BUSINESS UNITY SOUTH AFRICA

Response to NHI White Paper

Nedlac NHI Task Team

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Outline

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Principles

Inputs used

- White Paper
- Socio Economic Impact Assessment System Report
- High Level Panel recommendations on Health Care

Business supports social justice, human rights and democratic values as enshrined in the Constitution of the Republic of South Africa

Problem Statement

- SA faces quadruple burden of disease
- The health system is fragmented
- There are inefficiencies and wastage in the private and public health systems
  - Public sector: management, delivery and capacity challenges
  - Private sector: escalating costs and clinical governance challenges
- Lack of comprehensive health information system
- Skewed distribution of resources
- Declining per capita expenditure

Not all doom and gloom

- World Bank has assessed catastrophic health expenditure protection as being in top half of 183 countries surveyed
- Out of Pocket (OOP) expenditure levels are low relative to peers
- Improvements in SDGs over the last decade
    - Life expectancy: **increased** from 52 to 62
    - Infant mortality rate: **decreased** from 57.8 deaths per 1 000 live births to 34.4
    - Under-5 mortality: **decreased** from 85.2 deaths per 1 000 live births to 44.1
    - Maternal mortality rate: **decreased** from to 312 per 100 000 live births to 141
    - Mother-to-child transmission of HIV: **decreased** from 10.9% to 1.5%
- World class skills in terms of clinical and risk management
- …..So there is an opportunity

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Principles

- **Social solidarity**
  - Quantify and manage sustainable cross-subsidies
- **Equity**
  - Focus on vulnerable groups, those who can afford should provide for themselves
- **Affordability**
  - Planning is important so that promises can be kept; overall social security priorities
- **Efficiency**
  - Alternative delivery models (and transition pathways) should be considered to optimize
- **Effectiveness**
  - Quality assurance supported by effective information management is key to implementation
- **Appropriateness**
  - Innovative delivery models in terms of funding, pooling and service delivery need to be considered for an optimal outcome. A viable transitionary process consistent with these principles is required

- **Constitutional right of access**
  - Does not need to be interpreted as meaning that all costs and provisions should be the responsibility of the state. Only that the state must act so that the rights of access are progressively realised
- **Healthcare as a public good**
  - Vital social investment for public benefit (non-rivalrous criterion does not apply)

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Features

- **Progressive universalism**
  - Incremental service benefit package needs to be defined
- **Mandatory prepayment of healthcare**
  - Fiscally responsible planning, sustainable cross subsidies (research)
- **Strategic purchaser**
  - Resource planning is a key consideration (research)
- **Financial risk protection**
  - Investigate optimal delivery models and transitional considerations

- **Comprehensive services**
  - Realistic and sustainable service benefit package, management of expectations
- **Single fund**
  - Advantages of pooling and active purchasing can be achieved in alternative structures (research)
- **Single payer**
  - Objective is efficiency and affordability – alternative transitional considerations
- **Publicly administered**
  - Opportunity to harness all available expertise

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There is some urgency . . . .

- Revitalization of public sector is a pre-requisite and needs to be urgently addressed
- This includes resource planning and training
- Opportunity to address regulatory impediments in private sector to facilitate transition
    - Consider recommendations of HLP
    - Address gaps in social solidarity framework
    - Supply side challenges being addressed by the Health Market Inquiry (HMI)

Financing

Financing

- Definition of the service benefit package

- Alternative transitional roadmaps
  - Costing
  - Funding

- Approach
  - Incremental benefit package
  - Understand costs
  - Model implications under various scenarios
  - Develop phased approach
  - Encourage those who can afford it to provide for themselves

Work needed….

- Costing needs to be updated from 2010 figures
  - Economic growth
  - Inflation
  - Demographic changes
  - Burden of disease

- Costing requires a clear definition of services to be provided

- Available public funding needs to be clear
  - Public funding vs private household funds and subsidies
  - Misleading to refer to % of GDP

- Tax sources need to take account of other fiscal demands and economic pressures

- Overall social security funding needs to be considered (risk of crowding out)

- Flow of funds needs to be properly assessed – especially implications on provincial budgets

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Current healthcare expenditure in SA (per the WP 2017)

2016/7	Rm	Rm	% GDP
Gov expenditure		**190,600**	**4.3%**
National DoH	4,500		
Provincial DoH	166,400		
Other	19,700		
Private sector		**198,400**	**4.4%**
Medical schemes	164,300		
Out of pocket	27,200		
Other	6,900		
Donors		9,300	
		398,300	**8.9%**

Voluntary private expenditure

- 2025 cost 2010 terms: **R256bn**
- **R372bn** in 2017 with CPI (medical inflation even higher)
- Benefits not defined
- Shortfall needs realistic growth assumption (experience much less than 3.5%)

