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The National Health Insurance Act: can we balance access, quality AND cost of healthcare?

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"Of course, it is also a mistake to look at health, or any one component of wellbeing, by itself. It is a good thing to improve health services and to make sure those who are in medical need are looked after. But we cannot set health priorities without attention to their cost."

– Angus Deaton, The Great Escape: Health, Wealth, and the Origins of Inequality (2013)

INTRODUCTION

The National Health Insurance (NHI) Bill was signed into life as an Act by President Cyril Ramaphosa on Wednesday, 15 May 2024. The signing follows an almost six-month delay since the National Chamber of Provinces passed the Act on December 6, 2023. The Act was gazetted on May 16th, less than two weeks before the National Elections. The final Act can be accessed **here**.

The signing of the NHI Act follows a long post-apartheid journey of health financing reform. A few of the milestones[1] since 1994 are:

- The 1995 Committee of Inquiry into NHI (also referred to as the Shisana/Broomberg Commission of Inquiry);
- The 2002 Taylor Committee of Inquiry into Comprehensive Social Security;
- The 2002 Ministerial Task Team for Implementing Social Health Insurance;
- The 2009 Ministerial Advisory Committee on National Health Insurance;
- NHI Green Paper of 2011;
- NHI White Paper of 2017; and
- The NHI Bill of 2019.

Media reports indicate that at least two Constitutional Court challenges to the Act have been brought: by the trade union Solidarity and by the medical schemes industry association, the Board of Healthcare Funders (BHF). Other organisations have indicated their intent to bring similar applications to the Court.

President Ramaphosa has been re-elected for a second and final term, and a parliament representative of the Government of National Unity (GNU) has been established. At the time of writing, it is unclear how the GNU will approach NHI. As the BER, we do not question the critical goal of quality universal healthcare coverage (UHC). However, the full range of funding, infrastructure, capacity, and administration requirements must be carefully considered before implementing (any form of) NHI. Dr Smith's note unpacks some of these issues.

[1] Percept (2020). Available online: **https://percept.co.za/wp-content/uploads/2020/08/Universal-Health-Coverage-Pathways-for-SA.pdf**

WHAT IS THE NHI ACT?

The Act establishes the NHI Fund, which will serve as purchaser and payer of healthcare for all South Africans under an envisaged move to Universal Health Coverage (S2): "The purpose of this Act is to establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services…"

The Act will radically change the overall financing and structure of South Africa's private health insurance (medical schemes) and health service delivery markets.

About 15% of the South African population has private medical scheme coverage. The remaining 85% primarily use the public sector—some individuals in this group access private primary healthcare out-of-pocket. The Act aims to combine these two sectors by enabling the purchase of healthcare services from public and private providers for the whole population from the funds pooled in a single NHI Fund.

The Act (S49(2)(a)) identifies four sources of potential financing for the NHI Fund:

- General tax revenue, which includes a reallocation of funds from the provincial equitable share going to the provinces;
- A reallocation of medical scheme tax credits currently provided to medical scheme members;
- A payroll tax; and
- A surcharge on personal income tax.

The sheer scale of the NHI Fund will result in complexity and risk. Given the constant flow of a single-payer system (described in more detail below), oversight will be complex. It is unclear whether the state has the technical ability to administer this resource prudently, and it may require administrative support.

WILL THE IMPLEMENTATION OF THE NHI ACT LIMIT OR EXPAND ACCESS TO HEALTHCARE?

Healthcare access is a multidimensional concept. It includes physical access to healthcare facilities and providers, user acceptability (perceived quality by users), and clinical quality.

The National Department of Health anticipates that the Act and NHI Fund will have an expansive impact on overall healthcare **access,** with many individuals gaining more or better access. However, there are justifiable fears that removing the ability of medical scheme members to choose where they access their insured healthcare benefits will lead to a decline in the quality of services accessed.

Furthermore, inefficiencies in delivering public health services under the current (tax-funded) public health system will likely be carried over into the new health financing system. A recent review of performance in three critical health indicators across the various health districts in South Africa concluded that "*there are other systemic elements that contribute to better performance in service*

delivery [beyond health financing]. These may include both technical and allocative efficiencies, accessibility of facilities and services, quality of care, infrastructure, good governance and leadership".[2]

While no consistent healthcare **quality** measures or data is available across the public and private sectors, there are high-level indications that healthcare quality differs between the two sectors, especially if we consider differences in health outcomes. However, it is important to remember that health outcomes are influenced by the health risk profiles of the individuals served by the health system. Typically, individuals accessing services in the public health sector have poorer health states due to having lower incomes (inadequate nutrition and more limited healthcare in the past) and lower education levels.

