what if.

… we found a way to achieve universal health coverage

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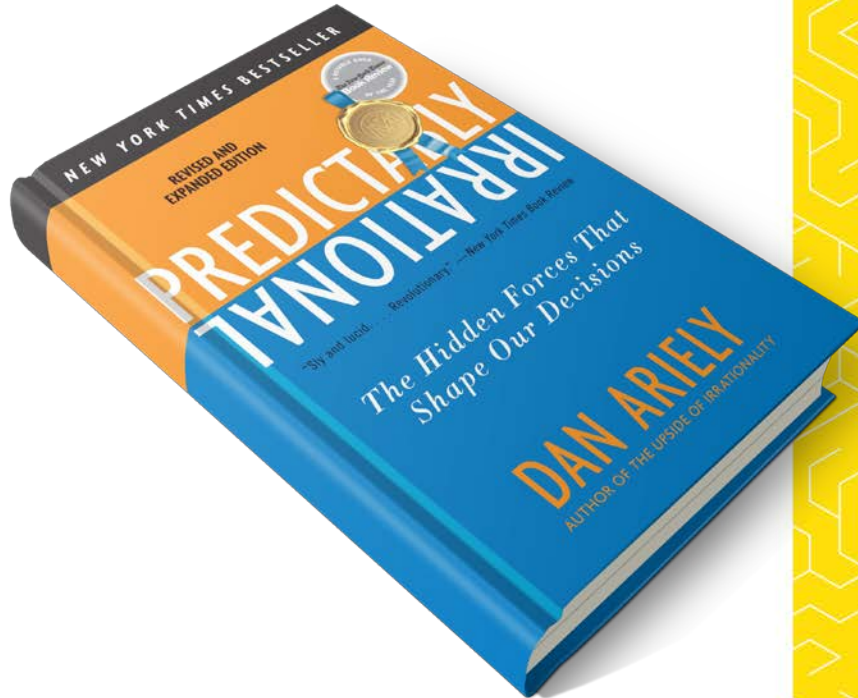
what if.



…people and policies were rational?

what if.

what if.

…health policy could be de-politicised?

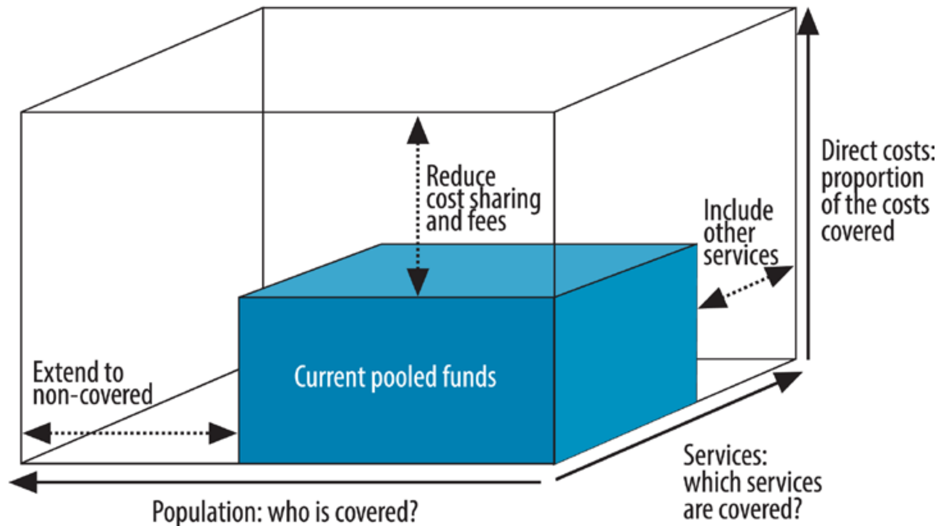
what if.

