Medscheme

HEALTHIER TOGETHER

PERSPECTIVES ON NHI

25TH JANUARY 2022

AGENDA

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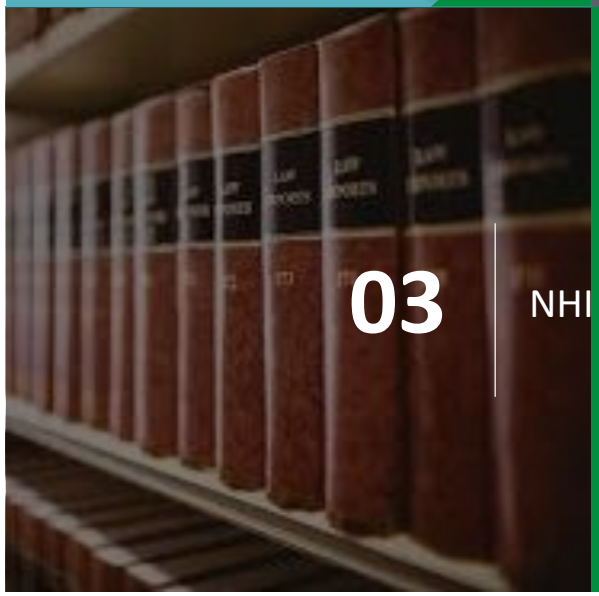
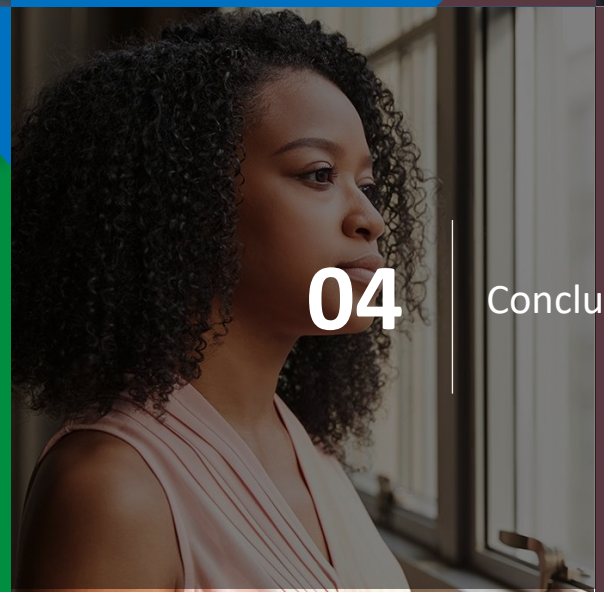
01 About us as Medscheme

02 Universal care



03 NHI Bill views



04 Conclusion

OUR TEAM

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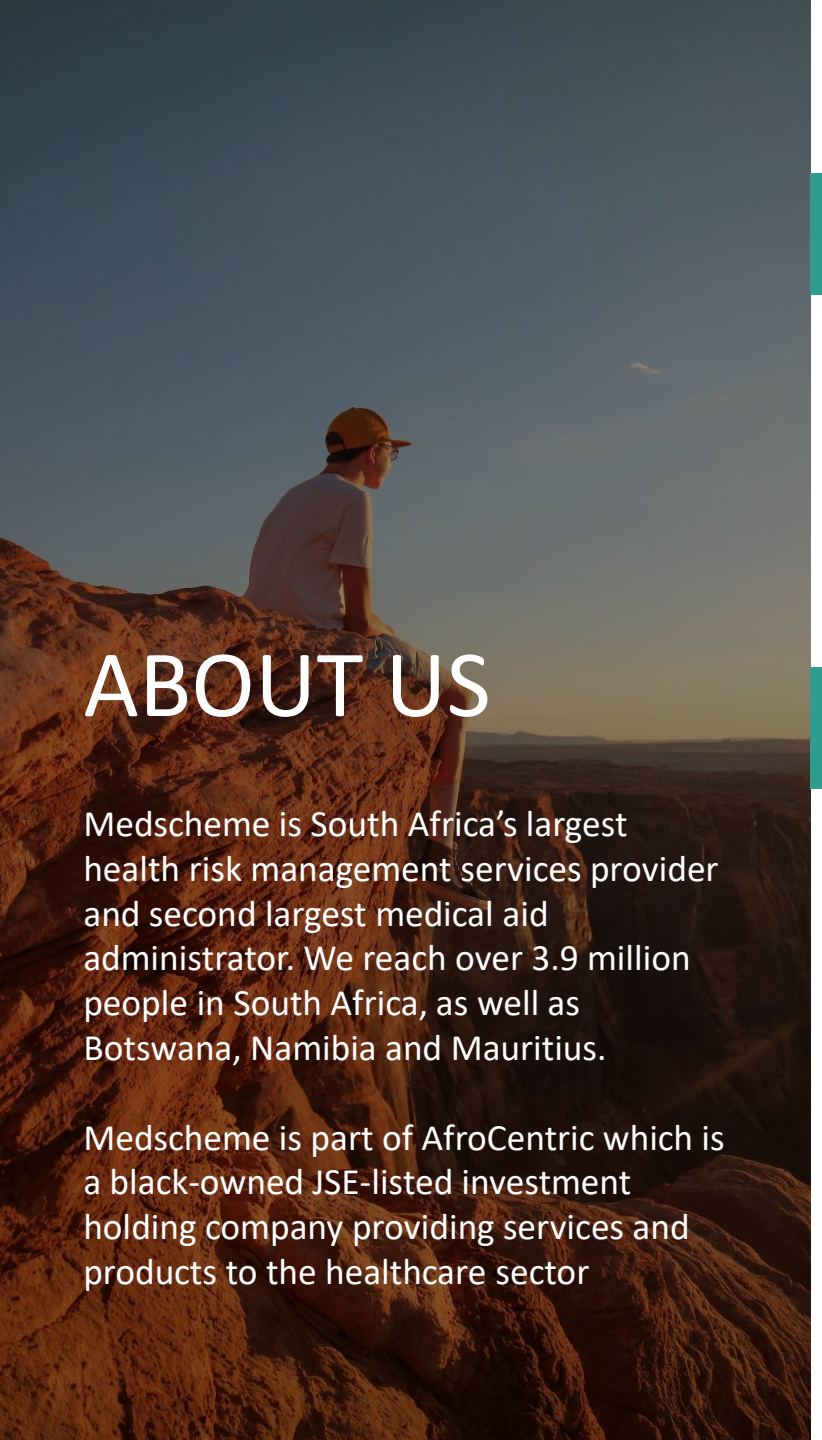
Managing Executive: Clinical Risk & Advisory

