Tying up the draft HMI recommendations on Supplier Induced Demand, Funder-, and Facilities concentration into a framework for the Organising and Financing of health services towards Universal Health Coverage

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Executive summary: Develop a trajectory towards universal health coverage aligned with the HMI recommendations

Instead of repeating previous submissions, this submission discusses considerations of health systems reform in the current South African context with very high levels of inequality and limited fiscal space for the expansion of public spending on healthcare. The document proposes a trajectory for the progressive realisation of the constitutional right to healthcare.

The high and increasing levels of public debt means that the fiscal situation will take at least a decade to improve before significant changes to healthcare financing could be realised.

The provisional recommendations made by the Health Market Inquiry (HMI) forms the cornerstone of the assumptions used to consider a feasible and desired interim state for the South African health system on the trajectory towards the aspirational end goal of a single payer system. These steps are designed to take the country closer to Universal Health Coverage as envisaged in the NHI and progressively realise the constitutional right to healthcare.

It is considered that the Risk Adjustment Mechanism recommended by the HMI should be the vehicle for tax funded contribution subsidies that are allocated on a risk adjusted basis to low cost insurance for primary care, low cost medical scheme options, and the full PMB package for medical schemes. This is required to ensure that the contribution subsidy is divisible and portable.

The document concludes that immediate work should start to expand cover for lower cost options to exist in parallel with standard medical schemes and the state health services. The introduction of a risk adjustment mechanism and the conversion of the tax credit to a contribution subsidy will accelerate the achievement of Universal Health Coverage.
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1 Point of departure and purpose of this document

1 MMI has previously made comprehensive submissions and the purpose of this document is not to replace or repeat these submissions. Instead, the objective of this submission is to show how the HMI recommendations could be tied together to progressively realise the right to healthcare for all South Africans.

2 In broad terms, MMI is largely in agreement with the recommendations in the provisional HMI report and is of the opinion that the interventions proposed in the provisional recommendations will go a long way to address the negative impact of funder concentration, facility concentration and supplier induced demand.

3 The law-making process which will follow after the report has been finalised will provide new opportunities to engage with specific issues that might arise as the proposed reform process unfolds. Some specifics include the development of low cost benefit options, the development of base benefit packages and the risk of cross-subsidy flows from low income to high income risk pools. The issue of mandatory membership and its gradual introduction is another area that will require further engagement once some of the other areas are successfully introduced.

4 The provisional recommendations are aligned with economic frameworks for cost containment applied in many OECD counties (1). The public consultation process that is required for the final policy development and law making process would ensure that the South African context is considered before final legislative measures are taken.

5 MMI understands that the HMI’s mandate ends with the submission of the final report with recommendations to parliament by September 2019.

6 To implement the final recommendations will require that Health Policy is reviewed so that the areas of Market failure and Government failure are addressed. The current market enquiry will take almost five years to be completed.

7 This inquiry has shown how complex the healthcare environment is and that it requires considerable capacity merely to understand the environment. The process to implement the suggested reforms will be equally daunting and, in some areas, might be faced with resistance.

8 To overcome this difficult challenge, it is requested that the final HMI report should make specific recommendations to ensure that a consultative forum is established to enable affected stakeholders to participate in the policy development process.

9 Section 2 of this document motivates why incremental changes must be made to the current health system on the trajectory to Universal Health Coverage and the progressive realisation of the constitutional right to healthcare. Section 3 discusses the current healthcare financing and demonstrates the levels of inequality in this respect. Section 4 shows that the current fiscal space is inadequate for large expansions in healthcare funding and that private funding will be important for a long time while Section 5 presents the overall architecture of a health system that is desirable and feasibly attainable. The overall architecture is presented in accordance with the WHO’s health system functions approach.
2 Motivation for the use of the current health system in the progressive realisation of access to care

10 The first sentence in the 2018 Presidential Health Summit report states (2):

“By 2030, the health system should provide quality care to all, free at the point of service, or paid by publicly provided, or privately funded insurance.”

