

NHI Task Team Feedback



QUANTIFYING RISK, ENABLING OPPORTUNITY

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ASSA Health CPD Day 2016

Agenda

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NHI Overview

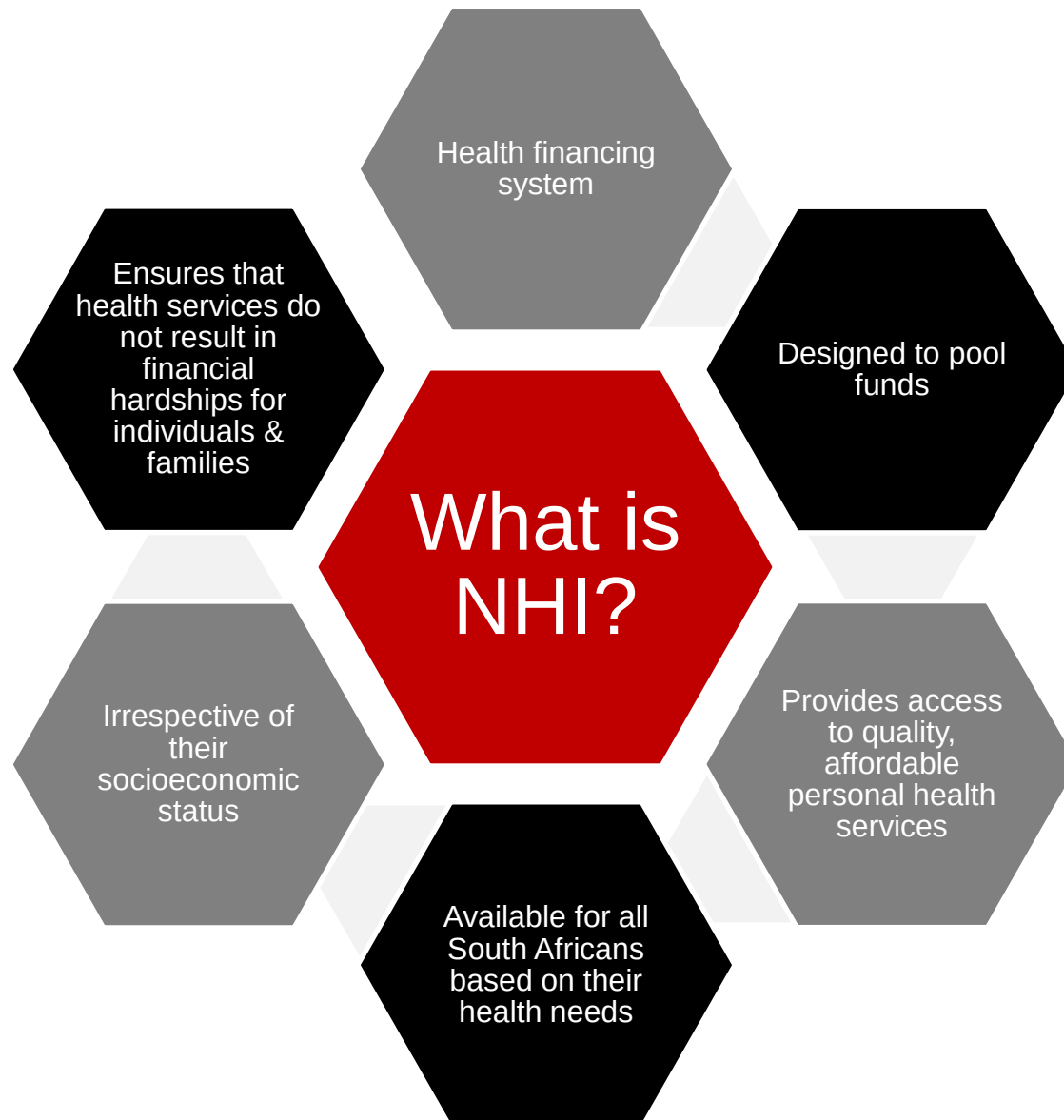
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NHI White Paper Commentary
Submitted to DoH

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NHI Costing Model Updates

1. NHI Overview



1. NHI Overview

Background of NHI

- Represents a substantial policy shift
- Necessitates a massive reorganisation of the current health care system (public and private)
- Derives its mandate from the NDP of the country
- Aims to achieve the progressive realisation of the right to have access to health care services (including reproductive health care)
- Will ensure that all South Africans have access to comprehensive quality health care services

Quality Standards of Care

- OHSC has been established to assure quality of health services (key in the certification of health establishments)
- Inspectorate will ensure compliance with norms and standards
- Ombuds person will enforce accountability and impose corrective measures where necessary

1. NHI Overview

Timelines

2011

- NHI Green Paper Published

2015

- NHI White Paper Published

2016

- ASSA's NHI Subcommittee submitted commentary

1. NHI Overview

Phased Approach

Phase 1

- Duration: 5 years
- 2012/2013 to 2016/2017
- Health System Strengthening Initiatives
- Moving central hospitals to the national sphere
- Establishment of the NHI Fund

Phase 2

- Duration: 5 years
- 2017/2018 to 2020/2021
- NHI card will be issued
- Transitional fund will be created to purchase PHC services at a non-specialist level.
- Users fees will be abolished.
- Establishment of a fully functional NHI Fund
- Establishment of NHI Fund Management and Governance Structures
- Amendments to the Medical Scheme's Act

Phase 3

- Duration: 4 years
- 2021/2022 to 2024/2025
- Introduction of mandatory prepayment for the NHI
- Contracting for accredited private hospital and specialist services
- Finalisation and implementation of the Medical Scheme's Amendment Act

