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N.H.I: The Good! The Bad! and the Healthy!

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N.H.I: THE GOOD! THE BAD! AND THE HEALTHY!

INTRODUCTION

National Health Insurance (NHI) is a health financing system that has been designed to provide access to quality, affordable health services for all South Africans. Access is to be based on the needs of the patient and is not dependant on socio-economic status. While the NHI has come under heavy criticism, there is consensus that healthcare in SA needs an overhaul. NHI will ensure that all South Africans have access to comprehensive quality health care services, allowing patients to access health care services closest to the residence.

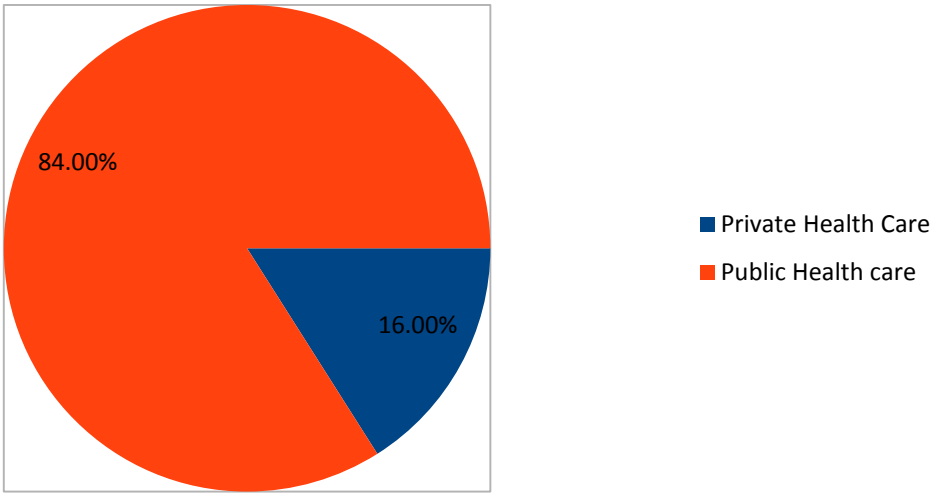
The health care services will be accessed at the appropriate level of care and will be delivered through certified and accredited health-care providers (both public and private) using the NHI Card. Every qualifying South African resident will receive a NHI card, giving the holder access to NHI-accredited health-care facilities and providers.

The NHI will focus largely on preventative and primary medical care with greater emphasis on the use of clinics, midwives and General Practitioners, while specialists will only be accessed through a strict referral system. This is not unlike the current practice of some Medical Aid Schemes in South Africa, who insist on General Practitioner referral to specialists as opposed to patients going directly. This is an attempt to reduce costs by avoiding the higher billing of specialists.

OUR CURRENT 'TWO-TIERED' SYSTEM

Currently, South Africans are exposed to a two-tiered health system divided into public and private health care. The public sector is available for all, whilst the private sector is available mostly for those who are covered by medical aid.

