National Health Insurance: COSATU Position

Below we provide the text of Cosatu's presentation, which has been in use since July 2008 (as far as we are aware).

COSATU's Central Executive Committee met this week and included in its deliberations were the "State of health care and education" and "Health Charter and National Health Insurance". Cosatu will be briefing the media on 27 November 2008.

Way - Back…..
"Because of the burden associated with paying for health services at the time of illness, in the long term we are committed to the provision of free health care at the point of service for all citizens of South Africa" – *A National Health Plan for South Africa* (ANC, 1994).

Listening to Adam Smith…..
"The proposal of any new law or regulation of commerce which comes from this order [capitalist class], ought always to be listened to with great precaution, and ought never to be adopted till after having been long and carefully examined, not only with the most scrupulous, but with the most suspicious attention. **It comes from an order of men, whose interest is never exactly the same with that of the public, who have generally an interest to deceive and even to oppress the public, and who accordingly have, upon many occasions, both deceived and oppressed it."** Smith, Wealth of Nations, Book 1)

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1. Introduction

- **Major achievements** since 1994, some examples:

    - Health is a human right
    - Apartheid institutional racial division formally abolished
    - Free health care for pregnant women and children under six
    - 700 new clinics to support our primary health care orientation, now we have 3,600 clinics

- **Many challenges** remain, often with expanded reproduction of apartheid legacies:

    - Key health indicators continue to disappoint and some worsening – life expectancy and child mortality rates
    - Slow movement toward primary and frustrated efforts to wards free health care to all
    - Racial and geographic inequalities
    - Human resource challenges
    - Popular mobilization around health

- At the heart of all these is the **two-tier, contradictory, wasteful health care system:**

- o On one hand is a **public health care** which treats health as a social need, yet starved of adequate funding and resources. Less than 40% of total health care resources are in this sector, yet it serves 85% of the population, majority of whom are black and poor.
  - o On the other is an expanding private sector, which treats **private health care** health as a commodity/business, accounting more than 60% of the total health care resources, including majority of health professionals (other than nurses), yet it serves a minority of the population, majority of whom are white, and wealthy.

- The creates market-driven private health care system based on avoiding the sick:
  - o medical schemes and private providers compete not so much by increasing quality and lowering costs, but by **avoiding unprofitable patients** and **shifting costs back to patients** or to the under-funded public health system.

- It generates huge admin costs that, along with profits, divert resources from clinical care to the demands of business.

- In addition, consulting and marketing firms consume increasing fraction of health care money

- Our **government policies** also contributed to this trend. We refer to, for example:
  - o **Macro-economic policy** that weakened the building of a wellresourced, well-remunerated the public health care system and movement towards free health care for all (for instance):
    - ▪ Budget cuts, including closure of health facilities like hospitals, nursing colleges
    - ▪ Various forms of privatization – outsourcing, ppps, including privatization of public hospital wards
  - o **Piece-meal reforms and policies**, that sought to *regulate* the private health sector - rather than *transform* the sector - leading to ever concentration of resources in a subsidized, for-profit private sector and ever rising costs of care etc. All these to the detriment of the public health sector.

(These policies have further entrenched the dualistic, two-tier health care system, rather than ending it).

- Regulatory reforms of the past had:
  - o emphasized private sector solutions to the question of universal coverage (LIMS, SHI etc)
  - o Endorsed central role of private medical schemes and nourished for-profit (shareholder) private ownership of care.
- But promises of greater ineffiency and cost control remain unfulfilled
- Meanwhile, membership of medical aids remain stagnant

What do we then propose?
- Fundamental change in the current health care system through **direct state intervention** in the private health industry.
- Introduction of a comprehensive national health insurance – NHI

2. Why NHI?
- **A universal, comprehensive, free national health care system** founded on the primary health care approach, requires a well-funded and well resourced funded public health system.
- There is a need to **radically shift the way society funds health care** – by incorporating all health care resources in the public sector.
- It builds upon the strengths of our public health system
- With 8,5% of GDP spent on health, **SA has enough resources to provide health care to everyone.**

- **NHI only provides the funding framework** for building a unified health care system, within which we can address our health care challenges.

3. What is NHI?

- The National Health Insurance (NHI) is a
    - state-mandated;
    - state-administered system; in which
    - a single authority organizes health finance; aimed at
    - ensuring that all persons, irrespective of his or her financial status has free access to health care at the point of service .

4. Principles of NHI

- **Health Care a human right**:
    - Constitution requires govt to provide for progressive realization of this right
    - Coverage cannot be tied to employment, but is *universal*
    - Private medical scheme companies past roles disqualifies them from the central role of managing health care
- **Social Solidarity**
    - Provides possible re-distribution of income from contributions, from the healthy to the ill, from the young to the elderly, from rich to the poor.
- **Decent work**
    - **Promotion of quality work and adequate conditions for workers**
- **Pursuit of private profit/commodification**
    - Has no place in care-giving
    - Creates waste of resources – a diverting resources away from patients to advertising, profit-making and useless medical interventions. Removing these costs will lead to substantial savings in the system.

