White Paper

The Utopia for South African Healthcare — NHI and Universal Healthcare

Understanding the complexity and impact of the NHI

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Introduction

The Government has been advocating for the National Health Insurance (NHI) and the introduction of Universal Health Care in South Africa since 1994, with more focused efforts to establish NHI commencing in 2003. The government portrays NHI as a potential solution to the challenges in healthcare delivery for underserved populations in the country.

South Africa's healthcare system is currently experiencing problems, according to numerous evaluations of the private and public healthcare sectors. Accessibility issues in the public sector, rising costs of medical aid contributions in the private sector, and a lack of resources are just a few. The consensus appears to be in favour of some reform and change.

The NHI Bill aims to guarantee equal access to healthcare services. The Bill outlines mandates, responsibilities, and organisational structure of the NHI fund. For all individuals who register with the Fund, the Fund will purchase healthcare services from the private sector to fill the gap of available services in the public sector.

The NHI Bill outlines the establishment of measures to ensure the resources of the fund are used fairly, effectively, and efficiently to satisfy the population's health needs. Further measures must be taken to prevent or restrict unwanted, immoral, and illegal practises in connection with the NHI Fund. The NHI Bill also aims to remove obstacles to access and support resource development.

The current South Africa healthcare system is a 2-tier system with a private sector that provides private healthcare to 14.9% of insured members who can afford private insurance and a public health system providing care for the remaining 85.1% of the population.

The large burden on the State to provide healthcare to most of the population and ensure universal healthcare, has been the biggest drive for reform.

There have been many objections from the current private sector stakeholders in relation to the reform. Private sector stakeholders claim that the government seeks to undermine a successful private healthcare system. The concern is that disruption of the private market will not alleviate the State burden but add to it, by adding an additional ~9 million lives.

It is untrue that the privatised healthcare system is an effective one. To begin with, a health system cannot be regarded to be effective if it only benefits a small portion (14.9%) of the population. In the 2020[1] Board of Healthcare Funders (BHF) journal publication reviewing out of pocket spend (OOP) for insured members were showed that the overall OOP incurred increased by 7.9% from 2013 to 2019, which constitutes 18.1% of the total amount claimed.

The intention of medical aid in South Africa was to ensure that members receive healthcare through the cross-subsidization of funds. Current insurance offerings provide benefit options structured based on member contributions, which do not cross-subsidize across the entire fund's population, but only within the specific benefit options population.

Higher contributions are aligned with broader access and more substantial benefits. Benefit options can be described as a 3-tier (high, medium, and low options) offering of benefits in breadth and depth.

Benefits provided to lower options are limited to Prescribed Minimum Benefit (PMB) treatment as per the regulations defined in the Medical Schemes act for acute care. There may be limited or no coverage for day-to-day care, such as dental and ophthalmology benefits.

The cost of private healthcare is spiraling out of control, leading to medical aid premiums increasing at a rate faster than the Consumer Price Index (CPIX) (See Figure 1). However, patient benefits fail to keep pace with the rising costs of medications and innovative technologies. As an example, joint replacement cost is an average of ZAR 40,000 per prosthesis[2], however, patients benefits often do no provide full cover for this cost due to benefit tiering across options.

