Why the implementation of National Health Insurance in South Africa will be a disaster

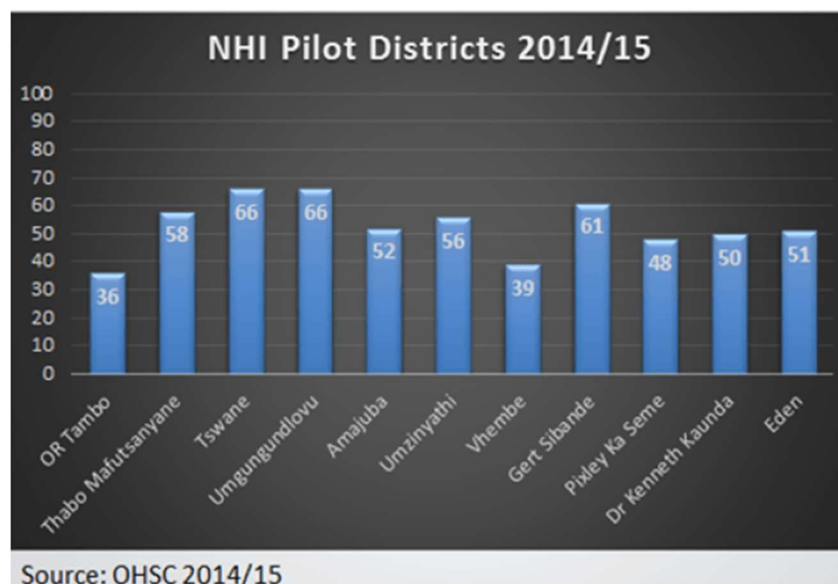
26 April 2016

The December 2015 White Paper on the National Health Insurance is long on dogma, but short on details with issues of affordability, free choice, human resources and quality not sufficiently addressed and quantified

The proposed National Health Insurance (NHI) stems from the ruling African National Congress (ANC) December 2007 Polokwane national conference and is largely ideological driven without regard to the practical implications of creating a universal health care (UHC) system so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status.

The Green Paper on the NHI released by the South African government in August 2011 set the parameters of the debate and after 39 iterations and 60,000 submissions spanning four years, the resultant White Paper in December 2015 failed to address the issues raised by the public consultation. Dr Chris Archer and Dr Johann Serfontein gave their view on the NHI at a Free Market Foundation seminar.

The NHI was intended to bring about reform that would improve service provision and healthcare delivery. A total of 11 districts were selected to pilot the system and prove the concept so that the NHI could be rolled out to all 52 districts, but a recent quality audit showed that these pilot districts had inadequate quality care ranging from a high of 66 percent to a low of 36 percent.



Source: OHSC 2014/15

The current national health system has a myriad of challenges, among these being the worsening burden of disease due to people living longer and being more sedentary resulting in a rise in non-communicable diseases (NCDs) such as cardiovascular diseases, diabetes, chronic respiratory conditions, and cancer, as well as the scourge of AIDS and tuberculosis, high maternal and child mortality together with high levels of violence and injuries.

In addition, the two-tiered health system of public and private health sectors, which is prevalent in most high and middle income countries, is considered to be inequitable and inaccessible to a large proportion of the population with the public sector burdened by underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure. In many areas access to health care has increased as more clinics have been built, but the quality of healthcare services has deteriorated or remained poor.

