Rands and sense: Why the National Health Insurance may lead to better health budgets

By Natasha Salant

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About 200m from where I work in Rosebank, Johannesburg, there is a private clinic housing a general practitioner, a team of specialised surgeons, a rehabilitation centre, and state-of-the-art imaging and radiology technology.

Photo: Bhekisisa Centre for Health Journalism

If I needed medical attention, I could seek it quickly — so long as I was able to pay upfront.

If I were among the 17% of the country's population that Statistics South Africa's 2016 household survey says is covered by a medical scheme, I might be able to claim back part of my upfront payment from my medical aid, depending on the type of cover I had.

Nine hundred kilometres from where I work, and 26km away from the nearest tarred road, lies a public healthcare facility. The people of this underserved rural district, where the hospital is situated, are dissuaded from travelling to it on the rough gravel.

So are emergency vehicles.

At one stage, the hospital's dire scarcity of doctors made it close to impossible for pregnant women to safely undergo emergency C-sections.

It's unjust that access to quality healthcare services in South Africa depends so heavily on how much you earn and where you live.

The Constitution is clear: access to quality healthcare is a right, not a privilege. Section 27 of the Constitution obliges the government to use its resources to progressively realise this right.

The state has made some progress in this regard — but amidst fierce criticism.

In June 2017, Health Minister Aaron Motsoaledi published the country's Health Insurance (NHI) White Paper, which will form the foundation for the soon-to-be released NHI Bill.

The NHI will pool funds to make basic healthcare services free at the point of delivery for everyone, regardless of their income.

But the NHI has been met with disapproval and serious concerns from many sectors — from its affordability to doubts about the ability of the country's public health system to deliver such a scheme.

Although many of the concerns about the scheme's implementation are valid, there are also those organisations and individuals who have slammed the mere concept of universal access to healthcare.

If we are among those who benefit from private healthcare, and our health and livelihoods are not threatened by the fragmented public system, we ought to be honest about the reasons we are bothered by the upcoming Bill.

Is it because we are uncomfortable with the dubiousness of the policy, or is it because we are too comfortable with the status quo? If it is the latter, are our positions of comfort shaken when we understand that the status quo remains apartheid's most loyal accomplice?

Achieving universal access to healthcare — in which everyone has access to the same level of healthcare, regardless of their income — is one of the Nations' Sustainable Development Goals (SDGs).

SDGs are targets that member states, including South Africa, are expected to use to frame their agendas and political policies over the next 12 years.
Universal health coverage has gained momentum in developing countries.

In Thailand, for instance, the universal coverage scheme (UCS) was rolled out in 2001. By 2002, 98% of the population was covered, and had access to a comprehensive healthcare benefits package, according to 2009 research into the scheme published in book form by Emerald Group Publishing.

Before the country's universal coverage scheme, out-of-pocket health spending was a considerable driver of poverty in Thailand, and two-thirds of infant deaths were caused by diseases that could easily have been prevented had healthcare services been affordable to all.

South Africa's NHI is modelled in part on the Southeast Asian country's successful universal healthcare programme.

There are two kinds of reforms that the policy proposes to make to our health system: Firstly, the [http://serve.mg.co.za/content/documents/2017/06/29/whitepaper-nhi-2017compressed.pdf [White Paper]] proposes a new financing system that will pool funds from all healthcare users and provide access to services by need rather than how much someone can pay. Secondly, it commits to massively reorganising the current healthcare system to address inefficiencies in governance and management.

There is considerable work to be done.

The relationship between poverty and poor health is simple: poor people have less access to care, but fall sick more often.

This applies particularly to rural populations. Studies reveal that rural areas carry a disproportionate burden of both communicable and noncommunicable diseases. They fare far worse than their urban counterparts on key health indicators such as child mortality, maternal mortality, diabetes, tuberculosis and HIV.

Factors such as low population density, higher costs for transport (including emergency services), and lack of economy of scale make the delivery of healthcare services in rural areas more expensive.

Although 35% of our population lives in rural areas according to 2016 World Bank data, current health policies and budgeting mechanisms do little to respond to these challenges.

Moreover, health workers and managers at clinics and hospitals, in both rural and urban areas, lack the authority to make crucial decisions.

A 2017 diagnostic report of the University Cape Town's Health Economics Unit notes that one of the key drivers of inadequate service quality and inefficiency across the board is the lack of decision-making authority at the provider level.

This impedes both hospitals' and districts' ability to make all the operational decisions relevant to ensure effective patient care, for instance about the procurement processes for the purchasing of medicines. The delegation of key decisions to provincial government creates unreasonable delays and makes it difficult to respond to district-specific issues.

The complexity of the problem requires that there is a complete health system overhaul. The NHI has the potential to do this: The policy commits to a reorganisation of governance structures so that important decisions are made at a sub-district level, instead of at a provincial level.

The NHI also can subvert inequity through budgeting mechanisms: instead of calculating resource distribution by utilisation rates, budgets can be adjusted based on indicators such as disease burdens and geographical-specific considerations. This could mean, for instance, that rural areas with poorer road conditions stand the chance of being allocated higher emergency medical service budgets.

Undeniably, the NHI policy as it stands is woolly and imprecise and requires substantial work before there is any hope of successful implementation. But it's crucial that South Africa gives it a chance.

Source: Bhekisisa Centre for Health Journalism

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