1. NHI Overview

Work Streams to be established

Work Stream 1
Prepare for establishing the NHI Fund (legislation, inter-governmental functions and fiscal framework)

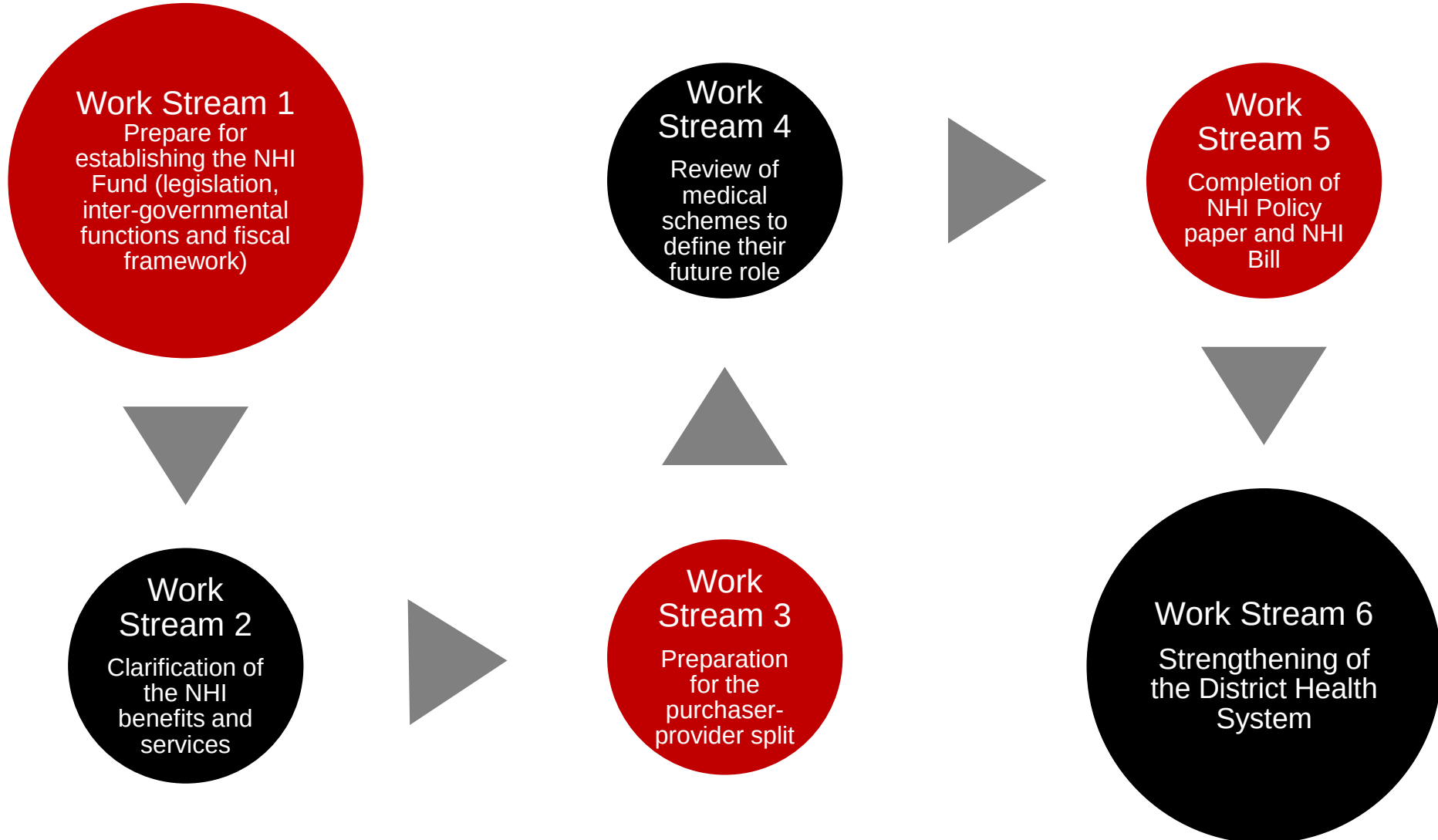
Work Stream 4
Review of medical schemes to define their future role

