

**South African  
Private  
Practitioners  
Forum Response  
to NHI White  
Paper**

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## **PART 1            SAPPF COMMENTARY ON THE WHITE PAPER**

### **Pre-Amble**

1. The South African Private Practitioners Forum (SAPPF) is a voluntary association of private specialists working in the South African private health sector. The organisation has a paid up membership of approximately 2689 specialists representing most specialist disciplines. SAPPF acknowledges the transformative elements in the Constitution and the Constitution's commitment to improve access to health care. Furthermore, our humanity compels us, to work towards quality universal access to health care for all of our citizens, within the constraints of resource.
2. The National Department of Health (DOH) published the draft Policy (40<sup>th</sup> version) on National Health Insurance (NHI) under Government Notice 1230 in the Government Gazette 39506 on 11 December 2015 (the White Paper), and invited interested persons to submit comments and representations on the White Paper. It is pursuant to this invitation that these submissions are made.
3. We note the contents of the White Paper and welcome the opportunity to submit comments and participate in this nationally important debate. The future of health care in this country is vital, not only to our membership and other participants in the health care industry, but to all South Africans. It is therefore with great disappointment that we take note of the small number of differences between the White Paper and the original draft Green Paper despite the indication in the White Paper that "Over 150 written submissions were received from interested individuals and organisations and were carefully reviewed and considered as part of the drafting of this White Paper. Inputs received from consultations with key stakeholders during national and provincial road-shows (which involved more than 60,000 people spanning over a period of four years) have also been taken into account. In addition, consultative meetings and workshops were held, some involving international experts." Despite all of this interaction, there is still much uncertainty contained in the White Paper. In particular, the extent of private sector involvement in the NHI is still unclear and the Treasury costing models have not been updated in four years. We are conscious of the fact that both the public and private the health care sectors faces significant challenges and are in need of reform, and we intend to participate constructively in the debate as to how these challenges are best addressed. SAPPF supports a pragmatic approach to health care reform and believes that any proposal which seeks a radical overhaul of the health care system should be carefully considered and empirically researched prior to implementation. Any such proposal should

also be subject to a comprehensive consultative process of engagement with all affected stakeholders.

4. We believe that NHI's impact on the economy, its likely cost and the details of the intended model must be substantively addressed by DOH in partnership with National Treasury and other role players, and disseminated to the South African people for their consideration and detailed commentary. The implementation of far-reaching health care reforms will be costly and could have significant adverse consequences if not implemented successfully. It will also involve a significant commitment to and from the South African people. Reforms should thus only be pursued if they are practically implementable and affordable. Although the World Health Organisation (WHO) is alluded to in the White Paper as cautioning that, while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the "exact number" when alluding to the estimated costs. Based on this, the DOH indicates that focusing on the question of "what will NHI cost" is the wrong approach as it is better to frame the question around the implications of different scenarios for implementing reforms towards achieving universal health care (UHC). The failure to update its cost models in the four years between the original Green Paper and the finalisation of the White Paper is especially worrying, as Ireland recently had to scrap their Universal Health Insurance proposal due to cost models that were completed 4 years after the publication of their White Paper indicated that the proposed model of Universal Health Insurance, was in fact not affordable for Ireland<sup>1</sup>.
5. A further concern to SAPPF is that the White Paper makes no reference to the constitutionality of some of the proposed reforms and, in particular, how such reforms may impact, limit and infringe constitutional rights afforded to South African health care users. This concern will be discussed in more detail later.
6. Specialists obviously play a vital role in any health system, and will need to continue playing such a role under any reformed health care system that is adopted in South Africa. For example, it is impossible for a primary health care (PHC) system to operate effectively without a well-functioning body of specialists to whom patients can be referred for tertiary care. The District Clinical Specialist Teams will also require specialists in certain disciplines to function effectively and it is therefore important that the role of specialists be considered and accommodated in any health reform proposal. As a body that represents a large number of specialists, many of whom have a wealth of experience in the health sector, SAPPF is well-

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<sup>1</sup> Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015

placed to comment on the proposals in the White Paper and, in particular, on the aspects that relate to the private health care sector. These submissions therefore commence with a detailed commentary on the text of the White Paper followed by two sections which focus on the role of the private sector and makes certain recommendations in respect of this sector, along with an alternative, affordable Universal Health Care model proposed by SAPPF.

## **A     Introductory Commentary**

7. The White Paper sets out the Minister of Health's rationale for proposing a radically different approach to health care provision in South Africa. The proposal is to establish a NHI scheme with the laudable, and ambitious, aim of ensuring that everyone has access to appropriate, efficient and quality health services.
8. The primary question is whether the proposals contained in the White Paper will have the desired effect. In our view, the White Paper does not convincingly demonstrate that the interventions suggested in the document are the best means of addressing the effective and equitable provision of health care in this country or, in fact, that the interventions are likely to succeed in addressing those issues.
9. As indicated above, there is no doubt that the health care system is in need of reform, and we support many of the proposals in the White Paper to improve health care service delivery in the public sector. The introduction of the Office of Health Standards Compliance (OHSC) (as contemplated in the National Health Act, 2003) is one of the measures that will help to improve quality in the Public Sector, as will the introduction of *Municipal Ward-Based Primary Health Care outreach teams, Integrated School Healthcare Programmes* and contracting of private health practitioners. These reforms are, however, not dependent on the introduction of NHI as a funding model. The approach that is taken to the structure of health care service delivery is distinct from the approach that should be taken to health care financing; although keeping in mind that the choice of each system will impact significantly on the effectiveness of the other. The introduction of the NHI fund and some of its mechanisms of work are discussed in the White Paper, but there is still very little detail on how this body will function on the massive scale that will be required for the NHI. As the Centre for Development and Enterprise (CDE) observed in its 2011 report "NHI is a financing mechanism only. No matter how finance is organised and from where it comes, organisation, management and leadership in the public sector will have to be overhauled".<sup>2</sup>

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<sup>2</sup> Centre for Economic Development. Reforming Healthcare in South Africa: What role for the private sector?

10. The nature of the omitted detail is critical to a comprehensive understanding of the Minister of Health's intentions and is necessary for a proper understanding of the NHI model envisaged for South Africa. Importantly, the White Paper identifies several weaknesses in both the public and private health care systems, yet provides little (if any) substantive detail on how these weaknesses will be addressed under NHI. For example, the White Paper recognises that management failings are a weakness within the public sector, yet there is limited mention of how this will be corrected. It is referred to as being critically important in the White Paper, but how it will be strengthened is not addressed at all.
11. Some mention is made regarding how the NHI fund will be structured and how it will function, but the sheer size of the venture is not acknowledged in the White Paper. The NHI Fund is likely to require a much larger staff complement than is currently serving the National Department of Health. There are allusions to the establishment of a provider payment system, health patient registration system, health provider registration system and fraud and risk mitigation systems that would need to be created in the NHI fund, but the scope of registering 55 million South Africans and inspecting and certifying between 33 200<sup>3</sup> and 74 558<sup>4</sup> private healthcare providers is not appreciated sufficiently.
12. The details of payment to private providers are also quite vague other than mentioning diagnosis related groupings (DRGs) and possible capitation payment systems. Reimbursing medical specialists on a capitation basis is not a practical solution, with the possible exception of gynaecology for ante-natal services. This is due to atypical usage patterns of specialist services. The White Paper also does not acknowledge that the majority of specialist services are provided in a hospital environment (such that they qualify as inpatient services) and that no employment or other business relationship exists between the doctor and the private hospital and no joint billing for services is currently possible in the private sector. Reimbursement through disease related groups and case mix is currently not feasible for specialists. Mechanisms that allow for the separate rendering of accounts by specialists and hospitals and for specialist outpatient services on a fee-for-service basis, will have to be considered if the NHI fund is to procure services from private providers. Furthermore, the issue of non-payment for conditions excluded in the basket of care is also not addressed sufficiently. Certainty on when funding decisions of a non-covered condition are made will need to be addressed, as diagnosis of this might happen while a patient is in ICU. If the patient

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<sup>3</sup> Major Medical Scheme Administrator 2015 Claims Figures

<sup>4</sup> Medpages figures. [www.medpages.co.za/stats](http://www.medpages.co.za/stats)

is not capable of affording a co-payment or a medical scheme for complementary cover, how will this be addressed if ongoing treatment is required?

**13. There are still some outstanding issues in the White Paper on which further details needs to be provided:**

- a) The suggested comprehensive benefit package to which persons will have access under NHI, which in turn impacts on the costing of NHI. The broad service package is described, but no further comprehensive details are provided, particularly of conditions and treatments that would be excluded from the package of care.
- b) The cost of NHI administration, with specific reference to the administrative costs related to its implementation, operation, monitoring, staffing, IT needs and related matters.
- c) The complementary role of private medical schemes. This cannot be clarified if there is no detail regarding which conditions and services will be excluded in the NHI and would have to be covered by medical schemes in this complementary fashion.
- d) There is no indication what would happen with reserves currently held in medical schemes when the number of schemes are drastically reduced and membership numbers fall, barring recent comments by the Minister of Health that they will be utilised for funding the NHI. The reserve funds belong to members of the scheme and taking possession of these to use in NHI could be considered unlawful seizure of members' property.
- e) In addition to payment systems, the manner in which reimbursement levels will be determined for purposes of NHI by the NHI Fund and the minister needs to be elaborated upon.
- f) The manner in which co-payments will operate in respect of both rare conditions and services not covered by the NHI, along with not following the necessary referral pathways.
- g) The mechanisms by which managerial performance within the health care sector is intended to be monitored, measured and made accountable.
- h) The principles and rules by which the NHI Fund will be regulated and assessed.
- i) The performance measures that will be utilised by the NHI fund to reimburse practitioners and improve quality are described in vague terms.
- j) Details on provider reimbursement by the NHI. There are only vague allusions to *capitation fees* and *diagnosis related grouping* payments. The only certainty is that *fee for service* will only be used for Emergency Medical Services and complex diagnostic services (which again need to be clearly defined).
- k) The funding needs of the NHI needs to be clarified. There has been no update since 2010 on the funding requirements for the system.



- l) What will happen to service providers that do not accept the rates offered by the NHI and subsequently choose not to contract with the NHI? Will these services have the same quality requirements as accredited providers? Will they be able to use Private/Public hospitals that are contracted to the NHI to admit patients?
  - m) What will happen in a rural area if healthcare facilities are of such poor quality that they do not get accredited by the Office of Health Standards Compliance? Will patients in these areas be transported at NHI expense to other areas? How will this impact doctors who work in those areas?
  - n) Patients with rare diseases will be subject to co-payments for expensive treatments. How will the constitutional right to healthcare of the indigent be protected in such a situation?
14. There is still a distinct lack of financial modelling in the White paper. 2010 costs are used and there is no consideration of current GDP growth rates that are sitting below 1%. **Besides the previously expressed concerns regarding lack of details in the White Paper, SAPPF has other concerns, which are summarised below. In most of these instances, the White Paper makes statements without providing the necessary supporting evidence:**
- a) We do not accept the White Paper's apparent premise that the current two-tiered system is to blame for the poor standard of service delivery in the public health sector, and that the existence of this two-tiered system is therefore a basis for introducing NHI.
  - b) We are concerned that the White Paper portrays the private health sector in a very negative light. For example, it - without providing proof - characterises service provider costs as being inappropriately high, questions the viability of the private sector and overstates human resources discrepancies between the public and private sectors. We submit that the private sector is not over-priced or unsustainable. On the contrary, SAPPF contends that the private health sector is a national asset which contributes significantly to enhancing access to health care and thus should be nurtured. Attention should rather be directed to address the real difficulties in access to quality care in the public health sector.
  - c) To simply criticise the private sector distracts attention from a pressing concern facing the health sector: the dire state of public health. We note that South Africa to some extent already provides the mechanism for universal coverage (albeit imperfectly and in a manner that requires considerable improvement). Our entire population is able to access health care, either in the form of public or private health care services. A

major obstacle to the achievement of substantive universal access is the availability and access to quality care in the public sector.

- d) There is no single, internationally accepted conception of NHI, and it is important that whatever model is adopted for South Africa is tailored to take into account the country's particular needs and circumstances, including resource constraints. The NHI cannot possibly be the only model being investigated if there is no detailed cost model that would test its affordability.
- e) The White Paper does not engage in any meaningful economic impact modelling of NHI, and fails to demonstrate that NHI is affordable. We submit that it is axiomatic that Government should not embark on such an ambitious and costly project without a demonstrable assurance that South Africa can afford it.
- f) The evidence provided to date does not demonstrate that the establishment of a single-payer NHI model is the best and most efficient model to support the much needed health care reforms. The White Paper does not offer any convincing evidence or argument to suggest that such a model will be effective in, or is the optimal way of, addressing the concerns around access to healthcare in this country. Moreover, it is doubtful that the complex NHI system contemplated in the Paper could be managed without incurring crippling costs that South Africa can ill-afford, particularly given our limited resources and the range of significant, pressing demands on those resources.
- g) It is doubtful whether the current South African tax-paying base is big enough to pay for such a complex and expensive restructuring of not only our health services but the manner in which those services are funded. Current levels of taxation are already very high and the imposition of an additional tax (whether taking the form of income tax, VAT, payroll tax levies or combination thereof), may thus have unintended negative consequences for the economy due to shrinking disposable income.
- h) Serious human resource constraints exist that mitigate against the establishment of NHI. It is critically important that any health care reform proposal is accompanied by a well-considered human resource strategy to convert the promises of a reform policy into a practical reality. Consideration should be given in this regard to expanding the role of the private sector in training of health care professionals and seeking to attract local medical graduates living abroad to return to South Africa. This approach is particularly appropriate given the call of the World Health Organisation (WHO) for countries not to recruit each other's health human resources deliberately.