Dr. Mike Marshall

Executive Manager: Research and Product Development

Dr. Samukeliso Dube

Group Functional Professional Specialist: Health Policy Unit



ABOUT US

Medscheme is South Africa's largest health risk management services provider and second largest medical aid administrator. We reach over 3.9 million people in South Africa, as well as Botswana, Namibia and Mauritius.

Medscheme is part of AfroCentric which is a black-owned JSE-listed investment holding company providing services and products to the healthcare sector

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PROVEN TRACK RECORD

Over 48 years experience	Driving to affordable healthcare	Partnership with healthcare providers
Built on data informed decisions	Service Excellence	Managing members back to health

OUR CLIENTS

Bonitas
gems Government Employees Medical Scheme
POLMED
Barloworld Medical Scheme
FEDHEALTH
AECI MEDICAL AID SOCIETY
PARMED MEDICAL AID SCHEME
hosmed medical scheme care for life
horizon medicalscheme
SABC On your Pulse Medical Scheme
MEDSHIELD your kind of care
MBMED
SAMWUMED Real Heritage. Real People. Real Health Care.

CREATING VALUE THROUGH PURPOSE

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OUR PURPOSE
Enhancing quality of life

OUR VISION
Transforming healthcare

OUR MISSION
To innovate a new integrated model of sustainable healthcare that measurably improves access to quality healthcare

HEALTH SECTOR COLLABORATION FOR THE GREATER GOOD OF SOCIETY

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Supporting members

Providing access to credible information through multiple interventions for ongoing support

- Creation of a COVID-19 Resource Hub
- Direct advice to infected members
- Dedicated COVID-19 call center

Protecting members

Targeted engagement to mitigate infection risk and nudge members to be vaccinated

- COVID screening at corporate
- Invitations sent to members to visit our vaccination sites
- 6 AfroCentric vaccination sites
- More than 150k jabs administered by AfroCentric

Supporting providers

Collaboration with healthcare practitioners to facilitate access to care through new mediums and funding models

- PPE provision and lower tariffs negotiated
- Setting up of telemedicine and virtual consultations
- Laboratory negotiations in terms of COVID-19 test prices

Supporting society

Engaging industry players to play a bigger role within society and a key player

- Collaboration with public and private sector for greater good of society
- Creation of additional vaccination sites for members and non-members (walk-ins) to improve access (100 affiliated sites)
- Collaboration with CMS in terms of PMB legislation