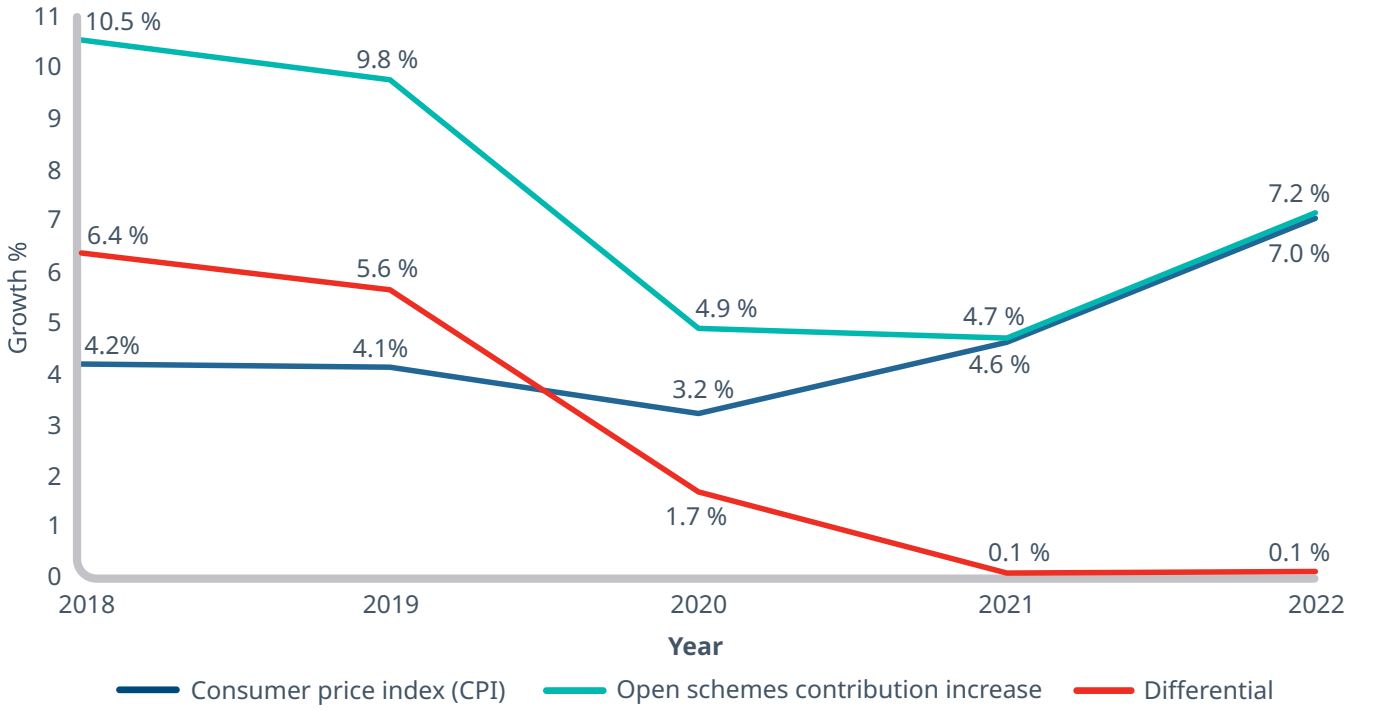
For the first time post COVID-19 and after an in-depth review of the private health insurance, we are seeing a decrease in the average annual contribution increases within the open insurance market. This could largely be attributed to the decrease in healthcare expenses during the pandemic with less planned surgical procedures and trauma related to motor vehicle accidents due to lock-down regulations.

The expectation is that the inflation on private medical aid contributions will return to what it was pre-pandemic and going forward start increasing again. It is estimated that if nothing is done to preserve households' finances (see Figure 2), middle-class households will spend a third of their income on health insurance premiums by 2030.

From as early as June to the end of the year, most medical aid members exhaust their out of hospital benefits and are no longer covered for primary care events. You cannot therefore, claim that a system is working well when it doesn't always provide complete coverage to its members and may lead to increased out-of-pocket expenses.