5. Coverage

- **Cover everyone**
- **Provide all medically-necessary services, free at the point of service (effectively eliminating out-of-pocket expenses and other charges for these services)**
    - Luxury and other unnecessary services will be excluded
- **Comprehensive:**
    - from preventive, acute, long-term, occupational, rehabilitative, prescription drugs and healthy-lifestyles.
- **Single-health insurance fund ("Single-Payer")**
    - No funds (medical schemes) for the rich and others for the poor
    - Will minimize complexity and expense of admin
    - Prohibits provision of NHI cover by private medical schemes

- **Why duplication of cover is rejected:**
    - Note that the market for private medical schemes will disappear, medical schemes will constantly lobby for under-funding of NHI;
    - If the wealthy remain in current medical schemes, adequate support for NHI will wane ('why pay for coverage we do not use')
    - Private coverage will encourage private providers to provide to "classes" of care (See NETCARE proposal).
    - Eliminating private medical schemes (along with other "middle-men" in the sector) is essential for cost containment – saving billions of Rands.

6. Funding

- Disburse all payments for health services
- Total expenditures set at
  - the **same proportion of the GDP** in the year preceding establishment of NHI (current at 8% plus)
- Funds raised the following ways
  - **Progressive taxation**
  - Additional funding **current general taxation**.
  - All public money (subsidies and contributions to public servants) in medical schemes in one form or the other will now be routed to NHI

Some preliminary results…

Table A: Total Savings with National Health Insurance in 2006

	Total Amount of Savings	% of Total Public and Medical Scheme Expenditure
Administrative Savings from Insurance Administration	R 7,939,617,323	
Administrative Savings from Physicians	R 1,847,221,416	
Administrative Savings from Hospitals	R 1,012,620,809	
Subsidies from the Government for purchasing private insurance	R 10,729,757,294	
Savings in clinical care expenditures due to bulk-purchasing power	R 9,375,409,780	
Savings in the Government Employees Medical Scheme	HCM editorial note: This is blank in the presentation	
Profit Margins	HCM editorial note: This is blank in the presentation	
Total Savings	R 30,904,626,622	27.5%

7. Payment of Services

- Payment options essential for **cost-containment**
- Pay to both public and private sector through the following payment options:
  - **Global budget** – health institutions could elect to be paid global budget for the delivery of health care, as well as education and prevention programmes.

   - **Capitation**, could elect to be paid capitation premiums for doctors and outpatient care.
- Converting for-profit, shareholder-owned providers into **not-for-profit providers** (we believe this could greatly reduce the costs of these services)

8. Purchase of drugs and supplies
- Payment based on national formulary for all drugs and medicines.
- Negotiate drug and equipment prices, based on their costs (excluding, for example, marketing or lobbying costs).
- This will save costs – as NHI will be the sole purchaser of these goods and will be able to exert pressure of suppliers to reduce prices
- NHI will be complimented by other govt efforts to reduce drug costs, including ANC Polokwane resolution to establish own pharmaceutical parastatal and other scientific projects.

9. Capital Funds
- Responsible for capital expenditures
   - New health facilities and existing infrastructure;
   - Building and expanding on existing government projects of revitalization

10. Administration
- Publicly administered
   - To be located within the State and attached to the Department of Health (details of which can be worked out)
   - Make use of available technologies for efficient and effective administration, including
      - use of electronic smart card that could be used by everyone for access health care services.

11. Transitional Arrangements
- Obviously, there will be dislocations during the reconfiguration of our health financing system.
- A **transitional plan** will therefore be required to minimize such dislocations.
- These include **human resources**, especially in the administrative activity of medical schemes.
   - Many of these workers could be placed in the expanding public health system, filling many support service functions, thereby freeing nurses of non-clinical tasks.

12. Implications on existing legislation
- Review of the Medical Schemes Act, to be replaced by National Health Insurance Act
- Other provisions in the National Health Act, as they relate to funding, service providers etc
   - This may include review of the constitutional powers of provinces.
- Latest legislative interventions announced by the Minister of Health have negative policy implications for NHI.

Proposals for Way-Forward
- ANC Task Team **finalise the recommendations** (to ANC-Sub-Committee on Health and Education) for the development of NHI policy and legislation;
- **Review on latest legislative interventions** that may negatively impact on NHI – withdraw the Bills!
- Consideration of a public **campaign drive on NHI**, including popular education drive and anticipation of a robust public debate.