



The National Health Insurance: *Can we afford it or can we afford not to have it?*

"A nation's greatness is measured by how it treats its weakest members"

Proverb attributed to Mahatma Gandhi

1. Introduction

The government has finally released its long awaited discussion document (Green Paper) on a National Health Insurance (NHI) scheme that aims to ensure the provision of 'essential healthcare to all citizens of South Africa (and legal long-term residents) regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund.'¹ It is essentially a financing system intended to give the more than 40 million South Africans who mainly utilise the public healthcare sector access to healthcare services that are comparable to those enjoyed by the 16.2% of the population that belong to private medical schemes.

Since its release, and even before that, the NHI has been generating a considerable amount of debate among the ANC's alliance partners, the private medical industry, opposition parties and the general public alike. Health reform is, as Stephen Thomas and Lucy Gibson put it, '... inherently political'; reforming the way healthcare is financed in order to promote equality, they argue, inevitably challenges vested interests and generates opposition².

The scope of this briefing will be limited to unpacking some details of the NHI and providing an overview of some of the more pressing questions about it.

2. Background

Universal healthcare coverage, or at least the idea of a national healthcare service for all, is not a new

idea. The World Health Organisation (WHO) commented in its World Health Report of 2000 that South Africa had considered, as far back as 1944, introducing a system 'comprising free health care and a network of community centres and general practitioners as part of a referral system' similar to the British model, but for various reasons it was never implemented.³

Since 1994 numerous reports by a host of committees, working groups and commissions, such as the Health Care Finance Committee (1994); the Committee of Inquiry into National Health Insurance (1995); the Department of Health Social Health Insurance Working Group (1997); the Taylor Committee of Inquiry into Social Security (2001); and the Ministerial Task Team for Implementing Social Health Insurance (2004/05), recommended some kind of national health insurance.

Although progressive academics put forth a number of ideas and proposals on the possibility of implementing a universal health insurance before 1990, these were never translated into any formal policy positions until the ANC's National Health Plan document of 1994. In fact, the subsequent proposals put forth by the Health Care Finance Committee and the Committee of Inquiry into National Health Insurance was very similar to the ANC's National Health Plan.⁴

It was the Taylor Committee which explicitly recommended the establishment of an NHI and it was the subsequent Ministerial Task Team that explored these recommendations. It is thus clear that the proposals contained in the Green Paper have to

some extent been a work in progress since the 1940s. So, what exactly is the Green Paper proposing?

3. Unpacking the NHI ‘Medicine Cabinet’

Despite a relative lack of detail (which in itself is not necessarily a bad thing, because it allows for interested parties to contribute to the policy-making process), the Green Paper does attempt to spell out what the NHI is, and what needs to be in place in order for it to work.

The objectives of the NHI⁵ are to:

- provide improved access to quality health services for all South Africans irrespective of whether they are employed or not;
- pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund;
- procure services on behalf of the entire population and efficiently mobilise and control key financial resources; and
- strengthen the under-resourced and strained public sector so as to improve health systems.

These objectives, which will ensure the implementation of universal health coverage, give effect to Section 27 of the Constitution’s Bill of Rights, which obliges the State to ensure that everyone has access to health facilities.

So how will the NHI realise these objectives, given that some critics have argued that simply throwing taxpayers’ money at an ineffective and under-resourced system will not deliver quality healthcare for all?

According to the policy document, the effective and efficient functioning of an NHI system rests upon quality healthcare services that can be provided and delivered to everyone, and which are underpinned by the provision of a comprehensive package of primary healthcare. And in order to achieve this, there would have to be better management and administration of healthcare facilities, and enough medical staff to provide the services.

3.1. Re-engineering Primary Health Care

The Green Paper notes that the provisioning of a universal healthcare system can only work if primary healthcare is re-engineered to focus “mainly on health promotion [and] preventative care, whilst also ensuring that quality curative and rehabilitative

services appropriate to this level of care are rendered”.

These services, which will be made available to everyone, will be delivered via three streams:⁶

1. *District-based clinical specialist support teams:* Specialists will include an obstetrician, a gynaecologist; a paediatrician; a family physician, an anaesthetist, a midwife and a primary health care professional. Currently, health districts have a serious lack of specialist resources to provide support to primary healthcare services.
2. *School-based primary healthcare services:* This programme, headed by a professional nurse, will ensure that all school-going children, from Grade R to 12, have access to services that would include a focus on oral health services, nutritional services, substance abuse, child and sex abuse, and HIV and AIDS.
3. *Municipal ward-based primary healthcare agents:* At least ten people, with each member responsible for a certain number of families, will be responsible in a particular ward to help identify health problems and behaviours that place individuals at risk of disease and injury.

