

BHF Info Line

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Highlights: BHF Conference 2008

National Health Insurance in South Africa

The topic of a proposed National Health Insurance (NHI) system for South Africa dominated the Board of Healthcare Funders annual conference, and was a recurring theme across many of the sessions. In her opening address, the minister of health, Dr Manto Tshabalala-Msimang, reiterated her view that NHI is a priority for implementation, and that proposed legislation is currently before parliament. "We need urgent review of those responsible for the purchasing, funding and provision of health care to ensure the momentous changes need to achieve a more efficient and equitable health system."

Supporting the minister's statements, Dr Steven Friedman, director of the centre for the study of democracy at the Rhodes University and the University of Johannesburg, noted that the current funding system has 'serious structural problems' that make it morally and financially unsustainable.

Dr Di McIntyre of the Health Economics Unit at the University of Cape Town got down to the nuts and bolts of how NHI might work in South Africa, although she acknowledged that at this point she was posing more questions than providing answers. "It's critical first to acknowledge the problem, and then be clear about what we want to achieve. We have been debating many of these issues since the 1980s, often acrimoniously, and too much of the debate has centred on wording and definitions."

Two key points to be kept in mind are the flatlining of public sector spending – this in the face of a dramatic increase in demand for services – and the cost spiral in the private sector which as seen medical aid premiums increase by more than 50% in the last decade. Much of this can be attributed to the private hospital industry, which is dominated by

three major players, whereas there are over 120 medical schemes. This seriously skews the balance of power between purchaser and provider.

"We're headed for a situation comparable with the American nightmare," she said, "where the majority of health funds lie with schemes and their risk pools are very fragmented. Yet these funds serve only around 14% of the population; government is responsible for the rest, with the result that there is a six- to seven-fold disparity between what is spent in the public versus the private sectors. Many people fall through the cracks, not being part of voluntary insurance and also not being eligible for state care."

NHI is intended to address this by providing universal cover, ensuring adequate and affordable health care while at the same time promoting cross-subsidies in the overall health system. Many of these terms require more precise definition, but given South Africa's massive disparities in income between wealthiest and poorest, it is envisaged that contributions should be aligned with ability to pay. NHI will thus address the challenges inherent in the current voluntary insurance environment and mitigate public-private mix disparities.

No two systems are the same worldwide, and South Africa will need to come up with one that is South Africa-specific. It will have to ensure effective revenue collection, pooling, purchasing and provision while inspiring trust in all South Africans. Speaking on behalf of the funding industry, Reg Magennis, CEO of Elixir Business Consulting, welcomed the NHI initiative, saying that anything that achieved universal coverage for all was to be supported. However, the industry needed to be proactive in its engagement with government to guard against legislation that could have unintended negative consequences. Private health care still has a role to play in bringing additional

resources and reducing pressure on public health systems. "We need to understand the constraints, and have a legislative environment that allows us to engineer solutions within those constraints," he said.

Public-private Initiatives and Partnerships

Public-private initiatives and partnerships (PPIs/PPPs) came under the spotlight at the Board of Healthcare Funders conference as one way to further the aims of NHI by ensuring the flow of funds from funders to the public sector. Johannesburg Hospital CEO, Sagie Pillay, underscored the need to look for new solutions where the public sector is a key player in the future of health care. "When the quality of the public sector is criticised, it's usually the so-called 'hotel services' that are being referred to. Our clinical standards compare favourably with those of the private sector, and sometimes surpass them. We therefore need to create synergies that align the interests of both the public and health insurance sectors. One of these could involve the development of lower-cost medical aid options in which the public sector is a preferred provider."

Malcolm Pautz, senior project advisor at the National Treasury, outlined a scenario whereby PPPs could enable the public sector to become the 'backbone of NHI'. The challenge is to find a way of achieving this that ensures sufficient incentive for the private party, something that he acknowledged can be 'politically fraught'. However, there are various international examples South Africa can learn from, and South Africa also has a head start in respect of being one of very few countries to have actually defined a PPP within a regulatory framework. "However, for PPPs to work on a large scale, we'll need political commitment, an enabling environment and strong decisive leadership," he said.

Dr Japie du Toit, specialist healthcare adviser to PriceWaterhouseCoopers, outlined some PPI successes in the Western Cape. These included a 'differentiated amenities project, which saw the introduction of private wards into certain public hospitals, and an agreement with the Road Accident Fund which saw the claim and collection process successfully outsourced to two private contractors. Dr Izak Fourie showed that PPPs could also make a positive difference in the arena of sub-acute hospitals (SAHs)/step-down facilities. There is a shortage of such facilities in South Africa, with a mere 762 beds nationally and serious geographic maldistribution. "There's no point in managed care systems encouraging the use of such facilities if they don't exist," he said. "As we're not going to build another 100 SAHs any time soon, PPPs are fundamental to alleviating the problem. This could be achieved in two ways. Existing SAHs can treat

the overflow of public sector patients at agreed reasonable rates; alternatively, under-utilised public hospital facilities could be outsourced for sub-acute use."

