

OUR HEALTH PLAN

THE DA'S PLAN FOR UNIVERSAL HEALTH COVERAGE



THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM

- Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.
- A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
- A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
- A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
- **Leadership and governance** involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability.

Source: *World Health Organisation (WHO)*

Briefly,

In South Africa, private and public health systems exist in parallel. The public system serves the vast majority of the population, but is chronically mismanaged and under-staffed. The wealthiest 20 per cent of the population use the private system and are far better served.

The DA aims to introduce strategic reforms to upgrade the public system, introduce greater competition in the private system and encourage more organised public-private partnerships, within the current resource envelop of healthcare, requiring no new taxes. But to free up resources, we propose to bring the off-budget medical aid tax credits valued at R17.4 billion, on-budget.

The strategic reforms will:

- pursuant to our Constitution, allocate a universal subsidy to every South African citizen and legal resident, irrespective of whether or not they are covered by the public or private health systems. The value of the subsidy would be set in relation to an affordable and comprehensive package of services available within the public health system;

- within medical schemes, benefits will be standardized in line with the public sector package of services, schemes will be allowed to offer top-up cover, and there will be a risk equalization fund, plus state sponsored reinsurance for small schemes;
- health provision will be free at point of service for both those who have medical aid membership and those who do not. Medical schemes will increasingly pay in a more organised manner for public services used by their members as the quality thereof improves. R2 billion of the Tax Credit Reversal Revenue (TCRR) – see next bullet point - is made available for this purpose;
- the universal subsidy will be funded by bringing the off-budget medical aid subsidy projected to be worth R17,43 billion (referred to as the Tax Credit Reversal Revenue or TCRR) in 2017/2018 financial year explicitly on budget for which there will be, for the first time, accountability;
- eliminate the funding gap for those who fail the means test and cannot afford medical aid, by eliminating the means test itself;
- provide for expanded Maternal and Child Health programmes (from the TCRR, we will spend an additional R2 billion in conditional grants, as a cross-subsidy, on Maternal and Child health);
- provide for an Expanded Clinic Building programme especially in under-served areas nationwide (from the TCRR, we will devote an additional R2 billion as a cross subsidy to building and staffing clinics);
- provide for expanded single number national public-private Emergency Services governed by an independent board (from the TCRR, we propose spending an additional R1 billion as a cross-subsidy on Emergency Services);
- use the remaining balance of the TCRR, R9,43 billion, to subsidise and therefore reduce the monthly contributions of medical scheme members;
- incentivise medical schemes to compete on the cost and quality of the health services they fund;
- establish a self-funded post-retirement and unemployment protection regime for medical aid members;
- establish regional training zones where academic health and emergency education and training institutions, guided by robust human resource forecasting, are rationally structured;
- provide for an expanded education and training medical and nursing platform to realise a scientifically planned sustainable pipeline of health care professionals (from the TCRR, we will devote an additional R1 billion in conditional grants to the Health Education and Training Platform);

- reinvest the funds spent on the Cuban training programme in domestic health education and training;
- remove discretion for political appointments into public services and related organs of state. All appointment processes will be decentralised, professionalised with all vulnerabilities to capture by special interests removed;
- provide for fit-for-purpose civil servant appointments and robust performance based accountability frameworks;
- introduce autonomous public hospitals and district health authorities having independent boards and wide operational discretion allocated to executive heads to carry out their mandates;
- provide for clinically trained chief executives of hospitals and managers of health facilities;
- extend nationally the Western Cape's management methodology where hospitals are treated as cost centres;
- extend and adapt nationally the Western Cape's system of decentralising district level and facility management systems;
- restructure the National Health Laboratory Services (NHLS) as a support service to provinces that would have wide discretion to work with accredited private and university-based laboratories where required;
- extend nationally the Western Cape system where public sector medical scripts are made available through private retail pharmacies;
- to prevent so-called stock-outs, reform provincial logistics to enable incorporating their costs into tender prices and structure depots to run like businesses;
- provide for an information system that makes transparent the nature, quality and price of every service provided by health facilities in the public and private sectors nation-wide;
- eliminate all national to provincial, and provincial to municipal, unfunded mandates when it comes to conditions of employment and primary health care services, especially with regards to clinic building and maintenance;
- introduce an *Information and Information Technology (IT) Regulator* to achieve data standardisation and the pooling of information on all parts of the health system, both public and private, funded by a small levy on medical schemes with matching allocations from public entities;

- reform the *Council of Medical Schemes (CMS)*, the prudential and market conduct regulator for medical schemes, to create a board firewalled from political interference and appointed independently of the Minister of Health and the entities it regulates;
- implement the strategic recommendations of the *Health Professions Council of South Africa's (HPCSA) Ministerial Task Team's November 2015 Report* to replace the dysfunctional HPCSA with new Councils that can fulfill the necessary statutory mandates; and
- introduce a *Quality of Care Regulator* to replace the weak *Office of Health Standards Compliance (OHSC)*. This Regulator will define and review the 'standard package' funded by the universal subsidy and oversee and audit the actual quality of care provided by all public and private health facilities.

For South Africans who have no medical aid, these reforms will herald improved service at clinics and hospitals, enhanced maternal and child care provision and access to efficient emergency services in urban and rural areas, free at the point of service.

For South Africans who are on medical aid, the universal health subsidy will result in the reduction of their medical aid contributions, enhanced choice and access to more efficient ambulance services, free at the point of service.

By bringing the medical aid tax credit on budget, and allocating some of it to build better services in the public health sector, those South Africans with medical aid are cross-subsidising those without, a welcome act of health justice.