WHAT ARE THE PROPOSED CHANGES TO SOUTH AFRICA'S HEALTH FINANCING LANDSCAPE?

While the Act brings many changes to South Africa's health financing landscape, the following are considered the most significant:

1. The Act establishes a single purchaser of health services.

The NHI Act establishes a single national health insurance fund that will purchase health services for the whole South African population covered by the fund (S35(1)). This is a **single-purchaser approach** to UHC and a policy decision by the South African government. However, many other countries (e.g., Germany and the Netherlands) have implemented UHC through **multiple** purchaser approaches.

The policy design process envisaged that having a single purchaser would bring economies of scale to the broader South African health financing and services landscape. However, as users won't be able to switch to competing funds, we will lose the potential for greater bottom-up accountability. Everyone covered by NHI will be locked into whatever quality of service the Fund provides. Such a single-purchaser approach will also require significant changes to the regulatory environment.

2. By establishing the NHI Fund, the Act introduces a clear purchaser-provider split.

The purpose of introducing a purchaser-provider split is to enable a more strategic approach to the purchase of healthcare services. In South Africa's current medical scheme context, medical schemes purchase health services for their members – i.e. there is a split between the purchaser (the medical scheme) and healthcare provider (the doctor). There is, at present, no purchaser-provider split in the public sector. However, both in the context of medical schemes and provincial Departments of Health, more strategic purchasing approaches to healthcare could be achieved without introducing the purchaser-provider split envisioned under NHI.

[2] Davèn, J., Madela, N., Khoele, A. and Blecher, M.. Chapter 4: Service capacity and access, Section 4.2 Health Finance. District Health Barometer 2022-2023 (2024). Available at: **https://www.hst.org.za/publications/Pages/-District-Health-Barometer-2022-2023.aspx** (accessed 12 June 2024).

3. NHI limits the cover provided by medical schemes to a complementary role.

The controversial Section 33 in the Act relegates the role of medical schemes to the provision of complementary cover only, i.e. *they will only be able to cover services not included in the basic benefit package of NHI*. However, the section reads that this limitation on the role of medical schemes will only come into effect once NHI has been fully implemented.

4. NHI will require the implementation of alternative payment approaches (beyond fee-for-service).

Most service providers in the primary healthcare sector are currently remunerated through a fee-for-service approach, i.e. paid for the cost of providing these services as and when services are accessed. However, it is foreseen that primary healthcare providers such as general practitioners (GPs) will be paid through a capitation[3] approach (S42(3a)).

While diagnostic-related groupers (DRGs) as a payment approach are already present in private-sector hospitals, they have not been used in the public sector. Though the Act does not explicitly mention DRGs, it implies their potential use (S42(3b)). It also gives the Fund leeway to experiment with alternative payment approaches beyond those mentioned.

Effective and sustainable capitation places substantial data demands on the user base. Disease incidence rates are not always well-captured in the public sector, often due to failures at the primary care and laboratory services level. As NHI is envisioned to cover the whole population, this data will have to be updated continuously to allow for shifts in population, disease, and other factors. A well-designed capitation system requires an electronic health information system that follows the patient, which South Africa does not yet have. To function well, this should be one of the first elements that the NHI Fund establishes.

5. It introduces a monopsony price-setter.

The NHI Act introduces a monopsony price-setter in South Africa's larger health services context and mentions "price" four times. As the single purchaser of most health services, the NHI Fund will have significant power as a price setter.

Section 11 of the Act gives the Fund power to "*negotiate the lowest possible price for goods and healthcare services without compromising the interests of users or violating the provisions of this Actor any other applicable law*." The Act also establishes a Health Care Benefits Pricing Committee (S26(e)), with the primary function of recommending prices to the NHI Fund.