- i) The White Paper does not adequately explain the envisaged complementary role for private medical schemes under NHI. In this complementary nature, under NHI, medical scheme membership numbers will fall rapidly. The premiums for remaining members will be un-affordably high, due to the rare conditions and expensive services that will be covered by medical schemes and the small number of individuals that will be able to afford additional medical scheme cover when already contributing to the NHI via increased taxes.
- j) SAPPF questions the accreditation process of the OHSC in certifying private facilities for accreditation and contracting into the NHI. The OHSC could only inspect 417 facilities in 2014/15 and doing the necessary inspections of between 33 200 and 74 558 private facilities/providers providing private healthcare will require substantial increases in capacity of the OHSC to fulfil its mandate. The administrative burden on the NHI in accrediting and contracting with 3880 public facilities and 33 200 to 74558 private facilities/providers that are currently submitting claims to medical schemes would be immense.
- k) The OHSC does not seem to have sufficient independence from the DOH to ensure independence in the accreditation process of facilities for inclusion into the NHI. This independence is necessary to avoid conflicts of interest with DOH's role as a provider of health care services.
- l) The White Paper should explicitly acknowledge the fundamental principle that any determination of reimbursement levels by the NHI Fund and the Minister of Health must enable service providers to cover their costs and to make a reasonable return on investment.
- m) The White Paper envisages the use of *risk-adjusted capitation* and *diagnosis related grouping* (DRG) models for service provider reimbursement. A risk adjusted capitation model carries the risk of encouraging under-servicing. DRG reimbursement models for hospitals assume that specialists work in private hospitals and will therefore share in the disbursements. The DRG model is therefore inappropriate for specialists who are independent contractors and do not have a business relationship with private hospitals.
- n) The White Paper should provide for the reimbursement of non-accredited service providers who provide emergency medical treatment to persons who cannot afford such treatment.

15. **The White Paper makes no reference to the constitutionality of some of the proposed reforms, and in particular how such reforms may impact, limit and diminish constitutional rights afforded to South African healthcare users. In this regard, the establishment of NHI as proposed in the White Paper triggers a number of constitutional concerns. In particular, the implementation of NHI may potentially:**
- a) Diminish access to health care for the current private medical scheme population (section 27 of the Constitution of the Republic of South Africa, 1996 (the Constitution))
  - b) Infringe on the right of access to healthcare for asylum seekers who cannot afford private healthcare insurance (Section 27)
  - c) Infringe the property rights of members of medical schemes, by seizure of reserve funds in medical schemes for utilisation in the NHI (Section 25).

## **B Detailed Commentary**

16. National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. We will now proceed to set out our detailed comments on the White Paper. For ease of reference, we follow the order in which the issues are canvassed in the White Paper and include the headings as they appear in the Paper. Unless the context otherwise indicates, references in this document to paragraph numbers refer to the paragraphs of the White Paper.

### **1 Introduction**

17. In Paragraph 1, the intention to ensure that the use of health services does not result in financial hardship, although noble, will not be achieved by the NHI in its current format. References to co-payments and rare conditions excluded from the basket of care will necessarily imply that the indigent population with rare diseases, seeking services not covered by the NHI will suffer catastrophic financial hardships. This may also imply that people who currently are covered for these benefits via their medical scheme membership, may now face financial costs/hardship under the NHI when they can no longer afford medical scheme contributions in addition to NHI taxes.
18. Paragraph 3 in the White paper states that *“NHI implementation is consistent with the Constitutional commitment for the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services including reproductive health care.”* The question of affordability

speaks to the availability of resources referred to in the constitution. If there are not enough available resources for the envisaged massive reorganisation of the public and private sector, should alternative approaches not be considered?

19. In response to Paragraph 4: The concept of fairness and social solidarity is already addressed in the current dispensation. Healthcare financing in South Africa is extremely progressive: The richest quintile of South Africans contribute 82.3% of total healthcare financing and receive only 36% of the benefits<sup>5</sup>. This happens via taxing and also spending their private funds on their own private healthcare.
20. In response to Paragraph 5: Cost estimates of the NHI system indicate that this will not be an affordable system for South Africa, as it would place an unaffordable burden on the small tax base in South Africa. Proper updates of the costing of NHI needs to be conducted by Treasury, to indicated how these will be affordable in the current economic climate.
21. In addition, we point out that critical terms such as “appropriate”, “efficient” and “quality” as used in Paragraph 7 of the White Paper should be defined, with clinically supported and universally accepted measurements. Quantitative goals should be set in order to determine exactly what is meant by and what is to be achieved through, the delivery of “appropriate”, “efficient” and “quality” healthcare services. This is necessary in order to monitor progress towards achieving this ambitious goal.
22. The first phase of the implementation if the NHI (Paragraph 9) is nearing completion and very little progress has been made regarding the quality of government services.
23. The re-engineering of primary healthcare (Paragraph 10) is commendable, but one does not need to re-organise the entire public and private health systems at great cost to achieve this ideal. This can happen within the current healthcare system and current budgets.
24. The current quality of government services makes it very difficult to implement a single payer system such as the NHI, with the public service as its “backbone” (Paragraph 12)
- 24.1 In 2013, the government published a report on a Baseline Audit for Government Health Facilities<sup>6</sup>. The investigations for the report took place in 2011/12. During this process, 3880 facilities were audited. There were six ministerial priority areas for the audit. These were

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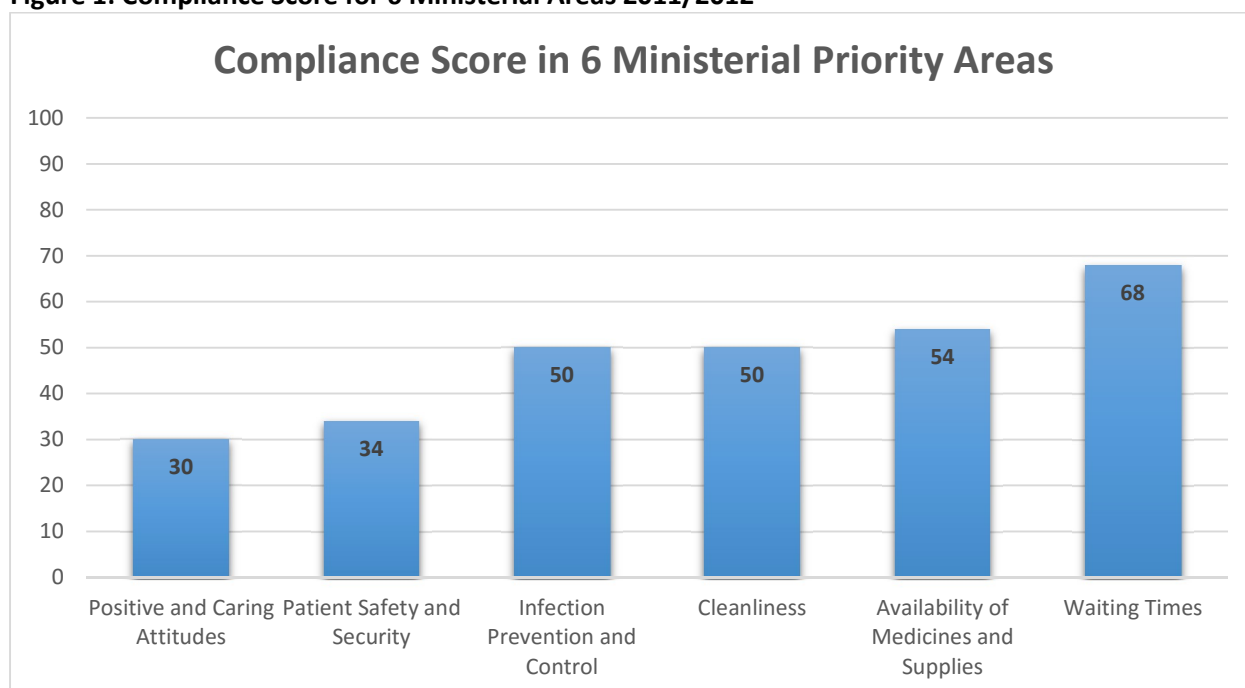
<sup>5</sup> Theron, Van Eeden and Childs “Financing and benefit incidents analysis in the South African Health System: An alternative view finding significant cross-subsidisation in the health system from rich to poor” Hospital Association of South Africa Private Hospital Review (2009))

<sup>6</sup> The National Health Care Baseline Audit, *National Summary Report*, 2013. National Department of Health

Positive and Caring Attitudes; Patient Safety and Security; Infection Prevention and Control; Cleanliness; Availability of Medicines and Supplies and Waiting Times. Figure 1 shows the results of this baseline audit with the average compliance scores for the six ministerial priority areas:

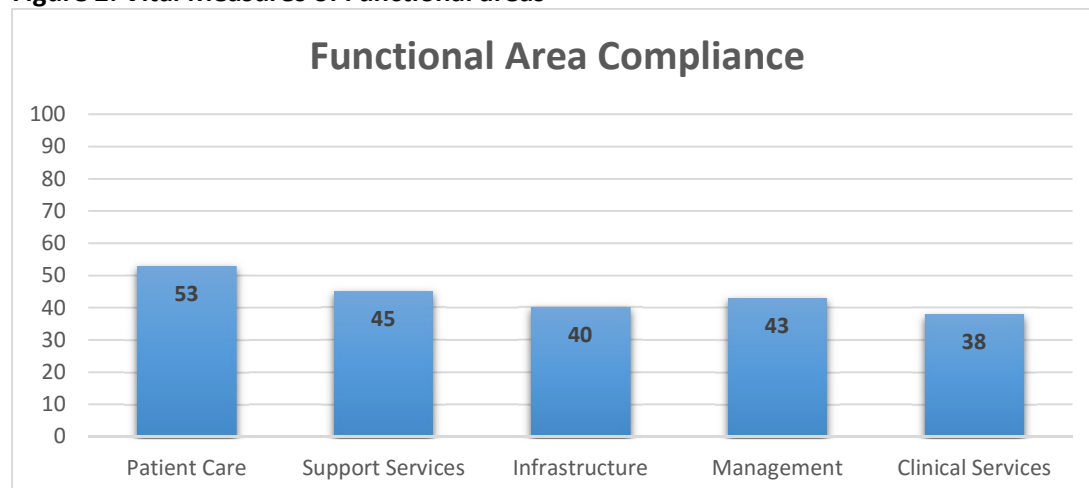
<i>Positive and Caring Attitudes:</i>	30%;
<i>Patient Safety and Security:</i>	34%;
<i>Infection Prevention and Control:</i>	50%;
<i>Cleanliness:</i>	50%;
<i>Availability of Medicines and Supplies:</i>	54%
<i>Waiting Times:</i>	68%

**Figure 1: Compliance Score for 6 Ministerial Areas 2011/2012**



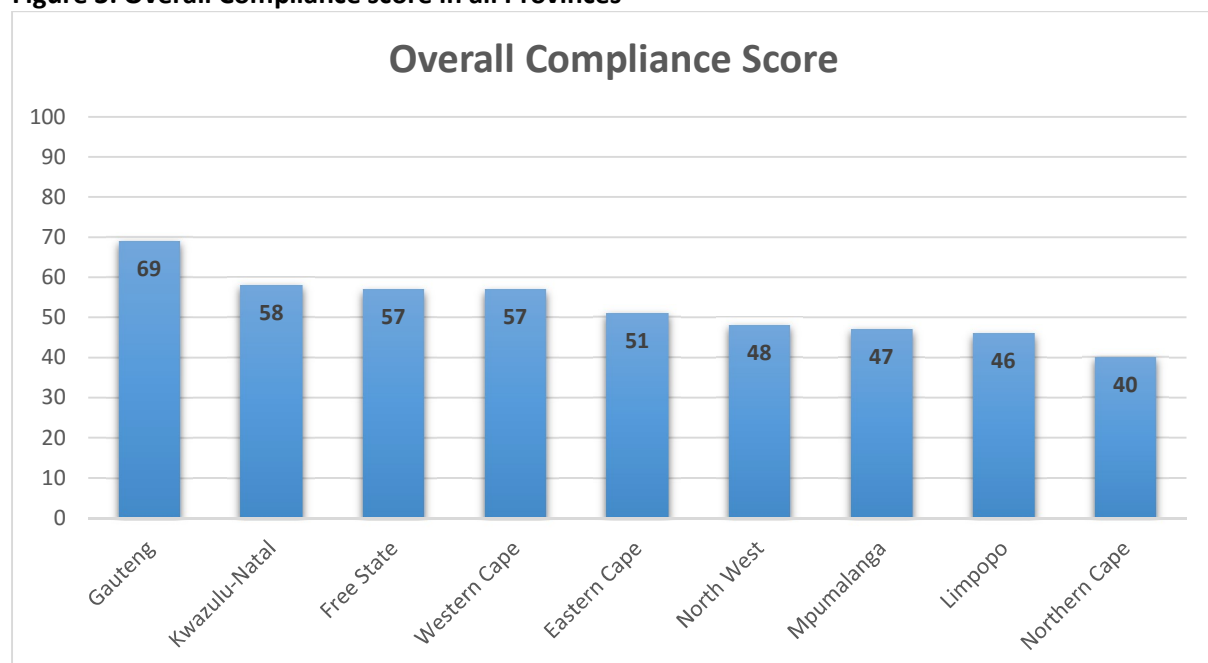
24.2 The vital measures of functional areas within the National Core Standards can be seen in Figure 2. These standards consist of Patient Care, Support Services, Infrastructure, Management and Clinical Services. As you can see in this figure, the results are even worse than for the six ministerial priority areas. Results ranged between 38% for clinical services to 53% for patient care. One of the worrying figures is the 40% score for infrastructure. Infrastructure is not a function of the Department of Health, but of the Department of Public Works. There is thus multi ministerial involvement in the poor state of health facilities.