Delivery

Funding

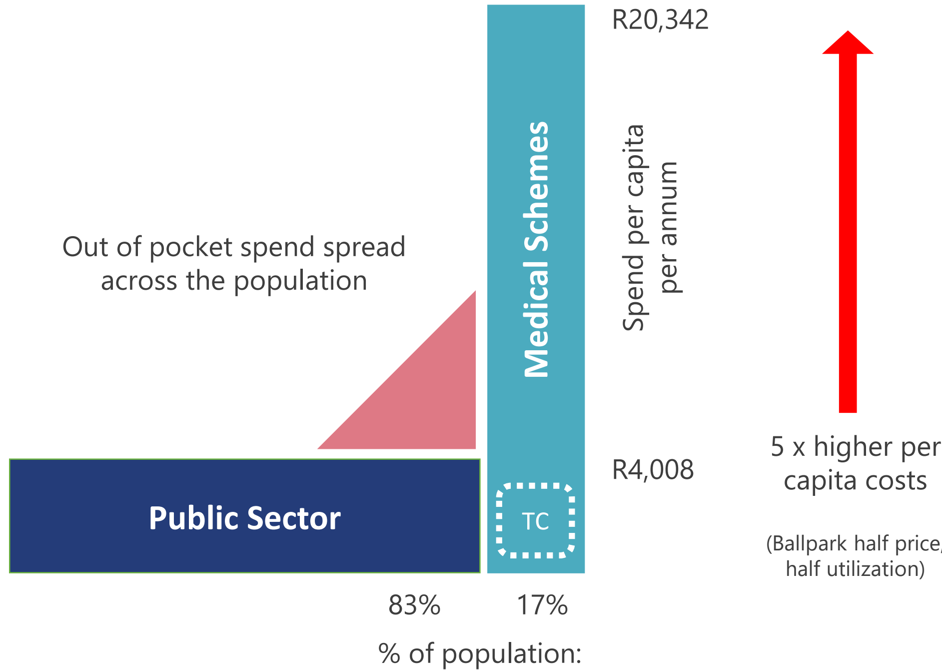
2007-
today
National Health
Insurance
2000-
2006
Social Health
Insurance
1998
Re-regulation (MSA)
1992
Deregulation

what if.



"The UHC journey is never complete"

The journey will always be an **incremental** process

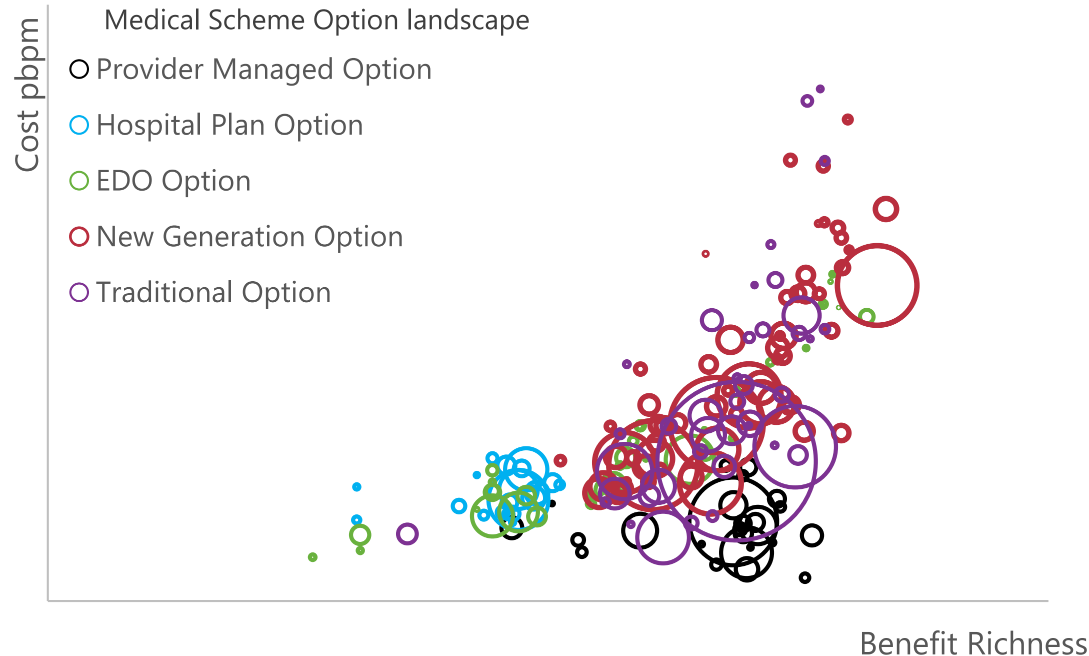


Coverage is provided for the whole population through either public health services, or medical scheme cover. Structurally this promises UHC.

Per capita differences in cost that translate to differences in access and quality mean we fall short on equity.

Lack of resources and governance failures compromise effective quality care delivery in the public sector.

Incomplete regulation, poor care co-ordination and care seeking behaviours make medical schemes expensive.



