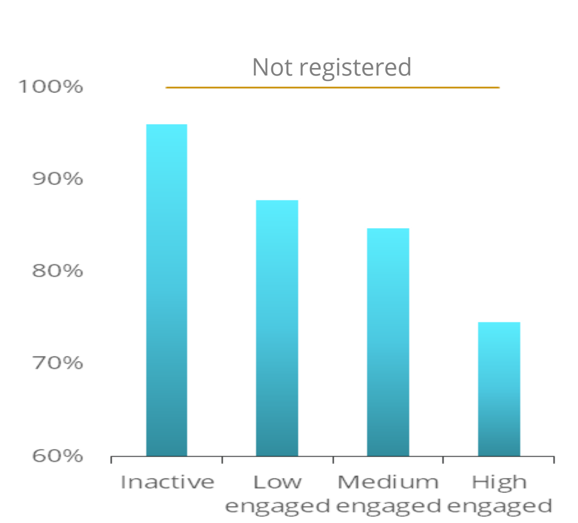
Vitality's Shared Value Model

Vitality engagement improves health outcomes

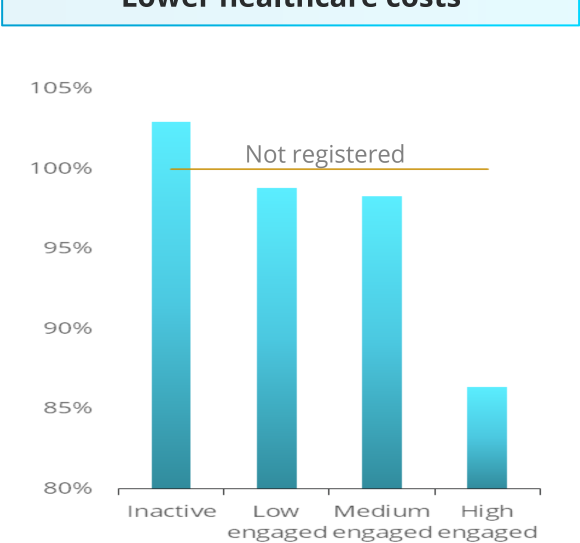
Lower admission rates



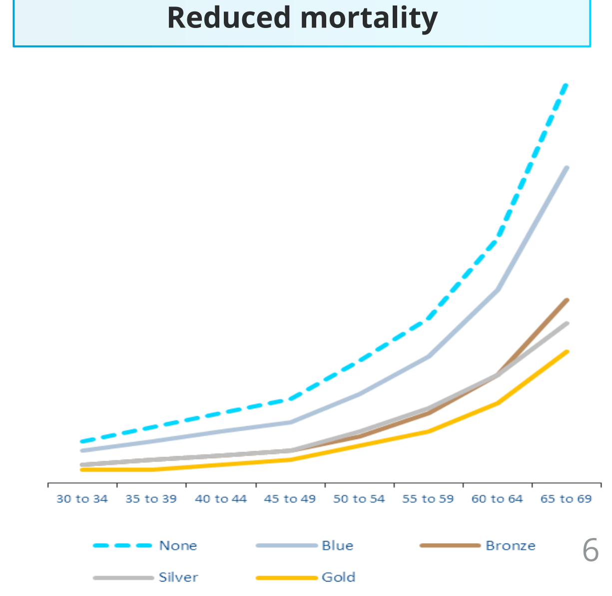
Shorter hospital stays



Lower healthcare costs



Reduced mortality

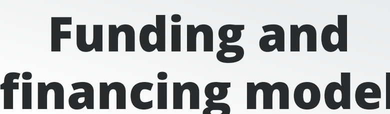


Discovery has been contributing meaningfully towards achieving UHC

Discovery has historical experience in strengthening the health system; and is committed to continue this in support of NHI rollout

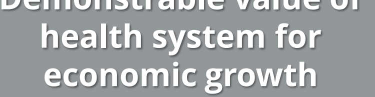
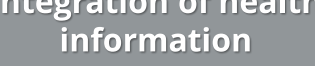
	Deepening the skills base	Developing tools to multiply system efficiency	Expanding access to primary care
Achievements to date	▪ Since 2006, Discovery Foundation has invested over R230million to train more than 400 medical specialists now working mainly in the public sector. ▪ Since 2013, the PHEF has spent R76million in support of medical students promoting transformation in the health system.	▪ Increasing digitisation e.g. HealthID and virtual consultations (CareConnect) ▪ Cost and quality containment through provider networks ▪ Successful wellness programme (Vitality) that delivers shared value globally	▪ Keycare benefit, currently servicing 400k beneficiaries has created access for lower-income members through provider networks and gatekeeping – largest capitation based network in SA ▪ Harnessing employer subsidies for greater access to primary care
Intentions for the future	▪ Support resource planning including human resources and infrastructure ▪ Implement Social Health Compact agreements ▪ Facilitate access to technical skills: actuarial, strategic purchasing, data analytics	▪ Share experience on digitisation, provider networks and value-based metrics ▪ Share experience on population behaviour change for wellness ▪ Support regulatory change for multi disciplinary teams and new reimbursement models	▪ Working towards implementation of Low Cost Benefit Options (LCBOs) ▪ Finding innovative approaches to deliver primary and preventative care ▪ Promoting sustainable partnerships in delivering care

COVID-19 also revealed fundamental changes needed to strengthen the health system in anticipation of NHI



