



MANDATORY HEALTH INSURANCE – A GATHERING STORM



NHI proposal team leader, Dr Olive Shisana, who is also Director of the Human Sciences Research Council.

Picture: Chris Bateman

It's radical, overdue, aims for equity, is hugely expensive and needs lengthy, careful, consultative 'phasing in'. It will forever change the face of private and public medical practice and the medical aids that doctors in private practice rely on most for payment.

That's what can safely be said about mandatory health insurance, more

commonly called National Health Insurance (NHI), which aims to level the South African playing field through universal, affordable health care in one system over the next 5 years.

What is far less certain is whether private sector doctor dependency on profit-driven medical aids will be swapped for a 'patient numbers, one

size fits all' fee structure in which GPs act as 'gatekeepers' for the new overall health care delivery vehicle.

Also up for fierce debate is how much more it will end up costing higher-earning members of private medical aids, whether the R200 billion funding model is 'workable' and, most crucially, whether a debilitated public health sector can be 'revitalised' sufficiently – or within the ambitious time frame.

There's huge common ground that urgent reform is needed. Even the sectors most threatened by the new proposals kick off their increasingly frenzied and anxious (what government protagonists call 'premature') lobbying, with this caveat.

Copies of the 'concept document' leaked into the public domain early this June, a month before the ANC task team, headed by HSRC chief, Dr Olive Shisana, was due to hand over the research to health minister, Dr Aaron Motsoaledi, for official release.

Motsoaledi's aim is a national 3-month 'review and consultation' process before a modified proposal is submitted to Parliament for draft legislation.

Highlights of the concept document are:

- Creating a new NHI funding and administration body, separate from the health department, to oversee a R200 billion implementation. It will promote cross-subsidisation between rich and poor, healthy and sick, young and old.
- Legally preventing medical aids from offering any benefits already offered by state facilities.
- Paying general practitioners directly from the new body, although probably less than many currently earn.
- Making state hospitals the first port of call for medical aid members – unless they pay out of pocket for private facilities.



- An income-related payroll tax on employers and employees alleviated by a state subsidy on existing payments to medical schemes.

- Up to 85% of medical scheme membership fees redirected to the NHI as a tax.

**‘Grand gesture’
overcompensation**

The private sector’s opening shots were over what specialist economist in public policy, health and social security, Alex van der Heever, called ‘over-compensation in the form of the grand gesture’.

These included predictions of an overall patient benefits result equal to about one-quarter of those currently available to private scheme members.

Nobody seriously doubts the honourable intentions of Shisana’s team, even though they may differ hugely on the ideology.

Here’s the context: the richest 10% of South Africans have 47% of all income, while the poorest 10% have 0.2% of all income, one of the greatest levels of income disparity in the world.

The apartheid legacy is that 60% of expenditure on health care currently flows via private intermediaries to serve just 14.8% of the population, while 40% of funding enters the public sector upon which 64.2% of people depend entirely.

Adding an exclamation mark are an additional 21% of people who currently choose to use private primary care doctors and pharmacies on an out-of-pocket basis – but additionally depend on the public sector for all other conventional health care services.

Income equals access to health care in today’s South African set-up.

Shisana describes her team’s proposal as driven by ‘a need to act in unity to achieve universal financial risk protection; more so now when the economic climate requires that individuals and companies start to contribute to a nation-building process’.

She admitted that the public health sector faced ‘major challenges’ in terms of the quantity and quality of services it provided, identifying human resource shortages and management capacity restraints, cumbersome procurement processes and an ever increasing disease burden. These aggravated its under-funding.

However, for the private sector she cited high non-health-related expenditure (R8.9 billion for 2007/2008), low bed occupancies, high specialist costs, excess capacity and over-use as ‘challenges’.

An eloquent *SA Health Review* (2007) table of health care coverage, expenditure and resourcing reveals that (in 2005) there were 243 people with private cover per primary care practitioner compared with 4 193 per primary care practitioner in the public sector.

That’s a lot of public sector doctor/patient pressure (and therefore denial of access).

The 21% of patients who used a combination of private and public health care relied on an average of one doctor among 588 of them.

Those are among the more potent realities driving Shisana’s proposals.

But a plethora of alarming unintended consequences, based entirely on the leaked task team document, were immediately and lucidly raised.

Jonathan Bloomberg, Discovery Health’s head of Strategy and Risk Management, pointed to countries with similar socio-economic profiles having taken ‘decades’ to establish universal health care access on the scale being attempted here.

Even First-World countries that had achieved full NHI systems took far longer. They shared several key characteristics – high per capita expenditures on health care, high employment levels, low levels of income inequality, and an adequate supply of human and physical health

care resources. Shisana refuted this, saying that in Taiwan planning took less than 5 years and its NHI took a year to cover 98% of the population in the midst of the worst Asian economic crisis. Thailand had taken 14 months and Tunisia 2 years, she added.