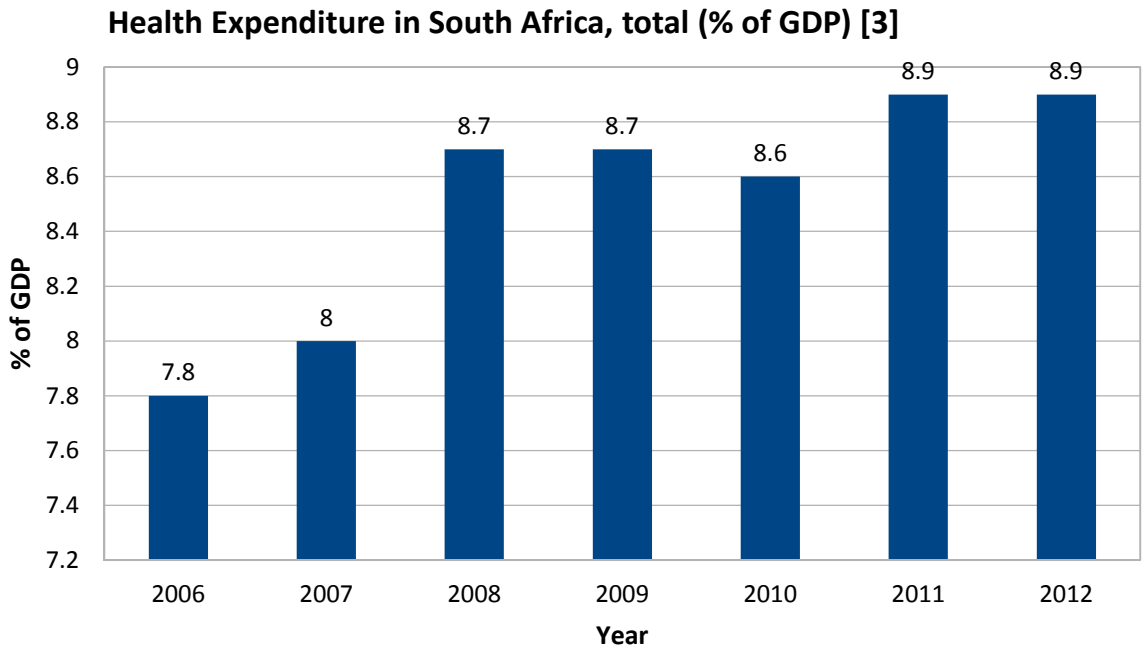
Percentage of Population in Private and Public Health Systems in South Africa [8]



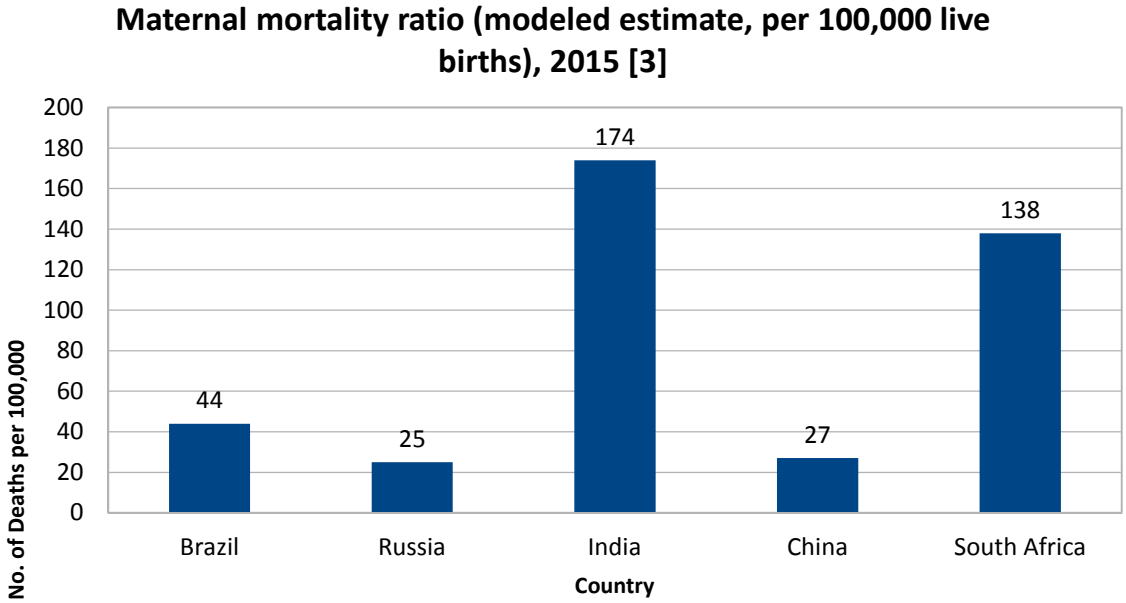
As per the White paper, with implementation of NHI, the public sector will become the foundation of the system, and the skills and resources from the private sector will be outsourced in order to compliment or fill in the gaps in the NHI until the system is more robust and can cater for the needs of the population. It is important to note that, currently, we already have private doctors working sessions in the public sector. Also, when ICU beds are unavailable in the public sector, beds are bought out in private and paid by the state. This will be similar practice once the NHI is implemented, but on a larger scale.