Private sector provides 280 options with a range of contribution and benefit levels

Insufficient income cross subsidy results in "you get what you paid for narrative" for benefits.

Long term trend of market consolidation continues.

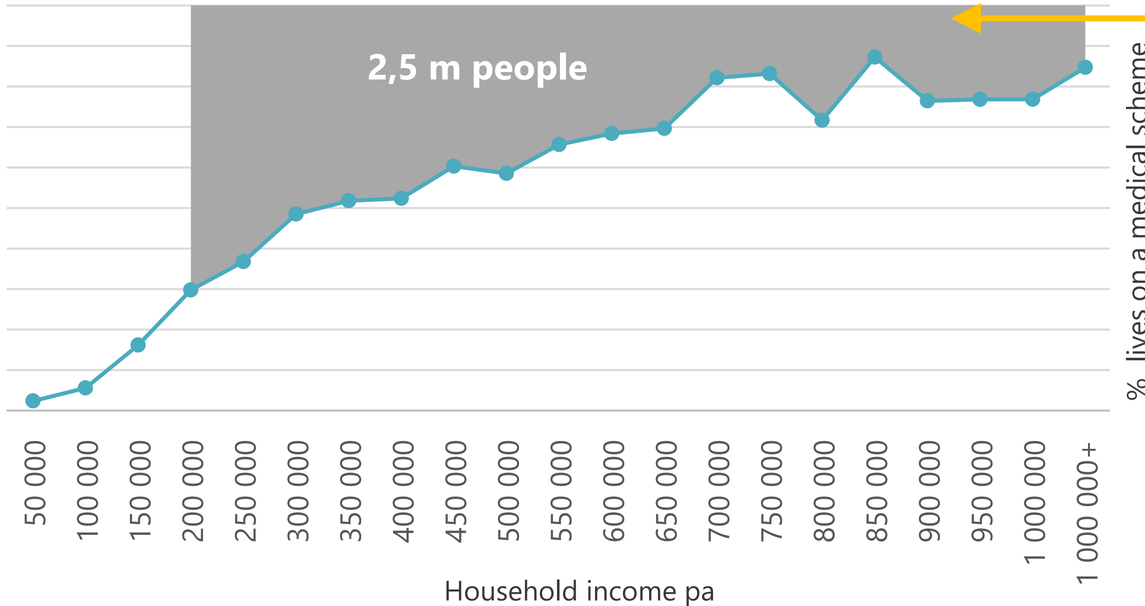
Embattled Competition Commission Health Market Inquiry yet to make final recommendations.

Other health insurance products filling gaps in scheme cover and unserved populations.

"Stagnant" membership levels driven by affordability constraint and floor cost of minimum benefits.

what if.

…some of the "Missing Middle" were in fact Free Riders?



"missing middle are employed, earning above the tax threshold and "not covered" or rather – paying out of pocket, or relying on the public system.

But they are also Free Riders
– anti-selecting into the scheme environment when sick, and not paying their way in terms of income cross subsidies for public care.

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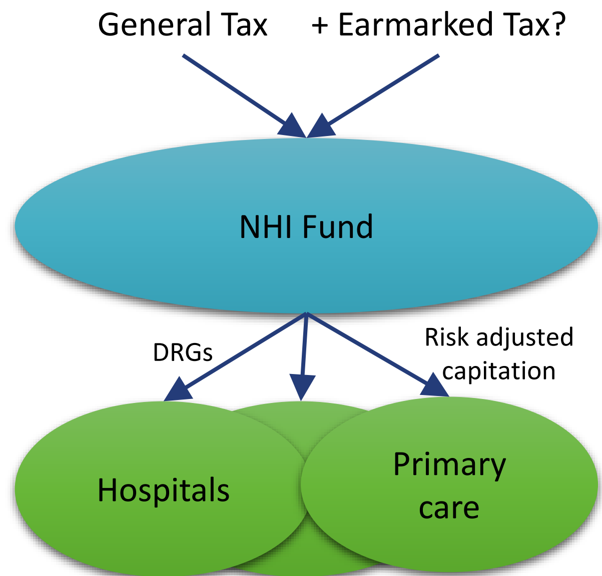
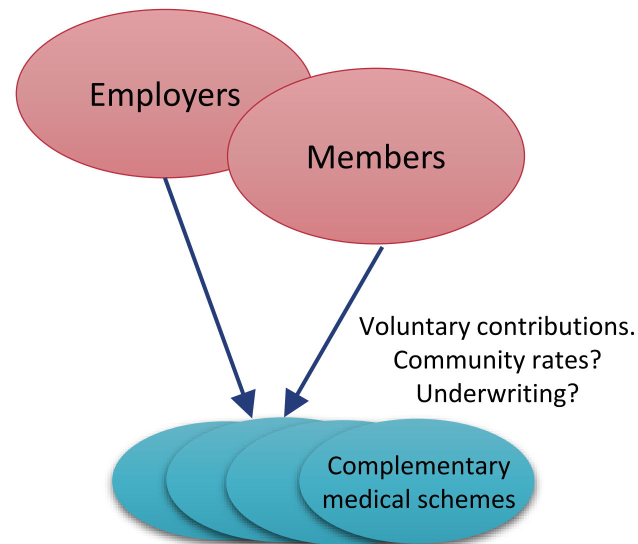
Option 1 – Current trajectory