Fix state hospitals first – or face failure

Bloomberg said fixing the ‘severe and ever-worsening’ problems of the public hospital system was paramount. Once public hospitals were able to offer an excellent service it would ‘make sense’ to move to some form of NHI at a rapid pace.

However, the process being used to implement NHI and the pace at which it was being done, could remove any hope of getting it right.

In an independent rating of health care system performance across 43 countries (conducted by Monitor Group), South Africa’s public sector ranked 36th. The private sector ranked among the top 7 – and was the 22nd most expensive.

Chris Archer, CEO of the South African Private Practitioners Forum (SAPPF), agreed that collapsing the private sector health care resources into one single-payer system administered by the state would not improve the health status of poorer citizens.

‘Unless managed with great caution and circumspection’, this could easily result in ‘a catastrophic loss’ of much-needed skills and resources, which would actually worsen delivery.

With 7 million personal taxpayers in a population of over 50 million (including 3.2 million principal members of medical aid schemes), the loss of every taxpayer, whether in the form of a specialist (current average age 52), or not, would have a debilitating knock-on impact.

The collapse of the private sector would lead to significant emigration of both principal members of medical schemes and specialists, ‘and with them





would go any hope of a viable system of universal access,' Archer warned.

Professor Heather McCleod estimates that it will cost the proposed payroll contributors some 15% of their income to achieve this.

He agreed with Bloomberg, who said the NHI proposals assumed that an NHI fund will be able to 'purchase' the package of benefits from both public and private health care providers.

Albeit laudable, this objective ignored the reality that the supply of health care providers was highly constrained, and that there was very little excess capacity to provide additional services to the entire population.

'This is certainly true for specialists, and for private hospital beds. The proposals also seem to assume that a single NHI "purchaser" will be able to use its purchasing power to reduce prices charged by private doctors and hospitals. This ignores the reality that our private specialists and GPs believe that they are currently under-remunerated by medical schemes. They are hardly likely to contract with an NHI purchaser which aims to reduce the prices they charge for their services,' he said.

Conversely, an improved public hospital system which created a more attractive working environment and paid doctors and nurses better, would attract private practitioners back, benefiting the entire system.

The biggest problem was the failure of the public health care sector to meet the health care needs of citizens and its failure to use scarce public funding efficiently and appropriately to improve accessibility, quality of care and health outcomes.

Bloomberg said with the economy shrinking (6% decrease in GDP in the last quarter) payroll taxes at the levels being hinted at (2 - 5%) would

impact on the cost of employment and therefore on the potential of the economy to create new jobs.

Even a 'dramatic' 30% increase in funding for overall health care (i.e. up from the current 3.5% of GDP to 5%), when spread out across the entire population, would still only buy a package of benefits equivalent to about one-quarter of the package currently obtained by medical scheme members.

Benefit improvements 'minor,' experts predict

Added Bloomberg: 'The harsh reality is that at our stage of economic development, an NHI system will only provide a very limited package of benefits beyond what is already provided within the public health care system'.

Van der Heever said the report appeared in part to motivate its changes on the 'improbable ground' that it can improve on private sector inefficiencies.

'However, there is no examination of the real risk that the proposals could deepen the service delivery crisis in the public system. Quite aside from the possibility that trying to implement this plan would deflect attention away from much needed reforms, the proposals would squander budget increases for paying public sector staff at private sector earnings levels,' he said.

'Remarkably', the task group recognised the possibility that health professionals would flee the country rather than be subjected to this process. 'To mitigate this inevitable consequence they envisaged again resorting to the importation of Cuban doctors – it is however not clear that the fleeing engineers, accountants, lawyers, and actuaries will also be replaced by Cuba,' he added caustically.

According to Professor Heather McCleod, a specialist in public health, family medicine, statistics and actuarial science (UCT and Stellenbosch University), cost would be

the main reason for not pushing ahead immediately to a national system where some contributed and all got the same benefits.

She estimates that it will cost the proposed payroll contributors some 15% of their income to achieve this, citing StatsSA 2005 population figures of 4.8% of the population being children under 20 and 61.6% being under 30.

Most importantly, nearly 90% of the under-30s were jobless, while 54% of the entire working age population was unemployed.

Citing the WHO, she said only Japan (36 years) and the Republic of Korea (26 years) had achieved universal coverage in under 40 years.

'The important thing is for South Africa to start a process of mandatory health insurance – we may not be able to cover everyone immediately but the intention is to do so as soon as employment and incomes make this feasible,' she added.

Others have added their shopping lists of matters to be addressed before NHI can begin to be introduced. These include:

- addressing the human resources problems
- addressing infrastructure problems, especially at hospitals
- establishing an effective procurement and supply chain
- implementing a proper IT system
- putting proper monitoring and evaluation systems in place in order to understand the disease burden
- finding an effective system through which to collect revenue
- addressing budgeting issues
- ensuring that the proposed system meets constitutional obligations
- addressing issues of accessibility to NHI, especially for people who do not have identity documents or who are not permanent residents.

Chris Bateman