Social solidarity for quality healthcare for all

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Health Minister Aaron Motsoaledi tells Independent Media's Khathu Mamaila that the main objective of the NHI is to provide quality healthcare to all South Africans regardless of their economic status

In summary, what is NHI?

NHI (National Health Insurance) is a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. It is exactly what medical aid schemes are doing but with two very notable differences: (i) The word "all" does not apply in medical aid schemes. They are for a selected few in society, whereas NHI will be for all South Africans in keeping with the fact that health is a right in the constitution and hence cannot be for a selected few; (ii) In medical aid schemes, you get a particular type of health service depending on your socio-economic status and not on your health needs. In NHI your socio-economic status will not matter but your health needs will determine what form of service you get. The World Health Organisation (WHO) and the UN call it Universal Health Coverage (UHC) because nobody is left behind.

What are the main objectives of the NHI?

NHI aims to achieve UHC for all South Africans. This specifically refers to financial health coverage. It aims to provide equity and social solidarity through pooling of risks and funds. It will create one public health fund with adequate resources to plan for and effectively meet health needs of the entire population not just for a selected few.

Under the NHI regime, will there still be private medical aid schemes?

Paragraph 400 of the White Paper on NHI states that "with the implementation of NHI, the role of medical aid schemes in the health system must change". This matter is still being debated by various stakeholders but what I can tell you is that state medical schemes will definitely cease to exist because there will be NHI. NHI is also going to be a mandatory pre-payment of health, ie your healthcare is paid for before you are sick and it is mandatory because once passed into law, every South African has to belong to it. This is unlike medical aid schemes which are voluntary pre-payment. The debate here is hence whether you could be allowed to keep another private medical aid scheme while you are mandatorily belonging to NHI.

What about private healthcare providers, will they continue to operate? If yes, what will be different?

Let me first clarify two different concepts which usually confuse many people. Private healthcare has two very distinct and different arms usually owned and operated by different groups. One arm is called healthcare funders: These are mostly medical aid schemes, but other funders include hospital plans and hospital cash plans. They pay for you when you are sick. The other arm is called health care providers: These are mostly private hospitals. But they also include private specialists and general practitioners as well as allied health professionals in private practice (optometrists, physiotherapists, occupational therapists, speech therapists, dental therapists and oral hygienists etc). They provide you with healthcare and the funder to which you belong pays for you. The private healthcare providers will definitely continue to operate. Contrary to popular belief, NHI is not going to abolish or do away with private health providers. However, they will operate under a completely different environment created by NHI. For instance, NHI will not allow them to charge the exorbitant fees they are charging today, especially the private hospitals. Certain practices will not be allowed under NHI. For instance, a healthcare provider will not be allowed to start treating you and then discard you and send you away after he/she has exhausted all your funds. Private ambulance providers will no longer be allowed to pick up only people who have medical aid, a credit card or cash, at the scene of an accident and leave behind the poor. Section 27(3) of the constitution will be strictly applied under NHI. It simply states

that nobody may be refused emergency medical treatment. Under NHI, private providers will no longer be allowed to charge you extra cash called a co-payment after NHI has paid them. Under the present system, a private provider may charge you extra cash over and above what your medical aid has paid them.

Critics of the NHI say government wants to disrupt a private healthcare system that is working well and that government should leave the private healthcare alone as this reduces the burden of providing healthcare from the state. What is your response?

It is definitely not true that private healthcare is a system that is working well. This assertion is a dangerous simplification of facts. For starters, a system of health cannot be said to be working well when it serves only a tiny minority of the population (only 16 percent of South Africans) and excludes the overwhelming majority (84 percent of South Africans). Secondly, the cost of private healthcare is spiralling out of control with the results that medical aid contributions are increasing more than the consumer price index, while the benefits to patients are reducing at a very fast pace. Most members of medical aid schemes run out of benefits and are no longer covered from as early as June until the end of the year. You cannot therefore claim that a system is working well when that system can take you out of the ICU while you are still very sick, simply because your benefits have been exhausted. Lastly, medical aid schemes are actually collapsing under the weight of the high medical costs. In 2002 there were 141 medical aid schemes. Today we are left with 83 and still counting down. GPs are being taken out of practice because they are simply not paid or paid very little by medical aid schemes compared with private hospitals. Actually, the National Development Plan (NDP) states that if we need to fix the health system, we need to deal with two problems. Firstly, to deal with the exorbitant cost of private healthcare. Secondly, we need to deal with the problems of the quality of the public health system. As you can see, both systems need to be fixed, not only the public health system. It is for this reason that paragraph 2 of the NHI policy document states: "NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current healthcare system, both public and private, and also derives its mandate from the NDP of the country".

