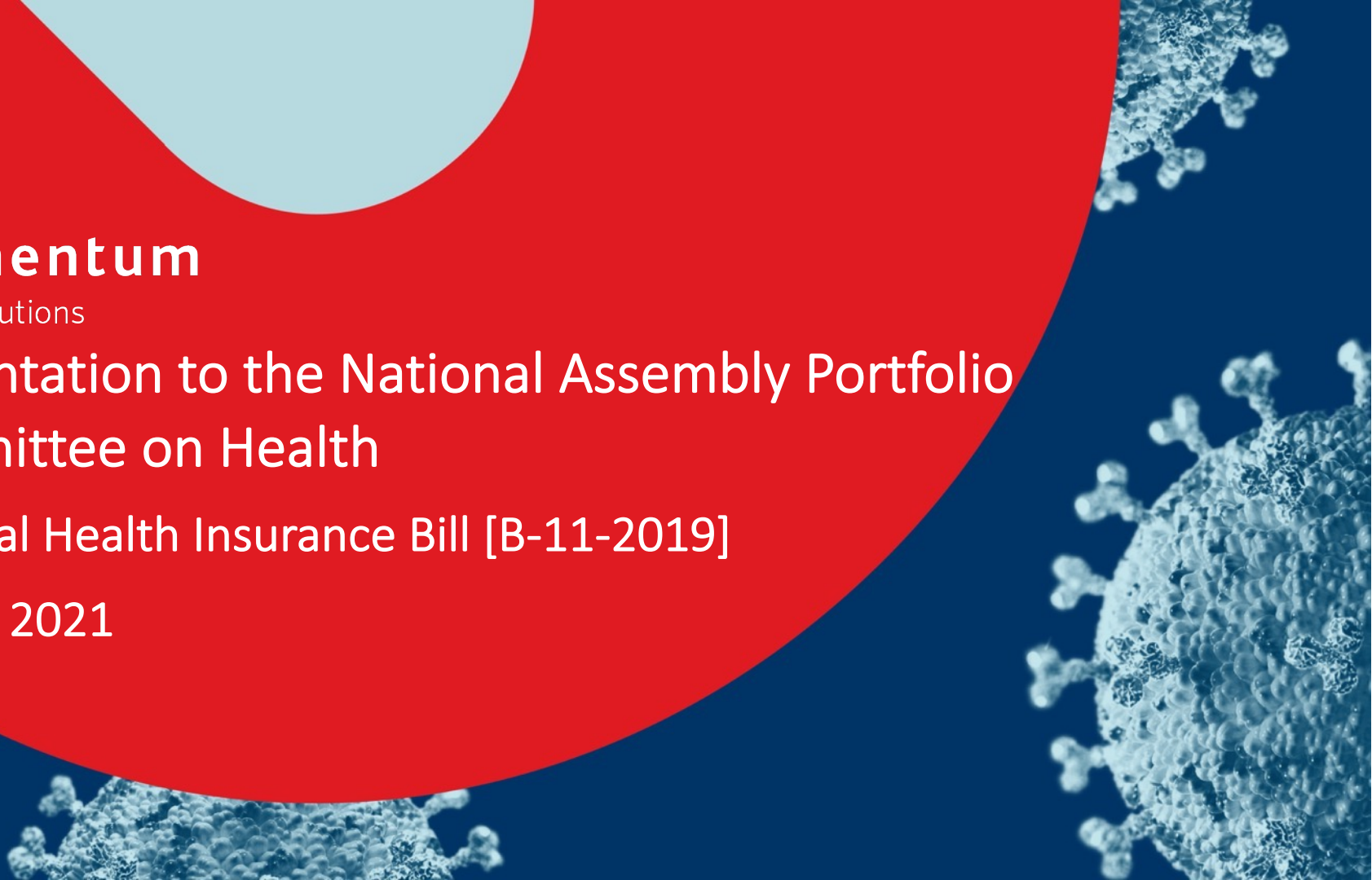
momentum
health solutions

Presentation to the National Assembly Portfolio Committee on Health

National Health Insurance Bill [B-11-2019]

14 July 2021



Introduction of Delegation
Mr. Mike Neubert
(Strategy and Corporate Schemes)

We are passionate about Universal Health Coverage; it is a non-negotiable and must be achieved

- Dr Ali Hamdulay (CEO: Metropolitan Health)
  - Introduction
  - Central Challenges to our health system
- Dr Boshoff Steenekamp (Health Strategist)
  - Areas of the Bill to be strengthened

