

National Health Insurance

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BACKGROUND

In the ANC's Election Manifesto - the result of the party's Polokwane Conference in 2009 - health and education were identified as two of the government's top priorities. This Manifesto outlined practical steps to be taken by the ANC in its fourth term of government.

As a result the National Health Insurance System (NHI) was introduced ...

The Manifesto states it as follows:

"The NHI will be publicly funded and and publicly administered and will provide the right of all to access quality health care, which will be free at the point of service. People will have a choice of which service provider to use within a district"

Some of the practical steps outlined in the Road Map for Health, which was handed over to the Department of Health, included:

- ⌘ the fight against HIV/Aids and other diseases;
- ⌘ improving of quality health care;
- ⌘ health information and planning systems;
- ⌘ boosting human resources;
- ⌘ reducing the cost of drugs; and
- ⌘ active promotion of healthy lifestyles.

CURRENT PROBLEMS IN THE HEALTH CARE SYSTEM

1 .A stagnation in funding allocations for the public health sector since 1994

This, together with an increasing disease burden, has put the public health care system under severe pressure. This problem was largely due to the constrained government expenditure associated with the Growth, Employment and Redistribution (GEAR) policy.

2. Inability to treat people with TB.

South Africa is one of the 22 high burden countries that contribute approximately 80% of the global burden of all TB cases, according to the Department of Health. This is made worse by the growth in cases of patients with Drug Resistant TB as well as Extensive Drug Resistant TB due to inefficient public health and poor social conditions.

3. Imbalances in the health sector.

Inequities in the public-private health care mix increased as the public health sector has barely kept pace with inflation, while real medical scheme expenditure per beneficiary has doubled in the past decade, with excessive cost increases in key parts of the private health sector.

A mismatch of resources in the public and private health sectors relative to the size of the population each serves, and inefficiencies in the use of available resources, has led to the very poor health status of South Africans, particularly in the lowest income population.

4. Misdistribution and shortages of the health workforce

A serious misdistribution of health workers (60% of nurses and 40% of doctors serving 85% of the population using the public health sector.) Most of the health workers work in urban areas, resulting in a serious shortage in the rural areas.

The 'brain drain': A shortage of medical practitioners and other allied professionals. In 2001 the OECD estimated that **8 921 South African doctors migrated** to developed countries in the north.

It is estimated that about **67% of nurses** trained between 1997 - 2005 have left the country for greener pastures in countries that pay higher salaries (Saudi Arabia, Oman, UK, USA, Canada, Australia).

5. Drug Shortages:

Shortage of drugs at public health facilities, especially AIDS drugs;

The inability to access medicines at lower prices;

South Africa's **rural population** has little or no access to pharmacies, as these are concentrated in the urban area. The private sector, however, has an oversupply of pharmacists. Despite government efforts to reduce the prices of medicines in the private sector, they remain **unaffordable to the majority** of South Africans;

Private insurance members often exhaust their medicines benefit before the end of each year and have to access their drugs through out-of-pocket payments or waiting in the long queues in the public sector

6. Private sector challenges requiring intervention

Medical scheme membership has declined considerably as a percentage of the population, from **17% in 1992** to less than 15% in 2005 (Council for Medical Schemes 2006). **This is the result of increasingly unaffordable fees.**

Main cost drivers of medical schemes expenditure have been private hospitals, specialists and medicines, administration and brokers. Expenditures on specialists increased by 53% between 1997 and 2005; and 74% on hospitals in the same period (CMS 2006).

Current tax expenditure subsidy on medical schemes' deduction has not contributed to increased access by low income earners in medical scheme membership nor improved the rising costs of the industry's contributors. People in high income tax brackets continue to benefit more from the subsidy than the middle and low income groups

7. Hospital capacity

While hospital beds in the public sector have declined, the number of private hospitals and clinics continues to grow. CMS 2008 annual report indicates 28 000 private beds available. Current bed occupancy rate in private sector is 65%. Specialists generate around 70% of hospital costs incurred and are the professionals who predominantly admit patients in private hospitals.

