Is the COVID pandemic doing Government's NHI plans any favours?
By Dr Johann Serfontein, senior consultant HealthMan

There has been a recent uptick in government rumblings that NHI would have prevented the current systemic issues which are hampering proper healthcare access in the COVID pandemic. The Minister of Health was quoted as saying "There were certain regulations that were fought in court- like the certificate of need and the Pricing Regulations: regulation that sought to address the deficiencies highlighted by the Health Market Inquiry." It is noteworthy that the Health Market Inquiry report did not name excessive pricing as a failure in the private sector. The 2010 RPL court ruling also, to this day, does not prevent the setting of prices by the Department of Health (DoH). The 2010 RPL was set aside because the Department of Health ignored cost studies that were submitted by Private sector providers, giving validated proof of the costs of rendering healthcare services. The DoH ignored these costs when setting tariffs. That was the historic precedent. The court did not say the DoH cannot publish tariffs, it simply said that a proper process needs to be followed, which includes considering the costs of rendering the service.

The other concerning recommendation the Minister refers to, is the Certificate of Need. The HMI recommended a certificate of need, based on national health needs. It is abundantly clear that the national health needs would indicate shortage of services in rural areas. In the absence of an NHI type system, where the government would pay for private health services in rural areas, there is unlikely to be a large enough Medical Scheme population or private users to keep a private practice running in such a rural area. Therefore, the implementation of a Certificate of Need, based on national health needs in the absence of NHI, would lead to a reduction of the available healthcare workforce in South Africa. There is also severe constraints on funded posts in the public sector. If one looks at the Department of Health 2012 Human Resource for Health Strategy document, there were 106 518 unfilled posts in the public sector, with a cost of R38 Billion in 2012. The total spend on state employed Healthcare professionals was R60 Billion at the time. It would therefore require a permanent 60% increase in staff funding to fill these posts. According the report, "There are high numbers of 'vacancies' in the public sector although this data is not reliable and it would be impossible to fund the 'unfilled' posts". So providers subjected to a certificate of need, who cannot cover costs of practicing in a rural area and cannot find a funded state post, would have little option than to leave the profession, or leave the country.

It is probably not unreasonable for Healthcare professionals to view the current management of COVID by government as an example of how NHI might be managed. Of utmost concern, should be the lack of consultation with the medical profession. While government spent copious amounts of time negotiating with hospitals, there was no negotiation with healthcare professionals themselves, who are not employed by hospitals, and who actually have to treat the patients. There was a "take it or leave it" approach to pricing. And the ICU fees for a government COVID patient for the physician team is about half of what a single Physician would charge for a GEMS ICU patient daily, despite cost breakdowns having been submitted. So once again, costs are ignored in a tariff setting process by government. There is an indication from the DoH that higher tariffs are simply not affordable, despite hospitals barely breaking even and doctors not being able to cover the actual costs of rendering the service. The private sector currently accepts this, due to national solidarity of managing the pandemic. But it is not a pricing situation that remains sustainable for the industry, for all patients and all conditions, as proposed by NHI. NHI was unaffordable to South Africa even before the economic calamity in the aftermath of COVID and will now remain unaffordable for at least the next decade.

Many private healthcare practitioners are currently struggling to make ends meet, with much reduced utilisation of healthcare services in the private sector. Patients are scared to seek healthcare, and in many cases can no longer afford healthcare, even that which is desperately necessary and

preventative of more severe symptoms at a later stage. Unmanaged and uncontrolled chronic conditions under COVID, could lead to hefty costs for the healthcare industry in the future. This is a red flag for the practitioner community, as it indicates what might happen to a practice which chooses not to participate in NHI. The flipside of the coin, is the pathological inability of government to consider practice costs when setting tariffs. So even contracting under NHI would not necessarily lead to a sustainable private practice, based on precedent.

The medical profession is caught between a rock and a hard place. Now needs to be the time to engage with government on NHI, or rather, a Universal Healthcare (UHC) Model that is affordable to South Africa and leads to sustainable private practice. It is clear that South Africa cannot afford NHI and it is clear that implementing NHI at a time when it remains unaffordable is going to lead to tariffs that will make running a private practice impossibly unsustainable. Perhaps the taxi industry approach needs to be taken- if the government does not listen, you make your own rules until you get your way. The South African Healthcare system currently cannot function without the private sector, and neither will future UHC.

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