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A: INTRODUCTION

1. There is no reason why South Africans must wait 10-15 years for the national government's *National Health Insurance (NHI)* to achieve a system of universal access to healthcare. The NHI is a slow, expensive, cumbersome and centralising journey to universal health coverage. By contrast, the *Democratic Alliance's (DA) Our Health Plan (OHP)* will take 5-8 years to realise, it will strategically reform the system within its current resource envelope and strengthen our constitutionally ordained and provincially organised public health care delivery system.
2. To secure our prosperity and wellbeing, South Africa requires an adaptable and efficient health system able to address the needs of all citizens and legal residents (emergency care for all). Health systems are not built around specific crises, but

they need to constantly address multiple disease and illness risks, some more routine in nature – such as the need for maternal and child care - others to address long-term demographic, social and environmental trends – some associated with urbanisation - and yet others to respond to unpredictable crises.

3. Responsible governments the world over adopt a rights-based approach, where it is understood that access to reasonable healthcare is not conditional upon a family's ability to pay. This approach is enshrined in Section 27 of our Constitution. As such rights cannot be accessed in the absence of a health system designed for their achievement, Government has an obligation to provide the necessary statutory framework, the systems and the appropriate financial subsidies to make it work.
4. South Africa has much of the necessary infrastructure in place for delivering on this obligation, but the present system is not equal to the needs of the country and its people - and falls far short of the rights provided for in the Constitution. It is our view that addressing these weaknesses is both possible and essential. We present here the strategic interventions required to make OHP realisable in 5-8 years and not the 15 years envisaged by the Government's *White Paper on NHI*.
5. The DA's OHP takes account of both international perspectives on strategic health systems reform as well as proposals considered and debated in the literature over the past 25 years. Importantly, they take account of the experiences of the DA in running the Western Cape and the City of Cape Town's health systems, which offer a rich source of lessons, best practices and innovations that have, for example, resulted in the lowest maternal mortality ratios¹ in the country.
6. Universal health coverage has three inter-related challenges for which a dynamic health system must have solutions and self-correcting mechanisms: firstly, *population coverage* - do we have the full measure of the current disease burden of the entire population resident in our country? Secondly, *health coverage* - are the health services on offer capable of preventing, treating and providing specialised

¹ Institutional maternity mortality ratio in 2013 (# maternal deaths per 100,000 live births): Limpopo (201.21), Free State (185.08), Eastern Cape (172.73), North West (168.48), Northern Cape (158.32), Mpumalanga (150.25), KwaZulu-Natal (146.54), Gauteng (114.99) & Western Cape (83.91). SOUTH AFRICA (153.50) (Source: Written Reply from Health Minister Aaron Motsoaledi No.3100 Internal Question No.2).

care to those who need it? And thirdly, *financial coverage* - are the services on offer affordable on a sustainable basis within our resource envelope?

B: OUR ASSETS

7. South Africa's health system is vast, and includes extensive assets in the form of hospitals, clinics and associated equipment. We have modern services, a highly skilled workforce together with an effective educational and training platform, a wide range of regulatory institutions and well-established public and private systems, both with long histories.
8. Our fast developing metropolitan areas are also equipped - albeit unevenly and unequally - with modern and responsive emergency services essential for the requirements of a diversified and fast changing economy and society. In addition, there is a responsive public health infrastructure with many years of experience in dealing with the complex health needs arising from economic development.
9. The primary healthcare infrastructure has improved since 1994, with extensive free coverage for both rural and urban communities within a reasonable walking distance from where people live. This provides a powerful service-related platform for an expanded range of health interventions over time.
10. Both South Africa's public and private health services are capable of delivering a complex range of services from the most basic to the latest and most specialised services available anywhere in the world. Across both the public and private systems the service mix has been sustained by regular, and largely stable, sources of revenue.

C: OUR DEFICITS

11. There is no explicit democratically established system of national cross subsidies² tied to a package of coverage³ designed to achieve universal access on the basis of the right to healthcare.

² The concept of a cross-subsidy is included in the concept of pooling, used elsewhere in this document, and refers to any system of implicit or explicit transfers between households. An insurance arrangement includes cross-subsidies from people who pay the premium to those that claim benefits (one form of horizontal transfer). Transfers can also be from higher-income groups to lower income groups (typically referred to as a vertical transfer). Government programmes that deliver services or benefits to communities invariably include elements of both forms of cross-subsidy. Means-tests enhance the vertical nature of some programmes, while services

12. There is no explicit democratically established process to determine the package of services and benefits that is regarded as fulfilling the right to healthcare.
13. The efficient delivery of services in the public sector is compromised by a combination of over-centralised decision-making and ineffective and deeply conflicted accountability mechanisms.⁴
14. The practise of nationally determining conditions of employment without reference to the availability of provincial funds (unfunded mandates) result in unmanageable financial shocks to the system.
15. The regulatory framework for medical schemes is incomplete⁵ leading to systemic market failures that reduce access, fairness and the sustainability of coverage over the medium to long-term.

distributed on the basis of need involve strong horizontal elements (as need is not equally distributed – young people need fewer health services than older people – large families need more services than smaller families).

³ The term ‘package’ when used in this context applies to the range of services or benefits covered by insurance. Usage of the term implies that a package has been explicitly determined by policy – which is not the case in many settings. Although this was the case with the Prescribed Minimum Benefits developed for medical schemes, the public system has evolved in the absence of specific prioritisation and planning. We propose, as they have it in the Netherlands, that a *Quality of Care Regulator* work on the ‘package’ issue.