Single payer publicly administered NHI fund, initiating a purchaser provider split. Comprehensive benefits, no co-payments. Accredited providers, referral pathways and clinical protocols



NHI to procure from public and private accredited providers. Provinces and districts likely to play provision role.



Benefits not covered or paid for by NHI
Some semantics to work on.
Could be very narrow or close to status quo.
Possibly relegated to gap cover type structure.
No tax credit. REF?

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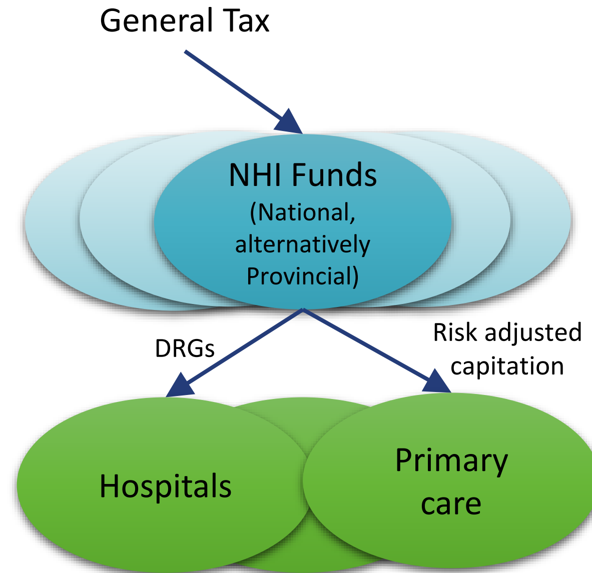
Option 1 – Current trajectory

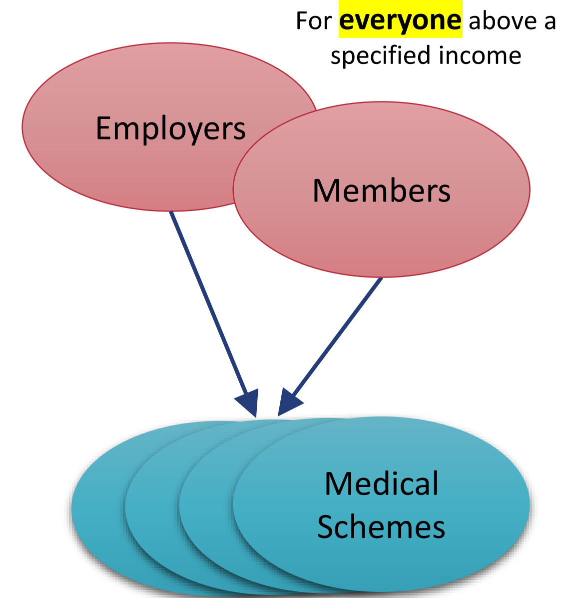
Pros	Cons
Could achieve greater equity	Big bang comes with big risks
Structurally simpler	Difficult to transition (big gap to jump)
Greater control	Risk of failure high
Monopsonistic pricing	Consequences of failure significant
Politically popular	Concerns about governance
One fell swoop approach	Expected resistance will protract process

Option 2 – Argue for the SHI pathway

Hard line between NHI (which would replace current public system) and medical schemes based on income. Scheme membership **compulsory** if earning above specified income.