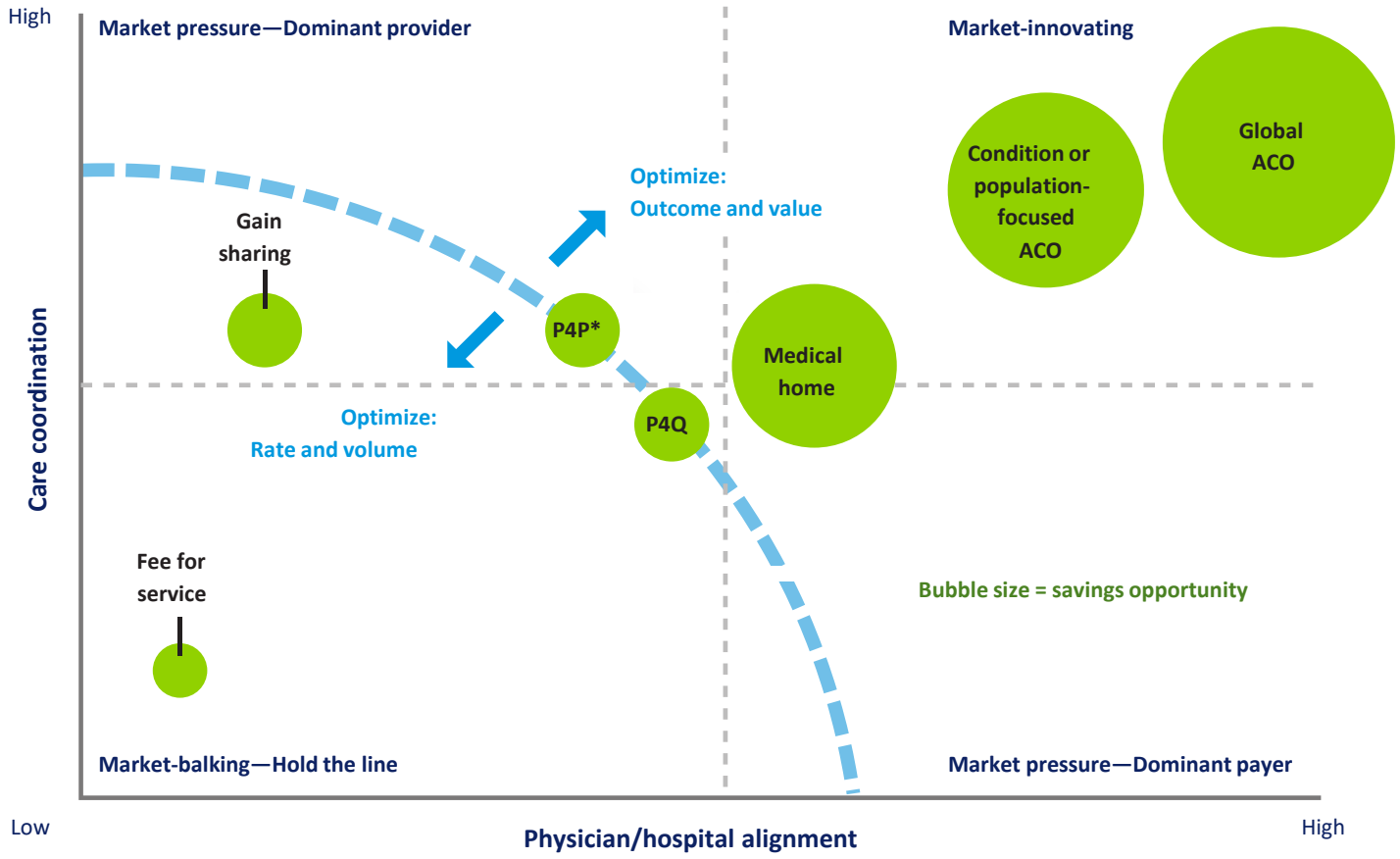
AN INFORMED TRANSITION – AREAS OF EMPHASIS

