

Proposal by the BHF Board of Directors on the role of medical schemes under NHI

Background

Details released by government thus far on the new National Health Insurance system are as follows:

1. NHI will offer a comprehensive package of services based on what is available in the public health sector.
2. The services will be provided by a mixture of public and private providers.
3. Accreditation of providers is a key principle. Private-sector practitioners healthcare service providers will be accredited as NHI providers based on their ability to provide services that meet quality standards and their willingness to accept NHI payment levels.
4. Sound quality of health services to be provided under NHI is non-negotiable
5. The system will be based on two principles: the right to health - which will mean health services will be free at the point of use - and social solidarity, where the rich will contribute a percentage of their income to fund health services for the poor.
6. The size of the individual contribution being considered within the ANC's working group is between 3% and 5% of personal income.
7. The second and main source of funding for the NHI will be tax revenue.
8. The public health sector will have to be substantially strengthened. The health budget will need to rise beyond the current R62,7bn. It is proposed that health expenditure should rise from 11% to 15% of total public expenditure.
9. The NHI will involve a more equitable and socially efficient distribution of health resources in the public and private sector.
10. Citizens would be able to choose between accredited providers in their area and would have an opportunity to change doctors within a window period.

The BHF proposal

The announcement at the Polokwane conference in late 2007 of a National Health Insurance system and the subsequent call by Dr Zweli Mkhize at the 2008 conference to medical schemes to prepare themselves for a system overhaul, set off a chain of activities undertaken by the industry body which will hopefully result in the medical schemes playing a critical role under the new healthcare system.

Based on the details released by government thus far, the Board of Healthcare Funders, representing 95% of medical schemes through Southern Africa has developed a proposal for the inclusion of medical schemes under the National Health Insurance System which will be implemented in the near future. BHF will adopt and vigorously advocate to government and other stakeholders the involvement of medical schemes within a South African NHI environment in the manner outlined below. The BHF model promotes the participation of medical schemes within the NHI environment in a mutually beneficial, constructive manner. This model proposes that medical schemes and administrators work actively towards the success of NHI because it will benefit their members and their businesses and the NHI system in turn is benefited by this work in terms of information management, health service quality monitoring and control, contract management, managed care initiatives, public private partnerships and consumer advocacy by schemes on behalf of their members.

The model enables a continued and potentially greater role for medical schemes into the future.

We propose that medical schemes and their administrators will collect contributions for NHI benefits from the NHI Agency as opposed to the members, as currently pertains.

Schemes will offer the benefits contained in the NHI package of benefits and such top up cover for shortfalls in the NHI package as their members can afford; The NHI package of benefits will have to be comprehensive for constitutional reasons but there are likely to be some areas where top up cover will be sought after such as the ventilation of neonates under 1000g or the availability of renal dialysis to patients who don't satisfy government rationing protocols.

The prices of the NHI package of benefits will be negotiated centrally with providers by the NHI Agency and therefore the latter will effectively be the single purchaser of health care services in South Africa as far as the NHI package of benefits is concerned. This will eliminate many of the problems which schemes currently experience concerning the various tariffs charged by health care providers and the significant cross subsidization of the Road Accident Fund and the COID Commissioner by medical schemes.

Medical schemes will continue to collect contributions in respect of top-up cover from members.

The proposed model promotes potential growth in membership of medical schemes without having to worry about the attendant dropping of reserves that this entails currently. The NHI Agency will have to provide the 'reserves' for the NHI system going into the future including those of medical schemes which function within the system as far as NHI benefits are concerned.

The model will eliminate the problems schemes currently encounter with designating public providers to render health services to scheme members. Public and private providers will be contracted by the NHI Agency at uniform reimbursement levels to serve NHI patients.

Medical scheme members will also be NHI patients in the recommended model.

This model will create a transition mechanism for NHI in the sense that the schemes can continue to offer greater or lesser top –up cover as the NHI backbone grows. If NHI experiences setbacks in terms of its implementation medical schemes will still be there to carry some of the health funding burden.

This model will ensure the workability of NHI in the South African environment without job losses within the private funding industry. It may even create jobs if administrators are subcontracted by the NHI Agency to administer certain NHI Fund beneficiaries, for example, at health district level.

The model allows medical schemes to provide top-up cover to members who want and can afford to purchase it. Medical schemes can cater for those that can afford it, as well as those who are only eligible for the NHI package of benefits.

It makes for seamless health financing experience for members of medical schemes and a painless transition for them into the NHI system. People will not have to terminate their medical scheme membership and be forced into an unknown and at first unpredictable new health financing environment. They may well have to register with the NHI Agency so that government can keep a record on how many beneficiaries NHI has but that may be the end of the changes apart from the payroll tax, that medical scheme members experience.

It recognizes and protects the constitutional rights of medical scheme members to the quality, scope and levels of care they currently experience. Medical scheme members have a constitutional right of access to the same levels of care and quality of care that they currently experience as members of medical schemes. Any diminution of that because they are being forced into an NHI system would be unconstitutional. The proposed model precludes this diminution of access by NHI in respect of current members of medical schemes.

It protects scheme reserves but at the same time makes it possible for individual schemes to take decisions concerning public private partnerships that benefit scheme members while strengthening the public health sector facilities for the good of all.

The NHI Agency will negotiate fees for health services covered by NHI.

There could be a regulated coding system that is universal throughout the SA health sector, the same provider fees applicable to all NHI covered health services resulting in cheaper administration fees for everyone.

Medical schemes will still be able to compete on the top up cover issues.

Non-scheme members will be able to join medical schemes in order to receive NHI benefits at no extra cost. The growth of schemes will ensure continued funding of schemes and volume based business for scheme administrators.

There will still be scope for managed competition between administrators for business which will promote efficiency of NHI administration and the most efficient and effective business models amongst administrators.

Boards of trustees will be able to play a strong consumer advocacy role and will provide opportunities for employers to still be involved in ensuring proper health care services for their employees that would otherwise be denied to them. Similarly organized labour, by participating in boards of trustees, will be able to get involved in schemes as vehicles for ensuring the workability and accessibility of NHI benefits by acting as consumer representatives and watchdogs to counterbalance government.

The model is the least disruptive method of transition into an NHI environment since medical scheme members will not be forced to leave schemes, people who previously could not afford to join schemes will find that they now can because their contributions are paid by the State and many may perceive this as a benefit in itself, schemes will not implode leaving the problem of what to do with their reserves and the consolidation of medical schemes within an NHI system will be greatly facilitated because everyone's NHI benefits will be the same.

The top-up cover offered by schemes will be voluntary but still be able to cater for those who want something over and above the NHI benefits.

The existing skill, knowledge and infrastructure of the private funding system will not be lost or wasted but will be harnessed to ensure that NHI works.

It is the scenario least likely to lead to constitutional challenges to NHI legislation by medical schemes and their administrators.

It is the scenario most likely to ensure the success of NHI going forward because it is marrying the goals of government around NHI with the rights and interests of medical scheme members into a single system.

The proposed model will encourage the willing participation of private health care providers within the NHI system.

It allows for the healthy evolution of a uniquely South African NHI system along the lines of what is most efficient, serviceable to the people of South Africa and viable in terms of health care provision taking into account their constitutional right of access to health care services.

Medical schemes, through their representative body, BHF, will engage with government, on an ongoing basis, on the principles of health care funding on behalf of their members including but not limited to benefit design and implementation, risk management, and ways to keep the costs of health care within the NHI environment down without compromising on quality.

These proposals are being taken to the BHF membership on Thursday 6th and Friday 7th August.