

# National Health Insurance: implications for medical practice

Van den Berg E  
Healthcare Navigator

Correspondence to: Esmé Prins-Van den Berg, e-mail: esme@healthcarenavigator.co.za

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## Introduction

The Green Paper on National Health Insurance (NHI) was published on 12 August 2011. It is open for public comment until 30 December 2011. The Green Paper contains the draft proposals of government for NHI. Once adopted by Parliament, it will be called a White Paper, and will then constitute official government policy. Although the Green Paper only contains high-level proposals, it provides a framework for the implementation of NHI. This article briefly reviews these proposals, and their implications for medical practice.

## Objectives and principles

The rationale for the introduction of NHI is to eliminate the current tiered system of healthcare delivery, in which those with the greatest need have the least access to healthcare services, and have suffered poor health outcomes.

NHI envisages that everyone should have access to a defined comprehensive package of healthcare services, which will be provided by accredited and contracted public and private providers. The focus will be on the provision of health promotion and prevention services. Funding of the system will be linked to an individual's ability to pay, but benefits will be in line with an individual's need for care.

The objectives of the NHI are:

- Universal coverage.
- Improved access to quality health services for all South Africans, irrespective of their employment, and therefore their ability to pay for such services.
- Pooling of risks and funds, so that equity and social solidarity are achieved through a single fund.
- Procurement of services on behalf of the entire population, which will allow for the efficient mobilisation and control of key financial resources.

- Strengthening of the under-resourced and strained public sector to improve health system performance.

The NHI will be guided by the principles outlined in Table I.

A number of socio-economic benefits have been highlighted, and these could be achieved through the NHI. The main benefit would be a healthier population, and this should translate into a productive and effective workforce. This would result in expanded local business, and attract foreign investors and grow the domestic economy. However, to ensure a positive macro-economic result, institutional and staff constraints have to be addressed, South Africa's health indicators have to be improved, productivity gains have to be achieved, and the system has to remain affordable.

## National Health Insurance fund

A single-payer model has been proposed, which means that all funds would be pooled in a single fund, the National Health Insurance Fund (NHIF), and all payments for services would be made from this fund. A multi-payer model is also being considered, although this is not the preferred model. A chief executive officer (CEO) would be appointed to the NHIF, who would report to the Minister of Health. Various technical committees, such as technical, advisory, audit, pricing, and remuneration and benefits advisory committees, would be appointed to support the CEO. The NHIF might draw on private health sector expertise with regard to the administration and management of insurance funds to develop in-house administration capacity.

## National Health Insurance beneficiaries

Under the NHI, all South Africans and legal permanent residents will be eligible. Other persons, such as short-term residents, foreign students and tourists, would have to obtain compulsory travel insurance. Refugees and asylum

**Table I: Guiding principles of National Health Insurance**

<b>Right to access</b>	In terms of Section 27 of the Constitution, everyone will have right of access to healthcare services. The State will take reasonable legislative and other measures (within its resources), to achieve progressive realisation of this right. The reform of health care is an important step towards realisation of this right. A key aspect is to ensure that access to health services are free at the point of care, and that benefits are available according to a person's needs.
<b>Social solidarity</b>	Social solidarity refers to the creation of financial risk protection for the entire population. This will ensure sufficient cross-subsidisation between the rich and the poor, and the healthy and the sick. In this way, health costs will be spread over a person's lifecycle. People will pay contributions when they are young and healthy, and draw on them later in life, in the event of illness.
<b>Effectiveness</b>	Effectiveness will be achieved through evidence-based interventions, strengthened management systems, and improved performance of the healthcare system. These should contribute to positive health outcomes, and improved life expectancy overall.
<b>Appropriateness</b>	Appropriateness refers to the adoption of new and innovative health service delivery models that will consider the local context, and respond to local needs. The health services delivery model will be based on a properly structured referral system, rendered through a re-engineered primary healthcare model.
<b>Equity</b>	Equity refers to a health system that will ensure that those with the greatest health needs are provided with timely access to health services. It should be free of barriers, and inequalities should be minimised. Equity in the health system should lead to the expansion of quality health services to vulnerable groups, as well as underserved areas.
<b>Affordability</b>	Affordability means that services will be procured at reasonable costs that recognise health as a public good, and not just an ordinary commodity of trade.
<b>Efficiency</b>	Efficiency should be ensured through the creation of administrative structures that minimise, or eliminate, duplication across national, provincial and district spheres. The majority of resources should be spent on actual health service delivery, and not on administrative structures.

seekers would be covered in accordance with the Refugees Act and international human rights instruments.