Funding and financing model	Capacity	Regulations	Disease Burden
Consider financing model (NHI Bill) in light of all the related factors that make up a **health system** **Sustainable funding** for health is demonstrably enabled by an active private sector	Enhancing **state capacity** is essential in order to reap the benefits of UHC System requires a major effort at **increasing the health professional capacity** (with private sector investment) during transition to NHI	Requirement for **simultaneous regulatory changes** in public and private health to improve access and lower costs, as per the HMI Report Improve channels for public-private collaboration	Invest in strategies to **reduce the burden of non-communicable disease** The NHI Fund should consider deliberate **investment in preventative care**

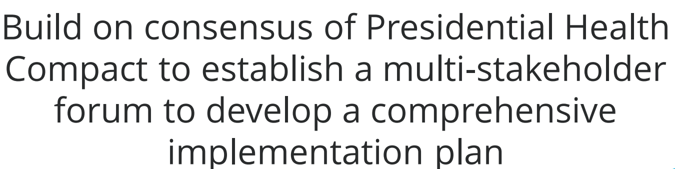
Additional insights from the national COVID-19 vaccination campaign

Theme	**Social solidarity for health**	**Role of whole health system in driving social inclusion**	 **Demonstrable value of health system for economic growth**	**Augmentation of state capacity**	 **Integration of health information**
Example	Strong public – private collaboration for vaccine access	Unitary approach to vaccine access	Economic activity boosted during periods of low Covid19 transmission	Private vaccination sites and systems as part of national effort	EVDS as the single data collection tool for all vaccinations
Implications for society	Private sector expertise and skills leveraged in mammoth national effort for vaccine procurement and planning of roll-out	Prioritisation of vaccine access by risk only, no separation of public /private access	"The best economic recovery plan is vaccination" **SONA**: Fundamental to our nation's recovery is an unrelenting and comprehensive response to overcome the coronavirus.	**MOH**: The role of the private sector was defined within a unified system, allowing for better use of and access to the capacity available in the health sector with better prioritisation of the vulnerable. **President:** We are encouraged by the commitment of the private healthcare sector to work with government, drawing on the immense capabilities that we have developed in the sector.	**MOH**: For the first time in history, there is one digital system for capturing and certifying all (Covid19) vaccinated individuals. Another lesson learnt is in the field of data management, integration, sharing and reporting

Foundations for sector collaboration towards UHC

Public Private collaboration

1



Build on consensus of Presidential Health Compact to establish a multi-stakeholder forum to develop a comprehensive implementation plan

2

Build on public/private relationships established during COVID-19 response

Public / private hospital contracting

Data sharing and analytical support in combination with the public data

3

The Lancet Commission and Health Market Inquiry have provided valuable and detailed recommendations for health system strengthening

4

Leverage existing resources of research institutions, academia and StatsSA to develop independent monitoring systems for NHI implementation stages

Examples of global health insurance models

	Parallel funding model	Dominant Public funding model	Blended funding model
Description	▪ Market for private health insurance alongside public insurance ▪ May include regulation or social solidarity framework ▪ May purchase service from public or private providers of care	▪ Single public funder model ▪ Public or private providers of care ▪ Smaller role for private insurers	▪ Multi-funder model ▪ Two or more funders ▪ Public and private insurers ▪ Compulsory membership elements
Country examples	*Australia* *Brazil* *Germany*	*Canada* *Ghana* *UK*	*Netherlands* *Thailand* *Indonesia*
Relevance to SA	▪ Incomplete social solidarity framework in the private sector can impede access in the public sector	▪ Smaller demand for private insurance in UK and Canada due to extensive access in public sector ▪ Large out of pocket expenditure in Ghana due to lack of access in public sector	▪ Employer role in funding can increase affordability ▪ Multiple pools enable competition ▪ Multiple pools increase ability to generate funds for cross subsidies

Across countries, healthcare reform pivots off existing infrastructure

No country has implemented a regulated limitation on the scope of private health insurance cover

The blended funding model is consistent with the policy objectives of the NHI

	Parallel funding model	Dominant Public funding model	Blended funding model
Description	▪ Public sector tax funded (84% of popln) ▪ Private medical scheme cover purchased on a supplementary basis (16% of popln)	▪ Single payer NHI ▪ NHI funded via compulsory taxes ▪ Medical schemes reduced to complementary cover	▪ Multi-funder system ▪ Public and private sectors act in an integrated way
Comments	**Benefits / Risks applicability to SA** ▪ Inequitable access to healthcare ▪ Unsustainable cost escalations in private sector ▪ Lack of access in public sector ▪ Inefficiencies in both public and private sectors ▪ Lack of co-ordination between public and private sectors ▪ Lack of competition in the public sector	**Risks of single payer model** ▪ Lack of consumer choice ▪ Lack of competition ▪ Monopsony power does not guarantee efficiency ▪ Monopsony power can put undue financial pressure on providers ▪ No incentive for innovation ▪ Concentration risk ▪ Implicit rationing, leaving citizens with no legal alternative ▪ Political and operational risks	**Rationale for recommendation** ▪ Afford consumers choice of funder and provider ▪ Funders and providers are incentivised to compete and innovate ▪ Reduced inequalities between public and private sectors ▪ Improved access to care for all ▪ Leverage off current social solidarity medical scheme framework to expedite attainment of universal coverage