**Figure 2: Vital Measures of Functional areas**



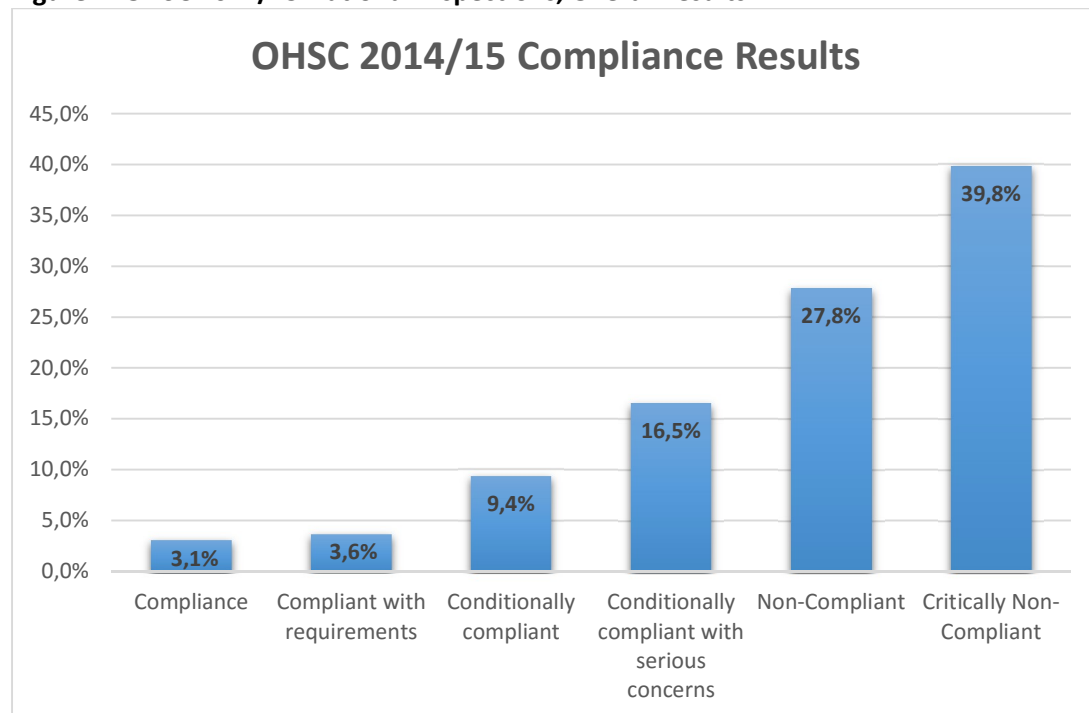
24.3 Figure 3 indicates the overall compliance score for all the provinces in the country. Gauteng scored the highest, with an average score of 69% with the Northern Cape scoring the lowest, with 40%. Of all 394 Hospital Facilities in the audit, only one scored 100% on all the necessary norms and standards to ensure compliance (Witransd Hospital in Potchefstroom). Of the total 3 880 facilities audited, only 32 complied with infection control guidelines and only a quarter of clinic staff had a positive and caring attitude. 93% of maternity facilities did not have the necessary equipment to ensure mother and baby treatment safety and only 2 facilities could guarantee general patient safety.

**Figure 3: Overall Compliance score in all Provinces**



24.4 In 2014/15, the Office of Health Standards Compliance conducted another audit on 417 facilities nationwide<sup>7</sup>. Figure 4 shows the results of these facilities including the NHI Pilot Districts. 3.1% of Facilities were considered *Compliant*, although none of these scored 100% for the inspections. Another 13% of Facilities were *Compliant with requirements* or *Conditionally compliant*. 67.6%% of the inspected facilities were *Non-Compliant* or *Critically non-compliant*. A further 16.5% were *Conditionally compliant with Critical Concerns*.

**Figure 4: OHSC 2014/15 National Inspections, Overall results**

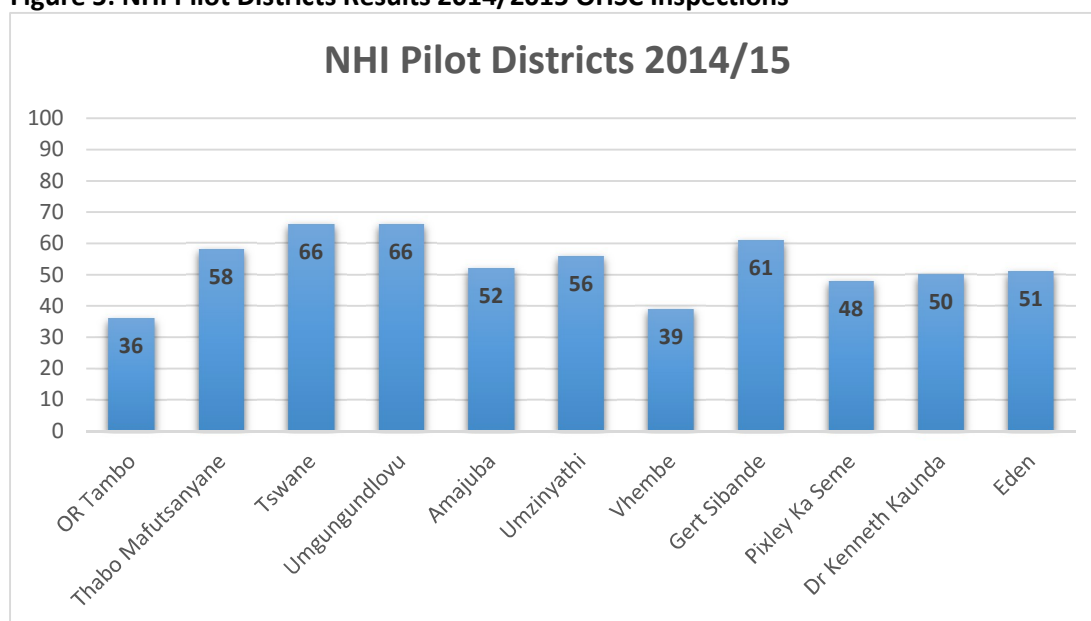


24.5 Of the 11 NHI Pilot Districts, only 4 scored more than 50% in all 6 ministerial priority areas. The results seen in Figure 5 are the overall performance scores, indicating that 6 of the facilities were *Conditionally compliant* or *Conditionally compliant with serious concerns* and 5 were *Non-compliant* or *Critically non-compliant*.

<sup>7</sup> Inspection Results- National Coverage 2014-2015. Office of Health Standards Compliance



**Figure 5: NHI Pilot Districts Results 2014/2015 OHSC Inspections**



24.6 The 2014 StatsSA *General Household Survey* indicated that satisfaction levels with public healthcare are in decline. Table 1 gives an indication of levels of satisfaction with healthcare, as compiled by StatsSA<sup>8</sup>. It can be seen that the percentage of people indicating they are very satisfied with public health services is decreasing and currently sits at 57.5%. The percentage of dissatisfied clients is 10.1% of the total. In comparison, dissatisfied users in private healthcare is 1.5% and 92.5% of users are very satisfied with private Healthcare, more than 30% higher than the public sector.

**Table 1: StatsSA General Household Survey Results<sup>8</sup>, Healthcare**

	2011	2012	2013	2014
<b>Very Satisfied</b>				
<b>Public</b>	61,9%	57,0%	60,5%	57,5%
<b>Private</b>	92,9%	91,7%	94,0%	92,2%
<b>Somewhat Satisfied</b>				
<b>Public</b>	21,7%	21,7%	22,0%	24,2%
<b>Private</b>	4,3%	4,8%	4,0%	5,3%
<b>Dissatisfied</b>				
<b>Public</b>	9,6%	12,7%	10,1%	10,1%
<b>Private</b>	1,9%	1,7%	1,2%	1,5%

24.7 In order to address issues of quality in health services in both public and private, the OHSC entity was established in 2014, based on the National Health Amendment Act of 2013<sup>9</sup>. The purpose of this office was firstly monitoring and enforcing compliance by health establishments with norms and standards; secondly ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a

<sup>8</sup> General Household Survey 2011-2015. StatsSA

<sup>9</sup> Mandate. Office of Health Standards Compliance. <http://www.ohsc.org.za/index.php/who-we-are/mandate>

procedurally fair, economical and expeditious manner and thirdly to inspect and certify health establishments as compliant or non-compliant with norms and standards and where indicated, withdraw such certification. Looking at the function of the OHSC in the NHI, paragraph 217 in the White Paper states: *“Health facilities that meet nationally approved standards will be certified by the OHSC to render health services, and will be eligible for accreditation and contracting by the NHI Fund”*. Furthermore paragraph 393(b) (i) indicates – *“All public health facilities which provide services at considerably lower cost than private for-profit providers, should be the backbone of the health system”*. Based on the current state of public health facilities as discussed and evidenced above, not many of these would get accreditation from OHSC. If 67.7% of facilities were shut down based on the latest OHSC assessment, it is difficult to see how 55 million people in the NHI will be served by the remaining 32.3% of public facilities and facilities currently serving the private sector. Occupancy levels at private hospitals suggest that the private sector does not have the capacity to absorb such large numbers of patients from the public sector.

25. Paragraph 14 of the White Paper infers that for the proper functioning of NHI, a safe and conducive environment for patients and health workers is essential. The National Healthcare Baseline Facilities Audit of 2012 shows a 34% compliance with *Improved Patient Safety* and only two facilities out of 3 380 provided the proper levels of patient safety. Further to this, 93% of maternity facilities did not have the necessary staff and equipment to provide for safety of both mother and newborn. These critical issues in the public sector need to be urgently addressed if one wants to move towards the NHI system. The first 5-year phase of the NHI is currently nearing completion and yet the quality of services in the public sector have not improved. This will directly impact future roll-out of NHI services, as there will now be increased utilization of these substandard services.
- 25.1 If the OHSC performed its mandate, only 32% of current Public Health facilities would be operational in the NHI. It has recently come to light that the OHSC can actually not enforce any action against failing facilities<sup>10</sup> until the Minister of Health promulgates the necessary regulations for norms and standards. Promulgating these standards in the current situation, would have led to between 67% and 84% of the facilities from the 2014/15 OHSC inspection being closed for failure to comply with norms and standards. The only apparent way to improve standards and protect the public is by the Minister of Health promulgating the Norms and Standards.

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<sup>10</sup> Kahn, T. “Hospital watchdog lacks power to enforce standards”. Business Day, 17 March 2016.

26. A further administrative issue regarding the NHI roll-out, is the issuing of an NHI card that is envisioned in the second phase of implementation (Paragraph 17). The addition of an NHI card adds another level of bureaucracy to the system. Between July 2013 and January 2015, the Government managed to issue just over a million smart Identity cards<sup>11</sup>. It took the Department of Home Affairs (whose primary goal is to provide identity documentation) 18 months to issue a million identity cards. It is reasonable to assume that the DOH (whose primary goal is provision of healthcare services) will take much longer than this to issue 55 million NHI cards. The current cost of the South African Identity card is R140, for a re-issue. If the NHI card costs the same, the cost of DOH issuing NHI cards for the entire population of 55 million South Africans, would be R R7.7 billion. Even at a cost of R10 per card, the costs would amount to R550 million. It is not clear if and how, these costs are included in the financial modelling later in the White Paper.
27. In response to paragraph 19, it is the opinion of SAPPF that there is nothing preventing Government from abolishing out-of-pocket payments at Government hospitals today. This will reduce financial hardship on households without having to wait 10 years and will realise access to universal healthcare immediately, without the huge cost burden associated with the NHI. In the 2012/13 financial year, the total income for all 9 provinces<sup>12</sup> for the sale of goods and services was only R1.616 billion. This amount includes claims from medical schemes, some of whom have the public sector listed as the Designated Service Provider (for prescribed minimum benefit conditions), for treatment of their members. Abolishing out of pocket payments would thus minimally impact the Government fiscus.
28. In Paragraph 23, it is indicated that Health Facilities that are eligible would have been certified by the OHSC by the final phase of implementation of the NHI (2025). According to 2015 claims data from a major medical scheme administrator, there are currently a conservatively estimated 600 clinics in the private sector and at least an additional 32 600 private healthcare practice facilities<sup>3</sup> that would need to be inspected by 2025 to be included for accreditation in the NHI. Figures provided by Medpages<sup>4</sup> indicate that there are 12390 Hospitals and clinics registered on their database, with an additional 62 168 registered private practices. No inspection of private facilities has commenced to date in 2016 and norms and standards for these inspections have not been promulgated by the Minister of Health. If these norms and

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<sup>11</sup> Department of Home Affairs. 2015. Smart Identity Document (ID) card roll-out. <http://www.gov.za/about-government/government-programmes/smart-identity-document-id-card-roll-out>

<sup>12</sup> Individual Annual Reports, Provincial Departments of Health 2012/2013 (Gauteng, Mpumalanga, North West, Northern Cape, Western Cape, Eastern Cape, Limpopo, Free State, Kwazulu Natal)

standards get promulgated, it would imply that the OHSC would have to inspect between 8300 and 18640 private facilities annually in the 8 years between 2017 and 2025 for possible inclusion and accreditation in the NHI. This is due to a certification from the OHSC only being valid for 4 years. In 2014/2015, the OHSC inspected 417 government facilities. The number of employees at the OHSC was 96 in 2015/16 and will be increased to 137 in 2017/18<sup>13</sup>. There is no indication whatsoever in the OHSC Annual Performance Plan document, which extends to 2020, of the inspection of approximately 33 200<sup>3</sup> to 74 558 private facilities for inclusion in the NHI. It is thus clear that the OHSC does not have the capacity to do the required inspection and certification of private facilities for inclusion in NHI contracting.

- 28.1 At the Competition Commission's Health Market Inquiry, it was indicated by the OHSC on 4 May 2016 that a certificate of compliance will only be valid for 4 years and that all facilities will have to be re-inspected every four years. This would require that the 3 880 public facilities and 33 200 to 74 558 private facilities will have to be inspected every four years. The OHSC will thus have to inspect between 9 145 and 19 484 facilities annually. With their current staffing complement of 7 inspection teams of 5 inspectors each, this would imply that each team will have to inspect between 5.2 and 11.07 facilities in every work day. In 2014/15 each team was, on average, able to inspect one facility every 4-5 work days. In order to do the necessary inspections, there would have to be between 182 and 388 teams of 5 inspectors working for the OHSC, giving it a staff complement of between 910 and 1 938 inspectors. There is no indication in the budget of the OHSC, which is projected up to 2020 in their annual performance review, of the necessary budget availability to increase their inspectorate capacity by between 2600% and 5500%.

## 2 International Context

29. There should be a distinction between *implementing the NHI* and *implementing Universal Health Care* (Paragraph 44). **Achieving Universal Healthcare is not dependent on the NHI model being implemented.** The NHI is only a funding model. UHC will ensure access for all in an integrated system, without the costs of the NHI's proposed radical reorganisation of the health system.
30. Affordability of healthcare reform for South Africa is indicated by comparison to various other developing, middle income countries in the White Paper. In Paragraph 47 of the White Paper it is stated that "*Previous attempts of health care reform worldwide that did not encompass reforms to health care financing have not always been successful in some countries whilst*

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<sup>13</sup> Office of Health Standards Compliance. Annual performance plan 2015/16 to 2019/20.

*countries such as Mexico and Thailand are examples of countries where attempts to transform health financing have been positive.”*

- 30.1 Comparing South Africa with these developing, middle income countries is an inappropriate comparison, as can be seen in Table 2. This table clearly illustrates the radical differences in unemployment rates between South Africa and the countries used for illustrative purposes. There are also large differences between the GINI coefficients of South Africa and these countries. On average, South Africa’s unemployment figures are 5 times as high (25.4% vs 5.84%) as the countries it is compared to and the GINI coefficient is 48.9% higher than these comparative countries.

