PRESENTATION TO THE PUBLIC HEALTH ASSOCIATION OF SOUTH AFRICA (PHASA) CONFERENCE

NATIONAL HEALTH INSURANCE (NHI)

Wednesday, 12 September 2018

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NATIONAL HEALTH INSURANCE (NHI) BILL

Definition

- NHI is a health financing system that pools funds to provide access to quality health services for all South Africans based on their health needs and irrespective of their socio-economic status.

Appropriate Platform for NHI

- It will need a massive reorganisation of the current health system, both public and private.
WHAT PROBLEM IS NIH TRYING TO SOLVE?

The central question is: Can we change the health care system of the country in terms of:

- Quality
- Access
- Cost
- Efficiency and
- Effectiveness

By just improving the public health system?
Chapter 10: Promoting Health - Targets for 2030,
• Under Universal Health Coverage:
  – Everyone has access to an equal standard of care regardless of their income;
  – A **common fund** enables equitable access regardless of what people can afford to pay or how frequently they need to make use of health services
WHAT PROBLEM ARE WE SOLVING IN SOUTH AFRICA TO ACHIEVE UNIVERSAL HEALTH COVERAGE?

DEEPLY ENTRENCHED INEQUITIES

- The World Health Organisation recommends that countries should spend 5% of GDP on health.
- South Africa currently spends 8.7% of GDP on health (2018)
- The private sector spends 4.5% of GDP on health but only provides care to 16% of the population.
- The public sector spends 4.2% of GDP on health but only provides care to 84% of the population.

<table>
<thead>
<tr>
<th></th>
<th>2015 (Bn)</th>
<th>2018 (Bn)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>GEMS</td>
<td>17.8</td>
<td>20.5</td>
<td>15%</td>
</tr>
<tr>
<td>Civil Servants not on GEMS</td>
<td>1.8</td>
<td>2.2</td>
<td>22%</td>
</tr>
<tr>
<td>SOEs</td>
<td>7.2</td>
<td>8.3</td>
<td>15%</td>
</tr>
<tr>
<td><strong>TOTAL GOVT AS AN EMPLOYER</strong></td>
<td><strong>26.8</strong></td>
<td><strong>31.0</strong></td>
<td><strong>16%</strong></td>
</tr>
<tr>
<td>MEDICAL TAX CREDITS AND REBATES</td>
<td>20.0</td>
<td>26.0</td>
<td>30%</td>
</tr>
<tr>
<td><strong>TOTAL STATE SUBSIDY</strong></td>
<td><strong>46.8</strong></td>
<td><strong>57.0</strong></td>
<td><strong>22%</strong></td>
</tr>
</tbody>
</table>
Change in Private Sector Spending

- Private sector events adversely affect the public sector and hence it is not possible to separate the two and solve their problems individually.
HOW DOES SA COMPARE TO THE REST OF THE WORLD?

- This state of affairs as outlined above, led South Africa to be completely out of sync with the rest of the world, as proven following slide which is very alarming
South Africa is an outlier: world’s largest share of spending from VHI

Source: WHO estimates for 2012, countries with population >600,000
WHO/OECD view on South African private health expenditure

- The previous slide indicates why the WHO and the OECD have contended that South Africa is the only country in the whole world, where so much money is spent on the health of so few people. (presentation to the Health Market Inquiry)
HEALTH MARKET INQUIRY
(What did we know?)
The private hospital market in metropolitan areas (50%+ of medical scheme population) was concentrated by 1999.

Only 12.3% of private hospital beds were outside three main hospital groups by 2006...
Private hospital real cost trends (2009 prices)

Coincides with market concentration

Real per capita expenditure

...hospitals demonstrated a large growth in their return on investment...
Competition Commission Ruling (2005)

1. Price negotiation as price fixing
2. Health as market commodity
3. Patient supposed to negotiate directly with their doctors
4. Minister of Health supposed to be a neutral arbiter
NHI AND RESULTS OF HEALTH MARKET INQUIRY
- WHAT DO WE DO?
Consolidation of Financing Streams

Presently, according to STATSSA, this is how the SA population is divided in terms of income, employment and hence, indirectly medical scheme coverage.