Funding considerations and options

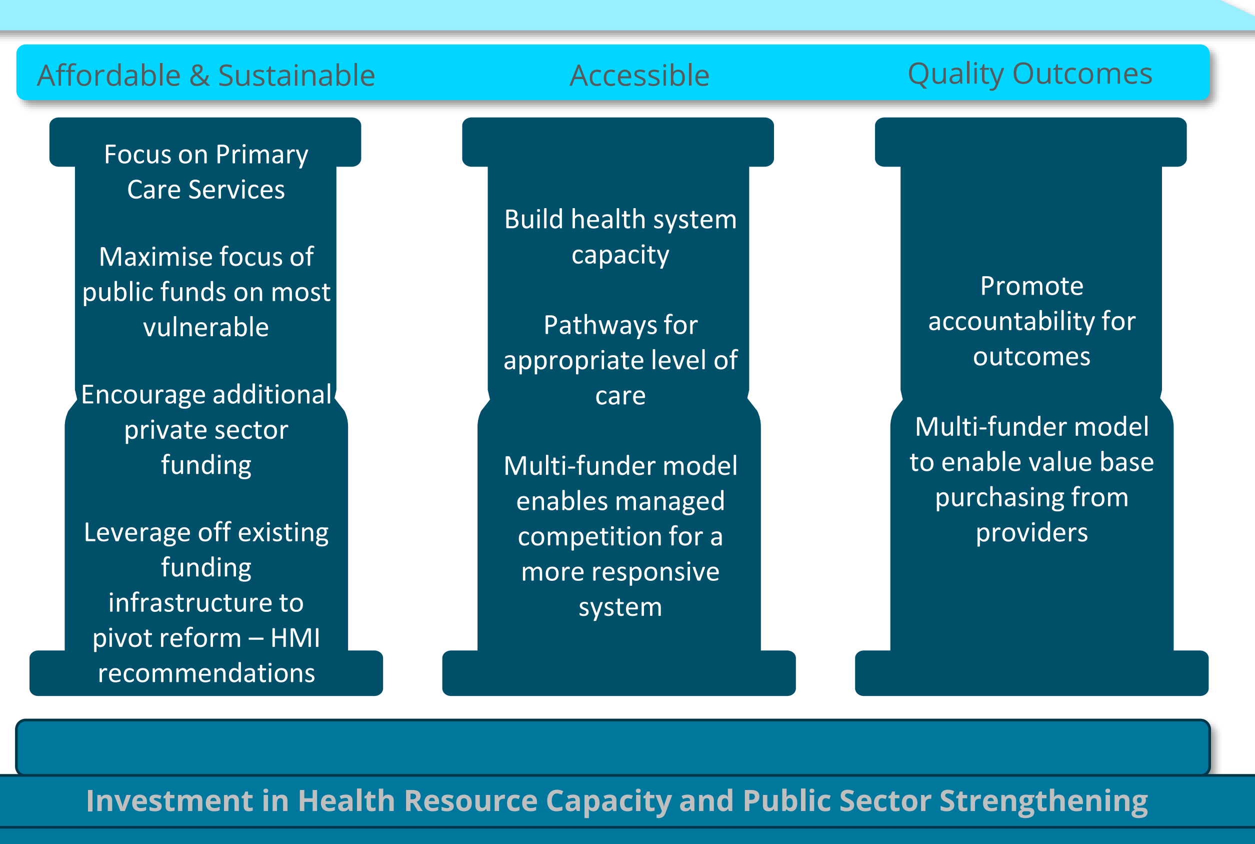
Parallel funding model

Dominant Public funding model

Blended funding model

- Private spend including the medical aid financing of **9 million** South Africans equates to **R212bn (44%)** of total healthcare funding
- If medical schemes are eliminated, the **R212bn** funding gap will need to be absorbed by the state
- If taxation is used to increase state healthcare budget to this amount, additional **4.1% of GDP** needs to be collected in taxes – unlikely to be feasible
- More feasible pathway to increase public sector per capita funding is to **maintain medical scheme funding**, expand access to employed population while state funds focus on most vulnerable

Discovery Health's perspective on the pillars of UHC



Achieving UHC via a blended funding model

South Africans

Opt-in / employment basis (additional contribution)

Tax-based Funding

Mandatory contributions

Financing

Medical Schemes (social solidarity framework)

Allocation for discretionary Package

Allocation for NHI benefit Package

NHI Fund

Benefits

Medical Scheme Discretionary Package

NHI Benefit Package

Provision

- Public and Private healthcare providers
- Regulated per HMI recommendations

- Accredited Public and Private healthcare providers
- NHI reimbursement framework (Managed Competition)

OOP for additional services

Benefits of a blended funding model for South Africa

NHI White Paper Policy Objectives	Objectives met by model
▪ Universal coverage through mandatory participation and common benefits	√
▪ Mandatory contributions into NHI Fund	√
▪ Single revenue pool for NHI benefits	√
▪ Virtual pooling ensures equity	√
▪ Extended financial risk protection	√
▪ Universal benefit package at regulated tariff	√

Additional benefits through blended model

- Reduced number of claimants from NHI fund
- Equitable access to medical care
- Managed competition for purchasing promotes quality outcomes
- User choice available
- Leverage existing capacity for wellness programmes, risk management and administration

Together in transition towards NHI implementation – approach to S57 of Bill

Public-private collaboration for system resilience

Solidify Covid19 platforms and collaboration

Catalyse Social Health Compact commitments

Accelerate human resources for health (HRH) training and skills; Quality improvement

