Comments on the White Paper: National Health Insurance for South Africa: towards Universal Health Coverage, Thursday 10 December 2015 (Version 40)

Submission made by the School of Public Health and Family Medicine (SOPH&FM), Faculty of Health Sciences, University of Cape Town.

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INTRODUCTION

Firstly, we would like to thank the National Department of Health for the opportunity to comment on the NHI White Paper 2015. We are making this submission as the School of Public Health and Family Medicine at the University of Cape Town, one of the longest-running and leading schools of public health in South Africa. Many of our staff members, through policy analysis, research and social responsiveness activities, have contributed to a number of health care reform initiatives, in partnership with government, over the past two decades, including significant contributions to the current reforms towards universal health care (UHC) for all South Africans.

There is major consensus in our School that policy reform towards Universal Health Care is essential and urgent to ensure that the 'Right to Health' of all South African citizens are realised and that all will have access to good quality health care services that are accessible and affordable. In this regard we wish to commend the Ministry of Health for placing the drive towards UHC on the policy agenda and for the many commendable initiatives taken so far in working towards this policy goal.

We have a strong shared concern with the Ministry that private sector cost escalation is completely unsustainable, untenable, and unacceptable and that this requires rapid attention in the country. We also recognise that the current health system (both public and private) needs significant reform and strengthening, to ensure among other things; equity, efficiency, accountability and satisfaction – and wish to commend the Department of Health for all efforts taken towards achieving this.

Our School has a diverse staff complement and in our submission we aim to reflect the diversity of views that include specific concerns and alternate recommendations on the various sections of the NHI White Paper as well as significant concerns and alternate process and conceptual suggestions on the direction and process of the proposed reforms.

Our submission has two sections:

- A section with general comments in which we outline the range of endorsements and concerns of the School
- A section with specific comments on the sections that appear in the NHI White paper (detailed comments, Table 1).

SECTION 1: GENERAL COMMENTS:

In this section we express two areas of key concern, followed by recommendations for each area of concern, followed by a third and final recommendations.

1. Our first key concern as the School of Public Health and Family Medicine is whether the current NHI reform proposals are indeed the best policy decision for the reform of the South African health care system towards UHC at this point in time, both conceptually and practically, and the details of our concerns are outlined below:

- A key concern expressed is the potential unintended risks of establishing an NHI, to fragile public health services as they currently exist. It has been acknowledged that establishing mature unified administration of public sector health services has been a slow and difficult process over the past 20 years. In each Province, the majority of services are delivered by a single health provider, with flexibility to rationally develop services within the public sector based on principles of equity, quality and efficiency. Transitioning public sector services to an insurance model with a purchaser-provider split may carry with it risks for public sector services. These risks include cost escalation towards the service and cost-structure of private medicine, the inability to protect against the inherent market failure of a fee for service based health care provision, the lack of management capacity to manage devolved purchasing of services, and fragmentation of service delivery with poor care co-ordination. These risks can only be mitigated by a robust regulatory environment.
- The inability to better manage efficiency, quality and co-ordination of private health care over the past 15 years is of great concern given that very similar checks and balances would be required on a much larger scale if we commit the entire health system to an insurance-based model.
- We are concerned about the power of the private sector and whether the NDoH will be able to adequately regulate the private sector and minimise possible perverse incentives of inappropriately establishing more private health care facilities to compete against currently weak public-sector facilities in securing NHI-related contracts.
- We recognise that it will require a strong and consistent core leadership and capacity within the National Department of Health to manage the large task of institutionalising such major reform as is proposed in the White paper, especially in relation to the establishment of a completely new entity such as an NHI fund and all the associated requirements. We recognise the presence of some exceptional officials in the National Department of Health, but also that they are thinly spread and that there is significant reliance on external consultants to support and drive major reform initiatives. We would therefore welcome greater detail on where and how such capacity will be generated and sustained.
- While we recognise the potential merit of a central pool of funds, we are concerned how this will affect the need for flexibility in decision making (to account for context) at the district level.
- The NHI White Paper is generally silent on the role of the provinces. While the role of Province is discussed in relation to some health services (for example NHLS and Provincial Emergency Medical Services), clarity is needed on the role of the Provincial Departments of Health. We

know that this is an evolving process as mentioned in the White Paper, but more detail could be provided now.

- There is much talk about the redistributive effects between the public and the private sectors, but very limited discussion in the White Paper on redistribution between hospitals and primary health care services.

