



NATIONAL HEALTH INSURANCE: GREEN PAPER

AUGUST 12 2011

**Dr Olive Shisana,
Chair: Ministerial Advisory Committee**

Introduction



- Two-tiered financing health care system- with proportionately more resources serving a minority
- Public sector is under-resourced and has to serve a large majority of the population
- The system is inequitable: all must benefit from NHI
- To successfully implement NHI there is a need to:
 - Transform health system completely
 - Overhaul it
 - Radically change administration and management
 - Re-engineer primary health care

Outline: Problem statement



- Burden of Disease
- Quality of health care
- Health care expenditure
- Distribution of financial and human resources
- Medical scheme industry



Outline: National health insurance



Health Policy Proposals

- Principles
- Objectives
- Socio-economic benefits
- Universal and Population coverage
- PHC and Health Care Benefits
- Accreditation of providers

Financing proposals

- Contracting of providers
- Payment and reimbursement of providers
- Funding mechanisms
- Cost
- NHI Fund
- Role of Medical Schemes
- Population Registration & Information system
- Migration to NHI
- Piloting of NHI

Burden of Disease

- **HIV/AIDS and TB**

- Disproportionate burden ; 0.7% of population and carry 17% of HIV + global population
- High Tb rate globally and highest TB-HIV co-infection at 73%

- **Maternal, Child and Infant Mortality**

- Very high
- AIDS and other causes contributes to this

- **Non-communicable Disease**

- High blood pressure
- Diabetes,
- Chronic heart disease
- Chronic lung diseases
- Mental illness

- **Injury and Violence**

- Road accidents
- Interpersonal violence and violence against women and children

Quality of Health Care



- Cleanliness
- Safety and security of staff and patients
- Long waiting times
- Staff attitudes
- Infection control
- Drug stock outs



Health Care Expenditure



- **South Africa spends 8.3% of GDP on health**
 - 4.1% in the private health sector-covers 16.2% of the population
 - 4.2% in the public health sector- covers 84% of the population
- **Private hospital costs have increased by 120% over a decade (2008) – too high a cost for users**
- **Source of funding for health care in SA:**
 - General revenue
 - Medical scheme contributions
 - Out of pocket expenses

Distribution of Financial and human Resources



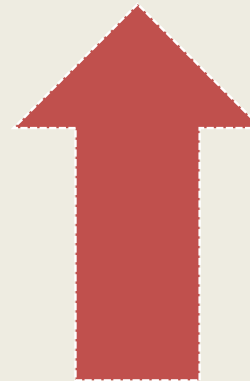
- Mal-distribution of human resources between public and private sector skews distribution in favour of the private sector
- Per capita spend vary:
 - R11 150 per person in the private sector
 - R2 766 per person in the private sector



Medical Scheme Industry



- Reduction of medical schemes from >180 in 2001 to 102 in 2009 because they are not financially viable..
- To address the problem:
 - Increasing premiums
 - Decreased member benefits
- Result
 - Benefits exhausted before year-end
 - Wage inflation
 - High cost of health care
- Compounding problems
 - High administrative fees
 - Oversupply of brokers



Premiums

Wage
inflation

Brokers



Benefits
reduced
and
exhausted



National Health Insurance

Principles of NHI



- Right to access health care- Sect 27 of Constitution
- Social Solidarity-cross-subsidisation
- Effectiveness-evidenced-based interventions
- Appropriateness
- Equity-those with greatest need are prioritised
- Affordability-procure services at affordable cost
- Efficiency-eliminate duplicate administrative structures at national, provincial and district spheres

Objectives of NHI



- Improved access to quality health services for all
- Create Single Fund: Pool risks and funds to achieve solidarity
- Procure services on behalf of the entire population
- Improve resourcing of the public health sector

Socioeconomic benefits of NHI



- A healthier population contributes to better wealth creation
 - Each extra year of life expectancy raises country's GDP per person by ~4% in the long run
 - Poor health reductions in adult mortality explains 10-15% of the economic growth between 1960-1990 in 52 countries
 - Over 37 million Indians fall below poverty line because of catastrophic health spending





