SA Journal of Child Health

# National health insurance and health system restructuring – does it offer anything to children?

The paediatricians and doctors I usually associate with, including colleagues who work in the public and the private sectors, seem to hold one of three views about the imminent introduction of national health insurance (NHI) in South Africa.

Proponents believe that it offers the country the ability to finally meet the health needs of all its citizens, since it promises a single, integrated health care system strongly founded on the principles of a primary health care approach, the right to health care, social solidarity and universal coverage, and a not-for-profit and publicly administered NHI fund.

Opponents believe that it is a prohibitively expensive, complex and layered system that will deepen the failure of public health and reduce the benefits of private health. They view it as a mechanism for further destroying the health system, granting those most responsible for crippling the present public health system – inept bureaucrats – enormous additional power over the whole health system.

The majority, however, are uncertain about the development, appreciating that it offers the possibility of delivering much-needed change, but unsure whether it can deliver on the promise of comprehensive and quality care to everyone and accessible free care (no user fees for services covered by NHI) at the point of service. All my colleagues are unanimous that the present state of health care is unacceptable and that drastic health care reform must occur if the health of South Africans, especially the majority poor and children, is to be improved.

There has been much media coverage of NHI, particularly since the Green Paper on NHI was released in August 2011.[1] This commentary will not attempt to examine any of the more controversial issues in detail. Rather, it will review and dissect the NHI through a child health lens, and attempt to present a realistic appraisal of potential child health gains as well as insights into difficulties and challenges with the imminent introduction of NHI.

## What are the critical challenges facing child health?

The challenges facing South African children attempting to access adequate health care are not substantially different from those faced by the rest of the population. The public health system performs poorly because of overly centralised decision making and fragmented service delivery. While there is a strong curative approach (hospital centrism), state hospitals and clinics are plagued by lack-lustre leadership, inadequate funding and poor financial management, a shortage of health professionals, inefficient and poorly motivated staff, deteriorating infrastructure and equipment shortages. Excellent child health policies abound, but there has been less success in transforming these into measurable actions and outcomes.

The inequities between public and private health and between urban and rural areas result in widely differing access to quality health care. Although primary health care should be available at no cost to everyone, and uninsured children under the age of 6 years are exempted from hospital fees, out-of-pocket payments had to be made by 17% of uninsured children attending public hospitals and 8% of children attending a PHC clinic.[2] This undermines the equity objectives of the government's exemption policies, and also demonstrates the 'discretionary power' of providers and bureaucrats to determine who qualifies for exemptions and health care. Further, unaffordable transport obstructed immediate care for 18% of children under the age of 6, but for only 1% of insured persons.[2]

The over-dependence on hospital-based care in South Africa not only makes the health care system expensive and inefficient, but also precludes much-needed investments in effective primary and preventive care. However, despite funding for primary health care increasing more than threefold since 1994, this has not resulted in an improved ability of clinics to serve children, primarily because most of the money was spent on infrastructure development rather than service delivery expansion and quality of care improvements.

Simultaneously, the private health care sector is riddled with its own set of inefficiencies, excessive administrative expenses, bloated prices and continued over-servicing of patients on a fee-for-service basis.

## What does NHI offer?

Key proposals in the Green Paper are that NHI will be based on the principles of the right to health care, universal coverage, social solidarity, and a single public administration where access to health will be based on need rather than the ability to pay (Fig. 1). The NHI Fund intends to include comprehensive cover extending from primary to quaternary services provided by accredited public and private providers. Quality health care that meets pre-defined standards is pledged. At the core of NHI is primary health care (PHC), the entry point into the health system. The Paper foresees a 're-engineered primary health-care system'.

## The re-engineering of primary health care

There is little in the Green Paper that specifically refers to children. However, the greatest excitement it might generate for child health advocates is the proposed reforms and innovations to PHC delivery

- Membership of NHI will be compulsory for all South Africans and permanent residents
- Publicly administered and publicly funded National Health Insurance Fund (NHIF)
- Centralised purchasing within a structure reporting to the Minister of Health
- Health care provided by private and public sectors, but paid for by the NHIF
- All South Africans equally covered – no financial barriers to accessing health care
- Health services covered by NHI provided for free
- Individuals may choose to continue voluntary private medical scheme membership (for 'top-up' cover)
- Comprehensive, basic package of health benefits, including primary care, inpatient and outpatient care, dental and rehabilitative care and essential drugs
- Negotiated risk-adjusted capitation methods for doctors linked to a performance-based mechanism
- All establishments (public and private) that render health services must meet core quality, service, management systems and performance standards
- Reforms to be phased in over 14 years
- Roll-out to start in 2012 in most seriously under-served areas

***Fig. 1. Key features of the proposed National Health Insurance (NHI).***

- Universal coverage – extends 'free' health care to all children, not just uninsured and those under 6 years
- Defined package of comprehensive care (services)
- Access to adequate care
  - Doctors and paediatricians
  - Secondary and tertiary care (including private clinics)
- Improved range of services
  - Home care
  - School care
  - Promotive and preventive care
- Fairer share of the health budget

*Fig. 2. What does the NHI offer children?*

(Fig. 2). The Paper makes specific reference to three community outreach and home-based service strategies: (*i*) district-based clinical specialist support teams; (*ii*) municipal ward-based PHC agents; and (*iii*) school-based services.