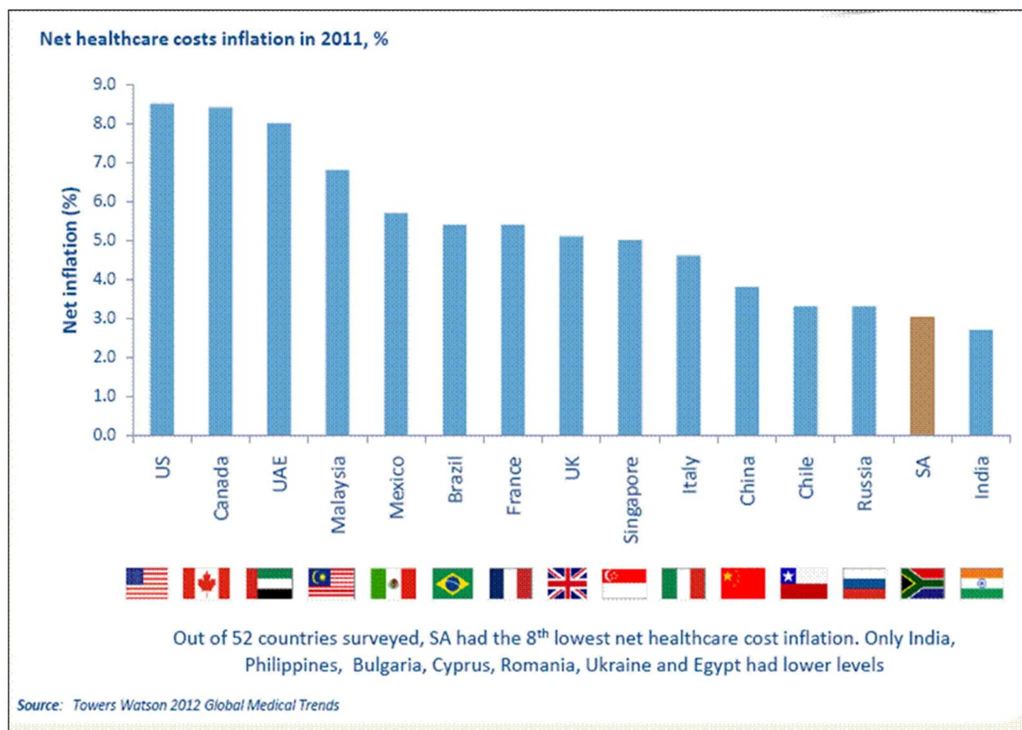
Levels of Satisfaction with Healthcare Facilities (StatsSA)

	2011	2012	2013	2014
Very Satisfied				
Public	61,9%	57,0%	60,5%	57,5%
Private	92,9%	91.7%	94,0%	92,2%
Somewhat Satisfied				
Public	21,7%	21,7%	22,0%	24,2%
Private	4,3%	4,8%	4,0%	5,3%
Dissatisfied				
Public	9,6%	12,7%	10,1%	10,1%
Private	1,9%	1,7%	1,2%	1,5%

Both Archer and Serfontein said there were several errors in the 2011 Green Paper that had not been rectified in the 2015 White Paper despite the numerous submissions. Chief amongst this was the oft-quoted statistic that only 16 percent of the population was medical aid members and that is was only these select few that used the private health care system. The reality is that because of the poor quality of the public health care system, many non-members chose to pay out of their own pocket for services in the private health care system. This meant that the usage was more than double the 16 percent and could be as high as 38 percent.

	Public	Private
Usage	72% - 62%	28% - 38%
Nurses	62%	38%
General Practitioners	63%	37%
Hospital Beds	86 774 (71.5%)	34 572 (28.5%)
Specialists	41%	59%
Econex, 2013		

On the other side of the spectrum, the private sector has its own set of problems, with concerns raised mainly related to the costs of services which is a result of pricing and utilisation of services. This too however was a myth that needed to be busted according to Dr Archer, as South Africa had the eighth lowest cost out of 52 countries surveyed in 2011, well before the subsequent slide in the rand. These low costs and the excellent quality in the private health care system was one of the reasons South Africa was in the top three destinations for medical tourism.