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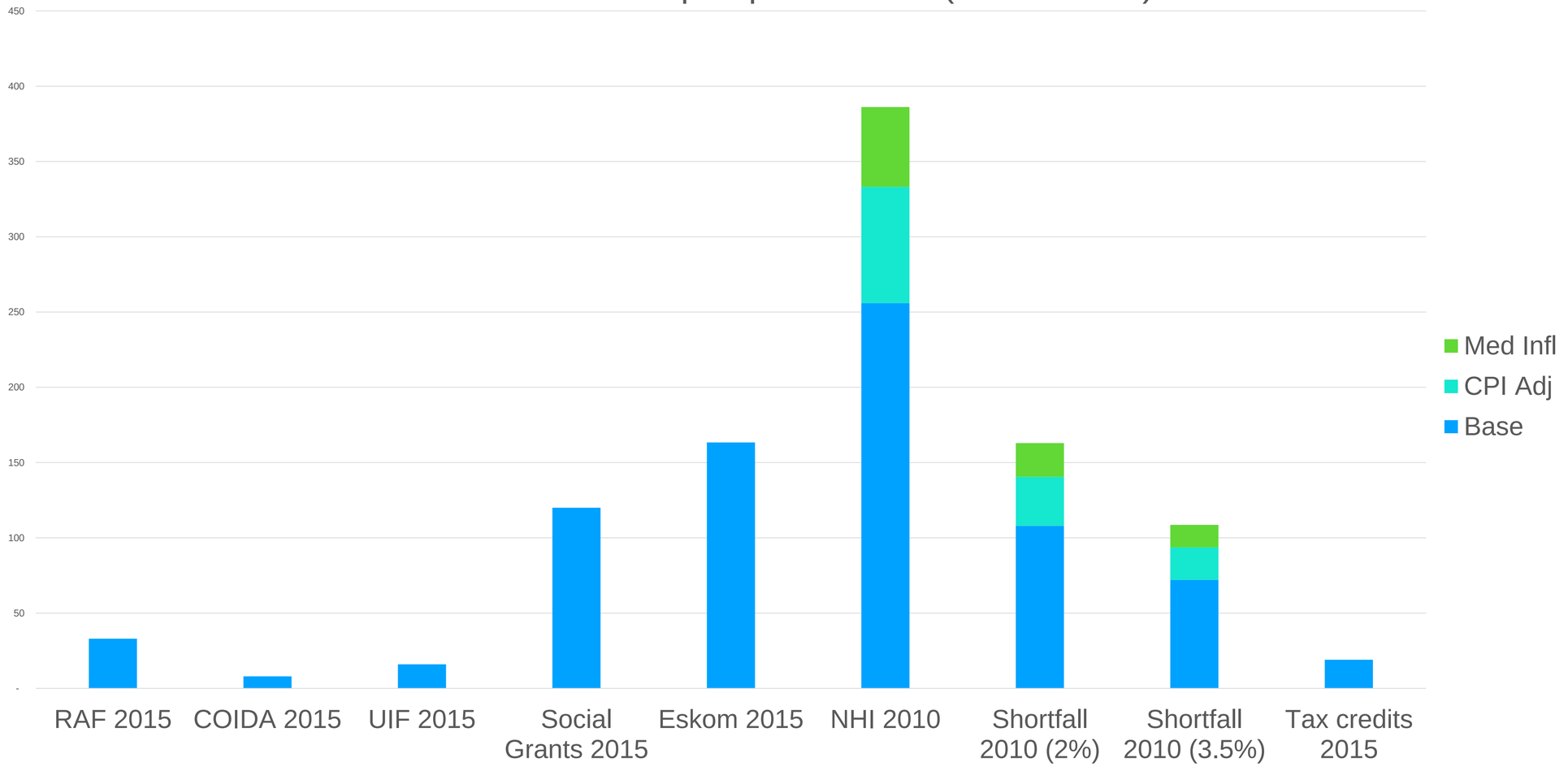
Funding requirements

- Assumptions
- Benefits
- GDP
- Popn



Funding requirements:

2025/6	2010 Rbn	2017 Rbn	**Rands per capita per annum**
Baseline health budget	109.8	160.7	2,845
Projected NHI expenditure	255.8	374.6	6,630
Shortfall (2%)	108.1	158.3	2,801
Shortfall (3.5%)	71.9	105.3	1,864
Shortfall (5%)	27.6	40.4	716

White Paper has:

- Shortfall is on optimistic assumptions….8 x tax credits
- Cannot assume private expenditure can be pooled
- Need to manage fiscal risk
- Other social security initiatives
- Implications on employment
- Sustainable cross subsidies

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Example of costs

WP costing in 2017 Rands:

- R6 630 per person = R 552 pbpm
- 90% is R 497 pbpm

Ave medical scheme claims:

- R1 161 pbpm on average
- R 726 pbpm for low cost options

CMS Report:

Open Scheme Options	Lives	%	pbpm
Low	1.1m	23%	R 726
Med	2.6m	53%	R 962
High	1.2m	24%	R 2,018
	4.9m		R 1,161

Needs:

- Clarity on service benefit package
- Alternative delivery and reimbursement mechanisms
- Risk management mechanisms (cost sharing, referral management, gatekeeper)
- Management of expectations in transition

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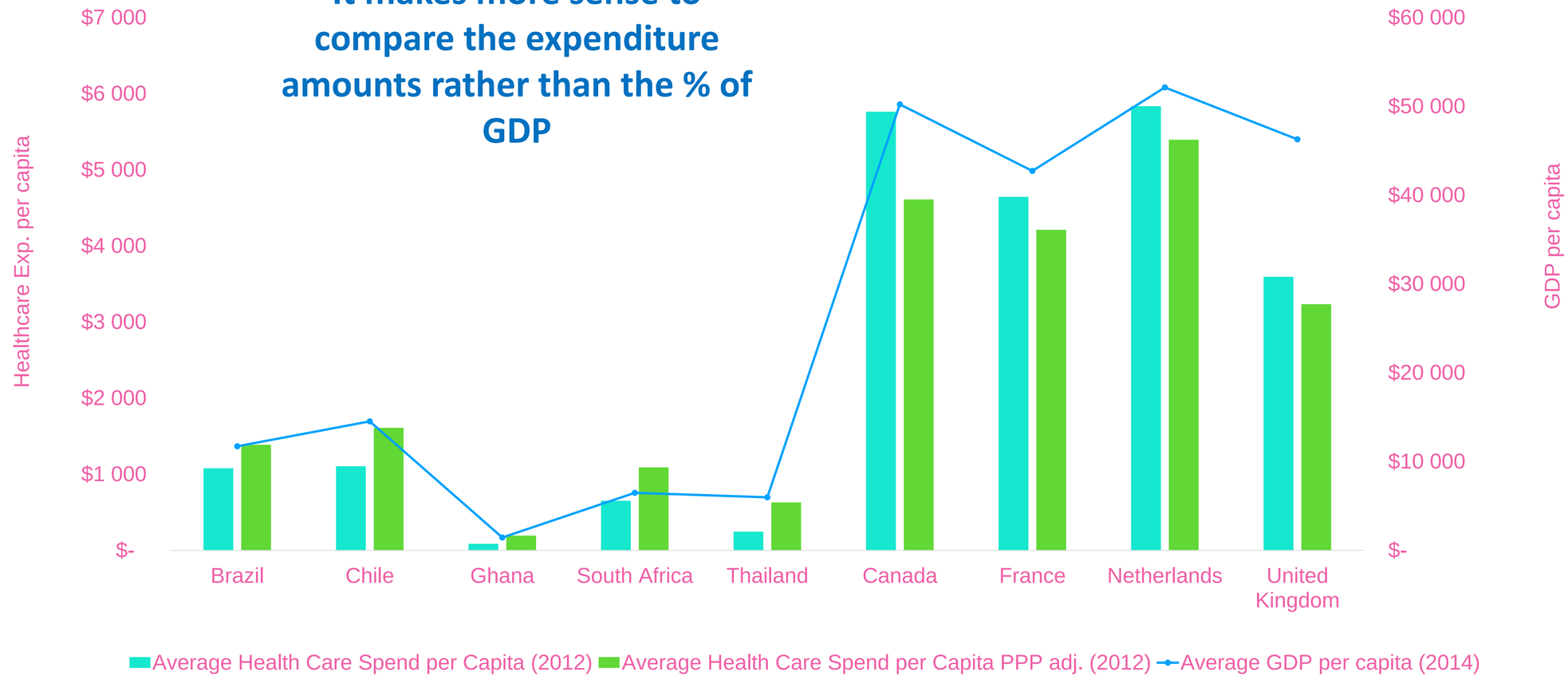
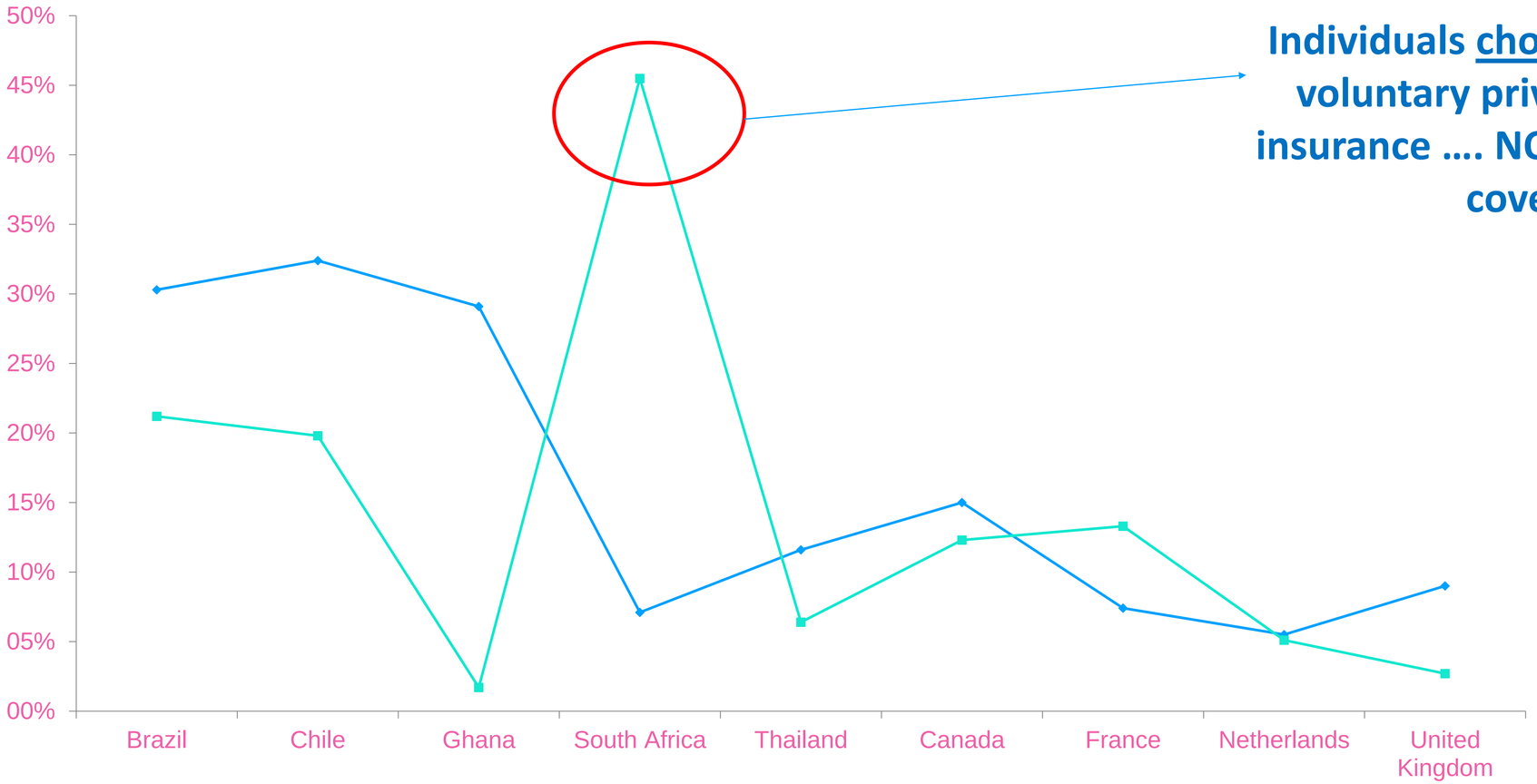
Health Expenditure vs GDP per Capita