**Table 2: Country Comparison of Unemployment and GINI Coefficient**

Country	Population	Unemployment Rate	Gini Coefficient
Turkey	74.93 million	9.2%	40.2
Brazil	202 million	6.8%	52.9
Costa Rica	4.87 million	9.7%	49.2
Thailand	66 million	0.8%	39.3
South Korea	50.42 million	2.7%	31.3
<b>Average</b>	<b>79.64 million</b>	<b>5.84%</b>	<b>42.58</b>
<b>South Africa</b>	55 million	25.4%	63.4

31. Table 3 compares levels of employment in South Africa to other countries with UHC systems. In Paragraph 49 of the White Paper, Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the UK are specifically mentioned (Paragraph 49) as countries that successfully implemented Universal Healthcare. The average percentage of employed people in these countries, is 59.38%. It can be seen in this comparison that South Africa has 52% fewer employed people in the population than these countries mentioned in the White Paper. When one includes other countries utilising UHC, such as Denmark, Mexico, France, Iceland, Japan, New Zealand, Costa Rica, South Korea and Australia, a similar employment pattern can be noted. This creates a major barrier for funding of the NHI through tax revenue, as there are simply not enough people that can pay for the system.

**Table 3: Employment percentages<sup>14</sup> in selected Countries with Universal Healthcare**

<b>Country</b>	<b>2014</b>
Brazil	65
Canada	61
Finland	54
Norway	62
Sweden	58
Thailand	72
Turkey	45
United Kingdom	58
<b>Average</b>	<b>59.38</b>
Denmark	58
Mexico	59
France	50
Iceland	70
Japan	56
New Zealand	63
Costa Rica	58
South Korea	75
Australia	61
<b>Average (ALL)</b>	<b>60.28</b>
South Africa	<b>39</b>

32. It is indicated that the implementation of NHI will take into account the country's experiences and global lessons learnt in the development of UHC (Paragraph 50).
- 32.1 There are several examples of lessons learnt internationally regarding universal health coverage that appear not to have been taken to heart in the South African context. If one looks at the case of South Korea specifically<sup>15</sup>, a National Health Insurance was implemented over a twelve year period. The government mandated medical insurance for companies with more than 500 employees and this was subsequently extended to the whole nation in 1989. This system ran smoothly until 1997, when a major economic crisis hit South East Asia. There was an increasing annual deficit in the NHI after this period. The South Korean government continued to raise the contributions to try and make up the deficit, but did not succeed in doing so. Increased government funding was not solving the problem, as South Korea was unable to control health care expenditure. The South Korean Government assumed exclusive control over medical care financing without including medical professionals in the policymaking process. Organised medicine complained that only 65% of customary medical costs were reimbursed by the government insurance system. 90% of the South Korean system

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<sup>14</sup> World Bank employment to population ratio. <http://data.worldbank.org/indicator/SL.EMP.TOTL.SP.ZS>

<sup>15</sup> Lee, J-C. 2003. "Health Care Reform in South Korea: Success or Failure". American Journal of Public Health 93(1)

was based on Private Fee for service consultations, with only 10% of services performed by public facilities, which contributed to raising costs. In 2009, there were 49 238 227 Koreans registered with the NHI. Of these, 57.7% (28.4 million) are employee insured members, who each contribute 5.08% of their annual income towards NHI, with their employer contributing the same amount. Self-employed, insured individuals amount for another 38.6% (18.9 million) members, who contribute various amounts. The government is responsible to provide coverage for the poor and indigent, who constitute 3.7% of the population<sup>16</sup>. There is a co-payment system of 10% to 20% of inpatient costs and between 30% and 50% of outpatient consultation costs. This research indicates that the South Korean Government is struggling to fund healthcare for the 3.7% of the population that cannot afford to self-fund.

- 32.2 To compare with South Africa, South Korea has 47.4 million users of the NHI that self-fund at a rate of between 6% and 10% of their annual income along with co-payments ranging from 10% in-hospital to 50% of outpatient costs. Despite this massive funding base, the government is struggling to fund the 3.7% of the poor and indigent in the NHI. South Africa has 5.7 million taxpayers who will be funding 55 million South Africans, without any co-payments, at a government suggested rate of a 4% tax increase. Based on the Korean model it is obvious that the South African funding approach to the NHI is totally insufficient, making the NHI system unaffordable. Further serious implications for the implementation of NHI in South Africa includes that utilising an NHI based system in periods of financial crisis does not work. South Africa is undoubtedly experiencing a financial crisis with twin deficits, low growth and a domestic currency which serves as a proxy for emerging market currencies and hence is subject to extreme volatility. Trying to implement an NHI in such circumstances is doomed to fail. Secondly, not including medical professionals in the policy making process, such as the NHI Fund and a Minister unilaterally determining reimbursement amounts for services, would be catastrophic.
33. Similar to South Africa, the republic of Ireland published a Universal Healthcare Insurance (UHI) White Paper in 2011<sup>1</sup>. This White paper did not allude to any costing of the Universal Healthcare system and did not describe the basket of services offered under the Universal Healthcare Insurance. In 2015, it has come to light that Ireland cannot actually afford the system, following costings and analysis from the Economic and Social Research Institute (ESRI). The ESRI study, which was based on the White Paper details, clearly shows the [Irish] Government's proposed model "is not affordable now or ever". UHI proved a vote winner in

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<sup>16</sup> Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal* 52(3)

the 2011 general election. However, the [ruling] party's failure to cost its own proposals then, and the Government's subsequent failure to do so until 2015 represented the "outstanding policy failure of the Coalition administration".

34. Looking at the situation in Canada<sup>17</sup>, it is seen that Canada has the second most expensive healthcare system as a share of the economy and adjusting for age. Long wait times in Canada have also been observed for basic diagnostic imaging technologies that many countries take for granted, which are crucial for determining the severity of a patient's condition. In 2013, the average wait time for an MRI was over two months, while Canadians needing a CT scan waited for almost a month. These wait times are not simply "minor inconveniences." Patients experience physical pain and suffering, mental anguish, and lost economic productivity while waiting for treatment. One recent estimate (2013) found that the value of time lost due to medical wait times in Canada amounted to approximately \$1,200 per patient. There is also considerable evidence indicating that excessive wait times lead to poorer health outcomes and in some cases, death. Dr Brian Day, former head of the Canadian Medical Association recently noted that *"delayed care often transforms an acute and potentially reversible illness or injury into a chronic, irreversible condition that involves permanent disability."* New research also suggests that wait times for medically necessary procedures may be associated with increased mortality. One of the important statements of this report, was that it was important to recognize that a single-payer model is not a necessary condition for universal health care. There are ample examples from OECD countries where universal health care is guaranteed without imposing a single-payer model.

### **3 Mal-distribution and Inadequate Human Resources for Health**

35. Paragraph 77 of the White Paper states that "The main contributor to inequity in health care is the existence of a two-tier healthcare system where the rich pool their health care funds and resources separately from the poor. These inequities have also resulted in mal-distribution of key health professionals between the public and private health sectors". This statement is fundamentally and factually flawed; there is also no evidence provided to substantiate such a claim.
- 35.1 Research published by Econex in 2013<sup>18</sup>, which was also used in the Department of Health Human Resources for Health South Africa 2012/2013- 2016/17 publication, is utilised for this paragraph (Table 4). In their research, Econex indicates that between 28% and 38% of

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<sup>17</sup> Clemens J, Barrua B. "If Universal Health Care Is The Goal, Don't Copy Canada". Forbes Magazine, 13 June 2014

<sup>18</sup> Econex. 2013 "The South African Private Healthcare Sector: Role and Contribution to the Economy".



residents in South Africa utilise private healthcare. 16% of these are members of medical schemes and the rest utilise the private sector by Out of Pocket expenditure. So the 16% of the population that belong to medical schemes do NOT constitute the entire private sector and should not be used to indicate imbalances in human resource distribution. Numbers for nurses indicate that 62% of nurses work in the Public sector. It was important to not assume automatically that every nurse registered with the HPCSA, who is not working for government, is employed in the private sector. This mistake is often made and leads to a disproportionate number of nurses being assumed to work in the private sector, when in fact, some of these have left the country or are no longer practicing. Many nurses also work for mining companies' clinics, non-governmental organisations (NGOs), non-profit organisation (NPOs) or retail pharmacy clinics – also providing care to the poor, while not being employed by the DOH. When it comes to General Practitioners, 63% of GPs are shown to work in the public sector. Looking at the number of Hospital beds, 71.5% of beds are in the public sector. Finally, when one looks at specialists, it can be seen that 41% of specialists work in the public sector, with 59% of Specialists working in the private sector.

**Table 4: Distribution of Healthcare Resources Between Private and Public Sector<sup>18</sup>**

	<b>Public Sector</b>	<b>Private Sector</b>
<b>Utilisation by Population</b>	62-72%	28-38%
<b>Nurses</b>	62%	38%
<b>General Practitioners</b>	63%	37%
<b>Specialists</b>	41%	59%
<b>Hospital Beds</b>	86 774 (71.5%)	34 572 (28.5%)

- 35.2 It is also important to note that the DOH is currently driving a Primary Health Care focus and there is thus a shortage of available, funded posts for specialists in Government. If these specialists were not accommodated in the private sector, they would have been forced to leave the country and would have been lost to the population. Table 5 is taken from the DOH Human Resources for Health South Africa 2012/2013- 2016/17 publication<sup>19</sup>. It shows the distribution of specialists between public and private sector. At the very bottom, one can note that 41.5% of specialists work in public- and 58.5% work in the private sector.
- 35.3 If one looks at 62%-72% of the population being served in the public sector, the distribution of personnel and beds are actually representative of the number of people utilising the services, with the exception of specialists. It is concerning to SAPPF that the DOH is ignoring its own human resource data in the NHI policy papers to try and justify radical changes to the healthcare system in South Africa in the form of the NHI.

<sup>19</sup> Department of Health. 2012. Human Resources for Health South Africa 2012/2013- 2016/17.

**Table 5 Distribution of Specialists Amongst Public and Private Sector<sup>19</sup>**

	<b>Public Sector</b>	<b>Private Sector</b>
<b>Anaesthetists</b>	405	794
<b>CardioThoracic Surgeons</b>	56	64
<b>Dermatologists</b>	55	131
<b>Emergency Medicine</b>	17	18
<b>Family Physicians</b>	521	269
<b>Forensic Pathologists</b>	42	3
<b>Maxillo Fascial Surgeons</b>	33	85
<b>Neurologists</b>	47	76
<b>Neurosurgeons</b>	31	105
<b>Nuclear Physicians</b>	21	24
<b>Obs &amp; Gynaes</b>	263	625
<b>Ophthalmologists</b>	69	204
<b>Orthodontists</b>	45	83
<b>Orthopedics</b>	184	421
<b>ENT</b>	91	201
<b>Pediatricians</b>	322	358
<b>Periodontists</b>	23	31
<b>Physicians</b>	302	339
<b>Plastic Surgeons</b>	50	107
<b>Prosthodontists</b>	32	40
<b>Psychiatrists</b>	302	339
<b>Public Health Medicine</b>	60	43
<b>Occupational Medicine</b>	12	10
<b>Radiation Oncologists</b>	71	82
<b>Radiologists</b>	320	393
<b>Surgeons</b>	303	332
<b>Urologists</b>	92	130
<b>TOTAL</b>	<b>3769 (41.5%)</b>	<b>5307 (58.5%)</b>

35.4 A further concern is the lack in the number of healthcare personnel being trained that would ultimately be available to render services in the NHI. There is an absence of steps being taken to increase the number of medical graduates in South Africa, which would lead to a radical shortage of NHI staff, going forward. In 2001, there were 1229 Medical school graduates in South Africa. In 2013 the number of graduates has increased to 1409<sup>20</sup>. This is an increase of 14.6% in graduates over a 12 year period, with a peak of 1511 graduates in 2005. In the same period, the population in South Africa increased from 44.8 million to 53 million. This amounts to an 18.2% increase in population. There is thus an absence in true correlation between population growth and the number of medical school graduates produced in South Africa. This serves to increase the shortage of doctors available to the NHI. In 2006 there were 5.9 million citizens per medical school, while in 2013 this number has increased to 6.6 million per medical

<sup>20</sup> Econex Report. August 2015. "Identifying determinants of and solutions to the shortage of doctors in South Arica: Is there a role for the private sector in Medical Education".

school. South Africa produces 3.7 medical graduates per 100 000 citizens, whereas the OECD average is 10.7 per 100 000 citizens<sup>20</sup>. There is no indication in the White Paper that the number of medical schools or graduates will be increased sufficiently to cover the requirements for the NHI.

- 35.5 A third concern is that in 2010, 42.5% of posts in the public health sector in South Africa were vacant, which was an increase from 33% in 2009 and 27% in 2005<sup>21</sup>. There is thus a decreasing number of health professionals working in the public sector, with provinces such as Limpopo facing 70% vacancies in posts. A concerning trend in the public health system is also that while medical doctor numbers have only increased from 15 554 in 1997 to 16 006 in 2006 (2.9% increase in 10 years) administration and management increased from 28 676 in 1997 to 37 419 in the same period, a 30.4% increase. There was also a 259% increase in managers in the same period (increased from 420 to 1091). Growth in public sector employment is thus focusing on the wrong areas. This is especially worrying, as there were 11 700 medical graduates from 2002 to 2010 and only 4403 additional posts were created in the public sector<sup>19</sup>. Despite massive numbers of vacancies, government is unable to retain medical staff, which is another indication that poor work circumstances is leading to loss of healthcare personnel.

#### **4 Out-of-Pocket Payments**

36. Paragraph 88 in the White Paper further alludes to the poor quality of Public Health. “The South African Human Rights Commission has also raised concerns about user fees and states: *Primary health care is provided free of charge. Children under six years of age, pregnant women, the disabled and the indigent do not pay user fees for higher levels of care, and the National Health Act allows for free health care to be extended to other categories of users. However, in research presented to the public hearing, it was found that only half of those who visited a public hospital obtained an exemption despite all being eligible. The research also found that general private facilities were more popular than public hospitals despite the costs involved with the former. Of the households interviewed, 20% incurred “unaffordable” costs.* Private healthcare is thus more popular than government facilities, despite the costs involved. This is another indication of the poor quality of public services in Healthcare. If the government is serious about NHI, the quality in the Public Sector needs to be addressed immediately, so as to provide the NHI with the “back bone” it needs.

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<sup>21</sup> Lloyd B, Sander D & Lehmann, U. 2010. “Human Resource requirements for National Health Insurance”. SA Health Review 2010.