⁴ The ability of Ministers and Members of the Provincial Executive Councils to appoint staff within the public services, and entities with operational responsibilities, such as healthcare services, creates a conflict of interest that can be exploited for private gain. A coherent accountability framework requires that any public authority have its discretion constrained, through a properly designed accountability framework, to the public functions that must be performed. For an accountability framework to work effectively four elements must be in place: (1) explicit performance requirements; (2) transparency of operations, together with reporting systems aligned to performance requirements; (3) unconflicted supervisory structures (such as independent boards); and (4) unconflicted compliance regimes (an ability to apply rewards and penalties based on performance). The public health sector lacks a coherent framework incorporating these four elements. It can be argued, therefore, that the current accountability framework is unable to constrain the discretion of delivery agents to the meeting of public objectives.

⁵ The medical scheme system has various measures in place to constrain competition based on the health status of applicants and beneficiaries. These include community rating, prescribed minimum benefits and open-enrolment. However, in the absence of inter-scheme pooling (through risk-equalisation and reinsurance) consumers are confused by benefit proliferation and schemes cannot manage the commercial implications of the risk groups they accumulate. A complete regulatory environment would make medical schemes compete on the cost and quality of the health services they cover, rather than on the risk groups they target. Risk-equalisation and reinsurance, together with benefit standardisation, would remove demographic discrepancies between schemes, leaving them with no option but to differentiate on the cost and quality of the services they cover. This would transfer the incentives to innovate from benefit

16. Our Primary Health Care system (PHC) is simply inadequate. The ideal is to have 90% of the population managed at PHC level, 8% at regional hospitals and 2% at the tertiary services' level, with robust referral systems.
17. The system of critical care is poorly coordinated between the public and private systems when it comes to resourcing, purchasing and provisioning, resulting in unequal access for those without adequate incomes.
18. No systematic information is produced on the performance of any part of the public or private system. The general public cannot make informed choices about the services they access.⁶

D: ACHIEVING UNIVERSAL HEALTHCARE

19. The strategic approach to reforming the South African health system to achieve and deepen UHC involves the following:
20. The implementation of a *national strategic resource allocation scheme* to operate within the first tier of government. This scheme would allocate a universal subsidy in respect of every eligible person⁷ in South Africa, irrespective of whether or not they are covered by the public or private health systems. The value of the subsidy would be set in relation to an affordable and comprehensive package of services available within the public health system.
21. The *main idea* is that both the public and the private sector will receive a subsidy, with an aim to achieve universal coverage of a standardized package of benefits in both. The value of the subsidy will be set according to cost of providing the package in the public sector. Within medical schemes, benefits will be standardized for the main package, schemes will be allowed to offer top-up cover,

designs (which are confusing to consumers) to optimising the cost and quality of services (which would need to be understandable to consumers for commercial players to derive any advantage). To reintroduce reinsurance will require a statutory measure.

⁶ The cost of treating health facility-acquired (or *nosocomial*) infections are borne by scheme members because there are legal problems of attributing liability to health-care institutions. A satisfactory solution for the problem has yet to be found.

⁷ Eligible persons are (1) citizens – financed from general revenue; (2) permanent residents – general revenue; (3) temporary residents including students and tourists – a reimbursement strategy in addition to general revenue; (4) refugees – general revenue; (5) illegal residents – linked reimbursement to the withholding of excise revenue collected by South African Customs Union (SACU) and an agreement with the Southern African Development Community (SADC).

and there will be a risk equalization fund, plus state sponsored reinsurance for small schemes.

22. Every person will be able to *choose whether to buy public or private sector cover* with their subsidy – with rules against opportunistic movement between the two. One of the ways in which this will be funded is through the removal of the current tax subsidy for medical scheme contributions. The means test for access to public hospital services would be removed, closing the gap for those who fail the test but are not on medical aid. Once done, we would have universal coverage.
23. *Public services are free at point of service* for both those who have medical aid membership and those who do not. Medical schemes will increasingly pay for public services used by their members as the quality thereof improves. An *Information and Information Technology Regulator* will provide data on which health services are available by cost and quality at every entity nationally. Both those who choose their cover through the public sector and through medical schemes would face free services at point-of-service when obtained from the public sector.
24. *The universal subsidy* would be funded from a combination of existing budget allocations for public services together with a re-allocation of a third of the off-budget tax credits presently allocated to medical scheme members via the tax system.⁸ No increases in taxes are envisaged to fund the subsidy. Although medical schemes would receive a subsidy per person covered equivalent to the average per capita cost of the public sector cover, they will be able to offer a discretionary top-up package of services in excess of the public sector package. The additional costs would be paid for out of medical scheme member contributions.
25. *Public health services* will remain a provincial competency. Although problems with service delivery within provinces have been evident over the past 20 years, these are principally attributable to corruption and governance failures flowing from improper appointments into the provincial health establishments. Corruption will

⁸ Tax credits for medical scheme members is an example of a tax expenditure subsidy. Such subsidies are transfers between households - mediated by government - but they fall outside of the conventional budget approval process. Such transfers are frowned upon as they fall outside the accountability framework of the budget process – despite having complex and quite onerous fiscal implications. They also tend to favour special interest groups. It consequently makes sense to convert the subsidy from off-budget to on-budget. The elimination of the tax credit required an amendment to the Income Tax Act.

be eliminated through revised arrangements for appointments and much more robust accountability mechanisms.⁹

