Many areas of concern in NHI paper

The Minister of Health has published a White Paper on National Health Insurance in the Government Gazette on December 11, 2015. The public now has a period of three months to provide comment on the contents of the White Paper.

Fundamentally, the White Paper presents a National Health Insurance Scheme or NHI to provide access to healthcare services for all South Africans. Paragraph 2 of the White Paper describes the NHI as "a substantial policy shift that will necessitate a massive reorganisation of the current health care system, both public and private and also derives its mandate from the National Development Plan (NDP) of the country."

A number of details are presented in the White Paper concerning the NHI and with which the public will be required to engage for purposes of providing comments on the White Paper ahead of the commencement of the implementation phase of the architecture to support the NHI. Therefore, perhaps it is, for purposes of this comment, more appropriate to deal with certain of the primary issues not dealt with in the White Paper about a possible NHI in South Africa.

Constitutionality

The concept of a NHI, which is premised on universal healthcare coverage, means that every South African will be required to join the NHI, whether they wish to or not. In addition, with what appears to be a reduced role for private healthcare funding, as stated in the White Paper, there may not be a choice but to join the NHI. Such a mandate may not pass constitutional muster in so far as the Bill of Rights is concerned. Section 18 guarantees every person the "right to freedom of association." Therefore, forcing one to belong fundamentally to a national healthcare club may unfairly and unduly limit one's right to decide with whom to associate – being the NHI or a medical scheme, for purposes of securing healthcare funding and assistance.

Quality of service

Statements are made in the White Paper concerning the precise nature of the quality of healthcare services, particularly in the public sector. Steps have been taken to introduce the Office of Health Standards Compliance in terms of the National Health Act No 61 of 2003. However, that office is yet to address directly and substantively quality concerns and the provision of healthcare in the public sector in South Africa. At paragraph 75 of the White Paper, the following statement is made:

"Quality of healthcare must be adequately addressed in both the public and private sectors. Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drugs stock outs, infection control and safety and security of staff and patients. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care."

Quality is a concern and arguably a central reason for a distrust in the South African public in respect of receiving healthcare from a public institution. Without significant improvements in the quality of healthcare services at public facilities, there will be resistance to the implementation of NHI, irrespective of the constitutional or otherwise legal basis, if any, for such a system.

Services

The White Paper makes much reference to the universal nature of the proposed NHI and the extent of the coverage that is to be provided. However, the White Paper lacks the requisite detail in respect of the scope and ambit of the services to be provided vis-à-vis the services currently purchased by users in the private sector, for example. Therefore, at paragraph 131 of the White

Paper certain services are described as being the services to be provided by the NHI, albeit that a qualification is included in paragraph 131 that these are services to be included in a NHI. These services are described as follows:

* Preventive, community outreach and promotion services.
* Reproductive health services.
* Maternal health services.
* Paediatric and child health services.
* HIV and Aids and Tuberculosis services.
* Health counselling and testing services.
* Chronic disease management services.
* Optometry services.
* Speech and Hearing services.
* Mental health services, including substance abuse.
* Oral health services.
* Emergency medical services.
* Prescription medicines.
* Rehabilitation care.
* Palliative services.
* Diagnostic radiology and pathology services.

It is unknown what services are embraced with references to "prescription medicines" or "palliative services". However, the White Paper does make it clear that the services to be provided, ultimately, will not be similar to the Prescribed Minimum Benefits currently provided by medical schemes as such benefits "cover a limited number of health conditions, are essentially hospi-centric without fully addressing the burden of disease." The emphasis of the NHI is on preventative services and not curative services, which arguably means that NHI, as proposed, may miss the point in the context of healthcare in South Africa in so far as the existing burden of disease is concerned.

Traditional healers

No mention is made in the White Paper about any involvement of or contribution by either African Traditional Healers or the Allied Health Professions and complementary medicines, all of which are now subject to formal legal recognition and regulation.

Payment

Chapter 7 of the NHI deals with the "financing of (the) NHI". However, no particular payment system is identified as constituting the payment system that will support the proposed NHI. Various options are examined, including direct taxation, an increase in Value Added Tax, a payroll deduction by employers and the imposition of premiums. Once again, being forced to join a national healthcare club, which is commented on above in terms of section 18 of the Bill of Rights is problematic, but is further compounded by the imposition of a requirement to make payment for the privilege of joining the club. The imposition of a requirement to pay to join the NHI seems to contradict one of the objectives of the NHI, which is described in paragraph 107 as "promoting equity and social solidarity through the pooling of risks and funds" read together with the statement in the introduction concerning the need to make access to healthcare more affordable. The White Paper does not address the economic effects of the implementation and imposition of the potential revenue sources on the average South African and the effect of the imposition of such revenue sources on the republic at large in the current and medium-term economic circumstances in which it finds itself.

Property

At paragraph 401 of the NHI, the statement is made that: “in future, all medical schemes will only offer complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits. Part of this work will require a complete overhaul to the existing Prescribed Minimum Benefits regime, taking into account the burden of disease and changing population demographics. This will ensure that the population is granted greatest possible access to health care services by everyone within available resources.”

The White Paper also states that the number of medical schemes in the country will reduce to “a much smaller number” (at paragraph 402). The effective removal of the ability of a medical scheme to provide benefits and charge for such benefits accordingly may constitute an unlawful infringement of a medical scheme's right to property. Therefore, the structuring of the NHI so as to deprive medical schemes of the ability to provide services and to structure their affairs accordingly, as is currently the regime under the Medical Schemes Act No 131 of 1998, as amended, (“the MSA”) may constitute a taking of property that is prohibited by section 25 of the Bill of Rights.

In terms of the MSA, medical schemes constitute juristic entities and are required to run their affairs accordingly and to be held accountable in terms of the MSA. The NHI does not explain why the role of medical schemes must change under a NHI as proposed or even what is achieved through such a change other than the removal of the desire by consumers to purchase private medical scheme cover as opposed to belonging to a NHI.

The NHI is to be implemented in phases in accordance with the provisions of Chapter 9 of the White Paper. The first phase, which extends from 2012 to 2017, deals with so called “health system strengthening initiatives”, the establishment of a NHI Fund, the “movement of central hospitals to the national sphere” and establishing the Office of Health Standards Compliance, District Health Management Offices and the National Health Commission.

Steps will have to be carefully taken as the NHI brings with it controversies relating to both the scope and ambit of the services to be provided and the costs of providing those services, the imposition of taxes and levies and the constitutionality of forcing people to belong to a system and then nevertheless requiring them to pay for that privilege. Presumably, based on the time periods applicable to the implementation of the NHI, time will tell.

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