

NHI: THE ROLE FOR THE MEDICAL SCHEMES INDUSTRY

A DRAFT DISCUSSION DOCUMENT

INTRODUCTION AND MOTIVATION

The BHF Board of Directors wishes to recommend the model for National Health Insurance described below. Over the last few weeks the RPC Committee has met to discuss a number of different scenarios for medical schemes concerning National Health Insurance. The following model was presented by the Regulatory Policy Committee (RPC) to the BHF Board of Directors on the 30th July, 2009.

It was agreed that it is imperative for BHF to adopt and vigorously advocate to government and other stakeholders the involvement of medical schemes within a South African NHI environment in the manner outlined in this document for the following reasons:

1. The model allows for a continued and potentially greater role for medical schemes into the future. The difference is that medical schemes and their administrators may possibly collect contributions for NHI benefits from the NHI Agency as opposed to the members. They will continue to collect contributions in respect of additional benefit cover, from members.
2. It eliminates many of the problems 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. A document prepared for the RPC Committee last year reflects these problems in more detail.
3. It creates a valuable transition mechanism for NHI in the sense that the schemes can continue to offer greater or lesser additional benefit cover as the NHI backbone grows. If, for whatever reason, NHI experiences setbacks in terms of its implementation medical schemes will still be there to carry some of the health funding burden.
4. It will substantially contribute to the workability of NHI in the South African environment without job losses within the private funding industry. It may even create jobs if a mechanism of subcontracting the current medical scheme administrators can be explored and found by the NHI Agency, to administer certain NHI Fund beneficiaries, for example, at health district level.
5. It promotes the participation of medical schemes within the NHI environment in a mutually beneficial, constructive manner. Medical schemes and administrators will work actively towards the success of NHI, because it benefits their members and their businesses. 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.
6. It 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 may 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.

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7. It eliminates 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 take NHI patients. Medical scheme members will also be NHI patients in the recommended model.
8. Medical schemes will be regulated by the NHI Agency since the majority of scheme business will be NHI benefits. The NHI Agency may find it necessary to regulate medical schemes additional benefit cover in order to ensure that there is no gaming of the system at this interface.
9. It allows medical schemes to provide additional benefit 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.
10. 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.
11. 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.
12. 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. A current example would be of a scheme that used some of its reserves to build a ward at the Tygerberg Hospital for use by scheme members and public sector patients. This included the scheme establishing a pharmacy and employing a pharmacist at a government hospital for the convenience of the scheme members and the public sector patients on a roster basis.
13. It will facilitate the management of contracts between the NHI Agency and providers of health care services not just for the benefit of scheme members but also for the benefit of non-scheme members. The NHI Agency will negotiate fees for health services covered by NHI. The advantage of this, if medical schemes participate in the system, could be a regulated coding system that is universal throughout the South African health sector, the same provider

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fees applicable to all NHI covered health services, and cheaper administration fees for everyone.

Scheme administrators and schemes would be able to exert pressure on providers regarding the provisions of the NHI contracts and ensure adherence by providers to these contracts. The provisions of the NHI contracts will be embedded in IT systems and claims payment procedures. Medical schemes will still be able to compete on the additional benefit cover issues.

14. Non-scheme members may 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.
15. The state may underwrite medical scheme liabilities (to the extent that they are NHI liabilities) and the legislative requirement for 25% reserves to be held by schemes may be greatly reduced. This in turn will ensure that valuable resources for health care services are not tied up in scheme reserves as they are currently and can be used for the benefit of scheme members both existing and new.
16. 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.
17. 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.
18. 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. The consolidation of medical schemes within an NHI system will be greatly facilitated because everyone's NHI benefits will be the same. The additional benefit cover offered by schemes will be voluntary but still be able to cater for those who want something over and above the NHI benefits.
19. It will encourage and promote efficiency in the administration of NHI by both the state and private administrators since they will be able to attract members on the basis of the quality and efficiency of services they provide.

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20. 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
 21. It is the scenario least likely to lead to constitutional challenges to NHI legislation by medical schemes and their administrators
 22. 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
 23. It is likely to ensure the willing participation of private health care providers within the NHI system.
 24. It will promote and facilitate government access to population demographics and health statistics so as to better manage the public health system, promote funding of health care service provision at local and district level closest to the consumer (thus observing the principle of subsidiarity endorsed by the Constitution).
 25. 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.

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BACKGROUND

From public statements by Dr Shisana and others on the NHI Task Team¹ we know that –

1. NHI will offer a comprehensive package of health benefits, including primary health care, in-patient and out-patient care, dental, prescription drugs and supplies
2. The services will be provided by a mixture of public and private providers and paid for publicly by the National Health Insurance Fund (NHIF)
3. To ensure improvement in quality standards, all providers will be accredited before NHI funds them..
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.