Still undergo purchaser-provider split to enable flexibility of purchasing and accountability in provision.
NHI either a **single national fund** or **multiple provincial funds**, provision is provincial and local.





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Option 2 – Argue for the SHI pathway

Pros

Provincial NHI funds would be one step away from current system

Incremental approach

Less risky

Stabilises medical schemes

Reduces medical scheme costs

Alleviates some load from public system

Cons

Forcing members to join schemes will be resisted (no choice)

Entrenches two tier system

Difficult to progress equity improvements

Difficult to deepen income and risk cross subsidies between public and private sectors

Lower NHI purchasing power

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Option 3 – Mandatory Insurance Participation

Mandated pre-funding key to UHC.

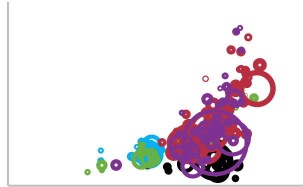
Above prescribed income level, choice should be to **join a medical scheme or pay an NHI tax**.

Risk based per capita spend from tax provides for horizontal equity.

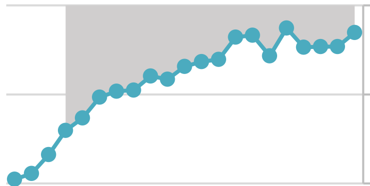
Define essential benefits similarly between NHI and Schemes.

Remove means test for uncovered lives. Retain income at facilities.

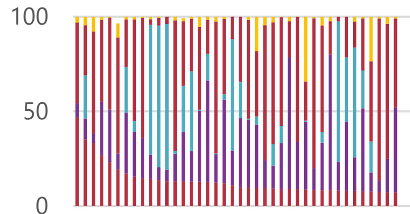
Option 3 – Mandatory Insurance



Number of schemes and options should be standardised.
Consolidation should proceed if and where it makes sense



NHI tax (contribution?) would need to be modelled considering costs, buoyancy, and degree of income cross subsidy desired



South Africa will show 8% OOP and 92% mandatory insurance for financing.

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Option 3 – Mandatory Insurance