## Benefit package

It has been proposed that a comprehensive package of evidenced-based health services, which include primary, secondary, tertiary and quaternary care, should be covered under NHI. The exact services to be provided have not been identified in the Green Paper. However, it would appear that the focus will be on primary care. Primary health care services will be re-engineered to focus on health promotion and preventative care, while also ensuring that appropriate, quality curative and rehabilitative services, are rendered.

Primary healthcare services will be delivered according to the following three streams:

- District-based clinical support teams, that will consist of an integrated team of specialists supporting the delivery of priority healthcare programmes in districts, especially those with a high disease burden.
- School-based primary healthcare services, namely health promotion, prevention, and curative health services, to address the health needs of school-going children. Services will focus on sex abuse, oral health services, vision screening, eradication of parasites, nutritional services, substance abuse, sexual and reproductive health rights, family planning, and human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) related programmes.
- Municipal ward-based primary healthcare agents.

Teams of primary healthcare agents will be deployed in all municipal wards, and allocated a certain number of families. They will facilitate community involvement and participation by identifying health problems and behaviours that place individuals at risk of disease or injury, as well as vulnerable individuals and groups. They will implement appropriate interventions.

The focal point of delivery will be the district health system. Private providers in the various districts will also be contracted for the delivery of primary healthcare services. The range of services to be provided will be specified.

As part of the overhaul of the health system, hospitals will be re-designated. (These designations relate to public hospitals, and were published for comment in the Policy on the Management of Public Hospitals in terms of the National Health Act, 2003).

Hospitals will be re-designated as either:

- *District hospitals:* In these hospitals, specialist care will be limited to obstetrics and gynaecology, paediatrics and child health, general surgery and family medicine. The package of care will include trauma and emergency care, inpatient care, outpatient visits, rehabilitation services, geriatric care, laboratory and diagnostic services, and paediatric and obstetric care. General practitioners will administer the anaesthesia.
- *Regional hospitals:* These hospitals will offer a range of general specialist services, namely general surgery, orthopaedics, general medicine, paediatrics, obstetrics and gynaecology, psychiatry, radiology and anaesthetics.

Referrals will come from district hospitals.

- *Tertiary hospitals:* These hospitals will render super-specialist and sub-specialist care. They will also serve as a main platform for health worker training, and the conducting of research. Care will include cardiology, cardiothoracic surgery, craniofacial surgery, diagnostic radiology, ear, nose, and throat services, endocrinology, geriatrics, haematology, human genetics, infectious diseases, general surgery, orthopaedics, general medicine, paediatrics, obstetrics and gynaecology, radiology and anaesthetics. Services such as renal transplants, neurosurgery, oncology, nuclear medicine, and a range of paediatric sub-specialties, might also be included;
- *Central hospitals:* These hospitals will be national referral hospitals that are attached to a medical school, and provide a platform for the training of health professionals and the conducting of research. They will render very highly specialised tertiary and quaternary services on a national basis, and will function as highly specialised referral units for other hospitals. They will have highly trained staff and state-of-the-art technology.
- *Specialised hospitals:* These hospitals will focus on a single discipline, e.g. tuberculosis or psychiatry, and might provide acute, sub-acute, chronic, or all levels of care.

Each level of hospital will be managed by persons with appropriate qualifications and skills as defined by the National Health Council. (The qualifications and skills requirements were published for comment in the Policy on the Management of Public Hospitals in terms of the National Health Act, 2003).

Systemic challenges, such as the fragmentation associated with the high cost, curative and hospital-centric approach, and excessive and unjustifiable charges, especially within the private sector, will need to be addressed to ensure the sustainability of the NHI.

### The role of medical schemes

Although membership of the NHI will be mandatory for all South Africans, medical schemes will continue to exist alongside the NHI. The intention is that the NHI benefits, to which all South Africans will be entitled, will be of a sufficient range and quality to provide South Africans with a real choice as to whether or not they should continue with their medical scheme membership, or draw on their NHI entitlements. Therefore, membership of medical schemes will be voluntary, and no tax subsidies will be available.

