To NHI or not to NHI, that is the question. A Serious One –

Daily Maverick 30 August 2019

By Shabir Moosa•

The government does need to be aware that the National Health Insurance is wide open to corruption. It should show more interest in engaging and avoid mixing facts.

There is a lot of criticism of the NHI Bill, but little of it is constructive. The NHI appears to be the only concrete plan in town that has attracted criticism either from vested interests or has been highly sensationalised.

Some basic concepts first. Pooling of resources is a basic principle of insurance: the young cross-subsidise the old (justifiable in any family), the healthy cross-subsidise the ill (justifiable if you don't believe that getting sick is your fault), and the rich cross-subsidise the poor (justifiable if you believe that diseases spread irrespective of who you are and that a healthy and productive population is good for the economy).

Making the pool bigger creates less risk. Pooling is not *the* fix, but it is an important starting point for equality. There were several attempts before NHI to get medical schemes to equalise the risk between them by the Risk Equalisation Fund. It floundered largely because medical schemes were reluctant to share information, ostensibly to preserve their market of young, healthy, rich members.

Many critics (Tamar Kahn, Laura Lopez Gonzalez) are saying that government *will* do away with medical schemes, but fail to highlight that the bill says in Clause 33 that once the NHI is "fully implemented", medical schemes "*may*" only offer complementary cover. May is not must, a big difference in law.

Clause 8.2 does say that NHI services will be free, but that a patient can pay cash if not entitled, if it is not medically necessary or wants to get beyond the referral requirement. Lots of needless drama about being denied care. No medical scheme is limitless.

I don't think government should have bothered with putting such a "threat" in the bill as I don't believe that any citizen can be prevented from having a medical aid scheme offering the full range of services (if it includes the NHI offering) because it will be so easy to challenge the NHI constitutionally. It will only require someone who suffers materially because of a simple primary care problem through an NHI-contracted provider to render that "may" unconstitutional. So medical schemes are here to stay as they are.

The NHI Fund plan to take the current health budget and add equitable and progressive contributions from all citizens via the various tax options will achieve a single national pool and less resistance to the taxes (if people are allowed medical schemes). It would be more useful as a strategy to ensure that all civil servants move to NHI, that a critical mass of the private sector (especially GPs) contract with NHI and that the quality standards are strongly held up. This should satisfy most users and shift the economics of the private sector enough to make NHI the choice for most providers. A limited role for medical schemes will happen

naturally. It will counter alarmist statements such as NHI collapsing the public and private sector into one organisation.

There is huge concern about costs, but to say NHI is unaffordable is simplistic. Most simply add up all expenditure and say it will all be thinly spread. The government can hardly simply confiscate all private spend, except as taxes. What that tax burden may be is far from clear and taxes can progressively increase as the envelope of services increase.

Contracting for primary care is very possible in South Africa. Costs from the District Health Barometer 2017-2018 shows that the cost per visit in the public service is R450 vs the visit to a GP costing R300 with a partly capitated medical scheme. The aware GP is waiting for NHI after being browbeaten by medical schemes, where GPs earn 7% of the spend compared to administrators who earn 15% of the spend.

Another concept is strategic purchasing. This is much more important than the pooling as it speaks to service delivery. Essentially, this is about separating the funder from a provider and developing accountable contracts with public providers (as opposed to current meaningless "budgets" handed down to publicly owned providers).

The funder can now also contract with privately-owned providers willing to contract. This creates a "market" of providers that can be better regulated (a key plank of strategic purchasing. There is a fear, especially among public service managers, Laura Lopez Gonzalez, and Alex van den Heever, that patients will all "flock" to the private sector. Why should this be a problem, if it is cheaper and better?

I think that the private sector will take time to respond and that the public service will not "collapse" from progressively fewer patients. In fact, competition, given patient choice, should push publicly owned providers to respond better than by simple national "policy decree" as it is at present.

Failures are in both the public and private sectors (Alex van den Heever, Tamar Kahn, Reynolds Sanders, Jan Gerber). Both publicly and privately owned providers need support to respond and this needs planning. It is a crisis of management and not resources in the public service. The NHI market provides the government with the opportunity to strengthen appropriate delegations and consequence management within publicly owned providers.

As Ferial Haffajee says, how will we reduce the bureaucracy? There are a raft of criticisms about public service delivery — medicines, healthcare worker problems and so on — as written by Ivo Vegter. However, these do not need to be a problem of the NHI if it gives various providers space to manage themselves and that the money comes to providers at a decentralised level.

The bill designates provinces as management agents, supposedly contracting with sections of the health system. For example, tertiary, regional services after designating provincial tertiary and regional hospitals or groups as autonomous legal entities in Clause 32.2b. and 32.2.c. Clause 7.2. f. says that central hospitals will be designated as national government hospitals and be "semi-autonomous".

This seems odd when tertiary and regional hospitals will be autonomous. *All* publicly owned hospitals should be autonomous, with clear and accountable governance structures, managed for integration with all other providers.