Work Stream 5
Completion of NHI Policy paper and NHI Bill

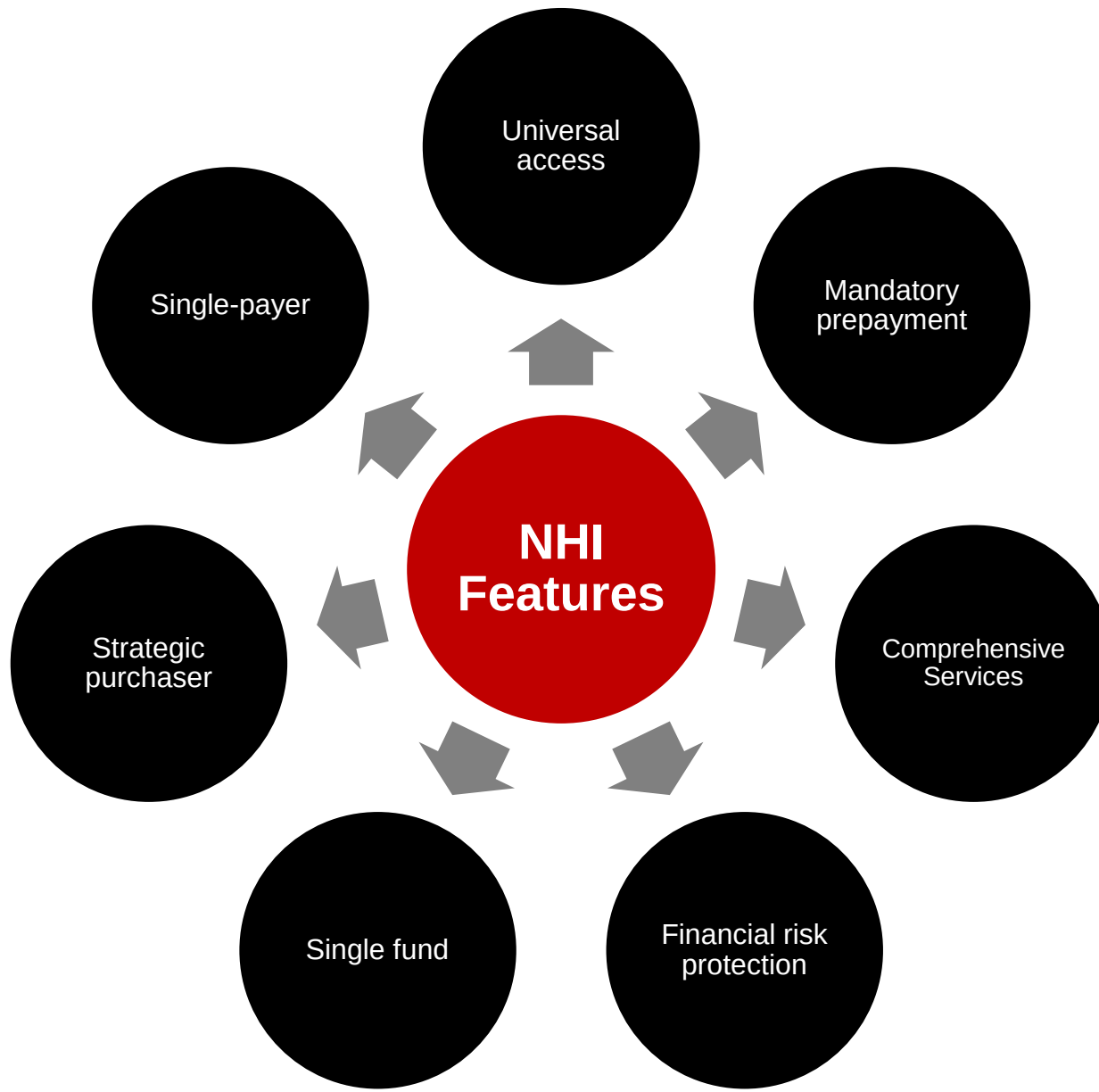
Work Stream 2
Clarification of the NHI benefits and services

Work Stream 3
Preparation for the purchaser-provider split

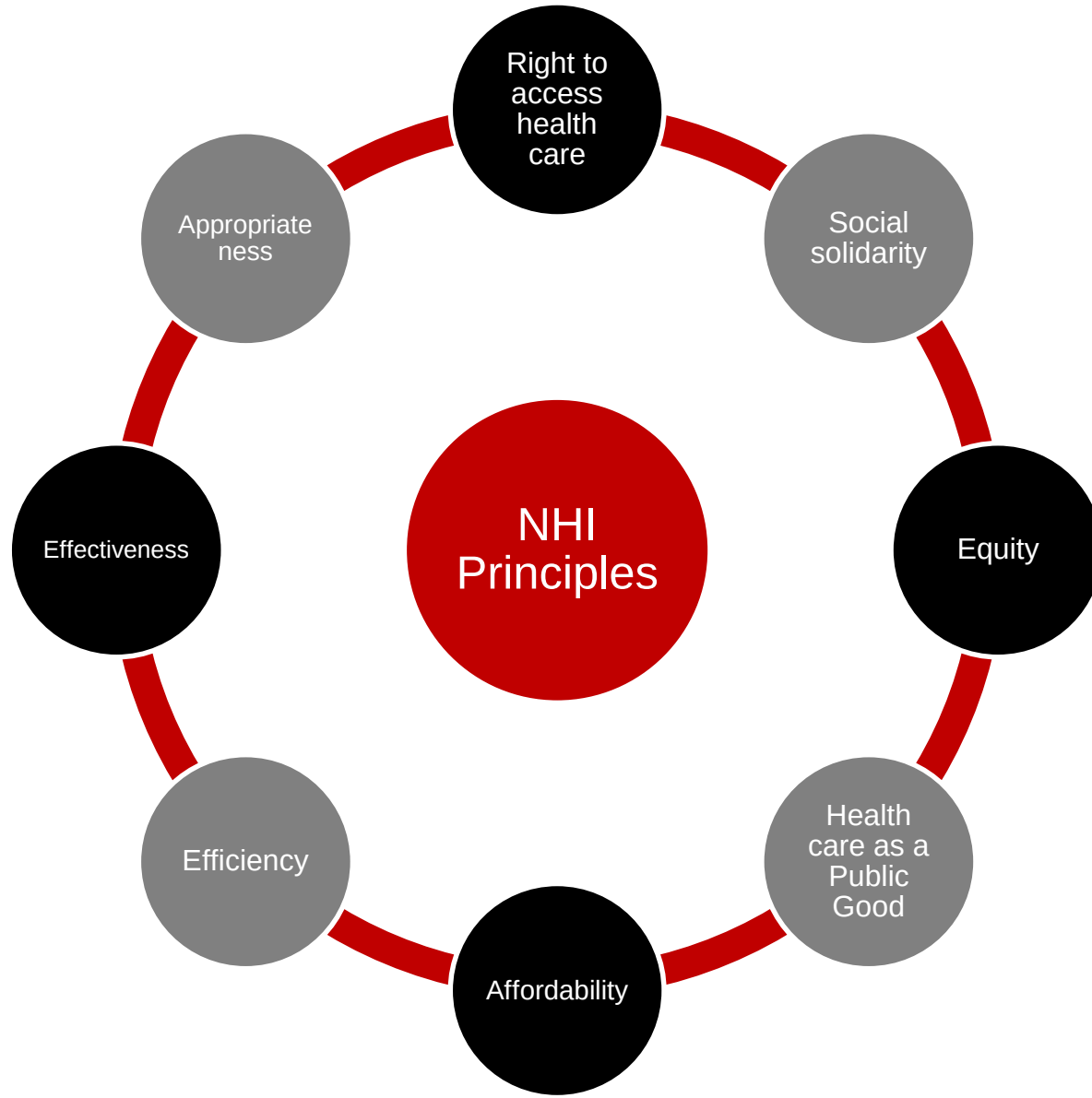
Work Stream 6
Strengthening of the District Health System