11 Privately funded insurance will be part of the healthcare financing system in the future. The challenge is to improve the system incrementally to reduce the current high levels of inequity. The NHS horizons team drives changes in the National Health System (NHS) in the UK, and suggests that small changes must be taken at a time, with emphasis on progress while learning from the best and persisting with incremental improvements (3).

12 It is abundantly clear that extensive changes are required to the South African health system to move South Africans closer to Universal Health Coverage (UHC). There is no one “best” financing strategy that applies in every context (4) and UHC is not directly linked to a specific financing mechanism or vehicle. An analysis of the existing healthcare financing structures through the application of the WHO healthcare financing country diagnostic (5) has identified a wide range of problems with the current financing system (6).

13 The National Development Plan (7) (NDP) has identified four prerequisites for building National Health Insurance (NHI):

- Improve the quality of public health care
- Lower the relative cost of private care
- More professionals in both sectors
- A health information platform that spans public and private health providers

14 These reforms will take time, require cooperation between the public and private sectors, and demand significant resources (7).

15 The provisional report of the Health Market Inquiry (HMI) (8) shows that there is market failure in the private health sector accompanied by government failure. The provisional report suggests a range of reforms that must be government-driven and will strengthen stewardship. The final report will be available by September 2019, but many of the recommended changes require new legislation and the development of new functions or the establishment of new institutions that will take many years to implement.

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1 The central challenges in the system are that the stewardship function, whereby overall governance of the healthcare system is exercised, has major gaps. Even though enough revenue is collected there is a limitation due to the narrow tax base of the country and the current high levels of personal, company and value-added taxes. Risk pooling is poorly governed and there are major challenges in the inequitable pooling between the provincial pools and medical schemes. Inadequate human resources for health are made available and service delivery is challenged.
In consideration of the fact that health systems are dynamic and path-dependent (4), this document presents proposals towards first steps that can be taken towards Universal Health Coverage through incremental increases in access to health coverage.

“Simply choosing from a menu of options, or importing what has worked in other settings, will not be sufficient. Health financing strategy needs to be home-grown, pushing towards universal coverage out of existing terrain. It is imperative, therefore, that countries develop their capacities to analyse and understand the strengths and weaknesses of the system in place so that they can adapt health financing policies accordingly, implement them, and monitor and modify them over time.”


The strategy presented here will enable stakeholders to take specific first steps aligned with the health systems reform approach promoted by the World Health Organisation (10). This approach broadly requires that specific interventions are taken incrementally to support:

- Changes to revenue raising, purchasing, benefit design, and overall system architecture and governance
- to address specific, identified problems that limit progress towards UHC (final and intermediate) objectives
- and provide a solid foundation for future development of a system
- that can be feasibly implemented given current and expected future contextual constraints.

Non-incremental reforms are one-off major interventions and are rarely successful except in exceptional circumstances. Most successful reforms are incremental in nature because reforms are usually constrained by pre-existing (legacy) systems. Because health systems reform is path-dependent, successful reforms use what are in place and make adjustments to these elements to improve equity. Such successful reform strategies in complex environments consider existing systems and strengthen the working elements while eliminating the dysfunctional parts (11).

To maximise revenue for a health system in a developing country it is necessary to rely on multiple revenue sources to ensure universal coverage. In countries with high levels of inequality governments are not able to fund health care for all from government revenue only because these countries typically have narrow tax bases. It is therefore inevitable that private funds are used in the financing of healthcare. The challenge lies in the structuring of the healthcare financing system to ensure that private financing of care leads to improved equity to ensure that health system development is sustainable.

This document sets out a trajectory that may be followed to broaden access to care in a sustainable manner.

3 **Current health care financing state**

Figure 1 below shows that in 2017 about R1,491 was spent per beneficiary per month on medical scheme benefits. This is four and a half times as much as the public expenditure of R334 on non-medical scheme members making use of public health care. This figure also shows that
expenditure on PMBs is more than double the expenditure per beneficiary for public sector patients.