37. Paragraph 89 of the White Paper refers to out of pocket expenditure (OOPs) amongst medical scheme members and is another concerning, incorrect statement used to justify the NHI. *“Within the private health sector, members of medical schemes are subjected to high OOPs. Private hospital fees, specialists’ and medicine costs account for the bulk of the OOPs. According to the Council for Medical Schemes annual report, OOPs increased by 11.9% to R20.7 billion between 2013 and 2014. This translates to approximately R6,000 per beneficiary (8.8 million covered beneficiaries) paid out as OOPs for accessed services.”* This mathematical equation is incorrect. Dividing R20.7 billion by 8.8 million beneficiaries gives an amount of R2 352.27 per beneficiary. It is concerning to SAPPF that erroneous statistics and mathematics are utilised to try and prove costs. This creates uncertainty regarding the soundness of the White Paper and the analysis therein. Given benefit structures and PMBs, it is also doubtful that ‘private hospital fees’ will account for the bulk of OOPs by medical scheme members.
38. In response to Paragraph 107(d): No evidence is provided that this new state-controlled entity will be more efficient than administrative entities currently operating within the competitive private sector. The White Paper simply asserts the proposition that NHI will be more effective.
39. Paragraph 107(e) of the White Paper appears implicitly to suggest that the single purchaser model will enable services to be purchased at a discount to existing medical scheme rates of reimbursement. It is important to note that current medical scheme rates of reimbursement are, in general, unreasonably low and it is thus most unlikely that the single purchaser will be able to drive costs down. The rates of reimbursement for service providers of the majority of medical schemes continue to be based on the RPL, which has been shown to be inappropriately low.
- 39.1 The cost studies prepared as part of the RPL process in 2008, indicated that the rates reflected in the then RPL were significant lower than they would be if a more rigorous approach to health care costing were to be applied. For example, the Rand Conversion Factor (RCF) in 2009 was R12.56 per minute for consultation services, while the cost studies indicated that the RCFs for consultations should vary from R18.25 for GPs to R28.70 for neurosurgeons. The discrepancies in respect of procedures were, in many instances, even more dramatic.
- 39.2 In fact, Ebersohn AJ, in striking down the RPL, observed that: “[t]he fact that the 2009 RPL reflected rates that were unreasonably low meant that private health care providers would

continue to struggle to cover their costs (let alone make a reasonable return on investment) - a burden many of them have already carried for a number of years”<sup>22</sup>

- 39.3 Any determination of reasonable costs must, at a minimum, enable practitioners to cover their costs (which costs are efficiently incurred) and to earn a reasonable living (i.e. a reasonable rate of return or margin). A rate of reimbursement based on a discount off existing medical scheme rates will push most doctors into bankruptcy or out of medicine or to emigrate, and cannot be considered reasonable. This could undermine the right of access to health care.

## 5 National Health Insurance Coverage

40. The intention to focus primarily on prevention of disease and the promotion of health is supported as the most appropriate use of state resources (Paragraph 116). Unfortunately, this paragraph of the White Paper provides no information as to the current gaps in the achievement of universal coverage in South Africa but simply reflects the WHO’s three dimensions for assessing universal coverage. Consideration should be given to the causes of a hospital-based system, which is curative by nature, especially those causes captured in the WHO Report. We note that this characteristic of a health care system often results from the disease burden, consumer demand and other factors not necessarily within the control of providers of health care services.
41. Paragraph 118 states that NHI will cover “all South Africans” and “legal permanent residents”. Medical scheme members currently fund their own health care needs. As explained above, this reduces the funds that the State must provide to fund the population’s health care needs, and frees up the State to concentrate its resources on serving the disadvantaged sector of society. Under the proposed NHI, the State will have to assume financial responsibility for this currently-insured segment of the population as well and will be responsible for their contribution to the national load of disease which will be treated via the NHI system.
42. Paragraph 123 of the Policy paper refers to “Temporary residents, foreign nationals (with and without visas), foreign students and tourists will be required to have their own medical insurance”. Paragraph 27 of the Bill of Rights in the South African Constitution states that:
- (1) **Everyone** has the right to have access to— (a) health care services, including reproductive health care; and

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<sup>22</sup> *Hospital Association of South Africa and Others v Minister of Health and Others*, 2010 (10) BCLR 1047 (GNP); [2011] 1 All SA 47 (GNP) at para 118.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

- 42.1 This paragraph does not specify “ALL CITIZENS have the right of access to...”, it specifies, “*Everyone* has the right to have access to...”. According to the latest South African census data of 2012<sup>23</sup>, there are currently 2.2 million immigrants living in South Africa. Of these, 1.7 million people were not South African citizens. If these migrants cannot afford medical insurance, 3.3% of the South African population could potentially be excluded from Healthcare services in South Africa. Excluding immigrants could potentially be in violation of the Constitution in this setting.
43. The NHI basket of care is painted in broad strokes in Paragraph 131 of the White Paper. It is important to note that these do not constitute a defined benefit package which can be costed. This basket will include, but is not limited to the following services:
- i. Preventive, community outreach and promotion services
  - ii. Reproductive health services
  - iii. Maternal health services
  - iv. Paediatric and child health services
  - v. HIV and AIDS and Tuberculosis services
  - vi. Health counselling and testing services
  - vii. Chronic disease management services
  - viii. Optometry services
  - ix. Speech and Hearing services
  - x. Mental health services including substance abuse
  - xi. Oral health services
  - xii. Emergency medical services
  - xiii. Prescription medicines
  - xiv. Rehabilitation care
  - xv. Palliative services
  - xvi. Diagnostic radiology and pathology services
44. The Basket of care in the NHI, will, however, not be all encompassing. This is alluded to in Paragraph 125 of the White Paper, which states: “NHI will provide a comprehensive package of personal health services. As resources are limited, the delivery of a comprehensive package will take into account the need to progressively realise the personal health benefits whilst undertaking priority setting. NHI will not cover everything for everyone”. It is further referred to in Paragraph 134 of the White Paper: “Health technology assessment will be used in priority setting and therapies that have little impact on positive health outcomes will not be paid for under NHI whilst the most cost-effective evidence based strategies will be deployed” There are even mentions of co-payments in Paragraph 150 “...South Africans will only pay out-of-pocket and/or co-payments for services that are not covered under NHI.” In Paragraph 375,

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<sup>23</sup> Census results 2012. StatsSA

which deals with fraudulent activities, the following is stated: “With respect to patients, they may use fake identity documents to access and use NHI health benefits even though they are not entitled to them. They may also agree to have the doctor write a wrong procedure in order to get the NHI to pay based on DRGs to avoid the NHI Fund declining payment of a rare condition or a condition not included in the service benefit”. It is thus, not quite a free comprehensive scheme for all, with mention of co-payments and rare conditions excluded from the service.

- 44.1 If one looks at specifically rare disease that might be excluded from the basket of care, one could look at a patient with Haemophilia (a non-curable blood clotting disease that is expensive to diagnose and requires lifelong, expensive treatment) as an example. This patient might get treatment at the local clinic for free for initial symptoms and would get referred on to tertiary structures as required for diagnosis. Once diagnosis is made, it is likely that this disease will not be covered in the NHI Basket of care, because it is rare and expensive to treat. The patient would now have the option to make co-payments to pay for treatment of his disease, as stipulated in the policy document, or having a medical scheme pay for the treatment, as this would potentially fall under the complementary nature of medical schemes as set out in the White Paper. If the patient is poor or indigent, it is unlikely the patient would be able to afford a co-payment or medical scheme cover. It is not clear what would happen to the patient in this situation. Even if they were able to afford membership of a medical scheme, the scheme will institute a mandatory waiting period for a pre-existing condition. In the current public health system, the patient would have received the care he required and would have ended up in one of the tertiary academic hospitals being looked after by an academic expert haematologist. Under the NHI, in these circumstances, the patient would be denied life prolonging treatment, which would have been provided under the current system.
- 44.2 Further to this, the question arises: How would a doctor know in advance that a patient has a rare condition or a condition not covered by the NHI? A diagnosis can only follow examination and diagnostic testing, hence arriving at a diagnosis. If it is at PHC level, the patient might be referred on to a secondary or tertiary facility and the diagnosis might only be made at this point. The PHC facility will then be punished by not being paid for treatment/testing already undertaken in their unsuccessful attempt to reach a diagnosis for a rare condition. Alternatively, the patient will be expected to make a co-payment.

## **6 Organisation of the Health Care System and Services under the NHI**

45. Paragraph 157 refers to NHI Pilot projects and lessons learnt that will be used to strengthen service delivery. A concern in the pilot process is that the main part of the NHI, namely the centralised NHI fund, cannot be piloted. The individual multidisciplinary Functional Business Units described in Paragraph 205 of the White Paper also cannot be piloted to assess the proposed capitation payment system. The pilot sites purely focus on service delivery processes, but the actual funding model has not been piloted in any way. The latest National Budget delivered by Minister Pravin Gordhan in February 2016, also does not make any financial provision for increased funding of the NHI pilots (nor the testing of the funding model specifically) up to 2018/19.

## **7 PHC Re-engineering**

46. In general, the concept of strengthening the PHC system, with its focus on prevention of disease and promotion of health (Paragraph 161), is supported by SAPPF. The appropriateness of such an approach was outlined by the WHO at the international conference on PHC held in Alma Ata in 1978.
47. SAPPF supports the intention to strengthen specialist services at the district level to manage the burden of disease in currently underserved areas (Paragraph 162c). Finding the necessary human resources to fill these posts may, however, prove to be quite a challenge and the development of a NHI model (and the timing for the implementation of that model) should consider this practical reality. Appropriate engagement with specialists is advised to design the most efficient way of serving these areas.

## **8 Role, functions, management and governance of Central Hospitals**

48. Paragraph 205 refers to *Cost Centre Management* which will include: *“Implementation of International Classification of Diseases Tenth Edition<sup>35</sup> (ICD-10), the use of diagnosis related groupers (DRGs) to determine costing and case-mix, cost accounting, statistics, practice management, budgeting, forecasting and expenditure control. Within the central hospitals, work is currently underway to pilot the implementation of the Diagnosis-Related Groupers (DRGs) in the ten central hospitals.”*
- 47.1 This entire process does not take into account the fact that costing in public facilities is radically different from those in the private sector. Budgeting, forecasting and expenditure control in the private sector displays much higher levels of overhead costs, as a public hospital does not have any rental or building maintenance costs, as these are managed by the



Department of Public Works. Generally, salary levels in the private sector are also higher than in the public sector, which needs to be taken into consideration. Costing of services for development of DRGs being purely done on a public platform will lead to under-compensation in the private sector and the inability of private practices and hospitals to remain financially viable.

## **9 Expenditure Projections and Cost Estimates for NHI**

49. Paragraph 249 and 250 refers: Although the World Health Organisation (WHO) is alluded to in the White Paper as cautioning that while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated costs. The DOH then seems to dismiss focusing on the question of “what will NHI cost” as the wrong approach, insisting that it is better to frame the question around the implications of different scenarios for implementing reforms that will achieve universal health care (UHC). It is a fatal flaw in assuming that one does not need to do a costing of the NHI in order to implement it. The WHO clearly states that costing assumptions and scenarios may be useful for raising *core policy issues* regarding the sustainability of reforms.

## **10 NHI Expenditure Projections: Modified Costing from Green Paper**

50. In its NHI Cost Projection (Paragraph 253), to reach R256 billion in 2025/26, “*NHI expenditure increases by 6.7 per cent a year in real terms after 2015/16, resulting in a cost projection in 2025/26 of R256 billion in 2010 prices. These projections would take the level of public health spending from around 4 per cent of GDP currently to 6.2 per cent of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5 per cent. This increase would be below the level of public spending (as a percentage of GDP) of many developed countries.*” The South African GDP growth rate has been slashed to 0.6% for 2016 and to 1.2% for 2017 by the International Monetary Fund<sup>24</sup>. The GDP growth projection used for this NHI model does not reflect reality. This will lead to a much larger spending shortfall, which will need to be financed. The 2010 baseline costs used, only indicate the public health budget for 2010. The NHI system will combine both public and private patients in one system, yet the estimated cost projections only included figures for Government spend on public healthcare. Furthermore, it is also indicated that treatment of Workmen’s Compensation Act and Road Accident Fund victims will also be moved to the Public Sector under the NHI. The budget for these two funds are also not included in the NHI cost estimates. As private spending was similar to public spending in

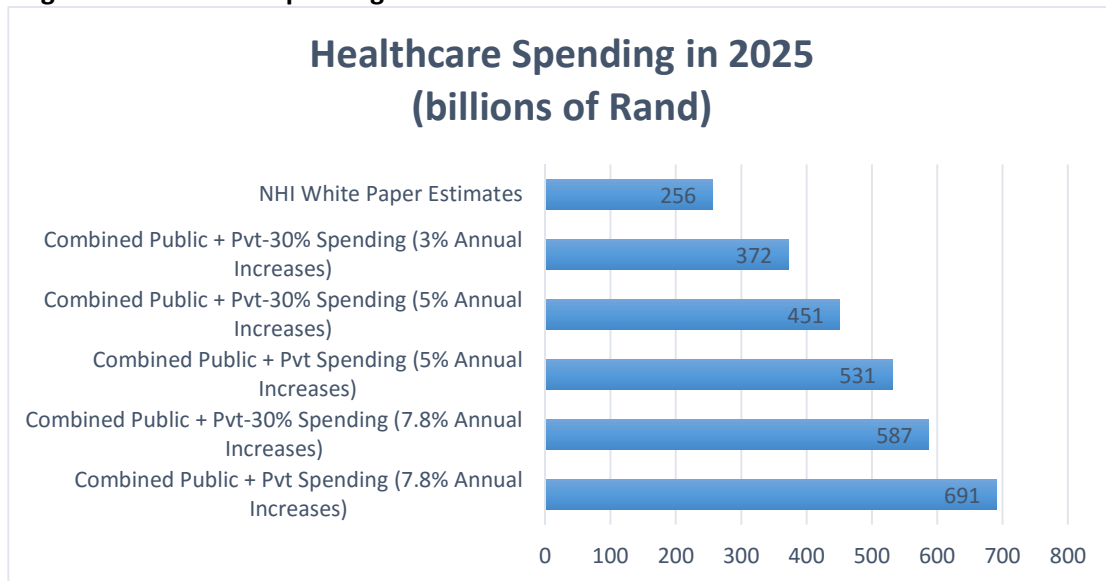
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<sup>24</sup> IMF. World Economic Outlook- Too slow for too long, April 2016.