More than twice as many hospital beds per beneficiary of private sector hospital services as for those dependent on the public sector.

(The report does not mention the occupancy rate in the public sector nor the amount of beds available)

8. Misalignment between the public and private health sectors:

Inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each.

Each pharmacist in the public sector serves 12 - 30 times and each generalist doctor in the public sector serves 7 - 17 times more people than those in the private sector. For nurses the rate is 23 times more in the public than in the private sector.

(Table p 13 of report)

Private-public mix disparities have deteriorated remarkably over the past decade as real per capita expenditure in the public sector was relatively stagnant over this period, while medical scheme contributions and expenditure have been growing at rates far exceeding overall inflation.

9. Incidence of health care financing and service benefits in South Africa

Looking at the burden of health care financing across socio-economic groups, it shows that the poorest 20% of the population contribute almost 6% of their household income towards funding health care (mainly out-of-pocket payments). The richest 20% contribute about 18% of their household income towards health care (medical scheme contributions)

Figures from Ataguba & McIntyre (2009) indicate that the richest 40% of the population receives about 60% of the health care benefits.

“Health care benefits are not distributed in line with the need for health care services. According to A&M "there is a lack of cross-subsidies in the overall health system in South Africa. Although health care financing is ‘progressive’, this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds It is indisputable that benefit incidence in South Africa is inequitable; benefits from health care are not distributed according to the need for health care.”

THE GOVERNMENT'S APPROACH TO HEALTH CARE

PRINCIPLES AND GOALS THAT LEAD TO NATIONAL HEALTH INSURANCE (NHI)

The core principles on which the proposed NHI will be established include:

1. **The right of every individual to proper health care;**

2. **Social solidarity and universal coverage** - a commitment to social solidarity in SA's health system, which means a **mandatory contribution by SA** to funding health care according to their ability to pay and a universal access to health services that meet established quality standards.

3. **Public administration:** A mandatory NHI system that is structured as a single purchaser public entity supports the strategies to achieve economies of scale, promote redistribution of health care resources and cost containment

4. **The goals of the national insurance include:**
 - ⌘ Universal coverage for all South Africans, irrespective of whether they are employed or not;

- ⌘ equity and solidarity among the population through the pooling of risks and funds;
- ⌘ accelerated national health system reform, especially in the public health sector;
- ⌘ increased strength of the health purchaser in negotiations with providers for both supply of services and rational provider payment levels will qualify assurance;
- ⌘ creation of one public fund with adequate reserves and funds for high cost care, health promotion and prevention and appropriate research and documentation on the development of national health insurance;
- ⌘ promoting efficient and effective service delivery in both public and private sectors; and
- ⌘ assurance of continuity and portability of national health insurance within the country.

KEY PROPOSALS FOR A NATIONAL HEALTH INSURANCE

1. Establishment of an NHI Fund

The main responsibility of the NHI Fund will be to receive funds, pool these resources and purchase services on behalf of the entire population. The fund will be publicly administered as a single purchaser with sub-national offices at the provincial levels to negotiate and contract with the health care providers and will be established within five years.

At national level, the NHI Fund will be managed by a CEO who will report directly to the minister of health similar to the way SARS head reports to the minister of finance. CEO will be supported by an executive management team and technical committees.

NHI Fund will be advised by a committee made up of experts in health care financing, medical and nursing services, public health, HIV/AIDS, research pharmaceutical services, labour, administration of public insurance schemes, actuarial sciences, information technology and communication.

The Fund must be a separate body for it to effectively perform its core functions: revenue collection and pooling and most importantly purchasing of services.

2. Universal Coverage:

Coverage will entitle individuals and households to a defined, comprehensive package of healthcare provided through appropriately accredited and contracted public and private health services providers.

3. Benefits under NHI

A comprehensive package of health services which includes all levels of care. The package will include Primary care and preventive services, inpatient care, outpatient care, emergency care, prescription drugs, appropriate technologies for diagnosis and treatment, rehabilitation, mental health services, the full scope of dental services, substance abuse treatment services, basic vision care and vision correction (other than laser vision correction for cosmetic purposes) hearing services including the provision of hearing aids.