Cover for all
South Africans,
permanent
residents and
refugees

Tourists, short-
term residents,
foreign students
must have travel
insurance at
entry into South
Africa



Universal and Population Coverage

Primary Health Care



- System will be based on PHC and population-oriented
- Provision of services will go beyond clinics, community health centers and hospitals to homes and communities
- Private sector PHC
- PHC focus will be on health promotion, preventive care, curative and rehabilitative services
- Defined package will be comprehensive at all levels and will guarantee continuity of care
- PHC will be delivered
 - District-based clinical specialist support teams
 - School-based PHC services
 - Municipal Ward-based PHC agents



Health care benefits under NHI



- **District Health Services**
 - Designed to meet the needs of the population
- **Private Providers**
 - Accredited and contracted to provide a range of services
 - General practitioner to provide PHC services
 - Arrangement that reduces inconvenience to the patient
- **Hospital Benefits**
 - Evidenced-based comprehensive package of services for each level of care
 - Hospitals redesignated as: District, Regional, Tertiary, Central and Specialised hospital

Accreditation of providers



- **Establishment of Office of Standards and Compliance**
 - Inspection
 - Norms and Standards
 - Office of ombudsman
- **Six core standards for health care**
- **Accreditation standards**
 - Specify minimum range of services to be provided
 - Delivery of PHC services linked to improved outcomes
 - Skilled health and medical staff
 - Defined referral system

NHI: Financing proposals



Contracting Providers



Payment and Reimbursement of providers



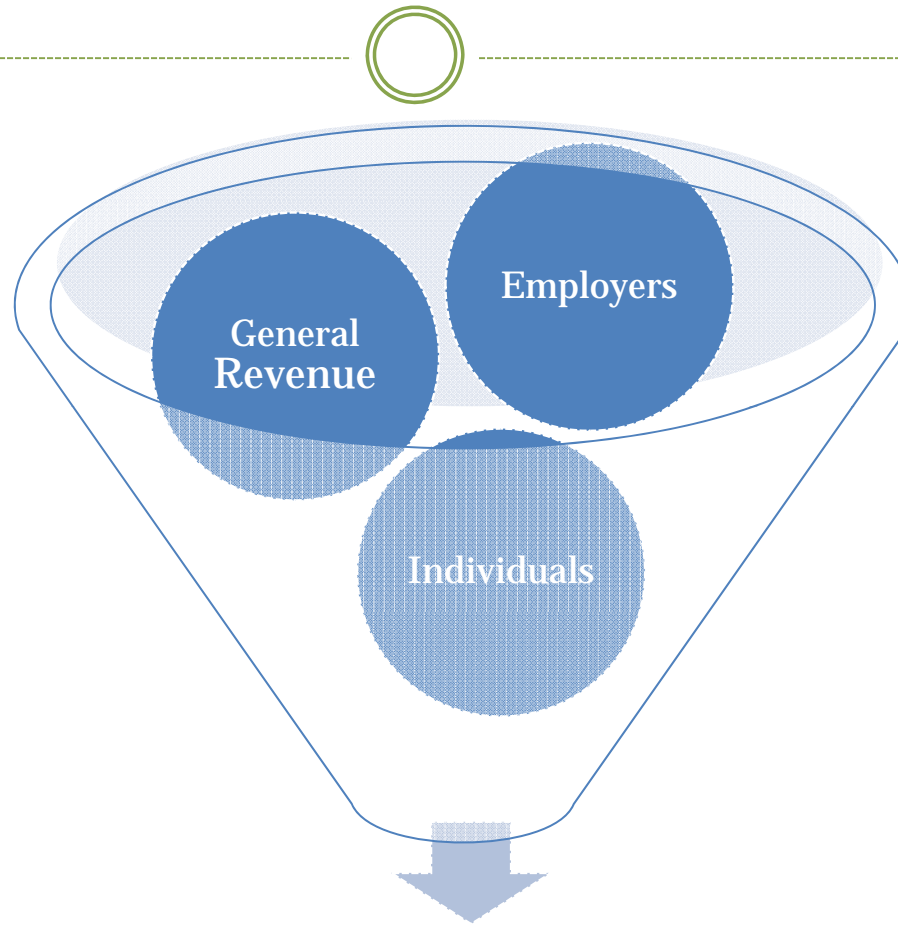
- At **PHC levels**, reimbursement based on risk-adjusted capitation linked to performance
- At **hospital levels**, contracted and accredited facilities: global budgets and migrate to Diagnostic Related Groups linked to performance
- **Public emergency** services-initially public hospital global budget and then case-based mechanism
- **Contracted provider emergency service**: case-based approach