It makes more sense to compare the expenditure amounts rather than the % of GDP



Out of pocket (OOP) & Voluntary private health insurance (VPHI)



Individuals choosing to buy voluntary private health insurance …. NOT the cost of cover

Implementation for Priority Programmes: lives

People covered	Year 1	Year 2	Year 3	Year 4
Maternity: Normal and high risk pregnancy	1,007,622	1,012,660	1,017,723	1,022,812
Women: Screened for cancer	3,278,435	7,953,044	10,710,088	19,075,119
Women: Cervical cancer	6,007	7,056	7,591	8,005
Women: Breast cancer	8,203	8,916	9,657	10,375
Paediatric cancer	4,737	5,324	5,749	6,127
School health	1,174,594	2,103,680	4,118,882	5,293,476
Elderly: Cataract surgery	70,000	100,000	100,000	120,000
Elderly: Hip and knee arthroplasty	4,450	4,472	4,495	4,517
Disabled: Rehabilitation	9,500	18,000	25,000	30,000
Mental Health Users: Screening, treatment and care	500,000	750,000	1,000,000	1,200,000

Source: Department of Health

Implementation for Priority Programmes : Rands

	Year 1	Year 2	Year 3	Year 4
Maternity: Normal and high risk pregnancy	5 668 836 884	5 697 181 069	5 725 666 974	5 754 295 309
Women: Cervical cancer	987 576 714	1 211 375 324	1 334 205 349	1 423 655 945
Women: Breast cancer	4 845 749 609	5 854 456 429	6 888 155 297	7 017 520 185
Paediatric cancer	778 728 434	875 288 568	945 215 203	1 007 750 431
School health	658 263 779	920 533 542	1 737 393 319	1 737 793 319
Elderly: Cataract surgery	318 182 400	198 864 000	198 864 000	218 864 000
Elderly: Hip and knee arthroplasty	136 116 450	136 797 032	137 481 017	138 168 422
Disabled: Rehabilitation	42 000 000	105 000 000	262 500 000	656 250 000
Mental Health Users: Screening, treatment and care	801 893 939	1 202 840 909	1 603 787 879	1 924 545 455
Total cost	**14 237 348 209**	**16 02 336 873**	**18 883 269 037**	**19 877 943 066**

