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National Health Insurance exposed

South Africa's greatest health news story for the past decades has been the HIV/AIDS pandemic. The next great story, which will remain headline news as it unfolds, will be National Health Insurance (NHI). Changes envisaged for the USA and South Africa have similarities;[1] both suffer from escalating health care costs, poor outcomes for expenditure on health care, and fragmentation of services.

A recent 'Health Summit'[2] hosted by the *SAMJ* and *Leadership* magazine provided a platform to expose the proposed NHI. Themes that emerged included that most citizens of South Africa favour a revamp of South Africa's current health system, but strong voices of reason urge caution of the perils ahead with the looming NHI!

Setting the scene

The Deputy Minister of Health, Dr Molefi Sefularo, refreshingly acknowledged failure of the Department of Health to make capital of the goodwill gained at the start of our democracy in 1994. A promising start included delivery of increased primary health care and services to children. However, since 2000 there have been the HIV/AIDS treatment (or rather lack thereof) debacle, serious decline in the public health system and an increasing sense of exclusion by the public and health professionals. Civil society resolved the AIDS debacle in 2007 by forcing reforms. An activist public now insists on immediate action rather than a gradualist approach to an NHI. He urged that a crisis should be seen as a challenge – if the rules of the game cannot be changed, 'play within them to beat the others'. The 'excluded' could influence the NHI Advisory Committee, which would take into account all views put to it and produce a White Paper. People could again respond to this before a Bill is put before Parliament, after which the Portfolio Committee could again take representations into account.

Dr Sefularo emphasised that the NHI is just one component of the National Department of Health's comprehensive ten-point plan to overhaul the entire health system, which includes addressing management issues and quality of services.

Cautionary tales

Policy must be feasible and appropriate and process is also important as bad process leads to bad outcomes, noted Alex van den Heever, an independent health economist. Government policy is very complex, and health reform is one of its most complex aspects. South Africa faces deep health care problems compared with countries with similar economies and health expenditure. There is minimal accountability in the public sector. Although public sector spending has increased significantly, including medication for HIV/AIDS, little has gone to the hospitals, resulting in their serious degradation. The institutional design (model) of a health system is crucial to its success.

Universal access to health care can be achieved by single- and multi-payer systems and by single- and multi-tier systems. Predominantly single-tier systems that are also always supply-rationed exist only in high-income countries, but there is no material difference between many models. 'Earmarked tax' is useful when people perceive that they are getting something back for it – when it is entirely redistributive it encounters the 'Laffer curve' effect, such as in increasing tax that at a point leads to diminishing returns. And finances will come up with hard limits no matter what!

A view from the medical profession

Providing insights from the medical profession Dr Trevor Terblanche, Secretary-General of the South African Medical Association, noted that the average age of the practising doctor in South Africa is increasing and many younger professionals emigrate. Those who remain face many problems such as the place of the auxiliary worker, the scope of practice being decided by third parties, and many legal and other restraints. The profession should respond professionally, and be informed, involved, respectful, organised, united and proactive.

Caveats concerning the NHI included that our people should firstly be better off; be wary of sloganeering; axiom – all health care is actually managed; the need to address public and private sectors; and the importance of moving forward in specific, goal-directed ways. Emphasising that health care is delivered by professional and support staff, Terblanche noted that the Occupational-Specific Dispensation (pay for professionals) may worsen the efflux. In any new system the private sector doctors must be retained and the present backlog of professional staff must be addressed. The question of affordability of an NHI, with our high unemployment rate and low tax base, was also raised.

Importing doctors

Over the past decade a static number of doctors have graduated and professionals have increasingly migrated, while needs have increased. The most cited reasons for leaving the public sector were management abuse and lack of appreciation. Dr Clarence Mini of Africa Health Placements called on the State to recognise that we are working in a globally competitive environment and that immigration of suitably qualified professionals should be encouraged. They were successful in overcoming barriers experienced by foreign-trained doctors wishing to work in South Africa by having personnel work closely with the Department of Health and the Health Professions Council of South Africa (an indictment of these institutions, which should routinely provide such services efficiently and effectively for any individual applicant!).

The role of medicines

Medicines are a major building block in health care provision in the public and private sectors. Val Beaumont of Innovative Medicines of South Africa (IMSA) sketched the changing profiles that will affect South Africa's future. An increasing

proportion of older women are projected from 2010 to 2025, while males will increase in the working age group. Cancers, rheumatoid arthritis (older women) and chronic diseases will increase significantly. Budgets will have to increase to cope with this increasing demand.