Capitation



- Capitation amount to be uniform across providers
- Linked to appropriate index
- Risk adjustments: population size, age, gender, disease/epidemiological profile
- Cost-containment using treatment protocols and avoid under-servicing

Funding mechanisms



Pooled NHI Fund

Real Recurrent NHI costs (R bill)

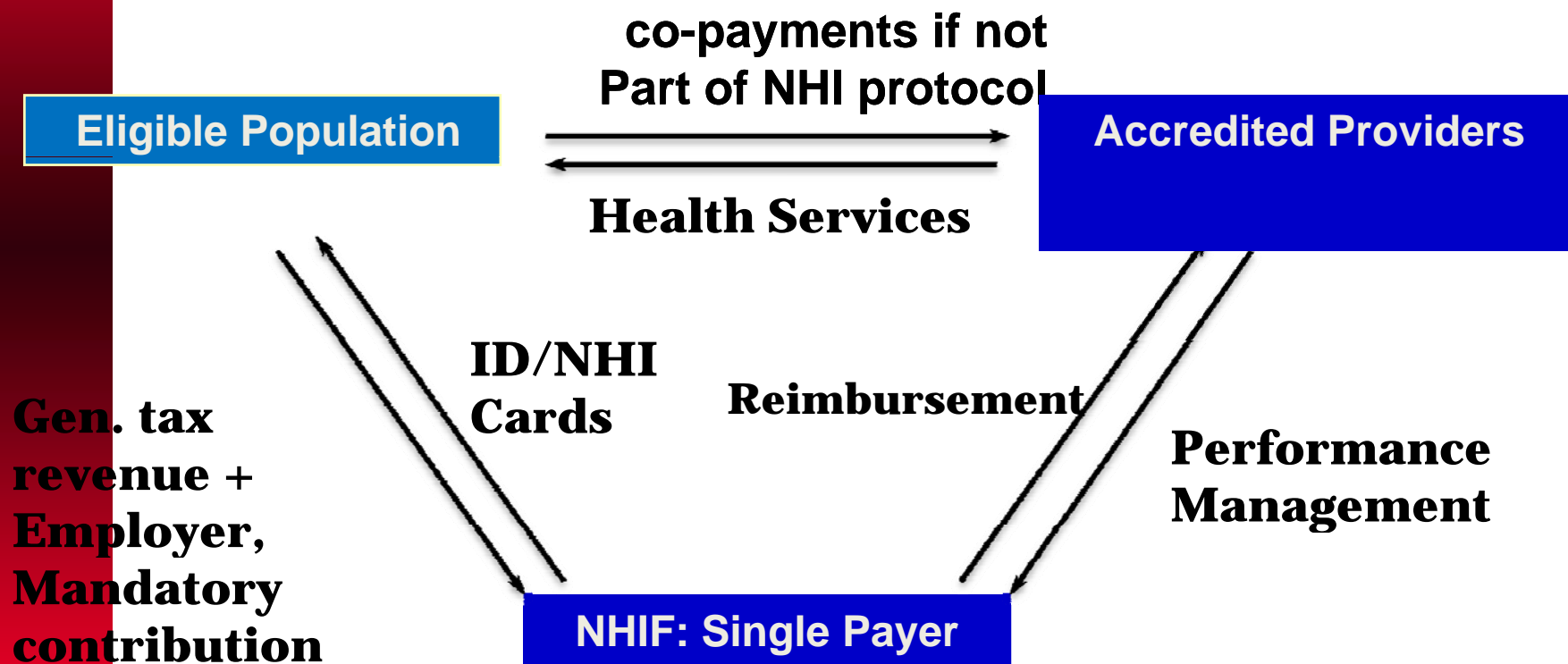
Year	Non-AIDS services	AIDS services	Other services	Admin	Total
2012	58	17	42	.58	125
2015	74	26	46	1.6	156
2020	112	39	52	4.0	214
2025	149	45	54	7.4	256

