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With NHI uncertain, we must work with what we have

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South Africa has postponed making critical health financing reforms for almost 20 years as it has waited for National Health Insurance (NHI) to fill the void. But now the cracks in our existing medical aid system are showing up without a workable alternative in place.

The outlook for NHI is deeply uncertain. Not only is it subject to several legal challenges, which could drag on for years, but the fierce tussle over the 2025 national budget has revealed society's deep antipathy towards tax hikes as a means of funding further government spending.

As a result, the state is battling to fund existing entitlements, let alone in a position to raise significant new funds to finance a plan as ambitious as NHI, especially if tax-funded contributions were to go towards care purchased by a public fund.

Amid these uncertainties, the medical schemes environment is starting to creak and groan as critical reforms have been postponed. A lack of risk-sharing mechanisms between schemes, combined with low employment and economic growth, have contributed to an aging membership base and rising costs. This is prompting calls for urgent regulatory reform.

This is quite apart from the fact that NHI - which is predicated on a single, large government-administered health insurance fund – would, when fully rolled out by 2029, dismantle medical schemes and with it, the country's main health risk-pooling mechanisms.

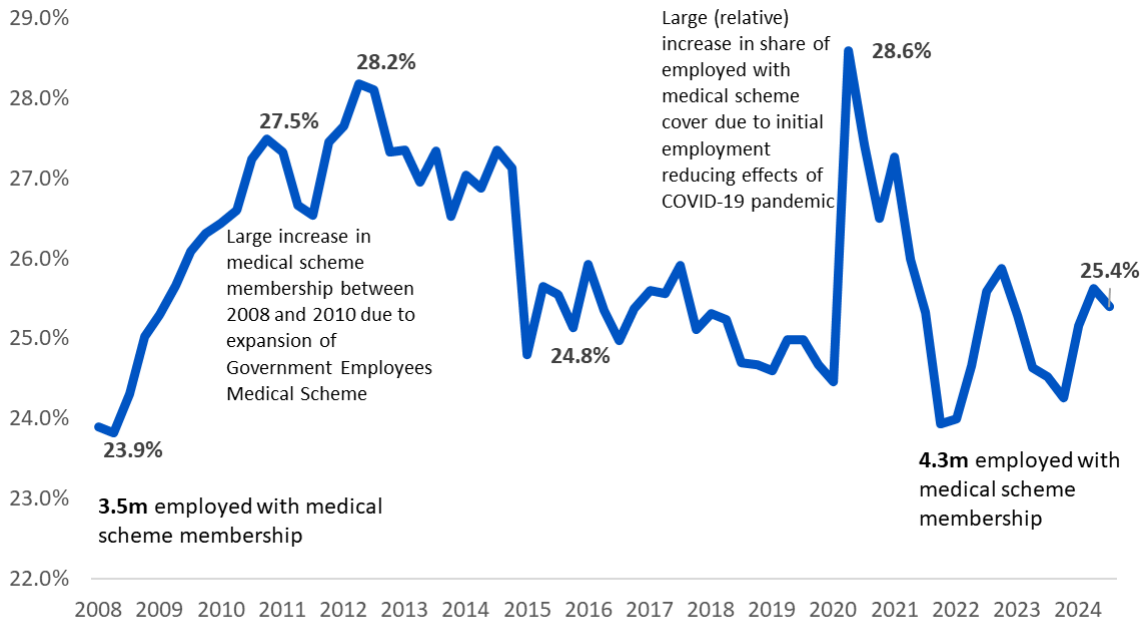
Earlier this year, a business grouping put forward an alternative proposal, suggesting that once the NHI Fund is established, it should compete with medical schemes in providing and expanding coverage to all formally employed individuals. Employers would have the option to purchase cover for their workers either from the NHI Fund or from existing medical schemes.

Before the ANC adopted NHI at its Polokwane conference in 2007, South Africa had been preparing full throttle for social health insurance. This model would have involved the

gradual extension of health insurance from the current medical scheme population of about 8.9m people to all 11.7m formally employed.

Currently about 26% of the employed, or roughly 4.3m South Africans (excluding dependants), have medical aid through their employer, but this cover is not mandatory. Under the social health insurance plan, only once all the employed had mandatory cover, jointly subsidised by their employer, would cover be extended to the rest of the population.

Fig 1: Share of the employed with medical scheme membership obtained through their employer (2008-2024)



Source: Quarterly Labour Force Survey, BER Data Playground, author's own calculations

Given the increasing improbability of implementing NHI as envisaged in the 2024 NHI Act, it may be worth reconsidering a phased social health insurance approach.

Among other things, this would require the implementation of a risk-sharing or risk equalisation fund (REF) between medical schemes to allow those with sicker, poorer members to receive a subsidy (risk transfer payment) from those with healthier, younger members. The medical schemes sector ran mock versions of a REF up until 2011/2012 but abandoned it once the focus switched to NHI. Hopefully, this preparatory work could be revived fairly easily.

To address affordability constraints for lower-income workers it may be necessary to offer a less comprehensive guaranteed package of minimum prescribed benefits than the current legislated one.

Fortunately, much work has been done over the past decade into the design of low-cost benefit options within existing medical schemes (also known as the Low-Income Medical Schemes or LIMS process). That work should be revisited.

Additionally, an uncovered middle-market population (of at least 3m people) - too wealthy for public hospital means-tested care but unable to afford medical schemes - has been largely overlooked. Many of the initiatives that could have supported better coverage for this group, like LIMS, were paused while waiting for the adoption of NHI.

While some limited private health insurance products have emerged to cater to this group, their existence (by potentially attracting younger households away from medical schemes), may have undermined the growth and stability of the sector as a whole.

To prevent further cracks, the recommendations of the Competition Commission's 2019 Health Market Inquiry (HMI) would also have to be implemented in full. They include:

- the establishment of a multilateral negotiation forum to facilitate price negotiations in the private sector.

- introducing a mandatory package of basic benefits for all medical schemes that covers at least preventative care if not hospitalisation.

- establishing an independent regulatory body to oversee pricing, licensing, and provider behaviour to prevent excessive costs and inefficiencies. The department of health finally announced in March that it would establish a healthcare capacity planning division internally to deal with some of these functions.

- compulsory membership for all formally employed individuals funded through joint employer and employee contributions.

One other critical reform not explicitly recommended by the HMI would be a move to income cross subsidies or income rating. This would entail aligning medical scheme contributions to the income level of the main member (that is, higher-earning members would pay higher contributions).

If all these reforms were implemented it would provide a solid base from which to systematically roll out risk-pooled health cover to the rest of the population, while facilitating social solidarity.

We have postponed critical health financing reforms for almost 20 years and now our health financing infrastructure is crumbling as the necessary system maintenance has not occurred. Without stabilising reforms, we risk those currently reliant on the private sector becoming a larger burden to the state.

Time is running out and the cracks in our existing system are showing without a workable alternative having been put in place. It is time to revisit old proposals and ideas.

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