South Africa's journey towards universal healthcare

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South Africa has a grand vision for healthcare: free and equitable access for all citizens. However, difficult questions over funding remain unresolved

Equitable access to good and affordable healthcare in South Africa remains a pipe dream to most, with 84% of the population – 45 million poor, mainly black women, men, and children – relying on over-burdened and under-resourced state facilities. The rest, 9 million medical scheme members, has access to good but very expensive private hospitals.

The quality of care in this two-tier system varies enormously. Government clinics and hospitals, where you pay for services based on your income, typically struggle with a persistent lack of funding, poor management of scarce resources, chronic drug stock-outs, shortages of equipment and specialists, and ailing infrastructure. These and other problems lead to unnecessary complications and fatalities. Take the maternal mortality rate, which stands at 138 of per 100,000 live births. This is significantly higher than ten years ago (112), and the country's Millennium Development Goal target of 38. The problems within the public sector are the main culprits.

Private healthcare facilities in South Africa, which are accessible to those with a medical insurance, locally known as medical aid, are typically less busy, more efficiently run, and significantly better resourced. They however struggle with what has been called an affordability crisis. Care has become increasingly expensive, largely due to an unregulated and fragmented system that compensates doctors based on the number services provided, and not on the quality of care.

"Because they are competing with one another for services and thus income, private doctors in South Africa usually don't work together," explains Brian Ruff, CEO of healthcare management company PPO Serve. "This leads to duplications, over-servicing, gaps, and unnecessary expensive hospitalisations, and drives up the cost of care. Private doesn't always mean better."

Administrators of private health insurance or medical schemes have to factor in the above-mentioned trend, Ruff says. This has resulted in skyrocketing monthly contributions. Between 2015 and 2016, premiums of South Africa's seven largest medical schemes went up by 7.26% to 10.92%, exceeding the inflation rate of 6%. Next year, contributions are expected to go up by 8% to 12%, making private healthcare increasingly unaffordable.

The NHI intends to tackle this situation by pooling private and state health resources – including hospitals, clinics, funding and medical staff – together, and doing away with the division between the

two systems. How this will be done and how people will be enrolled, is still unclear. These and other questions are being dealt with, says Rajesh Patel, head of benefit and risk at the Board of Healthcare Funders of southern Africa (BHF).

“Six working groups have been set up in response to the NHI White Paper, which was published last year. Each are dealing with various existing gaps and questions, including the extent of the fund’s benefits, the future of medical schemes, and the pooling of resources.”

What is clear, is the NHI’s ultimate objective: giving every South African and long-term resident – regardless of socio-economic status – access to the same comprehensive, quality essential healthcare which will be provided free of charge. Non-essential procedures that are not covered, will most likely require additional cover, Patel says.

Quality and affordable care for all is a good thing, says Sasha Stevenson, lawyer at social justice NGO Section27, which has been involved in the NHI’s formulation process.

“We have a particularly unequal healthcare system in which very few people are taken care of by a very expensive private sector, one which spends about 50% of all healthcare funding available,” she says, referring to statistics that show that South Africa’s private and public healthcare each spend around £9bn per year.

“Alongside, we have a dysfunctional, under-resourced and under-funded public system that has to service 84% of the population with the same funding. That doesn’t make sense. The premises of the NHI is to utilise and allocate resources better, and to make access to healthcare more equitable.”

In terms of costing, the NHI’s price tag – based in 2010 prices – has been set at £15bn. How this will be funded, by whom, when, and how potential shortfalls will be dealt with, is not yet certain. It is something the working groups will reveal in due course. More information on how the NHI will be funded next year, is expected next year when the Minister of Finance will publish his annual Budget Speech.

The perceived lack of information around how the NHI will be funded has triggered criticism. Based on £15bn, some feel that South Africa – a country with 21 million unemployed, 5 million tax payers and a growing budget deficit – can’t afford free medical care for all.

“Our fiscal situation at the moment is in such a state that we can’t spend one single cent more,” says senior economist Dawie Roodt. “The state’s revenue is under tremendous pressure, and we will probably see a downgrade. The money is finished.”

The £15bn estimate is unrealistically low, he Roodt adds. “To roll-out the NHI, you need to ensure that everyone has access to the same services regardless of where one lives. You will therefore need to employ a lot more people, including bureaucrats and medical staff. This costs a lot of money.”

Ruff isn’t too concerned about the NHI’s price tag. “Money isn’t the problem, at all. There is enough money to buy every South African quality healthcare,” he explains. “You just need to know what you are doing. You can’t judge what could happen based on the present, and on an ineffective system as things will change.”

His main concern is the question around the NHI’s benefits and the future role of medical schemes. “The NHI will cover essential care, with private medical insurance possibly serving as top-up providers for whatever is not covered,” Ruff says. “What exactly the NHI won't cover, is not defined yet. That is a reason for concern.”

Patel doesn’t agree with some of the pessimism around the NHI financials. “The fund’s planning and formulation process has to be completed still,” he stresses. “We are for instance still waiting for the financing paper of the Department of Finance and for the outcomes of the six working groups. These will wrap up their work towards the end of the year.”

Their reports will be consolidated and then sent to minister and cabinet, after which they will be incorporated into a new version of the white paper. Patel: “Yes, there are still a lot of unanswered questions, but they are being dealt with. Rome wasn’t built in one day, and neither will the NHI.”

Patel rejects Roodt’s comment that the future scheme will be excessively expensive because more employees will be needed to run it. He points at the skills and knowhow within the private sector. “In the medical scheme environment, we have a lot of expertise. We know governance and management, and we have administration capacity and experience, too. This is needed in the NHI. Like we said when we as the BHF became involved in the first discussions nine years ago: let’s tap into that existing expertise and don’t reinvent the wheel. We need to do this together.”

Roodt isn’t convinced. Apart from the affordability question, he doubts whether the NHI will be able to do what it envisions: improving people's access to better and more affordable care.

“I fear the NHI will pull the private sector standards down to the public sector’s standards,” he says. “The private sector has excellent facilities, whilst the public sector has often terrible medical facilities. The NHI should rather pull the state hospitals up to the standard of private facilities by privatising all government hospitals, and converting the budget of the Department of Health into a medical fund to which everyone belongs, with several buyers.”

Other concerns include the question of how South Africa's 70,000 community healthcare workers will be integrated in the NHI's structure. "Most of these are employed by NGOs and get a low stipend," Stevenson says. "The public sector however relies on them, in terms of vaccinations, the distribution of medicine, and other often preventative and primary services. It is an important cadre that needs to be incorporated and deserves better salaries."

Then there is the future of the private healthcare sector, a multi-million pound industry. Last year, medical scheme administrator Discovery Health alone made a £100 million (R1.78 billion) profit. Stevenson and Patel feel that objections by this particular sector are no reason not to disrupt the current status quo.

"The very expensive, powerful, and largely unregulated private healthcare sector has been able to do whatever is wants for a long time, so yes, it will be up in arms as the NHI threatens their power," Stevenson says. "Everyone however should have the right to access to good and affordable healthcare, whether it is funded by the state, the individual, or a private medical scheme. From Section27's point of view, the Department of Health has an obligation to regulate the private sector, to ensure good access to healthcare for all. That is happening at the moment with the NHI. We need it to work."

Patel agrees. "I feel that the majority of naysayers, particularly those in the private sector, want the status quo to remain because it is great for them," he says. "They are happy with escalating prices. *We can't continue like this."*

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