The educational platform should be wider than "central" hospitals (including primary care clinics/GPs and privately owned providers as well). The conditional training grant may be a more useful approach to support training platforms than this fragmented approach. In my view, the provincial office of the NHI, as the purchaser, should be at arm's length from the provincial health department as overseers/planners and publicly owned hospitals. The provincial NHI office should contract with all hospitals and districts.

Clause 37 sets up Contracting Units for Primary Healthcare Service (CUPS) as managing the provision of health services in the demarcated geographical area at sub-district level comprising district hospital, clinic, CHC and son on, and manages contracts or "contracting" of providers.

There will be huge management challenges for contracts to be managed at a sub-district level, with possibly 250 such units across the country. It makes better sense to leave the flexible management of contracts to a provincial unit of the NHI Fund, with oversight by the Provincial Health Authority, especially with historical imbalances of providers and services across provinces to deal with. Even district-level contracting may take some time before capacity is built up.

If, in fact, the CUPS is planned as the organisational form of the "contracted" publicly owned provider, then the organisation of primary care clinics and community health centres should be at a district level. However, this district organisation of publicly owned providers should be at arm's length from the NHI as purchaser and the district health management office (part of the provincial department of health) as responsible for planning/overseeing health delivery, otherwise there is no levelled "market" between various providers and no real choice for citizens, undermining the principles of strategic purchasing.

While it is unreasonable to be spoilt for choice there cannot be *no* choice. That the Competition Act is not applicable requires that clear principles of competition are enshrined in this bill. The district organisation of publicly owned providers should be autonomous, much like hospitals and managed by trusts, as suggested.

Boards for these district trusts can be appointed by the district health Authority and be consistent with the National Health Act. Sub-district-level or lower levels of the organisation may take some time before capacity is built up but should be pursued to reduce bureaucracy. Competition with the private sector will require stronger management decentralisation. The NHI review shows that there is a need for district management specialist teams (the equivalent of the UK's Clinical Commissioning Support Units) to help all providers develop capacity.

Primary healthcare is a priority (including action on social determinants of health) and fixing health service delivery at a local level should be the first step in progressive universalism. Contracting can be started there with administratively simple mixed capitation systems for non-hospital primary care. There are precedents in South Africa for enrolment in a voter roll and ID cards, if organised as campaigns.

A summary of a possible contract for NHI Primary Healthcare capitation is available. This is very doable within the timelines. I do have concerns, for example, Clause 5.1 states that a member may "register" with a provider as a user. To enable providers to register (as opposed to enroll a registered member) will open the NHI to huge fraud. Clause 7.3 on the portability of services suggests that if a provider is unable to provide services then they can "transfer".

This again is open to problems of moral hazard and should rather be addressed in regulation on contracts.

There is also a problem with undocumented migrants not being eligible for services, but this needs addressing with specifically targeted services or arrangements, otherwise the omission will risk public health.

There is a litany of concerns, especially about central corruption, and justifiably so (Nick Krige, Laura Lopez Gonzalez, Alex van den Heever, Ferial Haffejee, Kaymarlin Govender, Jan Gerber, Sasha Stevenson).

Alex van den Heever has a point: "Is NHI about transformation or patronage?" Ferial Haffejee raises the appointment of a board, CEO and chief procurement 0fficer as being at risk of cronyism. The bar could be higher than current SOEs, with transparent parliamentary appointments of the board and CEO. However, whether that will remove cronyism is moot, considering the current debate around the public protector.

Dr Aquina Thulare said that NHI will be publicly administered with no plan to outsource the administration. Such a bureaucracy does create alarm. GEMS is an example of efficiency. It achieved significant reductions in administration costs (±5% vs the industry standard of 15%) because of competitive outsourcing of administration.

This can happen with the NHI Fund's administration devolved to nine provinces (without splitting the single national fund pool). This administration market can range from one-million to 15-million (compared with the largest medical aid scheme, Discovery, having three-million beneficiaries). This can strengthen the rollout using existing resources and skills, reducing the cost-time and resistance by vested interests. It can also cater to transformation through BBEEE requirements and limiting market dominance across South Africa to 30%.

The bill should enable provincial parliamentary oversight of spending and contracting processes at this level and reduce the constitutional challenge. This will also allow the complexity of health systems including specialised hospital, specialist and other services to be addressed progressively towards more equitable distribution nationally and across provinces.

There is also concern about corruption at a decentralised level. Ferial Haffejee and Marcus Low raise the prospect of the most serious corruption being by poorly monitored middlemen in the CUPS. With Clause 54 on offences and penalties setting a maximum of R100,000 as a fine, there is little to deter patronage and cronyism at that level.

True, NHI is right, but the devil is in the detail. It is not true that the planned NHI has no equivalent. A World Bank study on universal healthcare systems in 24 developing countries shows implementation in many countries. The identification of risks in this study is to create stepping stones for implementing UHC, not arguing against it. Specific risks should be concretely addressed. Most are taken on board or are only relevant in plans after the NHI Fund is set up.

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