2010, the assumption by this model to only include government spend, would provide insufficient funds for the number of users of the system. This is a very unrealistic model. This model, using 2010 terms, also does not include the fact that the Rand has depreciated by 26% between 2010 and 2016 against the US dollar.

- 50.1 It is important to note that the cost of increased taxation in the form of a payroll tax on employers will ultimately be passed on to consumers through higher prices. This will, in turn, result in a loss to consumer welfare through the erosion of disposable income. The additional burden imposed on employers will also increase the labour cost which will, in turn, limit job creation and place downward pressure on salaries. Such effects on the labour market may be detrimental to South Africa, given that we already struggle with high unemployment and where job creation is explicitly stated as one of government's main objectives.
- 50.2 Figure 6 illustrates the projected NHI spend, if one looks at different inflation figures. It can be seen that combined Public and Private spending at 3% annual inflation and a 30% discount on Private spending (attributable to a government control of private costs) will lead to estimated spending of R372 billion on Healthcare in 2025. A 3% annual inflation is highly unlikely. A 5% annual inflator in the scenario described previously will lead to R451 billion in Healthcare spend by 2025. In the worst case scenario, current private and public spending is combined with a 7.8% annual inflator, without any cost control discounts in the private sector, which will lead to spending of R691 billion in 2025. In our opinion, the most realistic cost estimate is combined Public and Private spend (minus 30% government cost control), with a 7.8% annual inflator. This estimates a cost of R587 billion for healthcare spend in 2025. None of these figures take into account the decline of the Rand exchange rate to the dollar and the effect this would have on costs. The rand has depreciated by 25-30% against the Dollar between 2010 and 2016. All of these figures will make for a totally unaffordable NHI system.

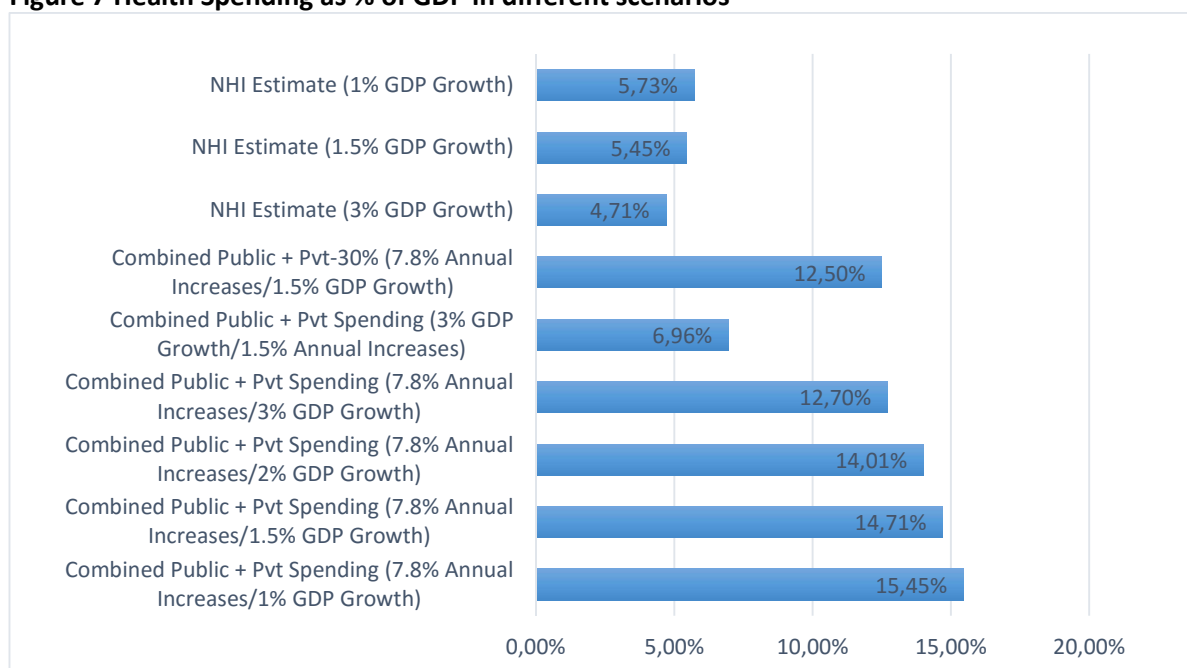
**Figure 6: Healthcare Spending Estimates with different scenarios**



51. In response to Paragraph 257, Figure 7 estimates the level of Healthcare spend as a percentage of GDP in different growth scenarios. It can be seen that the current NHI estimate at 3% GDP growth would result in healthcare spend equalling 4.71% of GDP. If GDP growth declines to 1% annually (2016 growth set at 0.6% by IMF<sup>13</sup>) NHI spending would total 5.73% of GDP at the current R256 billion Estimate. If one looks at the previous projection of Public + Private spending (30% cost control discount applied) at 7.8% annual inflation, the amount of R 587 billion will equate to 12.50% of GDP at a GDP growth rate of 1.5% annually. If one takes into account that South African Government budgeting is currently not allowed to exceed 25% of GDP, it can be seen that this healthcare spend would lead to half of the Government budget being spent on Healthcare. This is quite obviously neither affordable, nor feasible. Most of the other spending scenarios generate even worse figures than this.

51.1 The affordability of the NHI is definitely a core policy issue. One cannot ignore considering the costs involved, nor can we dismiss it as “the wrong approach”. South Africa cannot afford the NHI system. This does not, however, mean that South African cannot afford UHC. What it does imply, is that a different, more appropriate funding model needs to be considered. The low levels of employment and the small base of tax payers in South Africa compared to other countries using tax-funded public health systems is an indication that one needs to have higher levels of employment to sustain such a system. Affordability is a core issue. One cannot ignore this. Continuing to avoid investigating the costs involved will eventually end bring us to a point where the affordability issue can no longer be ignored, by which time billions of Rands would have gone to waste on pilot projects and other administrative expenses in trying to implement this unaffordable system.

**Figure 7 Health Spending as % of GDP in different scenarios**



## 11 Establishment of the NHI fund

52. Paragraph 322 of the White paper states that “NHI will be established as a single-payer and single-purchaser fund responsible for the pooling of funds and the purchasing of personal health services. The NHI Fund will be appropriately financed in order to be able to actively purchase personal health services for all who are entitled to benefit.” The NHI will be administered as massive medical scheme, governed by a ministerial board or trustee-like body and providing a prescribed set of benefits from a prescribed set of healthcare providers for a certain cost. It will be a medical scheme with approximately 25 times as many members as Discovery Health. Government has illustrated its perceived inability to administer organisations of this nature. As an example of this perception, we will look at the Compensation Fund specifically, as its business of paying out medical claims to practitioners and hospitals, is very similar to what the NHI would be doing in future.

52.1 The Compensation Fund registers about R8 billion a year in income<sup>25</sup> from contributions made by all registered South African employers. The fund currently has R52 billion in assets, most of which is administered by the Public Investment Corporation (PIC). In 2012/13 Medical Claim Payments were R1.5 billion, in 2013/14 R2.1 billion and in 2014/15 R1.4 billion. In April 2015, in answer to a parliamentary question, the Director General of Labour, Thobile Lamati, indicated that there were 231 000 outstanding claims<sup>26</sup>, to the amount of R23 billion. He

<sup>25</sup> Annual Integrated Report 2014/2015. Compensation Commissioner

<sup>26</sup> Ensor, L. “Claims Firm Stops Prefunding Doctors”. Business Day 12 May, 2016

further indicated that they were planning to have the backlog cleared up before June 2015. In this timeline, the DG was indicating that they were planning on paying more claims in 2 months than in the previous 10-12 years and they were planning on divesting half of the Fund's assets at the PIC within that period to do so. We think this raises justifiable concerns regarding the levels of administrative unawareness that run in the government administration. In the week of 15 April 2016, the previous compensation commissioner was sentenced with a three month suspended jail sentence for failing to comply with a court order where he agreed to pay outstanding claims in 75 days. The newly implemented Umehluko system was supposed to streamline the claims process, but last year, one of the largest pre-funders of WCA claims, Compsol, had to cease their pre-funding activities, as the new system "has virtually ground to a halt due to its dysfunctionality and incapacity to process and pay the volume of claims and medical accounts in SA"<sup>27</sup>. Claim payments have dropped from 1.8 million claims in 2013/14 to 609 000 claims in 2014/15. Furthermore, the RSSA and 19 radiological practices are litigating against the Department of Labour for R121 million in outstanding claims.

52.1.1 The Compensation Fund employs 1630 people that paid out R1.4 billion in medical claims last year<sup>28</sup>. In comparison, Discovery Health has 5 times this number of employees and paid out 26 times the amount in medical claims. The NHI budget is 32 times larger than that of the Compensation Fund and the amount of claims payable is likely to be a 100 times more, not including the payment of suppliers. Extrapolating the current levels of service in the Compensation Fund, this would require the NHI Fund to employ between 52 000 and 160 000 employees. To compare: the SA Defence Force currently employees 89 000 full time people. The inability of Government to run an R8 billion fund efficiently, raises serious concerns in SAPPF regarding the effective and efficient administration of a R256 billion NHI fund by the same Government.

52.2 If one looks at the department of Health in Gauteng as an indication of current inefficiencies<sup>29</sup>, the MEC indicated that there was R296 million owed to 509 companies in Jan 2016. Of these, R239 million (245 Suppliers) were outstanding for more than 3 months and R105 million (203 Suppliers) were outstanding for more than 6 months. It is difficult to believe that there isn't a similar situation in other provincial health departments, as Gauteng is generally considered

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<sup>27</sup> Ensor, L. "Claims Firm Stops Prefunding Doctors". Business Day 12 May, 2016

<sup>28</sup> Annual Integrated Report 2014/2015. Compensation Commissioner

<sup>29</sup> Bloom, J. "Gauteng Health owes 296m to 509 companies". Politicsweb

one of the more efficient departments. The governance failures highlighted in this paragraph, focusing on the Compensation Fund and the Gauteng Health Department raises serious concerns as to the suitability of government as the administrator of a single payer model such as the NHI.

- 52.3 To grasp some of the challenges facing SA's bureaucracy, consider the data gathered by the Lean Institute Africa<sup>30</sup>, which takes its philosophies on running leaner systems from the well-regarded Toyota Way, with its fundamental beliefs in continuous improvement, as well as respect for people.
- 52.3.1 The data was gathered in a series of 10 two-day workshops for public servants nominated by the premier in each province. The participants, who were all in senior positions in the public service, were told emphatically that the workshop schedule was long, and that punctuality was vital. What typically happened was that at 8am, only 11% of attendees had arrived for the workshop, and by 8.45am, only 78% were present.
- 52.3.2 On day two, participants were given the option of a later start time to guarantee punctuality, but by 8am, only an average of 33% of people were ready to start. In every session of the workshop, there were people who had committed to attend, but failed to arrive. This typifies what is wrong with the government. What should be abnormal has become normal, and it leads to instability, which in turn affects the people who should be served.
- 52.4 Research published by Rispel, De Jager and Fonn<sup>31</sup> in 2015 explored corruption in the South African Health Sector. The findings were a clear indication that there is poorly controlled corruption in all Provincial Health Departments. Reports from the Auditor General indicated that irregular expenditure in Provincial Health Departments more than doubled from R3.3 billion in 2009/10 to R 7.5 billion in 2012/13. The report further shows that financial audit outcomes for Provincial Health departments are getting progressively worse from 2004 to 2013. It is recommended in the report that mechanisms to reduce corruption should include the political will to run corruption-free health services; effective government to enforce laws, appropriate systems and citizen advocacy to hold public officials accountable.
53. Based on the current questionable administration and worsening corrupt state of Provincial Health Departments, the administrative mismanagement displayed in the Compensation Fund

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<sup>30</sup> Faull, N. "How SA can fix its broken bureaucracy". Business Day, 28 April 2016

<sup>31</sup> Rispel, LC; De Jager, P & Fonn S. 2015. "Exploring Corruption in the South African Health Sector" Health Policy and Planning 00 (0)

and general bureaucratic inefficiency displayed in Government, the prospect of a successful and efficiently functioning Government administered, single payer NHI fund is unlikely.

## **12 Contracting of health service providers**

54. There are various concerns regarding the proposed integration and reimbursement of private healthcare services in the NHI. The White Paper states *“The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms. Providers who wish to contract with the NHI Fund must comply with the stipulated pricing and reimbursement mechanisms”* (Paragraph 335). If Healthcare Professionals are not willing to accept whatever compensation the NHI is willing to offer them, or the reimbursement mechanism offered for their services, they will be forced to leave the country, leading to a drain of scarce, qualified healthcare professionals from South Africa. If one looks at the current state of the Compensation Fund, with massive payment backlogs and inefficiency as was discussed previously, one has to express concerns about the ability of the NHI (another proposed government bureaucracy) to administer payment to service providers in an effective and efficient manner.

## **13 Provider Payment at Primary Health Care Level**

55. *“In the initial phases the NHI Fund will pool all available PHC funds allocated for personal health services at the district level. These funds will be used to purchase PHC services from accredited and contracted public and private providers including general practitioners and other categories of health care professionals working in multidisciplinary group practices.”* (Paragraph 349) The HPCSA regulations regarding payment of practitioners and practice ownership will have to be changed if a single cost multidisciplinary practice needs to be established in the private sector, as it does not currently allow for this funding model.
56. These paragraphs refer that *“Once routine and reliable data becomes more readily available on the diagnoses of patients and services provided, additional steps will include refining the risk-adjusted capitation formula that is used to determine the global budget for each clinic and contracted multidisciplinary group practices. The capitation amount will be a uniform amount for the defined levels of providers, regardless of public or private ownership”* (Paragraphs 351, 353). If one looks at the referral to capitation payment, it states that private and public practitioners will all be paid the same capitation fees. This is highly unorthodox. Government doctors do not have overheads in the same manner as private practitioners. The Department of Public Works owns and maintains government buildings, they do not have rates and taxes and the Department of Health has a malpractice contingency fund for

Malpractice Insurance. Private practitioners have to pay their own rent/bond, rates and taxes, malpractice insurance, public liability/general insurance and are responsible for their own maintenance of buildings and equipment. Paying these groups the same capitation fee per patient does not have a logical base as it does not take this reality into consideration. If the government clinics have to be developed into fully independent cost units, the department of Public works will also have to be contracted into the arrangement to be reimbursed for rent, maintenance and rates and taxes by the Clinic Cost Unit. Malpractice costs will also have to be carried by practitioners in the government cost unit. The question would then arise, that if public clinics are truly run as cost centres with all the same corresponding overhead costs as a private facility, whether they will, in fact, still be more cost effective than similar private facilities?