Co-Payments



- Services rendered not in accordance with the NHI treatment protocols and guidelines;
- Health care benefits that are not covered under the NHI benefit package
- By-pass referral system
- Services that are rendered by providers that are not accredited and contracted by NHI
- Health services utilised by non-insured persons

Flow of funds under NHI





Membership to
NHI is mandatory

Voluntary Medical
Aid permitted

No tax subsidies for
Medical Aid
members

Top-up insurance
allowed and not opt
out

Skilled persons in
medical aid will be
co-opted to work in
a single-payer NHI
Fund



Role of Medical Schemes

Population Registration and Information System



- Only registered population will have access to services under NHI.
- Accredited and contracted health providers will only provide care to the registered population.
- NHI card will be provided to allow for portability of services.
- Integrated electronic National Health Information system is essential for supporting service provision under NHI and will provide basis for tracking population health.

Migration to NHI



<p>1. NHI White Paper and Legislative Process</p> <ul style="list-style-type: none">• Release of Green Paper for Public Consultation• Launch of Final NHI Policy Document• Commencement of NHI Legislative process	<p>10 August 2011 December 2011 January 2012</p>
<p>2. Management reforms and Designation of Hospitals</p> <ul style="list-style-type: none">• Publication of Regulations on Designation of Hospitals• Policy on the management of hospitals• Advertisement and appointment of health facility managers	<p>August 2011 August 2011 October 2011</p>
<p>3. Hospital Reimbursement reform</p> <ul style="list-style-type: none">• Regulations published for comment on Hospital Revenue Retention• Development of a Coding Scheme	<p>April 2011 January 2012</p>

Migration, Cont



<p>4. Establishment Office of Health Standards Compliance (OHSC)</p> <ul style="list-style-type: none">• Parliamentary process on the OHSC Bill• Appointment of staff (10 inspectors appointed)	<p>August 2011 January 2012</p>
<p>5. Public Health Facility Audit, Quality Improvement and Certification</p> <ul style="list-style-type: none">• Audit of all public health facilities<ul style="list-style-type: none">• 21 % already audited (876 facilities)• 64% completed (2927 facilities)• 94% completed (3962 facilities)• Selection of teams to support the development and support of quality improvement plans and health systems performance• Initiate inspections by OHSC in audited and improved facilities• Initiation of certification of public health facilities	<p>End July 2011 by end of December 2011 by end March 2012 October 2011 February 2012 March 2012</p>

Migration, cont'd

<p>6. Appointment of District Clinical Specialists* Support</p> <ul style="list-style-type: none">• Identification of posts and adverts• Appointment of specialists• Contract with academic institutions on a rotational scheme	<p>August 2011 December 2011 February 2012</p>
<p>7. Municipal Ward-based Primary Health Care (PHC) Agents</p> <ul style="list-style-type: none">• Training of first 5000 PHC Agents• Appointment of first 5000 PHC Agents• Appointment of PHC teams	<p>December 2011 March 2012 April 2012</p>
<p>8. School - based PHC services</p> <ul style="list-style-type: none">• Establish data base of school health nurses including retired nurses• Identification of the first Quintile 1 and or Quintile 2 schools• Appointment of school-based teams led by a nurse	<p>August 2011 October 2011 November 2011</p>

Migration



9. Public Hospital Infrastructure and Equipment

- **Refurbishment and equipping of 122 nursing colleges**
 - First 72 nursing colleges by end of financial year 2011-2012
- **Building of 6 Flagship hospitals and medical faculties through PPP's**
 - King Edward VIII Academic (KZN)
 - Dr George Mukhari Academic (Gauteng)
 - Nelson Mandela Academic (E. Cape)
 - Chris Hani Baragwanath Academic (Gauteng)
 - Polokwane Academic (Limpopo)
 - Nelspruit Tertiary (Mpumalanga)
- Refurbishment of public sector facilities