As it is, poor people can get free medical care in public hospitals. Why do you feel that we need an NHI to provide universal healthcare?

Poor people may be getting free medical care in public hospitals. But you and I know that free care is very difficult to deliver without adequate resources. Resources are both financial and human. The cream of the South African society, ie those with huge financial resources and skills, have hived off from the rest of society to have their own health financing system (medical aid) and health provision system (private hospital). They have hived off with huge financial resources. Skills and professionals follow the financial resources. Hence 80 percent of the specialists of the country are in the private sector serving only 16 percent of the population. The remaining 84 percent of the population is served by only 20 percent of specialists. Actually, our country is spending 4.4 percent of the GDP on only 16 percent of the population and only 4.1 percent for 84 percent of the population. The services may be free, but it is a struggle to deliver them with the meagre resources left in the public health sector. Some people argue that medical aid scheme money is private money and we have no business to meddle in it. This is a serious distortion of facts. The truth is that medical aid schemes are subsidised for a whopping R46.7-billion by the fiscus of the country. If it was not for this very heavy subsidy from the state, medical aid schemes would have ceased to exist. People who are not on medical aid do not have access to this subsidy. In the words of the director-general of the World Health Organisation (WHO), UHC is an equaliser between the rich and the poor. It is only NHI that can bring this UHC.

Isn't the elephant in the room the fact that public healthcare is collapsing due to factors such as under-funding, corruption, politics and incompetence and perhaps that if we want to ensure quality service for the poor we should deal with these problems and not throw the baby out with the bath water?

It is true that public healthcare is under-funded. But it is definitely not collapsing. It is just dealing with a huge burden of disease and a very huge population compared with private healthcare which is over-subsidised but has very few people to deal with. As an example, let us start at the beginning of life. There are 1.2-million women who fall pregnant every year. The private health sector takes care of only 140 000 of them with 80 percent of the specialist doctors. The public health system takes care of a whopping 1 060 000 with only 20 percent of the specialists. As things stand, the biggest killer of South Africans is TB. There are more than 400 000 South Africans being treated for TB each year. All of them, regardless of their socio-economic status, are treated by the public sector. The private sector is treating none. The TB cure rate used to be 67 percent in 2009, it was 85 percent by 2016. The second biggest killer, is HIV and AIDS. There are an estimated 6-million South Africans infected by this virus.

The public sector is treating 3.5-million of them whereas the private sector despite the huge resources at their command is treating only 200 000. There used to be 70 000 babies born HIV-positive by 2004. Because of the very highly successful PMTCT (prevention of mother-to-child transmission) programme, the figure is now down to 6 000. How on earth can all this be achieved by a system that is collapsing? It beats me. Corruption cannot be allowed in any system. We need to fight it. It is not part of NHI. The White Paper on NHI outlines what is being proposed to deal with fraud and corruption. We cannot then associate NHI with corruption. NHI abhors corruption because there can never be development where there is corruption.

What do you say to people who say NHI is a Rolls Royce solution when we cannot even afford a Toyota Tazz?

I will tell them that in fact a Rolls Royce is the present system, whereby only 16 percent of the population spends a whopping 4.4 percent of the GDP on their health and leaving 84 percent of the population with a measly 4.1 percent of the GDP. Which one is a Rolls Royce in this situation? In 2002 expenditure on private healthcare was R41-billion but by 2014 it was already R141-billion, but that is spent on only 16 percent of the population. It is for this reason that the WHO and the OECD (Organisation of Economic Co-operation and Development) has declared that South Africa is an outlier because we are the only country in the world that is spending huge amounts of money on very few people. Now that is a Rolls Royce. Rolls Royces are huge extremely expensive cars owned by very few people at the expense of the majority. NHI is not designed to be a Rolls Royce or a Toyota. It is designed to be a transport system for all South Africans, which is appropriate for all South Africans and which is affordable for the country. Chapter 2.3 of the NHI White Paper shows that affordability is one of the eight principles of NHI. The others are social solidarity, efficiency, effectiveness etc.

For NHI to succeed, many qualified health professionals would be required. Given the current shortage of skilled professionals such as doctors and nurses, where will we get professionals?