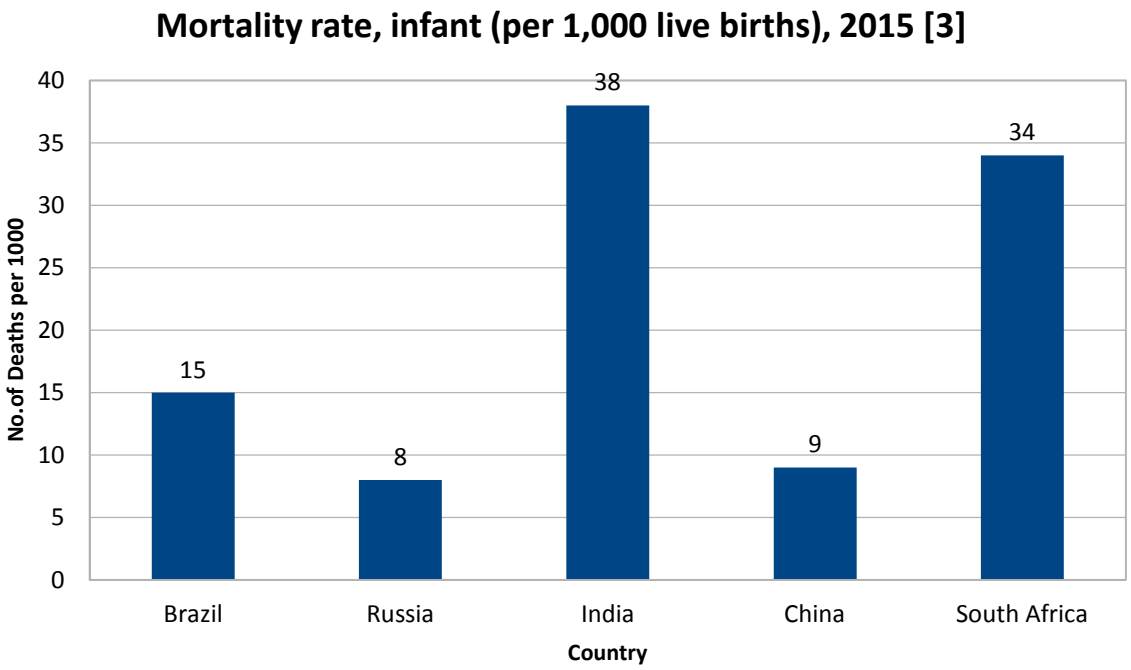
FINANCES

8.8% of S.A.'s gross domestic product (GDP) is spent on health, according to the National Treasury Budget Review (2015).[1] This percentage has been maintained over the last decade and is much higher than the recommended 5% by the World Health Organisation.[2]



Despite this high expenditure, health outcomes (measured by Maternal Mortality rates per 100,00 and Infant mortality rates per 1000) remain poor when compared to similar developing countries. These emerging market countries include Brazil, Russia, India, and China (BRICS).





Of the total amount spent on health in South Africa, only 48.4% is utilised for public health care (which services 84% of the population).[3] Life expectancy has increased from 52.2 years (2004) to 61.2 years (2014), but this is still shorter than in most other middle income and developing countries, and great challenges remain.[3][4]

The GDP spent on Health in South Africa in 2013 was 8.8% and divided as follows:

- 4.5% in the private sector, which covers 16.2% of the population or 8.2-million people, many of whom have medical cover.
- 4.3% in the public sector, which is made up of 84% of the population, or 42-million people, who generally rely on the public health care sector. [3]

This break-down clearly indicates that either the private sector is over-spending, or the public sector is under-spending. Taking into consideration the small amount of population utilising private facilities, as well as the suggested GDP of 5% by the WHO, the private sector appears to be guilty of overspending. High billing rates and unnecessary tests and procedures performed, and inappropriate use of high care and intensive care facilities may be the cause of this.

Funding the NHI shortfall

The DOH identified three primary sources from which SARS could derive additional revenue to fund an NHI system.

