Making sense of the NHI and your future medical costs – Biz News 15 August

15th August 2019 by Jackie Cameron

South Africa's state hospitals can be scary, inefficient, unsafe places. I know. I once gave up on being treated for an allergy-related breathing attack, such was the length of the queue at the Cape Town hospital nearest to where the symptoms came on. And, I've had the inconvenience of my clothes being stolen from a cubicle in a Tygerberg hospital while I was undergoing a gynaecological procedure. Few would argue that the state system needs to be fixed. The National Health Insurance (NHI) bill, released earlier this month, has the very aim of improving the health system so that there are equal opportunities for all citizens to access drugs and medical expertise when they are needed. But the NHI bill has sent shock waves across publicly listed companies that provide private medical care and related services, like medical schemes. Dawn Ridler, a certified financial planner based in Johannesburg, sizes up the government's plan and, like many others in the financial services sector, is worried that, while the intentions are good, the execution will not work. She provides pointers on how to prepare for future medical costs. – Jackie Cameron

By Dawn Ridler*

NHI – will it be implemented 20 years later? What can be done about future medical costs?

Money expert Dawn Ridler

The government appears to be hell-bent on implementing the NHI, despite the complete failure of all the pilot projects and no detailed or realistic budget on how this is going to be funded. Yes… no budget. Minister Mkhize has given a laughable thumb-suck of an additional cost of R30bn (over and above the R222bn at present) most other estimates (of which there are a number) are north of an additional R300bn. R20bn of that R30bn of Mkhize's pipe dream will come from the soon-to-be cancelled medical tax credit, and all that will do is bring the current, world-class private medical service down to the level of what the government currently provides. Nobody is arguing that something needs to be done to address the health needs of the poor, but destroying what we already have is obviously insane.

The NHI was first touted in 2003, and with a number of failed projects under their belt, most of us were hoping that someone in the ruling party would see sense and understand that we cannot afford a first-world healthcare system funded by a very small taxpayer base when we don't even have anything like a first-world education system. How on earth can Ramaphosa launch yet another State Owned Enterprise while other critical SOEs like Eskom, are in complete disarray – no resolution in sight? The shortfall is going to come from tax of course, but most taxpayers are not going to be able to afford yet more tax and their medical aid. It looks like medical aids are going to be allowed to offer 'top-up' services only for conditions not offered by the NHS. Who knows what that means.

What can you do to mitigate the effects (and you'll need to do most of these well in advance of the proposed changes):

- Take out good dread disease cover (from a reputable life company). Not all cover is equal, and when it comes to 'dread disease' there is actually the greatest disparity across the various providers, and their benefits change all the time. This will give you a decent lump sum so that you can get private (or even international) treatment. If the NHI comes into effect, you're not going to be able to choose your surgeon or hospital. Here are some tips when it comes to this sort of life cover:

- Use an Independent Financial Advisor so you can get a range of quotes from different providers. Be specific as to your requirements (see below) and be aware some brokers may try and sell you an inferior product (because they don't know better, are a 'tied agent' or because they can make the premium look cheaper with some fancy footwork). Rather take out less cover with a premium product than more cover for basic cover.
- Be aware that you already have health problems you may not be able to get cover, or the premium may be 'loaded' (increased).
- Take out a top tier product that pays out 100% at stage one of the most common diseases and reinstates after a claim (there are only a few that do that, and only with their premium plan.) This means that say you claim for cancer and get paid out, the cover is not 'lost' but will payout again if you have a heart attack or unrelated cancer. Having been an advisor in this field for over a decade I cannot emphasise this need for a very good product enough – I never want to be in a position with a client who has, for example, stage one cancer, and tell him or her that she is only going to get 25% of their payout because they bought a 'basic' plan because it was cheap ("…but come back when you get sick again").
- If you have children, choose a provider who will cover your children for dread diseases too if you're covered (often free of charge – and if your spouse takes out cover too it would be double). I don't know about you, but if my kid has a dread disease I don't want to have to take him or her to a government-appointed specialist or hospital or sit for hours in a clinic waiting to see a doctor.
- Have a "level" premium (ask for this specifically) that increases at at least inflation BUT where the increase in the benefit is exactly the same as the increase in premium. You can see this in the quote you get, where providers now give you a year by year benefit and premium breakdown. True level premiums are harder to find, but they are out there. Why is this important? You're going to want this cover for the whole of your life (unlike life cover, which can fall away when either your pension pot is full, or you no longer have a financial obligation.) Because dread disease cover is not cheap, brokers might be inclined to offer you an 'age-rated' product which starts off cheaper but increases, not in a straight line but an upwardly curving, exponential curve (part of the fancy footwork I was alluding to above). You might be told that you can "redo" the cover after a couple of years so you don't get this effect, but there is the very real possibility of being 'uninsurable', in other words having a medical condition that increases your risk and insurers either declining cover completely, or 'loading' your premium. As you enter retirement, your chance of getting a dread disease increases, and you don't want the premium to eat a bigger and bigger portion of your fixed-income until it becomes unaffordable so you cancel it (that's what the insurers are counting on.)
- Even if the life cover is not 'age-rated' most insurers still add a little bit more onto the premium each year as an 'age effect' or 'age-risk' or some other carefully worded small-print dreamed up by their actuaries. Every year you delay taking out dread disease cover will automatically make it more expensive because of the 'age risk' – so rather lock-in that risk with a truly level premium product (I only know of one that does a truly level premium). The long term effect on a 'compounding' age-risk premium is huge.
- One of the biggest risks, when you are hospitalised, is not the surgery but the aftercare. One of the reasons the NHI trials failed was the lack of suitably qualified staff, and we continue to haemorrhage skilled medical staff. Britain is already talking about ramping up the visas for skilled staff and will poach those professionals given half a chance, but there is nothing in the NHI proposals that addresses the retention of staff beyond the

compulsory 1 year internship for medical students – a lack of medical staff is probably going to be more of a problem in the future. A lump sum from life insurance like this gives you financial flexibility for private aftercare or even going offshore for your treatment.
    - Choose a provider that has a comprehensive list of diseases covered (they can range from 60 to well over 300). One way to determine a 'good' benefit from a so-so one is to find out when they payout for things like Alzheimer's or Parkinson's (it can be decades after you're diagnosed). Some will pay out on diagnosis of a dread disease, others only when it has manifest itself.
- Get a printout from your medical aid so you can analyse where your vulnerability is going to be should the NHI come into effect. If your day-to-day expenses are high, see how you can mitigate them.
- Understand what a Prescribed Minimum Benefit (PMB) is and whether you can use this legislation to your advantage. (I have a PMB list from the Council of Medical aid schemes that I am happy to send you). Medical aids are obliged by law to provide these to you free of charge, some will even deliver free – but these services are being cross-subsidised by the medical aid, so expect to have to queue at a govt dispensary for them in the future – or pay for them. Perhaps those robot pharmacy dispensers/ATMs will actually work and fill this gap.
- Over 65s have more generous medical tax breaks so make sure your tax practitioner uses them (while they are still there).
- At the moment you can change your medical aid plan once a year, in around Nov. Get a plan summary from your provider and see if a lower premium plan would suit you better and start your own savings fund.
- I always recommend that my clients have an emergency fund equal to at least 3 months expenses for the family, perhaps now is the time to start your own medical savings fund (at least you'll get more interest on the investment than the medical aids are giving you – and you have the flexibility to use it as you see fit). This should at least cover your day-to-day expenses, eye care and dental.
- "Hospital plans" are at the core of every medical aid plan, everything else is an add-on. Hospital care is the one expense that can break the bank, and where the aftercare in a govt hospital can kill you. See if it's viable for you to have a "Hospital Plan" and put all the premium savings (and more if you can) into the savings.