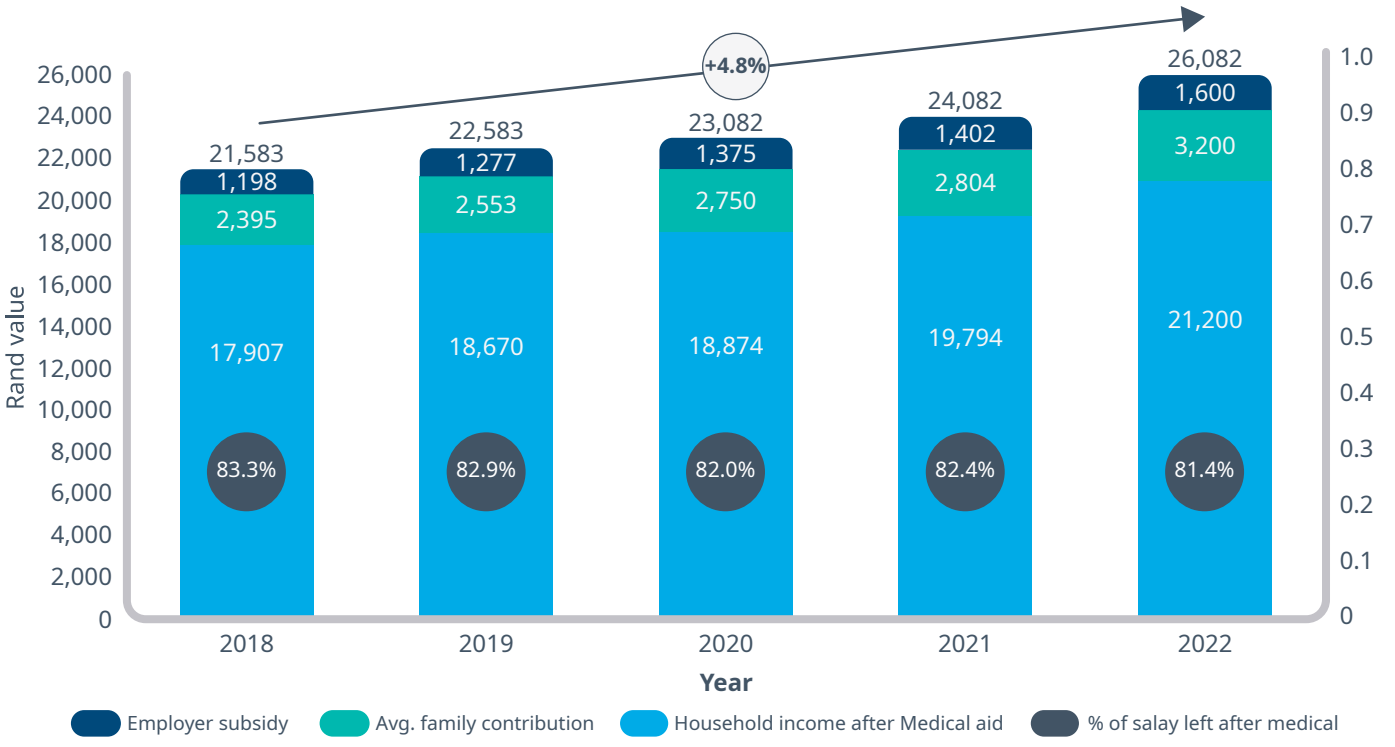
[1] Published by the 2020 BHF Southern African Health Journal.
[2] Costing total hip arthroplasty in a South African state tertiary hospital published in SAMJ in 2021 March vol.111 described mean cost of prosthesis.

Figure 1: CPI compared to medical aid contribution increases[3]



Source: Average contribution review Bestmed 2023; Counsel for Medical Schemes Circular 52 of 2020: Guidance on benefit changes and contribution increases for 2021

Figure 2: Average household income growth MAT 2018-2022



Source: Data published by The University of Cape Town's Liberty Institute of Strategic Marketing 2023 FEB; World bank data; Bestmed Medical Scheme contribution review open scheme average, CMS reports Annexures 2018-2023

[3] Top 6 schemes weighted average contribution increases as per Bestmed publication (Discovery, Bonitos, Momentum, Bestmed, Medihelp, Medshield)

NHI: THE JOURNEY THIS FAR

Since 1994, the government has faced challenges in achieving significant improvements in healthcare in South Africa. This is the sentiment of many South Africans including the 1,322 individuals who are laying malpractice complaints against the government amounting to ZAR13 Bn for 2021-2022 alone (as per Foster Mohale National department spokesperson to the Sunday independent).

These persisting challenges in the current ability to deliver healthcare of higher standards makes it essential to reform the healthcare system. The objective must always be to ensure better quality of care and health outcomes aligned to citizens expectations.

After passing parliamentary approval the NHI bill is now in review with the National Council of Provinces (NCOP). Once the bill is finalised and approved by the NCOP the decisive step will be for the President to approve it and sign it into law. The passage of the NHI bill then marks the end of the parliamentary process. The timeline of this process is not clear but as elections are looming in 2024, it is anticipated that this will happen soon to ensure the promises of previous elections are kept.

