Everyone benefits

National Health Insurance (NHI) – an opportunity to improve access to women's health services to poor and rich women alike. By Marion Stevens, Treatment Monitor (Women and HIV/AIDS Gauge), Health Systems Trust.

It's quite clear that our health system is struggling, and we need to address the challenges of the imbalances and inequity that is expressed in how disease and illness affects us. As nurses we have often shied away from policy debates and it's important that we do not miss this important space and voice our experiences in the processes around the National Health Insurance (NHI). We are at the coal face and bear the brunt of the South African experience of illness and disease. Whatever our experience (previously advantaged or disadvantaged, those working in the public or private sector) this affects all of us.

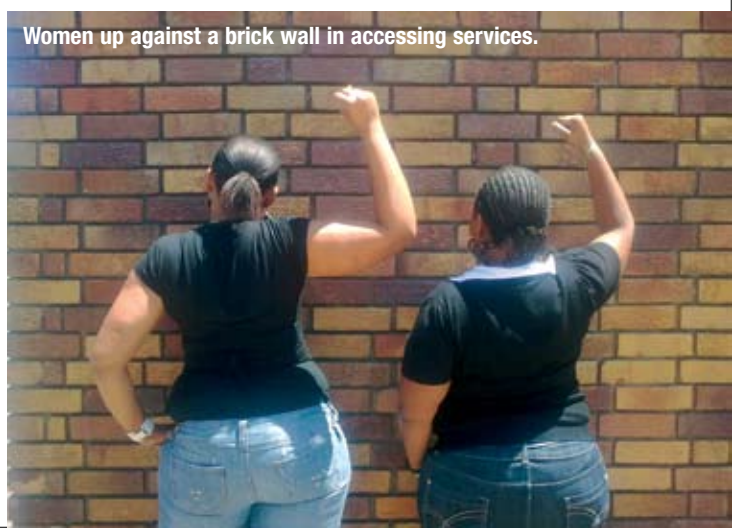
Common perceptions are held that the private sector provides a better level of care than the public sector. I think we need to question these assumptions and the policies that govern how the public and private sector function.

The orientation of the NHI is to put in place a national health insurance scheme in order to create more equitable access to quality medical care for everybody. The scheme would help to overcome the imbalance that exists in the quality of medical services available to South Africans. This approach addresses a need for a fund that supports everybody's right to safe and quality health care.

The NHI has been in the ANC Health Plan since before the 1994 elections and is clearly articulated in the ANC Health Plan published in May 1994. According to the ANC[1], the NHI will:

- Create a publicly administered and publicly funded National Health Insurance Fund (NHIF). The NHIF will be a single-payer fund that receives funds, pools these resources and purchases services on behalf of the entire population.
- Expand health coverage to all South Africans. This effectively means there will be no financial barrier to access health care. Each South African will be equally covered by NHI to access comprehensive and quality health care services delivered. Health services covered by NHI will be free at the point use, meaning no upfront payment will be required by the doctor or hospital. The only requirement is that the patient must produce an ID or NHI card. This is like putting money for health care in the hands of the patient, who then chooses which facility to use in the district.
- Provide comprehensive coverage of health services. South Africans will be entitled to a comprehensive range of health benefits, including primary care, in-patient and out-patient care, dental services, and prescription drugs and supplies. The services will be provided on a uniform basis at all health facilities.
- Provide publicly- and privately-delivered health care. NHI will be simply a financing system, with government collecting and allocating money for health care. Health care is provided by private and public sectors but paid for publicly by NHIF. To ensure improvement in quality standards, all providers will be accredited to meet quality standards before they are funded by NHI.
- Create social solidarity. Services delivered will be based on need rather than on ability to pay. In this case, coverage by NHI will not be interrupted and will be equal to everyone, thus ending the dependency of health on access upon employment status. Social solidarity also means those who can afford to pay for health care will subsidise those who cannot.
- Save enough on excessive administrative costs that characterise the current multi-payer medical scheme system, thus requiring no increase in total health care spending as a percentage of GDP.
- Control costs through cost-effective payment methods through: negotiated capitation methods for doctors; global budgeting for hospitals; and bulk purchasing of drugs and supplies.

NHI will be funded through a combination of current sources of government health spending (including the removal of the tax subsidy for medical schemes) and a modest mandatory (or compulsory) contribution by employer and employee contribution, which will be split equally. The contribution will be less than what workers and employers pay to medical schemes. Certain categories of workers, due to their low income status, will be exempted from the contribution.



Women up against a brick wall in accessing services.

What the NHI can contribute to women's health

While the mechanics and the details of funding the NHI need to be costed, modeled and budgeted for, I want to suggest some areas that can be improved around women's health by pointing out imbalances in the public and private sector.

Surgical gynaecology instruments – at the FIGO conference earlier this year – who has access to pap smears ?

Imbalances in the public and private sector

Public sector	
Abortion services	• Designated surgical abortion services have decreased from 70% to only 43% of surgical abortion services being operational. 70% of first trimesters are done by nurses • Medical abortion is not available
Contraception	• Limited options available. Most women given injectable contraceptives • Limited range of oral contraceptives, IUCDs, female condoms • Post exposure prophylaxis and emergency contraception not widely available
Cervical cancer screening and treatment	Not widely implemented – limited recourse to treatment for those with positive smears
Cervical cancer HPV vaccines	Not available
Integration of HIV/AIDS services fertility planning	Limited policy on integration. Instances of forced abortion, denied abortion, forced contraception and sterilisation

Private sector	
Contraception	• Not viewed as prescribed minimum benefit and not paid for by medical aids • Post exposure prophylaxis and emergency contraception available • Not usually covered by medical aids Household insurance now provides options for coverage
Abortion	• Surgical abortion not widely available • Medical abortion widely available
Cervical cancer screening and treatment	Women who are screened tend to be over-serviced
Cervical cancer HPV vaccine	Available. Not covered by all medical aids

These tables are a very superficial analysis of what is and what is not available in the private and public sectors. I am sure that colleagues can add and create more rows and columns indicating some of the gaps and inconsistencies.

As nurses, let's not miss these opportunities to also lay our cards on the table. For many of us medical aids are no longer affordable. I remember as a student nurse having all my bills paid for when I had my tonsils out and not having to do a thing! Now when my son had his grommets put in I had a barrage of bills which kept coming and we certainly did not know how to pay them. I am also aware, from having done research in a private hospital company, of their concern that nurses were not enrolling for disease management scheme options for HIV/AIDS treatment. They wanted to keep nurses healthy and at work and were willing to provide a co-payment – or subsidise membership. But in a climate of stigma, nurses were not enrolling for treatment access.

We can only be the change we want to be in our world – if we look after ourselves and put our needs on the table too.

Reference

1. African National Congress Today: 23-30 July 2009. National Health Insurance: A unified, equitable and integrated national health system that benefits all South Africans VOL 9 No 29.