    Sections 6, 8 and 33

    Some misconceptions about private sector funding

    Milestones to guide the progressive NHI implementation

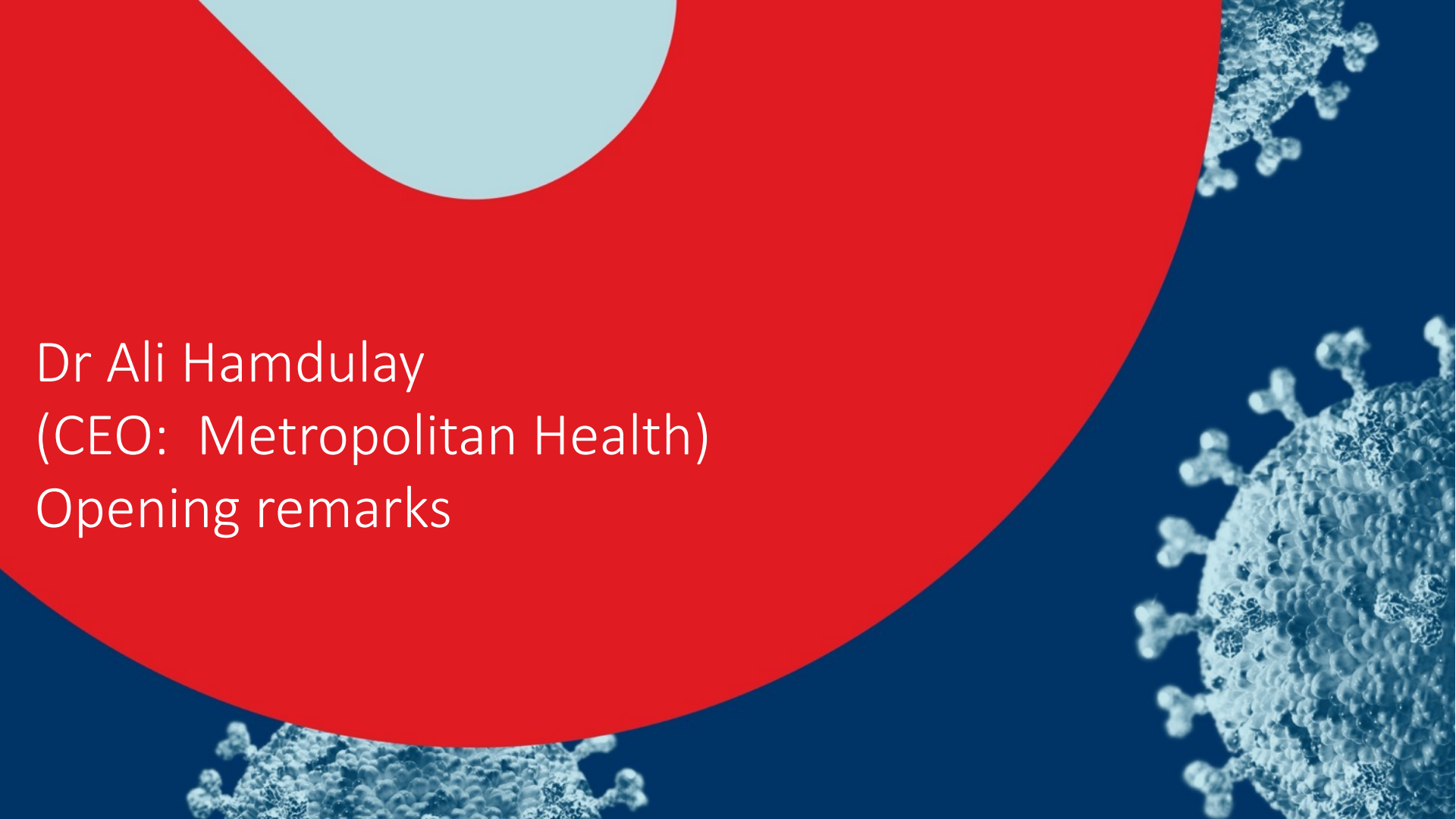
    Governance

    Institutions versus committees

    Creating a purchaser provider split

    Funding for NHI
- Mr. Nomo Khumalo (CEO: Health Solutions)
  - Concluding remarks

Dr Ali Hamdulay
(CEO: Metropolitan Health)
Opening remarks



Introduction

- Momentum Health Solutions is passionate about the achievement of Universal Health Coverage (UHC) and welcomes the NHI Bill
- We are convinced that continued and constructive engagement will result in unique solutions to ensure the progressive realistion of rights as contemplated in Section 27 of the constitution
- Momentum Health Solutions provides medical scheme solutions, medical insurance solutions and medical service solutions to more than 2.6 million people
- We are passionate about getting more health for less. The current trajectory of increased costs and poor health outcomes is not sustainable. We must get more health for less effort. This is a global challenge, many countries are making their best efforts to improve coverage
- We support the steps taken towards Universal Health Coverage and the development of an enabling legislative framework
- We comment on areas to be strengthened within the Bill as a collaborative effort to improve the health system
- This Bill represents the largest social change and health reform since 1994, it therefore requires special care to ensure that it realises the desired outcome

Central challenges to our health system

- Central problems that must be overcome for us to achieve Universal Health Coverage:
  - Cost
  - Affordability
  - Access
  - Quality
  - Equity
- Government initiatives to address these challenges have been concluded but their recommendations have not found their way into the NHI Bill (The National Development Plan, the Health Market Inquiry, the Fraud Waste and Abuse Steering committee)
- Unless these fundamental challenges are addressed in the Bill it is unlikely that we will achieve Universal Health Coverage
- Sustainable and meaningful improvements to our system can only be achieved if these fundamentals are addressed
- It is against this background that we have made submissions on the NHI policy papers to the Department of Health, the Health Market Inquiry, the Fraud waste and abuse initiative, the Davis Tax committee and the Financial and Fiscal Commission

Our clients

momentum medical scheme

moto HEALTH CARE taking care of our own

gems

sasolmed

transmed MEDICAL FUND

WOOLTRU HEALTHCARE

Imperial MOTUS MED

GOLDEN ARROW EMPLOYEES' MEDICAL BENEFIT FUND

FISHING INDUSTRY MEDICAL SCHEME

THEBEMED MEDICAL AID SCHEME

Medimed

medical aid society

bp

PG GROUP MEDICAL SCHEME

suremed

Category	Lives
Open Medical Schemes	349 979
Restricted Medical Schemes	2 109 820
Mining Health Services	80 848
Health Insurance	114 325
Total lives covered	2 654 972

Pick n Pay Medical scheme

RUMed

SISONKE HEALTH MEDICAL SCHEME

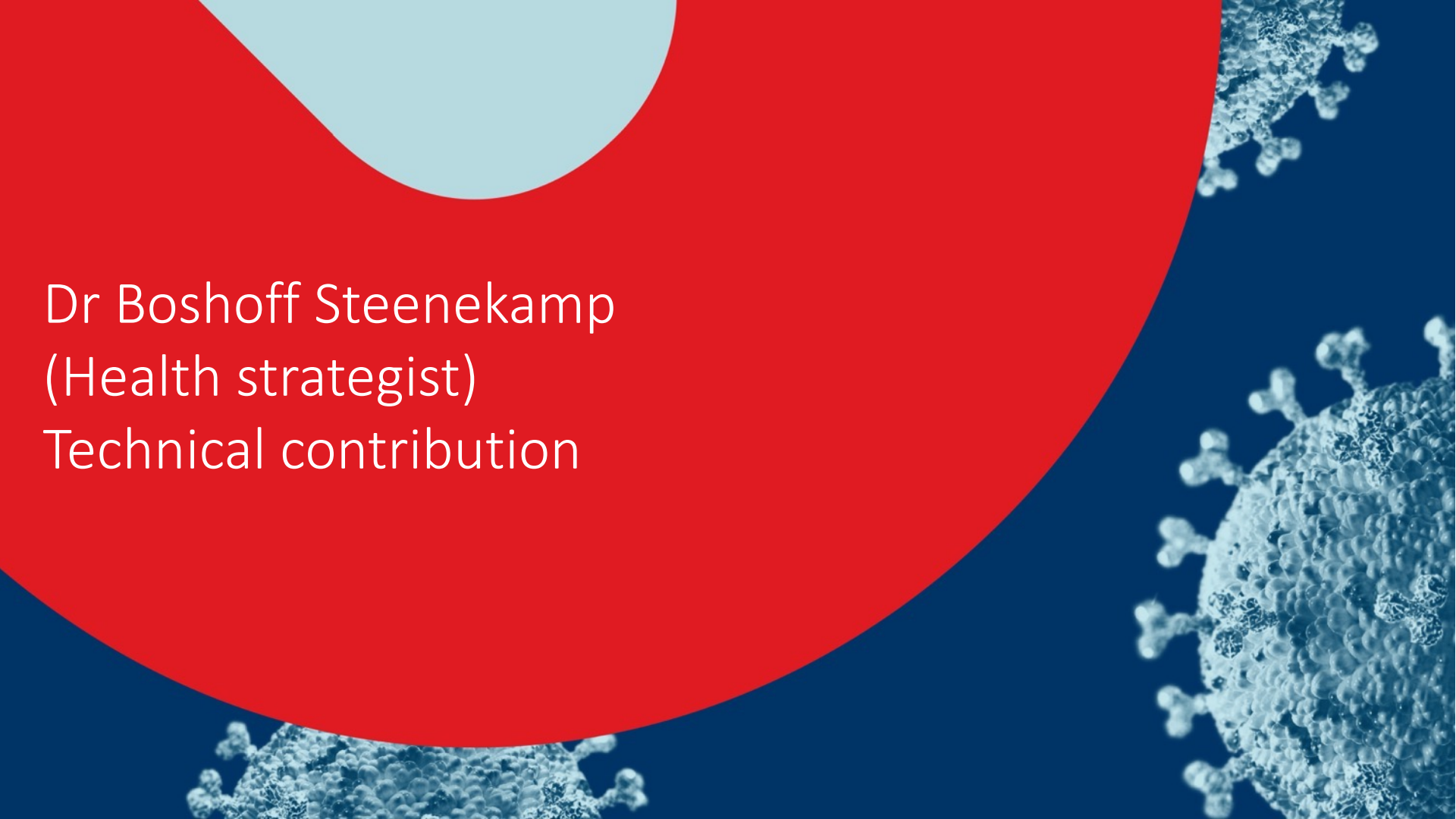
Wellness Clients:

- Transnet
- SASSA
- Department of Health EC
- Lewis Group Ltd
- Parliament of the Republic of SA
- SADTU
- Zone Fitness
- Coca-Cola
- PEP
- Barloworld
- Lucky Star
- SAFCOL
- DHL
- ISUZU
- Bidvest
- WC Government
- SAMWUMED
- Rand Water

Universal Health Coverage must be achieved

- The NHI Bill provides an **opportunity to harness all South African capabilities** for an all-inclusive effort to achieve UHC
- Evolving roles of public health services, medical schemes, health administrators and private service providers are required to contribute to the **administration, financing, purchasing and provision** of a **universally assured, equitable package of health benefits for all**
- Relying on the **tax base** to provide the full range of demands on the health system is **not adequate.** Countries at similar levels of development need significant levels of private funding to augment public funds
- **Phasing in of NHI provides an opportunity** for the public and private sectors to address these challenges jointly and systematically

Dr Boshoff Steenekamp
(Health strategist)
Technical contribution



Areas of the Bill that must be strengthened

Section 33 limits the right of access to healthcare funding

- **Section 33** in the Bill **removes the right to access medical scheme cover in specified circumstances** and constitutes a threat to achieving universal health coverage, it is critical that the reasons for removing this right is appropriate and substantively powerful so that the limitation of the right is justifiable (c.f. Section 36 of the Constitution)
- **There are less restrictive means to achieve Universal Health Coverage**. In this respect, we have submitted a discussion document on expanding low-cost cover
- This discussion document fully integrates the findings and the **recommendations of the Health Market Inquiry (HMI)** with the country's duty to achieve Universal Health Coverage and proposes progressive improvements to the system to **reduce the current unacceptably high levels of inequality**
- Similarly, the Health Market Inquiry (HMI) has recommended a **series of less intrusive steps** that Government could take to ensure that the health system operates in the public interest

Reading Sections 6, 8 and 33 of the Bill together

- These sections remove the existing constitutional right of citizens to acquire healthcare services from private providers through medical scheme cover, which conflicts with Sections 12(2)(b) [*security and control over own body]* and 27(2) [*access to healthcare]* and 28(1)(c) *[children's right to healthcare]* of the Constitution
- This indirectly limits the rights of healthcare providers and funders to trade (Section 22 of the constitution)
- Section 33 empowers the Minister to determine when NHI is fully implemented, and remove access to private funding
- If there are adequate reasons to remove these rights, it must be done in terms of Section 36 of the Constitution

Debate on the reasons for the removal of private funding is required

- The Socio-Economic Impact Analysis (SEIA) does not explore alternative routes to Universal Health Coverage and does therefore not provide any evidence that the limitation in Section 33 is "*reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.*"
- There is a negative impact by limiting medical schemes to only cover that what is not offered by NHI
  - Policy uncertainty affecting the health sector and other businesses in the country
  - The capacity in the private sector could be lost to other countries, many professionals have indicated that they will emigrate
  - Increased burden on the state to provide healthcare
  - Increased out of pocket expenditure
  - Cross subsidisation of medicines in the public sector will be lost if one price is charged for all medicines
  - Likely resistance through litigation

Reasons for the limitation of private funding vehicles

- Largely unclear, but there are many circulating misconceptions
- Claims that the private sector is not efficient: Health Market Inquiry found that the private sector is not competing effectively and suggested measures to improve this
- The private sector does not cause the general shortage of healthcare personnel
- Medical schemes do not run out of benefits
- The expectation is that the NHI fund administrative cost will be 1% – 3% of healthcare cost, but the cost of the **purchaser-provider split in the NHS exceeds 15% of all health costs**, these administration costs could be as high **as 20%**

Wishnia, Jodi, et al. The supply of and need for medical specialists in South Africa:. *Percept. Health. Solve.* [Online] https://percept.co.za/2019/10/06/the-supply-of-and-demand-for-medical-specialists-in-south-africa/**.**

Ensor, Linda. Market inquiry into private health care cost R197m, says Ebrahim Patel. *BusinessLIVE.* [Online] 2 January 2019. https://www.businesslive.co.za/bd/national/2019-01-02-market-inquiry-into-private-health-care-cost-r197m-says-ebrahim-patel/.

Discovery Integrated Annual Report 2018

South African Social Security Agency. Annual Report 2017/18. *South African Social Security Agency.* [Online] https://www.sassa.gov.za/annual%20reports/Documents/Annual%20Report%20-%202017%20To%202018.pdf

Centre for Health and the public interest. At what cost? Paying the price for the market in the English NHS. *Centre for Health and the public interest.* [Online] https://chpi.org.uk/wp-content/uploads/2014/02/At-what-cost-paying-the-price-for-the-market-in-the-English-NHS-by-Calum-Paton.pdf.

Savage, Wendy. Colossal waste in NHS commissioning costs. *The Guardian.* [Online] https://www.theguardian.com/society/2011/jan/20/colossal-waste-nhs-commissioning-costs?INTCMP=SRCH.