A list of pharmaceutical medical supplies and devices will be linked to the Essential Drug List (EDL) and updated on a regular basis.

It will exclude medically unnecessary services and expensive therapies that have little impact on health care.

4. Services to be provided under NHI:

The NHI Fund will contract with accredited providers (public and private) to provide a defined comprehensive package of services at each appropriate level of the referral hierarchy namely primary, secondary, tertiary and quaternary health services. A referral process will be defined for services within and outside the district and province to assure continuity of care and effective cost containment.

At primary level existing GPs can be accredited if they work in multi-disciplinary practices.

Both public and private facilities will be accredited by a separate National Office of Standards Compliance.

5. Funding Sources and Risk Pooling

The Ministerial Advisory Committee is working with key officials from National Treasury to explore the following options:

- ⌘ a surcharge on taxable income;
- ⌘ payroll taxes (for employees and/or employers); and
- ⌘ increase in VAT which is earmarked to the NHI

However, the main sources of revenue for the NHI Fund will be general taxation. All of these funds will be combined in the NHI Fund from which all services covered by the NHI system will be purchased.

Allocations from general tax revenue will be supplemented by a mandatory, payroll-related contribution. This will be collected by SARS. Everyone earning above the income tax threshold (adjusted annually) would be required to make this contribution.

Additional funding will include the elimination of the current tax-deductions for medical scheme contributions and channelling these funds to the NHI Fund to provide additional funds into the system

6. Reimbursement Models

The provider payment arrangements that the NHI Fund will use to reimburse all accredited providers will be **risk-adjusted per capita payments and global budgeting**. The annual capitation amount will be linked to target utilization and cost levels. Facilities that do not meet the requisite standards will continue to get the global budgets until such time they meet requisite standards through support for a given period. This applies to public and private providers in each category of service provision.

There will be no co-payments or out-of-pocket payments to accredited providers at the point of health service use. This will apply only to the non-insured (such as tourists) or for the health services excluded from the list of NHI benefits.

7. Distribution of Funds within an NHI

The allocated health insurance revenues will be used to pay for: health care benefits with improved quality, recruiting and retaining qualified health workers; health system issues; and a reasonable level of services.

The administrative costs should be kept to a minimum as existing registration and contribution collection mechanisms will be used for most of the population covered.

A needs-based formula for the allocation of resources will be developed.

8. Enrolment of people in to the NHI

The registration of the national population will be based on a health facility approach. The green-bar-coded ID or equivalent legal document will be used to register people for the NHI system. **They will eventually be issued with a NHI card on which their health information history will be captured**, making it easily accessible and portable.

9. Information systems and quality assurance

An integrated and enhanced National Health Information System (NHIS), based on an electronic patient record platform will be financed by the NHI Fund.

The system will support: monitoring of the extension of coverage of all population sectors; tracking the health status of the population and producing disease profile data; financial and management functions; utilization of health care benefits; quality assurance programmes; production reports; and research and documentation to support changes in the health care system.

10. Awareness campaign for the NHI

A transparent communications programme will be used in a proactive social marketing approach to increase people's knowledge and understanding of the NHI Fund. This will be done on a national, provincial and district basis.

It will include raising awareness among politicians and community leaders to enlist their support.

Brochures, posters, audio-visual material will be used in this awareness public campaign.

11. Medical scheme's role

The NHI calls for **mandatory membership** for all South Africans through mandatory contributions and social solidarity. However, it is up to the general public to **continue with voluntary medical schemes cover only after they have contributed to the NH Fund**.

12. Estimates of NHI prior to Public Consultation

The costing model uses a 'public sector framework'. This implies that a comprehensive package of services is provided for all South Africans, but the package is not specified as in current medical schemes in terms of specific services that will be covered.

According to the model, expenditure will increase from R128 billion in 2012 to R267 billion in 2020 and R375 billion in 2025 if phased in over 14 years.