### District clinical specialist support teams

An integrated team of specialists, involving a paediatrician, obstetrician, family physician, anaesthetist, midwife and PHC professional nurse, will be established in each of the country's 52 districts. The district paediatrician's possible role is outlined in Fig. 3 and includes integrating the various services and levels of care available for children; improving quality of services through development and promotion of guidelines, training and mentoring; and contributing to the district's financial and human resources management strategies. Although it will be difficult to fill all these posts immediately, the intention is to set aside dedicated funds and fill the vacancies as soon as a suitable applicant is identified.

### Municipal ward-based PHC agents

A team of at least 10 PHC agents, headed by a health professional, will be positioned in every municipal ward. This approach mimics that used in Brazil, where 30 000 such agents have been successfully deployed. Team members will be allocated primary responsibility for a certain number of households (about 200 per agent has been suggested). A large part of their work will involve children. Activities and interventions will be defined, in a yet-to-be-compiled service package, but will probably include health promotion activities (such as breastfeeding and immunisation promotion), problem identification (e.g. failure to thrive, inability to access a relevant grant), referral (e.g. to a PHC clinic or social service), and therapeutic options (e.g. counselling, food, medication).

- Promote development of appropriate neonatal, child and adolescent health services at primary, secondary and tertiary levels within the region (district)
- Support and improve the delivery of paediatric clinical care and child health services in the region (district) through development and implementation of clinical policies, protocols and guidelines
- Establishment of networks and liaisons between paediatric clinical staff, general practitioners, other health professionals, support services, non-profit organisations and social development and educational services
- Development and maintenance of an outreach programme for on-site support via clinical care and paediatric education and training in the district
- Support of 'vertical' programmes, e.g. PMTCT, IMCI, EPI, nutrition, APLS
- Establishment and maintenance of surveillance systems at facility and community levels
- Quality assurance, including audit, monitoring and evaluation, and mortality and morbidity reviews
- People management and leadership, including conflict and change management
- Strategic planning, business and operational plans, day-to-day administration
- Financial management, including budget management and expenditure control

*Fig. 3. Possible roles for the district-based paediatrician.*

### School-based services

These services will also be offered by a team, led by a professional nurse. Services will extend from pre-Grade Rs to Grade 12s at all schools in a district. Health promotion, prevention and curative services will be offered, such as nutrition and reproductive health counselling, dental and vision screening and worm eradication. Similar to the other proposed PHC services, much work is still needed to define the service package and plan implementation. This service will require substantial human resource injection, as it is estimated that there are currently about 178 school health nurses serving 24 699 schools.[3]

The prioritisation of schoolchildren over the needs of preschool children in the NHI needs some explanation, in view of the recognised benefits of good nutrition and development programmes for young children, and the limited ability to reverse stunting and cognitive deficits, for instance, once these are established in early life.

## Will NHI change health care financing for children?

The country spends 8.3% of its gross domestic product (GDP) on health,[1] and easily meets the World Health Organization's informal recommendation that so-called developing countries spend at least 5% of their GDP on health.[4] Highly resourced countries spend an average of 7.7% of their GDP on health, while middle-income countries spend 5.8%.[1] However, only 4.2% of South Africa's GDP was spent in the public sector, with 4.1% of GDP expended in the private sector which covers only 16% of the population.[1] In per capita terms R11 150 was spent per private medical scheme beneficiary, while the public sector spent R2 766 per uninsured person.[1]

While the country overall spends reasonably on health care, public sector spending is therefore inadequate. NHI is proposed as a cost-saving intervention, since by 2025 South Africa will be spending less (6.2% of the GDP) to serve all South Africans through the NHI. This is premised on private health care spending by individuals decreasing and their contribution being immersed into the national funding pool instead.

Most of the money needed to support NHI implementation has already been budgeted for by government. In 2012, R125 billion will be needed, of which R120 billion has been budgeted by Treasury. The shortfall of R5 billion will be covered by a conditional grant. In 2025, it is estimated that the NHI requirement will be R236 billion, of which R180 billion is 'budgeted' based on current spending trends and the country's projected economic growth. The estimated shortfall of R76 billion in 2025, for instance, is what requires new funds to be generated, through better efficiency or more probably through different taxation mechanisms that are currently being explored.