Offering the Competition Commission's view on PPIs, Thulani Kunene noted that the Commission is generally supportive of them, seeing them as encouraging rather than stifling competition. However, he added the rider that a PPI should be an agreement between the state and a single private provider. Where more than one private provider is involved in a PPI, it creates a platform for two potential competitors to collude. However, he acknowledged that there might be merit in joint participation in certain instances and that the Commission would evaluate cases individually in respect of the extent of the responsibilities and risks delegated to the public sector in terms of the specific PPI agreement.

Managing Non-Healthcare Costs

Along with private hospital costs, the increase in the amount of money spent in the private sector on administrative and non-healthcare costs is seen as one of the key elements in the sector's uncontrolled cost spiral over the past decade. Speaking at the Board of Healthcare Funders' conference, Professor Heather McLeod of the Department of Family Health and Medicine, University of Cape Town, and the Department of Statistics and Actuarial Science, University of Stellenbosch, set out to unpack and analyse administrative and managed care costs.

She posed the question, "Should there be an NHRPL process for administration and managed healthcare costs?" and answered it with a resounding 'No'. "It's a dreadful idea. Putting a process in place to control these costs would make the 'Gordian knot' worse."

She acknowledged freely that there was an issue, however. "Since the 1970s, real healthcare costs moved along fairly levelly until the early 1990s, when dramatic increases started to occur. This was a period of no regulation within the industry, and non-healthcare costs increased from 9% to 15% of the total spend during that decade. Since 2000, they have stabilised, but remain the highest in the world at 14%. The country with the next highest level is Germany at 8%."

Countries with social or national health insurance systems have levels of 2-3%. It's difficult to know what to aim for in South Africa, but 4-5% would probably be in keeping with international benchmarks. There are wide variations in gross administration expenses, however. While small self-administered restricted schemes generally have the lowest costs and large open schemes with third-

party administrators the highest, there is still a lot of variation within this trend, making patterns difficult to ascertain. The average for open schemes is R78/month and for restricted schemes R50.9/month.

Professor McLeod went on to cite a few striking exceptions, however. Platinum Health and Impala Medical Plan, which are self-administered and employ managed health principles, have monthly administration costs of R9.30 and R3.50 respectively. "That is the level or benchmark we need to aim for," she said. "Everything else is a result of unnecessarily complex elements in the environment we've created.

"What worries me is that incentives are not properly aligned. We need to look carefully at what we're incentivising the industry to do that has resulted in this inflation. We're talking human behaviour 101. If the incentives encourage additional services and therefore complexity, costs will rise. If administrators are paid a fixed fee per member, they're incentivised to attract as many schemes with as many members as possible. Once the money is in their hands, they now have a fixed income. As a result the tendency will be to do only what is necessary to retain the client, given that hiring additional staff to raise service levels will mean loss of profit.

"The current fee-for-service environment is a major problem – and what are we going to do to fix it? Humans are economic animals, so we get exactly what we incentivise. By paying a fixed fee for administration and managed care, we incentivise an increase in (often unnecessary) services, an increase in prices, duplication of services all over and service levels that are adequate, but seldom great. Fixing these prices or setting benchmarks doesn't address the core problems of the incentives we've created." Likewise, the promised introduction of the Risk Equalisation fund saw certain managed care organisations (MCOs) actively seek out beneficiaries with chronic disease list conditions. A fee was paid 'per diseased person', with the result that thereafter only the minimum service necessary to retain the client would be delivered.

The fee-for service model has led to what Professor McLeod calls the 'blame paradox' whereby all players point fingers at each other. She quoted Discovery Health CEO, Adrian Gore, as follows: "All stakeholders in the healthcare system consistently blame each other for the price and inflation pressures. The paradox is that each player's position, when considered on its own, seems noble and justified. Yet when you consider them collectively, they contradict one another ... As long as medical schemes pay for hospital care line-by-line and service by service, rather than at an agreed rate per day or better still a fixed amount per procedure *as in any other market*, it will be difficult to rein in costs."

South Africa needs a mechanism that works and incentives need to be aligned throughout the healthcare system. This is a technical issue, not a political or ideological one. She posed a number of questions in this regard. What is the best way for schemes and MCOs to ensure sufficient delivery of care? What is the private sector really good at, and how do we harness this in the best interests of everyone? Should schemes be demutualised? Should MCOs be allowed to gather and pool funds, thus removing the artificial barrier between schemes and the MCOs? Should schemes be different from MCOs?