Recommendations :

- **Deepen public debate before institutionalising an NHI as the preferred mechanism towards UHC:** Given the concerns about the possible trade-offs in establishing a new model – we appeal to the NDoH to deepen public debate on the different models - a single national insurance model versus consolidation of a federated national health system alongside better private sector regulation. Deepening public debate will ensure that different models have been fully considered and will improve public accountability, which is a necessary component in health systems development. We strongly urge the Ministry and the Department of Health to consider the release of all working group reports, so as to allow for a transparent and open process with which all civil society entities, including universities can engage and contribute meaningfully.
- **Allow for strengthening of current innovations first, before moving onto adoption and establishment of an NHI:** Recognising the significant scale of the reform envisaged in moving towards an NHI. Based on analyses and experiences of policy reform over the past 22 years and the impact this has on organisational and implementation capacity, we urge the Department of Health to allow current policy innovations to be strengthened and solidly embedded within the health system before any new innovations and policies are brought about. For example, the National Health Act of 2003 has not yet been fully implemented and the question that arises is how the Provincial and District Health System will cope with this major transition. In setting in motion the establishment of an NHI, it may be difficult, through path dependency, to turn back should this turn out to be unfeasible, impracticable and unaffordable. The focus should therefore be to consolidate the strengthening of public sector services with concomitant private sector regulation and reform that is currently on the agenda, and allow these initiatives to be properly established before moving on to the next phase of reform.
- **Tackle parallel fundamental restructuring and tighter regulation of the private sector whilst the public sector is being strengthened.** This should entail the identification of what private sector regulations are required and in developing and strengthening the regulatory environment it must include: the Office of Health Standards Compliance; medicine pricing and International Benchmarking; Health Technology Assessment; Provider Re-imbursement Policies and regulatory authority; to mention a few.
- **Take further steps in creating public ownership :** We acknowledge previous efforts made by the NDoH to spread the NHI message through a variety of mechanisms such as Road shows etc. led by the Minister. However, the future reform will be large and complex with many new decisions being made regarding the functioning of health system. We encourage the government to take further steps in ensuring that the public feels that the NHI belongs to them and to consider how ownership will be promoted so that communities are actively engaged in ensuring the success of NHI.

2. Our second key concern as a School of Public Health, given the profound impact of Social Determinants on health and health care, is that the NHI white Paper is almost entirely focused on the health system. We recognise that there is mention of intergovernmental alignment in various places in the document, but it is not clear how this alignment will speak to the Social Determinants of Health that falls within the ambit of other sectors [more is mentioned in the detailed comments]. Without adequately addressing the inter-sectoral partners in addressing population health, the NHI will fall short of its desired goal of universal health coverage. Furthermore, the consistent paradigm shift proposed in health care reform proposals over the past decades has been a shift away from hospi-centric care to community-based and primary level care- and at these levels the health issues and conditions are strongly driven by social determinants that lie outside of the immediate domain of the health sector. Policy reform must therefore be consistent in its direction and emphases and in this regard the NHI White Paper is not explicit and detailed enough on how the health sector will co-ordinate with other appropriate sectors in addressing health needs.

Recommendation:

This omission must be addressed through robust engagement with the appropriate stakeholders from other sectors and external agencies such as Schools of Public Health and that the appropriate processes and content regarding social determinants be included in the future policy process.

3. Our final general recommendation concerns the establishment of an independent evidence-based unit. Any major health care reform process can only benefit from the generation of pro-active, timely and appropriate evidence to guide policy reform and monitor and measure progress. Currently evidence to guide health care reform is piecemeal and mostly reactive. There are international models of good practice that can help to guide the functioning and structuring of such a unit.

SECTION 2: SPECIFIC COMMENTS

In this section we present the specific comments in Table 1. Comments correspond to the specific section in the White Paper and for some of the comments, suggestions for alternatives are offered.

Table 1: Detailed comments

Chapter	Comment	Suggestion
CHAPTER 6: Organisation of the health care system and services under NHI		
Chapter 6: Items 158 and	The section on Primary Health Care in the NHI White Paper is underdeveloped, particularly in	The question of whether any funding will be ring-fenced for

159	the area of prevention. Upstream interventions at the PHC level are essentially invisible in the NHI White Paper.	upstream interventions should be made clear.
Chapter 6: Items 158 & 159	There is a lack of consideration of the role of other actors in prevention (considering that prevention is much broader than health). And the role of Health in these prevention efforts should be considered.	Recognising that the SDoH are critically important, we do acknowledge that many of the actions required to improve the SDoH are outside of the ambit of the Department of Health. There is thus a need to clearly define what the role of health services *might be* specifically in this regard as the health system cannot be wholly responsible for the SDoH.
Chapter 6: Items 163 & 168	It is unclear how the district management teams (DMT) will handle efforts that currently support prevention activities, such as community health workers in the NHI White Paper.	Firstly clarity is needed on how services will be purchased from community health workers considering that as a group they are not a single entity that can be certified or accredited. Secondly clarity is needed how the DMT will then manage the provision of services of CHWs in relation to how those services are purchased (unless CHWs become staff in the public service).
Chapter 6: Item 224	The NHI White Paper is not clear on how *participation in practice* will happen. While hospital boards and committees are mentioned in the NHI White paper there is no information on '*how*' will we actively effect participation at the local level, for example in deciding on benefits (including dental, optical etc.) that patients will receive through the NHI fund. Currently such structure represents a very high level decision – unless hospital boards and health committees articulate with structures upwards throughout the system, there is no way participation will shape these decisions.	More detail and thought should go into presenting the 'how' of active participation, most notably in the context of top down decisions being made at National government level – how will the local level participate upward? In particular the mechanisms and processes by which users have a voice in major decisions affecting their health care must be outlined. Lessons could usefully be drawn from Brazil and Thailand in how they have responded to the challenge of

