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Author: JULIAN LARKIN

Will South Africans really have "free health care"?

COMMENT

JILLIAN LARKIN

ON JUNE 12, the National Assembly passed the National Health Insurance (NHI Bill) aimed at creating universal access to health-care services in South Africa.

The passing of a Bill – especially one that has been mooted for more than a decade – would usually indicate a deep level of familiarity with its implications, benefits and trade-offs. But, in GTC's estimation, South Africa is, unfortunately, light-years away from meeting our health-care objectives, with many more questions than answers – many of which still seem unresolvable.

What we have been told

Let us begin by investigating what South Africans have been told about the NHI. We do this not by unpacking the proposed Bill line for line (which has already been done by others), but by visiting the government's "What is NHI brochure".

This brochure confirms that; there will be no initial taxes imposed to fund the Bill; problems of decrepit infrastructure, staff training and functioning supply systems will be upgraded; maladministration and corruption will be rooted out; and that there will be no difference between the care provided in the public or the private health-care system. This brochure would be attractive to any South African and paints the NHI as utopic for all who require health-care cover. Universal approval for this infrastructure should surely be a foregone conclusion?

The reality is that the South African health-care system – and the provisions within the Bill – requires that we sit up and take note.

The brochure notes that there will be no upfront tax to fund the NHI, which will instead "pool funds that already exist" to cover the initial costs. Once the NHI is up and running, Treasury "may introduce a small tax" to augment this initial pool.

Of course, this is disingenuous. If existing funding was sufficient to cover the costs of the NHI in the first instance, there would be no talk about the combination of public funds and private medical aid contributions to create a funding pool big enough to initiate the launch of NHI. Finding sufficient funds for any substantial portions of the proposed NHI Bill in its current format is not a realistic objective.

The brochure advises South Africans that before the NHI becomes law, the government will focus on preparing the infrastructure for administering the fund to provide services, refurbishing clinics and hospitals, training and employing sufficient qualified staff, and employing suitable systems to improve care and medicine supply, and rooting out maladministration and corruption.

However, the closest existing administrators of anything near the NHI fund of the future are the present-day medical scheme administrators.

They comprise of well-run, efficient systems that effectively collect contributions and pay claims and, additionally, combat fraud, with medical aid administrators employing specialist workforces preventing fraud, for a client base of several million members. The government has shown, alternatively, that they are incapable of providing either administration services or preventing maladministration, fraud and corruption to a base of around 60 million members.

The government confirms in the brochure that the NHI will buy services for all South Africans from providers in the public and private sectors and combine public and private funds, integrated into one system. All providers will form part of this system and get paid from the central fund.

FROM a health-care perspective, reasonable electorate expectations would be the delivery of equitable – realistic – health-care needs, administered in an honest and efficient manner, says the author. | African News Agency (ANA archives)

GTC notes with caution that the brochure further provides for access to treatment at facilities or providers that are not registered with the NHI, though this will be subject to cash payments.

On the face of it, this is simple enough: Visit service providers that are within the NHI net and have these services paid for by the NHI, or pay to see someone else and fund that service yourself. Simplistically, those service providers, specialists, doctors, dentists and hospitals who do not want to form part of the NHI will simply not register for it.

Anyone using these unregistered services would then need to pay cash for these services. We anticipate that this will quickly evolve into a 'product' or 'fund' within a pre-funding mechanism to fund these additional cash payments to providers who fall outside of the NHI net, charging each participating member a premium to buy into this "cash" funding mechanism for unregistered service providers. Sound familiar? It should.

It's effectively how we access private medical care today, with payments pre-funded via privately owned medical schemes, which, in turn, pay for the services which we consume in the private health-care system.

The myriad unknowns

What we have been told about the NHI doesn't begin to address the myriad of questions we might have about how it will work in practice.

Let's consider one very basic element. Will existing providers still be allowed to charge their existing fees? No, not the NHI-registered ones, at least. Will they be required to charge public facility fees, work longer hours and see more patients for less income? The NHI-registered ones will.

Health-care professionals are valued and sought-after in many countries. What are the chances of our service providers remaining in South Africa to work under these restrictive conditions? The anticipated 'brain-drain' will be catastrophic for our health-care system.

We are told that medical aids can continue to exist, but they will provide complimentary services. This indicates that medical aid schemes will have far fewer members and provide far less cover, for lower premiums, of course. For this NHI to work, it is assumed that all current medical aid members will be required to pay over their existing contributions to the NHI Fund – or at least the balance of their existing fee less their new reduced contribution for the lesser benefits.

Of the 60 million South Africans, eight million of them are currently on medical aid. Their medical aid payments are not a burden on the state. Neither are the benefits provided by the private service providers who are funded by these medical aids. The demographics of the eight million medical aid members see them also representing the bulk of the tax-paying public. It is not certain that these same members will accept that they have to redirect their medical aid contribution towards funding the NHI, accepting a diminished level of care and trusting a government administrated system.

An electorate would have expectations of their chosen government delivering clean water, electricity, a decent education and a stable and secure place to live and work.

From a health-care perspective, reasonable electorate expectations would be the delivery of equitable – realistic – health-care needs, administered in an honest and efficient manner.

Given the many 'unknowns' of the Bill in its existing format, from the level and extent of benefit provisions to the confirmation as to whom the service providers will be within the NHI, the biggest threat to the South African public remains the unknown funding requirement for the Bill.

There's a long road ahead

One thing we know for certain is that there is a long way to go before the NHI is passed into law. The actual funding of this elaborate plan remains elusive within the South African economy and our tax budget, and as mentioned earlier, had it been possible, it would surely already have been implemented.

Is the recent passing of the NHI Bill really good business or a last-minute populist election ploy? This answer may well depend on the current state of a reader's health-care provisions.

Larkan is the head: Healthcare Consulting at leading financial