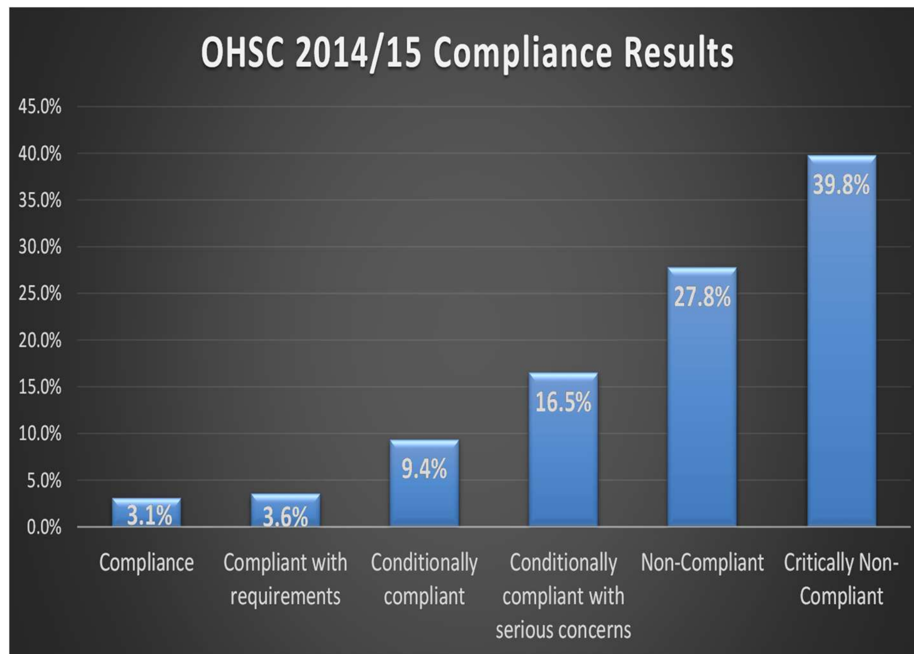
The Free Market Foundation has recommended that the government concentrate the little revenue it receives from the taxpayer on the poor, but attempting to provide “free healthcare for all” would inevitably be disastrous. Jasson Urbach of the foundation’s health policy unit said South Africans who can afford healthcare should be left “alone to seek out the cover that would suit them best”. It is a moral question of whether the government does or should have the right to determine the healthcare-related choices made by citizens.

Dr Serfontein warned that people with rare diseases such as hemophilia would not be covered by the NHI, whereas currently that person would be treated at an academic hospital by a professor in Hematology. The White Paper said the "NHI will provide a comprehensive package of personal health services. As resources are limited, the delivery of a comprehensive package will take into account the need to progressively realise the personal health benefits whilst undertaking priority setting. NHI will not cover everything for everyone."

Both speakers said that with current poor administrative competence in government agencies such as the Compensation Fund and the Gauteng Department of Health, the NHI fund would need an army of some 100,000 bureaucrats to administer the estimated R256 billion (2010 prices) in 2025 when the fund becomes active. The White Paper did not specify how that R256 billion would be funded. In May 2015 the Compensation Fund had 231,000 outstanding medical claims to the value of R23 billion, while the Gauteng Department of Health owed to R296 million to 509 companies in Jan 2016. These delays in payments had prompted 19 radiological practices to sue the Compensation Fund for R121 million in outstanding claims.

Failure to pay healthcare providers on time would result in an exodus of skilled healthcare professionals. South Africa currently produces some 1,800 doctors annually from 12 medical schools, but this is only a third of requirements. Doctors who work in the public sector already complain of long hours, lack of equipment and lack of leadership. These poor working conditions were reflected in the fact that only 256 posts out of 600 available in the 11 NHI pilot districts were occupied resulting in under-spending in the pilot districts.

In 2014/15, the Office of Health Standards Compliance (OHSC) conducted an audit on 417 facilities out of more than 3,300 facilities in existence nationally as the OHSC has limited resources. That means that a facility will only be audited roughly every six years, so if they are not compliant many facilities will remain dysfunctional for years on end. The 2014/15 audit showed that 84 percent of facilities were not compliant to varying degrees.



The bottom line is that if the NHI only pays compliant facilities, then South Africa's 55 million people would over-burden the 16 percent compliant facilities. There would be no public sector compliant facilities in three provinces, namely the Eastern Cape, Free State and the Northern Cape.

By Helmo Preuss