# Opinion

# National Health Insurance in South Africa

I am convinced that some form of National Health Insurance (NHI) is inevitable in South Africa; the only questions are when it will happen, and what form it will take.

In the USA, the gap in health care between the average citizen and the poor is regarded as unacceptable. For the record, 15% of the population of the USA has no health insurance; but that is 45.7 million people – roughly the population of RSA. The call there is for quality health care (however that is defined) for the $2.5 trillion spent annually; defining when medical treatment is cost effective; cutting costs per patient, and moving away from fee-for-service care. Medicare payments were cut by 21% this year, but as a prominent colleague pointed out, the government will take little notice of pleas of poverty from doctors earning close to $500 000 per year, while the poor are uncared for. While this was being debated at the American Orthopedic Association Congress, the Obama administration approved legislation to introduce a National Health System.

If all the above is true in the USA, how much more so is it here in South Africa. As Prof Solly Benatar notes, 'The challenges in South Africa are those of the world in microcosm'. That said, we do have some rather challenging challenges in our burden of disease.

Some 30–35% of conditions treated, and also deaths under 5 years of age, are HIV-related, with at least 300 000 deaths and 30 000 orphaned annually due to the epidemic. This does not take into account complications of other problems such as wound infections after surgery. HIV and related diseases such as TB are a direct result of criminally inadequate preventative medicine – despite the diversion of much of the health budget to primary care. If South Africa had started distributing ARVs to **all** HIV patients when Brazil did, we would probably have a similar HIV incidence of around 1%.

Many other factors affect our disease profile that are beyond medical control – sanitation and housing for example – so it is misleading to blame only the defects in our health services. Few surgical conditions are related in any way to primary health care; we cannot vaccinate against fractures or degeneration. However, the 14% of all patients requiring treatment that are due to trauma could certainly be reduced by better policing, education and social upliftment.

In South Africa some 16% of the population has health insurance, and are cared for by 80% of the country's doctors at an average cost of $1 500 per capita annually. This is not bad considering that we have one of the best (private) systems in the world, at approximately a quarter of the equivalent cost in the USA, and half that in Canada or Europe.

Unfortunately the other 80% of our population must exist on $150 per capita per year, and that does not buy much medical care. The naïve suggestion of pooling all medical budgets and contributions will not work because that would only increase the average annual expenditure to $350 per person, which buys little more.

A fact we must start to assimilate is that our private health system is not sustainable. We all decry the constantly increasing gap between payments to and benefits provided by health care funders, as well as the increasing difficulty in obtaining consent for treatment, but this is not peculiar to South Africa. Unlike doctors (!), medical aids are not philanthropists, and must remain financially viable, while complying with legislation; as a result ten or more are under threat of closure, demonstrating the increasing financial squeeze under which they operate. One of the problems is the lack of cross-subsidisation from young (healthy) to older (decrepit) people because the young see no reason to pay for the care of an older generation when they have more enjoyable uses for their money. The obvious flaw here is that trauma and HIV target the younger generation, who have no cover when they need it.

The system proposed by government includes contributions from all employed South Africans, funded by a payroll levy, general taxes and contributions to existing medical schemes, with 'top-up' cover for additional benefits and private care. Benefits would be two or three visits to a primary provider of choice (possibly only a clinic sister), and higher levels of care would need approval from NHI, or be at the patient's own cost. Preferred providers would be in the public sector, but private providers remunerated at below NHRPL would be considered.

I have problems with this proposal. This is really no better than currently exists for state patients. State hospitals are inundated with neglected patients who have not been referred at a treatable stage from dysfunctional primary services, and this package offers no solution. Less than 50% of state hospitals meet minimum accreditation standards and it will be very expensive to upgrade them. Medical and nursing staff shortages are universal, and there is no credible effort in the proposal to improve this situation in the public sector to deal with an increased number of patients. There is a serious lack of management expertise and fiscal discipline in the public health system, and there is too much political interference in management. Finally, and most critical, is the question of funding.

It has been estimated that the true cost of a reasonably comprehensive health care system for all South Africans would be around R100 billion, which the country cannot afford. The South African tax base is too small to allow significant increases in general taxation, with a third of the population living on social grants, while a quarter are unemployed. Effectively 5% of the population contributes over 90% of personal tax, which already exceeds company or other forms of taxation, and the gap is increasing with the economic downswing.

I believe the only practical solution is to keep, but improve on, the present two-tier system, offering basic but more comprehensive health care to the majority of the population, with a higher level available to those willing to pay for it. Funding would be as outlined above, but calculated to spread the financial load from younger to older and richer to poorer without excessively penalising the main contributors. Top-up private cover would be available for improved benefits, with some offset in costs from government, but the benefits would generally be less than are presently available for the same cost.

This could not possibly cover all the costs, and five further critical measures would be required to cover the remaining deficit:

1. I feel strongly that HIV/Aids management should be removed from the general health budget where it is a drain on the finances of all other aspects of health care. Although it does pervade all aspects of medicine, it is a specific problem requiring dedicated funding.
2. Improved management of public health systems is absolutely essential, and the private sector must be involved to eliminate incompetence, wastage and corruption. The state or an independent body must however monitor finances as private institutions are not immune to self-enrichment.
3. Salaries and wages account for 60–65% of the total state health budget, and we need new ways to reduce these costs while maintaining or increasing public access to doctors. In Australia and New Zealand, the majority of specialists are in private practice, but they treat state patients in public hospitals, for which they bill the state, and are involved in teaching. Surely some similar arrangement is possible here, perhaps with registrars helping the specialist in his private practice, or tax relief or a nominal salary for sessions worked in public hospitals. This would have the additional advantage of exposing registrars to the wealth of skills and knowledge available in our private colleagues, and helping our threatened training programmes.
4. The medical community must start to control medical expenditure; it is doctors who initiate health costs and we must learn to be discriminating. Medical expenditure for marginal or no benefit to the patient cannot be tolerated. Surgery to prevent a problem in one patient out of ten means an unnecessary operation in nine for the benefit of one, and increases the true cost of treating that single patient by a factor of ten. We must learn to be selective; observe the course of events and treat when necessary rather than pre-judge an outcome, and develop outcomes statistics to support our judgments. Implant costs must be curtailed, and new, more expensive products used only if they show a proven substantial benefit. I would prefer to retain 'fee for service' because then the patient is an individual not a problem to be disposed of with the least possible effort; but the system is abused, and we must be prepared to be audited if it is retained.
5. Finally we must educate our patients in realistic expectations of medical care. They must understand the fallacies of the 'present market-driven view of health care and the good life' in the words of Solly Benatar, and accept that we are not guaranteed a life without some degree of pain, disability or inconvenience. They must also learn that they are responsible for their own lifestyle with its effects on their health, and cannot expect someone else to pay for the consequences of their carelessness and self-indulgence.

The poor standard of health and medical services in this country affects us all, rich or poor, either directly or indirectly, and we cannot ignore the need to improve matters. Many factors are beyond our control, but we need to become more active in the areas we can influence. Health care rationing is on its way, and the medical profession should be leading the field now, not reacting to politicians and health care funders at some point in the future when we have lost control of the process.

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