While the Green Paper speaks of a ‘comprehensive package’ of health services, which would be delivered via the three streams of primary healthcare, it is silent on what precisely will comprise this package. All it says is that it will cover not only primary healthcare, but also specialised secondary care, and highly-specialised tertiary and quaternary⁷ levels of care.

Contrary to the criticism that the NHI will ‘abolish’ the private medical aid sector, the Green Paper notes that private sector practitioners, contracted⁸ to the NHI, will also be used to deliver NHI services.

3.2. Reforming Hospital Management

One of the many criticisms levelled against the implementation of the NHI is that proper health services need high-quality and efficiently run facilities that are supplied with the required number of medical staff and other healthcare professionals.

In order to meet the demands of the NHI, the Green Paper proposes that hospitals be re-designated into district, regional, tertiary, central and specialised categories. To make this a reality, the Department of Health has published a *Draft Policy on the*

*Management of Hospitals*⁹ (hereafter referred to as the *Draft Policy*), that proposes the re-classification of the hospitals and provides for the appointment of qualified individuals to manage hospitals.

The re-classified hospitals will provide different levels of care, viz.:

- *District Hospitals*: A small district hospital will have no less than 50 beds and no more than 150 beds. A large district hospital will have no more than 600 beds. The package of services provided at district hospitals will include trauma and emergency care, in-patient care, out-patient visits and paediatric and obstetric care. Specialists employed at these hospitals will include family physicians, gynaecologists, paediatricians and general surgeons
- *Regional Hospitals* will provide specialist services to patients who have been referred by district hospitals. These services will include all the services provided by the district hospital, plus others such as psychiatry, orthopaedics and radiology.
- *Tertiary Hospitals*, which will also serve as training and research facilities, will provide super-specialist and sub-specialist care, including cardiology, human genetics, infectious diseases, etc.
- *Central Hospitals* will also serve as training facilities and render highly-specialised tertiary and quaternary services on a national basis.
- *Specialised Hospitals* will provide specialist TB and psychiatry services. These hospitals will also include rehabilitation centres providing services to people with physical disabilities.¹⁰

To ensure that all health facilities are up to standard and able to provide quality services, the Green Paper proposes that an Office of Health Standards Compliance be established¹¹. This office will have the task of ensuring that all health facilities contracted to the NHI meet core standards and facilitate access to healthcare services.

3.3. Human Resources

In order for the NHI to be implemented successfully, South Africa needs to increase its number of doctors threefold, according to the Minister of Health.¹² And the Department of Health's *Draft HR Strategy for the Health Sector (Human Resources for South Africa 2030)* notes that South Africa has considerably fewer doctors, pharmacists, and oral health practitioners per 10 000 people than any other

comparable country. In the last ten years South Africa's medical schools have produced only 1200 doctors annually, compared to what Cuba, with a population of 11 million, produces – 4000 doctors from 21 medical schools.¹³

Thus, the 1200 doctors that South African medical schools produce each year will have to be increased to at least 3600 to meet the demands of the NHI. To achieve this, the Health Minister has asked medical schools to increase their intake of students, and has indicated that the ministry will be funding the building of new medical schools and training hospitals.

4. Funding the NHI

According to the estimates¹⁴ in the Green Paper, a fully implemented NHI will cost approximately R256 billion by 2025. Most of the money has already been budgeted for and the money for the first phase (5 years) will come from a Conditional Grant. For example, in the 2011/2012 budget of the National Health Department¹⁵ more than R3 billion (over a three year budget period – 2011 to 2014) has been allocated to improve quality; to strengthen Primary Health Care teams; to upgrade and maintain nursing colleges and to improve maternal and child health. Additional funding of R16 billion (over a 3 year period) has been earmarked to be allocated to Provinces for the preparatory work for the NHI. This will be mainly for registrars' posts; specialists' posts at district level; for family health teams and helping hospitals comply with norms and standards.

The rest of the funding (after the first 5 years) will come from taxes, compulsory contributions or company levies similar to the skills development levies companies pay. There are also indications that there will be potential for co-payments and user charges from individuals. The exact details are sketchy in the Green Paper; however more detail may be given when the Finance Minister delivers his Medium Term Budget Policy Statement (MTBPS) – better known as his 'mini-budget'. The 'mini-budget', to be delivered in October, will provide early insights into the Minister's 2012 Budget Speech.