1. *Payroll taxes:* This usually takes the form of a fixed rate of tax on earnings, which is levied on employer/employees or a combination of the two. This may pose a problem by having a potential detrimental effect on overall employment numbers and job creation. High payroll taxes could discourage formal employment, an issue our government will want to avoid. Furthermore, wealthy South Africans who are not formally employed would not share the higher NHI cost burden. [5]

2. *Surcharge on taxable income:* This method would simply increase the marginal tax rate of taxpayers. It would be relatively easy to administer and would have the added benefit of being progressive (higher earners pay more). However, careful consideration would have to be made of its impact on taxpayer's disposable income, consumer expenditure and savings rates. [5]

3. *Increase in Value Added Tax (VAT):* South Africa's VAT rate is low (14%) relative to the average (18%) in OECD (Organisation for Economic Co-operation and Development) countries. VAT collection is broad, reaching both formal and informal sectors and increased VAT rates have had little impact on the economy's ability to create jobs. Concern that increases in VAT rates are regressive (hurts low-income more than high-income earners) has been raised. [5]

Interestingly, The Alexander Forbes Health Diagnosis 2014/2015 (which analysed key trends in the medical schemes industry between 2000 and 2013), showed that over the past 14 years, the inflation of medical scheme rates has averaged 7.9% per year, compared with the Consumer Price Index (CPI) inflation of 5.8%. [6] The average medical scheme contribution inflation, during the same period, was 7.5% per year, with actual increases in medical scheme contributions per principal member exceeding Consumer Price Index inflation by at least 1.7% per year. In essence, medical aid members have been exposed to excessive rate increases over the last few years and should expect further increases, irrespective of NHI implementation.

Another important point to note is the decreasing cover accompanying increasing exclusion criteria and increased rates being offered by medical aids, and the importance of 'gap cover'. Gap cover allows for the excess claims not covered by ones medical aid to be paid for. Basically, medical aid members are required to take insurance on their health insurance in order to ensure maximum cover. Insurance for your insurance? Fair, I think not!

DOCTOR AVAILABILITY

There are three separate issues with regards to decreased availability of doctors for our population.

1. Decreased number of doctors in South Africa, in general
2. Decreased doctors in the rural regions as compared to the urban regions
3. Decreased doctors in the public sector as compared to the private sector

South Africa in comparison to the rest of the World

With regards to the availability of doctors, as a whole, South Africa has a minor 0.776 medical doctors per 1000 population compared with Brazil's 1.891, China's 1.491 and the United Kingdom's 2.809, according to the World Health Organisation.[7] The doctor-to-population ratio is estimated to be 0.77 per 1 000. But because the vast majority of General Practitioners (73%) work in the private sector, there is just one practising doctor for every 4219 people. [9]

In an attempt to increase the number of doctors in the country, South Africa signed a co-operation agreement in 1995 with Cuba. South Africa has since recruited hundreds of Cuban doctors. Simultaneously, South Africa has been able to send students to Cuba to study medicine. The South African government believes that the Cuban opportunity will assist in training an increased number of doctors it so desperately needs for the implementation of the National Health Insurance Scheme.

Other agreements exist currently with Tunisia and Iran, as well as between Johannesburg Hospital and Maputo Central Hospital. [9] SA has also been sending students from rural areas to Cuba to train as doctors in order to increase production. Motsoaledi says that the problem is addressed by not only increasing doctors' numbers, but by also increasing their concentration in underprivileged areas by the deployment of these doctors to rural areas when they return.

There are also plans for the development of medical schools in the rural regions. *"We also want to start putting up medical schools in these areas, such as the one we're going to establish in Limpopo, Polokwane. If you place a medical school there you're going to get rural people to train there. If you take them to study in Johannesburg they won't want to go back to rural areas. They'll want to live in that city."* says Motssaledi. This tactic will not only attempt to increase the number of health care providers in the rural areas, but also increase the production of medical professionals yearly, as a whole. [10]

Rural verses Urban Areas

Currently, South African Medical Association (SAMA) indicates that about 70% of doctors in South Africa work in the private sector, mainly in the urban areas. The private healthcare sector serves only 16.2% of the population, as mentioned earlier. The remaining 30% of doctors, employed in the public sector, work across urban and rural South Africa, mostly in urban regions. A survey done in 2009 showed that only 3% of newly qualified doctors will end up working in rural areas. Considering that about 38% of the South African population lives in rural areas, the shortage of doctors there is critical. [7]

The number of doctors working in rural areas has been an issue for S.A.'s health sector for years. The Rural Health Advocacy Project states that only 35 of the 1200 medical students graduating in SA every year work in rural areas. More than half of the populations of Limpopo, Mpumalanga, the Eastern Cape, North West and KwaZulu Natal reside in rural sectors (this approximates to 44% of the total South African population), and these are the provinces that are often most affected by diseases such as HIV/Aids and Tuberculosis [10] Even with the implementation of the community service programme, government has been struggling to recruit and retain doctors in rural health facilities.

