Healthcare is a social investment

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Are you intending to stop medical schemes providing the same services as NHI?

Healthcare finance is going this way around the whole world, as evidenced by the United Nations Sustainable Development Goals (SGDs) targets. The whole concept is of universal coverage reforms. Reform is based on the fact that there are only three ways of financing health. The first is mandatory pre-payment before a person is sick. The second is voluntary pre-payment and the third out-of-pocket payment, in which you use cash as you would buy any other commodity. NHI envisages a society based on values, justice, fairness and social solidarity. Healthcare is a social investment, therefore it should not be subject to the normal market forces and treated as a normal commodity. NHI is not a beauty contest between public and private. It's an endeavour to make us be able to utilise both systems. People in private say we will be taking away choice, but right now the system does not allow choice anyway. When 84 percent of the population have no choice, you can't say there's choice. We want a new system which will give choice to all, and so we chose a mandated pre-payment of health, the same as all universal coverage systems of health. You will be allowed to insure yourself against risk, and you will be allowed to buy additional private cover, if you would like to do that. But then this is outside the NHI fund and will be out-of-pocket. For example, if there's a backlog on hip replacements, and if you want to pay extra additional costs in order to get yourself treated quicker, that's your choice - as long as you understand that NHI is mandatory for you. A thing that we will do is amend the Medical Schemes Act when it comes to these various health plans which are not being controlled by the same rules as medical aids. They can't separate themselves out, but we can't stop you from buying your own insurance. What justification would I have to tamper with Discovery?

Are you intending to curb, if not entirely limit, private healthcare?

Health care can't start at the top. It must start at primary healthcare level, where we must see not only GPs but also occupational therapists, psychologists, audiologists - at a non-specialist level. All three, you will hardly find in the rural areas, so what must I do as a Minister? Am I going to tell a child you can't use those services because you are too poor? When we did the NHI pilots, we only contracted GPs and that was a mistake. What about a child who has a speech problem and poor eyesight? We must look at all of that as part of re-engineering primary healthcare. It's not a competition between us and private. If there's something good in private, if there's a service we need to use, money must not be a barrier. This is written even in the SDGs of the UN: that money should be no barrier. We must achieve financial risk protection and we can only achieve that if we have mandatory pre-payment. We will change the exclusive system of the rich. We will buy services in both public and private on behalf of citizens. The National Development Plan made it very clear that there

are two issues that need to be resolved. One is to bring down the exorbitant cost of private healthcare. The other is to deal with problems of lack of quality in public. Can we afford to implement the SDGs, which have a deadline of 2030 (like the NDP), if we keep saying it's an unprecedented agenda and we can't afford it? There's a lot of work to be done. For example, in the White Paper, it says central hospitals must no longer be provincial because they are national assets. But we are also saying they must, where possible, be semi-autonomous. Where universities use them for training, for instance, those universities must have a say in how they're run, rather than be controlled. We plan to have a system similar to school governing bodies, where people can have a say and also have the power to decide. If we want our public hospitals to be able to compete, they must be given the power to decide.

Was a battle with Treasury over the enormous amounts of public money it's going to take to fund NHI a main reason behind the delay in releasing the White Paper? The White Paper has GDP growth at 3.5 percent for the foreseeable future, given that current growth is below one percent, and next year's forecast is at 1.8 percent. How realistic are your numbers?

It's quite clear in our document that NHI presents a substantial policy shift and a massive reorganisation of the current healthcare system. We argued very much with Treasury. But whether GDP grows or not, health expenditure is still growing now in the country. Whether there's NHI or not, it's still growing exponentially in terms of private health insurance. In 2010, the total amount of money contributed by medical aids was R84.7 billion. This year, it's R126bn, so that's happening even while GDP isn't growing, and nobody's saying let's stop. This whole issue of cost… why does it come in only when we talk about private? Is it fair when there's a premium on inflation on medical schemes? The other issue I want to add is that benefits on medical schemes run out. My benefits on Parmed were finished before the end of the year. My brother is an engineer on Discovery and his benefits ran out in August. When that happens, people push over to state. In other words, they just demand more money for themselves. Meanwhile, the state is already subsidising public servants to the tune of R20bn, and that's an amount you can't see because Treasury doesn't send it directly to medical aid. Then, Treasury is also paying a tax incentive of R16bn for everyone on private medical aids, apart from the R20bn. All that money is not available to ordinary citizens, but to those who can already fend for themselves.

People who've been accessing private healthcare are, to be blunt, frightened of having to use public because of its poor reputation. What's the least they can expect?

