Elevating the NHI debate to realistic levels

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CAPE TOWN — If our Health Minister, Dr Aaron Motsoaledi, puts aside his NHI justifications and rhetoric and combs through this Free Market Foundation, (FMF), critique, we might well improve instead of aggravate health care delivery. Having covered the health care field and hearing Motsoaledi intone that we can't afford NOT to have an NHI and punting the (uncontested) moral argument of our deeply skewed healthcare access, this FMF analysis comes as a breath of fresh air. Dr Johann Serfontein, head of the FMF's Health Policy Unit, makes a telling argument on every front as to the deep folly of creating a financially-crippling monster health administration. The reason we have no NHI costing so far is that ideology outstrips pragmatic planning. Saying 'it's the right thing to do,' distracts from the vehicle being proposed. From the impact of scrapping tax credits, the implications of ditching civil servants medical scheme subsidies, the Davis Tax Committee's findings on our woeful tax-to-GDP ratio (never mind the economic downturn) and just 16% of our public healthcare facilities currently meeting minimum norms and standards, the NHI is surely a fool's endeavour. What of private-practice costs in setting realistic NHI payments and possibly forcing new doctors to set up practice in rural areas? (A Certificate of Needs Law is under revision). We urgently need a Plan B. – Chris Bateman

The concept of Universal Health Coverage (UHC) is a noble initiative and receives widespread support in South Africa. The World Health Organization (WHO) defines UHC as "Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services". The WHO principles of affordable access to quality healthcare is an absolute imperative in the South African context. The South African Constitutional principle of access to healthcare is also without question. The debate in South Africa, is whether NHI in its current form will lead to compliance with the constitution and with the WHO sustainable development goals.

Despite what the Minister of Health indicates, NHI is not a worldwide phenomenon. Universal Health Coverage is an international goal, with every country taking a different approach to achieving this objective. What is being questioned is the proposed NHI as vehicle to achieve UHC in South Africa. The WHO categorically states, "UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis". There is a distinct lack of answers coming from the Minister on some of the most pressing concerns within the NHI model.

The Minister proposes that “People follow money. They follow resources. And because money is in the private sector, skilled people tend to go mainly to that sector”. Between 2002 and 2010, there were 11,700 medical school graduates, while the government created only 4,403 posts in the public sector. If the private sector did not retain these doctors, they would have either joined the masses of unemployed in South Africa or left the country.

The Minister has also suggested that “the private sector is heavily subsidised by the state to the tune of R46.7bn, according to 2015 figures”. It is, however, important to remember that the origin of all money spent by the state is from the tax base. If these subsidies and tax credits are removed, would the public healthcare sector be able to cope with the additional 5 million South Africans dumped in the public sector when unable to afford private medical cover? A tax credit, also, cannot be considered a subsidy as it is simply a rebate of an individual’s own tax money and they are not burdening the state healthcare system.

The further question is whether R27bn in medical subsidies granted to government employees spent by the Department of Public Service and Administration would end up in the health budget. Trade unions are unlikely to favour a reduction of their members’ cost to company packages and would demand that money in cash. This would perversely increase inequality in the healthcare sector as less government employees would be covered by private medical scheme arrangements. It would also increase the burden on government healthcare facilities, without a concomitant increase in funding. Rational thinking explains why the withdrawal of the government subsidy to government employees is not in the interests of the healthcare system or the affected individuals.

The Minister states that “Time and again, when we want to include the poor to share in the country’s wealth, we are told how expensive it is”. Currently, the poor already have access to “free” healthcare in South Africa and yet they are still poor. The Minister also conflates private money spent privately on healthcare with taxpayer provided money intended to assist the poor. A wealthier population is a healthier population and, in order to grow and expand the economy, South Africa must address the chronic unemployment situation where over 6.2 million adults (27.7%) have been relegated to lives of destitution because they do not have any work.

If the government focuses on forming an employable population by improving education, the improved living standards of the newly employed will contribute more to health than healthcare spend ever will. In the NHI scenario, with mandatory medical scheme membership for the employed being part of the Minister’s interim plan, more people will leave the public healthcare sector, reducing the burden on the state and so improving the quality. The quality aspect could be addressed by the proper management of public hospitals, additional funding is not a requisite – simply pouring more

money into the system will not solve the underlying structural problems. This step alone would almost negate the need for the rest of the NHI plan as it will reduce costs in the private sector and improve quality in the public sector so everyone has access to affordable quality healthcare. If you are indigent, affordable would mean “free”, while there will be a reasonable price attached to healthcare for the more affluent.

If NHI is not just an ideology, we challenge the Minister to answer the following pragmatic questions on the NHI. With an NHI Act being mere months away, there are serious concerns as to why these issues have not been dealt with, as any number of them could lead to a catastrophic collapse of the healthcare system if NHI is continued:

On the issue of administration and funding

1. In the run-up to implementation, has the government considered the impact of scrapping tax-credits on medical scheme members who are lower-income earners and might have to cancel their scheme membership if tax credits are abolished? Some of these tax-payers earn above R350,000 pa, and, as a result, will have to pay full fees in public hospitals, which they probably cannot afford either. This grouping might thus end up without access to healthcare either in the private sector or the state as there are no NHI structures in place yet to cover them.

2. In the document on NHI Committees gazetted on 7 July, The National Advisory Committee on Consolidated Financing Arrangements, Terms of Reference included in the section dealing with Introduction of Mandatory Cover and Contributions related to Formal employment state that:

a) The costs of cover will include subsidisation by **government**, employers and employees

b) Where appropriate, the state will provide a subsidy against the annual contributions either upfront or **through the tax credit system**

This leads to the question of what the policy position is? Will medical scheme tax credits be removed or not?