¹ <http://www.netassets.co.za/article.aspx?id=928353>;
http://www.psghealth.co.za/news/PSG_Konsult_January_09.pdf
http://www.hsrb.ac.za/HSRC_Review_Article-80.phtml in which C Botha reports on a colloquium on NHI held by the HSRC. It was opened by the Minister of Health who stated inter alia that any reform towards a National Health System should be guided by the policy objectives that the policy option seeks to pursue with the following underlying principles for consideration in guiding the policy option: The right to health; Social solidarity; Universality; Equity; Universal access to health care; Efficiency in resource use.
Key issues that emerged during the deliberation at the colloquium include:

Advocacy for a National Health System as envisaged by the 1994 National Health Plan, namely a centrally-funded, basic package of care, free at point of use.

- In pursuit of the National Health System, the following steps need to be taken:
- Strengthen the public sector through increased human resource capacity by: implementing the National Department of Health's HR strategy; improved governance of the District Health System and public hospitals; and increased tax funding of the public health system.
- Distribute health-care resources equitably between the users of the public and private.
- Improve the public/private interface so as to explore various synergies such as the sharing of resources to improve efficiencies.
- Curb excessive costs in the private sector.
- Reform the tax subsidy of medical scheme contributions to reduce the indirect funding of the private sector.

The following suggestions were offered in relation to health-care funding:

- Funding of the National Health System through tax funding and mandatory contributions; revenue collection by existing institutions such as the South African Revenue Services (SARS); and pooled funds administered by the South African Social Security Agency (SASSA), or a resource allocation agency, or a central equalisation fund.
- The Government Employees Medical Scheme (GEMS) could be an alternative system for revenue collection, pooling of funds and administration, in which case the Basic Health Care Package could be offered by its low-cost Sapphire option.
- Services could be purchased from both the public and private sectors at affordable rates.
- A capitation payment system could be used with fee-for-service reserved for specified services.
- Affordability, percentage contribution and capitation fees could be determined by costing the basic health care package.

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6. The NHI will be simply a financing system, with government collecting and allocating money for health care.
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. Private-sector practitioners, like GPs, will be accredited as NHI providers because of their ability to provide services that meet quality standards and their willingness to accept NHI payment levels.²
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.

² "At the primary healthcare level, private GPs can be accredited if they work in group practices, which include primary healthcare nurses and a range of allied health professionals," says Shisana.

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RECOMMENDED MODEL: THE MEDICAL SCHEMES INDUSTRY BECOMES AN INTEGRAL PART OF THE NHI SYSTEM

In this model, the following possibilities exist:—

1. from an infrastructural perspective, there may be little changes within the medical schemes industry;
2. medical schemes become an integral part of the NHI system, but may retain their independent legal identities, especially if additional cover of benefits is envisaged.
3. medical schemes still have boards of trustees as they do now, and there is an arms length relationship with administrators;
4. medical schemes pay for benefits to their members under the NHI package and in terms of any additional benefit cover those members may have paid for from their own pockets;
5. from a medical scheme member's perspective he or she is entitled to NHI benefits and such additional benefits as he requires, but the system is seamless as the scheme pays for everything;
6. schemes get funded by the NHI fund in respect of the NHI benefits to which their members are entitled;
7. administrators play the important role of identifying the payments to which scheme members are entitled from the NHI Fund as opposed to what is covered in any additional benefits offered by the scheme;
8. schemes are accountable to the NHI Fund for the payment of benefits in respect of the comprehensive NHI package;
9. schemes have the potential to get much bigger than they are currently because of the potential to channel NHI funds through them to beneficiaries;
10. administrators will be subject to greater scrutiny as far as administration fees are concerned because of the NHI component but if they withstand such scrutiny they may be able to capitalize on the increased volume of members resulting from NHI;
11. schemes are regulated by the NHI Agency as far as the NHI package is concerned and also as far as additional benefit cover is concerned, because these products will have an impact on the beneficiaries of NHI;