1. ALTERNATIVE REIMBURSEMENT MODELS

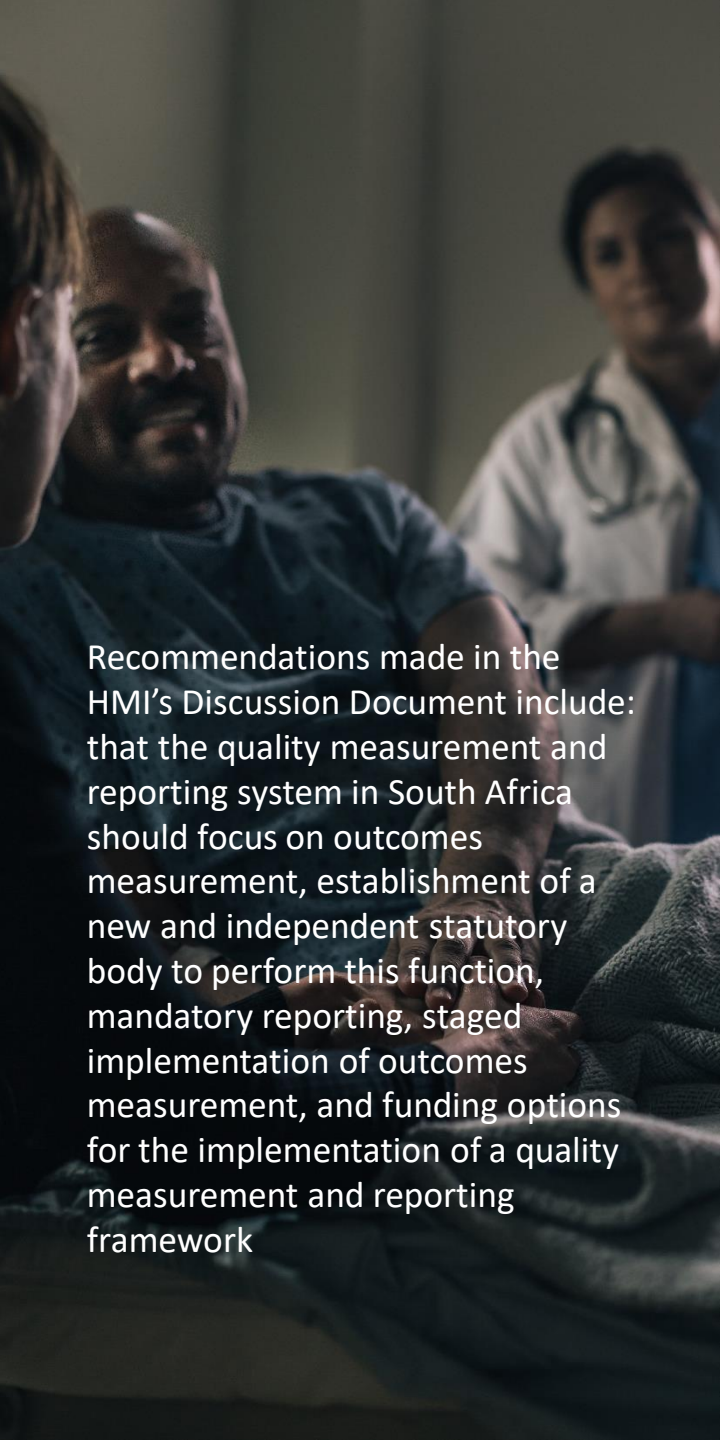
HEALTH MARKET INQUIRY HIGHLIGHTS

The South African healthcare market has generally been exhibiting a trend towards a greater acceptance and implementation of ARMs though the efficacy thereof has been questioned, as discussed further in the chapter that assesses facilities.

Both funders and practitioners have indicated their willingness to adopt new reimbursement models, however there have been legal restrictions to doing so given the HPCSA's interpretation of the ethical rules on sharing of fees (ethical rule 7), business models (ethical rule 8) and subcontracting (ethical rule 18).



* Includes payment for episode of care.



Recommendations made in the HMI's Discussion Document include: that the quality measurement and reporting system in South Africa should focus on outcomes measurement, establishment of a new and independent statutory body to perform this function, mandatory reporting, staged implementation of outcomes measurement, and funding options for the implementation of a quality measurement and reporting framework

AN INFORMED TRANSITION – AREAS OF EMPHASIS

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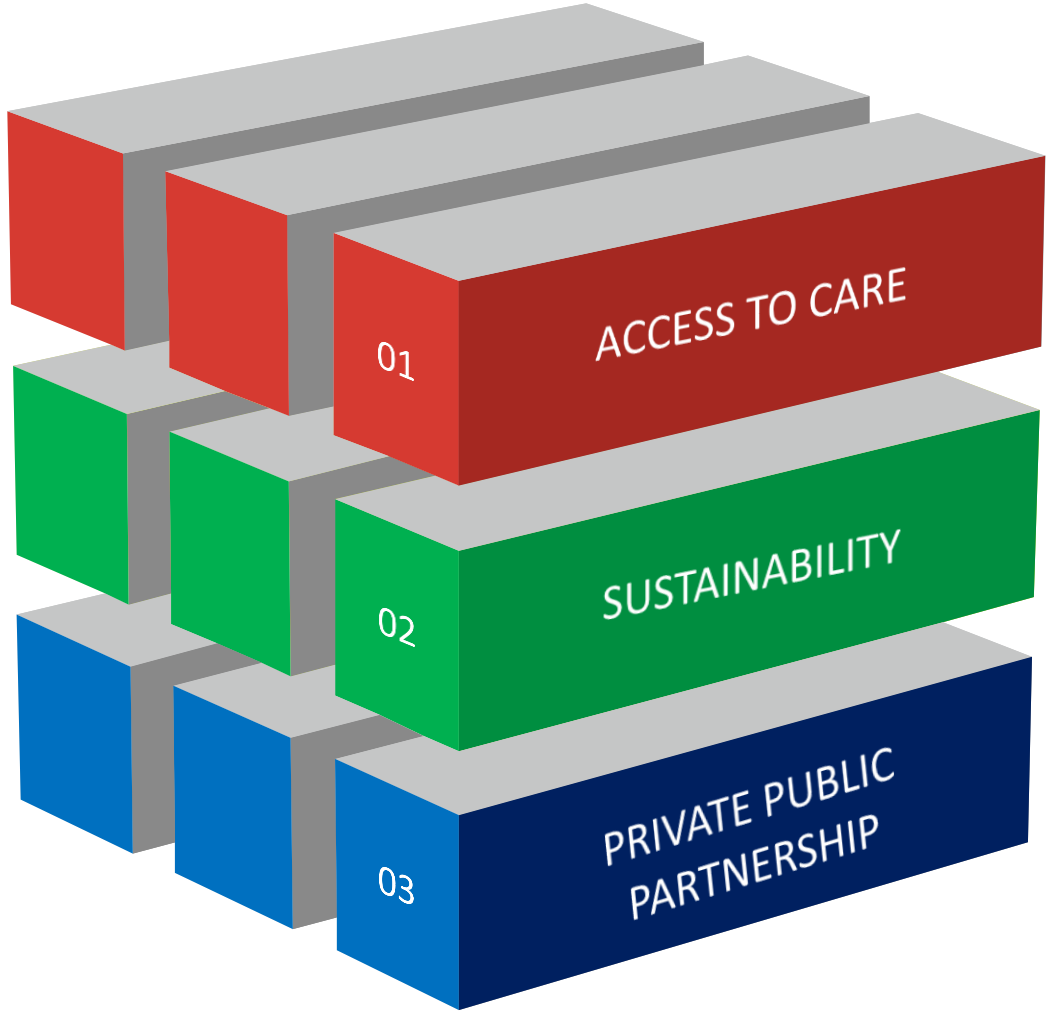
2. QUALITY AND OUTCOMES MEASUREMENT REPORTING SYSTEM