The government and NDoH will then need to overcome the obstacles that stand in the way of the full implementation. There has already been mention of several challenges in the pilot project review report of 2019. These challenges include human resources, financial management and infrastructure improvement. There will also be an urgency to improve record keeping and make advance technology upgrades faster.

Amid all this, there is also ongoing legal battles from industry stakeholders in relation to the new bill. All of these aspects must be addressed during the implementation of the NHI to ensure the success of the new universal healthcare model.

The consensus is that the full implementation of the NHI bill will not be realised before 2030.

1994

1994: Healthcare Finance Committee
- The Healthcare Finance Committee recommended the GEMS medical aid with a view to expanding coverage to other groups over time

1997

1997: The Social Health Insurance Working Group
- The working group developed the enactment of the Medical Schemes Act 1998, the focus was better governance of medical schemes

2002

2002: Committee of Inquiry into a Comprehensive Social Security for South Africa
- The Committee recommended that the State should create a national health fund through which resources should be channelled to public facilities

2009

2009: Advisory Committee on NHI
- The committee was to provide recommendations on reforms and matters relating to the design and roll-out of the NHI

2011-2017

2011-2017: NDOH policy paper and NHI pilot projects
- The Minister of Health at the time estimated the pilot project to be implemented in 3 phases and will take 15 years. The initial pilot roll-out initiatives did not provide overall positive results and highlighted lack of funding and human resources

2015-2018

2015-2018: NDOH and advisory committee
- During this period, we saw the full White Paper and then subsequently the draft NHI bill being published and comments from industry to follow
- Public hearings were conducted across the country

2019

2019: Introduction of the NHI bill before Parliament
- Stakeholders and interested parties could now provide further comment to the portfolio committee
- During this time the COVID-19 pandemic impacted the review and process was eventually completed in 2023

2023

2023: NHI Parliamentary approval
- The bill was passed in parliament on 14th June and is now going forward for review with the National Council of Provinces (NCOP)

*Government Employee Medical; Scheme (GEMS)

*Foster Mohale National department spokesperson to the Sunday independent Published Sep 21, 2022

What to expect for the future

The future holds some positive prospects in the execution of the NHI bill and the reform planned for the healthcare system. It is however, difficult for some non-believers to envision the implementation of the NHI as there remains some mistrust in the government with regards to management of funds and institutional governance of public entities. The examples put forward to support this sentiment include the recent deteriorating situations of Eskom (the Electricity Supply Commission) and SAA (South African Airways), both of which are facing severe financial and operational crises.

The NHI Fund will be predominantly funded by incorporating funds from the current healthcare budget, GEMS (Government employee medical scheme) member subsidies and tax breaks that were previously paid towards private insured individuals will now be paid towards the fund. Mandatory contribution for all individuals belonging to the fund will be incorporated into the pool of funding that will support the NHI fund (compulsory participation for every employed individual person).

The vision is that the fund will need an annual estimated budget of ZAR500Bn for the 2025 planned implementation. Several economic reviews have deemed this projected budget to be trivial, especially when considering the need to enhance service delivery in various areas to achieve the goal of universal access.

The first actions will involve upgrading and establishing advanced digital technology and infrastructure to support the health system transformation for NHI.

The digital health priorities outlined by the Ministry of Health in 2019 include:

- Development of a complete health electronic record which will improve patient management (Not yet finalised)
- Digitisation of the health system's business processes to ensure aspects of the healthcare delivery improve, such as human resource, medicine access etc. (Not started)
- Establishment of an integrated platform and architecture for the health sector information system which will also ensure interoperability and linkage of existing patient-based information system. (Not started due to the ongoing dispute with the private sector, as it is seen as conflicting with the POPI Act)
- Development of digital health knowledge workers working to support digital health in support of creating employment (Not started)

Furthermore, the NDoH has been working to revise treatment protocols and guidelines to guarantee that future services satisfy basic standards for medical care. The NDoH will routinely examine and amend the existing protocols of various health benefit packages and service benefits under the NHI. All services that the NDoH is unable to deliver in accordance with the new service requirements will be purchased through the NHI fund, which will primarily include the private sector services.