Gauteng Department of Sport, Arts, Culture and Recreation, Press release: 1 June 21, Covid-19 relief funds to struggling artists and athletes

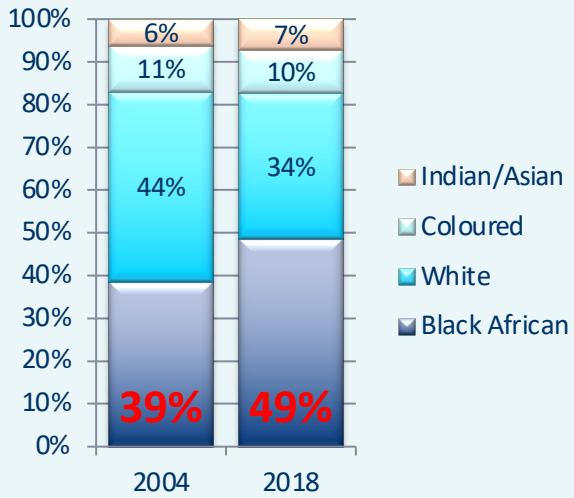
van den Heever, Alex. National Health Insurance: Is it about transformation or patronage? *Daily Maverick.* [Online] 27 August 2019. [Cited: August 28, 2019.] https://www.dailymaverick.co.za/opinionista/2019-08-27-national-health-insurance-is-it-about-transformation-or-patronage/.

Statistics South Africa. *General Household Survey.* Pretoria : s.n., 2002 to 2018. P0318.

General shortage of health human resources and medical scheme cover by race

- Limiting the role of medical schemes will not solve the shortage of human resources. There are too few health professionals in the country

Composition of medical schemes by racial group (2004 and 2018)



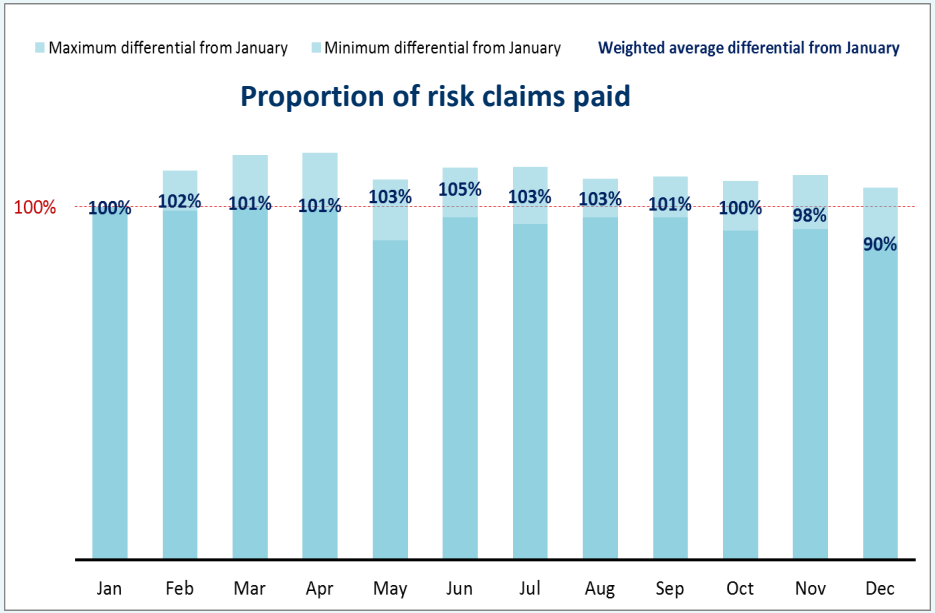
Wishnia, Jodi, et al. The supply of and need for medical specialists in South Africa:. *Percept. Health. Solve.* [Online] https://percept.co.za/2019/10/06/the-supply-of-and-demand-for-medical-specialists-in-south-africa.

Medical schemes do not run out of funds…

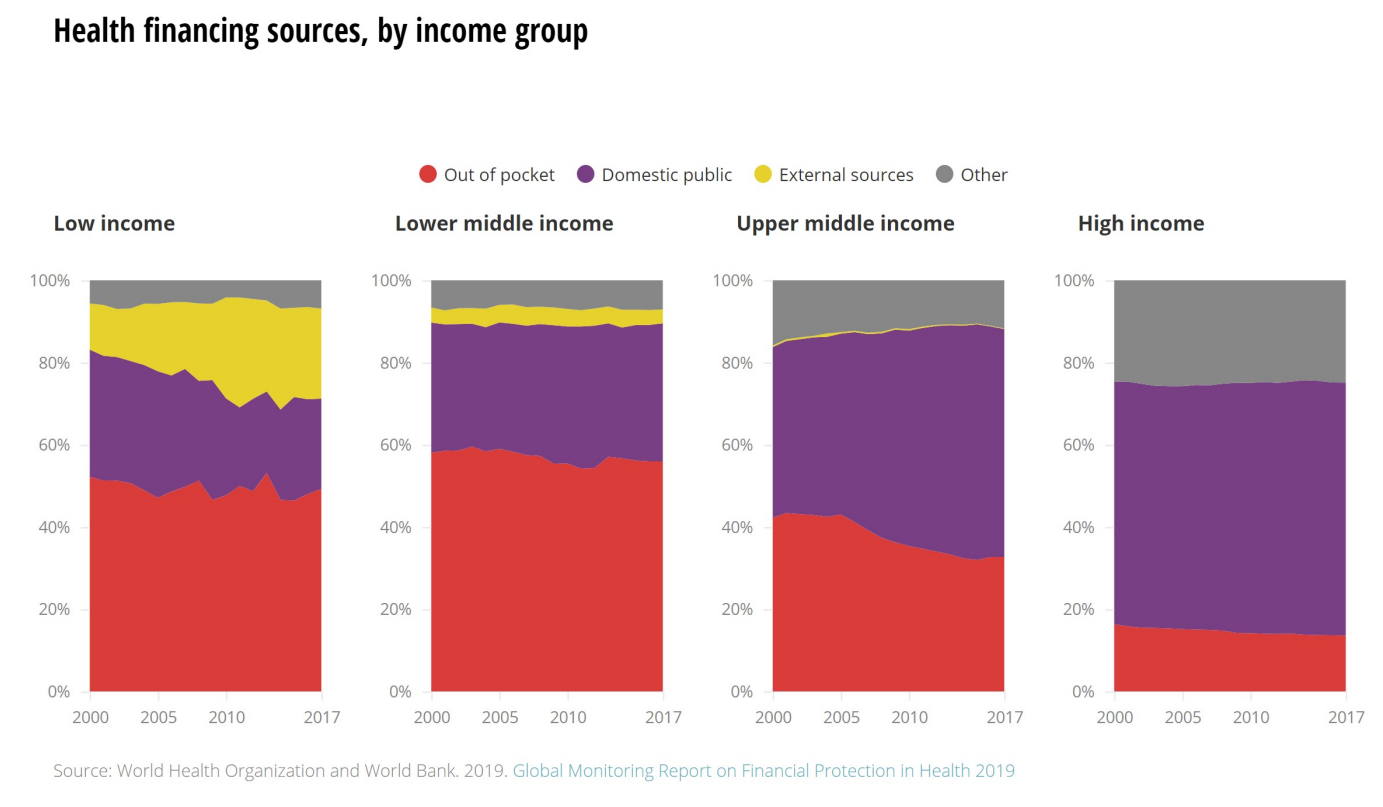
The graph shows that November is the first month in which the weighted average ratio of risk claims paid, to claims lodged, falls below the January level, ***at 98% – a difference of only 2%.*** The December weighted average ratio is the lowest, ***but still at 90% of January***.