Source: Department of Health

Provision

Provision

- Majority of delivery needs to take place in the public sector
- Opportunity for collaboration with the private sector (capacity)
- Need to ensure investment in improving infrastructure and health services – OHSC capacity
- Don’t need NHI to revitalize infrastructure
- Need to assess capacity requirements for delivery of benefits
  - Infrastructure
  - Human resources
  - Equipment, medication and consumables
- Human resource planning is key – especially training of required resources (role for private sector)
- Procurement and reimbursement processes need to be realistic
- Cost management processes need to be in place (types of rationing)

Current context to future healthcare provision

Inadequate capacity in a number of areas:

- **Human capital**
  - Absolute shortage of health professionals
  - Insufficient training capacity
  - Difficult to recruit foreign health professionals

- **Physical infrastructure**
  - Distribution of beds
  - Equipment

Current context to future healthcare provision

Possible approaches

Human capital

- Audit of total practicing health professionals
- Allow private sector training of health professionals
- Review process of recruiting foreign health professionals

Physical infrastructure

- Audit total capacity and quality of infrastructure
- Review procurement system to improve efficiency
- Consider contributions that can be made by the private sector

CORNERSTONE OF ACCESS:
Management, under purchaser provider split

Issues to be considered:

- Sound basis for price setting
- Smooth transitional arrangements based on clear planning process
- Employment of health professionals
- Procurement and management of supply chains
- Efficient billing systems
- Institutional changes required to achieve desired outcome
- Identification and management of risks

CORNERSTONE OF ACCESS:
Costing of services under purchaser provider splits

- Any costing process must be underpinned by scientific calculations based on actual input costs and performed by an independent authority with appropriate expertise and capacity

- Principles of cost recovery to be applied

- Contracts must be designed to succeed and might include:
  - Deep learnings from health systems with mature purchaser provider splits and external commissioning of services
  - Deep learnings from SA medical scheme administrators
  - Detailed Key Performance Indicators (KPI) – operational, financial and quality KPI's

- New forms of monitoring and evaluation ie external and independent adjudicator of performance

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CORNERSTONE OF ACCESS:
Phasing of Provision

- Private sector ready and willing to collaborate
- Piloting of collaboration models should commence as soon as possible

Phase 1 (2017-2022)	Primary healthcare services (incl. maternal health; school; mental; cataract and elderly arthroplasty backlogs)	Introduce governance and implementation structures	Amend legislation (11 statutes expressly identified)
Phase 2 (2022-2026)	"In later stages of 2nd phase… NHI fund will be established once NHI Act enacted" Will purchase from public & private PHC providers and public hospitals	NHI expanded to incorporate EMS (non-branded) and pathology (incl. private)	Last phase is to mobilise additional resources 'as approved by cabinet. "selective contracting … from private will be undertaken in this phase'

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CORNERSTONE OF ACCESS:
Provision perspective

- Alternative reimbursement systems being recommended

- Risk taking alternative reimbursement models at the get go rather than :
  - Assess activity based cost of public delivery
  - Ensure the reimbursement is sustainable for public facilities
  - Develop the skills for public providers to absorb and manage risk
  - Any DRG needs to be viable for investment.
  - Regulatory authority must base its function on accurate production cost data
  - Proposed DRG reimbursement authority must be impartial, established as an independent structure

The political incentive to set payments too low, amounting to a pretence that the system can deliver more than it is really able to. The result is accumulation of deficits by providers, and the emergence of dubious practices to try and manage their situations. In this respect, there are risks with the monopsony position of a single payer system.