[4] Estimates of National Expenditure published by National treasury 2022.

HTA reviews will become an essential tool for the NDoH to ensure medicine and technologies are reviewed fairly and scientifically for inclusion or exclusion as treatment options. A formal review will have to be completed before any additions are made to existing services packages and the essential medicine list (EML). The format and cost of these reviews are still unclear and how it will impact technologies and treatments which are now widely used in the private sector and are not included in the current standard service packages.

The EML committee (NEMLC) has been tasked by the ministry of health to review and align the current EML to the WHO list. The current EML has many gaps in the treatments that are not aligned to the WHO essential medicine list.

Reform is also on the way in the form of the Public Procurement Bill. Currently before the National Assembly, the bill has the potential to streamline and consolidate the legislative landscape governing public procurement to curb corruption, promote transparency and ensure better utilisation of public funds in the health sector. It is not completely clear from the NHI bill in its current state as to how the tenders and procurement process will be done in future, however there is expected to be a change from what is currently the process to ensure risk of corruption is limited.

The current healthcare system has been challenged since 1998 by staff shortages and challenges to fill the national deficit of doctors and nurses. The situation today is even worse as the system of educating healthcare professionals was mainly left to the department of education. A large exodus of healthcare workers in the past 6 months is also an indication that doctors and nurses are not supporting the limitations of their autonomy under the NHI.

The other factor is that the cost of human resources under the current budget is an average of 68% of the total healthcare budget. There has been a considerable proportion of positions not filled as the current budgets cannot sustain the resource demands. If more professionals are trained and available, where will the budget come from to pay their salaries?

What will happen in the private sector?

Medical aid programmes may only provide coverage for services that are not covered by the NHI Fund after the NHI Fund has been completely established. More than 9 million people who are currently covered by commercial medical aid insurances, will consequently fall under the state's fiscal responsibility. The challenge for the members who are now insured is that tax payments to support NHI will be mandatory. The medical insurance will be unaffordable for most members if no subsidies are made from the employers. It is envisioned that employers will no longer support individuals on monthly contributions under the new NHI system.

Single exit price changes:

Where previously the single exit price applied, the Medicines Act will have to be reviewed. The proposed amendment to the Medicines and Related Substances Act (Act 101 of 1965), which currently regulates pharmaceutical prices in the private sector, is expected to have a substantial impact on how the medicines are acquired and distributed. Single exit price (SEP) was defined in section 22G of that act as being the "only price at which manufacturers shall sell medicines and scheduled substances to any person other than the State". This would be amended to read "to the National Health Insurance Fund .... or any other person" in the amendment that is in progress to align to NHI bill.

In the current pricing legislation, the pricing in the private sector is significantly higher than the prices offered to the government through the tender process. This is predominantly due to the volumes that are included in the tender bid. Manufacturers therefore, must balance their profits between the private and public sales generated and often make most of their profit in the private sector. Under the NHI, the NHI fund will take on the primary role of procuring medicines, significantly reducing the sales currently generated in the private sector. How manufacturers will continue to be able to balance their profits will impact the price offered to the NHI fund as the primary procurer of medicine.

The second anticipated change involves logistic fees currently allowed under SEP legislation as part of the prices constructed for the private sector. Under the NHI system, these logistic fees will shift, and they will be paid to the NHI fund for its operations.

Distribution of medicine will be contracted by either the NHI fund or the individual provinces to ensure medicines are available to the members of the NHI fund.

The current dispensing fee allowed under the medicine price legislation will remain, however the vision is that the total cost of scripts will be less under the NHI and therefore, the dispensing fee earnings for pharmacists will decrease in relation.

Additional legislative reviews to be completed prior to NHI implementation.

Many experts believe it can take up to 15 years, if not longer, to successfully implement NHI.

From a legislative perspective, amending no fewer than eleven pieces of legislation to bring them into compliance with NHI objectives will be a laborious task.