At R178 per beneficiary per month, the government sponsored tax credit which supports medical scheme membership is at just more than half the level of the per beneficiary expenditure for public sector patients. The figure also shows total public and medical scheme health expenditure at R billion 192 and R billion 160 respectively.

Figure 1: Total health expenditure and monthly expenditure per beneficiary by risk pool (2017)

During the media briefing on the NHI White Paper, the Director General of Health suggested that as an interim step towards NHI, that the establishment of 5 large risk pools is desired before a single fund is created. Figure 2 (page 6) shows that these five groups have disparate income levels. In relation to access to healthcare, the population can be described as being in one of three groups. Higher income members of the public belong to medical schemes, members of the second group have considerable income and are able to contribute towards their own healthcare but cannot afford the high contributions of medical schemes, and finally members of the poorest group are reliant on the state for healthcare.

The missing middle represents the group of people who earn a regular income, but fall below the income tax threshold and cannot afford medical scheme cover. The diagram shows that there are approximately 6 million people registered with SARS with an income below the tax threshold plus a further 3 million people not registered with SARS, also with an income below the tax threshold, who may have the ability to make some contributions to their own healthcare costs. These individuals do not benefit from the tax credit shown in Figure 1 above. They have to pay out of pocket for expensive private care and have to pay for public sector care because their income is above the means test threshold.

An urgent solution must be found to provide cover for the missing middle. Proposals must be made to government whereby these individuals could receive government-funded contribution subsidies that are at least at the same level as the current tax credits in lieu of receiving part of their care in the private sector rather than in the public sector. If the missing middle is given the

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2 The average value of R178 is less than level of the tax credit of R310 for the member and the first dependant, and R209 for each additional dependant
3 The health expenditure and monthly expenditure per beneficiary by risk pool information is based on data obtained from (19), (20) and (21)
opportunity to contribute to pre-funding for their healthcare the burden on the state will be significantly reduced.

25 The provisional Health Market Inquiry (8) report recommends that a Risk Adjustment Mechanism is introduced to address the inequitable high risk differences between medical schemes and that the current tax credit is converted to a contribution subsidy for medical scheme members.

26 If contribution subsidies are made available to the missing middle, a package that provides hospitalisation care in addition to primary care might be affordable to many more households.

27 It is important that the missing middle is covered when the tax credit is converted to a contribution subsidy.
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Figure 2: South African employment groups, income levels, healthcare financing vehicles, service delivery channels and Government funding

Source for population, poverty and taxpayer numbers: SARS Tax Statistics 2018, StatsSA, NHI White Paper presentation. See references (12), (19), (20) and (21).
4 Fiscal space challenges in realising the aspirational end state of a single payer

Government is working hard towards establishing a single fund for health care financing for all South Africans. The 2015 NHI white paper does however make provision for the establishment of a “virtual” pooling arrangement (13). There are numerous challenges in the establishment of a single payer system. Not a single low- or middle income country has managed to introduce a single payer system.

In the current situation of low economic growth it seems that tax rates have increased beyond the peak of the Laffer curve with declining tax revenue. SARS has reported revenue shortfalls for the 2018/19 year of R57.4-billion (14).

Figure 3 below shows that at a growth rate of 10.7% per year, debt service costs is the fastest growing expenditure item. This is in contrast to the 7% annual growth in healthcare expenditure. By 2023/24 debt servicing costs will exceed health expenditure. Total government debt was 26% of GDP in 2008, is currently at 55%, and will peak at about 60% in 2023/24 (15) (16).

It is highly unlikely that the fiscal space will increase soon, and it will take a long time before the high level of inequality is reduced.

To overcome the challenge of having a narrow tax base and high levels of inequality in many low and middle income countries, social security systems have developed in accordance with the five pillars of social security developed by the World Bank.

The pillars include the non-contributory Zero-Pillar, which offers benefits to the entire population, is tax funded and available to all.

