OPINION Practicalities of NHI implementation have yet to be spelt out

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AT THIS late stage in the game, where we are mere moments away from a National Health Insurance (NHI) Act, we probably need to establish how the NHI will be implemented. In SA, government plans are a dime a dozen, but implementation, successful or otherwise, is a rare occurrence. Having been at it for a decade, it is extremely concerning that there is so little certainty on how the NHI will practically happen. The first big question is how the NHI Fund is planning to contract with public clinics and hospitals. There is every indication that it is in the plan, but exactly how? Public hospitals and clinics are not juristic entities and cannot contract with anyone. There is an indication that provinces will serve as agents for these facilities to contract with the NHI Fund. But that being the case, the facilities will still have to be funded by the provincial equitable share, which is being transferred to the NHI Fund. The other option is for every clinic and public hospital to be declared a public entity, which will make it a juristic person that can contract with the NHI Fund. Such a move requires several prerequisite steps to occur. Every facility has to undergo a feasibility study to determine whether it will be able to sustain itself as an independent public entity. If a facility is not of sufficient quality to contract with the NHI Fund, the feasibility study will show that it cannot sustain itself financially in the absence of NHI funding and the province will be stuck with it.

Little improvement

There has been little improvement in the Office of Health Standards Compliance inspection results, even in the NHI pilot projects, where extensive "health system strengthening initiatives" were implemented by the Department of Health. The next stumbling block would be the unions. About 250 000 public service employees will be moved from the public sector to these newly established entities. This would necessarily mean that they are no longer government employees and therefore are also no longer entitled to belong to the Government Employees' Pension Fund and the defined retirement benefits contained therein. The unions have been rather quiet on this. The third concern is the proposed stepwise implementation. This can either happen one district at a time, as suggested by Dr Anban Pillay, the deputy director-general of NHI, or by progressively expanding the basket of services. Either of these approaches would mean that instead of a two-tier system, we would have a three-tier system for however long it takes to roll out nationally. In a district-by-district stepwise approach, NHI type funding might be present in one district, equitable share type funding in the district next door, and private medical scheme funding alongside.

Three funding models

We would be using two sets of laws and three funding models concurrently for the entire period it might take to integrate all districts into the NHI system using this approach. Progressive reductions in the provincial equitable share would become very difficult in a district-based rollout, because patients would either flock to NHI districts if they prove successful, or flock to adjacent districts if they do not. If the basket of services covered by NHI is not comprehensive and is progressively expanded, or only covers primary care, how are additional services outside the basket going to be accessed by patients, especially those without medical scheme coverage? An incomplete basket

of care would necessarily mean that higher levels of care have to be accessed outside the NHI environment. Facilities providing such care would also have to fall outside the NHI environment.

Tertiary, regional, specialised and central hospitals would have to remain in the provinces, with concurrent provincial equitable funding to render such services. Furthermore, any service basket that proves smaller than that already available in the public sector would prove unconstitutional in terms of section 27(2) as not offering progressive realisation of access to healthcare. Scenarios need to be urgently considered by the government. This feeds into the timelines for implementation, as considerable numbers of government clinics need to be of sufficient quality to contract with the NHI Fund, either within a district, or nationally, depending on the model. No implementation of the proposed NHI Fund and national purchasing of services can happen prior to public facilities qualifying to contract with the fund and being converted into public entities. Without this, NHI will be a stillborn project.