What's wrong with the golden promise of NHI?

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The government claims that its proposed National Health Insurance (NHI) system will reduce the costs of health care and provide all South Africans (now numbering some 59 million people) with 'quality' health services that are free at the point of delivery.

Under the NHI, people who currently pay for the private healthcare of their choice will have to pay increased taxes to help fund the NHI – which, according to former health minister Dr Aaron Motsoaledi, will be 'like a giant state-run medical aid'.

The NHI will thus require 'a massive reorganisation' of the current 'two-tier' health system, with its public and private components. When it becomes fully operative in 2026, all health revenues will be paid into a single NHI Fund, which in turn will pay for all the health services provided to patients by both public and private practitioners and health facilities.

Pervasive state control is intrinsic to the NHI idea. Under the NHI, the state will decide on all aspects of healthcare – from the healthcare services to be covered to the fees to be paid to doctors and other providers, the medicines to be prescribed, the blood tests to be allowed, the medical equipment to be used, the new health technologies to be permitted, and the recommended prices to be paid for every item, from aspirins and ARVs to sutures and CAT scanners.

Both Dr Motsoaledi and Dr Zweli Mkhize, the current health minister, have claimed that these controls will be effective in reducing costs and enhancing quality. But the huge bureaucracy needed to implement them will be costly in itself. Pervasive regulation will also stifle innovation, reduce efficiency, and promote corruption.

The present private healthcare sector will effectively be nationalised, giving the government a monopoly over healthcare. This could be just as inefficient and vulnerable to 'capture' by a small elite as the state's monopoly over electricity (via Eskom) has proved.

The NHI's beguiling promises are likely to prove false. Despite steep tax increases to help fund the system, the NHI will lack essential financial and human resources. People will thus wait weeks, months, and even years for treatment. They will seldom get speedy help when they need it most: when children fall ill, or breadwinners are injured, or babies need to be delivered, or the elderly have strokes, or the chronically ill require medication. The treatment choices which currently exist will be removed – and people will find that they have no option but to rely on the state's medical aid, irrespective of how badly it works.

The problems with the NHI were clearly apparent in a 2011 green paper, a draft white paper in December 2015, and a final white paper gazetted in June 2017. However, little has been done to address the obvious defects. Instead, Dr Mkhize is pressing ahead with NHI implementation. He has

also tabled a revised NHI Bill of 2019 – which is much the same as its 2018 predecessor – and has invited the public to make written submissions on the new Bill by 29th November 2019.

The NHI Bill of 2019

The main purpose of the NHI Bill of 2019 is to establish the NHI Fund, along with a host of other entities needed for the NHI' implementation. However, like the June 2017 white paper on which it is based, the Bill fails to deal with a host of vital issues.

No remedy for public sector inefficiency

The government currently spends 4% of gross domestic product (GDP) on public health care, which is more than many other emerging economies can manage. But, despite the best efforts of many dedicated professionals working in the sector, the country gets little 'bang' for its substantial 'buck'. Instead, public health care is plagued by poor management, gross inefficiency, persistent wastefulness, and often corrupt spending.

The upshot is that at least 85% of public clinics and hospitals cannot comply with basic healthcare norms and standards, even on such essentials as the maintenance of hygiene and the availability of medicines. Cases of medical negligence – often involving botched operations or brain damage to newborn infants – have increased to the point where claims for compensation total R98bn. This is 44% of the entire R223bn budget for public health care in 2019/20.

The NHI makes no attempt to remedy these defects. It assumes that throwing more resources at the public sector will provide a cure-all, whereas poor skills, cadre deployment, and a crippling lack of accountability lie at the heart of the malaise and need urgently to be overcome.

A vast additional bureaucracy

The NHI will require a vast bureaucracy. This will start with the NHI Fund, into which all health monies will be placed and from which all health expenses will be paid. The NHI Fund will also have nine subsidiary units to decide on planning, 'benefits design', the payment of health providers, the accreditation process, the procurement of medicines and other health products, the monitoring of performance, and the prevention and investigation of fraud.

Many other bureaucratic entities will also be needed. These include various advisory committees to be established by the health minister, along with new 'District Health Management Offices' in every municipal district, new 'Contracting Units for Primary Health Care' in every sub-district, and a new 'Office of Health Products Procurement' at the national level. A comprehensive new 'National Health Information System' will also be required.

Unsustainably high costs

The NHI Bill is silent on the system's likely costs. The 2017 white paper put the NHI's costs, at its start in 2025, at R256bn a year (in 2010 prices). This figure is now nine years out of date and was a 'thumbsuck' from the start. The White Paper also suggested that the government would need an extra R80bn in revenue in 2025 to implement the NHI – and that this additional sum could be garnered by hiking the VAT rate, increasing personal income tax, and/or introducing a payroll tax.

