THE NATIONAL HEALTH INSURANCE:
WHERE ARE WE GOING?

Public Servants Association

July 2018

…….

There is broad consensus over the need for change in the South African healthcare system. At present, the system is deeply unequal, with the rich benefiting from private medical aid schemes that give them access to world class private medical health care. The poor, and largely black South Africans, on the other hand languish in overcrowded and under-resourced public hospitals that can hardly be an affirmation of human dignity. The result is not simply inequality in access to just any kind of service, but inequality in access to what ought to be a basic human right – health care to guarantee dignity. The Bill of Rights (Chapter 2 of the Constitution) states that "Everyone has the right to life…not to be treated or punished in a cruel, inhuman or degrading way." The conditions in under-resourced public hospital sector, and the bifurcated nature of health care delivery, go against this holy grail.

But as clear as the need for change is, the way the government is going about that change needs careful scrutiny. The range of legislative changes that are known as the National Health Insurance (NHI) system will completely redesign how healthcare works in South Africa. At its most basic level, the NHI reforms aim to flip how government pays for public healthcare. Instead of giving funding directly to public hospitals, the NHI will provide funds to patients who can then choose where to spend those funds. Proponents of the reforms argue that the NHI would allow poor citizens access to private hospitals and enable public hospitals to improve in order to compete on an equal footing with private hospitals. Critics, however, argue that the NHI means that the government is giving up on public hospitals, and abandoning the burden of addressing deep structural issues in the South Africa healthcare service, for a simpler route of providing funds.

In truth, it's too early to know how the balance between these two scenarios will play out. While Minister Motsoaledi released the two key pieces of legislation on 21 June 2018, they only layout a broad framework for the structure of the NHI, without going into detail on how it will be implemented in practice. Nevertheless, these two pieces of legislation - the Medical Scheme Amendment Bill and the National Health Insurance Bill - will be the key to understanding how the NHI works.

The Medical Scheme Amendment (MSA) bill won't in itself create the NHI, but it will lay the groundwork for how the NHI will operate. The MSA bill aims to make a number of changes - including regulating private medical aid rates, placing limits on co-payment by patients, and creating a national database of everyone with a medical aid. But the main change it will make is to create a superfund of all national health insurance funds, whether private or public.

In theory, this shouldn't radically change the operation of private medical aid funds, since private providers could still withdraw the money they contribute. What it will do is allow both private and public funds to leverage the full weight of all medical aid funding in the country, and thus to have a pool of funds that is less risky and can operate more effectively in financial markets.

As a simple pool of resources, the superfund concept is a good idea. But where things get more complex is in the government's stated intention to use the superfund to redistribute healthcare funds. Minister Motsoaledi was clear that: "Yes, under NHI, the rich will subsidise the poor. The young will subsidise the old. The healthy will subsidise the sick. The urban will subsidise the rural." This type of subsidization is definitely needed, but traditionally it has been facilitated by taxation, which allows for careful targeting of the richest and redistribution to the poor. How the superfund will facilitate redistribution is still unclear, and more detail is needed on how this could operate.

Perhaps the greater concern regarding the superfund is not its existence, but the way it will be managed. Efforts to create an NHI superfund comes at a moment of historical lows in trust in government. The last few years have been wracked by accusations of corruption, including massive scandals around efforts to 'capture' the Public Investment Corporation, despite strong administrative safeguards designed to prevent exactly that. Maladministration of a public health insurance fund would be catastrophic, and government will need to work extremely hard to convince the public and private sector insurers that they have the administrative capacity to make such a large and complex fund work.

Similar concerns about administration preside over the National Healthcare Insurance bill, the core piece of legislation that would make the NHI work. The NHI bill establishes a state fund that will aim to "actively purchase and procure health care services, medicines, health goods and health related products from service providers, health establishments and suppliers that are certified and accredited", as per the demands of the public for healthcare.

A number of concerns have been raised about the NHI, the most obvious of which is of course funding. Estimates of costs vary greatly, and few are likely to be accurate. The Davis Tax Commission estimates the NHI will cost R256 billion in annual funding, based on 2010 prices (accounting only for inflation, this would be R388,1 billion based on June 2018 prices). The Institute for Race Relations, a critic of the NHI, estimates the cost at R600 billion in 2026, but again this is likely only a ballpark estimate.