As it is at the moment, all countries in the world, with the exception of Cuba, have a shortage of health professionals. Sub-Saharan Africa has been declared a crisis point. The secretary-general of the UN has even come up with a global solution for this issue. But shortage of health workers is not a reason not to implement UHC. Actually, UHC will help a country like South Africa to effectively share the small pool of health professionals that we have. This shortage is exacerbated by not sharing what we already have. I can put in on record that one particular private hospital in Johannesburg has 30 specialist gynaecologists. Limpopo has only seven full-time South African gynaecologists to serve a total of 40 hospitals in the whole public sector, Mpumalanga has six to serve a total of 33 hospitals and North West has seven to serve a total of 22 hospitals. We had to get Cuban gynaecologists. If a teacher has got only 16 pupils to teach, and another one has got 84 to teach, comparing their performances without taking this into consideration, is grossly unfair, a distortion of facts and outright unscientific. The solution to the gross inequalities I have just outlined above is NHI (Universal Health Coverage) whereby the whole population will have access to all the gynaecologists that exist in our country, whether public or private. There are 3 000 optometrists in South Africa and only 250 of them are in the public sector. If we share under NHI the shortage will somehow be mitigated. I am on record that

NHI is not a beauty contest between the public and the private health sectors, but it is a system to make both sectors serve the whole population in co-operation rather than antagonistic.

One of the biggest problems faced by the public healthcare system is public servants who simply do not care about patients. How does the NHI propose to change this?

We established the Office of Health Standards Compliance (OHSC) and the Office of the Health Ombudsman (South Africa's first health ombud) to deal with some of these problems. We have even come up with a system of district specialist teams to supervise doctors and nurses in their duties. We also need strict application of the public service laws and the LRA (Labour Relations Act), as well as having good managers who manage without fear or favour like the health ombud.

What do you say to people who say the NHI is not affordable?

As I have already said, what is not affordable is the present system. I have given you the figures and numbers. People who believe that NHI is not going to be affordable wrongly think that under NHI, we are going to allow the present high healthcare costs. Both the WHO and the OECD have already declared that South Africa is running one of the most expensive healthcare systems in the world. The NHI is actually designed to fight these expenses. Both the WHO and OECD state that only 10 percent of South Africa's population can afford the present private healthcare cost. Clearly it is the present system that is not affordable, not NHI. Do you think under NHI we are going to agree to pay R7 000 to R10 000 for a simple circumcision as it is happening today in the present private health sector? No ways. NHI will not allow that. The problem is that people wrongly believe that NHI is simply going to be a bigger version of the present system. It is not going to be.

It has been a few years since pilot projects to roll out NHI were launched. How are these going? What have been some of the lessons of these pilot projects?

Yes, we launched pilots in order to learn what is feasible and what is not. We have learnt a lot. Under the pilots we have screened 3-million school kids for physical barriers to learning like eyesight, hearing and oral hygiene/speech. We now know how to tackle that. We have established district specialist teams to supervise doctors in each district. We now know where the gaps are. We have contracted GPs to work in public clinics and learnt that we also need to contract allied healthcare professionals like physiotherapists, speech therapists, oral hygienists, occupational therapists, psychologists, optometrists, etc. Primary health worker teams have visited no less than 4-million households to check their health status. We have finalised infrastructure needs for all 700 health facilities and have started the work of refurbishment and backlog maintenance.

What are you doing to mobilise society to support the NHI?

Since the Green Paper was released for public participation, I have addressed several meetings with an estimated number of people who attended cumulatively at 60 000. I have addressed several forums of doctors through their professional associations. A total of six work streams have been formed where several stakeholders were consulted. I have addressed organised labour, some chapter nine institutions and even Nedlac. From March 1 to 3 there will be a full day devoted to discuss NHI at the National Health Consultative Forum where stakeholders come together. Last year at the same consultative forum (it is an annual event) the only agenda item was NHI.

What other countries have implemented the NHI? What have we learnt from these?

Many countries have started implementing UHC even before the UN adopted it as one of the 17 sustainable development goals of the world. Countries call it by different names but the goal is one, namely UHC whereby every citizen in every country has financial coverage for their healthcare needs instead of only a selected few as it is happening in our country. The UK started it in 1948 and called it NHS. Japan started in 1961. Mexico started in 2001 and call it Seguro Popular. Brazil has it, all the Scandanavian countries have very good universal health coverage systems. On the African continent,

Ghana has started. Rwanda has also started. All 194 countries under the UN have become signatories to the notion of UHC, which means they are preparing to implement it.

Khathu Mamaila: Cape Times & The Star