In addition to the Zero –pillar, mandatory membership is required for 1st and 2nd pillar protection. In the South African healthcare context these could be a low cost benefit option for all who earn below the income tax threshold but can afford to make a contribution. The 2nd pillar could be mandatory medical scheme cover. The voluntary 3rd pillar could consist of additional supplementary cover in addition to the basic benefit package recommended by the HMI.

Using other forms of earmarked taxes such as mandatory payroll taxes for health insurance, or other mandatory membership of medical schemes, are likely to lead to major resistance because taxpayers may have to pay more taxes without gaining any personal benefit. In accordance with the benefit principle, the willingness to pay such taxes will increase only with increased benefits to tax-paying individuals.
Explicitly describing and funding this multi-pillar system will mean that considerable steps could be taken towards Universal Health Coverage.

5 Feasible and desired changes to the current system towards Universal Health Coverage

On the trajectory towards the achievement of a single fund as an aspirational end state, many interim steps will be required to prepare the country for this major and radical change.

It must however be borne in mind that there is not a single low or middle income country that has achieved Universal Health Coverage through the introduction of a single payer system. Figure 4 below shows that private expenditure makes up a significant portion of health expenditure, even in high income countries.

Figure 4: High levels of private expenditure even in high income countries

Figure 5 below shows that three different packages could soon be developed and become part of the national funding system considered in Figure 6 further below. The primary and preventive care package could be linked to private health insurance, and could become a vehicle for the purchasing of primary care for public sector patients. This is explored and budgeted for from 2019 onwards (17).

The primary and preventive care with hospitalisation cover for public health priorities must be developed as part of a low cost vehicle and may be aligned with the principles discussed in the CMS discussion document on low cost benefit options (18). Finally, the revised PMB package is currently under review by the CMS.

Figure 5 also shows that the public will be able to choose where it enjoys the universal coverage benefit. The full benefit could be funded and received in the public sector, primary and preventive care could be received in the private sector, primary care with hospitalisation for selected conditions may be in the private sector, or the full revised PMB package could be accessed in the private sector. The universal coverage benefit could be allocated in accordance with the mechanism shown in Figure 6 further below.

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5 Based on data downloaded from https://data.worldbank.org/
In alignment with best practice, it is important that the universal coverage benefit must be portable (this enable members of the public to enjoy their benefits in the public or private parts of a unified health system) and that the benefit must be divisible (a choice can be exercised where parts of the benefits are enjoyed).

Figure 5: Portability and divisibility of universal coverage benefit depends on benefit packages and private or public delivery channels

The provisional HMI report recommends that a system of risk adjustment is introduced to ensure horizontal equity. The report also suggests that the medical scheme tax credit is converted to a contribution subsidy for medical scheme members. Since taxes are collected in a progressive manner, the allocation of these funds on a risk adjusted basis improves both horizontal and vertical equity.

To achieve this, Figure 6 below shows how money from the fiscus equivalent in value to the current tax credit is paid to the Risk and Income Adjustment Vehicle (RIAV). Before a formal institution is set up, the age and gender of beneficiaries could be used to make risk adjusted payments. Over time the value of this contribution could increase to be at the same level as that spent on public sector health system users.

The figure also shows that medical schemes will receive funds as differential cost options (this means that the contribution subsidy must be divisible for different levels of contribution to own healthcare). This is to allow for contribution subsidies for primary care only, for a low cost medical scheme, and for standard medical schemes.

In sync with the NHI White paper, the figure also shows how the Risk and Income adjustment vehicle could link with a Central Equity Fund (a virtual single risk pool) which ensures that income and risks are ultimately shared between public and private sector users. Medical schemes will receive risk adjusted payments for their beneficiaries for each of the packages considered in Figure 5 above.

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In healthcare financing, horizontal equity requires cross subsidies from the young and healthy to the sick and old. Vertical equity requires cross subsidies from high income earners to low income earners.
Figure 6: Flow of funds to support horizontal and vertical equity in support of portable and divisible universal coverage benefits

Ultimately, the health system functions could be allocated as depicted in Figure 7 below.