These comprise of the following:

- Medical Schemes Act,
- Nursing Act,
- Occupational Diseases in Mines and Works Act,
- Mental Health Care Act,
- National Health Act,
- Health Professions Act,
- Traditional Health Practitioners Act,
- Allied Health Professions Act,
- Dental Technicians Act,
- Medicines and Related Substances Act,
- and several Provincial Health Acts

It is also imperative that we take the learnings from other national health systems and their successes as well as challenges into consideration. The NDoH have been reviewing several examples of other health systems to understand what successes they can incorporate into the planned reform. There are many examples that can identify pitfalls and gaps that will hopefully be prevented in the roll-out of the new universal healthcare plans for South Africa.

What can we learn from other National Health Systems

The National Department of Health throughout the past 20 years have gathered insights from across the globe to inform best practices and incorporate ideas into what we now know as South African Healthcare reform program.

Evaluating two of these markets is key to provide us with insights and context regarding the prospects for South African healthcare in the future.

Taiwan's and the United Kingdom's NHS represent key examples of the future NHI one fund vision. In review of these healthcare systems, we could gain insights on how the future system in South Africa might evolve and what future challenges might arise.

Taiwan National Health system

Taiwan's national health system (established in 1995) is ranked in the top 10 health systems worldwide in 2023. The system is structured as a single payer system that provides healthcare to the members of the fund.

As a single payer, Taiwan's NHIA can be conceptualized as a monopsony purchaser of health services and is aligned to the vision of the proposed NHI fund model for South Africa. Taiwan's NHIA covers over 97% of its population with a comprehensive benefits package that provides the same set of health service coverage to all citizens by contracting with 93% of all providers.

The size of contributions per individual differs based on income and the government funds premiums for vulnerable patient groups. Private employed individuals contribute 30% of premium payments, with their employers contributing 60% and central government the remaining 10%. Public sector employees such as civil servants and public office holders also contribute 30%, with their employers funding 70%.

Hospitals, doctors, and clinics are mostly private and are paid by the fund to service the population. Members of the fund who have a National Health fund card can select the HCP services they want to access. Specialist services are reserved through a referral process via primary healthcare.

The access to primary care is good with low waiting time. The challenge is however, that consultation times are short and often this result in diagnosis being missed and referrals not taking place.

There is a national database that provides access to all records and allows for planning and budgeting. The current review of the Taiwan system shows that the fund can manage budgeting and curb health costs through better planning and prediction because of the scale of health data available.

Annual medicine price review is mandatory for all medicines sold under the NHIA. This is a complex process and methodology but ensures all medicines are reviewed and price cuts for medicine can be mandated according to the scale outlined in price regulation. The result of the medicine evaluation process ensures the inflation on medicine remain low and is predicted to be ~3% in 2022 even with introduction of new advanced treatments.

In South Africa there is still no central database of health records and health services available and this makes the accuracy and prediction of the required budget for the NHI fund impossible at this time.

In Taiwan, there are some concerns from members of the fund regarding the quality of care they receive, which is associated with the fund's emphasis on cost-cutting. Patients often receive sub-standard treatments (consultation average is deemed to be 5 mins) and medicines as HCPs try to increase profits by using cheaper alternatives.

The low-cost approach often results in revisits and poor primary healthcare outcomes that puts strain on the specialist care due to a higher referral rate. There are also high co-pays associated with most care that result in members of the fund still paying an average one third of cost out of pocket. Healthcare outcomes in Taiwan is therefore, still not aligned to first world outcomes. Many citizens are now procuring private insurance to fill the gap in treatment.

In South Africa, most of the population is already exposed to limited access and low-cost services. If service levels deteriorate further in future, it will impact overall health outcomes.

[5] https://www.statista.com/statistics/1376359/health-and-health-system-ranking-of-countries-worldwide/

Key learnings from the Taiwan system will be to ensure primary healthcare standards are upheld. This will prevent a huge overflow to specialist facilities and hospital care and will impact the patient outcomes and put undue financial strain on the NHI fund budget for specialist care.

