National Health Insurance: A wing and a prayer

25 FEBRUARY 2016

GOVERNMENT'S National Health Insurance plan (NHI), which has the noble ambition of extending affordable, quality treatment to all, is based on the most dramatic overhaul of the SA health-care system since the ANC came to power in 1994.

But how and when it will come to fruition remains an open question, with gaping holes in the policy framework and implementation strategy.

The vision, outlined in the White Paper on NHI, is of a health-care system based on the principle of social solidarity in which everyone contributes to a funding pool according to their means. Clinics and hospitals will provide free care to the ill, and a centrally administered NHI fund will buy services from accredited public and private sector providers.

The White Paper was released by health minister Aaron Motsoaledi in December.

The problem is that it fails to take a position on any of the tough issues. It does not spell out what benefits patients will get; what they will cost; where the money will come from; or how the all-powerful provincial health departments fit into the picture.

Instead the paper sketches a nebulous list of benefits such as "maternity care", and calls for "further discussion" on how the different tiers of government will provide and pay for health services. The paper offers multiple scenarios for raising additional revenue for NHI in an economic context divorced from current reality. An ambitious 14-year timeline (set in 2011) for NHI to be implemented was left unchanged.

The White Paper is so long on rhetoric and thin on substance that observers struggle to make meaningful comment on it. To complicate matters, the public consultation period closes on May 31 — well before the six working groups appointed by Motsoaledi to thrash out the missing details are due to complete their work, in mid-2017. Many key players in health care declined to speak on the record because they didn't want to antagonise government. They feared critical comment would be construed as anti-ANC.

One exception is Mzukisi Grootboom, chairman of the SA Medical Association, the country's biggest doctor organisation, who is among those who are forthright about the White Paper's shortcomings.

"There are no technical details here at all. It is a major disappointment," he says.

Why, he asks, does the White Paper not explicitly review the impact of the 11 NHI pilot sites established in April 2012 to experiment with different ways of organising and financing primary health care? It barely alludes to the pilot sites, yet a year ago it was apparent that its plans for recruiting private sector GPs to work in its clinics had run into such trouble, and attracted so few doctors, that treasury slashed a three-year grant earmarked for this purpose. This failing is scarcely acknowledged. Nor is any useful information provided on the pilot-site outcomes, beyond discovering — through the process of implementing a school health programme — that several thousand children have problems with their sight, hearing or teeth.

Also perplexing is how little progress has been made in articulating a practical action plan, says Roly Buys, head of funder relations and contracting at private hospital group Mediclinic International.

"Take human resources," he says. "If you want to look after 50m people and give everyone primary health care, with X consultations a year, then how many nurses and doctors do you need? You need an audit, a model to predict the number you need so you have an idea of the gap. Without that you don't know what the budget will be."

What's beyond doubt is that SA urgently needs health-care reform. Despite its status as a middle-income country, the health system is buckling under a huge burden of infectious diseases such HIV and tuberculosis, noncommunicable diseases, high rates of maternal and infant mortality and very high levels of injury and violence.

Access to treatment remains deeply inequitable. While those with means can access world-class care in the private sector, many patients relying on state hospitals and clinics confront a service that frequently fails to provide even the most basic services.

But no-one has an easy time of it: the middle class battles to navigate the complexities of medical schemes and frequently faces large co-payments on their bills, while their premiums rise faster than inflation. Poor people who depend on the state struggle with the referral system, endure inadequate care, and often face large out-of-pocket costs for transport and loss of earnings. (See the tale of two patients, page 20).

A benchmark indicator of the state of a country's health system is its maternal mortality ratio. The ratio stood at 138 per 100,000 live births in SA in 2015, compared with 44 in Brazil and nine in the UK, World Health Organisation (WHO) data shows.

Provincial variations in the quality of care are stark: the institutional maternal mortality rate ranged from 83.9 per 100,000 live births in the Western Cape to a shocking 201 in Limpopo in 2013, according to the most recent Confidential Enquiry into Maternal Deaths in SA.

The malaise in state hospitals has been fuelled by the appointment of politically connected individuals to key positions even though they lack the skills. Corruption and maladministration have flourished, to deadly effect.

Unless these issues are confronted head on NHI is doomed, says Mark Heywood, executive director of lobby group Section27. "If the cabinet and president continue to protect people who undermine health, the minister cannot implement the vision in the White Paper," he says.

Tough questions also need to be asked about whether the private sector delivers value for money and needs tighter regulation, Heywood adds.

These issues are under the microscope at the competition commission's health market inquiry, which began its public hearings last week. It aims to finalise its report on the private health-care market by year end, but how far it will influence government thinking on NHI is anyone's guess.

There are sharply differing views as to whether NHI is the right medicine for SA's crippled health system.

Under former president Thabo Mbeki, government planned reforms to take some of the load off the public sector by widening access to private health care. The intention was to require better-off citizens to pay for health insurance either through private medical schemes or a state-run scheme, leaving government to provide free health care to the poor and unemployed, under a system it called social health insurance.

It hadn't happened by the time Mbeki was forced from office in 2008. Under President Jacob Zuma, rhetoric shifted to NHI.