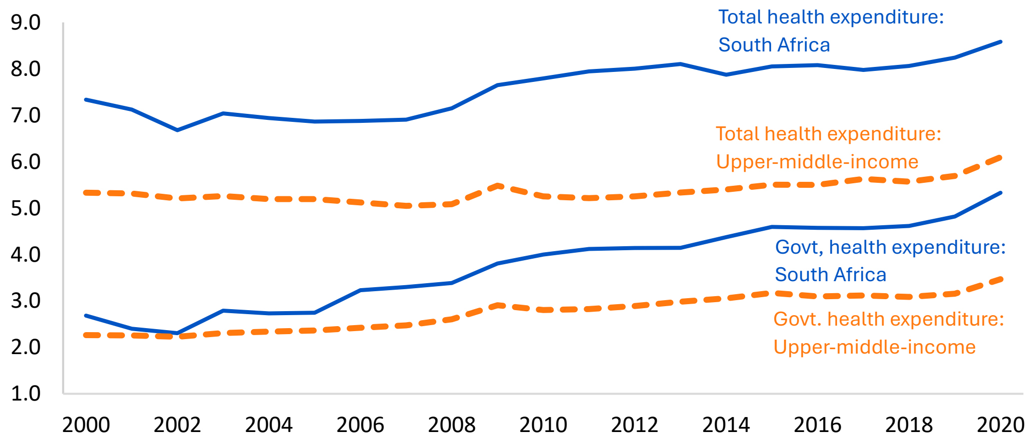
CAN SOUTH AFRICA AFFORD NHI?

Both *total* healthcare expenditure and *public* healthcare expenditure in South Africa exceed that of our upper-middle-income country peers. Between 2000 and 2020, South Africa's *public* expenditure on health averaged 3.9% of gross domestic product (GDP), compared to 2.9% of GDP in upper-middle-income countries. South Africa's *total* health expenditure as a percentage of GDP over the same period was also higher: 8.0% of GDP vs 5.6% for upper-middle-income countries. This implies that

[3] Paying a provider a fixed amount per member of the Fund under the providers care for a fixed package of services over a specified period. This reimbursement approach is thought to incentivise better preventative care but may lead to under-servicing.

funding is not necessarily the biggest constraint to South Africa's health system. However, the distribution of this funding is not ideal or equitable.

Figure 1: South African total healthcare expenditure and total public healthcare expenditure vs. that of upper-middle-income countries



Source: World Bank Health, Nutrition and Population Statistics, 2023

The question about NHI affordability is complicated and largely depends on how the basic benefit package is structured. Several estimates of the annual cost of an NHI scheme are in the public domain, but the National Department of Health has not yet shared its basic benefit package publicly. It is, therefore, not clear what will be included. It is likely that, at least initially, the basic benefit package will be focused on child health, preventative primary healthcare services and maternal and reproductive healthcare services, with the package to be expanded over time. The initial package will probably be closely aligned with the primary healthcare services offered at public primary facilities and emergency services provided in the public health system.

The potential cost of NHI becomes clearer if we use the Department of Health's cost estimates, of which the latest are available in the **NHI Green Paper** (2011). The White Papers of **2015** and **2017** shared the same cost estimates. At the time, NHI was estimated to cost R256 billion (2010 prices) by 2024/2025 (an assumed full roll-out scenario). Adjusting for CPI inflation, we arrive at a full roll-out cost of about R470 billion by 2024/2025 (2022 prices). The allocated government health budget[4] for 2024/2025 equates to R254 billion (in 2022 prices).[5] **This implies that the original projected NHI cost is about twice the current health budget.** The Green and White papers rely on reallocating private health spending to the NHI Fund and further fund-raising through other means. However, even this simple calculation illustrates that South Africa is unlikely to afford this cost, given current fiscal and economic conditions and competing areas of social expenditure such as grants and education. The idea that South Africa can double its health expenditure relies on the assumption that *private* health expenditure is fully reallocated to the NHI Fund, which is highly unlikely.

In addition, the complete financial details underlying the initial costings of NHI published in the NHI Green Paper are not in the public domain. The paper mainly focuses on the running costs of NHI rather

[4] Budgeted expenditure on the National Department of Health, provincial health departments and various health-related funds or entities for 2024/2025 is R271.9 billion.

[5] National Treasury. 2024. National Budget Review. Available at: https://www.treasury.gov.za/documents/national%20budget/2024/review/FullBR.pdf (accessed 20 June 2024).

than the extensive infrastructure expansion needed to enable full population coverage through the NHI Fund.

While the Act mentions potential funding sources, the exact sources and their relative magnitudes are unclear. The Department of Health will presumably provide more information at a later stage.