Motsoaledi says this is not a uniquely SA phenomenon. *"Anywhere in the world doctors would tend to go to urban areas. It's a world phenomenon. They prefer to work in urban areas — there's electricity there, and tarred roads. There are facilities that many educated people enjoy and that you don't find in rural areas. It's a big problem for many professions."[10]* Another solution is to send the Cuban doctors SA is recruiting to work in such areas.

The Department of Health has also introduced mid-level health-care providers, to work in under-served rural areas. In some communities, medical students provide health services at clinics, under supervision. Also, newly graduating doctors complete a year of compulsory community service in understaffed hospitals and clinics. The occupation-specific

dispensation was another tactic used to draw doctors into the rural areas. In terms of the dispensation, doctors working in rural areas are paid 18% more than those working in cities. This incentive has not appeared to have made much difference, indicating that money is not the only quest. Shortage of schools, limited social structures, distance from loved-ones, adequate facilities and lack of luxurious living all contribute to reasons why the rural areas are unsaturated with doctors.

Private verses Public

With regards to private health care, there are minimal private doctors and specialists in the rural regions. This is most likely due to the afore-mentioned reasons. Also, the bulk of patients utilising private health care reside in urban areas, and patients in rural areas are unable to afford private health cares exorbitant rates.

The large discrepancy between numbers of doctors in public and private is attributed to the following:

1. Increased salaries in private (at the expense of long working hours, however), resulting in high yearly net incomes.
2. Minimal wage in public, including overtime rates.
3. 'Frozen' posts resulting in few available posts.

In order to avoid unemployment, many doctors are forced to join the private sector in order to earn a living.

HEALTH SYSTEMS AROUND THE WORLD-An Overview

All developed countries, with the interesting exception of the USA, implement some form of universal health care. [11][12] In The World Health report 2000 assessment of world health care systems, the World Health Organization found that France provided the "close to best overall health care" in the world, and ranked France as No.1. The United Kingdom and USA rank 18 and 27 respectively, with South Africa ranking at 175. [13] Cuba ranked at 39, not far below the USA, definitely impressive for a developing country.

France

The French health care system is one of universal health care largely but not completely financed by government national health insurance. Large amounts are spent on health care approximately 11.6% of GDP [3], higher than most countries in the world, with the exception of the USA. The French NHI income is sourced primarily from income-based contributions from both employers and employees.

However, there have been a series of attempts to increase the social security system’s financial base and ensure it is less vulnerable to the fluctuations of wage and employment. This has resulted in employee’s payroll contributions to have fallen from 6.8 per cent to a mere 0.85 per cent of gross earnings, having been almost fully substituted by an earmarked tax called General Social Contribution (CSG).The CSG rate is calculated using total income rather than income earned and it depends specifically on the source of income. This results in a varying rate (e.g. revenue gained from gambling has a higher CSG rate compared to

income earned from employment). Together, employer contributions, employee contributions and CSG revenue made up 87.1% of total health insurance revenue in 2010.

The remainder consists of state budget allocation and a number of 'sin taxes' on tobacco consumption. The pharmaceutical company turnover is also taxed. In total, 85% of NHI expenditure is utilised for the coverage of health care costs. The remaining 15% is spent on cash benefits in the form of daily allowances for maternity, occupational accident leave, sickness leave and disability pensions. [14]

France is able to provide a basic level of universal health insurance using a series of mandatory, largely occupation-based, health insurance funds. These funds are basically private entities but are, however, heavily regulated and supervised by the French government. [15]. Premiums (funded primarily through payroll taxes), benefits, and provider reimbursement rates are all set by the French government. The Commission Competition will most likely lead to similar functioning in South Africa, controlling and regulating private sector rates.