Implement HMI recommendations

Significant private reforms to lower cost, reduce variability

Build on existing assets

Harness skills in academia, private sector, civil society

Harmonisation and standardisation

Alignment of primary care package

Successful NHI implementation

Funding and pooling reforms for equity

Next Steps: → Implement HMI recommendations → Collaborative health system strengthening → Incremental implementation of NHI Fund

There are misperceptions behind Section 33

Misperceptions

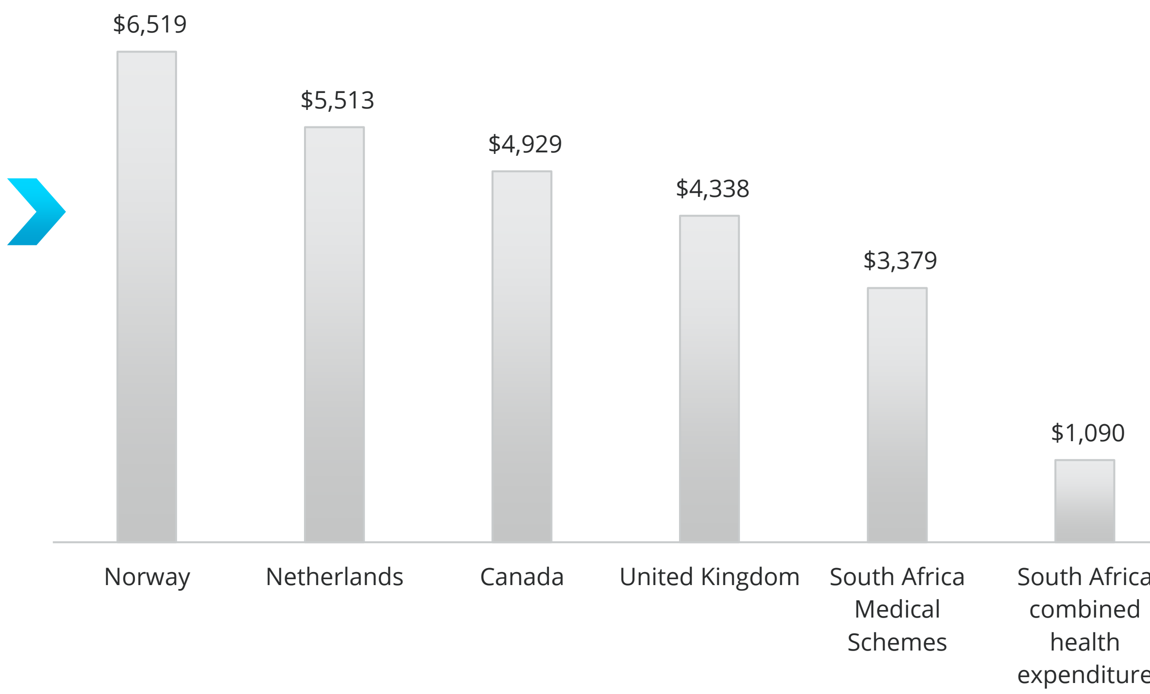
1.
Limiting the role of medical schemes **will not** solve the **misdistribution of health professional** resources between the public and the private healthcare system

2.
Limiting the role of medical schemes **will not improve inequities** in the healthcare system – economic consequences of additional taxes of 4% of GDP

3.
It is **factually incorrect** that medical schemes serve a **population** that is **predominantly white –** 65% of beneficiaries are black and 50% earn less than R30 000 per month

- HMI report **highlights incomplete implementation** of existing legislation and **inadequate application** of regulatory oversight as major driver of medical inflation
- Effective review of **PMBs,** introduction of **LCBOs** and implementation of a **Risk Based Capital** could improve efficiency of system
- While levels of medical scheme inflation have been high, the cost of private cover is **globally competitive**
- **Combined health expenditure in comparable monetary terms is low** relative to wealthier nations.
- The private healthcare system is an **asset** to South Africa providing strong **financial risk protection**

