

**DISCOVERY HEALTH (PTY) LTD and DISCOVERY HEALTH MEDICAL SCHEME
 COMMENTS ON GOVERNMENT GAZETTE NO. 34523, ON THE NATIONAL HEALTH ACT, 2003.**

GREEN PAPER: POLICY ON NATIONAL HEALTH INSURANCE

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INTRODUCTION

1. Discovery Health Medical Scheme (DHMS) and Discovery Health (Pty) Ltd (here jointly referred to as Discovery) appreciate the opportunity to comment on the NHI Green Paper.
2. The submission positively acknowledges several aspects of the Green Paper, as well as constructively suggesting areas for further consideration in refining the policy. The comments are arranged thematically, covering high level context and process points, before discussing the NHI package, delivery modalities, modelling and funding considerations. They then cover critical human resources issues, and structural and organisational issues concerning the fund and pooling mechanisms are discussed. Then discussed in some detail is how improved medical scheme regulation can assist in achieving objectives of the NHI, and more broadly, the roles that the private health sector could helpfully play in the emerging NHI system.¹

SECTION 1: GENERAL POLICY OBJECTIVES

3. We welcome the release of the Green Paper and we are in strong agreement with the following key policy principles contained in the Green Paper:
 - 3.1 The principles underpinning health care reform, namely: right to access; social solidarity; effectiveness; appropriateness; equity; affordability and efficiency.
 - 3.2 The objectives of providing appropriate, efficient and quality health services to all.
 - 3.3 The need to effect healthcare reforms in both public and private health sectors, in order to address the current healthcare challenges, and to ensure optimal health outcomes for South Africa's people.
 - 3.4 The strong emphasis on the primary healthcare system as the pivot of the entire NHI system.
 - 3.5 The objective of extending a comprehensive package of services, which includes high quality disease prevention, health promotion, curative treatment and rehabilitation, to the entire population over time, starting with the communities that have greatest need.
 - 3.6 The phased implementation approach, which is a realistic ambition that allows for iterative learning and adjustment as the system is incubated within the pilot sites that are planned.
 - 3.7 The adoption of a flexible policy position that is prepared to consider either a single-funder system or a multi-funder system.

¹ Our comments focus on areas where we are more qualified and have particular expertise, so for example, while we comment extensively on health informatics and relatively little on public sector management reform, this does not necessarily reflect the relative importance of these issues, but rather our own areas of experience.

- 3.8 The commitment to collaboration and co-operation between the public and private sectors.

SECTION 2: THE SOUTH AFRICAN CONTEXT

4. There are fundamental characteristics of the South African healthcare sector that must inform any policy debate and the ultimate policy choices. In this section, we highlight some of these key issues briefly, to provide important context for our comments and proposals.
5. South Africa faces an unfortunate reality of significant income inequality, leading to a dual economy, and indeed society, which is manifest across all sectors, including the health sector. This inequality is clearly unacceptable and requires urgent attention for moral, political and economic reasons. Yet the ambition to create equity and equality of care for all, must acknowledge that healthcare will not behave independently of the national economy. And thus the shift towards a more equitable healthcare system will occur over time, as similar changes occur in the wider economy. Certainly, appropriate healthcare reforms can accelerate the achievement of greater equity within the healthcare system, but the pace of such change is inevitably tied to some extent to the income distribution in South Africa's economy.
6. More effective investment in the health system will no doubt help to drive our economic growth, but the pace of improvement of healthcare equity will be moderated by the pace of economic growth. In the medium term, our GDP is expected to grow at a moderate pace of between 3 and 4% (Medium Term Budget Policy Speech, October 2011). The faster and more equitably our economy grows, the more fiscal space will be available to sustain health system investment and strengthening. The Green Paper does allude to these linkages to the wider economy, as evidenced by the proposal for gradual implementation of the NHI over time.
7. During this transition, and perhaps even after the NHI is fully established, those with higher levels of disposable income will certainly continue to purchase differential access to healthcare. Importantly, this feature of societies worldwide is not inconsistent with simultaneously recognising that healthcare is a fundamental human right. This is a right that needs to be realised through a high quality public health service available to all.
8. We believe that the NHI policy framework needs to acknowledge the reality of private access to healthcare beyond that provided by the state. This explicit acknowledgement will allow full debate and implementation of an appropriate regulatory framework which takes into account the duality in our healthcare system. Such explicit recognition can also enable the alignment of the entire system with the objectives of NHI in the short, medium and long

- terms. Conversely, if this reality is ignored, and the NHI framework is based on the assumption that the dual healthcare system will disappear, there is significant risk of multiple unintended consequences, which may impact negatively on the realisation of the objectives of the NHI policy. (For example, distortions in doctors' remuneration or working conditions could affect their relative inclination to work in public or private sectors; it is possible that the sudden inclusion of high healthcare users in the medical scheme population under public coverage could place heavy strain on the public system).
9. This underscores the need to develop policy that manages the two sectors, public and private, in a way that minimises negative consequences, while at the same time ensuring that the private sector contributes optimally to the achievement of the objectives of the NHI reforms.
 10. Fortunately, South Africa is able to draw on the experience of many other countries which also have dual healthcare systems, and that have embarked on similar reforms. Some of the most pertinent developing country examples include Ghana, India, Brazil, Colombia, and the Philippines. Some common emerging themes from analysis of the healthcare systems and reforms in these, and many other countries are that:
 - 10.1 Successful health service reform is usually highly path-dependent, involving rearrangement or reform to existing entities and assets, gradually creating new formations with a continuous feedback loop adjusting the reforms based on outcomes.
 - 10.2 Health services are financed through more than one mechanism, generally involving publicly financed services, contributory arrangements, private insurance and out-of-pocket payments, reflecting economic realities, Brazil being a good example.
 - 10.3 Where insurance systems are used, there is typically a mix of insurance providers incorporating both private and public insurers. Indeed single-payer systems are usually a misnomer – with private insurance playing a significant role even in Canada and the UK for example.
 - 10.4 Disadvantaged communities benefit from preferential support.
 - 10.5 There are no clear and consistent relationships between a choice between single and multi-payer systems, and the resulting health outcomes and efficiencies.
 - 10.6 Cost control in any kind of insurance-based scheme is very difficult. Rigorous and transparent performance management and incentivisation is critical at all levels in the system.
 11. As well as general themes, specific international case studies bring out different learnings which South Africa could usefully consider. These should be explored and circulated in much more detail to inform local discussions. For instance:

- 11.1 Mexican health reform benefited from the involvement of all political forces and generated social cohesion and broad agreements through early involvement of key stakeholders. Conciliation was pursued between private and public actors, trade unions, policy makers, federal and local authorities, and patient advocacy groups;
 - 11.2 The 1990's reform experience of Brazil shows the importance of primary care, that funding reform may be a necessary but not sufficient condition to address problems in health outcomes, and that provider buy-in is critical for successful reform;
 - 11.3 Chile's health reform in the 1990's showed how civil society organisations could be a useful mediating structure to involve all actors in the health space, and how unregulated private providers can drive costs in the system;
 - 11.4 Colombia's experience indicates how unintended consequences can bedevil reform initiatives, with poorly-structured competition failing to produce the improvements in efficiency and quality that were expected.
 - 11.5 Thailand's process illustrates the importance of early and significant investment in human resources to provide a base to open up a range of reform possibilities, as well as the importance of substantial consultation between role players;
 - 11.6 Ghana's reform indicates the need to balance political imperatives for reform with rigorous, impartial and widely-sourced technical input.
12. Our view is that the NHI reform framework should explicitly allow for both private and public sector healthcare access in South Africa, as is found in most countries worldwide. These two sectors should ideally co-exist in a way that optimises the interfaces between them, and avoids either causing harm to the other.
13. Within this context, appropriate regulatory reform to stabilise the current medical schemes environment, and to improve both cost and quality trends, is a key element of a comprehensive healthcare reform strategy, and will assist the achievement of the objectives of the NHI system, particularly easing pressure on the public sector during its internal reform processes.
14. An important mechanism of stabilisation in the private sector is a Risk Equalisation Fund to stabilise the risk exposure between medical schemes, and ensure adequate protection from anti-selective movement of individuals against and within schemes. In a similar vein, more discretion to manage anti-selective risks stemming from late joiners, and opportunistic joiners should be considered, in order to mitigate the significant imbalances and cost pressures that will arise over time from consistent patterns of anti-selection. On the supply side, a number of reforms are possible that could significantly reduce the upward cost trends, as well as improve quality of care.

15. Private sector stability will be further supported with the development and implementation of a reasonable and enabling framework for tariff negotiations with health professionals, who are in very limited supply in South Africa, in both the private sector and particularly the public sector.
16. Collectively, the appropriate public and private sector reforms can create a pragmatic pathway to secure improvement and equity in healthcare in South Africa, and to the achievement of the goals and objectives of the NHI. Conversely, failure to regulate the private sector effectively through necessary reforms may hinder the attainment of the objectives of the NHI.

SECTION 3: CONSULTATION

17. We acknowledge the significant efforts by the Department of Health and the Ministry of Health to explain the NHI Green Paper in numerous fora, and to consult on its contents, including the recent National Health Consultative Forum.
18. However, in light of the transformational nature of the reforms proposed, we would recommend that the Department of Health publish a comprehensive public consultation plan covering the steps after the submissions on the Green Paper. Furthermore, the legislative process should follow after the consultation period of the White Paper, rather than prior to this step. The consultation process should ideally include meetings with all relevant industry groups, business associations, policy institutions, healthcare professional associations, community representative bodies, and NGOs as well as individual companies and organisations. There should also be a series of open workshops to explore views on pivotal policy choices.
19. In light of the intensity of this process suggested, we would recommend that the time frames on page 51 of the Green Paper be reviewed to accommodate sufficient time for this full consultation process to take place. Anything less than six months is unlikely to provide for adequate consultation, processing of the views of various stakeholders, and synthesis into a White Paper. The consultation plan should ideally include recommendations regarding the ongoing consultation strategy planned for the entire 14 year NHI implementation period.

SECTION 4: DEFINITION OF THE BENEFIT PACKAGE

20. The Green Paper seems to define the NHI package as a range of services to be provided within different levels of facility in accordance with prescribed norms and standards. We agree with this approach. In this way, the package definition is not as rigid as an insurance based entitlement to a set of particular services or 'benefits', which is likely to generate

both higher overall utilisation, and high relative demand for curative, elective services that do not optimally address the public health challenges in South Africa.

