PROPOSALS FOR IMPLEMENTING NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

Aquina Thulare, MD, MBA, MSc
Moremi Nkosi, MPH

PRESENTATION TO THE
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Introduction

• SA in process of implementing an NHI
• Research areas identified:
  – Policy development
  – Policy implementation
  – Health Systems Strengthening
  – Ongoing monitoring & evaluation:
    • Universal coverage
    • Impact on health outcomes
• Local and international expertise drawn upon
Inherent Systemic Challenges

• Shortcomings in the overall health sector with poor health outcomes and value for money

• A greater part of financial and human resources for health services are located in the private health sector

• Private health insurance spends R11,300 per capita for health care for 16% as opposed to R1,900 per capita in the public health system for 84% of the national population not covered by private health insurance

• A further 16% of the population uses the private sector for primary care on an out-of-pocket basis, but still relies on public hospitals for specialist and inpatient care.
  – Out-of-pocket spending for this group is R2 500 per capita
  – Potentially catastrophic for low income households
PUBLIC

$$3\% \text{ of GDP}$$

$\text{R84.5 billion}$

Salaries; historical budgets; budget deficits and unfunded mandates

PRIVATE

$5.5\% \text{ of GDP}$

$\text{R113.1 billion}$

Fee for Service
Current Service Delivery Platform: High Cost Curative Model

- Quaternary Curative Care
- Tertiary Level Services
- Secondary Level (Regional)
- District Level
- Primary Health Care
Policy Mandates

• **Resolution 53** of the Ruling Party’s Polokwane Resolutions

• **Priority 2** of the Government’s Program of Action 2009 – 2014 and the DOH **Ten Point Plan**

• NSDA Output: **Strengthening Health System Effectiveness**
What are the main problems that the NHI seeks to address?

- High disease burden and poor health outcomes
- Increasing cost of health care – High expenditure but not comparable outcomes
- Lack of universal access to quality health services (highly inequitable access)
- Dual nature of the healthcare system (public-private --two worlds in one)
Why NHI…

• To introduce a consolidated/single funding pool for the population
  – Strategic purchasing, contracting and resource mobilization approach to health services delivery

• To provide a funding mechanism for improving cross-subsidization in the overall health system
  – Funding contributions explicitly linked to an individual’s ability-to-pay
  – Benefits from health services linked to the individual’s need for care
Why NHI… *cont*

- Better and more strategic mobilization and control of key financial resources
  - Strengthening the under-resourced and strained public sector
  - Pooling resources in the health system to **progressively realise the right of all to access affordable health care services** *(Constitutional Obligation on the State)*
  - Improved efficacy in the delivery of healthcare
- Enhance the role of the health sector in improving the social and economic well-being of the people
  - Improved health status: productivity ➔ economic growth
  - Improved life expectancy
  - Improved QoL
Principles of the NHI

• **The Right to Health**
  - Free at the point of use;
  - Rational choice of provider of care

• **Social Solidarity & Universal Coverage**
  - Mandatory progressive contributions according to their ability to pay
  - Universal access to health services that meet established and acceptable quality standards

• **Public administration**
  - Single funder
  - Public entity
  - Established by law
Creation of the NHI Fund

- NHI Fund established by Law through appropriate channels and processes
  - Separation of “funding” and “health services provision/delivery” functions
  - Principle Role: receive funds, pool and purchase services on behalf of the entire population
  - Will be publicly administered as a single purchaser with sub-national offices to negotiate and contract with the accredited health care providers (public and private)
NHI Coverage

• All South African citizens and legal residents

• Entitled to a defined, comprehensive package of healthcare services

• Services provided through appropriately accredited and contracted public and private health services providers
Provider Payment Mechanisms

• Reimburse all accredited public and private providers using risk-adjusted per capita payments and global budgeting
  – The annual capitation amount will be linked to target utilization and cost levels

• Payment mechanisms must assure appropriate incentives for providers

• Develop and implement case-based payment mechanisms (e.g. DRG’s) as an alternative to fee-for-service, especially at hospital level
  – Cost containment
Financial & Health Service Flows

The insured

No co-payments

Health Services
Quality, accessible & equitable

Accredited Providers

General Tax Revenue
+ supplemented by Mandatory Contributions (other???)

ID/NHI Cards

NHI Fund

PHC: Risk Adjusted Capitation

Hospitals: Global Budgets with move to DRG’s

Proactive Performance Management
Population Registration

• An NHI card will be ultimately issued to facilitate portability of services

• Multiple accredited providers in the vicinity of the members will provide choice to members who can request changes of provider once a year

• NHI cards for all population segments will be the same
  – Avoid the stigmatisation of subsidised households
Transformation of Service Delivery Platform: PHC Approach

Primary Health Care
(Clinic, CHC, Multidisciplinary Group Practices, Allied Health Professionals and Community Healthcare Teams)

District Level
(Level 1 beds)

Secondary Level
(Level 2 beds/Regional)

Tertiary Level
(Level 3 beds)

Quaternary Level
(Level 4 beds)
Simultaneous Health System Strengthening Plan

• Focus on (but not limited to):
  • PHC Re-engineering
  • Strengthening of the District Health System
  • Increased Autonomy of Public Health Care Providers
  • Improvement of Human Resources Capacity
  • Quality Improvement, Assurance and Accreditation Plans
  • General Infrastructure Inventory and Development
  • Integrated ICT and Health/Management Information Systems
Status Quo

• Implementation will be phased over **14 years**
• The initial priorities include, but not limited to:
  • Finalization of draft policy document
  • Wide consultation to get inputs from all stakeholders
  • Comprehensively review relevant legislation: **NHI Act promulgated by 2012**
  • Drafting of enabling legislation to facilitate NHI implementation
  • Continuous monitoring of sector developments
Key Policy Process Highlights

• 28 member Ministerial Advisory Committee appointed by in November 2009
  – 15 Technical Subcommittees established to further interrogate various aspects to support effective implementation
  – Provide advice on policy development, legislation and implementation processes
• Presidential pronouncement in September 2010 on inevitability of implementing NHI
Areas of Further Work for Knowledge Development

• Refining of Costing and Actuarial Models (iterative and continuous process)
• Economic Impact Modeling
• Tax Modeling for Revenue Analysis and Tax treatment
• Comprehensive Legislative Review
• Development of Purchasing Framework
• Development of Procurement Framework
• Development of DRGs Framework & supporting Coding Schema
• Institutional Arrangements & Governance Framework
• Transitional plan
Implementation will be a process, not a big bang approach
Thank you

Merci