In Taiwan, the system is also suffering from overservicing, and fraudulent claims being generated, resulting in a substantial proportion of the budget lost to these practices. It is crucial to design mechanisms and clear protocols to ensure such waste is eliminated.

NHS United Kingdom

In the United Kingdom, there was an early realisation that healthcare delivery will be a challenge in the future. This brought the establishment of the National Health System (NHS) 75 years ago. The objective of the system was to pool funds from different resources to procure healthcare services for the population. Today the fund is predominantly funded through tax and insurance contributions.

The NHS fund is the largest employer in the UK and one of the largest employers globally. The NHS employ an average of 1.2 million full-time employees as reported by the Kings fund in 2022. The salaries and wages associated with this large staff component amounts to ~45% of the total NHS budget.

In South Africa, the planned reform, and the establishment of a NHI fund makes no mention of what the total budget for human resources will be. There is no mention of the cost of healthcare professionals and the estimated cost for administration of the NHI fund in South Africa.

From latest news and reviews, there are a lot of concerns surrounding the delivery of services in the UK through the NHS. The total number of hospital beds has decreased by 50% over the last 30 years as per the Kings fund review 2021. The result of this is long waiting lists for planned surgeries and procedures. The average time to wait for such planned surgeries is 18 weeks. The average waiting time for A&E emergency department in the UK is ~3 hours.

Waiting times for hospital admission are impacted as elderly patients cannot be discharged from hospital due to a lack of community social services and care workers (social worker is 1:540 of the population). There has also been more investment into providing homecare for patients and the elderly as the system has identified a total of 500 000 patients that need homecare services in 2022. Additional budget will have to be applied to ensure the homecare services are developed and optimised to address the social needs.

[6] TheKingFund review of the number of hospital beds - Thursday 23 March 2023

In South Africa, we have even bigger challenges with social services and infrastructure. In 2022, there were 60,000 qualified social workers, of these 44,000 are in practice, the ratio of 1:1300 average being far lower than that of the UK.

With limited social and community care workers and most of these care workers burdened with caring for patients affected by HIV in our communities, there will have to be a renewed focus on this aspect under the NHI.

The NHS has an advanced HTA body, The National Institute for Health and Care Excellence (NICE), with years of experience on balanced reviews of innovative technologies, creating a scientific base for estimating demand and budget impact of new medicine and technologies. The price management and payback system also allow for medicine inflation to stay low and not escalate beyond the cap of 2% set by the NHS. The South African expertise in this field is still lacking and will have to be developed to ensure balanced and fair inclusion or exclusion of technologies based on scientific reviews.

Due to limited healthcare services and long waiting list in the UK, there has been a growth in the private insurance sector in the past 5 years. Private insurance is becoming more attractive for patients in the UK, who identify the lack of services, access to high-level care, long waiting lists and limited access to innovative treatments. Twenty-two percent of the population belongs to private healthcare and make use of private care. It is however, envisioned that an improvement in the NHS levels of service will result in a deceleration of this growth in the coming years.

In South Africa, the question arises: Why attempt to reduce the privately insured population when there is evidence from systems like the NHS that private insurance can help support the system and alleviate the burden?

Conclusion

For several years, South Africa has been on the verge of a significant overhaul of its healthcare system. Since the initial health-related white paper was published in 1997, many of the guiding ideas behind the effort to establish a national health system have not changed. The fact that changes undertaken during the NHI pilot project phase were so difficult and challenging to put into place, is evidence not just of the magnitude of the task but also the extent of the needs of South Africans.

It is imperative that reform procedures and efforts be synchronised considering the NHI Bill's introduction and the five-year Health Market Inquiry's conclusions, particularly regarding the gradual modifications both sets of proposals envisioned.

A successful implementation of the NHI and all its components are paradigm to ensure the future of healthcare aligns to the vision of universal healthcare, the success depends equally on public and private sector.

Services that will in future be procured through the NHI fund from the current private sector will have to be quality services across the total population to ensure better health outcomes become a reality for South Africans.

Keeping informed and abreast of changes will be key for stakeholders to ensure all efforts continue to keep the public's interest as a top priority throughout the implementation period of the NHI fund.

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