Health – e

NHI is a boost to health

09.11.2009 Olive Shisana

OPINION:The ANC proposed national health insurance (NHI) as seen through the ideological lense by Jasson Urbach of the Free Market Foundation in the Sowetan of 21 October 2009, which he labels a “threat to health,” is nothing but a scare tactic designed to persuade the public and policy makers to abandon the idea of implementing it. Once the government releases the policy proposal for public and stakeholder consultation, it will become clear that the arguments used in such negative campaigns are not well founded.

This article deals with three issues that seem to dominate negative thinkers on NHI. First, let us take the issue of choice, secondly clarify the issue of private sector provision under NHI and thirdly, attend to questions on quality of health care under NHI. These are the areas that are constantly cited as examples of an ill-conceived policy, prepared in a rush and not carefully thought through. This article aims to dispel the myth and give readers correct information.

Policy formulation on NHI has been ongoing at least since 1994. Some of the architects of the proposed NHI have been at this for a very long time, informed by scientific evidence as well as debates that have been raging since the 1940’s. Early pioneers such as Jack Collie’s NHI proposal (1941) and the Gluckman Commission (1944), which argued for a National Health Service, are just two examples of work that informed the development of the proposal. Experiences of countries in the North and South that have implemented NHI were useful in understanding the factors that contribute to success or failure in undertaking such a monumental health initiative. The debates in the ANC, including in several of the conferences, including the 2007 held in Polokwane, together with work of the labour movement, Congress of South African Trade Union, have all played a critical role in framing the proposal. Recent work of the Development Bank of Southern Africa on health care, with input from more than 60 stakeholders, including participants from the public and the private sectors has also been useful in understanding the current health profile and challenges facing the country. The 2008 SA Human Rights Commission Report on access to health services was also useful in this respect.

Research has profoundly informed the development of the NHI policy proposal, starting with the benefit and finance incidence study on health conducted by the **Health Economics Unit** of the University of Cape Town and household surveys conducted to get the views of a representative sample of the population on NHI, one by the HSRC in 2006 and another in 2008 by the University of Cape Town , Center for Health Policy at Witwatersrand, Department of Health and London School of Hygiene and Tropical Medicines which examined access to health care and views on NHI. The latter two surveys yielded critical information on the nature and form of NHI that South Africans can support.

The accusation that those who developed the policy on NHI will be depriving South Africans of choice is very much unfounded. The development of the NHI policy is evidence-based; in a national survey South Africans were asked if they would support a NHI scheme if it limited their choice of doctors or if waiting lists for non-emergency services were introduced and half of the respondents indicated that they would not support it. Those who prepared the ANC policy on NHI took into account the sentiments of the public by recommending that individuals will choose a

provider within their district, whether in the public or private health sector and register for service delivery. In addition, they proposed that the benefits must be portable, meaning that patients are covered even when they are away from their usual place of health care. The question of waiting lists for non-emergency care is happening now largely due to shortage of health workers, particularly doctors in some areas. For this reason, the ANC proposal recommends a set of actions to mitigate overcrowding, which will reduce waiting times; these are increase of doctors through retention, increased intake of students into medicine and importation of doctors.

With respect to use of the private sector clinics (including general practitioners) and hospitals, the ANC proposal states clearly that although funding will be through NHI, provision will be by both public and private sectors, on condition that each facility meets the criteria for quality of care and affordability. Primary health care will form the cornerstone of service delivery which will ensure continuity of care, including basic services such as immunization, chronic disease management including conducting educational programmes in clinics, nutrition counseling, counseling and testing for HIV status, TB management, etc. This means that no longer will private health care providers focus only on curative care, but will also begin to provide comprehensive care to reduce disease burden among patients served by the facility.

Quality of care in the public health sector compared to private sector is often stereotyped as poor, often citing examples that do not represent the overall situation. **University of Cape Town** scientists, together with their partners decided to investigate this assertion by testing the views of the public in a national household survey. They measured quality in terms of cleanliness of facility; privacy of consultation; confidentiality; respectful treatment by providers; effectiveness of drugs; waiting time; and general satisfaction. While the private sector in terms of these indicators, the public sector is not so far behind, suggesting that the usual criticism that the public sector is awful is not borne by experience of people who recently used these services. They found for example, that almost 91% of users of public clinics and community health centres vs 93% of users of private general practitioners were either satisfied or very satisfied with the cleanliness of the facility and between 75% and 90% of users of public hospital inpatient services reported being satisfied or very satisfied, however these were conditional on the aspect of quality of care. Yes, there are areas where things do not go well, but it is wrong to say ALL is bad in the public sector and ALL is well in the private sector. That is an ill-informed statement.

Even though the results suggest that most users are satisfied with the quality of health care they received in either the public or private sectors, one cannot ignore those who experienced poor quality of health services. These instances that put patients at risk must be tackled as a matter of urgency. The proposed NHI plan aims to introduce quality improvement programmes whose outcomes will be judged against the internationally accredited standards for health care, approved by professional bodies, professionals, patients and staff. These include management, clinical services, clinical support services, and physical infrastructure, including use of up-to-date technology. There is no intention to lower the standards of health care, if anything the plan is to regulate quality health care even in the public sector. Never before has government regulated quality of service provision for the majority of the population. The establishment of the Office of Standards and Compliance in the Department of Health is a good start, although there is a need to clearly separate quality improvement from quality assurance function and ensure the Department of Health is not a referee and a player.

While household research is not a substitute for consultation, its use of representative samples provides data that gives a good indication of the views of the public, who may not necessarily attend stakeholder meetings. Such views come race and ethnic groups, rural and urban residents and people with varying levels of education, including those without. The views of these people cannot be ignored. The next task is consultation of those who consider themselves to be stakeholders: those likely to benefit or lose from such a scheme, as no scheme can have the same impact on every stakeholder.

From the information presented, it is clear that the arguments levelled against introduction of the NHI on the basis of lack of choice, non-involvement of private sector and poor quality of health

care are probably based on lack of information. That said, constructive criticism should not be dismissed; this is because however well conceived the proposal may be, there will always be another way of achieving the same end.

The proposal is certainly developed taking into account the best available evidence on the South African health care system as well as experiences elsewhere. The ANC is right in adopting this policy; once it is released, the public should engage with it, with a view to strengthening it.

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