IDEAL QUALITIES OF A PERFORMANCE MEASURE

Acceptability	Feasibility	Reliability	Sensitivity to change	Predictive value
Acceptable to both those being assessed and those undertaking the assessment	Valid and reliable consistent data are available and collectable	Minimal measurement error, reproducible findings when administered by different raters	Has capacity to detect changes in quality of care	Has capacity to predict quality of care outcomes

OUR COMMITMENT TO UHC



Recognise that SA has a fragmented health system, and that we must all strive to make the health system more affordable, accessible and of a higher level of quality for all

Unequivocally support the need to move towards UHC in South Africa

- Phased implementation of NHI is critical
- Need an inclusive process to create an integrated and sustainable health system that offers quality, affordable, accessible health care to all

We are willing to work with government to make meaningful progress in the UHC journey

COMMENTS ON THE NHI BILL - B11 - 2019

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1. Singularity of the NHI Fund
2. Role of Provinces
3. Role of the private sector
4. Funding sources
5. Applicability of Bill and Complaints and appeals processes
6. Board and related governance issues
7. Duplication of functions (DHMO vs. CuPHC vs. Fund)

SINGULARITY OF THE NHI FUND

NHI Fund is intended to be the sole purchaser & payer of health care services

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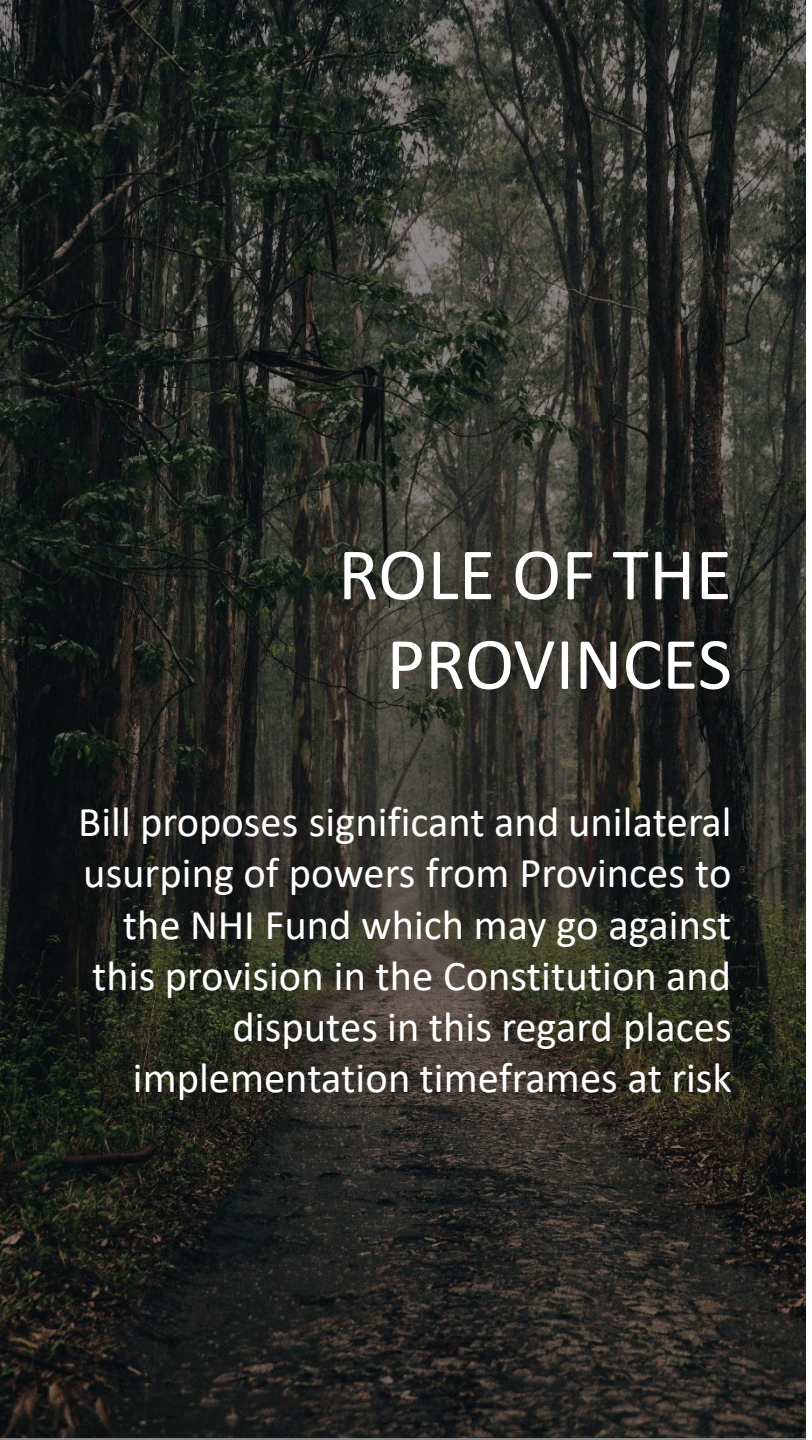
“Single” implies “the only one” or “not one of several”

