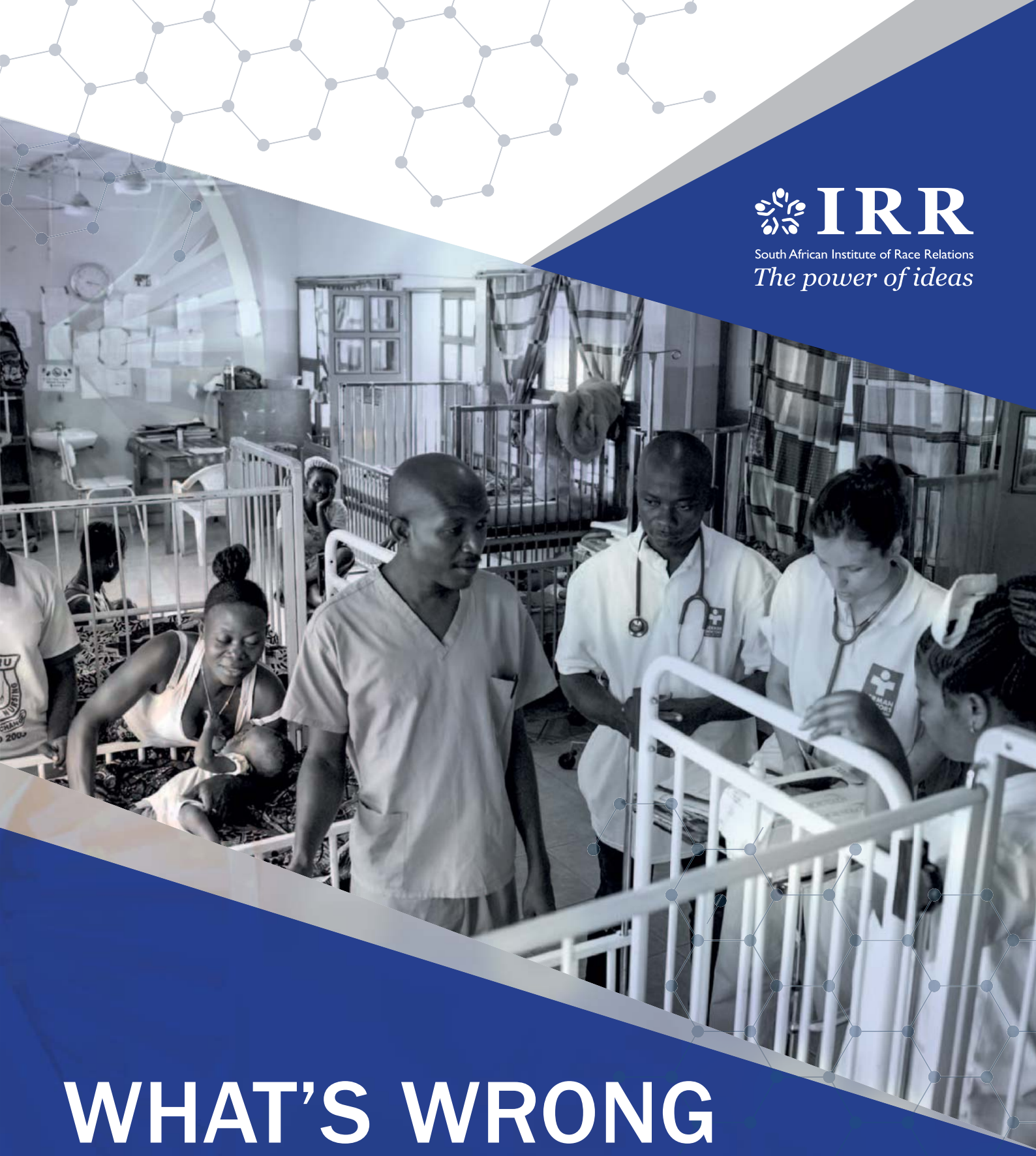

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WHAT'S WRONG WITH THE GOLDEN PROMISE OF NHI?

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WHAT'S WRONG WITH THE GOLDEN PROMISE OF THE NHI?

The government claims that its proposed National Health Insurance (NHI) system will reduce the costs of healthcare and provide all South Africans (now numbering some 58 million people) with 'quality' health services that are free at the point of delivery.

People who now pay for private healthcare will instead pay increased taxes to help fund the NHI, which (says 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, 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 prices to be paid for every item, from aspirins and antiretrovirals (ARVs) to sutures and CAT scanners.