However, citizens and legal permanent residents will still be obliged to pay the mandatory NHI tax, irrespective of whether or not they opt for medical scheme membership. This might impact on the affordability and sustainability of medical scheme cover. It has also been suggested that top-up insurance models could evolve, offering top-up cover for the NHI benefits.

### Costs

Only preliminary estimates of costs have been provided, pending further investigation to be undertaken by the National Treasury and the Department of Health. It has been estimated that R125 billion (in 2010 real terms) will be needed for the implementation of the NHI in 2012. By 2025, this amount might increase to R255 billion (in 2010 real terms). Since South Africa has spent in excess of R227 billion, when considering public and private healthcare expenditure together (almost equivalent to 8.5% of GDP), it is believed that sufficient funds are available to fund the NHI expenditure. It is also anticipated that people will leave medical schemes in favour of NHI cover. Nevertheless, various sources of funding will be deliberated, including the fiscus, employers and individuals. An individual mandatory NHI tax is anticipated.

It has also been suggested that, in certain instances, co-payments might be imposed, such as:

- Where services are not rendered in accordance with the NHI treatment protocols and guidelines.
- Where healthcare benefits are not covered under the NHI, e.g. originator drugs or expensive spectacle frames. In the event of non-adherence to the referral procedures; Where services are rendered by providers that are not accredited and contracted by the NHI.
- Where health services are utilised by non-insured persons, e.g. tourists.

### Providers

The District Health Authority will have the responsibility to contract service providers. It will also monitor the performance of contracted providers within that district. All public and private health service providers will be eligible to render health services under the NHI. However, they will have to meet quality standards, and be accredited by the Office of Health Standards Compliance. The accreditation standards will specify the minimum range of services to be provided at different levels of care. The provision of primary healthcare services that can demonstrate performance linked to health outcomes will be central to these standards.

The accreditation standards will include service elements, management systems, performance standards and coverage, as well as quality standards that will improve safety, and facilitate access to health care. Accreditation will also take into consideration the need for particular providers within a particular area, type of health services required, as well as available resources within the district. Access to the various categories of service providers will be referral based. The entry point to access the NHI benefits is likely to be through primary care providers.

Primarily, payment of service providers will be based on alternative reimbursement mechanisms, such as risk-adjusted capitation, linked to a performance-based mechanism for primary care providers, and global budgets and diagnostic-related groups (DRGs) for hospitals. The annual capitation amount would be linked to the size of the registered population, epidemiological profile, target utilisation and cost levels. Initially, public emergency medical services will be reimbursed through the public hospital global budget, and as the system matures, on a case-based mechanism. Contracted private emergency services will be reimbursed on a case by case basis. Payment mechanisms should ensure incentives for health workers and professionals in the public sector.

A uniform coding system will also be adopted to allow providers to uniformly report on services rendered, and goods provided, for the purpose of reimbursement.

In an attempt to avoid under-servicing, contracted public and private providers will be assisted in controlling expenditure through recommended formula, and adherence to treatment protocols.

## Implementation

The NHI will be phased in from 2012. Initially, it will occur on a pilot basis, with 10 districts to be selected for this

purpose. The districts will be chosen based on the audit of facilities by the Department of Health, demographic profiles, and key health indicators. Factors such as health profiles, health delivery performance, management of health institutions, income levels, social determinants of health, and compliance with quality standards, will also be considered. Thereafter, additional districts will be added annually until the system is fully implemented, which is expected by 2025.

Strengthening of the public health system and transformation of the health services delivery platforms are critical to the success of the NHI.

The first five years of the NHI will feature piloting and strengthening of the health system in the following areas:

- Management of health facilities and health districts;
- Quality improvement
- Infrastructure development
- Medical devices, including equipment
- Human resources planning, development and management
- Information management and systems support
- Establishment of the NHIF.

## Conclusion

Although the details of the Green Paper have to be finalised, for example, how the severe shortage among healthcare practitioners will be addressed, it is clear that Government is committed to the introduction of the NHI. Therefore, medical practitioners should consider what the implications are of the NHI for their practices, and consider accreditation in order to deliver services under the NHI.

## Bibliography

Policy on National Health Insurance. Department of Health. *Government Gazette* 34523, 12 August 2011.