- Implies no other entity can duplicate the functions of purchasing and paying for health care services – either in a complementary or duplicative form.
- By their nature and as per the provisions of the Medical Schemes Act, schemes are purchasers and payers for health care services on behalf of their members.
- Even in the revised definition of a business of a medical scheme that is in the amendment schedule in s.58 medical schemes will remain purchasers and payers of health care services, albeit within a complementary cover environment.

Recommendations

- Amend the definition to exclude the term “single”
- ensures that even in a duplicative cover environment, whether transitional in nature or not, medical schemes will also be able to act as purchasers and payers for health care services on behalf of their beneficiaries without conflicting with the provisions of the NHI Bill and the Fund’s duties, functions and deliverables



ROLE OF THE PROVINCES

Bill proposes significant and unilateral usurping of powers from Provinces to the NHI Fund which may go against this provision in the Constitution and disputes in this regard places implementation timeframes at risk

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Comments

- Bill goes to length in outlining the functions, duties and responsibilities of the NHI Fund, the DHMOs and CuPHC, albeit with some duplication, there is very elucidation of exact functions, roles and responsibilities that will be placed upon the PDOHs.
- Seems to ignore Chapter 3 s.41 of the Constitution which states that all spheres of government and all organs of state within each sphere must “(g) exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere”.