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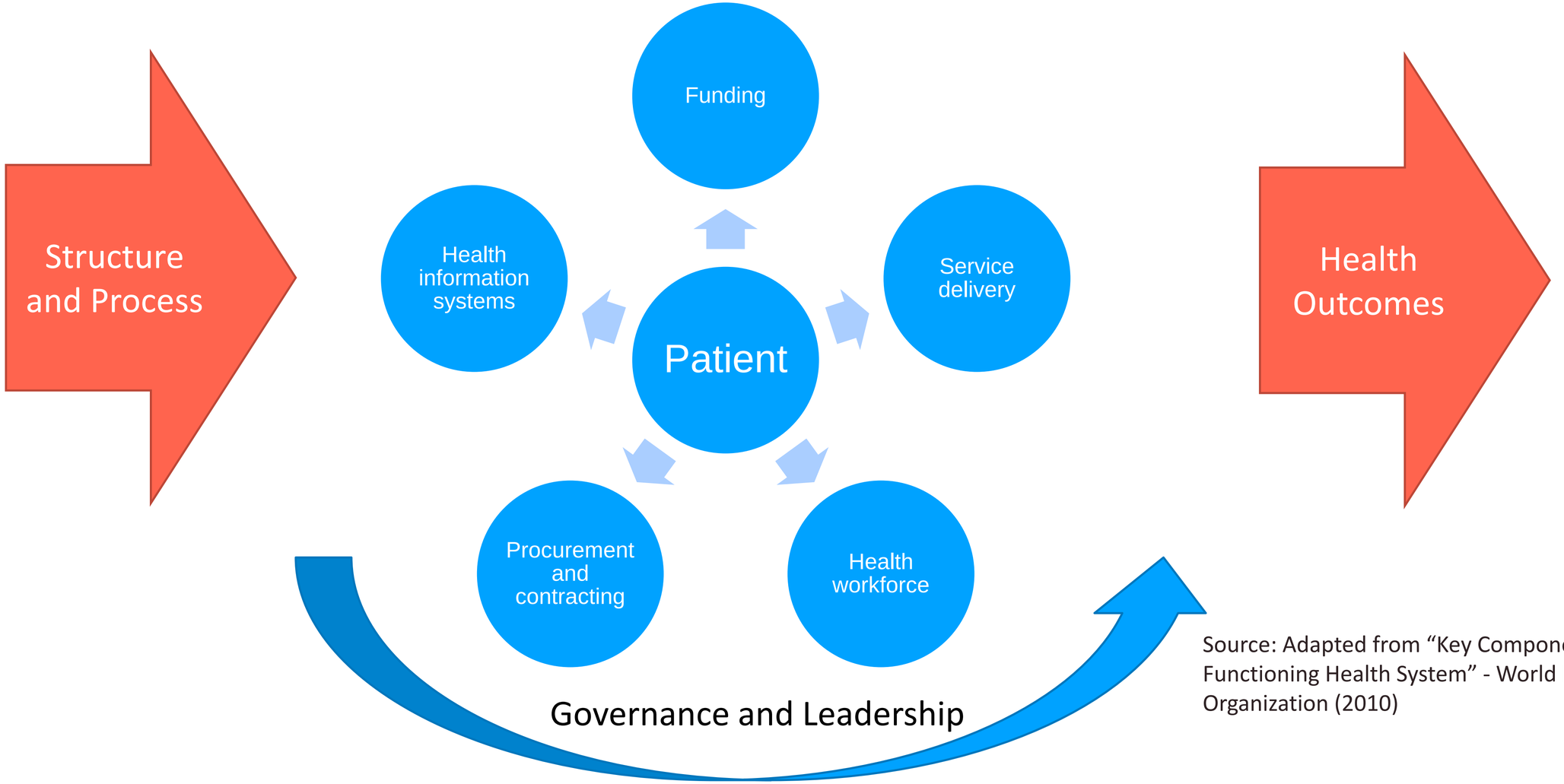
Governance

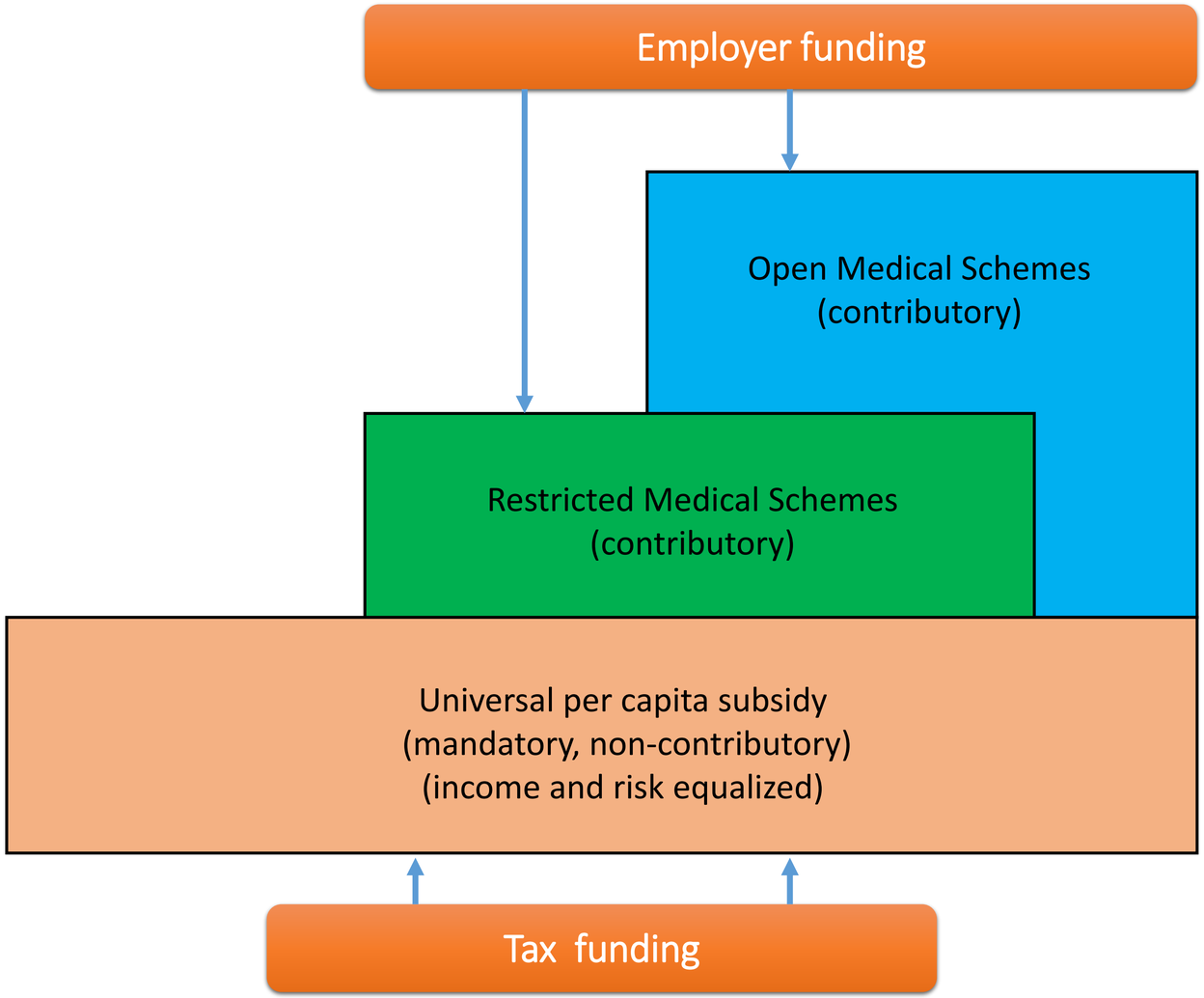
A Well Functioning Healthcare System | Key Components