21. We do however believe that the current package definition remains vague and that a more comprehensive definition of the health benefit package is required, to allow for more in-depth analysis and comments from interested parties, and to inform accurate costing. This should include more detail on the clinical policies in relation to which existing and new medicines and technologies are funded by the NHI. And this should be compared to the current package of services provided in the public health sector.
22. A critical area that is not defined in detail in the Green Paper is the provision of secondary, tertiary and quaternary services. Key questions here include how access to these services will be rationed, and how effective gatekeeping will be implemented to ensure optimal use of services at each level.

SECTION 5: PRIMARY HEALTHCARE RE-ENGINEERING

23. The renewed emphasis on primary health care is widely endorsed as the best approach to building an effective and responsive health care system. Particularly, we believe that health outcomes will be improved with a more pro-active approach to wellness and by ensuring that health promotion and prevention is implemented in a more structured way.
24. The disease burden from lifestyle-related conditions such as diabetes, obesity, hypertension, etc, is increasing. Engaging the population to exercise more, eat healthy foods, stop smoking and reduce drinking is a critical way to reduce this burden and save on the expensive treatments which become necessary if these drivers go unaddressed.
25. Discovery Vitality is internationally recognised as one of the world's leading pioneers in incentivising health improvement through behaviour change. Discovery is very willing to provide any assistance or expertise that might be useful in designing and implementing the critical wellness and prevention components of the NHI programme.
26. We strongly support the intention to deploy community-based healthcare teams, to implement school-based healthcare, to monitor and advise on chronic conditions in their areas, etc; and to set up roving teams of defined health professionals, including specialists, to improve access to these scarce resources in our health system. It is appropriate that the primary healthcare outreach teams are led by nurses, and include community health workers, in a way that increases the reach of the workforce without an excessive increase in the costs of the system.
27. As a result, a key element in the successful implementation of a renewed primary healthcare approach will be the appropriate definition of roles for each level of health

worker, and the creation of new cadres of health workers combined with task shifting approaches.

28. Critically, the intended mechanisms for effective demand management should start at the primary care level, in order to contain NHI costs over time. The Green Paper contains relatively little information or discussion of this key set of issues, and the NHI will require an explicit approach, including:
 - 28.1 Triage policies and mechanisms for ensuring that appropriate care is provided to those in most need;
 - 28.2 Policies for referral up from primary care level to secondary, tertiary and quaternary facilities and services, and how these will be enforced.
29. In the absence of such policies, the system will inevitably control costs through queue-based rationing, which will have negative equity and efficiency impacts, and will also undermine public support for the NHI over time.

SECTION 6: SERVICE DELIVERY MODELS

30. The NHI reform process provides an ideal opportunity for South Africa to experiment with a number of flexible service delivery models in the proposed pilot districts, in order to improve the cost effectiveness of service delivery.

Service delivery partnerships with the private sector

31. We believe that in addition to the important efforts already underway to improve the management skills, human resource capacity and information capability at all levels of public sector facilities, consideration should also be given to introducing more flexibility in the delivery models. These could involve integrating private sector resources more closely into the NHI system, but there is little detail on this in the Green Paper. This integration could occur through a range of public/private partnerships to expand service delivery capacity:
32. Possible examples are:
 - 32.1 Use of private providers to provide specific packages of benefits or levels of service. Partnerships with private GP's, particularly in rural areas, may be attractive to expand access to quality care in these underserved parts of the country;

- 32.2 Specialists, sub-specialists, radiologists, pathologists and hospitals in private practice also have skills that could usefully be contracted into the public sector;
 - 32.3 Use of private facilities' management capacity to manage, or advise on management of public sector facilities.
- 33. The mechanisms and levels of reimbursement for providers will be critical with regard to finding implementable approaches.
 - 34. Beyond extending the existing ways of working, and linking the existing sectors more closely, there is a valuable opportunity to enable and support much more innovation on the provider side, with application in both the public and private sectors.

Integrated delivery systems

- 35. In the medium to long term, given the current state of fragmentation and lack of coordination in healthcare provision, there could be substantial cost reductions achieved through reorganization of health care delivery into various forms of integrated delivery systems. There is a growing body of international experience in successfully achieving this, from which we can learn. The Green Paper acknowledges this approach, and we expand on it with some further comments here.
- 36. Such systems involve optimal use of different levels of health professionals, collaborating in teams. On the private sector side, they would also probably require the establishment of entities that are able to employ and/or share risk with health professionals, in order to adequately align incentives for cost effective care.
- 37. At the primary care level is the 'Patient-centred Medical Home'. This approach has been used in the USA and Germany to good effect, in both public and private sector delivery systems. These models have been shown to improve clinician communication and coordination of care, leading to improved patient care experience, reduced duplication of diagnostics, and reduced costs. They focus on mixed-discipline practice organisation (including levels from community health workers to general practitioners and specialists); on the use of collated patient health information in electronic health records; on the use of rigorous quality measures and evidence-based practice to drive quality, and on continuous improvement in approach through regular patient experience surveys.
- 38. Since they provide integrated care from preventative to basic acute care, such Medical Homes are more suited to reimbursement through capitation, potentially with incentive funding available partly based on quality and patient satisfaction metrics, to discourage the overprovision of services.

39. However, in the South African private environment, the current regulatory environment poses a major obstacle to the emergence of these integrated systems, certainly on the private side. The key regulatory hurdles to these developments relate to the employment of doctors and arise from the ethical rules and policies of the Health Professions Council of South Africa, as well as from other aspects of prevailing legislation, including those that define the scopes of practice of various health professions, and aspects of the National Health Act pertaining to Certificates of Need.
40. It is necessary to have an urgent review of the various rules and policies, in order to preserve the good intentions of these, while addressing their many serious unintended consequences. Reforms to these regulatory constraints could lead to quick gains in delivering low cost and high quality healthcare, and could therefore provide an early boost to the emerging NHI.

Low-cost facility licensing

41. Also on the private provider side, increased licensing of low cost hospitals would allow the emergence of low cost delivery models. These would focus on increasing day surgeries in place of overnight hospital admissions (over 90% of cataract and hernia surgeries are done on a day surgery basis in the US and Canada, compared to between 20% and 75% in SA), and likely be characterised by specialisation in high volume clinical areas, using standardised products, adhering to standardised clinical protocols, and deploying 'rightskilled' personnel rather than having clinicians delivering care for which they are overqualified. Even within the current hospital environment, better coordination of admissions, supply of pre- and post- operative information, clear clinical pathways and use of other forms of postacute care like step-down, rehabilitation and home-based care, would achieve lower costs and better quality than the current relatively uncoordinated and ward-centred system.
42. The efficiencies unlocked here would translate into lower private hospital costs, and therefore lower medical scheme contributions and better access within the private sector environment. Many lessons could be learned in this respect from the existing mine-based medical services, which are permitted to employ doctors, and which have a long history of providing high quality of care at relatively low costs.
43. The integrated care model could be constructively applied in the public primary healthcare system and in the private sector. Together with stimulus of the low cost private provider market, this would open up exciting opportunities for the NHI system to integrate private resources in order to better serve the wider population at reasonable cost.
44. Discovery fully supports the use of pilots to explore different service delivery approaches and to gain iterative experience as the reforms are implemented. A possible avenue to begin to create a single health system is by ensuring that the NHI pilots that are to start in 2012

include sites with different approaches, reflecting the various alternatives that are kept open by the NHI Green Paper.

45. One way to optimise this opportunity is to create sites that have different mixes of public and private elements, different funding and delivery models, etc. It is critical that the detailed results of these pilots are widely shared, for common learning. These results should also be considered within the longer-term consultation process recommended in Section 3.

SECTION 7: PRINCIPAL FUNDING MECHANISMS FOR NATIONAL HEALTH INSURANCE

46. We strongly support the following key elements of the proposals in relation to funding mechanisms:

- 46.1 The use of prepayment as a preferred mechanism for funding health needs;
- 46.2 That the revenue base should be as broad as possible;
- 46.3 The proposed alignment of the service offering with the benefits offered by existing statutory entities such as the Road Accident Fund;
- 46.4 The suggested use of appropriate levers to incentivise compliance with protocols, guidelines, benefit packages, accreditation, etc;
- 46.5 The application of initial funding to prepare the public sector for NHI, by improving quality, reengineering primary care, and upgrading infrastructure, amongst other initiatives.

47. There are several options left open in the Green Paper on composition of the NHI and of funding mechanisms. As a result there is a sequence of several decisions which need to be made, which will crucially influence costs and therefore funding requirements. These include:

Benefit package

48. Prudent and sustainable healthcare funding requires the benefit package to be fiscally sustainable. This in turn requires careful definition of the package, or at least clear specification of the levels of care to which beneficiaries have access, and effective triage and gate keeping, thus ensuring that care is delivered at the appropriate level.

Value for money improvements on existing resources

49. In addition to clear definition of NHI packages and effective gate keeping, to ensure best value for money is obtained from funding made available, there needs to be a specific focus on ensuring cost effective delivery of high quality, responsive patient care. In this regard,

the proposed management reforms in the public sector, and potential regulatory reforms within the private sector supply side could assist in improving quality and cost effectiveness of care in both the public and private sectors. (The private sector reforms are elaborated on in Section 6 and 16.) International experience suggests that a judicious mix of roles for public and private sectors on the funding and delivery side may help cost containment and therefore reduce funding burdens in emerging economies.

Savings from new delivery models

50. The nature of the delivery models are also a key driver of ultimate costs, and by implication, funding requirements. We would recommend that the pilot projects be designed to evaluate different delivery models, including those involving private sector delivery partners and/or private sector management expertise. This will allow experience to be developed in which models are most cost-effective for different levels of care in different geographical regions.

Out-of-pocket payments

51. The Green Paper opposes out of pocket payments as a funding mechanism except for very specific and valid circumstances. While we agree that co-payments can deter important access to health services for those in real need, there are situations where copayments can assist in ensuring that services are not over utilised, and in this case, may not necessarily create a barrier to accessing needed services. For these reasons, we recommend that small (potentially means-tested) copayments on high-utilisation, discretionary services, be considered. These services are often prone to unnecessary utilisation and small co-payments can ensure that utilisation is kept at appropriate levels, ensuring the NHI package is fiscally sustainable in the long term, and therefore actually helping to suppress the funding burden.