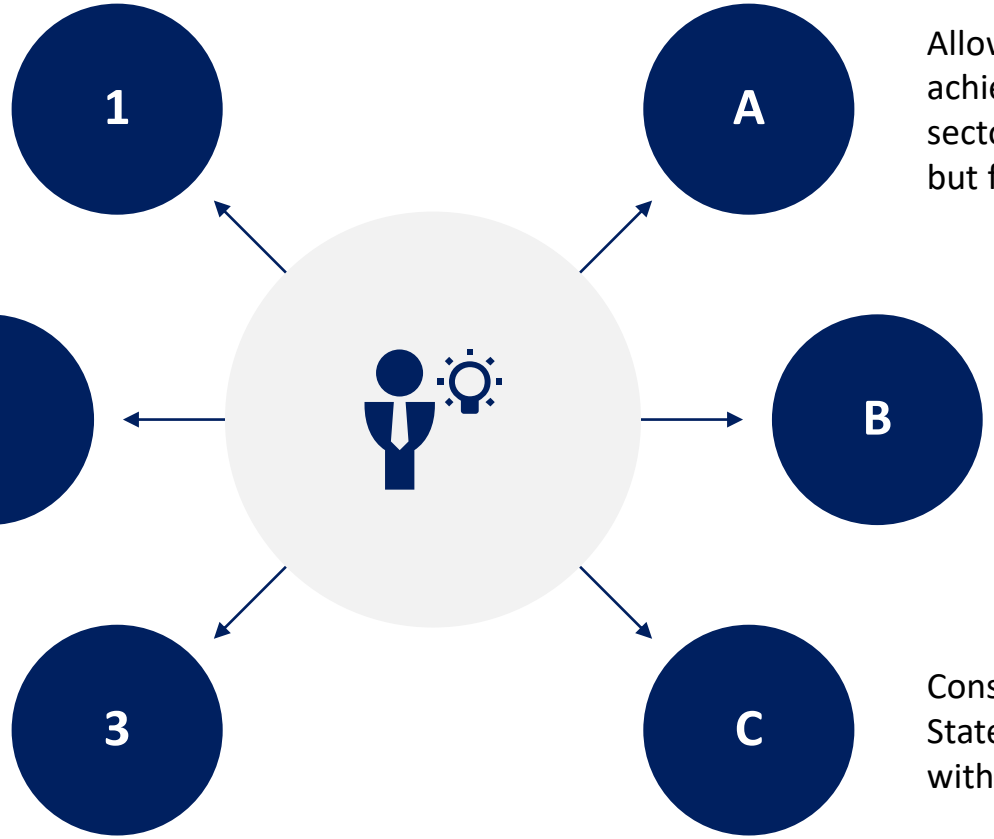
Recommendations

- Institutional, organizational and operational reforms provided for in the Bill must not go against spirit of the Constitutional provisions with regards to a functional and effective fiscal federal system.
- Must be resolved by including a separate section in the Bill that clearly outlines the functions of PDOHs

ROLE FOR THE PRIVATE SECTOR

Comments

1. s.33 categorically states that medical schemes will eventually play a complementary role in a mature NHI environment
2. s.8 (2) contradicts s.33 as it allows duplicative cover for (i) not following the referral pathway or (ii) receiving medically unnecessary care
3. Private VHI can be a major catalyst for achieving UHC



Recommendations

A. Allow for a more inclusive path to achieving UHC with greater private sector involvement – not just providers but funders and administrators

B. Take HMI findings into consideration e.g. SBBP can be used as an entry level package for all.

C. Consider the Netherlands example – State regulates and exercises oversight with involvement of private insurers

ROLE OF OTHER STATE ENTITIES IN PURCHASING HEALTHCARE SERVICES

The Bill does not outline the role and functions, or what changes therein, will be performed by other State entities who by their nature and enabling statutes are involved in purchasing and paying for healthcare services.

Comments	Recommendations
Compensation Fund (as provided for under the Compensation for Occupational Injuries and Diseases Act, 1993), and the Road Accident Fund (as provided for under the Road Accident Fund Act, 1996).	Bill should include a chapter or section that addresses this issue, not merely the amendments outlined in Section 58
Very little detail is provided for in the Bill with regards to their role in the transitional phase and post the creation of the NHI Fund	Outline a clearer delineation of functions and responsibilities between the Fund and these entities

APPLICABILITY OF THE BILL AND COMPLAINTS AND APPEALS PROCESSES

Comments

s.3 (5) states "The Competition Act, 1998 (Act No. 89 of 1998), is not applicable to any transactions concluded in terms of this Act."

- s.3 (3) it is stated that if any conflict arises between the provisions of the Bill and those of any other law, except the Constitution and the PFMA, the provisions of the NHI Bill will prevail. Why would exemption from the PFMA be required?

Bill does not recognise Consumer Protection Act

- However, given the process that is outlined in the Complaints and Appeals section,
- Strong relevance and applicability of the CPA to the provisions of the Bill

Recommendations

- Objectives of CPA relevant to the complaints and appeals processes in NHI Bill.
- Therefore, there must be greater clarity on the interplay between the provisions of the Bill and those of the CPA.
- Consider not making the Fund exempt from competition laws

BOARD & RELATED GOVERNANCE ISSUES

PHC is defined to include multidisciplinary teams

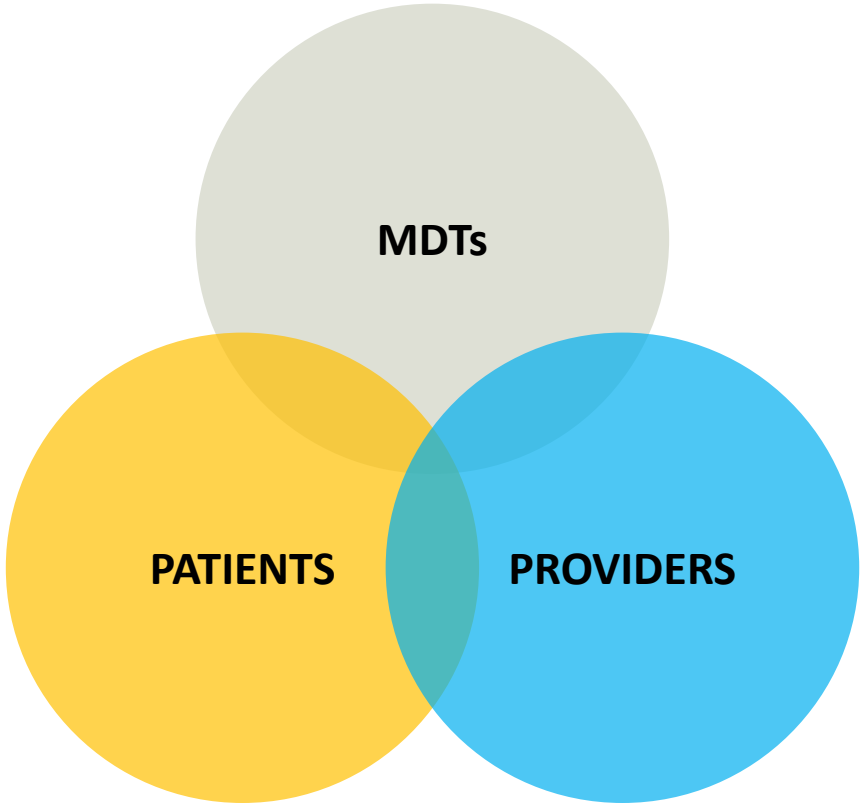
Bill does not define MDTs thus unclear whether the said practices should consist of all the named types of healthcare professionals (virtual or physical or both?)