Annual healthcare expenditure for selected higher income countries



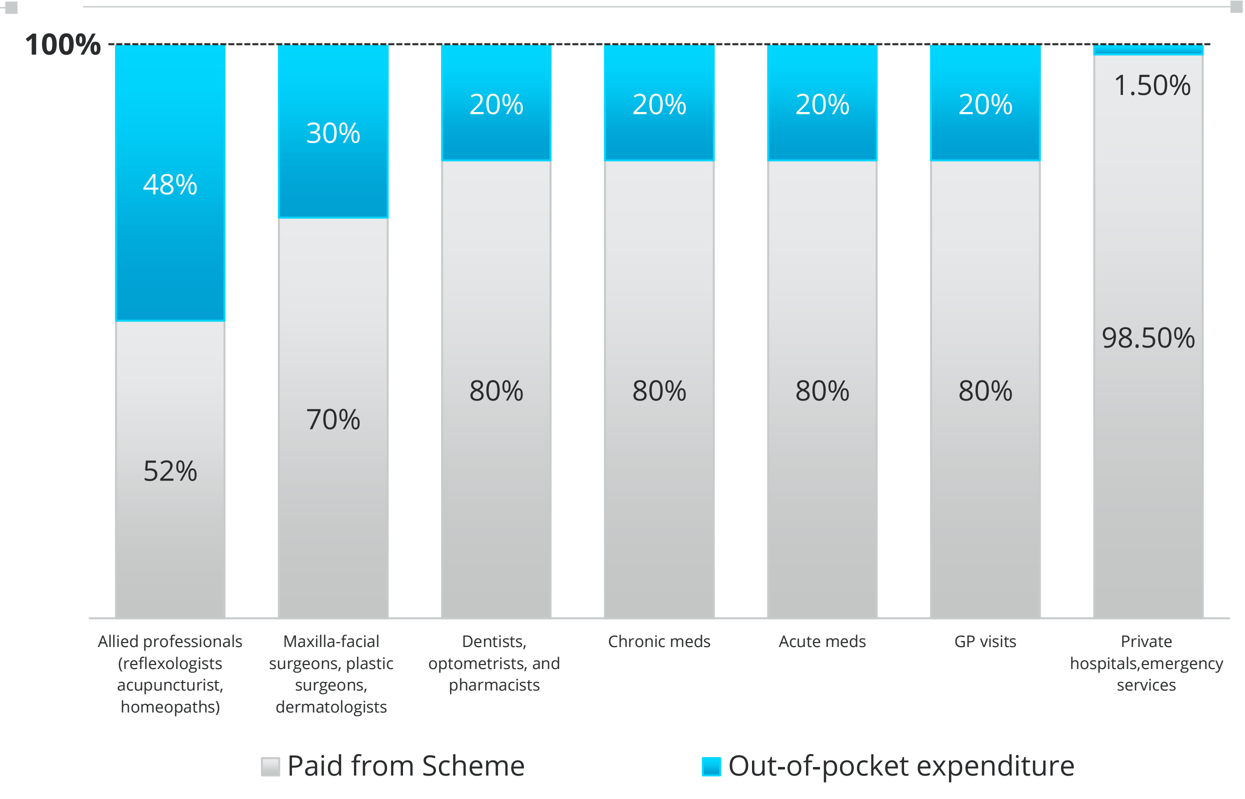
Source: WHO Global Health Expenditure database, CMS Annual Report 2016/17

Medical schemes provide strong financial risk protection against out-of-pocket expenditure

Trends in risk protection against out-of-pocket Expenditure (OOP)

- OOPs levels are set at high enough levels to incentivise member behavior, but low enough to prevent members facing a catastrophic loss.
- All DHMS benefit options have unlimited hospital benefits– OOPs tend to relate to discretionary items
- All DHMS options cover PMB benefits in full so members cannot run out of PMB benefits per year if they follow care pathways
- Over 50% of members have a positive day-to-day (including savings) balance at the end of the year
- KeyCare members have access to unlimited primary care and hospital benefits

Large out-of-pocket expenses are typically spent on "discretionary types of care"



Members cannot run out of cover for over 300 PMBs and chronic disease list conditions as these must by covered in full. Similarly, all hospital services are covered in full.

Risks of unintended consequences of limiting medical scheme provisions

The maldistribution of health practitioners may be exacerbated

Doctor migration rates increase in response to regulated public service requirements

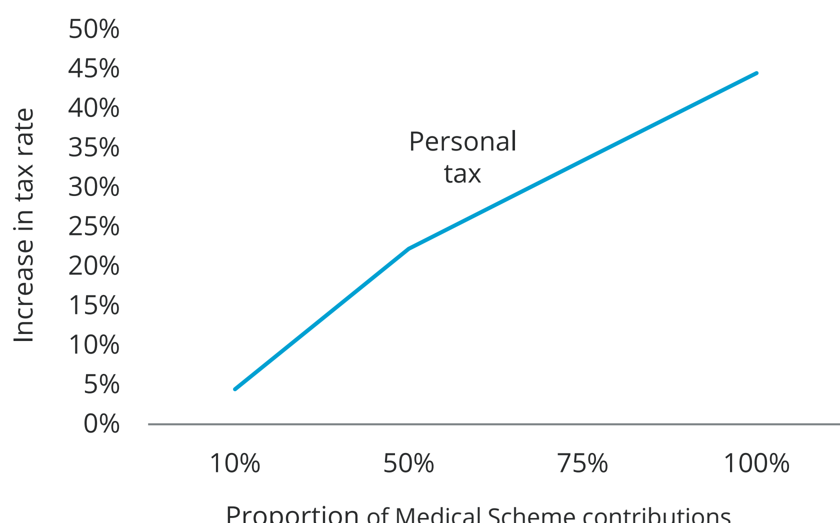
~10 800
Doctors from Sub-Saharan Africa working in USA

Migration attributed to attempts to limit the ability of doctors to earn income in the private sector

Increasing taxes will have broader negative consequences for the economy

Increase in Personal tax → **Decrease in disposable income** → **Decrease in economic expenditure**

Required increase in tax to collect equivalent Medical Scheme contributions

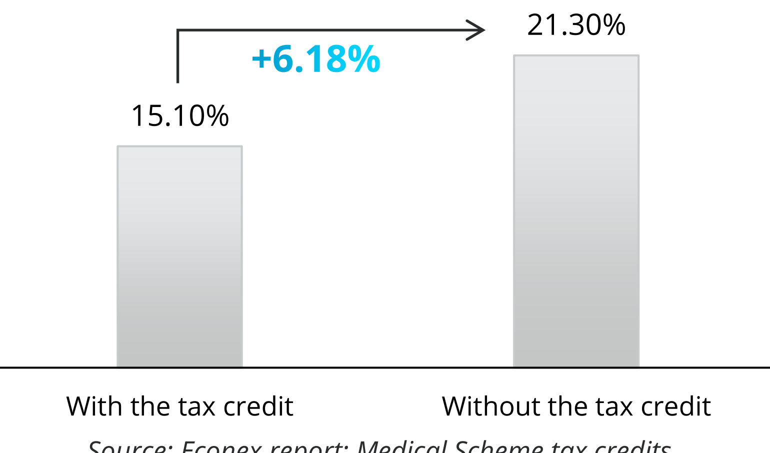


A significant increase in personal tax would be required to collect the current amounts being contributed to medical schemes