However, the NHI is more likely to cost around R700bn a year when it becomes fully operative in 2026 (the starting year now envisaged). Major tax hikes will be needed to generate this amount. These increased taxes will be depicted as vital to the NHI, but the extra revenue generated is unlikely to be ring-fenced for NHI purposes. Instead, it will probably be used (like the 'sugar' tax, for instance) to help fund government spending on such items as the public service wage bill and bail-outs for failing SOEs.

The increased tax burden will fall particularly heavily on some 700 000 individual taxpayers who earn more than R500 000 a year and currently pay about two-thirds of all personal income tax collected (and a hefty chunk of VAT besides). If a third of those taxpayers were to emigrate in the face of increased taxes and reduced health services, the impact on revenues – and hence on all government spending – would be severe.

Like his predecessor, Dr Mkhize has shrugged off the key question of what the NHI is likely to cost. Instead, he takes the view that 'nothing should stand between us and the NHI – not even the cost'. This refusal to deal with costs and affordability is simply irresponsible. This is especially so when both the National Treasury and the Davis Tax Committee have warned that the NHI is 'unaffordable' and 'unsustainable'.

The healthcare services to be provided

The NHI Bill is largely silent on the health services the system will provide, saying these will be decided in due course by the minister and other entities – particularly the proposed Benefits Advisory Committee. The director general of health, Dr Anban Pillay, has recently suggested that the health services to be covered by the Fund will vary from one year to the next, depending on the allocations made to it in annual budgets.

According to the June 2017 white paper, however, the NHI will cover cardiology, dermatology, neurology, oncology, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery, including organ transplants of various kinds. At the primary health care level, it will provide 'sexual and reproductive' health care, along with optometry, 'oral health rehabilitation', and a comprehensive range of remedies for mental disorders and disability needs. Treatment for 'rare diseases' and 'dread diseases' will also be covered.

This lengthy list reinforces concerns that the overall costs of provision for a population likely to number well over 60m by 2026 will be very high – and far more than the country's limping economy can afford.

The health providers and facilities available

South Africa is already short of nurses, doctors, specialists, and other health providers, but the NHI offers no credible means of increasing their supply. On the contrary, the pool of available health providers and facilities is likely to shrink once the NHI takes effect.

This is firstly because only 15% of public clinics and public hospitals currently do well enough on basic norms and standards of healthcare to qualify for NHI participation. The remaining 85%, as earlier outlined, fail to maintain proper standards of hygiene and the like and will thus be barred from taking part. In addition, many private specialists, doctors, and other health providers with

scarce skills might decide to emigrate, rather than subject themselves to all the NHI's controls over their fees and treatment decisions. (A recent opinion poll conducted among health professionals showed, for instance, that 21% of respondents were already taking steps towards emigration and that 42% would consider leaving when the NHI was implemented.)

Long waiting times and substantially unmet promises

The NHI will lack necessary human and financial resources and will in practice provide far less than it promises. Long waiting times are sure to result, as has happened even in well-resourced Canada (which has a single-payer system similar in some ways to the NHI). In Canada, average waiting times to see a specialist and then be treated have more than doubled from 9.3 weeks in 1993 to 20 weeks in 2018. For treatments in particularly high demand, moreover, waiting times are significantly longer.

In addition, as a recent (2015) World Bank study reveals, 24 developing countries which have promised universal health coverage have failed in practice to deliver it. In all these countries, reports the Bank, there is a significant 'gap between the free comprehensive benefit package promised...and the de facto actual benefits'.

South Africa's NHI is unlikely to fare better. However, by the time people realise that the NHI cannot deliver on its golden promises, the private health care system will effectively have been destroyed. South Africans will then be left with nothing but a failing state monopoly on which to rely.

The ANC's vendetta against private health care

The main purpose of the NHI is not to improve health services but rather to drive the private sector out of the healthcare sphere. The NHI will help achieve this by putting an end to the medical schemes that primarily fund private medicine and are essential to its survival.

Putting an end to medical schemes

South Africa has a world-class system of private healthcare, to which some 30% of its population on average, or roughly 17 million people, have access through their medical schemes, health insurance policies, or out-of-pocket payments. In the 2019/20 financial year, spending on private health care is expected to amount to R250bn, of which 83% (R207bn) will go to medical schemes, R35bn to out-of-pocket purchases, and R5bn to health insurance. South Africa's 79 remaining medical schemes (down from 163 in 2000) are thus vital in providing access to private health care.

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2018. However, because the population has increased more quickly, medical scheme membership as a proportion of the total has declined slightly (from 16% to 15.4%). The demographic representation of medical schemes members has nevertheless changed substantially, for 49% of members are now black, while 9% are so-called 'coloureds', 8% are Indian and the remaining 34% are white.