United Kingdom

With regards to health care, Great Britain represents both the good and bad aspects of a centralized, single-payer health care system. Single-payer health systems refer to systems whose funding is sourced solely from the state. Britain ranks above the U.S. with regards to most health measurements, specifically outcomes. This, however, may be an unfair comparison as both countries practice different health systems altogether. Its citizens do however have a longer life expectancy and lower infant mortality, and the country has more acute-care hospital beds per capita and fewer deaths related to surgical or medical mishaps.[16] Spending on health care fairly low and very equitable. The NHS system offers comprehensive coverage with no deductibles and minimal co-payments (these include small co-payments for prescription drugs, as well as for optical and dental care).

10% of Britons utilise private health insurance. Private health insurance replicates the coverage provided by the NHS, but gives patients reduced waiting times. Long waiting lists for treatment are endemic, and rationing pervades the National Health System. Unlike other single payer systems such as Norway, medical personnel are mostly employed by the government. In 2004, lower salaries for doctors in exchange for reduced work hours were negotiated. This has resulted in fewer physicians available at night or on weekends. Another issue is low compensation resulting in a significant shortage of specialists. Patients have limited choice of medical service providers as well as limited access to specialists. It is important to note that South Africans, currently, experience these similar scenarios when dealing with certain medical aids, so in essence, the NHI will not be exposing private health users to new obstacles. Currently, there are limited beds available in private hospitals, and the likelihood of no bed availability is very possible.

Also, after-hours, specialists are not available immediately in private hospitals, and the few that are, are having to be called out from their homes, increasing the waiting time for patients. Upon arrival at private institutions, patients are assessed by General Practitioners and have to wait for clearance from their medical aid before being admitted. In South African government hospitals, registrars and medical officers who are specialised for specific specialities are available on-site in order to see and treat patients. The numbers of patients to be seen in comparison to private institutions are much higher, and this contributes largely to increased waiting time in public health care institutions. [17]

USA

The USA is the only industrialized country that does not provide universal health care for all citizens. Programs for the elderly, the families of military servants, the disabled, children and some financially burdened through programs such as Medicare, Medicaid etc. are available but not efficient. Approximately 45 million Americans [16%] go uninsured each year while another 25 million are under-insured. With the worsening global financial crisis affecting America currently, more citizens are likely to lose their medical insurance, further dropping health care quality. [11] In the USA, health appears to be a privilege, rather than a right. I

A study done by *Himmelstein et al* showed that 62.1% of all bankruptcies in 2007 were of medical origin, with 92% of these debtors having medical debts greater than $5000. The remainder met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were found to be well educated, home owners, and had middle-class occupations. 75% of the medical debtors had health insurance. Observing statistics between 2001 and 2007, it was found that the share of bankruptcies attributable to medical problems rose by 49.6% in the USA. [18]

President Barack Obama has attempted to implement a Universal Health Care System, but has been met with resistance by the Republicans as well as Pharmaceutical and Private Insurance Industries. It appears that many Americans believe that their health system is an integration of all of the successful health systems in the world, and hence, falsely believing that it is functioning successfully. What they fail to see is that these positive aspects seen in the American system is not available to all equally, and thus results in poor, if not, no health care to many, and medical bankruptcy in the rest.

Cuba

With regards to developing countries, the health system in Cuba is recognized throughout the world for its excellence and efficiency. Cuba has managed to guarantee access to care to all, despite limited resources, and keep up with developed countries (with regards to outcomes). Margaret Chan, Director-General of the World Health Organization (WHO) was impressed by the country's achievements in this field, and praised the Cuban health care system: "Cuba is the only country that has a health care system closely linked to research and development. This is the way to go, because human health can only improve through innovation." [19].