> *Pervasive regulation will also stifle innovation, reduce efficiency, and promote corruption.*

Dr Motsoaledi claims these controls will be effective in cutting 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 Motsoaledi is pressing ahead with implementation through two bills tabled for public comment in June 2018. The NHI Bill seeks to establish the NHI Fund and other entities. The Medical Schemes Amendment Bill is intended to 'pave the way' for the NHI by making it difficult for most medical schemes to survive. But without medical schemes to sustain private healthcare, most

South Africans will have little choice but to turn to the NHI when it becomes fully operative in 2026 – by which time a dozen further statutes providing for it will have been adopted.

The NHI Bill

The NHI Bill seeks to establish the NHI Fund, along with various other entities needed for NHI implementation. Like the June 2017 white paper on which it is based, the NHI Bill fails to deal with a host of vital issues.

No remedy for public sector inefficiency

South Africa currently spends four percent of gross domestic product (GDP) on public healthcare, 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 healthcare is plagued by poor management, gross inefficiency, persistent wastefulness, and often corrupt spending.

The upshot is that 85% of public clinics and hospitals cannot comply with basic norms and standards, even on such essentials as 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 R56bn. This is more than a quarter (27%) of the entire R201bn budget for public healthcare in 2018/19.

> *Public healthcare is plagued by poor management, gross inefficiency, persistent wastefulness and often corrupt spending.*

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 will have 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 'sub-units' to decide on NHI benefits, approve treatment protocols, set prices, accredit health providers, procure medicines and other supplies, pay for all services and items purchased, monitor the overall performance of the system, and guard against fraud.

Many other bureaucratic entities will also be needed. These include an NHI Commission to oversee the NHI Fund, a National Health Commission to deal with non-communicable 'lifestyle' diseases, and a host of other committees to decide on treatment protocols, approve health products, oversee some 3 900 public hospitals and clinics, and maintain a data base with the details of all health providers, plus some 58 million patients.

Unsustainably high costs

The NHI Bill is silent on the system's likely costs. The 2017 white paper puts NHI starting costs in 2025 at R256bn (in 2010 prices), which is outdated and unconvincing. Even on this basis, however, an extra R80bn in revenue would be needed and would have to be

garnered by hiking the VAT rate, increasing personal income tax, and/or introducing a payroll tax.

The NHI is more likely to cost at least R500bn at its start. As the minister says, its costs will depend on its design and could go as high as R1 trillion. The more it costs, moreover, the more taxes will have to be raised. The burden will lie particularly heavily on some 600 000 individual taxpayers, who currently pay more than 60% of all personal income tax collected. If a third of these 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.

In releasing the NHI Bill, the minister again declined to provide any realistic cost estimate. The amount in issue was 'impossible to calculate', he said, and it was up to the Treasury to provide the necessary funding. This refusal to deal with costs and affordability is simply irresponsible. This is especially so when the Davis Tax Committee, having looked at likely costs, has warned that the NHI will be unsustainable without higher growth.

The healthcare services to be provided

The NHI Bill is largely silent on the benefits the system will provide, saying these will be decided by the relevant committee in the light of 'the potential funds' available. According to the June 2017 white paper, however, the NHI is to cover cardiology, dermatology, neurology, oncology, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery, including organ transplants of various kinds. At the primary healthcare level, it will provide 'sexual and reproductive' healthcare, 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.

> *The 2017 white paper puts NHI starting costs in 2025 at R256bn (in 2010 prices), which is outdated and unconvincing.*

This lengthy list reinforces concerns that the overall costs of provision for some 58m South Africans 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 to qualify for NHI participation. The remaining 85%, as earlier outlined, fail to maintain proper standards of hygiene and the like and will 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 NHI controls over their fees and treatment decisions.

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 similar single-payer system). Here, waiting times to

see a specialist and then be treated have more than doubled from 9.3 weeks in 1993 to 21.2 weeks in 2017.

In addition, as a 2015 study from the World Bank 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 healthcare 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 healthcare

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 2018/19 financial year, spending on private healthcare is expected to amount to R230bn, of which 83% (R192bn) will go to medical schemes, R31bn to out-of-pocket purchases, and R5bn to health insurance. South Africa's 82 medical schemes are thus vital in providing access to private healthcare.

