NHI brings radical change and critical risks

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Four factors are likely to determine the success or failure of the National Health Insurance (NHI), as the government this week released two new bills to enable its establishment, according to one analyst.

These are funding, collaboration between the public and private sectors, the availability of a skilled workforce and management – including avoiding corruption, said Nicholas Burger, a healthcare consulting analyst at market research company Frost & Sullivan.

Health Minister Aaron Motsoaledi this week published the NHI bill and the Medical Schemes Amendment bill.

The aim of the NHI is to provide healthcare services to all South Africans, regardless of their income level.

Motsoaledi explained that under the system, the rich will subsidise the poor, the young the old and the healthy the sick. The system is scheduled to come into effect in 2026.

Currently about 16% of South Africans are covered by private healthcare schemes, while the rest rely on the public health system.

Motsoaledi said during a media conference to introduce the two pieces of legislation that the NHI will cause “massive reorganisation of the current health system, both in the private and public sectors”.

He could not say how it would be funded. However, he said that if Treasury decides that individuals have to make contributions to the fund, they will probably have to do so according to what they can afford.

According to the 2017 NHI white paper, it will cost R256 billion in the 2025/2026 financial year, at 2010 prices. This is compared with a public health spending baseline of around R110 billion in 2010/11.

Burger said the NHI is likely to be funded using a “mixed model”, or different sources of revenue.

“It could require shuffling funds that are directed towards other programmes in order to satisfy parts of the NHI.”

According to the budget delivered in February, Treasury allocated R4.2 billion to the NHI until March 2021.

Motsoaledi said he has his eye on the R60 billion in reserves that the medical aid industry had piled up.

Burger said that the biggest likely winners from the NHI will be the underprivileged. "Ideally, they would be the biggest winners. It would only be fair as healthcare is a basic human right.

"Obviously there will be quite a bit of uproar from your upper echelons, who select private healthcare. They would argue that they are already paying exorbitant amounts of tax."

The NHI will require collaboration between the public and private healthcare sectors.

He said it is unlikely that the NHI will make medical aid schemes redundant. However, they will lose members.

"There will always be the option to use the medical aid schemes. They will obviously collaborate with government."

The Board of Healthcare Funders of Southern Africa said this week that it welcomes progress made towards universal healthcare for all. The board represents 45 local medical aid schemes, administrators and managed care organisations.

However, Burger said: "Medical schemes are holding their cards quite close to their chest."

This is particularly the case when it comes to releasing comprehensive data regarding their clientele and their healthcare records.

Motsoaledi said the NHI will **abolish co-payments**, a proposal contained in the amendment bill. This is when a medical aid doesn't cover 100% of costs and the scheme member has to pay to cover the shortfall.
"The amendment means that every cent charged to the patient must be settled fully by the scheme and the patient should not be burdened with having to pay."

This will mean that medical schemes might not be able to charge prevailing premiums, which could cause consolidation in the medical schemes sector.

Another aim of the NHI is putting an end to brokers. Almost two-thirds of principal members of medical aid schemes pay a broker monthly, as part of their premium. Many members are not aware of this, Motsoaledi said. In 2017, brokers raked in R2.2 billion.

"We want this money to be made available to pay for the direct health expenses of members, rather than serving brokers who are not needed in the healthcare system." He said the Council for Medical Schemes already did most of the brokers' work.

Those behind the NHI would like to see medical aid schemes pass savings back to members, if a member uses a designated service provider, in accordance with the scheme's rules.

The amendment bill will regulate the cancellation of membership and waiting periods between joining a scheme and accessing benefits.

"Under the NHI, there will be no penalty related to late joining or age," Motsoaledi said.

This provision is meant to protect the interests of living spouses after the death of the principal member, or after retirement, prior to payment of their benefits.

Burger said that when seeking medical help, patients would need to be registered with the NHI and could then select their preferred healthcare provider, who would need to be registered on the database.

“You can rest assured that there are going to be many teething problems. It is going to be an evolving process.”

The bureaucracy the NHI would involve is one concern.

Burger, however, said that there are examples in developing nations where relying on referral pathways and leaning on digital solutions has been successful.

“We can draw on examples in Botswana and Rwanda.

“Obviously comparing the NHI to the UK systems or other systems in Europe and elsewhere is not valid.”