Removing tax credits has consequences for those earning less than R300 000

480 000 beneficiaries (6% of total) will lose cover if the tax credit is removed and become dependent on public sector

Proportion of medical scheme beneficiaries who fall above the affordability threshold



Source: Econex report: Medical Scheme tax credits

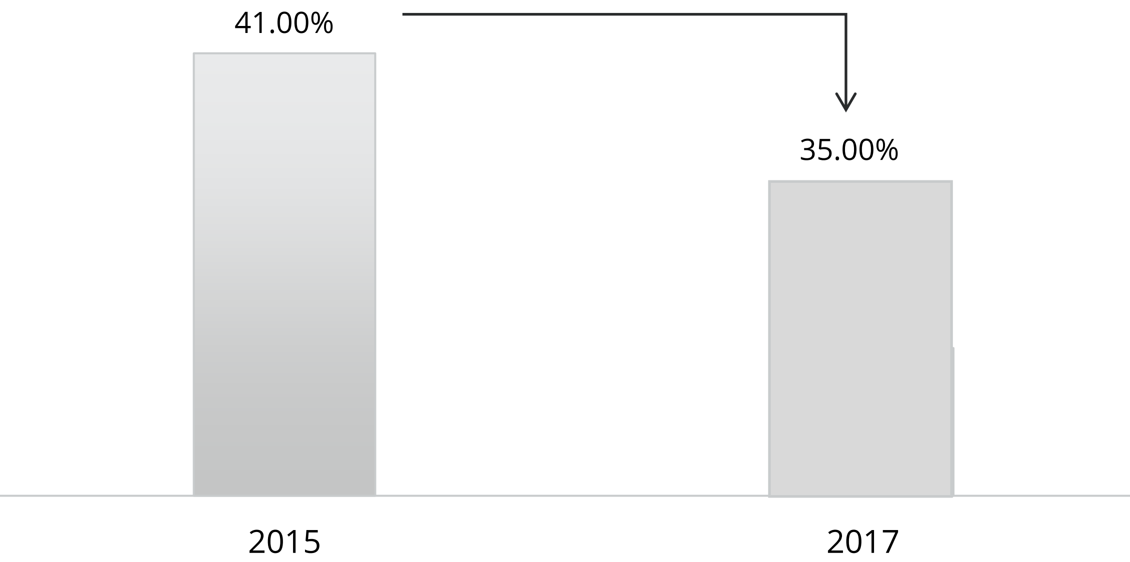
Recommendation: Transition towards a blended funding model for a more sustainable pathway to UHC

Risks of unintended consequences of limiting medical scheme provisions

Removing medical schemes will increase out-of-pocket expenditure

Experience in Ghana shows how poor access to over-strained facilities results in many citizens choosing to purchase care on an out-of-pocket basis

Reduction in Ghana's National Health Insurance System coverage rates

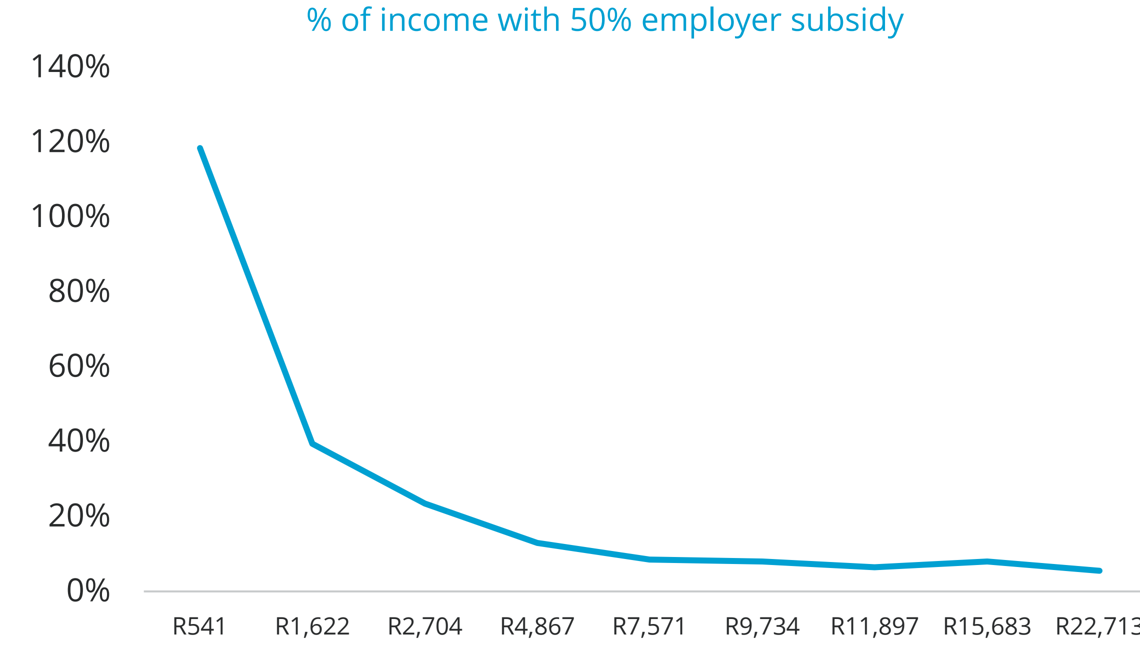


Source: Trends and characteristics of enrolment in the National Health Insurance Scheme in Ghana (2018)