1. NHI Overview



1. NHI Overview



1. NHI Overview

Service coverage

- NHI will provide a comprehensive package of personal health services.
- Delivery of a comprehensive package will take into account
 - the need to progressively realise the personal health benefits
 - whilst undertaking priority setting.
- NHI will not cover everything for everyone.
- South Africans will be able to access personal health services covered by NHI closest to where they reside using the NHI card.
- These services will be delivered through certified and accredited public and private providers to improve access and coverage.
- The point of entry to accessing health services will be at the primary health care level with referrals to higher levels of care by providers at the PHC level.

1. NHI Overview

Service coverage

- PHC services will be delivered by accredited integrated teams of providers or networks structured as multidisciplinary practices of a wide range of health care professionals such as
 - medical practitioners
 - dentists
 - nursing professionals
 - pharmacists
 - audiologists
 - optometrists
 - physiotherapist
 - oral health practitioners
- Those who practice as individual practitioners will have to be part of referral networks.
- The PHC providers will serve a catchment population that takes into account the community's:
 - Geographic profile
 - Demographic profile
 - Epidemiological profile

1. NHI Overview

Service coverage

Comprehensive package of health services includes:

Preventive,
community
outreach and
promotion services

Reproductive
health services

Maternal health
services

Paediatric and
child health
services

HIV and AIDS and
Tuberculosis
services

Health counselling
and testing
services

Chronic disease
management
services

Optometry services

Speech and
Hearing services

Mental health
services including
substance abuse

Oral health
services

Emergency
medical services

Prescription
medicines

Rehabilitation care

Palliative services

Diagnostic
radiology and
pathology services

1. NHI Overview

Service coverage

- Under NHI, the health services will not be based on a PMBs type of package.
 - This is because PMBs cover a limited number of health conditions, are essentially hospi-centric without fully addressing the burden of disease.
- To ensure equitable access to medicines and related pharmaceutical products, NHI will accredit and contract with private retail pharmacies based on need.
- Accredited and contracted retail pharmacies will be able to order drugs and other health products from the nationally agreed pharmaceutical contracts and will be required to dispense drugs that are procured at subsidised prices.
- The Uniform Patient Fee Schedule (UPFS) in the public sector will be abolished.
 - This will be done in the early stages of the transition to NHI in order to improve financial risk protection for the population.
 - No fees will be levied at public sector hospitals, except to non-citizens, third-party payers such as medical schemes, Road Accident Fund and Compensation for Occupational Injuries and Diseases.

1. NHI Overview

PHC Re-engineering

Municipal Ward-based Primary
Health Care Outreach Teams
(WBPHCOTs)

Integrated School Health
Programme

**PHC Re-
engineering
streams**

District Clinical Specialist
Teams

Contracting of private health
practitioners at non-specialist
level

New

1. NHI Overview

Cost Estimates for NHI

Health expenditure in SA public and private sectors, 2011/12 – 2017/18

Rand million	11/12	12/13	13/14	14/15	15/16	16/17	17/18	Annual Nominal Change
Public sector								
National Department of health care	1,772	1,926	2,243	3,955	4,610	4,585	4,842	18.20%
Provincial Departments of Health	111,324	122,492	130,690	140,889	150,869	159,540	169,350	7.20%
Defence	3,400	3,400	3,734	3,849	3,933	4,225	4,536	4.90%
Correctional services	519	584	628	692	734	759	825	8.00%
Local government (own revenue)	1,977	2,096	2,221	2,355	2,496	2,628	2,768	5.80%
Workmens Compensation	3,369	3,000	2,713	2,821	2,934	3,090	3,253	-0.6%
Road Accident Fund	785	1,138	1,204	1,279	1,352	1,424	1,499	11.40%
Education	4,929	5,274	5,561	5,875	6,133	6,458	6,781	5.50%
Total public sector health	128,075	139,971	148,994	161,715	173,062	182,710	193,854	7.20%
Private sector								
Medical schemes	107,383	117,528	129,789	139,134	148,456	158,105	167,591	7.70%
Out of pocket	18,202	19,294	20,452	20,452	21,679	22,980	24,198	5.80%
Medical insurance	3,120	3,392	3,687	4,007	4,356	4,587	4,830	7.60%
Employer private	1,491	1,621	1,762	1,915	2,081	2,192	2,308	7.60%
Total private sector health	130,196	141,835	155,689	166,735	177,873	189,082	200,210	7.40%
Donors or NGOs	5,308	5,574	5,852	6,145	6,097	5,876	5,642	1.00%
Total	263,579	287,379	310,536	334,595	357,033	377,668	399,706	7.20%
Total as % of GDP	8.60%	8.60%	8.60%	8.60%	8.50%	8.30%	8.10%	
Public as % of GDP	4.20%	4.20%	4.10%	4.20%	4.10%	4.00%	4.00%	
Public as % of total government expenditure (non-interest, main budget)	15.00%	15.20%	15.10%	15.20%	15.20%	15.20%	15.20%	
Private financing as % of total	49.40%	49.40%	50.10%	49.80%	49.80%	50.10%	50.10%	