		institutionalising participation
CHAPTER 5: National Health Insurance Coverage		
Chapter 5: Item 122 & 123	There is serious problem in how foreign migrants are treated in the White Paper. Those with asylum approval are able to access a package of 'basic health services' (undefined) by which is clearly less generous than the package available to South Africans, despite the NHI's commitment of ***"ensuring progressive realisation of the right to health by extending coverage of health benefits to the entire population…(para 106)" and*** **to** ***using "monopsony power to strategically purchase services that will benefit the entire population."*** *(Para 320).* For asylum seekers, the range of services available to them is restricted emergency care and notifiable conditions. This is neither moral nor practical. Does this mean that clinicians will treat an asylum seeker for their TB but not their HIV? Or, the asylum seeker will be resuscitated (at far higher costs) for their stroke or keto-acidotic coma, but will not have access to treat their hypertension or diabetes. As for denying undocumented foreigners, the secondary health, political and social consequences for South Africa are immense and not worth the risk.	The NDoH needs to rethink the entire question of health care for migrants to make it more realistic, more consistent with human rights principles and more functional from a health systems perspective. If a policy proposing restrictions on access to care for refugees is to be integrated into the NHI, it should not be based on arbitrary criteria but informed by current best evidence and be consistent with Section 36 of the Constitution which provides clear guidelines for when rights may be limited for the public interest.
Chapter 5: Item 126	The notion that people must only use services closest to them or otherwise be penalised is counterintuitive. In some parts of South Africa access to and quality of services are dismal and to force people to use poorly functioning facilities will exacerbate inequity and demoralise users who will lose faith in the NHI. Charging by pass fees is not a good idea in the short to medium term while facilities are still being certified and accredited.	Clarity is needed on how equity in access to services will be ensured in rural areas while all the changes are being made in preparation for the purchasing of services. Also if facilities remain poorly functioning over the long term we do not believe that forcing people to use the closest services will serve their interest.
Chapter 5: Item 130	A concern is who will be deciding what the benefit package will consist of? There is also a need for a broader understanding of what '*participation*' entails in terms of making decisions about the benefit package.	Clarity is needed on who will be represented in the NHI Benefits Advisory Committee. Clarity is also needed on participatory processes that will be used to gather inputs from a

		variety of sources. Clarity on the composition of those that participate in these decisions and what evidence is used to arrive at the decisions regarding what to include and what not to include will also need to be availed – mechanisms for transparency in these processes need to be included in the white Paper.
CHAPTER 7		
Chapter 7: Items 310, 332,333	While the principle of alignment of benefits across compensation funds such as COIDA and ODMWA as well as the safeguarding of double dipping to acquire these benefits is understandable, we are concerned that the pooling of these funds together with the NHI funds needs to be carefully evaluated and subjected to an actuarial analysis. These funds are raised with explicit aim of providing clinical care and compensation for those individual who are permanently disabled. Occupational injuries and diseases in most cases are due to inadequate occupational health and safety measures in the workplace. This is the explicit responsibility of employers. Should contributions by employers not fully address the inherent risks in their workplace, the consequences of these actions will be externalised to the NHI and the tax payer. Furthermore, some aspects of occupational health and safety such as preventive medical surveillance of workers (a responsibility of employers) are also likely to be compromised in this curative model of the NHI that does not accommodate preventive and promotive aspects of health.	This proposal needs to be reviewed. A detailed actuarial analysis of the implications of such a proposal needs to be conducted. In the absence of such information being made available, the consolidation of these funds (outside the NHI model) is a more important priority.
Chapter 7: Items 314, 315, 316, 317, 318	We appreciate that the White paper does take account of the prospective need for restructuring intergovernmental relations, we are still however concerned about the lack of clarity on what the role of the Provincial government will be in the future in response to the NHI. We are also concerned about the capacity of the district health system to institutionalise large drastic changes.	More clarity is needed on the future role of the Provincial Government. More clarity is needed on how the District Health System will be supported for change in lieu of a fundamental shift in the role of the provincial government.