26. Restructuring the provincial health system:

26.1 *Autonomous public hospitals¹⁰ and district health authorities¹¹* will be introduced, with independent boards and wide operational discretion allocated to executive heads to carry out their mandates subject to a transparent accountability and governance framework. A similar framework will be considered for emergency medical services, with allowance for provincial variation depending upon local circumstances.¹²

26.2 *Academic and tertiary hospitals* will remain the responsibility of provinces, with residual funding for academic functions and cross-boundary flows funded via specific-purpose conditional grants and demand-based reimbursement where appropriate.¹³ The expansion of our highly skilled health professional workforce and strengthening of the underlying educational and training platform would require the local reinvestment of

⁹ A revised governance framework is required to remove political influence in appointments, implements localised accountability systems to operational entities (such as hospitals and district health authorities), allows properly constituted hospital and district boards to hire and fire operational heads, restrict removals to instances of misconduct, offers no compensation for a resignation or early contract termination and decentralises decision-making into operational entities. The term of office for hospital or district health board members should *never* coincide with the term of office of politicians.

¹⁰ The Western Cape's Health Department's management methodology, where hospitals are considered as Functional Business Centres or cost centres and where district level and facility management, combining clinical and administrative governance, are decentralized, is highly effective. It should be noted that the NHI White Paper 'cut and paste' its model of hospital autonomy from that of the Western Cape. While intellectual property should be acknowledged, imitation is the highest form of flattery.

¹¹ Currently, District Health Councils (DHC) take on this function, but the Constitution defines municipal health services to include environmental health and the social determinants of health like sanitation, rodent control and food preparation safety inspection. Legislative change will be required to include personal health as well as to reconstitute the boards (DHC's consists of councillors) with the right mix of professionals and to meet robust accountability requirements. There presently are 52 DHCs, most of which are dysfunctional.

¹² This would be done by way of the National Health Act. Provinces could legislate within the framework established at the national level. It is worth noting, that in the absence of a coherent national framework, any province is free to legislate along these lines at present.

¹³ The authority established to manage the universal subsidy would determine and manage the inter-governmental transfer arrangements.

funds devoted to the Cuban training¹⁴ programme, improving resource flows into clinical research – via the *Health Professions' Training Grant* and *National Tertiary Services Grant* - and having much more effective partnerships with private sector research, development and training initiatives. We propose spending R1b a more year on the health education and training platform sourced from bringing the medical aid tax credits on budget.

- 26.3 *Pathology services* would fall under the control of provinces, with the National Health Laboratory Services (NHLS) restructured as a support service to provincial laboratories.¹⁵ Provinces would have a wide discretion to structure laboratory services to suit their needs, including the possibility of outsourcing to private and accredited university-based laboratories where required.¹⁶
- 26.4 The system implemented in the Western Cape whereby public sector medicine scripts are made available through private retail pharmacies would be extended nationally. This would substantially reduce the burden on hospital and clinic-based dispensaries. It would also bring services closer to the served public.

¹⁴ The Cuban training programme has not been good for us. South African medical colleagues trained there have not been provided with the appropriate education (for example, no to little training in HIV medicine) to reach their full potential, neither have they been equipped to look after patients in the our public sector. The US\$70 million (R1.05 billion today) to train 3,346 South Africans in Cuba would have been better spent on expanding our local medical education platform.

¹⁵ The increase in the number of unnatural deaths due to road accidents, violence and inter-personal injury demands more toxicologists (a scarce specialization) to conduct post-mortem alcohol and other chemical tests. To fund the laboratories provincial health authorities should get a percentage of traffic road fines, sin taxes, liquor license taxes and illegal dumping fines (environmental health) as well as require corporations in the energy business to invest in the health infrastructure of communities because, by the nature of their business, they tend to pollute.

¹⁶ Section 15(1) of the National Health Laboratory Services Act 37 of 2000 must be amended. In the meantime, the constitutionality of the NHLS Act can be challenged where it fails to provide effective services to provinces. If Government top-slices the funding for the NHLS, provinces would lose the money – even if they opt out. If this occurs, any province wishing to opt out would need to challenge the top-slicing in court. The right to opt out would be based on a challenge as to national government's right to over-ride provincial autonomy in this instance.

- 26.5 A revised framework for *provincial logistics services* must be considered, with the logistics' cost incorporated into the tender prices. Procurement is resource intensive and suppliers without stock are often a problem. Depots are essential to take the load from smaller institutions, but they must be run like businesses with strong management and procurement services. Monitoring and evaluation are essential. This would largely reduce the risk of so-called stock-outs.¹⁷
27. *Conditions of employment in the public health system:* The national government would be required to fully underwrite all national decisions regarding improvements to conditions of employment affecting health professionals. In future no province would be required to arbitrarily restructure its services resulting from unfunded improvements to the conditions of employment of health professionals agreed to at national government.¹⁸
28. *The guaranteed package: The Quality of Care Regulator* will continuously develop and review the guaranteed packages that must be made available in both the public sector and by medical schemes. The Regulator will be required to combine technical inputs with public engagement to constantly determine and update the packages universally guaranteed to all.¹⁹
29. *Pooling scheme for medical schemes:* So that medical schemes are not disadvantaged by unanticipated an uneven distributions of individuals of poor health status, a comprehensive regulatory regime for medical schemes is anticipated involving a combination of statutory risk-equalisation and reinsurance.²⁰

¹⁷ A specific legal framework should be developed to manage the procurement of medicines, medical devices and consumables. National legislation should establish tender prices that include logistics fees – removing the need for public sector logistics arrangements. The national legislation should provide the conditions under which provinces can opt out of the national framework. These should be restricted only to those instances where a discernible public interest is involved. The opt-out framework should establish audit requirements to enable an assessment of whether a public interest is being achieved.