December claims experience differ from other calendar months because of the holidays over the year-end, as evidenced by the reported monthly seasonality of medical scheme claims

The notion that risk benefits "run out" may originate from experience prior to the implementation of the Medical Schemes Act of 1998 when vastly different requirements in terms of open enrolment, community rating and PMBs applied. Claims experience has been subject to significantly different legislation since then



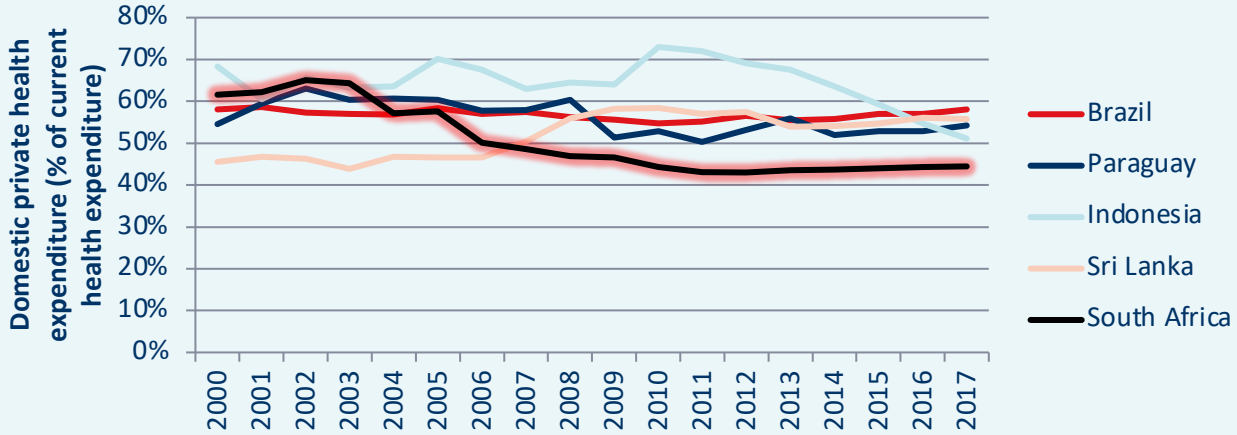
There have been many claims that the South African private sector is exceptionally large, but private funding is on par with that of peer countries



https://datatopics.worldbank.org/sdgatlas/goal-3-good-health-and-well-being/?cid=dec_tt_data_en_ext

South Africans spend a smaller portion on private healthcare than their peers

Even though South African GDP levels are like that of Brazil, Paraguay, Sri Lanka and Indonesia, South African private expenditure is lower than that in these countries
The current level of private expenditure is not unusual. It would be unusual to curb private expenditure



Country	Private Health expenditure as % of total Health expenditure	GDP per capita in PPP$
South Africa	44%	12,703
Brazil	58%	14,520
Paraguay	54%	12,594
Sri Lanka	56%	12,584
Indonesia	51%	10,936

Data downloaded from
https://data.worldbank.org/

Objective milestones to guide the progressive implementation of the NHI

Transition phases require milestones, preceded by testing

- The Bill identifies fixed dates for progression to the next phase of implementation. Many factors influence the progression and depend largely on economic growth. It is suggested that these dates are replaced by objective milestones
- It may have value to develop **pilots that truly test** the contracting and **strategic purchasing** required for a purchaser-provider split **before this is introduced nationally.** ("Try before you buy" - This is an area where Momentum Health Solutions has a keen interest to collaborate)
- Strategic purchasing includes **what to purchase?** (Explicit benefit package) Who to **purchase from?** (Contracting) and how to **remunerate?** (Alternate reimbursement mechanism: capitation, Diagnosis Related Groups (DRGs), case base, performance based, fee-for-service, – e.g., National Health Laboratory Services)

Stevenson, Sasha. Spotlight on NHI: What has actually changed in the new Bill? *Spotlight.* [Online] 23 August 2019. https://www.spotlightnsp.co.za/2019/08/23/spotlight-on-nhi-what-has-actually-changed-in-the-new-bill/.

Transition phases require milestones, preceded by testing (2)

- Widespread nationwide purchasing require the development of risk-based **capitation models** that should ideally be tested at a few districts before nationwide implementation
- **Diagnosis Related Groups** (DRG) are implemented in alternate reimbursement mechanisms, an appropriate grouper must be developed, and the clinical coding competency must be strengthened considerably
- Development of appropriate **governance structures for all the entities** – from the NHI Board, the Central hospitals, the District Health Management Offices (DHMOs) and the Contracting Units for Primary Care (CUPCs). These are new structures that will have to operate in a new environment with which we have no previous experience
- Consider appropriate governance structures to govern the expenditure of up to R10 billion annually in some of these districts

Governance

NHI Bill provides an opportunity to strengthen governance across the system

- The **most appropriate governance structure for centralised purchasing must be developed**. In the National Health Service (NHS) in the UK, purchasing is decentralised and left in the hands of clinical commissioning groups
- Auditing and financial reviews with strict controls are required to avoid Fraud, Waste and Abuse (FWA)
- District Health Management Offices (DHMOs) are established as national government components coordinated by the Director General for Health. The **DHMOs are not part of the NHI Fund and need their own governance system**
- If all purchasing for all health services were coordinated by the DHMOs, **the average DHMOs** would coordinate the purchasing of health care to the value of **R10 billion annually.** This necessitates the development of **appropriate, robust and transparent governance systems. But the funds will be directed to Contracting Units for Primary Care (CUPC)**
- The **NHI board will control one of the biggest budget items** in South Africa and would require the most dedicated, experienced and qualified board members to exercise proper control