Funding requirements

52. Once the funding decisions are made, it will be possible to further refine the NHI costing model with more accuracy (Section 8 contains discussion of some technical aspects of the modelling). And then it will be feasible to explore different sources of further funding (general taxation, payroll taxes, dedicated taxes, etc), together with their advantages and disadvantages.
53. Since funding mechanisms have potentially significant implications for the economy and for fiscal equity, any fuller details on government's thinking regarding funding mechanisms should ideally be released either prior to, or in the White Paper, and these can then form part of the White Paper consultation process.

SECTION 8: COSTS AND MODELLING OF THE NATIONAL HEALTH INSURANCE SYSTEM

54. We clearly recognise the difficulties in providing accurate costing of the proposed NHI system at this stage, given that the development of the prospective delivery model, benefit package, delivery models and payment mechanisms, is at a preliminary stage. However, it is critical that more detailed costing models, their mechanics, assumptions and results, be completed and made available for public comment prior to the ultimate finalisation and implementation of the NHI policy. The following specific constructive comments and recommendations are intended to assist in the ongoing development of the costing model.

Methodology and assumptions

55. The initial ILO modelling methodology, as outlined, may be appropriate for very high level estimation of cost impacts. We recommend that further iterations of the model should allow for different categories of disease and service, rather than considering only the overall average cost per generic admission or visit. The mix of these categories may change over time, and may differ between currently insured and non-insured populations.
56. So in order to underpin the costing model, a thorough understanding of the disease burden of currently uninsured lives and therefore the likely profile of financial demands on the NHI is critical, to ensure its ongoing viability and optimal resource allocation. The starting point should be to collect high quality clinical and related data from existing state health facilities. Discovery is one of the local organisations that can offer expertise in grouping this data to understand the profile of disease, and the likely impact of this profile on future healthcare demands. We are very willing to provide data, analytic capacity and expertise as required, if this can be of assistance in developing a detailed costing model based on accurate estimates of underlying disease burden.
57. Utilisation assumptions are not included in the Green Paper. Para 119 of the Green Paper refers to an ILO model that includes consideration of utilisation rates, but does not further clarify the utilisation assumptions as applied to South Africa. The model is based on these key assumptions, but does not take into account the potential impact on the system if some of these assumptions prove incorrect. For instance, utilisation rates and costs of the NHI may be significantly higher than current estimates assume, since these are based on average utilisation rates from public sector facilities, and do not take into account the high disease burden and historic utilisation patterns of current medical scheme members.
58. Similarly, the assumption of a large, general utilisation increase, as the NHI is introduced, also needs further research. In South Africa, it is mainly not financial barriers that restrict access to quality health services, given that existing public healthcare is largely free for those who need it. For example, less than 7% of the population are blocked from accessing

healthcare due to the cost or the distance of travel required (IMSA policy brief 16). For the majority of the population, therefore, the problem is more about quality than access issues in the public system. Any effects on utilisation with introduction of the NHI will depend on the extent to which quality as well as access issues are addressed.

59. As another example, a major assumption is that primary healthcare services will be provided effectively and that this will largely dampen demand for services at higher levels. While this is clearly the right base case assumption given the intentions of the NHI system, the costing model in development should provide sensitivity analyses to estimate the potential cost impact if the primary healthcare system is unable to provide effective gatekeeping. For instance, this may occur in the early stages of the implementation of the system and/or in different parts of the country.

Modelling of private sector interaction effects

60. In addition to the above points, an accurate model of future NHI demand patterns, and hence costs, must take into account key dynamics relating to the relationship between the proposed NHI system and the membership of medical schemes. We believe that tariff and medicine price dynamics between the NHI system and the private healthcare system need to be carefully considered.
61. Tariffs that will be paid to public and to private providers have not been defined. As the NHI proposals leave open the possibility of providing access to private practitioners and hospitals, both the acceptability of these tariffs to private providers and their affordability for the NHI are key parameters in estimating the costs and evaluating the feasibility of the NHI model. An understanding of how the policy will be implemented is closely related to an understanding of the tariff framework. This also affects transitional arrangements and impacts on the relationship between private providers and NHI providers.
62. Medicine prices in the private sector are tightly regulated through the Single Exit Price legislation. However, the Green Paper does not explicitly recognise the significant subsidisation relationship between current private sector medicine prices and state tender prices, nor does it clarify the intended pricing position for the NHI. To the extent that the NHI purchases a material basket of medicines that are currently purchased in the private sector, it is not clear whether these will be purchased at current state tender prices, or at some higher price level. Once this issue is clarified, the impact of this on state tender and current private sector prices can be evaluated in the model. It is vital that these effects be carefully modelled, as failure to do so may lead to unintended cost and or supply consequences in both the NHI and the private sector environments.

Economic modelling

63. As well as improved social equity, the Green Paper presents exciting potential economic effects that could result from improved health outcomes in SA. Discovery agrees with the Green Paper that the actual implementation of the National Health Insurance (as primarily a structural health system change) could have uncertain macro-economic implications depending on whether it is able to improve health indicators significantly, at an affordable cost, and in a way that improves labour productivity. As a result, we recommend that rigorous modelling, and analysis of the experience of other developing countries, be carried out to determine the relative contributions to economic growth of: (1) structural health system changes, (2) absolute levels of health expenditure, (3) actual health outcomes, and (4) other factors.

Process

64. The Green Paper (para 118) refers to an iterative process to refine cost estimates, but provides no further information about how the iterative process will occur, and what factors or developments might be taken into account in these iterations. As the costing model is a critical element of the overall proposal, the White Paper should provide further detail on the parameters and plans to iterate the costing model over time.

SECTION 9: HEALTH PROFESSIONALS AND WORKFORCE

65. In terms of addressing the acknowledged human resources shortages in the whole healthcare system, the Green Paper refers (paragraph 147) to a long term plan articulated in the recently released consultation document, “Human Resources for Health for South Africa – 2030.” We strongly agree with the Green Paper in recognising that the HR shortage in all areas (GPs, specialists and nurses of all levels) is a key cause of poor health outcomes in the public system and high costs in the private system. Therefore a robust strategy to address this national shortage is imperative in creating a stable foundation for any NHI model. Furthermore, it is critical that this strategy be integrated much more closely with the NHI proposals, in terms of pipeline of numbers and types of professionals emerging from training, and how this will affect NHI models being considered and their roll-out. As a result, our comments on the Green Paper also include reference to elements of the HR Strategy particularly relevant to the NHI.
66. The methodology and assumptions made in developing the National Department of Health Workforce Planning model referred to in the HR Strategy document are not given in great detail and hence it is difficult to comment meaningfully on these. Potentially due to data constraints, the targets and gaps are defined in terms of service planning and international benchmarks and care groups. Ideally the modelling process should aim towards projection of needs based on expected disease burden which is a much more accurate determinant of

actual demand on healthcare services, and hence a better method of predicting HR requirements.

67. We believe that the projections of availability of health professionals contained in the HR Strategy are somewhat optimistic (particularly in respect of specialists, where training lead times are so long), which will affect NHI roll-out and the delivery options available. The costs associated with increasing the numbers and breadth of health professionals may consequently be understated to some extent. It is also important to note that the recent implementation of the Occupational Specific Dispensation has resulted in higher than anticipated increases in personnel expenditure. The HR model presented therefore lacks adequate detail on the fiscal implications of a much expanded health workforce, which has important implications for NHI funding.
68. More detail is required regarding the impact that the proposed new service delivery models and the revised human resources strategy will have on the teaching curriculum, and on the use of available teaching platforms. There is a clear need for significant expansion of the available teaching platforms for all levels of health professionals. In this context, we strongly support the inclusion of new private sector teaching platforms for doctors, nurses and other health professionals. These private sector platforms should be fully integrated into the existing public sector academic teaching complexes.
69. In this way, our capacity to produce more health professionals can be expanded at a much faster rate than through expansion of current and new medical schools only. Full integration will also deal with concerns that private sector teaching platforms will deviate from appropriate public healthcare approaches, and will ensure clinicians produced contribute primarily to the public sector during and after their training.
70. The HR Strategy also envisages new cadres of health workers, including a different cadre of nursing staff and the formalisation of the career paths of community health workers. We strongly support these approaches, and would encourage further creative exploration of task shifting, including the development of various levels of healthcare technicians, who can carry out routine functions that do not require full medical training. Examples in use in other countries include anaesthetic technicians, who can assist in an operating room environment, allowing one specialist anaesthetist to supervise several patients in surgery.
71. In addition, we believe that certain other categories of skills will be required for the effective implementation of the NHI system. These include:
 - 71.1 General management of people and healthcare facilities;
 - 71.2 Purchasing and commissioning of healthcare services;
 - 71.3 Health information management – to implement systems for capturing and reporting clinical information which supports resource allocation decisions, efficiency monitoring, and effective management.

72. In respect of all of the projected increases in existing categories of worker and creation of new categories, the volumes of human resources, costs and timing of their production should be explicitly linked to the NHI modelling, funding and service delivery decisions.
73. This said, to make the best use of resources available, we strongly support the intention to build an ethos of healthcare teams. A major problem in current healthcare delivery arises from the fragmentation of care between different facilities or professionals. This is true in both the public and the private healthcare systems. However, the Green Paper does not pay sufficient attention to the considerable cultural change required before South African healthcare professionals will change their current modes of practice towards one in which teamwork and integrated care approaches are fully implemented. Detailed focus is needed on how training and incentives will be developed to encourage this form of integrated care, and to make the required changes to the organisational culture of current healthcare settings.

SECTION 10: THE ROLES OF DIFFERENT LEVELS OF ADMINISTRATION WITHIN THE NHI SYSTEM

74. In Section 16 of the Green Paper, it is stated that the NHI Fund will be established as a single-payer entity accountable to the Minister and Parliament. The Department of Health is envisaged to continue to hold responsibility for policy and planning, with the NHI Fund only implementing approved plans from the National and Provincial Departments of Health, through sub-national offices, who will manage nationally-negotiated contracts with District Health Authorities. A different section (Section 13.2) however identifies the District Health Authority as the contracting unit, and indicates that the NHI Fund will only provide support for contracting. This section also locates the service planning function at District Health Authority level, in contrast to Section 16 which locates the planning function at Provincial and National level.
75. These sections indicate a lack of clarity on the key roles to be played by different institutions within the NHI system, as it seems the NHI Fund will only implement purchasing decisions already decided by the Provincial and National Departments of Health. It is also unclear how the National and Provincial Departments will coordinate their plans, where final accountability will lie, and what the dispute resolution mechanisms will be amongst all three parties. The Provincial Departments of Health also have stewardship for service provision, thus blurring the purchaser-provider split that the policy seeks to achieve. In principle, if the provinces and metros remain as employers of health professionals, this means they will tender to DHA's to supply health services. If this is the intention, then the policy proposals need to be clear about the accompanying changes that will be required in the current budgeting system for provinces.

