NHI Healthcare – a building block to universal healthcare

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On the eve of a quarter century of freedom and democracy, South Africa is engaged in yet another project of transformation that will bring us closer to the fulfilment of our constitutional objective to create a caring, inclusive and more equal society.

Cabinet is shortly expected to consider the National Health Insurance (NHI) Bill, which sets out to create, as Health Minister Aaron Motsoaledi has said, a funding system for healthcare that will guarantee that every individual living in South Africa has access to a free and good quality healthcare at the time of need.

At the core of this initiative is to ensure the widest possible pooling of resources – financial resources to pay for healthcare, and the effective and efficient use of available human and other resources to provide quality healthcare to all.

In pursuing this policy initiative, South Africa is by no means out on a limb. Indeed, South Africa is seeking to align itself with global best practice as experienced in a number of developed and developing economies. The country seeks to answer the call of the World Health Organisation (WHO), which asserts that good health is essential for sustained economic and social development and poverty reduction. The WHO maintains that access to much-needed health services is crucial for maintaining and improving health, and propounds that people need to be protected from being pushed into poverty because of the cost of healthcare.

The WHO defines universal health coverage as ensuring that all people have access to much-needed health services (including prevention, promotion, treatment, rehabilitation and palliative care) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of the WHO.

For South Africa, the development and adoption of the NHI is an intervention that aims to end the inequality that is adversely affecting households and workplaces when people are denied certain levels and categories of healthcare, including access to certain technologies, purely because they cannot afford them.

Stories abound of patients being turned away from some health facilities because they cannot afford upfront payments running into tens of thousands of rand or of those critically injured being asked if they have medical aid before paramedics can decide where to take them for treatment. This is a sad violation of a basic human right to access medical treatment that our nation needs to deal with.

The *status quo* within the medical schemes industry and private healthcare system in general requires a complete overhaul in terms of pooling, purchasing and provisioning of care.

As demonstrated by the Council for Medical Schemes' (CMS) annual reports and other publications, and to a large extent the Health Market Inquiry Provisional Findings over the past years, medical schemes' membership growth has stagnated and has recently been declining. The medical schemes have either been amalgamating or liquidating.
Some schemes within this industry are also troubled by bad-risk profiles, and this often leads to increases in claims ratio and inevitably affects premium increases. All this occurs within the context of increased rates of supply-induced demand, excessive profiteering by third parties like administrators, dumping on the state (when beneficiaries run out of benefits), nomination of public healthcare facilities to provide healthcare without having service-level agreements with some medical schemes or the capacity to bill the medical scheme.
This industry is also plagued with issues related to fraud, waste and abuse across the entire healthcare value chain.
At an individual level, members are also experiencing increased rates of out-of-pocket payments and unaffordable premium increases are among other phenomena that leave millions of South Africans not just vulnerable to market forces but to worsening health status and mortality as well.
This has been demonstrated by a recent outcry from some medical schemes members like Zelda la Grange who have used social media to vent their frustration:

- "… I pay R5,000+ per month, and I was told last month that my chronic allowance is depleted, and I must now pay the last two months out-of-pocket. I haven't been to the Dr once this year. The NHI starts looking attractive…"
- "… A family of 5, I pay R12,000 per month and my kids haven't seen a doctor in the last 3 months, but our Medical Savings Account is depleted …"
- "… NHI has always been attractive. I pay R6,700 per month. Few months ago, I had to spend 3 days in a hospital and the medical scheme told me to pay R9,000…"
- "… I pay R4,000 with no dependants, I was told by my doctor that I need glasses and my medical scheme asked me to pay R800 over and above R4,000… Never thought I'd see the day when I say it, but NHI is looking attractive…"
- "… Utterly disgraceful, besides paying R12,000 every month, I must pay an extra R2,000 per month for chronic medicine… I ended up paying an additional R20,000 or so…"

Some of these principal members reduce the number of dependants covered, whilst others exit medical schemes due to different affordability challenges. Once these members exit the medical schemes environment, their financial protection against catastrophic healthcare costs diminishes and they now become beneficiaries of the public healthcare system.
All these issues occur within the context of excessive risk pool fragmentation (through multiple schemes and benefit options) and differences within medical schemes in respect of benefit option entitlements (or richness) and limited financial protection for the covered lives, especially the old and sick.
This is the segment of the population that tends to require more protection against catastrophic healthcare costs.
In response to this volatile environment, some medical schemes use benefit design to recruit the young and healthy population whilst the old and sick members will experience entry barriers such as paying late joiner penalties.
It is therefore understood that underwriting is meant to protect the schemes against adverse selection; one needs not forget that it can be viewed as discriminatory as well, especially for the segment of the population that enters the labour market late in their lives due to unemployment.

Unless addressed efficiently through effective implementation of the NHI, where there will be a single pool offering one benefit package being accessed by different types of risk profiles, risk pool fragmentation will continue being a barrier preventing progressive achievement of universal coverage in South Africa.

It is within this background that the WHO recommends that health-financing reforms should consider policy options to encourage risk-pool consolidation, otherwise, implementing other measures (such as increasing the level of prepayment funding) without paying proper attention to changes in risk pooling can result in increased fragmentation, and compromised equity and efficiency goals.

The legislative provisions included within the published NHI Bill should therefore be read in context alongside the NHI Green Paper and NHI White Paper and Policy Document.

Since the publication of the NHI Green Paper in 2012, changes in the current pooling, financing and purchasing mechanisms within the national health system were mooted.

Paragraph 395 of the NHI White Paper states that "… the role that medical schemes will play within NHI must be considered within the current context of the existing two-tiered health system. The establishment of NHI will ensure that the State optimally uses available resources to benefit the national population, including post-retirement entitlements. This requires government's strategic and decisive intervention to eliminate fragmentation in funding pools which has been shown to adversely impact the performance of the current health system…"

Paragraph 399 further states that "in line with international experience, individuals and households will have the opportunity to purchase voluntary private medical scheme membership to complement this universal entitlement if they choose to. Private health insurance coverage, such as that offered by medical schemes, can play various roles within South Africa's universal health coverage system… Once NHI is fully implemented, medical schemes will offer complementary cover to fill gaps in the universal entitlements offered by the state…"

These provisions seek to optimise utilisation of available resources, including financial and human resources, and to ensure that people do not insure against the same healthcare costs twice.

It is therefore important to ensure that services provided by medical schemes are rolled out in tandem with the NHI Fund to secure value for money, address current pooling inefficiencies and eliminate duplicative cover or double-dipping.

The recently published Medical Schemes Amendment Bill envisions how the role of medical schemes in our national health system will change and outlines a new interplay between the NHI Fund and the CMS.

This re-organisation of the health system is designed to address long-standing shortcomings within the health system in the areas of human resources, financial management, procurement and supply chain management, and the maintenance of infrastructure and equipment.

This effort to level a critical playing field in our society should be welcomed by all South Africans who respect our Constitution and wish to be part of a healthy, productive and more equal South Africa. **DM**4

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