Recommended solutions to the governance challenges

- Consider a **judicial panel for the appointment of the NHI Board**
  - This panel must appoint people based on experience with the requisite, relevant and collective skillset (i.e., an appropriate balance of medical, actuarial, financial, investment, legal, and corporate governance skills). The board must elect a chairperson from its members
  - Accountability must be to Parliament
  - Amend Sections 13 and 14
- The board should appoint the CEO
  - Amend Section 19(2)(b) and 19(3)
- Develop **governance structures** for the new **national government components:** District Health Management Offices (Supporting Contracting Units for Primary Care), and Central Hospitals
  - At the facility level, where central hospitals will become “semi-autonomous” entities, it is critical that appropriate governance structures are designed to optimise service delivery and accountability
  - Amend Sections 7(2)(f)iii; 57(4)(a);

Appointment of committees and governance structures for semi-autonomous national government components

- It is critical to establish clearer mandates for the various advisory committees to ensure that these committees can be held accountable to exercise their duties
- Some committee functions like price determination, health technology assessment and benefit design, are **probably better performed by institutions rather than committees.** (Consider the UK's National Institute for Clinical Care and Excellence (NICE), or the Health Intervention and Technology Assessment Programme (HITAP) in Thailand)
- The Health Market Inquiry (HMI) has recommended that a **Supply Side Regulator for Health (SSRH) is established**, and it could perform these functions independently (in support) of the NHI.
- The Health Technology Assessment (HTA) function leads to priority setting and the development of a benefit package. There is considerable **overlap between the skillsets required for the benefits advisory committee and the HTA committee**
- HTA is central to ensuring that health interventions are cost effective and may include assessment of interventions such as health promotion, and recommendations on telemedicine
- A clear relationship between these advisory committees, and the Office of Health Products Procurement contemplated in Section 38 of the Bill must be established
- The HMI proposed SSRH, with an independent governance structure is more likely to be **effective in the execution of technically complex tasks** such as priority setting than a committee

Appropriate, technically competent institutions are required to implement NHI

- **Clinical coding systems, DRG groupers and alternate reimbursement mechanisms** are central to the success of the NHI
- DRGs require a DRG grouper – a sophisticated piece of software, which must ideally be government owned and controlled. Global fees is another alternate reimbursement mechanism. These are technically highly complex and require highly specialised skills for development and introduction. Accurate clinical coding is a prerequisite
- This highly technical function is best performed by an institution like the HMI-proposed Supply Side Regulator for Health (SSRH). It is recommended that the SSRH does the technical work on clinical coding, development of DRG groupers and global fees. The pricing for these must be the **result of a negotiated process that is overseen by this regulator**.

Effecting a purchaser provider split

Challenges around the establishment of legal persons to contract as part of the creation of a purchaser provider split

- A requirement for the creation of a purchaser-provider split is that the **purchaser must enter into a contract** with the provider, and to have legally enforceable contracts, each of the **contracting parties must be a legal person (Section 39 of the Bill)**
- Provincial hospitals and clinics are not legal persons and contracting can only be entered into with provinces or municipalities
- Providers (hospitals, clinics, etc.) must be established as legal persons as a critical step towards the creation of a purchaser-provider split
- The NHI Bill (once enacted into law) will establish **District Health Management Offices (DHMOs) as national government components (legal persons)**, which in turn will establish Contracting Units for Primary Care (CUPCs). The section mentions that the Fund will transfer funds directly to the CUPCs. Section 41(3)(a) requires that the CUPCs remunerate primary care providers. CUPCs are not established as legal persons, and can therefore not open bank accounts, employ personnel, or contract with service providers
- The Public Service Act (1994) places **onerous requirements on the establishment of national government components.** This act requires that the relevant Minister must request the President to establish such an entity, a detailed feasibility study must be done to show that such an entity is viable, and the request must be supported by the Minister of Finance and the Minister of Public Service and Administration

The private sector has developed extensive administration and purchasing capacity over decades, which must be harnessed to serve the public interest

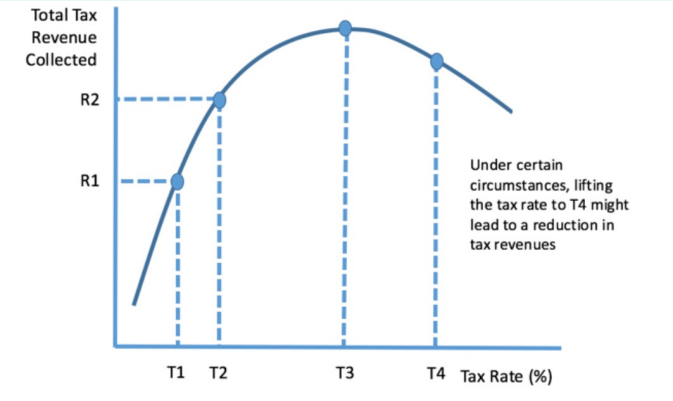
- The Bill makes no provision for the utilisation of the capacity in medical scheme administrators to assist in the purchasing of healthcare for the NHI
- Sophisticated administration systems and mechanisms have been developed to pay claims efficiently and experience with alternate reimbursement mechanisms will support NHI. Experience in fraud, waste and abuse management is crucial
- This capacity took decades to develop and serves only 9 million people
- Mechanisms should be developed to harness this capacity to serve the public interest, and the draft legislation should make explicit provision for private sector support

- Section 35 can be amended to make provision for the strategic purchasing of services for the NHI Fund by private administrators

Funding for NHI

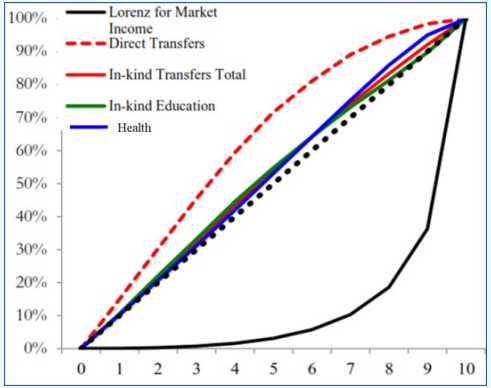
There are high levels of societal cross-subsidisation and a low likelihood of increased tax revenue

Laffer curve

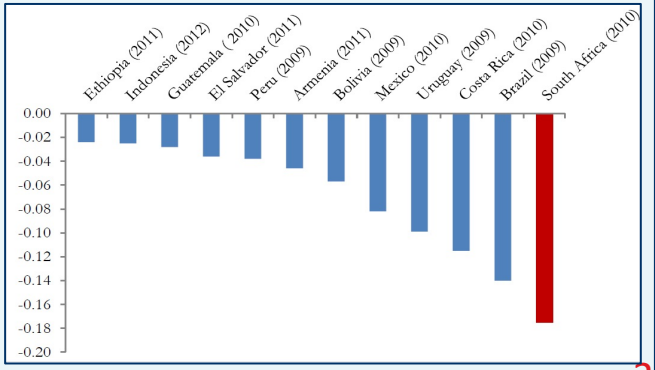


SA's current economic and tax situation does not allow for raising of NHI funds via increased taxes

Progressivity of health spending. Concentration curves and Lorenz curve for market income



Change in Gini: disposable vs market income



Inchauste, Gabriela, et al. *The Distributional Impact of Fiscal Policy in South Africa.* s.l. : The World Bank. Poverty Global Practice Group & Macroeconomics and Fiscal Management Global Practice Group, February 2015.
Riley, Geoff. Laffer Curve. *Tutor2U.* [Online] https://www.tutor2u.net/economics/reference/laffer-curve.