¹⁸ Technically this involves enforcing a principle already incorporated into the Public Finance Management Act 1 of 1999 (PFMA). However, this largely affects the way in which decisions in the bargaining chamber are made – i.e. all agreements must be funded.

¹⁹ Dedicated legislation is required for the authority.

²⁰ Risk-equalisation and reinsurance involve a system of formula-based inter-scheme transfers based on the risk profiles of schemes. A scheme with only young members would consequently transfer funds to a scheme with predominantly older members. These transfers

30. *Risk-equalisation and reinsurance for medical schemes*: A risk-equalisation scheme allows for risks to be pooled across multiple schemes without the need for the consolidation of funders.²¹ This is achieved via inter-scheme financial transfers organised by a pooling scheme, or risk-equalisation fund. The transfers are determined in accordance with a formula²² that determines the extent to which the risk profile of any individual medical scheme varies from the industry risk profile. The formula measures and corrects for prospective risk i.e. the expected claims behaviour of individuals.
31. *Statutory reinsurance* allows for a deepening of pooling achieved via risk-equalisation, by making formula-based adjustments based on the actual claims experience of individuals. Adjustments are consequently retrospective²³ in nature. Pooling mechanisms serve to enhance competition between medical schemes and will thereby improve the choices available to the public. Medical schemes are consequently encouraged to compete on the cost and quality of the services for which they provide coverage.²⁴ The reinsurance scheme also provides scope for the market entry of small schemes²⁵, which will not face the claims variation risks

would ensure that each scheme can price their benefits as if they had the same demographic profile of the industry as a whole. Such systems are in place in the Netherlands, Germany, Belgium, Australia, Israel and Colombia.

²¹ This requires dedicated legislation for the risk-equalisation and reinsurance fund. This structure could also manage the emergency insurance arrangement proposed below. Amendments to the Medical Schemes Act should dovetail with this legislation.

²² A Risk Equalisation Formula (REF) that takes into account age, gender and beneficiaries diagnosed with certain conditions that have been treated over the past 12 months. The reinsurance formula is used to calculate the average cost per patient event that is insufficiently compensated for by the REF, paid retrospectively.

²³ While risk-equalisation prospectively adjusts for the assumed risk of a medical scheme, reinsurance makes some adjustments based on actual claims. The smaller the risk pool, the larger the possible divergence between the prospective adjustments and actual claims experiences by scheme.

²⁴ Competition is enhanced as benefits are standardised, and risk profiles adjusted to that of the industry. Price competition can therefore only occur on the cost and quality of health services purchased. In the absence of framework, schemes will price differentiate on the risk groups they cover, which has nothing to do with the cost and quality of services they purchase.

²⁵ Reinsurance removes the possibility that a few large claims bankrupt a scheme. While this is not possible in a large scheme – as claims patterns converge on a normal statistical distribution – for small schemes their claims experience will be uneven. Reinsurance removes this claims variation risk, allowing a small scheme to price in a manner equivalent to a large

associated with a small membership. This will act to counter-balance the extensive consolidation that has occurred in the medical schemes system over the past 25 years.

32. *Mandatory medical scheme membership*: To remove the anti-selection risk associated with voluntary membership, mandating medical scheme membership for employers above a certain size, should be very seriously considered.²⁶ The benefits are enhanced sustainability of medical schemes and a consequent reduction in members' medical aid contributions as a result of risk-reduction.²⁷
33. *Old Age and Unemployment Protection*: The DA would undertake to establish a post-retirement, unemployment, self-funded (contributory) protection regime for medical scheme members. The purpose of the regime would be to smooth contributions across the life cycle of any person opting for medical scheme coverage. A surcharge on contributions would be structured to fund the requirements, over-and-above any government subsidy, to pay for any period of unemployment or retirement.²⁸
34. *National Emergency Care Fund*: The Fund would underwrite of all parts of the health system offering emergency services of any form. The purpose of the fund would be to ensure that all residents of South Africa face equal access to the nearest treating facility regardless of whether the individual is covered by a medical scheme or the public sector.²⁹ Though it makes up a small proportion of

scheme. This removes an inefficient advantage large schemes have over small schemes, forcing both to compete on value-for-money.

²⁶ If schemes are made mandatory, this could be achieved either by way of the Medical Schemes Act or the National Health Act. The former is preferred to keep the legal framework transparent. Mandating may however be considered a money bill and could require a dedicated money bill. This may also be a preferred route, as it requires concurrence by both the Ministers of Finance and Health.

²⁷ Germany has the strictest system, allowing no choice at all. Eligible persons there choose their scheme (either public or private) and are thereafter in it for life. Our medical schemes presently constrain the maximum waiting period – to switch from one scheme to another - to 12 months. Penalties apply if it is done earlier.

²⁸ This would be included into a Risk-Equalisation and Reinsurance Act.

²⁹ A dedicated Act should establish the authority and its benefits. It could also be a function of the risk equalisation and reinsurance authorities. There is some institutional benefit in avoiding the bundling of specialised functions into a broad authority as this usually results in inefficiencies.

the total health budget (public and private), the Fund will require increased allocations to remove the vast inequality in ambulance service provisions between residential areas in cities and between cities and rural areas. Although some efficiency savings could be had in the administration of the *Road Accident and Compensation Fund* and the contractual costs of private providers, most of the shortfall must be taken up by increased initial budget allocations in the course of time. This fund would also ensure that a common standard of service is achieved by all critical care services as a condition for funding. The fund will either directly purchase services or reinsure emergency services funded by a primary insurer (medical scheme). This fund will also contract with and reimburse public sector services. The full viability of this Fund must be carefully designed and costed prior to implementation. We nominally set aside an indicative amount of R1 billion a year towards the Fund, made available by bringing the medical aid tax credit on budget (see Appendix).