1. NHI Overview

Cost Estimates for NHI

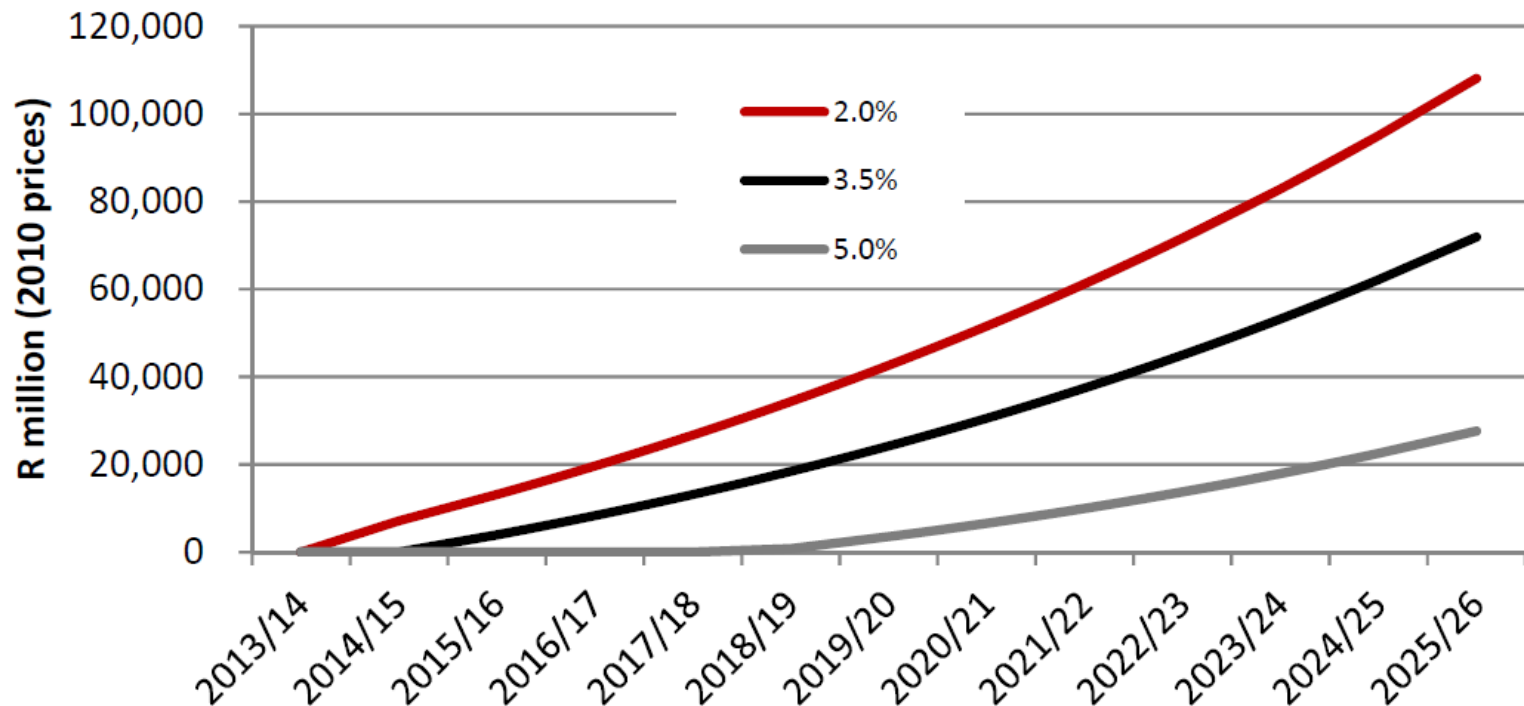
		Average annual per cent increase	Cost Projection R m (2010 prices)
Baseline public health budget:	2010/11		109 769
Projected NHI expenditure:	2015/16	4.10%	134 324
	2020/21	6.70%	185 370
	2025/26	6.70%	255 815
Funding shortfall in 2025/26 if baseline increases by:		2.00%	108 080
		3.50%	71 914
		5.00%	27 613

- Derived from a model of aggregate costs built on projected utilisation based on demographic trends.
- Based on more recent estimates of the costs of the NHI pilots and other reforms currently being implemented.

