NHI 14 October 2019

The tabling of the National Health Insurance (NHI) Bill in Parliament during August has generated a fair amount of hysteria – most of it not connected to what the Bill actually said. Some clarity on what the Bill says and does not say, can be useful.

Skeleton Framework

The NHI Bill sets the skimpiest of frameworks – a skeleton really; a lot will still have to be attached to give it substance. Take for example that most important element: which medical services will be covered? Not a single benefit is stated in the Bill. Benefits must still be determined by a "Benefits Advisory Committee" to be established in terms of the Bill.

One then wonders how people can make pronouncements on what NHI will cost if they do not even know what NHI will cover…? Funny how emotion can drive out common sense.

Nevertheless, from the skeleton Bill we can draw some observations on what is likely to follow.

Private Sector Will Continue

The key point about NHI is that it will buy services from approved service providers, both public and private. The NHI Fund will pay the service providers and the patients will not have to make a co-payment. To become a provider, minimum standards must be met, also by the public sector. Following the Presidential Health Summit, a major drive is now on the go to improve public facilities and capacity, precisely to prepare them for NHI.

There is no compulsion in the Bill that health professionals and hospitals must register with the NHI and must work for it. Should a practitioner decide not to register with the NHI, they will simply not be a NHI service provider. The suggestions that all doctors will have to work for the NHI and that they will not continue in private practice, is simply not in the Bill.

Obviously, doctors and hospitals who treat NHI patients will only perform procedures and charge rates approved by the Fund. This raises the fear that doctors will be paid so little they will have to emigrate to make a living. Reality is that if rates are unrealistically low, service providers will simply not participate in the NHI at all or make up for the lower fees with higher volumes. The NHI Bill does not suspend the laws of supply and demand.

For example, the explanatory memorandum to the Bill makes it clear that private primary health care providers will be drawn in to improve access to health services "especially in under-served rural and informal urban areas". Clearly tariffs will have to be set at a rate which will entice private providers in. The private medical sector will continue to exist, and doctors will not become destitute.

Benefits

As noted above, there is no detail yet on what benefits the NHI will cover. But there are clues.

The explanatory memorandum accompanying the Bill states that primary health care "is the foundation upon which the health system will be based". The Bill defines primary health as "… in the public health sector the clinic, and in the private health sector the general practitioner, primary care nursing professional, primary care dental professional and primary allied health professional(s)…" It further makes it clear that health promotion and disease prevention will be prioritised.

Clause 57 of the Bill states that the NHI will be implemented in six phases. The 6th and last phase will entail "… gradually increasing the range of services to which there is a benefit entitlement". Clearly, the NHI – even in phase 6 – will not be a big bang with the full range of services currently covered by medical schemes.

Benefits are inextricably linked to money available, so let's look at that.

Benefits will Follow the Money

This year public health spending in South Africa is budgeted to be R222 billion. R2,5 billion is earmarked for NHI,

rising to R3,1 billion next year. Most of this money has been re-prioritised (i.e. cut from other expenditures). Clearly R2,5 billion and R3,1 billion are modest provisions in the context of the Health budget. Where will more money come from?

The explanatory memorandum states that the Fund will "bid for funds though the main budget as part of the budget process." The NHI will thus have to compete with all the other priorities the state faces: education, security, Eskom ... It also says that "in a favourable economic environment there will be an initiation of an evaluation of new taxation options…". So, a special tax to help fund the NHI is linked to an economic turnaround. Even then the benefits will be limited to what the tax take can pay for.

The common-sense conclusion is that spending on the NHI will follow the money. Economics and re-prioritisation will determine the benefits available under NHI. That should put the cost fears to bed; but will probably also generate some disappointment about the extent of the cover the NHI will provide, at least initially.

Medical Schemes

Four regulatory forces are shaping the medical scheme environment. They are the NHI Bill (and complementary legislation), the Competition Commission's health enquiry, prescribed minimum benefits and the tax subsidy that medical scheme members currently enjoy on their membership fees.

NHI Bill

One of the most contentious clauses in the Bill is clause 33 which states that "once NHI has been fully implemented" medical schemes can only offer cover for services not covered by the NHI. With the emphasis on primary health care and a six-phase implementation for NHI, we are very far away from the NHI being "fully implemented". Medical schemes will be around for a long time and will continue after NHI for those procedures not covered by NHI. However, expect a strong pushback on clause 33.

In principle any system that is based on denying people choice, on preventing/delaying innovation and on protecting one player only, is bound to fail in the long run. Those three things – choice, innovation and competition – constitute the lifeblood of organic growth and renewal. It is very early days for the NHI, and it will have to grow organically into its proper shape and operation. Lack of choice, innovation and competition will undermine such evolution.

Apart from the philosophical, there are also formidable political and legal arguments against the curtailment of medical schemes, hence the prediction of a strong pushback.

Competition Commission Report

The Competition Commission's enquiry into the health industry recommends, inter alia, that risk equalisation should be implemented between medical schemes. Funds with healthier and younger members should subsidise funds with older and sicker members. It is a long-standing recommendation and if accepted, will strengthen the medical scheme industry overall.

Prescribed Minimum Benefits (PMBS)

The biggest expense of medical schemes (around 68%) is for some 270 prescribed minimum benefits. Those benefits have been under review for a while now and the introduction of NHI opens the possibility that the PMBs can be restructured. If a more basic package is prescribed in line with the primary health care and preventative approach of the NHI, it will strengthen medical schemes and could even make them more affordable.

Tax Subsidy

The Health Department wants to scrap the tax subsidy which tax-paying medical scheme members currently enjoy. Three years ago, in 2016/17 this already amounted to R27 billion. The Health Department wants that money to be diverted into the National Health Fund. The way the tax credit works, the cost of scrapping that R27 billion benefit will fall predominantly on the middle classes – think teachers, police officers, mid-level hotel and retail staff, civil servants…

A marvellous new book Black Tax: Burden or Ubuntu? edited by Niq Mhlongo, casts light on the financial pressures that new black middleclass members face. Good luck trying to pile more pressure on them.

The final decision will be Treasury's, not the Health Department's. So far Treasury has committed to increase the medical scheme tax credits by less than inflation for three years to release funds for NHI. This year there was no

adjustment for inflation in the credit and that harvested R1 billion extra income, which was re-prioritised to the NHI.

So What?

- Much detail remains to be settled before we have a clear picture of what NHI in South Africa will mean, what it will cost and how it will affect everybody.
- What the NHI essentially does is enable public sector patients to use private facilities in NHI-prescribed cases; while public sector facilities will have to up their standard of service to be accepted as service providers.
- It is clear from the numbers that a fully-fledged NHI is many years away and will be materially dependent on the tax cake getting bigger.
- The private medical sector will continue.
- Medical scheme will continue to exist, but clause 33 of the Bill (and other legislation) can curtail their offering. This will be a heavily challenged area of the Bill.

PS: In the previous Newsletter, which dealt with the clean-up of the state and was labelled Act 1, I promised an Act 2 on the economy. We are awaiting the announcements on the IRP, Eskom and the mini-budget and will then compile Act 2.