In reorganising the population, cognisance will be taken of these various categories, i.e. when we implement NHI, we have to start with those who are not covered.

Interim Institutional Structure

- Civil servants and their dependants (incl. SoEs) - 5.5m
  - Government Employees
  - State Owned Enterprises
  - Public Entities

- Formal Sector Employed and their dependants (large business) - 12m

- Formal Sector Employed and their dependants (SMMEs) - 6m

- Informal sector and their dependants - 8m
  - Domestic Workers
  - Hawkers
  - Taxi industry
  - Casual labourers

- Individuals in households with no income or are not employed - 24m
  - The elderly with no income
  - Children
  - School kids (12m)
  - Unemployed
  - Unemployable

Only 8.8m of these people have access to health services via medical schemes.

The central philosophy of implementation of NHI is to bring into fold those people who are not insured (specifically those who are unable to afford medical scheme cover).
The NHI Bill

• This cannot be achieved without creating a single common fund, which in itself will directly contribute towards:
  – a unified health system by improving equity in financing,
  – reducing fragmentation in funding pools across both the public and private sectors, and
  – making health care delivery more affordable and accessible for the population

• The NHI Bill is a crucial step in creating the common Fund.
Features of the Bill (not exhaustive)

- **Beneficiaries Covered** (Section 7)
  - Mandatory Pre-payment (Section 3(4))
  - No co-payments, free at point of service (Section 9 (a))
  - Registration of users (Section 8)

- **Rights of users** (Section 9 (a))
  - Fighting Corruption (Section 6 (1) (L)(vi), Section 6(1)(L))
  - Strategic Purchasing (no more tenders for health services) (Section 35(1))
  - Public and Private Providers (Section 5(1)(d))

- **Purchaser-Provider Split** (Section 35(1))
  - Single Purchaser (Payer) (Section 3(3))
  - Comprehensive Health Service Benefits (Section 11 (1) & 11 (2))

- **Affordability** (Section 9)
Key Features of the Bill (contd.)

- Entry point to health care system – PHC (clinics, GPs and other PHC providers) (Section 11(2)(a))
- Referral Pathways Section 11 (2)(b)
- When are Services not covered Section 12 (2)
- Sources of Funding - Minister of Health and Finance to jointly determine (Section 46 (1), (2), (3))
- Procurement through Chief Procurement Officer (National Treasury)
- Method of Payment – capitation, DRGs, Global fees (Section 35 (2), (3), (5))
- Ministerial Committees (Section 25, 26, 27, 28)
- Appeals and Complaints (Section 40)
- Schedule of Amendments (Annexure)
Transitional Arrangements

- Described in section 54 of the bill.
- Specifies the structures, and process of implementation
- Phase 1 was from 2012 to 2017.
- Phase 2 will be for a period of five years from 2017 to 2022 and will—
  
  i. continue with the implementation health system strengthening initiatives, including the alignment of human resources with that which will be required under the Fund;
  
  ii. include the development of National Health Insurance legislation and amendments to other legislation;
  
  iii. include the undertaking of Initiatives which are aimed at establishing institutions that will be the foundation for a fully functional Fund; and
  
  iv. will include the interim purchasing of personal healthcare services for vulnerable groups such as children, women, people with mental health disorders, people with disability and the elderly.
Transitional Arrangements (contd)

Phase 3 will be for a period of four years from 2022 to 2026 and will include—

i. the continuation of Health systems strengthening activities on an ongoing basis;

ii. the mobilisation of additional resources as approved by Cabinet; and

iii. the selective contracting of healthcare services from private providers.
COMMONLY ASKED QUESTIONS, CONCERNS AND OUTRIGHT MYTHS
MYTH/CONCERN NUMBER 1

