Role-players don't see eye-to-eye on the NHI

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Even among those who support the implementation of universal health coverage in the form of a National Health Insurance (NHI) there is disagreement on what the shift will mean especially for private medical schemes, writes AMY GREEN for HEALTH-E NEWS.

Minister of Health Dr Aaron Motsoaledi launched the HPV vaccine campaign at Gonyane Primary in Mangaung in the Free State in 2014

According to the new NHI White Paper, the role of medical schemes in South Africa will change fundamentally with the implementation of a universal healthcare system. The first victims will be government schemes, including the Government Employee Medical Scheme (GEMS), the Police Medical Scheme and the Parliamentary Medical Scheme (Parmed).

Speaking to Health-e News on Thursday evening, Health Minister Aaron Motsoaledi said he had gazetted legislation that day to set up teams to look into dismantling and reformulating these schemes to divert money to the future NHI Fund.

"We needed to gazette that and then get public participation… for such committees. But as soon as they get appointed they will start doing that work," he said.

Small schemes not "viable"

Motsoaledi said that he had been campaigning for the dismantling of Parmed for years: "Because Parmed consists of members of parliament [MP] and judges and I told them they do not meet the definition of a medical aid scheme because a scheme depends on numbers.

With 265 judges in the country and just over 1000 MPs he said the scheme has never been "viable".

"I was paying a premium of R 4000 in Parmed and around October, my benefits for chronic medication were finished. And they tell me if I want to be treated, I must be admitted to hospital. I mean that's ridiculous. A patient in hospital is much more expensive," he said.

He is also prioritising the removal of GEMS' lowest plan, Sapphire, which does not provide cover for private hospitals and only allows each member three visits to a doctor per year.

"About 40 000 public servants are on this plan and they don't pay a cent – not a single cent – everything is paid for by the state, and then they are also treated in state hospitals. It doesn't make sense," he said.

He said these are two examples of inefficiencies within the current private health financing system and why it deserves to be overhauled and for these funds to be diverted to a single NHI Fund.

Future of medical aids

According to the White Paper, future medical schemes would be relegated to providing only "complementary cover" for non-essential services not covered by the NHI.

But acting managing director of the Board of Healthcare Funders (BHF), Dr Clarence Mini, said that he believed that there should be more debate about the role of schemes in the future.

"Since 2008, we have supported the idea of the NHI and believe that it is in the interests of the greater good of everyone – and not just the 16 percent who belong to medical schemes," he said. "But we think medical schemes have a bigger role to play and should not be side-lined. We think it is a mistake to use a single-funder system, for example."

He said that having a "multi-player" system would mitigate a lot of risk and is one of the ways that the private sector can lend their expertise to the government regarding the setting up and management of pooled money within the NHI.

“The Road Accident Fund is an example of what happens when you have one funder; when that funder goes down you’re in trouble,” he said.

NHI: Thin on detail

But Motsoaledi, who said he would be meeting with the BHF to discuss these issues within the next week, maintained that the purchasing power of a single funder is too strong an asset to ignore. He pointed to Britain’s National Health Service as an example of where the purchasing power of a single funder has brought down the costs of medicine and services significantly.

Neil Kirby, director and head of healthcare at Werksmans Attorneys, said that while the White Paper is good in the way it “derives its mandate from South Africa’s Constitution”, it is not clear enough in how it will be implemented.

He said a lot of what is outlined in the White Paper requires substantive changes to legislation: “That is not a straightforward process; it has to involve public comment and can be lengthy. The lack of detail in the White Paper belies the amount of work need to get all of this right.”

Rural populations

UKZN research highlighted the extraordinary measures taken by health care workers to reach rural populations

Russell Rensburg, health systems and policy programme manager for the Rural Health Advocacy Project, also said the White Paper left him wanting more information. “It’s often the people with the lowest income who have the highest health need. The way the current system is structured there are many who are too poor to access health services. The NHI White Paper does go some way to create a system that is easier to access,” he said.

“But from the rural perspective we want more information. At the moment, the population is very sparse but not close to facilities. Are there plans for planned patient transport?”

Motsoaledi said he will “strengthen” mobile clinic services to reach these populations under the NHI. On the private sector he said that under the NHI, “because it will be something that is brought about by the state whole nation, you then cannot as the state provide medical schemes”.

“What is not yet resolved is the medical schemes that are purely private,” Motsoaledi said, committing to continue to meet with all key role-players, including those in the private sector.

“Whether it’s a single or multi-player system, you still use expertise from people who are experts. So we will meet with the experts.”

By Amy Green – Health-e News