Professor McLeod underscored that there is a need to encourage entrepreneurial behaviour while protecting key social values. Several European countries have strengthened market mechanisms and entrepreneurial behaviour while maintaining risk pooling and solidarity. In non-competitive environments administration costs of purchasers have been regulated, for example by means of a 'ceiling' fixed at a percentage of social health insurance revenue. "However, we need to be careful about just reducing fees," she cautioned. Having an efficient health insurance administration system does not mean minimising costs 'at any price'.

"Strategic purchasing is an important concern going forward and as an industry we need to focus on the interface between purchasing and delivery. Where purchaser models exist, as in South Africa, we need to move away from passive purchasing to a proactive strategic approach that asks, 'Which healthcare services should be purchased, how and from whom?' We still have to answer the question of who the most appropriate purchasing agent is. None of the models out there work all the time. We will need to come up with a local solution.

"Ultimately, we want purchasing and delivery incentives aligned between society, the administrator/MCO, the fund and the providers. There are no holy cows and no easy answers. We need dialogue and consensus as to what would work best for South African healthcare," she concluded.

Whither the healthcare broker?

Healthcare brokers/advisors have come under fire for their perceived role in driving up non-healthcare costs while delivering questionable value. Louis Botha, CEO of Health Quality Assessment, challenged this perception, arguing that South Africa's approximately 8000 brokers consume only 2% of medical scheme spend, and earn far less than other financial services and insurance advisors, despite medical aids being the most used insurance products.

"Rather than ask whether they have a role to play, a more appropriate question might be, 'Are brokers regulated effectively?'"

Botha pointed out that contrary to perceptions, the broker industry is in fact highly regulated. They need to be both CMS and FAIS accredited, as well as by individual schemes. Each of these has codes of conduct, qualifications and disciplinary procedures – and a compliance officer to monitor broker behaviour. In addition, brokers fees are capped at a certain level.

Botha argues that broker regulation should be simplified and clarified – and that where broker services can be improved is in the area of being more consumer-orientated. More attention needs to be paid to consumer education and ensuring that consumers actually understand their options and the managed care provided. But he is in no doubt that there is a role for healthcare advisors.

Healthcare Quality

Although cost concerns were given high priority at the Board of Healthcare Funders annual conference, the issue of healthcare quality was not neglected. As Louis Botha, CEO of Health Quality Assessment (HQA), pointed out, “If you know your quality, arguments around costs and access are strengthened.”

HQA is a BHF-supported industry initiative – a section 21 company that provides quality measurement services at low cost. So far, more than 20 schemes have joined in order to share data with a view to ‘develop a health audit report for the funding industry that focuses on quality with the goal of becoming the South African national standard for objective quality performance’.

Quality assessment is also a government priority, and the Office of Standards Compliance, established in terms of the National Health Act, is now functional as of the beginning of 2008. Chief director, Dr Carol Marshall, said that the OSC would focus on core standards for ensuring basic safety and integrity in both the public and private sectors, and reflected government’s essential role in protecting the public, especially the vulnerable. The overall aim would be to define, measure and improve quality in order to bring about better clinical outcomes in the entire healthcare system, along with better use of human and financial resources.

Freddy Beukes, principal officer of Sasolmed, highlighted the need to balance member care against a healthy balance sheet, two concerns that tend to oppose one another. Beukes underscored the necessity of not ‘fixating on solvency at the expense of quality care’. To this end, Sasolmed is investing much time and resources in preventive care, and is looking at both member and provider behaviour. Co-ordination of primary care and referral to specialists is receiving a lot of

attention, as is the formation of alliances with providers to align incentives that enhance quality.

He believes that good data shared with providers is key to a sustainable risk strategy, and that education of members, providers and trustees can both enhance quality and control costs.

Dr Simon Strachan, a Johannesburg paediatrician in private practice, gave a medical practitioner’s perspective on quality. The Paediatric Management Group, of which he is a member, is an initiative that was launched in 2002 in response to a need for cohesiveness in paediatrics and now represents 70% of paediatricians in private practice. It focuses on governance issues, using peer review mechanisms to understand the dynamics of particular practices, and also monitors the appropriateness of hospital admissions. It is currently expanding its assessment of quality of care, looking at areas such as in-hospital care, ambulatory care (including adherence to medication, assessment of chronic disease), primary care (including immunisations) as well as parental expectations and satisfaction.