Children comprise nearly 40% of the population, but it is unlikely that a similar proportion of the health budget is being spent on child health. No reliable data exist, as government departmental budgets do not specifically delineate expenditure on children, easily allowing this constituency to be short-changed or ignored. The expectation would be that as the introduction of NHI demands the establishment of health priorities and service packages, deficiencies in child health expenditure will become obvious, resulting in children being offered a bigger slice of the health budget. Improved future monitoring and evaluation of fiscal resources should ensure that any lapses in child health spending are promptly reversed.

## Why is NHI controversial?

Many aspects of the proposed NHI are controversial. As a public sector doctor my concerns are less about the funding and

remuneration issues, although I recognise that the livelihood of many private sector colleagues will depend heavily on how this aspect of the policy is finally crafted. Of critical importance to all is the development of measures and mechanisms to combat the systemic corruption within the health system and the looting of public health resources.[5] A greater concern is the ability of the health system to tackle the rampant inefficiencies in the system. Fundamentally, this requires behaviour change. Managers, health professionals and health workers will need to change attitudes and mindsets about much of what they do and how they operate.

If patient satisfaction is key, the *modus operandi* will need to change dramatically. What will induce health staff to do this? There is little evidence, even anecdotal, that the occupation-specific dispensation (OSD), which has undoubtedly boosted health professional salaries and attracted staff back to public services, has improved quality of care. Can established norms and standards and monitoring of these by the Office of Health Standards Compliance do the trick? Will revitalised wards and clinics motivate individuals to perform better? Will greater local autonomy lead to better resource allocation and use by managers and CEOs? In the absence of local evidence indicating that any of this can make a difference, one has to trust and seek inspiration from the international experience that suggests that health systems can change for the better with the right blend of leadership, governance and accountability structures, financing strategies and a motivated workforce.[6]

## Challenges for NHI implementation

There can be few who underestimate the challenges facing the national health department and individuals tasked with developing the policies and plans that are needed to support NHI implementation. Among other things they will need to establish the content of the service benefit package, develop norms and standards to allow quality assurance, address the huge shortage of critical human resources, fix the deficits in existing health infrastructure, and expand plans for the reform of the health sector, particularly of district and hospital management.

In all of these there will have to be a deliberate focus on the needs of children. A paediatric service benefit package has to consider the special needs of neonates as well as of adolescents. Similarly, norms and standards for paediatric wards, for instance, will differ from those in the adult service. A 2009 modelling exercise conducted in Gauteng, based on the UNICEF 'Marginal budgeting for bottlenecks' approach, estimated that an additional (marginal) investment of R4 billion over 5 years (or R70 per capita) in maternal and child health could save the lives of 14 283 children and reduce the under-5 mortality rate by 50%, almost meeting the provincial Millennium Development Goal target for 2015 (Gauteng Department of Health, 'Marginal budgeting for bottlenecks' – unpublished report, 2009). This additional investment required less than 5% of the existing provincial health budget (Gauteng Department of Health, 'Medium-term budget estimates, 2009/10' – unpublished). Not all of this needed to be 'new' money – much, but not all, of the money could be obtained through reducing health system inefficiencies. The hope is that data of this kind, which have been largely ignored to date, will be used to quickly remedy fiscal deficiencies as the NHI takes hold.

Other than meeting the huge deficit in nurse availability, the NHI will also have to address the deficiencies in other categories of health staff. Integration of the public and private sectors will allow about 400 paediatricians currently in the private sector to augment the services provided by 250 public sector paediatricians. However, even this measure cannot overcome the existing gross provincial inequity in this resource, with one paediatrician being available for 8 600 children in the Western Cape but one needing to serve over 200 000 children in Limpopo (Colleges of Medicine of South Africa, 'Project: Strengthening academic medicine and specialist training' – unpublished, 2009). Undoubtedly, many more doctors and paediatricians have to be trained to meet the current need. More importantly, smarter mechanisms will need to be identified to attract and retain health professionals in under-resourced settings.

Of course, the NHI and the health ministry alone cannot secure health for all. Achieving good health requires not only a well-functioning health care system but also interventions from other sectors such as education, agriculture, social development, housing, and water and sanitation, to list a few.

## The need for child health advocacy and action

The promise of the NHI is dramatic, but as always the devil will be in the details, through supplemental laws, regulations, choices made, and multiple interpretations and implementation decisions. Early decisions have already been made at the national level, but many major decisions with far-reaching implications lie in the future. It is necessary for those who are invested in the health and wellbeing of children – health professionals, advocates, parents, adolescents, and others who care about children's health – to study the NHI proposals, engage in policy debates, and contribute resources, skills and expertise to the development of the final product. We must not fail in bringing about an improved and integrated national health system that benefits all South Africans, especially our children.

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