NATIONAL HEALTH INSURANCE

The gap between reality and a coherent public purpose in the National health Insurance (NHI) proposals are best illustrated by Olive Shisana's (responsible for the ANC NHI process) recent comment, that no "*need exists for a Risk Equalisation Fund (REF) for medical schemes as there will be a single payer NHI*".

However, for Shisana's comment to make any sense it would imply that a single payer for everyone is envisaged sometime soon and would be sufficiently large to render medical schemes irrelevant.

Conversely, were it to take many years to materialise it would be rational and reasonable for government to introduce the REF to protect vulnerable groups from medical scheme risk rating in the meantime as recommended by inter-*alia* the World Health Organisation (WHO) which states that "*Policy-makers should ensure at an early stage that organizational mechanisms – known as risk equalisation measures – are in place to allow funds to be transferred from schemes with relatively low risk exposure to those at greater risk*."

The question is, therefore, how feasible is Shisana's proposal?

International precedent:

Internationally there is no developing country health system remotely similar to that proposed by Shisana. The focus instead is on the achievement of universal coverage through a pragmatic mix of mechanisms.

A WHO policy brief for developing countries states for instance that it is "*quite common for countries to have a mixed financing system, with specified groups covered by health insurance and the remainder of the population by general taxes. In almost all systems, individuals or households are still required to make some out-of-pocket payments…*"

Industrialised countries provide the only example of systems approximating a single payer solution. However, the predominant NHI model involves regulated medical schemes and mixed system arrangements.

Financial feasibility:

Existing public sector service providers:

As private health professionals will not agree to any reimbursement structure reducing their existing levels of remuneration, theirs will be the default remuneration norm for all health professionals. As the proposed NHI includes all private providers, existing public sector doctors and specialists will naturally migrate to the highest paying “accredited” service resulting in an additional annual expense of R14 billion, without expanding a single service.

The NHIA:

The proposed NHIA envisages a vast organisation with national, provincial, and district structures. Functions include: enrolling the entire population and issuing them with membership cards; accrediting and overseeing every single private and public provider; managing the enrolment of the entire population with every single public and private health care provider; reimbursing every health provider based on enrolled members; reimbursing private and public hospitals; determining healthcare referral arrangements; negotiating all prices and reimbursement rates; and managing and avoiding fraud. As proposed it would manage funds in excess of R200 billion per annum outside of the jurisdiction of National Treasury.

Presently the South African Social Security Agency (SASSA) which has a similar configuration, but with more straightforward functions, has administration expenditure equivalent to 8% of turnover. Extrapolating this minimum administration cost onto the NHIA would result in an expense of R16 billion per annum (at the low estimate of R200 billion turnover per annum) which would have to be up and running before extending a single service.

It can furthermore be predicted with some certainty that the proposed model, which involves political appointments to the NHIA, will dramatically increase the costs and inefficiency involved in running the organisation. All the best run health systems de-politicise the operational management and oversight of their health systems.

Public health priorities:

The Health Roadmap process co-ordinated by the Development Bank of South Africa estimated that recurrent budget improvements amounting to around R43.5 billion (using the latest figures) are needed to fund existing staff shortfalls, the antiretroviral programme, improved capital expenditure, district administration, quality assurance arrangements, and information systems.

The Financial and Fiscal Commission has estimated that an additional R50 billion per annum, grown over a period of 15 to 20 years, is required to get public hospital services to a target benchmark service level.

Focusing entirely on the priority needs of existing public sector users would therefore require an additional recurrent allocation of R93.5 billion unrelated to any NHI proposals.

Bringing medical scheme members into the NHI:

Attracting medical scheme beneficiaries into the public system would at a minimum require that government pay the existing cost for all private providers serving medical schemes amounting to R75 billion per annum.

To eliminate the pressure to opt out, due to the substantially diminished entitlement through the NHI, it is estimated that additional services over-and-above the full cost of the existing private system, amounting to roughly R77 billion per annum, is required. This would provide additional private providers at the same norm and standard as medical scheme members to the non-medical scheme population assuming a 20% efficiency cost saving. It also assumes an additional R10 billion per annum for hospital services.

Total cost of NHI:

Total annual expenditure required amounts to approximately R358 billion per annum (roughly similar to the estimates of Profs. Servaas vd Berg and Heather McLeod when the NHIA and antiretroviral costs are included) or 15.7% of Gross Domestic product (GDP) and require a payroll tax of 54.7%. This estimate incorporates efficiency improvements and the complete elimination of private medical scheme administrators, brokers, and managed care companies. Of this amount R127 billion includes health service providers that do not exist in South Africa.

Is there a short-cut?

Government could try to just buy up all existing private sector services by increasing taxes to the value of existing private sector health service reimbursement, ignoring the interests of medical scheme beneficiaries, supply constraints, and public health priorities. Simplistically, this would cost R187 billion or 8.7% of GDP and require a

payroll tax of 20.8% from existing taxpayers. However, such an approach would run into the following difficulties:

- The R30 billion associated with establishing an NHIA and a universal entitlement (the increased public sector costs) would have to be spent regardless.
- The R15 billion in additional financing required for antiretroviral would still have to be funded.
- Given the inadequacy of the resulting universal entitlement, particularly in the case of hospital services, medical scheme members would drive up the costs of the entire NHI by competing for the private providers.

Even this short-cut would cost R202 billion excluding the cost increases required to bid for private providers. This implies a payroll tax of 23.8% from existing taxpayers and require everyone earning more than R400,000 per annum pay tax rates of between 50% and 63%. If progressive the rates would be between 60% and 85%.

Were government to outlaw private insurance or out-of-pocket payments for private health services to avoid competition, they would invariably be defeated in the courts based on both international and domestic legal precedents. Importantly, whereas private purchasers only need to pay the enhanced price of a limited number of providers, the NHI has to extrapolate the highest bid price of the marginal provider to all its providers.

Based on the complete absence of international precedent, the vast expense involved, the excessive taxes involved, and the questionable institutional model, the possibility of the proposed single payer solution is implausible even as a long-term option.

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