35. *Maternal and Child Health Care*: The expansion of maternal and paediatric services at hospitals and clinics. This will include an extension of antenatal services and obstetric care to rural and under-served areas. The fund will also provide for an augmentation of specialized services (e.g. increasing the number of fully equipped obstetric and neonatal intensive care units). Furthermore, funding will be provided for targeted preventive and public health services, including initiatives that will increase early antenatal booking as well as early case detection of childhood illnesses. The Fund would be run nationally in the form of conditional grant. Clinics and hospitals would have to apply to the Fund and to be successful must meet pre-defined performance criteria. The full viability of this Fund must be carefully designed and costed prior to implementation. We nominally set aside an indicative amount of R2 billion a year towards the Fund, made available by bringing the medical aid tax credit on budget (see Appendix).
36. *Governance and accountability of provincial health services*: The DA regards the discretion for political appointments into public services and related organs of state as establishing a conflict of interest that exposes all public services, including regulators, to capture by special interests. As part of the strategy to structurally improve performance throughout the health system, all appointment processes

would be decentralised and professionalised, with all vulnerabilities to capture by special interests removed.³⁰

E: REGULATORS REQUIRED

37. Regulators play an essential role in the governance of any system. The present configuration of regulators, and their governance, is incomplete, with implications for performance throughout the system. The DA proposes the following:

37.1 *Council for Medical Schemes*: will remain the prudential and market conduct regulator for medical schemes. However, in future the Council and all appeal structures would be appointed independently of the Minister of Health and the entities it regulates. Consideration would be given to adding the supervision of certain specialist competition regulation mandates to the Council.³¹

37.2 *Health Professions Council*: implement the strategic recommendations of the Health Professions Council of South Africa's (HPCSA) Ministerial Task Team's November 2015 Report that it be dissolved and replaced with new Councils for pharmacists, nurses and health workers. All Councils must be appointed independently of the Minister of Health and the institutions and industry they regulate.³²

37.3 *Quality of Care Regulator*: will replace the weak *Office of Health Standards Compliance* (OHSC). This regulator define and review the 'standard package' that lies at the heart of the OHP. It would oversee and audit the actual quality of care provided by all public and private health facilities. It would also initiate independent investigations of facilities, the result of

³⁰ The Public Service Act must be amended. The National Health Act can establish new hospitals, districts and Emergency Medical Services (EMS) structures that remove political influence in appointments and dismissals.

³¹ Requires an amendment of the Medical Schemes Act 131 of 1998.

³² Requires an amendment to the Health Professions Amendment Act of 2008.

which would be made public.³³ It would be appointed independently of the Minister of Health.

37.4 *Information and Information Technology Regulator*: will be established to achieve data standardisation and the pooling of information on all parts of the health system, both public and private. This regulator would operate independently in accordance with a statutory mandate. Based on the information from this regulator, both the general public and decision-makers (including other regulators) would be better informed to make service choices, regulatory decisions and management decisions. As this would be a new regulator, it will be funded by a small levy on medical schemes³⁴ and a matching allocation in respect of public entities.³⁵

37.5 *Medical Scheme Pooling Authority*: this would be an independent authority with the sole responsibility for managing the transfer of the government subsidy to medical schemes, risk-equalisation, reinsurance and post-retirement and unemployment protections schemes.³⁶ A new regulator, this *Authority* will be funded via a small levy on medical schemes.

F: FINANCING OHP

38. Achieving universal health coverage requires institutional/structural reforms rather than additional financing. These reforms hold out the opportunity for substantial efficiency gains in both the public and private systems. However, bringing the medical aid tax credit on budget adds R17,43 billion (2017-18 medium expenditure estimate) in revenue to the national budget. In the DA's OHP budget (see Appendix) we nominally set aside from this amount an additional indicative R2b to Maternal and Child Health, R2b for the Primary

³³ Requires a new Act, and repeal the Act that established the Office of Health Standards Compliance.

³⁴ This is principally because virtually all private sector funding is derived from medical schemes. The best way to levy-fund both providers and funders is to levy the funders.

³⁵ This requires a new dedicated Act.

³⁶ This requires a new dedicated Act. DORA provides for the transfer and conditions. Transfers between the Authority and Medical Schemes can be governed by the Authority's own legislation.

Health Care clinic programme, R1b for Emergency Services and and R1b towards the Health Education and Training platform. The balance of R11,43b is paid over to medical aid schemes, R2b of which is used to finance their members' use of public health facilities and R9,43b to subsidise members' medical aid fund monthly contributions. Because the R17,43 billion belongs to medical aid members, the R6b devoted to improving public health will be a cross-subsidy from those who have medical aid to those who do not, an act of health justice.

39. At a macro level the DA envisages working within the current allocations expressed as a percentage of GDP – applicable to both the public and private systems. Five steps are considered essential for the new UHC framework to work:

39.1 Mentioned earlier, the off-budget medical credits for which medical aid members are eligible will be brought on-budget. This will require the elimination of 'medical credits' in our taxation system. The loss of the credit will be offset by the fact that all citizens and legal residents will receive the national subsidy, which should be used by medical aid schemes to subsidise their members' medical aid contributions.³⁷

39.2 Resource allocation mechanisms need to be designed and implemented at the first tier of government to allocate the explicit system of subsidies. The essential pre-requisite for this step is the implementation of platforms that institutionalise on-going development and maintenance of the resource allocation mechanisms. This includes both formula-based allocations and conditional grants allocated to provincial governments.