3. Although the Cosatu leadership is supportive of NHI, all indications are that their members will not accept it if the Government scraps their medical aid subsidy as an **increase** in medical scheme subsidy is part of the current PSA/public service bargaining discussions. Union members will be adversely affected by the cancellation of their subsidies and this will materially reduce their access to quality healthcare. Has the government considered that if the medical scheme subsidy is scrapped, unions might demand the equivalent in cash being added to pay packages as the subsidy forms part of cost to company? These funds might thus not be available for NHI use in any case.

4. Has there been any consideration of the Administrative costs involved with the NHI, as well as the fact both the national and provincial departments of health will require additional administrative funding outside of the proposed NHI costs?

5. Has there been any consideration of private administration of the NHI? The private sector currently administers half of all healthcare spend. It would be relatively easy to double their administrative capacity to cater for NHI, whereas the Compensation Fund, as the closest example of similar government administration, would have to be 100 times bigger to cater for NHI.

6. The NHI policy paper states "focussing on the question of what the NHI will cost is the wrong approach". This is disingenuous, to say the least, and it is of paramount importance that we know what the NHI will cost before the country is plunged into further financial misrule. The WHO also states that "costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms". Radically changing the health system would be a core policy issue and thus costing is vital. This leads to the obvious question: when will the National Treasury release its costing of the NHI which was supposed to be published in conjunction with the NHI White Paper?

7. If the service basket needs to be heavily reduced to fit into whatever budget is available, it could mean that people who currently have access to a larger basket of services in both the public and private sector now have access to fewer services. Would that not potentially be in conflict with Section 27 of the constitution and the aim of NHI?

8. In light of the current economic downturn and credit downgrades, is an increase in taxes to pay for "free" healthcare, even for those currently paying for themselves, a prudent choice?

9. On what basis was the decision to pursue a single payer and single purchaser model of NHI formed? Research from other single payer countries (Estonia, Taiwan, Canada) indicate that this type of model is expensive and not suitable for developing countries, especially one such as ours with its quadruple burden of disease and small tax base.

10. The Davis Tax Committee states that the tax to GDP ratio will need to rise "quite substantially" to fund the NHI. Has the government considered the job losses and losses in tax income which will result out of Private Medical Schemes and their administrators being closed down?

11. Has the Department of Health considered the potential impact on the government tax revenue if a significant proportion of South Africa's middle and high-income earners decide to leave our shores because their current access to quality healthcare is restricted? If 200,000 members of this grouping which currently pays 64% of personal income tax were to emigrate, this could reduce the tax income by R111bn.

Operations:

12. The OHSC currently has 35 inspectors who inspected 417 facilities in 2014/15 and just over 500 last year. How is the inspectorate capacity going to be enlarged to more than 1,000 inspectors who might be required to inspect between 31,000 and 74,000 private facilities every four years to be included for NHI contracting?

13. Currently available inspection results for the public sector shows just over 16% of facilities complying with the norms and standards. How is this going to be addressed before 2025 to ensure that sufficient numbers of public facilities are compliant and able to contract with the NHI fund? There has been little improvement since 2012 when the inspections were first done and some indications are that the situation has worsened.

14.How will the Department of Health realistically entice private providers to move to rural areas to contract with NHI? We know that areas with oversupply will not have everyone being contracted with NHI, with rural contracts offered as an alternative. Most doctors, if faced with having to move to a rural area to practice, might choose to rather emigrate to countries where they are welcomed.

14. Why does government require a single payer fund to drive down prices with monopsony buying power if the NHI Fund is going to be setting prices anyway? Why is a single payer required to bring these down, especially with co-payments not being allowed in the system either?

15. There is the indication that if referral paths are not followed, patients can face co-payments. Has the Department of Health considered that this might well lead to the more affluent members of society still having quicker and better access to specialist providers and tertiary services?

16. It is obvious that the NHI will not be able to cover all services and disease conditions. What happens to the indigent and poor with diseases that are not covered in the NHI basket? They cannot afford complementary medical schemes and will be without care for these afflictions. This is a large proportion of the population, so if these services get included for this group, it will be unaffordable for the system.

17. Current Pharmaceutical tenders in the Government are often at reduced rates due to companies subsidising these prices from their private sector pricing income. Has the Department of Health considered that combining the purchasing pool for pharmaceuticals might actually *increase* the NHI prices?

18. Is government considering the very real aspects of practice costs when setting prices in NHI? The cost structure for a private practice looks very different from Public, as the public sector does not have

elements such as rates and taxes, rent or bonds, malpractice insurance, public liability insurance and such that need to be considered. If private costs are not covered for private providers, they will have to close their doors and might be lost to the system altogether.

19. Some medical schemes are making attempts at Capitation and Diagnosis Related Grouper payments. The data requirements for this is immense and it is a very complicated matter. Where is the government going to get the necessary data for the entire population to implement these payment types within the next 7 years?

20. What is the actual cost of delivering services in the public sector? The public sector is covering a large part of the population and we know what the budget is, but how many members of the public access it annually and what does it cost per patient and procedure for those who do?

21. The NHI system does not appear to answer the problem statements as provided in the White Paper for the South African context. Many problems are shown, with the blanket statement that NHI will solve them. What is Plan B? There are many indications that NHI will be unaffordable and will not achieve its stated objective of increasing access to quality healthcare for all. Is the Department of Health willing to entertain other models of achieving UHC in South Africa? Models have been put forth that will have a smaller, more manageable NHI fund, alongside private medical schemes, which will integrate service provision in public and private. Why are these not being considered as they will also achieve UHC without many of the negatives?

*By Johann Serfontein**

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