76. There will be a similar change in the relationship between DHA's and regional and central hospitals, requiring astute and skilled negotiation and reimbursement skills at the DHA level. An example that South Africa could learn from is the model in the UK, where Primary Care Trusts contract with a centralised Centre for Business Intelligence in order to benefit from economies of scale in reviewing service delivery data and adjusting purchasing contract accordingly.
77. Academic hospital complexes are a key part of the health system both for service provision and for training. The Green Paper is silent about how these dual roles of the academic centres will be made available to all health districts.
78. We strongly recommend that consideration be given to the issue of economies of scale in the planning of the entire NHI. For example, a key requirement could be that local-level purchasing entities are purchasing services for a minimum of 2 million people, and that these entities have adequate contract management and purchasing capacity. The current health districts cater for populations ranging from 64,000 to over 3 million. They are mostly (with about 5 exceptions) too small to develop the purchasing power and scale of expertise to become effective procurement entities. It may therefore be more appropriate to locate purchasing responsibility and the responsibility for contract management at the level of regional health authorities and metropolitan authorities, who can aggregate such functions for a number of smaller District health authorities. Alternatively, smaller DHAs in a region can be grouped together to form larger purchasers with the required scale to develop the required skills and systems to procure efficiently.
79. In order to address the abovementioned lack of clarity and confusion in the proposed roles for each level of the healthcare service, we believe it is critical that the specific and mutually exclusive role of each level of the system in purchasing and/or in service delivery be carefully spelled out in the White Paper. Failure to do this will create significant risks of role duplication, conflict, overlap, failure of accountability and ultimately, the risk of service failure and inefficiency.

SECTION 11: THE NHI FUND – REVENUE COLLECTION AND POOLING

Collection

80. While we support the proposal that SARS be responsible for revenue collection, in order to provide comprehensive commentary on the funding side of the proposals, more detail is required on the nature and quantum of additional revenues to be collected to fund the NHI. Beyond obvious points relating to impact on the economy and fiscal progressivity, in the absence of more detail, it is not possible to comment in detail on the balance between the positive and potentially negative impacts of each method of raising revenue.

Pooling and equity

81. A key assumption of the proposed single risk pool approach to the NHI is that it will increase equity between current medical scheme members and those not currently on medical schemes. This equity improvement may however be undermined if the impact on demand for NHI services by those currently on medical schemes is not accurately estimated and modelled.
82. Current medical scheme members are on average older, with an average age of around 31.5 and pensioner ratio of 6.5% (Council for Medical Schemes Annual Report, 2011) compared to the current 'uninsured' population average of 26, with 5.4% over 65 (National Planning Commission Report, 2011). Scheme members due to historic patterns of income distribution and privileged access to health services and education, have significantly longer life expectancy than the uninsured population, and also a historical pattern of much greater utilisation of services, due to greater access over time, and the unfortunate incentives created by the fee for service payment system.
83. Apart from the potential imbalances due to age and life expectancy differences, medical scheme members have significantly higher levels of many chronic diseases and also the often high accompanying costs relative to the uninsured population. These differences arise because the open enrolment rules governing medical schemes allow chronically ill individuals to join with limited underwriting, meaning that very sick patients with expensive combinations of disease, who have the means, already tend to gravitate into the medical schemes environment. This has meant that the proportion of members registered for chronic conditions in big schemes has increased by just under 1% a year in the last five years. And it gives rise to a situation in which as little as 2% of the membership can be responsible for nearly 20% of medical scheme expenditure.
84. The net effect of these dynamics is that current medical scheme members may utilise NHI services at materially higher rates than those currently uninsured, and the cost impact of these members may well exceed the net incremental premiums contributed to the NHI by these members. This may be exacerbated by their longer life expectancy, meaning they claim for longer relative to the period they are likely to make most of their contributions. These dynamics may have several important, unintended consequences.
85. In particular, a key risk for the NHI is therefore that the currently uninsured population (younger, and therefore on average healthier) may end up on balance subsidising this pool of expensive scheme members. This result would directly undermine the equity-promoting objectives of the NHI. Effects such as these should be modelled carefully and impartially to ensure that the NHI equity objectives are not undermined, and particularly a lifetime view of equity as well as a year-by-year view needs to be developed.

SECTION 12: THE NHI FUND – ENROLMENT

86. All South African citizens are issued ID numbers from birth. In our view, this should be enough to verify eligibility, and it is unclear why a NHI-specific registration system is proposed. The process of issuing NHI cards to all eligible people is also fraught with the risk of fraud and abuse. For both of these reasons, we recommend that this costly additional requirement be eliminated and that the funds saved be allocated to more critical priorities. If ID numbers are used as the basis for registration and entitlement, additional clinical and demographic data can be collected over time and populated within an NHI information system which will be critical as the NHI system develops.
87. Our national borders are notoriously porous, and it will be unavoidable that the NHI will have to provide health services to many illegal immigrants. This problem may indeed become more serious if the improved NHI system itself becomes a magnet attracting cross border flows of people from neighbouring countries in search of good healthcare services. The forthcoming White Paper should explicitly address how this issue will be dealt with effectively. In practice, the most likely scenario is that migrants without SA citizenship will still be able to access NHI services. In this case, it will be important for the costing models to incorporate some estimates for the impact of migrants on utilisation rates over time.

SECTION 13: THE NHI FUND – PURCHASING

88. ‘Purchasing’ of healthcare may be interpreted in many ways. The Green Paper proposes that individual payments will be necessary when for instance the treatment options chosen fall outside the package of NHI service. This suggests the possibility of operating on a basis of retrospective claims submission by health service providers and reimbursement by the NHI via different levels of the healthcare system. It also discusses approaches where providers are allocated funding prospectively through various mechanisms like capitation, or in other ways that incentivise efficiency, e.g. DRG based reimbursement contracts. In all cases, purchasing can be done from various degrees of separation of one entity from another, e.g. with purchasers such as a national NHI fund, sub-national funds, District Health Authorities; and providers such as provincial health service management, individual hospitals, private GPs, etc. In this section, we briefly discuss the retrospective and prospective approaches, as well as alternative reimbursement mechanisms.
89. In our view, the potential use of a retrospective claims based system requires significant investigation and should not be assumed to be an optimal approach without careful consideration. In this regard, the following key points should be noted. Importantly, all of the key policy objectives set out in the Green Paper can be achieved without implementing

a claims based system, and could instead be achieved via simpler and less costly methods of payments between defined purchasers and providers. Examples of alternatives to a retrospective claims based system include budgetary transfers, and various forms of contract based payment methods. Secondly, there is no doubt that a claims based system is administratively more complex and more costly than the other approaches suggested here.

90. We strongly support the proposals to use various risk-adjusted capitation and alternative mechanisms to reimburse providers as a medium to long term objective of the NHI system. However, these approaches take significant time and expertise to develop and implement, for both the administrative and the health service provider components of the healthcare system, and will require the development of significant numbers of personnel trained in the use of these approaches. Areas of expertise that will be required include clinical coding, development of DRGs and capitation-based payment methods and health informatics. Approaches to developing this expertise should be expanded in the White Paper, since without these skills, the goals of the NHI in using these reimbursement mechanisms will not be achieved.
91. Discovery has extensive experience and expertise in this area, as well as assets that can quickly be deployed, and we would be very willing to assist in providing these assets and our expertise on a non profit basis.
92. The White Paper should also provide a clear transitional pathway from the current budgeting system used in the public sector to the full use of DRGs and capitation based payments in the NHI. Interim steps along this pathway will be required, since it will not be possible to move the entire system from simple budgets and salaries for personnel towards DRG and capitation systems very quickly.
93. Whatever approach is adopted, a critical element of any centralised healthcare purchasing function is an explicit prioritisation framework in order to optimise resource allocation. All healthcare systems throughout the world are forced to prioritise between different levels of care, and between different treatments and procedures. In the absence of an explicit prioritisation framework based on agreed principles which have the backing of the public, there is a material risk that the NHI system will ration by queuing or by other implicit 'rules' or systems, most of which are likely to be inequitable and inefficient to some degree. This is a vexing problem facing healthcare policy makers around the world, and the White Paper should provide detailed guidance on the approach that the NHI will take to resource allocation and prioritisation. As noted above, failure to develop and implement a fair and effective prioritisation system will quickly undermine efficiency and access, and this may itself lead to a loss of public support for the NHI.
94. The principle of fairness is an important foundation for a national health system. It is therefore important to ensure that the system of prioritisation is transparent, well

understood and seen to be fairly implemented. This principle extends to resource allocation as well to access to all types of health service available within the NHI.

SECTION 14: THE NHI FUND – GOVERNANCE

95. The governance of the NHI system as a whole involves that of the NHI Fund as well as any new or existing entities with redefined lines of accountability and areas of responsibility, such as local, metro, district and provincial structures. As stated in Section 10, the proposals in regard to which functions lie where need to be clarified, and these definitions will have governance implications.
96. Focusing on the single fund model in the first place, the Green Paper proposes a public entity (government owned and publicly administered). This entity is proposed to be both autonomous, and to report to the Minister of Health and to Parliament. The Chief Executive Officer of the NHI is to be appointed by the Minister. It is not clear in what sense the NHI will be autonomous if its primary appointments and reporting lines are to the Minister of Health. Ministerial appointments of entities that provide services, purchase services and monitor quality of services (like the Office of Health Standards Compliance) may be open to political interference, and may weaken the chances of rigorous control of cost and quality.
97. A robust governance mechanism would ensure that there are independent structures for oversight. These ambiguities need to be clarified and more checks and balances created to ensure effective functioning of the entity. We would argue strongly that any governance authorities within the NHI system should be truly autonomous. It should always be borne in mind that structures such as the NHI are long term, and over time it is possible that those exercising political custodianship over them may not be inspired by the same vision as the pioneers of the system.
98. Research shows that publically financed health systems are vulnerable to illicit workplace conduct (e.g. moonlighting), and the illegal charging of patients for public services. These kinds of abuse will not be readily obvious to the current structures that interact with the health system, such as the Auditor-General's Office, or the Office of Health Standards Compliance. Furthermore, there is a significant risk of moral hazard in any financing system. For health financing, the areas of particular vulnerability relate to the management, procurement and purchasing, using health funds belonging to the enrolled populace. Particularly, a single-funder model of NHI means that the procurement of all health services in the public sector will be done by one body (possibly with delegated purchasing authority to sub-units like DHA's). In all these respects, the population market has no recourse to

market accountability and in many respects little recourse to professional accountability. This lack of accountability inherent in the proposed structure creates a high risk that service quality and efficiency may suffer due to the lack of meaningful accountability to the users of the system.