39.3 The on-going development and maintenance of the universal health scheme, as a dynamic project in both the public and private systems, are essential. As with resource-allocation, a pre-requisite for success is to create a platform capable of meeting complex technical and institutional requirements.

39.4 The system of financial transfers required to distribute the subsidies that underwrite the universal package needs to be established together with a monitoring framework.

³⁷ 2016 Budget Review (National Treasury, 24 February 2016) p. 141. Also, 'Conversion of Medical Aid Deductions to Medical Tax Credits', (National Treasury, Chief Directorate Economic Tax Analysis, 11 October 2010).

- 39.5 The system of purchasers, both public (includes provinces, district health authorities and social insurance schemes) and private need to be harmonized and brought within a co-ordinated regulatory framework.
- 39.6 Fiscal Implications: The public sector package and its cost determine the value of the universal subsidy. This will be determined annually, with improvements tied to GDP growth and explicit opportunities to add value.
- 39.7 The private sector package, which would be consistent with the public sector package, will not be underwritten by the universal subsidy. Cost management over-and-above the value of the subsidy will be a risk transferred to the private system.
- 39.8 The efficient management of the private sector package will be achieved through regulatory design. This will seek to ensure that private purchasers and providers are able to manage the risk of excessive costs – keeping private sector package costs in line with the preferences of households.
- 39.9 The cost of regulators required to manage both the public and private systems will be funded by levies on regulated entities. Parliament will oversee the budget proposals of the regulators and any proposed levies.
- 39.10 The introduction of the universal social insurance scheme for emergency care faces a funding gap in the medium-term. This can in part be mitigated through efficiency improvements over a ten-year period. This scheme can also be introduced on a scalable basis, matching any funding gaps with efficiency improvements. We propose to add an additional R1b a year towards emergency care by way of an allocation from the medical tax credit revenue.

G: HEALTH WORKFORCE DEVELOPMENT

40. The successful implementation of the OHP requires adequate human resources for health (HRH). The myriad of HRH challenges currently faced in SA's health system appear to make this a formidable task. According to the WHO, SA falls below the threshold of one doctor per 1000 population, with only 0.78 per 1000. Even this number is skewed by inequalities, in that only approximately 41 per cent of the total number of doctors in the country work in the public sector. In

light of this, the DA will introduce a number of key initiatives to address these HRH challenges in carrying out its OHP strategy, including:

- 40.1 *Accurately forecasting HRH needs:* our country's HRH needs mapping in great detail. While it is recognized that the National Department of Health has been undertaking a Workload Indicators of Staffing Need (WISN) exercise, an update of the *HRH Strategy for the Health Sector* is urgently required. Specifically, HRH forecasting needs to be reviewed using more robust modelling, as this will allow for far better planning to meet future HRH needs, at national, provincial and district levels.
- 40.2 *Auditing current health training:* HRH analysis needs complementing with an exhaustive audit of the current state of health professional training. This will include an assessment of the actual benefits of the many medical school curricula reforms in recent years, as well as a detailed report on the training deficiencies in nursing education institutions (NEIs) and emergency care training institutions. Furthermore, we will assess the training needs related to increasing the output of allied and mid-level health workers, such as clinical associates, as their role in filling the HRH gap could be of particular value.
- 40.3 *Establishing regional health training zones:* academic health complexes, NEIs and emergency care training institutions must be incorporated into distinct zones within each province. Investing in the development of all training institutions within these zones can then be done on a rational and equitable basis, guided by the HRH forecasting and health training audit. By including academic health complexes, which have both training and service components,⁴ there will be far greater scope for increasing teaching and research capacity – resulting, for example, from an increased throughput of specialists and PhD graduates. This, together with infrastructure development (such as expanding the size and number of adequately-equipped medical school facilities) will bolster both the quantity and quality of HRH output.
- 40.4 *Effectively using public-private partnerships (PPPs) around HRH:* much better use should be made of PPPs than the current national government in at least two crucial ways. Firstly, we will aim to leverage the substantial

resources largely locked within the private sector to the benefit of many more citizens. For example, while private finance initiatives for large-scale capital projects (e.g. the construction of more teaching hospitals) come with many challenges, with proper planning they could be managed in a manner that ensures that there is actual value for money for the public. Secondly, PPPs could serve as a channel for the direct provision of HRH through service level agreements that incentivize private sector-based health professionals to participate in the public sector; however, this will require a substantial review of current contracting approaches.