The White Paper describes a common basket of services which will be covered by NHI. Let's start with the district authorities who're going to be running NHI. At the moment, the districts are mostly useless. You don't even have to tell me how much they need to be strengthened. I know. But let's go to OR

Tambo district in the Eastern Cape, which the most rural. There are very few private entities, very few GPs. That district is not like Cape Town's metro, so the manner in which we decide on service priorities is going to be very different there from Cape Town. The districts are going to be the ones who must decide strategically and then those who want to sell their service must prove themselves. Their health compliance must be accredited and if you're not good enough, we can't accredit you to NHI. For instance, after the public protector's report into Mamelodi Hospital, I can't accredit that place. I can't. It cannot be NHI because it's not up to scratch. Even if it is Bara, and it is below standard, we can't accredit because we would not be able to attract clients. The MECs will have a budget and they will allocate, and so the MEC will be forced to go and say, please improve up to this level. In other words, we will be constantly pushing them to improve so that we don't just read complaints in the media but have no legal force. We want a legal way so that we can provide the public with the service we've promised under NHI. On prices, we can't dictate to private, but we want to negotiate fair prices with them. One of the arguments is about private hospitals' return on capital, which they say must be built into their fees. But I want to know, if your hospital has already been around for 20 years, you should not be basing those fees on what the hospital would cost now. You already have a 20 years' return on investment. Otherwise, that feels like cheating.

What's the point in the Healthcare Market Inquiry (HMI) - which finally begins its public hearings at the Competition Commission later this month - when you've already published a White Paper which describes what you plan to do? What's the history?

It dates back from 2009 when I became Minister, and there were many, including medical aids and the Board of Health Care Funders who straight away started telling me medical schemes are collapsing, medical schemes are demanding lots of co-payments, and so on. So we had to look into that as a start. You have to understand that before 2003, private healthcare providers were, let's not say colluding, but they were antagonists sitting around a table saying what is fair, and they were actually trying to find a way to put prices under control. Then the Competition Commission said they may no longer do that and they should negotiate secretly, one on one. At face value, I think the Competition Commission made a mistake. I then tried to talk to private healthcare, and everyone agreed except the Hospital Association of South Africa (Hasa). They flatly told me, no, the Competition Commission told us we can't meet. But I felt, let's test this hypothesis of private healthcare's super profits. Is it a true fact or is it a feeling? Hasa has been calling the shots. I think the public hearings are very important because understanding the prices that are charged in private will change the public's mind. Once people really know what's going on, South Africans are going to arrive at a consensus. We need affordable healthcare, and that's not affordable. At the same time, the issue of quality has to be addressed in public hospitals. On prices, we called the medical aid schemes through BHF to talk to us, because we

had a court case (on the National Health Reference Price List, which government published in 2007 but was forced to retract after private healthcare providers took it to court, believing the list was irrational). The court ruled on appeal that we go back to the drawing board. So how can you set prices when they're just going to go to court again? The Competition Commission must remove its ruling.

Your critics have lambasted the timelines for NHI. You're looking at full implementation by 2025. Is that fair?

We've got a task team for NHI that specialises in various aspects. It includes experts from the World Health Organisation, the Organisation for Economic Co-operation and Development, the National Institute for Health and Care Excellence in Britain… organisations which have experience in this field over the past 70 years. They're advising us. But let's look at how long it took to implement universal coverage in other countries. We think, for instance, that in Qatar it took 18 months. But in reality they've been working on it since 1992. We're always very much in a hurry in South Africa, but international people are not like that. We're not reinventing the wheel. In Japan, for instance, they started their NHI in 1961, in a period when they were very poor, but their view was that, if you wait till things are very good, you won't need universal coverage. The United States introduced the Affordable Healthcare Act when the US was in a recession. We know from as far back as 2009, that private healthcare is threatening a constitutional challenge. They did not hide it and are still going on to prepare. Look at the Ngcobo Commission (the HMI, which is chaired by retired chief justice Sandile Ngcobo). They've hired almost all the senior counsel in the country. But we also remember that there were two constitutional challenges in the US before Obamacare, and these were from the same kinds of people as the Free Market Foundation, who are from the same ideological base as the rightwingers who challenged Obama. So we are not labouring under any illusions that things will go smoothly. We're waiting for them, and we're waiting to really test how South Africans feel about section 27 of the constitution. NHI is the first attempt to make section 27 alive, and if the Constitutional Court says no, we'll find another way to get there

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