NHI- International Lessons in Universal Healthcare

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In the NHI White Paper, it is indicated that the implementation of NHI will take into account the country's experiences and global lessons learnt in the development of universal health coverage.

There are several examples of lessons learnt internationally regarding Universal health coverage that did not seem to be taken to heart in the South African context. If one looks at the case of South Korea specifically[1], National Health Insurance was implemented over a twelve year period. The government mandated medical insurance for companies with more than 500 employees and was subsequently extended to the whole nation in 1989. This system ran smoothly until 1997, when a major economic crisis hit South East Asia. There was an increasing annual deficit in the NHI after this period. The Korean government continued to raise the contributions to try and make up the deficit, but did not succeed in doing so. Increased government funding was not solving the problem, as Korea were unable to control health care expenditure.

In 2009, there were 49.2 Million Koreans registered with the NHI. Of these, 57.7% (28.4 Million) are employee insured members, who each contribute 5.08% of their annual income towards NHI, with their employer contributing the same amount. Self-employed ensured amount for another 38.6% (18.9 Million) members, who contribute various amounts, ranging between 6% and 10%. The government is responsible to provide coverage for the poor and indigent, which amount to 3.7% of the population[2]. There is a co-payment system of 10% to 20% of inpatient costs and between 30% and 50% of outpatient consultation costs. Research indicates that the Korean Government is struggling to fund healthcare for the 3.7% of the population that cannot afford to self-fund.

To compare with South Africa, Korea has 47.4 Million users of the NHI that self-fund at a rate of between 6% and 10% of their annual income along with co-payments ranging from 10% in hospital to 50% of outpatient costs. Despite this massive funding base, the government is struggling to fund the 3.7% of the poor and indigent in the NHI. South Africa has 5.7 Million taxpayers who will be funding 55 Million South Africans, without any co-payments, at a suggested rate of a 4% tax increase. Based on the Korean model it is obvious that the South African Funding approach to the NHI is totally insufficient, making the NHI system unaffordable. Further serious implications for the implementation of NHI in South Africa includes that utilising an NHI based system in periods of financial crisis does not work. South Africa is undoubtedly currently experiencing a financial crisis and trying to implement an NHI in such circumstances is doomed to failure.

Similar to South Africa, the republic of Ireland published a Universal Healthcare Insurance (UHI) White Paper in 2011[1]. This White paper did not allude to any costing of the Universal Healthcare system and did not describe the basket of services offered under the Universal Healthcare Insurance. In 2015, it has come to light that Ireland can actually not afford the system, following costings and analysis from the Economic and Social Research Institute (ESRI). The ESRI study, which was based on the White Paper details, clearly shows the [Irish] Government's proposed model "is not affordable now or ever". UHI proved a vote winner in the 2011 general election. However, the [ruling] party's failure to cost its own proposals then, and the Government's subsequent failure to do so until 2015 represented the "outstanding policy failure of the Coalition administration". This is exactly the same situation in which South Africa is currently finding itself. The government is using the NHI concept to win voters, but they are failing to do the necessary cost studies to verify that the system is affordable or even implementable.

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[1] Lee, J-C. 2003. "Health Care Reform in South Korea: Success or Failure". American Journal of Public Health 93(1)

[2] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*

Looking at the situation in Canada[3], it is seen that Canada has the second most expensive healthcare system as a share of the economy and adjusting for age. Long wait times in Canada have also been observed for basic diagnostic imaging technologies that my countries take for granted, which are crucial for determining the severity of a patient's condition. In 2013, the average wait time for an MRI was over two months, while Canadians needing a CT scan waited for almost a month. These wait times are not simply "minor inconveniences." Patients experience physical pain and suffering, mental anguish, and lost economic productivity while waiting for treatment. One recent estimate (2013) found that the value of time lost due to medical wait times in Canada amounted to approximately $1,200 per patient. There is also considerable evidence indicating that excessive wait times lead to poorer health outcomes and in some cases, death. Dr. Brian Day, former head of the Canadian Medical Association recently noted that "delayed care often transforms an acute and potentially reversible illness or injury into a chronic, irreversible condition that involves permanent disability." New research also suggests that wait times for medically necessary procedures may be associated with increased mortality. One of the important statements of this report, was that it was important to recognize that a single-payer model is not a necessary condition for universal health care. There are ample examples from OECD countries where universal health care is guaranteed without imposing a single-payer model.

By Dr Johann Serfontein – News24, MyNews24

Dr Serfontein is Health Policy Unit Member at the Free Market Foundation and Senior Healthcare Consultant at HealthMan

[3] Clemens J, Barrua B. "If Universal Health Care Is The Goal, Don't Copy Canada". Forbes Magazine, 13 June 2014