57. The use of capitation as a reimbursement model for GPs prove problematic, if not researched adequately. It is important to note that every item of service to be provided for under a capitation system has to be individually priced in order to arrive at a fair and reasonable fee that remunerates the provider adequately. This will require the use of an extensive and comprehensive coding system, which will have to be much more complex and detailed than the system currently used in the public service. Capitation systems are generally extremely data intensive and require detailed data on the burden of disease, patient profile and other socio-demographic characteristics (particularly if a risk-adjusted capitation formula is to be used to determine the capitation payment). This data is currently not available and would need to be collected and assimilated before a capitation system can be implemented. Using Government data would also not work, as private practice overheads differ from those of the public sector. Meaningful interaction with medical schemes will have to be fostered to build a suitable capitation model.

- 57.1 It is, we submit, also insufficient for paragraph 351 merely to state that "Once routine and reliable data becomes more readily available on the diagnoses of patients and services provided, additional steps will include refining the risk-adjusted capitation formula." This creates the question as to how capitation formulas will be worked out prior to the data being available from the system. The reference to the provider payment mechanism being gradually phased in over the implementation period, would not be sensible, as government costs of rendering a service will be utilised for creating a capitation fee that will be the same for government and private facilities. This will not take into account the actual costs involved in running a private practice and will create reimbursement levels that will not be sustainable for private providers.



58. Suggested payments based on DRGs (Paragraph 356) to Private Hospitals does not take into account that, unlike public sector doctors, private doctors are not employed by private hospitals, nor are they allowed to be employed by private hospitals due to Health Professions Council (HPCSA) regulations. There is thus no reimbursement model given for private specialists in the White Paper and this of utmost concern to SAPPF. A further concern is, once again, that public hospitals are used for analysis to create these DRGs. The cost base of public hospitals cannot be compared to the cost base of private facilities.

#### **14 The future of Medical Schemes**

59. Paragraph 401 of the White Paper states: *"In future, all medical schemes will only offer complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits."* Medical schemes will thus only offer cover for those rare, expensive diseases not covered by NHI as well as excluded services such as (possibly) advanced dentistry. The impact this highly selective scope of medical scheme cover will have on the premiums involved would be astronomical, as there will already be a limited pool of medical scheme members due to NHI related increases in the tax burden, affecting affordability of medical schemes. This will lead to a drastic reduction in the number of medical schemes, which is admitted in the White Paper. There will also be a drastic reduction in number of members who can still afford these schemes based on increased tax burden of the NHI. The complementary nature of medical schemes, as envisioned in the White Paper, will lead to drastic increases in premiums, due to the rare disease bundle now covered by schemes. There will thus be a smaller pool of patients that will be able to afford private scheme cover, making continued existence of private medical schemes highly unlikely. In all likelihood such benefits will then be covered by short term insurance policies, which (unlike medical schemes) are for-profit organisations. As mentioned previously, this may imply greater financial hardship and exposure to unforeseen medical expenses for people who currently are covered for these.

## **PART 2            SAPPF CONCLUSIONS ON THE NHI**

60.        SAPPF does not support the NHI initiative in its current format as the correct model to address universal healthcare in South Africa. SAPPF is of the opinion that UHC should be addressed in the same manner as which Sections 26 and 29 of the Constitution (which deals with Housing and Education) is addressed. The state should supply free healthcare to the poor and indigent and letting those than can afford, look after themselves. At the moment, the poor already receive free healthcare at public institutions, barring a R20 admin fee. The more affluent are on voluntary private medical schemes that provide for their private healthcare. So if this R20 admin fee is scrapped, it only leaves the “Missing Middle Class” - the employed that have to pay unaffordable full prices for Public health yet cannot afford extensive Private Healthcare. These are the people that need to be assisted in some creative funding model. Low cost medical schemes were supposed to be implemented to help them, but that has now been scrapped in lieu of NHI. With the timelines of the NHI, this group is likely to remain struggling for a considerable period of time. Medical Schemes have indicated that the implementation of mandatory medical scheme membership for all employed people, will lower the premium costs for membership across the industry by 20%.
- a)        The quality of Public Sector Health facilities is currently very poor and these facilities are unlikely to be able to cope with the increased load that will result from the implementation of the NHI in its current format.
  - b)        SAPPF is seriously concerned about the inability of the Office of Health Standards Compliance to enforce quality norms and standards on any healthcare facilities. The Minister of Health promulgating the norms and standards will immediately help to improve the quality of Public Health Facilities without any additional costs to South African tax payers.
  - c)        SAPPF is further concerned with the capacity of the Office of Health Standards Compliance to inspect and certify the, conservatively estimated, 33 000 Private Healthcare Facilities in South Africa for accreditation under the NHI before 2025. There is no indication of the creation of this capacity in the OHSC Annual performance plan for the fiscal year 2015/16 to 2019/20. This would lead to the Private Sector not being able to contract into the NHI, at all.
  - d)        The size of the required administrative infrastructure to manage the NHI fund as a single payer would not be feasible, based on current government administrative inability. The Compensation Fund is an example of the Government being unable to administer a system where medical claims are paid out of a central fund in an effective

and efficient manner. The compensation fund budget is only 3% of that projected for the NHI.

- e) The continued referral in the NHI to utilising public health facilities to determine DRG payment arrangements and capitation amounts is of extreme concern to SAPPF, as these facilities currently do not have the same cost base as the public health facilities would have under the NHI and does not reflect the costs involved with running a private practice.
- f) NHI pilot studies do not address the differences in the funding model that would pertain under the NHI. Pilot sites are thus not a reflection of the actual way the NHI will be run at all, as the largest component in the NHI is the single funder payment model. Doing the cost projections for this funding model is thus of the utmost importance, to determine affordability,
- g) The affordability of the NHI system is highly questionable, based on the small tax base in South Africa, the high levels of unemployment and the costs involved with the system. Internationally, it can be seen that costing is a very important part of implementation of a radical policy change in public healthcare, there have been failures in running successful Universal Healthcare systems in both Ireland and South Korea, based on tough economic conditions. Other, more affluent countries are also experiencing difficulties in financing Universal Healthcare Systems in current economic conditions. SAPPF urges Treasury to do the necessary cost projections of the NHI to judge the affordability of the system in the current economic climate in South Africa. One cannot continue, or start making changes, for implementation of a system that will ultimately be unaffordable to the country. This leads to serious wastage of resources that could be employed more effectively.

## **PART 3            A SAPPF ALTERNATIVE TO NHI**

### **15        Introduction**

61.        Conceptually there is a distinction between universal health care (UHC) and a single payer system of healthcare insurance such as NHI. Consideration of alternative proposals to achieving UHC has not been a feature of the Government's side of healthcare debate in South Africa to date. This needs to change. If progress is to be made, proposals which require a large jump in revenue spend should be regarded with scepticism given the low prospects for growth in this country for the foreseeable future.
62.        To quote Andrew Barlow of the Helen Suzman Foundation (HSF)<sup>32</sup>; "Ambition is one thing, arrogance quite another. The government must make sure it is considering options without prejudice, that it is moving along the most efficient route to UHC, and that it is not over-reaching itself."

### **16        The distinction between a public and private good**

63.        According to Charles Simpkins (also of the HSF)<sup>33</sup>, certain aspects of healthcare are indeed a public good: "To the extent that the Johannesburg metro ensures fresh air, the collection of rubbish and the prevention of raw sewage running in the streets, all residents benefit. *A*'s enjoyment of fresh air does not prevent *B* from enjoying it. The reduction of risk from infection by vermin and E-coli for *C* is also a reduction for *D*".
- 63.1        "But a great deal of healthcare is a private good. The aspirin that *G* takes to cure his headache is not available to *H* and the stitches that are used to suture a wound suffered by *I* are not available to *J*."
- 63.2        "In so far as healthcare bears a private cost people have to consider it in the light of their expenditure as a whole"
- 63.3        South Africans that pay for their own private healthcare through prepaid medical schemes (16%) spend 4.4% of GDP against the 4.1% of GDP spent by the state on state responsibility patients (84%). This is private money that the state intends capturing to spend via NHI on all South Africans as the split between what is spent privately and what the state budgets for health is considered inequitable. But what if instead of it being spent on healthcare, this private money was spent on their private homes, would this be as inequitable? To quote

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<sup>32</sup> Barlow, A. 2016. UNIVERSAL HEALTH COVERAGE I – The World Health Organization on UHC and South Africa. *Helen Suzman Foundation*

<sup>33</sup> Simpkins, C. 2016. UNIVERSAL HEALTH COVERAGE V – Conclusions. *Helen Suzman Foundation*

Simkins again: “The decisions people make will depend on their circumstances and preferences. One might for instance consider a trade-off between seeing a doctor for a minor ailment and a meal in a restaurant, or expensive dentistry against the car one drives”

- 63.4 The demand for healthcare varies with one’s income. A large study conducted in the USA showed that as a country’s per capita income rose so too did the percentage of GDP spent on healthcare. What is true for individuals is also true for countries.
- 63.5 There are a number of alternative roads to UHC. NHI is but one. An analysis of the UHC systems in countries such as Great Britain, Germany and Austria, Canada, Israel and the Netherlands demonstrate that single payer systems such as NHI are not necessarily the holy- grail, and that exploration of these different versions of NHI might just reveal a more appropriate model for South Africa than the chosen version which currently seems out of reach financially.

## **17 The WHO and UHC**

64. The WHO lists four features it considers necessary for UHC
- (1) A strong efficient health system that meets a country’s health needs through people centred integrated care by,
    - a) Informing and encouraging people to stay healthy and prevent illness;
    - b) By detecting illness early;
    - c) Having the capacity to treat disease, and
    - d) Helping patients with rehabilitation
  - (2) Affordability
  - (3) Access to essential medicines and technologies
  - (4) A sufficient capacity of motivated healthcare workers
65. Each UHC system shares a commitment to provide a specified package of health benefits to all citizens as well as a degree of risk protection, but each system can vary in who is covered, what is covered, and to what extent the cost is covered. In other words UHC does not equate to free coverage for everyone and everything. Rather the idea is for everyone to be able to obtain the health services they need without suffering financial hardship when paying for them.
66. Everyone deserves access to adequate, equitable healthcare. That is after all enshrined as a human right in the constitution. However, it is not necessary, neither in terms of the WHO definition of UHC, nor as a requirement of the constitution, that the state must provide free healthcare for all. The successful two tier systems operating in Israel and the Netherlands

attest to this and suggest that UHC could be more easily attainable through South Africa adopting a similar approach rather than pursuing the single-purchaser NHI model currently in vogue, particularly as the one sector that is functioning well, albeit at a price most South Africans cannot afford, is the private sector. Philosophically it makes more sense to strive to raise the quality level in the public sector to that in the private sector, rather than reduce the quality in the private sector to that currently on offer in the public arena.

67. The state has an obligation to first demonstrate its capacity to correct the deficiencies in the state health service and to provide a sustainable and adequate service of reasonable quality (something the pilot studies have so far failed to demonstrate) before it commences with its ambitious and costly plans to dismantle the current two tier system in favour of an untried and untested single payer NHI. Were it to do that as a preliminary step it may well discover that the WHO requirements for a UHC system had already been met.

## **18 SAPPF Comprehensive UHC Model – National Combined Health Insurance Plan (NCHIP)**

### **19 Introduction**

68. Paragraph 50 of the NHI White Paper states that “South Africa’s approach towards achieving UHC will be through the implementation of NHI”. The World Health Organisation states that *“Universal health coverage (UHC) means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care.”* The position of the WHO continues, by saying that *“If people have to pay most of the cost out of their own pockets, the poor will be unable to obtain many of the services they need and even the rich will be exposed to financial hardship in the event of severe or long-term illness. Forms of financial risk protection that pool funds (through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection.”* There is a categorical statement in the WHO policy document that ***“UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.”*** The WHO continues to say that an important component of UHC is health financing, where attention needs to be paid to raising sufficient funds, minimising out of pocket payments through pre-payment and pooling and using available funds efficiently and equitably.

69. The WHO is thus quite clear that the UHC system needs to be affordable to the country. It does not specify free healthcare for all and does not specify a single payer system. SAPPF strongly believes that the NHI model is not the correct one for the South African context, as it would prove unaffordable and would not achieve universal healthcare objectives. SAPPF would like to propose an alternative model to achieve UHC, which will incorporate some of the work already done in preparation for the NHI, but not the NHI funding model or the proposed radical (expensive) changes to the entire South African Healthcare system.
70. The SAPPF Proposal of a National Combined Health Insurance Plan (NCHIP) is based on the implementation of a number of policies that were previously tabled, but now discarded, along with a number of other changes to the funding environment, including changes to the Labour Relations Act, 1995, The Medical Schemes Act, 1998, the Compensation for Injuries and Diseases on Duty Act, 1993 (COID Act), and the Short Term Insurance Act, 1998. These changes can happen concurrently, which will provide an environment conducive to enabling Universal Health Care in South Africa. The basis of the proposal is the expansion of the utilisation of Private Health Services, without the alienation of private providers and without creating an unaffordable system to the country. The proposal will be highlighted in the following changes:
- a) Introduction of Mandatory Low Income Medical Scheme (LIMS) cover for all Employees
  - b) Introduction of Mandatory Gap Cover for all employees
  - c) Introduction of a Private Health Access Fund
  - d) Introduction of Public Private Health Partnership and Private Sector Reforms
  - e) Current White Paper Proposals to be kept active
  - f) Funding of the NCHIP

### **19.1 Introduction of Mandatory Low Income Medical Scheme cover for all Employees**

71. The first step to the NCHIP will be mandatory enrolment of all currently uninsured employees in Low Income medical schemes. In the latest available figures, there are 3.9 million main members of medical schemes<sup>34</sup>. The total number of employed persons in South Africa is 15.6 million, according to StatsSA<sup>35</sup>. If these 3.9 million current members and the estimated 2.39 million working dependents are subtracted from the workforce, this step would add an additional 9.3 million people to the Medical Scheme environment. Along with the remaining 2.5 million dependents<sup>1</sup>, this will total 18.1 million South African citizens covered by health

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<sup>34</sup> Council of Medical Schemes Annual Report 2014

<sup>35</sup> StatsSA. Quarterly Labour Survey, 1<sup>st</sup> Quarter 2016.

insurance. The indications from medical schemes are that this step should lead to a decrease of 20% in medical scheme premiums across the population, due to enlarged risk pool and cross subsidisation of the sick by young and healthy members. The reconsideration and introduction of the *Risk Equalisation Fund* for medical schemes will also help to pool risk further, reducing the costs of underwriting. These step would require changes to the Medical Schemes Act, as the PMB basket in LIMS will look different from that in the current scheme environment. It will also require changes to the Labour Relations Act, to enforce the mandatory enrolment and funding of this benefit by employers.

