How other countries manage universal health coverage –

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The National Health Insurance (NHI) roadshow of public hearings by parliament's health committee kicked off in KwaZulu-Natal on November 22 and is expected to roll out nationally during early 2020.

The NHI makes big promises, including free and comprehensive quality healthcare for all citizens that will make private medical schemes unnecessary. Given the parlous state of public healthcare and the exorbitant cost of private cover, this utopia sounds very appealing — but the propaganda is similary to Medupi in terms of being built on time, within budget and without technical glitches.

NHI's most dubious claim is that it is the only path to universal health coverage (UHC). The thin policy analysis undertaken on NHI looked at only two scenarios: complete privatisation or complete nationalisation. This forced a binary policy choice between two opposing ideologies — free market capitalism or monopolised socialism. In so far as healthcare is concerned, the two best international examples of each ideology are the US and Cuba.

The US does not have UHC and has the world's most expensive healthcare system. It consumes a whopping $3.65-trillion annually, making the US health system the fifth largest economy in the world. Cuba's health system achieves UHC — but at a human rights cost. It internationally traffics its doctors as virtual slaves to generate foreign income.

Both these systems are unworkable outliers — but in deciding on how to attain UHC, the ideologies underlying these two systems are what was presented as the exclusive policy options by the SA government.

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Ideologically there was never going to be any leaning towards privatisation, so NHI became the de facto policy. But what this also unfortunately did was to conflate UHC with NHI, as if they are somehow inseparable and mutually inclusive.

Let me state this unequivocally: UHC and NHI are entirely incongruous.

Neither one is dependent on the other and the only factual commonalities they share are the word "health" and that they are both three-lettered abbreviations. Attaining UHC is a laudable and necessary policy objective now regarded as an international norm. NHI is merely one type of funding mechanism of which there are dozens of international variants.

So, the discussion point should not be "we need NHI to obtain UHC" but rather "how best to achieve UHC". On the latter, there are as many international variations in attaining UHC as there are false testimonies at the Zondo commission.

Here are some observations on UHC from around the world:

- The overwhelming majority of countries that attain UHC do so with a mix of publicly and privately funded healthcare. Public funding is via appropriations from the fiscus and/or specific health taxes, usually within a progressive tax framework where the wealthier subsidise the poorer. Private funding is achieved via out-of-pocket payments and/or voluntary pre-funded insurance, which can also be structured progressively so that wealthier participants subsidise poorer ones within the insurance risk pool. Even wealthy countries such as Australia have provided incentives for citizens to purchase private insurance to alleviate pressure on publicly funded care. Consequently, about half of Australians now choose to have private hospital insurance.
- Many countries with UHC also regulate the sharing of the above funding, whether public or private, between employers and employees.
- Some countries have achieved UHC purely via regulatory efforts — these governments have no assets in the financing or delivery of any healthcare, for example the Netherlands.
- Most UHC systems are decentralised with service delivery being managed and decided on regionally. Germany has mandated coverage, but citizens can make a choice from more than 100 sickness funds.
- Many countries achieving UHC do not segregate the public and private sectors. Private funders purchase care from public providers and vice versa. In Brazil, most primary care facilities are owned by the state whereas most hospitals are privately owned, yet both facility types are funded from public and private sources.
- In some countries with UHC, funding levels differ regionally, raised in accordance with benefits and affordability — Canada is such an example.
- In most countries with UHC, a defined set of essential benefits is universally mandated, regardless of whether it is received via public or private funding. Benefit levels are always constrained to what the country can afford, and it is typical that non-critical services, such as acute medicines, dentistry, optometry and/or allied medical services, are excluded as they are not seen as essential.
- Virtually all countries with UHC have user co-payments to control utilisation. These user co-payments can also be regulated and managed — Norway pegs a maximum amount that any patient would need to pay within a year. Many countries also exempt or limit certain vulnerable population groups, for example children and the indigent, from co-payments.
- Waiting lists are another mechanism by which many countries with UHC manage costs and utilisation. This often induces citizens to purchase private cover to bypass such waiting times, as in the UK.
- Strict qualifying criteria are usually set for immigrants when accessing publicly funded care, to avoid an influx from neighbouring countries with inferior health services.

It is obvious from even a cursory overview of international experience that attaining UHC comes at a fiscal cost that requires management and limitation. Hence virtually all countries with UHC institute controls such as co-payments and waiting periods with a limited set of mandated essential services. Furthermore, citizens are incentivised to purchase voluntary private insurance to further alleviate pressure on publicly funded care. It is also obvious that most UHC systems operate more efficiently with decentralised delivery and funding structures.

Internationally the NHI proposal has no equivalent. It is an outlier, in stark contrast to the reality of proven experiences in other countries. NHI represents a substantial policy failure by the government, meaning that the objective of UHC is simply not going to be attained.

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