1. NHI Overview

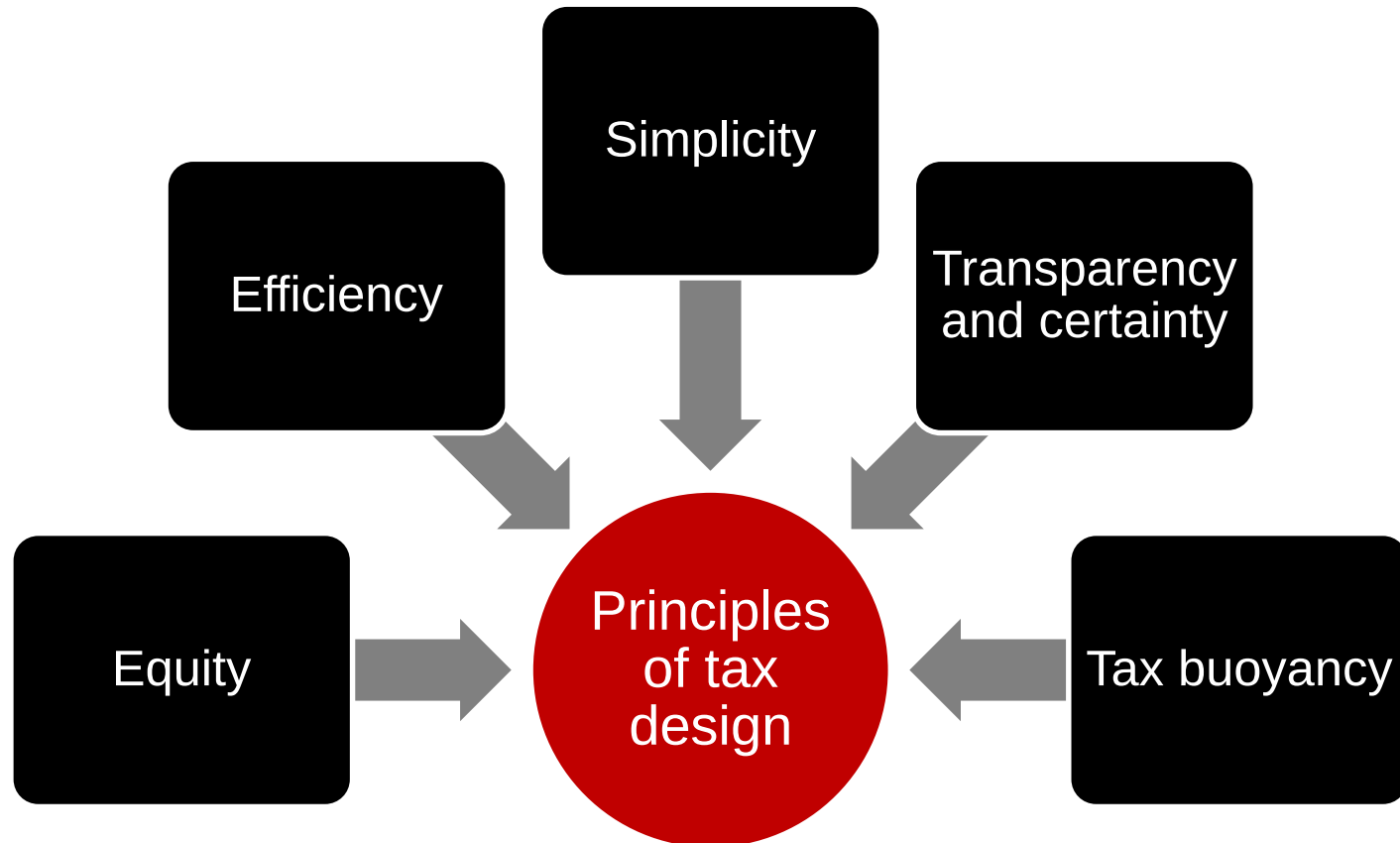
Cost Estimates for NHI

Funding shortfall under different growth paths



1. NHI Overview

Raising Revenue to Finance NHI: Raising Tax Revenue



1. NHI Overview

Raising Revenue to Finance NHI: Raising Tax Revenue

Potential revenue sources for NHI

Revenue Source	Definition	Examples
Direct Taxation	Taxes imposed on individuals or entities in relation to their income, earnings or wealth.	Personal or corporate income tax, surcharge on income, inheritance tax
Indirect Taxation	Taxes levied on transactions or goods and services, irrespective of circumstances of buyer or seller.	Value-added tax, national health insurance levy, financial transactions, fuel levy, taxes on alcohol and tobacco
Payroll Taxation	Taxes calculated on payroll, as either employer or employee contributions, or both.	Contribution to National Health Insurance deducted from pay check
Premiums	Collection of premiums or membership contributions from employee or informal sector.	Ghana NHI for informal sector workers

1. NHI Overview

Raising Revenue to Finance NHI: Other Sources of Revenue

- Additional revenue could potentially be mobilised from the current employer contributions (subsidies) to medical schemes
- Review tax credit for membership to medical schemes and for some medical expenses
- Alignment of funding allocated to compensation funds to avoid double dipping and fragmented funding.
- NHI coverage will also include medical benefits currently reimbursed through:
 - COIDA
 - ODMWA
 - UIF
 - RAF

1. NHI Overview

The future role of medical schemes

- Individuals will not be allowed opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund.
- Individuals and households will have the opportunity to purchase voluntary private medical scheme membership to complement this universal entitlement if they choose to.
- Role of medical schemes:
 - **During transition process:** supplementary role
 - **Once NHI is fully implemented:** some complementary cover
 - **In future:** only complementary cover
- The cover provided by medical schemes must only **complement** (and not duplicate) the NHI service benefits.
- When NHI is fully implemented, it is anticipated that the number of medical schemes will reduce from the current 83 to a much smaller number.

2. NHI White Paper Commentary Submitted to DoH

Main themes of Commentary submitted to DoH:

ASSA supports the principle of universal access.



ASSA fully agrees with a phased approach.



ASSA supports the revitalization of the public delivery system.



ASSA recommends that certainty is provided around the private sector regulation.



ASSA agrees with a phased costing approach in a fiscally responsible context.



ASSA recommends that impact on stakeholders be measured.



ASSA strongly recommends actuarial participation in the work streams.

2. NHI White Paper

Commentary Submitted to DoH

Universal
Access

A universal coverage system can be achieved in many different ways.

- It does not necessarily entail a single pool
- Can be achieved through a combination of methods to pool funds.

International research shows that efficiencies may be lost in a single payer structure.

- Consider operational efficiency
- Consider regional variations
- Consider continual improvement

NHI will take account of global lessons.

- Successful universal coverage has been achieved with different models involving varied functions
- Multiple sources of financing are features of healthcare systems around the world

Policy choices should be modelled robustly so that policy objectives can be evaluated based on evidence.

