# NHI - A partnership for quality health for all

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*Speaking to Independent Newspaper's Kathu Mamaila, Precious Matsoso, director general in the Department of Health, explodes the myth that the NHI will eliminate the private healthcare system*

**Kathu Mamaila:** Joe Soap currently pays R6 000 and his employer contributes another R6 000 towards his medical aid every month. How will this change under NHI?

**Precious Matsoso:** We must distinguish between interim/transition period and full NHI implementation. Under the interim period, medical schemes will continue to function, however they will be reformed to be aligned to the NHI. This means that they will start to offer services consistent with the NHI. There will be fewer options and schemes. Prices will be reduced, making medical schemes more affordable. In doing so, there will be a cross-subsidisation. This means that we will use some of the current medical scheme spending to cover the vulnerable groups. Under full NHI implementation, we must recognise that it might not be possible to prevent people from remaining medical scheme members. However, everyone will still need to contribute to the NHI fund.

Effectively this means that you will contribute towards the NHI through a tax-based system and if you still choose to belong to a medical scheme this is your choice on use of your after-tax money. The amount of your contribution will be significantly less through price and other regulation. It might be possible if the medical schemes industry evolves and transform along the lines necessary to support NHI that your contributions towards a medical scheme can be off-set against your contributions to the NHI, but there must be a risk cross-subsidisation mechanism to ensure that a percentage of your contributions still go towards the NHI Fund.

**KM:** If the NHI scheme will cover everybody regardless of income, how will you ensure that those who are contributing towards their medical aid continue to pay?

**PM:** The contributions towards medical schemes and the NHI Fund must be separated. Individuals and their employers will contribute through a tax-based system towards the NHI. Implementation through this method will ensure that it is mandatory to contribute.

**KM:** How will employers be forced to continue to make contributions towards medical aid of their employees?

**PM:** Again, we must distinguish between interim/ transition period and full NHI implementation Even under the interim period, a payroll tax will be imposed, therefore employers will start to contribute towards the NHI fund. Under full implementation and when the NHI system is fully matured, the

choice of employers to continue to subsidise the employee belonging to a medical scheme will be voluntary. It will not be mandatory for employers to do so. However, it will be mandatory for employers to contribute towards the NHI fund.

**KM:** Currently medical aid is a condition of service for many employees. Will this change, if yes, how?

**PM:** When looking at conditions of service, we must consider that when someone is employed and they then leave or retire they are not covered. Under NHI this will not happen. The principle is simple. NHI offers cover to all people, employed or unemployed. As contributions to the NHI fund will be mandatory through a tax-based system, there is no opting out. However, if an individual chooses not to access services through the fund, this is voluntary. As such any contributions towards a medical scheme through and employee or employer is voluntary.

**KM:** Which legislation must be amended to pave way for the implementation of the NHI?

**PM:** Many pieces of legislation will need to be amended. In the health sphere, the national health act, the medical schemes act, legislation relating to the conduct of health professionals such as the health professionals act, the nursing act, the pharmacy council will need to be amended. There will also need to be amendments to non-health related acts, including the public service act, the Labour relations act, the basic conditions of employment act, the road accident act, the compensation of occupational injuries act. The Tax Act will also need to be amended. The National Department of Health will work with the different departments overseeing these acts together with the Department of Justice and the Law Reform Commission and the office of the chief state law advisors to address these amendments.

**KM:** Will the role of the current medical aid scheme change? If yes, how?

**PM:** The White Paper is clear. It states that until NHI is fully implemented and matured, the role of medical schemes will not change. This does not preclude any changes to the business of medical schemes or transformation required in the medical schemes. We must again recognise the importance of transformation. Currently, the medical schemes role under a fully matured NHI is that of complementary services cover. This means that only services not covered by the NHI can be offered as cover. If medical schemes undergo both voluntary and regulatory reform to become aligned and consistent with the objectives of NHI, there will be a need to relook this. However, should this not occur, the medical schemes will conflict with the NHI principles and to mitigate the adverse impact on access to universal health coverage, their role will become limited to that of offering only complementary cover.

**KM:** If everybody is covered by NHI and can access any hospital or clinic of choice, don't you think that there will be an exodus from public to private hospitals?

**PM:** This is very real risk. The only way in which this can be averted, is for government to address issues with public health facilities - build confidence in these facilities and bring them on par with what people perceive as a difference in quality. Under NHI, all facilities must deliver a defined minimum standard of care, and this places pressure on the government to ensure that public facilities are NHI compliant and ready.

**KM:** How will you manage demand? Currently the medical aid can decline a request for a service because funds have been exhausted.

**PM:** The medical schemes will be more tightly regulated. We will amend the medical schemes Act to prevent this from taking place. The Prescribed Minimum Benefits (PMBs) will be replaced with a comprehensive set of services. These services will be protected from being "exhausted" as is currently the case. The pricing of services will be regulated, to ensure that it is affordable and available all year round. Only clinical reasons will be used to limit the medical scheme not paying for services. Things like co-payments and balanced billing including using diagnostic coding to limit services will be removed through legislative and regulatory changes.

**KM:** What is your biggest fear about NHI?

**PM:** For NHI to achieve universal health coverage requires a clear and firm commitment to partnership with the private sector. Politically and through stakeholders, including civil society, this must be appreciated and recognised. The second biggest fear, is having public health facilities that do not meet minimum standards. This requires a transformation within the public sector. If we don't implement innovative ways of changing the way care is delivered, NHI could fail.

**KM:** How do you intend to address your fears?

**PM:** We need to radically transform our approach to administering and managing public health facilities. We need to find lower cost approaches to delivering care both within the public and private sector.

**KM:** What are the possible risks about the NHI? How will you deal with these?

**PM:** The lack of understanding of what we are trying to do is the biggest challenge. Within this, is the need to understand that this is a process of transformation and this requires that we sometime need to take different paths to achieve the same goal. There must be a realistic and pragmatic approach that builds confidence and does not destroy what we have. This does not mean we compromise on our ultimate goals and objectives. Hence, all stakeholders must become part of the process of

implementation. In doing so, we are establishing key committees and structures to ensure that there is the right level of participation in what needs to be done.

**KM:** Given that there are different sections of the population - the unemployed, those in informal employment, the blue-collar workers such as petrol attendants, those working for big business and the public servants, it is apparent that we cannot have a one size fits all solution in the rolling out of NHI. Can you outline how you will deal with these fears and expectations of the various sections?

**PM:** The implementation of NHI must focus on those in greatest need, the most vulnerable groups of our population, those that do not have or cannot afford cover. We cannot start with those that already have cover. However, this does not mean we ignore the issues affecting the groups with cover. But we need to prioritise those in the most vulnerable groupings. For instance, one of the biggest concerns of people who have medical cover is that their funds get exhausted as early as June and they remain without cover for the rest of the year. Through NHI-inspired initiatives such as price regulation of medical service and the reductions of the cover options, we will ensure that those with medical aid cover are indeed covered throughout the year. This is the biggest problem facing those who have medical aid cover at the moment. On the other end of the spectrum, there are the unemployed who do not have any form of medical cover. We will prioritise this section of the population by extending cover to them. The plan is to ensure that all South Africans are covered.

*Kathu Mamaila: Cape Times*