s.5 (5) provides for documentary evidence to be used for registration purposes

Sub-sections (a) and (b) seem to imply that users will be expected to provide both an identify card and an original birth certificate prior to registration.

s.39 (5) provides for provider accreditation and the HPRS

Bill does not clearly outline how the required biometric information systems will be made available at accredited and contracted provider facilities, and how these will be paid for, managed and maintained



Recommendations

Provide definition of MDTs – can use the definition provided by HMI panel

Clarify documentary evidence to be utilized for registration (“or” rather than “and”)

Clarify principles on how the biometric system will be rolled out and maintained for all providers, not just public facilities

DUPLICATION OF FUNCTIONS (DHMO VS. CUPHC VS. FUND)

A

Roles of the DHMO & CuPHC re NHI Fund is unclear – this is particularly so when one considers the planned amendments to the National Health Act 2003 as outlined in the Bill

- Flow of funds from NHI Fund to DHMOs and/or CuPHCs unclear
- Governance and accountability framework not outlined clearly

B

Creation of the two does not minimise associated duplication and administrative costs

- Implies that there will be an estimated 252 CuPHC's across the country

C

Duplicated investigating powers in NHI Fund e.g. Investigating Unit s.20 (2) (e) vs. Risk & Fraud Prevention Unit s.20 (3)(i)

D

OHPP functions vs. NHI Fund and its units and others e.g. SAHPRA, OHSC

- Is the OHPP a new structure altogether or falls under NHI Fund's proposed units? If yes, why is it not provided for in s.20 (3)?

Recommendations

- Streamline structures to minimize duplication and administrative costs
- Integrate functions of DHMOs with CuPHCs to better utilize resources
- Improve governance and accountability of newly proposed structures by linking to PDOHs based on envisaged purchaser-provider split

CONCLUSION

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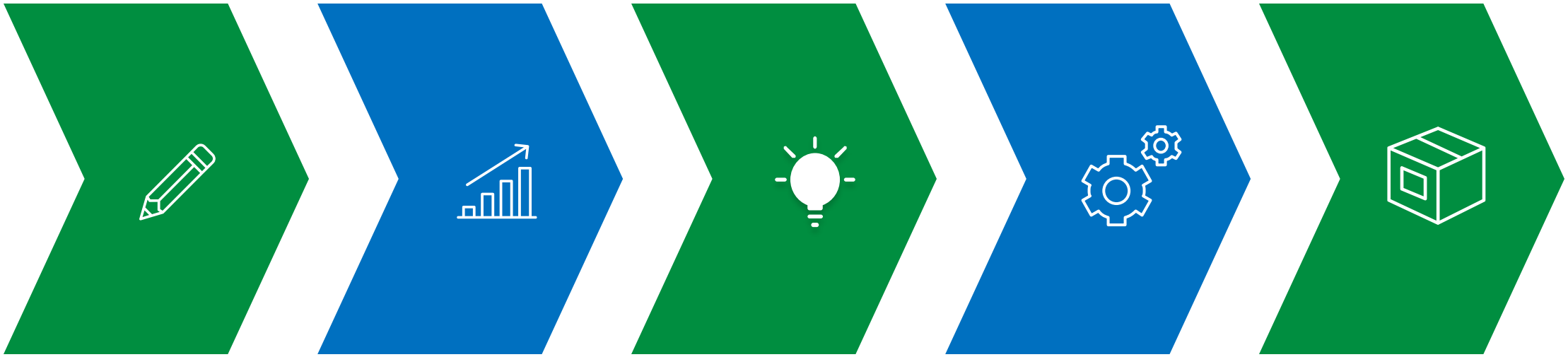

Contracting model

Use Public-Private-Partnership to leverage the experience of the private sector and drive

Scalability

Scalability of the solutions supported by robust operations, systems and processes

Reliability

The proven track record of the private sector will allow the use of best practice through experience

Technology

Technology is the ‘magic link’ between all stakeholders, and to additionally drive and showcase value

Integrated products

Integrated solutions will allow for the maximum benefit per rand through, administration, wellness and health risk management


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TOGETHER
THANK YOU