I have a copy of the white paper on the NHI. Basically, the implications are as follows:

One of the biggest problems for those of us used to private medical care is that everyone is going to be compelled to register with, (yes, all 59m of us) and go to, a clinic and wait to be referred to a hospital or specialist (of their choice) or the NHI will not cover the costs. Our clinics at the moment are notoriously poor with massive queues and under-qualified staff. This is where a chunk of the 'new' NHI money is going to have to go (There are not nearly enough) and is basically going to cut private GPs out. Will they move into the NHI, and probably have to take a significant knock in salary and dramatically increased workload? Salaries of all providers from GPs to Specialists are going to be capped, which ostensibly will reduce the spiralling cost of medical services. On that topic, here is an interesting graph (found here)

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Medical Aid insurance inflation has been running way above Health inflation. Obviously, the Medical aids dispute this, but part of this is increased 'demand' – in other words, people are using it more. Why? The average age of medical aid users is getting older (and things start to 'break') and lifestyle-related dread diseases certainly play a role. We also appear to be using

doctors and hospitals more (is there a culture of getting our money's worth?) One in 4 medical aid members are usually registered for at least one 'chronic' condition.

They say in the White Paper that the NHI fund is going to be established in 2021, so you're likely to see the end of medical tax credit by then (perhaps as soon as March).

The NHI will be allowed to invest the proceeds to maximise their returns – great idea seeing that PIC has done such a sterling job for government pensions and the appalling audit record of the departments of health which indicates that corruption and wastage are rampant. When the trial NHI sites failed, doctors weren't paid for months and were unceremoniously dumped.

Any shares related to medical aids, hospitals or pharma are going to be in trouble. The government is going to severely limit the prices charged and this is going to affect the profitability of those companies.

I am unsure the role 'Gap Cover' is going to play in the future and there is little in the media about this. Make use of it while you can, they may well bite the dust.

Read also: Prepare for accelerated looting, doctors emigrating amid NHI's implementation

One of the best things that you can do for yourself is to make sure you don't get sick. Sounds obvious right? Easier said than done, I know, but we all know that there are lifestyle risks that are under our complete control and that contribute to our ill health. Small changes can have a big and lasting impact. Perhaps what you need is a wellness coach, not a doctor. The NHI will take care of the hypochondriacs in your family.

The NHI white paper mentions the following that will be under their care: cardiology, dermatology, neurology, oncology, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery – including organ transplants. In effect, this means that the ANC will be able to decide who a woman's gynaecologist should be, as well as where and by what method her baby should be born. At the primary healthcare level, the NHI will provide, among other things, sexual and reproductive healthcare, the rehabilitation of oral health, and mental health treatments. There is already an issue in the UK's NHS where the latest cancer treatments are not provided because they are too expensive. Some very effective cancer treatments now cost over R1m (even medical aids don't pay for these in full – hence the suggestion of 'life' dread disease cover). Dental care is another that you're probably going to have to pay for yourself (if you don't already). You just have to take one look at the dental health of most people in Great Britain to see where we are headed. We do have one big advantage because we're behind the curve when it comes to fast-food diets, most of our population is still blessed with strong teeth.

The 'medical tax credit' – a pittance compared to the tax breaks you got in the past, is only worth R20bn to the Treasury, and Mkhize has thumb sucked that another R30bn in total is required, so he 'only' has to find another R10bn. Healthcare currently eats R222.8bn of R1.8trn in taxpayers funds (about the same we put into primary education). We have about 4.8 million taxpayers for a population of 58 million. You cannot solve the country's healthcare problems by dragging the whole industry, including a world-class private system, down to government health care level – which is what will happen if only R30bn is put into the fund.

Lifting our healthcare to first-world standards (think Canada) would require an additional R250bn by conservative estimates. (In the UK the cost of the NHS is £130bn – paid by taxpayers separately from income tax. Income Tax receipts are £190bn. In other words 68% of the level of income tax receipts!) Where is that going to come from? We could increase VAT to 25% then everyone pays (and Vat-free basics would have to be increased protect the poor). Double everyone's income tax would also get you the R250Bn you need. The problem of doing a half-assed job of the NHI and destroying private health care is that once destroyed there is no coming back.

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