“There is massive scope for improvement in the quality of delivered care and a need for improvement in quality measures, as well as for collaboration between the state, funders and providers. It is important that providers are recognised as important contributors to quality improvement,” he concluded.

In Conclusion

In closing the Board of Healthcare Funders annual conference held in Durban in mid-July, Dr Zweli Mkhize, Chairman of the Health and Education Subcommittee of the National Executive Committee of the ANC and MEC for Finance and Economic Development in KwaZulu-Natal, told delegates that the ANC’s 52nd national conference held in Polokwane late last year focused on both the achievements and the gaps in health care and education, and that there was no longer any question that a National Health Insurance (NHI) system would be implemented in South Africa. It is not a matter of ‘if’ but ‘when’.

The Polokwane conference highlighted that the implementation of NHI was an absolute necessity. Dr Mkhize pointed out that communities need to be more actively involved in their health care, especially when it comes to HIV/AIDS and TB. Mkhize also expressed his concern that, in his view, the country is not doing well in respect of meeting the millennium development goals (MDGs), especially where maternal and child mortality rates are concerned. Also worrying, he reported was the increase in XDR TB as well as the human resource

imbalance that exists between the public and private sectors.

Echoing sentiments that had been expressed throughout the conference, he noted that private healthcare costs are a problem. "We need to sit down and look at ways to optimise both the public and private healthcare sectors with a view to creating a partnership between them to ensure benefits across the spectrum. We also need to dispel the myth that government wants to abolish the private sector; rather we want a strong partnership between the two to achieve benefits across the spectrum."

Dr Mkhize pointed out that when one compares the differences in the increase in spend between public and private sectors, it's clear that government does not have the resources to invest enough in the public sector, e.g. for improving infrastructure. There is also an urgent need to increase the number of nurses and introduce and accelerate their training in the public sector. Partnering with the private sector can help to address challenges like these. There is a need to look collectively at the expertise in the country.

Government also needs to become involved in the affordability aspects of medical schemes with a view to increasing membership. "Affordability is the key issue for the man in the street and risk rating issues are a matter of concern," said Mkhize. He acknowledged that there are no easy answers, but that parties need to engage with each other and discuss issues meaningfully. He said that if more people with lower incomes can be brought into the system, then the private sector would be moving in the right direction.

He said that the funding industry needs to engage with government on PMBs and the reviewing of them. "We need to understand each other's challenges and identify the areas where the private sector and government can work together," concluded Mkhize.

Upcoming Events

ISPOR South Africa 1st Annual Conference

Bytes Business Park Conference centre, Midrand, 17-19th August 2008

International Society of Pharmacoeconomics and Outcomes Research South Africa (ISPOR SOUTH AFRICA) is an organisation of professionals with an interest in the study and practice of Pharmacoeconomics and Outcomes Research.

Its mission is to improve the standard of pharmaco-economic and outcomes research by promoting research, education, training and providing leadership towards optimal healthcare policies and standards.

The 1st Annual Conference of ISPOR South Africa is going to be held from 17th -19th August 2008. Both ISPOR and non-ISPOR members are welcome and the conference will be of value and interest to all those working in the funding environment, hospitals, healthcare providers, manufacturing and government where issues of cost-effectiveness and the value of new healthcare interventions are debated.

The conference will include 3 Short Courses which are half-day training courses on Pharmacoeconomic Modeling - Introduction, Pharmacoeconomic Modelling - Advanced and Interpreting the Data.

The Plenary presentation by Professor Diana Brixner, the current ISPOR International President will address the value of ISPOR – global and local perspective and Prof Brixner will also be presenting at the conference and running some of the short courses.

Other presentations and discussions include the South African Pharmacoeconomic Guidelines by Dr Anban Pillay and a Panel Discussion by stakeholders on Do We Need Cost-Effective Thresholds in South Africa?

The objectives of ISPOR SA are as follows;

- Provide an environment where researchers, healthcare practitioners, and decision-makers interested in pharmacoeconomics and outcomes research can share knowledge at a national and international level.
- Serve as a neutral forum in bringing together researchers, healthcare practitioners, and decision-makers interested in pharmacoeconomics and members of the pharmaceutical industry, health-related organizations, public health and academia.
- Act as a facilitator at a local level for individuals interested in pharmacoeconomics and outcomes research.
- Provide an opportunity for country-specific chapter members to become more familiar with the activities of ISPOR as well as participate in its activities.
- Endorse training/education programmes in pharmacoeconomics and outcomes research.
- To promote local development and monitor implementation of guidelines in pharmacoeconomics and outcomes research.

For more information on the South Africa Local Chapter and the conference, please contact the ISPOR South Africa Office:

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http://www.ispor.org/local_chapters/SouthAfrica/index.asp.