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12. the NHI Agency, as the single purchaser of health services, will negotiate prices with providers for the services included in the comprehensive package and those will be the only prices at which the services can lawfully be provided;
13. scheme products outside of the NHI package can be negotiated by individual schemes or their administrators as they case may be;
14. medical schemes and their administrators provide information to the NHI Agency on problem providers, interpretational problems with the NHI package, forensic management issues affecting the NHI Fund, financial issues affecting the Fund, population demographics for their memberships and the like
15. the relationship between medical schemes and their administrators on the one hand and the NHI Fund is one of mutual co-operation and assistance;
16. there is total transparency between medical schemes and the NHI Fund as far as the payment of NHI benefits by medical schemes is concerned;
17. the medical schemes legislation changes so that medical schemes are able to ring fence NHI funds and contributions paid for additional benefit cover;
18. board of trustees of medical schemes are of an appropriate size and are elected by virtue of their individual knowledge and expertise;
19. the NHI Fund has the right to make recommendations and determine the criteria for qualifying and disqualifying the appointment of trustees of medical schemes;
20. the activities of brokers are confined to the additional benefit cover offered by medical schemes and they are not paid in respect of members introduced to the scheme;
21. boards of trustees become more active in ensuring the protection of members' rights and assisting members to make appeals and representations to the fund in hard cases or where problems are being experienced with a particular provider or group of providers;
22. boards of trustees play a much stronger advocacy role for scheme members as far as NHI benefits and contributions are concerned;
23. administrators become stronger in terms of IT systems, financial management systems and expertise in the administration of contracts negotiated between providers and the NHI Fund;
24. administrators play a watchdog role in ensuring that providers adhere to contracts with the NHI Fund;
25. administrators are accredited by the NHI Fund Agency;

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26. there is no such thing as prescribed minimum benefits for medical schemes as the comprehensive NHI package has taken its place;
27. in some cases membership schemes might merge and grow to become sector wide medical schemes, for instance, mining, textiles, banking etc.
28. current distinctions between open and restricted schemes may become blurred and disappear if the NHI Agency negotiates administration fees with administrators in the same way that it negotiates with health service providers and the NHI Fund regulates the corporate governance of medical schemes;
29. some of the larger administrators may be accredited to administer the comprehensive package for a portion of the population covered by NHI directly, for example, regionally;
30. medical schemes and administrators participate with the NHI Fund in such activities as evaluation of new health technology, the accreditation of health service providers, the monitoring of the quality of health services rendered to NHI beneficiaries, the evaluation of treatment protocols and the efficacy and efficiency of various types of health interventions and the like.

ROLE OF ADMINISTRATORS

In the absence of a published document from the NDoH, the role of the administrator is largely uncertain. It has been stated that the NHI Agency will be publicly administered, possibly through a single administrator. In order for NHI to be effective, administration services and customer support services will be essential. Opportunities may therefore exist, for prepared entities, which will be able to meet the required needs, to be subcontracted by the single administrator. Furthermore, the NHI entity will probably look for a one-stop-shop for the required services.

Possible Roles

Role 1:

One NHI beneficiary administrator assuming the single purchaser model.

- This function could be outsourced to third parties as they have required resources readily available and there may be no need to re-invent the wheel.
- Administration system is procured or licensed from an existing administrator and other administration functions and capabilities are built in house.

Role 2:

Assuming a single-purchaser with multiple-payers system

- Administrators provide support services to District Health Councils, NHI agency or medical schemes.

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Administration activities include but not limited to:

1. Collect fees from SARS or NHIA and manage beneficiary database
2. Other activities as listed in “Requirements for accreditation of medical scheme administrators”, a publication of the CMS publication.
3. Collection of key health data to monitor health system performance including quality improvement monitoring, vital statistics and epidemiological data.
4. Administration service includes the provision of accredited managed healthcare services based on identified needs including disease management for priority health problems.
5. Provision of switching house services to NHI Agency and medical schemes as part of the administration service.
6. Forensic work
7. Communications to members
8. Management of the provider contracting arrangements depending on the needs and geographical location of their members

PROCEDURAL RECOMMENDATIONS

1. The BHF Board of Directors has adopted and fully supports these proposals. It would greatly assist BHF’s constructive engagement efforts with the NDoH, if the medical schemes and administrators expressly and knowledgeably support this proposed BHF model.
2. BHF will make its position on NHI publicly known and constructively engage with its members and Government.
3. The BHF should only engage provider stakeholders in discussions around NHI once it has a firm view on the model that is preferred and supported by medical scheme members of BHF and their administrators.

NOTE:

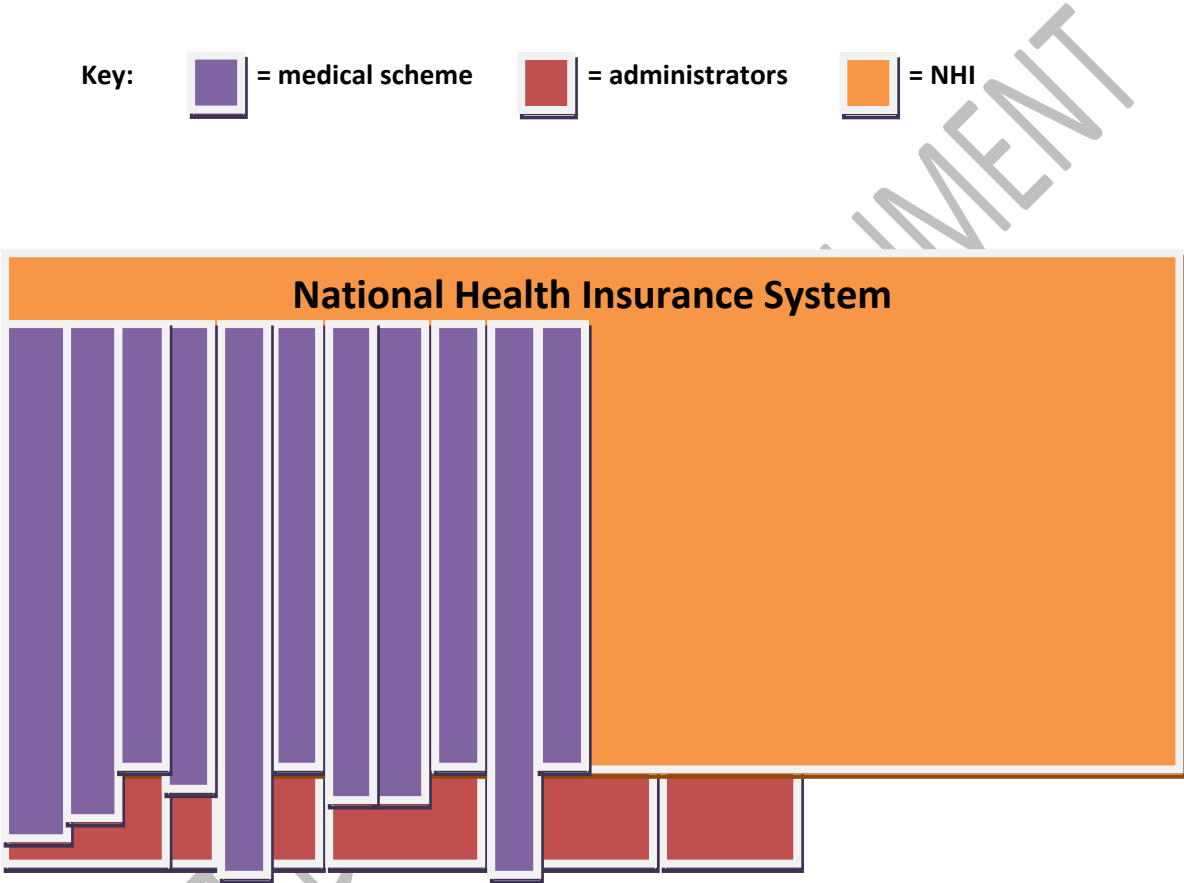
Annexure A contains a schematic of the recommended model

Annexure B contains a speculative additional benefit cover package to NHI for discussion purposes

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ANNEXURE A

Recommended Model: Medical Schemes Are Integrated Within the NHI System



Medical schemes sit within the NHI system and are agents for the payment of NHI benefits.

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ANNEXURE B

NHI may not cover the full range of benefits currently provided by medical schemes.

Additional benefit considerations, but not limited to, could include:

1. Optical benefit
 - a. Multifocal lenses
 - b. Financial additional benefit cover for frames
 - c. Contact lenses
 - d. Refractive surgery
2. Dental
 - a. Specialised dentistry
3. Radiology services which may not be available through NHI
 - a. Angiographic CT scanning
 - b. MRIs
 - c. PET scans
 - d. 3D ultrasound
4. Medicine (not covered by NHI)
 - a. Generics not covered on EDL
 - b. Ethical for which generics exist with or without co-pay
 - c. Ethical for which no generics exist with or without co-pay
 - d. Biologicals with or without co-pay
5. Prosthesis and devices
 - a. Limb prosthesis with joints
 - b. Battery operated wheel chairs
 - c. Other
6. Oncology
 - a. Medication not included in the EDL
 - b. Tier 2 or 3 of SAOC benefit proposal (Tier 1 linked to that available in public sector)
 - c. Biologicals
7. Hospitalisation
 - a. Acute care not provided in public sector
 - i. Newborn <1kg
 - ii. Multi disciplinary rehabilitation service at private rehab centre
 - b. Elective surgery not covered by the NHI
 - i. Infertility procedures and treatment
 - ii. Procedure requiring prosthesis not available in NHI
8. Emergency treatment received while abroad including repatriation where applicable

GLOSSARY OF TERMS

Single-Purchaser

In addition to the collection of revenue and pooling of risks, healthcare services are purchased by a sole agent. This could be either government or private (for profit or non-profit)

Multiple-Purchaser

In addition to the collection of revenue and pooling of risks, healthcare services are purchased by multiple agents. This could be a combination of government and private (for profit or non-profit).

Single-Payer

Healthcare services are paid for directly by a single or sole agent – either government or private (for profit or non-profit)

Multiple-Payer

Healthcare services are paid for by a range of agents. This could be a combination of government and private (for profit and non-profit).