The cost of the programme is of course important, but perhaps more important is what it means for the public hospital system. Underpinning the logic of the NHI is the argument that more funding for patient support (insurance) means there will be less need for infrastructure support (hospitals), because hospitals will now receive their government support through money received from patient's insurance. The major risk of this vision is that it seems to suggest that government will reduce direct support to hospitals, and perhaps even privatise state hospitals. This is a major source of concern.

Public hospitals have to grapple with decades of underinvestment in healthcare infrastructure. If they are forced to compete on an equal footing with the private sector, many will likely fail, or be forced to radically scale back their services.

If the pay-outs from the NHI are not set adequately, hospitals could also face a reduction in their income, perhaps to a level too low to fund the type of investment that is so badly needed. Similarly, if NHI standards are set high, many public hospitals could fail to be included in the scheme in the first place.

Public hospitals do not simply service those who cannot afford to pay, but play a number of other strategic roles, such as facilitating a proper spatial distribution of hospitals (ensuring availability across the country), serving as places for training new doctors and undertaking research, and offering a mechanism to address public health crises, such as HIV/Aids or unforeseen epidemics. From a healthcare worker perspective, changes in how government funds healthcare could see changes in working conditions, including cutbacks and reductions in salaries, and changes in bargaining structures.

Similar models have been followed across the world, notably in Europe. In many cases, the results were a reduction in the availability of hospitals and, in more radical cases, hospital beds. Belgium's healthcare reforms saw the country fall from having 531 hospitals in 1981 to 174 in 2006, even while the number of beds available remained constant. More serious reductions in hospital space were seen in the United Kingdom (4 000 beds withdrawn from service in 1987 alone), Austria (15% of hospitals closed between 1990 and 2003), Germany (134 232 beds lost between 1991 and 2004), and Italy (half of all hospital beds lost between 1990 and 2005). In Germany and Sweden, closures were accompanied by the sale of public hospitals to private companies; while in some countries, notably Britain, the management of public hospitals has been partially outsourced, into a mixed public/private system.

There is no clear evidence that government intends to get out of direct management or funding of hospitals. But if they don't, then the math behind the NHI really doesn't make sense. If the NHI simply adds to the R182 billion already spent on healthcare, rather than changing the structure of the budget, then new funding mechanisms will be needed, and it's not clear what those will be. The NHI will be compulsory, meaning everyone will likely contribute some amount, but even then, it's not clear how these payments will be structured and if they will be adequate.

Conclusion

There is a middle ground solution that is worth exploring: between NHI-supported partial privatisation and direct state support to hospitals - which would see the state keep running hospitals, but with funding split between indirect funding via NHI and direct transfers from the state. This middle ground seems by far the most likely scenario, but it raises an important question: why not then just invest newly raised revenues in revitalising public healthcare. Yes, that is an extremely difficult challenge, with the healthcare system riddled with inefficiency and corruption. This is precisely why efforts should go towards cleaning up the system, rooting out bad apples, improving management and efficiency, and build better infrastructure. This would help in restoring the confidence of the public not just in the health care system, but in a government that shows that it cares and grasps its constitutional obligations. resources to begin improving public service delivery will be essential.

A range of additional concerns remain on the NHI, such as: whether fees will be set at a level that will get private doctors involved in the programme, how comprehensive the coverage will be, how the transition to the new system will be managed, and what will happen to the current tax

deductions for private medical aid schemes (which have been discussed as possible cuts to fund the NHI).

None of these issues should be taken as criticism of the NHI as a concept. An NHI system can certainly work, and if it unlocks private healthcare for more people it will make an enormous contribution to addressing inequality. But building the NHI will be a very complex and difficult process, which must be undertaken by a state that is in the process of rebuilding both capacity and trust. Perhaps the core underlying question comes down to: do we want the state to fund access to healthcare, or to fund healthcare facilities directly. The challenge is that the government currently seems to be heading towards both models at one, a complex and expensive proposition, that - if it isn't carefully managed - could result in underfunding of exactly the type of investment that state hospitals so desperately need.