- Active testing and investigation of alternative policies must be performed
- Policy shortcomings and merits can be analysed with detailed quantitative analysis and sensitivity testing

2. NHI White Paper Commentary Submitted to DoH

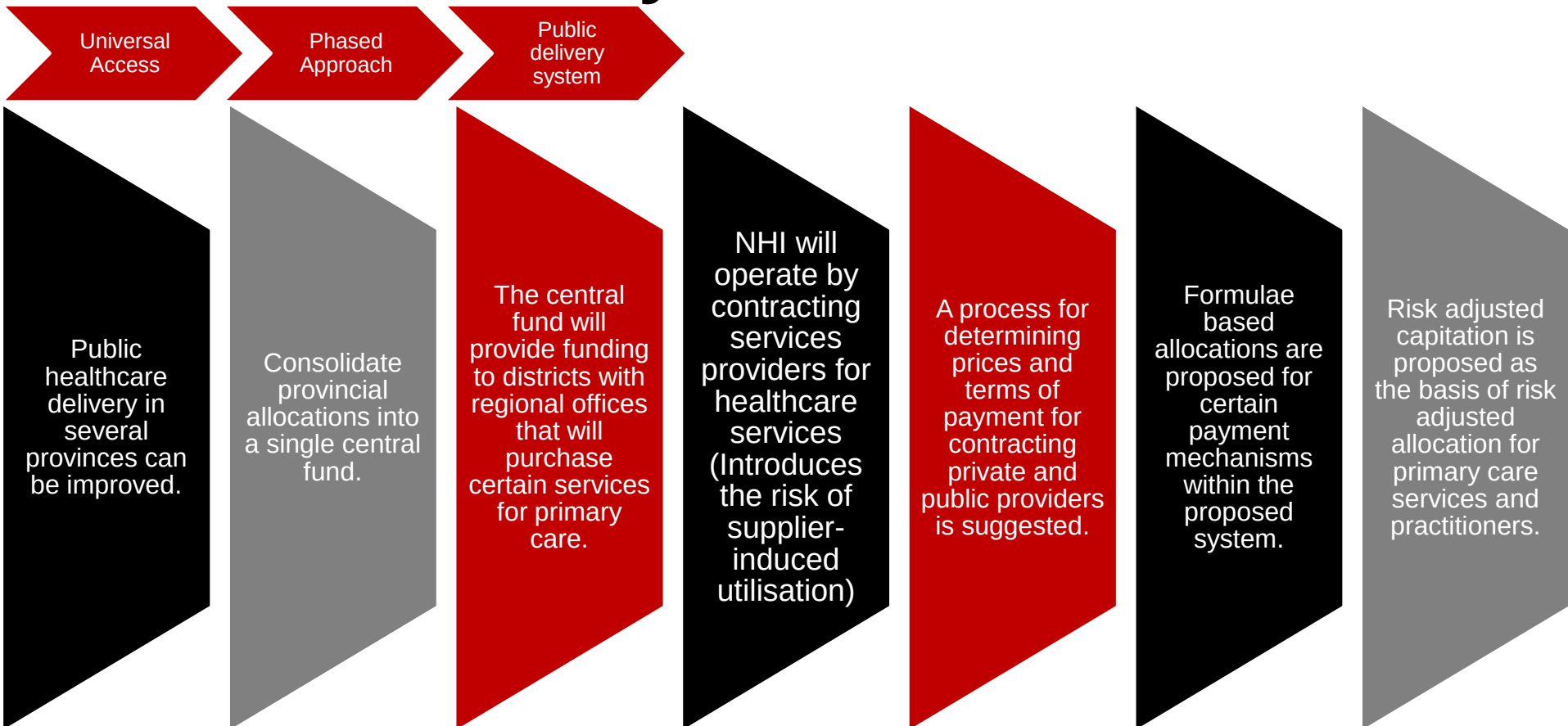
Universal
Access

Phased
Approach

- **The transition period requires:**
 - Access to prepaid health cover.
 - Improvements in efficiency in healthcare delivery.
 - Clarity regarding the role of medical schemes.
- **Order of implementation steps**
 - Ordering of steps in implementing reforms can have large impacts for different stakeholders.
 - Consider the financial impact of NHI on households, districts and provinces for each step.

2. NHI White Paper

Commentary Submitted to DoH



2. NHI White Paper

Commentary Submitted to DoH

Universal
Access

Phased
Approach

Public
delivery
system

Private Sector
Regulation

Functioning of medical schemes until the implementation of NHI should continue to be addressed.

Outcomes from the Competition Commission Healthcare Inquiry should be considered in the short-term.

There is an immediate need for clear rules that demarcate the market for healthcare insurance from medical schemes (and the future NHI).

Not well defined: The 'complementary' services and benefits that can be offered by medical schemes when the NHI is completely rolled out.

We recommend further modelling may be useful to understand the dynamics of various frameworks.

The necessary private sector reform should continue in the short-term:

- to stabilise the current environment
- to avoid potential harm in order to facilitate a better transition to a system of universal coverage.

2. NHI White Paper

Commentary Submitted to DoH

Universal
Access

Phased
Approach

Public
delivery
system

Private Sector
Regulation

Benefits
Coverage and
Costing

NHI Benefit Coverage

- NHI benefits will focus on primary care, but will also include curative care.
- White Paper defines NHI benefits as a range of services at different levels of care.
- There may be choices regarding the prioritisation of services, gatekeeping at different levels of care and how services will be rationed to lessen resource constraints as part of NHI benefits.

NHI Costing

- White Paper presented an estimate of the high-level expected cost of the NHI system.
- White Paper states that a single cost estimate of NHI should not drive the reform process.
- Policy choices should be evaluated based on alternative scenarios.