Potential loss of employer subsidies

50% employer subsidy significantly impacts lower income groups

% of income with 50% employer subsidy



Notes: 2020 KeyCare contribution rates using a family size of 1.35

Recommendation: Transition towards a blended funding model for a more sustainable pathway to UHC

Societal repercussions of these risks

Higher maldistribution of health practitioners	▪ Outward migration of health practitioners (through alternative careers/ emigration/retirement) **reduces access to care for all** ▪ **Training platforms** are compromised, with long-term impact
Economic impact	▪ **Increased taxes** are likely to result in diminishing tax revenues, thus compromising social welfare and security ▪ **Single-payer** market depresses innovation and dampens capital investment, thus reducing opportunities for jobs growth
Decreased access due to affordability barrier	▪ Higher **pressure on public facilities** as more people are left with no other options ▪ Risk of **catastrophic expenditure** increases; as does risk of **bribery and corruption** as care becomes harder to access
Worsening health system fragmentation	▪ Reduced opportunity for **collaboration** with providers who are not contracted to the NHI Fund ▪ More uncertainty about healthcare demand reduces appetite for **care coordination**

Recommendations: Discovery supports the establishment of the NHI Fund and an incremental approach to UHC via a blended funding model

Improve clarity of intent

- Simplify NHI Bill to focus on establishment of NHI Fund
- Include explicit definitions for “fully implemented” and for “not reimbursable”
- Allow medical schemes to offer both supplementary and complementary cover
- Tighten governance provisions

Enhance simplicity and clarify expectations

- Remove date milestones and establish an inclusive process to develop a phased plan
- Remove amendments to other Acts in the Bill to prevent unintended consequences, such as liabilities transferred to taxpayers
- Adopt an incremental approach including costing per phase of roll-out
- Develop and publish related documents i.e. (1) measurable implementation plan (2) financing model and (3) a revised SEIAS with proper risk assessment

Improve system stability in preparation for NHI

- Address challenges of regulatory inconsistency as highlighted in HMI Report – resolve regulatory barriers
- Outcomes of resolving regulatory barriers:
  - greater efficiency of healthcare professionals deployment – multi-disciplinary teams and global fees
  - lower costs - revised PMB and solvency requirements
  - double the covered population with access to primary care options
  - increase in per capita funding within the public sector, as scheme cover becomes more affordable
- Opportunity to improve efficiency and affordability of medical scheme environment with HMI recommendations and for employers to be partners in improving access to cover
- This leads to opportunities for co-ordination and integration of public and private sectors

Sections 6 and 33 of the Bill should be amended to allow medical schemes to provide both complementary and supplementary cover

The current wording of Section 33 creates material contradictions and ambiguities in the NHI Bill, in particular with Sections 6 and 8.

Section 6(0) on "Rights of Users	Should be amended in order to preserve the rights of citizens to purchase any health service benefits through a voluntary medical insurance scheme, any other private health insurance scheme or out of pocket payments, as the case may be.
Section 33 should be removed / reworded	Should be amended to the effect that medical schemes will be able to provide cover for services that are complementary as well as supplementary to the services reimbursed by the NHI.
Section 33 possible revised wording	Medical schemes may offer benefits to users in respect of relevant health services, notwithstanding that such benefits may be reimbursable by the Fund in accordance with this Act.