SYNCHRONISED IMPROVEMENT OF THE HEALTH SYSTEM

The NHI system will be implemented in parallel with health system strengthening over the next five years. A parallel health system strengthening plan has been developed to assure infrastructure maintenance, improvement and expansion (capital costs) and service provision (recurrent costs).

The key components of the health system strengthening plan are:

1. Improvement in infrastructure for the provision of health services

This will include a **detailed inventory of public and private facilities**, including infrastructure, human resources and technology. A subsequent **facilities refurbishment and expansion plan** will be developed in line with the existing health care facilities revitalisation program.

2. Improved functioning of district health councils

The district level offices will assist to manage the flow of funds from the NHI funds to providers based on agreed plans and using a combination of agreed payment mechanisms

3. Primary health care approach under NHI

The focus will be on the **improvement of access to quality health services** as the first point of entry into the health system (the principles are contained in the National Health Act Chapter 5). It deals with District Health System and universal coverage, defined as access to an essential package of health services based on need.

The composition of the primary care package of services will extend beyond services traditionally provided in health facilities such as clinics, community health centres and district hospitals to include extensive community and home based services in which community health workers forms an essential part.

Community and home based service will be provided by teams with each team being responsible for about 10 000 people. The team will consist of doctors/clinical associates and nurses as well as health professionals operating in fixed health facilities (clinics, CHCs and district hospitals).

It is critical that appropriate strategies be designed on how communities will be involved in planning of health services as districts level including their role in providing inputs into district health plans.

4. Giving public health care managers authority and responsibility to management

Concrete mechanisms will be created for increasing the efficiency of public health facilities, particularly of hospitals by increasing managerial autonomy in public health care facilities in order to improve decision making and accountability. The efficiency of procurement and supply functions as well as the use of provincial allocations will be reviewed.

5, Improved staffing of the health system

The NHI plan proposes a set of comprehensive strategies for **increasing the supply, quality, distribution and retention of various categories of health workers in the country**. South Africa is heavily undersupplied with key health professionals and is facing a huge challenge in the medium to long term.

A comprehensive audit of the health professional workforce across the country will have to be undertaken: province by province to determine the numbers and categories of personnel needed in the light of the NHI. Vacancy figures need to be validated and appropriate and context specific norms and ratios should be developed.

It will include:*** Nurses:**

South Africa has an urgent need for a reassessment of the restructuring of the public education system. Colleges must be re-opened. The public sector must resume its role in the production of enrolled nurses and enrolled nurse auxiliaries. The training of such nurses must be reprioritised in provincial and hospital budgets. The emotional and physical effects of HIV, AIDS and TB epidemics should be taken into account when considering the numbers of health workers needed.

*** Doctors:**

Identification, assessment, advertising and filling of vacant posts regarded as appropriate and creation of new medical practitioner posts where required.

Attention should be given to the workload of doctors; incentives to attract more doctors; improved hospital infrastructure and improved quality of accommodation in rural areas; task shifting where tasks are delegated to workers with lower qualifications; and learnership programs for the training of community health workers, HIV/ AID counsellors and home based carers.

*** Importing of health workers into South Africa:**

This should be used as a temporary measure to address the shortages in South Africa. Doctors and nurses from other African countries who are already in the country should be allowed to work here in their fields of expertise for specified periods. They should be deployed to areas where there are large numbers of refugees from other African countries, particularly their own.

NGO's which are seeking to recruit professionals from developed countries should be provided with financial support. Foreign doctors, meeting the requirements to work here, should not be restricted to the public sector.

*** Training of health facility managers:**

Management of health facilities from primary care to tertiary hospital level requires particular forms of knowledge and skills that need to be recognised and developed in health management training maybe via a health management program as part of university's curriculum.

Managers from the private sector and non-health sectors can also be utilised to improve efficiency and manage change.

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The rationale for introducing a NHI is that it would provide a system for improving **CROSS SUBSIDIZATION** in the overall health system, whereby **FUNDING CONTRIBUTIONS** would be linked to an individual's **ABILITY TO PAY** and **BENEFITS** from health services would be in line with an individual's **NEED FOR CARE**.

This would be achieved through a single funding pool,

SAPPF EXCO

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