A Green Paper in August 2011 proposed a system in which everyone would contribute to NHI, but this would not be their only choice, as medical schemes would continue to exist. The plan's architects assumed medical scheme membership would diminish as the various tax increases required to fund NHI would make medical schemes less affordable, and the quality services offered under NHI would diminish the need for medical schemes. Critics questioned this logic, arguing that demand for medical

scheme membership is remarkably inelastic, and numbers remain roughly constant even in tough economic times.

The White Paper articulates a more hostile view towards the medical scheme industry, saying schemes will be limited to providing cover for benefits not offered under NHI.

At the release of the White Paper, Motsoaledi described medical schemes as a “punishment for poor people” because they funded an industry that had attracted the majority of SA’s specialists, to serve a minority of the population.

Implicit in the paper is an assumption that the R140bn currently spent on medical schemes, along with the R21.7bn out-of-pocket spending on private health care and R4bn on health insurance, can and should be re-directed into NHI.

But threatening people’s ability to pre-fund private health care before trust in the state system is established is perplexing. Not only would it perpetuate inequity because the wealthiest individuals would continue paying for private health care out of their own pockets, (while conditions would be ripe for an unregulated black market in health insurance products), but the White Paper’s proposal to scrap the state’s generous medical aid subsidies for public servants is unlikely to sit well with its 1.3m employees (see *Public Servants and NHI: Subsidy scrap looms*).

The White Paper assumes patients who pre-fund their own health care by contributing to medical schemes somehow drive inequality.

It’s like saying parents who send their children to private schools or employ private security guards do the same thing.

“If the public sector was world-class, people wouldn’t buy medical scheme cover,” says Barry Childs, joint CEO of Insight Actuaries & Consultants. “Medical scheme membership is quite resilient even when the economy is under pressure: people sacrifice other things in their household budget.”

Already Motsoaledi seems to be having second thoughts, though.

“We do not envisage burning medical aids en masse,” he said in an interview with the Financial Mail. “We don’t think it will be fair to say that private schemes like Discovery are no longer going to work. We want people to make their own choice. We want to make it clear that NHI will be mandatory, just like it is in England. No millionaire is not part of the (UK) National Health Service but if he wants to do something privately, it’s allowed.”

Pushed to spell out why the White Paper assigns a minimal role to medical schemes, Motsoaledi goes a step further.

“That White Paper is a 400-page document (written) over four years, and when we released it, it was the 40th version,” the minister says. “It looks like they arrived at that proposal when they were debating with the treasury team, and I told them it is not very clear. It needs to be re-looked at. I was a little disappointed that the White Paper might appear to be giving the wrong impression. There is nothing wrong with giving a person the choice to buy whatever.”

This apparent climb-down may well be a response to fears within the ANC that restricting private medical aid cover would alienate middle-class voters.

“There is a local election coming up, and the ANC doesn’t have much on the table,” says PPO Serve CEO Brian Ruff. “The middle classes sympathetic to the ANC won’t stand for being told they can’t buy medical scheme cover.

“When it became obvious there would be a backlash, the ideologues would have had to back down.”

But the big question is: what will NHI cost? Just as the Green Paper ducks real analysis of the risks NHI poses to the fiscus, so too does the White Paper. While conceding that costs are difficult to estimate, it projects total NHI costs will be R256bn in 2025 (in 2010 prices), assuming expenditure grows by 6.7% in real terms after 2015-2016. That would take the level of public spending from its current 4% of GDP to 6.2% of GDP by 2025, creating a funding shortfall of between R28bn and R108bn, depending on how fast the baseline health budget grows.

The White Paper doesn't specify how this shortfall would be funded, but says options to be considered include a payroll tax, a surcharge on income and Vat increases.

The projections in the paper are based on the assumption that the economy would grow at 3.5% a year, a rate last attained in 2011. Last year's growth rate was 1.5% and the World Bank projects a mere 0.8% this year.

Motsoaledi is adamant that a lack of funding won't derail NHI. "No country implemented universal health care when the economy was rosy," he says. "Japan started in 1961 when the economy was very bad. Britain started in 1948, three years after World War 2, when it was very poor."

Pravin Gordhan's return to the finance ministry may inject more realism into the thinking around NHI, says Xelus Specialised Solutions MD Mike Settas.

"He has vowed to prevent a downgrade from the ratings agencies, which indicates strongly he will not be letting anything through that will increase government expenditure or cause uncertainty about future spending. It is inconceivable any tax increases would be allocated to anything other than narrowing the budget deficit in order to avert a downgrade," he says.

Introducing NHI under current fiscal constraints is an issue the credit ratings agencies have flagged as a concern.

But politics could dictate that NHI will go ahead in some form. The dream of free medical treatment is an integral part of the ANC's manifesto of "a better life for all", and the right to health care is enshrined in the constitution. Nelson Mandela instituted free health services for pregnant women and young children soon after he became president in 1994 and his administration rolled out clinics nationwide to provide free primary services.

The ANC pledged at the 2009 elections that NHI would be implemented and called for the plan to be speeded up at its mid-term conference last year. Both Motsoaledi and Gordhan are under pressure to show progress towards that goal when the party holds its national conference late next year.

While the NHI policy in its current form appears to be more of wish than a practical plan to reform SA's health-care system, Motsoaledi is adamant it's no pipe dream.

"NHI is not a luxury. Health is a social investment without which economies cannot thrive."

But until the minister supplies the hard details and a credible plan, the dream will remain just that.

By Tamar Khan – Financial Mail