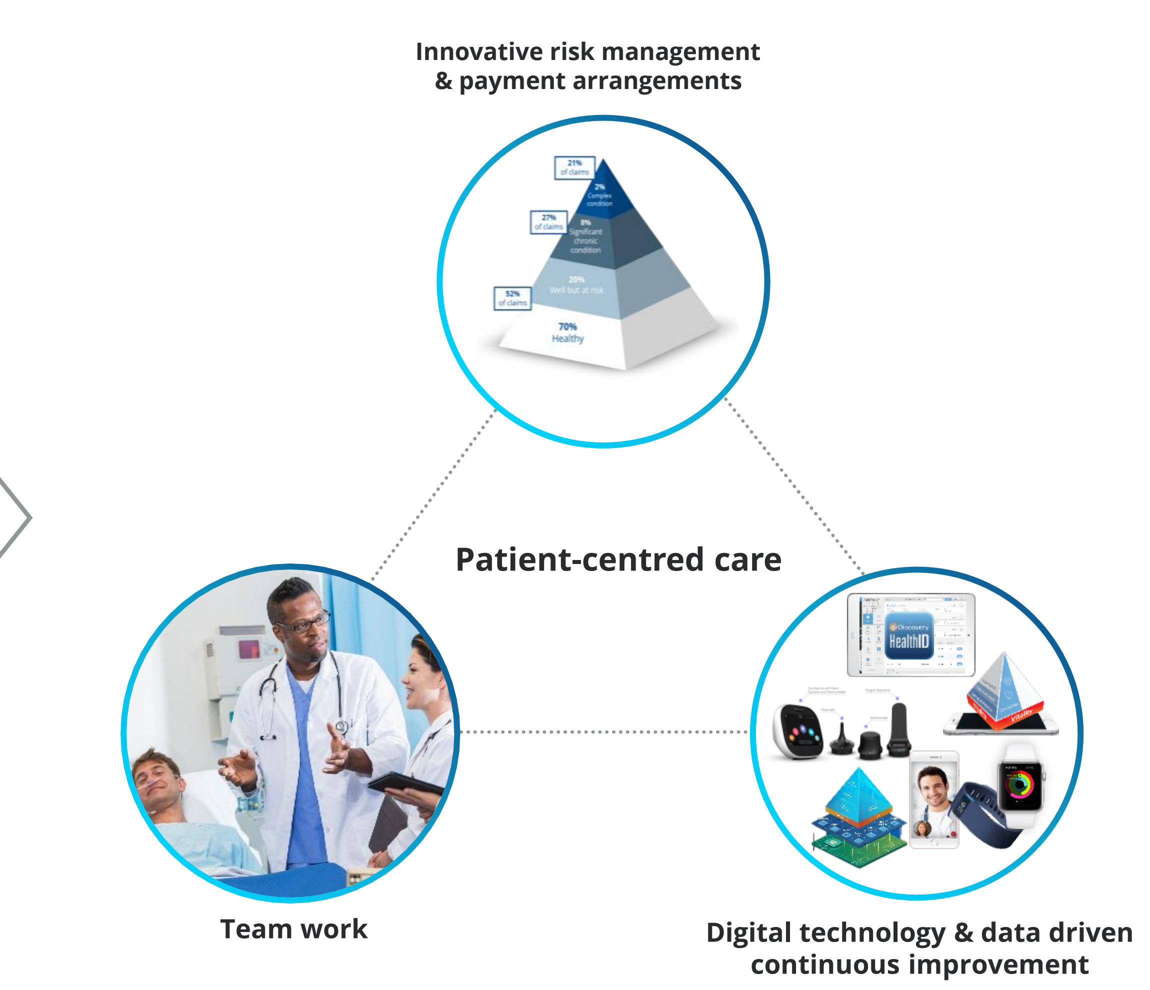
Further detailed recommendations

The NHI implementation process should be informed by the Treasury paper on the NHI and the associated opportunity for public input.

Implement best practice for governance (Sections 13,14,19,25,26,27 and 44)	Amend the governance structures of the NHI institutions adhere to the governance structures for the Supply Side Regulator for Health (SSRH) as proposed by the Health Market Inquiry (HMI) and the process used by the Judicial Service Commission (JSC).
Clarify Phased implementation (Section 57)	Each Implementation Phase should be defined on the basis of a set of clearly defined, detailed and measurable objectives with independent verification that these key milestones have been met before the next stage is initiated. This supports transparency and governance of the NHI implementation process.
Remove changes to the Medical Schemes Act (Section 58)	Proposed amendments are premature and they carry significant risks for 9 million beneficiaries. There remains significant uncertainties to the NHI service package, as well as with Section 33 and other Sections of the Bill.

Immediate opportunities to implement HMI recommendations to achieve a system objective of purchaser provider split

- Enact HPCSA regulatory changes to allow multi-disciplinary primary healthcare teams
- Develop enabling environment of practitioner registers and interoperable health information systems
- Optimise resources by facilitating digital health tools and deploying mid-level workers
- Develop health contracting capability for contracting at CUP level and NHI Fund; and for utilising new provider payment mechanisms
- Appoint multi-stakeholder technical committees to advise the interim NHI Office
- Develop a detailed and funded piloting plan linked to specific outcomes
- Build national research capacity for health system evaluation as per WHO guidance



Purchaser-provider split supports patient-centred care

Executive Summary

- Discovery **fully supports** Universal Health Coverage and the **overarching principles** as set out in the NHI Bill
- Discovery **recognises** SA's current socio-economic and health inequities and the need for **structural reforms** in the health system that will contribute towards building a society based on democratic values and social justice.
- Discovery is already **actively supporting** progress to UHC through initiatives including **training** and **access**
- Our sector has also learnt a lot through **COVID-19** period and should use these **learnings** as a base for the UHC collaboration and implementation
- Relevant global experience points to relevance of the role to be played by health insurers and opportunities for **collaborative phased implementation** approaches
- There is significant **risk** that **limiting medical schemes** and **Section 33** will have various unintended consequences
- There is **risk** associated with **single payor models** and **governance** and **accountability** challenges with the NHI Bill
- We have compiled **a workable model** towards **sustainable UHC**
- The approach to further developing and implementing the NHI Bill should be a more **inclusive process.** Discovery would like to offer our **contribution** and **support** to this process
- Discovery is committed to continue **constructive** engagement and **collaboration** with policymakers and social partners on implementable, **sustainable reforms** that will significantly enhance the quality of life of all SA citizens

Overview

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Covid-19 has demonstrated the importance of having **a resilient health system** and the opportunity for **public-private collaboration** in delivery of health care.

We are concerned that there are **risks** in the technical design of the system which will adversely affect the achievement of the objectives.

We suggest a **collaborative approach** that leverages off the **extensive expertise** in the health sector based on an aligned commitment to the policy principles.

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