NHI IS GOING TO BE UNAFFORDABLE?
What is unaffordable is this

- Private sector events adversely affect the public sector and hence it is not possible to separate the two and solve their problems individually.
# POOLING OF FUNDS IS WHAT IS AFFORDABLE

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>PUBLIC SECTOR PRICE</th>
<th>PRIVATE SECTOR</th>
<th>SAVINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumo (pcv13)</td>
<td>R266</td>
<td>R794</td>
<td>R1,584,300,000</td>
</tr>
<tr>
<td>Rota virus vaccine</td>
<td>R105</td>
<td>R364</td>
<td>R544,152,000</td>
</tr>
<tr>
<td>Hpv</td>
<td>R139</td>
<td>R730</td>
<td>R532,017,000</td>
</tr>
<tr>
<td>Sub-dermal implant</td>
<td>R115</td>
<td>R2 394</td>
<td>R1,823,200,000</td>
</tr>
<tr>
<td>Bedaquiline</td>
<td>$400 (reduced from $750)</td>
<td></td>
<td>R36,000,000</td>
</tr>
<tr>
<td>Viral load tests</td>
<td>SA volumes used to reduce global prices from $15 per test to $9.40 (SA volumes are 5m tests per year giving us further negotiating power for even lower prices)</td>
<td>R4,483,669,000</td>
<td></td>
</tr>
<tr>
<td>Estimated Total Savings</td>
<td></td>
<td></td>
<td>R4,483,669,000</td>
</tr>
</tbody>
</table>
MYTH/CONCERN NUMBER 2

• People are going to be required to pay more under NHI, burdening the black middle class even more;

• The poor are going to suffer because the middle class is going to fight for space with them in the already congested public sector
PEOPLE ARE PAYING MORE AS IT IS NOW

• E.g, an average household that earns R20 000 a month currently contributes R3 800 per month towards their medical aid. This is 19% of the family’s income. At the current rate of medical aid increase, in 2030, that family will pay 28% of their disposable income;

• The scenario adopted is that NHI will be predominantly be funded through general tax revenue allocations, supplemented by –
  - a payroll tax payable by employers and employees (total 2%). This funding approach has been developed by the National Treasury with a maximum payroll tax of 4% that will be used to fund NHI. This is also much lower than what poor and rich households pay as their contributions to medical scheme premiums. Therefore, the impact on households currently contributing to medical schemes will be much more positive under NHIFund; and
  - a surcharge on individuals’ taxable income (2%) to support the social solidarity principle of NHI.
INITIAL STEPS IN THE IMPLEMENTATION OF NHI

- The 2017 budget speech refers to the establishment of the NHI Fund.
  - The service package financed by the NHI Fund will be progressively expanded. In setting up the Fund, we will look at various funding options, including possible adjustments to the tax credit on medical scheme contributions. Further details will be provided in the Adjustments Budget in October this year, and in the course of the legislative process.
- The manner in which the NHI will be implemented will be informed by, among others:
  - Our Primary Health Care Approach (PHC is the heartbeat of the health care system)
  - Lessons learnt during the NHI pilot phase
  - The White Paper on NHI (Priority will be given to the population that is in greatest need, including vulnerable groups, and must include those experiencing the greatest difficulty in obtaining care.)
  - Nelson Mandela’s Elders position paper on Universal Health Coverage (which prioritises women, children, adolescents)
INITIAL STEPS IN THE IMPLEMENTATION OF NHI (contd.)