99. It is therefore of fundamental importance that there are institutional mechanisms to limit the discretion of key officials of the NHI Fund, and that these mechanisms are transparent to the general public. As such, the White Paper on NHI should incorporate specific first principles, from which the appropriate governance framework will flow. These should include self-evident principles such as: clarity in definition of mandates, transparency, accountability, supervisory independence, objectivity in performance measurement, and effectiveness of both performance-based sanctions and incentives.
100. For example, these principles could lead to governance structures involving various combinations of following features:
- 100.1 Transparent appointment of a board to govern the NHI, drawing on many pools of stakeholders (community, public and private sector representation), and unencumbered by political interference;
 - 100.2 Accountability to an independent regulatory/supervisory body (accountable in turn to parliament), such as the Council for Medical Schemes, which could have its mandate expanded to supervise all private schemes as well as the NHI Fund. This body, whatever form it takes, needs to be independent, impartial, free of conflicts of interest and resistant to capture by any entities it regulates.
 - 100.3 In keeping with the culture of performance targets that are already being required in the public sector, the NHI Fund should be required to set specific measurable performance targets, which will be available in the public domain. The annual report should be presented to Parliament and should also include an evaluation of success or otherwise in reaching these performance targets.
 - 100.4 The establishment of an institutional mechanism to ensure fairness in order to provide a channel of recourse in the event of unfair decisions that affect users of the health system.
 - 100.5 Incentives should be aligned to patient interest and to health outcomes. This implies that the monitoring of service quality (by the Office of Health Standards Compliance) will be an important mechanism to determine satisfactory patient experience, amongst other measures. Investigations and sanctions for corrupt or inappropriate practices should be conducted swiftly and transparently.
101. Should a multi-funder model be implemented (as described in a Section 17), the underlying principles are unlikely to change, though the implementation in governance framework

may. This model retains some market accountability, and may also be subject to some regulatory oversight perhaps by expansion of mandate and capacity in the Council for Medical Schemes. Additional governance and regulatory considerations related to multi-fund models are addressed in Section 17.

SECTION 15: TAX TREATMENT OF MEDICAL SCHEME CONTRIBUTIONS

102. The Green Paper proposes the removal of the medical scheme contribution tax subsidy, though it is not clear at what point in the reform trajectory this was intended.
103. While the historical tax subsidy system was inequitable, due to its bias towards higher income earners who purchased more costly medical scheme benefit plans, the recent policy changes to a system of tax credits now mean that the effective tax credit system is much more equitable. Given this modification, it is worth considering the relative costs and benefits of retaining rather than eliminating the restructured tax credit system.
104. The removal of the tax credit will in theory generate additional revenue for the fiscus, currently estimated to be approximately R15.7 billion (in 2008/09 terms, National Treasury, 2011), although it is not certain that this revenue will automatically be allocated to NHI Funds.
105. At the same time, the removal of the tax credit may result in a large number of current medical scheme members dropping out of private health insurance coverage, and becoming dependent on the public healthcare system for all of their healthcare needs. As noted above, the current membership of medical schemes is on average older and sicker than the average population and are heavy users of healthcare (hence their choice of private cover). Pushing these individuals back into the public sector will place significant additional burden on NHI facilities.
106. The White Paper should ideally compare the gains in tax revenues from removing the tax subsidy/credit with the costs to the existing public sector in the short term or NHI in the longer term, of caring for several million older and sicker individuals. Such analysis should also ensure that lower income, healthier contributors do not end up subsidising relatively wealthier, sicker people with longer life expectancies.
107. This comparison will almost certainly demonstrate that removing the tax credit will result in a material net cost to the NHI system. On the other hand, retaining an equitable tax credit that allows those lower income earners who can afford to do so to purchase private health insurance can be seen as a constructive way of reducing the clinical disease burden and service load on the public NHI system, at least for the initial 14 years or more during which the system is in development. The tax credit proposed in the recent National Treasury

discussion document (17 June 2011) is set at R216 per person per month for the taxpaying scheme member and first dependent, in 2011/2012 terms. Modelling work suggests that people with pre-tax incomes of R6,000-R10,000 per month on lower cost schemes (costing R500 to R1000 per person per month) would be the primary net beneficiaries of the tax change, with support of around R90 per person per month. This could well persuade those at the margin to use the private sector for their health needs rather than add to the burden on the public sector/NHI system.

108. The application of a tax credit is certainly consistent with the pathway outlined to the full NHI. There is recognition that the implementation of NHI will be phased in over a period of time. The tax credit supports a health system opportunity to leverage the synergies between private and public sectors over this time.

SECTION 16: MEDICAL SCHEME REGULATION

109. The Green Paper is relatively quiet on the role of the medical schemes in or alongside the NHI. It seeks to draw on the expertise in this sector in respect of managing funds for the purchase of healthcare. Discovery is keen to offer assistance as may be required in this regard.

110. However, we believe that medical schemes should be seen as a critical component of the broader healthcare system, providing adequate cover for a significant proportion of the population, and therefore removing from the NHI a significant component of the national disease burden.

111. In this context, it is essential that a comprehensive regulatory environment for medical schemes be established. This regulatory framework should complete the overall regulatory approach developed after 2000, which has been implemented in parts, but lacks some critical components. Completing the medical scheme regulatory framework requires a relatively simple set of policy and regulatory changes, for which much preparation has already been undertaken. These policies can be implemented without undermining the broader NHI objectives or trajectory, and in fact can help to strengthen their achievement. The reforms address key cost drivers of medical scheme membership and would help to reduce costs for scheme members. The critical elements which require regulatory reform include:

Direct management of anti-selection

112. Anti-selection by scheme members who join schemes only when they need healthcare, undermines the social solidarity objectives of the medical schemes regulatory environment and drives up costs for all members. This also leads to selective withdrawal from scheme membership where low risk members are unable to afford the contributions required to

subsidise those of higher risk and are forced to leave their scheme. The major sources of anti-selection include:

- 112.1 Age: young people defer scheme membership;
 - 112.2 Gender: females join during child-bearing ages and promptly leave the scheme after giving birth, but often leaving in schemes sick children requiring high cost care;
 - 112.3 Disease burden: people join when diagnosed with illnesses that are expensive to treat or with multiple illnesses;
 - 112.4 Scheme selection – poorer risks gravitating towards schemes or options with better benefits as they need them over time.
113. The deteriorating overall quality of the medical scheme risk pool due to anti-selection, is shown in the distorted age profile of demographic profile of scheme membership (50% of formally employed people under 35 are scheme members, compared to 70% of those over 60); and also by the increase in the share of scheme membership made up by women, from 50% to 55-60% at the child-bearing ages, who join to access maternity benefits and then promptly leave coverage.
114. Current regulations permit application of late joiner penalties (LJP's) to people who defer membership until after age 35, but with a maximum penalty of just below 80% on top of normal contributions. Waiting periods of up to two years are also permitted on certain conditions. The LJPs can be enhanced in a way that is fairer to more scheme members:
- 114.1 Make LJP's compulsory, as some schemes waive LJP's which can then no longer be applied if the member moves to another scheme within a 24 month period;
 - 114.2 Increase the level of LJPs to increase incentives to join earlier, particularly for people 65 and older. The Australian system can be considered, which applies LJP's on a simple and sound risk basis – loading 2% for each year over age 30 that someone is not a scheme member.
115. Waiting periods can also be made a more effective tool:
- 115.1 Allow waiting periods for maternity events within first twelve months for all new members;
 - 115.2 Increase condition specific waiting periods to 24 months or more as 12 months is not a strong enough disincentive to selective joining;
 - 115.3 Allow application of waiting periods when moving between schemes or between options in one scheme.
116. Regulatory changes could therefore allow schemes to manage anti-selection by prospective members more effectively and directly, through the enhanced application of waiting periods

and late joiner penalties. This will reduce the inclination of some people to join schemes only when ill and will thus reduce costs for all members.

Establishment of a Risk Equalisation Fund

117. The latest CMS Report (Council for Medical Schemes Annual Report, 2011) argues that the establishment of a Risk Equalisation Fund is essential to protect against discriminatory market forces that prejudice sicker and older members. Such a fund will transfer funds from schemes with younger, healthier populations to those with older, sicker ones, completing the aim of ensuring social solidarity in the schemes environment. It will therefore discourage 'cherry picking' of good health risks by schemes, and force schemes to compete on the basis of cost management, including through smart provider contracting, rather than the ability to attract young and deter older members.
118. From a scheme's point of view, it will also make them less vulnerable to anti-selection by members. If the fund mechanism takes account of the major health risk factors (age, sex, chronic condition status) this can significantly reduce the extent to which some schemes face solvency pressures due to a high proportion of high risk members as defined by these criteria.
119. It will stabilize the solvency of many schemes which contain a high proportion of older and sicker members. This will facilitate efficiency-promoting mergers in the environment. Importantly, it will also prevent the collapse of these high risk medical schemes, which all too often forces their members onto an over-burdened public sector.

Movement to risk-based solvency regulations

120. Current capital requirements demanded by the Medical Schemes Act and the related interpretation of how the 25% solvency requirement is to be calculated are unrelated to the actual risk each scheme is exposed to; and therefore unnecessarily conservative for large risk pools. The current requirement is to hold a flat 25% of total gross contributions in reserve – with new schemes allowed temporary exemptions. This means that many large and growing schemes have to charge higher contributions than would be required under a risk-based capital regulatory regime.
121. The effect is to significantly increase premiums and thus diminish affordability. It also removes large amounts (possibly R10-R15 billion) of potential savings and investment finance which could be better deployed in the economy for economic growth. Any release of this inefficiently held capital would allow schemes to reduce contributions without jeopardizing their actual solvency or the risk protection they provide to members for catastrophic events.