> *Twenty-four developing countries which have promised universal health coverage have failed in practice to deliver it.*

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 9.5m in 2017. However, because the population has also increased, medical scheme membership as a proportion of the total has remained much the same, at roughly 16%. The demographic representation of medical schemes members has nevertheless changed substantially, for 48% of members are now black, while 11% are so-called 'coloureds', seven percent 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. According to the White Paper, 'individuals will not be allowed to opt out of making mandatory pre-payments towards the NHI'. 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.

Medical schemes will also, as the NHI Bill makes clear, be confined to offering 'complementary' cover, so as to fill in any gaps in the benefits provided by the NHI. 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 will survive this double regulatory whammy.

Dr Motsoaledi remains adamant that 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 states.

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 healthcare more costly to access

Over the past decade, government regulations have helped to push up the costs of medical scheme membership and to 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;

> *The government plans to put an end to almost all medical schemes.*

- 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, by April 2019, will end the primary health insurance policies on which some 2 million people currently rely to access private healthcare from general practitioners (GPs) and others, also at a cost of some R200 a month.

More damaging interventions under the Medical Schemes Bill of 2018

The Medical Schemes Bill (the Bill) will tighten the regulatory stranglehold on medical schemes still further. Since most people do not realise how state interventions have pushed up the costs of belonging to medical schemes, many will doubtless welcome the Bill's apparent aim to make medical aid more affordable. However, any gains are likely to prove short-lived – for the Bill could soon push many medical schemes into bankruptcy.

The key proposed changes are as follows:

- medical schemes will no longer be allowed to offer different benefit options and will instead have to cover a single, comprehensive package of primary and other health

services (as decided by the government), which will replace the current PMBs;

- medical schemes will have to 'pay in full' for this package of health services and will be barred from seeking co-payments from their members;
- contributions will be based on income, rather than health status, and the better off will have to pay significantly more to subsidise the poor;
- medical schemes will have to admit all those who apply to join, without regard to their health status (though people who have not belonged to medical schemes in the past 90 days will have to wait three months before they can access their benefits);
- medical schemes will be able to terminate the membership of those who fail to pay their contributions, but will have to take back these non-paying members if they re-apply for admission; while
- the only penalty medical schemes will be able to impose on those who fail to pay and then apply to rejoin is an 'administrative penalty', equal (it seems) to one month's contribution.

Says Dr Motsoaledi: 'The essence of NHI, which must start now, even within the present medical aid schemes, is that the rich must subsidise the poor, the young must subsidise the old, and the healthy must subsidise the sick.'

The Bill could soon push many medical schemes into bankruptcy.

The proposed rules will encourage many low-income households to join 'open' medical schemes (those available to everyone and not restricted to employer groups). The monthly contributions of these new members will be low, in line with their incomes. Higher-income households will have to pay substantially more to subsidise these new entrants, but may be unhappy with the sole package of benefits now available to them. This could encourage high-paying members to withdraw. Medical schemes will then have larger and larger numbers of low-paying members, with few high-paying ones to help bear the financial burden.

Medical schemes will have to pay in full for all the health services accessed by this larger pool of low-paying members. People who anticipate a major health event – an operation, or the birth of a baby, for example – will have incentives to join schemes four months in advance (given the three-month waiting period), pay premiums for five months, say, and then exit once again. This will put medical schemes under even more financial pressure.

In addition, people may soon realise that they cannot be refused re-admission if their membership is terminated for a failure to pay contributions. They will have to pay administrative fines on re-admission, but for low-income families with small monthly contributions, this would not be much of a disincentive. Medical schemes may then find themselves with large numbers of members who, in practice, barely pay any contributions at all, yet are entitled to comprehensive health services that schemes must pay for in full. This will put even more pressure on their sustainability.

These proposed rules are a canny move by Dr Motsoaledi. Many people who now find it hard to afford medical scheme membership – and who resent the co-payments they often have to make – will welcome these regulations. They will also benefit substantially from them for a period, as the benefits they receive will far outweigh the contributions they have to make. In the longer term, however, medical schemes will find it increasingly

difficult to survive. By the time the NHI takes effect, many medical schemes may already have disappeared. This will reduce resistance to the NHI, as people will have few other options on which to rely.

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 healthcare. Both for this reason – and to help pave the way for its damaging regulatory interventions – it has repeatedly stigmatised the private healthcare system as costly, selfish, and uncaring in its constant drive to put 'profits before people'.

Behind this constant stigmatisation of private healthcare 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 then 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 national conference at Nasrec in Johannesburg in December 2017.

> *The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private healthcare.*

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.

Dr Motsoaledi is thus determined to press on with the NHI, which he rightly identifies 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 healthcare. 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.