On the Medical Schemes Amendment and NHI Bills

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INTRODUCTION

The National Health Insurance Green Paper was published in August 2011. A White Paper followed in December 2015, and the national Department of Health **(NDOH**) published draft legislation for comment in June 2018, with a closing date for comments in September. The legislation is not before Parliament yet, and it seems unlikely that it will be passed before the election next year. Since National Health Insurance has implications for medical schemes, a draft Medical Schemes Amendment Bill (**MSAB**) was published at the same time as the National Health Insurance Bill (**NHIB**).

THE MEDICAL SCHEMES AMENDMENT BILL

The release of the Medical Schemes Amendment Bill was not accompanied by an explanatory memorandum, so it is difficult to see what the government is intending to achieve by its provisions. There are some useful provisions in it. Strengthening the governance of medical schemes, an improved complaints procedure, and strengthening the position of children are all measures the HSF supports. On the other hand, there are grounds for concern. The provision for reduced contributions for young adults between the ages of 18 and 30 flies in the face of the principle that healthy people should subsidize those needing more medical assistance. Moreover, the MSAB excludes the Consumer Protection Act from applying to medical schemes matters, and it removes limitations of the waiting period for adults, both reducing rights.

Also, the provisional report of the Competition Commission's Health Market Enquiry has not been taken into account fully. We believe that the MSAB should not proceed until the final report of the Enquiry has been published. The NDOH should respond publicly to the final report, and the explanatory memorandum accompanying a revised version should deal with the extent to which the report's principles have been accepted by the government and how they are to be given effect by the MSAB.

THE NATIONAL HEALTH INSURANCE BILL

In the HSF's response to the White Paper on National Health Insurance (to read, click here), we made the point that, given the managerial problems in the public health system, it would be counter-productive to impose the extensive task of creating new links with the National Health Insurance Fund, including contracts between all public health service providers and the Fund. Rather, efforts should be devoted to strengthening existing management. We are particularly alarmed by the Office of Health Standards Compliance 2106/17 report. Only seven out of 851 inspections found health establishments fully compliant with requirements, with a score of above 80%. By contrast 532 establishments were assessed as non-compliant or critically non-compliant, with scores of below 50%. On this showing, most public health service providers would simply be ineligible to enter into contracts with the NHI Fund.

We were also alarmed at the lack of information about costing and financing. Especially in a period of low growth, such as South Africa is experiencing at the moment, there are many claims on additional tax rand. Our concern has been echoed by others[1].

Neither concern has been allayed by the publication of the NHIB. The government has divided introduction of national health insurance into three phases. The first phase is now complete, and we believe the NDOH owes the country a report on the pilot projects it undertook. No attempt by the NDOH to keep appraisals as confidential reports within government is acceptable to us.

Also, release of the NHIB has not been accompanied by any estimate of the costs of NHI, nor of the ways of funding it. The Minister of Health has referred the funding issue to the National Treasury. That cannot proceed until the basket of services and their cost are determined by the NDOH, a task they seem not to have tackled at all to date. Instead, they have left to two committees to be established in terms of the NHIB: a Benefits Advisory Committee and a Health Benefits Pricing Committee. This leaves ordinary South Africans clueless about what services they can expect from national health insurance and what they can expect to pay for them, not at the point of service, but by way of increased taxation or dedicated NHI contributions. It follows that the implications for medical schemes are also unknown, since the Bills specify that medical schemes will not be able to cover services provided by the NHI.

Health care is predominantly a private good, with some positive spillovers, particularly when it comes to infectious diseases[2]. This is not a matter for normative specification. Rather it emerges from the nature of the good itself. The only way to ensure equal provision of a private good is by an army quartermaster system, and this the NHIB seeks to introduce by way of standard service and referral protocols. Since not all services will be covered by the NHI, there will continue to be a two tier system: one part covered the NHI, the other by medical aids or out of pocket expenses. The boundary between the tiers will be relocated. The implicit assumption in the NHIB is that the two tiers will be distinct. But this is not the way in which users of the public health system operate at present. They may use the public system when effective treatment is on offer, but the available evidence indicates that many resort to the private system when it is not. Equally, under NHI, a user may well be happy to use an NHI contracted pharmacist, but may prefer a private consultation with a GP or specialist. Whether the private consultation will be possible for a service provided by the NHI is itself not clear, since a crucial section of the NHIB is ambiguous. In general, the NHIB makes no provision for people who shuttle between systems. It simply does not consider the possibility.

Accordingly, we believe the NHIB should be withdrawn, pending a radical revision of approach.

This view does not commit us to the status quo in the health system. We support the introduction of new services in the public health system, presently being finances by a national health insurance item in the health budget[3], but we note its small share (of the order of 1%) of national and provincial public health expenditure. We are also in favour of cost studies of services in the public sector as a continuing programme. Indeed, had they been done in the past, we would have a better basis for establishing the cost of the NHI.

CONCLUSION

Despite the problems discussed here, and elaborated in our submissions, the government seems determined to press ahead with national health insurance, and promises about it are likely to emerge in the coming election campaign. Accordingly, further developments can be expected during the life of the Sixth Parliament. The views of key constituencies will have to be considered carefully. No system not based on consensus can proceed.