Tax credits are not available for redistribution to the public sector – taxes must be increased before these funds could be allocated

- Section 49(2)(a)(ii) of the Bill incorrectly states that tax credits are currently being paid to medical schemes, it does not happen
- “Tax credits” means that after a person is assessed for income tax, that a discount is offered to individuals belonging to medical schemes. This is a fixed discount and applies equally to all taxpayers.
- Should tax credits be abolished it will have serious detrimental effects on lower income medical scheme members.
- Abolishing tax credits means an increase in the effective tax rate

The duty is on all of us to provide a solution, including the private sector

- *In Respect of housing, the constitutional court ruled:*

  "….that it is not only the state who is responsible for the provision of houses, but ***that other agents within our society, including individuals themselves****, must be enabled by legislative and other measures to provide housing. The state must create the conditions for access to adequate housing for people at all economic levels of our society. State policy dealing with housing must therefore take account of different economic levels in our society."*

- Through the implementation of the HMI recommendations, and ***stronger stewardship of the private sector***, public health objectives can be met and the health services revenue-net spans wider

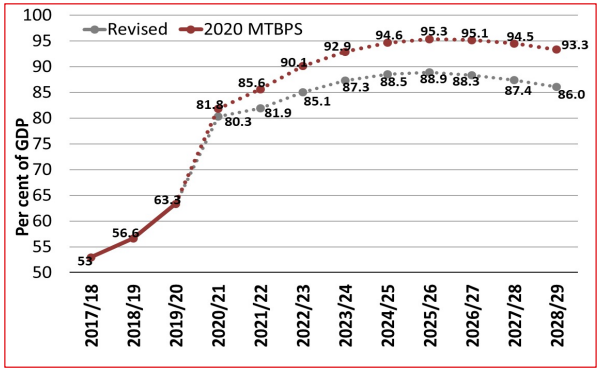
- Medical schemes rely on private contributions (after tax) to strengthen the health system. ***Medical scheme membership reduces the burden on the state***

- The extensive funding, administrative, purchasing, and health care provision capabilities in the private sector must be harnessed towards Universal Health Coverage

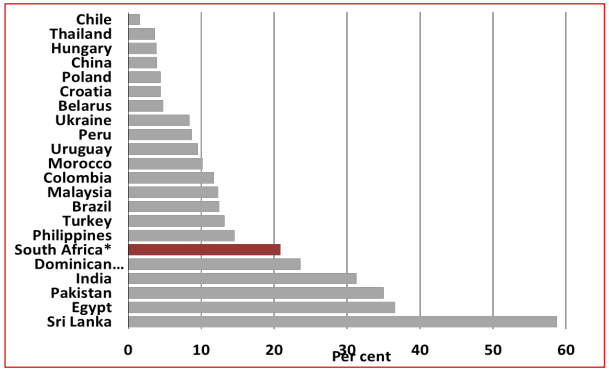
Constitutional Court of South Africa. Government of the Republic of South Africa and Others v Grootboom and Others. *Constitutional Court of South Africa.* [Online] 4 October 2000. https://collections.concourt.org.za/bitstream/handle/20.500.12144/2107/Full%20judgment%20(478%20Kb)-2798.pdf?sequence=4&isAllowed=y.
Competition Commission of South Africa. Health Market Inquiry. Final findings and recommendations. *Competition Commission of South Africa.* [Online] September 2019. http://www.compcom.co.za/wp-content/uploads/2014/09/Health-Market-Inquiry-Report.pdf.

Fiscal space

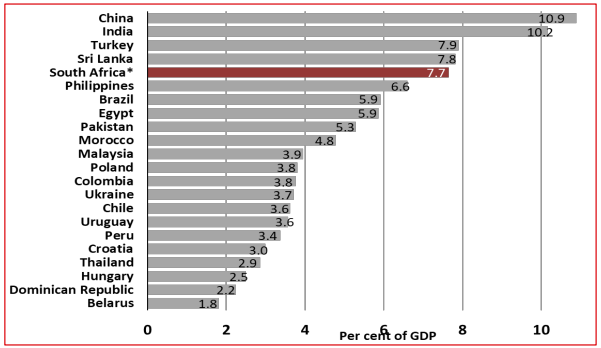
Gross debt-to-GDP outlook



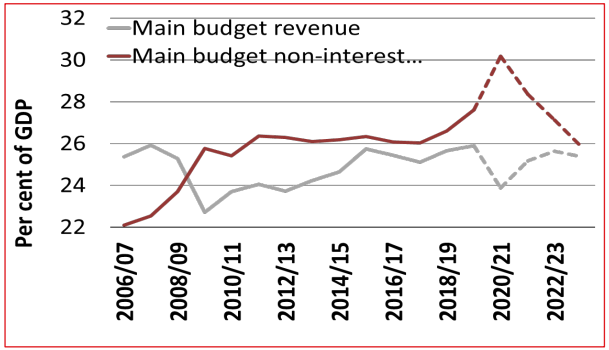
Average debt-service costs as a share of revenue, 2021–2023