March 2012
**Commence
2012**
Ongoing

Migration cont'd



<p>10. Human Resources for Health (HR)</p> <ul style="list-style-type: none">• Launch of HR Strategy• Short to medium term increase in supply of medical doctors and specialist• Increase in production of nurses• Increase in production of pharmacists• Increase in production of allied health professionals	<p>September 2011</p> <p>2012 – 2014</p> <p>2012 – 2014</p> <p>2012 – 2014</p> <p>2012 – 2014</p>
<p>11. Information Management and Systems Support</p> <ul style="list-style-type: none">• Establishment of a <u>National Health Information Repository and Data Warehousing</u> (NHIRD)• Provincial and District roll-out of the NHIRD• Appointment of Information Officers and Data Capturers	<p>July 2011</p> <p>November 2011</p> <p>November 2011</p>

Migration, Cont'd

12. Build capacity to manage NHI through the strengthening of District Health Authority

- Creation of NHI district management and governance structures
- Selection of Pilot Sites (First 10 districts)
- Development and test the service package to be offered under NHI in pilot sites
- Extension of Pilots from 10 districts to 20 districts

April 2012
June 2013

13. NHI Conditional Grant to support piloting of initial work in 10 districts

- Piloting of the service package in selected health districts
- Piloting fund administration

April 2012

Migration, cont



<p>14. Costing model</p> <ul style="list-style-type: none">• Refinement of the costing model• Revised estimates	<p>2012</p> <p>2013</p>
<p>15. Population registration</p> <ul style="list-style-type: none">• Partnership between Departments of Science and Technology, Health and Home Affairs on:<ul style="list-style-type: none">▪ Population identification▪ Population registration mechanisms	<p>Commence s April 2012</p>
<p>16. ICT</p> <ul style="list-style-type: none">• Scoping exercise with Department of Science and Technology and CSIR<ul style="list-style-type: none">▪ Design of ICT architectural requirements for NHI	<p>April 2012</p>

Migration, cont



<p>17. Establishment of NHI Fund</p> <ul style="list-style-type: none">• Appointment of CEO and Staff• Establishment of governance structures• Establishment of administrative systems	<p>2014</p>
<p>18. Accreditation and contracting of private providers by NHI Fund</p> <ul style="list-style-type: none">• Establishment of criteria for accreditation• Accreditation of first group of private providers	<p>2013 2014</p>

Piloting of NHI



- Pilot in 10 districts
- Dept of Health Audit of all healthcare facilities to facilitate choice of pilot districts
- Criteria for inclusion in pilot
 - re-engineered PHC streams,
 - basic infrastructure,
 - compliance with standards,
 - appropriate management levels.

Health System Strengthening



- ✦ Management of health facilities and health districts
- ✦ Quality improvement
- ✦ Infrastructure development
- ✦ Medical devices including equipment
- ✦ Human Resources planning, development and management
- ✦ Information management and systems support
- ✦ Establishment of the National Health Insurance Fund



Thank you

Workshop Questions



1. NHI covers all South Africans and medical schemes will provide top-up medical cover for those who choose. Any views on this?
2. GEMS is a medical scheme. What should happen to it once NHI is operational?
3. What about government medical schemes that serve state employees such as those for parliamentarians, police, etc.? Should they continue to exist once NHI is operational?

Workshop questions, cont



4. What should be the role of the private service providers under NHI? How should they be organised to provide services under NHI?
5. What should be the source of funding for NHI? Should it be general revenue, supplemented by mandatory contribution from employer and employee or other sources?
6. Should there be any co-payments for services under NHI at the point of service delivery?

Workshop Questions



7. Should NHI be administered by a single-payer public entity or by private medical schemes?
8. Should refugees and asylum seekers be entitled to get free services under NHI?
9. What about undocumented people, should they receive free services under NHI?

Workshop Questions



10. What should be taken into account in selecting pilot sites for implementing NHI?

11. How should funds from NHI Fund flow to service providers?

12. What should be the role of the District Health Authority in NHI