OTHER DEMAND AND SUPPLY IMPLICATIONS

On the supply side, how medical practitioners are contracted and paid will change, which is of great concern to health provider associations. As mentioned earlier, at the primary care level, NHI will entail moving away from fee-for-service payment to capitation. There is a fear that this will infringe on the income of these providers and will require a fundamental reorganisation of how they run their GP practices. It may also create income uncertainty, at least initially.

Given that the fundamental objective of NHI is to expand access to high-quality healthcare – including both primary (GPs) and hospital healthcare – there is a question of to what extent the current system (both public and private) can expand access. Potential avenues for expanding access include alternative referral, new reimbursement mechanisms and altered incentives.

There is likely to be pent-up demand for high-quality healthcare, but the full extent of additional demand is unknown. It will vary across categories of services and medical specialties. With explicit risk pooling across the whole population, the NHI Fund will be able to purchase services from private sector facilities. There is a concern that we do not yet have enough information about the demand for the basic basket of services (however defined) once they become universally available. If ill-conceived, the demand surge might easily overwhelm the supply of health services.

There are also concerns about the continued training of providers to ensure a steady pipeline and sufficient infrastructure to expand the supply of services. Private hospitals and specialists will need to be brought into training arrangements and become part of the referral networks, but it is unclear how this will be sequenced or approached.

These changes in the organisation of the health system and potential income uncertainty for private providers may affect their incentives to work in South Africa's healthcare sector, thereby undermining the very availability of human resources to provide the expanded healthcare access being pursued. We could see decreases in available healthcare workers (doctors, nurses, specialists and allied professionals) due to emigration for opportunities outside South Africa. In 2021, South Africa had about 21 doctors per 100 000 of the population, compared to an average of 232 for upper-middle-income countries (2022).[6, 7] A 2019 survey among healthcare professionals by trade union Solidarity found that 41% of respondents would consider emigrating when NHI is implemented.[8] However, a stated intention to emigrate does not always result in emigration and much will depend on how the NHI Fund is implemented, including timelines and how uncertainty is managed.

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[6] World Health Organization (2024). Global Health Observatory. https://apps.who.int/gho/data/node.imr.HWF_0001?lang=en (accessed 12 June 2024).

[7] Comparable data for South Africa and upper-middle-income countries were not available for the same year.

[8] Staff Writer (2019). South African healthcare workers say they are emigrating because of NHI. Available at: https://businesstech.co.za/news/business/350061/south-african-healthcare-workers-say-they-are-emigrating-because-of-the-nhi/ (accessed 12 June 2024).

On the demand side, individuals may have less funding available for their complementary medical scheme cover once they have paid their compulsory payroll tax – one of the ways foreseen to help fund NHI. The overall flow of funds to the private health sector, whether directly or indirectly through complementary health insurance, may be constrained as a big part of NHI funds will be directed towards public healthcare facilities.

SUMMARY AND THE WAY FORWARD

The NHI Act has been gazetted, but its implementation date is uncertain. When it starts—and especially once it is fully implemented—it will bring far-reaching changes to the South African health sector in terms of financing and the structure and availability of healthcare services.

Without a formally defined basic benefit package, it is hard to know if South Africa can afford NHI. Any (new) estimates before the National Department of Health shares the basic benefits package will be mere speculation. However, simple calculations using initial projections from the Department of Health suggest a cost close to double what the government currently budgets for healthcare.[9]

Public statements since the signing of the NHI Act suggest that it will be implemented over an extended timeframe. During the early years of implementation, which will focus on establishing the required institutions, it is unlikely that we will see significant shifts in healthcare financing and delivery. During this time, there may also be changes in the design and structure of the reform.

The new political landscape offers an opportunity to renegotiate certain aspects of the NHI Act – like the contentious Section 33 – which makes it illegal for medical schemes to cover the same benefits as the NHI Fund. If it remains in force and is not removed due to its potentially unconstitutional nature, it will likely have far-reaching consequences for healthcare access and delivery. These changes will generate uncertainty for health providers and health system users. It may lead to fewer healthcare providers living and working in South Africa. Since the role of medical schemes will be substantively limited, the medical schemes market in South Africa will shrink, and individuals will be compelled to access their covered healthcare benefits through the NHI Fund and its associated healthcare providers.

Many of the changes brought by the NHI Act are non-linear, and their impacts are hard to define. Given the scale of the envisioned policy, great caution should be applied to avoid unintended consequences that further strain an already fragile sector.

[9] Budgeted expenditure on the National Department of Health, provincial health departments and various health-related funds or entities.