Source: Adapted from “Key Components of a Well Functioning Health System” - World Health Organization (2010)

Incremental framework

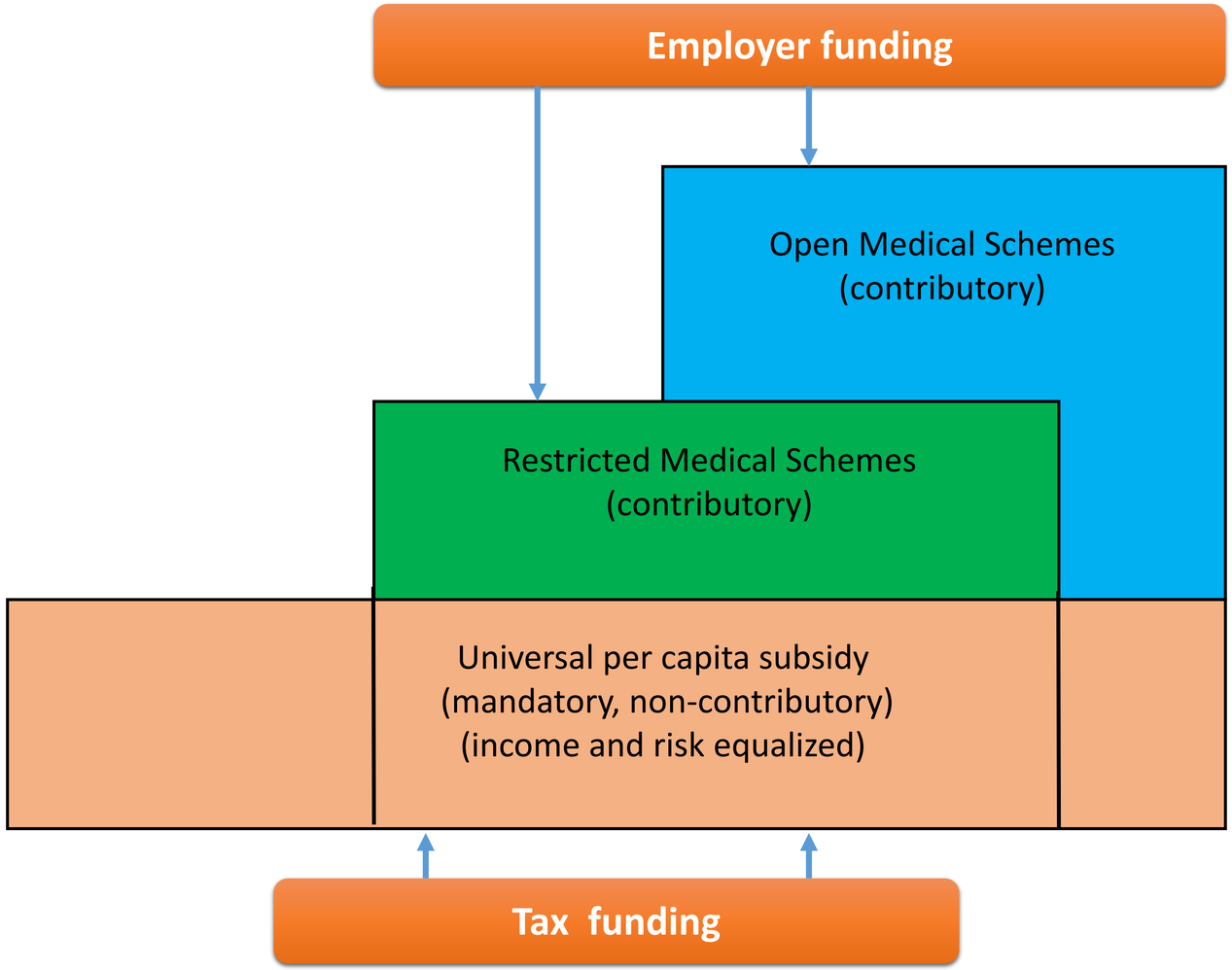
Incremental Strategic Financial Framework (Option 1)