The health care system in Cuba is based on prevention and the results achieved have been impeccable. The infant mortality rate is 4.2 per thousand births, which is the best on the continent and in the Third World overall. The infant mortality rate in Cuba is actually lower than the USA and ranks among the lowest in the world. [19] The life expectancy in Cuba is 78 years, achieving results similar to those of most first world countries. In 2025, Cuba will have the highest proportion of its population over the age of 60 in all of Latin America. [19]

The Cuban government operates a national health system and takes on an administrative responsibility for the health care of all its citizens. There are no private hospitals or clinics in Cuba, with all health services being government-run. According to the World Health Organization, Cuba provides a doctor for every 170 residents, and has the second highest doctor-to-patient ratio in the world, after Italy. The foundation of the health system are the community-based polyclinics, 498 clinics nationwide, each serving a catchment area of between 30 000 and 60 000 people. The polyclinics also act as the organizational hub for 20 to 40 neighbourhood-based family doctor-and-nurse offices, and as accredited research

and teaching centres for medical, nursing and allied health sciences students. The polyclinics essentially form the backbone of the Cuban health system. In the 1960s, the Cuban government implemented a program providing universal vaccinations. This helped eradicate many contagious diseases including polio and rubella. Other campaigns included a program to reduce the infant mortality rate in 1970 directed at maternal and prenatal care. As of 2012, infant mortality in Cuba had fallen to 4.83 deaths per 1,000 live births compared with 6.0 for the United States and not far behind Canada with 4.8.

IT WORKS FOR OTHERS....CAN IT WORK FOR US?

Principal fund holders at the NHS (known as Primary Care Trusts), in Britain, use a commissioning system, and allocate funds to practitioners via a capitation system.[20] As practitioners are required to 'break even' by seeing a certain number of patients daily, this approach could potentially affect the quality of care as doctors are forced to act as accountants and ration already limited resources. This can result in some patients not getting the necessary care, and diluting the effectiveness of the system. This indicates a possible weakness of the NHS, especially considering that, for a system that theoretically should always break even, overspending can result in enormous annual deficits [21].

In our current system in South Africa, this is already an issue, both in the private and public sectors. Considering that time equals money, private doctors have to maximise their billable hours. Rationing of already limited resources is already practised in our public facilities due to shortages and the need to 'stretch' resources in order to maximise the number of people receiving it. If this is a concern for a developed country like Britain, with a third of South Africa's unemployment rate (7.7% as at April 2011)[18], and without South Africa's levels of corruption, then it is not unreasonable to assume we will have the same issues, probably on an even greater scale, post- NHI implementation.

Another apparent issue, particularly when comparing the NHS with South Africa's proposed NHI, is that the eligibility for free services depends on residence status- permanent residents only have access to the NHS.[20] All such people are given a special card, and may only visit their designated practitioner.[20] This might prove problematic in a country such as ours, where we have a large number of foreign nationals and a migrant population which makes use of several different doctors in many different locations. Currently, all are treated in the public health system, irrespective of nationality. This requires acknowledgement when the NHI system is fully implemented, and hence incorporated, somehow, into the system, allowing for all foreigners to be treated too.

Apart from UK's government run, taxed-funded health care system, universal healthcare has been implemented in different ways in other developed countries; for example, privately run systems predominantly funded by government exist in France, and the Swiss have private insurance companies with government regulation and subsidies to allow for wide coverage and non-discrimination based on medical history or pre-existing conditions[22]. These systems function successfully enough, but this could very well be because of the large amount of funds used to maintain them. Hence, it is important to consider universal healthcare in developing countries so as to gauge whether finances will hinder South Africa's proposed NHI before it is even implemented.

The USA, even though they do not have health insurance for 100% of their citizens (similar to the South African two-tier system), currently have a public health system that covers approximately 83 million (around 28% of the US population), compared to the South African public health system covering 70% of the population. This, together with the fact that the USA is a first world country with minimal shortage of resources and high-end technology, can explain why they rank much higher on the WHO ranking system. They also spend a much higher percentage of their GDP on health compared to South Africa, and are actually the highest spenders in the world.

