NATIONAL HEALTH INSURANCE FUNDING HOW MUCH DO WE KNOW? I - PRELIMINARIES

This brief is the first of two. It assesses the extent to which government thinking has progressed on the health system. The second will consider whether quantitative modelling can help us think about the system's future.

Hope deferred makes the heart sick, but a desire fulfilled is a tree of life.
Proverbs 13: 21

Introduction

The National Health Insurance Policy, released on 28 June 2017, sets out the framework for the second and third phases of the implementation of national health insurance, stretching between 2017 and 2022, and between 2023 and 2026 respectively. It is not the intention of this brief to discuss the policy in its entirety. It will confine its attention to what the policy reveals about NHI funding.

The development of policy

A presentation by the Director-General of the Department of Health at the time of the release of the policy announced the intention to set up six new institutions in the second phase. Each has an extensive agenda. They are:

The Ministerial Advisory Committee on Health Care Benefits for the NHI
The National Health Pricing Advisory Committee
The National Advisory Committee on Consolidation of Financing Arrangements
The National Tertiary Health Services Technical Implementation Committee
The National Governing Body on Training and Development
The National Advisory Committee on Health Technology Assessment for the NHI

The first three institutions are the most relevant from the funding point of view. The policy and the DG's presentation make the following clear:

1. *No decisions have yet been taken on package of services which are to be funded under the NHI. Until these decisions are taken, it is not possible to estimate the cost of National Health Insurance. It is the fundamental reason why the National Treasury has not delivered the analysis which, it was promised, would accompany the policy. At this stage, it cannot. Its only contributions to the policy document are Tables 1 and 2 in Chapter 7 of the policy. Table 1 sets out an estimate of the cost of NHI from the 2011 Green Paper with slight emendations and Table 2 contains Treasury estimates and projections of expenditure on health expenditure in the public and private sectors between2013/14 and 2019/20. The policy excuses itself from trying to determine what the NHI will cost, preferring to*

frame the questions around the implications of different scenarios for the design and implementation of reforms to move towards universal health coverage…The funding requirements [the resources needed to provide comprehensive health care services for the population] will be determined, discussed and announced during the annual budgeting process [1].

It is far from clear how this finesses the cost estimation problem.

2. *New information on the treatment of medical aid schemes is revealed. The Department of Health has always regarded medical aid schemes as a major obstacle to the realisation of NHI. It seems to believe that they are the cause of inequality in health expenditure. They are not. The fundamental cause of inequality in health expenditure is inequality of income. Medical aid schemes merely insure their members against risk. On average, what members contribute, less administration costs (estimated at 8.6% of contributions in 2015 [2]) is what they receive as benefits. The Department's thinking veers between the view that medical aid schemes will die a natural death with the introduction of NHI, since people will not*

want to pay to be insured twice, and the view that they should be legally prohibited from financing services provided by the NHI, while continuing to fund complementary medical services. The latter view appears dominant.

What is new is information on how medical aid schemes are to be treated in the second phase of NHI. The policy observes that there are 83 medical aid schemes offering 323 benefit options. It plans to restrict benefit options to one per scheme and envisages standardisation of healthcare services across the schemes aligned to services provided by the NHI. What are the implications?

First, the standardisation cannot be carried out until the NHI service package has been defined. Secondly, the reasons why there has been differentiation within medical schemes are differences in income, health needs, preferences, perceptions of risk and willingness to accept restrictions on access to providers. The Government Employees Medical Scheme, for instance, offer six benefit options [3], with a wide variation in member contribution rates. The proposal simply disregards the reasons for differentiation. Thirdly, benefit options include both risk benefits, a pure form of insurance, and medical savings accounts, in terms of which members accumulate funds to pay for medical expenses. It is not clear how medical savings account options are to be dealt with.

The second new piece of information is that the National Advisory Committee on Consolidation of Financing Arrangements will be responsible for implementing:

The consolidation of funding streams into five transitional funding arrangements [which] will effectively reduce the current fragmentation and through a process of income cross-subsidisation allow for the transition towards the establishment of a single financing pool without having to wait for the raising of additional funding through the tax system.

What can this mean? The definitions in the policy include:

***Financial Risk Pooling**: A program created by law where financial resources are placed into a pool to provide a safety net for a broad cross section of society with differing medical risks with the purpose of benefiting from cross-subsidisation within the Fund.*

The fundamental intuitive desire is clear enough: there is all this money being contributed to medical aids which benefits their members only. How can these resources be captured for the population as a whole?

But can they? Suppose we have a country (and such exist) which relies on private health insurance to deliver universal health care to its citizens. The government specifies the services which must be provided, but does not intervene otherwise. Several health insurers will emerge, but the populations they serve may not have equal exposure to risk. For example, one may have membership concentrated among the old, while another serves mainly young adults. In this case, the first will have to charge higher premiums than the second. To avoid this situation, the government then creates a risk equalisation fund, into which the second will have to pay and from which the first draws. The size of the payment would be such as to make the premiums equal. This is the 'cross-subsidisation' referred to in the quotations above.

The clear long term objective of the policy is to have the polar opposite of a regulated system of private health insurers – a public single payer system. So risk equalisation is not an issue in the long run. People will have to contribute to the NHI Fund via general taxation and possible earmarked taxes, the effect of which will make the contribution of a rich person greater than the contribution of a poor one. Finish and klaar.

The issue then is: what are we to make of the proposal for the transition? The first step is to standardise the offerings of medical aid schemes, presumably to be made possible by a change in the law. And standardisation, according to the DG's presentation, is to be not only with respect to services, but also 'protocols and pathways" defining access to them. Suppose this has been accomplished. Then

risk equalisation could be applied across medical aid schemes, but not between them and the non-insured, who will have no scheme during the transition. So the major redistributive goal could not be achieved until the NHI is up and running, unless it is intended to impose a substantial levy on medical aids during the transition, in the name of risk equalization, to be paid into the already existing NHI Fund.

But then what would happen? The members of medical aid schemes, bludgeoned into a single option per scheme, in line with an NHI package which will not be defined completely until NHI is up and running, made subject to protocols and pathways they may not care for, and seeing reduced benefits for their contributions, will become fed up. Insurance is actuarially fair if the present value of contributions is equal to the expected present value of benefits. People will accept a degree of actuarial unfairness as the price of insurance against catastrophic risk. But beyond that, they will defect. The open risk benefit schemes (i.e schemes which anyone can join) will be the first to encounter defections, but the restricted benefits schemes (usually associated with present or past employment) will follow, as beneficiaries become discontented. People will look for other ways to insure against catastrophic risk, chased by a government trying to stop them. If the disappearance of medical aid schemes following the full introduction of NHI is death by exposure, and their outlawing is legislative murder, then the transitional arrangements would represent assisted suicide.

Conclusion

We have a government which brought the social grants system to the brink of collapse earlier this year. The distribution of social grants requires that recipients be checked for eligibility and that funds are transferred to them. National Health Insurance is an order of magnitude more complicated. It involves the entire population, extensive reconstruction of the existing system, new forms of regulation and the administration of a mass of contracts. Gelassenheit – the tranquil submission to circumstances- becomes a major temptation. Like Pater's Mona Lisa, our eyelids are a little weary. But first, the ability of modelling – long expected from the Treasury, but now a hope indefinitely deferred – to illuminate the issues must be considered. Our own modest efforts will be discussed in the next brief.

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[1] Policy, paragraphs 200 - 201
[2] Council for Medical Schemes, Annual Report 2015/16
[3] These are Sapphire (6% of members), Beryl (4%), Ruby (9%), Emerald Value, Emerald (75%) and Onyx (6%)