Adapted from Taylor Committee Report, 2002

Incremental framework

Incremental Strategic Financial Framework (Option 2)



Adapted from Taylor Committee Report, 2002

Governance | Guiding Principles

Process

1. Clarity on roles
2. Platform(s) & framework for stakeholder engagement
3. Transparency and information sharing
4. Service Benefit Package Design
5. Legislative & Regulatory Review
6. Industry Standards

Outcomes

- Equity in Coverage / Distribution
- Access to Healthcare Services
- Financial Risk Protection
- Financial Stability & Sustainability
- Ongoing Quality Improvement
- Institutionalized Trust & Accountability
- Stakeholder Satisfaction

CORNERSTONE OF ACCESS:
Quality outcomes and patient satisfaction: approaches

- Standards must be applicable to all providers.
- Quality reporting authorities tasked with the management and publishing of clinical quality and patient satisfaction data must be independent.
- Private and public sector should have the same reporting requirements to monitor quality and patient satisfaction, which should be publicly available.

competitioncommission south africa

Health Market Inquiry

Promoting Healthy Competition

DISCUSSION DOCUMENT AND CALL FOR SUBMISSIONS

Health outcome measurement and reporting: Improving the cost and effectiveness of clinical care in a competitive private healthcare sector in South Africa

28 AUGUST 2017

OHSC

Office of Health Standards Compliance

Ensuring quality and safety in health care

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Improving efficiency in the medical scheme environment

- The Health Market Inquiry
  - Pressure of PMBs
  - Price regulation
  - Contracting opportunities
- Addressing anti-selection
  - Risk Equalisation
  - Mandatory membership (phased)
- Capital requirements
- The role of medical technology
- Low cost benefit options

Regulatory

Issues to be considered

- Understanding the Constitutional right to health (Section 27, WHO)
- WHO does not prescribe single fund model or free healthcare
- Health Professions Council of South Africa (HPCSA) rules on employment of doctors
- Health Market Inquiry (HMI) recommendations
- High Level Panel (HLP) recommendations (mandatory membership)
- Districts as juristic entities (for billing of services, PFMA implications)

Regulatory reforms

- Understood to be imminent
  - NHI Institutions and Advisory Committees
  - NHI Bill: transitional fund for priority projects understood to be on the way to Cabinet; SEIAS report has been finalised
  - Amendments to Medical Schemes Act: to provide for a beneficiary register, requirements for benefit options and governance; Prescribed Minimum Benefits (PMBs); Solvency; Low Cost Benefit Options (LCBOs)
  - Amendment to National Health Act: institutional reform to give effect to new roles for all spheres of government
- Clarity requested on status

Amendments to be proposed (White Paper)

- Mental Health Care Act
- Occupational Diseases in Mines and Works Act
- Health professions Act
- Traditional Health Professions Act
- Dental Technicians Act
- Medicines and Related Substances Act
- Provincial Health Acts
- Various ambulance legislation
- Nursing Act

It is expected that as the process unfolds clarity on the required amendments will be provided

Amendments to be proposed additions to White Paper List (Government presentation)

- Compensation for Occupational Injury and Disease Act
- Occupational Diseases in Mines and Works Act
- Unemployment Insurance Fund
- Road Accident Fund

Clarity is required on the intention with including this legislation

Norms and standards for training

Opportunities exist for collaboration with the private sector on human resource training and development

Business is ready to make a presentation on this whenever required

Summary

- Business supports social justice, human rights and democratic values as enshrined in the Constitution of the Republic of South Africa.
- The key objective is Universal Healthcare Coverage (UHC), which Business embraces in principle.
- We generally agree with the problem statement in the NHI White Paper (2017).
- Business understands the advantages of a single-payer dispensation (pooling and purchasing), however not the most efficient mechanism in the current environment – needs a collaborative approach.
- More clarity is needed on the (incremental) basket of services, in order to meet expectations and manage affordability.
- There are resource constraints in the current environment that need to be taken into consideration.
- All resources need to be leveraged to attain UHC objectives – we need to start with what we have as a country.
- There is an opportunity for the State to enhance its capacity to deliver on its promise through co-operation with the private sector, by leveraging technical expertise, systems, infrastructure and other related resources available in the private sector.
- Priority should be given to vulnerable groups for public funding and an enabling environment created for the expansion of cover over time.

Way forward

- Prepare matrix of constituency positions under the four headings agreed
- Commence work of working groups using above matrix as starter document
- Seek agreement on principles in Task Team