With regards to developing countries, which may be better examples to use in order to analyse whether finances will hinder South Africa's proposed NHI, Cuba was one of the first countries in the world to set up a national AIDS commission in 1983. But the response to this was controversial due to human rights being questioned. Up to 1994 (nearly a decade), HIV patients were required by law to live in quarantine. That policy was eased thereafter, but still, newly infected patients had to spend eight weeks in a sanatorium. Today, as a result, Cuba has lower HIV prevalence rates than even the United States. [23]

This approach, however, may not be suitable in South Africa due to it being a democratic country with a Bill of Rights, but the institution of other aspects in the Cuban Health System, may assist in improving South African health care. Polyclinics, increased medical professionals (the addition of those currently in private institutions) and increased availability of resources to all as opposed to some, can definitely impact health care in South Africa in a positive way. South Africa shares similar Primary Health Care and Preventative Medicine methods with Cuba, including free immunisations and the legalised abortions. However, Cuba may not be an excellent example to compare to South Africa due to its socialist views. Their ability to run a world-recognised health system with limited resources, is however, worth appreciating.

THE IMPACT OF NHI ON DOCTORS IN S.A.

The White Paper stresses that accreditation is mandatory for all institutions and health practitioners before treating patients. Institutions will be inspected by the Office of Health Standards Compliance (OHSC) and these inspections will be based on specific criteria including infection control, patient safety and staff attitudes. Only personnel accredited by the OHSC will receive payment from the NHI Fund. Accredited personnel and good outcomes will be the driving force for budget allocations.

The NHI's intention is definitely noble, but uncertainty still exists with regards to its implementation. If support from the private health sector is lacking – particularly the scarce specialists, then the entire health system may be weakened if/when they leave for 'greener pastures', if they can leave at all. These first-world countries have made it difficult to leave with increased criteria and requirements e.g. examinations in order to acquire authority to practice there.

All NHI providers will sign contracts which will express "performance expectations with regards to: patient management; patient volumes; quality of services delivered; adherence to clinical protocols and treatment guidelines and improved access to health services", according to the White Paper. Institutions will not simply be paid "fees for service," as this

does not ensure adequate quality of care or address health outcomes. Instead, payment will depend on health outcomes, but the definition of this is vague so far.. Everyone will begin assessment and treatment at primary healthcare clinics, and access to specialists will be rationed to those that need it. [24]

Since 2012, approximately 10 National Health Insurance pilot districts have been instituted to improve healthcare at a primary level, and they have made some headway. But while progress has been made, weaknesses have also been revealed.

Attempts to contract private doctors to work in government clinics, for example, have failed in a number of districts because of the poor working conditions. [24] In the Umzinyathi district in KZN, many General Practitioners expressed their disapproval with the R381 hourly rate being offered by the Health Department, and therefore declined work. [24] It is difficult to imagine how specialists, often in short supply even in the public health system , will be persuaded to work harder for less in a single health system – particularly if they are used to a certain income level. However, if billing in private is to be regulated by the Competition Commission, private practitioners will have no choice but to accept the income level dictated by the government. The White Paper represents good intentions, but it does not explain how it will attract private practitioners to work for the NHI.

Getting buy-in from private doctors and specialists is crucial if the NHI marriage of the public and private sector is to succeed. But if rates are controlled by government in private, then support from private practitioners may not be that difficult to obtain. With regards to medical schemes, their future role as providers of complementary cover remains a source of uncertainty and the ongoing Competition Commission Inquiry will need to be observed in order to see how they will further contribute to the need for transformation in the private healthcare sector.

CONCLUSION

NHI: Noble?-Yes Beneficial? Yes Successful? Maybe!
Privatisation of any service is a business opportunity…this includes health care. If there is anything that NHI cannot or will not provide, this gap will be filled by the private sector. The size of this gap basically depends on how efficient and robust NHI will be.

Health systems are definitely an expensive option for the economy of a country, but may prove to be cheaper to South Africans, in the long run, taking into account exorbitant medical aid fees, Gap cover etc. It appears that health systems are a good investment in people. But the health system structure and spending is to be appropriate for the needs of the country it is supplying.

The comment period for the White Paper on the National Health Insurance which was stipulated in Government Gazette No. 39506, dated 11 December 2015 has been extended to 31 May 2016.Those interested are invited to submit any substantiated comments in writing on the proposed regulations :

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“Every system is perfectly designed to achieve exactly the results it gets.”

Let your voice be heard. Suggestions, questions and opinions may have an impact on what lies in our near future.

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