- 40.5 *Reforming the regulation of health professionals*: reform of the Health Professions Council of South Africa (HPCSA) should be urgently accelerated, as it plays a critical regulatory role in the provision of HRH. In November 2015, a Ministerial Task Team released a report on the HPCSA entitled 'A Case of Multi-System Failure.' The report found the Council to be in a state of severe dysfunction and recommended, amongst other actions, that it be dissolved and replaced with new Councils that could fulfil the necessary statutory mandates. These recommendations would have to be implemented in order to ensure a safe health workforce for OHP.
- 40.6 *Developing healthcare management capacity*: hospitals and clinics must be run by highly-skilled and professional managers. The WHO includes 'Leadership and Governance' as one of the building blocks on any health system. Despite this, weak leadership and management has longed been seen as one of the major reasons for weak health service delivery in our country. While the Minister of Health launched the *Academy for Leadership and Management in Healthcare* to much fanfare in early 2013, very little appears to have come of it. We will ensure that prospective managers of health institutions are grounded in academic and experiential training, and that healthcare management is rapidly established as a respected profession in its own right.
- 40.7 *Retention in rural and under-served areas*: initiatives aimed at ensuring that communities in our rural and under-served areas are provided with enough health professionals must be introduced. The poor availability of

HRH in these areas is one of the greatest drivers of inequality in our health system; correcting this is, therefore, a social justice imperative. However, we will not pursue restrictive policies that force health professionals into these areas. Instead, we will provide incentives, such as appropriate remuneration and professional development opportunities (e.g. the establishment of remote specialist training posts using telemedicine and visiting consultants for supervision) that will draw them in. Furthermore, we will provide talented young people from these communities with bursaries to medical schools and other health training institutions on the promise that they will return to serve these areas upon completion of their training. Finally, we will prioritize the revitalization of hospitals and clinics in remote areas so that they become working environments that are adequately-equipped, well-supplied and safe.

H: A LEGACY ISSUE.

41. Municipalities have a constitutional responsibility to provide sanitation, sewerage, garbage collection, rodent control, food inspections and water provision services to deal with what is known as the social determinants of health. However, many if not all municipalities, finance, maintain and build clinics, a long-standing historical practise that was changed in the 1990s when the full responsibility for clinics was handed over to provinces. It is in effect an unfunded mandate for necessary services that municipalities must *ipso facto* provide. In the case of the City of Cape Town, the provincial primary health care system is subsidised by an amount of about R488 million a year in ratepayers' money. The issue must be resolved in the best interest of the healthcare-seeking individual or patient. If the province can provide the best service it should do so paid from its budget. If the municipality provides the best service, the province should fund it as a subsidy to the municipality. This will free up considerable resources for municipalities to do what they constitutionally are required to do.

I: CONCLUSION

42. South Africa's disease profile shows that we become ill from, and die of, preventable diseases that are manageable in the PHC tier and can be treated at a

significantly lower cost than at second-tier hospitals. In the Western Cape the DA has adopted a health system approach defined by strong inter-sectoral collaboration with non-governmental health organisations, private companies (such as Clicks), pharmacists, private physiotherapists, General Practitioners or GPs and complementary medicine and allied health care practitioners. The Western Cape has embraced the prescribed 3 PHC service platform streams (1) home and community based services provided by Community Health Care Workers; (2) intermediate care; and (3) primary health clinics, community health centres and day centres. It is here that the bulk of health services should be rendered. The upscaling of this to a national level requires the acceleration of our clinic building and staffing programme. It is a travesty that the NHI PHC programme was underspent by 62% and 86% in direct and indirect conditional grant expenditures, which shows that upscaling is possible within the current resource envelope.³⁸ Additionally, we add R2 billion to an Expanded Clinic Building programme.

43. An important mismatch occurs between planning for service expansion and capital expenditure. The former should drive the latter, particularly in provinces with fast growing populations like Gauteng and the Western Cape. There has also not been any strategic planning that leverages and utilises the over-capitalisation in the private sector to the public benefit. It is important to note that the private sector has double the number of critical care beds compared to the public sector.
44. There is no compelling reason why South Africa has to wait 9-15 years, by which stage a quarter of our current population would have passed on, to have universal health coverage. If we were to eliminate the means test immediately, the institutional adjustment to which would take a year, the rest of the strategic measures outlined in this document to upscale public sector health and to reform private sector health so as to provide a free basket of healthcare services for all at the point of service, would take 5-8 years to implement.

³⁸ Over two financial years 2013/14 and 2014/15, expenditure was R392,7 million of a R1,02 billion budget in direct financing and R91,7m of R676,6m budget in the conditional grants. Managed by the national Department of Health, this represents an extraordinary inability to get a critical job done. With such a record, it is sheer folly for the NHI White Paper to assign the monumental responsibility of managing the NHI Fund to the national Health Department. It is a recipe for massive corruption and waste.

45. A higher growth economy would provide an enabling environment for OHP. Higher incomes would mean that individuals could buy more of their own healthcare and provide relief to an overburdened public healthcare sector. Higher economic growth would also mean more revenue could be spent on public health. For the rest, it would be up to individuals to take care of their health and to make sure that they do not put the health of others at risk. The decision to lead a healthy lifestyle is, in the end, an individual behavioural choice made possible by smart policies, a caring government and collaborative and inter-sectoral partnerships.

I: Revised OHP National Level Budget

Health Vote by Programme	Medium-term expenditure estimate	DA's UHC	Difference
Programmes	2017/18	2017/18	
1. Administration	516.6	516.6	-
2. Universal Health Coverage	739.7	739.7	-
3. HIV and AIDS, Tuberculosis, and Maternal and Child Health	18,432.7	20,432.7	2,000.0
4. Primary Health Care Services	286.3	2,286.3	2,000.0
5. Hospitals, Tertiary Health Services and Human Resource Development	21,072.4	23,072.4	2,000.0
6. Health Regulation and Compliance Management	1,730.4	1,730.4	-
Total	42,778.1	48,778.1	6,000.0
Medical Tax Credit	17,430.0		
Reallocation among programmes	6,000.0		
Balance	11,430.0		
Medical Aid Schemes	11,430.0		
Subsidy for Use of Public Health Facilities	2,000.0		
Subsidy to decrease Member's Medical Aid Contributions	9,430.0		

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