Despite this major shift, the government plans to use the NHI to put an end to almost all medical schemes. The Bill (like the White Paper before it) makes it clear that people will not be allowed to opt out of making 'mandatory pre-payments' into the NHI Fund. This financial obligation in itself

could bring about the demise of many medical schemes, as most people will battle to afford both their medical aid contributions and the additional taxes required to fund the NHI.

As the Bill makes clear, medical schemes will be confined to offering 'complementary' cover for health services 'not reimbursable by the Fund'. Restricting medical schemes in this way is likely to sound their death knell. A scheme could still cover a rare disease such as haemophilia (uncontrollable bleeding), if this was excluded from the NHI package. But the pool of potential members wanting cover of this kind would be very small. Monthly contributions would thus have to be set so high that only the very rich could afford them. Few medical schemes are expected to survive this double regulatory whammy.

According to Dr Motsoaledi, all medical schemes will 'eventually be gone', once the NHI is in operation. 'This will be a process that takes years and, in the transition, there will be consolidation', he says. Once the NHI has been rolled out, the medical schemes that remain will 'all be collapsed into a single state-run medical aid plan', he adds.

In the interim, the government has been moving towards this outcome by pushing up the costs of medical scheme membership and refusing to allow low-cost options.

Making private health care more costly to access

Over the past decade, government regulations have helped to push up the costs of medical scheme membership and exclude more affordable means of accessing private sector care. The government has thus:

- introduced an arbitrary reserve requirement (25% of annual contributions) which is unnecessarily high for many medical schemes;
- insisted on open enrolment and community rating, which requires the young and healthy to pay more than they otherwise would and deters them from joining medical schemes;
- insisted that all medical schemes 'pay in full' for some 300 'prescribed minimum benefits' (PMBs), irrespective of whether members want this cover or not;
- reduced the tax benefits which help make medical scheme membership more affordable, and pledged to eliminate these altogether over time;
- resolved to end the government subsidy which helps public servants pay their medical scheme contributions;
- barred the introduction (planned for January 2016) of low-cost medical schemes, which could have made membership available to a further 15 million people at premiums averaging R200 a month per adult member; and
- introduced regulations which aim to put an end to the primary health insurance policies on which some 2 million people currently rely to access private health care from general practitioners (GPs) and others, also at a cost of some R200 a month.

The real reason for the NHI proposal

The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private health care. Both for this reason – and to help pave the way for its damaging

regulatory interventions – it has repeatedly stigmatised the private health care system as costly, selfish, and uncaring in its constant drive to put 'profits before people'.

Behind this constant stigmatisation of private health care lies the ANC's commitment to the national democratic revolution (NDR): a strategy developed by the Soviet Union in the 1950s to take former colonies from capitalism to socialism, and ultimately to communism. In 1969 the ANC endorsed Moscow's idea that South Africa was 'a colony of a special type' (in which whites were the colonial oppressors and blacks their exploited subjects) and embraced the NDR. Though some 50 years have passed since then, the ANC regularly recommits itself to the NDR – as it did once again at its Nasrec national conference in December 2017.

The real aim of the NHI is to help advance the NDR by dislodging business from a key sphere of market-based provision, effectively nationalising private healthcare resources, building dependency on the state, and establishing the principle that private spending must be pooled with public revenues for the benefit of those in need. The NHI precedent may then be used to extend this principle to other spheres, including pensions – where proposals for a government-controlled 'national social security fund' are already being put forward.

The ANC is thus determined to press on with the NHI, which Dr Motsoaledi has rightly identified as 'the equivalent of "the land question" in health'. However, there is no need for expropriation without compensation (EWC) in the health sector when incremental reforms would greatly improve the universal health coverage already available to all South Africans.

Improving existing universal health coverage

Universal health coverage is already available, mostly for no charge, through the country's public clinics and hospitals. To function better, these need merit-based appointments, strict accountability for poor performance, and effective action against corruption and wasteful spending. Public-private partnerships would also help improve their operation.

The burden on the public system should also be reduced by increasing access to private health care. Low-cost medical schemes and primary health insurance policies should be allowed, while poor households should be helped to join these schemes or buy these policies through tax-funded health vouchers. To help spread risks, medical scheme membership and/or health insurance cover should be mandatory for all employees, with premiums for lower-paid employees buttressed by employer contributions for which businesses would garner tax credits. Medical schemes and health insurers would then have to compete for the custom of South Africans, which would encourage innovation and help to hold down costs.

The supply of health facilities must also be expanded through regulatory reforms allowing the private sector to establish more day hospitals and the like. Private universities and hospitals should also be permitted to train doctors, specialists, and other health providers, as public training institutions clearly cannot meet the scale of need.