122. And on the other hand, smaller and more fragile schemes should probably be required to hold more capital to enable them to meet the risks they bear for their members.
123. There is thus a critical need for more flexible solvency regime, probably a risk-based capital framework as is being adopted in many countries, in the health insurance, banking and general insurance environments. The change to a risk based capital approach would thus have several positive effects, including reducing scheme premiums and releasing a significant amount of capital into the productive economy.

SECTION 17: THE MULTI-FUNDER MODEL

124. The Green Paper is inclined towards the establishment of a single-funder, single-purchaser, publicly administered NHI Fund, giving a detailed outline of its proposed functions and roles. However, it also leaves room for consideration of a multi-fund model, which will by definition involve multiple purchasers and private administration of those purchasers/funds. In this section we explore some points to be considered in order to ensure that any model finally selected is informed by a careful evaluation of the alternatives available.
125. In general, a multi-funder NHI system would involve at least some competition between private funds in administering a nationally defined package of benefits, covering the whole population.

Relative advantages and disadvantages of single and multi-funder models

126. The major reason for adopting a multi-funder approach would be to harness the benefits of competition between the funds to attract members on the basis of better service, benefits and premiums (depending on what the funds are allowed to differentiate themselves on). This competition may also lead to administration costs that are similar or better than those of single-fund systems, which can be inefficient due to lack of competitive pressure.
127. Single-fund systems also tend to be naturally less responsive to the public in terms of service as the public has no alternative. A multi-fund approach probably makes it more likely a range of different types of health coverage will be available to the population, from which they can choose to best suit their needs.
128. Another reason to choose a multi-fund system would be if significant capacity, expertise and assets already exist in vehicles which could perform the role of these funds, and if the state does not immediately have the ability or desire to build and manage the required skills.
129. Finally, a multi-fund model is best placed to support system- wide capacity for innovation.

130. On the other hand, single fund systems may be more efficient in collecting revenue (particularly with a well functioning tax authority like SARS), and having a single risk pool facilitates cross subsidies by making them less obvious.
131. The extent to which single funds generate more social solidarity is more ambiguous. They can redistribute resources more effectively, but too much cross-subsidisation can alienate the contributing population. Multi-funds with differentiated membership and benefits, and transfers between the funds may strike a better balance. Single funds also will not require any kind of risk equalisation mechanism since all risks are already in the one pool, whereas multi-fund systems generally would. But if risk equalisation can be done efficiently, then multi-funds have the advantage of offering a range of coverage options to consumers, with significantly greater accountability to users.
132. A single fund, by being a monopsony purchaser, can obtain better prices from providers and exert more control of services through technology assessments, formularies, etc. This power has to be exercised with care though to avoid encouraging exit of skills and investment from the provider side (Ref: Hussey & Anderson, A comparison of single- and multi-payer health insurance systems and options for reform.)

Types of multi-funder model

133. Sources of variation within the broad conception of a multi-fund system would include:
- 133.1 Whether the funds offer a package of benefits on an insurance basis (involving administration of actual claims from providers), or are involved in the purchase of services (at determined norms and standards) using a set budget for a defined population.
 - 133.2 The basis on which a population is allocated to a fund, for instance, geographically, or at the choice of the citizen.
 - 133.3 Whether citizens can choose from state-run, alternative fund(s), which compete(s) with the private funds.
 - 133.4 If the funds make sustainable returns from administration fees and/or take claims risk.
 - 133.5 The source of money into the funds: a combination of contributions directly from members, subsidies from the state in respect of poor members, channelled through a risk equalisation fund, etc.
 - 133.6 The funds' freedom to set premiums and contract at their own negotiated rates with providers (public and private).
 - 133.7 If the funds are for-profit, or non-profit.
 - 133.8 What benefits the funds can provide over and above the nationally defined benefits.
 - 133.9 The type and level of regulation governing the multiple funds.

134. These variances individually have their own advantages and disadvantages, which are explored in turn below, with in the South African context.
135. For instance, in South Africa it would probably not be desirable at this stage to put in place an NHI that works on the basis of claims and reimbursements of providers being performed by these funds, i.e. a demand-driven system. This is because the disease burden of the country consists mainly of long-term, essentially chronic-type conditions (HIV/AIDS, TB treatment, diseases of lifestyle). As a result, the most appropriate care consists of preventative measures and long-term treatment. This needs to be actively promoted to the population and usage is driven by supply.
136. A claim and reimbursement model works better when the population's health needs require mainly curative services; thus the population drives usage through demand. In addition, a claim and reimbursement system can end up driving overutilization, which leads to inefficient and inequitable allocation of resources. Once health professional shortages have been eliminated it will be more widely possible for multiple funds to contract competitively with providers and therefore be able to drive efficiency in the whole system even on a claims reimbursement basis. Until then, multiple funds should rather be engaged to define the disease burden of a population, and to mutually agree with the state a budget and norms and standards within which to manage this disease burden. To do this, each fund would contract with facilities (public and private) on the basis of quality and cost to fulfil its contracted mandate. This kind of budget-driven approach is much more suited to SA's health needs, and the Green Paper does seem positively inclined towards this approach, whether through a single or multiple funds.
137. Geographic allocation of members to multiple funds can be straightforward, but also generates problems when people naturally migrate or travel in the country, and if it leads to low competition in an area (effectively creating a single fund in a geographical area). Allocation by free choice is most likely to lead to capture of the benefits of competition between the funds, although regulation of advertising and marketing by the funds may be required. There may need to be regulation as to how frequently someone can change funds.
138. If it is considered desirable to have a state-run fund competing alongside private funds, then it is critical that the playing field be level in respect of funding allocations, solvency requirements and market conduct regulation. This would require that the state entity operates at arm's length from the Department of Health, with its own board, and reports on the same terms to the same regulator that regulates private funds.
139. If the funds take risk, that the cost of purchasing services for their membership exceeds the income they receive, they need to be able to control various levers to manage this risk. If the package of benefits they offer is fixed, then they have to be able to control the level of contributions coming in, and their outflows, in the form of rates negotiated with providers.

- If either of these is centrally determined, without subsidy, it becomes very difficult for funds to manage risk effectively.
140. Regulation of contributions or contracting therefore also needs to be done very sensitively. An alternative to the funds taking insurance risk would be for them to receive administration fees, which they determine to cover their costs, and which would be added onto the claims portion of the premium. Competition would ensure these administration fees are as low as can be sustained. Fixed administration fees are likely to lead to poor member service, due to lack of proper competition between funds, or risk that the fund is unable to provide its services within the amount given.
 141. Any centralised collection of contributions (through payrolls, income tax, etc) could be done by SARS, or through the funds themselves. For the funds to be able to take risk, they will likely need to collect contributions themselves rather than relying on transfers from a centralised authority.
 142. It is also possible to limit the participation of funds to non-profit entities. However, non-profits are unlikely to be able to raise the capital to take risk or build up the complex administration infrastructure necessary to manage this risk. So they are likely to have to contract in the administrative services of for-profit entities able to raise share and debt capital.
 143. Another choice concerns what kinds of benefits the funds can offer. Can they offer only the NHI benefits; can they offer these plus top-up benefits in the same package to be able to attract more members? Regulation here needs to be careful not to permit cherry-picking of members through the benefit offerings, particularly if the funds are able to make risk profits.
 144. The regulation governing a multi-fund environment will depend entirely on these policy choices. For instance, an environment which permits member choice of a risk-bearing fund will probably require a risk equalisation mechanism to ensure that the risk pools remain stable. In an environment where contributions into the funds are centrally determined, then provider reimbursement will also have to be centrally determined and it is likely that the funds will not bear risk, but rather play almost entirely an administrative role. Similarly, if provider reimbursement is pre-determined, funds will be unable to take risk and contributions will also have to be centrally determined. The regulatory environment requires careful design, to ensure that the country achieves value for money in the administration of its healthcare provision.

International experience

145. Obviously, the choices that can be made between these elements of multi-funder models permit only certain logical combinations. Experience in several countries is illustrative of the options.
146. The Dutch system allows multiple funds to compete on premiums and service to attract members. Here, competing Sickness Funds offer a basic insurance package (ZFW) determined by the state which covers GP's, dental care and short-term hospitalisation, for those earning under a certain threshold (about 63% of the population), who pay premiums both to a central fund (which are passed on to the Funds), and directly to the Funds. Most of the remaining 37% of the population buy private insurance from insurers in respect of these benefits. Another set package of benefits (AWBZ) covers serious illness, mental health, old age care and long-term disability, and this is compulsory for the whole population, provided by the Sickness Funds, and funded with a premium depending on income, with no private insurance available. Budgets in respect of the ZFW are given prospectively from the central fund to the Sickness Funds (with annual partial adjustments for actual experience), while reimbursement for AWBZ benefits is given retrospectively. The Funds compete on premium and the quality of services purchased for their members. A risk equalisation fund blunts the incentives for Sickness Funds and private insurers to risk select (CARE Monograph No 3, Risk Equalisation Methodologies : An International Perspective).
147. This system would appear to be quite feasible in South Africa, using existing medical schemes as Sickness Funds, and the existing PMB package as the nationally defined benefit package. However, it still relies significantly on an insurance relationship between Funds and providers, and it applies in a context of a well resourced provider sector making selective contracting viable, and this will probably be very difficult in SA in the short to medium term, due to the health professional shortages.
148. Colombia perhaps provides an example more closely related to SA's existing socio-economic status. Here, the formally employed or self-employed with sufficient incomes (about 41% of the population) pay 12% of their income (of which 8% covered by the employer) to what is known as the Contributory Regime. Under this Regime they can join private health insurance companies or public Health Promoting Organisations (EPS) which provide a standard package of benefits. Then there is a Subsidised Regime, for the rest of the population, which is funded by the state and by a 1% contribution from the Contributory Regime members. This offers a reduced package of benefits, with the aim being to ramp it up to the Contributory Regime standard over time (Bossert et al, Applied Research on Decentralisation of Health Systems in Latin America.) In both cases the EPS's purchase care from semi-autonomous public and private providers, on a fee-for-service or capitation basis.
149. This system reflects the level of inequality in the society at its present level of development and the level of cross-subsidy acceptable to the Contributory Regime members. But it has

the disadvantage of being an insurance-based model, with EPS's consequently experiencing problems in managing overutilization by providers. In turn, EPS's have become increasingly for-profit enterprises, increasingly cream-skimming good risks and leaving the worse ones for the public sector. The system also fails to offer the social solidarity that would be built into a more universal system. Furthermore, primary care networks (for profit and non-profit) tend to be private and more independent of this system, rather than being an integral part of it, so has de-emphasised public health for the sake of curative services. A more fundamental problem which has become evident is the failure of competition based on quality-adjusted costs. Health outcomes are economically difficult for consumers to assess, and comparison between EPS's is therefore driven more by observable factors like waiting times, service and appearance of facilities they have access to. In this way, competition has probably not yet delivered the incentives that were intended to improve health outcomes and efficiency in the system.