The role of private hospitals

Private hospitals in South Africa, including the early mission hospitals, pre-date public hospitals. Kurt Worral-Clare from the Hospital Association of South Africa (HASA) noted that the private sector contributes 22% of the bed capacity in South Africa (v. 78% public). Of the 31 000 private sector beds, 4 500 are for psychiatric patients and 95% are for adults. Beds are not interchangeable and children are therefore under-represented. In considering the role of private hospitals in an NHI general assumptions cannot be made, but details must be understood. Currently the public and private sectors do not share information, which is necessary for NHI synergies to work.

Funding the NHI is fine, but where are the doctors and the nurses? In trying to address problems such as the shortage of nurses, the private sector faces regulations and can only provide bridging courses for nurses (accepted by the Nursing Council); it cannot offer degree courses. The NHI will require nursing resources, and nearly 6 000 nurses trained in the private sector can only do their required 'community service' in the public sector.

Although HASA wants to be a part of the solution and engage constructively, the private sector has not been engaged. Big business that uses health care services and makes donations and the broader public should also be actively engaged in the debates.

The ANC solution

Many delegates got their first authoritative exposure to the ANC NHI plans from Tebogo Phadu of the ANC Policy Desk. Although the ANC task team's key proposals were adopted by the National Executive Committee of the ANC, there is a difference between Government and the ANC. The brief of the Advisory Committee established by the Government includes wide consultation that is also legally required.

The decision to implement an NHI included inequalities between care, resource constraints, mismatch between the public and private sectors 'like apartheid', wastage of resources and a significant shortfall of personnel. Its rationale includes improved cross-subsidisation linked to the ability to pay and in line with individuals' need for care. The economic rationale includes job creation by filling currently vacant posts in the public sector (80 000 jobs), increasing jobs for trainers of health professionals, and reducing the cost of employment. The envisaged nature of the NHI model is a combination of tax-funded and compulsory social insurance funding by employer and employee, a model supported by the World Health Organization for low- and middle-income countries.

The principles of the NHI include the right to health – free at point of use and a choice of provider of care; social solidarity and universal coverage – mandatory progressive contribution according to ability to pay, with universal access to health services that meet established quality standards; and a public entity administration and single not-for-profit funder (massive savings are envisaged). Providers will all have to be accredited.

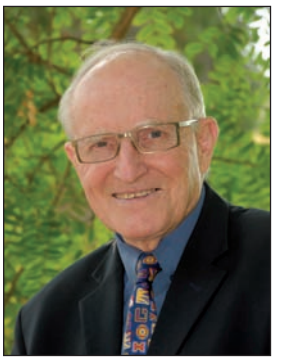
An NHI Fund with an independent Board will be created. Funding has not been completely worked out, but sources of revenue include a general tax increase in the public health budget: mandatory progressive payroll-related contributions will be collected by the South African Revenue Services from the employed, employers and self-employed taxpayers, with government contributions from those who cannot contribute. Additional smaller funding sources include current tax subsidies from private health insurance contributions, which should be directed to the Fund, and out-of-pocket payments from the uninsured, e.g. tourists.

Existing medical schemes would have mandatory membership of the NHI, but voluntary contributions to the medical schemes could still be made.

Human resources are at the core of the NHI, and their training and production are critical. Financial viability and sustainability would be addressed by cost containment and economies of scale. The disease burden has been factored in and the implementation will be slow – perhaps years – to be advised by the Advisory Committee.

Conclusions

The NHI has been exposed. The appointed NHI Advisory Committee has an extremely short time to adequately consult and to draft recommendations for parliament. Key players (including medical specialists who are not represented on the Advisory Committee) who currently feel excluded must be given an opportunity to be taken seriously. Their further exclusion may be harmful to the professional staff and to the implementation of the NHI. Considerable and complex problems not previously adequately considered require attention. However, there was a clear willingness by all parties to engage positively, and to paraphrase Dr Sefularo, this remaining goodwill capital should be made to grow and not be destroyed.



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1. Ncayiyana DJ. NHI or bust – the road of no return for health care reform. *S Afr Med J* 2009; 99: 765.
2. www.industryleaderssummit.co.za