The stewardship role would execute the HMI recommendations and create the rules under which the health system functions would be executed. Some of the HMI recommendation which are likely to have a significant impact on the landscape include the introduction of a risk adjustment mechanism, health outcomes measurement and the flexibility that is required to develop innovative health service delivery models.

In respect of revenue collection, it is unlikely that there will be a significant real increase beyond the R200 bn that is currently spent on health care. The economy is growing poorly; the debt burden is too high and unemployment is at a very high level. It is likely to take at least a decade before the necessary fiscal space is created to have material changes in this respect. Employers and members will therefore play a more important role in the funding of healthcare for the next decade. Because the current cost of medical scheme cover is too high for the missing middle, lower cost options must be developed.

The HMI recommends that a risk adjustment mechanism is developed to improve horizontal equity between schemes. This must be expanded to include the provinces, low cost benefit options and primary care.

Through the application of a risk-adjusted contribution subsidy to the different risk pools, both horizontal and vertical equity can be fully achieved over time.
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### 6 Conclusion

This document shows that there are considerable fiscal constraints which prevent the establishment of a single fund to take steps towards Universal Health Coverage. In parallel with the international approach towards social security, the document proposes the establishment of primary care products and low cost medical scheme options to operate in parallel with state health services.

The document proposes that specific delivery vehicles for primary care and low cost options are developed with emphasis on PPPs for hospital delivery.

Immediate work should start to expand cover for primary care packages, and low cost medical scheme packages to exist in parallel with standard medical schemes and the state health services.

In this manner there will be progressive realisation of the constitutional right to healthcare.

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**Figure 7:** Allocation of roles in the Health System in accordance with the WHO defined health system functions

<table>
<thead>
<tr>
<th>Stewardship</th>
<th>Facility licensing</th>
<th>Innovative delivery vehicles</th>
<th>Alternate reimbursement</th>
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<tbody>
<tr>
<td>Training curriculum</td>
<td>Health outcome measurement</td>
<td>Competitive shareholding</td>
<td>Tariff negotiations</td>
</tr>
<tr>
<td>Treatment guidance and HTA</td>
<td>Risk adjustment</td>
<td>Mandatory membership</td>
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<table>
<thead>
<tr>
<th>Revenue</th>
<th>Employer contribution</th>
<th>Member contribution</th>
</tr>
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<tbody>
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<td>National fiscus</td>
<td>Medical Schemes</td>
</tr>
<tr>
<td>Provincial</td>
<td>Provincial allocation</td>
<td>Low cost options</td>
</tr>
<tr>
<td>Primary care</td>
<td>Health status, other risks</td>
<td>Primary care only</td>
</tr>
<tr>
<td>Low cost</td>
<td></td>
<td>Government funded contribution subsidy</td>
</tr>
<tr>
<td>Base benefit</td>
<td></td>
<td>must be available to all</td>
</tr>
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</table>

**Benefits**

- Government funded contribution subsidy available to purchase basic package
- Low cost with hospital provision through PPPs
- Base benefit option
- Private purchasers (Medical schemes, administrators)

**Service delivery**

- Public, Private, PPPs
- Primary care teams, PPP facility management, Centres of Excellence

**Creating resources**

- PPPs for Human resources, medical products, technologies, and information

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Figure 7 above also shows that to improve service delivery the flexibility must be created for the development of PPPs that could improve public sector hospitalisation, with specific management structures and information system support to improve revenue collection by public sector facilities. Improved service delivery also requires the development of primary care teams and the development of centres of excellence.

To create the required human resources for health the capacity in the private sector must be developed and adjusted so that human resources could be trained in the private sector as well. The private sector initiatives to share information must be made accessible to other health system players as well.
7 Works Cited


12. **Minister of Health.** MEDIA BRIEFING ON NHI WHITE PAPER. *Pretoria : s.n., 29 June 2017.*