150. Other countries with multi-funder variants offer useful lessons, including Switzerland, Germany, Belgium, Israel, etc. And other countries have varying mixes of integrated public and private elements which could conceivably also constitute a type of multi-fund environment, e.g. Australia. Some countries have moved from a single to a multi-payer system (e.g. Czech Republic), others from multi to single-payer (e.g. Taiwan). As with all international comparisons, attention has to be paid to the system as a whole, rather than simply the funding elements, including the supply of health professionals, the structure of public and private hospital sectors, historical reasons for the origin of the system, the level and distribution of income in the population, disease burden, and other factors.
151. It would certainly be possible to find a multi-fund model which can work for South Africa. One approach would reduce emphasis on multiple funds, and rather involve the contracting out of aspects of the administration of a single national fund, to multiple competing providers of these services. Another approach, steering away from claim-based models of provider reimbursement, would be to rather use competing funders to manage the purchasing of services on a budget-driven basis. The UK explored this avenue in the late 2000's, looking at the contracting of private funders to manage their primary care trusts. This requires sophisticated contracting and capacity in regulators and public and private providers.
152. The above sections presuppose a relationship of mutual collaboration between public and private sectors, building on the strengths and capabilities that each bring towards the national objectives.

SECTION 18: THE PUBLIC-PRIVATE INTERFACE

153. We appreciate the implicit acknowledgement in the Green Paper that both public and private sectors make valuable contributions to the nation's health. There is no doubt that

collaboration and partnership in establishing the NHI will be beneficial for all South Africans, and will significantly increase the probability of successful implementation of the NHI.

154. It will be useful to establish a systematic consultation mechanism between the government and the private sector in order to enable mutual learning and to promote partnerships that respond to implementation challenges as they arise during the 14-year period.

155. However, there are several areas that immediately lend themselves to public-private partnerships. These can be done on a commercial or non-commercial basis, but either way their conceptualisation, contracting, implementation and monitoring needs to be done in an absolutely rigorous and transparent manner. The areas of possible cooperation include:

Human Resources capacity development and training

156. This involves the shared funding and utilisation of training platforms for all levels of health professionals, including doctors, specialists, nurses, allied health professions and all other levels of health workers. Current private hospitals, and the health professionals who work within them, provide high quality care using advanced technology, to a large volume of patients. The experience of these professionals, the large clinical load, and the advanced technology available could significantly enhance the current training capacity of South Africa's medical and other health professional training institutions. Appropriate partnerships between designated private hospitals and existing medical and allied health professional schools would be an ideal vehicle for this form of collaboration.

Facilities management

157. The private healthcare sector has extensive experience in all aspects of the development and management of all levels of health facilities, including primary care, and small, medium and large sized hospitals. This expertise could be used to improve the quality of management of public healthcare facilities. A wide range of models could be used to draw on private sector management expertise, including:

157.1 Leasing of public facilities in whole or in part to private hospital groups to provide services to NHI beneficiaries

157.2 Management contracts with private hospital and other health sector groups to manage some or all of the functions of public sector hospitals.

Health Informatics

158. The Green Paper correctly identifies effectiveness, appropriateness and efficiency of care as three of the seven guiding principles of NHI in South Africa. All three require well-coded clinical data for adequate monitoring and evaluation. Most current public health reporting

- measures are based on epidemiological factors with specific disease statistics aggregated across a population. However, patient-level coded clinical data brings together combinations and trajectories of diseases in a holistic view. Combined with the epidemiological view it becomes possible to manage geographically-defined populations on the basis of their specific disease burden, also looking at combinations of diseases at a more granular level, thus enabling the health system to respond to their health needs with optimised recourse allocation.
159. It enables management to manage for optimum results in health care efficiency and quality, as it is easier to apply care protocols and pathways, and to support long-term patient tracking. A whole-patient view shared by different providers makes for more coordinated and therefore efficient and appropriate care.
160. For these reasons, it is essential for the NHI plan to include the development and implementation of a system to provide patient-level coded clinical data (with development of a cadre of health personnel who are competent in the use of these tools and can deploy them widely throughout the public health system.) Managers should use health informatics data to perform trend analyses of disease and treatment experience, and to identify lapses in the quality of care and take remedial steps. This could become an iterative process that incorporates incremental improvements in quality of care on an ongoing basis, leading to better health outcomes.
161. We note that the Green Paper refers to using coding systems as a tool for reimbursement in Section 13. While this is part of the rationale for using such a system, such a narrow restriction of the application of these systems is unnecessarily limiting; as outlined above, much more benefit can be captured in the system if this more holistic approach is adopted.
162. Both the funding and delivery sides of the private healthcare system have extensive and longstanding expertise in various aspects of health informatics, which could be of significant use in the development and implementation of the NHI system. On the delivery side, all major hospital groups have well developed information systems for the management of all aspects of their facilities, which could be adapted and applied in the management of various levels of public sector facilities within the NHI.
163. On the funding side, there are a number of areas of health informatics in which some of the major funders have expertise, which could be effectively applied in an NHI context. Key elements of these include:
- 163.1 Rigorous development and application of clinical coding for diagnoses and procedures, which forms the bedrock of subsequent analysis and action
 - 163.2 Development of coding based software groupers for the analysis of health claims and related data and for the management of health procurement contracts. This can be done to aggregate disease and treatment data at the

level of a hospital admission (Diagnosis Related Groups), at the level of a particular condition which could involve in and out of hospital treatment (Discovery Episode Groups and disease staging algorithms), and at the patient level (patient risk scoring algorithms like Johns Hopkins Adjusted Clinical Groups)

- 163.3 Systems for the synthesis of patient-centred data from a wide variety of sources (pharmacy, GP, specialist and hospital claims, as well as voluntarily submitted health lifestyle questionnaires) into electronic health records. These are stored, can be analysed and retrieved by treating clinicians to ensure the care given is based on a full knowledge of the patient's health status and history.
- 163.4 Classification of surgical items and drugs to better track and manage costs

Health insurance administration

- 164. South Africa's major health insurance administrators have extensive systems, personnel and world leading expertise in key skills that may be required by an NHI system including:
 - 164.1 Premium collection and debtor management
 - 164.2 Prompt loading of new members onto systems
 - 164.3 Management of call centres to swiftly authorise claims, handle and resolve coverage queries from members as well as providers (as many as 6 calls per member per year)
 - 164.4 Real-time claims processing ability (as many as 25 per member per year)
 - 164.5 Handling of written and electronic communications
 - 164.6 Data security and uptime management, data recovery processes
 - 164.7 Claims rules systems for auto-adjudication and processing of huge volumes of claims with quick turnaround to ensure provider and member satisfaction
 - 164.8 Customer satisfaction measurement
 - 164.9 Record-keeping of interactions to enable evaluation and resolution of any later problems

Health services procurement and provider contracting

- 165. South Africa's major health insurance administrators also have longstanding expertise in the range of skills required to procure health services effectively. This includes contracting on a fee-for-service basis with all types of health service providers, and in the case of Discovery Health, extensive experience in capitation-based procurement of services provided by GPs, as well as alternative risk sharing arrangements with hospitals, typically based on DRG based contracts of various kinds.

Health professional and hospital network development

166. In addition to general health services procurement expertise, Discovery Health has developed proprietary tools for the analysis of the relative efficiency of hospitals, and has extensive experience in the use of these tools to select and optimise networks of hospitals. This results in the channelling of members to more efficient providers, therefore encouraging lower costs and better quality in the overall environment. Importantly, as well as allowing for selection of efficient service providers, it allows for engagement with providers using these tools in order to improve their efficiency over time. As well as hospitals, these tools have been used to apply efficiency evaluation and network development to GPs, specialists and pathology firms. These skills could easily be adapted and applied in the context of the NHI system to support cost-effective provision of services.

Health insurance risk management

167. In addition to administration and procurement/contracting expertise, South Africa's major health insurance administrators have also developed high levels of expertise in the full range of health insurance risk management skills and systems including. Some of these are itemised below.
168. Management of hospital costs, particularly high costs driven by overutilization of items during hospital stays. This is done through alternative reimbursement mechanisms that rely on fixed payments for certain complexities of procedures, encouraging efficient management of resources by the hospital. Even when utilising fee-for-service contracts with hospitals, most administrators have some expertise in the automated monitoring and sophisticated clinical review of invoices from providers to check for compliance with billing and tariff rules, duplicate or mistaken invoicing, and overuse of products and services in treatment. This can be done both real-time and in retrospective audits.
169. Management of health professional costs. As discussed above, efficiency profiling of health professionals relative to peers can identify outliers in terms of costs. The drivers of these costs can be identified, whether they are evident in overly high admission rates, usage of pathology and radiology, consultation and prescription behaviour, etc. They may also be driven by inappropriate coding practice. These conclusions can be fed constructively back to the professional, to peer review systems or to the relevant professional bodies, to determine an optimal approach thereafter. In addition, performance based reimbursement systems can be driven by these types of analyses.
170. Management of medicine costs. Based on evaluation of costs and benefits of drugs from international clinical review literature, formularies of high quality but lower cost drugs can be developed giving patients low cost access to the most cost-effective but clinically supported treatments.

171. Management of members with chronic diseases, often involving registering them onto a disease management program which gives them tools to manage their own condition better, improving their quality of life and reducing costs associated with poor management of their condition.
172. Analysis of the disease burden of defined populations can be performed. It is then possible to identify and monitor high risk members, often those with multiple and unstable chronic conditions, who frequently require acute care. Disease management programmes can be designed and implemented, to be able to remotely manage these individuals and ensure they are empowered to keep their conditions under control. For very high risk members, care coordination programmes in the community have been developed to allow for even closer monitoring and assistance by trained clinical staff to the member and their family.
173. An integrated approach to combating fraud. Forensic systems include automatic data crawlers that seek unusual and repeated billing patterns, flagging providers and members for further investigation by forensic personnel.
174. Specific governance initiatives can target areas of longer term risk in the health system, for instance, the overuse of antibiotics in hospitals, which is, in future, likely to lead to the emergence of antibiotic-resistant strains of infection, requiring even more expensive antibiotics to treat.
175. Sophisticated data analysis and interpretation expertise combining clinical, statistical and actuarial skills underlies all of the above risk management approaches.