Sensitivity Testing

- White Paper shows sensitivities with regard to the pace of economic growth.
- Sensitivity of results to further variables can also be projected.
- The modelling process should be transparent to enable stakeholder to understand the effects of policies.

Methodology

- White Paper costing methodology uses utilisation levels, unit costs and population coverage by age and gender to produce aggregated costs for NHI.
- Assumptions regarding utilisation and expected cost levels under NHI should be detailed further.
- The costing can be expanded to include greater detail of the population covered, economic environment, benefits and delivery of benefits under NHI.

ASSA's Microsimulation model

- Projects healthcare costs, household impacts and healthcare resource requirements, amongst other outcomes in the design of NHI.
- Microsimulation divides the population into heterogeneous cells (defined by demographic, socio-economic and health conditions).

2. NHI White Paper Commentary Submitted to DoH

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Costing

Stakeholder
Impact
Measurement

Modelling should consist of measuring financial effects on different stakeholders directly affected, e.g.

- Individuals and households
- Organised labour
- Employers
- Taxpayers including those who pay income tax, VAT, fuel levy and customs and excise taxes
- Pooling organizations as in medical schemes.

There can be a range of relevant objectives that relate to different stakeholders. Objectives for evaluating different scenarios could include:

- Affordability of contributions for types of households
- Degree of cross subsidisation among socio-economic groups
- Degree of equity among socio-economic groups
- Degree of benefit coverage for different groups
- Fiscal affordability
- Budgetary efficiency for targeting of resources
- Impact on wages and employment

2. NHI White Paper

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Stakeholder
Impact
Measurement

Actuarial
Participation

ASSA has been working on an NHI costing model (initially developed in 2008)

- Can add value by assessing the risks associated with various scenarios in terms of benefits, remuneration structures, transition strategies and funding models.
- This is key to implementation in a fiscally responsible way.

ASSA members have extensive experience

- Design, development and management of health care funding vehicles
- Analysis of healthcare data
- Research on reform-related topics.

Concern: there is no actuarial involvement in the work streams.

- Actuarial involvement can add value to the objectives set out.
- Actuaries are very familiar with assessing impacts on various stakeholders often with conflicting interests (
- White Paper does not consider different stakeholders)

ASSA participation in the Work Streams:

- 2: Design and implementation of NHI Health Care Service Benefits
- 3: Prepare for the Purchaser-Provider Split and accreditation of providers
- 4: The role of medical schemes in an NHI environment.

3. NHI Costing Model Update

Summary: how the model works

- Population defined by:
 - demographics,
 - socio-economic variables and
 - medical scheme membership
- Population transitions over time with regard to demographic and socio-economic characteristics and household responses to purchase insurance
- Model performs costing of benefit packages for NHI and medical schemes, supply modelling, labour market impact model
- Costing based on medical scheme utilisation curves with assumptions to inform utilisation rates and unit costs, and option to retain budget allocations for some services
- User can input a set of policies (benefit packages, funding methods, supply of resources, role of schemes) and model simulates aggregated costs, insurance coverage, financing and supply side requirements

3. NHI Costing Model Update

Scenarios that the model can currently test

- Choices regarding benefits and their eligibility and global budget allocations
- Alternative funding sources - income-based mandatory contributions modelled in detail
- Role of medical schemes (no role, parallel and top up). Scenarios for medical scheme regulatory reform included
- Modelling of household responses purchase of insurance
- Transitional implementation by benefits, population group and location
- Supply of resources integrated into costing

3. NHI Costing Model Update

Further model development

- Refine model to directly address relevant policies in the White Paper
- Enhanced research for a number of assumptions and model components
- Draw on the best evidence for assumptions. Where no direct evidence is available, try to tie as much as possible to related evidence
- More detailed outputs, in particular at a household level
- Data and population point updates

3. NHI Costing Model Update

Updates in light of the White Paper

- Benefits will be comprehensive but not yet explicitly defined - allow for alternative benefits in model inputs
- Risk adjusted capitated primary care costing within districts
- Governance structure with regard to delivery in districts and provinces
- Possibility of universal subsidy allocated on risk adjusted basis from a central fund to multiple purchasers including provinces, districts, schemes

3. NHI Costing Model Update

Updates requiring more information

- Estimating the unit cost for delivering services under NHI
- May need to consider:
 - extent of economies of scale
 - price-setting where contracting occurs
 - payment methods
 - rationing of services (such as gatekeeping, extent of freedom of choice, waiting lists)
 - treatment settings
 - efficiency in delivering services
- International evidence, local evidence, data from pilot projects can potentially provide useful information
- Integrating this into the costing may involve combining information from a range of sources

3. NHI Costing Model Update

Enhanced research

- Research on predicting costs for non-medical scheme lives risk factors from existing population characteristics
- Projection of household private and public out of pocket expenditure
- Updated numbers of healthcare practitioners and facilities in private and public sectors
- Mapping healthcare professionals and facilities to benefits and geographies
- Updated projections of
 - GDP
 - growth in government revenues
 - CPI
 - wage inflation
 - healthcare inflation
 - sensitivity tests for these variables
- Research on the decision to purchase healthcare insurance
- Assumption for non-healthcare costs taking account of governance structure, purchasing methods and care management

3. NHI Costing Model Update

Updating data and population points

- Updated utilisation curves for benefit packages and for disciplines and facilities
- Shape and level of the utilisation curves adjusted for differences in public sector costs compared to medical schemes, such as:
 - Rationing in public sector, for example, lower caesarean section rates and neonatal ICU use
 - Benefit design restricting costs in medical scheme data
 - Anti-selection among high cost members
 - Population information and projection updated for new data and to include district, race, health status

NHI Task Team Feedback



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