Average budget deficit, 2021–2023



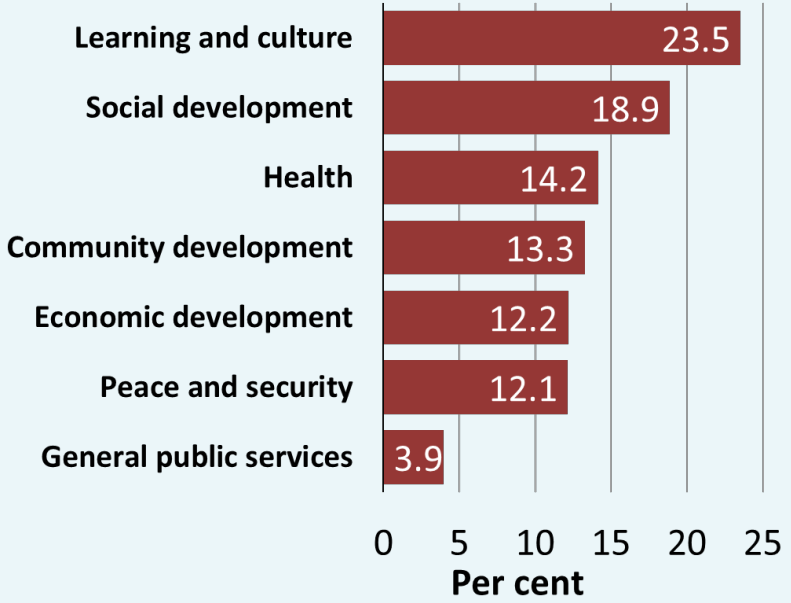
Main budget revenue and expenditure



http://www.treasury.gov.za/documents/national%20budget/2021/default.aspx

The Abuja target is that 15% of public expenditure should be on health

With 14,2% of government expenditure being spent on Health, government demonstrates its commitment to health
(More than 20% goes to debt servicing in 2021 -2023)

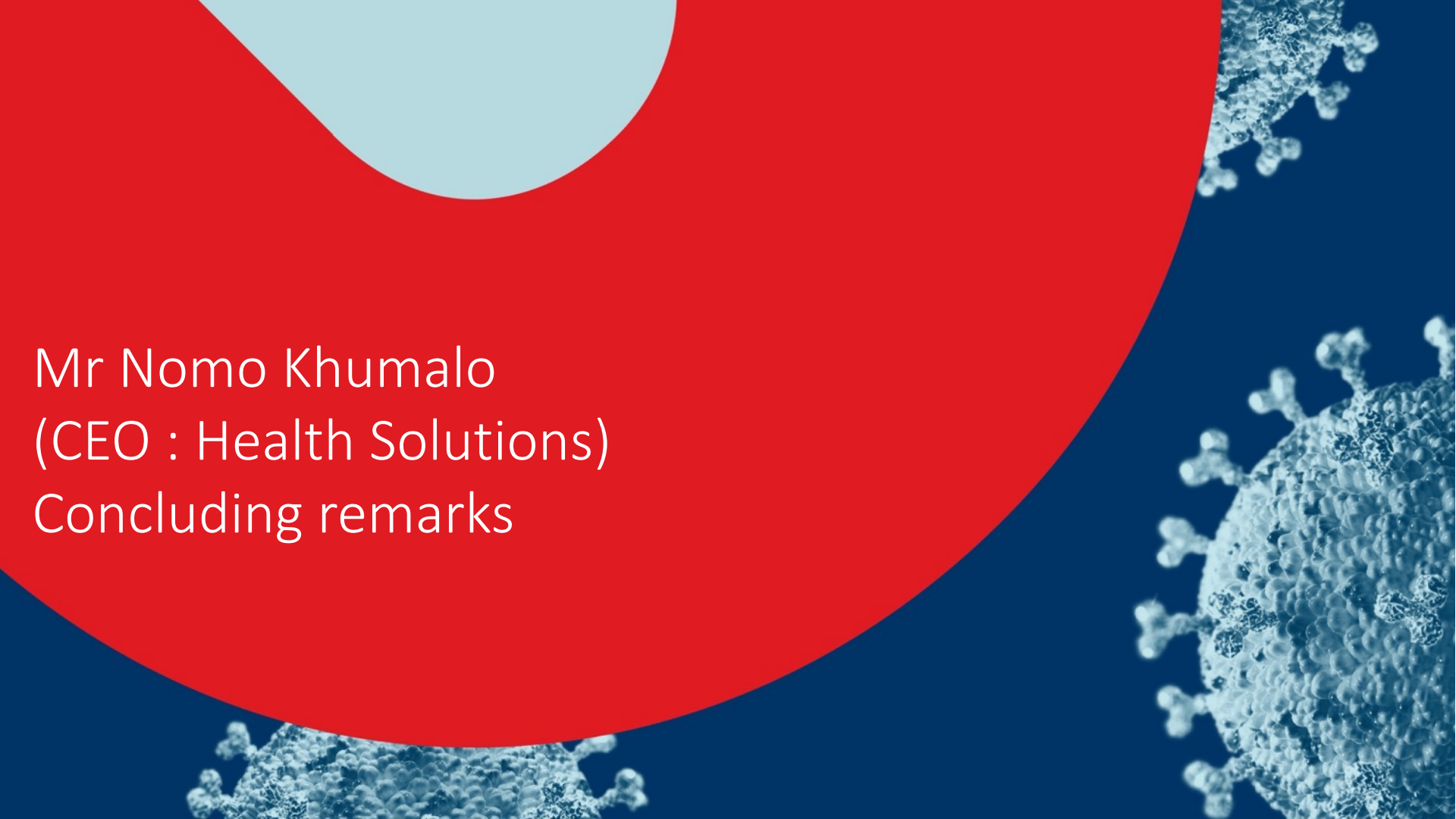


In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. https://www.who.int/healthsystems/publications/abuja_declaration/en/

Other pertinent points in the Bill

- Coverage for migrants, asylum seekers and other. The Bill departs from the current arrangements and limits care
- Registration of the population: Independent Electoral Commission experience
- Fund should report to Parliament, appointment of board to be addressed, as well as the appointment of advisors
- Role of the provinces is significantly curtailed: Not clear how this will affect appointments of Staff in the Provinces (Funds follow function)
- Progressive implementation and piloting will assist a lot
- Use research to inform policy
- Innovation and expertise

Mr Nomo Khumalo
(CEO : Health Solutions)
Concluding remarks



Conclusion

- There was a lot of work done to arrive at the Bill to date. We appreciate these efforts, and we hope that our contributions improve the Bill
- Our comments serve to highlight challenges that should be resolved in the interest of an improved system for all South Africans
- We are in testing times, and we have to keep cool heads to ensure that we solve the underlying problems in our society
- We are confident that we will find an appropriate pathway and solution to achieve Universal Health Coverage. We are at the disposal of the committee and offer our services to improve the health system

Conclusion (2)

- Challenges to be resolved include:
  - Governance: The appointment of the Board, structures for new entities, Contracting units for Primary Care, District Health Management Offices and Central Hospitals
  - The role of medical schemes: Application of HMI recommendations and increased capacity
  - The single payer approach: Sections 6,8 and 33
  - Phased implementation: Introduce milestones in Section 57, including the testing of a purchaser provider split. We are eager to participate in pilots to test this prior to full implementation
  - Funding: Must include the freedom, and the duty, to fund privately