• Within the uninsured population implementation will be prioritised in the following order:
  a) Learners (School Health)
  b) Maternal and woman’s health (ANC, contraceptives and Family Planning, as well as screening and treatment for breast and cervical cancer)
  c) Mental illness (Screening, referral and care)
  d) Elderly (cataract, hip, knee surgery and the provision of assistive devices such as wheelchairs, hearing aids, glasses)
  e) People with disabilities (provision of assistive devices such as wheelchairs, hearing aids, glasses)
## Scale Up Phases Total Cost for Implementation

<table>
<thead>
<tr>
<th>Programme</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother and Women - Normal + High risk pregnancy</td>
<td>1,007,622</td>
<td>1,012,660</td>
<td>1,017,723</td>
<td>1,022,812</td>
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<tr>
<td>Mother and Women - Screened for Cancer</td>
<td>3,278,435</td>
<td>7,953,044</td>
<td>10,710,088</td>
<td>19,075,119</td>
</tr>
<tr>
<td>Mother and Women - Cervical Cancer</td>
<td>6,007</td>
<td>7,056</td>
<td>7,591</td>
<td>8,005</td>
</tr>
<tr>
<td>Mother and Women - Breast Cancer</td>
<td>8,203</td>
<td>8,916</td>
<td>9,657</td>
<td>10,375</td>
</tr>
<tr>
<td>Paediatric Cancer</td>
<td>4,737</td>
<td>5,324</td>
<td>5,749</td>
<td>6,127</td>
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<tr>
<td>School health</td>
<td>1,174,594</td>
<td>2,103,680</td>
<td>4,118,882</td>
<td>5,293,476</td>
</tr>
<tr>
<td>Elderly - Cataract surgery</td>
<td>70,000</td>
<td>100,000</td>
<td>100,000</td>
<td>120,000</td>
</tr>
<tr>
<td>Elderly - Hip and Knee arthroplasty</td>
<td>4,450</td>
<td>4,472</td>
<td>4,495</td>
<td>4,517</td>
</tr>
<tr>
<td>Disabled + Rehabilitation</td>
<td>9,500</td>
<td>18,000</td>
<td>25,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Mental Health Users - Screening + Treatment + Care</td>
<td>500,000</td>
<td>750,000</td>
<td>1,000,000</td>
<td>1,200,000</td>
</tr>
<tr>
<td>Programme</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
<td>Year 4</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Mother and Women - Normal + High risk pregnancy</td>
<td>5,668,836,884</td>
<td>5,697,181,069</td>
<td>5,725,666,974</td>
<td>5,754,295,309</td>
</tr>
<tr>
<td>Mother and Women - Breast Cancer</td>
<td>4,845,749,509</td>
<td>5,854,455,429</td>
<td>6,888,155,297</td>
<td>7,017,520,185</td>
</tr>
<tr>
<td>Mother and Women - Cervical Cancer</td>
<td>987,576,714</td>
<td>1,211,375,324</td>
<td>1,334,205,349</td>
<td>1,423,655,945</td>
</tr>
<tr>
<td>School health</td>
<td>658,263,779</td>
<td>920,533,542</td>
<td>1,737,393,319</td>
<td>1,737,393,319</td>
</tr>
<tr>
<td>Elderly - Cataract surgery</td>
<td>318,182,400</td>
<td>198,864,000</td>
<td>198,864,000</td>
<td>218,864,000</td>
</tr>
<tr>
<td>Mental Health Users - Screening + Treatment + Care</td>
<td>801,893,939</td>
<td>1,202,840,909</td>
<td>1,603,787,879</td>
<td>1,924,545,455</td>
</tr>
<tr>
<td>Disability + Rehabilitation</td>
<td>42,000,000</td>
<td>105,000,000</td>
<td>262,500,000</td>
<td>655,250,000</td>
</tr>
<tr>
<td>Childhood cancer</td>
<td>778,728,434</td>
<td>875,288,568</td>
<td>945,215,203</td>
<td>1,007,250,431</td>
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<tr>
<td>Total cost</td>
<td>14,237,348,209</td>
<td>16,202,336,873</td>
<td>18,833,269,037</td>
<td>19,877,943,066</td>
</tr>
</tbody>
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