Pros

Moves system to mainly mandatory prepayment

Fixes missing middle problem

Allows establishment of NHI and time to grow and learn

As NHI delivery improves, more people will opt in as costs will likely be lower

Greater fluidity and lower risk

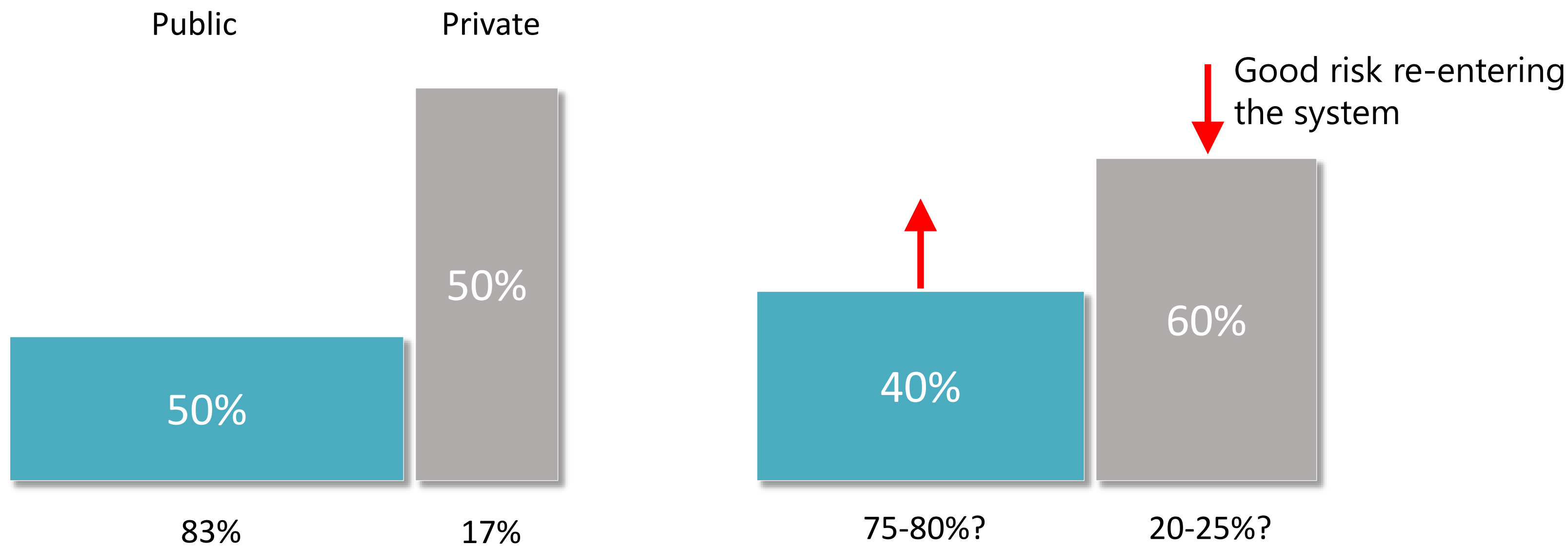
Cons

Will still require additional fund raising from current free riders

Risk of trench digging

Does not solve selection difficulties in scheme environment.

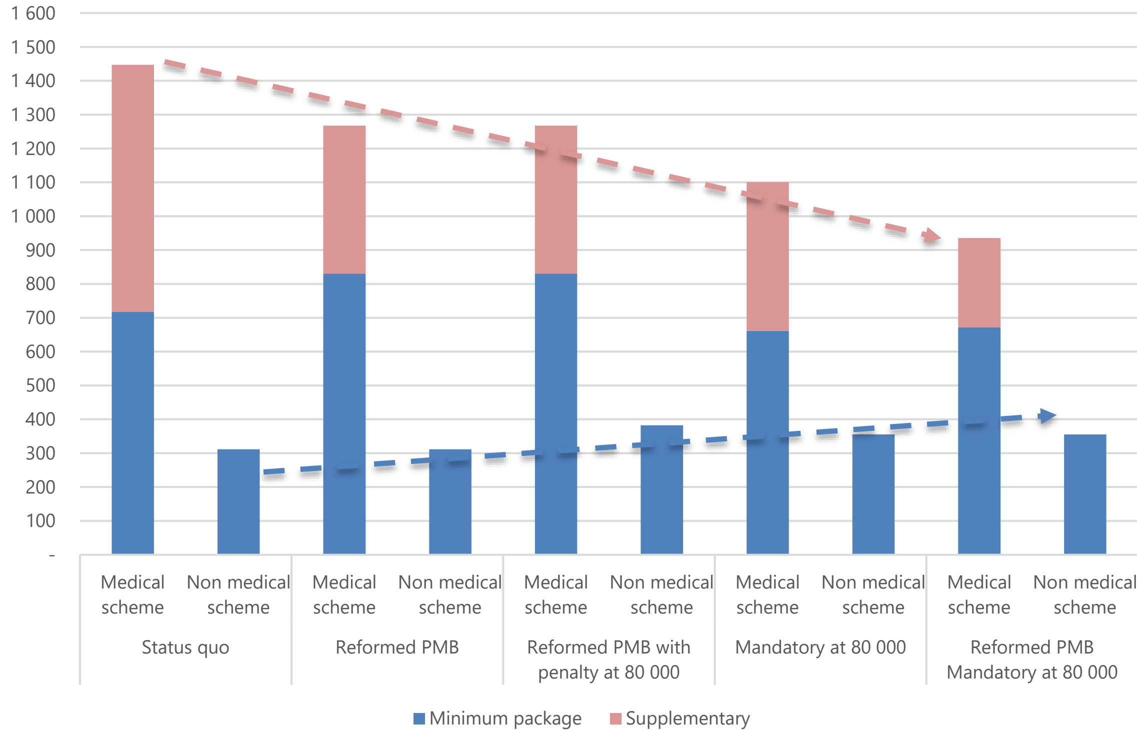
what if. mandatory contribution could increase equitability



Proportionally less
...but more per capita

Initial costing scenarios

Proudly Brought to you by insight



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what if.

Further considerations

No Middle Income Country has successfully achieved UHC via a single payor model.

There is **no one solution** to health reform, but some are better than others and most are better than nothing

Income inequality, driven by high unemployment means **incomes cross subsidies are critical**, but also finely balanced.

Pre-conditions for NHI (**improved public sector quality**) should not be forgotten. *(MoH, BHF conference 2012)*

Pace of reforms is **excruciatingly slow** and wandering, resulting in piecemeal solutions.

We must be vigilant about protecting the **public interest**, not narrow interests.

BIG BANG:

PHASED:

thank you.
a different
perspective
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