## **19.2 Introduction of Mandatory Gap Cover for all employees**

72. The second step would be for all employers to provide all employees with a mandatory gap cover insurance product, which will cover any further unforeseen medical expenses and costs in hospitals that could potentially lead to financial hardships and co-payments, if medical expenses are at a higher level than that covered by current medical scheme rates. This will broaden the risk pool further and will create an additional funding mechanism, which will further increase access to affordable health services of South Africans. Gap cover can be acquired for as little as R79 per month per employee. This will require changes to the Labour Relations Act and the Short Term Insurance Act.

## **19.3 Introduction of Private Health Access Fund**

73. As previously indicated, the introduction of LIMS should reduce premiums in the medical scheme market by 20%. In order to realise a progressive taxation system, in concert with the transformative elements in the Constitution that concurrently improves access to quality healthcare for all, this 20% saving in premiums will not be passed on to medical scheme contributors, but will be pooled using a Medical Scheme Levy in a new fund. This fund will be created for the express purpose of funding healthcare for poor and indigent members of society that are currently utilising public sector health services, by paying for services provided to these people by private doctors/ facilities. This fund will be referred to as the Private Health Access Fund (PHAF). At the latest available medical scheme contribution figures (2014), a 20% contribution would lead to an annual income of R26.6 billion for the Private Health Access Fund. This is also a progressive payment model, with the rich subsidising the poor, without an increase in taxation. The R26.6 billion budget would account for 49.5% of all Government spending on *District Health Services* in 2012/13 (R53.7 billion).
74. The PHAF will also be further expanded by contributions from employers that would have previously been paid to the Workmen's Compensation Fund. This would lead to an additional



R 8 billion in annual contributions to the PHAF. The Workmen's Compensation Fund would cease to exist in its current administrative format and payments for Injury on Duty (IOD) claims will be administered by the PHAF. The administration of the PHAF will be put out to tender on a 5 yearly basis and all Medical Scheme Administrators would be invited to tender for administration of the fund. This would lead to the most efficient and cost-effective way of administering the PHAF, as well as compensation for IOD claim. It can be clearly seen from the failures in administering the Compensation Fund that government administration of a fund of this kind will not lead to efficiency or cost effectiveness.

75. Medical treatment of victims of road accidents will also be funded by the PHAF. The cost of any claims where the Road Accident Fund is liable for medical expenses, will be pre-funded and the costs will be claimed back from the Road Accident Fund.
76. The PHAF will enhance access to private healthcare for the poor and indigent, as the R26.6 billion budget is equivalent to 49.5% of public sector spend on district health services in 2012/13. The primary focus will be on access to primary healthcare, by contracting private providers of primary healthcare services with the PHAF. This contracting will happen on a capitation fee basis and will greatly increase access to primary healthcare of all South Africans. Patients will thus be able to utilise private sector primary healthcare services in their area, and will be referred on to secondary and tertiary services in the public sector as required.
77. Savings with the utilisation of capitation payments will also allow for further contracting to happen with specialists to provide vital services such as gynaecological consultations as well as radiology services. Government in-patients could thus be transported to a radiology department at night, and MRI scans etc., for which there are currently long waiting periods, could be administered. Procedures for which there are currently long waiting periods in public health facilities, such as hip replacements surgeries and cataract surgeries, could also be contracted with private providers in a Global fee arrangement. Current reserve funds from the Compensation Fund (Estimated R52 billion) that are being administered by the Public Investment Corporation, can also be transferred to the PHAF for utilisation.
78. In order to establish the PHAF, changes would have to be made to the Medical Schemes Act; the COID Act; the Road Accident Fund Act and the National Health Act. A Private Health Access Fund Act would have to be drafted, which would include functions of the COID Act and would also contain elements of the Medical Schemes Act.

## **19.4 Introduction of Public-Private Health Partnership**

79. The Public-Private Health Partnership will be the vessel which is utilised for private practitioners to contract with the PHAF to render services to the public, based on a capitation fee payment arrangement. This capitation fee arrangement must take into account actual practice costs of the private practice. This will increase access to healthcare for all citizens, without imposing an additional cost burden on government while concurrently reducing the burden on public health facilities and staff. Certification for service delivery will still occur under the ambit of the OHSC. After the funding of capitation agreements with primary healthcare providers, surpluses in the PHAF will be utilised for contracting with medical- and surgical specialists, which will occur on a “needs” basis on a regional level, based on the required speciality needs and the waiting periods for specialist services in a specific area. This will lead to a managed care approach of purchasing private specialist and hospital services in a specific areas with specific providers and hospitals.

### **19.4.1 Reforming the private sector**

80. SAPPF contends the private sector is an asset worth protecting. That is not to say that the sector is not in need of reform. This fact has been acknowledged previously by SAPPF and forms an important element in the SAPPF submission to the Health Market Inquiry (HMI), which is publically available.
81. Some examples of reforms that will make private healthcare more affordable and accessible include the following:
- Integrated practice units
  - Emerging Technology
  - Alternative Reimbursement Models

# ARM options

## Continuum of risk transfer from funder to provider

- As risk transfer increases, incentive to provide most appropriate, cost-effective services increases



### 19.4.1.1 Integrated Practice Units

82. The WHO describe integrated practice units as a basic requirement for a UHC system. The systems envisaged by Michael Porter et al will require amendments to both the NHA and the HPCSA Ethical Rules but hold clear opportunities for developing strategies that will create economies of scale and structural benefits that will allow closer integration between state and private healthcare services.

### 19.4.1.2 Emerging technologies

83. Another area that will undoubtedly bring down costs is the increasing use of emerging technologies to bring healthcare services within reach of rural communities.

## 19.5 Current White Paper Proposals to be kept active

84. There are various proposals in the White Paper that will help to improve the quality and provision of healthcare services to all South Africans. The OHSC is one of the current proposals that will definitely help improve quality of public health services. There will have to be a major increase in the number of inspectors, to deal with the burden of inspecting all public and private facilities every four years. Current inspection rates indicate that the OHSC will have to employ between 910 and 1 938 inspectors to have the necessary inspection capacity. The introduction of Municipal Ward-Based Primary Health Care Outreach Teams to strengthen public primary health care is an important measure that is not reliant on the introduction of

the NHI. A re-introduction of an integrated school based health system and establishment of district clinical health teams will also improve primary health service delivery in the public sector. Centralised procurement and the decentralised distribution of medication could still occur, as well as the continued improvement and upgrading of public health facilities as was currently envisioned.

85. The current Competition Commission Health Market Inquiry is also necessary to be completed, so that competition in the private space can be normalised and that legislative measures that have been lacking, such as annual PMB review can be implemented.

## **20 Funding of the NCHIP**

86. The Private Health Access Fund will be funded by the funds that are saved by 20% decrease in underwriting costs caused by mandatory enrolment in medical schemes for all employees, as well as the mandatory contribution of all employers that were previously administered by the Compensation Fund. This would create a budget of R34.6 billion annually, in 2016 currency. The fund would also have R52 billion in reserves, obtained from the reallocation of current reserves from the Compensation Fund. The Government expenditure on all district health services in the 2012/2013 Financial year, amounted to R53.7 billion for all provinces. 64% of district health services could thus be funded out of the Private Health Access Fund with this funding basis, 49.5% if Compensation Fund income is ring-fenced and excluded from PHC payments. This cost would not add any additional costs to the government budget and would essentially be funded by the private employers and private individuals, without adding to their individual expenditure. It would also not add any additional financial burden to individual contributors to medical schemes, as the savings due to risk pooling via mandatory enrolment will create this surplus.
87. Mandatory enrolment of all employees on medical schemes will be funded by employers and tax credits can be created for this. Research published in 2006 by Sharon Swanepoel<sup>36</sup> indicated that the costs for LIMS would be R200 for the main member per month. With an annual inflator of 6.7%, this would amount to R382 per member per month in 2016. The total costs to employers, to add the additional 9.3 million employees to LIMS would be R 42.6 billion per annum. A tax credit to reduce some of this burden on employers is an important part of this process, as the estimated 9.3 million employees that will now be cared for by private healthcare providers, will not be burdening the public healthcare system. If employees

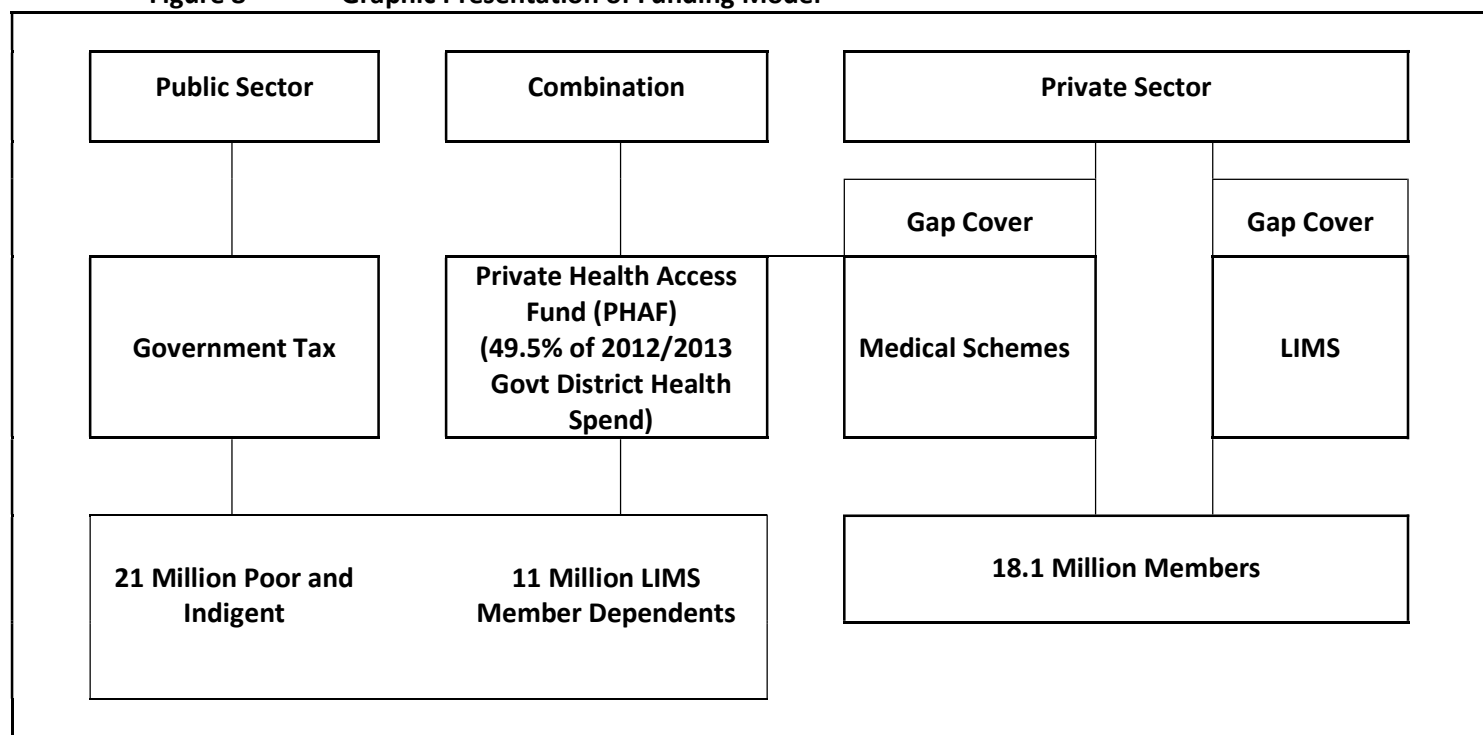
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<sup>36</sup> Swanepoel, S. Healthcare for Low earners a step closer. <http://ftp.bhfglobal.com/healthcare-for-low-earners-a-step-closer>

contribute R100 per month towards their own LIMS, the total cost to employers would be R31.5 billion per annum. This cost can be transferred to Government in the form of a tax credit. A further benefit to Government is that the cost to provide these individuals with access to healthcare is now capped at R31.5 billion, where it was previously an “uncapped” expense in public sector utilisation.

88. The outlays of providing gap cover for 15.6 million employees at a cost of R79 per employee per month, would be a total of R14.8 billion per year. This would negate any co-payments in Hospitals and would also reduce out of hospital co-payments. If employees fund 50% of the contribution, the cost to employers would be R7.4 Billion per annum.
89. The public Health budget can also be reduced by R26.6 billion, due to the private sector now shouldering a larger portion of the patient care burden. Using these figures, one can introduce Universal Health Care at a maximum cost of R31.5 billion to Government, assuming a 100% tax credit for money spent on LIMS contributions and a R100 per month contribution by all employees. This will be offset by the smaller budgetary requirements of the Public Health System, as the PHAF, which is funded by a Medical Scheme Levy will contribute a further R26.6 billion in district health services. This R26.6 billion is equivalent of 49.5% of current Government spending on district health services in all 9 Provinces combined. The PHAF will not cost government anything and will further reduce the patient burden on the public sector by 50%. The public burden would amount to providing healthcare to 32 million South Africans, with a further potential 16 million of these patients being serviced in the private sector with the utilisation of the Private Health Access Fund. **The nett additional Government costs of the National Combined Health Insurance Plan, would thus be R4.9 billion, assuming a 100% tax credit on employers’ LIMS contributions (and the corresponding R26.6 billion reduction in district health spending). Employers will spend an additional R7.4 billion annually on gap cover, while employees will contribute R18.5 billion annually in LIMS (R100 per month) and Gap Cover (R39.50 per month) contributions.**

**Figure 8      Graphic Presentation of Funding Model**



## 21 Conclusion

90. SAPPF believes that this model addresses the Universal Health Care requirements of all South Africans, without placing an undue tax burden on the already small tax base and without any costly reorganisation of the entire healthcare system and healthcare funding environments. It also improves equity and provides access to the private sector for people that currently utilise the public healthcare system, through the Private Health Access Fund.