In an effort to show just how the NHI billions will be spent, the Green Paper provides some preliminary cost estimates. In 2012, 46% of the R125 billion will be spent on 'non AIDS-related services'; 13.70% on 'AIDS-related services'; 33.70% on 'additional services'; only 0.50% on NHI operational costs; and 6% on implementation costs. The 2025 projected cost estimates suggest an increase in 'non-AIDS-related' services (58.40%) and 'AIDS-related'

services (17.50%). This is unfortunately the only breakdown of estimated costs and it is hoped that a more detailed breakdown will be provided once the department starts rolling out the NHI pilot-project in 2012.

Much of the criticism levelled at the funding model is that the South African tax base might just be too small – in 2009 SARS had on record only about 5.9 million individual taxpayers.¹⁶ A large proportion of these registered taxpayers are concentrated in the taxable income bands of R150 000 to R200 000 and R200 000 to R300 000. While the Green Paper does not indicate how individuals will be taxed, a 2010 ANC document on health insurance suggested that a sliding scale be used of 1% (for the lowest band) to 8% for the highest. Using this scale, it is argued that only about R53 billion would have been raised in the 2009 tax year.

However, a tax on individuals is just one of the suggestions to fund the NHI. Mandatory contributions are strongly suggested in the Green Paper, but this may also not be enough. Organisations like the Black Sash have argued that certain groups of individuals should be exempted from mandatory contributions. These individuals would include people receiving social grants, the unemployed, and those who fall below the income

tax threshold. This would inevitably shrink the potential pool of contributors.

Whatever mechanism government employs to fund the shortfall in the NHI, it will most likely be a combination of taxes, mandatory contributions and levies. It must be noted, however, that because government has already budgeted for the NHI, any additional funds will only be needed after the first 5 years of the implementation of the scheme.

5. Conclusion

The implementation of the NHI is the biggest, most ambitious and most significant social policy development since the introduction of social grants. The Green Paper lays a good foundation for addressing a health system that has not responded well to the health challenges of South Africa. Experiences in other countries, such as Australia and the United Kingdom, have pointed to the fact that implementing an NHI will initially be met with opposition, but eventually, with time, the social benefits of such a system will be there for all to see. Let us hope that the experience in South Africa will not be any different.

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¹ Health Minister Aaron Motsoaledi (2011): *Media statement on the release of the Green Paper on National Health Insurance, August 11 2011.*

² Stephen Thomas & Lucy Gibson (2004): *Actor management in the development of health financing reform: Health Insurance in South Africa, 1994-1999.* Health Policy Plan, 19(5), 279-291. Available online at: <http://heapol.oxfordjournals.org/cgi/reprint/19/5/279>

³ WHO (2000): *The World Health Report 2000: Health Systems: improving performance, p13.* Available online at: <http://www.who.int/whr/2000/en/index.html>. The (South African) Report of the National Health Services Commission of 1944 advocated a national health service based on health centres that would integrate curative and preventive work. Parallel with this were plans by the provinces for free hospital treatment.

⁴ Di McIntyre & Alex van Heerden (2007): *Social or National Health Insurance.* Chapter 5 in South African Health Review 2007. Available online at: http://www.hst.org.za/uploads/files/chap5_07.pdf

⁵ Department of Health (2011): *(Green Paper) Policy on National Health Insurance in South Africa. Government Gazette, No. 34523, Vol. 554, 12 August 2011.*

⁶ *ibid*

⁷ Refers to highly specialised tertiary care and it often refers to levels of care that cannot be widely accessed.

⁸ A District Health Authority is to be established with the sole function of doing all the contracting of services for the NHI.

⁹ Department of Health (2011): *Government Gazette No. 34522, Vol. 554, 12 August 2011.*

¹⁰ *ibid*

¹¹ A Draft Bill on establishing the office is awaiting Cabinet approval. The Bill will in all likelihood be introduced to Parliament before it rises at the end of the year.

¹² Mia Malan (2011): *NHI: Behind the proposals.* Mail & Guardian Online, 22 July 2011. Available online at <http://mg.co.za/article/2011-07-22-behind-the-proposals>.

¹³ *ibid*

¹⁴ Preliminary costing estimates are based on a model recommended by the International Labour Office. The model takes into account various variables such as the population size, how frequently different groups use health services and how it may change over time and how much will it cost to provide each type of service.

¹⁵ Minister Motsoaledi (2011): *Health Budget Speech.* May 31, 2011.

¹⁶ Innovative Medicines South Africa (2011): *National Health Insurance Policy Brief 20: The tax base in South Africa.*