Health technology evaluation

176. Discovery Health has a strong health economics unit and a longstanding capacity to undertake health technology evaluation, including both clinical and health economic evaluations of new medicines and healthcare technologies. This involves assessing whether the new treatment is safe and ethical, if it has a clinical advantage over existing ones, and what uncertainty exists around this, if there are alternative treatments available, and what are the relative costs of the treatments (both current and projected). These skills are used to make decisions on the funding of various new technologies, as well as to negotiate pricing where legislation allows this. Protocols for use of certain treatments can be agreed with relevant professional societies. Alternative funding arrangements and innovative benefit structures can be designed to give members access to less proven or cost-effective treatments, and to share costs where appropriate.
177. The emergent NHI would benefit from the establishment of an independent national institute to perform health technology evaluations, possibly as a model similar to the UK

National Institute for Clinical Excellence (NICE). Discovery Health would be happy to provide technical support towards the establishment of such an institute.

Health service delivery

178. The NHI presents an opportunity for much more collaborative health service delivery between the private sector and the public sector, harnessing the particular strengths that come from each.
179. It is also an opportunity to transform some of the services that could best be managed across both sectors, such as emergency medical services.
180. In addition to the management of health services facilities, the private healthcare sector has the capacity to deliver services directly to the NHI. Such services include pathology and radiology services, as well as general clinical services at all levels of the healthcare system.
181. We believe that, in the light of the wide ranging skills and experience summarised here, it is essential to include the private sector in the initial pilots for the NHI, to facilitate rapid mutual learning, and to facilitate optimal outcomes for the NHI pilots.

Discovery's willingness to share expertise

182. Discovery Health has long standing expertise and experience in a number of the skills areas briefly summarised above. We would be very willing to provide such expertise to the emerging NHI, and are entirely open to discussions with respect to the basis on which such expertise and services would be provided. As a general principle, our approach to sharing our expertise and experience would not be a commercial one, but rather based on our desire to contribute to the successful emergence and development of the NHI. We would therefore be willing to provide tools, systems and expertise on a pure cost recovery basis, and subject only to protection of our intellectual property against usage by commercial competitors.
183. Other entities within, or related to the Discovery Group also possess expertise and resources that could be applied in assistance to the NHI.
184. The Discovery Foundation already funds training and research for registrars and academic specialists and subspecialists, with an emphasis on growing specialist capacity in rural areas. Discovery is willing to assist with other training and management training needs for the public sector.
185. The Discovery Vitality programme has had significant local and international impact and recognition for developing effective approaches to educating people about how to improve their health and incentivising them effectively to do so. Vitality has acquired considerable

expertise in setting up and managing such programmes both for adults and for school children, and Discovery would be willing to share its expertise in this vital health and wellness promotion and prevention area for the NHI.

SECTION 19: CONCLUSIONS

186. In summary, Discovery fully supports the objectives of the NHI reform, to dramatically and rapidly raise the quality and accessibility of care for all South Africans, to reduce the unacceptable inequities that currently exist in health outcomes between segments of our population. To accelerate this process, the Green Paper's articulation of willingness to engage with the private health sector is welcomed. A fundamental element of the NHI reforms is the objective to create an equitable health system, and to progressively move away from the current two-tier system. This objective will be facilitated by a conscious choice to optimise the public-private interface. This calls for the development of platforms to partner with the private sector so as to enrich the new health system, and also to increasingly achieve a mutually beneficial alignment of private and public sectors.
187. With regard to the benefits and delivery models, the proposed comprehensive service package in the NHI is to be welcomed, along with further detail in future in terms of what this contains and the basis for selection of the constituent services. As discussed extensively in the Green Paper, the proposed reconstruction of the healthcare system is critical, anchored by a strong primary care foundation, including community health workers and a focus on preventative care.
188. More detail will doubtless follow on the enforcement of gatekeeping and referral processes to control usage of higher level services and ensure optimal use of scarce resources. The latter objective will also be achieved through the proposed wider use of innovative, team-based approaches to improve efficiencies in care delivery in the public sector. And in the longer term to address the overall, underlying shortages, the massive and rapid upscaling in production of health professionals is essential at all levels.
189. The potential for the NHI to contract with private providers needs to be explored in greater detail than in the Green Paper, to enable access by the whole population to the entire asset base of public and private health provision in South Africa.
190. It will be of enormous value to use pilots to evaluate service delivery models, these can usefully include mixes of public and private providers.
191. With regards to funding, in a country characterised by severe income inequalities it is imperative to have in place progressive, prepayment funding of healthcare under the NHI, from a broad contribution base.

192. But before funding decisions are made, detailed and publicly available modelling of the NHI is required, including linking to an HR model, and modelling linkages with private sector dynamics. Discovery has expertise to offer in this respect. Broader economic impact modelling results should be transparent to the public for collective understanding of reform of this magnitude.
193. In respect of structural and organisational issues, again, more clarity is likely to emerge on the various roles and responsibilities of different entities in the NHI structure, including, the Fund, provincial health departments, District Health Authorities, and others.

SECTION 20: RECOMMENDATIONS

194. In addition to these areas where Discovery is in strong agreement as noted above, we make additional, specific and constructive recommendations for consideration by the Department of Health:

Modelling and funding

195. Maximising the value obtained from additional funding, would best be served by first identifying a fiscally sustainably benefit package, ensuring optimal value for money is extracted from existing funding, and realising potential savings from innovative delivery approaches.
196. Modelling of equity under the NHI system is imperative, particularly taking into account lifetime contributions and claims from the NHI by both currently insured and uninsured populations. This needs to take into account their relative disease burden and usage of health services, to ensure that the NHI does not unintentionally undermine equity-promoting objectives, by loading the public system with millions of additional users while it is in the process of organisational reform.
197. Low, possibly means-tested, co-payments on discretionary, high utilisation services (as used in many other countries) should be considered to manage demand and therefore cost.

Governance and structural issues

198. An insured benefit/claim and reimbursement approach in the NHI is likely to be undesirable for South Africa, and will tend to generate overutilization, and fraud, and ultimately remove focus from public health priorities. Similarly, specific enrolment in the NHI would seem to add little value, and an approach based on current ID's and residency is preferred. Thus the

leaning in the Green Paper towards a service package approach, driven by prospective payment of providers through innovative types of budgeting, is to be welcomed.

199. That said, a slow shift towards a purchaser-provider split in the public sector will be necessary, with accompanying changes in budgeting based on capitation and other alternative reimbursement mechanisms. These processes are complex and can be disruptive. Discovery can share its own experience in developing and implementing these approaches.
200. A clearer set of governance principles is also necessary, from which will flow a set of institutions which can independently purchase, provide and monitor quality of care.

Private health sector environment

201. In future policy documents, explicit recognition should be made of the indispensable role the private health sector plays in the current health system. It is to everyone's advantage that the private sector, and specifically medical schemes, should continue to operate alongside the NHI for the foreseeable future. This approach will augment the stability and sustainability of NHI as current members of medical schemes constitute a significant risk pool that will not place demands on the NHI; and furthermore it will be assured that the general health demands that are beyond the scope or capacity of NHI will still be met. Conversely, the movement of large numbers of current medical scheme members out of that system will place significant incremental unfunded demands on the NHI, and will slow the realisation of its objectives.
202. However, the role the private health sector can play goes far beyond acting as a passive way of relieving burden on the public system. Indeed, there is plenty of scope for the private sector to actively contribute towards the components of a successful NHI. Explicitly recognising these roles for the private sector, and investing effort in active partnerships between the NHI and various private sector entities will allow the private sector to contribute more actively to the goals of improving healthcare and reducing inequity, and hence to the successful emergence of the NHI. Examples are given in the points below.
203. Permitting use of private facilities as training platforms (obviously with requirements on public service) can significantly ramp up production of clinical personnel.
204. Licensing of low cost hospital facilities in the private sector will open the space for low cost assets to be developed that can contract with and therefore support the NHI.
205. Lifting regulatory restrictions on the employment of doctors in the private sector, and revisiting scope of practice regulation to permit more task-shifting will allow the emergence

of low cost, team-based delivery models in the private sector. Such integrated models can be usefully contracted into the NHI delivery platform.

206. We support the introduction of the more equitable medical scheme tax credits, and suggest that in the foreseeable future, such a system should be maintained. Careful consideration should be given to unintended consequences from reducing scheme affordability particularly for low-income taxpayers, which may direct them back onto the public sector system, thus increasing the burden on the NHI disproportionately to the additional funds generated by the proposed changes to the tax treatment of scheme contributions.
207. It is critical to stabilise the medical schemes environment in a way that will support the NHI objectives, particularly so it can serve the population better while the NHI ramps up over the next fourteen years. These measures include the establishment of a Risk Equalisation Fund, to stabilise risk pools between schemes, thus protecting members from undue scheme collapse. Also included are regulatory modifications to give schemes more ability to control anti-selection, and a more rational approach to managing their solvency.
208. A multi funder model has several advantages to recommend it, and the arguments against this approach and in favour of a single payer model are not compelling. We therefore recommend that a multi funder approach to the NHI be carefully considered.
209. Overall, the timeline given to achieve the aims articulated in the Green Paper is realistic. Many elements of the reform (such as increased production of doctors) will take several years to be realised, but more generally, multiple moving parts in the whole healthcare system, public and private, need to be analysed to ensure that unintended consequences are avoided.
210. Discovery has significant expertise and resources built up over 17 years, many of which are highly relevant to the proposed NHI system. Discovery is very keen to put its expertise, people and assets at the disposal of government, as required, in areas such as: use of health informatics in the NHI to drive efficiency, modelling of population disease burdens, design of appropriate service packages, development of provider networks with innovative reimbursement approaches, management of healthcare cost risks and evaluation of new technologies in making coverage decisions, and health insurance administration and operations.
211. These comments are given in a spirit of constructive engagement, and we look forward to engaging with the Department of Health, and all other relevant stakeholders and policymakers to explore ways of giving support to these endeavours at the earliest opportunity.

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