Chapter 7: Items 322 – 326	The White Paper clearly outlines the establishment and the organisation of the NHI fund at the National level, we are however concerned about where the capacity (human resources and funding) to accomplish these activities will come from at the National level.	More transparency is needed about where the capacity to manage change at the National level will come from and be maintained. National (meaning indigenous) capacity should be built rather than relying on consultants employed by development and aid agencies or large non-state actors who have no accountability to local communities.)
Chapter 8: Purchasing of health services		
Chapter 8: Item 330	In South Africa there is a lack of private primary care providers in the rural areas, which means that there may not be services from which the national government can purchase in the short term. This may limit access to the rural poor compared to access that will be enjoyed in the urban areas and in more well human resourced provinces who have a large private sector. This can exacerbate inequities in the short to medium term especially if public sector providers are not supported to achieve accreditation in the short term.	Clarity is needed on how equity in access to services will be ensured in rural areas while all the changes are being made in preparation for the purchasing of services. Resource allocation formulae could take account of rural disadvantage when allocating budgets to rural services.
Chapter 8: Item 330	As the NHI fund will purchase services from the private sector, there is potential for the creation of a lucrative gap in the market for the private sector in rural areas where private services currently do not exist, there is the risk that the foreign private sector will capture this market. The NHI White Paper currently does not make any firm statement about whether this will be allowed or not and/or how they will ensure that the private sector will not capture the market in the face of World Trade Agreements that follow Free Trade.	Clarity is needed on mechanisms that will be in place to prevent the 'capture' of the rural markets for healthcare by the foreign private sector.
Chapter 8: Item 331	There is not enough mention of how and what will be done to support the accreditation of public sector facilities. Inevitably the poorest and marginalised areas will be the last to be accredited; this could result in reduced access to services for the rural poor in the medium term.	There is a need for more clarity on the type and timeliness of the support that will be given to help public facilities attain accreditation.

Chapter 8: Item 377	While we acknowledge the detail provided on the NHI Risk and Fraud management platform in the White Paper we are concerned about how confidentiality of all patient information will be ensured when using the NHI card. This is especially the case where intermediaries handle these data. Medical Information is regarded as highly portable and highly desirable as a commercial asset for companies in the for-profit area.	Careful attention should be paid in the development of information systems to ensure they are compliant with the Protection of Personal Information Act, including its applicability to any non-South African companies contracted to manage NHI data systems. In fact, we would strongly encourage development of local capacity rather than contracting of any foreign companies for such a sensitive matter.
Chapter 9: Phased Implementation SD		
Chapter 9: Item 336	Who will get the NHI card first? Inevitably those residing in urban areas will gain access first. *There is a need to ensure that this does not exacerbate inequity in access at the beginning of implementation. It is mentioned in the White Paper that the NHI cards will be linked to the Home Affairs Smart Identification system. We are concerned about the capacity of the Department of Home Affairs in facilitating this process.	There is a need to ensure that this does not exacerbate inequity in access at the beginning of implementation. More clarity is needed on the process of distribution of NHI cards. The White Paper should indicate the capacity requirements for the Department of Home Affairs and be transparent on how this is being negotiated.
Chapter 9: Item 406	Acknowledging that the *implementation* of interventions in the NHI pilot site is not a simple process and can be long and complex, we note that there is no indication when monitoring and/or evaluation results of interventions that are taking place in pilot sites will be available. Learning from both successes and failure in the Pilot districts is key to providing implementation level evidence to guide further reforms.	To indicate in the White paper a process and/or a forum for sharing monitoring and/or evaluation results of interventions that were implemented in the NHI pilot sites. The Department should make a major effort to share and disseminate the findings, both positive and negative, emerging

		from the pilot sites. This should be an explicit part of the consultations on the NHI.
Chapter 9 general comment	We note that there are no moments for pause and reflection between the phases of implementation. This may result in movement into subsequent phases without fully reflecting on whether the prior phase has been achieved and / or whether the prior phase has resulted in unintended consequences that need to be thought through first.	The current short timelines for the phases of implementation of the NHI, in the way that they have been set, are counter-productive in such a major reform process and relates to our earlier general comments. Unless initial changes are adequately consolidated and strengthened before moving on to new initiatives, the system runs the risk of collapse due to insufficient resilience to absorb constant changes. There should be a way to ensure that certain key things have been achieved in a phase before progression to another phase. There should be clearly defined results that can be monitored and should be provided to the public for scrutiny before movement to the next phase. For example, 80% of all public hospitals should be accredited before the next phase begins. A phased approach; first get one step right and then move onto a next step rather than a massively targeted approach that is linked to yearly timelines which we know will not necessarily be achieved. There is a concern that rushing to the finish line might actually exacerbate inequities in access to services in the rural poor communities.